Pulse Healthcare Limited

Pulse - Leeds

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

Our inspection took place on 10 and 11 August 2016 and was announced. At our last inspection in January 2014 we found the provider was meeting all the standards we looked at.

Pulse Community Healthcare Associate provides social care and health support services to people in their own homes. Pulse Leeds works with a variety of organisations to provide bespoke 'care packages'. The agency provides care and support to a wide range of people including people who are elderly, people diagnosed with dementia and people with learning or physical disabilities. At the time of our inspection there were 17 people using the service.

There was a registered manager in post at the time of our inspection. 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.

Risks associated with people's care and support were well assessed, and documented in detail to ensure staff worked with people in ways which minimised those risks. The provider ensured staff were knowledgeable about the risks of abuse and had policies, practices and training in place to ensure staff understood their responsibilities under safeguarding.

We saw accidents and incidents were reported to the office and logged on an electronic system. We were able to see what actions had been taken in response to these reports.

Recruitment of staff was safe. The provider undertook thorough background checks of applicants and kept records of applications and interviews used to assess their suitability for the role.

Medicines were well managed, and where errors in recording had occurred we were able to see documents which showed the registered manager had taken action to prevent the error re- occurring.

Staff received a thorough induction which included checks on their competencies with a variety of procedures before they began providing care and support unsupervised. We saw there was a programme of training in place which included mandatory training which was regularly refreshed. Staff also received training specific to the needs of people they supported. A programme of regular supervision meetings and annual appraisals was in place.

People gave consent for their care and treatment, and there were appropriate systems in place to ensure that people who lacked capacity to make decisions were appropriately supported with best interests' decisions and reference to the Court of Protection.

The provider asked at interview about potential staff member's approach to maintaining people's privacy

and dignity, and we received feedback from people to confirm staff worked in ways which ensured peoples' dignity and independence were respected.

People were involved in writing their care plans, which were written in a person-centred way and contained guidance for staff to enable them to deliver care and support in the ways the person preferred. Care plans were reviewed regularly with people to ensure they always represented up to date care and support needs.

We saw the provider had robust systems in place to ensure any complaints or concerns were recorded and investigated.

Feedback about leadership in the service was positive, and we saw there was a high level of provider support for the registered manager. Quality in the service was measured at provider level, with the registered manager receiving reports and action plans as required.

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.

Risks associated with care and support were identified and guidance put in place to help staff minimise the risk of harm.

The provider had policies and practices in place to ensure recruitment of staff was safe.

Medicines were managed safely. We saw the registered manager had taken action in relation to one error we found in the records of medicines administration.

Is the service effective?

Good

The service was effective.

Staff received a thorough induction and had access to a comprehensive range of training to ensure they were effective in their roles. Their competency was checked regularly.

Staff had regular supervision meetings with line managers and an annual appraisal.

The provider was working within the Mental Capacity Act 2005. People were asked to give consent to care and support, and there were appropriate processes in place for people who lacked capacity to make decisions.

Is the service caring?

Good

The service was caring.

People told us staff were caring and worked with people in ways which respected their privacy, dignity and independence.

Care plans were person-centred and written with input from people to ensure they captured peoples' preferences, likes and dislikes.

Is the service responsive?

Good

The service was responsive.

Care plans were regularly reviewed to ensure they reflected people's up to date care and support needs. The frequency of review was flexible and in proportion to the complexity of the care and support people needed.

People were supported to maintain their social lives.

There were procedures in place to ensure complaints were investigated and resolved.

Is the service well-led?

Good

The service was well-led.

We received positive feedback about leadership in the service. Staff told us there had been a number of positive changes made by the registered manager and the provider.

Quality monitoring was carried out regularly by the provider.

Staff were kept up to date with changes to policies and procedures.

Pulse - Leeds

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.

Our inspection took place on 10 and 11 August 2016 and was announced. We gave the provider 48 hours' notice as they provide services to people in their own homes and we needed to be sure someone would be in the office to speak with us.

The inspection team consisted of one adult social care inspector. Before the inspection we reviewed the information we held about the service including previous inspection reports and notifications sent to the CQC by and about the service. In addition we contacted Healthwatch and local authorities who commission services from the provider to ask whether they had any feedback to share with us. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not provide any information of concern.

We sent a provider information request (PIR) before this inspection. 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 reviewed what the provider had told us before the inspection.

During the inspection we looked at records relating to the running of the service and provision of care. We looked in detail at two people's care plans and records relating to their medicines. We also spoke with the registered manager, the provider's quality assurance manager, two nurses, two case managers, two members of care staff, one person who used the service and one person's relative.

Good

Is the service safe?

Our findings

In the PIR the provider told us, 'We risk asses our clients in order of their condition and grade this. Level 1 - complex airway management, level 2 - some clinical input, level 3 - no clinical input.
All level one clients receive a daily call to ensure that there are no issues within their package.'

We looked in detail at two people's care plans and saw risk was assessed across a number of areas such as moving and handling, behaviours that challenge, social choices and support of people whilst driving. Risk assessments were recorded onto an electronic system which then prompted the person completing the record to complete a care plan to show how to deliver care and support in ways which minimised the associated risks. We saw the guidance for staff was detailed and individual to each person. In addition we saw there were risk assessments in place to cover the person's home environment including fire safety and boiler testing. This was appropriate as staff spent long periods with the people they supported.

People using the service were further protected because the provider had a safeguarding policy in place and ensured staff received training in safeguarding. Staff were able to access the policy electronically at any time and the staff handbook also contained information about protection of people from abuse. Staff we spoke with were able to tell us about their responsibilities to report any concerns and said they believed the registered manager would act appropriately on what they were told. One member of staff said, "We ensure people are safe and we are safe."

In addition to the safeguarding policy there was a scheme called 'Boomerang' which encouraged staff to alert the provider to any concerns they did not want to raise with senior staff in Pulse Healthcare Leeds. Staff we spoke with said they had heard of this but had not used it, however we saw one incident which had been identified through this system and saw appropriate action had been taken to investigate and respond to the staff concerns.

There was an electronic system in place for the recording and management of accidents and incidents. We looked at the records stored in this and saw incidents were categorised to assist in analysis and full records of actions taken were added. Categories included 'inappropriate behaviour', 'equipment incident', 'medication' and 'clinical'. We were able to see regular updates added to this system and concluded there was a good culture of reporting and investigating incidents that occurred.

In the PIR the provider told us, 'We have a stringent recruitment process, all staff must have at least 6 months experience within the field of care & are referenced up to 2 years, with no gaps in work history without explanation, full enhanced DBS, competency based interview.'

We looked at the recruitment records of four members of staff. We saw these contained records of interviews and written tests used to assess their suitability for their role. In addition the provider had undertaken background checks including employment references and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about people who may be barred from working with vulnerable people, and making checks with them helps employers make safer recruitment decisions.

We looked at four people's Medicines Administration Records (MARs). MARs were returned to the office from people's homes each month for checking and filing. We saw three were fully completed with no gaps and explanations for any entries relating to failure to administer medicines, for example when the person had been sleeping or had refused to take them. MARs were completed with guidance as to when or how often medicines were to be taken, and included entries for as-and-when medicines, also known as PRNs. These include pain relief medicines. One MAR was not completed correctly. There were gaps in the signatures for administration and guidance to identify PRN medicines was not completed. We raised this with the registered manager during the inspection. They showed us correspondence sent to staff alerting them to these omissions. They told us they were in the process of reviewing MARs to ensure mistakes were not repeated.

Good

Is the service effective?

Our findings

In the PIR the provider told us, 'Workers complete mandatory training & specialist training which is delivered by our in house clinical team in which they undergo a test at the end of the training, they get a pass or fail in the relevant interventions for the client's needs & they have a period of shadowing before they are assessed and deemed competent by the registered nurse before working independently. All competencies are reassessed on an annual basis or sooner if required. Supervisions are completed with our workers on a regular basis to monitor their progress and they can also raise any concerns they may have and identify any training needs for their professional development.'

We saw records which showed new staff received a thorough induction which included classroom training in a number of areas including safeguarding, moving and handling and various procedures relating to the needs of people who used the service. In addition all staff had a period of shadowing more experienced staff, during which time their competence to provide care and support was assessed. People who used the service were asked for their comments on whether they felt confident with the member of staff. A nurse who undertook competency assessments told us, "If someone is not ready to be signed off then we would arrange for the new member of staff to be retrained. How long this takes depends on the complexity of the care being given, for example to sign off competency for a tracheostomy vent change we would look to see three faultless changes, and this would take three months."

Staff we spoke with told us they had access to a broad range of mandatory and client-specific training to help them to be effective in their roles. One member of staff told us, "We have a lot of training, and there are no barriers to asking for more training when you identify you need it. The budget is there." Another member of staff told us, "We have all our mandatory training and we are checked yearly on this. We definitely get the training we need." We saw there was an electronic system in place to alert the registered manager to training that was due to be refreshed. When training or competency checks were out of date we saw the system prevented case managers from allocating staff to calls, meaning staff did not provide care and support unless their training was up to date.

Staff told us they received further support through a programme of supervision meetings and an annual appraisal. One member of staff told us "I have a supervision every three months and a yearly appraisal. I can raise anything and I know it will get completed." Records of supervisions showed a standard agenda was followed which included a review of current objectives and progress, support needed, learning and development and a reflection on what Pulse Healthcare Leeds could do better.

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 told us they received training in the MCA, and we saw evidence this was the case. The registered

manager and staff we spoke with told us people were assumed to have capacity to make decisions unless they were told otherwise. We saw people signed consent to their care and treatment. In one care plan we saw the person had been assessed as lacking capacity to sign consent, and we were able to see documents which showed a best interest decision had been made involving social and health care professionals and the Court of Protection.

Good

Is the service caring?

Our findings

In the PIR the provider told us, 'We ensure that our clients, family and friends are included in the design of their care package to ensure that its person centred and caters to all of their social and clinical needs. We ensure that all carers and internal staff members all have compassion and caring attitude.'

Feedback about the staff told us they were caring and encouraged people to be as independent as possible. We were told they were respectful of people's privacy and dignity and involved people and their relatives in the planning and organisation of their care and support. One member of staff told us, "I know people I support very well. One person I support smiles as soon as I come into the room, they like me to talk to them as soon as I come into the room."

We found staff at all levels were knowledgeable about people who used the service, their individual characters and specific support needs. All staff spoke about people with fondness and respect.

Interview records in staff files showed that candidates were asked about how they would ensure people's privacy and dignity were respected and maintained. Staff told us about how they ensured people's dignity and human rights were respected and promoted. One member of staff said, "We make sure people know we are doing personal care. We shut doors and curtains and cover people up." Another member of staff told us, "We encourage people to do things for themselves, asking them all the time to do things for themselves. It's about knowing the person and what they can do."

People had copies of their care plans at home, meaning they could check what was written in them, and feedback from people confirmed they and their relatives were involved in planning their care and support. A member of staff told us, "People are involved in making changes to their care plans with the nurses." Copies of care plans were stored electronically, which senior staff could access from the office or on tablet computers. The files were password protected which protected the confidentiality of people who used the service.

Care plans contained information about people's likes, dislikes and preferences for care, meaning staff had access to information to enable them to provide personalised care. Documents were completed in the first person, meaning content was written using phrases such as, 'How I would like my care to be provided,' and 'Times I would like my care to be provided.' This showed the provider recognised the important of person-centred care.

Good

Is the service responsive?

Our findings

In the PIR the provider told us, 'Once the package of care commences we complete an initial telephone review within 48 hours and a face to face social review within the first week. We complete clinical reviews either fortnightly or monthly depending on the client's needs and
social reviews every four weeks. A full review of the Service User Care Plan & Risk Assessment will take place every 12 months as a minimum.'

Care plans were generated on an electronic system which prompted staff to completed risk assessments, care plans and guidance for staff in response to information entered about people's care and support needs. This meant care plans were bespoke to each person and contained comprehensive information to enable staff to understand what each person's needs were and how these would be met. One member of staff told us about the information they had access to when in someone's home. They said, "All the policies and procedures, emergency information and care plans, which tell you everything about their needs."

We saw evidence care plans were kept under regular review, with the frequency dependent on the level of complexity in their care. All care plans were reviewed monthly with people and their relatives by the case manager. Where people had complex care needs a nurse employed in the service reviewed the plans fortnightly. Reviews checked whether care and support plans reflected people's current needs and preferences, checked whether any equipment used was functioning properly and were also used to assess staff competencies when these were due. Detailed records of reviews were kept and we saw changes were made to care plans when necessary. People we spoke with told us they felt they were kept involved in the reviews of their care plans.

People's social needs were understood and support plans were in place to ensure people were able to maintain their preferred lifestyles and social interests. Care plans contained information which showed how staff would support people to achieve their social aims, including risk assessments and guidance for use of equipment. For example, one person's care plan contained guidance for staff who drove a person's vehicle to enable them to see friends. This included risk assessments and instructions for making sure the person was secure in their wheelchair when using their vehicle and risk assessments for staff who were driving.

In the PIR the provider told us, 'All incidents and complaints are logged onto Datix which is managed by our complaints and incidents team, who provide feedback and trends on both local and business wide incidents and complaints. Document reviews are also undertaken following any incident or complaint.'

The provider had policies and procedures in place to ensure complaints were well managed. Any issues raised with the service were recorded in the provider's online system, which enabled a centralised complaints team to manage any investigation and responses to people. This ensured a consistency of approach. We looked at records of complaints relating to Pulse Healthcare Leeds and saw there was detailed information about the issue and clear recording of actions taken to investigate and resolve the concerns. Both the registered manager and the quality assurance manager were knowledgeable about issues which had been raised and what had been done in response.

Good

Is the service well-led?

Our findings

In the PIR the provider told us, 'Our Clinical governance team, who are managed by the clinical director, provide support on serious incidents, aid with trend analysis, Audit PCH every 3 months unannounced & manage all policies and procedures. Documentation is reviewed during spot checks, reviews and then audited when it is returned to the office, any errors or incorrect forms of documentation are identified and workers retrained. Our Quality assurance team send out our customer satisfaction survey Bi annually, this information is collated and fed back to the office and the results are published and issued to our clients outlining improvements we are implementing from their feedback.

There was a registered manager in post on the day of our inspection. We received consistently positive feedback about their leadership, with comments including, "She wants us to be the best", "Things used to be a bit chaotic but she has improved that" and "She is supportive and approachable." Staff we spoke with also told us the provider maintained a visible presence in the service, referring to regular visits by the regional manager and quality assurance manager. Staff told us they felt they worked for a well-run service. Staff referred to a number of positive changes at provider level which they felt had helped improve quality in the service. One staff member told us, "There was a lot of change including a new person at the top. There was a lot of positive change as a result, they came and spoke to people individually and told us about their vision for the service. It got people excited, and it is really embedded in what we do."

Quality monitoring was undertaken by the provider's quality assurance manager and team, who undertook checks within the service and analysed findings to enable any emerging trends to be identified. Checks included reviews of accidents and incidents and complaints and concerns raised by people who used the service. We saw the audits were carried out regularly and action plans were sent to the registered manager as required.

Staff working in the office told us they had meetings each week to discuss issues in the service, however the registered manager was candid about the challenges in bringing care staff together. The service covered a large geographical area and staff were often with people who used the service for several hours each day. Staff told us they were kept in touch with urgent matters by phone or email, and we saw the supervision process was also used as a communication tool to ensure staff were up to date. For example, we saw staff were told about changes to policies and procedures as part of the supervision process. One member of staff told us, "I am really well supported in my role. They contact me all the time to check I am ok."

The registered manager told us they had good support from the provider. They told us the regional manager visited the service regularly and carried out a conference call weekly to enable registered managers to discuss issues within their services and share insights and learnings. In addition the registered manager attended regular managers meetings. We saw meeting minutes which showed a range of issues were discussed and action plans produced as needed.

The provider undertook a survey with people who used their services, however results were collated and communicated to people for all the services; there was no data available to the registered manager or

people who used Pulse Healthcare Leeds that was specific to their service. The registered manager told us, "We are in very regular contact with people who use the service, especially when their care packages are reviewed. People will tell is if they are happy or not, this is our best way of understanding how we are doing."