The Oakhaven Trust

Oakhaven Hospice

Inspection report

Lower Pennington Lane
Pennington
Lymington
Hampshire
SO41 8ZZ

Tel: 01590670346
Website: www.oakhavenhospice.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection of Oakhaven Hospice took place on 8 and 9 August, 2016. The hospice is a charitable organisation owned by Oakhaven Hospice Trust, which is a specialist palliative care service providing care to people in The New Forest and Waterside area who have been referred by a health care professional. Oakhaven Hospice provides specialist care to people, carers and families who are facing complex physical, emotional and practical difficulties arising from advanced progressive life limiting illness. This may be cancer or other diseases. The service delivers physical, emotional, spiritual and holistic care through teams of nurses, doctors, counsellors and other professionals including therapists. The service provides care for people through an inpatient unit (IPU), outpatient day service, a hospice at home service and The Coates Centre. The Coates Centre provides information and support for anyone in the local community who feel their lives have been impacted by illness.

At the time of the inspection there were eight people using the inpatient service. The day services provided offered a range of services to people diagnosed with life limiting conditions, their carers and families. The service provided specialist advice, courses, complementary therapy sessions and clinics. Oakhaven Hospice provided a counselling and bereavement service for people and their families if required.

Oakhaven Hospice had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager at Oakhaven Hospice was also known as the Head of Clinical Services.

Staff had been trained in relation to safeguarding vulnerable people and knew how to protect people from abuse and harm to keep them safe.

Potential risks to people had been identified and managed appropriately. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm.

There were effective health and safety systems to protect people from harm within the inpatient unit and Day Services. Regular audits and daily checks by nominated staff ensured that the environment and equipment used was safe and fit for purpose.

The service provided support for people in the community through a specialised equipment loan system. This system has recently been improved based on a recent audit to ensure all equipment is safety checked and decontaminated after each use.

Accidents and incidents were recorded and monitored to identify how the risks of their recurrence could be prevented.

People were supported by sufficient numbers of staff to provide care and support in accordance with the individual needs of people. People who were receiving care in the in-patient unit told us the staffing numbers were appropriate and assistance was provided promptly when requested.

Staff had undergone robust pre- employment checks as part of their recruitment, which were documented in their records. People were safe as they were cared for by staff whose suitability for their role had been assessed by the provider.

People's medicines were managed effectively to ensure they received them safely. People and relatives told us people had their medicine when they needed it and staff were quick to respond to any needs they had. Staff involved in medicines administration had regular training and had undergone competency checks to ensure their knowledge and practice remained up to date.

People received effective care, based on best practice, from staff who had the necessary skills and knowledge to do so. Staff received effective training and supervision to fulfil their roles and responsibilities. Staff were highly motivated to undertake their roles and deliver sustained high quality care. People were extremely confident and positive about the abilities of staff to meet their individual needs.

People were supported to make as many decisions as possible. We observed staff seeking people's consent about their daily care and allowing them time to consider their decisions, in accordance with their care plans.

Staff understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. Staff were able to demonstrate that a process of mental capacity assessment and best interest decisions promoted people's safety and welfare and protected their human rights. Staff understood the importance of giving people choice in the support they received.

People had nutrition and hydration assessments and plans, which were up-to-date and where necessary recording of people's intake had been completed. Staff were aware of people' dietary requirements and preferences and people were offered a range of choices to meet their nutritional needs. People and their relatives praised the food they received and enjoyed their meal times.

People were provided with clear information and explanations by staff in terms they understood about their healthcare, treatment options and their likely outcome. Staff made referrals quickly when required to relevant healthcare services when people's needs changed.

People were involved in making decisions about their own care. People told us that when consultants and doctors thought another course of treatment was appropriate they always sought their views and acted upon them. This made people feel their views really mattered and they were in control of their treatment.

People told us that staff were kind and considerate, not only to them, but their family and friends. Staff had developed positive caring relationships with people. We observed staff engage people in conversations about things which interested them, that did not just focus on the person's support needs. Staff supported people to express their views and encouraged them to be actively involved in decisions about their care and treatment.

People were supported to maintain relationships with people who were important to them. People told us that their friends and relatives visited regularly and were welcomed to the hospice at any time.

Staff had completed training to ensure they understood how to respect people's privacy, dignity and human rights, which we observed being delivered in practice.

Staff respected and followed people's choices and wishes for their end of life care as their needs changed. People were supported at the end of their life to have a comfortable, dignified and pain free death.

People's wishes were at the centre of their care planning. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. People`s constantly changing needs were assessed and discussed by staff on a daily basis or more frequently in order to address them appropriately. Staff attended thorough handover meetings at the beginning of their shift. Each person was discussed in depth including care needs, changes to treatment, care plans and medication requirements.

The provider delivered considerate and person-centred care and support that had a positive effect on people. People were asked about their needs and preferences by the staff. Staff were able to demonstrate their understanding of how to give people personalised care. The care given to people followed the guidance in their care plan, for example; detailed information about the person's pain and plans to manage the symptoms.

The provider sought feedback from people, their relatives, staff and community professionals using various different methods, which was overwhelmingly positive. People told us staff were quick to respond especially if their needs changed, which we observed in practice. We observed all staff working together to ensure people's requests for attention were answered as quickly as possible.

The service had received a large number of compliments concerning the kind, compassionate and caring manner of the staff team. People told us staff dedicated their time to listen to people and did not rush them.

People had access to information about how to make a complaint, which was provided in an accessible format to meet their needs, before people started to use the service. During the previous year there had been no formal complaints about the service. Where people had raised concerns these were used as an opportunity for learning or driving improvement in the service.

There was a clear management structure at the service and staff were aware of the individual roles and responsibilities of the management team. All the managers demonstrated an excellent understanding of all aspects of palliative and end of life care, which we observed in practice. The registered manager who had been in post for almost 10 years and senior staff had created an open and transparent, blame free culture within the service, which encouraged learning from mistakes.

Staff spoke with passion and pride about the hospice and the people they supported. Staff told us there was an 'unequalled team spirit' at Oakhaven which had been driven by a stable management team who were totally committed to people using the service and their staff.

Staff understood the ethos and values of the service and how to put these into practice. They felt valued, listened to and well supported. This resulted in the staff team being motivated to provide high quality care to people.

The Senior Physiotherapist, who is the quality lead for the organisation, effectively operated processes to evaluate the quality of service provision, including regular surveys of people, their families and staff, seeking feedback on their experience of the service.

The registered manager recognised and encouraged innovation in order to provide a high quality service to the community, for example; the Acorn Project, which was an outstanding feature of the activity programme provided by Oakhaven Hospice. This scheme works with patients and within schools and local communities to raise awareness of living with long term illness, palliative care and issues around death and dying. Another outstanding programme was the Oakhaven Neighbours Project which brought Oakhaven patients together with volunteers who visited them in their own homes, offering companionship and support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt they were safe being cared for in the service. Staff had been trained to recognise and respond to any actual or potential abuse.

Potential risks to people were identified, assessed and measures were put in place to reduce risks. Accidents and incidents were analysed and learning was shared amongst staff to prevent further reoccurrence.

There were sufficient numbers of staff with the appropriate skills and knowledge to meet people`s needs at all times. The provider completed relevant pre-employment checks to ensure staff were suitable to work with vulnerable people. These checks were also carried out for volunteers.

People were protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely.

Is the service effective?

Good

The service was effective.

People received support and care from the staff team who were well-trained and used their knowledge and skills to meet people`s needs effectively.

Staff understood how to uphold people's human rights and took appropriate action if people did not have capacity to make decisions. People were encouraged to make as many decisions and choices as they could.

Staff encouraged and supported people to have a balanced diet that met their individual needs.

Staff were responsive to changes in people's needs and ensured people were supported by palliative care specialists promptly when required.

Is the service caring?

Good

The service was caring.

Staff developed positive relationships with people which enabled them to provide compassionate care to meet their needs and fulfil their wishes.

People were actively involved in making decisions and planning their own care and support.

People were treated with care and compassion by staff who promoted their privacy and dignity.

Staff supported the emotional well-being of people and their relatives with end-of-life care being provided with sensitivity and compassion. The care people received enabled them to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Outstanding

The service was outstandingly responsive to the needs of people and their families.

The service worked innovatively to respond to the needs of the people in their local community. For example, the Oakhaven Neighbours Project brought Oakhaven patients together with volunteers who visited them in their own homes, offering companionship and support. The service provided person-centred care which was planned and reviewed in partnership with them and their families to reflect their individual wishes and what was important to them.

The service sought feedback from the people who use the service, their families and the community to monitor and improve the quality of care delivered.

A process was in place for managing complaints. The provider had a positive approach to using complaints and concerns to improve the quality of the service.

Is the service well-led?

Good

The service was well-led.

There was an open and positive culture that placed people and staff at the centre of the service.

The registered manager gave strong and effective leadership and

provided a clear strategy for the long term development of the service to its staff and the wider community.

Staff felt supported, valued and included in decisions about how the service was run.

The service worked in partnership with other organisations to ensure they kept up to date and provided a high quality service.

Oakhaven Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 9 August 2016 and was unannounced.

The inspection was carried out by an adult social care inspector, a pharmacy inspector, a specialist advisor and an expert by experience. A specialist advisor is someone who has recognised clinical experience and knowledge in a particular field. In this case the specialist advisor had expertise, skills and knowledge in relation to palliative end of life care in a hospice environment. The expert by experience was a person who had personal experience of having used a similar service and had cared for someone who had used a similar type of care service.

Before the inspection we read all of the notifications received about the service. Providers have to tell us about important and significant events relating to the service they provide using a notification. We reviewed the Provider Information Return (PIR) about the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the provider's website to identify their values and details of the care and services they provided.

We spoke with 12 people who used the in-patient unit (IPU), hospice at home and day care service, eight of their relatives and two friends.

We spoke with 30 staff, including two charge nurses who managed the inpatient service, the hospice at home sister, three clinical nurse specialists, the physiotherapy lead, 16 nurses and care staff, the two housekeepers, two chefs, the chaplain, two service administrators and 10 volunteers.

We also spoke with the provider's registered manager (also known as the head of clinical services), the chair of the board of trustees, lead consultant in palliative medicine, head of nursing, the Senior Physiotherapist (who is the quality lead for the organisation), head of human resources and volunteers, two doctors

specialising in palliative care and ten volunteers.

We used a range of different methods to help us understand the experiences of people using the service who were not always able to tell us personally. These included observations and pathway tracking. Pathway tracking is a process which enables us to look in detail at the care received by an individual. We pathway tracked the care of three people using the IPU service and one using the hospice at home service. Throughout the inspection we observed how staff interacted and cared for people across the course of the day, including mealtimes, during activities and when medicines were administered.

We looked at twelve staff recruitment files, and reviewed the provider's training records. We reviewed the provider's policies, procedures and records relating to the management of the service. We considered how comments from people, staff and others, as well as quality assurance audits, were used to drive improvements in the service. We looked at a selection of six medicine records to check medicines were managed safely.

The service was last inspected on 14 February 2014 during which no concerns were identified.

Good

Is the service safe?

Our findings

Without exception people who used the inpatient unit, hospice at home service, day services and the Coates Centre were highly complementary about the service they received at Oakhaven, strongly reinforced by their family and friends. A common theme repeated by people related to the safe and peaceful haven created by all of the staff. People told us they felt safe and cared for by staff who knew them well and met their needs. One person told us, "The staff here are so kind and are very good at making you feel that they are there to listen and provide the care you want, which makes me feel safe and has relieved any worries I had." Another person told us, "The staff make you feel you are in a safe place and inspire confidence because they know your needs and spend time getting to know you as a person rather than a patient." One person's relative told us, "The support from the whole team here for (their loved one) and us has been unbelievable. (Their family member) was frightened but now feels safe and would not wish to be anywhere else." A family member told us, "People are safe here because staff are experts in the different types of complex care that people need. You often see staff responding to emergencies in a calm, unflustered manner which makes you feel people are in the best place possible."

No safeguarding incidents had occurred at the hospice since our last inspection. People were protected from abuse and the risk of harm because staff were trained and understood the actions required to keep people safe. Staff were able to explain their role and responsibility to protect people, which included personal intervention to prevent further abuse and reporting issues to the appropriate authorities outside of the hospice if necessary. Staff told us they had completed safeguarding training and regular updates to ensure their knowledge in safeguarding vulnerable people from abuse was current. We reviewed staff training files and the training schedule to confirm this. One staff member told us, "With the managers and staff here it is inconceivable that anyone would be abused but I would tell my manager immediately if I had any concerns and would notify other authorities like the CQC if required. "

Oakhaven staff provided a warm welcome to visitors whilst ensuring the provider's security measures to protect people, such as signing in and out, are completed. The provider has recently implemented a CCTV system in accordance with national guidance to improve security.

People's care records demonstrated that all potential risks to their safety had been identified and managed appropriately. Risk assessments were completed with the aim of keeping people safe while supporting them to be as independent as possible. The multi-disciplinary team (MDT - consultants, doctors, nurses, care staff, physiotherapists, occupational therapists, social workers) reviewed people's needs, symptoms and associated risks daily, for example; people's care records during the two days of inspection identified people's increased risk of falls, deteriorating skin integrity, diminishing nutrition, and increased emotional risk. The hospice completed a daily bed management, referral and admissions discussion for prioritising care for people. The hospice also held weekly MDT meetings with external professionals from the wider community. Risks to people receiving care at home were discussed, including strategies for supporting people and their families with increased symptoms, for example; increased risks of bleeding or choking. Staff knew people well and were familiar with their needs, which informed positive risk awareness and management to support people achieve things that were important for them, for example; to remain in their

own home and not be admitted to hospital. Staff received clear guidance from risk assessments which we observed were followed in practice to provide the required support to keep people safe and promote their independence.

Incidents and accidents were assessed and monitored daily by the registered manager, head of nursing, and the MDT. The provider maintained a live- time risk register for the service, which identified the type and seriousness of the risk and the staff member designated to ensure necessary action to prevent a recurrence was completed within specified timescales. Information regarding incidents, including near misses, was discussed in regular clinical governance meetings which were recorded. Staff told us they were encouraged to report any incidents or near misses which occurred, for example; incidents involving falls, pressure area management, medicines administration and record keeping. The different actions and learning points from each incident were shared with the relevant staff in meetings and handovers so necessary lessons could be learned. All staff knew and understood the provider's incident and accident reporting process to ensure all risks were identified and managed safely.

People using the inpatient unit and their relatives told us staff responded immediately when they required assistance. During our visit we observed a rapid response from all staff, when assistance was requested. People and their relatives using the hospice at home service told us staff always responded promptly whenever they required assistance which, "Reassured them and made them feel safe."

The charge nurses completed a daily staffing analysis to ensure there were sufficient suitably qualified staff available to meet people's needs. Rosters were completed eight weeks in advance and demonstrated that the required number of staff to meet people's needs was provided. Advance rotas we reviewed ensured there was a good skill mix within the respective teams and all staff absence was managed within the provider's own establishment. This ensured people received safe and consistent care from staff who knew them. The hospice did not use agency staff but had a number of regular bank staff who had previously worked in the service, which provided continuity of care.

The MDT demonstrated how they considered requests for admissions on a daily basis, which were also considered in relation to availability of suitable staff to meet the person's individual needs. People, their relatives and staff told us they had no concerns regarding the staffing levels. One person told us, "This is a wonderful place where staff are there whenever you want them. It's like they know before you do." A relative told us, "They must have staffing levels right because nobody has to wait and the nurses and carers are always calm and unhurried which adds to the air of tranquillity."

Without exception staff told us there was an excellent team spirit at Oakhaven which meant colleagues always volunteered to cover unforeseen staff absence when required. Staff told us there were enough staff to spend quality time with people and ensure they received safe quality care. Regular staff told us they valued the support of the volunteers working at the hospice, which enhanced the quality of care provided to people.

When people's health deteriorated quickly we observed the staff ability to provide one to one care increased people's safety and reduced the risks of harm to them. We spoke with the nursing lead of the hospice at home service who told us there were sufficient staff to provide the current level of service provided. We reviewed proposal documents which considered increasing the level of the service and detailed the required increase in staffing to resource these. This demonstrated the provider's determination to ensure people received safe care from sufficient staff.

People and their relatives using the hospice at home service told us told us staff were always on time and

spent as much time with the person as required. One person told us, "They never let you down and are always on time. If there is a problem they always let you know." A relative told us, "The hospice at home carers are brilliant. They are a real life saver not just for people who may be poorly but for their families. It makes you feel that (their loved one) is in safe hands and everything is under control. It makes you feel you are not alone."

Staff told us they had undergone robust pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicants conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff had provided proof of their identity and right to work and reside in the United Kingdom prior to starting to work at the service and had completed relevant health questionnaires. Prospective staff underwent a practical role related interview before being appointed. The hospice received support from volunteers, who were also subject to a robust pre-selection process to ensure their suitability to support vulnerable people. People were safe as they were cared for by staff and volunteers whose suitability for their role had been assessed by the provider.

There were effective health and safety systems to protect people from harm within the inpatient unit and day services. Regular audits and daily checks by nominated staff ensured that the environment and equipment used was safe and fit for purpose. Environmental assessments identified the risk from potential hazards, for example; use of chemicals, the disposal of waste materials, slips, trips and falls. Risk management plans had been created to ensure action had been taken to mitigate such risks.

The service had contingency plans to manage emergencies, for example; evacuation in relation to a fire or flood. This ensured the provider had prioritised people's care provision during such an event. Staff understood these plans and knew how to access them if required.

Escape routes, fire warning systems, emergency lights and fire safety equipment were checked on a daily basis. Records indicated that fire safety equipment and emergency lighting had been regularly tested. There was a fire risk assessment in place for the building. Staff told us and records confirmed that fire drills were undertaken to ensure people's safety and staff understanding of the procedures. The provider maintained effective dialogue with the fire service safety officer, which had led to improvements in monitoring of the whereabouts of staff and volunteers in the event of an emergency.

The service provided support for people in the community through a specialised equipment loan system. This system has recently been improved based on a recent audit to ensure all equipment was safety checked and decontaminated after each use.

The service was safe because people were protected against the risks associated with medicines. People's medicines were managed effectively to ensure they received them safely. People and relatives told us people had their medicine when they needed it and staff were quick to respond to any needs they had. One relative told us, "It is reassuring to have nurses and doctors explain things about medication in a way you can understand, especially when they need to be changed."

Systems were in place for obtaining medicines including those required in an emergency. At the time of our inspection staff were reviewing how they obtained medicines to ensure the suppliers had the required licenses. Dedicated prescription and administration charts were used for prescribing, including the administration of medicines via a syringe driver (portable pumps that are used to provide a continuous dose of medicine through a syringe). Nurses administered discretionary medicines when required from an agreed

list. This allowed nurses to respond in a timely way to treat people's minor ailments. Nurses clearly recorded the administration of medicines on the charts. Appropriate processes were in place for the disposal of medicines. Staff involved in medicines administration had regular training and had undergone competency checks to ensure their knowledge and practice remained up to date. Staff had ready access to policies, guidelines and references which provided information about the safe and correct use of medicines.

Medicines were stored safely and securely, in locked medicine cupboards within a secure treatment room. Medicines that require additional controls because of their potential for abuse, for example; controlled drugs, were stored securely with appropriate records.

Medicines requiring refrigeration were kept within their recommended temperature range to ensure they remained effective, which was demonstrated through medicine refrigerator temperature records. Staff re-packed commonly used creams for personal care into smaller containers. A range of emergency medicines, including oxygen, were readily available. Records indicated regular checks of these had been undertaken in accordance with the provider's policy and procedure.

Since the last inspection there had been 19 medicine incidents reported which could have resulted in potential harm. There were regular medicines management group meetings where these incidents were reviewed to ensure learning was implemented. There was a system in place to deal with alerts and recalls of medicines. People and their relatives had daily review meetings where nurses and doctors discussed with them issues around medicines and agreed their medicine management plans.

People were protected by the prevention and control of infection. Staff told us that infection control was a priority because many people had reduced immune systems and were vulnerable to infection. Staff understood their roles and responsibilities in relation to hygiene. Housekeeping staff maintained comprehensive cleaning schedules and were observed to follow best practice guidelines to reduce the risk of cross infection between different areas of the building. We observed staff washing or using hand gel as they came out of bedrooms or before they went in. Housekeeping staff had completed detailed training in relation to the impact of effective cleaning in relation to infection control. Housekeeping staff had attended external training provided by the suppliers of cleaning materials and equipment to ensure these products were used safely and effectively, in accordance with their guidelines. The service maintained and followed infection control and hygiene policy and procedure in accordance with national guidance.

Good

Is the service effective?

Our findings

People and relatives thought that all the staff were well trained and delivered a high quality service. One person said, "The staff are brilliant at putting you at ease so you don't even realize they are doing things until they are done." Another person said, "From the doctors to the volunteers, they all know what they're doing and have time to talk to you, which inspires confidence." A relative told us, "From the moment you arrive, whatever time day or night, you are welcomed by smiling staff who know what is happening to everyone they care for."

The service employed a broad range of healthcare professionals including specialist palliative care consultants who linked daily with the specialist palliative care doctors and nurses. The hospice clinicians were available to all the services provided and visited people in the inpatient unit, hospice day service and specialist out-patient clinics when required.

The hospice at home team visited and provided specialist palliative care to people in their own homes. The hospice provided a holistic approach to supporting people with their Counselling and Bereavement Team, Physiotherapy and complementary therapy Teams and chaplain. People using the hospice at home service praised the professional and caring service they received. One person told us, "The nurses are amazing. They have been able to allay all of my fears and always know what to do. They make you realize that you're not alone."

The hospice at home staff knew people's needs and managed risks to people being supported to live with their illness at home, in accordance with their wishes, for example; physiotherapists had arranged specialist equipment to be installed in people's homes to provide the support required. People and relatives told us the quality of their lives had been enhanced by the introduction of specialist equipment, arranged by Oakhaven staff, for example; an appropriate bed to manage pressure areas effectively, alarm mats and monitors to allow relatives to remain in contact when elsewhere within their homes. A person's relative told us, "What they are good at is making sure you get the right equipment at home and don't allow you to struggle on."

New staff completed a comprehensive induction programme which included topics related to palliative care competency, and training on how to sensitively handle subjects surrounding death. Volunteers also completed an induction programme relevant to their role and responsibilities. The respective induction programmes ensured that the care people received was consistent and staff were competent and skilled to meet people`s needs effectively.

People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the specific care needs of individuals. Staff told us they received all the training that was required to work effectively and to provide the best quality of care. One staff member told us, "Compared to other areas I have worked in within the health service, the training here is excellent and there is a real ethos encouraging staff to share best practice."

Staff had been trained to deliver best practice in relation to end of life care. Clinical staff also had to complete regular training in relation to resuscitation, symptom and pain management, discharge planning, tissue viability and bereavement interviews. The provider's computer records and staff files confirmed mandatory staff training was up-to-date. This ensured staff had the appropriate knowledge and skills to support people effectively and were enabled to retain and update them.

Staff were supported to complete further training in more complex techniques relevant to their role and specific to the needs of the people they supported, for example; designated staff completed training in relation to pleural drainage systems (intermittently draining fluid build-up which can relieve discomfort and pain). Physiotherapy staff received training in Western medical acupuncture. All multi-disciplinary team members received nationally accredited advanced communication skills training. The provider had enabled experienced nursing staff to take on lead roles in different areas like tissue viability (skin and wound care). The staff fulfilling these roles were supported with more specialist training to increase their knowledge and experience.

Nurses are required by their regulatory body to have their practice re-validated every three years. The provider effectively supported and encouraged staff with their continued professional development and to revalidate and update their training to maintain their professional qualifications.

The service also held frequent 'Journal Club' and "Sage and Thyme" learning sessions for all palliative care staff where a variety of topics relevant to their roles were discussed, for example; on the days of our inspection the positives and negatives of different types of pain relief were discussed. A junior doctor on a temporary placement told us they found the issues debated in relation to the use of different pain relief highly informative. A member of care staff told us, "We learn so much during these sessions, which doesn't seem like training but we cover all sorts of really interesting stuff about developments and best practice."

All staff told us that the two charge nurses were "invaluable" and a "credit to their profession", which was reinforced by people and their relatives. Without exception the staff said that whilst they would normally speak with the charge nurses if they needed advice and guidance, the registered manager and head of nursing were always approachable, readily available and supportive.

Staff told us they had received regular formal one to one supervisions with their designated line managers, which identified staff concerns and aspirations. Supervisions provided staff with the opportunity to communicate any problems and suggest ways in which the service could improve. The service had begun to complete monthly 'Schwartz Rounds"' and provided monthly clinical supervisions to all staff. 'Schwartz Rounds' provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in the hospice. Staff received a range of clinical supervision to support the individual needs of staff; this included group supervision, coaching and individual supervision where felt appropriate.

People told us that they had been involved in making decisions about their care and support. People felt their opinion mattered, their input was valued and that they were listened to. People were supported to make as many decisions as possible. We observed staff seeking people's consent about their daily care and allowing them time to consider their decisions, in accordance with their care plans. One person told us, "They (staff) are always talking to me about what I want and if I am happy before they do anything but they manage to make it seem just like a chat." A person's relative who was receiving end of life care told us, "The nurses and carers are so compassionate. They (staff) are just so caring and always seek your permission before changing any treatment."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had received training in relation to the Mental Capacity Act 2005 (MCA) and were able to explain the main principles. Staff understood the importance of giving people choice in the support they received, and observed staff always sought people's consent before providing any support. People were supported to make their own decisions where appropriate, in accordance with the MCA.

People were supported to make advanced decisions, for example; whether they wished to be resuscitated or not. We saw examples of Do Not Attempt Cardio Respiratory Resuscitation (DNACPR) forms that had been signed by people. One person receiving end of life care had not signed the DNACPR within their care records. We discussed this with the registered manager and lead consultant who were able to demonstrate a best interest decision process regarding this decision. People were enabled to make informed choices and decisions regarding their life and treatment.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in hospices are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of the inspection the service had no DoLS applications or authorities in place. However, the registered manager and staff knew what action to take if required to ensure people's human rights were recognised and protected. We reviewed a previous DoLS application completed since our last inspection, which demonstrated that a process of mental capacity assessment and best interest decisions promoted people's safety and welfare when necessary. These processes and best interest decisions had been recorded effectively.

People and relatives told us the food provided at Oakhaven was "Outstanding" and praised the quality and choice of food prepared by the chef. All food was freshly prepared in the fully equipped on-site kitchen, which had received a 5 star rating from the Food Standards Agency.

People had nutrition and hydration assessments and plans, which were up-to-date and where necessary recording of people's intake had been completed. The chef was aware of peoples' dietary requirements and preferences and offered a range of choices which met their nutritional needs.

We observed the lunchtime meal service in the inpatient unit and the day centre. The food served on the day looked appetising and people were encouraged to have a meal by the staff. Where people required assistance with eating, staff spent sufficient time to ensure they ate enough food. Kitchen staff had a detailed knowledge regarding individual's dietary requirements. Kitchen volunteers were also able to tell us which people were on a special diet and which foods people preferred. Where people found it difficult to eat due to loss of appetite, staff encouraged people to eat an alternative meal or suggested they could try to eat later.

People using the hospice at home service told us the reassurance and advice provided in relation to pain and symptom management to support people with their condition was invaluable. A relative of a person

using the hospice at home service told us, "Words cannot describe what they have done for us. They (staff) have been unbelievable and are there when you need them, when you're worried they really put you and your family first."

The hospice offered a programme of activities where people had ongoing support from members of the multi-disciplinary team. These clinics aimed to provide positive support and encouragement to people to effectively manage their life limiting condition. People told us attending these clinics was essential to maintain their health and well-being. One person told us, "I wasn't sure at first but now I really look forward to them. They really brighten up my day." People received effective on-going healthcare support.

People's healthcare needs were described in their care plans. There was a holistic approach to care that took account of the person as a whole, their family and friends and their wishes regarding their treatment and aspirations. Staff told us that individual care plans provided all of the necessary details to inform them how to meet people's needs.

Staff had a handover for in-patients and people using the hospice at home service at the change of each shift. These meetings were chaired by the charge nurse or senior nurse, who encouraged contributions from all staff to plan care and to pass on all relevant medical and health information. Each patient was discussed in detail including information about their family, primary diagnoses, medical issues and other important health care needs. We observed three handovers. The appropriate level of information was shared and discussed in order to facilitate the continued safe care of people during the next shift. The incoming staff had ample opportunity to ask questions and to seek clarification about tasks that needed to be undertaken. This system ensured that the continuity of care was maximized for individuals. Volunteers told us the communication between them and staff was good and that they were always aware of what was happening on the previous and current shifts.

Good

Is the service caring?

Our findings

Without exception people, their relatives and friends, praised the welcoming environment and caring ethos created by the registered manager, their staff and volunteers. People and relatives repeatedly spoke with warmth about the "Oakhaven Effect". A person's relative told us "As soon as you walk in you can feel the positive energy and an overwhelming sense of well -being." Another relative told us, "People have the wrong impression about hospices. This (Oakhaven) is a place where you see the best of people and it never fails to raise my spirits."

People told us that staff were kind and considerate, not only to them, but their family and friends. One person using the day service told us about the caring experience they had shared with a loved one who had used the inpatient unit. They spoke passionately about the quality of care provided by staff and finished by saying, "How we were loved by strangers."

A relative of a person who had been an inpatient told us how staff had supported their grief stricken family with kind ness and compassion. They told us, "I am sure that people go beyond what they are meant to offer here. When we arrived we were in a distressed state. They cared for me, my husband and my teenage daughter, finding us accommodation here, washing our clothes and feeding us day and night. As for (their loved one) how they cared for her. Treating her with such respect, even though she was in a coma they spoke to her so gently and explained everything that they were doing. The nurse (name), should have gone home but she stayed with our daughter who was so upset. The compassion they showed towards her was exceptional." The person continued to explain how staff had then continued to provide support and counselling to comfort the family coming to terms with their bereavement.

People were encouraged to make their room their home and were welcome to bring personal possessions. Their relatives could stay overnight or in a separate room. There was open visiting and people were supported by staff to bring their pets in with them such as, for example, birds and on one occasion a horse.

We observed staff knew people's needs and preferences well and provided care to meet these with kindness and compassion. After shift handovers we observed staff immediately go to speak with people to see how they were and introduce themselves to new inpatients. We also observed staff, where appropriate, visit them and their families to say goodbye at the conclusion of their shifts.

People were involved and informed about the care they received. Staff having discussions with people about the future when they started using the service enabled people to prepare and make informed decisions about what was important for them and make the most of their remaining time. We talked to a member of the Counselling and Bereavement Team who told us about this distinctive skill, "We help people to feel at peace with themselves and their illness. We help them establish what is important to them and prioritise." They told us about a person who they were working with to build up a "Legacy of happy moments" to leave behind for their family to remember them after death. During the inspection we saw the member of the Counselling and Bereavement Team meeting with the family and the person to talk about the priorities and how to achieve those. They told us, "First we work closely with the medical team to build

the person`s strength up. Then we will start on building the memories they want."

Nursing staff with experience working in other departments of the NHS told us that they would not wish to work anywhere else, due to the fulfilment they had experienced from being enabled to deliver quality nursing care. Staff working in all areas of Oakhaven hospice told us they were fortunate to work in such a positive environment and were "immensely proud" of the caring service they provided. A nurse told us, "Working here is very rewarding, sometimes very emotional, but you always look forward to coming in because you have an opportunity to provide care and support and make a difference to the quality of someone's life."

Staff had developed positive caring relationships with people. We observed staff engage people in conversations about things which interested them, that did not just focus on the person's support needs, for example; one person was a keen athlete and enjoyed running and other physical exercise. This person told us they were very happy when staff immediately made arrangements for them to watch coverage of the Olympics whenever they chose. We observed people were relaxed and happy in the company of staff and chose to spend time with them.

Staff knew people and what was important to them, which enabled them to show compassion, for example; one person was visiting the day service on the anniversary of their sister's death, to whom they had been very close. We observed staff engage with this person and talk with them about their feelings. This person told us all the staff were "wonderful" and it was "little things" like "remembering her sister" which made Oakhaven staff "special".

People, or where appropriate their representatives, were involved in making decisions about their own care. People told us that when their needs changed which required alternative treatment staff consulted them to discuss their views which they then acted upon. This made people feel their views really mattered and they were in control of their treatment. One person we spoke with who had a wealth of professional clinical experience told us, "The staff are unfailingly kind and deal with my anxieties with exceptional sensitivity. I have been fully involved in my care planning which has been driven by my wishes based on questions I have asked, which have always been answered honestly." Relatives of people who had used the various aspects of the hospice service told us staff had compassionately prepared and supported them to make important and emotional decisions, for example; about their loved one's preferred place of death.

People were supported to maintain relationships with people who were important to them. People told us that their friends and relatives visited regularly and were welcomed to the hospice. Times and lengths of visits were not restricted unless desired by the patient.

There was a chaplaincy service available (reverend and chaplain) to offer support and comfort to meet the multi-denominational spiritual needs of all people and their family members. The hospice had a chapel situated in the inpatients unit, which was easily accessible, and available to people of all beliefs. The environment could be adapted to display religious objects specific to people's individual faith. Bereavement, counselling and social support was available to people and their families or friends. This provided emotional support to those who required it. Examples included the Bereavement Cookery Course, Lunch Club, Bereavement tea and coffee mornings. Also the service had a close collaboration with the Widowed Friendship Club.

People and their relatives told us staff always respected their privacy and dignity. The provider had a policy informing staff how to promote and maintain people's privacy and dignity, in accordance with their dignity in care training. Records confirmed all staff had received dignity in care training. Staff were able to explain

how they respected people's privacy, which we observed in practice whilst delivering people's care, for example; staff always knocked on bedroom doors and waited for a response before entering. When staff were providing care to people we observed staff closing doors and curtains to ensure people's privacy and dignity were respected. Staff used appropriate signs to indicate the room was in use and to prevent the person being disturbed. One person told us staff quickly recognised when they required pain relief or support with nausea and breathlessness, which we observed in practice, in accordance with their care plan. The person told us, "The staff are marvellous, they realise when I am in pain or becoming breathless and sensitively ask my visitors to let me rest and come back later."

We observed staff at the Day Services gently support a person who was becoming distressed to move into a treatment room. This person told staff that the dressing on their leg was causing them pain and should be changed daily by district nurses, which had not happened that day. Staff reassured the person and then placed a new dressing on their leg which allowed them to rejoin the activities with their friends.

People and relatives told us that conversations about their ongoing care needs were always held in private and discussions were completed in a sensitive, empathetic manner. One person told us, "I know they (staff) are supporting me with my battle against illness but when they are with me I know they see me the person and not the illness." The relative of a person with a young family told us how they would not be able to cope without the kindness and compassion shown by Oakhaven staff. They told us, "You sometimes feel overwhelmed with everything and at those times the staff just know what to say and how to say it to give you strength to carry on. I don't know what I would have done without them. " People were treated as individuals by staff who knew them well and understood how to promote their privacy and dignity.

People were supported at the end of their life to have a comfortable, dignified and pain free death. At the time of our inspection we observed staff providing end of life care in accordance with national guidance such as 'Achieving Priorities of Care for the Dying Person' to two people. At this time people's care was subject to care plans in accordance with national guidance. We found care and treatment was developed to meet the person's own needs and wishes in relation to how their care should be managed, including any treatment preferences they may want to express. People's care plans included attention to symptom control, for example; pain relief and the person's physical, emotional, psychological, social, spiritual, cultural and religious needs. People were supported to eat and drink as long as they wish to do so, and their comfort and dignity was prioritised. Care plans documented consistent information about people's needs and wishes, which was shared with all those involved in the person's care and available at the time the information was needed.

Outstanding ☆

Is the service responsive?

Our findings

People received person centred care that was focussed on the individual's needs and wishes and responsive to any changes. People and relatives appreciated that staff involved them in regular reviews of their care. People told us that staff listened to them and involved them in the development of their care plans. People's relatives told us that they had been encouraged by staff to voice their opinions, which made them feel their views mattered. A relative of a person receiving support from the hospice at home service told us, "They are very good at explaining things in simple terms and finding out how you feel and what you want." A person who used the hospice at home service told us, "They (staff) take you through what will happen step by step and how they will be there to support you, which makes you feel you are not alone." People and relatives where appropriate told us they were involved in all decisions about their care and were fully consulted before any changes were made.

Staff told us how they involved people in regular reviews of their care plans and risk assessments, which were confirmed by people and their relatives. We observed clinical staff in the inpatient unit discussing and developing plans with a person and relatives of a person whose health was deteriorating. Relatives told us they appreciated the responsiveness of staff and their ability to give them clear straightforward information empathetically.

During the inspection we spoke with a person after they had had a consultation with clinical staff. The person told us they appreciated the ability of staff to provide them the information they needed to make choices about their treatment. One person using the inpatient unit told us, "They (staff) are very kind in the way they talk to you. You can tell that they often have to tell people things they don't want to hear but always make sure they are supported and understand." At the time of the inspection one person was choosing to retain only selective information being provided by medical staff. We observed staff sensitively support this person whilst empathising with their family.

People's wishes were at the centre of their care planning. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. People`s constantly changing needs were assessed and discussed by staff on a daily basis or more frequently in order to address them appropriately. Staff attended thorough handover meetings at the beginning of their shift. Each person was discussed in depth including care needs, changes to treatment, care plans and medication requirements.

The provider delivered considerate and person-centred care and support that had a positive effect on people. People were asked about their needs and preferences by the staff. People had detailed individualised care plans which described their needs, personal histories, preferences and choices. Staff were able to demonstrate their understanding of how to give people personalised care. The care given to people followed the guidance in their care plan, for example; detailed information about the person's pain and plans to manage the symptoms. Discussions with people about their wishes and their consent about any changes in their treatment were recorded. We saw examples of clear medical admission assessments. People told us the staff were very flexible and always listened to them if they wanted things changed or done a different way. Staff shared people's information with other relevant people at the hospice, for example;

information about people's diets and preferences was shared with the kitchen staff. Information about other aspects of care was shared with the appropriate members of the multi-disciplinary team.

The hospice staff provided a range of rehabilitation, wellbeing, counselling and bereavement services through its day services and the Coates Centre. During the inspection we observed and talked to people whilst they were participating in a range of physical programmes designed to improve people's mobility and general well-being, delivered by a physiotherapist. We also observed people engage in and enjoy a mindfulness relaxation exercise.

An art session, run by a visiting artist, gave people the opportunity to create their own landscape paintings. We saw pottery being painted with glaze prior to it being fired. Staff and volunteers told us the rational of people being able to leave something for future generations of their families and friends to look at, was at the heart of many creative activities.

A wide range of therapies that were additional to medical and nursing care were available to respond to people's needs in regard to relaxation and general wellbeing. Complementary therapies included aromatherapy, massage, reflexology, music therapy and yoga. People were able to try and choose the therapies they preferred and when they wished to have them.

People who used the day service told us that they looked forward to visiting Oakhaven Hospice because they enjoyed the therapies and also met their friends and staff, which was good for their social well-being. One person who took part in the art session was proud of their landscape and said, "I can't paint for toffee but look at what I have done" with a broad smile on their face.

Staff supporting people told us the activities encouraged people to interact socially and provided a stimulating environment which improved their mental well-being. One person told us, "Look at the wonderful things we do, when we're here we can forget that we are ill and focus on living and what we can do."

The hospice was outstandingly responsive to the needs of the people in their community and services offered by the hospice were developed to meet these needs. For example they delivered a range of activities from the Coates Centre to meet the needs of people living with a range of life-limiting illness that might not traditionally receive a hospice service. The Coates Centre hosted events, courses and conferences for carers, bereaved relatives and community groups. These included friendship clubs, for example; Thursday Ploughman's Club, sing for fun, cookery classes for bereaved men, a widows group, and the Mulberry Club for people living with advanced cancer and a bereavement coffee morning.

The Coates Centre offers free support and information for those whose lives have been impacted by illness. At the Coates Centre people can access support groups and a range of wellbeing activities along with complementary therapies to help them cope with their individual challenges. Everyone was welcome to the centre and did not need a referral or have to live in any specific post code. We spoke with the coordinator of the Coates Centre who told us that a chat over a cup of tea, with someone who has an understanding of what is happening, can be all it takes to start to make a little positive difference. One person who had used the day service told us, "This place is marvellous, it's better than tea and cake."

Another outstanding feature of the activity programme was the Acorn project The 'Acorn Project' aimed at working with patients and within schools and local communities to raise awareness of living with long term illness, palliative care and issues around death and dying. Under this project children visited the hospice and spent time with people who use the service who had volunteered to take part in the programme. One

person taking part in the project told us, "Two rules apply, the children can ask any question they want but we can decline to answer. 'Of course we always answer' ". Another person told us, "The children were doing a project on volcanos so we helped them make them and they wrote words describing emotions. They would pull out a word and we would talk about it." Another activity involved wrapping up items used in the hospice such as syringes, syringe drivers, catheters and catheter bags. These were then placed in a tub and pulled out in a lucky dip by the children who would try and guess what the items were used for.

The project involves children from the age of 6 upwards and is designed to demystify issues around death and dying and give them the opportunity to talk things through with people who have real experience of what is often considered a taboo subject. A number of children involved in the project had experienced bereavement and their involvement has enabled them to ask the questions that they felt unable to ask before. Staff involved have spoken at a national conference about the success of the project. The Acorn project has received national acclaim and has been implemented by other organisations.

The hospice supported a learning project to improve the quality of end of life care in local nursing homes. They also provided the outstanding Oakhaven Neighbours Project. This project brought Oakhaven patients together with volunteers who visited them in their own homes, offering companionship and support. The Neighbours Project mainly provides company, but can also assist with small tasks such as dog walking, gardening, driving patients to appointments or taking them out. This service also benefits carers, allowing them to take a little time for themselves while the Oakhaven Neighbour is with their loved one. In 2015, Oakhaven Neighbours spent over a thousand hours with their assigned patients. One written testimonial from a person's relatives said, "Thank you so much for sending the Oakhaven Neighbour. My father loves to talk about the war, and both he and the Neighbour are interested in history, which is lovely for him. He appreciates having another man around, since his carers are all women."
People's families were encouraged to remain involved with the service for as long as they wished after their loved ones had reached the end of their life. There was a 'memory tree' onto which relatives placed remembrance messages. They were encouraged to attend support groups and socialise in the support groups at the Coates Centre in a comforting setting to ease their grief.

People told us that they appreciated and valued the services and in particular the social interaction and support which these enabled. One person said, "Just talking to another caring human being who is willing to sit and listen is amazingly therapeutic. It picks you up better than any tonic." One person told us, "I was just in a black hole with no light at the end of the tunnel until I found Oakhaven. I would recommend it to anyone without hesitation. It has given me hope and changed my life."

The service had effective communication with other partner agencies such as community nurses, adult services and clinical commission groups. Information was shared during various meetings, and prospective referrals were also considered at the weekly MDT meeting.

People who were using the in-patient unit were supported to maintain relationships with people who were important to them to avoid social isolation. We observed friends and relatives visited regularly and there were no restrictions on the times or lengths of their visits.

The provider sought feedback from people, their relatives, staff and community professionals using various different methods, which was overwhelmingly positive. People told us staff were quick to respond especially if their needs changed, which we observed in practice. We observed all staff working together to ensure people's requests for attention were answered as quickly as possible.

The service engaged effectively with local social workers. A social worker told us they had an excellent

working partnership with Oakhaven staff supporting people and families with their worries and fears for the future, their care planning and discharges to their home.

People's families were encouraged to engage with the hospice bereavement services if they wished and were invited to remain and visit the hospice. Families were supported to attend groups and socialise with others who had similar experiences to ease their grief.

People had access to information about how to make a complaint, which was provided in an accessible format to meet their needs, before people started to use the service. During the previous year there had been no formal complaints about the service. Staff knew the provider's complaints procedure but told us they dealt with small concerns as soon as they arose to prevent them escalating. One person being transported to the day service raised a concern that the driver did not drive smoothly and the person felt insecure in their wheelchair. All staff and volunteers were reminded of the need to drive with consideration and to ensure that wheelchairs were secure. All hospice vehicles were checked to ensure that hoists and wheelchair fixings were in good working order. The registered manager and staff were responsive to people's concerns and complaints and
implemented action plans to improve the service.

Without exception people and their families were genuinely surprised when we asked them how staff responded to any complaints or concerns they had raised. People overwhelmingly proceeded to provide further compliments regarding the service. The service had received over 100 compliments during the previous year from different sources, including letters and cards, with numerous daily verbal compliments which were not always recorded. Consistently compliments we reviewed were about the high standards of care, which had been circulated to the staff team.

Good

Is the service well-led?

Our findings

There was a clear management structure at the service and staff were aware of the individual roles and responsibilities of the management team. All the managers demonstrated an excellent understanding of all aspects of providing care to people, which we observed in practice. The registered manager who had been in post for almost 10 years and senior staff had created an open and transparent, blame free culture within the service, which encouraged learning from mistakes, which staff had fully embraced, for example; one person was admitted to the hospice with a pressure area which had deteriorated despite recognised tissue viability treatment. The provider thoroughly investigated the incident and pressure area management procedures to ensure any lessons were learned and implemented. Staff told us that when incidents were reviewed in relation to the quality of care provided they were fully supportive. One member of staff told, "There is no blame culture here just a desire to get it right and if we can do something better we all want to know."

Staff spoke with passion and pride about the hospice and the people they supported. Staff told us there was an 'unequalled team spirit' at Oakhaven which had been driven by a stable management team who were totally committed to people using the service and their staff. Staff told us that everyone from the Board of Trustees through to volunteers were dedicated to providing the best possible care for people and continually striving to improve. Without exception staff and volunteers told us all of the management team were approachable and supportive. One volunteer told us, "There is no us and them and there are literally no closed doors. You can wander in and ask anyone if you need help or advice and you are always greeted with a smile." Staff overwhelmingly praised the charge nurses for their "unswerving passion and devotion to the aims and values of Oakhaven Hospice. One staff member told us, "When you see nurses like (charge nurse) and (charge nurse)it inspires you to become the best you can to reach and maintain their exceptional standards. They are the heartbeat of the hospice".

Staff told us they felt truly valued and supported at Oakhaven both professionally and personally. One of the nursing staff told us, "The managers really encourage and support your personal development". The registered manager told us, "We encourage staff to enhance their roles by enabling them to attend courses such as nurse prescriber and extended scope practitioner. "

Some staff told us about invaluable support they had received from managers and colleagues when they were experiencing difficult situations in their personal lives, for example; coping with bereavement and family illness. Staff we spoke with often referred to Oakhaven as a family where everyone was mutually supportive of one another. "

A staff forum meets six times a year to allow the opportunity to discuss concerns in an open, safe and confidential manner. It is chaired by the human resources manager and has representatives from as many departments as possible. The hospice engages in a continuous programme of reflection, learning and acting upon incidents and accidents, being accountable to the Clinical Governance Board, which meets quarterly.

The provider has encouraged leadership development such as the head of nursing post, which aims to

strengthen nurse leadership and creation of the new hospice at home sister`s post.

Oakhaven Hospice was supported by over 400 volunteers who formed an important part of the service and provided support in a variety of ways. Many of the volunteers we spoke with had personal experience of the service provided by Oakhaven and told us volunteering was a way of repaying the kindness of the staff. One volunteer told us, "Everyone deserves the opportunity to experience the kind of love and caring provided here and if my small contribution means just one more person is able to come here then it is all worthwhile." One volunteer told us, "Oakhaven is at the heart of the local community which is proud of the service and why so many people are willing to volunteer."

The hospice's staff were encouraged to participate in shaping the service. Their ideas and suggestions were sought and taken seriously by the registered manager. A member of staff told us, "The management team always listen to staff and volunteers if they have any ideas or suggestions and will provide necessary support and guidance."

The registered manager was determined to provide the best quality of palliative care possible for people using the service. The lead consultant told us that whilst they accepted they were smaller than some other hospices they were proud of their achievements, which demonstrated how they were "punching well above their weight". The senior management team were committed to meeting the need of a wider group people to dismiss misconceptions that hospice provided a "luxury" service for the few.

People, their relatives and staff told us the management team consistently provided clear and direct leadership and were highly visible throughout the service. Staff told us the registered manager, chief executive officer and head of nursing frequently walked through the service and spoke with them. People and their families told us they were surprised by the level of individual attention they received from the consultants and palliative care specialists.

The inpatient unit was well led clinically, with daily admission and weekly MDT meetings, which considered incidents and identified good and poor care practice, with recommendations for urgent action where required. We observed effective communication between care staff, nurses and clinical staff. Communication was particularly effective in regard to planning for people's admission and discharge.

The registered manager and Senior Physiotherapist (who is the quality lead for the organisation) worked effectively with other organisations providing a similar service to Oakhaven to promote good practice through shared training and learning events. This enabled the management team to continually review the quality of the service provided and drive improvement, for example; updating blood transfusion and infection control practices and procedures. The provider also proactively promoted learning and development within the wider medical community, providing development opportunities for student nurses and doctors.

The provider ensured that responsibility and accountability was understood at all levels, for example; all trustees of the board had to complete an appropriate induction and shadowing programme across all service areas. The provider has continued to implement recommendations set out in the Business School /Hospice UK Board Development Programme findings for the hospice. This aims to support the Board of Trustees (BOT) in the principles of good governance including integrity, accountability and effectiveness in delivering the purpose of the organisation. An action plan was in place to achieve this including outcome measures looking at the BOT's improved understanding of good governance and self-awareness.

The management team consistently operated systems to ensure they shared information with external

organisations effectively, in a timely way, for example; accidents and incidents were reported to the relevant authorities, including the CQC.

A clinical governance group met quarterly to drive continuous improvement for the benefit of people who use the service and staff. The clinical reference group monitored key performance indicators such as medicine incidents, falls, safeguarding reports and DoLS applications. The clinical governance group was also responsible for the review of relevant NICE documents, policy review and review of audits and satisfaction surveys.

The management team benchmark the service against other hospices and used this as a measure of how they were doing. The benchmarking aimed to identify the areas where improvements needed to be made, and these were introduced immediately, for example; updating prescribing practices for dosage and routes of administration of the same drug to ensure people received their medicines safely.

Records accurately reflected people's needs and were up to date. Detailed care plans and risk assessments were fully completed and provided necessary guidance for staff to provide the required support to meet people's needs. Other records relating to the running of the hospice such as audit records and health and safety maintenance records were accurate and up-to-date. People's and staff records were stored securely, protecting their confidential information from unauthorised persons, whilst remaining accessible to authorised staff. Processes were in place to protect staff and people's confidential information.

The Senior Physiotherapist (who is the quality lead for the organisation) effectively operated processes to evaluate the quality of service provision, including regular surveys of people, their families and staff seeking feedback on their experience of the service, for example; Voices (Views Of Informal Carers Evaluation of Services). The provider had introduced a modified version of Voice tailored to Oakhaven to be completed quarterly and was awaiting evaluation of these at the time of inspection.

The Senior Physiotherapist (who is the quality lead for the organisation) operated an effective system of audits for the whole range of hospice services provided including infection control, medicines, incidents and accidents, training, care records and health and safety, for example; an audit identified an improvement priority in relation to ensuring information sharing with partners complied with people's wishes. The provider has implemented a new electronic record system, which was in its infancy at the time of inspection, which will ensure 100% compliance with people's wishes in relation to the sharing of information.

The service was forward thinking when managing their workforce. The head of nursing told us that one of Oakhaven's main strengths was the consistency and continuity of care provided by staff and the high retention rate of staff. The management team had identified that a high percentage of highly skilled and experienced staff were approaching retirement and had begun succession planning to ensure this did not affect the quality of the service. People and relatives told us the hospice team of clinical nurse specialists were often their first point of contact and their expertise and knowledge immediately instilled trust and confidence. People were often referred to the service by the clinical nurse specialists. The head of nursing and clinical nurse specialists had also identified a need for succession planning in this vital area of service delivery.

The provider was an integral member of representative national organisations and were committed to improve their quality of service and continually striving for excellence. The registered manager told us the provider was currently exploring the feasibility of a research study to fully understand the end of life needs of their community so they can improve the service provided and target it more effectively to meet those needs.