Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Healthcare Inspection Report (Announced)

Tŷ Hafan Children's Hospice, Sully

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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 Hafan Children's Hospice on 01 and 02 October 2024. The following hospital wards were reviewed during this inspection:

- 10 bed ward for children providing palliative and end of life care, and pain management services.

Our team for the inspection comprised of two HIW Healthcare Inspectors, two clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

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:
It was evident that staff at all levels worked hard to provide the children with a good experience. This was reflected in the responses of the HIW survey issued to children and carers ahead of the inspection and from observations during the inspection. All respondents said the hospice had sufficient activities for their child and that there were excellent facilities for family members and carers to spend time with their child, or to be nearby.

We saw that information was provided to the child and families to ensure informed consent was obtained. The care planning and was via a multidisciplinary team (MDT) approach to the provision of care with good communication processes in place. The MDT provided children with individualised care according to their assessed needs.

Parents and carers who contributed to the inspection expressed satisfaction with the care and treatment provided at Tŷ Hafan. They told us that staff were kind and caring.

We observed staff treating children with complete dignity, kindness and compassion.

This is what the service did well:

- Children were treated with dignity, kindness and respect
- There was inclusive care planning and provision
- The bereavement service was seen to be very supportive, with many staff trained to support bereaved families
- Ensured medication was provided in a timely manner.

This is what we recommend the service can improve:

- To consider the child and carer groups at the hospice and obtain and display relevant leaflets and posters.

Delivery of Safe and Effective Care

Overall summary:
We found there were sufficient arrangements in place to provide safe and effective care to the children at the hospice. The environment was clean, clutter free, bright and well maintained.

We viewed general and specific risk assessments which were in place for most eventualities, to reduce or mitigate the risk of injury or harm to children, staff or visitors.

The hospice environment was well maintained with regards infection prevention and control measures. There appeared to be very good housekeeping and maintenance arrangements in place. We found that medical equipment was routinely checked to ensure it was available for use, and promptly reported if a fault was discovered.

Adequate safeguarding arrangements were in place with staff attaining level 3 or 4 depending on their position. All staff were able to state who the safeguarding leads were and how to reach them.

Navigating the patient record system was quite difficult and may not be easily used by agency staff or locums.

This is what the service did well:

- Provision of nutritious and healthy food
- Personalised provision of care through person centred care plans
- Good links with local authority safeguarding teams
- Multidisciplinary team working across the hospice
- Good management of medical devices and equipment.

This is what we recommend the service can improve:

- To consider introducing a standardised format for the patient records.

Quality of Management and Leadership

Overall summary:
We found very good leadership and management at the hospice with staff commenting positively on the support that they received from their line managers and other senior managers.

The management team were dedicated and very passionate about the services provided to the children and their families. Staff told us that they were treated fairly at work and a supportive culture existed. Staff also told us that they were aware of the senior management structure within the organisation and that the communication between senior management and staff was effective. They told us it had helped that along the corridors, names with staff pictures from all teams within the organisation were displayed.

This is what the service did well:

- There was an effective governance structure in place, with regular meetings in place to discuss incidents, findings, concerns and child care
- There was very good compliance with mandatory training
- Supervisions and appraisals were taking place when they were due
- Staff felt supported by the management teams
- The management team were dedicated and very passionate about the services provided to the children.

3. What we found

Quality of Patient Experience

Patient feedback

Prior to the inspection, HIW issued questionnaires to obtain parent and carer views on Tŷ Hafan, Children's Hospice and their experience of the services offered. We also spoke to children and their parents or carers to obtain their views on their experiences at the setting.

In total, we received 29 responses from parents and carers. Some questions were skipped by some respondents, meaning not all questions had 29 responses. Responses were positive, with all rating the service as 'very good' or 'good' and agreeing the hospice was child friendly. All respondents said the hospice has sufficient activities for their child and that there are sufficient facilities for family members and carers.

Comments included:

> ***"Tŷ Hafan is an amazing place and the care they give me and my grandson and family is amazing couldn't wish for anything better."***
>
> ***"Tŷ Hafan is an exceptional provision. We are lucky enough to be able to access. One of the biggest advantages about being in Tŷ Hafan is that their approach to our child is very individual and completely based around our child's needs."***
>
> ***"Our son (and our family) has been cared for by Tŷ Hafan for over 12 years. Everyone involved in the charity is lovely and only ever want the best for our children. It feels like they're part of the family."***
>
> ***"Every single time my child has been at the hospice, the level of care is amazing. The staff are always friendly and they always remember him. Everyone there is amazing."***
>
> ***"The hospice has given my daughter and us as a family a quality of life again. They have cared for us all as a family and helped my daughter's pain tremendously. I don't know where we would be without them."***

"Tŷ Hafan is a lifeline for us, they provide my son with the care that he needs whilst also giving me the peace of mind that I need to be able to leave him."

We asked how the hospice could improve; some respondents suggested:

"It couldn't [improve]. The best thing for the hospice is more financial backing, then they could reach more families like ours, that desperately need their help and support."

"To be in the position to offer respite breaks not only emergency beds and symptom management stays."

"Hydrotherapy pool open sooner"

Health promotion, protection and improvement

We saw evidence of some health promotion material, including domestic violence posters, and signage such as No Smoking. We were told that most health promotion advice was within Tŷ Hafan's community hubs, delivered by the community teams, which consists of a support practitioner, support worker, play worker and complementary therapist. However, there was little information displayed on prevention such as breast screening, bowel screening and dental health. Whilst the hospice is mainly for children, such information would be helpful for parents and this would allow appropriate signposting to various services.

The employer should consider the child and carer groups at the hospice and obtain and display relevant leaflets and posters.

There was also a television in reception with information for both parents and staff.

We found a considerable amount of services being provided at the hospice, such as hydrotherapy (although the pool was out of order at the time of the inspection), music therapy and arts, crafts and play. We were shown the excellent facilities outside main hospice building for children to play with picnic tables for families overlooking the Bristol Channel.

Dignity and respect

During our inspection we noted that children and their families were treated with kindness and compassion. It was clear that staff made every effort to respect the children's privacy and dignity as far as practicable. The children were nursed in single rooms which optimised general privacy and dignity. Their bedrooms were

centred around them in terms of choice of bedding and decorations. The bedrooms were provided with the appropriate duvet cover to suit the child so that they felt as homely as possible. The child was allowed to choose their favourite character or colour and staff endeavoured to put that bedding on their bed and posters on the door next to the room number.

We found that whilst toileting needs were dealt with in a dignified and sensitive manner, the children's bedrooms were not en-suite. Despite this, multi-gender toilet and bathroom facilities were available close by, which were spacious and well equipped, including fixed ceiling hoists to aid transfers where required. It was clear the environment had been thoughtfully designed; rooms were spacious and furnished and decorated to a very good standard. Donor funding had allowed for several recent refurbishments to take place including a 'den', upgraded family accommodation on the first floor, and the family kitchen / relaxation area with new 'divides' to give the element of privacy, whilst not being fully enclosed.

Staff had a central team office where multi-disciplinary team (MDT) staff could close the door to communicate children's information. Throughout the inspection this door was closed. There were communal areas, such as a dining area where staff, children, families and visitors could sit together for their meals if desired.

There were various rooms for play and cognitive therapy with a play team including therapists allocated to each child. There were communal areas if children wished to be with other people as well as being able to use play or therapy rooms individually if appropriate. For example, we were told if a child needed to be extubated, there was a private soundproof room with a waterbed big enough for a parent to lay beside their child during this procedure.

There was a self-contained flat available on the ground floor, for children to use with family members if they needed time together, or for a young adult to spend time with their partner, in a well-equipped private environment. This flat was in addition to several bedrooms with ensuite bathrooms on the first floor providing family accommodation, where families could stay near their children.

Children told us they were treated with respect and kindness. Several parents said how incredibly supportive the staff were, ensuring that families were supported in all aspects, including researching anything that they were unsure of to help the children and families. The children were encouraged, where possible, to maintain skills and a sense of independence.

From evaluation of questionnaires and during the inspection, it was clear that privacy was respected. Feedback from families also confirmed that the children were well cared for and was very positive with children being allowed privacy and

dignity in care. This was reinforced when walking in corridor/ward areas where nurses ensured that doors were closed and curtains drawn when dressing children and attending to their needs.

All but one respondent of the HIW survey said that staff were kind and sensitive to their child when carrying out care and treatment.

The hospice bedrooms allowed the child/young person to lie, after death, in peaceful surroundings and to afford their family and friends the opportunity to say their goodbyes in their own time and in their own way. There was also a tranquil garden which provided a private space for bereaved families to use as well as an onsite multifaith / pastoral area. This room was also used after death by the local acute hospital.

Patient information and consent

Interviews with families concluded that children or their families/carers were listened to and that staff took time to explain about their care. When asked if they had been involved in decisions about their child, all bar one answered that they were involved as much as they wanted to be.

From records we sampled, there was always a Paediatric Advanced decision process (PAC) in place, which included carers/next of kin thoughts and wishes. This was used instead of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for children. This process was often completed prior to admission. The PAC plan, despite being created ahead of admission, would be discussed with parents and palliative care consultant and the clinical nurse specialist to ensure it was accurate, inclusive and up to date.

The hospice had many tools in place to support information giving as well as specialist staff. This included play therapist, music specialist, electronic and pictorial equipment to support different child needs and their ability to communicate. There was also massage, reflexology and head massage, which staff could also use for their wellbeing.

Communicating effectively

We saw notice boards on walls in corridors showing very clear information of staff on duty by day and night with photographs and grade.

The hospice had a comprehensive statement of purpose and patients' guide in place which met the requirements of the regulations in terms of its content. Both documents were sent to all prospective children and their families which explained about the services provided such as therapies, catering, visiting, parking, available services and how to raise concerns or feedback.

Whilst a hearing loop was not available, managers explained that each case was dealt with on an individual basis. The hospice ensured that they could obtain translated information leaflets where necessary. They utilised the Welsh Interpretation Services via the Health Board. They also used online translation and private translators. Families confirmed that information was available to them and staff communication was good.

Staff teams were very experienced in handling sensitive information and communicating the same. Relevant staff had training in advanced communication skills.

Staff were very aware of the need for discretion and sensitivity when communicating or sharing child information. We observed a doctor having a discussion with a nurse regarding a child in front of a translator and their carer. They were very discreet and appropriate in their use of language and inclusivity of the child and carer.

Signs were in place on the care wing toilet doors, which were open to everyone and were inclusive for those with sensory impairments or cognitive needs.

Care planning and provision

There was an MDT approach to the provision of care with good communication processes in place. The MDT provided children with individualised care according to their assessed needs. MDT meetings with families included assisting them in seeking legal advice outside the hospice as there were no legal teams within the hospice.

Staff informed us of initiatives that were in use to assist them with care plans for children with additional needs, sensory impairment or cognitive needs. We examined paperwork showing child diagnosis and how their needs had been identified using a holistic approach to care including parents and health professional views. There were different specialists and teams available to the hospice for specific support, for example an external respiratory team who could offer telephone advice.

Children were encouraged to be active and given equipment to help them walk, move, eat, hear, or see, to their own limitations. The hospice had high quality equipment allowing a child to game electronically only using their eye movement to play. Independence was promoted with the equipment they had including a hydro pool where children with all conditions could enjoy the facility supervised by a suitably qualified member of staff. Childcare was clearly child centred and staff

were very knowledgeable regarding the individual child's preferences and needs especially those that come in regularly for respite. Individualised support is clearly afforded to carers and all family members.

A consultant was based on the site on a part time basis, there was also an on-call team accessible for advice.

We saw that children could take part in a wide range of activities to ensure they spent time doing things they enjoyed, including music, computers, play specialists, pet therapy and themed occasions. We were told they felt they had virtually unlimited possibilities to ensure that hobbies, interests, work and education were accessible to the child, due to the team at Tŷ Hafan, including unpaid volunteers.

We saw evidence in patient records that all parents were involved in the care planning of their child from admission, and ongoing, particularly where their child was unable to communicate their needs.

Family and carer responses to the questionnaire indicated that:

- All who answered said that staff encouraged them to ask questions about their child's care and that staff allowed and encouraged them to care for their child whilst at the hospice

- Most respondents who answered said they had been involved as much as they wanted to be in decisions about their child's care

- All answered that staff discussed the child's care plan with them.

Parent comments included:

> ***"The care is always outstanding. It is person centred and led by our child's individual care needs, preferences. The care is holistic and always looks at the whole picture, not just one area. Everyone works together to provide our child with the best quality of life possible."***
>
> ***"It was such a superior level of care for our son and ourselves. It was a 'gift'."***
>
> ***"We have never had any concerns about the care they provide. On two occasions in the last 10 years the team have raised issues themselves and provided us with a detailed plan to avoid such issues in the future. These things were minor but it gives us confidence that they will always be honest and professional while caring for our son..."***

Equality, diversity and human rights
We found that arrangements were in place to promote and protect children's rights.

All staff had received training for Equality, Diversity and Inclusion (EDI). The hospice had multiple EDI champions in place and also a member of the board was the designated EDI board lead. There were several up-to-date policies in place alongside a main equality policy, including flexible working, anti-bullying and harassment and a hybrid working policy. We were told that EDI was also considered during recruitment.

We were told that children were protected from discrimination and all rooms were multi-gender. Adaptations were put in place for those with additional or complex needs. There was eye-gaze equipment, communication tools, sensory play tools – including a full sensory room. In addition, decisions that needed to be made for the service were inclusive where the youth forum and families could be represented.

The PAC-plans included language preference and gender preference and pronouns.

All respondents who completed the family/carer questionnaire told us that they had not faced any discrimination accessing or using this hospice. However, one member of staff answered that they felt they had faced discrimination at work based on one of the several protected characteristics under the Equality Act 2010.

All but one member of staff respondents said they had not faced discrimination at work within the last 12 months. Additionally, all but one member of staff who answered, said all staff have fair and equal access to workplace opportunities (regardless of Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation).

Citizen engagement and feedback
The hospice concerns and complaints procedures were included in the statement of purpose, patients' guide and on the website. These arrangements were consistent with regulations and standards.

There was evidence that the hospice sought feedback from children and their carers about their experience of using the hospice, which were reported to the clinical governance meetings monthly and the clinical governance committee, which included the hospice trustees, on a quarterly basis.

A strong youth forum had been established to address issues for younger people through feedback such as concerns or specific ideas. This was also another avenue for information to be provided to children and from children, ensuring that information was age appropriate for young people and allowing them a voice.

There were several examples provided where child / carer feedback had been used to inform improvement. This included during the refurbishment the creation of a den and cinema room. The results from child / carer feedback were made available, together with how their feedback has been acted upon on a ‘you said, we did’ board which was updated monthly.

Delivery of Safe and Effective Care

Managing risk and health and safety

The environment was clean, clutter free, bright and well maintained. We viewed general and specific risk assessments which were in place for most eventualities, to reduce or mitigate the risk of injury or harm to children, staff or visitors. These were satisfactorily completed. On examination of a sample of children's care records we found that falls risk assessments and pressure area risk assessments were undertaken in most cases on admission and reviewed regularly. A tissue viability nurse could be accessed if required. However, we noted one instance out of five records checked where a falls risk assessment was not undertaken. Whilst assessments were generally in place for falls, navigating the patient record system was quite difficult and may not be easily navigated by agency staff or locums who also may find difficulty in finding these documents on the electronic system if needed.

The employer must ensure that falls risk assessments are completed for every patient on admission.

The employer should consider introducing a standardised format for the patient records.

All cupboards containing cleaning chemicals were securely locked to prevent unauthorised access, in line with Chemicals or Substances Hazardous to Health (CoSHH) guidelines. We also saw signage available to identify hazards, such as yellow 'wet floor' moveable signs.

There were extensive gardens at Tŷ Hafan which were well maintained and the play areas within the grounds had equipment which considered the needs of the children. There was an estates department that monitored the grounds and managed staff and volunteers who attended the grounds regularly to assist in the upkeep of outside areas.

Infection prevention and control (IPC) and decontamination

There appeared to be very good housekeeping and maintenance arrangements in place at the hospice. The children's playroom had a lot of equipment but did not appear cluttered. There was no dust evident when we checked high areas and behind shelved toys. We saw that soft toys were fogged after each single child use.

The entire hospice environment appeared well maintained as regards IPC, including a hands mural painted along various walls, which were panelled over with perspex that could be removed for thorough cleaning of the walls behind.

Each bedroom, the playroom, sensory room and other rooms were deep cleaned and fogged in between children. Rooms were also cleaned daily following a daily cleaning schedule. Antiseptic disinfectant wipes were generally used to clean equipment unless they required a deep clean. 'I am clean' stickers were used to show the next user, that equipment and the room was sterile. Chlorine based cleaning solutions were used within the clinical areas and housekeeping segregated their cleaning equipment to cover infected areas.

There was an infection control policy in place supported by comprehensive cleaning schedules. We saw that there was a good supply of personal protective equipment (PPE) available to help prevent the spread of infection, which we saw staff using this appropriately. Staff we spoke with were able to describe what to do in the event of a needlestick injury.

Due to the nature of the hospice, infection rates were closely monitored. The hospice did not screen for Meticillin-resistant staphylococcus aureus (MRSA) or Carbapenemase-Producing Enterobacteriaceae (CPE) for incoming children from other hospitals as mostly children come in to spend their final days if transferred from other hospitals. However, the hospice was very stringent about staff infection. All staff understood the importance of not attending work if they had any signs of a virus or infection. The management team monitored staff illness closely and supported staff as necessary.

We noted that staff compliance with infection prevention and control and decontamination procedures was monitored through a regular, comprehensive audit programme plus risk assessment and staff training.

All staff in the questionnaire said that there were appropriate infection prevention and control procedures in place.

Nutrition

Nutritious and healthy-looking food was provided in a mixed staff and child canteen setting. The young people were very happy with this engagement, even if they were alternatively fed.

Specialist dietary needs were managed such as via Percutaneous Endoscopic Gastrostomy (PEG) and Naso-gastric (NG) tubes. Staff received training on the use of these, via competencies, as well as being assessed on the ward and being fully risk assessed.

On examination of care files and from discussion with staff, we found that children's eating and drinking habits and nutritional needs were identified at their initial assessment then monitored for changes throughout their admission. The pathway for feeding was through dietician planning and needs were regularly reviewed. The paperwork was retained in the care notes and transferred onto the "patient status at a glance" board in the nursing office.

The nutrition policies in place appropriately followed the National Institute for Health and Care Excellence (NICE) guidelines, as the All Wales Nutritional Pathway was not specific to children.

Medicines management

During the inspection we found that there were suitable arrangements in place for the safe storage and administration of medicines including controlled drugs (CDs). CDs were checked in and out by two qualified staff and were again checked on shift changes. We found that weekly checks were recorded in the CD book.

We viewed the medication management policy for Tŷ Hafan, which was in date and had been reviewed.

The hospice employed a part time pharmacist. There was no access to an out-of-hours pharmacy.

To ensure the effective management of children's medication administration the hospice had paper medication charts and used the online British National Formulary and palliative care formularies to check medication dosages were correct. Adult and child doses were included in this software. Drug calculations would often consider a child's weight, these were stored in the system and updated regularly. To mitigate the risk of medication errors as best as possible, staff went through thorough training.

We saw that oxygen cylinders were used at the hospice, all securely stored and all relevant staff trained in their use. If an incident occurred this would be logged on the Radar system, a healthcare system, and would be investigated and action taken if required, this could include additional training for example.

In lieu of wrist bands, each child's chart had the photograph of the child which was checked with the administering nurse. A medication ward round was observed during the inspection. We noted that correct procedures were followed on medication checks. Children were re-positioned in readiness for their medication, which was checked and administered in line with the dosage, route and frequency

prescribed. In the rare instance that a child self-medicated, risk assessments would be put in place around this.

Safeguarding children and safeguarding vulnerable adults

The hospice had barriers on entry in terms of security. The hospice doors were locked to prevent unauthorised entry and during office hours there was a receptionist who managed the entry and exit through the doors electronically and they could also not allow access.

Children were under constant supervision due to safety requirements regarding their condition and occasionally behaviour. Carers and parents were encouraged to stay with children unless the child was in hospice for respite care.

Staff had a good understanding of safeguarding and were trained to appropriate levels. Body map charts were completed on admission to identify any body marks. Any concerns would be raised with the safeguarding leads initially. The safeguarding leads liaised with the local authority and risks and advice was shared and followed.

Emergency admissions were very rare out of hours, though this could happen for end-of-life care or extreme social concerns. Social workers would accompany children into the hospice if there were social welfare concerns. The enhanced training of staff also helped appropriately support children in those circumstances.

Medical devices, equipment and diagnostic systems

The hospice had a range of medical equipment available which was in good condition and maintained appropriately through the internal facilities department or external companies under contracts managed by facilities.

All devices required were available and appropriate to the client group. The facilities department onsite arranged the testing of scales, beds and slings, and also for portable appliance testing (PAT). For larger items, we found some were under warranty and had servicing plans. Those that had expired had arrangements made by the facilities department for further servicing when required.

Where faults were found by staff, they would contact the facilities department and we were told prompt action was always taken. Items would be removed and repaired or disposed of appropriately. Similarly, the information technology (IT) department did the same for computer equipment.

The medical equipment log showed equipment such as syringe drivers, nebulisers, thermometers and vital signs machines, with two external companies being used

for breakdowns. They both provided certification for any necessary repairs and any faulty items were taken out of use.

We undertook a check of the emergency resuscitation trolley, for use in a patient emergency. This was well organised and contained all the appropriate emergency equipment, including a defibrillator. We noted daily checks were taking place on this equipment and equipment check logs completed.

Safe and clinically effective care

There was a "patient status at a glance" board housed in the care team office room which was locked. There was no child identifiable information in view outside of this room. This was up to date with information that the care team had identified as required. Observation requirements were identified on the board in the form of different coloured magnets.

We noted that paediatric early warning signs (PEWS) charts were used for each patient. This identified triggers for further monitoring and sepsis. All staff were trained to identify the risk of sepsis and the registered staff would administer oxygen and paracetamol where appropriate but would not administer antibiotics or fluids. If appropriate children would be urgently transferred to hospital via the emergency services.

When reviewing patient records, we saw evidence of a child being transferred out within 10 mins of calling the emergency services. This showed quick identification and response. The Director of Nursing told us that they were in the process of arranging placements for staff in the acute sector to improve their skills and confidence with medication, cannulation and phlebotomy. The medium-term plan at the hospice was to be able to administer intravenous (IV) fluids or medication to the children if required.

Records management

There were robust systems in place to ensure that information pertaining to children or staff were kept securely. We saw this in both paper and electronic records. Child care records were well maintained and updated as expected.

The filing system and cover sheets supported files to be laid out in a way that was easy to navigate. However, as previously mentioned, we were told that risk assessments were quite difficult to navigate electronically.

There was largely good practice noted in the care notes record keeping, however, some improvements could be made to the record keeping as follows:

- There was not a turn chart

- The pressure ulcer grading tool was not used within care notes. There was a poster in the care team office with the grading. There was no evidence of the scoring tool being used in practice. There was a reliance on individual staff members professional judgement which was poorly reflected and represented for pressure area assessment in the care records

- The staff member making entries in the care record would normally give their name but they also needed to include their grade, as it was not clear whether a qualified or unqualified member of staff had written the care entry in the record

- Regarding the pain score from a check of five children, there were two instances where the pain score had not been completed correctly. For one child whilst the evaluation documented was completed regularly regarding analgesia but the Face, Legs, Activity, Cry, Consolability (FLACC) pain assessment had not been carried out since last year. Staff do not appear to be using a pain score directly within their evaluation. For another child who was not frequently in pain, whilst there was evidence in the nurse evaluation that they had been asked, no pain score referenced. Not all low grade pain relief e.g headaches was necessary scored, as a result a pattern could be missed. Anyone with any pain should be recorded and scored.

The employer must ensure that:

- **There is a turn chart available for staff to reference**

- **The pressure ulcer grading tool must be used within care notes**

- **Staff must include their grade as well as their name**

- **The pain score must be used consistently and whenever any child expresses any pain and the need for pain relief.**

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on Tŷ Hafan Children's Hospice and their experience of working there. The questionnaire complemented the HIW inspection in October 2024. In total, we received 40 responses from staff at this setting. Some questions were skipped by some respondents, meaning not all questions had 40 responses. All respondents who provided comments agreed they could be published anonymously within the HIW inspection report.

Responses from staff were positive, with all staff being satisfied with the quality of care and support they gave to children. All staff agreed they would be happy with the standard of care provided by their hospice for themselves or for friends and family and recommended their hospice as a good place to work. Most respondents felt communication between senior management and staff was effective.

Governance and accountability framework

There was clearly strong leadership and governance exercised at the hospice. We spoke to senior staff including trustees and they were clear in their role and of how they fitted into the governance of the organisation.

Senior staff had the relevant documentation, including policies and procedures available for the inspection and were keen to engage with the inspection process.

We were provided with a copy of the most recent statement of purpose (SOP) and patients' guide (PG). Both were available at the hospice, sent to prospective children and was on the hospice's website in English and Welsh. The documents contained all the relevant information in accordance with the regulations.

We were told that all services were provided in accordance with the SOP and the hospice ensured they benchmarked against this each year. The HIW registration allowed for ten patients (children) to be cared for at any one time. The setting was operating as a nine-bed ward, with one bed being used as a clinical skills training suite.

We saw the organisational structure, electronically and on paper records. The team structures were also displayed on the walls in the corridors leading to the ward.

There were measures in place to implement recommendations from any safety notifications received. All medication alerts were received by the administrative staff and immediately sent to the pharmacist and team leads every day to be

actioned. If the pharmacist needed to remove a medication or order more if there was a shortage, this would be actioned.

We were told of a safety alert that identified paediatric bed rail heights and compliance with this. Some beds in the hospice did not meet the new guidance and replacements had to be ordered. Due to time constraints in ordering, the setting put a risk assessment in place until the new beds were procured and delivered.

All relevant changes due to safety notices were shared internally with staff at daily meetings, emails, one to ones and electronic notice boards.

It was clear from conversations with staff at all levels, that they were extremely proud of their roles and were doing the best for the service. Most staff felt their immediate manager consulted them before decisions were made affecting their work. Most staff said that their immediate manager could be counted on to help with a difficult task at work and gave clear feedback on their work, as well as being supportive in a personal crisis. Most staff were also positive in the questionnaire on their comments about senior managers.

There was a governance manager responsible for ensuring the review of all the policies for the organisation. There was a tracker in place showing all policies, who was the lead, the date of renewal and who needed to sign off the review. The version control of policies and procedures was in order as well as the monitoring when reviews were due.

Senior staff we spoke with said that they had an open door policy in place should any staff wish to speak to them. There was also evidence of joined up working within and between teams.

Dealing with concerns and managing incidents

There were established processes in place for dealing with concerns and managing incidents. There was a formal complaints procedure in place and information on how to make a complaint was noted in the statement of purpose, patients' guide, a leaflet called “raising a complaint about Tŷ Hafan”, and on their website. These documents were provided to children and carers ahead of the children admission and were available in hard copy at the setting.

We reviewed a sample of records relating to incidents and found that these had been dealt with in line with the hospice's policies. We reviewed one incident from the last 12 months and were shown the entire process from start to finish. All required documentation was thoroughly completed, all necessary agencies were notified. We could see that staff and family members who were involved were

kept up to date at each stage of the process. This was also a very good example of how the management had made changes to reporting and investigating.

Similarly for complaints and concerns, documents we reviewed followed policy. We found that analysis was taking place for common themes. This showed five complaints and one concern in the last 12 months. Analysis also showed the action from that one concern, which was a recommendation from safeguarding, for the service to put a procedure in place to ensure timely communication, had been dealt with swiftly.

In the questionnaire we asked staff questions about reporting incidents and concerns. All respondents said their organisation encourages them to report errors, near misses or incidents and all but one who answered thought staff who are involved were treated fairly. All respondents who answered said they knew how to report a concern about unsafe clinical practice.

Workforce recruitment and employment practices

Staff recruitment was managed by the Human Resources (HR) department and there were in date recruitment and retention policy and procedures. All necessary checks and vetting were carried out and once all checks were completed the new employee would start a comprehensive induction process.

Locum consultants and GPs were recruited in a similar manner to permanent staff. However, this was under the 'practicing privilege' policy. In rare cases, where there had been a deviation to the recruitment where an emergency privilege waiver had been granted, otherwise a contract would be in place.

To ensure the healthcare professionals registration with their regulatory body remained current and to check all staff remained suitable for work, the hospices' professional development lead kept records and tracking for revalidation and mandatory training.
In addition, HR carried out regular disclosure barring services (DBS) checks. We saw evidence that staff had professional development requirements to follow, both mandatory and anything additional required.

There was also an outsourced occupational health service available to staff.

Workforce planning, training and organisational development

All staff were subject to a comprehensive induction, during which time, they would be considered as supernumerary member of staff for at least a month. When both the hospice and the staff were confident and competent to work, they would start work unsupervised. If longer was required, this would be accommodated.

There was a continual needs analysis for all staff and staff found managers very supportive.

There was evidence of a comprehensive annual review being carried out of staff as well as mid-year reviews. Those who did not meet the requirement for an annual review were subject to six-month probationary period with regular checks throughout.

There were sufficient numbers of appropriately qualified, experienced and competent staff to provide children with safe care and treatment. We were told there was a 70/30 split of qualified to non-qualified staff but occasionally some were higher grades. There was always a Nurse in Charge who was not included in staff numbers and always a nurse “floater”. Admissions were based on staff availability.

If there was a sickness absence or an emergency intake without enough staff on duty, then bank staff would be used. This was now done via a ‘pool’ of the hospices’ own and previously employed staff wanting to help. Many said they found Tŷ Hafan heavily staffed, but this allowed for more intakes where required.

Staff were supported to develop and maintain their knowledge and skills and these professional days were paid for and available to all staff.

Meetings were held on a regular basis. MDT meetings would discuss all children in and out of the hospice which was electronically recorded twice a week. There was a staff forum taking place once a month, where staff could discuss any concerns/improvements. Furthermore. other meetings took place, including a medication forum.

We were also shown minutes from a clinical risk management group. These discussed the outcomes from risk assessments, audits and improvements. If staff were unable to attend meetings or view the minutes, the care team tv displayed important information.

We inspected a sample of staff files and confirmed that staff had access to mandatory and other service specific training. We were provided with a copy of the hospice’s staff training plan, which was comprehensive and listed the subjects covered, completion dates and expiry dates. We found there were sufficient numbers of appropriately qualified, experienced and competent staff who were supported to provide children with safe care and treatment. Compliance with mandatory training was very good with the majority over 90%. Additional training included sepsis training.

We requested information relating to performance appraisals and were able to confirm that the majority of staff had received an annual appraisal within the previous twelve months. We were told that the lead nurse carried out the nurses and healthcare support workers' appraisals. These sessions were recorded and passed to the HR team for collation and retention on individual staff files. Staff maintained their own record of objectives.

Professional development questions were asked of staff in the questionnaire, most staff felt they had appropriate training to undertake their role.

> ***"New to the management aspects of the role but am undertaking ongoing participation in the internal management development pathway offered at the hospice."***

> ***"With a high turnover at the time of my induction I was not provided training on key systems needed to do my job."***

Question of staff on service user care showed the following:

- All but one respondent felt they were able to meet all the conflicting demands on their time at work and most felt there were enough staff for them to do their job properly

- All who answered thought they have adequate materials, supplies and equipment to do their work

- All respondents said patients' privacy and dignity was maintained

- All but one said service users were informed and involved in decisions about their care.

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 summaries 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 Hafan Children's Hospice

Date of inspection: 01/10/2024

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 assurance 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 Hafan Children's Hospice

Date of inspection: 01/10/2024

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.	There was a shortage of health promotion material on display at the hospice. We were told that this is usually dealt with by the community hubs.	The employer should consider the patient and carer groups at the hospice and obtain and display relevant leaflets and posters.	Independent Health Care (Wales) Regulations 2011 regulation 9 (g) National Minimum Standards Health Promotion, Protection and Improvement	Identify suitable and respectful health promotion posters/leaflets for service users to include: Dental Care Healthy Eating Smoking Cessation Breast screening Bowel screening	Rebecca Bryant (Administration Manager).	4 Weeks – to be completed by 26/12/2024

2.	Whilst assessments were in place for falls, navigating the patient record system was quite difficult and may not be easily navigated by agency staff or locums who also may find difficulty in finding these documents on the electronic system if needed.	The employer should consider introducing a standardised format for the patient records.	Independent Health Care (Wales) Regulations 2011 regulation 23 National Minimum Standards Records Management	All risk assessments have now been moved to one central area on the care database and staff are aware of where these are now stored. Meetings with staff have been held by the Care Database officer to identify key areas that cause problems, and to identify solutions to make the system more user friendly.	Tracy Sullivan (Care Database Officer)	Complete 8 weeks - To be completed by 26/01/2025
3.	However, we noted one instance out of five records checked where a falls risk assessment was not undertaken. A tissue viability nurse could	The employer must ensure that falls risk assessments are completed for every patient on admission.	Independent Health Care (Wales) Regulations 2011 regulation 23 National Minimum Standards Records Management	A revised falls risk assessment will be created and added to the admissions process for all children. The risk assessment will then be added to the risk assessment	Sian Middleton/Tamsin Rees.	8 weeks – to be completed by 26/01/2025

	be accessed if required.			section on the care database.		
4.	Some improvements could be made to the record keeping as follows: • There was not a turn chart • The pressure ulcer grading tool was not used within care notes.	The employer must ensure that: There is a turn chart available for staff to reference • The pressure ulcer grading tool must be used within care notes	Independent Health Care (Wales) Regulations 2011 regulation 23 National Minimum Standards Records Management	Turn chart is now in place and used for all medium/high risk resident children. Pressure Ulcer risk assessment tool, policy, grading and actions to take depending on risk now in place, all staff have received training in how to use this during our recent professional development day (18/11/2024)	Sian Middleton Sian Middleton (Director of Nursing and Clinical Services)	Complete Complete

	• The staff member making entries in the care record would normally give their name but they also needed to include their grade	• Staff must include their grade as well as their name		All staff are now including their grade/job role in all care database documentation. The Care Database Officer will add all staff roles to the Care Database next to their names in the next 4 weeks to save them having to add this manually.	Tracy Sullivan (Care Database Officer)	4 weeks – 25/12/2024
	• Anyone with any pain should be recorded and scored.	• The pain score must be used consistently and whenever any child expresses any paid and the need for pain relief.		CNS completed training session on pain management and pain scoring (18/11/2024). Symptom management chart in place. Symptom management audit in place which will be reviewed regularly and any further improvements required made according to audit results.	Elise Alderman (CNS)	8 weeks

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): Sian Middleton

Job role: Director of Nursing and Clinical Services (Registered Manager)

Date: 28/11/2024