Pulse Healthcare Limited

Pulse London

Inspection report

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Date of inspection visit:
19 February 2018
20 February 2018

Date of publication:
17 May 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Pulse London was first registered with the Care Quality Commission [CQC] in December 2014. The service had changed their address on 3 March 2017. The service is located in central London and provides support to people in London as well as in other counties including Sussex, Kent, Berkshire and Surrey.

Pulse London is a domiciliary care service and a community health care service that provides personal care and support to people living with dementia, learning disabilities and mental health conditions, as well as children and older people with physical disabilities or sensory impairments. At the time of our inspection, the service provided care to 41 people. This was the first inspection of the service at the current location.

During the inspection, we found numerous shortcomings in the quality and safety of the service provided which had not been identified during the provider's own audits. These related to the management of safeguarding concerns, dealing with complaints, mitigation of identified risk to health and wellbeing of people who use the service, record keeping and notifying the CQC about notifiable events.

We noted that prior to our visit the provider had identified a number of other shortcoming and they had begun taking action to remedy the issues found. These were related to the completeness of care plans and medicines administration records.

Identified safeguarding concerns had been investigated internally and actions were taken to help to protect people from harm. However, the provider had not communicated sufficiently about identified safeguarding concerns within the organisation, had not notified external bodies as legally required and had not identified all safeguarding concerns within the service.

The service had assessed risks to health and wellbeing of people who used the service. However, staff were not provided with sufficient guidelines on how to manage and mitigate identified risks. Consequently, people were at risk of receiving care that was not safe.

Staff received training and assessment of their skills. However, we found that the provider's training and assessment process was not always fully followed. Staff did not always have the sufficient level of skills to support people with their complex needs. Staff did not always received supervision and appraisal of their skills to help them to support people in a safe and effective way.

The service had not always dealt with complaints promptly and people told us they were not always satisfied with the outcomes of complaints they had made.

We found that there were improvements made in how the service managed people's medicines. Further improvement were needed in relation to transcribing of medicines onto medicines administration charts (MARs) to ensure people received their medicines as prescribed.

There was mixed feedback on staffing arrangements. The majority of people felt there were enough staff deployed to support them. However, improvements were needed in how the service communicated with people about rotas and changes to staff cover.

The provider followed a safe recruitment procedure, therefore, people were safe from unsuitable staff. There were appropriate systems in pace for recording and management of accidents and incidents. Suitable infection control training and staff practice protected people from avoidable infection.

The service had assessed people's needs and care preferences before they started providing support to people. We saw that gathered information was then used to formulate people's care plans.

People were supported to have a nutritious diet that met their needs, preferences and clinical requirements. Staff supported people to have access to health professionals when needed. People said they trusted staff to help them if immediate and emergency help was required.

Staff sought people's consent before providing care and support. People's mental capacity had been discussed at the time of the initial assessment. At the time of our inspection all people using the service had capacity to make decisions.

People were supported by caring and respectful staff. Staff listened to people and involved people in making decisions and expressing their views about their care. Staff had taken into consideration people's communication needs and preferences when providing support. People's dignity and privacy was respected. People could choose a female or male care worker when receiving personal care.

People's care plans were personalised and included information about health, wellbeing and social aspects of people's life. People's clinical care needs and personal preferences were described in their care plans and staff were provided with guidelines on how to support people.

People's care was reviewed and the frequency of reviews dependent on the complexity of people's needs. People said they felt involved in planning and reviewing of their care.

Staff told us they felt supported by their managers. Operational staff spoke positively about the recent changes within the service and they said these were needed and reassuring.

People were encouraged to voice their views. There were regular satisfaction surveys carried out by the service and people were encouraged to give their feedback bout the care and support provided by the service.

We found five breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 safe.

Safeguarding concerns had not always been communicated effectively within the service organisation and with relevant external organisations. Not all safeguarding concerns had been identified by the service.

Staff were not always provided with sufficient guidelines on how to manage risks to health and wellbeing of people who used the service.

Some improvements were seen in how the service managed and recorded medicines administration. Further improvements were needed in relation to transcribing of medicines on people's medicines administration charts.

There were sufficient staff deployed to ensure that people's needs were met although improvement were still needed in how the service communicated with people about staff changes and rotas.

There was a robust recruitment procedure in place and people were protected from unsuitable staff.

There were systems in place for management of incidents and accidents. Sufficient infection control measures were in place to protect people from avoidable infection.

Is the service effective?

Requires Improvement

The service was not always effective

The provider's training and competencies assessment process had not always been effective and staff did not always have sufficient skills and knowledge to carry on their tasks.

Staff had not always received supervision and appraisal of their skills to help them to carry out their duties effectively.

People's needs and preferences had been assessed prior to receiving support from the service.

Staff supported people to have a nutritious diet that met their needs and have access to healthcare professionals when required.

Staff sought people's consent before providing any care and support.

Is the service caring?

Good

The service was caring.

People received support from kind and respectful staff who knew their needs.

When possible people received support from the same staff which promoted continuity of care and helped to build friendly relationships between staff and people

People were listened to by staff who supported them and encouraged to express their views about their care.

Staff took into consideration people's communication needs and preferences when supporting them.

Staff respected people's privacy and dignity when providing personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service did not always handle complaints promptly and to the satisfaction of people who used the service.

People's care plans were personalised, included information on people's specific care needs and had guidelines for staff on how to provide care to people.

People were aware of their care plans and they felt involved in formulating and reviewing of their care.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were significant shortcomings identified around management of the regulated activities that were not identified in the provider's own audit.

The service had not always communicated effectively with people, front line staff and external healthcare professionals.

The provided had started to take action to address gaps in the service provision which had been identified during the recent internal audits.

There were regular customer satisfaction surveys carried out in which people were encouraged to give feedback about the care and the support 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 checked 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 19 and 20 February 2018 and was announced. We gave the provider 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure someone was available to talk to us during our inspection.

This inspection was carried out by one adult social care inspector, one pharmacist specialist inspector and one Expert by Experience. An Expert by Experience (ExE) is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service. These included notifications of significant events affecting the service that the provider submitted to the CQC as part of their legal responsibility. We also gathered information from a Provider Information Return (PIR). 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.

Prior to our visit our ExE's carried out telephone interviews with seven people who used the service. and one relative who gave us their feedback about the service.

During our visit, we spoke with the group clinical director who was also the nominated individual for the service, the registered manager, the operations manager, one community nurse and two care coordinators.

We looked at records, which included care records for five people, recruitment, supervision and training records for eight staff members. We also looked at other documents relating to the management of the service.

Following the inspection, we contacted and received feedback from five care staff and two external health

professionals.

Requires Improvement

Is the service safe?

Our findings

The systems in place to respond to safeguarding concerns were not always effective. Safeguarding concerns had been recorded on the provider's incident reporting system and the provider's complaints department investigated them. The nominated individual told us that safeguarding matters were discussed in various forums. These included the provider's monthly quality meeting, clinical governance meeting, senior management meetings, staff meetings as well as 1-1 supervisions. Records showed that actions were taken following internal investigations to raised concerns. We communicated with the service about various safeguarding matters prior and post to our inspection. We found that the service's care managers who initiated internal safeguarding referrals were not always aware of outcomes of these investigations. They needed to contact the provider complaints department for information. This indicated the communication about safeguarding matters was not always effective, as the outcomes of investigations were not shared with front line members of the team (including care managers and care staff). Consequently, we were not confident that lessons from investigations were learned to help to protect people in the future.

The service had not always identified and acted on safeguarding concerns. During our inspection, we found two examples of safeguarding matters that had not been recognised by the service. One was related to an incident when a person had not received their medicines as prescribed for over five days. We saw that this error had been recorded on the provider's incident reporting system as an incident but it was not identified as a safeguarding concern. The nominated individual confirmed a safeguarding alert had not been raised following this incident. They agreed appropriate referrals should have been made when the situation occurred. We also found a record of a complaint made to the service about a bruise found on a service user by their relative. This incident had also not been investigated through the provider's safeguarding procedure.

We found that the service had not always worked in partnership with relevant external organisations to ensure full scrutiny of the concerns and to ensure that action had been taken to protect people. On the day of our inspection, we were provided with a list of 13 matters identified by the service as safeguarding concerns. From the records, it was not clear if these concerns had been referred to the host and a commissioning local authority as required. Following our inspection, we requested clarification on this matter. Based on information provided there was no evidence that six of these concerns had been referred to a respective authority. We were told that seven remaining complaints had been referred to the local authority. However, the service could not give us details of communication with these authorities and what action was taken by the authorities in regards to the raised concerns.

The above is evidence of a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the nominated individual contacted us to let us know that the provider was in the process of updating safeguarding processes. This was to ensure that respective local authorities were informed about safeguarding concerns within the service and that the service followed up on the outcomes of the investigations carried out by these authorities.

We saw that the service had not informed the CQC about eight safeguarding concerns as required by legislation. The service was not able to provide us with the rationale as to why the notifications had not been made. We are looking further into this.

People using the service told us they felt safe with staff who supported them. Their comments included, "Yes I feel safe with my carers" and "I have had a live in carer for years and yes I feel safe in their care." There was a safeguarding policy in place. Records confirmed that staff received appropriate training on safeguarding children and adults. Staff we spoke with had a good understanding around the principles of safeguarding and they knew they had to report and safeguarding concerns immediately to their managers or to the Local Authority and CQC.

Risk to peoples' health and wellbeing had been assessed, however, risk control measures for identified risks lacked sufficient guidelines for staff on how to minimise these risks. For example, one person had a risk assessment related to them when using a car. Staff accompanied the person during car trips. At times the person was not feeling well enough to drive. The risk control measures did not give sufficient information on how staff should help the person to reduce the risk of them driving when unfit to do so. It also did not say what staff should do if the person decided to drive regardless. In another example, a person had been identified as at risk of isolation. Risk control measures, and other care documents, stated that the person had an active social life. It was not clear what the actual risk was and how staff should help the person to minimise it.

The majority of risk assessments we saw during the inspection directed staff to other documents. This meant staff did not have an instant access to information on how to keep people safe. One person was at risk from a significant medical condition and we saw a number of risk assessments in the person's file relating this this condition. The control measures in these risk assessments stated that staff should be appropriately trained, act appropriately in case of the attack, refer to a number of care plans and read and understand appropriate standard operating procedures (SOP). Another person was as at risk of chest infection. Similarly, the control measures for staff stated that staff must be fully trained, competent and ensure SOPs were followed. There were no specific instructions for staff on how to reduce these risks.

Records showed that lack of clear risk management plans affected the safety of service delivery. We saw a log of an incident reported by a staff member. An important piece of equipment used to provide a person with food and medicines had broken. Staff contacted the service's office, as they did not know how to manage the situation. They were advised by a clinical member of staff to refer to a particular care plan in the person's house. However, the care plan was not available. The staff was then asked to contact an emergency service and a district nurse to get further instructions.

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were environmental assessments in place providing staff with information on various aspects of the health and safety of the environment that staff worked in. This included information on exposure to hazardous substances and equipment in peoples home's, such as water heating systems.

At our inspection in October 2016 we found that the service had not managed their medicines safely. At this inspection, we saw that some improvements had been made and more improvements were required.

At our previous inspection we found dates on medicines administration records (MAR) were recorded against incorrect days of the week and staff used incorrect codes to mark medicines administration. Since

our previous inspection, the provider introduced re-designed MAR charts. These were clearly dated and staff recorded medicines administration using appropriate codes. Four out of five people's MAR charts had each person's medicines administration recorded with no gaps. One MAR chart for one person had five gaps in recording of medicines administration that were not explained.

At our previous inspection, we found issues with transcribing of medicines onto MAR charts. At this inspection, we found this still required improvement. The provider's own transcribing processes described in their medicines policy were not always followed. In one instance, in October 2017, a MAR chart we saw contained incomplete information for four medicines, where the dose and frequency of the medicines were missing. We noted this was correctly completed on MARs from December 2017. In another instance, we saw discrepancies between the information in the medicines care plan and the information on the MAR charts. A nurse we spoke with confirmed that information on the MAR chart was incorrect. We were not provided with additional documentation showing that the medicines for this person had changed which would explain the discrepancy.

As we found at previous inspection, MAR charts had not always been signed by two staff trained in transcribing (i.e. nurses or competent care staff) to confirm information recorded was correct and as per the provider's medicines policy. Therefore, there was a risk that medicines were not administered as intended by the prescriber. Three out of five MAR charts we looked at were checked by two staff. One had only been checked by one responsible staff member. Another MAR chart had no records made to prove whether a second staff checked the transcription. We were told that this would be documented in the daily records. We cross-referenced with respective daily records and we did not see any evidence to suggest that the transcription was checked at all.

Errors or omission of transcribing of peoples' medicines when preparing MAR charts had direct impact on people who use the service. One person did not have their antibiotics recorded on MAR charts. Consequently, they had not received their medicine for five days. In the provider's incidents and accidents records, we saw that 12 more medicines transcribing errors were identified and reported by staff at Pulse London. Although these were spotted and corrected by the service, this showed that staff had not always followed the correct transcribing procedure.

Each person had a medicines care plan in their file. However, the care plans we saw did not always have full information. When we saw instructions for medicines to be crushed on the MAR chart and in care plans, we did not always see the authorisation to do this from the clinicians. It was difficult to ascertain if this was being done in accordance with the doctor's instructions. However, we were told that staff only crushed medicines in line with the instructions from the respective prescription.

We saw that medicines care plans held in the service's office had more medicines information than the corresponding MAR chart. Because most current MAR charts were kept in people's homes, we could not say that staff had access to accurate information relating to dosage. This information could have been recorded on the medicines dispensing labels in people's homes. However, these were not available for us to view during the inspection.

We saw evidence of changes recorded to people's medicines in people's care plans. We noted that on one occasion the prescription to provide the authority for the dose change was not available. However, notes had been made by the nurse to detail the dose change and which doctor had authorised this.

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw good examples of care planning related to medicines management. For example, there were medicines care plans in place for a person receiving their medicines via a PEG tube (external feeding tube).

At our previous inspection we 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. At this inspection, we saw that this issue had been addressed. The redesigned MAR chart had a dedicated PRN section with written instructions detailing how often PRNs could be given, and what they were used for. Some people had MAR charts provided by their pharmacy. In such cases staff ensured that PRN medicines were marked on these MAR charts to make it clear that they were not regular medicines.

The provider had medicines management policies and standard operating procedures for the administration of medicines. Staff could access these documents and signed to take responsibility for reading them. Records showed that staff received training in medicines management and were assessed as competent by a nurse before they were allowed to administer medicines.

We saw that when people were supported with medicines there were medicines care plans that contained information relating to peoples' individual medicines support needs and where medicines were stored. Staff documented any medicines errors found on the provider's web-based incident reporting and risk management software.

We received mixed feedback from people and their relatives about staff cover arrangements. The majority of people we spoke with told us there were enough staff deployed to support their needs and they arrived on time. One person told us, "In general the staff turn up on time." Another person said, "It is the timing of staff change over which can cause a problem." Records of complaints received by the service suggested people and their relatives were not always informed in advance about which staff would support them or if they could not provide staff for the visit. This indicated the rota arrangement systems used by the service were not always fully effective. They required improvement to ensure that there was clear communication between people and the service and that people received the service that had been initially agreed.

The provider had a system in place to record accidents and incidents. These were documented on the provider's web-based incident reporting and risk management software. All incidents and accidents were discussed in the service's regular quality and safety meeting as well as in the weekly office team meetings. We saw that all incidents were investigated and any relevant learning was discussed and shared with staff. Staff also shared learning with other providers from different locations across the country.

The provider had appropriate recruitment procedures in place to ensure only suitable staff were appointed to work with people who used the service. We looked at the files for nine staff members and we saw that appropriate recruitment checks were in place. These included Disclosure and Barring service (DBS) criminal checks as well as relevant qualification checks for the nurses and verification of staff employment history.

The provider had appropriate policies and procedures to ensure appropriate infection control. Staff were provided with basic personal protection equipment (PPE) to ensure they were safe from avoidable infection. We saw that guidelines on infection prevention were also recorded in people's care plans as well as the provider's staff handbook. Additionally, the nominated individual told us, staff could receive immediate support from an occupational health nurse in case of any incident for example a needle stick injury.

Requires Improvement

Is the service effective?

Our findings

New staff undertook an induction that consisted of the training the provider considered mandatory. The training was a mixture of a classroom and online training. It included management of medicines, manual handling theory and practice, safeguarding of children and adults and the Mental Capacity Act (MCA) training. We were told that staff had not completed the Care Certificate induction, as this had already been included in the provider's mandatory training. The Care Certificate is a set of standards that health and social professionals should abide by when providing care and support to people. New staff were required to shadow their more experienced colleagues and their competencies had been assessed by clinical nurses before staff provided care unsupervised. Records showed and staff we spoke with confirmed they received induction training. They said, "I was trained thoroughly before being assessed as a competent worker" and "I had quite a number of courses and I was assessed before I started working independently."

Staff were required to pass yearly refresher training and their competences were reassessed to ensure they had suitable level of skills to support people. The service's training matrix showed that the majority of staff completed their yearly refresher training. The training for 11 staff members had expired and three of them had been booked for the yearly refresher. The nominated individual told us, and staff confirmed, unless staff were re-assessed and considered competent in relevant interventions they would not be assigned to work on further shifts.

Although there was a comprehensive training and competencies assessment process we found evidence that the system used by the service had not always been robust and carried out in accordance with the service's protocols. The nominated individual told us, and some staff confirmed, that staff had to complete all the training and have their competencies signed off, or renewed for longer employed staff, before they were allowed to care for people. If these two conditions were not met, staff would be blocked on the provider's shift booking system and they would not be scheduled to work. However, we found that this system was not always followed.

The majority of people were happy with the competency of staff. However, one person and one family member said staff did not always have sufficient skills and knowledge to support people. They said, "My regular care staff are brilliant. I need to train staff who cover absence of my regular staff." A family member told us, "It would be good to have someone [staff] more qualified to deal with my relative's complex needs."

One staff member told us, they had not completed their yearly refresher training and, they were able to carry out their duties. We found two incidents recorded on the service's incident reporting system stating that a staff member had not had their competency to do with a specific intervention reassessed/updated after it expired. However, they had carried on working. We found further six records relating to specialist equipment being used, stating that staff had not operated it correctly or did not know what to do when it had broken. The provider's own quality audits from January 2018 showed further issues around staff competencies checks. For example, two staff had their competencies observed and signed during the time they were not on shift. Another staff had their competencies signed off by an assessing nurse stating a staff completed their training and were competent in a specific intervention. Records showed that in fact, the training was

deferred and the staff did not attend it prior to the competencies being renewed.

Care staff told us they felt supported by their line managers and their colleagues. Their comments included, "I can have open conversation with my manager and my colleagues are also supportive", "I feel supported, they [care managers] come to observe your practice and to ensure you are equipped to do your job" and "I had a few care managers. They do listen to me."

According to the provider's policy, staff should receive formal general and clinical supervision rotating every 3-4 months. Staff should also receive an annual appraisal of their skills. Evidence showed that the service had not always followed their policy and staff had not received regular supervision and an appraisal.

We spoke with 11 staff, including members of the management team. Five of them said they had not received formal supervision whilst being in their current role. The nominated individual provided us with a list of supervision expiry dates for care staff employed by the service. We were told that the expiry date meant the date when staff were due their next formal one to one meeting. We saw that over 90 % of staff supervision planned dates had expired. This indicated that staff had not received formal one to one support when it was due. Over 25 % of these supervisions expired over six months prior to our visit. We look at records for four staff members who were employed at the service for longer than one year. Records showed that all four staff members had received only one supervision session in 2017. We found that although supervision dates had been recorded there was not always corresponding paperwork available. Therefore, we could not say what was discussed in these meetings. We found that one supervision record was also a yearly appraisal record in which staff discussed their training and work satisfaction. There were no records of annual appraisals for three other staff members. The providers own audits had highlighted that supervision had not taken place as required. This was even when a staff member was identified as having gaps in their performance.

We spoke about this with the operations manager. They explained that supervision and appraisals for care staff had been taking place, however, it had not always been recorded on the provider's system. They said that prior to our inspection a new administrator was tasked with ensuring all supervision meetings had been recorded and saved on the provider's electronic system. However, because of staff feedback and the lack of records we could not be confident supervisions were taking place.

The above is evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care needs and preferences had been assessed before people received support from the service. New potential care packages were initially evaluated by the service based on the information provided by the referrer. This was to ensure the service had the right number of staff in the respective geographical area to be able to support a person. Allocated nurses had carried out a clinical assessment of people's needs to ensure the service had the right set of skills or was able to provide suitable training to meet people's clinical needs. The information gathered during the initial assessment was then used to formulate people's care plans. These were prepared with participation of people and their representatives prior to staff supporting people. Records showed that completed assessments consisted of detailed information on people's clinical and social care needs. We also saw that information gathered in these assessment was then translated into respective care plans giving staff guidelines and information on how to support people.

Staff supported people to have enough food and drink and a nutritious diet that met their needs. Some people required staff's support at mealtimes, such as preparing meals or warming up already prepared food of their choice. For those people who needed staff's support we saw care plans in place with guidelines for

staff on how to support the person with eating and drinking. For example, one person's care plan instructed staff to prepare health food options and avoid deep-frying. It also reminded staff to respect the person's food choices. We noted that the care plan also requested that staff completed food and fluid intake monitoring charts. However, we did not find evidence of these documents having being completed. We spoke about this with a nurse responsible for monitoring this care package. They explained that the charts were not needed and the care plan consisted of incorrect information. The nurse informed us they had recently taken over the package and they would make necessary amendments to the care plan.

A large number of clients required assistance with feeding through a Percutaneous Endoscopic Gastrostomy (PEG) tube. PEG feeding is a medical procedure in which a person is provided with food or medication via an external tube when oral food intake is not sufficient or possible. Records showed that care plans for people who received food via PEG feed had recently been audited. We saw that any information gaps in these care plans had been highlighted and actions were agreed to ensure staff were provided with full information on how to support people effectively. We looked at an example of a recently audited and updated care plan for a person who received food via a PEG tube. We saw there were detailed instruction for staff informing them on the individual's feeding regime and how to prepare and manage each feed. The nominated individual explained to us that an ongoing work was carried out to ensure all care plans were up to date and had sufficient details for staff to enable them to provided care as required.

People told us they felt supported by staff to contact external health and care professionals when needed. They said, "I contact the doctor myself but I am sure staff would contact medical help if it was needed" and "If I need to see a doctor my relative arranges that but I am supported by a staff member to go there." We saw that information about involvement of health professionals in people's care was recorded in people's care plans. Staff understood their role in ensuring people had prompt access to external services when required. They said, "If a person was not well I immediately discuss this with my manager or call an ambulance in case of emergency", "If a person needed an emergency help I would contact health professionals and my manager".

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.

People's mental capacity had been discussed during the initial assessment. At the time of our inspection, none of the people using the service lacked the capacity to make decisions. The nominated individual explained that although all people using the service had capacity, this could at times fluctuate. If staff had any concerns these would be communicated with the funding authority for further mental capacity assessment.

We found that staff sought people's consent before providing care and support. One person told us "The staff are very caring they always ask permission before carrying out any care." We saw that people's care plans included information reminding staff to always ask for people's consent before performing tasks. Staff we spoke with received the MCA training and they had good understanding and knowledge of the Act. Some of their comments included, "If decisions are made on behalf of people who have no capacity, they need to be made in their best interest by appropriate healthcare professionals and legally appointed representatives", "The Act refers to people over 18 years old. If people do not have capacity, appropriate

legal deputy may be appointed to ensure decisions are made in people's best interest."

Good

Is the service caring?

Our findings

People spoke positively about staff who supported them. Their comments included, "The staff are very caring respectful and I really am very pleased with them" and "The staff are very caring they also seem to know my needs." Staff spoke kindly about people they supported. They told us, "I love doing what I do. I always ensure the person I support is well fed, washed and dressed."

People's care records were personalised and consisted of information on their social needs, important relationships and things they liked to do. When possible, people received care from the same staff. This ensured the continuity of care and enabled staff and people to build positive and friendly relationship with each other. A person using the service told us, "There are five staff members that I have been using for a long time. They are brilliant I cannot fault them." A staff member told us, "I have been working with the person for a very long time. I know them well and I just understand what they want". Another staff member told us, "I feel I do have relationship with people I look after."

People were supported to make decisions and express their views about their care. People told us they felt listened to by staff who supported them. One person said, "I feel fully informed about my care and feel that staff know what my needs are and what is important to me." Each person had a personal care plan in which we saw detailed information on how people would like to received their care and what their treatment goals were.

The provider had an equality and diversity policy in place. Staff received equality and diversity training to ensure they understood individual needs and preferences of people who used the service. The majority of people we spoke with said they did not have any specific religious and cultural needs that they wanted staff to understand and respect. One person felt staff were thoughtful and respectful towards their religious beliefs. A care manager told us, "We take into consideration people's preferences when matching them with staff. We also explore if people's choices are not caused by discrimination towards others."

Staff knew how to communicate with people in the way people understood and preferred. People's communication needs had been discussed at the point of the initial assessment. Staff were provided with guidelines on how to communicate with people effectively. For example, one person due to their physical condition was not able to project their voice loudly. Staff was advised to always face the person when providing support so they could see if the person wanted to communicate something. Another person was not able to communicate verbally. In the person's care records we saw description of how they would use their body language to express what their preferences were when receiving support.

People told us staff respected their dignity and privacy when providing personal care. One person said, "They [staff] are very respectful when dealing with my personal care and always ask permission before doing anything." Staff understood how to provide personal care to enable people to feel comfortable and to have as much independence as possible. They told us, "I always close the door and cover up the person I am supporting" and "I always communicate with people when providing personal care. They may not be able to speak but I observe their body language to know if they are ok." Records showed that people could choose if

they were supported by a male or female worker.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found that some people using the service and their relatives had little confidence in the ability of the provider to adequately communicate with them regarding concerns raised. The senior regional manager at that time advised us that they had been aware of this issue and the service had begun addressing the concerns people and relatives raised around dealing with complaints in relation to communication, rotas and overall service.

Since our last inspection there had been 16 formal complaints recorded by the service. We saw that nine complaints were related to staffing and shifts cover. We saw that the outcomes of these complaints were recorded as communication or operational issues. This indicated that the provided had not addressed the matter fully and there were still concerns around how the service communicated with people about shift covers and rotas.

Records showed the provider had not dealt with received complaints as outlined in their own complaints policy. We found that 10 out of 16 complaints were not acknowledged with the person complaining within two working days as stated in the policy. Five of these complaints had been acknowledged over 21 days after the complaint had been made. The provider's policy stated the provider would investigate each complaint and provide a written response within 28 days. We saw that 11 complaints were not formally concluded and the investigation outcome letter had not been sent to the complainant within this timeline. In one example, we saw that the complaints team were advised not to send the outcome letter as the family had already been spoken to directly. Two further complaints were closed within 28 days, however, they were not resolved but passed to a different team within the organisation.

At this inspection, the majority of people told us they did not make any complaints about the service and they knew who to contact if they had any concerns. Two people told us they made a complaint and one of them stated they were not satisfied with how the service dealt with it. They said, "I have complained but they don't seem to take on board what I say."

The provider had not recorded all received complaints, therefore we could not be confident that all complaints made by people were dealt with by the service. During our inspection we were made aware of two other complaints made to the service, however, we did not find any records of these complaints in the documentation provided to us during the inspection.

The above is evidence of a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care that was personalised and reflected people's care needs and personal preferences. The majority of people using the service had complex clinical needs. People's care plans were formulated by an allocated care coordinator and a clinical nurse. This ensured both social and clinical aspects of people's care were included. Each person had a number of care plans that corresponded with their specific care needs and had detailed guidelines for staff on how to provide care effectively. Care plans covering social

aspects of people's life included communication, daily routine, social living activities and accessing the community care plans. Care plans describing clinical aspects of caring for people included mobility, pain management, matters related to spinal injuries and incontinence care plans.

The service provided two levels of care based on assessed complexity. This was reflected in the frequency of clinical care reviews carried out by allocated nurses. People with more complex needs, described as Level 1, received their review every two weeks. People with less complex needs, described as level 2, were reviewed monthly. Records showed that matters discussed in these meetings related to any medicines changes, reviews by external health professionals and any changes to the care or equipment used. People also received a social review of their care. Records showed that in these reviews, people could discuss their satisfaction with the service, staff and any issues arising. We noted that the majority of care plans we saw had been reviewed a few days prior to our inspection. The nominated individual explained that the service had been undergoing a full audit of all people's care plans and records review for all people who used the service. This was due to the provider's most recent service audit that highlighted gaps in the quality of the record keeping and found parts of care plans missing. We were told that undertaken work aimed at ensuring all people's care plans consisted of all information needed to provide people with care they required.

People using the service were aware of their care plans and they told us they felt involved in the formulating and reviewing of their care. One person told us, "I have a copy of my care plan and I feel involved in reviewing of my care." The person attributed it to initial teething problems in the relationship with a new coordinator. Staff we spoke with told us they were aware of people's care plans and they used them to inform their knowledge about people's needs and to update them of people's care requirements. One staff member said, "The care plan is easy to follow and I can always call the office if I need further clarification." There is a lot of information about people's routine, social life their likes and dislikes."

At the time of our inspection, the service had not provided end of life care to any person who used the service.

Requires Improvement

Is the service well-led?

Our findings

During the inspection, we found significant shortcomings in the service provision. Audits seen by us had not scrutinized all of the areas of the service provision. Therefore, they had not identified issues that were highlighted by us during the inspection. The audits failed to identify that not all safeguarding concerns had been identified and appropriately acted upon by the service. Audits we saw had not recognised that the service had not informed the commission about notifiable events related to safeguarding of people who use the service. The provider's audits had not monitored and analysed complaints received by the service. Therefore, there was no system in place to ensure received complaints were dealt with promptly and as per the provider's policy. We found that the provider's audits had identified the lack of appropriate risk assessment in individual files. However, these audits had not addressed the quality of existing risk assessments to ensure staff had clear guidelines on how to keep people safe.

During the inspection, we also found issues related to communication between the service and people who use it, front line care staff and external professionals. We received mixed feedback on this matter. One person using the service told us, "The office are easy to get in touch with." Three other people said, "I am not sure that there is good communication between the carers and the management", "I feel listened to by my carers but not by the service" and "It is always very difficult dealing with the service. I can't get through to them and sometimes they don't call me back. I would like to be kept more informed." The provider's incident recording system showed number of complaints from people or their relatives relating to poor communication around shift covers.

Staff we spoke with told us they generally felt supported by their managers, however, they also said they had not always been informed about matters related to the service and the service provision. They said, "The service just texts me. I would expect them to call me to discuss things", "You cannot keep up with who is who in the office. It is a bit disorganised" and "I am not informed about things until they already happened."

External health professionals gave us varied feedback about communication with the service. One health professional said, "In all my dealings with Pulse they are always very professional". Another health professional stated, "I am extremely concerned that Pulse do not appear to recognise the importance of robust incident reporting and information sharing."

The provider's quality audit from July 2017 showed that people using the service had highlighted communication as the area of the service that needed improving. In the office meeting minutes from December 2017, we read that the issues of communication had been known to the service. This matter had been highlighted, however, viewed records and feedback from stakeholders suggested this issue had not been addressed. The most recent audits and improvement plans provided by the service had not included information on what action had been taken to address it. Consequently, we could not say this matter was being addressed.

The above is evidence of further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the beginning of our inspection we were told by the nominated individual that the registered manager had resigned shortly before out visit. However, they agreed to assist us during the inspection. The nominated individual explained the current operations manager would take on the managerial duties with the aim of them registering with the CQC as a registered manager.

Since October 2017, Pulse London had been going through other managerial changes. The operations director left in October 2017 and shortly before our inspection one of the clinical nurses responsible for overseeing of clinical interventions provided to people had also stopped working at the service. Since then the registered manager was supported by the new operations manager and two senior clinical nurses. Both senior clinical nurses were allocated by the provider to support the service with improving the quality of clinical interventions provided. The provider had also appointed a new operations director who started supporting the service in January 2018. These changes were significant to the service. They initiated the review of the existing auditing systems within the service. The review had identified the shortfalls in the service delivery, which was positive.

The service had carried out regular, periodic audits of the care provided. However, these audits had not been effective in addressing issues identified. In October 2017, the provider carried out a standard audit of a sample of care packages managed by the service. The audit identified significant failings of the service provision and that issues identified during previous audits were not always acted upon. The nominated individual informed us the failings were mainly related to completeness of care plans and medicines administration records. Consequently, in January 2018 the provider had carried out further comprehensive audits of all care packages managed by the service. The audits showed gaps in care documentation for all of the packages. Based on the findings the provider had formulated an improvement plan and began taking action to remedy identified issues. During our inspection, we cross-referenced example of missing information identified in the provider's audits with respective care files. We found that information in these files had been updated to reflect people's needs and ways staff should support them. This indicated that the service had begun the improvement process to ensure people's care records had sufficient information on how to support them.

Additional measures were put in place to ensure staff were competent to carry out complex clinical tasks. The nominated individual told us, and one community nurse confirmed, the provider's senior nurses assisted the service's community nurses in staff competencies assessment. This was to ensure the process was carried out correctly and staff had required skills to support people. The nominated individual also told us about weekly conference calls between the representatives of the senior management team, senior clinical director and senior nurses. These calls were scheduled to ensure actions agreed in the improvement plan had been followed. After the inspection the nominated individual provided us with further evidence showing the provider was in the process of addressing issues found during the latest service audit. These included plans of actions for individual care packages, including dates when the actions were expected to be completed. We also saw records of meetings with individual community nurses indicating that needed actions were discussed with them and they were made aware of what was expected from them to improve the quality of the service provided.

The operational staff (including case managers and the community nursing staff) spoke positively about the recent improvement work and staff changes within the service. They all thought the changes were needed and they were positive the service was working towards improving. They told us, "There has been a

definitive conscious effort to make positive changes", "Recent discussions about changes were reassuring. The changes are reasonable and justified" and "The atmosphere in the office is at times low but the new Operations Manager brought people's spirits up and they are very supportive."

There were a variety of meetings for the management team in which participants could discuss matters related to the service provision. This included weekly meetings to discuss care provided to people and monthly office meeting about wider range of matters related to the service delivery. This included incident reports, staffing, medicines management and training.

The provider carried out periodic satisfaction surveys in which people could voice their opinion about the care provided and any improvements that they felt could be made to the service. People could also provide their feedback during the provider's file auditing process that included conversations with people on how they experienced the service. All people we spoke with confirmed they were asked for their feedback about the care provided.

The provider had up to date policies and procedures in place and staff could access them through the provider's intranet online portal.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users because, they did not do all that was reasonably practical to assess and mitigate risks to care and treatment of people who used the service. Regulation 12 (2) (a) (b) The registered person did not ensure the safe and proper management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure there was the right level of managerial scrutiny and oversight in relation to all safeguarding matters. The registered person did not ensure that records of incidents and accidents and complaints were used to identify potential abuse and did not take preventive action where appropriate. Regulation 13 (1)(2)

Regulated activity	Regulation

Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person had not ensured that people's complaints were dealt with promptly and to their satisfaction. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effective systems to: Assess, monitor and improve the quality of the service. Regulation 17(2)(a) Assess, monitor and mitigate the risks relating to health, safety and welfare of service users. Regulation 17(2)(b)

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured that staff received sufficient training, supervision and appraisal of their skills. Regulation 18 (2) (a)