

Hospital Inspection Report (Unannounced)

Maternity Unit, University Hospital
of Wales, Cardiff and Vale Health
Board

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

Our purpose

To check that 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.



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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, University Hospital of Wales (UHW), Cardiff and Vale University Health Board on 19 - 21 March 2024. The following hospital wards were reviewed during this inspection:

- Delivery Suite
- Maternity wards - providing antenatal and postnatal care, including transitional care and induction of labour
- Obstetric assessment unit
- Midwifery led unit (MLU)
- 3 obstetric theatres
- T2 ward for elective caesarean sections.

Our team for the inspection comprised of three HIW healthcare inspectors, three clinical peer reviewers (two midwives and an obstetrician) and one patient experience reviewer. The inspection was led by a HIW healthcare inspector.

During the inspection we invited patients or their carers 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 34 questionnaires were completed by women and birthing people and 86 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.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Staff were observed providing kind and respectful care to patients and their families. We found that all staff at all levels worked well as a team to provide women and birthing people with a positive experience that was individualised and focussed on their needs. All women and birthing people that we spoke to were positive about their care and the staff. We observed some ongoing concerns related to the environment for care and the ageing building.

This is what we recommend the service can improve:

- Address challenges in relation to the environment, including a leaking flat roof
- Improve the postnatal ward environment.

This is what the service did well:

- ELAN team providing support for vulnerable families
- Support for women seeking sanctuary and survivors of harmful practice
- Wider range of health promotion initiatives targeting different groups and health promotion areas
- Baby friendly and breast feeding support
- Wellbeing support for women and birthing people.

Delivery of Safe and Effective Care

Overall summary:

We saw arrangements were in place to provide women and birthing people with safe and effective care.

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

We observed good multidisciplinary team working across services such as neonatal, pharmacy, theatres and anaesthetics.

We noted the efficiency improvements in relation to the online booking appointment as well as the automation of some processes that had increased the time available for staff to care for patients.

We raised some concerns around issues with the aging environment / estate. We also raised some concerns around processes related to controlled drugs and storage of cleaning fluids.

The following issues were raised in an immediate assurance letter. Further details of the immediate improvements and remedial actions required are provided in [Appendix B](#):

Immediate assurances:

- Harmful cleaning fluids were not always stored appropriately and safely
- Birth partners not wearing theatre scrubs when attending a theatre delivery
- Security measures in place to ensure that babies were kept safe and secure did not adhere to policy and guidelines
- Daily checks of the resuscitation trolley in the Day Assessment Unit were not always recorded
- Medicines checks and processes related to the disposal of controlled drugs were not always clearly documented.

This is what we recommend the service can improve:

- Medicine storage and fridge temperature checking systems
- Continue efforts to address historical backlog of low level incidents logged on the DATIX system
- Improve theatre staffing in line with other specialities
- Ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.

This is what the service did well:

- Digital checking and compliance monitoring of emergency equipment via a quick response (QR) code
- Multidisciplinary review, monitoring, management and information sharing related to new incidents
- Use of live digital data and information to track and improve flow and patient experience and safety throughout the unit
- Good multidisciplinary team working seen across the service.

Quality of Management and Leadership

Overall summary:

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

This is what we recommend the service can improve:

- Introduce mechanisms for monitoring of staff satisfaction levels
- Mandatory training compliance for doctors.

This is what the service did well:

- Multidisciplinary team working
- Preceptorship support for newly qualified midwives.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in [Appendix B](#).

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 women and birthing people. A total of 34 were completed. Many of the respondents rated their experience positively, rating the service as 'very good' (20/34) or 'good' (8/34) sharing comments such as:

"We received amazing care from the midwives at the hospital, particularly post-natal, as I was admitted for 2 weeks after birth."

"The staff are all wonderful and incredibly supportive. I really appreciate having things explained so that I feel prepared and can make choices which I think the midwives have all been really good at."

"We were treated with love and compassion, we were respected and listened to. The staff were excellent and made sure we had the birth experience we wanted where possible and kept us all informed and safe. The level of care was exceptional and was a huge improvement from my previous experience."

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

"The (postnatal) ward itself, however, is extremely tired and depressing."

"The only downside is the waiting times for emergency appointments and the car park at the hospital is far too small so almost always full."

Person-centred

Health promotion

We saw health promotion information in paper and digital format available to all women throughout the unit. This information was available in English and Welsh. Further information and picture flash cards were also available in multiple languages.

A digital booking form was in use for women to register a new pregnancy. This form and associated information was available in English and Welsh with links to direct women and birthing people, and their families to health promotion information. We were told that this booking form was completed face to face with all women and birthing people for whom English was not their first language. This would be supported by a translation service to minimise the risk of miscommunication and improve patient care.

The maternity unit had achieved the United Nations Children's Fund (UNICEF) Baby Friendly accreditation in 2018 and were re-accredited in 2022. We spoke with the consultant midwife for public health who confirmed that there were two infant feeding leads in place and a breastfeeding clinic for women and birthing people needing support. All of the patients that we spoke with (postnatally) during the inspection told us that they received support with breastfeeding if they needed.

The hospital was a designated no smoking zone, which extended to the use of vapour and electronic cigarettes. We saw appropriate information and staffing support promoting smoking cessation. We were informed about the obesity in pregnancy clinic to support women to obtain a healthy weight in pregnancy with an aim to improve healthy outcomes.

Staff members told us about initiatives to support health promotion in pregnancy with women seeking sanctuary as well as women and families whose first language was not English. Parentcraft classes for diverse groups of women were delivered monthly in a wide range of different languages, dependant on need. These sessions were delivered with translators and shared health promotion messages, information and built positive relationships. They were also an opportunity for peer support. This was considered a noteworthy practice.

Dignified and respectful care

Throughout the inspection we saw staff treating people with care, sensitivity, kindness and respect throughout all areas of the unit. Staff interactions with women and birthing people were friendly and professional. All women and birthing people, and families that we spoke with during the inspection, and most questionnaire respondents (88%), felt that staff treated them with dignity and respect.

Most staff that answered the HIW questionnaire confirmed that, in their view, patient privacy and dignity was maintained.

“I felt listened to well informed and supported. Everyone I encountered had treated me with dignity and respect.”

The inspection team heard all staff being polite and helpful towards all women and birthing people and their families. Conversations around care were discreet and curtains pulled, although conversations could sometimes be heard as a result of the layout of the bay areas.

We saw that some improvements in the Induction of Labour (IOL) ward area had been implemented since the previous HIW inspection in March 2023. There was a newly appointed Induction of Labour lead as well as a change in staffing levels to better support women through this area. The inspection team welcomed the addition of side rooms since last inspection which meant that some privacy was available to women and birthing people, and their families.

There were ensuite facilities available in all of the birthing rooms and some postnatal rooms, which helped promote the comfort and dignity of women and birthing people during their stay. Where there were no en-suite facilities, shared toilets and shower rooms were available nearby. We saw signs on some shower facilities in postnatal areas indicating that they were out of order. One woman had told us that the drainage on her shower in the postnatal department pumped up “dirt / bugs.” This feedback was shared with senior staff who addressed the concern with the estates department. One woman told us:

“Shower and toilet facilities were not ideal.”

The health board must implement a robust and effective process to ensure that estates faults and improvements are resolved in a timely manner and to a sufficient standard.

We saw dedicated bereavement rooms within the unit. Our discussions with staff demonstrated that bereavement care was provided in a timely, sensitive manner. Staff we spoke with said they had received bereavement training and would feel confident in accessing the correct policies to enable them to appropriately care for recently bereaved parents and families. Some midwives told us that the room for providing care to a baby after delivery who was born sleeping was not appropriate or fit for purpose. We were told that work was in hand to improve and enhance this area.

Individualised care

Throughout the inspection we heard staff, at all levels, having supportive and caring conversations with women and their families around their care and treatment. All women that we spoke with in the maternity unit were complimentary about their care.

Most women and birthing people we spoke with told us that their choices around care were respected. This included the opportunity to have their baby in the midwife led unit. On review of patient records, we saw those discussions around labour plan, pain relief and feeding were well documented. All bar two women answered that the staff explained birth options and risks, and provided support.

The health board ran a birth choices clinic. This was led by a consultant midwife and allowed women and birthing people to discuss possible birth choices, risks and options that may be outside of formal guidance.

The hospital provided a chaplaincy service and there was a multi-faith hospital chapel for the use of patients and their families. Staff told us about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs. Some women that we spoke with were happy to be able to receive halal meals whilst they were inpatients, they told us that this was important to them.

The patient experience midwife confirmed a variety of ways that women and their families were able to visit the unit and gain information on their birth at UHW prior to labour. This included options for visits, information sessions and open evenings.

We were also told about the four surveys that were sent out to families to collect feedback at different stages in their birth journey. This feedback was monitored and themes tracked to inform developments and improvements.

The health board had appointed a well-being midwife, working alongside the perinatal mental health team, whose role was to work alongside the perinatal team, supporting women who did not meet the threshold for perinatal mental health support but required additional support around wellbeing. This role gave women who had, for example low level anxiety, post birth trauma and depression, the tools to support them through their pregnancy journey. In the past 14 months, 236 women had received support in wellbeing clinics.

Timely

Timely care

All women and birthing people that we spoke with told us that they did not have to wait a long time to receive care or pain relief. Most responses from the patient survey indicated the same.

Improvements in the induction of labour processes had been made in relation to the management of potential delays for women undergoing induction of labour. Women were now offered a time period for induction, rather than a specific appointment that offered those delivering care the flexibility to change the time for induction in line with acuity and bed availability. Staff told us that this had improved levels of patient satisfaction as delays to appointments were minimised.

Equitable

Communication and language

All staff that we spoke with provided examples of catering to additional communication needs of women and all staff stated they would refer and escalate appropriately.

Women and birthing people gave a positive response in relation to communication. All women that we spoke with told us that staff took the time to listen and understand them. All bar two who answered the survey said that their wishes were listened to by staff.

We spoke to many women and families during the inspection. Women from diverse ethnic backgrounds that we spoke with told us that they felt welcome and well supported. Staff members confirmed that they were aware of the issue with language barriers and the potential for miscommunication. All staff we spoke with confirmed how they would use a variety of translation and support services to ensure that the woman and their family felt listened to and understood.

Interpreters were used appropriately to support patient care and language line facilities were also available. All staff that we spoke with were conversant with the use of language line and were confident in its use. Many staff told us that they had been encouraged to use more translators in the delivery of care.

Additional communication tools were seen to support women where English was not their first language. One example was the use of flash cards for patients to communicate needs or symptoms to staff.

We noted an increase in provision for women seeking sanctuary and survivors of harmful practice. Whilst this important work could always be strengthened it was positive to see more staff involved in the delivery and championing of these important initiatives to improve outcomes.

Staff members confirmed that plans were in place for a basic sign language course for staff to support communications for women and families that used sign language to communicate.

We met some Welsh speaking staff and were told that all Welsh speakers were identifiable to patients as they had a “iaith gwaith” logo on their uniform or name badge.

Rights and Equality

Equality and inclusion information was accessible on the health board website. We saw specific information was available, updated regularly and accessible to the public and staff in English and Welsh. We reviewed extensive information and resources available for staff to support equality and diversity. This information was available for all staff on a shared IT system.

At the entrance to the Maternity Unit, we saw a large colourful and engaging welcoming mural representing the diversity of women that accessed the unit. This was noteworthy practice.

All but two women and birthing people who answered the questionnaire said that that had not faced discrimination when accessing or using this health service on grounds of any protected characteristics under the Equality Act (2010). Those two women did not share further detail with us.

The staff that we spoke with were all aware of Equality Act (2010) and provided examples where reasonable adjustments were in place, or made, so that everyone, including individuals with protected characteristics, could access and use the service.

We met with a diverse staff team and viewed training compliance records confirming that diversity and equality training was mandatory for all staff, with high training compliance levels at 93%.

All staff that we spoke with, at all levels, confirmed that they had seen and utilised further initiatives implemented with the aim of improving the safety and experience of Black, Asian and Minority Ethnic women that used the maternity services. We were told that initiatives already in place had been further embedded and developed.

We spoke with women from diverse backgrounds and ethnicities on the days of the inspection who all told us that they were happy with the care received. We saw evidence of effective monitoring of outcomes for all women, including a focus on outcomes for Black, Asian and Minority Ethnic (BAME) women in line with Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRACE) recommendations.

The specialist service for pregnant women seeking sanctuary as well as the ELAN team that provided additional support for women, for example those experiencing mental health problems, young parents and survivors of trauma. This was noteworthy practice.

The maternity unit had accessible rooms, bathrooms and wide corridors to enable easy access for all. We were told of examples of care being tailored, safely, to support accessibility requirements.

Delivery of Safe and Effective Care

Safe

We saw arrangements were in place to provide patients with safe and effective care. We noted improvements since the last HIW inspection in March 2023. Many areas of obstetric and midwifery care was benchmarking nationally recognised good practice and following national and international guidance. Multidisciplinary team working continued to be a positive feature in this maternity unit.

Risk management

In general, there were established processes in place to manage and review risks and to maintain health and safety within the hospital. This assisted staff to provide safe and clinically effective care.

All patient rooms had access to call bells for use in an emergency. The unit appeared appropriately lit and well ventilated. We found corridors and clinical areas to be largely clear, clean and uncluttered.

During the inspection we saw that there were issues with the building. There were ongoing issues relating to a leaking flat roof and multiple buckets of rainwater in corridors, the training room as well as in the theatre where rain water collected during poor weather. We also noted that the heating was not functioning in one theatre. We reviewed some evidence that these ongoing issues had been escalated, were risk assessed and being addressed. Many staff also told us of their concerns around these issues relating to the physical environment of the maternity unit. Many staff members told us of their frustration in spending their clinical working hours attempting to resolve leaks and temperature issues in the theatre. Some staff told us of a negative impact of poor working environment on staff morale and patient experience.

These continued challenges particularly during wet weather, negatively impacted the functioning of the lifts on the unit. Whilst it was reported that this has improved on 12 months ago, challenges remain. The lifts that served the unit to transfer patients between the delivery unit or theatres (floor 2) and other areas of the maternity unit were often subject to delays and lift malfunctions. Whilst it was reported that these had decreased in number recently, there remained an ongoing risk that women in an obstetric emergency could experience delays to care as a result.

We met with staff responsible for the estate who confirmed a significant backlog of jobs requiring attention as well as staff vacancies within the team. Whilst HIW

recognised some of the challenges, improvements need to be made to ensure that the physical environment was safe and effective for staff, women and their families. We noted that works appeared to be in place in an attempt to address the leaks and whilst some reassurance was given, we noted continued challenges.

The health board must implement a robust and effective process to ensure that estates faults are logged and improvements are resolved in a timely manner and to a sufficient standard.

During the inspection we saw that cleaning fluids were not always stored safely. A clean utility room (treatment room) in the maternity unit remained unlocked for the duration of the inspection. The room contained substances which, if ingested were hazardous to health. HIW were not assured that potentially harmful cleaning fluids were stored safely to reduce the risk of unauthorised access. **This issue of cleaning fluid storage described above was dealt with under HIW's immediate assurance process and are referred to in [Appendix B](#) of this report.**

We noted effective multidisciplinary team working in the review of incident reporting and significant events. Appropriate governance arrangements were in place to ensure that any incidents, of all levels of severity, were monitored, addressed and appropriate action taken in a timely manner to include learning disseminated appropriately. We viewed minutes and agendas from a range of meetings in relation to reporting of incidents and management of risk. These included weekly rapid review Datix meetings, monthly safety investigation group, maternity and neonatal safety meetings and clinical risk meetings. We were told of the appropriate tools available to review incidents including tools to identify themes and promote learning.

HIW reviewed the number of open cases of the DATIX system for Obstetrics which confirmed a historically high backlog of open cases. The breakdown of open cases was reviewed during the inspection and leaders shared evidence of a comprehensive range of appropriate actions in place to decrease this historic backlog. This included increasing in the frequency of clinical risk meetings, additional training for incident managers, managers with a high number of open historic cases.

We met with staff members leading this work, they confirmed that nationally reportable incidents and locally reportable incidents open on Datix were low in number at the time of inspection (less than 10). Information was shared as to the status of these reportable incidents which confirmed that they were all being actively and appropriately tracked and monitored. Further evidence was reviewed whereby learning from incidents had been shared and when appropriate, practice

amended. Staff members confirmed that learning from incidents was actively and regularly shared. We saw evidence of this from safety briefings and meetings.

All staff we spoke with told us that the organisation encouraged them to report errors, near misses or incidents. Almost all staff that answered the question on the survey confirmed that their organisation encouraged them to report errors, near misses or incidents.

Many said their organisation treated staff who are involved in an error, near miss or incident fairly. When errors, near misses or incidents were reported, most staff confirmed that the organisation took action to ensure that they do not happen again. Most agreed that they were given feedback about changes made in response to reported errors, near misses and incidents.

The health board should continue their work to reduce the backlog of open Datix incidents in a timely manner and monitor progress.

Theatres

During the inspection, we reviewed the theatre environment and staffing levels. We saw evidence related to the increased number of elective caesarean section deliveries taking place between Monday and Friday. We were told that a number of challenges and inefficiencies in staffing levels remained and theatre staffing levels were not consistent with other specialities. Senior leaders confirmed that there was a business case, which was nearing completion, to enable significant improvements in theatre staffing.

The health board should review capacity for theatres and improve 24 hour maternity theatre staffing in line with other specialities and ensure consistent staffing levels and to ensure patient safety.

In addition to staffing challenges, there were a number of ongoing estates concerns noted in theatre:

- leaking roof with a bucket to catch rain water in one theatre
- broken heating system in one theatre
- Doors to theatre that did not open automatically, with the potential to delay theatre based emergency care.

Whilst these issues were being actively mitigated, staff members told us of repeated challenges in relation to estates and time taken to resolve these estates issues on a regular basis.

The health board should review the environment for theatres and resolve persistent issues and threats to IPC, patient safety and experience.

We reviewed effective care pathways for women and babies. We also reviewed an escalation pathway with clear guidance, staff that we spoke with were aware of the pathway and the guidance.

Infection, prevention and control (IPC) and decontamination

We found that all areas of the unit that we inspected were clean, and free of clutter. We reviewed audit reports indicating that regular IPC and cleanliness audits were taking place and actions tracked on an appropriate system called Tendable.

During the inspection, our team noted that birth partners that attend the caesarean section or theatre delivery of their babies were permitted to attend theatre in their own clothes with limited PPE and without scrubs. This practice must be updated to ensure that the safety of women and birthing people is not compromised in theatres.

The issue of scrubs for birth partners in theatre was addressed under HIW's immediate assurance process and is referred to in [Appendix B](#) of this report.

Feedback from women that we spoke with was mostly positive in relation to cleanliness with some exceptions. Most women that answered the question on the survey agreed that the unit was "clean" or "very clean." However, two different comments were made about the postnatal ward being old and unclean.

"We received amazing care from the midwives at the hospital, particularly postnatally, as I was admitted for 2 weeks after birth. The ward itself, however, is extremely tired and depressing. We received multiple bites, some of which became infected. I also found the showers to be very old and unclean. Overall, the amazing midwives really redeemed this and meant that we left with really positive views on our care."

"Cleanliness of the room in postnatal care was not great. There was dust all over the plug unit behind the bed. The floor was not clean. Service and care was good."

Whilst we did not observe this on the inspection, seven staff members commented on fleas or mites reported in the unit.

Evidence received following the inspection confirmed that concerns were logged via the Datix system. We reviewed evidence to confirm that concerns were

appropriately escalated to housekeeping and pest control. Deep cleaning was completed as a precaution. Confirmation documentation from pest control indicated that, following investigations, the unit did not have fleas or mites.

The health board should ensure that effective communication systems are in place to ensure that staff are aware of outcomes of actions following the raising of their concerns.

Safeguarding of children and adults

Safeguarding training was mandatory and training compliance was at 90% of staff. All staff we spoke with were aware of their responsibilities in relation to safeguarding and could confirm the processes. Senior staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern.

We reviewed established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required. Staff had access to the health board safeguarding procedures via the intranet.

There was an appointed lead safeguarding midwife for the health board who provided support and training to staff. All staff received safeguarding training that included guidance regarding female genital mutilation, domestic abuse, sexual abuse, exploitation and bruises on pre-mobile babies.

During the inspection we considered security measures in place to ensure that babies were safe and secure. Access to all areas was restricted by locked doors, which were only accessible with a staff pass or by a member of staff approving entrance. Upon arrival all members of the team had identification requested. During the first full day of inspection, we were told that babies were not being routinely security tagged whilst inpatients due to a shortage of tags. The inspection team informed senior staff and this was addressed immediately. On the second full day of inspection additional security tags were delivered, communicated to all staff and confirmed as in use to ensure the continued safety of babies. **This immediate assurance issue was resolved during inspection and is referred to in Appendix A of this report.**

Staff told us that no baby abduction drill had taken place during last 12 months and we confirmed that the policy stated that these should be undertaken annually. To protect the safety of babies, we issued an immediate assurance notice to complete an abduction drill and share findings. **These issues of security above were dealt with under HIW's immediate assurance process and is referred to in [Appendix B](#) of this report.**

We confirmed with staff that when a social services birth plan required a mother and baby to have 24 hour supervision, this supervision was conducted by ward staff as no local authority staff were provided. This could be difficult for staff on duty to fulfil this task, particularly if there were staff shortages. In order to protect patients and staff, 24 hour supervision should be secured from social services. Staff confirmed that a meeting was planned with the local authority children services to discuss women and babies under constant supervision.

The health board should work with social services to ensure that 24 hour supervision is provided by social services staff and will not require staff from the maternity unit to deliver 24 hour supervision.

Management of medical devices and equipment

During the inspection we reviewed processes and documents related to the required daily checking and monitoring of medical devices and equipment including resuscitaires and defibrillators. We saw that a digital monitoring system was in place to ensure compliance, in most of the unit. Staff confirmed that the QR code on equipment was used to confirm checks had taken place and that compliance was monitored in real time. The monitoring for the equipment with the digital checking system was in place in most areas of the unit. Where it was being used we confirmed 100% compliance. This development, since the previous inspection, was noted as good practice and this system should be rolled out to the whole unit.

We reviewed the documentation related to the resuscitation trolley checks in the Maternity Day Assessment Unit. Records confirmed inconsistent and infrequent recording of checks in the records for this trolley. We were not assured that consistent daily checks were being conducted on this resuscitation trolley. The checks are essential to ensure that lifesaving equipment is in full working order for use in an emergency. Records indicated it had been checked in February but no specific date was logged. This trolley was immediately checked by staff and the detail logged. **This issue was addressed under HIW's immediate assurance process and is referred to in [Appendix B](#) of this report.**

Some midwifery staff we spoke with told us that they did not always have access to essential medical equipment to provide care to patients. This was confirmed by the staff survey, only 18% of staff said they have adequate materials, supplies and equipment to do their work. This posed a risk if prompt observations could not be conducted in a timely manner. One member of staff commented within the questionnaire:

“Lack of equipment is often an issue that makes a simple task much more difficult. Lack of staffing is also an issue especially on the wards which can result in 'firefighting' instead of providing good care.”

Some staff told us of delays to patient care and frustrations around time spent looking for handheld equipment to deliver clinical care.

The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.

Emergency evacuation equipment was seen within the birthing pool rooms, which could be used in the event of complications arising during a water birth.

Medicines management

We reviewed systems and process in relation to the safe storage and administration of medication. We were told that pharmacy support was available to the unit and an out-of-hours computerised system allowed staff to check the stocks of drugs across the hospital to ensure there were no delays in patients receiving medication. There was also take-home medication stock available to facilitate discharges in a timely manner.

We observed drug charts to be generally completed correctly by midwifery and medical staff responsible for administering the medication.

We reviewed the records for daily fridge temperature checks across the unit and whilst the majority of checks were in place, we noted that approximately 25% of checks were not recorded on the medicine fridge in the induction of labour ward in line with the health board medicines code. This posed a potential risk to patient safety.

The health board must implement an effective system of checking and monitoring temperatures of all fridges daily, in line with the health board medicines code to ensure safe storage of medicines.

We reviewed storage and records related to the management of controlled drugs, on the Labour Ward, Induction of Labour Ward and on T2. It is noted that not all checks were documented in line with the health board's medicines code when discarding a controlled drug that was not administered. Some documentation relating to unused controlled drugs and how they had been witnessed being discarded were not legible and some entries not signed by both signatories.

These issue of management of controlled drugs was dealt with under HIW's immediate assurance process and is referred to in [Appendix B](#) of this report.

Effective

Effective care

We found suitable systems in place for capturing and sharing relevant information. We reviewed information related to the management and tracking of audits and sharing of results and actions and these were in order.

Developments and further improvements in the maternity dashboard were noted and live digital information was available for staff members to inform clinical and management decision making.

Following the previous inspection, senior staff had introduced daily 'walk arounds' to check in with staff and identify any concerns or risks. This was seen as a positive development to ensure safe and effective delivery of patient care.

Nutrition and hydration

Most women that we spoke with were happy with food and drink options available. Staff on the wards had access to facilities to make food and drinks for patients outside of core hours and there was a trolley service available for hot meals where patients could pre-order food.

Patient records

We reviewed six patient records. Overall, we found the standard of record keeping was adequate, with care plans well documented between multidisciplinary teams. We saw that records were well organised and easy to navigate. All records reviewed included appropriate observations charts, care pathways and bundles.

We reviewed ante-natal risk assessments, maternal early warning system (MEWS) and national early warning score (NEWS) information completed consistently in the records that we reviewed. However, we did note some inconsistencies in some patient records for example where no signature sheets were seen and in some cases medical signatures were difficult to read.

The health board must ensure that:

- Staff are reminded of the need to sign all relevant documents and ensure that the signature is legible
- Regular documentation audits are conducted and learning takes place from the findings.

Efficient

Efficient

We reviewed appropriate information and systems that were being used to track and improve patient flow. We saw that this information was reported via daily, health board wide situation report (sitrep) meetings.

Staff members confirmed a range of patient flow improvements that had been implemented within and around the induction of labour. This included the sharing of live data with other areas of the unit to ensure that patient safety was appropriately managed. Staff confirmed that a new digital calendar was in place for referrals for inductions. This calendar was colour coded depending on the urgency of need of induction. This system had freed up time for midwives to care, as they were not on the phone making multiple calls. This had helped to manage the flow of women and birthing people through the unit which had helped to manage numbers and improve communication and their experience.

We saw that live, colour coded patient information and data was used during the staff handovers to ensure safe and effective communication and that appropriate information was shared. This included a status button to input at what point of care women and birthing people were. This was time stamped and could include medical risk factors. This improvement in sharing of live patient information digitally to track the flow of patients was viewed as notable practice.

The appointment of a non-clinical data analyst who shared an office with the deputy ward manager was viewed as a positive support for the unit. The data analyst worked closely with the informatics midwife to ensure that effective use of data was used to inform work.

We reviewed appropriate processes in place in the antenatal assessment, including the use of a midwife to triage phone calls and using a skill mix and good use of maternity care assistants to deliver appropriate care. Staff told us of a reduction in the delays experienced by women needing obstetric care. We also saw changes in the way that transitional care was delivered, many staff that we spoke with were positive about these changes.

Quality of Management and Leadership

Staff feedback

In total, we received 86 responses from staff. Some questions were skipped by some respondents throughout. Responses from staff were mostly positive, with most being satisfied with the quality of care and support they give to patients (64/86), most agreeing that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (63/86), and many recommending their organisation as a place to work (55/86).

Few said they have adequate materials, supplies and equipment to do their work (15/85).

Almost all told us that there were not enough staff for them to do their job properly (17/86). Staff members that we spoke with during the inspection confirmed that they felt that staffing levels were still low, however they confirmed that this had improved in the last 12 months (for doctors and midwives) albeit with still a way to go.

Staff comments included:

“We are grossly understaffed for our acuity.”

“Lack of equipment is often an issue that makes a simple task much more difficult. Lack of staffing is also an issue especially on the wards which can result in 'firefighting' instead of providing good care.”

“UHW is a nice place to work. I feel supported by my seniors and know I can come to them at any time with concerns. However, the serious lack of equipment makes it very difficult to do my job. There is little basic equipment available such as pulse oximeters and BP cuffs and they are not stored correctly which can make assessing women in our care promptly difficult.”

Leadership

Governance and leadership

A management structure was in place and clear lines of reporting and accountability were described. After a period of instability in leadership it was pleasing to see a stable leadership structure in place. Most staff (midwives and doctors) that we spoke with spoke highly of the leadership team. With most (63/86) respondents to the questionnaire confirming that senior managers are committed to patient care.

We saw that there had been changes within the senior management team since the last inspection (March 2023). There was a recently appointed Clinical Director, Director of Midwifery and Head of Midwifery. Senior leaders told us that they had worked hard to improve culture, increase staffing levels and make improvements throughout the unit. Feedback from staff through the survey and conversations indicated that morale had increased and communication had improved. There has been a significant improvement in staffing levels and an improvement in retention levels.

Throughout the inspection we witnessed good multidisciplinary team (MDT) working. This MDT working was confirmed as positive by staff members that we spoke with.

Many band 7 midwives were relatively new to management. We reviewed plans in place to develop and support these and future midwives to ensure that effective training was in place to support their development.

Managers were visible on all areas of unit and comments from staff members confirmed that they were approachable.

Midwifery managers office had moved to 2nd floor to be more visible, to be closer to clinical area to be available and to offer support when needed. Many managers and staff members confirmed that this move had been well received.

Workforce

Many staff we spoke to (medical and midwifery) confirmed ongoing challenges with staffing, however all recognised an improvement over the last two years. Rotas confirmed that midwifery staffing over the recommended levels meant that when unexpected absences occurred the impact was minimised. Extra shifts are available for staff to sign up to two months in advance to allow for planning.

There was a staffing e-roster system in place. This live system showed how many midwives were on duty in each clinical area. This, alongside the patient tracking system, worked to address any peaks in acuity in each area.

We were told of the increase in consultant presence in the clinical area as well as the plans to ensure weekend staffing is increased, whilst ensuring that fairness and equity for all staff is strived for.

Skilled and enabled workforce

Most staff members told us that they had received values based appraisals in the last 12 months and we reviewed evidence that indicated an 86% compliance rate.

We reviewed effective processes for monitoring staff attendance and compliance with mandatory training. Practical Obstetric Multi-Professional Training (PROMPT) compliance at the time of inspection, was over 90% for midwives and 76% for doctors. We noted compliance rates with other mandatory training amongst the midwifery team was consistently high and above 85%.

On reviewing training compliance amongst the medical team, we saw lower levels of compliance in some areas of mandatory training. We discussed training compliance with senior clinical team and they confirmed that a risk based plan to achieving improved levels training compliance in the short term. They confirmed that recent doctors strikes had impacted on their compliance levels. PROMPT and CTG Training was in prioritised with dates booked in the coming weeks to improve compliance. Consultant mandatory training compliance was better than F2s in some areas of training as F2s do not run clinics and so would not need to be high priority for some mandatory training.

The health board must improve compliance with mandatory training for doctors in the short term and ensure an appropriate system is in place to enable future compliance.

The health board developing training in relation to obstetric recovery post-operatively as well as High Dependency Unit training for midwives. These were seen as notable practice.

Feedback from the staff survey in relation to training confirmed that most staff felt that they had appropriate training to undertake their role. 63/85 agreed fully and 18/85 partially agreed.

Many staff members, newly qualified and experienced staff confirmed that the support for newly qualified midwives had improved significantly in the last 12

months. We were told that a preceptorship midwife was in post to support Band five midwives during the preceptorship period. This had helped to retain band 5 midwives as well as ensuring that they are supported and developed in their early careers. This was notable practice.

Culture

People engagement, feedback and learning

We saw that there was information on each floor of the unit detailing how women could feedback on their experiences. This information was also seen in antenatal clinic reception. There was You Said We Did information displayed detailing how concerns and comments from people have been used to develop and improve the service.

The response regarding the visibility of senior management was mixed with half of survey respondents agreeing that senior management were visible. The executive team confirmed a range of appropriate initiatives that were in place to enable staff members to feed back to senior team. Including QR code feedback for staff to send feedback to senior team, although themes from this staff feedback were not tracked for themes. Some staff told us that the “staff voices” option to feedback did not appear fit for purpose as no themes seem to be discussed, resolved or fed back.

We were told of plans to introduce a staff “Pulse” survey for all staff to ensure leaders can continuously gather and track staff feedback and measure satisfaction within teams.

The health board should introduce their pulse survey, monitor, review and act on themes that emerge to monitor and improve staff satisfaction.

We reviewed appropriate initiative to support the wellbeing of staff member. We viewed the health passports for staff as positive practice.

We were told of increased psychologist support for staff members that may need it within the department. We also reviewed information related to staff debriefs following emergencies.

During the inspection leaders were visible and approachable, there was diversity and difference valued at all levels of the organisation.

Information

Information governance and digital technology

The inspection team considered the arrangements for patient confidentiality and adherence to Information Governance and the General Data Protection Regulations (GDPR) 2018 within the unit. We saw evidence of patient information being stored securely.

There were packages that the unit used to ensure information and communications technology was used safely and effectively, ensuring that it enabled staff to work effectively. We saw many examples of digital technology being developed, trialled and used effectively to improve effectively and release time to care. The ability to track patient flow and monitor risks and staffing levels digitally according to acuity is notable practice. The digital maternity dashboard includes comprehensive data and information for clinicians to track, monitor and act upon in the interest of their patients.

Learning, improvement and research

Quality improvement activities

Many areas of innovative good practice were noted during the inspection in relation to quality improvement and research. There were examples of standardised training courses being developed (where no similar programmes were available) to support skills and professional development of staff. Courses included Band 7 Labour Ward leader training, Obstetric Recover training programme.

We saw evidence of a participation in a range of appropriate research programmes.

There were defined systems and processes in place to ensure that the maternity unit focussed on continuously improving its services. We saw the service held regular meetings to improve services and strengthen governance arrangements. Such meetings included maternity quality and safety group, maternity and neonatal improvement board meeting, maternity quality and safety meetings, monthly audit review meetings, labour ward forum.

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
<p>During the inspection we identified that a shortage of available Baby security tags meant that not all babies on the unit was tagged.</p>	<p>The alarm systems on the doors of the unit are activated with a baby security tag. Without these tags there was a potential risk to baby safety.</p>	<p>HIW raised with leaders during the inspection</p>	<p>Leaders confirmed that additional security tags had been delivered and communication issued to all staff to inform them of the delivery and requirement for use on all babies.</p>

Appendix B - Immediate improvement plan

Service: University Hospital of Wales, Maternity Department

Date of inspection: 19 -21 March 2024

The table below includes any immediate non-compliance 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	Standard / Regulation	Service action	Responsible officer	Timescale
1. We reviewed records of the checks conducted on the adult resuscitation trolley and noted inconsistent and infrequent recording of checks in the records for the trolley located in the Day Assessment Unit.	The health board is required to provide HIW with details of the action taken to demonstrate suitable daily checks and monitoring of resuscitation equipment in every area of the maternity unit.	Standard - Safe	To expand the existing digital equipment checking system beyond Delivery Suite. Additional areas will be the antenatal and postnatal maternity wards, Obstetric Assessment Unit, the Midwife Led Unit and the Day Assessment Unit. All emergency and resuscitation	Digital Transformation and Quality Improvement Lead Midwife Digital Transformation	Complete 26/03/2024

				<p>equipment will be included in the digital checklist and daily compliance data will be held on a central database for assurance and auditing.</p> <p>Maternity and Resuscitation Services to discuss the lessons identified within the maternity unit so that the wider organisational perspective can be considered.</p>	<p>and Quality Improvement Lead Midwife and Resuscitation Service</p>	<p>End of April 2024</p>
2.	<p>During attendance at elective caesarean sections our team noted that birth partners that attend theatre delivery of their babies are permitted to attend theatre in their own clothes with limited</p>	<p>The health board is required to ensure birth partners attending theatre are appropriately dressed in scrubs prior to entering the sterile theatre area.</p>	<p>Standard - Safe</p>	<p>Disposable scrub clothing has been ordered for use by all birth partners attending theatres. Birth partners will be asked to change in a designated area prior to entering the theatre for both emergency and</p>	<p>Senior Midwifery managers for Inpatient services</p>	<p>End of April 2024</p>

	<p>PPE and without scrubs. This practice must be updated to ensure that the safety of women and birthing people is not compromised in theatres. This represents an infection control risk in a sterile theatre area where women are undergoing abdominal surgery.</p>			<p>elective cases. Lockers for birth partner valuables to be made available.</p>		
3.	<p>On 19 March 2024 HIW identified that the Clean Utility / treatment room door on Labour Ward was not locked. This utility contained substances which, if ingested are hazardous to health. This cupboard was easily accessible to any visitor, woman, or</p>	<p>The health board is required to safely secure substances used on the maternity unit to help prevent unauthorised access.</p>	<p>Standard - Safe</p>	<p>Maintenance Request was submitted to the Estates/Security team and an urgent repair of the TDSI door access to Delivery Suite treatment room has been carried out.</p>	<p>Senior Midwifery managers for Inpatient services & Head of Estates</p>	<p>Complete 26/03/2024</p>

<p>unauthorised member of staff. HIW inspectors raised this issue with senior staff on 19 March 2024. However, for the duration of the inspection, the room remained unlocked. HIW was therefore not assured those substances stored on the maternity unit were being suitably stored to reduce the risk of unauthorised access.</p> <p>This poses a potential risk to the safety and wellbeing of women and birthing people as well as other individuals who may access, tamper with and / or ingest substances considered hazardous to their health.</p>					
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4.	<p>The inspection team also considered the security of newborn babies in the maternity department. We did not receive assurance that an abduction drill had taken place in the last 12 month. HIW did not receive sufficient evidence to ensure that the measures in place to ensure the safety of babies in the department have been tested during the last year.</p>	<p>The health board is required to confirm baby security measures are tested to ensure that babies are safe and secure across its maternity services.</p>	Standard - Safe	<p>An abduction drill has been undertaken within the maternity unit and the outcome of such documented appropriately using the UHB abduction drill proforma.</p> <p>Abduction drills to be undertaken every 6 months going forward.</p>	Head and Deputy Head of Midwifery	<p>Abduction drill complete 26/03/2024.</p> <p>Ongoing</p>
5.	<p>We reviewed storage, and records related to the management of controlled drugs, on Labour Ward, Induction of Labour Ward and on T2. It is noted that not all checks were</p>	<p>The health board is required to provide HIW with details of the action taken to demonstrate Controlled Drugs are subject to required checks when administered, stored and disposed of in line with the</p>	Standard - Safe			

<p>documented in line with the health board's Medicines Code when discarding a controlled drug that was not administered. Some documentation relating to unused controlled drugs and how they have been witnessed being discarded are not legible and some entries not signed by both registrants.</p>	<p>health board policy and guidance</p>				
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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):

Job role:

Date:

Appendix C - Improvement plan

Service: University Hospital of Wales, Maternity Department

Date of inspection: 19 -21 March 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	Standard / Regulation	Service action	Responsible officer	Timescale
<p>1. Environmental issues identified inspection included</p> <ul style="list-style-type: none"> - Non functioning shower drainage - Multiple leaks from flat roof with buckets of rainwater in corridors, theatre and other areas 	<p>The health board must implement a robust and effective process to ensure that estates faults and improvements are resolved in a timely manner and to a sufficient standard.</p>	<p>Safe</p>	<p>All showers have been inspected, and no drainage issues have been identified.</p> <p>Staff aware to report any such maintenance issues to the Estates team and escalate to Directorate Management Team if there are delays</p>	<p>Senior Manager for Inpatient/Outpatient areas</p>	<p>Complete</p> <p>Complete</p>

<ul style="list-style-type: none"> - Lift malfunction - Heating malfunction in theatre - Reports of fleas and bugs 			<p>in them being addressed</p> <p>Theatre flat roof has been repaired.</p> <p>Work commenced to resolve the ongoing leak in delivery suite corridor (rooms 8-12)</p> <p>Two of the lifts in the main maternity block are to be replaced by December 2024. All maternity lifts currently in service.</p> <p>Air flow repair performed in theatre to aid temperature regulation. Now working correctly.</p>		<p>Complete</p> <p>End June 2024</p> <p>December 2024</p> <p>Complete</p>
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				Referral to Housekeeping and Pest Control undertaken, MLU area treated by pest control. Follow up assessment by pest control on 5/4/24 confirmed no flea infestation. A monthly walkaround of the maternity unit is in place between estates, IP&C, partnership colleagues and senior management to discuss existing reports and requirements.		Complete Complete
2.	We reviewed a high backlog of historical open incidents on the Datix system.	The health board should continue their work to reduce the backlog of open Datix incidents in a timely	Efficient	Appointment of Deputy ward managers on Delivery Suite and First Floor to assist	Head of Midwifery and Clinical Risk & Governance Lead midwife	Complete

		manner and monitor progress		<p>with workload and incident backlog on Datix system.</p> <p>Monthly Senior Management review of incident reports with trajectory to reach monthly closure target of 200 incidences, which will address both backlog and new incidents. This will be monitored within the monthly band 7 operational meeting and escalated to the monthly Clinical Board Performance Review meeting.</p>		<p>Complete and on monthly review</p>
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3.	Staffing levels for theatres have not yet been made consistent with other specialities. Evidence of theatre use indicated an increase in elective Caesarean section deliveries between Mon - Fri.	The health board should review capacity for theatre and improve 24-hour maternity theatre staffing in line with other specialities and ensure consistent staffing levels and to ensure patient safety	Effective	<p>Business case incorporating a new staffing model, consistent with other specialties for maternity theatres has been submitted to the Executive team.</p> <p>System implemented to allow ease of bank and overtime for staff in maternity theatres. Staffing monitored daily and escalated/actioned if issues identified.</p> <p>Theatre staff vacancies currently advertised for both Recovery and Scrub Nurses.</p>	<p>Director of Midwifery</p> <p>Senior Manager for Inpatient Services</p> <p>Deputy Head of Midwifery</p>	<p>Complete</p> <p>Complete</p> <p>October 2024</p>

4.	<p>Theatre related issues</p> <ul style="list-style-type: none"> - Doors to theatre that do not open automatically with potential to delay theatre-based emergency care <p>Heating malfunction</p>	<p>The health board should review the environment for theatres and resolve persistent issues and threats to IPC, patient safety and experience</p>	Safe	<p>The theatre doors do not automatically open however they are fitted with devices to remain open when required to aid safe transfer to theatre.</p> <p>It is not a standard across the UHB to have automatic doors into theatre and due to the environment on delivery suite, having automatic doors would interfere with an individuals' dignity and privacy.</p> <p>There have been no reported clinical incidents or delays</p>	<p>Operational Lead for each area with oversight from Senior Midwifery Management team</p>	Complete

			<p>in transfer to theatre due to non-automatic doors.</p> <p>Air flow to obstetric theatres is resolved. However, the heating system is monitored by estates to ensure that this position is maintained.</p> <p>The leak in theatre has now been repaired.</p> <p>Monthly Tendable audits to be undertaken by Operational Leads to audit IP&C standards within maternity theatres.</p>	<p>Operational Lead for each area with oversight from Senior Midwifery Management team</p> <p>Operational Lead for each area with oversight from Senior Midwifery Management team</p>	<p>Complete</p> <p>Complete</p> <p>June 2024</p>
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5.	Reports of cleanliness concerns were made by some women and some staff in relation to specific areas of the unit.	The health board should review the feedback and address the cleanliness concerns of some women and staff	Safe	Housekeeping colleagues are present in all areas of the unit throughout the day and attend out of hours when requested. Housekeeping Supervisor aware of feedback and HIW findings and will increase spot checks in the area. Any reports of uncleanliness or hygiene concerns are addressed immediately. Housekeeping Supervisor to increase audits on	Housekeeping Supervisor Operational Lead for Ward area Housekeeping Supervisor	Complete Complete July 2024

			<p>the postnatal ward to bi-weekly to ensure all areas are maintained to excellent standard of cleanliness.</p> <p>Maintenance Request to be raised for some areas to be repainted to improve ward environment.</p> <p>Estates walk arounds occur monthly to address IP&C concerns and outstanding maintenance requests, which IP&C colleagues attend.</p> <p>Patient feedback via 'Civica' is obtained monthly, and shared by the</p>	<p>Operational Lead for Ward area</p> <p>Senior Manager for Inpatient Services</p>	<p>Complete</p> <p>Complete</p> <p>Complete</p>
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				clinical board to maternity management. Any concerns from Civica are picked up with the Operational Lead in the area and addressed at that time.	Operational Lead for Ward area	
6.	We confirmed with staff that when a social services birth plan required a mother and baby to have 24-hour supervision, this supervision was conducted by ward staff as no local authority staff were provided.	The health board should work with social services to ensure that 24-hour supervision is provided by social services staff and will not require staff from the maternity unit to deliver 24-hour supervision.	Effective	Liaise with social services to discuss this recommendation and develop a plan for these instances. SOP to be written and shared with Children's Services.	Senior Midwifery Manager for Inpatient Services Lead Midwife for Safeguarding	August 2024 August 2024

				Plan made to scope shared cost for provision for new born by bank staff in the absence of available foster carers in maternity.	Senior Manager for In-patient Services	August 2024
7.	Some staff told us of delays to patient care and frustrations around time spent looking for handheld equipment to deliver clinical care.	The health board must ensure that staff always have access to essential medical supplies and equipment and that a more robust system is put in place for monitoring and tracking equipment.	Efficient	<p>There was an equipment audit undertaken early March 2024 and clinical equipment ordered following this.</p> <p>A band 3 colleague has been employed to order and monitor frequent use items. Procurement team engaging with senior management team regularly to discuss identified trends</p>	Operational Lead for Delivery Suite Senior Manager for Inpatient Services	Complete Complete

			<p>and possible improvements to ordering.</p> <p>Equipment is ordered when requested, reception staff in all areas are aware how to send items off for repair.</p> <p>Daily room check lists are in place within intrapartum areas; this includes required equipment for each room. Any gaps are escalated and ordered if required.</p> <p>Regular equipment audits to be taken every 6 months</p>	<p>Operational Lead for area</p> <p>Operational Lead for area</p>	<p>Complete</p> <p>Complete</p>
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					Operational Lead for area	November 2024
8.	25% of daily checks of one medicine fridge in the Induction of Labour ward were not documented	The health board must implement an effective system of checking and monitoring temperatures of all fridges daily in line with the health board medicines code to ensure safe storage of medicines.	Safe	<p>A digital equipment checking system is now in place for all wards within the maternity unit.</p> <p>An additional recording for fridge temperature will be built into the equipment checking system. This will include formatting on the dashboard to highlight "Normal</p>	Digital Midwife Digital Midwife	Complete End June 2024

				Temperature" or "Urgent - Incorrect temperature"		
9.	Some inconsistencies in patient records were identified. These included lack of signature sheets and / or poor signature legibility	<p>The health board must ensure that:</p> <ul style="list-style-type: none"> • Staff are reminded of the need to sign all relevant documents and ensure that the signature is legible • Regular documentation audits are conducted and learning takes place from the findings. 	Safe	<p>Antenatal hand-held records audit currently ongoing.</p> <p>Exemplar documentation examples have been shared with staff by the Clinical Supervisors for Midwives via group supervision and email.</p> <p>CSFM and Governance teams feedback themes via clinical incident discussions; this includes reminders regarding legible documentation with signatures. These are shared via</p>	<p>Clinical Risk and Governance Lead Midwife</p> <p>CSFM</p> <p>Clinical Risk and Governance Lead Midwife</p>	<p>Complete re-audit in 6 months</p> <p>Complete</p> <p>Complete under Monthly review</p>

				<p>email, staff social media page, SharePoint and face to face meetings.</p> <p>An updated signatory list for all registered staff to be collated and held on record within the Maternity Department for identification.</p>	Deputy Head of Midwifery	End of June 2024
10.	Lower levels of mandatory training compliance for some doctors were confirmed. Evidence of a risk based plan was in place to	The health board must improve compliance with mandatory training for doctors in the short term and ensure an appropriate system is in place to	Safe	A new teaching session has been setup for Junior doctors and has been commenced. This teaching will include CTG table top learning.	Clinical Director and Obstetric Lead	Complete

	improve compliance to keep patients safe	enable future compliance.		<p>When new medical staff join the team, they will be asked to supply their mandatory training record from the previous rotation. This will include CTG, PROMPT and Gap Grow. Where compliance has lapsed, medical staff will be booked onto the next available date.</p> <p>Doctors mandatory training compliance to be presented monthly at the Directorate Governance and Audit day.</p>	<p>Clinical Director and Obstetric Lead</p> <p>Obstetric Lead</p>	<p>Complete</p> <p>Complete</p>
11.	Staff satisfaction feedback system	The health board should introduce their pulse survey, monitor,	Effective	The maternity service collates staff feedback	Digital Midwife	Complete and updated quarterly

<p>with monitoring of themes not in place</p>	<p>review and act on themes that emerge to monitor and improve staff satisfaction.</p>		<p>through the "Staff Voices" system where staff can share concerns and improvement ideas/requests to senior staff anonymously through a simple QR code that is displayed in all areas. This is a popular route for staff feedback and has collected 467 submissions from staff since its implementation in May 2022 (approximately 20 submissions per month). With the use of Artificial Intelligence this will be summarised into themes each quarter, acted on appropriately and</p>		
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				<p>information fed back to staff through the HOM monthly updates.</p> <p>By September 2024, the Directorate will be launching a pulse survey in addition to the “Staff Voices” system.</p>		September 2024

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): Lois Mortimer

Job role: Head of Midwifery

Date: 30/05/2024