Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

Maternity Unit, Prince Charles Hospital, Cwm Taf Morgannwg University Health Board

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

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. 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 Maternity Unit of Prince Charles Hospital, Cwm Taf Morgannwg University Health Board on 9, 10 and 11 January 2024. The following hospital wards were reviewed during this inspection:

- Ward 21 – 23 beds - antenatal ward (before delivery) and postnatal ward (following delivery) and Induction of labour.
- Labour Ward – 6 beds and one birthing pool
- Day assessment unit (DAU)
- Triage assessment area (also known as Maternity Prioritisation Unit (MPU))

During the inspection we invited women and birthing people or their families to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 105 questionnaires were completed by women and birthing people or their families and 68 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Our team for the inspection comprised of two Senior HIW Healthcare Inspectors, three clinical peer reviewers, compromising of two registered midwives and a consultant obstetrician, and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

It was evident that staff at all levels worked hard to provide a good experience for women and birthing people. This was reflected in the patient questionnaire results, which included positive feedback regarding the staff. We also found that staff responded in a positive and prompt manner, where we identified issues during the inspection. Although the unit was very busy, we observed staff interacting with patients in a kind, courteous and respectful manner.

The environment allowed women and birthing people to be cared for in a way that preserved their privacy and dignity. We found care was being provided in a timely manner, and in most cases the care was personalised to reflect the individual needs of women, birthing people and babies in their care.

This is what the service did well:

- Patients were treated with dignity, respect and compassion
- Patient records were comprehensive, with the wishes of the patient and individual needs appropriately risk assessed
- The 'active offer' to provide a service in Welsh without someone having to ask for it
- The bereavement service was seen to be very supportive, with many staff trained to support bereaved families.

This is what we recommend the service can improve:

- Review visiting arrangements and communicate timings effectively with families ahead of admission
- Ensure that appropriate pain relief is given in a timely manner
- Ensure women and birthing people are not disadvantaged due to their age, disability or sex
- Work towards achieving reaccreditation of the UNICEF Baby Friendly initiative.

Delivery of Safe and Effective Care

Overall summary:
We found there were sufficient arrangements in place to provide safe and effective care to women and birthing people. There were also well-established processes in place to recognise, report and manage incidents across the unit, for sharing outcomes and lessons learned.

Effective infection control measures were in place throughout the unit, and the processes were well documented. Medical equipment was routinely checked to ensure it was available for use, and promptly reported if a fault was discovered.

We observed good multidisciplinary team (MDT) working across services such as neonatal, pharmacy, theatres and anaesthetics. We also found security measures were in place throughout the unit that ensured newborn babies and their families were safe.

Immediate assurance, resolved during inspection:

- There were some improvements needed in relation to the safe storage of medication.

Immediate assurances:
The following issue was raised in an immediate assurance letter issued following the inspection. Further details of the immediate improvement and remedial action required is provided in **Appendix B** of this report.

- There was a requirement to lock the doors to all cupboards that contained chemicals or substances hazardous to health (COSHH).
- Sufficient and safe levels of midwifery staffing and skill mix was not secured for all night shifts, to ensure that safe and effective care could be delivered to patients.

This is what the service did well:

- Good links with local authority safeguarding teams
- Notice boards displaying patient information and patient feedback that has influenced changes
- Multidisciplinary team working across the unit
- Management of medical devices and equipment
- A range of specialist midwives in posts across midwifery services.

This is what we recommend the service can improve:

- Some areas of patient record keeping, including date, grade and legible signatures on documents.
- Staffing levels and skill mix to be reviewed against staff questionnaire comments, taking account of safe staffing levels for the triage assessment area and Ward 21.

Quality of Management and Leadership

Overall summary:
It was positive to find that many improvements had been made since the last HIW inspection in September 2022. We also found several examples of noteworthy practice during the inspection. However, the staff survey results were negative, and comparable to the results from the previous inspection.

The management team were dedicated and very passionate about the services provided to women and birthing people. The management team included a newly appointed Head of Midwifery (HOM), who was supported by a Director of Midwifery (DOM) to lead the team.

Governance of the department was robust, and there were many examples of effective and efficient multidisciplinary working throughout the unit. Also, the rate of mandatory training compliance for staff on the unit was excellent.

Senior managers described a wide range of initiatives that have taken place to support well-being, and promote engagement with the staff. This includes a leadership and culture plan to improve relationships between management and staff. However, some negative feedback was received from midwifery staff in the staff questionnaire, and some similar comments were made during the inspection. This included a perceived lack of visibility of management on the unit, lack of engagement and confidence in management. The midwifery staff also raised concerns regarding low staffing levels, which has contributed to some staff experiencing burnout.

This is what the service did well:

- We found an effective governance structure in place in terms of regular audit activities and meetings to discuss incidents, findings and issues related to patient care
- Very good compliance with mandatory training
- Maternity dashboards with live data
- Evidence of thematic reviews from audits of practice.

This is what we recommend the service can improve:

- Whilst we recognise the efforts and actions taken to since our last inspection, there remains a need for continued effort and action regarding the less favourable comments and themes in the staff survey
- Consideration should be given to moving midwives from theatres and reassigning to more relevant areas, replacing with nursing staff.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B of this report.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 105 were completed. Not all respondents answered all the questions, meaning not every question received 105 responses.

Some of the comments provided by patients on the questionnaires included:

> *"The midwives were amazing but very understaffed. Any failings I reported were due to there not being enough of them. The midwives were empathetic and kind."*
>
> *"My labour experience was exceptional and the care I received on labour ward was above and beyond what I could have ever imagined."*
>
> *"My birth experience was as close to what I wished for as possible. The staff are hardworking, I had a lovely midwife who I felt had time for me and she rarely left my side during my labour, I felt supported and cared for and I have very positive memories of my birth experience."*
>
> *"Birth was extremely traumatic. Got little to no emotional support from any staff. Given the wrong dose of medication and discharged with no follow up care even with serious health concerns. Felt like a burden to everyone."*
>
> *"All staff were supportive, kind and reassuring, not just for me but my birthing partner too."*

We asked what could be done to improve the service. Comments included the following:

> *"The midwives need to start listening when we are telling them we are in labour. They assume every woman is the same and we are all different."*
>
> *"The patients should always be listened to not ignored."*

"Visiting hours."

"Partners should be allowed to stay the first night at a minimum."

"I was alone for much of the next day, visitors came during visitor hours but I would have liked to have my family there (husband and eldest son)."

"My husband had to leave at 8pm and could return at 9:00am . . . . labour and birth does not stick to visiting hours. I was in intense pain from 6:00am until I gave birth at 10:00am. My husband only arrived an hour before the birth."

"My partner (the father) had to leave when I was transferred from the birth centre to the ward it would have been nice if he could have at least come into the ward and settled me in before leaving."

A mixed response was received on whether hospital visiting hours were sufficient, with over half indicating their partners or someone close to them were unable to stay as long as they wanted (64/105).

The health board should review visiting arrangements and communicate timings with families ahead of admission.

The health board should ensure that patient concerns are taking into consideration based on patient comments throughout the report.

Person Centred

Health promotion

We viewed a variety of health promotion material available to women, birthing people and their families by the bedside and displayed throughout the unit, about their health and wellbeing. We also noted the extensive health promotion material available relevant to pregnancy, birth, and postnatal care on the health boards website. This included skin to skin advice, breastfeeding support and mental health advice pre and post-delivery. This was available in English and Welsh.

We saw plaques on the wall from 2018 showing that the UNICEF Baby Friendly Initiative accreditation had been achieved. Accreditations are reviewed every three years, and whilst the neonatal unit had been newly accredited, the maternity unit had not and therefore was not currently compliant. We were told that reaccreditation had not taken place for number of reasons, however with

ongoing work in this area, they were hopeful reaccreditation would be achieved within the next year.

The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.

Dignified and respectful care
The ward environment allowed for women and birthing people to be cared for in a manner that preserved their privacy and dignity. There were adequate facilities and amenities for patients appropriate to their needs. All rooms on labour ward were private with ensuite facilities, as were the rooms in the birthing unit. However, Ward 21 had only two private rooms. Other patients, both antenatal and postnatal, were situated in four bedded bays. There were shared toilets and showers close by for women and birthing people only, which were lockable for privacy. Birthing partners or relative toilets were situated off the ward.

From the interactions observed throughout the inspection, staff were courteous, respectful, and professional to patients and their families. Curtains were drawn around patient beds when midwifery or clinical staff were providing care, or in discussion with patients. Staff were also respectful when entering rooms by knocking the door first.

Every patient spoken to during the inspection, bar one, felt that dignity, compassion, respect, and kindness was adhered to. However, the one felt that was not the case and expressed how she felt like a *"nuisance"* when asking for assistance to go to the toilet.

Most survey respondents (75/105) felt that staff treated them with dignity and respect. Comments included:

> *"Midwives on the labour ward were incredible in every way possible, however midwives in the maternity ward, both before and after birth were not attentive enough and were questioning what myself and other mothers were experiencing."*
>
> *"Our birthing experience was better than expected. All staff from midwifes, surgical team were fantastic."*
>
> *"The midwives and support staff were all amazing, but they are so overstretched. Being moved to a ward when you cannot move, having just undergone major surgery in extremely traumatic circumstances and with your first child who is just hours old is a terrifying experience in itself."*

"There are some fantastic midwives at the unit & some awful midwives. It's potluck on what you have."

"All staff are amazing. Student staff are also really helpful here. Just a shame about lack of resources for them to deliver the standard of care we know they would love to give. The service has been impacted by hospital being understaffed. And earlier discharge of patients due to needing the bed. Information has been delayed to us by the staff being too busy."

There was a bereavement suite situated in a quiet area of the maternity unit. This was a welcoming and safe space with cold cots available, allowing parents to have time with their child and to be supported in a sensitive and compassionate manner away from the main wards. All medical equipment was concealed from view, allowing for a more homely environment during their time of grief. All midwifery staff we spoke with said they had received bereavement training and felt confident in delivering appropriate care for bereaved families. There was also a dedicated bereavement midwife in post.

We were told that partners were not permitted to stay overnight and must leave by 8:00 pm to protect the privacy and dignity of others and allow for rest. Unless in active labour where birthing partners could be present until birth occurred, and for up to two hours after delivery. We found Ward 21 to be very busy throughout the inspection and cubicles were small, and appeared to be cramped when more than one visitor attended the patient.

Individualised care

Most patients told us their needs and choices were respected and fully listened to. Language line was utilised, and cultural differences were considered, specifically with pain relief and blood transfusions. Discussions around birthing options and patient wishes were mostly discussed around thirty-six weeks of pregnancy, these individualised birth plans were documented and held in maternity records.

We saw evidence of some patient choice being enabled which was occasionally outside of national guidance and pathways. When this deviation was requested by women and birthing people, these choices had appropriate written risk assessments, plans and agreements in place. **We saw this as noteworthy practice.**

One patient we spoke with advised that her wishes for minimum pain control was fully listened to and that everyone involved in her care worked together and communicated effectively. Conversely, another patient felt their labour experience was traumatic due to poor communication and felt her wishes for the birth and administration of pain relief were not listened to.

Of patients who answered the question in the survey (79/105) answered that they were involved as much as they wanted to be in decisions made about them and their pregnancy.

A patient commented:

> *" I really felt like I was treated holistically, and my past negative birth experience was taken into account and all staff were aware and reassured us which made the experience so positive."*

Staff met twice daily to handover from the previous shift. Midwifery handovers were held separately due to medical staff not following the same work pattern. We attended a handover meeting with the clinical team, and it was clear these were well structured and evidence based. Patients' needs and plans were discussed with the intention of maintaining continuity of care.

There were specialist midwives in post to support patients and their families who needed additional support. We saw individualised care throughout, and advocacy arrangements in place for those requiring it. We were told that due to deprivation in the surrounding areas in which the maternity unit is placed, additional services would often be utilised. In patient notes we saw evidence of continuous assessment of needs with referrals to specialists and support groups as appropriate.

Timely

Timely care

Most patients told us although the unit was very busy, the staff tended to their needs in a timely manner. However, we found that patients waiting in the day assessment unit for pre-admission medication for planned caesareans could wait up to two hours. This was attributed to low staffing, and triage beds being full and taking priority.

We were told that Ward 21 cared for antenatal, postnatal and induction of labour (IOL) patients across four bays containing four beds per bay and two side rooms. Whilst we were told that these cohorts are not regularly mixed, this does occur occasionally due to acuity on the ward. We were told by some midwifery staff that Ward 21 often had lower staffing levels than labour ward and the birthing unit, meaning they could only provide suboptimal care. Also, whilst medication rounds took place four times a day, breakthrough pain relief was said to be delayed often. We noted, however, that clinicians were available to review pain relief where medication was required and not already prescribed.

Some patients who answered the survey reflected this. Comments included:

> *"Staff were extremely friendly. Unfortunately, not enough staff to support everyone, e.g. having to wait for pain relief as they are so busy."*
>
> *"I asked for pain relief for 3/4 hours as I had a c section was in pain, midwives ignored me and told me someone was coming, and no one came. I pressed the buzzer for help as I couldn't get out of bed and baby was crying and no one came, a lady who had a c section had to help me as no midwives were coming."*
>
> *"Not given paracetamol until I repeatedly asked, midwives forgot to give me IV antibiotics, only found out when I read on my notes "apologies expressed" - they weren't. ID tag was never put on baby. Made to "go as long as possible" 3 days after waters broken thus resulting in crash team coming in to give me an emergency c section. Overall experience resulted in 2 years of PTSD, counselling and therapy."*
>
> *"I was asked to come to Prince Charles hospital after my water had broken for a checkup. I signed in as requested and was made to wait for 2 hours before seeing someone. I was not checked for whether I was dilated. I expressed concern about some mild abdominal pain which was dismissed and told it couldn't be contractions. I was sent home. My labour progressed extremely fast with unbearable pain. We called PCH and they dismissed my pain. Luckily, we were able to stop off at Royal Glam, otherwise I would have given birth in the car. I am deeply disappointed with how I was handled in PCH and the lack of care and consideration I was given. I will be actively avoiding this hospital maternity service for my next child.*

There was a sepsis screening tool within the patient care records we reviewed which helped to identify patients who may become unwell or develop sepsis. We noted the actions required for a patient with sepsis were also displayed in the treatment rooms. We found that midwives and doctors were quick to recognise the signs of a deteriorating patient and acted in a timely manner in line with national guidelines. Whilst on inspection we were advised that an inpatient had recently been transferred to the intensive care unit after becoming unwell postnatally, which showed that procedures were being followed as per guidance.

The health board should ensure that appropriate pain relief is given in a timely manner.

We understand in times of heightened acuity there are occasions where ante and postnatal patients are together for a short period of time. This is to enable

timely care, and flow of patients to and from labour ward. However, the health board should ensure procedures are in place to ensure this is only used as a last resort.

Equitable

Communication and language
There was clear signage displayed at the hospital to find the maternity department and to navigate around the unit. We saw excellent use of bilingualism across the unit, this included on all notice boards, in discharge packs and all relevant reading (information) materials. Welsh speaking staff or those learning Welsh had an identifying logo embroidered on their uniforms, we also saw a small number of lanyards worn by staff who were not in clinical uniform, to indicate they spoke Welsh.

There were 'welcome boards' on entry to Ward 21 and Labour ward with helpful information showing who was on duty. In addition, it showed the colours of each uniform so patients and relatives could easily identify staff and their roles.

During the inspection we spoke to several patients who were generally positive about their interactions with staff, however one did not feel that way. Similarly, overall, the response from the HIW patient survey was quite positive. Of 105 respondents, many patients confirmed staff had explained their birthing options and risks related to pregnancy with them (81/105) and knew where to go in an emergency (84/105). In addition, two thirds of patients said they had enough information on what would happen during birth (70/105). However, nearly half of all patients (50/105) felt they did not have enough information about what would happen after the birth.

Positive comments included:

> *"My birth experience was as close to what I wished for as possible. The staff are hardworking, I had a lovely midwife who I felt had time for me and she rarely left my side during my labour, I felt supported and cared for and I have very positive memories of my birth experience."*

> *"The staff at this hospital are an absolute asset! All of the staff we came into contact with during our time at the hospital from initial phone call prior to attending, to triage, throughout labour, birth, theatre & afterwards on the ward were fantastic! Everyone was really friendly, kept us informed of what was happening, took time to understand our birth preferences & make sure we were able to have the birth we had*

envisioned. We felt safe, well cared for & supported during our time there. Our wishes & choices about labour & birth were upheld."

"All staff were supportive, kind and reassuring, not just for me but my birthing partner too. Staff acted quickly once baby was born and I needed medical help. We cannot thank the staff enough; a scary experience was handled so well and I was given the opportunity for a debrief after."

However, we received some negative and concerning comments regarding communicating and understanding:

"Lack of communication between staff and patient. Talking in medical terminology. Need to breakdown so can understand. Explain what's happening. Lack of empathy and understanding."

"I was ignored throughout my pregnancy almost died from a blood clot because no one would listen to me was told the swelling in my leg was just pregnancy related without anyone actually looking at it every time I was sent over to be monitored I was made to feel like an inconvenience and one time the midwife literally complained I was there from behind the curtain we could hear her moaning about us."

"I felt forced into being induced by my consultant. Also, during labour. When it was decided I needed forceps. A doctor I think came in explaining things to me but I was unable to listen and understand as he kept talking through my contractions. I was in so much pain and exhausted I just agreed."

"I was completely unaware of the complications of not delivering the placenta naturally. This meant that my options were presented to me in a very rushed manner."

The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits, and informed consent should be gained.

Rights and Equality

A small number of respondents who completed the patient questionnaire (14/104) told us that they faced discrimination when accessing or using this health service, and over a third of respondents from the staff questionnaire (24/66) answered that they had faced discrimination at work, based on several protected characteristics under the Equality Act (2010), including age, disability, pregnancy, and sex.

All staff who we spoke with told us they were aware of what constituted a protected characteristic, as Equality, Diversity and Inclusion training was mandated in this health board. We found compliance with the training was good overall. However, one staff member felt that more emphasis on cultural competence, and the understanding of the needs of patients with protected characteristics should form part of the training.

We received the following two comments from the staff survey:

> *"The diversity is only within the obstetric medical team…This is obviously a massive issue though midwifery education. Not always inclusive between the midwifery and medical team."*

> *"There is a diverse multidisciplinary workforce in terms of ethnicity and, to a lesser degree, sex / sexuality etc. Everybody seems tolerant and supportive."*

The health board is required to provide HIW with details of how it will ensure that mothers and staff members are not disadvantaged due to their protected characteristics under the Equality Act (2010).

Delivery of Safe and Effective Care

Safe

Risk management
We considered the environment and found sufficient security measures were in place, to ensure babies were safe and secure in the unit. We were provided with evidence of the most recent baby abduction drill that had taken place. It was clearly structured, well planned and upon actioning the drill, the interception was extremely quick, indicating measures in place worked very well.

We reviewed the processes in place to manage risks and maintain health and safety in the maternity unit. All areas were well lit and ventilated with spacious corridors. However, on the first evening of the inspection we noted that cleaning storage cupboards across the unit, clearly displaying signage for the storage of hazardous chemicals, were unlocked. This posed a potential risk to the safety and wellbeing of patients and other individuals who may access, tamper with and / or ingest substances considered hazardous to their health. We noted that although the doors were lockable via key code entry, the staff did not know what the codes were. We brought this to the attention of senior staff, who escalated this to the estates department to assist or replace the locks. For the duration of the inspection the cupboards remained unlocked, as the estates department needed to order new fixtures.

The issue above was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Staff we spoke with were able to describe the birthing pool evacuation procedure and identified which equipment was required. We were advised that part of the PROMPT study day included training on what to do in the event of a maternal collapse, or complications while in the birthing pool. We found that all patient rooms and bays were fitted with red button alarms to pull in an emergency. These alarms were also present in each of the patient toilets.

We spoke to senior staff around the processes of reporting and dealing with significant incidents and concerns raised and found the processes in place for this was sufficient. We were advised that all incidents were reportable through Datix and incidents that were categorised as medium or high would go through to multi-disciplinary teams (MDT) for discussion. This MDT included the fetal surveillance midwife, governance midwife, Clinical Supervisors for Midwives (CSfM) and consultant anaesthetist among others, whereas low grade incidents would be dealt with at ward level by operational leads.

We were provided with information around the management of incidents, who and how they are actioned, and who was involved in investigations. The serious incident tracker was viewed and showed the ability to be filtered for cases, causes and actions. Root cause analysis was also discussed and other investigations where necessary which includes those under Duty of Candour. We were shown the governance around incidents and multiple sources of evidence of shared learning, including through the CSfM, a monthly newsletter, feedback directly to those involved in one-to-one meetings and safety briefings.

We reviewed various risk assessment documents, including those for individuals where the care had either deviated from the All-Wales guidelines, or from risks encountered on the pregnancy journey. Those viewed were comprehensively completed, dated, signed, and retained on maternity records.

Infection, prevention, control and decontamination
We found that all areas of the unit were clean, tidy, and free of visible hazards, allowing for effective cleaning. Hand washing and drying facilities were available, together with hand hygiene posters displaying the correct hand washing procedures in the patient, visitor and staff toilets above the sinks. Hand sanitiser was also available for use throughout the unit. We saw staff washing their hands and using hand sanitiser when required.

Personal protective equipment (PPE) was available in all areas and was being used appropriately by all staff. We noted that whilst nearly all staff adhered to the bare below the elbow, some staff did not.

Regular IPC audits were undertaken and recorded on the audit management (AMAT) system. We viewed evidence of the most recent IPC audit which was at 95%. We also confirmed high levels of compliance with hand hygiene audits and uniform audits.

We were told that the birthing pools were thoroughly cleaned after each use, and twice a week if they were unused. This was the responsibility of the healthcare support worker, using IPC approved cleaning products. The triage assessment area (MPU), day assessment unit (DAU) and the alongside midwifery led unit (MLU) were also thoroughly cleaned and sanitised by midwives or support workers in a timely manner.

Deep cleaning and general day to day cleaning across the unit were carried out by health board domestic staff. We viewed all cleaning schedules for the unit and noted these were fully completed and up to date. All equipment was labelled to show that it was clean and ready for use.

We were shown that IPC training was completed in a timely manner, with excellent compliance recorded.

Safeguarding of children and adults
During the inspection we considered the security of newborn babies in the maternity unit. We found security measures were in place throughout the unit that ensured newborn babies and their families were safe.

Access to both maternity units was via an intercom camera system, with remote opening. Alternatively, access would be granted by ward staff who checked the identity of the presenting individual and approved access with their identity fobs. Within both units there were further restrictions by way of an 'airlock' style approach and further locked doors. Discussions were held with management regarding one set of doors that were not locked. Although these doors were within a secure area on the unit, we felt consideration was needed to make the doors lockable or secure, to ensure the ongoing safety of families and babies. We were advised the doors were immediately secured.

There was one safeguarding midwife in post supported by the corporate safeguarding team. There were also eight safeguarding champions in place. We viewed various staff records which showed excellent compliance with safeguarding training for both adults and children. All midwives were trained to level 3. There were also adequate health board policies in place to promote and protect the welfare of both adults and children.

We were told that due to the demographics of the areas covered by this hospital, there was regular communication between the unit and the local authority safeguarding team. The safeguarding midwife worked closely with the Multi agency safeguarding hub (MASH), and we found this to be good practice.

Blood management
There were systems and processes in place to ensure safe blood management and transfusion. The blood transfusion process was described, and we are told this works well and the team have not encountered issues with this. Blood is not stored in the unit but used immediately by the relevant staff. The blood bank has an online site which is checked against the unit.

Management of medical devices and equipment
The staff we spoke with during the inspection confirmed they had appropriate medical devices and equipment to provide safe care to patients and their babies. However, less than a third of respondents to the staff survey said they had adequate materials, supplies and equipment to do their jobs.

We were told that operational leads would oversee and ensure that servicing of equipment took place with Electronic and Biomedical Engineering (EBME) when due. Labels were located on all equipment to indicate the last service date and service due date.

We found the emergency resuscitation trolley, for use in a patient emergency, was well organised and contained all the appropriate emergency drugs and equipment, including a defibrillator. We noted daily maintenance checks were taking place on this equipment, although some daily checks on the emergency trolley on labour ward were missed intermittently. We saw evidence of good practice with the introduction of digital checking of resuscitation equipment, which had increased compliance to 100% on those checks.

We were told that the birthing pools in labour ward and the birthing unit have water run through them daily. Emergency evacuation equipment was also seen within the birthing pool rooms, for use in the event of complications during a water birth. We were also assured that all staff had received training in their appropriate use in the case of emergency. Guidelines for obstetric emergencies were clearly displayed in all birth rooms.

Whilst we were told there were arrangements in place for reporting faults with equipment, the response rate did not appear timely. During the initial evening of inspection, we were informed that there were five birthing rooms, however only four were available as there was a faulty bed that had been reported several weeks prior but to date had not been repaired.

Medicines Management

During the inspection we found that there were suitable arrangements in place for the safe storage and administration of medicines including controlled drugs. We viewed the medication management policy for the health board, which was in date and had been reviewed.

Pharmacy support was available 24/7 and accessing medications out of hours was via the pharmacist on call. We were told that the maternity unit had plans to move to a dedicated pharmacy lead, however until the new system is in place, the unit linked with the same pharmacist.

Most medicines were stored in a safe, secure system with fingerprint access. However, on day one of the inspection we found that Omeprazole was being stored in an unlocked drawer in the MPU in readiness for patients who were attending for a planned caesarean the following day. Staff were made aware and rectified this immediately by moving the drugs to a locked cupboard.

Controlled drugs were checked at each handover and a logbook completed. We found that medicine administration was recorded consistently and contemporaneously throughout patient records.

Further information on measures around medication management and security that were resolved during the inspection can be found in Appendix A of this report.

Effective

Effective Care

We were provided with evidence of audits that had been taking place. These were on the AMAT audit system and regularly reviewed. We were told that whilst the AMAT system was relatively new, it was comprehensive. Senior management told us that the system still needed to be fully embedded.

Several clinical audit results were on display throughout the unit, this showed notable transparency to all patients and visitors.

There was a maternity dashboard that all staff spoken with were aware of and familiar with its use. It was a live system with live data that could be interrogated in real time, covering all national indicators. Data was available from 2019 onwards to monitor trends. There was evidence of thematic reviews from audits of practice that had identified themes and trends. We found this dashboard to be **noteworthy practice and commendable.**

We found local and national guidelines were easily accessible. Policies and procedures were reviewed and updated between 2020 and 2022, however there had been issues with uploading newly renewed policies to the WISDOM system due to staffing issues in a neighbouring health board who were providing this service. Updated policies were available to staff in hard copy and on a shared system in the meantime.

Nutrition and hydration

Ward staff had access to adequate facilities to make food and drinks for patients. Women had a choice of what they wanted to eat and drink from a set menu, and consideration was given for allergies, intolerances, and religious requirements. Water was provided each morning and replaced each afternoon, unless required sooner.

Food appeared appetising, portion sizes were sufficient, and this was delivered in a timely manner, ensuring food remained hot. Outside of mealtimes, mothers

could ask for food and drinks, this was encouraged for mothers who were breastfeeding.

Whilst on labour ward, following the birth, mothers were offered tea and toast prior to being transferred to the postnatal ward.

Patients who arrived for planned caesareans were nil by mouth, so this became problematic where any delays were experienced. We were told that delays were infrequent and closely monitored. Patients were updated regularly on any delays to reduce anxiety in the patient. Where the surgery was postponed, the patient would be provided with food and drinks until they needed to fast again.

We saw that all fluids, including IV fluids were being monitored and recorded on the All Wales fluid balance charts in patient records.

Patient records

We reviewed nine sets of patient records. Overall, we found the standard of record keeping was good. The notes were easy to navigate as they were very well organised, and we found clear evidence of plans of care; where relevant, they reflected the clinicians review, escalations and/ or discussions with senior clinicians where necessary. We found that entries corresponded with events and were clearly documented.

We reviewed some records that needed improvements:

- Entries into records not always being dated on the clinical notes, no signatories or grade of the clinician (no stamps used to record name and NMC/GMC number or block signature)
- One case with no specified reason for CTG being performed for gestational age whilst on All Wales pathway for normal labour
- One case of intrapartum monitoring not clearly documented and carried out in accordance with NICE and All Wales clinical pathway for normal labour
- Out of five postnatal records checked only three had signed baby ID number on the handover SBAR of the delivering midwife to P/N midwife
- One case with missing VTE, birth plan for labour, and special consideration not completed.

The health board must ensure that regular documentation audits are conducted, and learning takes place from the findings.

Efficient

Efficient

We reviewed systems and processes in place to maximise efficiencies. We noted that staff were working across services to ensure the right people were involved with families at the right time. Operational leads and CSfM advised that they were keen to promote MDT working.

There were systems in place to rotate staff to different areas within the maternity unit to ensure safe staffing levels and mitigate risk as far as reasonably practicable. We also found that managers had implemented quarterly rotation to ensure staff could retain their skills in all areas of the unit and for fairness of all staff. As part of this process occupational health had been engaged to provide advice, and reasonable adjustments were made where possible. However, we note from comments in the staff survey that some staff felt the rotation had not been implemented well and was feared by others.

We found the facilities overall were mostly adequate, however, the MPU area appeared too small to deliver safe and effective care to both DAU and triage patients. We also found staff facilities for changing (including theatres) were not entirely fit for purpose, meaning midwifery staff arrived in their uniforms. We further noted the sluice on Ward 21 was very large so clinical equipment was being stored there. We were told that consideration had been given to divide this into two areas to create a storage room and separate sluice, however the area would require major structural adaptation and renovation and therefore this was not currently supported by the health board.

Quality of Management and Leadership

Staff feedback

HIW issued a questionnaire to obtain staff views on the maternity services provided at Prince Charles Hospital and their experience of working there. In total, we received 68 responses from staff. Some questions were skipped by some respondents throughout. Overall, the responses from the staff survey were comparable to the last HIW inspection in September 2022.

Responses from staff were generally negative, with just over half being satisfied with the quality of care and support they give to patients (42/68), less than half agreeing that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (27/68), and fewer recommending their organisation as a place to work (19/68).

Staff comments included the following:

> *"Staff on the ground are really supportive, dedicated and caring of women. Overall level of care is good. Senior managers have an obvious desire to improve and are obviously interested and engaged on what happens on the ward with their front-line staff. Middle managers rarely come out of their office, don't share the workload don't value the staff and appear resistant to change."*

> *"The staff that work on the shop floor are amazing. Supportive to both the women and each other. I feel that our care to the women is exceptional, but we don't have enough staff."*

> *"Staffing levels are always a struggle..."*

We asked what could be done to improve the service. Comments included the following:

> *"…Patient care on a day-to-day basis should be everyone's top priority so staff should be encouraged to work on the shop floor if needed. Capacity is not enough, we would have benefitted from a few more beds when the refurbishments took place. We have improved greatly in engaging our women in improving our services and feel that we have made improvements in collaborating with our women in their care."*

> *"Suturing training is vital for all midwives but has been removed from mandatory training for acute and stand-alone midwives. Therefore, we are having to attend training in our own time. Therefore, mostly we don't*

attend as already working over and above contracted hours we can't fit it in and have family time."

"…I feel we do not have adequate space to provide safe and effective care to our patients. We now cover a huge geographical area covering 2/3 health boards (Cwm Taf, Aneurin Bevan and Powys patients). Most shifts we work our bed space on ward 21 is full often working on only 3 midwives which can be tough."

"Shortage of staff. Junior staff are often given the more challenging workload/women. Some coordinators are unfair in distributing the workload and are not as supportive. Not enough staff allocated to ward 21 in order to provide a good level of care."

The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary.

The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.

Despite the staff comments, we were assured that there is no requirement for staff to attend training in their own time. We were told that midwives are given study time for mandatory and statutory training, which is set for the year according to emerging themes trends, guidance and priority.

Additionally, the maternity unit had a Learning Needs Analysis database in place. This is for all other opportunities that are not mandatory or statutory training such as conferences, shadowing, lunch and learns and leadership courses.

We were also advised that bookings and births are monitored via a Clinical Dashboard. The unit had been operating within service level agreements. There was evidence showing that there had been less bookings than previous years, and the birth rate had fallen.

We reviewed rotas showing that three midwives working on ward 21 is BR+ agreed requirements. In addition, there is a team of nursery nurses and maternity support workers, who support under the delegation of duties.

Leadership

Governance and Leadership

We found there was a clear leadership and management structure in place, with clear lines of reporting and accountability. Governance of the department appeared robust. We saw many examples of effective and efficient multidisciplinary working throughout the unit. Senior staff felt their commitment to, and support of ward staff was provided at a high standard. The Director of Midwifery (DOM) and recently appointed Head of Midwifery (HOM) ensured a focus on continuously improving services.

There was a rolling programme of audits and an established governance structure enabled nominated staff to attend regular meetings. The meetings were used to discuss clinical outcomes, patient feedback, incidents and other essential quality and safety meetings associated with delivery of safe maternity care.

During the inspection we found that management were visible across the unit. However, some midwifery staff said it was not normal practice, and was only due to HIW's presence across the unit. All the midwifery staff we spoke with (band 6 and below) advised that they rarely see band 7 staff or above working on the ward. This is consistent with the survey responses, where very few midwifery and support staff (13/68) felt that senior managers were visible, and less felt communication between senior management and midwifery staff was effective (9/68).

However, we were advised that if the operational or specialist midwife is not needed, as the acuity is green, they will return to their office and continue with daily duties. Then if needed the Labour Ward Coordinator will seek her support. Therefore, there is no requirement to remain sat on the labour ward if there is no clinical work to undertake.

Comments from the staff survey regarding management visibility included:

> *"Senior managers and specialist roles are never visible on the unit other than when H.I.W were on the unit but as soon as H.I.W left so did the managers and senior specialist midwives which is what they are always like."*

> *"Operational leads and upper management are not visible. It is insulting to see that when HIW attend, these managers suddenly appear and stay visible in clinical areas."*

"Management from all levels very rarely come into the clinical areas. They only assist on the unit when we have inspections, so it looks like they are supportive."
"Middle management are invisible and don't give support to its staff."

"No support from senior team when ward is really busy!"

However, there were other more positive comments including:

"Good working relationships amongst band 5's and 6 midwives. Great working relationship amongst midwives and the obstetric teams. Particularly with some consultants. [names redacted] - these consultants ensure midwives feel supported not only regarding work decisions but also personally. These consultants regularly check the wellbeing of the team, making the work environment feel psychologically safe."

"Excellent staff but regular poor staffing levels."

"All staff working in the shop floor are hardworking kind and considerate. Op leads are helpful at times, other specialist midwives are not so keen to help out when staffing is short."

Also, when staff were asked if their immediate line manager asks for their opinion before making decisions that affect their work 53/68 of staff disagreed.

Senior and middle management must reflect on the feedback, which includes a perceived lack of visibility. Many aspects of the staff feedback regarding management were concerning, and highlights a cultural issue regarding the perception of some management roles.

Based on the negative comments in the staff survey, there should be consideration for the allocation of duties to the midwifery staff. This should include daytime shifts for middle managers i.e. band 7 and above on the wards. This will promote an understanding of the problems on the ward, improve communication and create more cohesion.

It was clear from conversations with midwives and the midwifery team that they were extremely proud of their roles and were doing the best for the service. However, some midwives felt this was sometimes to the detriment of their own health and wellbeing. Many indicated that ward-based staff and clinicians were extremely helpful and that they work in a supportive environment with those staff. However, some explained they often have no time or cover for breaks, and to

ensure continuity of safe care to mothers they often worked up to an hour after their shift had ended.

Many midwifery staff advised they felt unsupported when carrying out their duties. Additionally, our survey indicated that less than half of midwifery staff felt their immediate manager could be counted on to help with a difficult task (27/68), and fewer staff felt that their immediate manager consulted with them before making decisions that affected their work (15/68). The DOM acknowledged that whilst a lot of work had been undertaken regarding staff culture and improving relationships between staff and senior management, this needs to be an area of continued attention and focus for the health board to resolve.

The clinical obstetric team expressed a positive experience of working across the unit, and commented that there was always effective communications with their leadership team and healthy working relationships with staff at all levels.

Workforce

Skilled and Enabled Workforce

During our inspection we met a committed and professional team focused on providing safe and effective patient care. The staffing levels on the first evening of our inspection fell below Birth Rate Plus (BR+[1]) and we were told that it was a regular occurrence, specifically on night shifts. However, over the following two inspection days staff levels appeared appropriate to support the safety of patients within the hospital at that time.

We reviewed evidence over the eight-week period prior to the inspection, plus four days leading up to, and including the inspection (60 days total). This showed that 53 out of a possible 60 night shifts, had midwifery staffing levels below the establishment requirement. (13 midwives as per BR+ methodology).

We further noted that on 20 of the possible 60 night shifts, midwifery staffing levels were at nine midwives on duty (5 out of 60 shifts) or 10 midwives (15 out of 60 shifts).

HIW was not assured that safe and effective patient care could be delivered during night shifts with inadequate midwifery staffing levels. Although, we were told that the management team have reviewed all flexible working arrangements, in an

[1] The Birthrate Plus methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period, utilising the accepted standard of one midwife to one woman, in order to determine the total midwife hours and therefore staffing required.

effort to maintain safe staffing, and also to ensure that flexible working is fairly accommodated.

The issue regarding staffing levels at night was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

The clinical team advised that there was 24/7 anaesthetic and consultant cover, after hours was via an on-call system. Junior doctors said that consultants come in promptly, and this was confirmed by midwives that we spoke with. Most commented that they felt patients receive very safe care with a consistent and highly skilled workforce.

There was a Datix reporting process in place where staff could raise concerns around staffing and skill mix. Accuity was monitored two to four hourly on labour ward. Staff we spoke with understood the processes for escalation and were aware of the escalation process document in place for this. We saw that some staff raised concerns via Datix when they had concerns around low staffing levels. However, some staff confirmed that a Datix was not always completed with their rationale being, they either did not have enough time to complete them or did not complete them as they believed nothing would change if they did.

We were told that there was a bank process for additional staff, although some midwives told us that they would only agree to work a bank shift when specific band 7s were on shift.

We saw there was a very effective MDT in place with representatives across all specialities. There was a knowledgeable clinical director covering the unit and the doctors spoken with were very supportive to midwives.

The process explained to us around risk and governance did not appear fully MDT in nature. Low level Datix were reviewed by operational leads only, and this included staffing Datix. However, all the Datix at moderate and severe were reviewed through MDT and SMDT.

The health board should undertake a review of the processes for assessing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.

We found good practice in that the Neonatal and Maternity work closely together to keep women and babies safe and maximise efficiency.

We were shown mandatory training rates that were excellent amongst doctors and midwives. Some non-mandated training and development was also supported,

although there were occasions where study time was not available for all opportunities. We were provided evidence of Journal Clubs, lunch and learns, away day development sessions for Band 7 and 8 staff where time has been allocated, and other learning opportunities through clinical supervision and Quality Improvement programmes of work.

We were told that there was an expectation that professional registrants take personal responsibility for some of their continual professional development as per the NMC Code (2018).

The survey results included 24 respondents who told us they did not have appropriate training to undertake their role, or did not have fair and equal access to workplace opportunities. Although, we were told that 24 suturing study days were arranged last year, to offer midwives the opportunity to refresh their skills. However, the sessions were very poorly attended.

Comments on where training they would find useful included:

> *"All HCA's should be given mandatory training in phlebotomy. I believe this would help take the pressure off the midwives during busy periods on the ward. This includes all regular bank HCA's also."*
>
> *"Disappointed that the suturing update/training has been made not mandatory for acute midwives as this is a vital skill for midwives. When I asked why the rationale was that a Doctor is present in the unit if needed for suturing. Our Doctors are continually busy and this does not fit in with continuity of care for our women and birthing people."*
>
> *"I think a month in main theatre to learn how to be a runner."*
>
> *"Suturing training is vital for all midwives but has been removed from mandatory training for acute and stand alone midwives. Therefore we are having to attend training in our own time. Therefore mostly we don't attend as already working over and above contracted hours we can't fit it in and have family time."*
>
> *"Suturing and coaching."*
>
> *"Training in pressure care and further diabetes care."*

Specialist midwives and other operational leads were passionate about the services delivered to women. On discussions with these staff members, all seemed enthusiastic and positive. However, some reported feeling burnout and that the

volume of work, accompanied by very little support, had significantly impacted their mental health. Some of these staff reported sickness absences due to wellbeing issues, and with limited support from management when absent, they had to seek help themselves. However, from the staff survey results, (55/86) were aware of the occupational health support available. We were shown evidence of monthly newsletter that encouraged midwives to self-help with provision such as the Employee Assistance Programme.

We were shown tools such as a 'worry box' that staff could air their worries, and a 'positive affirmations' box where staff could remove a positive affirmation for when they may need a 'boost' if feeling overwhelmed or of low mood.

Culture

People engagement, feedback and learning

As mentioned in the previous section, the staff survey results and comments from midwifery staff during the inspection indicated a cultural challenge on the ward. This is regarding the perception by some midwives, on management or specialist roles. We were told that work is underway to address this through the leadership and culture plan. This includes a wide range of initiatives to engage with staff, to support wellbeing and development.

We saw that the health board's Putting Things Right concerns process on display. This encouraged feedback on any concerns a patient or their relative may have had whilst on the unit or the wider hospital. We also saw evidence of a 'You said, we did' style board displaying outcomes of feedback.

We were advised by the HOM and DOM that staff were encouraged to speak up about anything they needed to discuss. They were keen to hear from staff so they could work together to improve services. Some Band 7 midwives also appeared keen to improve services. However, a small number of midwifery staff told us improvements had been raised, and not addressed.

Some midwifery staff indicated they had not felt listened to by the management team, where they have highlighted a problem. Also, the midwifery staff were not engaged with to help reach a possible solution. They felt that the outcomes were decided by non-clinical managers who do not normally work within the area of concern.

Less than half of midwifery staff (30/68) felt secure about raising concerns about clinical practice, and only a small amount (15/68) felt confident that the organisation would address their concerns.

The clinical team expressed how their management and leaders were always visible. They were encouraged to speak up with new ideas/concerns and had a no blame culture. All were proud and happy to work for the service. Doctors felt supported at all levels, both clinically and from an educational perspective. Views and experiences were captured and acted on to improve services. We were told of a Trainee Voices Forum where matters are raised and discussed with the appropriate leadership teams.

The health board must ensure its senior leaders continue their efforts to encourage supportive and inclusive relationships so that staff feel valued, respected, and confident to speak up and raise concerns. Whilst a vast amount of evidence was provided of the initiatives in place to support well-being, development and engagement during the inspection, staff comments in the survey did not reflect this. Therefore, the health board must ensure staff are aware of initiatives in place so that staff can work together to become a more cohesive team who communicate, consult, and make decisions together to improve the working environment for all and to optimise patient care.

Information

Information governance and digital technology

During the inspection we considered the arrangements in place for patient confidentiality and adherence to the General Data Protection Regulations (GDPR) 2018. We were told and saw evidence that staff had their own individual computer login details to ensure information governance was maintained.

On the first evening of the inspection, we saw cardiotocography (CTG) monitoring with patient identifying information displayed on a large television screen on Ward 21. We also saw patient notes left unattended on top of a filing cabinet on Ward 21. This was raised with the relevant staff who ensured the notes were put away and the CTG monitoring taken down from the main screen and instead displayed on the computer screens on the nurse station that evening.

On the third inspection day, we returned to Ward 21 where we once again saw CTG monitoring with patient identifying information displayed on the large television screen, visible to passing visitors and patients. Furthermore, we found the lockable notes trolley was unmanned and the top was wide open. We noted various patient notes inside which were easily accessible to anyone passing.

HIW were not assured confidential patient information was used and stored in line with GDPR.

The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to provide assurance that documentation is stored in line with GDPR.

Learning, improvement and research

Quality improvement activities

We found several quality improvement activities in place. There was a quality improvement consultant midwife in post to look at constant quality improvement initiatives. There was a Perinatal Safety Support Champion in post, and the work from this role was **notable good practice**. This included the maternity dashboard, two national 'Once for Wales' programmes, MEWS and 4 care bundles adopted in the health board.

The two research midwives in post gave examples of research activity undertaken by the health board, such as a recent study for vaginal breach deliveries. We were told that clinical research activity had been underway for some time with many studies open and available to review if required. The health board hoped to lead on more clinical research in the future.

Whole system approach

Partnership working and development

As mentioned in previous sections of the report we saw good examples of partnership working. This included both within the health board and with external agencies. We were told that patients were regularly referred to service that included the local authority safeguarding, mental health services, bereavement support and third sector organisations.

4. 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 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 how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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
On day one of the inspection we found that Omeprazole was being stored in an unlocked drawer in the MPU in readiness for patients who were attending for a planned caesarean the following day.	Medications not securely stored posed a risk to the safety and wellbeing of patients or other individuals who may access, tamper with and / or ingest medications not prescribed to them.	Senior staff were made aware of this finding by the HIW inspection team and rectified this immediately.	Drugs were moved into to a locked cupboard and staff on the unit were made aware of this change of storage location, including the reasons behind the change to ensure moving forward this medication is stored appropriately.

Appendix B – Immediate improvement plan

Service: Maternity Unit, Prince Charles Hospital

Date of inspection: 9, 10 and 11 January 2024

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
We reviewed evidence over the eight-week period prior to the inspection, plus four days leading up to, and including the inspection (60 days total). This showed that 53 out of a possible 60 night shifts, had midwifery staffing levels below the establishment requirement. (13 midwives as per BR+ methodology). We further noted that on 20 of the possible 60 night shifts, midwifery staffing levels were at nine midwives on duty (5	The health board are required to provide HIW with details of how it will ensure there are sufficient numbers of suitably qualified and trained staff on every night shift within the maternity service.	a) Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month) b) Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty. c) Contact has been made with the Assistant Director of Nursing and	Senior Midwifery Manager / Head of Midwifery Senior Midwifery Manager Senior Midwifery Manager / Head of Midwifery	Completed 16.01.24 Completed 15.1.24 February 2024

out of 60 shifts) or 10 midwives (15 out of 60 shifts). HIW was not assured that safe and effective patient care could be delivered during night shifts with inadequate midwifery staffing levels.		People's Experience to explore potential recruitment of overseas midwives. Awaiting meeting to discuss	
		d) Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate	Senior Midwifery Manager Started November 2023 expected completion end of March 2024
		e) Continue to work closely with people services to ensure that the All Wales Attendance at work policy is adhered to and absences are managed appropriately. Senior management meet with HR monthly to discuss Long Term Sickness (LTS) and attend meetings with individuals on LTS at	Senior Midwifery Manager In place

			certain intervals and at formal triggers.	
		f)	Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff	Heads of Midwifery	In progress February 2023
		g)	Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time)	Heads of Midwifery / Senior Midwifery Managers	Commenced – September 2023. Due for completion February 2024.
		h)	The Service is moving from the Birthrate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Heads of Midwifery	1.3.24
		i)	Review safe care tool to ensure that red flags according to NICE safe	Heads of Midwifery	31.1.24

		staffing 2015 are included in the tool		
		j) Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB	Heads of Midwifery & Senior Midwifery Managers	29.2.24
		k) Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Head of Midwifery	In Place
		l) Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Senior Midwifery Manager	In place

		m) Senior Manager on call out of hours to support the staff on duty and ensure that staff available are redeployed to the areas of greatest need or transfer out if closure of the unit is necessary	Heads of Midwifery/ Senior midwifery manager	In place from 22.01.24
		n) Initiate formal workforce staffing safety briefing twice a week to ensure oversight and forecast of staffing requirements of staffing requirements across the service and sites to allow timely intervention where possible.	Heads of Midwifery	13.1.24
		o) Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Heads of Midwifery / Senior Midwifery Managers	In place 30.1.24

		p) A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave = to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Senior Midwifery Manager	In place 16.1.24
		q) The team are working with the wider Health Board initiative to ensure maternity services are included as part of 'Safe to Start'.	Senior Midwifery Manager	31.1.24
		r) Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Heads of Midwifery	13.1.24
		s) Temporary cease midwifery rotation to other areas	Heads of Midwifery	

		t) Review annual leave to ensure consistent levels of annual leave at any given time. This a feature on the Allocate e-roster tool	Senior Midwifery Manager	31.1.24 & Monitoring in place
		u) The Health Board continues to work with Welsh Government and Health Education & Improvement Wales to develop a Perinatal Workforce Plan as part of the Maternity and Neonatal Safety Support Programme	Director & Heads of Midwifery	11.1.24 & ongoing national meeting attendance
		v) Review night time rosters to determine whether any cultural concerns which may impact attendance at work	Head of Midwifery / Senior Midwifery Manager	31.1.24
		w) Bank & Overtime Hours offered to midwives	Head of Midwifery / Senior Midwifery Manager	17.1.24

On 9 January 2024 HIW saw that most equipment storage cupboards across the unit, clearly displaying the sign “COSHH chemical items are stored in this room”, were unlocked. These cupboards were located throughout the unit, and all had keypad entry locks in place but these were not in use. These cupboards were easily accessible to any visitor, patient, or unauthorised member of staff. HIW inspectors raised this issue with senior staff on 9 January 2024. However, for the duration of the inspection, the COSHH cupboard on ward 21 remained unlocked. HIW was therefore not assured those hazardous substances, stored on the maternity unit were being suitably stored to reduce the risk of unauthorised access.	The health board is required to provide HIW with details of the action taken to safely secure COSHH substances used on maternity unit to help prevent unauthorised access.	Locks to be replaced an all COSHH cupboards – Estates colleagues contacted during the Inspection. Locks changed on 4 cupboards 1 x Lock ordered for further cupboard awaiting delivery Domestic Supervisors have shared a safety briefing with her team, to ensure they are aware of the requirement. Continued oversight though monitoring through the AMaT ward audit schedule.	Senior Midwifery Manager / Estates Team Estates Domestic Supervisor Operational lead midwives.	Completed 15.1.24 19.01.24 Completed 12.01.24 In place

This poses a potential risk to the safety and wellbeing of patients and other individuals who may access, tamper with and / or ingest substances considered hazardous to their health.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Suzanne Hardacre**

Job role: **Director of Midwifery and Nursing, Children and Families Care Group**

Date: **19 January 2024**

Appendix C – Improvement plan

Service: Maternity Unit, Prince Charles Hospital

Date of inspection: 9, 10 and 11 January 2024

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.

Risk/finding/issue	Improvement needed	Service action	Responsible officer	Timescale
Visiting times Many respondents of the HIW patient survey told us that they felt that visiting times were not sufficient.	The health board should review visiting arrangements and communicate timings with families ahead of admission.	Visiting hours within Cwm Taf Morgannwg are in line with other Health Boards in Wales. In response to the service user feedback, an extraordinary My Maternity My Way meeting was held on 22nd January 2024 to discuss visiting and birth partner arrangements. In response to suggestions from service users, visiting hours will be extended for birth partners from 4th March 2024. Visiting hours for the nominated birth partner is being extended until 10pm at	Consultant Midwife Women and Families Experience / Head of Midwifery	4th March 2024

		night. The service will also facilitate a 30 minute settling in period for partners on transfer to the postnatal ward. Changes to visiting arrangements are advertised via social media, website, communication via all midwifery teams and posters within antenatal clinics (community and hospital).		
Questionnaires Concerns raised from review of the HIW patient questionnaire.	The health board should ensure that patient concerns are taking into consideration based on patient comments throughout the report.	The service regularly reviews themes and trends from Patient Reported Experience Measures (PREM). Overall women and birthing people report a high level of being treated with kindness / understanding / dignity and respect. The service shares stories for learning where women and birthing people feel they have not been treated positively through audit, supervision and	Consultant Midwife Women and Families Experience / Head of Midwifery	1st March and under continual review

governance sessions. The annual PREM report was shared at the Health Board Quality and Safety Committee in May 2023 with plans in place to share again in May 2024.

The service is developing a social media campaign to support women and pregnant people to identify signs and symptoms of VTE.

Members of staff who are named in concerns / negative feedback are supported to complete customer care training, discussions are also held with clinical / educational supervisors

The Ombudsman supported training for concerns management to team leaders and senior midwives on 11th November 2023.

		Proactive feedback is sought throughout the ante and postnatal period via PREM (CIVICA). Feedback is analysed and thematically reviewed monthly. Feedback is monitored via service level assurance groups, and Maternity and Neonatal Safety Board in accordance with the Maternity and Neonatal Assurance and Escalation Framework. GMC/NMC attended audit and governance day on 11th October 2023. Lunch and learn facilitated by NMC on 14th September 2023. Both discussion were around professional standards and behaviours. Mythbusting – NMC facilitated session on the approach taken when investigating concerns 14th November 2023.	

		Further NMC session planned 29th April for newly qualified midwives.		
UNICEF Baby Friendly Initiative We saw outdated plaques on the wall from 2018 showing that the UNICEF Baby Friendly **Initiative** accreditation had been achieved. As accreditations are reviewed every three years the maternity unit was not currently compliant.	The health board must work to achieve the UNICEF Baby Friendly Initiative reaccreditation.	There are dedicated infant feeding co-ordinators in place across the perinatal services who are working together toward BFI reaccreditation. The service is currently undertaking a number of audits in readiness for re-assessment which is planned for April 2024. Recent PREM data shows that infant feeding experience is positive. The service has implemented a feeding voice partnership.	Head of Midwifery, Infant Feeding Coordinators	1st May 2024
Pain relief Some women and birthing people had disclosed that pain relief was not provided in a timely manner.	The health board should ensure that appropriate pain relief is given in a timely manner.	The ward manager is responsible for ensuring women receive timely analgesia. A service user audit is underway to further explore the concerns raised. The	Senior Midwifery Manager, Head of Midwifery	31st March 2024

		results of which will be shared via clinical supervision, practice development, audit and governance days.		
Mixed cohort wards We were told that whilst it is only occasionally antenatal and postnatal patients are in mixed bays, this does happen dependent on capacity issues.	We understand in times of heightened acuity there are occasions where ante and postnatal patients are together for a short period of time. This is to enable timely care, and flow of patients to and from labour ward. However, the health board should ensure procedures are in place to ensure this is only used as a last resort.	Mixed cohort wards occur as result of acuity, flow and capacity. Whilst ideally ante, postnatal and transitional care should be delivered in separate areas, there are occasions where the midwife in charge is required to review all areas to ensure that there continued flow and timely transfer to and from the intrapartum areas.	Ward Manager, Senior Midwifery Manager.	In place and reviewed daily
Informed choice Some women and birthing people told us that they were not always fully aware of all obstetric treatment choices and their risks and benefits. Some did not always feel that they	The health board should ensure that all patients are fully aware of all obstetric treatment choices and their risks and benefits, and informed consent should be gained.	The service has invested in Birthrights training for midwives and obstetricians on 11th July 2023 which included choice and informed consent. Informed consent and decision making training was facilitated by the CTM legal team, at a service audit and	Consultant Midwife, Head of Midwifery, Lead Obstetrician for Antenatal Care	In place and monitored via PREM. Audit July 2024

could make an informed choice about their care and treatment.

governance day which took place on 8th February 2023.

BRAIN, informed consent and decision-making are referenced within clinical guidelines. Informed decision-making features within PROMPT and Fetal Surveillance training. An induction of labour Quality Improvement collaborative is underway which monitors women and birthing people's experience of informed decision-making. A range of decision-making tools are being developed around indications for induction of labour.

Annual PREM data (2022-23) showed that over 80% of women and pregnant people had definitely or mostly been given enough information to help them make choices about

		their pregnancy care, health and well-being. Consent audit added to the Forward audit plan for June 2024		
Equality of access A small number of respondents who completed the patient questionnaire (14/104) told us that they faced discrimination when accessing or using this health service. Additionally, a third of staff members (24/66) indicated they had been discriminated against in the workplace.	The health board is required to provide HIW with details of how it will ensure that mothers and staff members are not disadvantaged due to their protected characteristics under the Equality Act (2010)	Equality and Diversity training for all staff in place. Rates of training were reviewed during the inspection and revealed high levels of compliance. We work in partnership with our trade union, workforce, occupational health and organisational development colleagues to ensure our people are supported. Service partnership forums are in place to ensure any concerns are escalated and discussed. The Care Group are working with Diverse Cymru and cultural competence training	Care Group leaders Heads of Midwifery Clinical Director	July 2024

		has been arranged for senior leaders on 10th April 2024. Following this session, the training will be rolled out across service groups and develop a cultural competence plan for submission in July 2024.		
Locked doors Within the secure unit were a single set of unlocked doors that HIW felt needed further securing to maintain the safety of babies across the unit.	The health board is required to provide HIW with details of further action it will take to ensure measures are in place to maintain the safety of babies across its maternity services to prevent baby abductions.	The doors were rectified immediately following the inspection and are now secure. During the inspection the service provided evidence of a recent abduction drill. Abduction drills are annually facilitated and a further drill planned for 2024 as part of the annual audit plan.	Senior Midwifery Manager / Head of Midwifery	Completed January 2024
Record keeping Minor improvements were required resulting from the review of records by HIW.	The health board must ensure that regular documentation audits are	Annual record keeping and documentation audits are in place, actions are monitored	Head of Midwifery / Senior Midwifery Manager / Clinical Supervisor for Midiwves / Clinical	May 2024

	conducted, and learning takes place from the findings.	via the Health Board AMAT system. Midwives undertake record keeping and documentation audits as part of clinical supervision for midwives,	Director for Obstetrics	
Staffing (also detailed in Appendix B) We found sustained periods of staff shortages across night shifts, and sometimes by day. From viewing staff rotas and analysis of feedback obtained verbally and from the staff survey responses, we found staffing regularly fell below BR+ safe staffing levels. Staff advised they were unable to meet all their patients care needs with conflicting demands on their time. Whilst day numbers did not often fall below BR+ several staff members advised that senior	The health board should ensure that operational team leaders work within their clinical area of responsibility and be available to help, guide and support their staff when required. To support staff during times of high acuity or low staffing levels, all specialist roles should be allocated to clinical shifts where necessary. The health board should continue to focus on recruitment and retention of staff to fill vacancies at all levels, mitigating patient risk and improving patient experience and outcomes.	Review of Day assessment activity has been undertaken identifying areas where midwifery hours could be re-allocated to cover the night roster (48 hours a month) Access to electronic roster has been restricted to ensure appropriate oversight of changes to off duty. Review of all Flexible Working arrangements within the department to ensure that this support is proportionate and appropriate Continue to work closely with people services to ensure that	Senior Midwifery Manger / Head of Midwifery Senior Midwifery Manger Senior Midwifery Manger	Completed 16.01.24 Completed 15.1.24 Started November 2023 expected completion end of March 2024

staff included in the numbers did not assist when required.		the All Wales Attendance at work policy is adhered to and absences are managed appropriately. Senior management meet with HR monthly to discuss Long Term Sickness (LTS) and attend meetings with individuals on LTS at certain intervals and at formal triggers.	Senior Midwifery Manger	In place
		Work is in progress analysing the staff establishment alongside the birth-rate plus report to ensure appropriate allocation of staff	Heads of Midwifery	In progress February 2023
		Working with finance colleagues to develop a new model for obstetric theatre nursing (releasing midwifery time)	Heads of Midwifery / Senior Midwifery Managers / Care Group senior leaders	March 2024.
		The Service is moving from the Birthrate + acuity app to the Health Board's 'Safe Care' acuity system which links with Allocate Health Rosters and ensures wider Organisational scrutiny.	Heads of Midwifery	1.3.24

		Review safe care tool to ensure that red flags according to NICE safe staffing 2015 are included in the tool	Heads of Midwifery	31.1.24
		Work with the Corporate Communications department to develop a Comms Recruitment strategy to demonstrate the benefits to attract staff to work in CTM UHB	Heads of Midwifery & Senior Midwifery Managers	29.2.24
		Rolling advert to continue to appoint band 6 midwives, closed and continuous advert for bank midwife.	Head of Midwifery	In Place
		Review of specialist and operational roles and required commitment for clinical aspects of role to enhance short fall in acute areas as well as staff currently released on secondment.	Senior Midwifery Manager	In place
		Senior Manager on call out of hours to support the staff on duty and ensure that staff		In place from 22.01.24

		available are redeployed to the areas of greatest need or transfer out if closure of the unit is necessary	Heads of Midwifery/ Senior midwifery manager	
		Initiate formal workforce staffing safety briefing twice a week to ensure oversight and forecast of staffing requirements of staffing requirements across the service and sites to allow timely intervention where possible.	Heads of Midwifery	13.1.24
		Nursing (and Midwifery) productivity workforce meetings held within the Care Group Structure.	Heads of Midwifery / Senior Midwifery Managers	In place
		A corporate nursing and midwifery dashboard is being developed to consistently capture vacancies, sickness, annual leave = to be shared in Care Group Nursing & Midwifery Workforce Productivity Meetings.	Senior Midwifery Manager	30.1.24
		The team are working with the wider Health Board		

		initiative to ensure maternity services are included as part of 'Safe to Start'.	Senior Midwifery Manager	In place
		Rotation of Staff from well-established areas to ensure consistent safe staffing across the service and weekly review, meetings in place.	Head of Midwifery	In place
		Temporary cease midwifery rotation to other areas	Heads of Midwifery	31.1.24
		Review annual leave to ensure consistent levels of annual leave at any given time. This a feature on the Allocate e-roster tool	Senior Midwifery Manager	31.1.24 & Monitoring in place
		The Health Board continues to work with Welsh Government and Health Education & Improvement Wales to develop a Perinatal Workforce Plan as part of the Maternity and Neonatal Safety Support Programme	Director & Heads of Midwifery	11.1.24 & ongoing national meeting attendance
		Review night time rosters to determine whether any		

		cultural concerns which may impact attendance at work Bank & Overtime Hours offered to midwives Agency midwifery introduced to support	Head of Midwifery / Senior Midwifery Manager Head of Midwifery / Senior Midwifery Manager Head of Midwifery / Senior Manager	31.1.24 continues under review 17.1.24 1.3.24
Visibility of management Staff survey results showed that a substantial amount of staff felt managers were not visible and did not feel they were included in decisions that affected their work.	Based on the negative comments in the staff survey, there should be consideration of the allocation of duties to the midwifery staff. This should include daytime shifts for middle managers i.e. band 7 and above on the wards. This will promote an understanding of the problems on the unit, improve	Operational and specialist midwives are rostered to support clinical activity.	Head of Midwifery	1st March 2024

	communication and create more cohesion.			
Datix reporting The process explained to us around risk and governance did not appear fully MDT in nature, with low level Datix reviewed by operational leads only, this included staffing Datix.	The health board should undertake a review of the processes for reviewing incidents. The reviewing team should include clinicians and practitioners with the appropriate experience and expertise.	All moderate and above are reviewed by the MDT and SMDT. A review of all no and low level incidents is underway to explore any emerging themes, trends and ensure that the service is addressing any concern / incident in a robust manner. A wider review of governance process is underway to ensure that there is sustainability and assurance in accordance with the Duty of Quality and Maternity and Neonatal Assurance Escalation Framework. The review was discussed in the Maternity and Neonatal Safety Board in February 2024, the outcome of this work and any recommendations will be	Head of Midwifery/ Risk and Governance Lead Midwife	April 2024

		presented at the Maternity and Neonatal Safety Board in April 2024.		
Discussion and staff survey results A small number of midwifery staff told us improvements had been raised, and not addressed. Some midwifery staff indicated they had not felt listened to by the management team, where they have highlighted. Also, the midwifery staff were not engaged with to help reach a possible solution. Less than half of midwifery staff felt secure about raising concerns about clinical practice, and only a small amount felt confident that the organisation would address their concerns.	The health board must ensure its senior leaders continue to encourage supportive and inclusive relationships so that staff feel valued, respected, and confident to speak up and raise concerns. It is vitally important that the health board engage more with its staff and work together to become a more cohesive team who communicate, consult, and make decisions together to improve the working environment for all and to optimise patient care.	Partnership forums are in place with staff side colleagues to ensure any concerns are addressed in a timely manner. Quarterly meetings are in place to review the caring for you action plan with colleagues and staff side representatives. Learning needs analysis in place to support team and individual development and learning opportunities. Consultant midwife for Quality Improvement and Innovation in post. Annual quality improvement plan in place. 75 midwives have completed introduction to quality	Head of Midwifery / Senior Midwifery Manager	In place and reviewed monthly

		improvement training. 26 members of the multi-disciplinary team have completed improvement in practice training. Further improvement in practice training is planned in March and April 2024. 'QI Wednesdays' are facilitated by the Consultant Midwife for QI and innovation to share ideas for improvement which has positive engagement. Clinical midwives and support workers are involved in several QI projects such as BSOTS, Neurodiversity, Postnatal Contraception, Female Genital Mutilation, Booking by 10 completed weeks, ATAIN, smoking cessation, physiotherapy, induction of labour.		

		By September 2024, all midwives will have completed QI training. Evaluation of QI sessions are completed on each occasion and are very positive. Engagement forums in place led by Head of Midwifery and Senior Midwifery Manager (last meeting 23rd February). Next Head of Midwifery and Band 7 meeting 18th March with trade union representatives Band 7 and 8 away day development sessions held throughout 2023. Maternity support worker away day being developed for Summer 2024.		
GDPR Throughout the inspection, we saw cardiotocography (CTG) monitoring with patient	The health board is required to provide Healthcare Inspectorate	This was rectified at the time of the inspection. The ward manager monitors this daily.	Senior Midwifery Manager / Ward Manager	Completed and monitored daily.

identifying information displayed on a large television screen on Ward 21. We also saw patient notes left unattended on top of a filing cabinet. Despite being raised with the relevant staff, we returned to Ward 21 where we once again saw identifiable CTG monitoring information displayed. Furthermore, we found the lockable notes trolley was unmanned and the top wide open. We noted various patient notes inside which were easily accessible to anyone passing.	Wales (HIW) with details of the action taken to provide assurance that documentation is stored in line with GDPR.			

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Suzanne Hardacre

Job role: Director of Midwifery & CYP Nursing, Children & Families Care Group

Date: 29th February 2024