Enter and View Report

Maternity Assessment Unit (MAU), Royal Stoke University Hospital (RSUH)

Date and time of visit

5th March 2020

10:30 a.m. – 12:30

Name of Service Provider

University Hospital of the North Midlands (UHNM)

Premises Visited

Maternity Assessment Unit, Royal Stoke University Hospital (RSUH)

Manager: Sister Julie Hulse

Authorised Representatives

To provide consistency, our visit team consisted of the same visitors as on the previous visit.

Simmy Akhtar, Paul Harper and David Rushton

Representatives have undertaken Enter and View Training and are enhanced CRB checked

Purpose of visit

Healthwatch Stoke-on-Trent had undertaken an Enter and View visit in December 2019 to Wards 205 and 206 of the Maternity Unit and it was noted that some negative comments had been received regarding the MAU. The published report stated that Healthwatch Stoke-on-Trent would visit the MAU at some point within 'the next three months'.

Methodology

Letters were sent to the Ward Manager on 12th February 2020 informing her that we would undertake the visit. Although the visit took place in early March 2020, due to the Covid-19 crisis, this draft report was misplaced and, following it being re-sent, Healthwatch Stoke-on-Trent received comments back from the MAU team on 8th July 2020. These comments and feedback have been incorporated into this, the final report.

Environment

The Maternity Assessment Unit (MAU) provides additional care and assessment for women from 16 weeks pregnancy to six weeks after birth. People may call the unit's emergency telephone number 01782 672300 at any time during their pregnancy to discuss any problems or to receive advice.

They will be asked various questions about their pregnancy and condition to enable the unit to establish the best place to assess or treat people. They may be advised to attend the unit if staff thought they have a problem which needs attention from a midwife or an obstetrician, or they may be referred to the unit by their midwife, GP or clinic.

On admission, their problems can be assessed by a midwife or doctor and further care planned as necessary. The MAU also provides outpatient care should people require extra attention but not admission to the inpatient wards.

People are advised not to contact MAU prior to 16 weeks of pregnancy. Instead, they are advised to contact their GP or community midwife for professional advice and support. The MAU has 10 beds and receives GP referrals. There is a triage system in place – by phone, although there is no designated person for this role. The ward clerks are often the first point of contact and information taken will be given to the midwives on duty for screening. Alternatively, since there is no designated person, it may be the midwives and support workers themselves who take the calls. *We were informed that this should not be the case as:* ***Midwives offer clinical advice to women only, support workers do not offer any advice or make recommendations for care.***

At the time of our visit, Julie Hulse, the Ward Manager was not available but we were welcomed by Jill Tooth. As part of her introduction, Jill told us that she was an Interim Band 7 midwife, on only her second day in post, which is meant to be split as 0.6 in MAU and 0.4 in the Labour ward. Jill confirmed that there is no like for like cover on the Labour ward and currently, some staff are on sick leave. She explained clearly her understanding of the role of the unit and the needs of the patients. She also demonstrated a vision for the continued working of the unit and the needs of the staff working there.

One thing she said concerned us and that she was unaware of our previous visit report, although she knew we had carried out an Enter and View visit to Wards 205 and 206. We believe it is important to share such reports and other feedback with members of staff.

One of the observations by the Healthwatch visitors highlighted how small the team office space was. It is a small area consisting of space for three staff to sit. The area is not very long or wide, providing very limited space for hand overs or team discussions. There were only two computers and staff commented they would like three as two are not enough at times. *This comment attracted the following comment from staff at the MAU:* ***This area is for clinical documentation, handover of care does not take place here as it does not offer sufficient confidentiality, hand overs take place in the office area behind a closed door. Computer on wheels (COWS) are situated in various locations around the department which allow bedside documentation to take place. These COWs***

have access to the same programmes and systems as the PC's in the office area.

There are no doors to this area and it is possible to overhear what is being said when standing at the ward clerks desk. This reduces confidentiality, privacy and dignity for patients.

The workstations face one wall but the information white board is on the wall behind them which our visit team felt should be in front of the staff for better and easier information and communication.

Staff also shared the observation about the lack of space and white board.

This was reported back to Jill and she agreed that this needs to be addressed.

The waiting area (located in a main corridor outside the ward) lacked privacy, comfort and informality. We felt that this is not good if people are feeling stressed, unwell or distressed awaiting assessment. *We have subsequently been informed that: **Any woman who is unwell is triaged immediately and not expected to sit on the landing. The landing is for women who have been assessed and are clinically well enough to wait for further tests or review***

Operational procedures within MAU.

MAU care can continue for up to 28 days after the birth. The busiest 'peak' time is during daytime hours but it can vary on any given day.

The unit is described as "very busy" and is usually operating at full capacity. On the day of the visit it was not at full capacity, however during the visit ten referrals were made to the unit and all were expected at some point during the day.

Referrals are made for a range of issues and concerns, such as:

no baby movement;
bleeding;
high blood pressure;
premature labour;
or feeling "poorly".

All referrals are assessed and graded as follows:

Red – seen within 15 minutes

Amber – seen within 1 hour

Green – seen within 4 hours

The grading is given using a national tool called Birthrate Plus which gives a score based around five categories. These are described at the end of this report. We were informed that this tool works well.

At time of discharge, Jill reported that the process is often delayed due to lack of Doctor availability to complete a medical review and ideally, she would like to see a full-time daytime Doctor designated to MAU. Where medical input is required then they have to use medics from the delivery suite.

Multi-disciplinary team (MDT) working

Jill informed us that MDT is working well. We spoke to a ward clerk and the four midwives and all confirmed that they felt that the team worked well and were supportive of each other. "An excellent MDT" one person reported.

We were also told: "We work very closely with each other" and levels of communication within the team were stated as being "very good"

Jill stated that she is very keen to ensure that the MDT works well and there is continued close working and that she believes that she is very approachable and supportive of staff and obviously recognises the importance of that for the unit.

She informed us that she has worked in the maternity unit for 25 years and has a good overview of the unit as a whole and the cross departmental pathways.

Miscellaneous comments made by Jill Tooth

- She said that the imposition of Financial Measures is making it difficult to obtain supplies and workforce is covered by in-house bank staff.
- Furthermore, she told us that changes at County Hospital have had a huge impact on demand at RSUH and that pregnant ladies choose RSUH more so than Walsall or Wolverhampton.
- Finally, she told us that if County maternity services were to close this would hugely negatively impact the administrative burden at RSUH as staff at County complete many of the data tasks. She is aware of how busy they are as she also covers County.

Staff training

All staff have to complete their annual mandatory training. Much of the training is online and e learning as it is across the UHNM. Staff reported that lower staffing levels at times can hinder the time available to access training.

It is the manager's role to ensure all staff complete the necessary training.

The maternity unit has a safeguarding lead. There are two practice education leads for the whole maternity unit. In addition there is a Clinical education Midwife working within the maternity department.

Staffing

The Staffing ratio is two midwives to cover basic needs and one for day-care. Jill told us that three plus one would provide the ideal levels. We did note that the latter was the case on the day of the visit.

The staffing includes Band 6 and Band 5 midwives, plus support workers at Band 2.

There are three ward clerks, but, just as we on wards 205 and 206 (previous visit) if there are no clerks on duty then some of the work is done by the clinical staff, which again is time consuming for the clinicians and it means the clerks have to play 'catch up' on their return).

The unit has one domestic. Outside or normal working hours one domestic will work across several different units.

Patient feedback

We were able to talk with four patients and below are their comments:

Patient one

- Lovely and helpful staff
- Monitored weekly to ensure liver is functioning as it should

Patient two

- Consultant referral to MAU, 33 weeks pregnant
- Long wait times in waiting area despite having a 10am appointment and was not given a bed until 11.10am.
- Waiting area is extremely uncomfortable.
- Patient annoyed that despite there being so many empty beds she was left in discomfort.
- Staff are busy and do their best, they need more staff

Patient three

- Lovely staff who provide invaluable reassurance
- Wait times are long but not complaining but would if she was in an emergency situation
- Annoyed that discharge is delayed due to waiting for prescribed drugs from

Patient four

- Staff are good

Summary and conclusions

We were impressed with the efficient and collected manner shown by all staff during our visit to the MAU. We understood it was not 'as busy as usual' but this did not detract from the professionalism displayed.

We would like to thank Jill Tooth for her hospitality and willingness for us to ask questions to gain a better understanding of the MAU.

We would make the following recommendations:

- In future, ensure that all relevant documents and reports are shared with ALL relevant staff to improve relations;
- Consider how the visitors' area can be improved in terms of comfort and the need to provide a degree of privacy;
- Similarly, the team office space needs to be relocated to provide a more reasonable and effective working space for members of the team. Privacy for team meetings needs to be improved.
- Furthermore, the number of workstations should be increased to three to provide the necessary equipment to enable a significant part of the role to be carried out effectively.

We would like to thank Jill and all other members of the team we met on the day for their time, consideration and helpfulness.

The triage system is based upon the BSOTS model

Category I This is the most normal and healthy outcome possible. A woman is defined as Category I [lowest level of dependency] if: The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring.

Category II This is also a normal outcome, very similar to Category I, but usually with a perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention.

Category III Moderate risk/need such as Induction of Labour with Syntocinon, instrumental deliveries will fall into this category, as may continuous foetal monitoring. Women having an instrumental delivery with an epidural, and/ or Syntocinon will become a Category IV.

Category IV More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

Category V This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third-degree tear may be in this category.