Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Inspection Summary Report

Prince Charles Hospital - Maternity Services, Cwm Taf Morgannwg University Health Board

Inspection date: 26 - 28 September 2022

Publication date: 1 February 2023

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

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Overall, we found evidence that the Health Board had started to implement systems and processes to address areas identified from our previous inspection in 2019.

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed staff interacting with patients respectfully throughout the inspection.

We identified several areas that required improvement particularly around areas of, essential monitoring and recording processes not being undertaken in a timely and consistent way.

Improvements in communication and engagement between senior and middle managers and ward staff is required to develop a trusting relationship and improve staff morale.

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

What we did

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

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Maternity Unit, Prince Charles Hospital, Cwm Taf Morgannwg University Health Board on the evening of 26 September, and the following days of 27 and 28 September 2022. The following hospital wards were reviewed during this inspection:

- Ward 21 - antenatal ward (before delivery) and postnatal ward (following delivery) with capacity of 23 beds
- Midwifery led unit – with capacity of three birthing rooms and two birthing pools
- Labour ward – (during labour) with a capacity of six delivery rooms and one birthing pool
- Triage assessment area.
- Antenatal Clinic

Our team for the inspection comprised of two HIW Inspectors, two clinical peer reviewers and one lay reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

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

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

Quality of Patient Experience

Overall Summary

We found a dedicated staff team that were committed to providing a high standard of care to patients. We saw staff interacting with patients respectfully throughout the inspection. Patients we spoke to told us they were receiving good care at the hospital.

Where the service could improve

- Quality of meals provided to patients
- Work towards achieving UNICEF reaccreditation.

What we found this service did well

- Staff interacted and engaged with patients respectfully
- A good range of health promotion information was displayed
- Patients we spoke to told us they were happy and receiving good care
- There were good arrangements in place to provide patients and families with bereavement support.

Patients provided us with the following comments:

> *“Staff are really friendly and know what's going on with my care. I've had everything explained to me and I'm not afraid to ask questions if I don't understand anything”*

“Staff are amazing, and nothing is too much trouble.”

Delivery of Safe and Effective Care

Overall Summary

Overall, there were good processes in place within the unit to support the delivery of safe and effective care. We found there were robust processes in place for the assessment and timely relief of pain and the management of clinical incidents, ensuring that information and learning is shared across the service. We made recommendations for improvement on some areas of infection control. In some cases, essential monitoring and recording processes were not undertaken in a timely and consistent way. This requires improvement and further monitoring by the health board.

Where the service could improve

- Communication with staff on ward rotations
- Some areas of patient record keeping including more evidence of frequent recordings on foetal movements during second stage of labour, and more robust CTG monitoring being recorded in notes
- Some areas of infection prevention and control, to include more up to date external audit and compliance with bare below the elbow requirements.
- Sufficient staffing numbers for the triage area to ensure that patients are not left unattended.

What we found this service did well

- Good range of meetings in place to improve safe care, for example neonatal and maternity improvement meetings.

Patients told us:

That the food wasn't great and was sometimes cold.

Quality of Management and Leadership

Overall Summary

It was positive to see that improvements had been made since the last inspection. There was dedicated and passionate leadership displayed by the Director of Midwifery. Staff were able to access training to allow them to develop their skills and knowledge appropriate to their role. However, we were concerned by some negative staff comments verbalised, and the volume of negative staff comments recorded on staff questionnaires. For example, some staff told us about a perceived negative culture and that they do not have the opportunity to attend regular staff meetings. Improvements are required in communication and engagement between senior and middle managers and the ward staff to develop a trusting relationship.

Where the service could improve

- A stable and consistent senior management team with improved communication and better engagement between senior and middle managers and the ward staff.
- Staff morale and consideration of the less favourable staff comments highlighted from our staff questionnaire.

What we found this 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
- Compliance with mandatory training.

Staff provided us with the following comments:

"As staff we have filled in numerous surveys regarding morale, improvements needed and concerns. However, nothing has been done with the information, no improvements have been made, it feels as if the negative feedback/areas of concern highlights by staff is ignored and not acknowledged by the senior team, and I feel that they are oblivious to what is happening on the unit or the welfare of their staff"

"Massive changes for the better have been made at this health board over the last few years. Staff have embraced the changes and made it a much better place for the women and their families."

"Management need to be more visible and come and listen to staff and their concerns. Try to give positive feedback to staff rather than negative all the time".

Next steps

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

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

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