Regulation 28 Report- Shawe Lodge- 16 November 2015

1. All staff have received further supervision and training in relation to documentation. This is a process that began in March and improvement is evident in current documentation. Instructions have been added to in relation to your specific concerns.
2. Staff requested a visit from a private podiatrist in relation to a corn on Mr Tolen's right toe. There was no evidence of infection and the visit, although required, was not deemed to be of an urgent nature. It has been requested of all staff that failure to receive a response to a message left should be reported immediately to a senior member of staff.
3. The Clinical Manager's response to your concern about training was intended to indicate that staff did not have training specific to podiatry requests. All nurses are aware of the procedure to follow should they have difficulty obtaining medical assistance. This support is available constantly through an established on call system within the home.
4. Circumstances surrounding Mr Tolen's admission to hospital were discussed by management at the time and staff were deemed to have acted immediately and appropriately in relation to suspected cellulitis . An investigation was carried out at the end of May in relation to actions surrounding the discovery of possible cellulitis at the request of the Safeguarding Team and submitted to them on 2 June. Staff appear to have acted promptly on discovery of imflammation to Mr Tolen's left lower leg and when visited by [redacted] it was not considered to be in need of antibiotic treatment. Staff also acted promptly the next day requesting a further visit due to deterioration and suggesting transfer to hospital.To date the outcome has not been received although we were informed that an inquest was to be held.
5. The notes written by staff at Shawe Lodge did not indicate that Mr Tolen's nail had been removed. This was an entry made by the podiatrist. The subsequent investigation for safeguarding contained an error made by myself when attempting to decipher the shorthand and abbreviation used by the podiatrist. All visiting professionals have been advised that the home will not accept the use of abbreviation and our own staff have also been reminded of this.
6. The diary is used as a communication tool from one shift to the next or as a reminder to themselves of what is required to be done the next day. As it is a document that relates to more than one resident details are kept to a minimum and should refer the reader to the resident's own notes. I would agree however that the notes are too brief and did not contain clear instruction or request. Neither did they contain clear explanation of progress to date. It has been requested of all staff that requests are stated clearly and that progress is recorded rather than ticking the message. The home does not have a GP visit book or an MDT visit book. This information is kept on sheets at the front of the resident daily notes and is intended to provide a quick reference to previous visits thereby removing the need to read through weeks or months of daily reports. These sheets should not, however, be used as a substitute for recording in the daily notes. All details should be entered in full in the daily notes with a brief explanation being entered on the visit record. This has been discussed with all nurses and is being monitored regularly.
7. The podiatrist stated at the inquest that staff were available, and initially present, to help with persuading Mr Tolen to move to another location but that Mr Tolen refused. Mr Tolen was independently mobile and his reasons for not moving were down to choice rather than ability. Whilst Mr Tolen had no issue with having his feet examined he became physically aggressive when it was suggested that he should move.

8. The podiatrist made the decision to examine Mr Tolen's feet in the lounge but this is not the policy of the home whether or not a procedure is planned. Staff have been requested to ensure that all intervention from any member of the MDT is carried out in the resident's own room. If this is not possible, for any reason, the appointment should be rescheduled.
9. Staff from Shawe Lodge did not advise that Mr Tolen was subject to a DoLS authorisation. This claim was made by Mr Tolen's wife and confirmed by her friend. Staff from the home disputed this claim but advised that, due to a delay between authorisations being requested and granted, they could not confirm that one had never been requested without having access to his full notes which were not brought to the inquest. This information was confirmed the next day as requested.