Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Bronglais General Hospital, Maternity Unit (Gwenllian Ward)
Hywel Dda University Health Board
Inspection date: 1 - 3 August 2023
Publication date: 3 November 2023

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

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We found a dedicated staff team that were committed to providing a high standard of care to women and their families.

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 women and birthing people with a positive experience that was individualised and focussed on their needs. All women and birthing people that we spoke to were positive about their care, the staff and the maternity environment.

Staff responses were positive about the support and leadership they received, and staff described a positive culture.

A management structure was in place and clear lines of reporting and accountability. Managers were visible and comments from staff said that they were approachable and receptive to feedback.

We saw arrangements in place to provide women and birthing people with safe and effective care. There were established processes and audits in place to manage risk, health and safety and infection control.

There were some areas for improvement around the training and development for some staff as well as the processes around on-call staffing.

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 Bronglais General Hospital, Hywel Dda University Health Board between 1 and 3 August 2023. The following hospital wards were reviewed during this inspection:

- Gwenllian Ward - providing antenatal, labour and postnatal care

Our team, for the inspection comprised of two HIW Senior Healthcare Inspectors, 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 women and birthing people with a positive experience that was individualised and focussed on their needs. All women and birthing people that we spoke to were positive about their care, the staff and the maternity environment.

Where the service could improve

- Ensure that all women are fully aware of all obstetric treatment choices and their risks and benefits before informed patient consent is gained.

What we found this service did well

- Supporting women with communication difficulties through the Maternity Passport scheme
- Offering choice for women and birthing people that would like to birth outside of guidelines
- Offering bilingual English and Welsh care
- Providing light and spacious individual ensuite rooms and modern facilities.

Patients told us:

"The staff have been extremely helpful and supportive throughout."

"I thought that all the midwives were caring and friendly. I also felt that I was able to talk to them about my concern or how I felt."

Delivery of Safe and Effective Care

Overall Summary

We saw arrangements were in place to provide women and birthing people with safe and effective care. There were established processes and audits in place to manage risk, health and safety and infection control.

Patient records we reviewed confirmed daily care planning promoted patient safety. We found there were robust processes in place for the management of clinical incidents, ensuring that information and learning is shared across the service.

There were some areas for improvement around staffing plans to deliver the service.

Where the service could improve

- Review the on call rota for midwives and scrub nurses to ensure that appropriately skilled staff are available onsite 24/7
- Review clinical governance arrangements for the neonatal stabilisation room
- Increase the frequency on antenatal scanning for fetal growth in line with national guidelines.

What we found this service did well

- Comprehensive dynamic risk assessment and escalation processes in place to keep women, birthing people and babies safe
- Visibly clean and tidy unit with all checks for equipment up to date and well documented
- Comprehensive clinical audit plan in place.

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 and comments from staff said that they were approachable and receptive to feedback. There was dedicated, passionate, supportive and visible leadership displayed within the senior and middle management team. We noted that compliance with mandatory obstetric emergency (PROMPT) training in some teams was low.

Where the service could improve

Immediate assurance:

- Low levels of mandatory obstetric emergency training (PROMPT) for the anaesthetist team was low at around 30%.

Other recommendation for improvement

- Visibility of consultants in the clinical area.

What we found this service did well

- Positive culture around reporting and learning from incidents
- The leadership team were visible, supportive and very engaged with the staff team
- Quality improvement initiatives to improve safety/experience
- High levels of satisfaction amongst staff and a motivated team.

Staff told us:

"I feel we are able to provide very safe and individualised care to our patients, putting their needs first and ensuring they are part of their care & the decisions that are made. We are able to provide one to one care on a regular basis, and due to being a small team there is often continuity which is not only positive & reassuring for those we care for but for us as staff too."

"The women/birthing people and their families are the centre of everything that happens on the ward. It is a very supportive environment to work in. Service users and service providers are treated with dignity and respect."

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.