Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Nightingale House Hospice
Chester Road
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Inspection 2009/2010

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Inspection Date:	Inspection Manager and Reviewers:
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Introduction

Independent healthcare providers in Wales must be registered with the Healthcare Inspectorate Wales (HIW). HIW acts as the regulator of healthcare services in Wales on behalf of the Welsh Ministers who, by virtue of the Government of Wales Act 2006, are designated as the registration authority.

To register, they need to demonstrate compliance with the Care Standards Act 2000 and associated regulations. The HIW tests providers' compliance by assessing each registered establishment and agency against a set of *National Minimum Standards,* which were published by the Welsh Assembly Government and set out the minimum standards for different types of independent health services. Further information about the standards and regulations can be found on our website at: **www.hiw.org.uk**.

Readers must be aware that this report is intended to reflect the findings of the inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times.

Background and main findings

Nightingale House was first registered in November 1995. The inspection process consisted of one unannounced visit and three announced visits, two in June 2009 and one in October and November 2009. Interim report letters were sent to the setting in relation to regulatory requirements arising from the inspections. The hospice submitted action plans which were monitored and followed up by Healthcare Inspectorate Wales (HIW).

Nightingale House in Wrexham is a hospice providing respite and palliative care for adults who suffer from life limiting conditions. It is purpose built standing in its own grounds and provides inpatient, outpatient and day care in separate areas which were linked by a corridor.

Management of the hospice was of a democratic nature with clear management structures and auditing procedures in place to assess the care and provision both within the hospice and against other respite and palliative care establishments. The atmosphere was very positive and it was apparent that staff enjoyed working in Nightingale House. The care largely met the National Minimum Standards and the aim was to ensure continual improvements in care. The treatment provided was person centred and needs assessments were thorough and based on recognised evidence. Palliative care provision was based on the "All Wales" standards of which staff were aware and the Standards were constantly monitored and audited. Procedures and policies were available and used by, staff to guide them in care provision.

Statement of purpose & Patient guide

Nightingale hospice had a clear statement of purpose and patient guide containing easily accessible information. A patient information folder was provided to patients on admission describing the services and facilities available. The patient information folder and supplementary information leaflets were also available to prospective patients, families and visitors who were considering accessing services at the hospice.

Quality of Care

Care was person centred, based on evidence and of a high standard. There were clear monitoring and auditing systems in place. There were appropriate policy and procedures in place to assist staff with the provision of care although some of these policies required updating. Care was determined according to individual patient need and 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 were provided in private bedrooms, or by the use of consulting rooms, clinical rooms, and sitting rooms according to the choice of the patient and relative.

Management of patient conditions at Nightingale House was informed through membership of independent associations and groups which included “Help the Hospices” the “Disease Orientated Network” of North Wales, the “National Council for Hospice and Specialist Palliative Care Services” (NCHSPCS), as well as the Independent Hospice Joint Planning Group and the expertise of medical personnel.

A multidisciplinary approach 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. However, some prescription chart were difficult to read and the need to improve this was discussed. Multidisciplinary case conferences were held weekly to discuss planned admissions and discharges and the care of patients in receipt of services. Case conferences involved community professionals and MacMillan Nurses as required who were based at Nightingale House.

There were auditing procedures in place and the hospice was involved with other similar hospices for benchmarking standards of care as well as exchanging guidelines and clinical care practices.

Care of the Dying

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. A grand round system had been implemented which had enabled staff education and discussion about aspects of clinical care especially those that were ethically or clinically based and require interactive teaching and exploration.

Nightingale House had in place a policy to guide practice and decisions in relation to CPR and advanced directives. These sensitive decisions were reached with the consent of patients or their relatives if they the patient was unable to, and recorded in care plans.

There were plans to develop a system for determining dependency levels of patients in order to facilitate staffing provision. It was hoped that this could be incorporated into a model for care.

Patients' Views

Patients and relatives views of the service were collected via questionnaires twice yearly. 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. Interviews with patients and relatives during visits demonstrated very high levels of satisfaction with all aspects of service provision at the establishment.

Policies & Procedures

There were written policies and procedures for monitoring quality of care. There was an extensive range of policies and procedures guiding operations and practice at Nightingale House. All policies had an issue date and review date. However, as had been noted previously a number of policies required review and updating.

Human Resources

There was a clear organisational and management structure for Nightingale hospice and a extensive and robust Human Resource policy was in place. There were appropriate personnel policies and procedures in place. All medical, nursing and allied therapeutic staff were registered with the appropriate professional organisation confirming registration to practice. All staff had a Criminal Records Bureau (CRB) check. All newly employed staff and volunteers followed an induction programme that included health and safety issues.

The manager of the hospice had appropriate qualifications and experience. Other staff members 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 led nursing care both in the ward and day centre supported by health care support workers. Many nurses held specialist palliative care qualifications. 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 inspection. 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, an NHS employed specialist in palliative care, who attended the hospice four times a week. The assistant medical director, again a specialist in palliative care, was employed by the hospice and provided medical care on a daily basis plus an on call service. He was supported by a further two part time medical staff with palliative care expertise. There was a system for group and individual clinical supervision for the staff.

Medical, nursing, therapeutic professionals and ancillary staff engaged in annual appraisal, performance review, and personal/professional support and supervision. 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. However, it was noted that the training records required updating

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 did not provide personal care. In determining suitability for engagement at Nightingale House, volunteers submitted to the same rigorous procedures as staff recruited for employment. Volunteers participated in an annual performance review and were provided with induction and ongoing training opportunities. This year younger people and those who were unemployed within the hospice had worked within the hospice.

Protection of Vulnerable Adults and Children

Protection of vulnerable adults procedures were available. Confidentiality was maintained appropriately and staff members were aware of the need to report any breaches of this and any other poor practice, or abuse. The hospice cared for adults only, however, children were visitors to the hospice.

It was noted that an update of Protection of Vulnerable Adults (POVA) and Children (POVAC) training was required for nearly all staff.

Complaints

A robust complaints system was in place. The establishment had a whistle-blowing policy and procedures and there were channels available for staff to raise concerns.

Premises & Facilities

The main entrances into the building and rear entrances for access to gardens were well maintained and suitable for wheelchair access. All patient facilities were located on the ground floor. There was a signing in process for visitors. Patients' facilities included eight single en-suite bedrooms, three of which were designed to accommodate family visits, plus two four bedded patient rooms. Fixed screening protected privacy within the shared rooms. The three family rooms included en -suite showers and there were a four additional bathroom areas that included toilets.

Though not designated for single sex use, each could be locked when in use. A separate bathroom and toilet was available for day care patients. There was a total of six outpatient consulting and treatment rooms.

All areas of the hospice visited during inspection were seen to be clean and well maintained. A cleaning schedule for the premises was in operation. All patient and visitor areas were decorated and furnished to a high standard and appeared light, bright and warm. The garden areas were accessible, attractive and well maintained. Patients and visitors spoken with on the day of inspection testified to the pleasant and comfortable surroundings. An ongoing programme of redecoration and refurbishment was in place.

However, on testing of water temperatures it was noted that variable water temperatures were present in both patient and staff areas. As far as inspection and recording of water treatments were concerned, it was advised that the cold water storage tanks were chlorinated on a regular frequency, but nothing downstream of the tank positions. In addition, no regular testing of hot water delivery temperature took place, or regular cleaning of shower heads. There was evidence of thermostatic blending valves beneath some sanitary appliances, but the efficiency of these had not been checked for some time.

Catering

The catering staff had undertaken intermediate and advanced food hygiene training. All required documentation in relation to risk management and patient records were in place. A changing and varied lunch menu was in place from which patients were able to make choices. The cook visited each patient daily before each meal was prepared. Should patients prefer something not stated on the menu the cook ensured that any patient choice was met. Ongoing training and support from nursing staff ensured that the catering team were knowledgeable and skilled in the preparation of food to meet specialist dietary and nutritional requirements as well as individual requests. Specialist nutritional and dietary advice was available as required. Snacks and drinks were continuously available and a snack preparation area was available on the ward for relatives and visitors.

Health & Safety

A comprehensive health and safety policy was in operation. The policy made reference to the Health and Safety at Work Regulations 1999, and addressed safe working practices, safe use of equipment and hazardous substances, first aid and reporting of injuries, diseases and dangerous occurrences regulations 1995 (RIDDOR) reporting. Control of Substances Hazardous to Health (COSHH) data sheets were continuously reviewed and updated and were held in all departments. There was a designated health & safety person within the hospice.

Medicines Management

Policy documentation was clear on roles and responsibilities. The establishment had access to up to date, relevant reference sources i.e. British National Formulary (BNF).

However, it was noted that the medicines policy documents that were in place had an expiry date of January 2008. It was stated that review of these is nearly complete. An error reporting process was in place and evidenced.

Records were kept of ordering, receipt, supply, administration and disposal of all medicines, dressings and medical gases in order to maintain an audit trail. However, it was noted that some prescription charts were illegible. This was a regulatory requirement from 2008-2009.

Emergency boxes were present around the unit containing intranasal midazolam and anaphylaxis medicines. It was stated that the expiry date of these medicines was noted in ward diaries for checking, but it was not clear how this was assured.

There was a daily monitoring of the temperature of the medication refrigerator. Temperature records were kept via a thermal data logger, printed computer records were present. There was no written procedure for action to be taken if temperature is outside range.

There was a written procedure for the receipt of, and responsibilities for taking action on, hazard warnings and drug recalls, assisted by the supplying pharmacist. The process for alerts was described and evidenced. Records must be kept for eight years from the date of discharge or death of the patient. It was not evidenced from the policies present how long records were to be kept.

Information Management

Policies that guided practice included information management, patient access to records and health records creation, management, storage and destruction. The information management policy reflected Caldicott principles on confidentiality and disclosure.

The medical director was the nominated Caldicott guardian. Policies were referenced to relevant legislation including the Data Protection Act 1998. Access to Medical Records Act 1990 and NMC/GMC professional guidelines and include information regarding the Freedom of Information Act 2005.

An Information Technology (IT) policy guided the use of computerised databases and detailed all information that was legitimately held on computer. Computerised health records were not in use. Computers were linked to the Northeast Wales NHS Trust Hospital intranet and electronic records continued to be backed up daily by the Trust IT department. A password protected IT link had been created to enable named persons within the hospice, IT development group to directly access the Northeast Wales NHS Trust hospital pathology, radiology and outpatient departments.

Health Records

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.

Policies and procedures were regularly updated. The policy for patient access to records described the procedure for requesting access and guided the response of the clinical director and registered manager in agreeing to, or withholding access.

A documentation audit was completed annually using a sample of recent discharges and deaths. Results of audit were presented to the clinical effectiveness committee for corrective action planning and subsequently disseminated to relevant staff departments.

Confidentiality

A confidentiality policy was in place to control unauthorised disclosure of information. Information management, including confidentiality/ disclosure of information, was addressed during the induction of all staff to Nightingale House, including volunteers.

Achievements and compliance

It must be noted, that timescales to meet the regulatory requirements have not been met on a number of occasions and HIW have had to initiate contact to follow-up agreed action plans and outcomes.

There is one outstanding requirement from the 2008-2009 inspection visit. A number of prescription charts were illegible. However, it is also noted that the senior management team have been pro-active in reviewing and action planning with regard to this area and to meeting other regulatory requirements arising from 2009-2010 visits.

Registration Types

This registration is granted according the type of service provided. This report is for the following type of service

Description
Independent Hospital
Palliative care - Hospice for adults

Conditions of registration

This registration is subject to the following conditions. Each condition is inspected for compliance. The judgement is described as Compliant, Not Compliant or Insufficient Assurance.

Condition number	Condition of Registration	Judgement
1.	The total number of persons accommodated at any one time in the Hospital aged 18 years and over, must not exceed Sixteen (16) in-patients and Fifteen (15) day care patients.	Compliant

Assessments

The Healthcare Inspectorate Wales carries out on site inspections to make assessments of standards. If we identify areas where the provider is not meeting the minimum standards or complying with regulations or we do not have sufficient evidence that the required level of performance is being achieved, the registered person is advised of this through this inspection report. There may also be occasions when more serious or urgent failures are identified and the registered person may additionally have been informed by letter of the findings and action to be taken but those issues will also be reflected in this inspection report. The Healthcare Inspectorate Wales makes a judgment about the frequency and need to inspect the establishment based on information received from and about the provider, since the last inspection was carried out. Before undertaking an inspection, the Healthcare Inspectorate Wales will consider the information it has about a registered person. This might include: A self assessment against the standards, the previous inspection report findings and any action plan submitted, provider visits reports, the Statement of Purpose for the establishment or agency and any complaints or concerning information about the registered person and services.

In assessing each standard we use four outcome statements:

Standard met	No shortfalls: achieving the required levels of performance
Standard almost met	Minor shortfalls: no major deficiencies and required levels of performance seem achievable without extensive extra activity
Standard not met	Major shortfalls: significant action is needed to achieve the required levels of performance
Standard not inspected	This is either because the standard was not applicable, or because, following an assessment of the information received from and about the establishment or agency, no risks were identified and therefore it was decided that there was no need for the standard to be further checked at this inspection

Assessments and Requirements

The assessments are grouped under the following headings and each standard shows its reference number.

- Core standards
- Service specific standards

Standards Abbreviations:

C = Core standards
A = Acute standards
MH = Mental health standards
H = Hospice standards
MC = Maternity standards
TP = Termination of pregnancy standards
P = Prescribed techniques and technology standards
PD = Private doctors' standards

If the registered person has not fully met any of the standards below, at the end of the report, we have set out our findings and what action the registered person must undertake to comply with the specific regulation. Failure to comply with a regulation may be an offence. Readers must be aware that the report is intended to reflect the findings of the inspector at the particular inspection episode. Readers should not conclude that the circumstances of the service will be the same at all times; sometimes services improve and conversely sometimes they deteriorate.

Core standards

Number	Standard Topic	Assessment
C1	Patients receive clear and accurate information about their treatment	Standard met
C2	The treatment and care provided are patient - centred	Standard met
C3	Treatment provided to patients is in line with relevant clinical guidelines	Standard met
C4	Patient are assured that monitoring of the quality of treatment and care takes place	Standard met
C5	The terminal care and death of patients is handled appropriately and sensitively	Standard met
C6	Patients views are obtained by the establishment and used to inform the provision of treatment and care and prospective patients	Standard met
C7	Appropriate policies and procedures are in place to help ensure the quality of treatment and services	Standard almost met
C8	Patients are assured that the establishment or agency is run by a fit person/organisation and that there is a clear line of accountability for the delivery of services	Standard met
C9	Patients receive care from appropriately recruited, trained and qualified staff	Standard met

Number	Standard Topic	Assessment
C10	Patients receive care from appropriately registered nurses who have the relevant skills knowledge and expertise to deliver patient care safely and effectively	Standard met
C11	Patients receive treatment from appropriately recruited, trained and qualified practitioners	Standard met
C12	Patients are treated by healthcare professionals who comply with their professional codes of practice	Standard met
C13	Patients and personnel are not infected with blood borne viruses	Standard not inspected
C14	Children receiving treatment are protected effectively from abuse	Standard almost met
C15	Adults receiving care are protected effectively from abuse	Standard almost met
C16	Patients have access to an effective complaints process	Standard met
C17	Patients receive appropriate information about how to make a complaint	Standard met
C18	Staff and personnel have a duty to express concerns about questionable or poor practice	Standard met
C19	Patients receive treatment in premises that are safe and appropriate for that treatment. Where children are admitted or attend for treatment, it is to a child friendly environment	Standard almost met
C20	Patients receive treatment using equipment and supplies that are safe and in good condition	Standard met
C21	Patients receive appropriate catering services	Standard met
C22	Patients, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately	Standard almost met
C23	The appropriate health and safety measures are in place	Standard almost met
C24	Measures are in place to ensure the safe management and secure handling of medicines	Standard almost met
C25	Medicines, dressings and medical gases are handled in a safe and secure manner	Standard met
C26	Controlled drugs are stored, administered and destroyed appropriately	Standard met
C27	The risk of patients, staff and visitors acquiring a hospital acquired infection is minimised	Standard almost met
C28	Patients are not treated with contaminated medical devices	Standard met
C29	Patients are resuscitated appropriately and effectively	Standard almost met
C30	Contracts ensure that patients receive goods and services of the appropriate quality	Standard met
C31	Records are created, maintained and stored to standards which meet legal and regulatory compliance and professional practice recommendations	Standard almost met

Number	Standard Topic	Assessment
C32	Patients are assured of appropriately competed health records	Standard met
C33	Patients are assured that all information is managed within the regulated body to ensure patient confidentiality	Standard met
C34	Any research conducted in the establishment/agency is carried out with appropriate consent and authorisation from any patients involved, in line with published guidance on the conduct of research projects	Standard met

Service specific standards - these are specific to the type of establishment inspected

Number	Hospice Standards	Assessment
H1	Arrangements for care in hospices	Standard met
H2	Palliative care expertise and training for multi-professional teams	Standard met
H3	Assessment of patient's and carer's needs	Standard met
H4	Delivery of palliative care	Standard met
H5	Records of care	Standard met
H6	Infection control	Standard met
H7	Resuscitation	Standard met
H8	Responsibility for pharmaceutical services	Standard met
H9	Ordering, storage, use and disposal of medicines	Standard almost met
H10	Administration of medicines	Standard almost met
H11	Self administration of medicines	Standard met
H12	Storage and supply of medical gases	Standard met
H13	Assessment and care of children	Not applicable
H14	Qualifications and training for staff caring for children	Not applicable
H15	Environment of care for children	Standard almost met

Schedules of information

The schedules of information set out the details of what information the registered person must provided, retain or record, in relation to specific records.

Schedule	Detail	Assessment
1	Information to be included in the Statement of Purpose	Standard met
2	Information required in respect of persons seeking to carry on, manage or work at an establishment	Standard met
3 (Part I)	Period for which medical records must be retained	Standard almost met
3 (Part II)	Record to be maintained for inspection	Standard almost met
4 (Part I)	Details to be recorded in respect of patients receiving obstetric services	Standard not inspected
4 (Part II)	Details to be recorded in respect of a child born at an independent hospital	Standard not inspected

Requirements

The requirements below address any non-compliance with The Private and Voluntary Health Care (Wales) Regulations 2002 that were found as a result of assessing the standards shown in the left column and other information which we have received from and about the provider. Requirements are the responsibility of the 'registered person' who, as set out in the legislation, may be either the registered provider or registered manager for the establishment or agency. The Healthcare Inspectorate Wales will request the registered person to provide an 'action plan' confirming how they intend to put right the required actions and will, if necessary, take enforcement action to ensure compliance with the regulation shown.

Standard	Regulation	Requirement	Time scale
C9.6	Regulation 17(2)(a)	**Findings:** Records of staff mandatory training not available **Action Required:** The registered person is required to update records of staff mandatory training required.	Two weeks (Discussed on day of visit) (Completed March 2010. Confirmed By RI)
C9.5 C23.4	Regulation 17(2)(a)	**Findings:** Some staff have not undergone training for managing challenging behaviour **Action Required:** The registered person is required to ensure all staff receive training in managing challenging behaviour	One Month (Discussed on day of visit) (Completed and Ongoing, March 2010. Confirmed By RI)

Standard	Regulation	Requirement	Time scale
C9.5 C9.4 C14.4 C15.3 C15.1	Regulation 17(2)(a)	**Findings:** Many staff have not undergone POVA and POVAC training **Action Required:** The registered person is required to ensure that all staff undertake training in POVA and POVAC	One Month (Discussed on day of visit) (Completed March 2010. Confirmed By RI)
C22.1	Regulation 24(2)(d)	**Findings:** The health and safety policy is out of date **Action Required:** The registered person is required to review the health and safety policy.	Two weeks (Discussed on day of visit) (Completed March 2010. Confirmed By RI)
C22.1	Regulation 24(2)(d)	**Findings:** The hydrotherapy policy is out of date **Action Required:** The registered person is required to review the hydrotherapy policy.	Two weeks (Discussed on day of visit) (Current policy reviewed. Planned completion April 2010. Confirmed By RI)
C22.1	Regulation 24(2)(a)(d)	**Findings:** Insufficient evidence that maintenance monitoring and audit was undertaken within the establishment. **Action Required:** The registered person shall ensure that the premises are of sound construction and kept in a good state of repair externally and internally: All parts of the establishment to which patients have access to are so far as reasonably practicable free from hazards to their safety.	One month and on-going from July 2009. (Completed March 2010. Confirmed By RI)

Standard	Regulation	Requirement	Time scale
C24.3	Regulation 14(5)	**Findings:** Some prescription charts were illegible. **Action Required:** The registered person is required to ensure that all prescriptions are legible.	Immediate and on-going (Discussed on day of visit) (Planned review ND and action plan to be forwarded to HIW April 2010. Confirmed By RI)
C25.2	Regulation 14(5)	**Findings:** The medicines policy documents that were in place had an expiry date of January 2008. **Action:** The registered person is required to ensure that up to date medicines policies are present.	Two weeks (Discussed on day of visit) (Completed March 2010. Confirmed By RI)
C25.2	Regulation 14(5)	**Findings:** Emergency boxes were present around the unit containing medicines. It was stated that the expiry date of these medicines was noted in ward diaries for checking, but it was not clear how this was assured. **Action:** The registered person is required to ensure that a process for confirming that expiry dates of medicines in emergency boxes are checked regularly	One week (Discussed on day of visit) (Completed March 2010. Confirmed By RI)
C25.9	Regulation 14(5)	**Findings:** There was no written procedure for action to be taken if the medication fridge temperature was outside the appropriate range. **Action:** The registered person is required to ensure that a written procedure for action to be taken if the medication fridge temperature is outside the normal range	One week (Discussed on day of visit) (Completed March 2010. Confirmed By RI)

Standard	Regulation	Requirement	Time scale
C31.1	Regulation 8(1)(c)	**Findings:** The health records policy is out of date **Action Required:** The registered person is required to review the health records policy.	Immediate and on-going (Completed March 2010. Confirmed By RI)
C31.2	Regulation 20 (1) Schedule 3 Part I	**Findings:** Records must be kept for eight years from the date of discharge or death of the patient. It was not evidenced from the policies present how long records were to be kept. **Action:** The registered person is required to ensure that there is a records policy present that details how long records are to be kept.	One week (Discussed on day of visit) (Completed March 2010. Confirmed By RI)