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Dear Mr Savage,

21st July 2014

Re: Healthcare Inspectorate Wales announced visit to Nightingale House Hospice on the 15th April 2014.

As you are aware Healthcare Inspectorate Wales undertook an announced visit to Nightingale House Hospice on the 15th April 2014.

Background

Nightingale House Hospice is a registered charity providing inpatient and outpatient palliative care services for adults with life limiting illnesses, including cancer.

Methodology

The inspection of facilities and services included reviewing documentation provided by the hospice during inspection and viewing environment and facilities during the visit. Discussions relating to registration and service provision were held with the registered manager. Records kept at the hospice were made available for inspection, and the inspecting officer observed care practices and interaction between staff, patients, and visitors.

Overall View of the Healthcare Setting

Nightingale House hospice is a modern purpose-built facility opened in 1995. It is located on the outskirts of Wrexham town centre, easily reached by car, public transport and on foot. Parking is limited, but public car parks are located within a five minute walk from the hospice. There was an open visiting policy unless the patient requests restrictions. Children were welcomed visitors, and pets may be brought in by arrangement.

The hospice is registered to provide inpatient care for up to 16 patients over the age of 18 years and day care for up to 15 patients over the age of 18 years. Due to

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financial constraints, the hospice had reduced its inpatient capacity to 12 patients. Outpatients' clinics were also held weekly throughout the year providing access to specialist medical consultants, medical treatments and a nurse-led day care centre.

Palliative care services included physiotherapy, occupational therapy, hydrotherapy and complementary therapies both for inpatients, outpatients and day care patients. The physiotherapist, nursing staff and a volunteer had obtained qualifications in their relevant areas of expertise to carry out complementary therapies. Medical and nursing care included symptom control, respite care and terminal care. Other services provided by Nightingale House include a bereavement service for children and young adults up to the age of 19 years, access to counselling and support services for relatives and carers. A recent development is the creation of a Monday drop in clinic based in Corwin for people who require palliative care advice or symptom control.

There was no fee charged for care or services at Nightingale House. Referrals for care and treatment were accepted from National Health Service (NHS) Trust services, community social and health care services, and self-referrals from members of the public with General Practitioner consent.

Management of the hospice was democratic with clear management structures and auditing procedures in place that assessed the care and provision both within the hospice and against other respite and palliative care establishments. The atmosphere was very positive and it was clear that staff were encouraged to develop care and enjoy working there. Recent staff changes due to retirement and career development had created difficulties of late with the continuity of clinical governance structures. A strategy and action plan needs to be developed to ensure that present and future staff vacancies are reviewed on a monthly basis. The care overall meets the National Minimum Standards (NMS) and there were aims to ensure continual improvement of care. The treatment provided was person centred and needs assessments were thorough and based on recognised evidence. Although a review and update is required, as many core care plans were found to have been written in 2006 and clinical care has developed since then in many areas of practice.

The building itself was attractive, welcoming, warm, clean, light, and bright. It was decorated, furnished, and maintained to a high standard, and a variety of up-to-date equipment was available. Pleasant and well-maintained garden areas were accessible to wheelchair users and visitors. All inpatient rooms had patio access. All patients' facilities were located on the ground floor. The first floor provided administrative and educational services only. Inpatient facilities include a ward area comprising shared, single and family rooms, conservatory and dining area. Single rooms had en-suite facilities, and there were also shared bathrooms that incorporated adapted bathing facilities. Visitors and families were provided with amenities to prepare drinks and snacks.

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Nightingale House has a hydrotherapy pool and physiotherapy area, used by inpatients, outpatients, and families. Fully equipped and private treatment rooms were available for medical treatments, nurse-led clinics and complementary therapies, and private rooms were available for medical consultation.

A small chapel was integral to the facilities available to inpatients, outpatients, families, and visitors, holding services and open 24 hours a day for private prayer. The hospice employed a part-time chaplain for religious or spiritual support.

Food was cooked on the premises by a team of qualified staff to patients' own choices, preferences or medical requirements. There had been recent changes to the catering personnel and food delivered was designed to meet the needs of people who were nutritionally compromised due to their health condition. Catering staff liaise with nursing staff and patients on admission to ascertain specialised requirements and choices. Patients spoken with on the day of inspection testified to the quality and choice of meals available. The catering department is subject to inspection by the Environmental Health Department of the local council, and achieved a Gold Award for standards of catering hygiene in 2012.

Quality of Treatment and Care

Care was person centred, based on evidence reviewed and was of a high standard. There were clear monitoring and auditing systems in place. There were some appropriate policies and procedures in place to assist staff with the provision of care but others required updating. A system had recently been put in place for existing policies to be used until review, which will take place over next six months. A timetable had been developed for future policy review.

Care was determined according to individual patient need, assessment, and documentation about patients was extensive and ongoing. A consent to treatment policy was in place that included obtaining written consent. Privacy, dignity, and confidentiality during discussions or examinations was provided in private bedrooms, or the use of consulting rooms, clinical rooms, and sitting rooms to the choice of the patient and relative.

Management of patient conditions at Nightingale House was informed through membership of independent associations and groups including 'Help the Hospices' the 'Disease Orientated Network' of North Wales, the 'National Council for Hospice and Palliative Care' (NCPC), as well as the 'Independent Hospice Joint Planning Group' and the expertise of medical personnel. This addresses all of the relevant aspects of practice described in National Minimum Standards.

Patients and their relatives were involved in all decisions and planning for the terminal stage of a patient's illness and their wishes were recorded in care plans. A care of the dying pathway guided practice. Pain relief was medically prescribed and continuously monitored and reviewed.

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There was an ongoing education and training programme for staff working within the hospice. The clinical supervision system that was in place has lapsed due to staff changes. This needs to be reintroduced especially in light of new members of staff who will require management, education, and emotional support whilst developing into their new roles.

Nightingale House had a policy in place to guide practice and decisions in relation to Cardio Pulmonary Resuscitation (CPR) and advanced care planning. These sensitive decisions were reached with the consent of patients or their relatives if they were unable, and recorded in care plans.

Patients and relatives views of the service were collected via questionnaires and suggestion boxes were located around the hospice for both patients and visitors to register their comments or ideas. Results from surveys indicated high levels of satisfaction with services at nightingale House and there had been no complaints for the past two years.

There had been a recent evaluation to determine dependency levels of patients in order to facilitate staffing provision and it is planned to incorporate this into a model for care.

Management and Personnel

There was a clear organisational and management structure for Nightingale hospice. The Registered Manager of the hospice had appropriate qualifications and experience to ensure satisfactory care. Staff working at the hospice were also suitably qualified and there was an ongoing system of education and personal development for each member of staff. There was a mixture of staff disciplines within the hospice, all of whom had relevant qualifications and training to undertake their roles. Qualified and experienced nurses lead nursing care both in the ward and day centre supported by health care support workers.

The ward duty roster confirmed that the number and skill mix of staff on each shift over a 24 hour period were appropriate to the number and needs of inpatients at the time of the visit. Staffing levels were adjusted to meet varying inpatient needs and numbers as required. Nursing staff maintained their practice in accordance to their registration body the Nursing and Midwifery council (NMC). Medical care was led and reviewed by the medical director.

Human Resource policies were available. All medical, nursing and allied therapeutic staff were registered with the appropriate professional organisation confirming registration to practice. The Disclosure Barring Service (DBS) checks all staff and there are systems in place to ensure that all staff are up to date with their professional qualifications. All newly employed staff and volunteers followed an induction programme that includes health and safety issues.

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A large number of volunteers were engaged and provided a valuable service in a variety of roles both within the hospice and through fundraising. Volunteers do not provide personal care. In determining suitability for engagement at Nightingale House, volunteers submit to the same rigorous procedures as staff recruited for employment. Volunteers participate in an annual performance review and are provided with induction and ongoing training opportunities.

Medical, nursing, therapeutic professionals and ancillary staff engaged in annual appraisal, performance review, and professional support and supervision. However, the staff supervision system requires formalisation and recording. Staff were expected to keep themselves up-to-date with both clinical and professional practice and with the policies and procedures used within the hospice. All attended regular training to maintain and update skills and knowledge to palliative care and statutory health and safety issues. Many nurses held specialist palliative care qualifications.

A multidisciplinary approach (MDA) to patient care was maintained at Nightingale House. Patients documents viewed at inspection confirmed that medical, nursing, physiotherapists, and occupational therapists were involved in an individual's care.

Multidisciplinary case conferences were held weekly to discuss planned admissions and discharges and care of patients in receipt of services, confirmed by a meeting held on the day of inspection. Case conferences involved community professionals, MacMillan Nurses, other members of the wider multidisciplinary team, and outside agencies as required.

Nightingale House is active within the community in its fundraising role, and many volunteers are involved in fundraising, lottery and promotions in North East Wales and in particular the Wrexham Area. Consequently, Nightingale House has a high profile within the area, and had a reputation for high standards of care and services.

The Nurse Manager role description had been developed and was awaiting ratification by the hospice management board. In the interim an experienced member of the physiotherapy staff was undertaking aspects of the role two days per week. This interim development was discussed during the visit as to whether this arrangement would continue as a post share with a nurse in future. The post will be advertised as soon as possible so that development work and aspects of education and management can be maintained.

Many nursing staff had recently undertaken training in medical gases and have found this both informative and helpful for their work.

Premises, Environment and Facilities

Clinically the environment supported a good standard of care with up to date equipment available. All equipment including medical equipment, lifts and hoists, electrical equipment and systems, gas, water and fire safety systems were serviced under external contracts according to manufacturer instructions. Maintenance

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persons were employed to address day to day checks and general repairs, and were qualified to carry out maintenance of named specialist equipment/systems following training and agreement with manufacturers. The hospice was compliant with fire safety regulations. The emergency lighting had been recently tested and gas and boiler certificates were available. Legionalla Risk assessments certificates were available. Fire risk assessments had been undertaken.

Records Management
Patient records were clear, extensive and up-to-date and all members of the multidisciplinary team used the same record system. There was a range of policies and procedures to guide staff in practice and for audit and benchmarking purposes, however, many of these were in need of review.

A review of the Controlled Drugs register indicated that this was properly completed. Reminder systems had been put in place in the clinical room and all relevant staff had been reminded about the importance of ensuring that controlled drugs were treated according to the Controlled Drugs Act and NMC Guidance on Medicines Administration. The process for dealing with drug errors had been reviewed to include the ward sister in discussion and it was planned that the Registered Manager will become the Accountable Officer for controlled drugs rather than the associate Medical Director.

Research
The hospice had clear and appropriate research policy, protocols and guidelines to ensure appropriate conduct and research was undertaken with the appropriate informed consent. There was a research assistant employed by Nightingale Hospice.

Verbal feedback was undertaken throughout the visit and a verbal overview at the end of the visit with the registered manager.

There are no regulatory requirements as a result of this inspection.

Good practice Recommendations:
Clinical supervision systems should be formalised.

Healthcare Inspectorate Wales would like to thank the staff members for their time and co-operation during the visit.

Please do not hesitate to contact me should you wish to discuss the content of this letter.

A copy of this letter is being sent to Mrs Tracy Livingstone, Registered Manager and Director of Nursing and Patient Services at Nightingale House Hospice.

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Yours sincerely

Phil Price
Inspection Manager

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