

Independent Healthcare Inspection Report (Announced)

Nightingale House Hospice, Wrexham

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Vision

A future where healthcare in Wales was safe, effective and high-quality for everyone.

Our Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.



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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our [website](#).

Healthcare Inspectorate Wales (HIW) completed an announced inspection at Nightingale House Hospice, Wrexham on 21 and 22 July 2026.

Our team for the inspection comprised of two HIW healthcare inspectors, one clinical peer reviewer and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 39 questionnaires were completed by patients or their carers and 76 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Nightingale House Hospice provided a highly positive patient experience, with overwhelmingly positive feedback from patients, carers and staff. All patients rated the service as good or very good, highlighting compassionate staff, excellent volunteer support, a peaceful environment, attractive gardens and valuable services such as physiotherapy, wellbeing programmes, bereavement support and respite care.

The hospice demonstrated a strong commitment to dignity, respect, privacy and person-centred care. Patients consistently reported feeling listened to, involved in decisions and treated as individuals. Staff were observed providing compassionate, unhurried care, with access to a wide range of therapies and support services to promote physical, emotional and psychosocial wellbeing.

Accessible information was available throughout the hospice, supported by bilingual signage, patient information packs and online resources. Strong communication practices were evident, with efforts made to meet individual language and communication needs. The hospice also promoted self-referral and had expanded services through patient feedback, including new support groups and enhanced outpatient services.

The Neurological Link Nurse role had significantly improved access for patients with progressive neurological conditions, leading to a 40% increase in uptake of wellbeing services since March 2025. Equality, diversity and inclusion were embedded throughout the organisation, with proactive efforts to support underserved groups and ensure equitable access to care.

This was what we recommend the service can improve:

- Ensure all Welsh-speaking staff wear language identification lanyards
- Increase staff awareness of how patient feedback is used to inform organisational decision-making.

This was what the service did well:

- Patient satisfaction and positive feedback
- Strong culture of dignity, respect, compassion and person-centred care
- Wide range of therapeutic, wellbeing and support services available
- Effective use of patient feedback to drive service improvements.

Delivery of Safe and Effective Care

Overall summary:

Safe, effective and person-centred care was provided within a well-maintained, clean and welcoming environment. The premises were safe, secure and fit for purpose, with appropriate facilities, controlled access arrangements and strong information governance practices.

Comprehensive systems were in place to manage risks, maintain business continuity and support health and safety. Infection prevention and control arrangements were particularly strong, with high compliance rates, robust cleaning schedules, excellent environmental cleanliness, regular audits and the use of ultraviolet decontamination technology. Patients and staff reported confidence in the hospice's infection control measures.

Patients were supported to meet their nutritional needs through flexible, personalised catering arrangements, access to specialist dietetic advice and 24-hour availability of food and refreshments. Medicines management processes were safe and effective, with secure storage, appropriate controlled drugs management, anticipatory prescribing and person-centred approaches to medication administration.

Safeguarding arrangements were well established, with staff demonstrating good knowledge of procedures and access to specialist advice. Equipment was readily available, maintained and suitable for patient needs. Clinical care was supported by effective risk assessments, safety huddles, audits and governance processes. Patient feedback demonstrated high confidence in the quality and safety of care provided.

The hospice showed a strong commitment to quality improvement, using audits, innovation, patient feedback and partnership working to develop services, including bereavement support, wellbeing programmes, phlebotomy services and specialist support groups. Record keeping was of a high standard, providing clear evidence of safe, coordinated and responsive care.

This was what we recommend the service can improve:

- Completion and recording of DoLS considerations and ensure they are routinely reviewed throughout a patient's stay

- Safety measures, displaying oxygen-in-use signage, timely completion of Venous Thromboembolism assessments and enhancing hand hygiene provision at mealtimes.

This was what the service did well:

- Clean, safe and well-maintained environment
- Strong infection prevention and control systems with high compliance rates
- Safe and person-centred medicines management practices
- Comprehensive quality improvement programme driven by feedback and innovation
- Clinical records, risk assessments and governance arrangements supporting safe care.

Quality of Management and Leadership

Overall summary:

The hospice was well led, with a strong governance framework, visible leadership and a positive organisational culture. Feedback from staff respondents was overwhelmingly positive, with all staff reporting patients' dignity was maintained, patients and families were involved in decision-making and high-quality, compassionate care remained the organisation's priority. Staff consistently described the hospice as a supportive workplace that valued wellbeing, learning and professional development.

Governance arrangements were robust, with clear lines of accountability, effective committee structures and strong oversight from the Board of Trustees. Staff reported good access to managers, effective communication and opportunities to influence service development.

There were effective systems for managing complaints, incidents and regulatory reporting. Learning from feedback and incidents was shared across the organisation and used to improve services. Recruitment processes were generally strong, with appropriate pre-employment checks, low staff turnover and effective workforce planning. Volunteers continued to play a significant role, with around 500 volunteers supporting care and hospice services.

Training, supervision and staff development were well established. Compliance with mandatory training was high, staff had access to specialist education opportunities and wellbeing support was embedded through supervision, appraisals and occupational health services. The hospice was viewed as forward-looking, innovative and committed to continuous improvement while maintaining a patient-centred ethos.

This was what we recommend the service can improve:

- Develop and implement a standalone recruitment policy to strengthen governance arrangements.

This was what the service did well:

- Strong, visible and supportive leadership culture
- Governance and accountability arrangements with active trustee oversight
- High levels of staff satisfaction, wellbeing support and professional development opportunities
- Effective systems for managing complaints, incidents and organisational learning
- Excellent workforce stability, recruitment practices and volunteer engagement.

3. What we found

Quality of Patient Experience

Patient feedback

HIW issued a questionnaire to obtain patient views on the care at Nightingale House Hospice for the inspection undertaken in July 2026. Patient responses were captured onsite via hard copy questionnaires and posters displaying the online survey link. In total, HIW received 39 questionnaire responses from patients, families or carers who shared their views on the setting. Almost all responses from patients were positive. Overall satisfaction was extremely high with 94% of respondents rating the service as 'very good' and the other 6% rating the service as 'good'. Patient comments included:

"Peaceful and friendly."

"I attend the wellbeing programme, the staff, volunteers are professional, polite and generous in what they do. cannot fault them in anyway."

"The hospice has wonderful facilities. The grounds are very well kept with a beautiful patients garden. The cafe was a welcome addition to the premises."

"Gardens are excellent and are a credit to the people who look after the gardens."

"The staff and services are outstanding. Everyone goes beyond - all staff. I needed this place before I knew it, It was a valuable resource that was underestimated."

"Very well ran, volunteers are worth their weight in gold, respite was an amazing facility offered to all, family support was second to none, thank you."

"The staff are very kind and supportive, very happy and peaceful environment."

The positive themes from patient comments included compassionate and supportive staff with praise for staff and volunteers. Respondents described staff as:

- "Lovely and welcoming"
- "Kind and supportive"
- "Friendly and caring"
- "Professional"
- "Wonderful"
- "Outstanding".

Many respondents stated they felt safe, respected, listened to and well cared for. There were positive comments about the environment respondents frequently praised including relating to:

- The peaceful atmosphere
- Attractive and well-maintained gardens
- Clean facilities
- Comfortable surroundings
- The hospice café
- The welcoming wellbeing centre.

Respondents highlighted the value of hospice services, these were:

- Physiotherapy services
- Wellbeing programmes
- Family support services
- Bereavement support
- Respite care
- Volunteer support.

Health promotion, protection and improvement

Information and resources to support patients' health and wellbeing were available and accessible within the hospice environment. A wide range of information leaflets relating to available services and wellbeing support was readily accessible. This included information on hydrotherapy, complementary therapies, spiritual care, providing feedback or suggestions and details of key contacts for support and advice.

Numerous condition-specific information leaflets were also available. Literature produced by recognised national organisations, including Macmillan Cancer Support, was available and provided advice on lifestyle, health and wellbeing for both patients and carers. Patients spoke positively about the availability of information and the balance between externally produced resources and hospice-developed materials.

Appropriate bilingual signage was displayed throughout the hospice, including on patient rooms and key areas, ensuring patients, carers and visitors were informed of relevant information and any known hazards.

There was also information on anxiety management, sleep hygiene and alcohol consumption, particularly in relation to medication considerations. Whilst smoking cessation information was not observed during the inspection, signage clearly communicated that the hospice operated as a smoke-free site.

The hospice also provided a wellbeing programme for outpatients, supported by volunteers and healthcare support workers (HCSWs). The programme focused on peer support, social engagement and wellbeing through a variety of activities, including games and facilitated group discussions. Topics ranged from light-hearted social interaction to more sensitive discussions about the impact of illness on individuals and their families.

Dignity and respect

There was evidenced of a strong organisational ethos centred on preserving and promoting patient dignity, respect, privacy and independence in all aspects of care delivery.

Staff were consistently observed treating patients with dignity, respect and kindness. Interactions between staff and patients were compassionate, professional and person-centred, demonstrating a genuine interest in patients' views, experiences and individual needs. Conversations were constructive and unhurried and there was no evidence of care being rushed.

A strong emphasis was placed on supporting patients' physical, emotional and psychosocial wellbeing. Patients had access to a range of therapeutic and supportive services, including physiotherapy, hydrotherapy, counselling, Eye Movement Desensitisation and Reprocessing (EMDR) and Cognitive Behavioural Therapy (CBT). One patient spoke positively about the support received from the physiotherapy team, explaining that exercise therapy and activity pacing had significantly improved their functional ability, including their capacity to walk and manage stairs.

Patient verbal feedback was positive, with individuals describing strong collaborative working relationships with staff and highlighting the compassionate and person-centred approach adopted by the hospice. Patients reported that staff worked with them to establish realistic and meaningful goals, reflecting a high degree of partnership and shared decision-making.

The hospice environment and equipment provision promoted both comfort and independence. Patients had access to appropriate mobility aids and adaptive equipment, including walking aids, cushions and raised-height chairs. Support was provided according to individual need, while maintaining a clear focus on preserving independence wherever possible. A hearing loop was also available to support communication needs.

Patients were observed to be appropriately dressed, clean and comfortable, including those with significant challenges relating to self-care and independence. This reflected the positive and dignified approach adopted by staff in supporting personal care needs.

There was a strong commitment to meeting patients' communication and language requirements. Several Welsh-speaking staff members were available to support patients who wished to communicate in Welsh. The hospice was also encouraging staff engagement with Welsh language learning and planned to introduce informal sessions to allow staff to practise and develop their language skills. The use of language line services was evidenced during the inspection and the organisation was developing information booklets to ensure key patient information was available in individual rooms and readily accessible to staff.

Privacy screens were available and used when required and no private conversations were overheard during the inspection. A multidisciplinary team handover observed at 09:00 was conducted in a private room with the door closed. Discussions were professional, respectful and demonstrated a good understanding of patients' individual circumstances and care needs.

In the patient questionnaire relating to dignity, respect and compassion, responses indicated exceptionally positive experiences of care. All patients agreed that staff treated them with dignity and respect, provided care when needed and were kind and sensitive.

Patient information and consent

Arrangements were in place to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussions and decision making was undertaken appropriately and sensitively. With the consent of the patient, carers, family members and relevant professionals were also provided with appropriate information to support care planning and decision-making.

It was positive to note the roles of all staff in ensuring the patients received effective and timely care. The hospice employed a Neurological Link Nurse with the aim of engaging patients earlier in their illness and increase awareness of the hospice as a place of wellbeing, support and education, rather than solely end-of-life care.

Working closely with outside organisations and multidisciplinary teams, the nurse had strengthened partnerships and improved access to hospice services. Since March 2025, there had been a 40% increase in uptake of wellbeing services for people with neurological conditions. A dedicated multiple sclerosis (MS) group had been introduced, for outpatients who could access rehabilitation, complementary therapies, counselling and wellbeing programmes.

The role included home visits, enabling more flexible and personalised support for those whose symptoms made travel difficult. This approach ensured care was tailored to individual needs and supported patients throughout their disease progression.

The role also promoted advance care planning, patient choice, symptom management, respite care and coordination of individual care. The success and development of the role had led to an invitation from Hospice UK to present this work at its annual conference.

We spoke with the Director of Communications and Fundraising who described how the hospice actively encouraged referrals and self-referrals by promoting the full range of services available and ensuring information was easy to access. Patient information materials were reviewed every six months and booklets were provided during assessments. Whilst the hospice was well known in Wrexham, a key objective was to increase engagement in areas further from the hospice.

The director highlighted that only around 20% of funding came from statutory sources, with the remainder raised through fundraising. Regular newsletters, social media, patient stories and digital displays raised awareness, a strong focus on staff engagement had helped create a positive organisational culture.

Staff questionnaire responses showed that most thought care of the patient was the organisation's top priority and overall they were content with the efforts of the hospice to keep patients safe.

Communicating effectively

Staff demonstrated a strong commitment to confidentiality, with sensitive discussions taking place in private settings rather than public areas. Good communication was evident both in practice and within clinical records, supporting person-centred care and positive patient experiences.

Patients and carers were provided with clear, accurate and accessible information to support informed decision-making about their care. A wide range of information was available through both digital and paper-based formats, ensuring patients could access guidance in ways that met their individual needs.

A user-friendly online patient guide was available, which included quick response (QR) codes linked to information about services and patient leaflets. Information was primarily available in English, with Welsh versions accessible online.

The hospice had effective arrangements in place to meet patients' language and communication needs. Patients were offered information about their diagnosis, prognosis, treatment and care options to the extent they wished to receive it and preferences regarding information sharing were identified and documented on admission and reviewed throughout care.

Consideration was given to producing information in alternative formats, including large print and audio resources. Where necessary, information could be translated into languages relevant to the local community or individual patient needs and the hospice made every effort to access interpreter services.

Room names and areas were clearly signposted in both English and Welsh. Whilst some maps were displayed around the site, directional signage was limited in places and the absence of a clear site map in reception may make navigation more difficult for some visitors. Nevertheless, parking arrangements were clearly signposted and easy to understand. The hospice should consider the patient and carer pathway to ensure direction signage was appropriate.

A wide variety of information resources were available throughout the hospice. Posters identifying senior managers and trustees were displayed in reception, alongside information explaining how to raise concerns. Numerous safeguarding posters were visible across the site, helping patients, visitors and staff understand safeguarding processes and reporting routes. Clinical areas displayed information explaining staff uniforms and professional roles. The hospice had introduced “Welcome to the Inpatient Unit” folders, containing practical guidance on call bell use, Wi-Fi access, mealtimes, visiting hours, complaint procedures, contact details for HIW, smoking policies, alcohol policies and staff identification information.

Extensive information was available on hospice services, spiritual care, discharge planning and symptom management. Bereavement counselling services for children were also supported by age-appropriate information and resources.

Feedback from patients and carers was consistently positive and demonstrated that individuals felt involved in decisions about their care. Patients reported that their wishes were respected, while carers described feeling listened to and included in care planning. In the questionnaire all patients said that staff listened to them and answered their questions.

A total of 11 members of staff who completed the staff questionnaire stated they were Welsh Speakers. However only three said they wore a ‘iaith gwaith’ lanyard.

The hospice must ensure that Welsh speaking staff (including Welsh language learners) wear an appropriate lanyard identifying them as Welsh speakers.

Care planning and provision

The hospice demonstrated a strong commitment to providing safe, person-centred care and treatment tailored to each patient's individual needs. Patients were supported and encouraged to maintain their independence and function at the highest level possible, with activities adapted to suit their abilities and energy levels. During the

inspection, an example of highly individualised care was noted, with a patient receiving end-of-life care being supported to have their family and pet on-site.

Patients generally received assistance from staff in a timely manner. Feedback indicated that, although staff could occasionally be required to support more than one patient with complex needs simultaneously, they consistently found ways to ensure that care and support were delivered promptly and effectively.

Where outpatient clinics experienced delays, staff proactively communicated this to reception personnel, who then informed patients on arrival and kept them updated regarding waiting times.

There was clear evidence of personalised care throughout the inspection. Environmental adaptations, including signage on toilet doors and other key areas, were in place to support patients' independence and orientation.

The hospice promoted patient wellbeing through a broad range of supportive and therapeutic services, including hydrotherapy, reflexology and massage. In addition, a variety of wellbeing activities were coordinated through the outpatient service. The hospice took proactive and innovative approaches by engaging with potential patients before admission, helping to establish relationships and understand individual needs at an early stage.

Staff have access to specialist palliative care advice and expertise 24 hours a day, seven days a week, with support provided through Supportive Care UK (SCUK). To further support person-centred care, patients and staff were encouraged to complete an "A Bit About Me" booklet, which captured personal preferences, individual goals and aspirations that patients may wish to achieve during their care. This enabled all staff to find out about the individual.

Advance care planning was recognised as a key priority by staff to ensure patients received care in line with their wishes, particularly given the absence of an in-house overnight doctor. The hospice used the Australian-modified Karnofsky Performance Scale to assess patients' functional status and monitor changing needs. Staff worked within the All-Wales Competency Framework for Adult Palliative and End of Life Care, supported by a dedicated end-of-life care plan.

Patients we spoke with felt they were treated as an individual with a positive focus on laughter and holistic care.

In the patient questionnaire regarding personal care and responsiveness, positive responses were also recorded regarding assistance with personal care with all patients agreeing they were offered choices regarding toileting arrangements and staff assisted with toileting sensitively. All patients who used a buzzer agreed they had access to one and staff responded when called. Most respondents felt involved in their healthcare and received adequate information with 96% agreeing their privacy was protected and

were given enough information to understand their healthcare. Slightly less, 93%, agreed they were involved in decisions about their care as much as they wished.

Equality, diversity and human rights

The hospice demonstrated a strong commitment to promoting equality, diversity and inclusion, ensuring that patients were protected from discrimination and treated with dignity and respect. Staff described a culture where everyone was treated equally regardless of background, identity or personal circumstances, supported by a clear organisational commitment to inclusivity.

The hospice was actively working to improve access for underserved and marginalised groups. Staff highlighted outreach initiatives, including engagement with homeless individuals and local minority communities. Services were available to all patients and efforts had been made to improve access for people living in more deprived or rural areas.

A range of measures were in place to support equality of access. These included access to support from learning disability leads. Staff receive mandatory equality, diversity and inclusion training, alongside autism awareness training and management development focused on inclusive practice. A learning disability link nurse was also available to provide specialist advice and support.

The hospice environment reflected a commitment to representation and inclusivity. Reading materials, artwork and displays included people from diverse ethnic backgrounds, disabled people, minority groups, same-sex couples, transgender and non-binary individuals and families with children. Consideration had also been given to the inclusion of Welsh language resources where possible. Counselling and support rooms were designed to create a welcoming environment for all groups.

Patients were provided with information about their rights and how to raise concerns relating to equality, diversity and human rights. The staff handbook included policies on Equal Opportunities, Dignity at Work and Personal Harassment, stating the organisation's commitment to equality regardless of any protected characteristic.

There were positive examples of reasonable adjustments being made for staff and patients. Recruitment and interview processes had been adapted to better support neurodivergent candidates, with documents circulated in advance and opportunities provided for clarification and questions. Staff described an individualised approach to supporting transgender patients, including asking people how they wished to be addressed and ensuring their preferred name was respected. The family support and social work teams had worked effectively with transgender patients and families to ensure equitable treatment.

An equality and diversity policy was available which included the hospice commitment to eliminating discrimination, promoting inclusion and reducing inequalities for patients, families, carers and visitors who access or support hospice services. Staff consistently demonstrated inclusive values.

In the staff questionnaire, 68 staff said they had not faced discrimination at work within the last 12 months, five members of staff preferred not to say and one said other. In all, 93% of staff agreed they had fair and equal access to workplace opportunities and 92% felt the hospice supported equality and diversity. A member of staff said that *"Inclusivity was one of our Values"*.

Citizen engagement and feedback

Patient and carer feedback was actively sought through a variety of methods throughout the hospice. Patients and carers are also encouraged to raise concerns directly, with staff demonstrating a willingness to discuss and respond to feedback promptly. Information on providing feedback and making complaints was clearly visible across the hospice, including "Talk to Us" posters and QR codes linking to feedback opportunities.

Evidence showed consistently high levels of satisfaction with hospice services. Patient and Carer Feedback reports presented in January 2026 indicated overall experience scores of 10 out of 10, while customer feedback collected via the reception tablet showed a 98% positive rating. Patients and carers were informed about feedback processes on admission and discussions with patients and families were routinely documented within care records.

Feedback was used to drive service improvements. Examples included alterations to patient room design to enable patients to control their own lighting, improving independence and comfort. Catering arrangements had also been revised following feedback, with menus simplified and adapted to better meet patient preferences. Feedback has additionally identified areas for future development, such as plans to refurbish the hydrotherapy area when funding permits. This facility was still popular and well maintained.

The hospice has effective systems for sharing feedback and learning across the organisation. Feedback, complaints and resulting improvement plans were reviewed regularly through meetings, safety huddles, ward meetings and staff communications, including being shared with volunteers. Inspectors noted the presence of a "You Said, We Did" board, demonstrating that patient feedback was acknowledged and acted upon.

Staff responses in the questionnaire stated they were generally aware of patient feedback processes and commented:

- Patient experience feedback was collected - 83%
- They received regular updates on patient feedback – 77%
- Patient feedback informed decision-making – 67%. However, 29% reported they did not know whether feedback was used to inform decisions.

Delivery of Safe and Effective Care

Environment

The hospice environment was observed to be of a high standard, demonstrating good maintenance, cleanliness and suitability for patient care. All areas inspected were clean, tidy and well organised, contributing to a welcoming, calm and peaceful atmosphere. Noise levels throughout the hospice were low, supporting a therapeutic environment for patients and visitors.

No significant trip hazards were identified during the inspection. Fire escape routes and exits were free from obstruction and fire doors were observed to be closed appropriately. Equipment and furnishings were in good condition and the overall state of repair throughout the premises was good. Where hazards had been identified, action was taken to reduce the risk of harm to patients, staff and visitors, as far as possible.

The hospice provided enough toilets, bathrooms and shower facilities. These areas were clean, hygienic and equipped to support the safety and independence of individuals with reduced mobility. The environment was considered fit for purpose, with appropriate facilities, sufficient bed capacity and suitable spaces to meet patients' needs.

The premises were safe and secure, with controlled access arrangements in place.

Patient-identifiable information was not displayed on whiteboards or electronic bed boards in communal inpatient areas. Staff compliance with wearing "Hello, my name is..." badges was variable, the campaign encouraged all staff to introduce themselves to patients. However, all staff were wearing identification lanyards.

The hospice must ensure that staff wear the appropriate "Hello, my name is..." badges for this initiative in a prominent position.

The hospice was clearly signposted and provided designated disabled parking spaces close to the main entrance. Outdoor areas were well maintained and positively viewed by patients. Feedback from patients, carers and members of the outpatient participation group was consistently positive, with individuals describing supportive relationships with staff and fellow patients. Positive comments regarding both the

hospice environment and outdoor spaces were confirmed through discussions during the inspection and observations made during site walkarounds.

Managing risk and health and safety

There was evidence that risks and hazards had been identified and that appropriate measures were in place to minimise the risk of harm to patients, staff and visitors. The hospice maintained a current Business Continuity Plan, which included Emergency Response Action Cards and an IT Disaster Recovery Plan. These documents outlined the organisation's strategic arrangements for responding to major incidents and provided guidance on the immediate actions required during an emergency.

There was also an up-to-date Business Continuity Plan relating to the care system used. This described the processes and controls in place to maintain business continuity, with a particular focus on information security.

The hospice also provided access to outdoor garden areas that were safe and suitable for patients, visitors, children and young people. These spaces offered opportunities for recreation, relaxation and wellbeing and appeared appropriate to meet the care and support needs of those using the service.

Infection prevention and control (IPC) and decontamination

Patients, visitors and staff were protected from healthcare associated infections through comprehensive IPC arrangements. Patients with suspected or confirmed infections were managed using appropriate barrier nursing procedures. All patient bedrooms were single occupancy with en-suite facilities, eliminating the risks associated with shared accommodation. Where required, relatives could stay within patient rooms, reducing unnecessary movement throughout the hospice. Alcohol hand gel, personal protective equipment (PPE), handwashing facilities and patient bathrooms were readily available throughout the service.

Staff explained that visitors displaying symptoms of infectious illness would be advised not to attend the hospice where there was a risk of transmission. Individual risk assessments would be undertaken where necessary, including for patients receiving end-of-life care with compassionate visiting arrangements.

There were clear IPC protocols displayed throughout the hospice and staff demonstrated a strong understanding of infection prevention procedures.

Cleaning arrangements were supported by detailed schedules, records and audit processes. They were maintained by ward and facilities teams, with completed cleaning records displayed behind doors within clinical areas. The hospice environment

was observed to be exceptionally clean, tidy and well maintained. Domestic staff were seen visibly undertaking cleaning duties in a respectful and unobtrusive manner. Cleaning audits were comprehensive and included environmental monitoring activities such as water temperature checks. Evidence reviewed, including the daily cleaning schedule, demonstrated that cleaning activities were completed consistently.

Store cupboards were secured through swipe-card access. However, it was noted that toilet rolls and paper towels were stored on the floor of a ward cleaning cupboard.

The registered manager must ensure that items are stored on shelving above floor level to support good infection control practices.

The service had an up-to-date Infection Control Guidelines Policy in place, covering purpose and scope, responsibilities, training requirements, monitoring arrangements and compliance expectations. Staff had access to IPC policies and procedures through the intranet. Training modules were linked directly to relevant policies, requiring staff to access and review the supporting guidance as part of the learning process.

The IPC framework included detailed procedures covering decontamination of medical equipment and devices, safe handling and disposal of sharps, prevention of sharps injuries and waste management. Water management arrangements included contracts for routine legionella monitoring and testing.

Clinical waste was managed through established external contracts. Appropriate arrangements were in place for the safe disposal of contaminated waste, including medical sharps, dressings and PPE. Sharps awareness training was reinforced through refresher sessions, including lunch-and-learn activities. Staff demonstrated a clear understanding of the actions required following a needlestick injury.

Occupational health support was available through an external provider. Staff could be referred directly by the hospice or self-refer where appropriate. Vaccination programmes were available to staff undertaking patient-facing duties.

Records relating to staff immunisation status were maintained securely within relevant clinical staff records. Control of substances hazardous to health (COSHH) products were securely stored in locked metal cabinets. An external contractor provided cleaning services and staff described the service as effective and reliable.

Monthly hand hygiene audits were undertaken and shared with staff. Audit data demonstrated generally high levels of compliance. However, two of the previous three hand hygiene audits identified a shortfall relating to the availability of alcohol hand rub at patient bedsides. This requirement should be consistently addressed unless an individual or ward risk assessment justifies an alternative approach.

The registered manager must ensure that any issues with audits result are included in an action plan with appropriate documented follow up.

Staff were observed undertaking hand hygiene appropriately between tasks and patient interactions. Signage promoting effective hand hygiene practices was displayed throughout the hospice, particularly in and around handwashing and sink areas, supporting IPC measures.

Reusable medical devices and equipment were cleaned after use and identified with “I Am Clean” labels. Where equipment required repair, staff decontaminated items appropriately before removal from clinical areas.

The hospice operated a comprehensive system of daily safety huddles, including discussions relating to patient safety risks such as falls, nutrition, pressure damage and resuscitation status. Staff reported having access to the equipment, cleaning materials and chemicals required to undertake their roles safely and effectively.

The hospice also used an ultraviolet (UV) decontamination system and maintained a regular cleaning rota for its use within our clinical areas. This supported their aim of creating a less clinical and more homely environment for patients whilst maintaining high standards of cleanliness and infection prevention. This enabled effective room decontamination, including hard-to-reach areas, corners and surfaces, typically within an hour.

In the patient questionnaire, all respondents described the hospice environment as ‘very clean’ and reported that IPC measures were being followed.

Staff in their questionnaire also responded positively as follows:

- The organisation implemented effective infection control arrangements – 97%
- There was an effective cleaning schedule – 95%
- Appropriate PPE was supplied and used – 100%
- The environment supported effective IPC – 97%.

Nutrition

Patients were supported to meet their individual nutritional needs and provided with a choice of food and drink that had been safely prepared. The hospice demonstrated a strong commitment to meeting patients' individual nutritional and hydration needs. Patients were offered a choice of food and drink that reflected their nutritional, therapeutic, religious and cultural requirements. Dietary preferences and needs were routinely discussed with patients, staff ensured that these requirements were accommodated wherever possible. Access to dietetic support was available when specialist advice or intervention was required.

The hospice also recognised the needs of carers and family members who stayed overnight or spent extended periods on site. Carers were encouraged to make staff aware of any dietary requirements so that appropriate arrangements could be made.

Patients had continuous access to fresh drinking water. Water jugs and glasses were readily available and positioned within patients' reach. In addition, there were kitchen facilities within both the inpatient and outpatient areas where patients and carers could access complimentary water, tea and coffee. A café situated on site also provided refreshments during normal opening hours.

Food and drink were available to patients 24 hours a day. Outside normal catering hours, drinks and light snacks remained available in the kitchen areas, ensuring patients and carers could access refreshments whenever required.

At the lunchtime meal service patients were appropriately supported to eat and drink safely. Patients were positioned comfortably and, where required, staff helped with seating and positioning before meals were served. Bed tables were cleared, cleaned and placed within easy reach. Interactions between staff, volunteers and patients were positive and attentive, promoting a dignified and pleasant dining experience.

Meal services were delivered in a calm, organised and seamless manner. Volunteers played an important role by taking meal orders from patients, guided by information provided by clinical staff. This enabled volunteers to identify patients who required additional assistance at mealtimes and spend time supporting them. Volunteers maintained regular communication with clinical staff and reported any concerns regarding patients' food intake or wellbeing promptly.

Staff and volunteers had a good level of awareness regarding individual dietary requirements for both patients and, where appropriate, carers. Feedback received consistently described the quality of the food as 'excellent'.

The hospice was able to support patients with specialist dietary needs, including those requiring enteral feeding through Percutaneous Endoscopic Gastrostomy (PEG) or nasogastric (NG) tubes. Care was guided by individual assessments and care plans. There was one patient receiving nutrition in this way in accordance with their expressed wishes and documented care plan.

Patients could choose to eat meals in their own rooms or within the dining facilities available in the outpatient area, supporting personal preference and independence. Patient rooms were observed to be clean, tidy and uncluttered, providing a suitable environment for mealtimes.

Antibacterial hand wipes were not provided as part of meal tray set-ups, although hand sanitiser stations were available throughout patient areas. This would further support hand hygiene immediately prior to meals.

The registered manager must ensure that patients are provided with antibacterial wipes both prior to and after meals to support hand hygiene.

The patient questionnaire responses relating to nutrition and hydration showed that all patients requiring support with eating agreed staff provided appropriate assistance and they had sufficient time to eat at their own pace. Additionally, all patients requiring support with drinking agreed staff provided appropriate assistance and they always had access to water.

Medicines management

The hospice had appropriate arrangements in place to support the safe and effective management of medicines. Pharmacy services were provided through the local district general hospital, ensuring access to specialist pharmaceutical support and oversight.

A clear procedure was in place for obtaining medicines during normal working hours. Out-of-hours prescriptions were currently obtained through the out-of-hours GP service. Staff advised that a formalised process was being developed to further support the safe management of medicines for patients admitted outside normal working hours.

The hospice had an up-to-date Medicines Management Policy. Staff demonstrated an awareness of the policy and were able to describe the appropriate escalation processes should concerns arise.

Staff and medical practitioners demonstrated a good understanding of anticipatory prescribing and confirmed that this approach was used where clinically appropriate to ensure patients' symptoms could be managed promptly and effectively.

Medicines were stored securely in locked cupboards and medicine trolleys within a locked medicines room. Medicine trolleys were secured to the wall when not in use. Refrigerated medicines were stored appropriately, with fridge temperatures monitored and recorded daily.

Controlled drugs (CDs) were managed appropriately. Staff monitored and recorded the receipt, administration and stock levels of controlled drugs in the relevant controlled drugs register, which was stored securely within the controlled drugs cupboard. Controlled drugs audits were undertaken to provide assurance regarding accountability and stock management.

The hospice supported self-administration of medicines where this was appropriate and safe to do so. In such circumstances, patients stored their medicines in a locked cupboard within their room, promoting independence while maintaining security.

An electronic incident reporting system was in use to record and monitor medicine-related incidents, near misses and other safety concerns.

Arrangements were in place to support the safe use of medical gases, including oxygen therapy. Staff confirmed they received training in the use of oxygen cylinders and oxygen therapy, with annual refresher training provided. During the inspection, staff advised that a refresher session delivered by BOC was scheduled for the following week.

However, there was no signage displayed outside patient rooms to indicate when oxygen was in use. Staff explained that this information was communicated during handovers and displayed on an "at a glance" patient information board located within the staff office. The board was fitted with doors to help maintain patient confidentiality. Whilst these arrangements informed staff of oxygen use, additional visual alerts would further support safety.

The registered manager must ensure signage is displayed outside patient rooms to indicate when oxygen is in use.

Staff were seen preparing and administering controlled drugs via a syringe driver safely and in accordance with expected procedures. Patients were appropriately positioned when receiving medicines and staff demonstrated an understanding of the importance of ensuring patients could take medicines safely and comfortably.

The hospice demonstrated a person-centred approach to medicines administration. Staff described how medicines could be adapted to meet individual patient needs, including changing tablets to liquid formulations or, where swallowing difficulties arose, using alternative routes of administration such as subcutaneous or intravenous delivery.

Medicine trolleys were not left unattended during medicines rounds and medicines were not left on bedside lockers. A calm and organised atmosphere was maintained throughout the ward during medicines administration activities.

Patients were generally wearing identification bands. Whilst one patient chose not to wear their identification band, it was kept at the bedside. Staff caring for the patient were familiar with the individual and appropriate measures were in place to confirm identity.

We reviewed a random sample of medication records for two patients. The records reviewed demonstrated that:

- Patient names and identification details were recorded clearly throughout
- Medicines prescribed and administered were documented appropriately
- It was evident who had made clinical decisions and authorised treatment plans
- Records supported clear accountability for care and treatment decisions

- Oxygen therapy was prescribed on the All Wales Medication Administration Record (AWMAR) where applicable.

However, a Venous Thromboembolism (VTE) assessment had not been completed for one patient. The assessment was absent from both the medication chart and the electronic record. Assessments should be completed in line with organisational requirements and that risks are identified and managed appropriately.

The registered manager must ensure VTE assessment are completed for all patients in a timely manner.

Safeguarding children and safeguarding vulnerable adults

The hospice had appropriate arrangements in place to ensure safeguarding policies and procedures were aligned with national legislation and the Wales Safeguarding Procedures. The safeguarding policy provided direct links to the relevant safeguarding procedures, referral forms and contact details for local safeguarding teams. Staff demonstrated a good understanding of safeguarding processes, were able to readily access the required guidance and referral documentation and who to contact for safeguarding advice and support.

The safeguarding lead was clearly identified throughout the hospice, with contact details prominently displayed on laminated posters in clinical and non-clinical areas, including ward and public spaces.

Safeguarding training was delivered through the online learning system and supplemented by training provided by the local health board. Staff working in clinical and senior nursing roles had completed Level 3 safeguarding training.

Staff described clear reporting arrangements and escalation pathways. Safeguarding concerns would be reported to the safeguarding lead and managed through established governance processes. No reportable safeguarding allegations relating to the organisation had been identified and there was no evidence of unresolved safeguarding concerns.

Staff were able to access safeguarding escalation flowcharts on the ward, in outpatient areas and through shared electronic systems. Reporting and information sharing processes were clearly understood and embedded within practice.

Advocacy services were available to patients and were actively promoted throughout inpatient and outpatient areas. Patients and carers consistently reported feeling safe within the hospice and stated they would feel confident raising concerns if required. Information regarding safeguarding and how to report concerns was readily available to patients, visitors and staff.

At the time of the inspection, no patients were subject to Deprivation of Liberty Safeguards (DoLS). Discussions with staff indicated that consideration of DoLS was informed by relevant legal requirements and focused on patients' best interests, welfare and safety. Senior staff demonstrated an understanding of the implications of DoLS. There was an opportunity to strengthen practice by ensuring that consideration of DoLS was consistently and robustly documented for all relevant patients.

We spoke with social workers at the hospice and they described their role regarding DoLS as providing advice, guidance and education to the ward regarding the process and in supporting the development of hospice policy to reflect recent legal and procedural changes. They stated that the responsibility for initiating a DoLS application was with the ward manager and inpatient unit team, while specialist guidance was sought from the local health board's DoLS team when required. Cases would be discussed within the multidisciplinary team (MDT), including nursing and medical staff, with consideration given to mental capacity assessments where appropriate. Decisions were made collaboratively, taking account of capacity, best interests, relevant case law, including the Cheshire West judgement and any care arrangements needed to support the patient's wellbeing and safety.

The registered manager must ensure DoLS considerations are part of the admission criteria and at every opportunity during a patients stay as well as during safety huddles.

Medical devices, equipment and diagnostic systems

The hospice had suitable and sufficient equipment available to meet the needs of patients. Standard clinical equipment was readily accessible throughout the service and all equipment inspected was found to be clean, well maintained and fit for its intended purpose.

Appropriate arrangements were in place for the servicing, maintenance and calibration of equipment. The hospice maintained relevant service contracts to ensure equipment remained safe, reliable and compliant with regulatory requirements. All equipment checked during the inspection was within its maintenance and servicing dates, providing assurance that it was subject to regular review and testing.

A clear process was in place for reporting equipment faults, with issues recorded in a dedicated fault-reporting log. At the time of the inspection, there were no outstanding equipment-related issues requiring attention.

Safe and clinically effective care

Feedback from patients and carers was consistently positive and demonstrated high levels of satisfaction with the care provided. Survey results and verbal feedback described the hospice as “peaceful”, with staff viewed as “kind”, “excellent”, “like family” and “friends”. Patients and carers consistently expressed confidence in the safety and effectiveness of the care and treatment they received.

The hospice had effective systems in place to support safe care delivery. Staff described how patient placement decisions considered individual needs and risks, ensuring patients were accommodated in the most appropriate environment. Daily safety huddles reviewed risks such as falls and informed care planning, including bedrail assessments and other preventative measures. Technology was also used to support patient safety and enable staff to respond promptly to changing needs.

A comprehensive programme of audit activity was in place. The Deputy Ward Manager completed regular monthly audits, with findings discussed during handovers and communicated to staff through electronic systems. More extensive audits were undertaken bi-monthly, with increased monitoring where concerns were identified. Evidence showed that audit findings were shared with staff and used to support continuous improvement.

The hospice maintained a range of risk assessments covering clinical and non-clinical areas. Risks were regularly reviewed and monitored through established governance processes.

Staff had access to sepsis training, which was being actively rolled out across the organisation. Most clinical staff had completed the training, with full compliance expected shortly after the inspection. Staff also had access to face-to-face training and sepsis escalation guidance was available on the emergency trolley.

Whilst the hospice did not have a standalone sepsis policy, staff followed recognised assessment and escalation processes, including the use of the National Early Warning Score (NEWS2). Given the nature of the patient population, sepsis was rarely encountered and intravenous antibiotics were not routinely stored or administered on site. Staff demonstrated a clear understanding of escalation arrangements, including transfer to hospital where appropriate for patients requiring acute intervention. Sepsis escalation posters were also displayed.

Appropriate arrangements were in place to respond to emergencies. Emergency protocols were readily available and staff were aware of designated clinical leads for each shift.

In the staff questionnaire, 92% of staff would recommend this hospice as a place to work and 96% stated that if a friend or relative needed support they would be happy with the standard of care provided by this hospice.

Participating in quality improvement activities

The hospice demonstrated a strong commitment to continuous quality improvement through a combination of audits, stakeholder feedback, innovation, partnership working and service development. Management actively engaged with Hospice UK and maintained links with other hospices and professional networks to share learning, identify best practice and inform service improvements.

Quality improvement activity was driven by feedback from patients, families, staff and external partners. This had led to the development and expansion of a range of therapeutic, wellbeing and bereavement services. Services available included bathing and showering support for individuals unable to manage personal care independently, a phlebotomy service introduced in response to delays in accessing blood tests elsewhere, seven-day admission arrangements, music therapy, outpatient clinics and a range of wellbeing programmes. The hospice also hosted specialist support groups, including fatigue, anxiety and breathlessness (FAB) sessions, multiple sclerosis support groups, cancer support groups and regular coffee mornings. Dedicated support for carers was available several times each week.

Bereavement support was particularly well developed. Structured bereavement programmes encouraged ongoing peer support and social connection, with many participants continuing friendships formed through these groups. Additional initiatives included monthly memorial services for families wishing to remember loved ones, a monthly "Step Together" walk for bereaved relatives and specialist child bereavement support, accepting referrals from schools and families.

The hospice environment had been thoughtfully designed to support the wellbeing of patients and families. Facilities included individual rooms with accommodation for relatives, private reflection rooms, accessible gardens, a dedicated "Noddfa" room for quiet contemplation and welcoming arrangements for family pets to visit. These features reflected a person-centred approach and responsiveness to the needs of patients and those important to them.

A comprehensive audit programme was in place, encompassing both clinical and non-clinical areas of service delivery. Audit findings were reviewed regularly and informed service improvements. Inspectors saw evidence that audits had resulted in changes to practice and supported effective monitoring of service quality.

Several quality improvement projects were underway, including the development of patient "A Bit About Me" booklets to support personalised care and debrief initiatives

designed to strengthen staff learning and wellbeing. Regular innovation meetings enabled staff from across the organisation to contribute ideas for service development and review ongoing projects. Separate activities meetings evaluated the effectiveness and popularity of patient and family activities, ensuring resources were directed towards services that met identified needs.

The hospice also met its regulatory responsibilities through the production and publication of annual reports, which were accessible to the public through the organisation's website.

Records management

The records reviewed demonstrated a high standard of record keeping, providing clear accountability and evidence of how decisions relating to patient care had been made. Documentation was accurate, factual, clear, dated, timed, signed, up to date, complete, understandable and contemporaneous.

A random sample of two patient records was reviewed. Patients were assessed for pressure ulcer risk on admission and skin assessments were completed and reviewed daily, with care plans developed and documented in accordance with identified risk levels. There was evidence of regular repositioning and pressure area care, supported by clear and comprehensive documentation. Food and fluid intake monitoring was in place as appropriate and oral health assessments and care plans were documented where required.

Falls risk assessments had been completed and recorded on the patient record system for patients expected to remain in the hospice for more than six hours. Where a risk of falls had been identified, there was an individualised and up-to-date care plan in place, evaluated and reviewed daily.

There was evidence that pain assessments were undertaken, with pain levels monitored, appropriate actions recorded and outcomes evaluated. Other relevant risk assessments had been completed where required. Care provided was documented within patient care plans and clinical records. Clinical decisions, including DNACPR decisions where applicable, were clearly recorded.

The hospice appeared to have an effective records management system in place, which supported comprehensive and accessible record keeping

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on a wide range of areas such as patient care, professional development and management for the inspection undertaken in July 2026. Staff responses were captured onsite via posters displaying the online survey link. In total, HIW received 76 survey responses from staff who had shared their views on the setting. Staff were overwhelmingly positive about patient care. All respondents agreed or strongly agreed patients' privacy and dignity were maintained, patients and relatives were involved in care decisions and they were satisfied with the quality of care they provided.

Key Themes from comments included that there was a supportive culture. Many respondents described a supportive working environment where staff cared for one another and provide emotional support during difficult situations. There was also patient-centred care described. Staff consistently reported that patients and families were at the centre of decision-making and that delivering high-quality compassionate care remained the organisation's primary focus.

Several respondents praised opportunities for learning, development, communication from leadership and the organisation's willingness to implement staff suggestions. Comments identified several recurring issues for improvement:

- Staffing pressures in some clinical areas
- Requirement for additional specialist clinical training
- Equipment and supply availability
- Perceived inconsistencies in staff treatment
- Communication between senior management and frontline clinical teams
- Greater visibility of senior leadership within clinical environments.

Staff comments included:

“This was the first place I have worked that staff opinion counts. The managers take time each year to present the annual staff meeting, our questions are answered and changes have been implemented following suggestions. In 2026 maternity pay matching the NHS was introduced.”

“I have only been working at the Hospice for about {withheld}, I have found it to be the most welcoming place to work. The staff are extremely friendly and helpful. It was a lovely working environment with great facilities. The handover/training that I have received has been excellent.”

“The hospice was an enjoyable place to work. We promote patient centred care to all our patients and families. There was a good supportive network of staff I can rely on at the hospice. I went through a difficult time 18 months ago and the staff at the hospice supported me through this.”

“Nightingale House Hospice has always been very supportive of my development and has provided a safe and positive place to work. The ethos and environment of Nightingale House holds core values at the heart ensuring that the patient was always put first and ensuring that we are able to maximise our reach to as many individuals and their families living in the area are able to experience the support of the hospice when they need it the most.”

“Nightingale House was a really positive and supportive place to work, with patients and their families always at the heart of everything we do. Teams work well together and everyone shares the same goal of providing the best possible care. The hospice was open and honest about the financial pressures it faces, keeping staff informed through annual meetings and regular staff and volunteer newsletters. Despite these challenges, there remains a strong commitment to staff wellbeing, training and development, career progression and offering competitive salaries wherever possible. There was a positive culture of continuous learning and improvement, with staff encouraged to develop their skills and share ideas. The hospice was also forward-looking, continually adapting and developing services to meet future needs while ensuring we continue to deliver the highest standard of care and support for the patients and families who rely on us today. I always feel very proud saying that I work for Nightingale house.”

Governance and accountability framework

The hospice was well led and managed, there was a positive and supportive culture throughout the organisation, with staff consistently describing high levels of support from senior leaders. Staff provided examples of receiving compassionate support following difficult patient deaths, exposure to family grief and personal bereavement. Feedback obtained during the inspection reflected a caring leadership approach that valued staff wellbeing, promoted openness and supported the delivery of high-quality patient care.

There were clear lines of accountability, effective governance arrangements and a robust framework for decision-making. Staff across all disciplines were able to readily identify senior leaders, line management responsibilities and escalation pathways, reflecting a well-established and visible leadership culture.

The service had an up-to-date statement of purpose available for patients and visitors, onsite and on their website, which contained the required information and accurately reflected the services provided by the hospice. Services observed during the inspection were found to be delivered in accordance with the statement of purpose.

The patient guide formed part of the patient introductory package and was available in paper format on the ward to support easy access throughout a patient's stay, with clear information about the facilities, services and support available. An example of good practice was the use of the "A Bit About Me" document, which enabled patients to share personal information, preferences and details about what matters most to them. This supported personalised care and helped staff understand each individual beyond their clinical needs.

Strong governance arrangements were evident throughout the organisation. Accountability was supported through a range of boards and committees, including the Board of Trustees and Executive Committee, which provided strategic oversight and assurance regarding quality, safety and service development.

Effective processes were in place to ensure that safety alerts and notices were reviewed, acted upon and communicated to relevant staff. Clinical leaders, prescribers and pharmacy colleagues supported the dissemination and implementation of any required actions.

The organisation had a robust policy management process. Policies and procedures were reviewed by relevant departmental leads and considered through formal governance structures, before final approval by the Board of Trustees. Once approved, policies were published through the online learning platform and communicated to staff. Staff were required to confirm they had read updated policies, enabling managers to monitor compliance and ensure organisational guidance remained current and understood. The policies and procedures reviewed were up to date and subject to appropriate review processes.

We spoke with senior members of the board of trustees who described their role of providing strategic oversight and ensuring the hospice operated with strong governance, holding the Executive Board accountable for delivering excellent patient care. Although not involved in day-to-day management, trustees acted as ambassadors, promoting consistent messages about the hospice and challenging the misconception that it is only for end-of-life care. They described how the hospice encouraged innovation and responded positively to staff ideas, including developing new groups and courses. Five ambassadors were currently in training to raise community awareness and dispel myths about the hospice. A new trustee praised the welcoming, engaging and supportive culture across the organisation.

Responses to the staff questionnaire on immediate management and senior management were positive. In total, 91% of staff agreeing their manager could help with

difficult tasks, 88% felt they received clear feedback and 84% agreed their manager sought their views before making decisions. The staff views of senior management showed that 92% of staff agreed senior managers are visible and 84% felt communication between senior managers and staff was effective. In addition, 95% of staff believed senior managers were committed to patient care.

Dealing with concerns and managing incidents

The hospice had effective processes in place for managing complaints, concerns and incidents. Information about how to raise a concern or complaint was clearly displayed throughout the hospice, including information about contacting HIW. Patients, relatives and visitors could raise concerns verbally or in writing, ensuring the process was accessible and responsive to individual communication needs.

Staff described a culture that encouraged concerns to be addressed at the earliest opportunity. Wherever possible, issues were resolved promptly and informally by the staff member or manager closest to the matter. If not, these were escalated through the formal complaints process. The complaints policy outlined clear timescales. Staff consistently reported that an initial telephone call would usually be made to ensure concerns were understood and addressed sensitively. The medical director also described making courtesy calls to patients and relatives to seek feedback and identify any concerns at an early stage.

Complaints were investigated openly and appropriately, with records maintained detailing the complaint, investigation, outcome and any actions taken. Evidence showed that complaints were monitored through a complaints log and reviewed by both the Clinical Effectiveness Committee and Executive Team. Since January 2026, the hospice had received 12 complaints, all of which had been investigated and closed appropriately.

Outcomes and actions from complaints were shared with staff through meetings, handovers and internal communications, resulting in service improvements where required. Staff confirmed that feedback and learning were routinely discussed, with more sensitive issues managed individually before wider organisational learning was shared.

The complaints policy was current and regularly reviewed. Consideration could be given to including reference to the Duty of Candour during the next scheduled policy review.

Appropriate arrangements were also in place for the reporting of notifiable incidents. Staff understood the process for notifying HIW of reportable events and records demonstrated that notifications were submitted promptly, usually by the next working day. Relevant staff were knowledgeable about their responsibilities, providing

assurance that regulatory reporting requirements were being met.

The staff questionnaire responses demonstrated a positive safety culture with over 90% understanding the Duty of Candour, their role in meeting the Duty and feeling encouraged to raise concerns when things went wrong. Additionally, 100% of respondent agreed the organisation encouraged incident reporting, 99% believed action was taken and 89% reported receiving feedback following incidents and that the organisation treated staff who are involved in an error, near miss or incident fairly.

Workforce recruitment and employment practices

The hospice had largely robust recruitment and workforce assurance processes in place to safeguard the health, safety and wellbeing of patients.

A review of five staff personnel files demonstrated that appropriate pre-employment checks had been completed and recorded. Evidence showed that professional registrations were actively monitored. Automated reminders were issued to staff and managers in advance of renewal dates and systems provided an additional level of oversight. A sample review of nursing and medical staff records confirmed that registrations with relevant professional bodies were current.

Arrangements were in place to ensure staff remained suitable to work within the organisation. Records reviewed during the inspection confirmed compliance with this requirement.

The hospice had established recruitment procedures supported by employment documentation, including induction, probation, performance review and training processes. Employment records provided evidence that appointed staff possessed the necessary skills, qualifications and experience to undertake their roles safely and effectively. Medical staffing arrangements included GP Registrars working through established university training programmes. All clinical staff worked under contractual arrangements.

At the time of the inspection, staff records did not consistently include evidence of hepatitis B vaccination or immunity status for relevant clinical staff. The hospice had already recognised this gap and implemented improvements, including a revised pre-employment health screening form requiring hepatitis B information during onboarding. Existing staff had also been contacted to provide evidence of vaccination or immunity, with compliance being monitored through a confidential assurance tracker. Where evidence could not be provided, arrangements were in place for assessment, testing or vaccination through primary care services or occupational health providers.

Whilst the organisation demonstrated effective recruitment practices overall, inspectors noted that a standalone recruitment policy was not in place. Formalising existing recruitment processes within a dedicated policy would provide additional

assurance and strengthen governance arrangements. Management considered there was not a requirement for a recruitment policy as the need for this was negated by their other internal policies (primarily Equal Opportunities). However, they stated they would consider if a specific policy would strengthen this area and were discussing this with their external HR Consultant.

The hospice received highly positive ratings regarding organisational culture in the staff questionnaire. In all, 91% of staff felt the hospice was supportive, 92% agreed the hospice took swift action to improve when necessary and 96% agreed partnership working with other organisations was effective. Staff strongly believed patient care was prioritised and most respondents felt safe and supported within the organisation.

Volunteers were a large part of the workforce and the way in which they were supported was robust. They had their own contract and checks and their own handbook. Volunteers were included in all staff communications and were treated as a team member. Many volunteers had been with the hospice for a number of years, providing long standing support.

Workforce planning, training and organisational development

The hospice had effective arrangements in place to ensure enough appropriately qualified, experienced and competent staff were available to provide safe and effective care. Staffing levels were reviewed in line with patient acuity, dependency and occupancy levels. Where short-notice sickness occurred, the hospice used a small pool of regular bank staff who were familiar with the service and its patients.

Recruitment and retention appeared strong, with only two vacancies identified at the time of the inspection. Staff turnover was low and many employees had worked at the hospice for a considerable period. Volunteers played a significant role in supporting service delivery and patient wellbeing and senior volunteers also provided supervision and support to other volunteers.

A structured induction programme was in place for all new staff and was tailored to individual roles and experience. New starters completed a corporate induction before being introduced to relevant departments and mandatory training requirements. The duration and content of the induction programme were adapted according to individual learning needs and previous experience.

Staff were well supported through regular supervision, appraisal and wellbeing arrangements. Clinical supervision sessions were facilitated monthly, providing staff with protected opportunities to reflect on practice, share learning and discuss challenges. Annual performance development reviews (PDRs) were undertaken, with interim reviews where required. In addition, quarterly wellbeing meetings provided dedicated time for managers to discuss individual support needs with staff.

The hospice demonstrated a strong commitment to professional development. Staff were actively encouraged to undertake further education and specialist training. Recent examples included nurses and physiotherapists completing independent prescribing qualifications, development of an Advanced Nurse Practitioner role, postgraduate study in palliative care and specialist “link nurse” roles in areas such as IPC and learning disabilities. Study leave was routinely supported where learning aligned with service needs.

Mandatory training compliance was monitored electronically through the online learning platform, which provided automated reminders to staff and managers when updates were due. Records reviewed during the inspection confirmed high levels of compliance across mandatory training subjects including safeguarding and IPC. Additional training was available in areas such as falls prevention, diabetes, sepsis awareness, autism awareness, oral health, bullying and harassment and whistleblowing.

Staff were aware of how to raise concerns through grievance and whistleblowing procedures and reported feeling confident to do so. Clear policies were in place, providing access to senior leaders where concerns could not be addressed locally. Overall, staff described a highly supportive working environment where education, wellbeing and continuous professional development were actively promoted, contributing to the delivery of safe, high-quality patient care.

The results in the staff questionnaire indicated a strong culture of training and development, 87% felt they had received appropriate training for their role, with 10% stating they partially received appropriate training. All but one member of staff agreed that that learning and development helped them do their job more effectively, stay up to date with professional requirements and delivered a better patient and service user experience.

In total 95% of staff said they had received an appraisal or development review within the last 12 months. Staff suggestions on training topics included:

- Palliative care emergencies
- Advanced symptom management
- Medicines management
- IT systems training
- Strategic planning
- Face-to-face learning opportunities
- Specialist clinical skills development.

Staff responses showed positive experiences regarding wellbeing support with 89% agreeing their job was not detrimental to their health, 83% agreed the organisation took positive action regarding health and wellbeing and 86% reported good work-life balance. Additionally, 88% were aware of occupational health support.

Most staff stated they would feel able to raise concerns, 99% knew how to report unsafe clinical practice, 87% would feel secure raising concerns and 81% believed their concerns would be addressed appropriately. Additional responses in the staff questionnaire, where applicable included:

- Staff were able to meet the conflicting demands on my time at work – 96%
- They had adequate materials, supplies and equipment to do my work – 92%
- There were enough staff for them to do their job properly – 85%
- They were able to access ICT systems needed to provide good care and support for patients – 94%
- Staff were involved in deciding on changes introduced that affect their work area – 75%.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions was provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's [website](#).

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns identified.			

Appendix B – Immediate improvement plan

Service: Nightingale House Hospice

Date of inspection: 21 and 22 July 2026

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Findings			
Improvement needed		Standard / Regulation	
1.	No immediate non-compliance issues		
Service Action:		Responsible officer	Timescale

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan was actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Service: Nightingale House Hospice

Date of inspection: 21 and 22 July 2026

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1. A total of 11 members of staff who completed the staff questionnaire stated they were Welsh Speakers. However only three said they wore a 'iaith gwaith' lanyard.	The hospice must ensure that Welsh speaking staff (including Welsh language learners) wear an appropriate lanyard identifying them as Welsh speakers.	National Minimum Standards (NMS) - Communicating effectively	- The hospice will further promote the use of Welsh language lanyards among Welsh speakers and learners and new starters will be offered a 'iaith gwaith' lanyard when they start in post - Additional Welsh language training and development opportunities will be supported and encouraged.	Registered manager in conjunction with HR.	October 2026

				A Welsh language conversation group will be established to help Welsh speakers and learners practise their skills and build confidence.		
2.	Staff compliance with wearing “Hello, my name is...” badges was variable, the campaign encouraged all staff to introduce themselves to patients. However, all staff were wearing identification lanyards.	The hospice must ensure that staff wear the appropriate “Hello, my name is...” badges for this initiative in a prominent position.	NMS – Environment	- Remind staff to wear “Hello, my name is...” badges in a visible position. - Promote the initiative through team briefings and reminders. - Carry out regular compliance spot checks. - Ensure replacement badges are readily available.	Registered Manager and Clinical Leads	Ongoing
3.	It was noted that toilet rolls and paper towels were stored on the floor of a ward cleaning cupboard.	The registered manager must ensure that items are stored on shelving above floor level to support	Independent Health Care (Wales) Regulations 2011, regulation 9 (1) (n) and regulation 15 (8) (c) (iii)	- This was addressed on the day of inspection. - Monitor compliance through	Registered Manager	July 2026

		good infection control practices.		regular environmental audits.		
4.	Two of the previous three hand hygiene audits identified a shortfall relating to the availability of alcohol hand rub at patient bedsides. This requirement should be consistently addressed unless an individual or ward risk assessment justifies an alternative approach.	The registered manager must ensure that any issues with audits result are included in an action plan with appropriate documented follow up.	Independent Health Care (Wales) Regulations 2011, regulation 15 (8) (a)	• Patients have individual rooms with handwashing facilities located at the bedside area and close to the room entrance. • Alcohol hand gel is available at all ward and patient room entry points. • Hand gel dispensers have been removed from the end of beds. • Any issues identified through hand hygiene audits will be documented within an action plan.	Ward Management Team	September 2026

5.	Antibacterial hand wipes were not provided as part of meal tray set-ups, although hand sanitiser stations were available throughout patient areas. This would further support hand hygiene immediately prior to meals.	The registered manager must ensure that patients are provided with antibacterial wipes both prior to and after meals to support hand hygiene.	Independent Health Care (Wales) Regulations 2011, regulation 15 (8) (a)	• This was actioned immediately as antibacterial hand wipes were already available. • Staff and volunteers have been reminded to offer antibacterial wipes. • Compliance will be monitored through routine observation and audit.	Ward Management Team	July 2026
6.	There was no signage displayed outside patient rooms to indicate when oxygen was in use. Staff explained that this information was communicated during handovers and displayed on an "at a glance" patient information board located within the staff office. The board was fitted with doors to help maintain patient confidentiality. Whilst these arrangements informed staff	The registered manager must ensure signage is displayed outside patient rooms to indicate when oxygen is in use.	Health and Safety (Safety Signs and Signals) Regulations 1996.	• A discreet oxygen-in-use door sign will be designed and implemented for patient rooms. • Compliance will be monitored through routine environmental and safety audits.	Ward Management team and Facilities Manager	September 2026

	of oxygen use, additional visual alerts would further support safety.					
7.	A Venous Thromboembolism (VTE) assessment had not been completed for one patient. The assessment was absent from both the medication chart and the electronic record. Assessments should be completed in line with organisational requirements and that risks are identified and managed appropriately.	The registered manager must ensure VTE assessment are completed for all patients in a timely manner.	Independent Health Care (Wales) Regulations 2011, regulation 23	• VTE assessment completion has been reinforced as part of the patient admission process. • Additional pharmacy support is in place to provide oversight of handwritten medication charts. • The implementation (2027) of electronic prescribing will provide an additional safety net by prompting and supporting completion of VTE assessments for all patients. • Compliance will be monitored through regular documentation audits.	Registered Manager and Medical Director	August 2026

8.	They stated that the responsibility for initiating a DoLS application was with the ward manager and inpatient unit team, while specialist guidance was sought from the local health board's DoLS team when required. Cases would be discussed within the multidisciplinary team (MDT), including nursing and medical staff, with consideration given to mental capacity assessments where appropriate. Decisions were made collaboratively, taking account of capacity, best interests, relevant case law, including the Cheshire West judgement and any care arrangements needed to support the patient's wellbeing and safety.	The registered manager must ensure DoLS considerations are part of the admission criteria and at every opportunity during a patients stay as well as during safety huddles.	The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008	• DoLS and Mental Capacity considerations will continue to be assessed at admission, discussed within MDT meetings, and reviewed throughout the patient's stay. • DoLS awareness and responsibilities are included within mandatory staff training. • DoLS considerations will be incorporated into daily safety huddles to ensure any changes in capacity or restrictions are identified promptly. • Mental Capacity Assessments and best interest decisions will be completed and documented where required. • Advance Care Planning (ACP), patient	Registered manager and Medical Director	July 2026
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				wishes, and preferred place of care/death will be considered alongside capacity assessments to ensure decisions remain person-centred.		
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The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan was actioned.

Service representative: Tracy Thomas

Name (print): Tracy Thomas

Job role: Director of Patient and Clinical Services

Date: 15/09/2026