Hospital Inspection (Unannounced)

University Hospital of Wales, Cardiff and Vale University Health Board, Maternity Services

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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 receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

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 University Hospital of Wales within Cardiff and Vale University Health Board on the 18, 19 and 20 November 2019. This inspection is part of HIW's national review of maternity services[1]. The following hospital sites and wards were visited during this inspection:

- Delivery ward
- Postnatal wards (east and west)
- Midwife Led Unit (MLU)
- Obstetric Assessment Unit (OAU)

The inspection team visited the induction of labour suite (T2) and new theatre area, however these were not considered in detail during the inspection.

Our team, for the inspection comprised of three HIW inspectors (one lead), three clinical peer reviewers (one consultant obstetrician and two midwives) and a 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 that care was provided across the service in a safe and effective way. We found that there was strong and effective multidisciplinary working, which was provided in line with up-to-date clinical practice.

We found some evidence that the health board was not fully compliant with the Health and Care Standards in all areas, and identified where improvements were needed.

This is what we found the service did well:

- Staff provided care in a dignified and personal way
- Support and information was provided to patients to help them make an informed decision about their birth choice
- Individualised support and care to patients who had experienced a previous difficult pregnancy or birth, or baby loss
- Specialised breastfeeding support and information
- Pleasant and homely environment in the midwife led unit
- Designated physiotherapy support to patients during the antenatal and postnatal periods
- Care was provided in an evidence based way, based on up-to-date clinical guidance
- Robust process for assessment of patients in the Obstetric Assessment Unit (OAU) to ensure they were appropriately prioritised
- Staff reported positive multidisciplinary team working across the service
- Support for newly qualified midwives and the preceptorship programme
- Good processes for the management and review of clinical incidents.

This is what we recommend the service could improve:

- Availability of patient lifts across the service
- Review of patient confidentiality on information boards in some areas
- Ensuring that patient records are kept secure at all time
- Some elements of patient record keeping, to ensure that documentation is completed consistently
- Access to hand sanitiser alcohol gels across some areas of the service
- Clarity around checking fridge temperatures across the service
- Arrangements for checking equipment and drugs used in patient emergencies
- Keeping the door locked at all times to treatment rooms
- Ensuring cleaning products are kept secure at all times
- A review of the arrangements for storing blood on the wards
- A review of reception staffing numbers
- Presence and leadership of medical staff on the postnatal wards and OAU
- Review of staff morale across the service.

3. What we found

Background of the service

Cardiff and Vale University Health Board is one of the largest NHS organisations in the UK. It is a teaching health board with close links to the university sector and together they train healthcare professionals and work together on research.

The health board employs approximately 14,500 staff and provides health and well-being services to a population of around 472,400 people living in Cardiff and the Vale of Glamorgan. It also serves a wider population across south and mid Wales for a range of specialties and provides acute, primary care, community, and mental health and learning disability services to adults and children. These services are provided through acute, general and community hospitals, health centres, GP's, dentists, pharmacies and optometrists.

A wide range of maternity services are provided by the health board across Cardiff and the Vale of Glamorgan. Their main services are located at University Hospital of Wales, with midwifery outpatient services available at University Hospital of Llandough.

Women who birth within the health board have the choice of three birth settings. These include homebirths, a midwife led unit and an obstetric led unit within the University Hospital of Wales.

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.

We observed polite, friendly and professional interactions between staff and patients across the service. We found that care was delivered in a way that upheld patient dignity and privacy. Patients we spoke with provided positive comments about the care they received.

We found patients were provided with information to help them make informed decisions about their care and were supported by a dedicated team of specialist midwives.

Breastfeeding support was available to patients, both on the ward and in the community. Specialist support was available to patients who may have experienced a traumatic or difficult birth.

We found that action was needed to ensure that lifts are easily accessible throughout the service.

Consideration must be given to ensure that displayed patient information upholds patient privacy.

During the inspection we distributed HIW questionnaires to patients and carers to obtain their views on the services provided. A total of eight questionnaires were completed. We also spoke with a number of patients during the inspection. Patient comments included the following:

> *"I'm not sure how to express how amazing the midwife truly was during my son's birth and the aftermath with the emergency - throughout she kept calm, attended to my son and after all of that she still managed to make me a priority, whilst teaching her student. What a fantastic mentor and midwife she was. Should be the standard which medical professionals are held".*

"Extremely good service from consultant lead care unit and maternity ward".

"Everybody I have come to contact staff have gone above and beyond. Friendly staff who have taken the time to put my mind at ease".

"All staff have been so kind and helpful. Everyone listens to your concerns and questions and gives you the help you need".

Staying healthy

Across the service we saw numerous information leaflets and posters displayed for patients to read. Information in relation to breastfeeding, smoking cessation, maternal mental health, healthcare associated infections, contraception choices, perineal wound care and details of support networks for new mothers were displayed.

We saw there were clear 'no smoking' messages displayed outside the maternity entrance and a button which patients, staff and visitors were encouraged to press if they saw somebody smoking. A loud no smoking message would then be heard over a tannoy, to prevent and stop people smoking as patients and visitors were leaving or entering the building.

The service was UNICEF[2] baby friendly accredited and we saw a posters advertising this throughout the unit. Two midwives were responsible for providing specialist breastfeeding support and advice to staff and patients. All staff were trained to provide breastfeeding support to patients. Additional community staff were able to hold clinics in the community to support those during the postnatal period. Antenatal breastfeeding clinics were provided by community midwives.

Hand hygiene posters and hand washing guides were displayed in patient toilets, and next to hand gel dispensers across the service. However, we found that some of these, specifically in and around the postnatal and delivery wards, were

[2] https://www.unicef.org.uk/babyfriendly/

inaccessible, broken or empty. A recommendation is made about this issue within the Delivery of Safe and Effective Care section of this report.

Dignified care

During the inspection, we observed polite, friendly and professional interactions between staff, patients and visitors. We saw curtains were drawn around patient beds whilst staff were providing personal care and support, to uphold patient privacy and dignity.

All patients who completed a questionnaire agreed that staff were always polite to them and to their friends and family. Nearly all patients agreed staff listened to them and their friends and family. All of the patients agreed staff called them by their preferred name. Patient comments included:

> *"Staff are friendly and personable, they have been very helpful when attending to my son as I am in a lot of pain they have taken the time to help me with medication, getting around. Hygiene and even bathed my son whilst teaching me to do so. This is something small but something I am very grateful for as I was nervous. I now feel I have the confidence to do this at home alone safely"*
>
> *"Staff are supportive and friendly"*
>
> *"Everyone was also fantastic on the recovery ward upstairs during my stay. Very attentive and supportive!"*

We saw there were patient at a glance boards displayed in the OAU and on the postnatal wards. Whilst they did not display patient names in full, we did find they contained detailed personal information, such as medical issues, which we felt did not fully uphold patient confidentiality. The boards were in a main walkway within these areas and we found they could be viewed easily by patients and visitors walking through. We discussed this with senior managers who explained there was very limited space in these areas for them to be stored elsewhere and for the safety of patients, they needed to be easily accessible to staff. Similar boards in other areas of the maternity service, such as in the midwife led unit, were located in places that upheld patient privacy and dignity.

We found the midwife led unit provided an environment that was homely and care was provided in a way that upheld the ethos of a midwife led unit. Soft furnishings, lighting, decorative sky tiles and the use of virtual reality created a homely environment.

We found the newly opened T2 unit (induction of labour ward) was pleasantly decorated and provided a pleasant waiting area for patients and partners. This included a small kitchen allowing patients and partners to make drinks and snacks.

The service had two designated bereavement rooms to support recently bereaved parents. We found the rooms to be very pleasantly decorated, calm and peaceful. We were told that parents were able to spend as much time as needed in the rooms and a cold cot[3] was available for patients wishing to spend time with their baby. Parents were also able to take their baby home with the support of staff, should they wish to, to enable them to spend time with them in their own environment. The service had a specialist bereavement midwife, who was able to provide specialist support, information and guidance to parents during very difficult times.

The service also held a Rainbow Clinic, for those patients who had experienced loss of a previous baby. This was with the aim of providing additional support to parents.

Improvement needed

The health board must ensure the arrangements for patient at a glance boards in the obstetric assessment unit and postnatal wards fully uphold patient confidentiality and dignity.

Patient information

The service had a website that provided a wide range of information to patients in a number of languages, we found it was easy to navigate and provided relevant and useful information to support patients making informed decisions about their care.

[3] A cot designed to allow bereaved parents to spend a longer amount of time with their baby in order to grieve and say goodbye as a family.

Information was included about all stages of pregnancy, labour and postnatal care. We also found there links to numerous resources to provide information to patients during all stages of their pregnancy and birth. Contact details for all the departments were displayed, as were the key contacts within each area. This included a photograph and biography of some senior members of staff. Details of infant feeding support was provided, again including useful information about support groups and resources. A virtual tour of the maternity service was also available, taking patients through the different departments of the service.

Communicating effectively

We observed conversations between staff and patients visiting the service. We found staff to be welcoming and knowledgeable in their conversations with patients.

We saw there were regular handover meetings, where staff were able discuss patient needs and plans, with the intention of being able to provide continuity of care. We observed one handover meeting on the delivery ward and found it to be informative, constructive and attended by a range of different professionals, meaning they were able to provide a multi-disciplinary approach to patient care.

We saw the majority of information displayed throughout the service was available in English and Welsh. As previously mentioned, the website provided a large amount of information, leaflets and resources in a number of different languages.

The service had a number of ways of being able to communicate with patients, relatives and visitors whose first language may not be English or Welsh. Alongside the telephone translation service, staff were also able to use a translation service through Skype and we saw IPads were available for staff to do this. We were also told that they were able to use the equipment to translate sign language. This was a very new introduction to the service and we were told that it was currently being rolled out to ensure all staff were aware of the facility.

Timely care

Staff told us they were highly attentive to patient needs, ensuring their personal, nutritional and comfort needs were met in a timely way. We saw evidence of this within the patient care records we looked at.

We were told that transfers from the midwife led unit to the delivery ward happened in a timely manner, to prevent any delays to care and treatment. There was an appointed overall midwifery manager on every shift who would coordinate

the care between the different areas within the service, as well as being aware of any likely transfers from the OAU and midwife led unit.

We were told that whilst there had been some improvements to the numbers of medical staff within the service, staff would often be based on the delivery ward, with limited dedicated time to the OAU and postnatal wards. This meant that patient reviews and patient discharges could be delayed. A recommendation is made about this in the Quality of Management and Leadership section of this report.

Individual care

Planning care to promote independence

Different departments within the service were located across different floors in the hospital. Whilst we found the areas to be clean, tidy and free from hazards, we found that two of the three lifts in the service were not working. This meant that patients needing to use the lifts had to wait for the one working to become available. A recommendation is made about this in the Safe and Effective Care section of the report.

The consultant midwives held a number of clinics, providing information to patients to discuss birthing options. Weekly birth choice clinics were held, providing information and advice to patients about their pregnancy and labour choices. Information for patients who may sit outside of the normal labour pathway, who may wish to have their baby at the midwife lead unit, were also provided during these clinics.

The service provided a clinic known as the Birth Afterthoughts clinic to patients who had experienced a previous traumatic birth, for those who wanted to debrief or understand more about their birth experience. Patients were also given the option of meeting with senior midwives to talk though their experiences and receive additional information. Patients were able to have an individual meeting to discuss their concerns, issues or worries associated with a previous birth. The midwives providing the service were able to offer a three-step therapy programme, which seeks to relief the symptoms of birth trauma. Patients were provided with a leaflet about the clinic when they were discharged and were able to self-refer themselves for an appointment. We found this to be an area of noteworthy practice.

People’s rights

Visiting hours for partners was between 9am to 9pm every day, with some availability to stay overnight, depending on whether double rooms were free.

In a sample of patient records we looked at, birth choices were documented clearly, with risk and benefits outlined, thus supporting patients to make an informed decision about their care.

Listening and learning from feedback

We saw information was displayed throughout the service about who patients, relatives and visitors were able to raise a complaint with, information about the NHS Wales Putting Things Right Process was also displayed.[4]

The service had a women's experience midwife in post, who was responsible for coordinating concerns, complaints and compliments received. We saw there was a process in place that ensured patients were able to meet with the women's experience midwife to discuss any concerns and advise on the formal complaints process. A process was in place for ensuring that any issues were shared across the service and appropriate investigations were carried out.

The women's experience midwife worked closely with the clinical risk midwife, in order to ensure that themes and trends of concerns or complaints were identified and acted upon.

We were able to see that feedback from patients was obtained by the service. Patients were provided with a leaflet upon discharge asking them to complete a short questionnaire which enabled the service to obtain at patient experiences.

The service also had an active social media presence, allowing patients to provide comments and information about the care and treatment received. We were told that should there be any issues or concern raised this way, patients would be contacted directly and discretely to explore any issues further.

We saw an example of where the service had acted upon feedback from patients. The service had put patient kitchens onto the wards allowing patients and relatives to make themselves drinks and snacks during their stay. This was as a result of direct feedback from patients.

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

Delivery of safe and effective care

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

Overall, we found that care was provided in a safe and effective way.

There was a good process in place on the OAU for assessing and prioritising patient care needs.

Patients who were outside of the typical labour pathway, were supported to enable them to make decisions about their birth choices.

Some improvements were needed in the completion of patient documentation.

We found checks on emergency drugs and equipment were inconsistent and needed to be improved. We also found the door to one treatment room was unlocked.

Clarity was required around the process for checking fridge temperatures.

We also found that a review of storage of blood on the wards must be considered.

Safe care

Managing risk and promoting health and safety

We found the service generally to be uncluttered, clean and tidy. We found there were differences, however, with the amount of storage available across the different departments. Within the newer areas, such as the midwife led unit and T2, these were able to accommodate equipment more easily. We found in the older areas of the hospital, including the postnatal, delivery and OAU wards that storage was limited. We saw cleaning trolleys were left in corridors with cleaning materials on. We raised this with managers who arranged for the cleaning equipment to be removed and stored securely immediately.

As described earlier, there were three lifts servicing the OAU, postnatal, delivery and theatre areas of the service. We saw that two of these were not in use and waiting to be fixed. As a result, during the inspection we observed one individual carrying a pushchair and baby up the stairs. Staff and the management team raised this with the inspection team as an issue, highlighting they had been out of order for some time. Whilst we were told this issue was on the health boards risk register, this had been an ongoing issue and in need of prompt attention.

The service ensured that babies were secure on the wards by using electronic tagging system. Patients and relatives were also required to be let in and out of the unit by staff, to help ensure they remained safe. However, we looked at the child abduction policy and found it to be out-of-date. We raised this with managers who explained that it was currently in the process of being reviewed, and would be ratified internally by the quality and safety committee in December 2019. The health board must ensure that any changes to the policy are clearly communicated to staff to ensure they are fully sighted of the procedure to follow.

The inspection team considered the arrangements for the checking of emergency equipment throughout the service. We found that checks of equipment used in a patient emergency were insufficient. This is because checks were inconsistent and not all were recorded as being carried out appropriately. We found this in relation to the following:

- Neo-natal resuscitaires (daily checks)
- Emergency resuscitation equipment (daily checks)
- Difficult airway equipment (weekly checks).

We also found out-of-date equipment, including one airway and blood sample bottles on one emergency resuscitation trolley.

We also looked at the storage arrangements for the emergency resuscitation equipment, including a defibrillator on the postnatal wards. We found equipment was stored in a cluttered room which prevented ease of access in an emergency.

We found a door to a treatment room on the delivery ward was unlocked. The room contained stock, including an epidural trolley and intravenous fluids which could be at risk of unauthorised access.

Our concerns regarding the above issues 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.

Improvement needed

The health board must ensure that the revised child abduction policy is communicated with all staff so they are aware of any changes to procedures.

Falls prevention

We saw leaflets and posters displayed around the service regarding keeping babies safe and preventing falls and babies being accidentally dropped, known as 'Babies Don't Bounce!'[5] We were told this was in response to a number of incidents where babies had fallen out of cots and beds. We found the information was displayed in prominent positions throughout the service and we were told that incidents of babies falling or being dropped had reduced.

Infection prevention and control

Overall, we found the service to be clean and tidy. We observed domestic staff cleaning thoroughly during the inspection. We saw also records to show that the birth pools were cleaned daily, as well as after each use.

Personal protective equipment was readily available for staff to use. We observed staff upholding the standards of being bare below the elbow[6] to uphold infection control standards.

Hand washing and drying facilities were available throughout the service. We saw posters above sinks displaying the correct hand washing procedures to follow as a prompt for staff, patients and visitors. Alcohol sanitiser gels were available throughout the service, however, we found a number of these to be either empty, broken or inaccessible.

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5 http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Babies%20dont%20bounce%20poster%20barcodes.pdf

6 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.

Improvement needed

The health board must ensure that alcohol sanitiser gels are available and fit for use across the service to uphold infection control standards.

Nutrition and hydration

Meals were provided by the catering team and we saw them being delivered whilst hot to patients. Patients were provided with a choice and different dietary requirements including vegan and vegetarian were catered for. Patients we spoke with told us they had access to food outside of meal times. We overheard a member of staff helpfully telling a patient to ask if they needed anything else to eat.

We saw that patients had access to jugs of water and drinks were placed within easy reach to ensure they had ease of access. Patient kitchens were available across the service, meaning that patients and their partners were able to make hot and cold drinks and food when they wished.

The service had the support of a dedicated infant feeding team, known as the Seren team. We were told that all staff are trained to provide breastfeeding support to patients, and the Seren team is able to provide additional, specialist support to staff and patients when needed. The Seren team also provided postnatal clinics in the community, to provide advice and support to those with infant feeding needs. We were told that for babies requiring additional support, feeds would be recorded in the patient records to help ensure their nutritional needs were being met.

Medicines management

Overall, we found there were safe arrangements for the management of medicines. There were, however, some improvements needed in some areas.

We looked at the storage, checks and administration of controlled drugs and found there were appropriate processes and procedures in place for the safe management of these.

We looked at a sample of patient records and found that drug charts had been completed in an appropriate way. We also saw patients wearing identification bands to help ensure that medication could be administered safely.

Medication was administered on the postnatal wards on a regular basis. We saw that in all other areas medication was administered as required.

The service had the support of a dedicated pharmacist during the day and was able to call on support from the hospital site manager during out-of-hours if needed to source any required medication. Staff told us this happened very infrequently, but described the process they would need to follow in such circumstances.

We found there were inconsistencies in the way fridge temperatures, used to store medicines and expressed breast milk, were recorded across the service. We saw there were different forms in use across the service, which required different information to be recorded, such as the temperature parameters of the fridge. However, when we spoke with different members of staff they were unable to clearly explain why the information was recorded and what they would do if the temperatures fell outside of the parameters. Staff were also unable to locate the policy which would provide this clarity.

As mentioned previously in this report, we found areas of concern in relation to the arrangements for checking the drugs and equipment used in a patient emergency and also a treatment room door being kept unlocked. These were dealt with via our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

Improvement needed

The health board must ensure that:

- The policy for checking fridge temperatures used to store medicines and expressed breast milk is easily accessible and clearly communicated to all staff
- Staff are aware of what action to take if temperatures fall outside of acceptable parameters
- Consideration is given to reviewing the forms in use to record temperatures to ensure they are appropriate.

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 were vulnerable or at risk. Safeguarding

training was mandatory and the majority of staff who completed a HIW questionnaire told us they had received training within the past 12 months.

There was a dedicated safeguarding team within the service, who were able to provide specialist advice and support to staff and patients with safeguarding needs. We saw, in a sample of patient records we looked at, that routine enquiries[7] were being carried out during the antenatal period, with the intention of identifying those who may have safeguarding needs. We saw that patients identified as having safeguarding needs were referred to a specific team, known as the Elan team. Specialist midwifery support was able to be provided to those during antenatal and postnatal periods, ensuring continuity of care for these patients. The team also had midwives with specialist knowledge in substance misuse, perinatal mental health, smoking, teenage pregnancy, domestic violence and asylum seekers.

Within the team there was an appointed Female Genital Mutilation (FGM)[8] midwife, who was able to provide support and advice to patients. A specialist FGM clinic was provided by the team and had been in operation for around 18 months and we were told this was the only one in Wales. The clinic was able to provide psychosexual therapy to women who had experienced FGM, with the aim of providing support and help to aid recovery. We found this to be an area of noteworthy practice.

There was a designated perinatal mental health midwife for the service based in the Elan team, who was able to provide support to patients with mental health needs. We were told that the midwife works collaboratively with the adult mental health team within the health board, to help ensure that care is provided in a holistic way.

[7] The routine enquiry is where a professional caring for a woman during the antenatal period asks questions in relation to her personal safety. This should be done, as a minimum, twice during the antenatal period and recorded as such.

[8] https://www.nhs.uk/conditions/female-genital-mutilation-fgm/

Blood management

We were told that there was nowhere on the wards to store blood products, meaning that when required it would be delivered onto the wards and would need to be used immediately. We discussed this with senior managers who explained that the health board had made the decision to remove the blood storage options from all wards across the hosptial. We questioned whether, due to the often complex nature of some of the patients, it would be worthwhile to revisit this decision to ensure blood products were readily accessible.

Improvement needed

The health board must consider whether the current arrangements for obtaining and storing blood products are appropriate to the maternity service.

Medical devices, equipment and diagnostic systems

Most staff we spoke with told us they had enough equipment to carry out their roles. We were told that any issues with faulty equipment would be reported to the estates team to arrange repair or replacements. We looked at some pieces of equipment and could see they had stickers to show when they had last been maintained, the ones we looked at were in date.

Effective care

Safe and clinically effective care

Overall, we found the service provided safe and effective care, that was evidenced based and in line with up-to-date clinical practice and guidelines. We found there were many complex patients within the service during the inspection, with high levels of care needs. University Hospital of Wales has a fetal medicine unit[9], which manages complex patients during their pregnancy and labour from the local area, but also provides a regional service. This results in many complex patients receiving their care at the service.

[9] http://www.cardiffandvaleuhb.wales.nhs.uk/maternity-fetal-medicine-unit

On every shift, there was an overall midwife in charge, the Midwifery Unit Manager. Their role was to coordinate the care being provided across all areas of the service. Whilst predominently based on the delivery ward, their role included providing managerial oversight and support to staff in the other areas, to ensure care was being provided in a safe and effective way. We were told they would look at the acuity of the wards to determine whether staff needed to be moved around to ensure there was appropriate numbers of staff in the right areas. There would be a handover between Midwifery Unit Manager at each shift change to provide information about the service, including staffing, and to ensure they were aware of any likely transfers from the OAU or midwife led unit to allow them to plan and prepare appropriately.

We saw that the cardiotocography (CTG) system the labour ward used to monitor the fetal heart rate was linked by computer to allow the staff to view it live from outside of the individual patient rooms. Staff CTG training was mandatory and clinical teaching sessions were held on a weekly basis which were multi-disciplinary based. All staff who completed a HIW questionnaire said had received CTG training in the last 12 months.

One of the postnatal wards provided transitional care to support to babies with additional needs. We were told this included those requiring closer monitoring or observation, but not needing admission to the neonatal unit. Care on the ward was provided by midwives, maternity care support workers and nursery nurses. Support was also provided by neonatal doctors who would be able to review babies on a daily basis.

A dedicated physiotherapy service was available to patients during the antenatal and postnatal periods. Patients were able to be referred to the service through their midwife or GP from 13 weeks of pregnancy and were able to receive care up to four months post natal. Information and advice, as well as physical interventions, were able to be provided by the department. Staff reported that this was a beneficial and positive service for patients.

As mentioned previously in the report, a team was able to provide specialist breastfeeding advice to patients and staff. We were also told that one member of the team had attended additional training to be able to offer a tongue tie[10] division

[10] https://www.nhs.uk/conditions/tongue-tie/

service, to help ensure babies and mothers were able to be supported to breadfeed if they wished to. Babies would be assessed at a clinic and then a decision would be made about the suitability of offering the service. Staff told us that there was only one other midwife in Wales within the NHS able to offer this procedure.

In a sample of patient records we looked at, we found when requested, patients were provided with pain relief in a timely way. All patients who completed a HIW questionnaire told us a midwife stayed with them during labour and felt that the pain relief received during labour was adequate.

A number of midwives were trained to provide hypnobirthing, a method of pain management that can be used during labour and birth. It involves using a mixture of visualisation, relaxation and deep breathing techniques. We were told that 20 additional midwives were to be trained in this technique in 2020. We also saw that the service was trialling the use of virtual reality for patients undergoing induction of labour and early stages of labour. The intention of this service is to provide distraction and offer alternative pain relief options to patients.

We looked at the arrangements for assessing the needs of patients on the OAU. We saw that patients were put into three categories, red, amber and green. Red being the most urgent level of need/care. We found this to be an area of noteworthy practice, resulting in staff having prompt and clear access to those patients whose care needed to be prioritised.

Quality improvement, research and innovation

There was a lead research midwife appointed to the service, who was responsible for carrying out research in conjuntion with others to improve the quality of care being provided to patients.

A new theatre had recently been built which will be used for elective and planned caesarean sections. A purpose built recovery ward was alongside the theatre. We were told that when opened, it will potentially reduce the need of cancellations of planned caesarean sections, as the theatres close to the labour ward will be dedicated for emergency caesarean sections only.

As previously mentioned in the report, the service was trialling the use of virtual reality as a method of pain relief. We also found the consultant midwives, and the Elan team provided a high quality service to vulnerable patients, and those in need of additional support.

Information governance and communications technology

We found improvements were needed with regards to the storage of patient records in some areas across the service. During an initial tour of the service, we found patient records were not safely secured on one postnatal ward and on the OAU. Records were left in places that meant they could potentially be accessed by unauthorised individuals. We raised this immediately,and action was taken quickly to ensure the records were secured.

Improvement needed

The health board must ensure that patient records are kept secure at all times to prevent unauthorised access.

Record keeping

Overall, we found the standard of record keeping to be adequate. Some patient records we looked at were difficult to navigate, resulting in the need to for us to search for information, rather than it following a logical format. Improvements to record keeping are required in the following areas to ensure documentation is consistently completed across the service:

- Obs Cymru[11] documentation
- Waterlow charts (to assess the risk of a patient developing pressure ulcers) to be fully documented
- Venous thromboembolism (VTE)[12] risk assessments
- Maternity Early Obstetric Warning Scoring system [13] documentation

[11] http://www.1000livesplus.wales.nhs.uk/obs-cymru

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

[13] Maternity Early Obstetric Warning Scoring system, used to identify early physical deterioration in a patient

- Ensure that staff clearly document their role and sign and date when making an entry into the records.

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.

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.

Staff reported there to be good, positive and supportive multidisciplinary team working across the service.

Support for newly qualified midwives was positive and staff had the option to rotate throughout the service to experience all areas of work.

There were robust processes in place for the management and oversight of clinical incidents.

The presence and leadership of medical staff in the postnatal wards and OAU needs to be strengthened.

Some staff reported that morale was low and the health board must consider the reasons why.

Governance, leadership and accountability

During the inspection, we distributed HIW questionnaires to staff and we received 11 completed responses. Findings of this questionnare are referenced throughout this section of the report.

We saw the service had in place a number of regular meetings, to support the flow of communication between the clinical areas and management teams. These meetings included clinical risk, governance, weekly incident review meetings, directorate quality and safety, team meetings and professional lead meetings. Staff confirmed these meetings were well attended and felt they provided detailed information to support the delivery of safe and effective care.

We saw there was a maternity dashboard in place, which is a tool to monitor clinical performance of the service. We found the information was collated on a monthly basis and shared with senior managers, to help provide clear information

about the performance of the service. We saw the areas were rated, to highlight where standards were, or were not being met. This information was reviewed on a regular basis by the senior management team and wider clinical board.

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)[14] and Each Baby Counts[15] were taken forward. 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.

We were able to see that the governance team carried out regular audits of clinical performance, including areas such as blood results, urine analysis and documentation review. Information following these audits was shared by the team with senior managers to review clincial performance of the service.

On the ward audits were carried out by appointed staff and we were told that this information is collated on a monthly basis. Audits included checks of controlled drugs, emergency equipment, staff uniform compliance, baby identification badges and environmental audit, fridge temperatures and medicines management. We saw the results of the audits conducted in July 2019 and found there were varying degrees of compliance with the set standards. As referenced earlier in the report, we found inconsistencies in checks of emergency drugs and equipment. It was therefore unclear what actions had been taken by the health board to make improvements.

We found there were clear governace processes in place for the reporting and investigation of clinical incidents. There was a risk manager in place, who held responsibility for the management of concerns and incidents. Regular incident review meetings were held with senior members of staff to ensure that all clinical

[14] 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, newborn and infant health services.

[15] 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.

incidents were reviewed appropriately and action taken where necessary. The service had a ‘reg flag trigger list’, which provided staff with clear guidance about what incidents needed to be reported through the electronic recording and monitoring system. We found this provided staff with clarity over what needed to be reported.

Whilst staff told us they were encouraged to report clinical incidents or near misses, some expressed concern about the way incidents were sometimes managed. Some commented that whilst openness was encouraged, there was a punative approach to those involved in incidents.

We were told that learning from incidents and audits, alongside areas of good practice was shared with staff through a newsletter. Where there were any areas for immediate learning, information would be shared with staff via safety briefs and individuals involved directly in any incident would be contacted directly.

However, around half of staff who completed a questionnaire agreed they were given feedback about changes made as a result of reported errors. One member of staff commented that they would like to see regular feedback provided to staff support practice.

Improvement needed

The health board must provide assurance to HIW of the action taken to address the outcomes of monthly audit activity.

Staff and resources

Workforce

The service had recently recruited an additional 26 whole time equivalent midwives to work across different areas. We were told that the majority of these were newly qualified midwives. During the inspection, we found there were sufficient levels of midwives to accommodate the needs of patients. The management team confirmed there were no vacancies within the midwifery and support team services at the time of inspection.

During the inspection, however, we found there were limited reception staff across the areas and were not provding 24 hour cover. We saw this impacted on some of the ward areas, as it meant clinical staff needed to open the doors to patients and visitors and take phone calls, therefore taking them away from providing patient care.

The service had recently completed a workforce exercise, Birth Rate Plus[16], to determine whether the current staffing levels were in line with this tool. The outcome of the report was due shortly following the inspection. Whilst we were told by senior managers that they believed they currently had the right numbers of staff, they explained that the complexity of some of the patients receiving care at the service had increased. The service was reviewing the type of patients being seen by the service, to determine if there is any further action needed to accommodate increasingly complex patients.

We were told that shortages within the medical team meant that there was no designated ward rounds for the postnatal wards or OAU. Ad-hoc arrangments were in place for medical reviews of patients in these areas. As a result of these arrangements, we found there was limited medical leadership in these areas, in comparison to the evident medical leadership on the delivery ward. Staff told us that this could often cause delays in patients being seen and also discharged.

We also saw there was limited senior medical cover on the wards between 5-8pm and during weekend days. In order to address the gaps we were told that consultants were often stepping down in their roles to cover these shifts as registrars, meaning they were often working long hours. As a consequence, some staff told us that morale within the medical team was low. We discussed this with the senior management team who explained that a recent recrutiment exercise had been successful and in early 2020, four new consultant obstetricians will start employment. They told us this would ease the pressure and ensure there was sufficient and appropriate medical cover in all areas of the service.

Staff we spoke with were positive about the multidisciplinary working across the service, with many expressing their gratitude about the support received from other professionals. We observed positive and professional discussions and interactions between different professional groups.

We found 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

[16] https://www.birthrateplus.co.uk/

prompts to inform them when their training is due to expire to ensure they remain within timescales. We were also told that compliance with training is monitored by line managers through the end of year performance appraisal and development review.

The service holds four mandatory maternity related study days across the year. One of the days is Practical Obstetric and Multi-Professional Training (PROMPT)[17] training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. Nearly all staff who completed a questionnaire said they had attended this training.

A professional day, public health day and CTG training day made up the three remaining mandatory days. The professional day included areas such as incident reporting, governance overview and clinical training such as basic life support. The public health day included, amongst other areas, safeguarding training and public health issues, which was organised by the Elan team.

The health board had a practice development midwife and part of their role was to monitor compliance with training across the year. We were able to see that this was monitored and information shared with senior managers on a regular basis. We saw that the service considered staff ability to attend training seriously and where an individual was unable to attend due to work pressures, a red flag event would be highlighted, to ensure that the situation would be looked into. We were told that this very rarely occurs.

We found there were good arrangements in place to support newly qualified midwives into the service, coordinated by the practice development midwife. A preceptorship programme was in place, meaning that additional support was provided to newly qualifiied midiwves in their first year of post qualification. We saw they were required to wear a pink preceptorship badge on their uniforms during their first year, indicating to staff and patients that they were newly qualified. Staff we spoke with told us this was very beneficial, as it made other staff members aware they may need some additional support or guidance. Staff within the preceptorship programme rotated across the service, meaning they were offered the opportunity to experience different areas of work. Again, staff

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

we spoke with were positive about this experience, resulting in exposure to a variety of settings and being able to make an informed choice about their own career pathway.

Three clinical supervisor for midwives were in place across the service. Supervison sessions were held in a variety of formats, group sessions, one-to-one meetings and also through a two hour session during the mandatory professional study day. We were able to see a report to show that in 2018-2019 and 94.9% of midwives were seen for the required four hours of supervision during the year.

Some staff we spoke with expressed their concerns about staff morale within the service, believing that it was currently low. We explored this with some staff who explained they felt the service was not fully joined up between the different areas, such as delivery ward and the midwife led unit. Examples provided included staff believing that incidents are handled differently across the areas and different levels of prestige awarded to the different areas, with increased management focus and attention. We were also made aware of concerns raised by junior medical teams around what they felt could at times be a punitive culture.

Whilst the service had recently recruited a large number of midwives, some staff explained that staffing issues prior to this meant they had been working additional hours and had resulted in low morale.

Improvement needed

The health board must review the arrangements for providing reception cover across the service to ensure it is meeting current needs.

The health board must review the availability, leadership and structure of medical support provided to the postnatal and OAU wards.

The health board must explore the reasons why staff reported there to be low morale across the service and take action where appropriate to address any issues.

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

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
During a tour of the service we found patient records were not kept in a secure way on one postnatal ward and on the OAU.	Confidential patient records could be accessed by unauthorised individuals.	We spoke with staff immediately to highlight the concerns.	Staff removed the patient records immediately and they were stored in a secure location.

Appendix B – Immediate improvement plan

Hospital: University Hospital of Wales

Ward/department: Maternity Services

Date of inspection: 18, 19 and 20 November 2019

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that checks of equipment used in a patient emergency are carried out in line with policy. The health board must ensure that action is taken to remove and replace out of date equipment.	2.1 Managing Risk and Promoting Health and Safety 2.9 Medical Devices, Equipment and	Immediate actions were taken during the inspection to address the issues identified. Feedback has been shared with all staff with responsibility for improved checking procedures reinforced to operational lead midwives & anaesthetic colleagues Out of date equipment was removed at the time of inspection.	Q&S Consultant Anaesthetist lead for Q&S within Obstetrics Senior Midwifery Manager for Inpatient Services / Head of Midwifery	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Diagnostic Systems	Resuscitaire & emergency resuscitation checklist arrangements reviewed and confirmation that systems are in place. C&V Resuscitation team are attending on Monday 25th November 2019 to review all resuscitation areas / access to equipment / AED Feedback from the review will be discussed at:- • Professional Governance meeting on Friday 29th November 2019, (where plans for monitoring arrangements will be agreed and disseminated) • Directorate Quality and Safety Forum on 6th December 2019.		25.11.19 Completed 20.11.19 29.11.19 6.11.19 26.11.19

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		• Clinical Board Quality and Safety Forum on 26th November 2019		
The health board must ensure that equipment used in a patient emergency is easily accessible to staff at all times.	2.1 Managing Risk and Promoting Health and Safety	Immediate action was taken during the inspection. The Operational lead midwife for the area had addressed this issue with staff. The area has been added to the ward manager's weekly environmental audit template for ongoing monitoring	Senior Manager for Inpatient Services / Head of Midwifery	
The health board must ensure that the treatment room door is closed and locked at all times, as per the signage on the door.	2.1 Managing Risk and Promoting Health and Safety	Addressed immediately. Staff reminded of requirement for restricted access and closed doors at all times. No TDSI security issues identified at the time of inspection. However one access plate found to have failed on 22.11.19 reported to security for urgent attention	Senior Midwifery Manager for In Patient Services / Head of Midwifery	Completed 20.11.19 29.11.19

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): Suzanne Hardacre

Job role: Head of Midwifery

Date: 22nd November 2019

Appendix C – Improvement plan

Hospital: University Hospital of Wales

Ward/department: Maternity Services

Date of inspection: 18, 19 and 20 November 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 the arrangements for patient at a glance boards in the obstetric assessment unit and postnatal wards fully uphold patient confidentiality and dignity.	4.1 Dignified Care 3.4 Information Governance and Communications Technology			
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the revised child abduction policy is communicated with all staff so they are aware of any changes to procedures.	2.1 Managing risk and promoting health and safety			
The health board must ensure that alcohol sanitiser gels are available and fit for use across the service to uphold infection control standards.	2.4 Infection Prevention and Control (IPC) and Decontamination			
The health board must ensure that: • The policy for checking fridge temperatures used to store medicines and expressed breast milk is easily accessible and clearly communicated to all staff • Staff are aware of what action to take if temperatures fall outside of acceptable parameters • Consideration is given to reviewing the forms in use to record temperatures to ensure they are appropriate.	2.6 Medicines Management			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must consider whether the current arrangements for obtaining and storing blood products are appropriate to the maternity service.	2.8 Blood management			
The health board must ensure that patient records are kept secure at all times to prevent unauthorised access.	3.4 Information Governance and Communications Technology 3.5 Record keeping			
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.	3.5 Record keeping			
Quality of management and leadership				
The health board must provide assurance to HIW of the action taken to address the outcomes of monthly audit activity.	Governance, Leadership and Accountability			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must review the arrangements for providing reception cover across the service to ensure it is meeting current needs. The health board must review the availability, leadership and structure of medical support provided to the postnatal and OAU wards. The health board must explore the reasons why staff reported there to be low morale across the service and take action where appropriate to address any issues.	7.1 Workforce			

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: