Hospital Inspection (Unannounced)

Princess of Wales Hospital – Maternity Services, Cwm Taf Morgannwg University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Princess of Wales Hospital within Cwm Taf Morgannwg University Health Board on 30 September, 1 and 2 October 2019. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital wards were visited during this inspection:

- Ward 12 - antenatal ward (before delivery) with a capacity of 12 beds and postnatal ward (following delivery) with a capacity of 14 beds
- Midwifery led unit - with a capacity of two delivery rooms and one birthing pool
- Labour ward - (during labour) with a capacity of six delivery rooms and one birthing pool
- Triage assessment area
- Two operating theatres.

Our team for the inspection comprised of three HIW inspectors, two clinical peer reviewers (one consultant obstetrician and one midwife) and one lay reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

[1] https://hiw.org.uk/national-review-maternity-services

2. Summary of our inspection

During this inspection, we identified a number of immediate concerns and areas for improvement. As a result, we could not be assured that patient care was always provided in a safe and effective way.

This is what we found the service did well:

- Women and their families were positive about their care and treatment
- We observed professional and kind interactions between staff and patients and we saw care provided in a dignified way
- Arrangements were in place to provide women and families with bereavement and perinatal support
- Strong midwifery leadership and good support offered to staff.

This is what we recommend the service could improve:

- Regular checking of resuscitation equipment for newborn babies and adult patients
- Mitigation of risks around baby abduction
- Review of induction of labour medication prescribing
- Storage of medicines
- Review of policies and procedures
- Some areas of patient record keeping
- Availability of health promotion information throughout the unit.

3. What we found

Background of the service

The Princess of Wales Hospital is located in Bridgend and forms part of services provided by Cwm Taf Morgannwg University Health Board. The health board was formed on the 1 April 2019 and covers the areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

The health board has a catchment area for healthcare services containing a population of approximately 450,000. Acute, intermediate, primary, community and mental health services are all provided. Services are delivered in a variety of settings, including three hospitals: Royal Glamorgan, Prince Charles and Princess of Wales Hospitals.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Women who birth within the health board have the choice of a number of birth settings. These include homebirths, a free-standing midwifery-led unit, midwife-led care at alongside midwifery units and obstetric units.

In April 2019, the health board's maternity services (based at Royal Glamorgan and Prince Charles Hospitals) were placed into special measures[2] by the Minister for Health and Social Services. This followed an independent review[3] of maternity services conducted by the Royal Colleges of Midwifery and Obstetrics and Gynaecology.

[2] https://gov.wales/cwm-taf-morgannwg-maternity-services-put-special-measures-report-identifies-serious-failings

[3] https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients were positive about their overall experience of the service and felt they had always been treated with dignity and respect.

We observed polite, friendly and supportive interactions between staff and patients. We saw care was provided in a way that upheld patient dignity.

The provision of health promotion information needed improvement to inform patients and families about staying safe and healthy.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided. A total of nine questionnaires were completed. We also spoke with 13 patients during the inspection.

Patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent (scores were detailed as nine out of ten and above). Patients and their families who we spoke with said they had a good experience in the whole of the unit. Patient comments included:

> *"Couldn't do enough to help, go above and beyond to help. If bell is rung they come immediately".*
>
> *"Doctors, nurses and anaesthetist have been wonderful. They have been absolutely fabulous. They come in and out during the night".*
>
> *"Always clean and tidy. Staff lovely, friendly".*

However, just under half of the patients who completed the questionnaire told us that a partner or someone close to them had not been able to stay with them for as long as they wanted to.

Most of the patients who completed a questionnaire agreed that midwives had talked to them about the emotional changes they may experience after giving birth and gave support to help them feed their baby by their chosen method and respected their decision. However, one patient said they felt there was not enough advice and support provided around breastfeeding.

Staying healthy

We saw limited information displayed for patients on notice boards and leaflets were not readily available to inform patients of how they can stay safe and healthy. Although the hospital was a designated no smoking zone which extended to the use of vapour/e-cigarettes, we saw little information in relation to smoking cessation throughout the unit.

There was very little health promotion information displayed in relation to breastfeeding, skin to skin advice, post-natal mental health and general advice on keeping healthy before, during and after pregnancy. However, we were told by patients and staff we spoke to that there was well established perinatal mental health support available if needed.

We saw a plaque on the wall stating the unit was UNICEF[4] baby friendly accredited in 2017. Accreditation is reviewed every three years which confirms compliance with this.

Improvement needed

The health board must ensure that health promotion is readily available throughout the unit.

Dignified care

During the course of our inspection, we witnessed many examples of staff being compassionate, kind and friendly to patients and their families. We saw staff treating patients with respect, courtesy and politeness at all times. Staff were seen to take the time to support patients when required. The majority of comments within the patient questionnaires were very positive.

[4] https://www.unicef.org.uk/babyfriendly/ - The Baby Friendly Initiative is transforming healthcare for babies, their mothers and families in the UK, as part of a wider global partnership between the World Health Organization (WHO) and Unicef.

We saw staff promoting privacy and dignity when helping patients with their personal care. We reviewed care documentation and did not find any areas of concern regarding dignified care.

There were en-suite facilities within some of the birthing and postnatal rooms which helped promote patients' comfort and dignity during their stay. Where en-suites facilities were not available, shared toilet facilities were available nearby.

There was a private feeding room for new mothers on the postnatal ward which allowed for private personal time for mothers and their babies.

The majority of the patients who completed questionnaires said they saw the same midwife in the birthing unit as they did at their antenatal appointments. The majority of the patients also told us that they were six to 12 weeks pregnant when they had their booking appointment. There were positive comments regarding the patients being offered a choice about where to have their baby with most strongly agreeing or agreeing to this taking place.

The majority of the staff we spoke to advised that they had received training in bereavement and would feel confident in accessing the correct policies to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit. We saw this provided a suitable environment for patients and families to use. If this room was in use, we were told that an unoccupied postnatal room would be made available. We were told there was a lead bereavement midwife who worked across the health board to offer support and advice during core working hours. Some staff raised concerns about the wide geographical coverage for a single lead to support all maternity sites. One member of staff highlighted that, in the absence of the bereavement lead, there is no-one to cover the role and its requirements. However we were advised and gained assurance that bereavement champions were being developed across the health board to support succession planning.

Patient information

We found that directions to the maternity unit were clearly displayed throughout the hospital. This made it easily accessible for people to locate the appropriate place to attend for care. However, we found that there was a lack of clear parking information provided for patients and visitors to the hospital.

Daily staffing details of the unit were not displayed within the unit to inform patients of who would be caring for them.

Information was predominately available in English, with limited information in Welsh. We were told there was a rolling programme in place to ensure that all

information was bi-lingual and current information was in the process of being translated.

Staff we spoke with were aware of the translation services within the health board and how they were able to access these. Welsh speaking midwives were identifiable by the Welsh speaker logo[5] on uniform or lanyard.

Improvement needed

The health board must ensure that information about staff is displayed for patients.

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire said they felt confident to ask for help or advice when assistance was required. The majority of patients also said they had been listened to by midwifery and medical staff during their stay. Most patients told us that staff had always spoken with them about their birth choices.

We saw that staff tried to maintain patient privacy throughout the unit when communicating information. However, we saw there was limited privacy within the antenatal six bed bay due to the small size and curtains, which gave no privacy when having confidential conversations. We did however notice that it was usual practice for staff to close doors of consultation rooms when providing care to protect patients' privacy and dignity.

We saw that staff within the unit met twice daily, at shift change-over time. At the handover meetings we attended, we saw there was effective communication between staff when discussing patient needs and plans, with the intention of maintaining continuity of care. Patient handover information was not seen to be actively captured or logged and there was no evidence of an attendance sheet

5 The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying the Welsh speakers on your team. If someone is wearing a badge, or lanyard, this shows that they can have a conversation in Welsh.

being consistently used. However, we were advised by the management team that handover sheets were in place and should be used daily.

Each ward had a patient safety at a glance board[6] which were found to be inconsistently updated in a timely manner. These boards should be used to clearly communicate patient safety issues and daily care requirements or plans, as well as individual support required and discharge arrangements.

Improvement needed

The health board must ensure that:

- Use of handover written information and records is improved
- The patient safety at a glance boards are consistently updated to ensure the most up-to-date information is available for all patients.

Timely care

The patients we spoke to told us that staff were very helpful and would attend to their needs in a timely manner. We were also told by staff that they would do their utmost to ensure patients were regularly checked for personal, nutritional and comfort needs. This was seen within the patient's records we reviewed. We also saw that call bells were seen to be easily accessible and answered promptly. This was also confirmed by patients.

We saw that patient observations were recorded on a recognised national chart to identify patients who may becoming unwell or developing sepsis[7]. Staff were aware of the screening tool and reporting system for sepsis, which allowed for appropriate and timely action to be taken.

[6] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

[7] Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body's own tissues and organs.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit.

We looked at a sample of patient records within the unit and found evidence that patients' personal beliefs and religious choice were captured during antenatal appointments. This was to help ensure they were upheld throughout their pregnancy, labour and postnatal care. We saw that care plans promoted people's independence based on their assessed abilities.

We found that medical and midwifery staff promoted individual care and choices for patients. Birthing partner support was also promoted. All of the birthing rooms were well equipped. One birthing room had a plumbed in birthing pool which patients could use during labour.

The use of language line was available for those patients whose first language was not English, meaning they were able to access care appropriate to their needs. We also saw that communication needs, including any need for interpreters or for the information to be made available in other languages was assessed appropriately during antenatal appointments.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes to ensure that all members of the team were informed of patient preferences.

The hospital provided a chaplaincy service and there was a hospital chapel. We were also told about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs.

Listening and learning from feedback

Information was available on the health board's website relating to the procedure for patients to follow should they have concerns they wish to raise. There was information available on the unit. We were told by the senior management team that ward managers within the unit were fully aware of the Putting Things Right

Regulations[8] and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints but they told us that they did not routinely provide patients with details of the Community Health Council (CHC)[9], who could provide advocacy and support to raise a concern about their care.

We were told that following an informal complaint, lead matrons would contact the patient offering to discuss their issues, as well as promoting the formal complaint procedure should they wish to follow this route. Staff explained that this was used as a way of addressing concerns, but also to highlight any practice issues that may need resolving. Staff told us that communication was maintained with patients and families throughout any concern received and they were given the opportunity to meet with senior members of staff to discuss their concerns further.

We spoke to the Patient Advice and Liaison Services (PALS) team based in the hospital. Their role was to ensure there was an emphasis on obtaining views on the care and services provided. The team explained that any information relating to the maternity unit was shared with the ward teams.

Staff told us that they regularly seek patient feedback through feedback cards or questionnaires one of which is the 'have your say' comments card which is given to all women following birth. These are acted upon by the senior management team and shared with staff during lessons learnt meetings and appraisals.

Improvement needed

The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

[8] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

[9] http://www.wales.nhs.uk/sitesplus/899/home

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We identified twelve immediate concerns during the course of the inspection. As a result, we were not assured that patient care could always be provided in a safe and effective way. This is because we identified issues regarding the checks of resuscitation equipment, secure storage of medication, mitigation of baby abduction risks within the unit, obstructions to the fire exit and intensive care unit, security of patient records and concerns regarding induction of labour medication prescribing.

We also identified areas for improvement regarding infection prevention and control.

We did however, identify some good processes in place within the unit, such as clinical incidents management.

We found patient safety was promoted in daily care planning and this was reinforced within the patient records we reviewed.

The service adhered to appropriate arrangements for safeguarding procedures, including the provision of training.

We saw that breastfeeding support and provision within the unit needed to be reviewed.

Safe care

Managing risk and promoting health and safety

The unit appeared to be clean, appropriately lit and well ventilated. We found most areas to be clutter free and well organised. However on ward 12 we saw cardboard boxes stored on corridors which posed a risk of trips and falls. In addition we saw a fire extinguisher that was stood unsupported on the floor on entrance to the main corridor leading to ward 12. This was as a result of the

cradle bracket not being adequately fixed to the wall. These issues were escalated to the Matron of the unit and rectified immediately.

We observed utility, kitchen and sluice doors wedged open throughout the unit. There were medication cupboards left unlocked during the first day of the inspection and patient record storage cabinets were found to be open and unlocked throughout the time of the inspection. It was felt that this could pose a potential risk to both the safety of patients and also a risk to appropriate safe storage of patient identifiable information. This was raised at the time of the inspection and where possible, these were rectified immediately. We have included further details around patient information under the section on Information Governance and Communications Technology.

During the inspection, we noted that the link corridor to the Intensive Care Unit (ICU) and the fire exit route within the delivery suite were blocked by beds and wheelchairs. This meant that in the event of an emergency, such as a fire, there were risks preventing safe evacuation. A completed risk assessment had been carried out in relation to emergency transfer of patients to ICU from the delivery unit, however, this did not provide assurance for safe and effective evacuation.

The inspection team considered the security of new born babies on both the delivery suite and Ward 12. Insufficient security measures were in place to ensure that babies were safe and fully protected at all times. The service used a cot security alarm system which was activated by a key mechanism (for the mother or midwife). When switched on, if a baby was lifted from the cot, an alarm would activate. However, although closed circuit television cameras where in place, the exitswere not always monitored, on both the delivery unit and Ward 12, and allowed patients and visitors to easily exit at any time. There was a high risk that a cot (with baby) could be removed from the unit/ward, or a baby carried out of the unit by a mother or visitor, if the cot alarm was not key activated. This therefore presents an immediate risk to the safety and security of new-born babies within the unit.

We were advised that an abduction drill had taken place earlier in the year, however, assurance was not gained that the issues the inspection team identified, had been considered then, previously, or since.

Our concerns regarding these were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

We looked at the arrangements within the unit for accessing medical assistance in the event of a patient emergency. We found that all rooms had access to an

emergency buzzer and call bells. We found the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate equipment, including a defibrillator. The emergency drugs were also stored on the resuscitation emergency trolley, however, we could not be assured that regular stock, and the date and maintenance checks were taking place on this equipment.

The immediate concerns highlighted above were dealt with under our immediate assurance process. This meant that we wrote to the service immediately following the inspection, requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided within Appendix B.

There were emergency evacuation nets seen within the unit. However, these were not stored within close vicinity of the birthing pool. We were assured that all staff had received appropriate training in their appropriate use in the case of emergency.

Improvement needed

The health board must ensure that organisation of utility rooms within the unit is maintained to high standards.

Falls prevention

We saw there was a risk assessment in place for patients within the unit as well as those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

As previously mentioned, we did see various trip hazards througout the unit such as empty boxes within corridors and tape on floors where substantial damage was being covered.

Infection prevention and control

We found that the clinical areas of the unit were generally clean and tidy, however, the furnishings and fittings throughout the unit were generally in a poor state of repair. We saw many areas within the unit where tape had been used on the floor to cover breaks in the floor surface. This posed significant risk to

standards of infection prevention and control and was escalated to the senior management team during the inspection.

We observed some, but not all staff, adhering to the standards of being Bare Below the Elbow[10] and also saw good hand hygiene techniques. We found hand washing and drying facilities were available, however, we did not see posters displayed promoting the correct hand washing procedure to follow as a visual prompt for staff. Alcohol sanitiser gels were available throughout the unit. We saw that personal protective equipment was available in all areas and was being used by all healthcare professionals.

We were told that an infection control audit had been carried out by the health board recently and we were shown the results of this. Compliance was seen to be good and any improvements identified were dealt with in a timely manner. We found that cleaning schedules for the unit were in place and consistently completed by midwifery staff. We also saw designated labels on equipment to signify that it was clean and ready for use.

The inspection team considered the Infection Prevention and Control (IPC) measures in place within the theatres situated on the delivery suite, and had concerns with the environment. Large amounts of tape were in place on the floor between the anaesthetic room and operating theatre, which would allow for the accumulation of dust and debris thus harbouring bacteria. We saw the floor was not sealed to the edges, with a loose gap between the floor and skirting, which would prevent adequate clean thus harbouring dust, debris and bacteria. An IPC audit had taken place in June 2019, which highlighted that the standards for IPC were not adhered to in relation to the environment, in particular, the floor and walls. We found the double doors to the theatres and the corridor were left wide open, with an instrument tray visible on the trolley, with its outer sterile packaging unwrapped, whilst waiting for a patient. Furthermore, access to the theatres was not secure from potential wandering visitors or patients.

Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in

[10] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

Appendix B. We saw compliance with infection prevention and control training and staff explained that any concerns raised regarding infection prevention and control would be escalated to senior members of staff.

Some side rooms within the unit were available for patients use, should there be a requirement to reduce the risk of infection and help prevent infections being transferred to other patients.

We were told that the birthing pool was cleaned daily and regular water testing takes place as guidance states. However, we saw that there were a number of stains within the birth pool, which may be mistaken for not being clean.

Whilst we found the general cleaning of the unit was adequate, we noted in some areas within the unit where the cleaning schedule had not been completed by the domestic cleaners.

Improvement needed

The health board must ensure that:

- A review of bare below the elbow is carried out
- Hand washing posters are to be displayed
- Explore options for the removal of stains within the birthing pool
- All cleaning schedules are appropriately completed.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met throughout the day and night.

Within the unit there were facilities available to purchase drinks if required. We saw patients being offered hot and cold drinks and water jugs were within easy reach. Staff on the unit had access to facilities to make toast and drinks for patients outside of core hours. Patients also told us that the food and drinks available were to a good standard. However, we were told by patients that there was limited choice of food options for patients with diabetes.

In the patient care records we reviewed, we found that patient nutritional requirements were well documented.

Improvement needed

The health board must ensure that nutritional choices are reviewed to accommodate all patients within the unit.

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. There were daily checks of the fridge temperature at which medication was stored, however, we were not assured that escalation was taking place of temperature discrepancies.

The inspection team considered the arrangements for the safe storage of medications throughout the unit and found there were a number of areas where medication was not being securely stored to prevent unauthorised access and to uphold patient safety. We found that there was no door in situ to the medication room on the delivery suite. Prescription fluids such as Intravenous (IV) potassium chloride and normal saline were visible and easily accessible on shelves on direct entry to the room, and opposite the entrance. In addition, within this room the medication fridge was also unlocked.

We noted large quantities of vitamin K and lignocaine ampoules were stored within unlocked and accessible trollies on the delivery suite, and also alongside these, were syringes and needles.

It was of additional concern to find that the issue in relation to the IV fluids in the medication room was raised with senior staff upon our initial arrival to the unit, and were still present on the final day of the inspection.

The inspection team reviewed the process in relation to induction of labour, and found that the doctors were prescribing both PROPESS and Prostaglandins (hormones used in induction of labour to open cervix), with no indication or instruction of the administration requirements. We were advised by staff that it was presumed that the midwife caring for the labouring woman, would know when to use which medication, however, the inspection team felt that this was unsafe practice, due to the risk of incorrect or inappropriate administration.

Our concerns regarding these were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

We looked at a sample of medication records and saw the majority had been completed appropriately, however, we found there to be gaps in prescriptions being consistently signed and dated when prescribed and administered. The health board medicines management policy was available electronically and also stored in a file within the unit areas. Staff confirmed that they knew where to locate this when required.

Pharmacy support was available to the unit and an out-of-hours computerised process was available for staff to check stock and availability of drugs across the hospital during these times, to ensure there were no delays in patients receiving medication. The unit also had access to a stock of take home medication, allowing patients to be discharged in a timely manner.

Improvement needed

The health board must ensure that regular audits of prescription charts take place.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be at risk. Safeguarding training was mandatory, and all staff we spoke with confirmed they had received training within the past 12 months.

There was an appointed lead safeguarding midwife for the health board who would provide support and training to staff. We were told that safeguarding training included guidance regarding female genital mutilation, domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. Formal safeguarding supervision had been recently introduced, and was mandatory for staff to attend two sessions per year. The health board recently started to roll-out the process to community based midwives, with the intention of expanding this across the rest of the service over the year.

There were appropriate procedures in place to alert staff to safeguarding concerns with regards to patients being admitted onto the unit, to ensure care and treatment was provided in an appropriate way, however upon review, there appeared to be incompatibility and non-availability of notes from other health boards providing antenatal care when delivery is at a different hospital. We were

however told that it is the responsibility of the transferring health board to communicate concerns to the receiving health board.

Improvement needed

The health board must ensure that safeguarding assessments are reviewed.

Medical devices, equipment and diagnostic systems

We considered the arrangements for the checking of resuscitation equipment within the unit. We found the checks on the neo-natal resuscitaire[11] throughout the unit and emergency resuscitation trolley checking on ward 12 to be inconsistently recorded, and did not demonstrate that they had been carried out on a daily basis.

Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

An additional recommendation is made within the Quality of Management and Leadership section of this report, with regards to the oversight of the day to day checking of equipment.

We found that regular checks of other pieces of equipment, such as blood pressure machines, had been carried out in a consistent and regular manner.

Effective care

Safe and clinically effective care

During our inspection, based on our immediate concerns identified, we were not assured that patient care could always be provided in a safe and effective way.

[11] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

As described above, this was because of inadequate checks on emergency equipment. Prescribing the induction of labour medication was open to variation in interpretation. Personal information also not always protected. We also found there was insufficient management oversight of ward activities, to ensure essential processes and procedures were being followed to support the delivery of safe and effective care. It was however, positive to find that staff reacted quickly and promptly to address the issues we raised.

We were told by staff and confirmed by patients within the birthing unit that patients would always be kept comfortable and well cared for. Pain relief would be available to patients during labour.

We observed staff effectively prioritising clinical need and patient care within the unit, and from the patient records reviewed, it was evident that clinical need prioritisation was at the forefront in care planning.

Although we saw that a breastfeeding coordinator was appointed, staff told us that the substantial workload meant that visibility on the unit to promote breastfeeding was greatly reduced.

Staff who we spoke with told us that they were happy with the quality of care they were able to give to their patients.

We saw that patients within the unit appeared comfortable and well cared for. We also saw good evidence of medical assessment and treatment plans throughout the patient records reviewed.

Improvement needed

The health board must ensure that breasting feeding support is reviewed and that visibility is increased throughout the unit.

Quality improvement, research and innovation

A lead clinical research and improvement midwife was in place, who covered maternity services across the health board. We were told that projects to support

education in GAP and GROW[12], epilepsy in patients, and the full review of documentation and creation of care pathways across the unit had been recent projects completed. We were advised that there was to be further work to appoint innovation champion midwives across the service, who would be encouraged to get involved and support the wider team in innovation and research projects.

The health board maternity practice development midwife was seen to carry out continued promotion of Practical Obstetric and Multi-Professional Training (PROMPT)[13], which had been successfully implemented within the maternity services across the health board.

The unit was an early adopter of the quality improvement initiative for the management of postpartum haemorrhage (Obstetric All Wales Strategy), with evidence in the health records reviewed by the inspection team of continued implementation of strategy recommendations.

Information governance and communications technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and General Data Protection Regulations 2018 within the unit. We found within the delivery unit, that patient information was not being securely managed or stored, to prevent unauthorised access, and to uphold patient confidentiality. This included cupboards containing multiple patient records that were unlocked and with the doors wide open, a birthing register was left out on a desk and patient identifiable information was seen within a patient information stacker. These were all located within a patient/visitors assessable corridor.

It was of concern to find that this issue, raised upon our initial arrival to the unit, was still seen to be unresolved on the final day of the inspection.

[12] GAP – Growth assessment protocol - GROW – Gestation related optimal weight (A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[13] PROMPT - Practical Obstetric and Multi-Professional Training. Its importance is to train teams to be teams within their working environment.

Our concerns regarding these were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures. However, a lot of these were found to be out of date and requiring review. We found that the unit was using a maternity dashboard. This is an electronic tool to monitor the clinical performance and governance of their services. This also helps to identify patient safety issues so that timely and appropriate action can be taken to ensure high quality care. We were told that all staff within the unit had their own computer access login ensuring information governance was maintained.

We were however, told by staff that there was no access to the clinical portal which is where testing results are located. This was felt to have a detrimental effect on care given, delay in care planning and delays in efficiently discharging.

Improvement needed

The health board must ensure that:

- Policies and procedures are reviewed and updated within appropriate timescales
- Access to clinical portal is reviewed.

Record keeping

Overall, we found the standard of record keeping to be adequate with care plans well documented between multidisciplinary teams. However, some patient records we reviewed were disorganised and difficult to navigate. We saw appropriate observations charts and care pathway bundles being used. However, whilst we saw that preventative measures had been put in place to prevent Venous Thromboembolism (VTE)[14] for patients on the on the unit, risk assessments had not been documented to support the reason why.

[14] https://www.nice.org.uk/guidance/ng89/chapter/Recommendations#risk-assessment

We also saw inconsistencies across the medical health records reviewed with gaps in areas such as signature and General Medical Council registration number documentation.

Improvement needed

The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping. Including being able to identify all clinical carers with printed names and GMC numbers.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Specialist midwives were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

Staff reported that there was good multidisciplinary team working and we saw evidence to support this.

We found evidence of good leadership and management amongst midwifery and medical teams within the unit. Unit staff who completed questionnaires, and those we spoke with, were positive regarding the support they received from senior staff.

However, we saw inconsistency in training compliance of healthcare professionals across the unit.

Governance, leadership and accountability

We saw the service held a number of regular meetings to improve services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, monthly audit review meeting and obstetric clinical review of incident meeting. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums, and a weekly multidisciplinary meeting.

We found that there was audit activity taking place which was being monitored and presented in appropriate quality, safety and risk meetings and forums. However, we found from speaking with staff, that the audit process required improvement in relation to follow on work from audit results, with more work required to strengthen the assurance in this area.

As previously discussed, a monthly maternity dashboard was produced, which included information in relation to the whole health board, but broken down to each hospital. This provided information with regards to the clinical activity, induction of labour, and clinical indicators and incidents. The dashboard was rated red, amber and green depending upon the level of risk associated with the numbers and figures.

In addition, the senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)[15] and Each Baby Counts[16] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies, such as MBRRACE, and ongoing work takes place to ensure the unit is in line with the recommendations made.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were never dealt with in a punitive manner. However, we were told by staff that not all senior staff have access to Datix to review the incidents raised.

Monthly risk and governance meetings are held across all three sites of the health board where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. The lead governance midwife presented themes and trends to this meeting, with the view of highlighting any areas of practice, which were in need of addressing across the heath board.

[15] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.

[16] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

However, the views of staff we spoke with highlighted there were inconsistencies in lessons learnt sharing across teams. We did however see evidence of an informative monthly newsletter which was seen to be a good means to provide positive feedback to staff, and to highlight where good practice had been evident.

We were assured that the internal risk register was monitored and acted upon when required.

Daily leadership within the unit was advised by staff to be very good. However, staff advised us that they would like to see further empowerment in daily management tasks, and that they felt this would be possible with appropriate leadership support. This would enable senior managers to reduce strain in their daily work activities.

We saw good work carried out by the consultant midwife to achieve expert practice, such as development in user engagement, strategic service development and creation of many training initiatives to increase learning and development.

Staff we spoke with told us that they felt the merger of Princess of Wales into Cwm Taf Morgannwg University Health Board, which took place in April this year, did not have a negative impact on the care they were able to give. However, some staff raised concerns that the senior managers, who had supported the unit, had been moved to support maternity services in another site within the health board. Staff felt this move was unsettling and would negatively impact the morale and efficiency of the unit due to a lack of senior manager support. We were also told by staff we spoke with that although the site management was excellent and very supportive, staff felt less supported by the Cwm Taf Morgannwg University Health Board overall.

Improvement needed

The health board must ensure that:

- Learning from audits is reviewed
- Access to Datix incidents for senior staff is reviewed
- Consideration is given to how staff can be effectively supported and informed during service changes/improvements.

Staff and resources

Workforce

We were told by all staff we spoke with that the leadership and support, be it personally or in a work perspective, is excellent. Strong team working was seen to be encouraged by all senior managers and staff confirmed this in the positive feedback received in face to face interviews and via the 18 completed staff questionnaires we received. We were told by many staff that they considered their working environment to be very close and they were happy to work within Princess of Wales. Some of the completed questionnaire comments included the following:

> *"Previously I would have responded much differently, however, over the past twelve months especially I feel much more positive with support provided in this area".*

> *"Very supportive manager during long term sickness I had. Effective phased return plan in place".*

We were told by senior managers that midwifery rotas were well managed within the unit. If there were any shortages of staff cover, we were told that community midwives would be called in. Senior managers would also step in to cover when required. However, some of the staff we spoke with told us that there were regularly issues with medical and midwifery staffing coverage. We were told that there isf long term sickness and vacancies, although these appeared to be managed well. We saw there were escalation processes in place for use in times of staff shortage, and all staff we spoke with were aware of how to locate the policy and how to escalate issues.

Following conversations regarding temporary staffing, we were not assured that the working time directive[17] was effectively being monitored, where staff were working above and beyond their core working hours.

We saw evidence of a robust induction programme in place for midwifery staff, and staff advised that these were found to be of benefit when commencing in

[17] A law in which staff are not allowed to work more than 48 hours in a working week to maintain staff safety and wellbeing.

role. However, induction packs were not available for new medical staff, although we saw that ongoing training and mentorship for medical staff was in place. Medical staff we spoke with confirmed that the training, support and guidance was of a very high standard. This was also seen to be the case within other staff interviews conducted.

We found that there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training, such as health and safety, fire safety, infection prevention and safeguarding, was predominately completed on-line, and was monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire, to ensure re-training is completed within appropriate timescales. However, upon reviewing training records and speaking with staff, we saw training in Cardiotocography (CTG)[18] was inconsistent and had a poor compliance rate.

We identified that midwives working within the obstetric theatres (as either scrub or recovery midwives), had not received comprehensive training in line with national guidance, and did not have evidence of completed competencies to reflect appropriate training and individual competence. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

The service holds three mandatory maternity related study days across the year. One of the days is PROMPT training, which is a multidisciplinary training event, used to encourage multidisciplinary working in emergency situations. All staff we spoke with said they attend this training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that regular training was taking place. This was also confirmed in the staff questionnaires received.

The health board had a lead midwife for practice education/ practice facilitation, and part of their role was to monitor compliance with training across the year.

[18] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

Staff are required to book themselves onto the relevant training days and attendance is reported to the senior teams.

Clinical supervisors for midwives were in place across the health board. Their roles were to provide support and professional supervision to midwifery staff. There is a national target[19] to make sure that supervisors meet with midwives for four hours each year. The health board monitor compliance with this target during the previous financial year and were continuing this on an ongoing basis.

Staff we spoke with told us that they have regular appraisals and they see them as positive meetings to increase continuous professional development, which was confirmed in the compliance data seen.

We found that there was a good level of support in place from the specialist lead midwives who were knowledgeable about their specialist roles. These leads provide support and guidance through study days, supervision sessions and meetings with staff as and when required.We were told there are nursery nurses employed within the postnatal ward and we also saw that maternity support workers were encouraged to develop their skills to the next level in qualification. This would mean more support could be given to the midwives and new mothers in areas, such as breastfeeding, bathing and general care needs.

Improvement needed

The health board must ensure that:

- The medical and midwifery staffing is reviewed to ensure safe staffing is met
- CTG training compliance is improved.

[19] https://gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

Service: Princess of Wales

Area: Maternity services

Date of Inspection: 30 September – 2 October 2019

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
N/A			

Appendix B – Immediate improvement plan

Service: Cwm Taf Morgannwg University Health Board

Area: Maternity Services Unit - Princess of Wales Hospital

Date of inspection: 30 September – 2 October 2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take to: Ensure that checks of the neo-natal resuscitaires and emergency resuscitation equipment is carried out on a daily basis and in line with their policy. Ensure that checklist for the mobile neo-natal resuscitaire units are stored appropriately with the equipment at all times.	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment and Diagnostic Systems	Communication set out to staff reminding them of the requirement to ensure safety checks of equipment on labour ward and Ward 12. Labour ward coordinators to check this at the start of each handover to ensure compliance with the requirement. Following team discussions it has been agreed that the resuscitaires will be permanently numbered so that staff are signing the daily checking sheet for each resuscitaire they have inspected and assessed. Concern was raised that the checklists could be damaged or misplaced if attached to equipment and it was agreed that numbering each resuscitaire would be a safer and more effective process.	Midwifery Matron Midwifery Matron Labour Ward Coordinators Midwifery Matron Labour Ward Coordinators	Completed 01.10.2019 Completed 01.10.2019 Completed 01.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action it will take to ensure that: Medication is stored safely and securely at all times.	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	Vitamin K has been removed from the baby trolley and is locked in a secure cupboard in the treatment room. Staff have been reminded about the importance of safe storage of medications. Lidocaine ampoules have been removed from unlocked drawers and are stored in a locked cupboard in the treatment room. Clean Utility Room - The treatment room does not have a door to secure the room. The IV fluids save been removed and stored in a secured location. Estates have been to assess fitting a door to this room. This is now in process but also requires a fire inspection due to heating and ventilation (potential fire hazard) of the room and this has been logged for urgent action. The inspection has been arranged 10.10.2019. Once the report from the fire inspection team has been received and the room is assessed as safe with no fire hazards identified the door will be fitted and the ceiling will be replaced with a 6 - 8 week lead time for completion. We have been advised that	Midwifery Matron Labour Ward Coordinators Midwifery Matron Deputy Head of Midwifery POW Hospital General Manager	Completed 01.10.2019 Completed 01.10.2019 Completed 02.10.2019 Commenced 03.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the ceiling will need replacing before a door can be fitted. 22/10/19 update The fire inspection has been undertaken and the report findings advise on the next steps for completing the installation of the fire door. This is expected to be completed within 6 weeks The fridge in the treatment room has been locked. The labour ward coordinators have communicated through safety briefings that this must be locked at all times. Ad hoc checks will be carried out by the Midwifery Matron for compliance. To date 5 checks have been carried with no breaches identified. Any breaches will be DATIX'd. 22/10/19 update The Deputy Head of Midwifery has now undertaken an additional 3 spot checks and on each occasion the fridge has been locked – all staff have been advised of the requirement. The senior midwives will continue to monitor this through the assurance audits.	Midwifery Matron Labour	Completed 01.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
			Ward Coordinators	
The health board is required to provide HIW with details of the action it will take to ensure that: A new assessment is carried out on the delivery unit, to ensure that safe and effective evacuation is always possible in the event of an emergency, such as a fire.	2.1 Managing Risk and Promoting Health and Safety	Fire Officer asked to undertake a fire risk assessment on labour ward 10.10.2019 with ward staff. Staff asked to keep this corridor clear in order to undertake emergency evacuation. No other space on labour ward is available to store delivery beds when women require ward beds for prolonged labour ward stays. The Health Board is reviewing the current environment to ensure that all fire regulations are met. 20/10/19 update The fire assessment has been completed – attempts have been made to locate any labour ward beds not in the birthing rooms on the antenatal ward – however this is not practical due to manual handling issues	Midwifery Matron Midwifery Matron Estates Manager General Hospital Manager Chief Operating Officer	Completed 10/10/19 Completed 08.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		with the beds. The plan now is to store the unused beds second theatre (which is rarely required). A fire drill is being organised to test the evacuation of the labour ward with when there is a requirement for a bed to be left in corridor. The maternity services will complete a risk assessment of this action and add to the risk register.	Matron Head of Midwifery	Nov 19 25.10.2019
The health board must provide HIW with details of the action it will take to ensure that: There are appropriate systems in place, which maintains patient confidentiality, and prevents unauthorised access to patient records at all times.	3.5 Record Keeping	Push pads locks have been fitted to all cupboards containing women's records and also the labour ward office. The lock on the records trolley on Ward 12 has been repaired 20/10/19 update The requirements to lock both the cupboard and the notes trolley has been communicated to the staff via communication tool and at handovers. The Deputy Head of Midwifery has now undertaken an additional 3 spot checks and on each occasion the	Midwifery Matron Ward Manager	Completed 04.10.2019 Completed 04.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		doors and the notes trolley have been locked. This will continue to be monitored via the assurance audits		
The health board is required to provide HIW with details of the action it will take to ensure that: Further assessment and repair / replacement of the theatre floor is carried out within the Theatres, to ensure infection prevention and control measure are maintained at all times.	2.1 Managing Risk and Promoting Health and Safety 2.4 Infection Prevention and Control (IPC) and Decontamination	Infection Control Team (IPC) asked to provide inspection of the issues identified in theatres. Repair of taped area of floor and replacement skirting's inspection meeting with contractor on 04.10.2019. IPC team have completed an inspection of the theatre floor, this has been passed as fit for IPC measures. The theatre skirts have been inspected and have been advised these should be replaced. Estates have been contacted to book this to be completed urgently, date yet to be confirmed Update 20.10.2019 The repair works have been booked and estates are liaising with labour to plan the availability of the theatres – this is being coordinated with main theatre availability – it is anticipated this will be completed by 31.10.19	Midwifery Matron POW Hospital General Manager IPC Team Estates Manager	Completed 03.10.2019 Order raised 07.10.2019 Email received from the IPC Team and forwarded to the Estates manager for urgent action 09.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take to ensure that: All midwifery staff who work within the theatres in both the role of scrub and recovery midwife, are appropriately trained in line with national guidance, and competencies are completed and are stored appropriately for review, and training updates are provided where applicable.	2.1 Managing Risk and Promoting Health and Safety 3.1 Safe and Clinically Effective Care	Main Theatres, Theatre Specialist Trainer is undertaking competency assessment for the 3 core elective scrub midwives. These assessments commenced on 04.10.2019. This team will then continue the competency assessments of all other scrub midwives based on the competencies used in main theatres. The core scrub midwifery team have been requested to provide timescales to bring all staff training and compliance up to date by December 2019. The Theatre Specialist Trainer has completed assessments of 2 of the 3 core elective scrub midwives and have been assessed as competent. The third midwife is scheduled for assessment on her return from leave next week. Core competencies are being developed with support from the Theatre Specialist Trainer and will form an annual assessment of staff. Update 22.09.2019	Midwifery Matron Deputy Head of Midwifery Theatre Specialist Trainer	Commenced 04.10.2019 Completed 2 of 3 09.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		The competency assessment programme used by the main theatre training lead is the 'National Safety Standards for Invasive Procedures'. (WG 2016) Ongoing training is planned to ensure all midwifery staff providing scrub role in obstetric theatre undergo assessment – this will be completed by December 2019.	Midwifery Theatre Lead Midwife Midwifery Theatre lead	Commenced 09.10.2019 31.12.2019
The health board must provide HIW with details of the action it will take to ensure that: The prescription of induction medication is reviewed, to minimise the risk of administration errors.	3.1 Safe and Clinically Effective Care	Communication sent out to all staff via the safety brief regarding the planned admission of women for induction of labour. Medication charts charted in advance of admission with Propess and Prostin. Guidelines states give "either or" based on the Bishop Score on admission. Medication charts to clearly state Propess or Prostin and a new sticker has been developed and placed on the front of the medication chart in the comments section indicating administration of Propess or Prostin based on Bishop Score. This was developed with the maternity staff.	Deputy Head of Midwifery Deputy Head of Midwifery	Completed 02.10.2019 Completed 02.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A risk assessment has also been carried out for Prince Charles Hospital and a make safe process has been completed for this site. Update 24.10.2019 Confirmation of the appropriateness of the sticker for the drug chart has been gained from the lead pharmacist.	Deputy Head of Midwifery	Completed 08.10.2019
The health board is required to provide HIW with details of the action it will take to ensure that: Measures have been put in place, to ensure that babies are safe and secure across its maternity services to prevent baby abductions.	2.1 Managing Risk and Promoting Health and Safety 2.7 Safeguarding Children and Safeguarding Adults at Risk	Risk assessment carried out to ensure make safe to support security of the new born added to the Risk Register. Cardiff and Vale Postnatal Ward contacted for advice on their security system. Company contacted to provide a quote for this system. Pre-planned blind (unknown to staff) abduction drills to be undertaken on a six monthly basis. Staff have been advised of the need to ensure the desk area on Ward 12 and the Labour ward is staffed at all times.	Deputy Head of Midwifery Midwifery Matron Midwifery Matron	Completed 03.10.2019 Completed 04.10.2019

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		IT available in the delivery rooms on labour ward so staff remain with the family during their period of care on labour ward. Prince Charles Hospital operate the X-Tag security system as is in place in Cardiff and Vale UHB Update 22.10.2019 Safety of the new-born and the risk of baby abduction is fully acknowledged by all staff and is included in the staff. The service does not have 24 hour ward reception and out of hours clinical staff base themselves at the main ward desk to be able to observe activity into and out of the ward. Women & families are risk assessed during pregnancy in relation to parenting concerns and families at high risk and involved with social services all have pre-birth plans which are communicated to the service to ensure the appropriate level of observation or supervision is provided.		To commence in October This was already in place Already in place

Service / health board Representative:

Name (print): .....Greg Dix.....

Role: ..... **.....**

Date: ....25th October 2019.....

Appendix C – Improvement plan

Service: Princess of Wales

Area: Maternity Services

Date of Inspection: 30 September – 2 October 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that health promotion is readily available throughout the unit.	1.1 Health Promotion, Protection and Improvement	The public health midwife to ensure public health messages are displayed throughout the unit.	Public Health Midwife	Completed – September 2019
The health board must ensure that information about staff is displayed for patients.	4.2 Patient Information	Staff information is now on display on the antenatal & postnatal wards	Ward sister	Completed - November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the use of handover written information and records is improved.	3.2 Communicating Effectively 3.1 Safe and Clinically Effective Care	There are handover sheets with all information recorded on them and these are filled electronically. The service will undertake a spot check of the quality of the 'handover sheets' when undertaking the assurance audits. Requirement to check when undertaking the assurance audits – has been added to the assurance audit template	Labour ward coordinator Midwifery matron & ward sister	Completed November – 2019 Completed December 2019
The health board must ensure that the patient safety at a glance boards are consistently updated to ensure the most up-to-date information is available for all patients.	3.2 Communicating Effectively 3.1 Safe and Clinically Effective Care	The unit to review the PSAG boards and ensure they are clearer for staff to complete	Ward Sister & Midwifery matron	Completed – October 1st 2019
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	6.3 Listening and Learning from Feedback	The service to circulate information to the ward areas on the role of the Community Health Council in providing support and advocacy	Womens experience midwife	Completed 11th December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board must ensure that organisation of utility rooms within the unit is maintained to high standards.	2.1 Managing Risk and Promoting Health and Safety	Ward sisters to check the clinical utility rooms as part of the daily checking process.	Ward sisters	Completed - December 12th 2019
The health board must ensure that a review of bare below the elbow is carried out.	2.4 Infection Prevention and Control (IPC) and Decontamination	The service has re-sent the CMO guidance on 'Bare Below elbows' to the clinical staff. The ward sisters and the leads for Infection Prevention & Control to ensure regular audits and challenges of poor practice take place.	Head of Midwifery Ward sisters	Completed – October 2019 Completed - December 12th 2019
The health board must ensure that hand washing posters are to be displayed.	2.4 Infection Prevention and Control (IPC) and Decontamination	The maternity services to contact the Infection Prevention & Control teams to request for the posters to display in all the clinical areas.	Midwifery matron	Completed - December 12th 2019
The health board must explore options for the removal of stains within the birthing pool.	2.4 Infection Prevention and	The service has requested support for a new birthing pool.	Consultant Midwife	Completed - October 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
	Control (IPC) and Decontamination	Funding has been approved and a pool is being ordered awaiting date for installation	Midwifery Matron	January 2020
The health board must ensure that all cleaning schedules are appropriately completed.	2.4 Infection Prevention and Control (IPC) and Decontamination	The cleaning schedules on the unit to be reviewed and monitored as part of the assurance audits.	Midwifery Matron	December 16th 2019
The health board must ensure that nutritional choices are reviewed to accommodate all patients within the unit.	2.5 Nutrition and Hydration	The service to check that nutritional choices are recorded at the time of admission. Monitoring will be via the assurance audits	Ward Sisters Midwifery Matron	December 16th 2019 December 31st 2019
The health board must ensure that regular audits of prescription charts take place.	2.6 Medicines Management	Audits of prescription charts to be undertaken via the monthly assurance audits	Midwifery Matron & ward sister	December 31st 2019
The health board must ensure that safeguarding assessments are reviewed.	2.7 Safeguarding Children and	The Safeguarding midwife has established electronic safeguarding files.	Safeguarding Midwife	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	Safeguarding Adults at Risk			
The health board must ensure that breasting feeding support is reviewed and that visibility is increased throughout the unit.	3.2 Communicating Effectively 3.1 Safe and Clinically Effective Care	The infant feeding coordinator provides annual updates to the Health care support worker and the nursery nurses based on the postnatal ward. There are nursery nurses employed on the ward over the 24 hours.	Infant feeding coordinator	March 2020
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	3.4 Information Governance and Communication Technology 3.1 Safe and Clinically Effective Care	The guidelines are being reviewed through the clinical forums. This includes ensuring the guidelines are merged since the boundary change in April 2019. The plan from the quality & safety group of the boundary change was that POW would cease using Swansea Bay guidelines by March 2020.	Chairs of the clinical forums	March 1st 2020
The health board must ensure that access to clinical portal is reviewed.	3.4 Information Governance and Communication Technology	All staff have access to clinical portal – this is given to them when they start in the Health Board. The management team will write to all staff explaining this and requesting they	All staff Deputy Head of Midwifery	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	3.1 Safe and Clinically Effective Care	contact us if they require further training in the use of the portal		Completed December 12th 2019
The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping. Including being able to identify all clinical carers with printed names and GMC numbers.	3.5 Record Keeping	The service is currently undertaking record keeping audits which will be completed by end of January 2020. Medical staff to be reminded of the requirement to include their GMC number in their documentation.	Clinical supervisors for midwives Clinical Director	January 31st 2020 Completed December 12th 2019
Quality of management and leadership				
The health board must ensure that learning from audits is reviewed.	Governance, leadership and accountability 3.1 Safe and Clinically Effective Care	The audit and research group will review how the learning from audits is shared to the wider team. This will include: • increasing the number of midwives who attend the audit/governance days • developing an audit outcome newsletter which can be circulated to staff	Consultant Midwife & Lead Obstetrician Senior Midwives Audit leads	 January 2020 January 2020

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• including learning from audits on the professional midwifery forum	Head of Midwifery	December 2019
The health board must ensure that access to Datix is reviewed.	Governance, leadership and accountability 3.4 Information Governance and Communication Technology	All staff have received training on Datix and annual updates on incident reporting will continue. Ward sister & labour ward coordinators have been booked onto training in order to review and support managing the incidents in their clinical areas	Risk Midwife & Practice Development Midwives Risk Midwife & Practice development Midwives	March 31st 2020 February 29th 2020
The health board must ensure that consideration is given to how staff can be effectively supported and informed during service changes / improvements.	Governance, leadership and accountability 3.2 Communicating Effectively	There are midwifery professional forums for staff to be updated on operational and strategic matters. Staff meetings are organised and communicated Medical staff meetings are held monthly	Head of Midwifery Midwifery Matron Clinical Director & Directorate Manager	Completed Completed September 2019 Completed September 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the medical and midwifery staffing is reviewed to ensure safe staffing is met.	7.1 Workforce	The unit has 40 hour labour ward cover and medical staffing levels to be monitored by the Directorate team. Staffing levels to be reported via the workforce dashboard and weekly to welsh Government The unit to act on the Birth Rate + assessment recommendation – report received November 2019 (POW compliant – all vacancies recruited into in October 19)	Directorate Manager & Clinical Director Head of Midwifery & Clinical Director Head of Midwifery & Matron	Completed September 2019 Completed October 2019 Completed November 2019
The health board must ensure that CTG training compliance is improved.	7.1 Workforce	The training compliance to be monitored via the training group and dashboard. The service to facilitate additional training days for medical staff to access.	Head of Midwifery & Clinical Director	March 2020 Completed December 6th 2019

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Jane Phillips

Job role: Support Head of Midwifery **Date:** 12th December 2019