Pulse Healthcare Limited

Pulse - Newcastle

Inspection report

West 1, Asama Court
Newcastle Business Park
Newcastle Upon Tyne
Tyne And Wear
NE4 7YD

Tel: 03335773014

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Pulse - Newcastle is a community health care agency that provides personal care and health support services to people in their own homes. At the time of the inspection, services were being provided to 23 people across the North East region.

The service had last been inspected in October 2016 when we had followed up on breaches of legal requirements relating to governance, medicines and safeguarding. Prior to this we had carried out a comprehensive inspection in February 2016 and rated the service as 'Requires Improvement'.

At this inspection we judged improvements had been sustained and have changed our rating of the service. We found suitable systems were in place for reporting and responding to any safeguarding concerns. Administration and recording of medicines continued to be kept under close scrutiny to ensure staff followed safe practices.

The registered manager had left in recent months and the provider was in the process of recruiting a new manager. Appropriate arrangements had been made to manage the service in the interim.

People's care was well-planned to reduce risks to their personal safety and welfare. New staff had been thoroughly vetted to assess their suitability before they were employed. There was sufficient staffing capacity and most people now had their own team of allocated support workers for consistency.

The staff were supervised, supported and given training that enabled them to provide effective care. Where it formed part of their care plan, people were provided with the necessary assistance to meet their health care and nutritional needs.

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.

People and their relatives spoke positively about relationships with their support workers and their caring approach. They described being treated respectfully and with dignity.

Care plans were individualised and agreed in consultation with the person and their family. Where applicable, the service supported people to take part in social activities and access the community.

There were methods to assure the quality of the service, including seeking people's views about their care experiences. Most people and their relatives were satisfied with how the service was run and it was evident complaints were taken seriously and acted on.

Further information is in the detailed findings below.

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.

Improved arrangements for responding to safeguarding concerns and managing people's medicines had been sustained.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Requires Improvement

We could not improve the rating for: 'Is the service well-led?' from 'requires improvement' as there was currently no registered manager for the service.

Pulse - Newcastle

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 was 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. We checked if improvements to meet legal requirements had been sustained following our last inspection in October 2016.

The inspection was announced and took place from 17 May to 19 July 2017. We gave 24 hours' notice that we would be visiting as we needed to be sure that someone would be in at the office. The inspection was carried out by two adult social care inspectors 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.

Before the inspection, the provider had completed 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. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted commissioners of the service and Healthwatch, the local consumer champion for health and social care services.

During our inspection we had telephone contact with two people, six relatives and seven support staff to obtain their views about the service. We talked with staff at the office including the manager, the clinical governance lead, the regional nurse team leader, a branch community nurse and a case manager. We reviewed three people's care records, staff training and recruitment records, and other records related to the management of the service.

Good

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe with the staff who supported them. Their comments included, "I do feel safe", "My relative is happy with the care workers with regard to safety", "My relative definitely feels safe", "They make my relative feel very comfortable and safe" and "Oh yes, no problem with safety."

At our last inspection we had judged the provider was no longer in breach of the regulations relating to safeguarding and management of medicines. During this visit we found the service had sustained improvements in these areas.

Safeguarding issues had been notified to the relevant authorities and managed appropriately. Staff were informed about and had access to procedures for safeguarding and whistleblowing (exposing poor practice). A 'duty of candour' policy had also been developed and disseminated to staff. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

Safeguarding training was completed by staff at induction, and updated annually, to make sure they were aware of how to recognise, prevent and report abuse. This included a course on child protection, in the event of care services being provided to children. Staff demonstrated they understood people's vulnerabilities and their responsibility to protect them from harm. They told us, "My priority is my client, they come first", "We have had training on safeguarding and what to look out for. Someone might become quiet and not want certain staff to come in. I have never witnessed any bad behaviour, I would report it straight away" and "I'd have no problem raising a safeguarding concern."

Staff involved in the handling of prescribed medicines continued to be trained and have their competency assessed on an annual basis. The staff we talked with gave accurate accounts of the medicines procedure and were familiar with the levels of support people required. They told us, "The nurse checks that we are competent and confident to administer medicines" and "They review our competencies to make sure we deliver care safely." People and their relatives confirmed that medicines were correctly administered by their workers.

The service had implemented further measures to improve and have more consistent oversight of the way people were supported with their medicines. New administration records had been introduced and regular audits were carried out to monitor that medicines were accurately administered and recorded. A branch nurse confirmed this and showed us the process they followed to keep administration under closer scrutiny. Any deficits highlighted, such as recording omissions, were acted on, including retraining staff to ensure medicines were managed safely.

Steps were taken to identify and reduce risks to people using the service, with strategies built into care plans to guide staff on providing safe care. The risks addressed included those associated with the individual's home environment, nutrition, health, skin integrity, moving and handling, and use of equipment. The level of

supervision the person required, for example when travelling, in the community, and whether they were safe to be left alone for periods of time, was also specified. Systems were in place for the reporting, analysis and follow up of any accidents or incidents that occurred. Financial transactions undertaken by staff were documented and regular audits were conducted to check people's money was being safely handled.

New staff were recruited according to demand for the service and we saw all necessary pre-employment checks were undertaken to assess their suitability. The staff team currently had sufficient capacity to co-ordinate and deliver people's care provision. External agency staff were not used to cover absence and each person had an agreed contingency plan for their staffing arrangements.

Changes had been made in the service to give people a designated team of support staff for continuity. Staff told us, "We work it between the team so calls are never missed" and "I work back to back with another lass. They are introducing another support worker to cover holidays." One relative raised issues about staffing with us which we followed up with the manager, a case manager and a social worker. We were told they were taking action to resolve the relative's concerns and that a review of their family member's care service was arranged.

Good

Is the service effective?

Our findings

People using the service and their relatives felt their support workers were appropriately skilled to provide their care and support. They told us, "Yes they are trained and experienced", "They do everything we need doing", "We have no problems with training or skills, they are all very good", "They look after my relative very well" and "My relative has complex needs and they know how to support her."

Staff were given induction training when they started working at the service to prepare them for their roles. This was aligned to the 'Care Certificate', a standardised approach to training for new staff working in health and social care. Staff also shadowed experienced workers and undertook training specific to the needs of the people they would be supporting.

The training staff received was a mix of practical, face-to-face and e-learning courses with knowledge tests. Mandatory training in safe working practices had been completed, such as moving and handling, basic life support and health and safety. Other training topics provided included equality and diversity, mental capacity law and data protection. Particular elements of training in relation to clinical needs, such as caring for people with tracheostomies, were followed by an assessment by a qualified nurse to determine competency. Staff were also given opportunities to study for nationally recognised care qualifications to support their personal development.

The service had an IT system that flagged up when training was due and prevented work being allocated if a staff member's training had lapsed. The staff we talked with were positive about the training provided and felt this equipped them with the appropriate skills to care for the people they visited. They told us, "The induction is really good and the training is detailed. Some is e-learning but a lot is hands on training; I prefer that", "The training is brilliant, second to none", "I am getting loads of training. We have to pass online exams" and "The training is fantastic, the best company for training. They look at the needs of people."

Arrangements were in place for staff to receive individual supervision and annual appraisal. The manager told us that supervisions for a minority of the 93 support staff were overdue. These sessions had been scheduled and were planned to be completed in the coming weeks. Consideration was being given to incorporating different care-related themes into the supervision process.

Staff confirmed they had regular supervision and that spot checks of their performance were also carried out. They told us, "The supervisions are usually with my team leader or case manager. They ask about training and if I have any concerns with the package" and "I feel completely supported, the nurse is brilliant and you can go to them for anything."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff were trained in the MCA to help them understand the implications for their practice and upholding people's rights. People and their families had agreed the content of their care plans and told us their workers sought permission at all times before providing care. The clinical governance lead told us consent was being more explicitly captured within the new electronic care planning system. A reassessment of one person's capacity was being instigated by the service due to deterioration in their mental health. No-one using the service currently had Court of Protection arrangements in place around their care and treatment.

People's nutritional needs and risks were assessed, care planned and, where required, food and/or fluid intake was monitored. Any assistance needed with enteral feeding (where food and supplements are provided through a tube in the abdominal wall into the stomach) was provided by staff who had been trained accordingly.

Staff prepared meals, snacks and drinks where this formed part of the person's care plan. They told us, "I record input and output on a fluid chart as the client has a catheter. I prepare food if requested, but work nights. The client wasn't eating so we were monitoring but they have picked up" and "We talk to the client about healthy eating and prepare what they want and when they want it." Relatives confirmed that staff assisted their family members appropriately with their eating and drinking needs. They told us, "They assess my relative all the time. She is on a peg feed, they monitor this carefully" and "They feed my relative with special (soft texture) food he can eat."

During the assessment process the service established people's medical history and their current physical and mental health conditions. We saw this information was used in detailed health care plans, with step-by-step protocols and interventions for meeting the person's needs. The manager explained that staff routinely worked closely with medical professionals involved in people's care. Staff were able to support people to access health services and attend appointments. A support worker told us, "We contact the district nurse, GP and other services. If we feel a referral is needed we will make it, or if unsure, we discuss it with the office." Hospital 'passports' had also been devised, to relay essential information and enable people's care and treatment to be co-ordinated in the event of admission to hospital.

Good

Is the service caring?

Our findings

People using the service and their relatives described having supportive relationships with their workers. They told us, "They are like one big family. They make my relative smile and have a good laugh with us. They know when my relative is down, they try to support her all the time", "Care workers are not a problem at all. I cannot fault them", "They're very good indeed" and "I can't sing her (regular worker) praises enough, she's very valued."

The manager told us 'meet and greet' visits had been introduced before new services were started. During these visits people and their families met their staff team and were informed about what they could expect from using the service. A support worker told us, "I received all my training prior to seeing the client. This is a new package, it is very early days and they are still coming to terms with the situation. I was introduced to the client and their family whilst they were still in hospital."

The recruitment of new staff considered their caring qualities, including questioning about person-centred care and respecting privacy and dignity. The manager said they attempted to match staff to people's preferences, wherever possible, and would change workers if asked, for instance, if there were compatibility difficulties.

The staff we talked with supported either an individual or a small group of people. They spoke warmly about the people they cared for and had a good understanding of their needs. Their comments included, "I have one amazing client to support. I have a good relationship with the client and their family. I'm a guest in their home" and "The package is made up of a number of staff who all know the client." Another support worker said, "It's lovely to see a client finally out of hospital after a long time, enjoying being back at home, comfortable with all their belongings, close to their family."

Staff were mindful of the ways they communicated, supporting people to exercise control and independence in their daily living. They told us, "With one client who was unable to communicate, I would go through the alphabet and they would indicate a letter. It allowed them to let us know what their wishes were", "I support one person with eating. It's at their pace and all about choices, from the meal to how the client likes to be supported", "I always ask the client's opinions, what do they want?" and "I'm always respectful of clients' needs and wishes. It's about being patient, allowing them to do as much as they can, encouraging but not pushing."

People and their relatives felt staff were caring, respectful and provided dignified care. Their comments included, "They are always good to me. Of course they respect me", "They give me respect, dignity and listen to me", "We are definitely happy. They are good and caring with my relative" and "They do everything for my relative and are very good. They are very patient with her, as she is difficult at times, but the care workers handle this very well."

Staff told us about how they maintained dignity when caring for people. They told us, "I cover the person as much as possible when supporting with personal care. Only people who are needed should be in the room"

and "We respect the client wishes, cover their private parts and make sure they are comfortable. I ask how they would like to be supported, if they want to clean themselves, or for me to do, and the type of product they want to use."

The service aimed to give people information in a way they could understand and support them in expressing their views. A guide to the service was provided which included contact details, key procedures and the duties staff would and could not undertake. The guide also set out the principles underpinning the service and informed people of their rights to privacy, dignity, independence, security and their civil rights. People and their relatives were routinely involved in care planning, asked for feedback at reviews, and could complete satisfaction surveys.

Good

Is the service responsive?

Our findings

Most of the people and relatives we talked with felt they received a reliable service. They told us their workers were always or usually on time, stayed for the agreed visit duration, and completed the care and tasks they required. Their comments included, "I have a team of care workers. I know them all and am happy with this" and "Yes we have good, regular care workers." One relative said they had brought issues to the attention of the service about different workers visiting, which had been responded to. They told us, "For the past month we have had the same care workers. This has been brilliant for my relative. It is truly brilliant at the moment due to the consistency."

The manager told us services were arranged in line with the extent of care and support that people required. They said they aimed to manage people's expectations, such as the timing of visits, and for staff to work flexibly to accommodate requests. Visits were never less than an hour's duration to ensure staff had enough time to provide the person's care and 24 hour care was provided, where needed.

A local authority commissioner commented, "We have been involved with a specific case and have found staff to be responsive to our findings." Another commissioner gave less favourable comments which we followed up with the manager. They acknowledged there had been times when decisions were taken to cease people's services due to reduced hours and funding. The manager told us in these instances they sought to continue provision of services, wherever possible, until another care provider could be established. Reports were also submitted to commissioners when people's services needed to be adjusted, to confirm the reasons.

Care records showed people's needs and any risks which could impact on their care had been thoroughly assessed. A 'rapid response' assessment was completed in the event of urgent referral to provide end of life care. Care plans were recorded to a good standard and described in detail the support required by staff to meet the person's identified needs. Each care plan was individualised and included a section with the person's comments about how they liked their care to be provided.

Reviews of each person's care and treatment were carried out at least monthly by the service's case managers and branch nurses. At times reviews were also done in conjunction with social workers.

Staff told us they felt they were given enough information about people's needs and how they preferred to be supported. A support worker said, "An initial care plan is in place when someone joins us, then more is added as we get to know what the person likes and dislikes." Another worker commented, "The client, their family and I all have input into the care plans. If anything changes I discuss it with the office". Staff confirmed they followed care plans and recorded handovers to keep other staff updated about people's well-being and any changes in their needs.

Where it formed part of the care plan, the service provided support to people to socialise and access the community. Staff told us, "We encourage the client to do activities but at the moment they are receiving lots of visitors. We arrange things for them, asking about films or just going out, it's early days" and "I currently

look after two clients. One is about social engagement, supporting them in the community. We go to the pub or for a walk and you can see they really enjoy it."

People and their families had been informed about the provider's complaints procedure. Most people we talked with had no concerns and felt the management were approachable, listened and acted on any issues they raised. We saw complaints received since the last inspection had been investigated and responded to. A further stage of appeal to the provider's clinical director was offered if a complainant was dissatisfied with the outcome of a complaint investigation. The service had also taken action in response to the findings of a complaint investigated by the Local Government Ombudsman office.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The provider had notified CQC in March 2017 about the registered manager leaving. The branch business manager was managing the service in the interim until a new manager was appointed and applied for registration.

The manager told us they were well supported in their role, with regular contact and at least weekly visits from their regional director who they described as being very 'hands-on'. They kept the regional director appraised of the running of the service, including staffing resources and any safety issues or potential risks to the business. Weekly branch meetings were held with the office based staff who had delegated accountability for co-ordinating different aspects of the operation of the service.

The provider had displayed the CQC's rating of the service on their website and in the service, as required, following the publication of the last inspection report. The manager and office based staff were aware of the requirement to notify the CQC of any events which affected the service.

As recommended at our last inspection, further action had been taken to review the planning of care visits and travel arrangements. Most people using the service now had regular support workers who mainly worked within particular geographical areas. Overlap in the timing of visits was being prevented and a new system for travelling costs had been implemented.

Staff we consulted expressed no concerns about their work and told us the service provided them with good leadership and support. Their comments included, "It's a good organisation to work for. I had an issue (about communication) and discussed this at supervision. They do listen because when it happened again it was very different", "I feel I am well supported. We have a good team and support each other" and "The nurses are great, very supportive." Some staff said they were able to work flexible hours and maintain a good work/life balance. We were told a support worker of the month award was being introduced, based on the CQC's five key questions, to commend staff for their work.

People and their relatives gave variable feedback about the running of the service. Most told us they were happy, with comments such as, "The company does have its moments. Before they were struggling, but now the new people in are much better, new nurse, new case workers. The company structure is much better and I am very happy the way it is being run at the moment" and "This is the best company I have had, I changed from another company. This company specialises for my relative. There is a new girl that has taken over, she is very good. They are very good with me."

One person and a relative told us they felt communication was problematic due to messages not being passed on and changes in case workers. The manager acknowledged there had been changes in personnel and staffing arrangements. They told us the service aimed to work inclusively, dedicating a case manager to

each person and their family, who reviewed their care service and sought feedback on a monthly basis, or more often if needed. A commissioner told us they were looking towards building a positive working relationship with the management in order to progress changes they required in a co-productive way.

The clinical governance lead had taken on responsibility for undertaking quality audits of the service. The audits were scheduled to take place every six months and were based on meeting the CQC fundamental standards of quality and safety. The clinical governance lead and other senior management also kept oversight of incidents logged via the branch's online reporting system. This included monitoring that all necessary remedial action was taken in response to accidents, untoward incidents, complaints and safeguarding issues.

Spot checks were conducted to ensure staff adhered to the provider's values and standards of care. Records were now also being regularly returned to the office for auditing purposes to validate the care people had received.

People and their families were invited to complete twice yearly surveys to rate their satisfaction with the service. Whilst only a small number had been completed, the findings from the latest 2017 survey were generally positive and were due to be shared with the manager. An action plan was then required to be formulated to address comments and demonstrate how people's views influenced the service.