Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Royal Gwent Hospital – Maternity Services, Aneurin Bevan University Health Board

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Fax: **0300 062 8387**
Website: www.hiw.org.uk

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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 Royal Gwent Hospital within Aneurin Bevan University Health Board on the 2, 3 and 4 September 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 4 - antenatal ward (before delivery) with a capacity of 16 beds
- Midwifery led unit - with a capacity of two delivery rooms, one birthing pool and four postnatal beds
- Ward 5 - postnatal ward (following delivery) with a capacity of 26 beds, four post operation beds and two high dependency beds
- Labour ward - (during labour) with a capacity of nine delivery rooms with three more rooms in development
- Triage assessment area with a capacity of three trolley bays and a waiting room
- Two operating theatres.

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives) 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

Overall, we found evidence that the service provides safe and effective care to patients. However, we identified a number of improvements to meet national guidance and the Health and Care Standards.

This is what we found the service did well:

- Women and their families were positive about the care and treatment provided during their time in the unit
- We observed professional and kind interaction between staff and patients, and care provided in a dignified way
- There was a safe and robust process inspected for medicines management
- High standard of care and communication
- Strong leadership and good support offered to staff.

This is what we recommend the service could improve:

- Regular checking of resuscitation equipment for new born babies
- Signage to the department
- Some areas of patient record keeping
- Availability of health promotion information throughout the unit
- Infection prevention measures
- Availability and choice of food for patients.

3. What we found

Background of the service

The Royal Gwent Hospital is located within Aneurin Bevan University Health Board. The health board was established on the 1 October 2009 and covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys.

The health board has a total catchment area for healthcare services containing a population of approximately 600,000. Acute, intermediate, primary and community care and mental health services are all provided. Services are delivered across a network of primary care practices, community clinics, health centres, one learning disability hospital, a number of community hospitals, mental health facilities, one local general hospital and three district general hospitals; Royal Gwent, Nevill Hall and Ysbyty Ystrad Fawr.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages around 6,000 births per year, with around 3,500 of these at the Royal Gwent Hospital.

Women who birth within the health board have the choice of four birth settings. These include homebirths, a free-standing midwife unit, midwife led care at an alongside midwife unit and an obstetric unit. The Royal Gwent Hospital comprises of an obstetric led unit together with a midwifery led unit (birthing centre).

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.

Health promotion information required improvement throughout the unit to maintain active sharing and learning regarding staying safe, healthy and well informed.

Women told us that the food they were supplied was very good, however we found availability of food needed to be reviewed.

Most patients told us they were happy with the care and support provided to them. We observed polite, friendly and supportive interactions between staff and patients.

We recommended improvements to the systems to seek feedback from patients and their families.

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 eight questionnaires were completed. We also spoke with thirteen 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 also said they had a good experience in the whole of the unit. Patient comments included:

> *"The staff were very friendly and helpful".*
>
> *"All the staff we have encountered have been fantastic and have gone above and beyond to make our stay as comfortable as possible".*
>
> *"It is lovely to build a relationship with consistent midwives. This is a really strong aspect of care here".*

"We are confident in the midwives and medical staff that look after them us".

"Midwives and the rest of the staff on the ward are amazing very kid and helpful".

Staying 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. However, we were told that the health board had recently employed three smoking cessation advisors to provide support and information to patients.

We saw a plaque on the wall stating the unit was UNICEF[2] baby friendly accredited in 2017. Accreditation is reviewed every three years which confirms compliance in this.

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. The majority of comments within the patient questionnaires were very positive.

We also 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 maintained dignity during the patient's stay. Where en-suites facilities were not available, shared toilet facilities were available nearby.

All but one of the patients who completed questionnaires said they saw the same midwife in the birthing unit as they did at their antenatal appointments. The

[2] 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.

majority of patients were six to twelve weeks pregnant when they had their booking appointment and there were mixed comments regarding the patients being offered a choice about where to have their baby. Four of the 13 questionnaires completed also highlighted that they were not asked by the midwife about how they were feeling and coping emotionally in the antenatal period.

The majority of the staff we spoke to advised that they had received bereavement training and would feel confident in accessing the correct policies and support, to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit, known as the 'butterfly room', available if required. 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 suitably available. We were told that although the unit did not have a specific bereavement lead, there is a team of six midwives who could be called upon during a 24 hour period to offer advice and support to bereaved families.

Patient information

We found that directions to the maternity unit were not clearly displayed throughout the hospital. This could make it difficult for people to locate the appropriate place to attend for care.

Visiting times were clearly displayed within the unit and staff told us that there would be flexibility around this if requested.

We found 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.

Daily staffing details of the unit were displayed on Ward 4 and 5, however this was displayed within the labour ward.

Information was predominately available in English, with limited information in Welsh. We were told there was a rolling programme was 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 also identifiable by the Welsh speaker logo[3] on uniform.

Improvement needed

The health board must ensure that:

- Signage at the hospital is reviewed to ensure it is clear for all patients and visitors
- Health promotion is readily available throughout the unit
- Information about staff is displayed for patients, including within the labour ward.

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 advise when required. The majority of patients also said they had been listened to by midwifery and medical staff during their stay. Most patients also said staff had always spoken with them about their birth choices.

We saw that staff maintained patient privacy when communicating information. We noticed 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. Midwifery and medical handovers were held separately due to midwifery and medical shifts not following the same working pattern. This raised concern regarding communication between the teams and the negative effect this could have on the patient's care. The handover meetings we were able to attend displayed effective communication in discussing patient needs and plans with the

3 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.

intention of maintaining continuity of care. Information was also captured in handover sheets, to ensure all staff were kept up-to-date with relevant patient information.

Each ward had a patient safety at a glance board[4] which was used on a daily basis by multidisciplinary teams. These boards clearly communicated patient safety issues and daily care requirements or plans, as well as individual support required and discharge arrangements.

We were also told that a Facebook Social Media page had been created to electronically communicate information to patients. There was also an internet page for the service which provided useful and relevant information for women and their families.

Improvement needed

The health board must ensure that the process of handover is reviewed.

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 also seen within the patient's records we reviewed. We also saw that call bells were seen to be easily accessible.

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

[4] 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.

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 patient's 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 also promoted people's independence based on their assessed abilities.

We found that senior 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 of the birthing rooms also had plumbed in birthing pool which patients could use during labour.

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.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit between 9.00am and 8.00pm. Staff also told us that birthing partners could stay with the patient during labour.

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

Whilst 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 limited 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[5] regulations and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints but they also told us that they did not routinely provide patients with details of the Community Health Council (CHC)[6] who could provide advocacy and support to raise a concern about their care.

Informal complaints could be referred into the service through feedback from community midwives, health visitors and social media. We were told that following an informal complaint, a consultant midwife would contact a patient offering discuss their issues, as well as promoting the formal complaint procedure should they wish to follow this route. Staff explain that this was used as a way of addressing concerns, but also with a view 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 also given the opportunity to meet with senior members of staff to discuss their concerns further.

We were told that the maternity services engage with service users through attendance at the health board patient experience group and also at the national sub-committee for maternity service user feedback (All Wales). We also saw that there was a maternity services user group known as the BABI group (Birth and Bump Improvement Group) where health professionals, birth advocates and service users meet every two months to share feedback and influence service improvements. The chair is a service user and the meeting is always attended by a consultant midwife.

We also saw that feedback is obtained on a daily basis through the maternity services social media pages, and responded to in real time.

Improvement needed

The health board must ensure that:

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

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

- Information is clearly displayed and readily available about how patients and families/carers can raise a concern about their care
- Patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

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 two 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 for new born babies and the security of patient information.

We identified areas for improvement regarding infection prevention and control.

We did however, identify some good processes in place within the unit, such as arrangements for medicines management, pain management, clinical incidents and to ensure learning is shared across the service.

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

The service described has 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

Whilst the unit appeared to be clean, appropriately lit and well ventilated, the overall environment was tired and in need of attention. We also found a number of areas where disorganised and cluttered such as utility rooms and sluice room on Ward 4 and 5.

Within the midwifery led unit, we found that one of the birthing rooms was being used inappropriately to store a mop and bucket. This was immediately escalated to the midwife in charge and was removed. We also found that the door to the

domestic store room on Ward 4 was not securely locked and we found bleach on the counter. This could pose a risk of unauthorised access to hazardous substances.

We found that an incorrect style of waste storage bin was being used throughout the unit. There was also no information displayed to advise staff on correct waste segregation.

We observed utility, kitchen and sluice doors were wedged open throughout the unit. There were also no appropriate locks sited on entrance doors to two of the medication/patient record storage rooms within the unit. 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 rectified immediately with all doors being closed and the locks which had been ordered were fitted straight away. We have included further details around patient information under the section on 'Information governance and communications technology'.

We considered the unit environment and found sufficient security measures in place to ensure that babies were safe and secure within the unit. We noted that access to the birthing unit was restricted by locked doors which were only accessible with a staff pass or by a member of staff approving entrance. We were also assured that abduction drills and fire drills regularly take place to ensure safety is maintained in an emergency.

We looked at the arrangements within the unit for accessing emergency help and 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 emergency trolley and we were assured that daily checks were being maintained on this equipment.

There were emergency evacuation nets seen within the birth pool rooms, which could be used in the event of complications during a water birth. We were also 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:

- Domestic schedule cleaning of the unit is reviewed to maintain high standards
- Waste storage bins are in line with infection prevention and control guidelines and staff are advised of appropriate waste segregation
- Organisation of utility rooms within the unit is maintained to high standards
- All cleaning equipment and supplies are stored appropriately and securely
- Doors to the medication/records room are securely closed to maintain safety.

Falls prevention

We saw there was a risk assessment in place for patients using birthing pools across the unit. 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.

Infection prevention and control

We found that the clinical areas of the unit were clean and tidy and we saw that personal protective equipment was available in all areas and was being used by all healthcare professionals.

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[7] and saw good hand hygiene techniques. We found hand

[7] 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.

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 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 up-to-date, however we did not see designated labels on equipment to signify that it was clean and ready for use.

We saw high compliance with infection prevention and control training. 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 a weekly microbiology check of the water was carried out. These checks ensured that the birthing pool was appropriately cleaned and safe to use.

We noted although there were single use straps for use with the cardiotocography[8] (CTG) equipment, we found there were previously used straps on the CTG machine. This meant there was a risk they could be re-used which would not support the minimisation of infection. We also found non-disposable fabric curtains, shower heads and shower curtains throughout the unit which posed a risk in relation to contamination.

Whilst we found the general cleaning of the unit was adequate standard, however we were told by staff that due to the limited hours of work allocated to the domestic cleaners, this had a detrimental effect on how well they could deep clean throughout the unit.

[8] A machine used to record the foetal heartbeat

Improvement needed

The health board must ensure that:

- Designated labels are used on equipment to signify it has been cleaned and is ready for use
- Consideration is made to review non-disposable items to reduce infection risks such as fabric curtains, shower heads and shower curtains
- All single use items are disposed immediately after use, including CTG straps
- Adequate arrangements are in place to ensure effective deep cleaning of the unit.

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. However, staff told us that patients admitted during the afternoon or evening would often be left with little choice of food, as meals were only ordered in the morning.

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

Improvement needed

The health board must ensure that patients have access to food options through the day and night-time.

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. There were daily checks of the temperature at which medication

was stored. We found there were suitable arrangements for the safe and secure storage and administration of controlled drugs. However, we found medications left out on worktops in one of the treatment rooms. This was escalated to the midwife in charge immediately and was rectified straight away.

We looked at a sample of medication records and saw these had been completed appropriately. They were 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.

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 medication is stored appropriately and securely at all times.

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 to 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 (FGM), 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.

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[9] to be inconsistently recorded and did not demonstrate that they had been carried out on a daily basis. It was of concern to find that this issue had been brought to the attention of the health board through HIW's maternity inspection of Nevill Hall Hospital in July 2019, with a recommendation to ensure that improvements were to be made across all wards and departments within the health board.

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 we based on our immediate concerns identified during the course of the inspection, we were not assured that patient care could always be provided in a safe and effective way. This was because of inadequate checks on emergency equipment and personal information 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

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

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, and we saw medication appropriately prescribed in postnatal care and patients receiving it promptly within the patient records we reviewed.

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 forefront in care planning.

We were also told that the unit had dedicated theatre staff coverage from the general theatres in the hospital. There were two operating theatres seen and within those, midwives we spoke with confirmed that unless they were trained to do so, they were never expected to practice as a scrub nurse.

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

Staff who we spoke to 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 innovation midwife was in place, who covered maternity services across the health board. Champion research midwives were also appointed across the service, and were encouraged to get involved in research projects to support the team. The team was involved in research

associated with local university projects to support service and patient experience development.

A large element of the teams' work involved developing service user engagement. We saw that the service had developed their social media engagement as a way of reaching out to patients. From the 8000 hits received to the Facebook page, we were told that there was only one negative comment detailed of which was addressed immediately and concerns of the patient report this were instantly elevated.

The health board led a national project, 'Your Birth – We Care[10]', a survey of women's views of maternity services across Wales. One of the outcomes of the project was that women told the survey they wanted to hear more positive birth stories. The health board collated a large number of positive birth stories from women and published them into two books and made available for patients to buy and read. Profits from the books are put back into charitable funds for the health board to help improve services for patients.

We were also shown evidence of the generic e-mail that had been established. The e-mail would be sent following on from a birth and would offer the new mother and her family support, advice and guidance.

Information governance and communications technology

We found there were a number of areas where patient information was not being securely managed or stored to uphold patient confidentiality and to prevent unauthorised access.

Patient information on Ward 4 was not being securely managed or stored, to prevent unauthorised access and to uphold patient confidentiality. This is because we found a trolley containing patient records on the postnatal ward which was unlocked and located within an open corridor. It was of concern to find that this issue had previously been brought to the attention of the health board following HIW's inspection of Nevill Hall Hospital maternity services in July 2019, with a recommendation to ensure that improvements were made across all wards and departments within the health board. Our concerns regarding this issue was

[10] https://gov.wales/sites/default/files/publications/2019-03/your-birth-we-care.pdf

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. 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 may also help to identify patient safety issues so that timely and appropriate action can be taken to ensure high quality care. We were also told that all staff within the unit had their own computer access log in ensuring information governance was maintained.

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 looked at were disorganised and difficult to navigate. We saw appropriate observations charts and care pathways bundles being used. However, whilst we saw that preventative measures had been put in place to prevent venous thromboembolism (VTE)[11] for patients on Ward 4, risk assessments had not been documented to support the reason why.

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

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.

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

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 also 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 generally positive regarding the support they received from senior staff.

We saw improvements were needed in audit compliance and learning from audit results.

We identified that there could be delays in swift and effective patient discharges due to shortages of neo-natal medical discharging staff.

Governance, leadership and accountability

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

We found there was good, overall monitoring and governance of the staffing levels of the service, and we were assured that the internal risk register was monitored and acted upon when required.

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

A monthly maternity dashboard was produced, which included information in relation to the whole health board, but also broken down to each hospital. This provided information with regards to the clinical activity, induction of labour, and also 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, MBBRACE[12] and Each Baby Counts[13] 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 MBBRACE, 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. Incident and concern investigations are shared between the senior staff who provide support, insight and guidance to each other alongside the 'Putting Things Right' Midwife and Governance Midwife. 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.

Monthly risk meetings were held at the Royal Gwent Hospital where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared

[12] 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.

[13] 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.

across maternity services across the health board to support changes to practice and learning.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife also 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. Following this meeting, a monthly feedback newsletter was produced and circulated to all staff, summarising the month's issues. We also saw that this newsletter was used to provide positive feedback to staff, and to highlight where good practice had been evident.

We understand there had previously been a gap in the daily leadership on one of the wards but this has recently been covered and staff said they felt more supported.

We also saw good work carried out by the consultant midwife regarding the induction of labour within community settings and the outpatient department. The project acknowledges that not all women are given correct information when babies are in breech position[14] and projects such as 'midwives voices' and 'your birth – we care'.

We were told by staff that there is a shortage of neo-natal check doctors which has an effect on timely discharges of mothers and their babies. We were advised that this was being reviewed by senior management with a view to resolve this.

We were told that the health board is planning to move the maternity services within The Royal Gwent Hospital into a new purpose built environment within Cwmbran. This was due to take place in the year 2021. In general, staff said this was a positive move and they felt their feedback was being taking on board in this project.

[14] Where the baby has its bottom or feet facing downwards in the womb.

Improvement needed

The health board must ensure that:

- Further work is progressed to ensure audit compliance is strengthened and maintained with active learning taking place from result findings.
- A review of neo-natal medical staffing takes place to ensure timely and effective discharge take place.

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.

We were told by all staff we met that midwifery and medical rotas were well managed within the unit. If there were any shortages of staff cover, community midwives and medical staff would be called in. Senior managers would also step in to cover. All the staff we spoke with told us that there are very rarely any issues with staffing coverage. They advised that the senior management manages this very well. We saw there were escalation process in place and all staff we spoke with aware of where to locate the policy and how to escalate issues.

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 and safeguarding is predominately carried out on-line, and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

The service holds three mandatory maternity related study days across the year. One of the days is Practical Obstetric and Multi-Professional Training

(PROMPT)[15] 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 show compliance figures for PROMPT training and were assured that regular training was taking place.

The health board had a lead midwife for practice education/practice facilitator, and part of their role was to monitor compliance with training across the year. We saw that a quarterly report is produced for the head of midwifery, deputy head of midwifery and senior midwifery staff to show compliance with the training. Staff are required to book themselves onto the relevant training days and attendance is reported to the senior teams.

Three clinical supervisors of 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[16] to make sure that supervisors meet with midwives for four hours each year. The health board started to monitor compliance with this target during the previous financial year and were continuing this on an ongoing basis.

The clinical supervisor of midwives were also responsible for carrying out appraisals. We were told that within the Royal Gwent Hospital all appraisals were up-to-date. Staff we spoke to told us that they have regular appraisals and they see them as positive meetings to increase continuous professional development.

We found that there was a good level of support in place from the specialist lead midwives who were knowledgeable about their specialist roles. Staff told us they were visible and approachable within the unit. These leads provided support and guidance through study days, supervision sessions and meetings with staff as and when required. We also saw a good range of skill mix throughout the unit.

Although we were told there were no nursery nurses employed within the services, we saw that maternity support workers were encouraged to develop to

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[15] PROMPT - Practical Obstetric and Multi-Professional Training. The course teaches attendees how deal with obstetric emergencies.

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

the next level. This would mean more support could be given to the midwives and new mothers in areas such as breastfeeding, bathing and general care needs.

We also saw that the training and mentorship for medical staff was very positive. Medical staff we spoke with also confirmed that the training, support and guidance is of a very high standard. This was also seen to be the case within the staff questionnaires completed. The staff we also spoke to told us that the organisation will do its utmost to encourage and support good teamwork.

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

Hospital Inspection: Immediate improvement plan

Service: Royal Gwent Hospital

Area: Maternity Services

Date of Inspection: 2 – 4 September 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
No immediate concerns noted			

Appendix B – Immediate improvement plan

Hospital Inspection: Immediate improvement plan

Service: Royal Gwent Hospital

Area: Maternity Services

Date of Inspection: 2 – 4 September 2019

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
No immediate improvements required				

Health Board Representative:

Name (print):

Role:

Date:

Appendix C – Improvement plan

Service: Royal Gwent Hospital

Area: Maternity Services

Date of Inspection: 2 – 4 September 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 signage at the hospital is reviewed to ensure it is clear for all patients and visitors.	4.2 Patient Information			
The health board must ensure that health promotion is readily available throughout the unit.	4.2 Patient Information			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that information about staff is displayed for patients, including within the labour ward.	4.2 Patient Information			
The health board must ensure that the process of handover is reviewed.	4.2 Patient Information			
The health board must ensure that information is clearly displayed and readily available about how patients and families/carers can raise a concern about their care	4.2 Patient Information			
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	4.2 Patient Information			
Delivery of safe and effective care				
The health board must ensure that Domestic schedule cleaning of the unit is reviewed to maintain high standards.	2.1 Managing risk and promoting health and safety			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that waste storage bins are in line with infection prevention and control guidelines and staff are advised of appropriate waste segregation.	2.1 Managing risk and promoting health and safety			
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			
The health board must ensure that all cleaning equipment and supplies are stored appropriately and securely.	2.1 Managing risk and promoting health and safety			
The health board must ensure that doors to the medication/records room are securely closed to maintain safety.	2.1 Managing risk and promoting health and safety			
The health board must ensure that Designated labels are used on equipment to signify it has been cleaned and is ready for use.	2.1 Managing risk and promoting health and safety			
The health board must ensure that consideration is made to review non-disposable items to reduce	2.1 Managing risk and promoting health and safety			

Improvement needed	Standard	Service action	Responsible officer	Timescale
infection risks such as fabric curtains, shower heads and shower curtains.				
The health board must ensure that all single use items are disposed immediately after use, including CTG straps.	2.1 Managing risk and promoting health and safety			
The health board must ensure that adequate arrangements are in place to ensure effective deep cleaning of the unit.	2.1 Managing risk and promoting health and safety			
The health board must ensure that patients have access to food options through the day and night-time.	2.5 Nutrition and Hydration			
The health board must ensure that medication is stored appropriately and securely at all times.	2.6 Medicines Management			
The health board must ensure that breasting feeding support is reviewed and that visibility is increased throughout the unit.	3.1 Safe and Clinically Effective care			
The health board must ensure that patient records are fully reflective of the care and	3.4 Information Governance and			

Improvement needed	Standard	Service action	Responsible officer	Timescale
treatment provided to patients and in line with standards of professional record keeping.	Communications Technology			
Quality of management and leadership				
The health board must ensure that further work is progressed to ensure audit compliance is strengthened and maintained with active learning taking place from result findings.	Governance, Leadership and Accountability			
The health board must ensure that a review of neo-natal medical staffing takes place to ensure timely and effective discharge take place.	Governance, Leadership and Accountability			

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):

Job role:

Date: