Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

The Grange University Hospital, Maternity Unit
Aneurin Bevan University Health Board
Inspection date: 6 - 8 June 2023
Publication date: 14 September 2023

This summary document provides an overview of the outcome of the inspection

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Women and birthing people provided positive feedback about the care and treatment provided to them and their families on the Maternity Unit at The Grange University Hospital.

We found arrangements in place to provide safe and effective care. However, we noted a small number of issues in relation to daily equipment checking and cleanliness in some areas.

We found that all staff at all levels worked well as a team to provide patients with a positive experience that was individualised and focussed on their needs. We saw staff delivering patient centred care despite some staffing pressures on the department.

A suitable management structure was in place with clear lines of reporting and accountability.

Generally, staff responses were positive regarding management, teamwork and the action taken by the organisation in relation to health and wellbeing. However, the responses indicate improvement was needed around staffing levels on the unit. We also identified improvement was needed in relation to compliance with some mandatory training.
Note the inspection findings relate to the point in time that the inspection was undertaken.

What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection at The Grange University Hospital, Aneurin Bevan University Health Board on 6 to 8 June 2023. The following hospital wards were reviewed during this inspection:

- Antenatal Ward – 8 beds
- Labour Ward – 17 beds (including 5 High Dependency beds)
- Postnatal Ward – 16 beds
- Alongside Midwifery Unit (Birth Centre) – 6 beds
- Induction of labour Ward – 8 beds
- Post operative Ward – 8 beds

Our team, for the inspection comprised of a HIW Senior Healthcare Inspector, a HIW Healthcare Inspector, HIW's Head of Quality and Acute Clinical Advice, three clinical peer reviewers (two midwives and one obstetrician) and a patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

This summary version of the report is designed for members of the public.

A full report, which is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients can be found on our website.

Quality of Patient Experience

Overall Summary

Staff were observed providing kind and respectful care to women and their families. We found that all staff at all levels worked well as a team to provide patients with a positive experience that was individualised and focussed on their needs. Almost all patients that we spoke to were positive about their care, the staff and the maternity unit environment. We saw staff delivering patient centred care despite some staffing pressures on the department.

Where the service could improve

- Review and consider increasing the availability of birth pools within the unit
- Review visiting arrangements and communicate timings effectively with families ahead of admission
- Review and consider increasing post-natal bed capacity to improve patient flow.

What we found this service did well

- Delivered patient centred care taking account of individual needs
- Light and spacious individual ensuite rooms and modern facilities
- Pregnancy information available in multiple languages via the Healthier Together website
- Patient representation via the Bump and Birth Improvement group (BABI) used to drive improvement in maternity services.

Patients told us:

"The care and support received by all staff was outstanding and thanks to this my whole birth experience was a positive one."

"During labour, the care I received was impeccable, but the aftercare was not so good.

"All care was delivered in a completely non-judgmental, open, honest and individualised manner."

Delivery of Safe and Effective Care

Overall Summary

We saw arrangements were in place to provide patients with safe and effective care. Some elements of good practice were seen. However, we did identify a small number of issues in relation to equipment checks and infection prevention and control (IPC) where HIW requires immediate assurance from the UHB on the action taken to address these.

Where the service could improve

Immediate assurances:

- Some furniture, fixtures and fittings in two rooms for care and treatment were observed to be visibly soiled with blood and bodily fluids
- Daily checks of one of the essential resuscitaires was not always recorded
- Daily fridge temperature checking of one of the medicines fridges was not always signed as checked
- Insufficient management and security of some confidential patient information.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- Ensure that all fire doors to cleaning cupboards are closed
- Review capacity and succession planning for all specialist midwife roles
- Ensure that staff have ready access to essential medical equipment
- Implement regular documentation audits and follow up learning for patient records

What we found this service did well

- Innovative initiatives to identify risks
- Clear and effective pathways of care for women and babies

Quality of Management and Leadership

Overall Summary

A management structure was in place and clear lines of reporting and accountability were described. Managers were visible on all areas of unit and comments from staff said that they were approachable and receptive to feedback. All staff said that there was a positive, supportive culture in place. We saw friendly, kind, approachable and well-functioning teams that worked well together all areas of the department. Some challenges were seen in relation to staff recruitment and retention. We also noted that compliance with mandatory training in some areas was poor.

Where the service could improve

Immediate assurances:

- Low levels of mandatory training compliance in some areas including key clinical skills.

This is what we recommend the service can improve:

- Recruitment and retention of staff to fill vacancies at all levels
- Improve staff access to spaces to take time out from clinical area
- Improve system for tracking of staff training.

What we found this service did well

- Routinely feeding back from patients to staff
- Including staff in learning and good practice identified in incident investigations
- Staff development opportunities available to all staff at all levels.

Staff told us:

Staff provided us with the following comments:

Note quotations that support what the service did well or areas that require improvement

Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the appendices of the full inspection report.

When we identify concerns that pose an immediate risk to patient safety we ask the health board to undertake urgent action. These concerns are outlined in the appendices and outline the action taken by the health board to protect patient safety and approved by us. We also provide a detailed table of improvements identified during the inspection where we require the service to tell us about the actions they are taking to address these areas and improve the quality and safety of healthcare services. In addition, we outline concerns raised and acknowledge those resolved during the inspection.

At the appropriate time HIW asks the health board to confirm action has been taken in line with management responses documented in the improvement plan. We also ask health boards to provide documented evidence of action taken and/or progress made.