Pulse Healthcare Limited

Pulse Essex

Inspection report

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Date of inspection visit:
22 August 2017
24 August 2017

Date of publication:
14 September 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was announced and took place on 24 and 26 August 2017. This was the first ratings inspection at this location.

Pulse is registered to provide care and support for people in their own homes including those that require nursing care. At the time of inspection Pulse Essex were providing care and support to eight people aged between one years old and 70 years. Most people receiving support from Pulse Essex had complex physical health needs requiring specialist care and support. As a result, many of them had limited communication skills so were unable to speak with us, although had nominated loved ones who had power of attorney for their care and welfare.

The service had a registered manager. 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.

Each person with complex needs had small teams of staff assigned to them who were specifically trained to meet the needs of that person. Risk assessments gave clear guidance to staff about how to minimise risks for people in line with their needs and preferences. Communication was robust and concerns about people's care was managed quickly.

Staff received excellent levels of on-going training, and were supervised regularly. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff had a good understanding of the Mental Capacity Act 2005, and how to support people who lacked capacity to make certain decisions. This meant their human rights were respected.

People's privacy and dignity was respected at all times, regardless of their ability to communicate their needs to staff. Staff worked closely with peoples loved ones to ensure they received care and support in a respectful way.

Staff knew people very well and care was person centred. Care plans addressed every area of need to maintain and improve people's health and wellbeing. However, parts of some care plans required additional information to ensure they were person centred. Although, information from, staff, relatives, and written daily notes demonstrated that staff knew people very well and that care was person centred.

The registered manager and clinical governance team actively listened to the views of people using the service, their loved ones, and of staff employed. The provider had a good oversight of issues at each location and supported managers to maintain standards of care. Robust systems were in place to audit the quality of the service and the service was continuously learning and adapting processes to provide quality care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

There were enough staff to meet people's needs. Recruitment of staff was safe and robust.

Staff had a good understanding of safeguarding issues and how to report concerns.

Risk assessments were robust and person centred, covering every aspect of need.

Staff managed medicines safely and good auditing systems were in place to identify and learn from mistakes.

Is the service effective?

Good

The service was effective

Induction and training provided staff with the skills necessary to provide good quality care.

Staff followed the principles of the Mental Capacity Act (MCA) 2005, ensuring that consent to care was sought.

Staff managed people's nutritional needs effectively.

Excellent links with other health and social care professionals, meant people accessed timely support.

Is the service caring?

Good

The service was caring

People were treated with dignity.

Staff respected the people in their care and those people that were important to them.

The care team often went above and beyond their role to meet people's changing needs.

Is the service responsive?

Good

The service was responsive.

People and those representing them were involved in the care planning process at all stages.

Robust processes supported people to raise concerns.

Is the service well-led?

Good

The service was well-led

There was an open and transparent culture at the service. This supported continuous learning.

The service's values focused on the individuals receiving care.

The service had a robust quality assurance system and identified shortfalls were addressed promptly. As a result the quality of the service was continually improving.

Staff were encouraged and supported to provide good quality care.

Pulse Essex

Detailed findings

Background to this inspection

This inspection took place on the 22 and 24 of August 2017 and was announced.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be there to greet us.

The inspection team consisted of one inspector due to the size of the service.

Prior to the inspection we reviewed all the information we held about the service, including any statuary notifications we may have received that the provider is required to send to us by law.

We also requested information from other professionals, for example the local health commissioners, the local authority and health watch.

At the time of the inspection, the Provider Information Return was in the process of being completed by the provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into consideration when making our judgements.

As part of the inspection we talked to one person using the service, and four relatives. We visited a person in their home and reviewed the information that was kept to inform people and carers of the interventions that person received.

We reviewed five care plan records and associated risk assessments for individuals using the service, and a selection of the services policies and clinical procedures.

We spoke to the registered manager, clinical governance lead, community nurse and care co-ordinator working at the service. We also spoke to two care staff.

We looked at staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Good

Is the service safe?

Our findings

This service was safe.

People had small teams of staff specifically recruited to meet their individual needs.

Employment records confirmed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the vulnerable adults who used the service.

People were protected from abuse. One relative told us, "We had concerns about one per person and reported these to the manager. They dealt with these concerns quickly and the person was dismissed, although no harm came to my [loved one]."

Staff completed regular safeguarding vulnerable adults and children training. All staff we spoke to had a good understanding of safeguarding concerns and how to report them.

Staff were recruited safely and the Pulse's Internal clinical governance team checked references were appropriate and that they had undergone background checks to ensure they were fit to work with vulnerable people. A computerised rota system in place ensured that if checks had not been completed, or were out of date, staff could not be rotated to work with people. This also applied to training that was not completed or out of date. If this was the case, staff would not be able to work.

Relatives, who were often the primary carers for people with complex nursing needs, took part in this process and took part in training staff by allowing them to shadow themselves, nursing staff, and existing carers. One relative told us, "They never make any decisions without talking to us first which makes us feel safe and in control."

On occasions the manager told us that there had been differences in opinion about how to support people, for example how to use manual handling equipment. Whilst they always attempted to support people and loved with care needs in the way they wanted, on occasion they were not able to do so due to the health and safety guidance. This demonstrated that whilst people's preferences were central to decision making, ultimately people's safety and the safety of staff was paramount. Staff always discussed and agreed these issues with people and relatives, and documented this in care records.

Risk assessments were robust and provided staff with guidance on how the risks to people were minimised. This included risks associated with numerous clinical procedures and conditions, such as how to safely care for a person who had a PEG feed in place, or who had diabetes and epilepsy. These risks were continually reassessed and monitored in order to identify potential themes and trends which may indicate additional support was needed. One member of staff told us, "The [care] plans are excellent; they tell me exactly what to do and what to look for to support [Person] safely."

Emergency plans were in place for people with complex health needs. This provided staff with step by step guidance for staff including; how to manage equipment, what to look for if people deteriorated, and emergency plans and contacts.

People and loved ones had their own equipment to support their needs, such as equipment to help them move. They took responsibility for ensuring this was maintained and safe. However, care plans included contingency plans and numbers of staff to contact in case equipment broke down, and a full environmental risk assessment had been completed in people's home to assess and manage the risks associated with using the equipment. This included identifying that's safety checks had been undertaken within regular reviews. This mitigated the risk of equipment failure so staff could support people safely. If additional equipment identified as needed to carry out tasks safely staff could support people to access what was needed.

There were usually enough staff to deliver people's assessed care needs. Emergency plans were in place to manage staff sickness. In some cases, an agreement was made with the relatives who were the primary carers to manage the person's needs. In these cases, the relatives had an assessment to demonstrate that they were competent to do so. If additional support was needed arrangements were made to outsource care to Pulse's qualified nursing agency, local hospitals and hospices, matching skills and competencies. The manager was able to demonstrate that whilst very infrequent, these contingency plans had worked well.

Relatives told us they felt that the recruitment process could be quicker as care teams were not always at full capacity. However, they also acknowledged that staff had to undergo specific training to meet loved ones need's and that this took time. One relative told us, "I know it's difficult to recruit, it's like trying to find a perfectly fitting glove. I wish it was faster, but I understand why it isn't."

The majority of people receiving care from Pulse Essex, either managed their medications themselves or relatives did so. For those few that required support from staff, systems were in place to monitor whether medication was administered safely. Staff had undergone medicine training which was revisited at yearly intervals to ensure competency. This included observations in practice.

Good

Is the service effective?

Our findings

The service was effective.

Care needs of people using this service were complex. Care staff underwent a robust induction and mandatory training programme before being trained in various different care interventions relating to the person's needs. Pulse's community nurse carried out training, and some specialist training was out sourced to hospices, and other organisations with specialist knowledge.

Whilst Pulse Essex did not use the National Care Certificate induction, which sets out 15-core care competency standards, they had mapped their staff induction to these core standards to make sure they were covered. One person told us, "They are trained really well." A relative commented, "The staff know what they are doing and they are all trained to it same way,"

Staff told us that training was excellent. One said, "The training is the best I have ever had and I've worked for a few agencies," another said, "It is excellent, I felt I had been prepared well to care for [person], I really can't fault it." Qualified nurses undertook competency checks and relatives who held power of attorney for people's health and welfare would say whether they felt the member of staff was competent or required additional shadowing and training. For those people able to express themselves they were empowered to have the final say on this process.

We spoke to the clinical governance lead for Pulse Essex, who was able to produce evidence that training and training resources had been informed by current best practice for a variety of health conditions and clinical procedures. This included the Royal College of Nursing, National Institute for Health and Care Excellence (NICE) and the Pharmaceutical society on best practice.

A number of people receiving care had a tracheotomy in place, (an incision in the windpipe made to relieve an obstruction to breathing). Staff had attended specialist training to manage this intervention safely before working alone with the person. Competencies were checked frequently through observation and supervision. People received effective care, based on best practice, from staff who have the knowledge and skills they need to carry out their roles and responsibilities.

Community nurse and co-ordinator roles were supported with the same robust training, as well as additional opportunities to attend national conferences on various health conditions. The company ensured that registered nurses received support to revalidate with the Nursing and Midwifery Council (NMC), the registered nursing body. One nurse told us, "Training is really excellent," they added, "We are also expected to undertake the same training as the care staff so that we know what level they have been trained at. I have to say the medicine training is extremely thorough and informative."

All staff we spoke with told us that they had monthly supervision and yearly appraisals. The clinical governance team monitored that these were taking place. These took place either one to one, or in a group within individual care teams. One staff member said, "Yes I get supervision monthly, I feel very supported."

We saw examples in clinical supervisions when errors had occurred, or if a person using the service had voiced a concern, that staff received additional training and development identified within clinical supervision. They would write a reflective report as part of the investigation, demonstrating learning from the incident and competencies would be revisited, checked and signed off before they were able to work unsupervised.

All staff we spoke to had a good understanding of the Mental Capacity Act (MCA) 2005. They received training, and yearly online refreshers in this area. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People receiving care from the service mostly had relatives as the court appointed person to oversee their health and financial affairs due to a lack of capacity caused by physical health conditions. Others had capacity to make decisions about their care. In all cases we found that staff were working within the confines of the act, liaising with the appropriate person, be that the primary carer, person themselves or appointed professional in regards to people's needs. This included working closely with advocacy services, social care and commissioners, as well as advocating on behalf of people if needs changed.

Staff supported people to eat and drink to maintain a balanced diet. A nutritional assessment had been carried out for each person, including weight assessments using the recognised Malnutrition Universal Screening Tool MUST assessment tool. This is a tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines, which can be used to develop a care plan. This informed whether people needed to have fluid, diet and weight documented and how often.

Some people received their nutrition through a PEG feed (a procedure in which a tube (PEG tube) is passed into a patient's stomach to provide a means of feeding). Clear structured care plan interventions were in place to ensure they received the nutrition they needed. When a nutritional need was identified, we saw evidence that staff were completing these records appropriately and that the community nurse was auditing these on visits to people's homes. If needed, additional support was requested from speech and language therapists and dieticians.

There were strong links with other professionals involved in people's care so that staff could contact the right people for advice if they had any concerns. The community nurse for Pulse Essex carried out regular care reviews to ensure that if people's needs had changed they were supported to access the additional help needed to maintain their health. This was reviewed either monthly, two weekly or weekly depending on level of need.

The nature of people's complex health needs meant that they would receive various forms of input from other professionals. As staff often completed long shifts in people's homes, they were able to help people access these appointments. As they knew people well they were able to provide support and supply professionals with the information needed.

Good

Is the service caring?

Our findings

The service was caring.

People told us that staff were kind, caring, and considerate to their needs and preferences. One relative told us, "Although [person] cannot communicate to them [staff] still tell them everything they are doing and are very gentle doing it," another said, "I can't fault the staff really, they are the best team and so caring to [person] and to me."

Where people previously had carers supporting them in hospital, whom they had built trusting relationships with, the provider had taken this on board and worked to recruit those people to Pulse to support the continuity of care. This helped people feel cared for and that their individual needs and preferences mattered.

The manager always sought people and relatives views on carers and they were able to have the final say. One relative told us, "We have had people that we just didn't get on with personality wise, nothing to do with their skills, but just didn't feel comfortable, so we said no and they respected that." After said, "We've had one [staff member] for over five years. [Staff member] really is excellent and knows [person] well. They are part of the family and I trust them. Because of that I can take a break and leave [person] in their capable hands."

Staff told us about the people they cared for and were able to demonstrate that they knew them well. This included their likes, dislikes, and preferences. A relative told us, "They are very human. My [relative] is helped to look and dress like the age they are. It's the little things that count. We couldn't have asked for better."

People and their loved ones told us that staff became part of the family; "They aren't just kind to [person] they are kind to me and our family and friends." People told us that this extended to the office staff and registered manager, "I know that the manager will always return my call. They are all very approachable."

One relative told us, "The community nurse is excellent and goes above and beyond. When we've had issues or concerns about [persons] needs, she comes out even at weekends and in the evening, although she works regular office hours." Another said, "They come so often to review and make sure everything is going well that they are just part of the family."

Staff had a good understanding of equality and diversity issues, and how to support people who had protected characteristics, for example, physical and mental health disabilities, religious need's or sexual orientation. One member of staff told us, "We assess all individual's needs prior to the service starting, including those things that are very important to them and we help match carers to support these needs. We have supported people who practice certain religious practices. In those cases we have spoken to them, loved ones, and researched about the boundaries of that religion and incorporated that into the care plan."

People were treated with dignity and respect, regardless of their level of disability and or ability to express

their needs and preferences. Relatives gave examples like, "They always let [person] know what they are doing," and "They cover [person] up when washing them, it's very dignified." People had final say of who provided care and what gender of carer they felt comfortable with. The manager was able to give specific examples of when this had occurred.

Staff were able to give us specific examples of how they supported people to remain as independent as possible, even when they lacked capacity to make decisions. This included accessing advocacy support when people did not have relatives to advocate for them. One member of staff told us, "It's important for people to do as much as they can for themselves. We are led by them."

An advance decision about end of life care was documented and staff knew prior to working with a person for the first time if indefinite DNACR'S (Do not attempt cardiac resuscitation) was in place and where to locate them in people's homes.

Good

Is the service responsive?

Our findings

The service was responsive.

Everyone we spoke to told us that they were involved in planning their care, and staff told us this was an important part of the service. Care plans demonstrated that involvement had taken place.

Reviews of people's care ranged from weekly to monthly depending on individuals level of care need. These reviews took place in people's homes with either the community nurse or care co-ordinator. People, relatives, and staff on duty all took part in these reviews to ensure that people had the right support. In addition, the care team invited social workers and other health professionals involved in the people's care. If invitees could not attend, minutes of the meetings would be sent. One relative said, "At the end of the day, we get the last say, unless they just can't do something in which case we have a discussion."

Some relatives felt that information could flow better, for example, if they contacted the office for information. "They are good but I think they could on occasion be quicker getting back to me, although sometimes it's because they don't know the answer to a clinical question and have to go elsewhere to find out. They do always call me back." Office staff logged all contacts so that they would be followed up appropriately and when people required information that had to be sourced, staff would return the call the same day.

Staff documented people's histories, likes and dislikes in the social needs section of the initial assessment. This information was an integral part of the initial assessment of people's needs, used to feed into the care provided. People and those acting on their behalf told us that staff knew people's likes and dislikes very well.

The information obtained in the review of people's social needs had not always been included in the part of the care plan which guided staff how to support people with their everyday needs. For example, although social care reviews included information such as, "[person] enjoys listening to music," and "[person] likes people to read to them." Additional detail such as what type of music a person liked or what style of book or author, would assist staff in supporting people in line with their preferences. We discussed this with the clinical governance lead for Pulse Essex who oversaw the sign off of care plans and they acknowledged that the care plans had recently changed format. This information had been incorporated more fully before, and this would be addressed. In spite of this we found that people did receive person centred care.

Staff took action in response to changes noted in people's care plan reviews. For example, liaising with other agencies to get additional support people needed such as specialist equipment to access additional activities outside of people's home or additional access to funds to help the person pursue an interest or hobby.

The service had good complaints procedures in place to support people and loved ones acting on their behalf to make complaints. Staff sent these to the clinical governance team for review, who would make

recommendations on how to resolve issues, and how the service could learn from complaints and errors. We saw evidence of additional training for staff following errors. People were kept informed throughout these processes, which were resolved in timely way.

At the time off inspection, the service had not received a formal complaint for many months. Contact numbers were available in people's homes if they had concerns. People told us, "It never gets to a serious complaint because if I have problem I just phone the office up and they deal with it." They were able to give specific examples of when issues had been immediately resolved. Another relative told us, [Office staff are very approachable. I never worry about telling them what I think, they always listen and act appropriately."

Good

Is the service well-led?

Our findings

The service was well-led.

All staff working at the service were provided with a clear set of values and principles that put the person they would provide care for at the heart of the service. These values were based around quality, choice and promoting independence. Because staff would be entering people's homes and personal spaces, all assessments of people's needs included a review of that person's own "house rules." For example how they wanted staff to behave in their homes.

The registered manager had good oversight of the service and understood the responsibilities of this role. They were supported by a community nurse, care co-coordinator and administration staff at the location. All staff understood how their own roles worked together to provide safe and continuous care to people.

Managers had a shared understanding of the key challenges, achievements, concerns, and risks for the service. The registered manager regularly attended meetings with other managers within the organisation to share best practice and discuss changes within the service. They told us that they had regular supervision and could pick up the phone at any time to head office for support.

The provider's associate handbook was given to staff gave a brief overview of the key points of various important policies and procedures, aimed at safeguarding staff and people using the service. It included a clear code of conduct that staff were expected to follow and laid out processes in place for staff to account for their decisions, actions, behaviours and performance. It was easy to read and acted as a guide to give carers working in the community the right resources to report concerns. This included information about whistleblowing, raising safeguarding concerns and contact details for the Care Quality Commission.

Staff told us they felt supported and that they enjoyed working for the company. One said, "I'm not just saying this but they are all really supportive. I can ask anything."

The service recognised staff who had worked above and beyond their role by issuing thank you cards, for example, if someone worked extra shifts to support a person whilst another member of the team was on annual leave. A carer of the month incentive had also been implemented. The registered manager explained, "It is focused on the quality of care they have provided and feedback from people using the service. Staff work hard and deserve that recognition."

In addition to this, the provider also ran a yearly achievement award for staff at all of Pulse's community services. The nominees would be invited to attend a reward ceremony and ceremonial dinner. This demonstrated that staff were valued by the management team.

Policies, procedures, and standard clinical practices were regularly reviewed by the provider. This included National Institute for Health and Care Excellence guidelines for domiciliary care, ensuring that staff recruited matched people's needs and that the team of carers remained small to ensure that people received good

continuity of care. The provider had good links with other health and charitable organisations that supported the learning culture. This included utilising training resources and expert advice from hospice's and hospitals.

The location team received additional support from a clinical governance lead for Pulse community health care, who had a clinically trained background. They provided sign off risk assessments, care plans, and investigations into incidents. This team reviewed and incidents, reported errors, and all audits carried out at the location in line with nationally recognised best practice, and made recommendations for improvements. For example, if staff needed additional training before recommencing work with people. The clinical governance lead also carried out spot checks at the service to ensure that the service provided to people was safe.

When staff reported incidents, the organisations governance processes, policies and procedures were followed. The registered manager kept staff and people updated during investigations into incidents. The providers medicine audits had demonstrated that staff were at times not signing Medicine Administration Records (MAR) for applying topical creams to people. The investigation noted that staff were however, completing daily written entries and body charts. Consequently, this had been addressed in supervisions with all staff and there had been an improvement in this area.

The provider supported staff to quality assure their own practice. Staff completed reflective accounts of clinical practice to identify their learning needs and staff told us they were able to ask for additional training and refreshers in training whenever they needed it. Reflective writing is an activity where care staff analyse a situation and their own responses and skills in order to learn and improve. This demonstrated a learning culture within the organisation.

The registered manager phoned people on a monthly basis to check in with them and see if they were happy with the carers and the care provided and if things could be improved. People told us the openness and transparency of the service made them feel valued.

This demonstrated that quality assurance systems were robust and that provider identified concerns and implemented actions to improve the quality of the service.