Pulse Healthcare Limited

Pulse - Liverpool

Inspection report

Unit F2
Cables Business Park
Prescot
Liverpool
L34 1PB

Date of inspection visit:
19 September 2016

Date of publication:
23 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 19 September 2016.

Pulse Liverpool is registered to provide personal care to adults and children in their own homes. There were 10 people using the service at the time of this inspection. Each person was in receipt of a bespoke care package which involved a team of staff delivering care and support in people's homes and within the community. The service is based in an office on the first floor of a building. The office is accessible via a passenger lift and accessible toilet facilities are available.

There was 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.

We carried out an unannounced comprehensive inspection of this service on 18 August 2015. After that inspection we received concerns in relation to how people's care was planned for and delivered. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those/this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pulse Liverpool on our website at www.cqc.org.uk"

Systems were in place to regularly audit people's care plans and the quality of service people received. We have made a recommendation in this report that the registered provider further develops this process to include the quality of the records maintained. This is because we found that the content and language in some daily record entries needed improvement.

People's needs were assessed and planned for. Each person had their own care planning documents that detailed what support they required and how staff were to deliver the support. Care planning information was reviewed on a regular basis to ensure that up to date information about a person's needs was available at all times.

Where potential risks had been identified, assessment of these risks took place and wherever possible, action was taken to minimise the risk from occurring. Action plans had been developed to help ensure that in the event of an emergency, for example a power cut, people's needs could be safely met.

People were supported by a team of staff who had received specific training for their role. This enabled people's care and support to be delivered safely.

Regular multi-disciplinary meeting took place between the service and other healthcare professionals and agencies involved in people's care. This helped ensure that important information about people's needs was shared.

Policies and procedures were in place to offer guidance and support to the staff team. This meant that staff knew how to support people in a safe, respectful manner.

The registered manager liaised on a regular basis with other healthcare professionals to ensure that people received the care and support they 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.

Care plans were in place to enable staff to deliver people's care and support safely.

Identified risks were reviewed and minimised whenever possible.

People were supported by a staff team who had received training for their role.

Is the service well-led?

Good

The service was well-led.

Regular reviews of people's care and support needs took place.

The registered manager liaised with other agencies to help ensure that up to date information about people's needs was available.

Policies and procedures were in place to offer guidance and support on delivering safe care.

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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 and to look at the overall quality of the service.

We inspected the service against two of the five questions we ask about services: is the service safe and well-led. This is because we had received some concerns about how people care and support was planned and delivered. Where concerns had been raised in relation to safeguarding people, these concerns had been forwarded to the local authority, the lead agency in managing safeguarding concerns. At the time of this visit these concerns were in the process of being investigated.

The inspection was carried out by two adult social care inspectors.

Prior to the inspection, we reviewed any information and notifications that we had received about the service. During our visit to the service we looked at a number of documents, policies and procedures in relation to the safe planning of people's care and support. This included three people's care planning documents and associated records. This information was brought to the office. The registered manager was not working within the service on the day that we visited. However, the area manager and two other staff supported us with our inspection.

Good

Is the service safe?

Our findings

We looked at care planning documents to establish how people's needs were assessed and planned for in a safe way.

People's individual needs, in relation to their care and support requirements, had been assessed and planned for. Each individual had a care plan detailing these needs. People's care plans contained information as to what actions and tasks staff needed to carry out for people in order to meet their personal needs and wishes safely. In relation to people's medical needs, healthcare professionals had carried out individual assessments and care plans had been developed to ensure that staff had sufficient information to deliver the care and support required safely. For example, we saw that comprehensive and clearly written care plans were in place for the use of a nebuliser, the use of a catheter and tracheostomy care.

Identified risks to people had been assessed and planned for to minimise any risk of harm wherever possible. For example, risk assessments and care plans had been developed in relation to moving and handling, nutrition and skin pressure care. The completion of these assessment helped identify specific instances where a person could be at risk from harm.

Action plans had been developed to enable people to be kept safe in the event of an emergency. For example, in the event of a person requiring oral suction, in the event of a power cut where people were reliant on power for their safe delivery of care or and when people were out and about in the community. These plans gave clear instruction as to whom staff needed to contact and what action they needed to take to ensure that people were kept safe.

Records were maintained of all care, support and medical interventions provided by staff. The frequency of these records varied depending on the needs of the individual. For example, for one person required hourly records to be maintained in relation to their health, safety and wellbeing. When required, specific guidance had been developed for staff as to when records needed to be completed. This guidance helped ensure that records were maintained in line with people's agreed care and support plans.

Care and support plans for people were reviewed on a regular basis to ensure that individuals' continued to receive safe, effective care. A clear system was in place to ensure that a review of people's care took place when needed. Within the first week of a person using the service a social care review took place to ensure that people were receiving the care and support they required to keep safe. Following this, further reviews took place on a monthly basis, or more frequently if a person's needs and wishes changed. In addition to these care reviews, when required a nurse reviewed people's medical needs on a regular basis. These reviews meant that that people's medical needs were being met safely. In the event of a person's planned care plans changing, the registered manager informed the staff team in writing. Staff were then required to sign that they had read the updated care plan. This system helped ensure that all staff were aware of any changes to people's care needs.

Each person who used the service was supported by a team of staff recruited specifically to support them.

Records demonstrated that staff had received training specific to the needs of the person to help ensure that all care and support was delivered safely. For example, the staff team had received training that included medication, epilepsy, tracheostomy care, and the use of suctioning and nebuliser equipment.

Good

Is the service well-led?

Our findings

People's support requirements, records and reviews were managed by case managers based at the service's office. It was also the responsibility of the case managers to liaise with other agencies involved in ensuring people needs and wishes were met. At the time of this inspection the service had a vacancy for one case manager.
People's care planning documents demonstrated that regular multi-disciplinary meetings (MDT) took place with social workers, professionals who manage people's funds, healthcare professionals and other agencies involved to providing and monitoring people's care and support. These records contained detailed information of the content and outcomes of meetings held. Where actions were needed, a clear record of who was responsible for carrying out the actions was recorded. Regular staff meetings took place to ensure that changes to people's needs were shared with their staff team. Minutes of these meeting were readily available at the office.

An electronic system was in place to record all incident, accidents and changes to people's care and support needs. These records contained the name of the person, the nature of the incident, detailed information about the situation and any action taken. In addition, information relating to discussions with other healthcare professionals in relation to people's care, support and equipment updates were recorded. Once a record had been completed the electronic file was updated instantly. This system helped ensure that information was recorded in a timely manner. Guidance was available to staff that clearly stated whose responsibility it was to report any concerns or changes to a person's needs.

Records of decisions made on behalf of people, for example, by the Court of Protection, were readily available to ensure that people rights under the relevant legislation such as the Mental Capacity Act 2005 were protected.

The registered provider had a system in place to regularly review people's care planning documents. However, the reviewing process had failed on occasion to identify concerns in how people's information was recorded in daily records and what could be done to improve this. For example, when referring to changes in people's behaviour, the language used was not always appropriate.

We recommend that the registered provider further develops their reviewing process to consider the content of daily records.

Policies and procedures were place to support staff in carrying out their role. For example, procedures offered clear guidance to staff in relation to delivering care and support in a safe manner and protecting the personal information and documents of the people they supported. This information was available to all staff electronically and at the office.