Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Princess Anne Wing

Royal United Hospital, Weston, Bath, BA1 3NG

Tel: 01793604020

Date of Inspection: 16 July 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard

Details about this location

Registered Provider	Great Western Hospitals NHS Foundation Trust
Overview of the service	Princess Anne Wing is a maternity service provided by Great Western Hospitals NHS Foundation Trust. The wing is located within the premises of the Royal United Hospital in Bath. Great Western Hospitals provides antenatal, intrapartum and postnatal care to women who elect to receive or require care in an acute hospital setting. Some aspects of treatment, care, housekeeping and estates management are provided by the Royal United Hospital NHS Trust under a service-level agreement.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Princess Anne Wing had taken action to meet the following essential standards:

- Cleanliness and infection control
- Staffing

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 16 July 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

Princess Anne Wing is part of Great Western Hospitals NHS Foundation Trust's maternity services. On our previous inspection of this location, we found the service needed to make improvements around cleanliness, and infection control systems and procedures. We also found staffing levels in relation to midwives were not always at levels acceptable to safely meet the needs of patients.

The trust sent us a series of action plans to outline how it was going to improve in these areas. We went back to the hospital to check on progress, and ask patients about their care and experiences of the service.

All the patients we met said their care was good. We were told staff were "kind", "caring" and "can't do enough for you."

We found improvements had been made in cleanliness and infection control systems and processes. There was still remedial work to be carried out to the premises to improve infection control risks, but the trust was managing this. The funding for the upgrade to the premises had been secured from a Department of Health grant. We saw the plans and dates for the commencement of the project, which would start in August 2013.

Patients told us they found the infection control practices to be as they would expect. We were told all staff were seen to regularly wash their hands, and did this before and after any patient contact. They said they found the hospital clean, but had recognised some areas were, as one said, "getting a bit shabby."

We found staffing levels had improved through shift changes and additional recruitment. Further recruitment was being funded to bring the number of midwives up to the approved level over the rest of this calendar year. This would reduce the need for bank staff or unplanned shift changes. Patients told us they felt care was safe and effective. One said

staff were "sometimes clearly very busy, but that does not appear to have compromised their care in any way. They are brilliant."

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

Although some upgrading work still needed to be started and completed, people were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a generally clean, hygienic environment. The areas in poor state of repair were effectively managed.

Reasons for our judgement

On our previous visit to the Princess Anne Wing in December 2012 we found some areas of cleanliness and infection control needed improvement. During that inspection we found the arrangements for cleaning did not provide staff with a clear definition of specific roles and responsibilities. The environment was not maintained in some areas to fully prevent and control the spread of infections. There were a number of gaps in the infection prevention and control procedures to audit and monitor cleanliness and prevention and control of infections.

The trust provided us with a series of reports detailing the improvement plans and actions they were taking and kept us informed about how these were progressing. We went back to the Princess Anne Wing to check on these improvements.

We examined both the maternity ward (Mary Ward) and the delivery suite for cleanliness, infection prevention and control (CIPC). Staff showed us the improved audit reports for checking various elements of CIPC. Audits took place once a month, although on a day when it was expected, and not as spot checks. We asked the trust to think about the routine nature of the audits. The reports we saw included action plans taken when audits were not fully compliant, and how these areas were re-audited after two weeks. We looked at a number of audits and the majority were compliant. We were able to follow the actions and saw improvements in future audits, which were done sooner than the routine audits, following any non-compliance found.

We checked the environment, fixtures and fittings for general cleanliness. We found those areas we were concerned about before were significantly cleaner than on our last visit. Some areas, and specifically a patient toilet block which was in a poor state of repair on our previous visit, remained so. However, some of the toilets in a more unacceptable state of repair were now marked as 'out-of-service' for patients. Staff had assessed the number

of toilets required for patients. They had concluded some could be taken out of service until refurbishments began in August 2013 without compromising the welfare of patients. The other toilets were clean, although the fabric of the premises remained in need of redecorating, which was to take place shortly. We were given copies of the plans for the upcoming refurbishment, and it was confirmed the grant from the Department of Health to pay for the work had been received. We saw one of the refurbished birthing rooms was being assessed by staff for functionality and on how it would improve CIPC.

The provider may find it useful to note while the remedial work and upgrade to facilities remained to be started, some parts of the ward needed careful cleaning and management due to their poor state of repair. This was mainly due to peeling or missing paint on walls. Staff were aware and assured us CIPC risks would be effectively managed before and, importantly, during this schedule of remedial repairs.

We met the cleaning staff and their team leader. These staff worked through a service level agreement (SLA) with the Royal United Hospital NHS Trust. One of the staff told us they did not feel they had enough time to complete the cleaning work they had to undertake. They told us the time they were allocated to clean a large kitchen and, once a week, the refrigerator, was insufficient. We made the team leader and senior staff aware of this.

We observed cleaning staff working hard and effectively. The cleaners' trollies were now organised so rubbish bags were now carried away from clean items. On inspection, we did find, however, some of the harder to reach areas were dustier than we would expect. Some curtain rails were dusty as was some of the framework under beds. We saw the dust was, however, recent and would not have been lying there for more than one or two days. The dust was addressed during our visit and those responsible for those areas asked to review their effectiveness in cleaning areas less easy to reach.

We discussed the SLA and how the measures of success were working with the General Manager of Women's and Children's Services. We were told a significant amount of time had gone into the improvements to this agreement, and it was working better. We found staff were clearer about their own responsibilities, and those responsible for the contract cleaning were more available to discuss concerns or suggestions for improvements.

The provider may find it useful to note cleaning staff told us they were short-staffed and already 24 hours of contracted cleaning had not been provided in the month of July 2013. In June 2013, we were told 28 hours of contracted cleaning had not been provided. This may have meant some areas of the service were not getting the attention required. We brought this to the attention of senior staff who informed us this shortfall of agreed contracted cleaning time had been addressed through the service level agreement. The trust was looking for a reimbursement for cleaning time not provided.

We found the majority of the areas midwifery staff were responsible for cleaning were clean and well organised. There were a few areas which midwifery staff were responsible for which were not cleaned as well as they should be. Of the six cots we lifted and looked beneath, all were slightly dusty where staff had not lifted them from their frame to clean them. Only the front area which was easy to reach had been cleaned. There were also some sticky residues on furniture and fixtures where, it appeared, labels had been removed and the glue not cleaned effectively. We found one drip stand with a sticky residue where it had not been cleaned effectively, despite being labelled as such.

Other portable equipment such as monitors, resuscitaires, weighting scales and the majority of drip stands were clean. They were now being labelled with a green sticker once they had been cleaned. This was dated and signed by the responsible member of staff. Staff said if a piece of equipment was not labelled, they would clean it before use and again once it had been used, before labelling it. We found the clean and dirty sluice rooms to be tidy, well organised and equipment stored as it should be. One of the cupboards had some equipment stored on the floor, despite the trust action plan saying this had been resolved. We reminded the senior management of the need for equipment to be stored off the floor to allow effective cleaning of the floor area in this much-used space. Staff were addressing this while we were on site.

If a patient used the bath or shower facilities, a sign would be posted on the door to say the room had just been used and was waiting to be cleaned. We saw this practice being used effectively. We asked a patient about the use of the signs and they said they thought this was good practice. They said they had not noticed the signs on the bathrooms being there for long, indicating cleaning of the bathrooms was carried out relatively quickly.

We observed good CIPC practice from clinical staff, including the student midwives and maternity care assistants. We saw staff washed their hands effectively before and after any intervention with a patient. People visiting the ward were asked to use hand-gel before passing reception. We heard the young brother of a newly born baby tell his father when arriving on the ward, to make sure he used the hand gel as "you can't come in here otherwise as the nurses will not let you."

Other patients and visitors we met said they observed staff washing hands. They said staff wore personal protective equipment, and had seen staff with gloves and aprons. They said staff uniforms looked clean and fresh. They said staff wore limited jewellery and were therefore able to wash their hands effectively.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

On our previous visit to the Princess Anne Wing in December 2012 we found there were not enough maternity staff to meet the recognised guidelines of Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologists (RCOG), 2007). There was some evidence staff shortages had impacted upon patient care, particularly one description of care provided by a family who had been delivered of a baby recently at Princess Anne Wing. Staff also told us they did not feel they operated at safe levels at all times, and some staff "had to do everything."

The trust provided us with a series of reports detailing the improvement plans and actions it was taking and kept us informed about how these were progressing. We went back to the Princess Anne Wing to check on these actions and improvements.

Patients we met during this visit all told us they were not concerned about staffing levels. Some said they knew staff were busy and sometimes the ward or delivery suite were busier than at other times, but patients we talked with felt it had not impacted upon their care. Patients also said they thought the staff caring for them were skilled, experienced and competent. We were told by patients all the staff they met knew what their roles were and what they could and could not do. One patient told us, for example, if a maternity care assistant (MCA) or student midwife could not carry out a specific task a patient had requested, that member of staff went to locate the relevant member of staff.

Patients told us the consultants were "excellent", "terrific" and "have a very reassuring and calm manner." Patients told us the wards were well led and one said of the ward manager: "they have an air of calm even when you know there's pressure. This is so important for us probably over-anxious parents." This person went on to say: "nothing is too much trouble, even the smallest things, and those daft questions we ask." We were told staff had "all been amazing", "all very friendly", and "I can't fault them at all. I am really glad we came here."

Staff told us staffing levels had improved recently. New midwives had been recruited to the trust, and more were expected over the coming months. One of the trust's community birthing centres had also just been temporarily closed for intrapartum (labour/birth) care to

alleviate staffing shortages at the acute hospital. This had been done following an extensive study of the options available to the trust to deal with staffing shortages and an acknowledged national shortage of midwives. Antenatal clinics and postnatal care would still be available at the community hospital and birthing would take place at any of the other local acute or birthing centre services.

We were provided with the trust's Maternity Service Staffing Plan 2013-14 as evidence of progress made and plans still to be realised. This document included the contingency plans the trust had in place for covering shortages of staff. Contingency plans included mobilising the trust's midwifery bank staff for short-term cover, or moving to the trust's escalation policy for more serious or longer-term shortages of staff. The escalation policy included closing any of the services to new admissions and diverting patients to other local services.

The RCOG guidelines for the ratio of midwives to births was proposed in 2007 as one midwife for 28 births, or 1:28. When we visited the trust in December 2012, the ratio in the clinical area in which Princess Anne Wing sat (the 'Bath clinical area') was around 1:40. These were the figures from October 2012 which were available to us at that time. We found on our return in July 2013 the ratio was down to 1:29, following recruitment and changing shift patterns. This was expected to further improve with the influx of midwives from the temporarily suspended intrapartum care at the community hospital.

In January 2013, the midwifery directorate validated the Birthrate Plus® model for midwifery workforce planning. This model was used to inform the executive committee in May 2013 of staffing levels to be achieved. It was accepted by the trust as the most effective available for planning required staffing levels for a mixed-service maternity directorate. The model used past data for a "minimum period of four months on intrapartum care, hospital, and community activity, and all other aspects of care provided by midwives from pregnancy until the mother and baby were discharged from postnatal care" (source: The Greater Western Hospitals' NHS Trust BR+ Ratios Summary December 2012 updated January 2013). The model built sickness and training time into the calculations, as well as extra time needed for community care and home births. The running of the model for the Princess Anne Wing concluded the staffing levels currently identified were almost exactly as Birthrate Plus® had calculated. The objective for the trust was then meeting these levels, with long-term sickness, maternity leave and vacancies taken into account.

The drive for new recruits and temporary transfer of midwives from the community service had largely resolved these issues in July 2013. Although as the trust acknowledged, there was still some further recruitment needed to fully meet its own targets. Staff and patients we met at the hospital told us they felt the current levels were predominantly safe, unplanned shortages were addressed more quickly, and patient care was not compromised. A member of staff said staffing levels were "always difficult to get right, and we seem to suffer more long-term sickness than other areas it seems." We were told the bank staff brought in were mostly all experienced and regularly worked in the maternity unit. A staff member said of the experience of the bank staff: "this makes a significant difference from the person not being familiar with us or anything around them."

A recently recruited member of staff said they thought care provided had been safe "all of the time". They said the department was sometimes "very well staffed, but not always." They went on to say: "the department always works hard to cover any shifts not covered." We were told this was done by pulling in staff from the other ward if they were able to

spare staff; use of bank staff; bringing in trained management staff to work a shift; and calling in bank staff. Another member of the senior staff said "staffing is definitely better." It was also confirmed five midwives would be starting at the end of August 2013 and further were expected to start in September 2013. Another member of staff said with a smile: "we won't know ourselves when all these staff arrive. It will be quite a luxury."

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk