Pulse Healthcare Limited

Pulse - London

Inspection report

The Podium, Room 202
1 Eversholt Street
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10 August 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection took place on 9 and 10 August 2016. This was an announced inspection and the provider was given 48 hours' notice. This was to ensure that someone would be available during the inspection to provide us with the necessary information.

This was the first inspection of the service since it registered with the CQC in December 2014.

Pulse – London is a domiciliary care agency based in central London which provides home based care for people with complex care needs. The service provides up to 24 hour support depending on the assessed needs of people using the service. At the time of the inspection, there were 19 people using the service. Although based in central London, Pulse – London provide care for clients in London and surrounding counties such as Kent, Berkshire, Sussex and Surrey.

There was no 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. A senior regional manager was managing the location on an interim basis and was based at the location three to four days per week. The senior regional manager told us that the registered manager
position is being actively recruited for; however, they have not yet found a suitable candidate.

Medicines were not always managed safely and effectively. We found the administration of medicines was not always recorded accurately. Some Medicines Administration Records (MAR) were not transcribed correctly or counter signed to ensure accuracy. The provider did not record the administration of medicines from a blister pack on a MAR chart.

There was a complaints procedure in place which was displayed for people and relatives. Complaints were logged, investigated and resulting actions and learning points were monitored for trends. However, people and relatives told us that complaints made in relation to staffing and rotas had not been addressed and they had little confidence in the service as a result.

People and relatives told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. All staff had completed training in safeguarding adults and demonstrated an understanding of types of abuse to look out for and how to raise safeguarding concerns. People spoke positively about their core team of carers. However, people and relatives had little confidence in the provider to communicate staff changes and provide rota's in a timely manner.

Detailed current risk assessments were in place for people using the service. Risk assessments in place were

reviewed and updated regularly. The risk assessments explained the signs to look for when assessing the situation and the least restrictive ways of mitigating the risk based on the individual needs of the person.

We saw evidence of a comprehensive staff induction and on-going training programme. Staff were recruited with necessary pre-employment checks carried out. Staff had regular supervisions and annual appraisals.

Staff had received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff understood what to do if they had concerns about people's mental capacity to make certain decisions. These safeguards are there to make sure that people who receive support are looked after in a way that does not inappropriately restrict their freedom. Services should only deprive someone of their liberty when it is in the best interests of the person and there is no other way to look after them, and it should be done in a safe and correct way.

People were supported to maintain good health and had access to healthcare services. Referrals to appropriate healthcare professionals were made promptly when concerns were raised as regards people's health.

Staff regularly met with people and their carers to ensure the service was meeting their needs and they were providing a good service.

There was an incident and accident procedure in place which staff knew and understood. There was evidence of learning and improvements as a result of incidents. There was evidence of audits on medicines and overall compliance.

People and relatives told us that staff were caring and respected their dignity and privacy. People were supported to be independent and access the community, where possible.

Assessments of people's care needs were carried out before the service provided personal care to ensure if people's needs could be met. Care plans had been developed which were person-centred and had sufficient detail to guide staff providing care to people. Staff understood people's needs. People and their relatives expressed satisfaction with the care provided.

The provider had quality assurance processes and procedures in place to monitor the quality and safety of people's care.

At this inspection we identified a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Medicines were not always managed safely and effectively.

Risks to people who use the service were identified and managed effectively.

There were sufficient staff to ensure that people's needs were met although people raised concerns as regards communication of staff changes and rotas. There was a robust recruitment procedure in place.

Staff were aware of different types of abuse and what steps they would take if they had safeguarding concerns.

Is the service effective?

Good

The service was effective. Staff had access to regular training, supervisions and appraisals which supported them to carry out their role.

People were given the assistance they required to access healthcare services and maintain good health.

Staff understood the Mental Capacity Act 2005 and principles of the code of practice were being followed.

Is the service caring?

Good

The service was caring. People and relatives told us they had good relationships with their core group of carers.

People and relatives told us their privacy and dignity was respected.

People were encouraged to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive. Complaints were logged and investigated, however people and relatives told us that their complaints were not always addressed or if improvements had been made.

Care plans were person centred and reviewed regularly by a registered nurse. Support was planned in line with people's care needs.

The service requested feedback from people and relatives, however feedback obtained in December 2015 had not been analysed.

Is the service well-led?

Good

The service was well led. There was no registered manager in post. A senior area manager was managing the service on an interim basis whilst a registered manager was being recruited. Staff told us that they were confident in the current management structure in place and felt supported.

We received mixed comments from people and relatives regarding the service overall.

The quality of the service was monitored and an action plan was in place to address previously identified service shortfalls and improve the overall service provided.

Pulse - London

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 9 and 10 August 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service.

This inspection was carried out by one inspector, a specialist advisor in nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience supported this inspection by carrying out telephone calls to people who used the service and their relatives.

Before the inspection we reviewed the information we already held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed notifications, and safeguarding alerts. We also contacted five local placing authorities and clinical commissioning groups (CCG) and received feedback from one CCG.

During the inspection we reviewed six people's care records, which included care plans, risk assessments and Medicines Administration Records (MAR). We also looked at staff files, complaints and quality monitoring and audit information.

We spoke with three people using the service and eight relatives. With permission, we visited the homes of two people using the service. We also spoke with a clinical director, a senior regional manager, a compliance manager, a group quality manager, a senior case manager, two case managers, a care coordinator team leader, a care co-ordinator, a recruitment administrator, a senior nurse and eight support workers.

Requires Improvement

Is the service safe?

Our findings

We looked at the way medicines were managed in the service. Everyone we spoke with told us they received their medicines when they should do. Medicines were administered by staff who had been trained in the safe handling of medicines and their competency had been assessed. Staff told us what they would do if they had any concerns in relation to medicines management. One member of staff told us, "I would contact my line manager or nurse. If medicines had been given twice or an overdose I would immediately seek advice."

Care plans contained detailed instructions for staff to follow when administering medicines. One care plan guided staff on how to respond when a person refused to take their medicines, by advising staff to offer the person the medicine at three 15 minute intervals and record on the person's Medicine Administration Record (MAR) and call the GP or specialist nurse if the medicine was refused. Care plans also gave detailed instructions for staff when administering medicines through a Percutaneous Endoscopic Gastrostomy (PEG) feeding regime.

We looked at a sample of MAR charts and found inconsistencies in recording. Monthly MAR charts did not include all the dates in the month, only the days of the week which were initialled, for example 'MTWTFSS'. The 'week beginning' date was handwritten across the top of each seven day period. On one MAR chart the date had been entered as Monday being 1 May 2016, when 1 May 2016 was a Sunday. This meant that for the month the MAR chart was in use, the day of the week corresponded with an incorrect date.

We also found inconsistencies with how the service recorded the administration of "as needed" medicines (PRN).' As needed' medicines are medicines that are prescribed to people and given when required. The MAR chart detailing PRN medicines was set out in a column basis working from right to left across the page. We found instances of staff using different columns to record medicine administrations which meant that the dates these medicines were administered were not consecutively recorded.

On one MAR chart reviewed, we found 13 gaps in recording the administration of medicines which was established to be a recording error. There were codes on MAR charts to specify when medicines had not been administered as prescribed, however we found that these codes were not being consistently or correctly used.

Staff were required to transcribe the prescription instructions on the MAR chart which was then countersigned by another staff member as a first quality check. However, we found instances where the second staff member did not countersign the MAR chart which meant that potential errors in transcribing the prescription instructions were not always found in a timely manner.

On another MAR chart we saw that a person had been prescribed a seven day course of an antibiotic. The course ran in to the start of the following month however the dosage instructions had not been transcribed onto the new MAR chart. We saw another instance of where an antibiotic was prescribed, however the start date of the prescribed course of antibiotics was not recorded on the MAR chart.

Where medicines were administered from a blister pack, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. Instead, staff recorded the administration of medicines from blister packs in the person's daily records. MAR charts are the formal record of administration of medicines within the care setting. We discussed this with the senior regional manager who told us that it is the policy of the provider not to record the administration of medicines from a blister pack on a MAR chart as the carer could not be sure what was in the blister pack. We confirmed that the list of medicines contained within the blister pack was listed on the blister pack and saw this was the case when we looked at medicines in the home of a person we visited.

The quality of medicines administration was checked by a registered nurse when carrying out a review. On one occasion, a senior nurse recorded that some medicines which had been prescribed had not been administered and gaps had been noted in MAR charts. The action taken was to raise a Datix (incident) for further follow up and investigation with the person's named nurse and assess whether the staff in question would require a supervision session or further medicines training.

The clinical director told us that as a result of an increase in medicines incidents being reported in March, April and May 2016, the quality and compliance team carried out a review of the medicines administration procedure. As a result, medicines calculations were introduced into medicines training. However, despite the clinical overview of the management of medicines, we could not be confident that all people who required support with their medicines received their medicines as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people using the service and their relatives told us they felt the service provided was safe and they were comfortable with the care workers provided. One relative told us, "I trust them. My [relative] trusts them and is very fond of them. I am quite strict about things, but I can sit back knowing if there are any problems they can call me." Another relative told us, "My [relative] receives very good care. Since he has had the care at home with two carers he has improved leaps and bounds. The carers know him inside out and backwards. They are so good with him. He likes them and they like him. I like them too. They are wonderful. They can cope with every day things. No two days are the same. Every day is variable." Another relative told us, "[My relative] has really good carers. We can trust them and we can rely on them."

However, one relative told us that on one occasion a member of staff attended to provide care who was not qualified to work with a certain piece of care equipment. We discussed this with a care manager who confirmed that the carer sent to the assignment was acting as a second carer and the main carer had been trained and assessed as competent in the safe management of the particular piece of equipment.

There was a safeguarding policy in place. Staff had received training in safeguarding adults. They were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. One staff member told us, "If I have any concerns, I would go to the package manager. Then if not satisfied, I would take it higher to the head office. I also have the right to look outside the organisation; to the CQC."

A relative told us of an incident where a nurse removed a piece of breathing apparatus in error and caused the person to have breathing difficulties. The senior regional manager told us that the nurse in question was an agency nurse who was removed from providing care to the person, the agency was informed and a safeguarding alert was raised. At the time of the inspection, the incident was under investigation.

Where significant incidents had occurred, the service reviewed the incident, identified learning points and completed an action plan to monitor implementation. One action plan completed after a significant incident included action points such as changes to staff training, the staff competency process and completion of an environmental assessment if a worker is found to be sleeping on duty to minimise the risk in future.

We saw that risk was managed effectively. Comprehensive, personalised risk assessments were in place for people which identified risks and guided staff on how to identify and mitigate risks. We saw that risk assessments were in place for the use of specialist equipment such as tracheostomy and Percutaneous Endoscopic Gastrostomy (PEG) feeding regime. Detailed risk assessments were also in place for health conditions such as diabetes, pressure sores and mental health conditions which may pose a risk to the person and the staff supporting that person.

Risk assessments in place also contained procedures for staff to follow in case of an emergency. For example, one assessment provided guidance for staff to follow when the person suffered from a seizure. Seizure charts were in place, which were correctly documented describing the time the seizure commenced, the type of seizure, if medication was administered and the recovery period.

People and relatives told us they were confident that staff reported incidents and were able to respond in an emergency situation. One relative told us, "My [relative] gets one to one care at home and it keeps him out of hospital. It keeps him out of a nursing home. In general the carers are excellent at calling extra help such as a doctor." Another relative told us that staff were "Brilliant" at informing of any incidents.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults and children. Records confirmed that staff members were entitled to work in the UK.

We received mixed comments from people and relatives when asked if there was sufficient staff to meet their care needs. A relative told us, "It is helpful that my [relative] has three main carers as it helps him to get to know them, rather than have a different face every day. It gets confusing if he sees too many faces." However, one person told us, "Generally the carers will tell me when they are coming or going on leave. Pulse is not very good at telling me. I have to chase to ensure that my care is covered. It brings a lot of stress not knowing who is coming. The past month or so I was down to two carers doing all the work because I didn't have a third carer. It was down to other agencies to fill in. Recently, it has got better because I have pushed." A relative told us, "There has not always been sufficient staff. It has taken three and a half years for them to get a third person in. They promised and promised. I told them my [relative] needs continuing care but it has been water off a duck's back when I have complained." Another relative told us, "I never know what the rota will be, or who is coming if someone can't come. Their administrative system leaves a lot to be desired. The carers tell the office in advance when their holidays are but it is not organised. They need to get the rotas firmed up when there are holidays." Another relative told us, "There has been an issue with relief staff. It is difficult having someone stepping in who knows my [relative] well. Pulse would send someone who didn't have a clue and then I would have to stay off work. Pulse has just employed a floater, who has covered for one of my [relative's] carers. She is a good safety net. The main carers are committed and will go out of their way to cover each other."

Staff we spoke to told us that they provided care for a small number of people on a permanent basis. People and relatives told us that they were happy with their core group of carers. We discussed staffing arrangements with the senior regional manager who explained that when care cover is needed, when, for

example staff are on leave or sick, there is a contingency plan in place for all people using the service. The contingency plan is also contained within people's care records. The senior regional manager explained that initially support staff within the person's care team is asked to provide cover. If this is not possible, the care coordination team attempt to source cover from a bank of staff who have been signed off as competent in the areas of care the person requires. The senior regional manager told us that incentives such as increased pay are offered to staff to provide cover. If cover is unable to be sourced from internal staff who have been signed off as competent, the provider engages the services of a nursing agency and a registered nurse is assigned to provide care as an interim measure.

Good

Is the service effective?

Our findings

Most people and their relatives told us they felt that the staff that provided them with care and support had the skills and knowledge that met their needs. A relative told us, "The carers are definitely well trained. You get a feel for knowing that people know what they are doing, such as how to use the PEG. They are very good at assessing my [relative's] needs on a day to day basis. They give him suction if he needs it. I can't speak highly enough of the carers. My only regret is not having heard of Pulse earlier." Another relative told us, "I am pleased with the staff. I can relax and I don't have to worry about [my relative] so much. They understand his needs, totally. They seem to know all about his medical history. From being briefed by the manager they know all about my [relative]." However one person told us, "For 13 weeks Pulse had to find staff from another agency, but the staff are all trained now. But this has just happened the last month. I had been fighting since last September. I would ring every day and send emails. They would say 'we are trying'."

Staff told us they received training to enable them to deliver safe and effective care. They expressed the view that training was a key strength of the service. One staff told us, "I am well trained. I receive training in ventilation, cough assist and PEG" and another staff commented, "Wow! It is like you are doing nursing. Training is very in depth which is a good thing."

Another member of staff told us about their experience of the induction process by saying, "The induction was one of the best trainings I have had. I did three days mandatory training and four days additional training because of the complex care. I had a period of shadowing and then I had a competency assessment." The senior area manager told us that new staff undertook the 'Care Certificate' to further increase their skills and knowledge in how to support people with their care needs. The Care Certificate was introduced in April 2015 and is a standardised approach to training new staff working in health and social care.

Records showed that staff received mandatory training on a yearly basis such as basic life support, moving and handling, safeguarding adults (and children where necessary), medicines management, food hygiene and health and safety. Additional training was also provided to staff who provided care to people with a specific care need or diagnosis. Training records confirmed that staff had received additional training in areas such as tracheostomy, ventilation, cough assist, oral suctioning, PEG feeding, epilepsy, diabetes, stoma and spinal care. The senior regional manager and clinical director told us that training and competency checking was recently reviewed and pass rates for certain training courses had been increased in addition to tighter scrutiny of marks awarded to staff completing training courses.

All staff we spoke with told us they received regular supervisions, spot-checks and annual appraisals. One member of staff told us, "I have a supervision every three months. I am due for my fourth one. It is an opportunity to put our concerns across." Another member of staff told us, "I had a supervision a few weeks ago. I find them quite good. I can go with my concerns and we discuss if there have been any changes with the package."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do when needed. When they lack mental capacity to take particular decisions, any decisions 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 the best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Care plans were created electronically on a bespoke software system called Mobizio. The senior area manager told us that staff completing care plans and reviews carried an iPad with an adapted pen so people could sign their care plans to indicate that they consented to receive care and treatment. We saw electronic signatures in place on care plans where people were physically able to sign to consent for their care. We spoke with a senior case manager and a case manager who told us they have to be firm with relatives and insist if the person has capacity they (where possible) sign their consent forms and care is discussed with the person.

Staff we spoke to demonstrated knowledge of MCA and how it affected the people they provided care for. One staff member when asked about MCA told us, "It is assessing people's capacity to make decisions and if they can't it is to make decisions in their best interests."

People and relatives told that staff asked for consent when providing care. One person told us, "[Staff] make sure I am involved in every decision made." A member of staff told us, "Consent? Yes that's the rule. Before meds and personal care."

The service provided care to people in their own homes. A significant number of clients required assistance with feeding through a PEG tube. We saw detailed instruction in people's care plans on how to prepare feed, the type of feed to be used, the duration of the feed and the flush amount. Staff were trained in how to administer medicines and food via PEG tube. All staff undertook a food hygiene course.

We saw from care records that people's appointments with healthcare professionals such as district nurses, GP's and physiotherapists were recorded and recommendations were communicated to the staff assisting the person, for example, carers assisting the person with breathing exercises and changes made to dressings. Where care was also being provided by an additional service, for example care during the day was provided by one agency and night care by Pulse - London, we saw that carers used a notebook to communicate messages, which also had updates from healthcare professionals. A relative told us, "The carers know [my relative] so well they would know if they thought he was unwell. They could tell by his demeanour or his temperature. They would tell me, or ring me at work or take action themselves."

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. One person told us, "I have three girls. They are very good and very caring. I get on well with them." Comments from relatives included, "They give [my relative] a lot of tender loving care and they listen to him", "It is the way they include [my relative]. They always talk to him and ask him what he wants. They sort him out if he is not comfortable. It is the way they react to him," and "The staff who have been coming recently are caring. They are concerned. They talk to her, asking her if she wants anything. There is a caring atmosphere. The relationships are good." We observed a genuinely caring and mutually respectful relationship between a case manager and a person using the service during the inspection. The case manager engaged the person in a friendly conversation about the person's current health, their family and made arrangements to attend a religious service together.

People and relatives told us that staff respected their privacy and dignity. A relative told us, "When they are toileting [my relative] they hoist [my relative] to the commode. They turn [my relative] so [my relative] is not facing them. They go out when [my relative] is using the toilet. When they are giving [my relative] a bed bath, they cover the parts that aren't being washed. [My relative] would tell them if things weren't right. [My relative] has the capacity to do this." Staff told us they respected people's privacy and dignity. A staff member told us, "When carrying out personal care. It is private and the door is shut. Even though the family is there." A relative told us that the service complied with their request for male carers.

People and relatives told us they were involved in planning the care they received. One person told us, "They make sure I am involved in every decision made." A relative told us, "[My relative's] opinion matters very much to the live-in carer. He goes above his duty of care. He is meticulous where [my relative] is concerned." Care plans were comprehensive and included background information, medical history about the person and each care plan contained information about people's goals. For example, one care plan noted that the person was anxious about starting to receive care and having people in their home. It stated that it was important that the person had a stable care team to reduce their anxieties about care. During the inspection, we spoke with this person who confirmed that they had a regular team of carers and were happy with them.

People and relatives told us they were supported to be independent. One person told us, "The carers are starting to help me get out and about and to do the exercises I need to do. I run a charity from my bed. I am starting to walk again." Information contained in people's care plans reflected the importance of supporting people to be independent. For example, one person's care plan stated that the person was physically able to wash dishes after eating although at times was reluctant to do so and should be encouraged to complete this task themselves.

The provider had an equality and diversity policy and staff received training on equality and diversity. Staff we spoke to understood what equality and diversity meant and how that affected the care they provided for people who use the service. We asked staff about supporting people who identified as lesbian, gay, bi-sexual or transgender. One member of staff told us, "Everyone is the same with their different needs. We respect them for who they are. You just have to get on with it." Another member of staff told us, "Everyone has been

taught about equality and diversity. We had an instance of where a Muslim support worker told us they were unable to support male clients. We get requests for support worker to speak certain languages and we try to accommodate those requests."

Requires Improvement

Is the service responsive?

Our findings

The service had a complaints policy and we saw that complaints were logged and investigated promptly with learning points identified where necessary. We saw that complaints were raised in relation to medicine errors, staff sleeping on duty and incorrectly logging/scheduling visits. The provider's complaints log showed that complaints and incidents were logged from a number of sources; relatives, staff and healthcare professionals. Records showed that complaints were also discussed at a weekly staff meeting. We received a mixed response from people and relatives when we asked them about complaints. Some relatives told us they had never complained. One relative told us, "There are no complaints so far. The staff and manager listen. The manager comes round every two weeks and phones the carer every day." Other relatives told us when they made a complaint, the issue was resolved appropriately. One relative told us, "There were a couple of carers they sent at the beginning that we didn't feel were suitable, but they took that on board and found the two that [my relative] has gelled with."

However some relatives told us they did not feel that the provider had listened to their complaints, especially when the complaints were related to communication around staffing and rotas. A person using the service told us, "My carers are great but from my point of view the organisation is not very good…I have been shouted at down the phone by one of the coordinators when I was asking why I had no care. The office is a nightmare." A relative told us, "I went to the regional manager when I asked what was happening about a third carer, but I don't know what was done about it. My [relative] has been in the same situation for years." A member of staff told us, "Communication with people and relatives does not always happen. Sometimes we are unable to get through and we send text messages as a last resort."

Records showed that complaints and incidents related to logging and scheduling visits were recorded as 'service issues' and actions noted was that they were dealt with in branch and logged as a Datix (incident) for recording purposes only. Therefore we could not be confident that all concerns raised by people and relatives in relation to staffing and rota allocation were investigated and resolved under the providers complaints procedure. Despite the comprehensive complaints monitoring and management system in place, some people and relatives had little confidence in the ability of the provider to adequately communicate with them regarding concerns raised.

We discussed the feedback received with the senior regional manager who advised us that this was an issue management were aware of and had begun to implement an action plan, which was seen during the inspection to address the concerns people and relatives raised around communication, rotas and overall service. Actions identified include increased quality checks made to both people and staff, case managers confirming people and relatives understood how to complain, random checks with staff to ensure they have received their rotas on time, increased contact with staff in general, case managers to contact people and relatives to confirm their preferred method of receiving rotas and improving methods of communicating rotas such as registered post. The senior regional manager told us that their long-term aim is to have rotas accessible via a portal which people and relatives could access on a real-time basis. The action plan was updated on a monthly basis with actions completed and carried over when an action was not completed with reasons why and new target date.

Feedback was obtained from people every six months via an independent survey. The compliance manager told us that they were still assessing the results from the survey which had been completed in December 2015.

We reviewed six people's care plans and found them to be person centred. Care plans were drafted by a care manager assigned to manage the person's package. In addition, care plans related to the clinical aspects of care were drafted by a registered nurse also assigned to manage the person's package from a clinical aspect. Each person had a named point of contact with regards to the clinical and social aspects of their care package. Each person using the service had a number of care plans which was relevant to their medical and social needs. We reviewed the care plan of one person who had a complex condition. There was detailed information contained with the care plan about the condition and the immediate intervention the carer should take in a medical emergency.

Care records included a client information sheet which contained personal details, contact details of professionals involved in their care, medical information and social history. People's likes, dislikes and preferred activities were included within their care plan. Care plans described people's daily routine in detail, including information on what people could do for themselves and what they required assistance with. This helped care workers understand people's individual wishes and provide care that was tailored to their individual requirements.

People's care needs were reviewed on a regular basis dependant on the level of care required. People using the service were categorised as either level one which meant that they had a fortnightly review by a nurse; level two which meant a monthly review took place or level three which meant that the person had a three monthly review as they did not require clinical intervention. Records confirmed that reviews took place on the specified basis and care plans were updated accordingly.

In one person's care plan we found a number of inconsistencies in relation to their condition. We also found that this person was not being supported to take a required amount of fluids each day. This was fed back to the senior area manager who advised that they would look into the concerns we noted.

People told us the service was responsive in accommodating their particular routines and lifestyle. Where appropriate the service helped people maintain links with their local community and enabled access to community facilities, including educational services and activities. A relative told us, "If [my relative] is tired and doesn't want to get up that is okay, but he can go out if he wants to." This meant the service worked with people's wider networks of support and ensured their involvement in activities which were important to them. A member of staff told us about a person, who when they started using the service their vision was very poor and a specialist walking device was developed with pointers for care staff to refer to in the persons care plan. The staff member told us that, as a result, the person can go shopping, go for walks, daytrips and weekends away.

Good

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager with day to day responsibility for the operation of the service. The last registered manager cancelled their registration in respect of Pulse - London in February 2016. Another manager was then employed; however, they left the service in May 2016 prior to completion of their registration with CQC. A senior regional manager was managing the service on an interim basis. The senior regional manager confirmed that they were actively recruiting for the post of registered manager for Pulse – London.

Staff spoke positively of the current managerial oversight of the service by the senior regional manager. One member of staff told us, "[The senior regional manager] is brilliant. She has been with the company a long time and we can call with anything and she will always have an answer." Another member of staff told us, "[Senior regional manager] – I can't praise her enough. She is fantastic even though we are going through a transition at the moment."

We received mixed comments from people and relatives about the service overall. Some relatives spoke positively about the provider and comments included, "They are really professional. Everything goes to plan and fits into place"; "The coordinators are always very pleasant. They are all on first name terms. I like the relaxed atmosphere," and "There have been a few changes. The office was in Kent but that closed and it is now in London. The care industry is not easy. They have coped well with changes. I can always get in touch with a manager." Another relative told us, "They are reasonably well led but [my relative] has never had a care company before to compare. They were good at coming in at short notice."

However, not all relatives we spoke to were complimentary about the service. A relative told us, "I would give Pulse eight out of ten for safety and four out of ten for procedures and admin. It takes the responsibility away from me but I feel like their pharmacist. The case manager comes out once a month but it is like ticking a box. I would think twice about using them again." Another relative told us, "At times there is a little chaos. There is no rota even though I have requested it. The carers write on the calendar when they are coming. My recent request about a rota went unanswered. This is unsatisfactory." We discussed this feedback with the senior regional manager who showed us their action plan to address the concerns raised by people and relatives in relation to communication and rota problems.

Quality assurance systems were in place to monitor the quality of care delivered and staff competency. Following the transition of care records to a new software system earlier this year, the clinical director told us that a review is being undertaken of all care packages by a senior clinician to ensure that all care plans are robust and clinically accurate. Records showed that staff competency was assessed on a regular basis by a registered nurse which was also confirmed with staff we spoke with. Records showed that medicines were checked regularly during reviews and concerns noted were reported as a Datix (incident) which were then analysed by senior management in light of an increase in incidents reported. The clinical director told us that staff were unable to work with people unless they had been signed off as competent in the aspects of care the person required.

The senior regional manager told us that since taking over day to day running of the service in May 2016, she devised an action plan for the service to ensure that immediate improvements were made to certain aspects of the service, such as ensuring staff received regular supervisions and appraisals, ensuring regular staff meetings took place, ensuring all new care plans were quality reviewed and signed off by the senior regional manager and ensuring all incidents and complaints were reviewed on a weekly basis with recommendations from complaints followed up.

Staff attended regular meetings. Every Monday morning office based staff attended a meeting which lasted for approximately two hours. Notes from these meetings seen during the inspection showed that feedback from the weekend on call system, a risk register for people using the service, new referrals, complaints and incidents and competency assessments amongst other topics were discussed. A member of staff told us, "They are really good. We are all involved and every Monday we touch base and any outstanding issues, we work on them through the week."

The service also operated a regular drop-in session for field based staff to attend. This gave staff an opportunity to speak with the senior regional manager and case managers to discuss issues and concerns. The regional manager also told us that incentives for staff performance had also been recently introduced which included a worker of the month award, vouchers, long service awards and a monthly newsletter for staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(g) Medicines were not always managed safely and effectively.