Hospital Inspection (Unannounced)

Nevill Hall Hospital / Maternity Services – Labour ward, Pen-y-cwm ward and the birth centre / Aneurin Bevan University Health Board

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

Our purpose

To check that people in Wales 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 Nevill Hall Hospital within Aneurin Bevan University Health Board on the 22, 23 and 24 July 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:

- Labour ward
- Pen-y-cwm (postnatal and antenatal ward)
- The birth centre (midwife led unit).

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

HIW was also joined by two patient experience reviewers from the Aneurin Bevan Community Health Council[2] (CHC) on one day of the inspection. The CHC reviewers spoke with patients on Pen-y-cwm ward during one day of the inspection. The CHC report for this visit, once published, can be found on the CHC website[3].

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

[3] http://www.wales.nhs.uk/sitesplus/901/page/45214

2. Summary of our inspection

Overall, we found that the service provided care in a respectful and dignified way to patients.

However, we identified a number of improvements were required to ensure that the service was providing safe and effective care at all times. This included ensuring that there was sufficient oversight of the day to day activities on the wards.

This is what we found the service did well:

- Most patients told us they were happy with the care received
- We observed professional and kind interaction between staff and patients, and care provided in a dignified way to uphold privacy
- Good arrangements for the reporting and management of clinical incidents
- Support provided by specialist midwives across the service
- A reported good multidisciplinary team working environment
- Oversight and management of the medical staffing issues facing the directorate.

This is what we recommend the service could improve:

- Arrangements for keeping babies safe on the wards
- Arrangements for the safe storage and management of patient information
- Checks on emergency equipment, temperatures at which medication is stored
- The environment of, and the health boards ability to staff the birth centre sufficiently, limiting birth choices
- Toilet and bathroom facilities on the wards
- Infection control arrangements

- Some areas of patient record keeping
- Arrangements for oversight and management of audit activity
- Ensure the right staff are appointed onto shifts appropriate to their skills, knowledge and experience.

3. What we found

Background of the service

Nevill Hall Hospital is located in Abergavenny, and forms part health care services provided by 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 2,300 of these at Nevill Hall 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. Maternity services at Nevill Hall Hospital comprise of the birth centre (an alongside midwife led unit) and the labour ward, which provides both obstetric and midwife led care.

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.

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.

Toilet and bathroom facilities could be improved to ensure patient privacy and dignity was upheld at all times.

In order that patients and their families/carers better understand their rights in terms of raising concerns/complaints about their care, relevant information needs to be readily available and clearly displayed.

Improvements are required with regards to the birth centre, to ensure that it is fit for purpose and supports patient birth choices.

During the inspection, HIW was joined by two patient experience reviewers from the CHC who spoke with patients on day one to find out about their experiences during their stay. The CHC report, once published can be found on the Aneurin Bevan CHC website[4]. HIW also spoke with patients during the second day of the inspection, and our findings can be find outlined within this report.

Staying healthy

[4] http://www.wales.nhs.uk/sitesplus/901/page/45214

We saw that some information was displayed for patients on notice boards and in leaflets. Information in relation to breastfeeding and skin to skin advice was displayed in the corridors, to provide support and information to patients about the benefits of both breastfeeding and skin to skin contact to help them make an informed decision about their care.

We did not see any information in relation to smoking cessation on the wards. 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 wards were UNICEF[5] baby friendly accredited in 2015. It was unclear however, if this had been updated more recently.

Hand hygiene posters, and hand washing guides were also displayed in patient toilets, and next to hand gel dispensers on the wards, however three of these were found to be empty. A recommendation is made about this issue within the 'Delivery of safe and effective care' section of this report.

Dignified care

During the course of the inspection, we saw staff speaking with patients with kindness and respect. We saw curtains were drawn around patient beds whilst staff were providing personal care and support, to uphold patient privacy and dignity. Patients we spoke with told us that staff were supportive and friendly. Patients also told us that night staff were respective of the need for peace and quiet, whilst they carried out duties during this time.

We found, however, that toilet and bathroom facilities across the wards were limited. Not all rooms on the labour ward had access to en-suite facilities, meaning that patients in labour were potentially required to share facilities with other patients. There were also limited toilet facilities on the wards, and no facilities for birthing partners meaning they had to leave the wards to access facilities.

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

There were shower facilities on Pen-y-cwm ward, which were shared with toilets in a cubicle style. The shower cubicle was separated from the rest of the facilities by a waterproof curtain. The inspection team did not feel that this provided appropriate levels of dignified care to patients. We raised this with managers who confirmed that services will be transferred to the new hospital, due to open in 2021, with rooms having en-suite facilities.

We saw that one shower on Pen-y-cwm ward was broken, in that the shower head needed to be held by hand for it to be used. We raised this with managers who reported it to the estates team for it to be fixed.

The service had a designated bereavement room on the labour ward, to support recently bereaved parents. We found this room to be pleasantly decorated, calm and peaceful. Parents were able to spend as much time as needed in the room, and a cold cot[6] was available for parents wishing to spend time with their baby. The room had access to a garden for parents to use, and they were able to hang gifts and name tags on a tree as a way of remembrance. Again, we found this to be a peaceful and calm environment. The service did not have an appointed bereavement midwife, however we were told that training has been secured for one midwife to start in September 2019.

Improvement needed

The health board must consider whether the current toilet and bathrooms facilities uphold the dignity of patients.

Patient information

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

We saw on Pen-y-cwm ward that a large notice board displayed clear and detailed advice about contraceptive care. We found this to be informative for

[6] 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.

patients. Breastfeeding information was also displayed across the wards, providing advice and guidance to patients. We also saw information in relation to sepsis was displayed, again providing advice to patients on the signs and actions to take. However, we found little other information for patients to either read on the ward or take away with them.

Information was predominately available in English, with very limited information in Welsh. We were told by senior departmental managers that a rolling programme was in place to ensure that all information was bi-lingual and current information was in the process of being translated.

No information was displayed regarding the staff on duty, such as name and designation of staff caring for patients. This would help to ensure that patients were able to contact the most appropriate person in case of need, and to identify who was responsible for their care.

We saw that visiting hours were clearly displayed around the wards.

Improvement needed

The health board must ensure that:

- Signage at the hospital is reviewed to ensure it is easy to read for all patients and visitors to the hospital
- Information about staff is displayed for patients.

Communicating effectively

We saw that staff on the wards met twice daily, at shift change over time. This was in order to communicate and discuss patient needs and plans with the intention of maintaining continuity of care. Information was also captured in handover sheets, to ensure all staff were kept up-to-date with relevant information.

There was a patient information board displayed on each ward. The boards provide information regarding patient safety issues, daily care requirements, plans as well as individual support required and discharge arrangements. We found these to be a good tool to communicate with staff across the wards. These were kept out of view of patients and visitors to protect patient confidentiality.

Timely care

Patients we spoke with on Pen-y-cwm ward told us that staff were attentive to their needs, and answered bedside call-bells quickly when called.

Just under two thirds of staff who completed a questionnaire told us that they were sometimes unable to meet all the conflicting demands on their time at work.

Labour ward had the use of STAN[7], a system to continuously monitor the fetal heart. The recordings were able to be viewed centrally in the midwives office on labour ward in real time, and highlighted where there were potential issues. This meant that timely access to additional support, care or treatment could be highlighted and acted upon. In addition, as the recording were able to be viewed centrally, this meant that patients did not have to be disturbed to view the findings.

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.

Individual care

Planning care to promote independence

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

The use of a language line was available for those patients whose first language was not English, meaning that they were able to access care appropriate to their needs.

Patient's personal beliefs and religious choice were captured during antenatal appointments, with a view to ensuring they were upheld throughout their pregnancy, during labour and postnatal care.

Carers were encouraged and welcomed to stay on the wards, to support patients who may have additional needs.

People's rights

[7] A fetal monitor which combines standard cardiotocography (CTG) technology with ST-Analysis (analysis to detect and alert changes that are related to the risk of fetal hypoxia)

Whilst we saw that the service had a birth centre, allowing patients to choose midwife led care, we found that this choice could often be restricted due to staffing issues. The birth centre had two dedicated midwives responsible for covering the shifts during the day, however, there were no dedicated midwives during the evening or night. We were told that community midwives would be called in to support a woman in labour during these times. However, due to difficulties in staffing the birth centre, due to staff absences, it was not often used and patients would receive their care on the labour ward. Whilst they may receive midwife led care on labour ward, they would not have access to the birth centre facilities, such as the birthing pool. This could potentially impact upon the birth choice of patients wishing to use the facilities. A recommendation regarding staffing is made in the 'Delivery of safe and effective care' section of this report.

We found the facilities within the birth centre did not uphold the ethos of being a midwife led unit[8]. This is because we found it to be a medicalised environment with limited equipment to support patients in low risk labour wanting a midwife led experience in a less clinical setting. There were no birthing mats for the floor, neither were beanbags available. Birthing balls were stored in a cage in a corridor, however they were dusty and it was unclear if and when they would be used.

We were told that the health board held birth choice clinics, to promote the birth options available to patients and to provide information to help them make an informed decision. However, we looked at a sample of patient care records and found limited documentation of discussions held with patients regarding their birth choices. A recommendation is made about this in the 'Delivery of safe and effective care' section of this report. One patient we spoke with told us about their negative experience because they believed they were not given any choice regarding their birth.

Improvement needed

The health board must consider whether the current arrangements and facilities provided in the birthing centre uphold the standards and ethos of a midwife led unit to actively support patient choice.

[8] Often midwife led units provide a home from home environment in a non clinical setting

Listening and learning from feedback

We saw only one information leaflet across the wards relating to the complaints procedure for patients to follow should they have concerns they wish to raise. Information was available on health board's website, which provided contact details the procedural information for patients. Advocacy information was also included on the website. We were told that there was a designated midwife lead within the health board who would liaise with the Putting Things Right[9] team for consideration of formal patient complaints.

The service also had a process for addressing non-formal complaints, with the intention of resolving them at an informal level. Informal complaints could be referred into the service through feedback from community midwives, through health visitors and through social media sites. 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 complaints procedure should they wish to follow this route. We were told that this was used as a way of hopefully addressing any concerns, but also with a view to highlight any practice issues that may need resolving.

As a consequence of a review of a neighbouring health board's maternity services[10], we were told that the service was actively trying to promote their social media outlets with a view to obtain patient feedback. We were told that feedback received is presented on a monthly basis to the services clinical governance meetings highlighting any themes or trends.

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

[10] https://gov.wales/sites/default/files/publications/2019-04/review-of-maternity-services-at-cwm-taf-health-board_0.pdf

We also saw that there was a graffiti board on Pen-y-cwm ward which allowed patients to write comment about their care and treatment received. We saw that there were many positive comments provided by patients, expressing their thanks to the staff on the wards.

Improvement needed

The health board must ensure that details of the complaints procedure, Putting Things Right, is clearly displayed across all wards.

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 a number of 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 including the following:

- The security of babies on the wards
- The storage of equipment for use in a patient emergency, and associated emergency protocols
- Irregular and inconsistent checks on emergency equipment
- Irregular and inconsistent checks on fridge and freezer temperatures used to store medicines
- Management and security of confidential patient information
- Security and storage of the drugs trolley.

We also found areas for improvement with regards to infection control processes and procedures across the wards.

We found that there were robust processes in place for the management of clinical incidents, ensuring that information and learning is shared across the service.

The service described good arrangements for safeguarding procedures, including the provision of training.

Safe care

Managing risk and promoting health and safety

We considered the ward environment and found insufficient security measures in place to ensure that babies were safe and fully protected on the wards at all

times. In contradiction to the health board's own policy, the service was not using any form of electronic security measures, such as electronic tagging, to ensure that babies were secure on the wards, and to prevent baby abductions. We were told by staff that electronic tags had not been used for approximately one year due to the system becoming obsolete and being unable to source additional security tags.

The health board's own policy on Prevention of Infant Abduction, Maternity Units issued 1 February 2018, confirmed that the ward should be using electronic tagging as a form of security. The policy also states that the system (of electronic tagging) will be function checked on a daily basis.

We also found that the health board's own risk register for the Families and Therapies Division stated that baby alarms were in place at Nevill Hall hospital covering the labour and Pen-y-cwm ward.

We raised this immediately with representatives of the senior management team, and some additional security measures were put in place. Baby bands from the special care baby unit were sourced and babies on the wards were tagged. The buzzer entry system in and out of Pen-y-cwm ward was activated and patients, staff and visitors were required to be buzzed both in and out of the ward, and required visual sight by a member of staff for this to happen.

However, the service was only able to locate 10 electronic tags, and these were to be shared across maternity services and special care baby unit.

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

We found labour ward was bright and relatively uncluttered. However, we found the environment on Pen-y-cwm ward and the birth centre to be tired and dated. There were pieces of equipment located in walkways and corridors, potentially causing trip hazards. We also found that a cleaner's cupboard on Pen-y-cwm ward was left open and unlocked, with cleaning materials left within easy access. This was raised immediately and action was taken to rectify the situation, details of which can be found in Appendix A.

We looked at the arrangements on the wards for accessing emergency help and assistance in the event of a patient emergency. We saw that in the birth centre there was one birthing room which did not have access to an emergency buzzer. Whilst there were emergency call bells in the toilets and bathrooms in Pen-y-cwm ward, none were located in the bays or side rooms. Staff told us that they would

press the call bell three times to request help and phone the labour ward in the event a patient needed to be transferred and/or additional help was required.

We also found the emergency trolley, for use in a patient emergency, was disorganised and did not contain all the appropriate equipment, including a defibrillator. We found this was kept on another ward opposite Pen-y-cwm ward. The emergency drugs were also not stored on the emergency trolley.

During a patient emergency, this would mean one member of staff being required to get the defibrillator, and another locating the emergency drugs, potentially causing a delay to treatment.

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

Falls prevention

We saw there was a risk assessment in place for patients using birthing pools across the wards. We were informed that any patient falls would be reported via the health boards electronic incident recording system, and their incident reporting system would be followed to ensure lessons learnt recorded and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the wards were clean and tidy, however, we found areas where improvements needed to be made to overall infection control arrangements.

We saw that personal protective equipment (PPE) was available in all areas and was being used by all healthcare professionals.

Hand washing and drying facilities were available, together with posters displaying the correct hand washing procedure to follow as a visual prompt for staff. Alcohol sanitiser gels were available throughout the wards, however we found that three were empty.

We were told that an infection control audit had been carried out by the health board in the week prior to the inspection, however the results and findings were yet to be received by the service.

The service had an en-suite room available for patients use should there be a requirement for barrier nursing, to help prevent infections being transferred to other patients.

We saw that the window sills across the wards were dusty, as was the non-patient stairwell leading from Pen-y-cwm ward to the labour ward. Birthing balls were also stored in this stairwell in a cage which looked dirty and dusty.

We observed one occasion where a patient bay had been cleaned and the bed had been made up ready for a new patient. The clean bed was moved to ensure cleaning of the floor could be carried out, however, a chair was upturned and placed upon the clean bed. This could potentially contaminate the clean bed and prevent effective cleaning and infection control.

Whilst we found the individual rooms on labour ward to be clean and tidy, the cleaning schedules did not reflect that they had been cleaned on a daily basis. We discussed this with members of the senior management team who confirmed that this should be done every day, and records maintained. We were told that the cleaning schedules are collated on a weekly basis by a senior manager to check that this has been done.

In the birth centre, there was a plumbed in birthing pool. A thermometer was attached to the side of the pool via a piece of string to prevent losing it. However, the string was unable to be effectively cleaned between patient use, therefore not upholding effective infection prevention standards. We also found that the birthing pool was not cleaned every day, neither was a weekly check of the water carried out consistently as required. These checks would ensure that the birthing pool was appropriately cleaned and safe to use.

During the inspection, we observed a number of staff not upholding the standards of being Bare Below the Elbow[11]. We saw staff wearing wrist watches, long sleeved clothing, bracelets, rings and nail varnish.

There were double doors leading into the theatre department, and we found one of the set of doors chipped and damaged. Tape was put around some of the damage, however, due to the doors being wooden, any chips or damage may prevent effective cleaning.

[11] 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 heath board must ensure the following:

- Cleaning standards are upheld across all areas of the department, including the patient and non-patient areas
- Hand sanitiser gels are replaced promptly to make sure staff, patients and visitors are able to effectively clean their hands
- Domestic staff are aware of the standards and processes for ensuring effective cleaning to uphold infection prevention and control standards
- Labour rooms are cleaned daily and records maintained to demonstrate this
- The thermometer used in the birthing pool is appropriately attached so that effective cleaning can be maintained
- The birthing pool is cleaned on a daily basis and weekly checks of the water are carried out. Records must be maintained to demonstrate this has been actioned
- All staff are reminded of the bare below the elbow policy
- The theatre doors are either fixed or replaced to ensure that effective cleaning can be carried out.

Nutrition and hydration

Patients we spoke with told us they were happy with the food they were provided. They told us that portion sizes were generous and that they had a good selection of food to choose from, and meals arrived hot and ready to eat. Patients had access to a large, spacious day room on Pen-y-cwm ward, and were encouraged by staff to have their meals there. Breakfast provisions were set up in this room, and patients were able to help themselves. For those unable to do this, staff would ensure patients were supported to have breakfast in a place of their choice.

Staff on the wards had access to facilities to make food and drinks for patients outside of core hours, which allowed for nutritional needs being met throughout the day and night.

All patients had water jugs, and drinks were placed within easy reach to ensure patients had ease of access.

Medicines management

We found improvements were needed with regards to areas of medicines management across the wards.

We looked at the arrangements for the storage of medicines on the wards. We found that fridge temperatures were not consistently checked on a daily basis. We also found the temperature of the freezer used to store medicines on the postnatal ward was not checked daily. These checks are needed to ensure medicines are stored at the appropriate temperature and safe for use. We also found that ice-lollies and drinks were also found to be stored alongside medicines. Food items should not be stored alongside medicines to prevent cross contamination.

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

We observed the storage, checks and administration of controlled drugs to be safe and secure. However, during the tour of Pen-y-cwm ward during our night visit we found the drugs trolley was unattended and unlocked, with the keys being kept inside. This was raised immediately and action taken to rectify the situation, details of which can be found in Appendix A.

Drug rounds were carried out three times a day, and other medication was prescribed on request as needed. We observed staff asking patients if they were in pain and/or in need of medication. We found that the administration and recording of medication was appropriate and well documented.

Pharmacy support was available to the wards. 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 ward also had access to a stock of take home medication, allowing patients to be discharged in a timely manner.

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 all except one member of staff who completed a HIW questionnaire confirmed that they had received training within the past 12

months. The remaining staff member stated that their training had been booked to be completed within the next six months.

There was an appointed lead safeguarding midwife for the health board, and they provided us with a detailed account of the support and training provided to staff. Safeguarding training was included in the health boards mandatory study days, and we were told that sessions included training and 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. The lead safeguarding midwife was also available for telephone discussions to provide support and guidance to staff on the wards. 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 wards, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

We considered the arrangements for checking of resuscitation equipment on the wards. We found the checks on equipment to be inconsistently recorded and did not demonstrate that they had been carried out regularly. We found checks had not been carried out on the following equipment:

- Neo-natal resuscitaires[12]
- Emergency trolley.

We raised this immediately with representatives of the senior management team who confirmed these checks should be carried out daily, on each shift.

[12] Equipment used in the resuscitation and clinical emergencies of babies

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

We also found that regular checks of other pieces of equipment, such as blood pressure machines, were not carried out in a consistent and regular manner. We could not be assured that all equipment being used on the wards were being checked on a regular basis and in-line with the frequencies associated with individual pieces of equipment.

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 activities on the wards, including checks of equipment.

Improvement needed

The health board must ensure that all equipment is regularly checked within appropriate timescales to ensure it is safe for use.

Effective care

Safe and clinically effective care

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, insufficient security measures in place to fully protect babies on the wards, personal information not always protected and the drugs trolley left open and unsecured. We also found there was insufficient oversight of ward activities to ensure essential processes and procedures were being followed to support the delivery of safe and effective care. It was, however, positive to find that staff reacted quickly and promptly to address the issues we raised.

Whilst the labour ward utilised cardiotocography (CTG) and STAN monitoring, and had good sight of live activity of fetal heart monitoring, we did not see that

there was a 'fresh eyes'[13] approach to those patients under constant monitoring. This is required to ensure that the interpretation of CTG readings are appropriate, and concerns or issues can be promptly acted upon and should be conducted hourly.

Some staff told us that there were occasions where midwives (core birth centre and community midwives) were taken away from the birth centre and/or the community to provide care on the labour ward, due to staffing issues. Staff reported that they did not feel they had the appropriate up-to-date skills and knowledge to deal with acute patients. Some staff told us that they had experienced difficulty in transferring patients from the birth centre to labour ward, when issues during labour had occurred.

As previously mentioned in the report, we found that the use of the birth centre could be restricted due to staffing issues, therefore affecting the care provided to patients and their birth choice. Whilst we found some issues regarding the suitability of the birth centre environment, we found this to be an underused resource within the service.

We saw that patients on the wards appeared comfortable and well cared for. Pain relief was available to patients during labour, and we saw medication appropriately prescribed in postnatal care and patients receiving it promptly. We were told that inflatable birthing pools were previously used on labour ward, as non medical pain relief, however the service no longer used these. As previously mentioned, there also appeared to be an underutilised birth pool in the birth centre which could offer non medical pain relief. Whilst we saw that posters were displayed detailing different labour positions, there was limited equipment to allow patients to be supported in these positions.

Improvement needed

The health board must ensure that CTG interpretation is undertaken in line with best practice, including the use of a 'fresh eyes' approach.

[13] Where continuous CTG monitoring is in place, it is recommended that another healthcare professional looks at the CTG readings as a new pair of eyes

The health board must ensure that staff are appropriately appointed into roles during shifts to account for their skills, knowledge and experience.

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.

The health board led a national project, 'Your Birth – We Care[14]', 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.

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. This included the following:

- Confidential waste being stored in unsecure and unlocked rooms in Pen-y-cwm ward and the birth centre

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

- Patient identification labels being found on the wrong patient record
- During an out-of-hours tour of the maternity service, we found the door open and unlocked to the obstetric records room with old patient records in waiting to be archived
- The trolley containing patient records on Pen-y-cwm ward was unlocked and not located in a non-patient area.

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

Record keeping

Overall, we found the standard of record keeping to be adequate. Some patient records we looked at were disorganised and 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:

- SBAR[15] for triage patients to be fully documented
- Discussions with patients regarding their birth choices to be fully documented, including the risks and benefits of all procedures
- Waterlow charts (to assess the risk of a patient developing pressure ulcers) to be fully documented
- Whilst we saw that preventative measures had been put in place to prevent venous thromboembolism (VTE)[16] for patients on Pen-y-cwm ward, we did not see that risk assessments had been documented to support the reason why

[15] A tool used to clearly communicate patient information amongst staff in a clear and concise way under four domains; situation, background, assessment, recommendation

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

- Limited evidence of carbon monoxide testing for those patients who indicated they smoke, in line with NICE guidelines[17].

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.

[17] https://www.nice.org.uk/guidance/ph26/chapter/1-Recommendations#effective-interventions

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.

We found the service to be in a fragile state, with uncertainty about the future. We found this affected staff morale across the hospital.

Whilst there were difficulties with regards to ensuring medical rotas were sufficiently filled, we found there were robust arrangements in place to monitor the situation to ensure care and treatment was not compromised.

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

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

Governance, leadership and accountability

The provision of maternity services at Nevill Hall hospital was co-dependent upon a number of services across the health board, such as neonatal and paediatric services. We found that due to the fragility of staffing, in particular some medical rotas across these services, that the ability of the health board to continue to provide obstetric led maternity care at Nevill Hall hospital was at times compromised.

The medical cover for neonatal services at Nevill Hall hospital were provided by the paediatric doctors. We were told that the paediatric medical rotas at Nevill Hall hospital had been difficult to staff fully to ensure there was sufficient cover at all times, directly impacting upon the neonatal service and as a consequence also maternity services. This meant potentially compromising the service for babies born pre-term and requiring specialist care from the neonatal team.

We were told that the health board had a two phase plan to centralise the services (maternity and neonatal, potentially followed by paediatrics) to the Royal Gwent hospital in Newport. We also saw that the health board had a plan in place should they need to centralise the services in an emergency, at short notice. However, we were told that the planned move to centralise the services had been put on hold, due to circumstances outside of the control of the health board. This was in relation to a neighbouring health board, Cwm Taf Morgannwg University Health Board, maternity services being placed into special measures, and the impact it may have on maternity services for women in the local and neighbouring area.

We were assured that the health board was monitoring the medical rotas on a weekly basis, via a medical sustainability impact assessment, to ensure that the services could be maintained safely and effectively. At the time of inspection, there was no immediate plan to move maternity services from Nevill Hall.

A six-weekly Women and Children's Transition Board meeting is also held by the directorate. This meeting is held with a view to providing a strategic oversight of the service, in relation to the other services and their co-dependencies within the directorate.

However, whilst we found that there was good, overall monitoring and governance of the staffing levels of the service, we were not assured that all areas of risk were monitored appropriately by the health board. As referenced earlier in the report, the Families and Therapies Division own risk register stated that electronic monitoring of babies in Nevill Hall hospital was in place. However, during the inspection we found that this had not been in place for approximately 12 months. This raises the question whether the risk register accurately captured all risks relevant to maternity services, and whether senior management of the health board were fully sighted of all relevant risks.

We also found that there was insufficient audit activity being carried out on the ward, to ensure that essential activities were being undertaken. This is demonstrated by findings earlier in the report, including, but not limited to, the following:

- Daily checks on emergency equipment
- Daily checks on medicine storage temperatures
- Regular checks of the electronic security baby band system
- Cleaning arrangements for the wards and birthing pool
- Arrangements for security of patient information

- Arrangements for the security of the drugs trolley.

We were told that some staff with management responsibility did not have any non-clinical time, impacting upon their ability to undertake some of these tasks. We were not assured that there was sufficient oversight by the management of the wards to be confident that there was a robust process in place for audit activity, to help demonstrate a safe and effective service.

We were able to see that there was a good level of oversight of clinical activities and patient outcomes. 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 on the wards i.e. number and category of births (vaginal, caesarean section, assisted), induction of labour, and also clinical indicators and incidents, such as complaints, investigations, eclampsia[18], intensive care admissions, blood transfusions, neonatal admissions and neonatal morbidity. The dashboard was rated red, amber and green depending upon the level of risk associated with the numbers and figures.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff who completed a HIW questionnaire either agreed or strongly agreed that the organisation encourages them to report errors, near misses or incidents.

Bi-weekly risk meetings were held at Nevill Hall hospital where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. This information also included other maternity sites within the health board, with a view to sharing best practice and any learning to improve practice and processes.

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

[18] The onset of seizures during pregnancy

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.

Improvement needed

The health board must ensure there are robust audit processes in place of ward activities, and that there is sufficient oversight of this within the health board.

The health board must ensure that staff with managerial responsibilities are provided with appropriate time and are supported to carry out non-clinical tasks.

Staff and resources

Workforce

As referenced earlier within this report, the service was in a fragile state, as a result of staffing issues across both maternity services and due to the direct relationship with other services provided by the hospital, such as neonatal and paediatric.

We were told that midwifery rotas were currently stable, and whilst there were some vacancies, these had all been appointed into, with them due to be filled by October 2019. In the meantime, the service was reliant upon bank staff to cover shifts. Most staff also rotated between the labour ward and Pen-y-cwm ward, meaning that they were able to adjust and move staff around based upon need and acuity. We were told that this was sustainable and manageable in the short term, whilst waiting for new staff to start.

Over half of staff who completed a HIW questionnaire told us that there was sometimes enough staff at the organisation for them to do their job properly, with the remainder answering that there was usually enough staff. One member of staff said there was never enough staff.

We were told that there were staffing issues within the birth centre. We learnt that there were around 18 shifts in August 2019 where the health board was unable to provide midwives. This may have a direct impact upon the choice of a woman to have her birthing wishes fulfilled.

We were told that obstetric rotas within the service were currently stable, however there were more long term locums employed compared to full time substantive

staff. Whilst fragile, we were able to see that the health board had appropriate and robust processes in place to manage the rotas, which were co-dependent upon other services, as previously highlighted. In an attempt to mitigate the staffing issues, the health board had recently advertised for additional medical staff at various levels, to help ensure that rotas were sustainable and could be maintained. The recruitment process was due to be completed in August 2019.

As a consequence of uncertainty of the future of maternity services at Nevil Hall Hospital, some staff told us that morale was low. Staff felt they received mixed messages about whether the service would be centralised, and felt insecure about their future. As a consequence of this, we were told that a number of midwives left the service in January 2019. Senior staff told us they felt that communication with staff was consistent, in that a decision to centralise services had not been made, staff we spoke with did not convey this message.

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 PROMPT[19] training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. Five members of staff who completed a HIW questionnaire told us that they had not attended PROMPT training within the past 12 months, however two of these stated that they had been booked on to complete the course within the next two months.

Training included in the other mandatory study days included cardiotocography (CTG), safeguarding, incident reporting, basic life support, supervision, public health amongst other topics.

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

Whilst staff responses to the HIW questionnaire regarding completing training within the past 12 months was generally high, we found that only a quarter of those who completed a questionnaire had received Gap Grow[20] training within the past 12 months. We were told that there was an agreement for additional midwives to attend this training to support best practice within the health board.

We were told that attendance at study days prior to April 2019 had been poor, this was often due to staffing issues and acuity levels on the wards, resulting in staff being taken out of training sessions to attend to a clinical area. As of April 2019, a new process was put in place meaning that only a senior manager was able to authorise a member of staff being taken out of training due to clinical need.

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 were able to see 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 and non-attendance at training is reported to the senior teams. Attendance was rated red, amber and green to highlight if any action was required to ensure that staff were attending relevant training. The health board had also put in place four additional PROMPT training sessions at Nevill Hall hospital for the remainder of the year, as a result of staff feedback in finding it difficult to attend training sessions at other locations.

Three clinical supervisors for midwives were in place across the health board. Their roles were to provide support and professional supervision to midwifery staff. There is a national target to make sure that supervisors meet with midwives for four hours[21] each year. The health board started to monitor compliance with this target during the previous financial year, and were continuing to monitor it on an ongoing basis. We were told that this was a difficult target to meet, as there

[20] GAP/GROWTH Assessment Protocol (GAP) has been shown to significantly increase the detection of fetal growth restriction (FGR) which is a significant cause of stillbirth, neonatal death and perinatal morbidity

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

was no designated non clinical time for staff supervision sessions, resulting in only 55% of midwives having received four hours of supervision.

The clinical supervisors for midwives were also responsible for carrying out appraisals. We were told that there were nine appraisals overdue from the previous financial year. All bar one member of staff who completed a HIW questionnaire told us that they had received an appraisal of their work within the past 12 months.

We found that there was a good level of support in place from the specialist lead midwives. Whilst they were not based at Nevill Hall hospital, we found they made efforts to be visible and approachable to ward staff. Information provided to us during the course of the inspection demonstrated that they were knowledgeable about their specialist roles, and they provided support and guidance through study days, supervision sessions and meetings with staff as and when required.

Staff reported that there was good multidisciplinary working within the service. One staff member who completed a HIW questionnaire commented:

> *"There is a strong teamwork ethic in this maternity unit and I am proud to work here."*

The majority of staff who completed a questionnaire told us that the organisation either always or usually encouraged teamwork.

Improvement needed

The health board must ensure that the birth centre is adequately staffed to be able to provide a service supportive of women's wishes and needs.

The health board must review the adequacy of communication with staff, to ensure all staff receive a consistent message in regards to the future of the service and provide support during times of uncertainty

The health board must consider how they enable staff to attend supervision sessions in a timely way in line with national targets.

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
We found during a tour of Pen-y-cwm ward that the door to the cleaner's cupboard was open and unlocked, with various cleaning materials kept inside.	This meant that there was potential for patients and visitors to have access to hazardous materials.	We raised this immediately with the midwife in charge.	The door was locked immediately to prevent unauthorised access.
We found during a tour of Pen-y-cwm ward that the drugs trolley was open and unlocked, with the keys kept inside.	This meant that there was potential for patients, unauthorised staff and visitors to have access to medication.	We raised this immediately with the midwife in charge.	The keys were removed and the drugs trolley locked immediately. The trolley was removed from the corridor out of patient access.

Appendix B – Immediate improvement plan

Hospital: Nevill Hall

Ward/department: Labour, Pen-y-cwm ward and the birth centre

Date of inspection: 22, 23, 24 July 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 provide assurance about the measures put in place to ensure that babies are safe and secure across its maternity services in the immediate and long term to prevent baby abductions. The health board must ensure that governance arrangements for the Families and Therapies Division in relation to risk management are fit for purpose, that the risk register accurately reflects current risks, and is updated and reviewed regularly.	Health and Care Standards (April 2015) 2.1 Managing Risk and Promoting Health and Safety 2.7 Safeguardin	Immediate action was taken during the inspection to address the security issue. Nevill Hall Hospital uses the 'Spectra' tagging system. It is an aged system and no longer available to procure, therefore sourcing the respective tags has been a challenge.	Deb Jackson – Head of Midwifery	Completed with ongoing checks in place

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	g Children and Safeguarding Adults at Risk	The Health Board are aware of the issue and this has been identified on the Divisional Risk Register. Contrary to the HIW findings there are deemed to be sufficient tags in local stock, based on predicted demand, to ensure effective baby tagging until the commissioning of the GUH. Despite this, the tagging system was non-operational at the time of the HIW visit and this is unacceptable. The tagging has been reinstated. Should there be increased demand &/or insufficient tags the risk score will be elevated with mitigating actions. The Divisional Risk Register is formally reviewed monthly. Daily checks have been introduced, undertaken by Midwife in Charge of		

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		the Unit, to ensure all babies are tagged. A system of weekly checks by the Senior Midwife has also been introduced.	Cath Graves - Senior Midwifery Manager	Complete
		The ABUHB can confirm that the security systems for the Royal Gwent Hospital, Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan are robust and effective, with the identified issues in NHH not a problem elsewhere.		
		Multi-disciplinary abduction drills are carried out in all areas and the next one is scheduled within the next 3 months, as per policy.	Deb Jackson – Head of Midwifery	In place and Ongoing
		A process of reviewing risk is in place through monthly divisional Quality and Patient Safety meetings. The division will reconcile risks identified and mitigating actions through the	Deb Jackson – Head of Midwifery	In place and ongoing

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		risk management process and monitoring. The senior midwifery manager and Head of Midwifery have formally met with lead midwives, for all sites, to communicate the HIW findings to staff.	Cath Graves / Deb Jackson	Complete
The health board must ensure that drug fridges and freezer temperatures are checked and recorded on a daily basis in line with their policy. The health board must ensure that non-medical items, such as food, are not stored in freezers used to store drugs.	Health and Care Standards (April 2015) 2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	All non-drug items were immediately removed from the drug storage fridge/freezer during the inspection. Fridge temperature monitoring charts, which are completed and recorded daily, have been renewed. All midwifery staff have been informed and reminded, via email, at ward team meetings & via group supervision sessions of the importance of temperature checks and appropriate use of fridges and freezers.	Cath Graves - Senior Midwifery Manager Cath Graves - Senior Midwifery Manager Cath Graves - Senior Midwifery Manager Carolyn Middleton – Associate Director of Nursing	Complete Complete Complete August 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	2.9 Medical Devices, Equipment and Diagnostic Systems	Communication is to be cascaded across the Health Board reminding all staff, beyond midwifery, of the importance of temperature checks and appropriate storage, as per the ABUHB policy.		
The health board must ensure that checks on emergency drugs and equipment are carried out on a daily basis in line with their policy. The health board must ensure that emergency drugs and equipment are organised in a way that they are easily accessible and available for use quickly in a patient emergency. The health board must provide assurance that the emergency call systems in place are appropriate and provide sufficient support to staff and patients on the wards.	Health and Care Standards (April 2015) 2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices,	The importance of daily equipment checks of the resuscitaires and emergency equipment and recording of such has been reinforced with the midwifery staff, across the Division. The check list identifies all the necessary equipment required, its presence and location. The rationale for one AED being shared with Glan Usk was based on the resuscitation council guidance that in the event of a cardiac arrest in hospital the AED should be attached to the patient within 3 – 5 minutes of CPR commencing.	Deb Jackson – Head of Midwifery Cath Graves – Senior Midwifery Manager Deb Jackson Cath Graves – Senior Midwifery Manager Meabh Cassidy - Pharmacy Manager Paul Taylor - Resuscitation Officer /Lisa	Complete Complete Complete Complete September 2019 September 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
	Equipment and Diagnostic Systems	A further AED specifically for Pen Y Cwm has however been ordered. Immediate action has been taken to ensure Adrenaline is located on the trolley, as per ABUHB policy. The Pharmacy Department will coordinate a Health Board wide check of Adrenaline and its location on all emergency trollies. The resuscitation team, in conjunction with pharmacy, are undertaking a review regarding drug Cardiac Arrest boxes and location. The current system in place with the ring of 3 in an emergency will continue with a written protocol, to be shared with all staff. All new staff and temporary staff will be informed of the process on induction. A risk assessment will be undertaken by the Health and Safety Officer in collaboration with the Clinical Governance Lead Midwife to	Forey - Pharmacy Manager Gwyneth Ratcliffe – Clinical Governance Lead	August 2019 August 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		determine the level of risk posed with the present call bell system. Upon completion actions will be considered by the Divisional Management Team.		
The health board must provide assurance that there are appropriate processes and systems in place which upholds and protects patient confidentiality, and prevents unauthorised access to patient records at all times.	Health and Care Standards (April 2015) 3.5 Record Keeping	The Health Board takes seriously its responsibilities for information governance and data security, with clear policies and auditing processes. To this end, the Family and Therapies Division was recently audited by the IG Team with positive results. In light of the HIW findings further auditing will be initiated. Divisional staff have been formally reminded of their information governance responsibilities and of the correct and safe storage of patient information, via email and team meetings. An Information Governance notice will be issued to reinforce the importance of upholding and	Deb Jackson – Head of Midwifery Deb Jackson – Head of Midwifery Richard Howells – Head of Information Governance	October 2019 August 2019 August 2019

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		protecting patient information, access to records and the security of confidential waste across the Health Board.		

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): Deb Jackson

Job role: Head of Midwifery and Associate Director of Nursing

Date: 30th July 2019

Appendix C – Improvement plan

Hospital: Nevill Hall

Ward/department: Labour, Pen-y-cwm ward and the birth centre

Date of inspection: 22, 23 and 24 July 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 consider whether the current toilet and bathrooms facilities uphold the dignity of patients.	4.1 Dignified Care	The Health Board has considered carefully the findings of the inspection. It is recognised that the toilet and bathroom facilities are limited, with not all rooms on the labour ward being en-suite. As outlined during the inspection the maternity service at NHH will move to the Grange University Hospital (GUH) and all rooms will have en-suite facilities.	Dave Williams - Divisional Director Family & Therapies	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Therefore this will not be prioritised for capital investment at NHH. It is pleasing to note that the inspection found that staff did maintain the privacy and dignity of patients. A free standing Birth Centre will remain in NHH. The location is to be confirmed and a key consideration will be the facilities for women and their families.		
The health board must ensure that: • Signage at the hospital is reviewed to ensure it is easy to read for all patients and visitors to the hospital • Information about staff is displayed for patients.	4.2 Patient Information	Signage for Maternity Services has been reviewed to ensure easy read for women their families and visitors, with changes made. Consideration has been given to a display board and this has been discussed with the team. However review has confirmed that women and family members are aware of key contacts and it was not felt that a display board was required. Midwives on each shift introduce themselves to the women they are caring for. There have been no	Kerry Jefferies - Service Improvement Manager, Family and Therapies Cath Graves - Senior Midwife Manager, Family and Therapies	Complete Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
		concerns raised that women are not aware of the midwife who is caring for them.		
The health board must consider whether the current arrangements and facilities provided in the birthing centre uphold the standards and ethos of a midwife led unit to actively support patient choice.	6.2 Peoples rights	The environment and equipment offered to women within the Birth Centre ensure optimal birth outcomes and the arrangements and facilities uphold the standards and ethos of a midwife led unit. The facilities include the birthing pool, soft furnishings, more homely lighting, and space for family members and privacy. Birthing mats are not used within this area to avoid the risk of trips and falls and bean bags are not provided in line with Infection control risks.	Louise Taylor – Consultant Midwife, Family and Therapies	Complete
The health board must ensure that details of the complaints procedure, Putting Things Right, is clearly displayed across all wards	6.3 Listening and Learning from feedback	Putting Things Right Leaflets are available and posters are now displayed within the Maternity Unit.	Kerry Jefferies - Service Improvement Manager, Family and Therapies	Complete
Delivery of safe and effective care				

Improvement needed	Standard	Service action	Responsible officer	Timescale
The heath board must ensure the following: • Cleaning standards are upheld across all areas of the department, including the patient and non-patient areas	2.4 Infection Prevention and Control (IPC) and Decontamination	The clinical areas of the wards were found to be clean and tidy. Immediate action was taken to ensure that the dust identified on window sills and in the non-patient areas was addressed. Ongoing monitoring is in place to ensure cleaning schedules are kept up to date.	Gareth Hughes - Divisional Director of Facilities	Complete
• Hand sanitiser gels are replaced promptly to make sure staff, patients and visitors are able to effectively clean their hands		Hand sanitiser gels were replenished immediately with ongoing monitoring in place.	Cath Graves - Senior Midwifery Manager, Family and Therapies	Complete
• Domestic staff are aware of the standards and processes for ensuring effective cleaning to uphold infection prevention and control standards		All domestic staff receive training with regard to infection prevention and control. The findings of the inspection have been shared with the facilities team.	Gareth Hughes - Divisional Director Facilities, Family & Therapies	Complete
• Labour rooms are cleaned daily and records maintained to demonstrate this		Labour rooms are cleaned daily with monitoring in place to ensure cleaning schedules completed.	Cath Graves - Senior Midwifery Manager. Family & Therapies	Complete
• The thermometer used in the birthing pool is appropriately attached so that effective cleaning can be maintained		Immediate action was taken to remove the thermometer and it is now kept in the pool room. This is cleaned as part of the daily cleaning regime.	Cath Graves - Senior Midwifery	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
• The birthing pool is cleaned on a daily basis and weekly checks of the water are carried out. Records must be maintained to demonstrate this has been actioned • All staff are reminded of the bare below the elbow policy • The theatre doors are either fixed or replaced to ensure that effective cleaning can be carried out		The pool is cleaned daily with a record of the cleaning. Water samples are sent weekly as per Health Board policy and a record kept. This is monitored by the lead midwife on the ward. All staff have been formally reminded of the requirement to be bare below the elbow. A review of the theatre doors has been undertaken by the infection control team and estates. The advice is that the doors do currently meet infection control requirements, the doors will be regularly monitored to ensure they meet the required standards.	Manager, Family & Therapies Cath Graves - Senior Midwifery Manager Deb Jackson - Head of Midwifery Dave Williams - Divisional Director, Family & Therapies	Complete Complete Complete
The health board must ensure that all equipment is regularly checked within appropriate timescales to ensure it is safe for use.	2.9 Medical devices, equipment and diagnostic systems	The Health Board has provided immediate assurance on the regular checking and safety of equipment. Equipment such as blood pressures machines are included in the daily cleaning standards and this is regularly audited.	Deb Jackson - Head of Midwifery, Family & Therapies	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that CTG interpretation is undertaken in line with best practice, including the use of a 'fresh eyes' approach. The health board must ensure that staff are appropriately appointed into roles during shifts to account for their skills, knowledge and experience.	3.1 Safe and Clinically Effective care	The Health Board provides multi-disciplinary CTG training and PROMPT training in line with Welsh Government fetal surveillance standards and this includes the "fresh eyes" approach. The Maternity Service is birth rate plus compliant. At the time of the inspection the maternity service had no vacancies. Rostering is undertaken to take account of staff skills, knowledge and experience. However, on occasions due to sickness staff are moved to provide cover. This is closely monitored.	Deb Jackson - Head of Midwifery, Family & Therapies Deb Jackson - Head of Midwifery, Family & Therapies	Complete Complete
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	It is noted that the overall record keeping was found to be adequate, however some records were found to be disorganised and difficult to navigate. This has been brought to the attention of the medical records department. Staff in the Maternity Services have been reminded of the importance of fully completing documentation and care of the records.	Deb Jackson - Head of Midwifery, Family & Therapies	November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Record keeping audits are undertaken to review the organisation of records and completeness of documentation. The next audit will be November 2019 via the Clinical Supervisors for Midwives notes audit.		
Quality of management and leadership				
The health board must ensure there are robust audit processes in place of ward activities, and that there is sufficient oversight of this within the health board.	Governance, Leadership and Accountability	Ward level audit activity was immediately reviewed following inspection. This is being monitored via the Senior Midwifery Manager. Monthly reports of ward audit results are received by the Head of Midwifery. Walkabout checks are in place.	Jackie George - Senior Midwifery Manager, Family & Therapies Deb Jackson - Head of Midwifery, Family & Therapies	Complete Complete
The health board must ensure that staff with managerial responsibilities are provided with appropriate time and are supported to carry out non-clinical tasks.		The Head of Midwifery has reviewed responsibilities of staff with managerial responsibilities to ensure that sufficient time and support is available.	Deb Jackson - Head of Midwifery, Family & Therapies	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the birth centre is adequately staffed to be able to provide a service supportive of women's wishes and needs.	7.1 Workforce	The Integrated Community Midwifery Team support the delivery of this service to women. A review has been undertaken by the Senior Midwifery Manager to ensure there is midwifery cover for the birth centre at all times.	Jackie George - Senior Midwifery Manager, Family & Therapies	Complete
The health board must review the adequacy of communication with staff, to ensure all staff receive a consistent message in regards to the future of the service and provide support during times of uncertainty		The Health Board has a communication and workforce strategy to support the changes aligned to clinical futures. This is being taken forward with clear action and timescales and the maternity staff are a key group of staff included with this. It is recognised that this is a time of change for our staff.	Geraint Evans – Executive Director of Workforce & OD	Ongoing

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must consider how they enable staff to attend supervision sessions in a timely way in line with national targets.		Given the fragility of services in addition to the Maternity Services and divisional meetings and staff communications in place the Health Board has identified an Executive Director who meets weekly with staff to monitor and support service provision. All Midwives have ring-fenced time to attend midwifery clinical supervision sessions and this is in line with midwifery supervision requirements set out in key performance indicators submitted to Welsh Government. Current compliance is monitored and is in line with full year plan.	Peter Carr - Executive Director of Therapies & Health Science Deb Jackson - Head of Midwifery	Ongoing Ongoing

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): Deb Jackson

Job role: Head of Midwifery and Associate Director of Nursing

Date: 17 September 2019