Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Tŷ Gobaith Children's Hospice, Conwy

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

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 goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

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 Tŷ Gobaith Children's Hospice, on 8 and 9 July 2025.

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

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 12 questionnaires were completed by patients or their carers and 19 were completed by staff. An additional two questionnaires were completed by patients. 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:

The inspection of Tŷ Gobaith Children's Hospice revealed a positive environment for children, families and staff. All 12 patient or carer respondents to the questionnaire rated the service as "very good," praising the child-friendly atmosphere, engaging activities and supportive staff. Comments highlighted the hospice's vital role in providing safe, compassionate respite care.

The hospice demonstrated a strong commitment to health promotion, with accessible, age-appropriate information and therapeutic activities. Infection prevention measures were visible and effective. Patients' privacy and dignity were consistently respected, with personalised care, private rooms and discreet communication practices. End-of-life care facilities were thoughtfully designed to support families with sensitivity and respect.

Communication was clear, bilingual and tailored to individual needs. Staff used various aids to support non-verbal patients and feedback mechanisms were in place to gather and act on patient and family input. However, the patient guide and statement of purpose required updates to meet regulatory standards.

Care planning was inclusive and individualised, involving families and siblings. Patients were supported in education, hobbies and daily routines, with access to specialist palliative care. Staff were praised for their kindness, attentiveness and ability to build trust with families.

Equality and diversity were actively promoted, with inclusive policies, training and accessible facilities. Staff and families said reasonable adjustments were made to ensure equitable access to services.

Feedback was regularly collected and used to inform service improvements, including facility upgrades and care planning. Initiatives like "Family Voices" and a "You said, we did" board demonstrated a commitment to listening and responding to families' needs.

This is what we recommend the service can improve:

- Ensure the statement of purpose and patient guide comply with the regulations.

This is what the service did well:

- Quality of the environment and equipment
- Staff interaction with patients
- Provision of activities and therapy services
- Family engagement and support.

Delivery of Safe and Effective Care

Overall summary:

The inspection highlighted a safe and well-managed environment delivering high-quality care. The hospice was described as calm, clean and welcoming, with excellent facilities tailored for children and families. The building was fully accessible, with secure entry, well-maintained gardens and dedicated play areas.

Health and safety practices were robust, with clear risk assessments, emergency protocols and infection prevention measures. The hospice maintained high standards in cleanliness, with comprehensive cleaning schedules and audits. Staff demonstrated strong hand hygiene practices and equipment was appropriately cleaned and stored.

Nutritional care was personalised and safe. Staff were trained in Percutaneous Endoscopic Gastrostomy (PEG) and Naso-gastric (NG) tubes feeding and meals were tailored to individual needs and preferences. Patients and families praised the food quality and the respectful, supportive approach of staff during mealtimes.

Medicines management was safe and well-regulated. Medication records were accurate and staff were trained in administration procedures. A pharmacist and pharmacy technician supported the hospice and anticipatory medications were effectively managed. However, the transcribing policy required improvement to ensure patients were weighed before transcription.

Safeguarding procedures were comprehensive, with designated leads, regular meetings and staff training. The hospice supported families through advocacy and transition services and all safeguarding records were well-maintained.

Care was clinically effective and personalised. Staff used tools like paediatric early warning score (PEWS) and sepsis protocols and patients received one-to-one or two-to-one care as needed. Families were involved in care planning and feedback indicated high satisfaction with pain management, communication and emotional support.

Quality improvement was embedded in practice, with regular audits, incident reviews and feedback mechanisms. The hospice collaborated with health boards and charities to enhance care delivery, including bereavement and out-of-hours support.

Record keeping was exemplary, with secure, accurate and accessible documentation.

This is what we recommend the service can improve:

- Tightening the rules around transcribing in the policy.

This is what the service did well:

- High standards of cleanliness
- Safe medicines management
- Comprehensive safeguarding procedures
- Exemplary record keeping.

Quality of Management and Leadership

Overall summary:

The inspection of Tŷ Gobaith Children's Hospice revealed a well-led, safe and supportive environment for both staff and patients. Feedback from 19 staff members was overwhelmingly positive, with all expressing satisfaction with the quality of care provided and recommending the hospice as a good place to work. Communication between staff and senior management was largely effective.

Leadership was visible and structured, with clear lines of accountability. The Responsible Individual (RI) demonstrated a strong commitment to safety, staff morale and a forward-looking strategy that prioritised children and families. Governance systems were robust, with up-to-date policies, regular reviews and effective dissemination of updates.

Processes for managing complaints and incidents were transparent and effective. Staff and families were aware of how to raise concerns and there was a strong culture of learning from incidents. Staff felt encouraged to report issues and were treated fairly when doing so.

Recruitment practices were safe and thorough, with appropriate checks and documentation in place. Staff received comprehensive induction and ongoing

support, including access to occupational health and an employee assistance programme. Training compliance was good and staff felt well-equipped to perform their roles.

Workforce planning was effective, with appropriate staffing levels and skill mix. Retention was strong and staff reported feeling supported and valued. Regular appraisals and development opportunities were in place, including study leave and specialist training.

The hospice fostered a culture of openness, teamwork and continuous improvement. Staff had access to supervision, a speak-up champion and counselling services. All staff agreed patient care was the organisation's top priority and their managers were supportive and responsive.

This is what the service did well:

- Positive staff feedback
- Visible structured leadership, with clear lines of accountability
- Recruitment practices with good training compliance
- Effective workforce planning.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback
HIW issued a questionnaire to obtain parent or carer views on Tŷ Gobaith Children's Hospice. In total, we received 12 responses from patients or carers at this setting. Responses were positive, with all 12 rating the service as 'very good' and agreeing the hospice was child friendly. All respondents said the hospice had sufficient activities for their child and there were sufficient facilities for family members or carers. Some comments we received on the service were:

> ***"Tŷ Gobaith are amazing at what they do. They care greatly for the children."***

> ***"Without this service we would be lost and shattered, this service gives us respite where I know my child is 100% safe."***

> ***"Just that if we didn't have Tŷ Gobaith life would be so much more difficult. Really pleased with the care my daughter receives."***

> ***"This place is beyond improvement."***

Both patients who completed the questionnaire agreed staff were friendly and there was enough entertainment and activities suitable for their age. Patient comments about what was good at the hospice were:

> ***"Staff, view, food, entertainment."***

> ***"Swimming in hydro, different activities suitable for my age. Big space and like the family bedroom."***

Health promotion, protection and improvement
Patients' wellbeing and health was well supported at the hospice. There was a wealth of information available about therapeutic activities to promote wellbeing. Full information was on view in the reception areas as well as sensory perception being clearly identified along with an arts and crafts room and support from staff. Information was age appropriate for children and young people. Notices were bright and clearly aimed at children. Relevant health promotion material was displayed and available at the hospice.

Signage was fit for purpose and healthcare information was seen to be available and strategically placed.

Dignity and respect
We noted patients' privacy and dignity was always respected during the inspection. Patients were nursed in single rooms with adjacent bathrooms. The staff team provided personalised care with the room preparation including using bedding specific to the child's interest, for example bedding with Unicorns printed on them.

All rooms had signs with clear messaging on the rooms purpose and facilities offered in bright child friendly colours. The use of pictorial messaging was noted.

The hospice staff were largely bilingual and Welsh was noted as being used with a patient whose predominant language was Welsh. The Welsh speaking staff wore lanyards with the 'iaith gwaith' logo to identify them as Welsh speakers and we heard Welsh being spoken to patients.

There were specific rooms for end-of-life care that were well presented with privacy blinds that also allowed patients and families to enjoy the views over the valley. There was a bereavement viewing room that optimised dignity for the deceased and families. Funeral directors had discreet access and families had access to a private lounge and garden area. Although it was part of the hospice it gave the feel of being separate in a positive way.

Staff were very discreet when discussing patient information, the central staff hub had a keypad locked office that was always locked. When staff discussed patients, it was done in sensitive caring way and conducted discreetly in appropriate surroundings.

Patients seen were very presentable when using the communal lounge and dining room. Patient cubicle doors were kept shut when staff were helping patients with their personal care, with 'do not disturb' notices on the doors. Personal care of patients was observed being undertaken by staff in a timely and caring way

We interviewed one former patient who used the words excellent and outstanding for the standard of care, consideration and regarding upholding their privacy and dignity. The three patients observed during the inspection were being cared for with kindness, respect and care by hospice staff.

Parents and carers we spoke with during the inspection stated they felt staff were outstanding, competent and supportive, this gave them the confidence to take the respite care on offer knowing their child would be well cared for.

The environment and staff actions all focused on privacy and dignity being maintained. Specific rooms were available which were dedicated to the privacy of parents and patients.

The patient and staff interactions were conducted with a high level of regard for patient privacy and focussed on maintaining the dignity of the patients and their families. Staff were not rushed, when observed and patient and family interviews stated there were excellent staff, patient and family relationships in private secure surroundings.

All staff in the questionnaire said patients' privacy and dignity was maintained.

Patient information and consent
An advance care planning (ACP) and future wishes programme was in place. Future wishes were discussed by the admission nurse who gauged the response to such discussions with the next of kin and carers. They had direct insight as to whether families were ready to discuss such arrangements or not and outcomes were shared with the team. Resuscitation status was also recorded on each patient's handover sheet. Initial discussions were usually nurse led within the hospice, we were told there had been training on these difficult conversations with staff, to try and improve compliance and related documentation. Parents were also included in the advanced care planning regarding future wishes. This planning was ongoing and changeable.

We were provided with a bilingual copy of the patient guide given to patients dated June 2025. The guide, called "Welcome to Tŷ Gobaith", contained details of the background, meals, staff safety measures, safeguarding, concerns and patient views. However, the requirements of the relevant regulation required the following additional information to be included in the patient guide:

- Where available, a summary of the views of patients and others obtained

- The address and telephone number of the appropriate office of the registration authority

- The most recent inspection report prepared by the registration authority or information as to how a copy of that report may be obtained.

The employer must ensure that the patient guide includes all the relevant sections required by the regulations.

Communicating effectively
Patients received clear and accurate information when they needed it, was appropriate to the patient need and made directly with parents or guardians. Information was made available to patients or their parents or carers bilingually, in English and Welsh.

The statement of purpose (SoP) provided an outline of the services offered by Tŷ Gobaith and the responsible persons. This was compared to the requirements of the relevant schedule to the Independent Health Care (Wales) Regulations 2011. The SoP needed to be reviewed and updated to include:

- The relevant qualifications and relevant experience of the registered provider and any registered manager

- Details of the responsible individual's roles and responsibilities within the organisation

- The number, relevant qualifications and experience of the staff working in the establishment

- The registered provider's organisational structure.

The employer must ensure that the SoP includes all the relevant sections required by the regulations.

There were posters in the main corridor on how patients and families can provide feedback and how they could complain. Families were given feedback cards they could post in a box giving their feedback. The results of this feedback would be shared quarterly in clinical governance meetings and with staff in quality and assurance meetings as well as being shared on online applications.

The needs of Welsh speaking patients wishing to communicate and receive information in Welsh were considered by the setting, with Welsh language leaflets available.

In total seven parents or carers said they spoke Welsh, of those who commented further, all bar one said they were you actively offered the opportunity to speak Welsh throughout their patient journey. All who commented said they felt comfortable using the Welsh language within the hospice and all but one said healthcare information was available in their preferred language. In total 11 staff

who completed the questionnaire said they were Welsh speakers. They all said patients were asked to state their preferred language.

There were iGaze iPads for patients to use with their eyes. The setting had also considered the needs of patients without digital access such as visual communication booklets or Makaton signage.

The patient's welfare, comfort and safety was central to all the teams focus. When patients were admitted, parents or guardians were taken into a comfortable office where the team could discuss any issues with them in privacy. At the same time the patient was orientated to their room by other members of the nursing team. All such discussions were documented as part of the initial assessment.

Staff were very aware of the need for discretion when communicating with patients. When we saw patients and the nursing team communicating it was very evident the staff were very kind in their approach. Staff also leant down when communicating with patients ensuring they were at the same eye level with the patient. Staff were extremely empathetic and kind with patients and provided a lot of stimulation and fun for the children, singing to them and playing with them. Patients seemed very comfortable in the company of staff.

The one-to-one staff to patient nursing ratios as well as the additional staff available ensured communication was individualised and non-verbal patients were engaged on an individual basis and multiple ways to communicate were used dependent upon the patient's needs (such as non-verbal and sensory impairment).

At the entrance and in the main corridor there were staff notices with their role responsibilities and photographs as well as colours of uniforms and their designation.

We interviewed one patient and one set of parents during the inspection. The patient stated they felt staff explained things in a supportive and caring way they could relate to and they could comfortably approach anything with them. The family was equally happy and stated all involved with their child's care were open, supportive and were able to explain in simple terms the complex issues in relation to their child's condition.

Care planning and provision

It was clear patients received safe, individualised care and treatment. There were initiatives in use to assist staff to care for patients with additional needs, sensory impairment or cognitive needs. Patients were encouraged to be active and given equipment to assist them.

Patients were supported to spend time doing the things they enjoyed with a wide range of toys, games and facilities suitable to their needs and cognitive abilities. They were also supported to continue their schooling and education, with the agreement with the parents or guardians.

Carers and family were involved in the planning and provision of care for patients. Parents would complete the care plan on admission. Siblings were included in care plans and could stay on the unit if needed. Care planning considered future needs and ensured requirements could be put in place. Care plans were individualised with the focus on what was important to the patient, including addressing patients by their known names. A palliative care plan was used with a palliative care team onsite.

There were excellent facilities on site for patient hobbies and interests. There was a full-time staff member dedicated to this activity area along with craft equipment and a "Digital Chest" which contained computer games and iPads for patient use.

The patient interviewed stated the response times for help when needed were excellent. In talking to staff, patients and families, the care given was prompt and efficient. It was observed that care was delivered in a caring supportive way at patient interactions that were seen on inspection

Regarding hospice staff, all parents and carers in the questionnaire felt staff were always polite to the child and the family and staff listened to their child and their family. They also all said staff explained what they expected of them during the child's stay. Comments we received on the staff at the hospice included:

> ***"All the staff at Tŷ Gobaith are like a family to me and I would do anything for them."***
>
> ***"Staff have developed my son so much in his self-confidence."***
>
> ***"The care my child received from the staff is excellent."***

All patients, where applicable, in the questionnaire said staff provided care to their child when needed and when their child needed to go to the toilet, they were enabled to do so as independently as possible. They also all agreed staff helped their child with toilet needs in a sensitive way. All patients said they were able to stay with their child overnight and if they were not able to stay, staff explained how their child was cared for in their absence. Parents commented as follows about the care their child received:

"My son is very happy and likes going to Tŷ Gobaith. He sleeps well and has plenty of attention that he requires with a variation of activities and physio including hydropool."

"Support from all staff is family led. Community support is invaluable and gives Tŷ Gobaith an insight into daily need insight."

"The whole family is treated with the greatest care and respect."

"Trust and confidence in the care of my child."

"Excellent care as always."

When asked how the hospice could improve the service it provided, parents commented:

"Get more details and pictures what he does eat and do every day. Maybe a diary and photos every evening?"

"The service they provide is excellent."

"Needs a hydropool."

"More services for family teenagers."

"I dont think they cam improve their services they are an amazing hospice."

"Hydropool. But no improvement at moment."

Equality, diversity and human rights

Equality and diversity was promoted within the hospice. All policies had equality impact assessments and there was a section on the project methodology to consider equality. Staff were involved in Pride week, as well as there being menopause and wellbeing groups. This was in addition to an equality and diversity policy and mandatory equality and diversity training.

Staff had completed Oliver McGowan training online, this was training for staff who worked with autistic people and people with a learning disability. However, they had not completed the face-to-face element of the training due to the lack of availability of trainers. Staff had also undertaken neurodiversity awareness training.

There was a diversity statement on the hospice website, available to all. Patients were protected from discrimination, through the policy and processes, level access, sensory rooms and access to all areas. All staff, patients and visitors were treated the same. Staff we spoke with said they worked in a person-centred way.

There were examples where reasonable adjustments were in place or made so everyone, including individuals with protected characteristics, could access and use services on an equal basis. These included hoists, sensory rooms, level access, equipment to increase and improve access to all areas of the hospice, including the gardens, also with level access.

All parents and carers in the questionnaire felt they could access the right healthcare at the right time, regardless of any protected characteristics. Additionally, none felt their child faced discrimination when accessing or using the hospice.

Staff said they had not faced discrimination at work within the last 12 months, they had fair and equal access to workplace opportunities and the workplace was supportive of equality and diversity. Staff commented:

> ***"I believe that our workplace and team are inclusive and supportive of equality and diversity."***

> ***"I believe that all staff are given equal workplace opportunities regardless of whether or not they have a protected characteristic..."***

Citizen engagement and feedback

The views of patients and carers were actively sought and used to improve the services provided. There was information clearly displayed about how patients or carers could provide feedback about their care. There was a suggestion box by the hospice entrance. Examples were shared of directly reaching out to parents when implementing changes such as the end-of-life room where the area needed improvement following the passing of a patient in the hospice. The parents of this patient were engaged with, to ensure improvements were made in line with their suggestions.

We spoke with the Quality and Assurance Practitioner, who explained their new role. This included input into different areas of quality and assurance, particularly service user engagement and to be involved in the care side of health and safety. The role was also embedded into each individual project and policies across the two hospices in the group including garden spaces and child spaces in the hospice, to capture voices of children and families.

They were undertaking a review of service user feedback and benchmarking about what had been done currently for the service user engagement plan. This included looking at how to capture voices of the children supported, as well as family voices and other organisational work. 'Family voices' part one results were available on the hospice website this looked at what families felt was most important to them from hospice services and where they would access the services in the community or in the hospice. Alongside Tŷ Hafan, the hospice was involved in 'family voices' part two to gather a whole Wales picture.

The hospice were currently interviewing families to understand their experience with Tŷ Gobaith, any barriers to access, referral process, what went well and impact of services and their child. The aim was to give a voice and understanding to improve the process and services for the family.

There had also been a family feedback survey undertaken in February 2021. Families were asked about their experiences on their use of the hospice services during the second national lockdown during the pandemic. The feedback went towards informing future modelling and development of the care strategy to ensure the delivery of an efficient and effective service.

Additional work included looking at a spiritual review of services, to gain service user feedback that child and family voices were heard and with sibling support. Listening to families as opposed to assuming what they need, designing services with the voice of the families.

We noted patient and parent or carer feedback was used to inform improvement, this included a community clinical nurse specialist giving continuity of care in the community across settings. The hospice were also looking at the feasibility of having a hydrotherapy pool on site, they currently used a local hydrotherapy pool. There was a 'You said, we did' board displayed at the hospice which was updated regularly.

Patients were provided with details about organisations and advocacy support for assistance to raise concerns if they needed to. Pamphlets and posters were available in the entrance and reception areas pointing to advocacy help and external support for several schemes and organisations.

All staff in the questionnaire agreed patient experience feedback was collected within the hospice.

Delivery of Safe and Effective Care

Environment
The environment was calm, welcoming, bright, clear and clean, with wide corridors which were well decorated, with stunning views across the Conwy valley. We noted low noise levels with a calm ambience There was piped oxygen in all areas and the rooms could be used flexibly. The equipment was all clean, with ample hoists, shower and bath facilities. There were well maintained gardens and grounds.

The premises were safe and fit for purpose. Signposting was seen from the adjoining road to the hospice. There was disabled access and all areas were wheelchair accessible. The environment was fit for purpose and suitable for the way it was used. The premises were designed well to offer the full facilities and in an excellent condition. There were no obvious hazards, such as clutter and tripping hazards. Family facilities seen were comfortable and well maintained.

There were safe areas for children and young people to play. We were shown playrooms and outside areas specifically designed for safe use. The hospice was secured against unauthorised access with all external doors locked with key fob access. All staff wore identity badges whilst on duty.

Patients, parents and carers we spoke with all said the environment and facilities were excellent. The building was tailor made for hospice care delivery, in excellent condition with very good facilities for patient care and family support.

Managing risk and health and safety
Hazards had been identified and action taken to reduce the risk of harm to patients, staff and visitors, as far as possible. The hospice was on one level with entrances to rooms and flooring allowing for smooth access and egress. The hospice itself was secured from the outside and everyone without a key fob had to be given access and everyone had to sign in. Patient equipment was geared to each patient in terms of the bed required, sling sizes, wheelchair use and access to all facilities such as the sensory room and games room. Risk assessments were in place for use of the hospice vehicles that carried patients.

There was a padded room in the garden that was not used currently, but there were plans to turn it into a forest learning environment for the children. A member of staff had received forest schools training.

There were suitable arrangements in place to respond to emergencies. Emergency equipment was available to staff, including a resuscitation trolley, two mobile

suction units and a resuscitation grab bag. Patients also brought in their own appropriate emergency equipment from home when being admitted for care if they had any.

The hospice had close support from the local health board, if a patient was deteriorating or required a higher level of care, they could ring the paediatric ward the patient was linked to, to check bed availability. Alternatively, the hospice could call for an emergency ambulance.

Infection prevention and control (IPC) and decontamination
There was evidence that patients, visitors and staff were protected from healthcare associated infections. There had not been any instances noted of infected patients. Patients would be barrier nursed in single rooms if required. Advice would then be sought from the health board and Public Health Wales.

Cleaners' cupboards were locked and contained colour coded buckets in line with recognised cleaning standards. Chemicals were stored off the floor and in a locked room in line with the Control of Substances Hazardous to Health (COSHH) requirements. Cleaning records and schedules were in place to support effective auditing and monitoring systems in place. There was a cleaning manual including every method and standard required. We were told the manual cleaning schedules were in the process of becoming electronic.

An up-to-date IPC policy was in place to which staff had access via the knowledge library available on all computers. Safer sharps were in use and sharps boxes, though not used often, were correctly signed and not overfilled. We saw evidence of the safe disposal of contaminated waste.

There was an annual hand hygiene audit and a full IPC audit twice a year which was very comprehensive. We were told staff would swap sites to complete an audit to provide objective views. This audit was based on the Hospice UK IPC audit, with compliance of around 95%. Staff were supported to maintain good hand hygiene through IPC training. We were told there was a proactive IPC lead and there were clinical champions in the care team. The new extension had clearly been designed with full consideration of IPC.

There was signage and guidance displayed for visitors raising awareness of hand hygiene to prevent and control infection. Notices in reception for visitors and hand hygiene dispensers were evident throughout the building. During the inspection we witnessed good hand hygiene practices. There were appropriate sanitisers, sinks, taps and hand gel available. Alcohol based wipes were used to disinfect equipment in-between patient use. Baths were cleaned after each patient use with a chlorine-

based fluid as was the sensory room. Water taps were run to schedule by the estates team, to reduce the risk of legionella.

Shared equipment and reusable medical devices were stored and decontaminated appropriately. We saw equipment being stored on shelves within a code locked room. Patient beds and mattresses were checked and appeared to be very clean. “I am clean” stickers were used on the patient baths and on any equipment used within the bath. All toys were wipe clean.

All parents or carers in the questionnaire agreed the hospice was clean and tidy and infection control measures were appropriate. All staff said there were appropriate IPC procedures in place.

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 dieticians wrote dietetic care plans that the catering staff had access to and allergies were highlighted on staff handover sheets as well as case notes. There was a hospice specific nutritional pathway in place.

During staff induction, training was given on Percutaneous Endoscopic Gastrostomy (PEG) and Naso-gastric (NG) tubes. Staff were then supervised and assessed as competent before they could carry out this care independently. The team had access to the patients’ dieticians.

Staff were aware they could access the relevant policy and training online, this included a new feature to the PEG feed pumps used. The care plans and risk assessments were completed to a very high standard prioritising patient safety and preferences.

Two patients were observed at mealtimes sitting in the dining room in their wheelchairs with staff at the table. It was noted that staff were very mindful, caring and considerate of the patients. Patients were assisted with feeding without rushing them and staff adopted excellent communication skills to encourage patients with their diet. One patient was given their favourite chocolate pudding and was very excited when eating it. Staff were aware of patient dietary needs and their preferences and tastes. Patients were sitting upright when fed. We also saw staff wiping patients faces and hands where necessary.

Staff were noted to feed the two patients at the point the food arrived having checked the food temperature for the patient first. There did not seem to be any delay in feeding patients in a timely way. Food looked very appetising and staff and patients eat the same food, unless the patient was on a special diet.

All patients' food and dietary requirements and preferences were upheld where possible, which met their nutritional, therapeutic, religious and cultural need. At pre-admission the caterers had access to the patient record regarding nutrition to make sure they had the food on-site when the patient arrived. The staff also had a daily sheet for the caterers every morning, highlighting those patients in the hospice. The caterers also had dietary requirements and family food preferences if they were present for mealtimes.

The feeding regime for a patient with a PEG was very comprehensive and personalised as far as reducing feed volume and increasing water where necessary. Patients had access to fresh water when they wanted it. Food and drink was available to patients 24 hours a day, with snacks left in the fridge overnight. This was part of the caterers knowing patient preferences. Patients and parents we spoke with said the food was outstanding.

In the questionnaire, all parents and carers agreed that:

- Staff helped their child to eat, if they needed assistance
- Their child had time to eat food at their own pace
- The food had been child friendly with appropriate portion sizes
- Staff helped their child to drink, if they needed assistance
- Their child always had access to water.

Medicines management
The hospice had suitable arrangements in place to order, obtain, store, control, supply, prescribe, administer and dispose of medicines. Medication records were complete with no errors found. We checked a sample of four patient medication records and noted the use of All Wales Medication Administration Records were completed correctly, consistently signed and dated when medication was prescribed and administered. This included administered oxygen prescribed.

The patient's name and identity was recorded throughout and it was clear what had been administered. Intravenous (IV) fluids were prescribed, monitored and recorded. There was appropriate oxygen signage in place to alert people to the use of oxygen. Clinical staff were appropriately trained in how to use oxygen cylinders. Anticipatory medications were effectively managed for end-of-life care by the palliative care team.

A pharmacist visited the hospice on a weekly basis, with a pharmacy technician working there five days a week. There were arrangements for accessing medicines out of hours, the hospice could also contact the local hospital and an advice line.

There was a medicines management policy and medicines management file stored on the intranet. There was also a policy for covert medication, should the need arise. Medicines were stored safely and securely and there was evidence of the daily monitoring of the temperature of the storage room and medicines fridge, which had built in monitoring. There were regular checks of controlled drugs evidenced in accordance with legal requirements.

The arrangements in place to effectively manage children's medication administration included drug calculations considering a child's weight. Staff had the necessary skills and competence to manage children's medication administration effectively.

We observed the administration of medication and noted photographic identities were used. Patients were positioned in readiness for medication. Medicines were checked and administered to patients appropriately in line with the dose, frequency and route prescribed. Patients received support where necessary to take their medication. Clearly there was a system for the safe and calm administration of medicines.

All parents agreed in the questionnaire that staff had considered their child’s previous medical history.

We spoke with the medical officer for the hospice, employed on a part time basis from a local GP practice. They described their role and time spent at the hospice and said they had no concerns with the running or procedures at the hospice. We also spoke with the medical officer about the transcribing and the transcribing policy. For medicines, the Royal Pharmaceutical Society (RPS) and the Royal College of Nurses (RCN) define transcribing as the accurate copying of previously prescribed medicines details to enable their administration in line with legislation (i.e. in accordance with the instructions of a prescriber).

The medical officer said admissions tended to be avoided on a Saturday and there was a policy for 48 hours being allowed on bank holidays between the transcribing and the medication being authorised by an independent prescriber. They stated transcribing and authorisation usually happened within a maximum of 18 hours. There had not been any errors in the last four years. There was a requirement for the weighing of the patient within 24 hours. The transcribing policy and process was robust in terms of training and supervision of staff. However, as it was embedded as part of a qualified nurses’ role, there was a need to further tighten

the policy to ensure patients were weighed prior to transcribing, not solely within 24 hours.

The employer must ensure that the prescription transcribing process is improved and requires the weighing of the patient prior to transcribing.

There had also been a change in the process with the four-weekly panel for patient's admissions reduced to two weekly which would reduce waiting times for admission and therefore reduce the need for emergency admissions. An urgent panel would be called for emergency admissions.

Safeguarding children and safeguarding vulnerable adults
There were arrangements to ensure safeguarding policies and procedures were in line with the national policy and legislation and local area procedures. There were suitable, up to date, safeguarding and whistleblowing policies and procedures in place.

There were nominated safeguarding leads and an in date safeguarding policy in place. Safeguarding referrals made followed local authority procedures and forms, with weekly safeguarding meetings. We were also told there was a pre-admission safeguarding checklist.

The Head of Family Support and Therapies was the designated safeguarding lead for both Hope House and Tŷ Gobaith, with deputy leads at each setting. We spoke with them and they stated they had overall responsibility for community workers, the social workers, transition and outside teams. They also provided one to one supervision and support to staff for challenging cases, as well as addressing complex needs with the local authorities and escalation when staff felt they were not listened to. All safeguarding cases were discussed in Monday morning meetings.

The Tŷ Gobaith safeguarding lead also provided support for families as well as advocacy and general support for families. Additionally, they coordinated deprivation of liberty safeguards (DoLS) documentation. They had also designed bespoke and service user specific training for children with life threatening conditions. All patients had a Mental Capacity Act (MCA) and DoLS assessment where applicable.

We were told records of safeguarding referrals and outcomes arising from any safeguarding referrals were maintained and communicated to the individual and within the governance structure through the software system used. Records were also kept on the patients' records. All families had family support from a social worker and transition support worker. The hospice also used an advocacy service.

All staff completed mandatory training and appeared to understand DoLS, mental capacity and safeguarding. Measures were in place regarding emergency admissions and the potential impact this had on the individual.

We saw the local safeguarding policy in place in the knowledge area on the website for staff to access. There were also safeguarding posters in place and all staff spoken with could describe the processes for safeguarding.

Medical devices, equipment and diagnostic systems
We noted there was suitable and adequate equipment available and safe to use at the hospice. This included the hospice having the correct equipment to meet the needs of patients using the service. There were no issues in the maintenance or repair of equipment. The equipment checked was appropriate for the environment. We noted there was in house servicing and maintenance. Labels showing when the equipment was last checked and serviced were noted on the equipment. There were suitable contingencies for equipment which was out of use.

Safe and clinically effective care
It was clear from observation and examination of documentation that patients were provided with safe, effective treatment and care. There was evidence of audit activity being regularly undertaken, which was displayed at the setting in the main corridor. Risks were monitored and there were a significant number of risk assessments covering various eventualities.

A Paediatric Early Warning Score (PEWS) tool was used appropriately and regularly, adapted to the patients. The PEWS was for different age groups and included the sepsis tool. We were told staff received face to face sepsis training every three years. PEWS charts were used as an early warning and trigger score.

The hospice ensured staff were up to date with sepsis guidelines through an online system which included any updates and new training as well as a knowledge library. We were told senior staff attended different meetings to keep abreast of any changes. There were various networks that staff engaged with, to keep current with assessments. Any cases of sepsis were managed effectively and according to best practice guidelines and would be escalated to the GP or if an emergency, by emergency ambulance as indicated in the sepsis pathway. Staff we spoke with understood and were aware of sepsis and how they would manage sepsis cases.

We saw a patient status at a glance board in the main clinical area and each patient had a board for their care in their room, for example whether nil by mouth and any pressure care issues.

Staff we spoke with felt they had enough time to provide care safely; all patients were on one-to-one care and two to one if there was manual handling involved. They felt the number of staff in the hospice was appropriate to meet the needs of the patients. Staff also knew how to access the relevant clinical policies and procedures, and qualified staff knew how to access relevant guidance. We noted a safety notice board in the main corridor to inform staff of patient safety notices.

Whilst only 75% of parents and carers in the questionnaire knew who their child's key worker was, they all knew who their child's consultant was. Parents and carers all agreed with the following comments about patient care in the questionnaire:

- Staff were kind and sensitive to their child when they carried out care and treatment
- Staff did everything they could to assist their child with pain management
- Staff discussed their child's care plan with them
- Staff encouraged them to ask questions about their child's care
- Staff allowed and encouraged them to care for their child whilst at the hospice
- They were involved as much as they wanted to be in decisions about their child's care.

Patients commented:

> ***"Tŷ Gobaith is a very special place for us as a new family on the books. [Child] has stayed there on 3 occasions and they made us all feel as part of their special family."***
>
> ***"We can leave our child with staff knowing they will be very well looked after."***
>
> ***"I would not be able to cope with my son's condition without the hospice help."***

Patients all agreed the support received from the hospice was either 'good' or 'very good' for family and sibling support in addition to bereavement support, play and activity specialist, physiotherapy and outreach services.

Participating in quality improvement activities

There were effective processes for quality improvement, included monitoring and assessing the quality of the services provided. There was a quarterly Patient Safety Incident Response Plan (PSIRP) that looked at all incidents and gave a trend analysis and master action plan of clinical governance and feedback learning through the clinical practice educator to staff. This included a health and safety incidents summary, that we noted dated January to March 2025, along with a medicine incidents summary with a summary and discussion of incident analysis. There was also a safeguarding incidents summary with a summary and discussion of the incidents analysis. Additionally, there were the audit results, where if compliance fell below 80% there were plans and actions to monitor this compliance.

We were told the arrangements for producing the six-monthly return for HIW in accordance with the regulations and we were provided with a copy of the latest six-monthly Trustee/CEO visit report dated 6 May 2025.

We spoke with the consultant paediatric palliative medicine from the local health board, a post which was also partly funded by the hospice. They described their role as working alongside the hospice team to provide specialist palliative care for children as well as training and supervising the nursing team with prescribing and clinical practice.

In addition to being the only hospice provision for the health board, the hospice also provided care after death referrals for children not previously known to the hospice. Those sudden death patients could spend time in the bereavement room and the family would receive psychological and bereavement care from the hospice.

The hospice also provided a joint arrangement to provide out of hours nursing support for children dying at home in partnership with the health board. Some nursing staff also supported paediatric ward staff for children on a paediatric ward in the health board who were at end of life in a local hospital.

Examples of quality improvement activity and how this had resulted in better outcomes for patients were provided, this included audits and patient feedback. The hospice were part of Together for Short Lives, a children's charity and had a positive working relationships with Tŷ Hafan.

Patients in the questionnaire all said they used the hospice for respite care.

Records management
The overall quality of patient record keeping was good with no issues noted. There was evidence of clear accountability and how decisions relating to patient care

were made. The patient records were accurate, factual, clear, dated, timed, signed, up to date, complete, understandable and contemporaneous and completed to a very high standard.

Patient records were easily accessible when required and there was an appropriate method of disposal of records according to the regulations. There was secure storage for patient records in compliance with the Data Protection Act 2018 and the General Data Protection Regulation (EU) 2018. The hospice had an effective records management system.

Nursing documentation was comprehensive and completed to a very high standard.

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on Tŷ Gobaith Children's Hospice and their experience of working there. In total, we received 19 responses from staff at this setting. Responses from staff were positive, with all being satisfied with the quality of care and support they gave to patients. All agreed they would be happy with the standard of care provided by their hospice if a friend or relative needed support and recommended the hospice as a good place to work. All but one of the respondents felt communication between senior management and staff was effective.

Governance and accountability framework

Overall there was evidence at the inspection that the hospice was well led and managed. There was clear leadership evident in the hospice with visible management. This leadership was clear both onsite and between the two hospice settings in Oswestry and Tŷ Gobaith. There were clear lines of leadership seen and staff we spoke with clearly described lines of reporting and accountability. There was very much a team ethos, working as a blended team from senior staff downwards.

We spoke with the responsible individual (RI) who described their role as making sure patients and staff were safe and to pass information onto the chief executive and trustees. They were also responsible for ensuring there was good morale and staff felt safe to speak up, with a learning and no blame culture. They also provided leadership of the organisation and sustainability, being able to provide services that were safe and consistent with children and families at the heart of decisions. They provided a forward-looking strategy, responding to changing needs of children and palliative care and making sure the hospice was fit for purpose. The RI also referred to embedding nursing in the community nursing team for children with life threatening conditions.

We noted there were measures in place to implement recommendations and shared this internally from any safety notices received on the system used. Notifications were sent out by internal email.

The system used for reviewing and agreeing policies and procedures before they were implemented was described. Staff were made aware of new policies and changes to existing policies and procedures by a software package and emails were also sent out for staff to sign to say they were aware of the changes and had read these. All the relevant policies and procedures checked were up-to-date and in place.

We noted the HIW registration certificates and schedules were available and prominently displayed. The details on the certificates were correct and the conditions of registration were being complied with. There was also evidence of the current employer's insurance and public liability insurance displayed.

All staff in the questionnaire said they knew who the senior managers were and senior managers acted on staff feedback and were committed to patient care. Most staff said senior managers were visible and they tried to involve staff in important decisions.

Dealing with concerns and managing incidents
There were effective processes for dealing with concerns and incidents. Patients were made aware of the complaint's procedure through bilingual posters in the main building as well as information on the hospice website. We were provided with an up-to-date complaints policy.

Complaints were acknowledged and dealt with in a timely manner as well as being investigated openly and effectively by an appropriate person. Where there were lessons to be learned and shared to improve services, feedback to staff and any training needed would be through the clinical practice educator and debriefs with staff.

Staff we spoke with also confirmed the process for both formal and informal complaints along with the appropriate escalation being in place and processes for keeping individuals informed.

All parents or carers in the questionnaire said they knew who to raise concerns should they have any. In the staff questionnaire, regarding reporting incidents and concerns, all staff agreed that:

- They knew how to report concerns about unsafe clinical practice
- The organisation encouraged them to report errors, near misses or incidents
- Staff involved were treated fairly
- The organisation encouraged staff to report errors, near misses or incidents
- The organisation treated staff who were involved in an error, near miss or incident fairly.

- When errors, near misses or incidents were reported, the organisation took action to ensure this did not happen again.

- Staff were given feedback about changes made in response to reported errors, near misses and incidents.

Workforce recruitment and employment practices
We noted a safe and effective recruitment process in place to safeguard the health, safety and welfare of patients. There were suitable and up to date recruitment policies and procedures in place.

The process for recruitment and conducting pre-employment checks was arranged through the HR department at Hope House, the sister hospice in Oswestry. This included the relevant documentation needs. There was also evidence of pre-employment health screening, where required. We checked a sample of five sets of employee staff files and all had the relevant documentation on file.

There was a system to check a healthcare professional's registration with their regulatory body was current. HR ran a monthly report of when registration was due and informed the registered manager. The same process was in place for DBS renewals.

Arrangements were in place to ensure the staff were suitably trained, experienced and qualified to carry out their duties. This included induction, minimum of a month, where they were supernumerary, also preceptorship for newly qualified staff, the practice educator led on this. There was a local induction guide for both staff and managers, as well as an induction workflow. The hospice also welcomed student nurses from the local university, they would be allocated a mentor and assessor.

We were told there was a GP Service Level Agreement (SLA) with a local GP practice and an SLA with the health board pharmacy for the provision of pharmacy support.

Senior staff we spoke with said there was an open-door policy, we noted a supportive culture and staff were always offered support when needed. Occupational health support was formally offered by the local health board. Staff also had access to an employee assistance programme.

Staff in the questionnaire all agreed that in general, their job was not detrimental to their health and the organisation took positive action on health and well-being. In addition, they all agreed their current working pattern allowed for a good work

life balance and they were aware of the occupational health support available to them.

Workforce planning, training and organisational development
We noted sufficient appropriately qualified, experienced and competent staff on duty to provide patients with safe care and treatment. This included appropriately qualified and experienced paediatric trained nurses. Senior staff used an electronic rota along with a template of ideal staffing. Staff could request dates to be absent and they could self-roster. There was an aim to ensure there were more staff working on Monday and Friday, the main admission days. There were also additional requirements for staff at nights as well as a dependency scoring, relating to the acuity of the patient

All staff we spoke with confirmed they felt there were appropriate numbers and skill mix of staff within the hospice. Staff also felt supported to carry out their job roles. There were no issues with retaining staff and many staff had worked at the hospice for many years. Staff also confirmed they had a six-month appraisal and an annual appraisal. In the questionnaire all staff confirmed they had an appraisal, annual review or development review of their work in the last 12 months.

Whilst there was only an annual staff meeting, there were weekly multi-disciplinary team meetings and the minutes were sent to all staff. In addition, the registered manager met with senior nurses monthly and there were quarterly quality and assurance meetings.

The arrangements for supporting staff to develop and maintain their knowledge and skills included staff completing a palliative module or the degree. There were three staff nurse prescribers and two attended a tissue viability conference or courses as well as an IPC link nurse course. There were study leave opportunities where staff could request what they wanted to do and there was a training budget to pay for the courses. Management said there was plenty of training available, if training needs were identified in the hospice and skills needed improving then training was sourced and delivered. Further examples included autism training as well as specific medical training and any training needed by speech and language therapy. A further positive example of the development of staff, was a health care support worker training to become a registered nurse, who was supported through their application and was guaranteed a job for a period of time after qualifying.

The arrangements to support staff to raise issues of concern were described. Staff had clinical supervision, with clinical supervisors across both sites. There was also a speak up champion and the hospice social worker, whom staff could use. In addition staff could speak with the registered manager and if support was needed the deputy head of care acted in this role. The hospice also had a health assured

employee assistance programme for staff to access counselling sessions. There was also an in-date whistleblowing policy in place.

We checked the compliance with mandatory training for the five staff which was good. Overall training compliance was 88%, varying from 70% in IPC to 100% for health and safety. Compliance with mandatory training was monitored monthly by management and staff were informed of the training courses that were due to be completed.

When asked in the questionnaire, all but one member of staff felt they had appropriate training to undertake their role, the one remaining respondent felt they had 'partially' appropriate training. Staff all agreed the training, learning and development had helped them to do their job more effectively, to stay up to date with professional requirement and deliver a better patient and service user experience.

When asked a series of questions about patient care in the questionnaire all staff felt they were able to meet all the conflicting demands on their time at work and there were enough staff for them to do their job properly. All staff thought they had adequate materials, supplies and equipment to do their work and patients were informed and involved in decisions about their care. Again, all staff agreed they had enough time to give patients the care they needed and there was an appropriate mix of skills. Most said they were involved in deciding on changes introduced that affected their work area.

Regarding the hospice, all staff in the questionnaire agreed the hospice encouraged teamwork and was supportive including supporting staff to identify and solve problems. They stated partnership working with other organisations was effective and the hospice took swift action to improve when necessary. In addition to being able to access systems to provide good care and support for patients they believed care of patients was the organisation's top priority and acted on concerns raised by patients.

During the inspection we noted the hospice hosting an afternoon tea for a member of staff who had completed 10 years employment at the hospice which demonstrated staff were recognised and supported.

All staff agreed their immediate or line manager could be counted on to help them with a difficult task at work, gave clear feedback on their work and was supportive in a personal crisis. Most agreed their immediate or line manager asked for their opinion before making decisions that affected their work.

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 is 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 were identified on this inspection			

Appendix B - Immediate improvement plan

Service: Tŷ Gobaith Children's Hospice

Date of inspection: 8 and 9 July 2025

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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate non-compliance issues.					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Tŷ Gobaith Children's Hospice

Date of inspection: 8 and 9 July 2025

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.	We were provided with a bilingual copy of the patient guide given to patients dated June 2025. The guide, called "Welcome to Tŷ Gobaith", contained details of the background, meals, staff safety measures, safeguarding, concerns and patient views. However, the requirements of the relevant regulation required additional information to be included in the patient guide	The employer must ensure that the patient guide includes all the relevant sections required by the regulations.	The Independent Health Care (Wales) Regulations 2011, Regulation 7	The patient guide has been updated to reflect the requirements	Karen Wright / Vanessa Thomas	Completed

2.	The statement of purpose (SoP) provided an outline of the services offered by Tŷ Gobaith and the responsible persons. This was compared to the requirements of the relevant schedule to the Independent Health Care (Wales) Regulations 2011. The SoP needed to be reviewed and updated to include the relevant sections.	The employer must ensure that the SoP includes all the relevant sections required by the regulations.	The Independent Health Care (Wales) Regulations 2011, Regulation 8 and Schedule 1	The statement of purpose will be amended to include all the relevant sections required by the regulations to include: • The relevant qualifications and relevant experience of the registered provider and any registered manager • Details of the responsible individual's roles and responsibilities within the organisation • The number, relevant qualifications and experience of the staff working in the establishment • The registered provider's organisational structure.	Karen Wright	For approval at next board meeting 24th September will then be shared with HIW via Objective connect.
3.	The weighing of the patient must occur within 24 hours. The transcribing policy and process was robust in terms of training and supervision of staff. However, as it was	The employer must ensure that the prescription transcribing process is improved and	The Independent Health Care (Wales) Regulations 2011,	Medicine management policy and SOP have been updated so that children are weighed on admission.	Louise Bradshaw – Pharmacy Technician	Completed Approved with Medicine management group 17/07/25

	embedded as part of a qualified nurses' role, there was a need to further tighten the policy to ensure patients are weighed prior to transcribing, not solely within 24 hours.	requires the weighing of the patient prior to transcribing.	Regulation 15 (5)			and clinical governance on 6/08/25. Care team made aware and now normal practice.

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

Service representative

Name (print): **Angharad Davies**

Job role: **Head of Care**

Date: **20.08.25**