Care Quality Commission

# Royal Cornwall Hospitals NHS Trust

# St Austell Hospital - Penrice Birthing Unit

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Are services safe? | **Requires Improvement** |
| Are services well-led? | **Good** |

# Our findings

## Overall summary of services at St Austell Hospital - Penrice Birthing Unit

**Requires Improvement** 

**We inspected the maternity service at St Austell Hospital - Penrice Birthing Unit as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.**

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice **announced** focused inspection of the maternity service, looking only at the safe and well-led key questions.

Our rating of this location stayed the same. We rated it as requires improvement.

We also inspected 2 other maternity service run by Royal Cornwall Hospital NHS Trust. Our reports are here:

- Royal Cornwall Hospital – https://www.cqc.org.uk/location/REF12
- Helston Birth Centre - https://www.cqc.org.uk/location/REFZ1

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

# Maternity

**Requires Improvement**

Maternity services at Penrice Birthing Unit include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care. Services were delivered on the premises of St Austell Community Hospital and were provided by Royal Cornwall NHS Foundation Trust. The midwifery-led unit provides intrapartum care for women who met the criteria and were assessed to have low risk pregnancies. The birth unit has two birthing rooms, all of which have birth pools and ensuite facilities.

Intrapartum activity levels at the Penrice Birthing Unit were low. The trust reported 37 babies were born at the unit in the year December 2021 to November 2022, this represents 1% out of 3792 total births in Cornwall overall.

Women could self-refer to the service online.

Our rating of this service stayed the same. We rated it as requires improvement because:

- Care records were not always dated and signed, medicines were not always managed safely and there was limited evidence of learning from incidents.

However:

- The service had enough staff to care for women and keep them safe and kept the environment clean.

## Is the service safe?

**Requires Improvement**

Our rating of safe stayed the same. We rated it as requires improvement.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Data showed 86% of midwives and 84% of maternity support workers had attended the maternity update day. This was slightly below the trust target of 90%. The trust had a focus on improving compliance with mandatory training at the time of inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders monitored mandatory training compliance through the monthly update in the maternity and neonatal safety report to board.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed professional obstetric multi-professional training (PROMPT) training once a year. Data showed as of December 2022 98% of midwives and 97% of maternity support workers had completed this training. Newborn life support training was included in yearly PROMPT training.

# Maternity

The service did not complete regular birth pool evacuation training or baby abduction drills at the Penrice Birthing Centre. Staff received one-off training in safe evacuation of birthing pools and had access to a birth pool evacuation video. Data showed in 2022, 57 staff completed this training across the trust.

## Safeguarding

**Staff had training on how to recognise and report abuse and they knew how to apply it. Staff had not completed baby abduction drills at the Penrice Birthing Centre.**

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Data showed as of November 2022 95% of midwives and 85% of maternity support workers across the trust had completed safeguarding level 3 training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff attended monthly safeguarding meetings and there was a safeguarding clinic once a week. Managers monitored compliance with safeguarding supervision through the quarterly safeguarding report.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the safeguarding team for advice and support.

While the trust had a baby abduction policy, this had not been tested with staff at the Penrice Birthing Centre.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. For example, we saw staff used ‘I am clean’ stickers to show equipment was clean and ready to use.

Staff completed weekly flushing of the birth pool and bath.

## Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The birth unit was secure. There was a buzzer entry and exit system to the unit and staff monitored CCTV.

Staff had access to a neonatal resuscitaire that they would place outside of birthing rooms ready to use if needed. Staff carried out daily safety checks of specialist equipment most of the time. However, there were four gaps in daily checks in October 2022, one gap in September 2022 and one gap in August 2022.

# Maternity

Staff did not have access to adult resuscitation equipment at Penrice birthing unit. The matron told us this was discussed with the trust resuscitation team and minutes of the November 2018 resuscitation committee confirmed this. Following the inspection the trust told us they planned to fully risk assess the lack of access to a defibrillator at the Penrice birthing unit site.

Staff had access to safe equipment to evacuate a person from the birthing pool in the event of maternal collapse. Staff had access to an all-purpose patient transfer slide and flotation aids.

The service had suitable facilities to meet the needs of women's families. Both birthing rooms were en-suite, one had a birthing pool and the other had a bath. Women and birthing people had access to birthing balls and mats to support active labour.

Staff disposed of clinical waste safely.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration**

Midwives at the Penrice birthing unit provided advice and support to women antenatally but did not do triage assessments for women in early labour. Women in early labour were triaged through the Royal Cornwall Hospital maternity triage phone line.

Staff completed risk assessments for women and birthing people antenatally and throughout their pregnancy. Midwives used personalised fetal growth charts in line with national guidance. Women and birthing people could access antenatal screening services at the main hospital site. We saw evidence in the 3 records we reviewed that women and birthing people were given the 'Kicks Count' leaflet to explain what normal fetal movements were and what to do if there were changes in the fetal movement pattern.

Staff assessed if women and birthing people were suitable to birth at the birthing unit at 36 weeks. We reviewed 4 risk assessments and found a formal assessment tool was not used to ensure women met the criteria for birthing at the free-standing midwifery led units. The community matron told us this assessment would be completed at a routine antenatal appointment. If women wanted a home birth, there was a home birth risk assessment form that midwives completed and attached to the woman's electronic record.

Women who chose to birth outside of guidance from consultants and midwives attended a birthing options clinic staffed by a consultant midwife and consultant obstetrician to discuss risks and options available to create a suitable birth plan together.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the maternity early obstetric warning score (MEOWS) to identify women at risk of deterioration. Matrons completed MEOWS documentation audits. The January to March 2022 audit of 90 records from across the service showed there was good compliance at overall 93%.

Staff completed risk assessments for each woman on arrival to the birth unit in labour.

# Maternity

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments in relation to venous thromboembolism (VTE) and pressure area risks. Information was displayed on sepsis recognition and management in the community office.

Shift changes and handovers included all necessary key information to keep women and babies safe. Staff used a situation, background, assessment, recommendation (SBAR) format to share information. The last SBAR audit completed in November 2022 of 16 sets of notes selected randomly from across the service showed the tool was used in 55% of cases and was not fully embedded in the maternity service. We saw on inspection there were reminders on staff noticeboards about the use of the SBAR tool.

Leaders monitored transfers from the free-standing midwifery led units into the labour ward on the main hospital site. Transfer rates were low compared with national averages.

Midwives based in the community did not rotate into the Royal Cornwall Hospital labour ward or Truro birth centre. There was a risk due to the low levels of intrapartum activity at the centre, midwives would not be up to date on key skills such as suturing (stitching wounds) or cannulating (inserting a small tube into a vein for intravenous access).

### Midwifery Staffing

**The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, appraisal rates were low.**

The service had enough nursing and midwifery staff to keep women and babies safe. Penrice birthing unit was open 9am to 5pm seven days a week. Overnight, the 3 freestanding birth units (Penrice, Helston and the Isle of Scilly) were staffed by community midwives operating an on-call system. The maternity service had three pairs of midwives available every night to support birthing people requesting a community birth (home or birth unit).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The last midwifery workforce review was in March 2022 and was completed using a nationally recognised maternity acuity tool. A staffing consultation was in progress at the time of inspection to ensure all areas across maternity on the main hospital site and in the community were staff safely.

The service had reducing sickness rates. The maternity dashboard showed the sickness rate for community midwives was reducing and was 5% or less in the past three months September to November 2022. The service did not use agency midwives.

Managers supported staff to develop through yearly, constructive appraisals of their work, but appraisal rates were low at the time of inspection. Data showed appraisal rates across the maternity service were low. As of 6 December 2022, 57% of midwives had received an annual appraisal and 43% of midwifery support workers.

### Records

**Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

# Maternity

Women's notes were comprehensive, and all staff could access them easily. Matrons completed audits of basic record keeping. The December 2022 audit of 71 randomly selected sets of notes from across the service showed compliance was 90%.

We reviewed a sample of 3 sets of notes and found records were not always dated and signed.

The service was updating the paper records used for care in labour at the time of inspection. A new booklet for care of women in labour had been produced but was not in use.

When women transferred to a new team, there were no delays in staff accessing their records.

Staff stored paper records securely.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely. However, staff could not access the midwife's exemption list at Penrice birthing unit and the midwives exemptions were not clearly recorded in the trust medicines management policy.

Staff completed medicines records accurately and kept them up-to-date.

Staff did not always store and manage all medicines safely. We found stocks of pethidine that was last used May 2022. There was a risk stocks were not double checked in line with the trust medicines management policy for controlled drugs when the service was not staffed overnight.

### Incidents

**Due to low activity levels, evidence of learning from incidents at Penrice birthing unit was limited.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. A trigger list with examples of reportable incidents was displayed in the staff office.

Managers at the main hospital site met weekly to discuss maternity incidents.

## Is the service well-led?

**Good**

Our rating of well-led improved. We rated it as good.

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.**

# Maternity

Penrice birthing unit was managed as part of the Women, Children and HIV services care group of Royal Cornwall Hospital. This care group was managed by a director of midwifery, a clinical director and a general manager. Staff we spoke with told us the director of midwifery had visited the birthing unit and was approachable.

On a local level, Penrice birthing unit was managed by the community matron, supported by 1 community team leader.

A non-executive director had visited maternity community services and the feedback from this visit was shared at the September 2022 maternity and obstetric business and governance meeting.

### Vision and Strategy

**The service was developing a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.**

The trust maternity strategy was in draft at the time of inspection following the arrival of a new director of midwifery in Spring 2022. Leaders planned to launch the new strategy by 2023.

In line with national recommendations the implementation of maternity continuity of carer was paused at the time of inspection. A business case was agreed and progressing to increase the capacity of the 'WREN' (women requiring extra nurturing) team to ensure existing maternity continuity of carer focused on those living in areas of high deprivation and those from a black or ethnic minority background.

Maternity leaders were working with the local council to re-start the peer-support breastfeeding service that was available at the Penrice birthing unit before the pandemic. Maternity support workers were available to support with breastfeeding at the unit at the time of inspection.

Maternity services was included in the trust workforce plan which included a recruitment and retention strategy that was launched in November 2022.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of women receiving care.**

There was no information on how to make a complaint or raise concerns available on the unit. The maternity section of the Royal Cornwall Hospital website included a section on providing feedback to the service.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. There were no formal complaints relating to Penrice birthing unit or community midwifery care between 1 September 2022 and 5 December 2022. There was one informal complaint relating to community midwifery care in this period.

The community matron told us the culture between community staff and hospital-based midwifery staff was improving.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

# Maternity

The Penrice birthing unit was managed as part of the Royal Cornwall Hospital maternity governance structure. A monthly maternity and obstetric business and governance meeting reported up to the Royal Cornwall Hospital trust board.

We reviewed the minutes of the last two maternity and obstetric business and governance meetings for September and October 2022 meeting and found community activity was discussed at this meeting and the impact of pressure on the ambulance service on the number of births in community settings.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff had access to clinical guidelines on an electronic system. Clinical guidelines were the same across all Royal Cornwall NHS Trust sites. At the Penrice birthing unit, we reviewed two clinical guidelines: standard operating procedure for Penrice birthing unit and the waterbirth guidelines and found these were up to date and in line with national guidelines.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.**

Managers monitored outcomes for women and babies on a maternity dashboard. The dashboard contained minimal data relevant to Penrice birthing unit. The data that was relevant to the unit included: the number of deliveries at Penrice, the number of women booked for delivery at Penrice, total births in the community and number of intrapartum transfers from the community.

Penrice birthing unit did not have a local risk register but managers were aware of risks that related to the unit. There were no risks recorded that related specifically to Penrice birthing unit. Risks that related to community maternity services generally included a midwifery staffing risk, the ability of the ambulance service to respond to births in community settings due to ongoing pressures and community midwives working across the Cornwall and Devon border.

### Information Management

**The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Paper records and electronic records were used at the time of inspection.

The trust was rolling out electronic prescribing to all locations. At the time of inspection Penrice birth unit used paper prescription charts.

The trust had a digital midwife in post.

### Engagement

**Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.**

# Maternity

The service had strong links with the local maternity voices partnership (MVP). For example, the service had worked with the local ambulance service and MVP to draft a letter outlining the impact of pressures on NHS ambulance services and the impact on response times even in emergency situations. The letter supported women to make an informed decision in planning to birth at home or in a freestanding midwife led unit such as Penrice or Helston.

### Learning, continuous improvement and innovation

**There was limited evidence of learning and continuous improvement at Penrice birthing unit.**

There were no examples of quality improvement projects, research or innovation at the Penrice Birthing Unit.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the trust MUST take to improve:**

**Penrice birthing unit**

- The service must ensure that there is a full risk assessment for the level of emergency equipment at Penrice birthing unit. Regulation 12 (2) (a) (b)
- The service must ensure staff complete daily checks on emergency equipment. Regulation 12 (2) (e)

**Action the trust SHOULD take to improve:**

**Penrice birthing unit**

- The service should ensure staff complete regular birth pool evacuation training and baby abduction drills at Penrice Birthing Centre.
- The service should ensure there is clear documentation of how women and birthing people meet the criteria for using the free-standing midwifery-led units for care in labour.
- The service should ensure compliance with use of the situation, background, assessment, recommendation (SBAR) tool improves.
- The service should ensure staff sign and date all records.
- The service should ensure that there are effective processes for learning from incidents at birth centres.
- The service should ensure all staff receive a yearly appraisal.
- The service should consider improving how information is displayed on how to give feedback and make a complaint about the service.

# Our inspection team

The team that inspected the service included 2 CQC inspectors and a midwife specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.