St Luke's (Cheshire) Hospice

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Inspection report

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on 21 and 22 March 2016 and we gave short notice to the registered provider prior to our visit. This was to ensure that key people were available during the visit.

St Luke's Hospice provides specialist care for people with advanced life limiting illnesses, including day and inpatient services to people over the age of 18 years. There are 10 inpatient beds at the service. During the last year the hospice supported 182 people in the inpatient unit and 140 people in the day services. The hospice delivers physical, emotional and holistic care through teams of nurses, doctors, counsellors, chaplain and other professionals including social workers, benefits advisors and therapists. The service provides specialist advice and input, symptom control and liaison with healthcare professionals.

The services provided include counselling and bereavement support, a Lymphedema service (for people who experience swellings and inflammations), an outpatient clinic, occupational and creative therapy, physiotherapy, chaplaincy and volunteer services that include approximately 1200 volunteers. The service is situated in Winsford, close to the shops and other local amenities. Car parking is available to the side of the premises.

The previous inspection was undertaken in August 2013 and the service had met the regulations in place at that time.

There is a registered manager in place at this service, who has been registered for three months. 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.

People told us that they received a good quality of care from all the staff at the hospice. They staff were kind, patient and caring towards them and supported them to meet their physical, social and emotional needs. People described the culture of the hospice as positive.

People told us they felt safe at the service with the staff team. Staff had been trained to recognise and report any signs of abuse. No safeguarding issues had arisen at the service since the last inspection.

The staffing levels were good and sufficient staff were seen on the days the inspection took place. Staff were well trained and had access to a variety of courses to enable them to develop their skills and knowledge base. Good support was given by senior management and regular meetings and supervision sessions were undertaken.

End of life care was given in sensitive and appropriate ways that acknowledged people's rights and preferences. The service promoted a "focus on living" approach to care which supported people and their

families to enjoy the time they had together and enhance their feelings of well-being.

Robust staff recruitment processes were in place which ensured that only staff who met the service's high specifications regarding experience and qualifications, character and caring abilities were employed. This included the recruitment of volunteers.

The management of medicines was safe. We noted some areas for improvement which the management team agreed to implement following the inspection process.

People told us the food was good and that they had access to snacks and drinks whenever they wanted them. Care plans showed that a nutritious diet was encouraged.

The service worked closely with other professionals and agencies to ensure people's holistic needs were fully met.

There was clear evidence of close and effective partnership working between families, carers, and between the service and external professionals.

Regular checks were made regarding the safety of the building and equipment. Staff were given training in safe working practices and provided with any necessary personal protective equipment. During a tour of the building we noted it was clean, hygienic and in a good state of repair.

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.

Robust and safe recruitment practices were in place. Staff were trained and aware of how to protect people from abuse and harm and knew how to report any concerns.

Risk assessments were centred around the individual and their specific needs. There were sufficient staff on duty to meet the needs of people safely.

Is the service effective?

Good

The service was effective.

Staff were trained appropriately and had a good knowledge of how to support each person to meet their specific needs.

The registered manager understood the principles of the Mental Capacity Act (MCA) 2005 and how to apply these. Staff had received training on the MCA 2005.

People told us the food was good and that they could have food and drinks whenever they wished.

Is the service caring?

Good

The service was very caring.

People's feedback about the caring approach of staff was extremely positive and was described as "Excellent". The service was very flexible and responded quickly to people's changing needs or wishes.

Staff showed kindness and knew when and how to convey empathy to people when they faced difficult situations.

Is the service responsive?

Good

The service was responsive.

People and their families were fully involved in assessing their

needs and planning how their care should be given.

Staff delivered people's care in a person-centred way and encouraged them to make choices about their daily lives.

Complaints were dealt with appropriately by the registered provider.

Is the service well-led?

Good

The service was well led.

There was a clear management structure and lines of accountability in place. People and staff told us the service was well managed.

Systems were in place to monitor the quality of the service provided

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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.

We inspected the service on 21 and 22 March 2016. We gave short notice to the registered provider because we needed to be sure that key people would be available for our visit. The inspection team consisted of two adult social care inspectors and a pharmacist specialist advisor.

We spent time at the service looking at records. This included three people's care and support records, four staff recruitment files, policies and procedures and other records relating to the management of the service.

Before our inspection, we reviewed all the information we held about the service. This included looking at any safeguarding referrals received, whether any complaints had been made and any other information from members of the public. Before the inspection we looked at notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We contacted the local authority safeguarding and contracts teams for their views on the service. No concerns were raised about this service.

On the days of our inspection we spoke with six people who used the service, two relatives, the registered manager and eight staff members.

Good

Is the service safe?

Our findings

People told us they felt safe with the staff and in the service. One relative commented "People are safe here." Staff told us about how people were kept safe and they said that if they had any concerns they would inform the person in charge. They were aware of how to raise concerns and felt confident that they could speak to the senior person on duty. Staff said "I would be concerned if someone had bruises or obvious harm. I would be concerned if someone was not able to voice their own views and was being dominated by someone else", "I would report concerns to my manager or the CQC", "Safeguarding can include physical or verbal", "Bruising, skin damage, financial, worries and obvious fear" and "I'd tell the police, matron or the social work team." Staff said they had received training in safeguarding adults and children and records seen confirmed this. The registered provider had safeguarding policies and procedures in place and a copy of the local authority's safeguarding policy was available to the staff team. A flow chart was in place to show what to do in the event of suspected abuse. Other policies staff had access to included whistle blowing and child protection. Staff confirmed they were aware of these policies and procedures and told us that the employee handbook also contained information on what they should do if they had any concerns.

People said "I'm amazed at how many staff there are", "People come promptly to the buzzer", "There are enough staff on. People are safe" and "Yes there's enough staff." Staff said there was always enough staff on duty and staff commented "Yes there's enough staff. Staffing levels are dependent on complexity and the management seem to get it right. People are not at risk" and "There is good staff retention- A lot of us have worked here for years. We're employing at the moment because of people retiring". We looked at staffing levels within the service and reviewed staff rotas. We saw that staff were available during the day and night to support people who were staying at the hospice. During our visit we saw that staff responded quickly to people's needs and that there was enough staff available to meet people's needs. The care staff team were supported by cooks, domestic, laundry and administrative staff. The registered manager explained that they had their own group of bank staff who covered the service as needed which helped maintain the consistency of the care being provided.

We looked at recruitment processes and reviewed four staff recruitment files. These were well presented and information was easy to access. Staff had completed an application form and attended an interview where questions and answers had been recorded on an interview matrix. References and a Disclosure and Barring Service (DBS) check had been undertaken to ensure staff were suitable to work at the service. A DBS is undertaken to ensure that staff are suitable to work with people within this type of service. This meant that robust recruitment processes were in place to ensure people were supported by suitable staff.

People told us that they received their medication when needed and that staff were responsive to their medication needs. Both had come into the hospice for symptom control and this had been achieved. They had been given their medicines at the appropriate time and had access to 'when required' medicines for pain and nausea as needed.

Although we found some areas for improvement in the medication processes, the management team were responsive to the comments made and agreed to make changes to improve the processes undertaken.

There were policies and procedures in place covering the ordering, receipt, storage, prescribing, administration and disposal of medicines. These had not been reviewed since 2008 and during discussion with the registered manager it was agreed that this should occur at least every five years to ensure they reflected current practice. There was no policy on anticipatory prescribing and the registered manager agreed to address this. Medicines were all stored safely and securely in appropriate cabinets. Fridge temperatures were monitored and recorded daily. Patients own medicines were clearly segregated from stock medicines both in the cupboards and in the medicines trolley. Emergency medicines were securely stored but were readily accessible to authorised staff if needed.

There was no Controlled Drugs Licence in place at the service. However, the Home Office guidance stated that this was not required where a hospice is wholly or mainly funded directly through charitable or public funds, as was the case with St Luke's. However, this information should be included in the Controlled Drug policy to ensure clarity about the Controlled Drug Licence.

Staff completed Medicines Administration Records (MARs) which showed that medication had been administered, and at what time. Appropriate information was also provided to staff where people had allergies. Where people's own medication was being stored and administered, this was clearly marked by a red dot both on the product and on the MAR. Medication was administered safely by appropriately qualified staff and appropriate checks were carried prior to the medicines being given to people.

Medicines were supplied from a local community pharmacy against signed orders and prescriptions. On admission people's own medicines were initially used. When checking one person's medicines it was found that an unlabelled medicine was in their medicine tray which meant that it was not clear if this medication had been prescribed to this person. We also found that a reduced dosage for one medicine was not being administered as directed on the label of another medication. We found another example where one medicine had been prescribed outside its licence. We followed these issues up with the nurse on duty and appropriate measures were subsequently put in place.

Medicines were disposed of appropriately in dedicated waste disposal bins. Disposal records were kept of the disposal of medicines, including for Controlled Drugs. An authorised witness for the safe disposal of Controlled Drugs had been appointed, who oversaw this process. There was also an Accountable Officer for Controlled Drugs who oversaw all issues which related to controlled drugs.

Procedures were in place for annual audits on medicines. However the audits were not accessible to staff and were not available to view on the day of the inspection. Also they were not being completed in line with the registered provider's policy, which suggested that several areas should be audited each year. An audit, on one area of medication at the end of life was dated 2014 and therefore the information was two years old. Although this did not affect people's safety on a daily basis, it should be undertaken so the registered provider can demonstrate that their practice is in line with their policies and national guidance.

Staff who were responsible for medicines were qualified Nurses. Medicines were prescribed by Medical Practitioners with appropriate backgrounds. Evidence was seen of training on Controlled Drugs handling.

Care records contained up-to-date risk assessments for areas such as pressure care, manual handling and pain management. The registered manager explained it was the hospices policy for people's skin to be checked within six hours of admission and care files confirmed this had been undertaken. We saw that risk assessments were up to date and reviewed every few days.

During a tour of the building we found the service to be clean and free from offensive odours. Staff told us

they had undertaken training in infection control and commented "We wear aprons and gloves and dispose of these in appropriate bins. If people have specific infections then they are nursed appropriately" and "I've had training in infection control. We wear aprons and gloves and ensure we wash our hands before and after all tasks." We noted that doors into the ward were not locked and we discussed this with the registered manager who said that they are locked at 7pm. We saw there was no policy in place around when to lock them during the day, for example, if there was someone staying at the service with a high risk of leaving. The registered manager said they would look into this. Comments from relatives indicated that people were requested to sign in. One relative said "Security is good. I got told off for not signing in".

Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to remedy these in a timely manner. We saw that safety checks were in place for the gas and electrical systems and that the fire alarm and nurse call systems were regularly checked and serviced. This meant that good systems were in place to ensure that the service was safe and adequately maintained

Good

Is the service effective?

Our findings

All the people we spoke with said the food was very good and that they could have drinks and snacks whenever they wanted. People said "The food is very good. It's very tasty", "If you don't like it you get something else" and "Tea and coffee is offered through the day. They call me Mr Tea." Other comments included "Food is very good. It is not like hospital food. It's like home cooked food", "Tea and coffee are offered through the day. I have just had a tea and a piece of cake". Jugs of water were provided to people in their rooms and were kept within reaching distance in case people became thirsty. We observed a nurse bringing a cup of tea and cake to one person and heard a member of the kitchen staff telling another person "Have whatever you like [for lunch]".

There was a five weekly menu in place which showed a three-course lunch and dinner was provided. Choices were available at each mealtime and one staff member explained that if the person didn't want the menu on offer then other options such as omelettes, sandwiches or jacket potatoes were also available. We saw that the menu was varied and people were asked each morning about their food choices for the day. A nutritional needs and preference sheet was seen and showed people's dietary needs or concerns and any further information. For example, one person couldn't have 'nuts or seeds' and another person 'could not eat big meals or digest meat well'. This document helped staff offer suitable foods to people who used the service. Temperature checks were undertaken on fridges, freezers and hot food with records kept and seen. This meant that all foods were stored and served at appropriate temperatures to ensure that risks were minimised. Details regarding food allergies were seen and people were encouraged to make staff aware of any known allergies they had.

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. 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 2005. People who normally live in their own homes can only be deprived of their liberty through a Court of Protection order.

We checked whether the service was working within the principles of the MCA 2005, and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager was aware of the principles of the Act and how to determine people's capacity. The registered provider had up to date policies and procedures in regard to the MCA 2005 and DoLS, Best Interests and Lasting Power of Attorney (LPA). LPA is where someone is appointed by the Court of Protection to make decisions on the person's behalf within specific areas of their life. Care records showed that people's mental capacity was considered. Daily notes recorded that care staff assessed people's capacity prior to carrying out care tasks, for example in one record it stated "Patient has full capacity for care decisions".

Staff had received training in the MCA 2005, and were aware of their roles and responsibilities in regard to this. Staff told us that Mental Capacity is a person's ability to make decisions. They commented "I wouldn't

do anything against their wishes unless there was a high risk of them harming themselves. That's when we may need a DoLS", "People's capacity can fluctuate", "Yes I assess people's capacity daily. I look at their ability to use, weigh and retain information", "DoLS are required when people make decisions that are not in their best interests". One staff member said "We have no one subject to a DoLS at the moment. Anyone with fluctuating mental capacity is discussed in the weekly Multi-Disciplinary Team meeting. People involved in these meetings included the social worker, Doctor and members of the nursing team. This is because of the complexities involved in managing people with fluctuating MCA".

Staff told us about the training they received. They said they completed a days "mandatory training" each year and that the training was good. Other comments included "At the moment we're doing some work around increasing staff confidence. We get different staff to lead on the handovers. People have fallen into the pattern of letting more experienced staff doing it, however some of the more experienced are retiring. We want to keep skills up" and "Training is very good. We have a mandatory training day". All staff undertook a range of training which included health and safety, manual handling, fire safety, safeguarding for adults and children and infection control. Other training included end of life care, living and dying with dementia, supporting young people with loss and grief and advanced communication skills. The registered manager explained that staff had the opportunity to discuss their work and training needs with a senior staff member and that these were also identified within annual appraisals.

Each staff member had an induction which was appropriate to their role and needs. An employee health and safety induction training record was completed and signed and dated. The employee staff handbook and health and safety handbook were both made available to the staff and it was a requirement by the registered provider that they read this. Statements were seen on staff files which showed these documents had been seen and read by the staff team and were signed and dated by them.

Good

Is the service caring?

Our findings

People who used the service, relatives and healthcare professionals told use how they positively appreciated the service that was provided and the way in which it was delivered. All their comments were overwhelmingly positive. People told us that they were very pleased with their care. People commented "Staff are lovely", "I've had such good care here" and "They've been absolutely brilliant". Other comments included "Staff come in and chat with me. I'm a person", "10/10 for care. I've been well looked after", "They're supportive" and "They're excellent". Relatives commented "Politeness of staff is very good", "Cups of tea or coffee are available for relatives" and "Staff are approachable".

Staff supported people with personal care when needed and people commented "I'm very lucky. I left my pride at the door (with regards personal care) and they've been unbelievable. They're very respectful", "I have the door shut and I'm left alone when I'm in the bathroom. They cover me up when I'm on the toilet- That goes a long way. Its how I like it" and "Yes they're respectful during personal care". Some nursing staff also undertook training in statement of intention to prescribe [medication] and syringe driver use which helped them further support people who used the service.

During discussions with the staff we asked them how they showed dignity and respect to people who use the service. Staff said "I make sure they're covered up and that I have input from them. Curtains and doors are kept closed", "If a relative becomes upset take them somewhere quiet", "I make sure screens are closed". We saw that staff knocked gently on bedroom doors and waited before entering. Bedroom doors were left open or closed at the person's request and staff regularly checked on people's well-being.

There was a homely feel to the service throughout. There was a social atmosphere where people were encouraged to chat if they wished to and were listened to. Staff and volunteers were smiling and engaging with people and they stopped and listened to people and responded to them with genuine warmth and friendliness. Staff approach was kind, patient and respectful. There was friendly and humorous banter between people and staff and staff addressed people respectfully and by their preferred name.

Staff were attentive to people's needs including their emotional needs. People commented "I'm well supported" and "I have some apprehension about going home but I feel very reassured". One relative said to staff "I know that you treated [name] so kindly. Your staff also showed me enormous kindness and compassion when I came to sit with [name] at such a tremendously difficult time." Counselling therapy was offered and provided to people. This extended to relatives, young people and children. This often involved using creative activities such as drawing and painting to enable them to express their thoughts and feelings about what is happening to them and their relative. Mindfulness sessions were also carried out by the chaplain as a means of providing emotional and psychological support to people, their families and staff. A range of leaflets were available to people to assist them in getting support such as befriending service, bereavement support groups for young people and family support unit counselling.

Visitors told us they were welcome at any time. Comments included "I can visit at any time" and "We are made to feel welcome here". The registered manager said that visitors were welcome day and night and that

sleeping facilities would also be provided, either within the room of the person or a separate room if preferred.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Each person's wishes were at the centre of the service. A pain management programme was written for each person and symptom control and pain management was discussed with the individual prior to changes being made. When a person's health condition changed, the side effects of any medication change was explained to the person and whether they wanted the change of medication. The person was fully involved in the decision making process and their wishes were respected.

People had access to a Chaplain, who was available to meet people's religious needs. One person told us "I went to the chaplain yesterday for palm Sunday." Within the care records there was evidence of engagement with people and their relatives, for example "(Relative) states that they find it very hard to have faith when they see [name] suffering. To introduce support when able for their consideration". We saw that the Chaplain undertook services for people with differing religious needs and that that the "Chapel" also had a prayer mat and other items that could be used by people with different religious needs.

Good

Is the service responsive?

Our findings

People and their relatives told us that the way staff responded to their needs was "Excellent" and "Support is available and helpful". They said that they were treated as an individual and that staff were "Very kind" and "They've been good to me".

There was an extensive collection of positive comments about the support that was provided by the staff and the service. This feedback was received from people who use the service, relatives and friends and they all expressed how responsive the staff had been to people's needs. All the comments were extremely positive and thanked the staff for all their support. Comments included "Thank you for the amazing care", "Nobody could have cared more" and "You do fantastic work".

People had access to a range of activities whilst at the service. A wide range of complimentary therapies were available to respond to people's needs in regard to relaxation and general well-being. These included massage, touch therapy, aromatherapy, reiki, reflexology, occupational therapy and physiotherapy. Fit Start was introduced and used the local leisure centre to help people maintain or regain fitness levels. The registered manager explained this was an activity that had recently been introduced and had become very popular. Many paintings around the service had been completed by people who used the service. People were able to try and use the therapies they preferred and when they wished to have them.

People's care and support was planned in partnership with them. People said "Yes I discussed my needs and was involved in the development of the care plan" and "To begin with they have to do it in their own way. I'm not used to having someone help me like this. But they involve me". Staff sat with people and spent time encouraging them to explain what their expectations were, to ask questions, discuss their options and to reflect upon the information received. Prior to people entering the service, an initial assessment was completed, which included information such as their previous medical history and current medical issues. General information around NOK, other professional's involved and religious preferences was also included.

We looked at three care plans and associated documents which were all up to date. Care plans covered a wide range of information including personal care, moving and handling, management of pressure areas and pain management. Do Not Attempt Resuscitation (DNAR) authorisations were in place for some people. However, in one instance we saw one in place for one person, that the DNAR had not yet been discussed with the individual. Their care notes stated "Not discussed on admission, assume that they are for resuscitation until I have the discussion with them". We spoke to one of the nurses regarding this who said that the person had "Been too sleepy to discuss this with." Information around the support that people required was included in the care plans. For example "Requires the assistance of one", "[Name] appeared anxious on admission, and the goal was "To relieve anxiety and promote acceptance" and "[Name] can be incontinent of urine. Encourage two litres of fluid and consider if depression or over-sedation could be contributing to incontinence." Care records were reviewed every few days.

Care plans contained information on the management of pressure areas and in one example we saw this included the mattress type required and gave specific information on the location of skin issues. Daily notes

evidenced that pressure area care had been given as appropriate. One person's pain management plan contained information on the location of the pain and a score on how severe the pain was. Daily notes contained evidence that pain relief was given. Daily notes contained information on the support that had been provided each day with regard to nutrition, pain and mental capacity for example "Patient has full capacity for care decisions" which was recorded on a regular basis. Other records included dietary and fluid intake.

Following discharge from the in-patient unit, people were visited by social workers who worked within the service. They completed a review to ensure that sufficient support networks were in place. One person told us "The social worker has been working with me to make sure everything at home works". The registered manager explained that there were good links with the local community to ensure that good co-ordinated care was provided to people. This included links with people's GP, community nurses and MacMillan nurses.

Staff told us that team meetings and handover sessions were constructive and useful. They commented "Yes we have staff meetings. We discuss upcoming changes, for example the changes to the computer systems. It gives us opportunities to bring up issues, like the night staff informed management that the door wasn't locking properly so they fixed it", "We have a taped handover from night staff. We listen to it whilst they're still on the ward and then ask questions if we have any. The senior person will also discuss plans for the day. We're given specific rooms, but also assist each other", "Yes they're effective", "We have taped handovers and verbal follow ups" and "Changes in people's needs are well communicated. Senior nurse liaises with Doctor in the morning and gives us an update."

A comments and complaints policy was on display in the foyer and there were forms available to fill out. We saw that two complaints had been received by the registered manager over the last year and documentation showed that the complaints were dealt with in a timely manner and to the satisfaction of the complainant. The registered manager explained that when verbal concerns were raised these were dealt with at the time and that people were offered the option of a "formal" complaint process to be undertaken.

Good

Is the service well-led?

Our findings

A registered manager was in post that had been registered with the Care Quality Commission (CQC) for three months. The registered manager was supported by the registered provider, another registered manager, nurses, care workers, other professionals and volunteers.

There was an open and positive culture within the service which focussed on people who used the service. People told us the service was "Excellent" and "Well run". Our observations over the two days of inspection clearly indicated that staff were highly motivated, kind, friendly and supportive. One staff member explained that the staff were encouraged to share ideas that they had suggested about "Having baby changing facilities in the visitor's toilets as we had a lot of people with young children." These were introduced following this.

Team work and communication between staff was good, as was communication with people and their visitors. Staff said that the management team were approachable and other comments included "Management are visible. We're well supported by supervision and informal meetings", "The team look after each other", "This is a nice place to work. Good team work". Other comments included "The management are approachable and open to suggestions, for example, through appraisals, team meetings or informal discussion" and "Management are approachable, good and supportive. Emotional support is there if you need it". One of the management team said "All staff know that I have an open door. I work alongside the team on the ward so I have a good relationship with them. I have regular meetings with the registered manager once a month, quarterly clinical meetings, quarterly team meetings. We disseminate information through staff meetings and make minutes available".

The registered manager told us the extensive use of volunteers played a major role in bringing the community into the service. This included those who worked directly within the service and also the people who regularly volunteered their services in the charity shops and other fund raising events within the community.

The registered manager was open and transparent. They regularly notified CQC of significant events that affect people or the service. These are incidents that a service has to report and include deaths and injuries. We saw the notifications had been received shortly after the incidents occurred which meant that we had been notified in a timely manner.

The service worked in partnership with other organisations to ensure they provided a high quality service. They worked in collaboration with Clinical Commissioning Groups (CCGs), Local Authority services, End of Life Partnership (EoLP), The Dementia End of Life Practice Development Team and the Cheshire Living Well, Dying Well Programme. Working with the EoLP the service had developed a care plan for End of Life in response to the review of the Liverpool Care Pathway. This was put in place to provide high quality, compassionate care for the dying person and those important to them and is the system used at St Luke's.

The registered provider was working towards gaining access to NHS secure e-mail, which was being

completed in line with information governance legislation. This was part of the process for implementing a new system to enable information sharing with other professionals, for example GPs, physiotherapists and Macmillan nurses. We saw minutes from the 'Patient care and clinical governance working group' with discussion around ensuring that this is in place. Action from meeting was for the management team to visit GP surgeries "To allay concerns around this and information sharing agreements".

The registered provider had an emergency and business continuity plan in place. This showed what to do if there was a serious incident such as a loss of premises, computer system or electricity, gas or mains water. Also included was what to do in the event of a fire. The Director of Care was noted as responsible for co-ordinating any response needed under the plan and internal and external key contacts were included in the plan. A business impact analysis had been completed which detailed the likelihood of risk and options available dependant on level of risk.

A relative's questionnaire was completed in August 2014 and an analysis of the information had been completed. Comments included "The nursing care was exceptional", "The staff were very kind and supportive as we came through a sad and difficult time" and "We as a family really appreciated the hard work of all the staff". The conclusion of the analysis was "The feedback on care given to the dying patient and their family continues to be good". The service was in the process of sending out feedback forms to relatives of people who had died within the service.