Dear Mr Gittins

Following issue of the Regulation 28 report please find below actions that have been taken by the Pendine Park Care Organisation.

1. All pre - admission assessments are now being conducted in person except for emergency admissions.

2. Our pre - admission assessment document has been updated and includes prompts to ensure all information is requested prior to admission , this includes a section for diabetes , see attached pre-
admission assessment document .

The information gathered in the pre -admission assessment is then used to formulate the care plan.

Yours Sincerely

[redacted]
Registered Manager Highfield & Nominated Responsible Individual for the Pendine Park Care Organisation

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Pre-Admission Assessment

All residents to be assessed before admission except emergency admissions to be assessed within 24 hours of admission. For the Assessment, have the Enquiry Form available, and update any gaps. To be completed by: Clinical Lead Nurse as relevant to conditions and/or Registered Manager or as authorised by RM. Use this Assessment to create the Care Plan then discontinue within Care Plan. Archive after 12 months.

Name of proposed Resident	Current Location
Date of Pre Admission Assessment	Pre Admission Carried out by
Proposed Date of Admission	Proposed Home / Room No (if known)

Privacy: **Please ensure proposed resident/representative is made aware**: All information recorded on this document is processed to decide if we can provide the required services and, if so, prepare for admission accordingly. On admission, this document will be part of the care and support plan. If services are NOT taken up with Pendine, this information will be disposed of securely. All Privacy Notices are on our website www.pendinepark.com/privacy.html

Pendine Admission Criteria & Control Check

All must be **Yes** to approve an Admission Date within next 5 days.

If time lapse between date of Pre-Admission Assessment and proposed date of admission is more than 7 days, have you ensured that the Pre-Admission data is still current and valid?	☐ Yes ☐ No	If no, ensure relevant information is sought and gained prior to making decision
If this is an EMERGENCY admission, have you obtained enough assessment information to make judgement?	☐ Yes ☐ No	If no, ensure relevant information is sought and gained prior to making decision
Have you got the DST and all other relevant Third Party Care Plans/Assessments relevant?	☐ Yes ☐ No	If no, do NOT admit until all received
Does the DST identify Category of Care and does this agree with the proposed admission?	☐ Yes ☐ No	If no, admission may not be possible. Discuss with relevant parties/RM/NRI.
Residential: Have the District Nurses been given the DST and are satisfied that they can provide appropriate care to support this admission?	☐ Yes ☐ No	If no, admission may not be possible. Discuss with relevant parties/RM/NRI.
Is all equipment in place to enable appropriate care to be delivered from admission onwards?	☐ Yes ☐ No	If no, do not admit until all relevant equipment in place.
Have you considered ALL factors and ensured there are no limiters to the admission?	☐ Yes ☐ No	If no, admission may not be possible. Discuss with relevant parties/RM/NRI.
Have fees been formally agreed with family and/or funding authority?	☐ Yes ☐ No	If no, admission may not be possible. Discuss with relevant parties/RM/NRI.
Are you satisfied that the proposed admission is appropriate and all assessed needs can be met?	☐ Yes ☐ No	If no, admission may not be possible. Discuss with relevant parties/RM/NRI.
Have Resident and family made a definite decision to come to Pendine home AND proposed admission is appropriate with an admission date within next 5 days?	☐ Yes ☐ No	If no, await decision. If yes, bed can be held for 5 days. If admission date moves forward, bed may not be held, without SRI's express agreement and a (SRI's discretionary) non-refundable fee.

Pre-Admission Communication

EMERGENCY ADMISSIONS	☐ Ensure admitting staff are aware that information within the Pre-Admission may not be sufficient and assessments must reflect this
Care Planning	☐ Ensure blank Care Plan has been requested including any Advanced Assessments and Care Plans that will be required (**complete and send pages 17/18 to Admin**) ☐ Consider Primary and Named staff – noting Resident preferences & current allocations? ☐ **Primary Nurse:** ..... ☐ **Primary CP:** ..... ☐ **Named CP:** .....
Equipment	☐ Ensure all equipment required is in place prior to admission
Nursing & Care Department	☐ Ensure relevant staff updated regarding all physical health, behavioural, personal care and enrichment needs. DIARY POINT and prepare.
Catering Department	☐ Ensure relevant staff are updated regarding any special diets, special aids, allergies etc ☐ Complete dietary needs including food levels on **Page 17/18 and send to Admin**
Housekeeping & Laundry	☐ Ensure relevant staff updated regarding any allergies or special requests
Administration Department	☐ Ensure relevant staff updated regarding proposed admission date, room number, funding issues etc
Maintenance Department	☐ Ensure relevant staff updated regarding any special equipment/servicing/room adaptations required/extra electrical sockets etc

Pre-Admission Assessment

Resident Personal Details			
Full Name			
Title		Known as	
Current Location			
Home Address		Tel No(s)	
Date of Birth		Marital Status	
Ethnicity		First Language	

Contacts	**Next of Kin / Closest Relative**	**Second Contact**
Name		
Relationship		
Address		
Tel No		
Mobile		
Email		
	Current GP	**Care Manager/Social Worker**
Name		
Address		
Tel No		
Email		

Will Resident retain this GP: ☐Yes ☐ No	Third Party Care Plans Exist ☐Yes ☐ No
If No, contact local surgeries or HB to secure/register GP	e.g. LA/CHC, physio, SALT, dietician etc If yes, obtain copies

Consultant and Professional Contacts (Consultants, CPNs, District Nurses, Advocate, IMCA etc)

Name	Role	Contact Details

Funding Source	☐ LA ☐ LHB - CHC ☐ LHB – Sc117 ☐ Joint LHB/LA ☐ Private
Name	
Address	
Tel No	
Email	
Continuing Care App Status:	

Note: For all physical, behavioural and personal care, record any staff preferences or specific needs (i.e. gender, height, strength, triggers behaviours etc)

Physical Health

Past and Current History and Physical Health (include relevant dates)

Resident's understanding of what is happening to them

Medication

List Current Meds Explain kept in Pharmacy where administered. Explain policy on self-administration/homely remedies	.....

Resident wish to self-administer? ☐Yes ☐ No If yes inform multi-disc. Ass't is required & will be carried out in due course

Does Resident require Insulin to be administered by Community Nurses? ☐Yes ☐ No
If Yes, has Discharge Team notified Community Team & confirmed they have capacity to action this? ☐Yes ☐ No

Covert Administration Plan in Place? ☐Yes ☐ No If yes, plan available? ☐Yes ☐ No

Vaccines – Provide dates of most current

Flu		Covid		Other	

Pain - State if Acute or Chronic and provide details including signs of pain and management thereof	.....

Allergies

Allergies - Food / Drink / Conditions e.g., shellfish, hay-fever, bee stings etc	.....
Allergies - Medication	.....
Allergies – Skin i.e., washing powder, plasters etc	.....

Breathing						
Oxygen Therapy?	☐Yes ☐ No	Saturation Levels	%	Normal Range	% to	%
Plan if out of normal range on discharge						
Oxygen Suppliers				How much O2 in place:	litres	
Oxygen Therapy Contact		Tel		Email		
Nebulisers						
Inhalers - Preventers						
Inhalers - Relievers						
Smoking Habits / History	.....					
History of Asthma, COPD, or other Lung Conditions	.....					
History of Heart Disease	.....					
Tracheostomy Type		Size		Date Last Changed		
Ventilation	.....					
Suction Frequency		Suction Machine Required If yes, check availability		☐Yes ☐ No		
History of DVT / Embolism / Anti-coagulants use or need	.....					

Diabetes

Diagnosed?	☐ Yes – Type 1	☐ Yes – Type 2	☐ Yes - Prediabetic	☐ No – skip section
First Diagnosed				
History	.....			
Blood Glucose	From:	mmols/l	To:	mmols/l
Current BM Charts	☐ Viewed in Hospital/Current Setting	☐ Copies provided	☐ Not seen	
Risk?	☐ Hypo ☐ Hyper	On Insulin?	☐ Yes ☐ No	
Insulin Type		Dosage		Route:
Antidiabetic meds				
Current HbA1c	%	Target HbA1c	%	
Test Frequency		Date of last test		
Plan if outside Blood Normal Glucose Range on Discharge	.....			

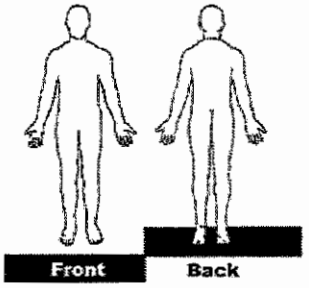
Elimination and Continence

Urinary	☐ Fully Continent ☐ Incontinent – type:	☐ Functional ☐ Stress	☐ Overflow ☐ Urge
Bowel	☐ Fully Continent ☐ Incontinent – type:	☐ Functional ☐ Constipated	☐ Leakage ☐ Urgency
Continence Products	☐ Bladder ☐ Bowels	Date Assessed and Referred for Products	
Products	.....		
Catheterisation	☐ Urinary Catheter	Size and Type	
		Date last changed	
	☐ Trial without Catheter	Outcome	
History of any Bowel Issues	.....		
Stoma – Size and type of bag			

Teams	Contact	Tel	Email
Urology			
Bowel			
Stoma			

Nutrition and Hydration							
Special diets incl. diabetic, vegetarian, low fat/salt, supplements etc	.....						
Textured diet or as assessed by SALT	.....						
Food Level			**Fluid Level**				
Food Likes							
Dislikes/foods to avoid							
Assistance with Eating / Drinking Required	.....						
Special cutlery/ crockery							
NG/PEG Feed	☐ Bolus ☐ Flex	Size		Type		Feed & rate per hour	
Last changed			Proposed date of Re-insertion				
History of Weight Loss/Gain and Current Management	.....						
Weight (Kgs):			**Height (m):**				
History of Eating Disorders - Anorexia, Bulimia, Obesity etc	.....						

Teams	Contact	Tel	Email
Comm. Dietician			
S&L Therapist			
PEG Nurse			

Tissue Viability and Pressure Care			
Current Maelor Score		How often repositioned:	
Pressure Relieving Equipment (check availability)			
Skin Condition (History / Current)	.....		
Pressure Ulcer(s)?	☐Yes ☐ No	Moisture Lesion(s)?	☐Yes ☐ No
If yes, give details including Grade & note on Body Map	..... 		
Dressings used			
Vascular Issues with Legs i.e., Venous leg ulcers? If yes, give details including management thereof	☐Yes ☐ No		
Any Malignant Lesions? If yes, give details including management thereof	☐Yes ☐ No		
Diabetic Foot Care Regime	.....		

Teams	Contact	Tel	Email
TVN			

Safety, Mobility, and Movement					
Mobility	☐ Independent ☐ Immobile	☐ Walks with aids: ☐ Walks with assistance e.g. 1 or 2 staff	☐ Frame	☐ Walking Stick	
Wheelchair Type					
Resident's Own Equipment - list					
Moving and Handling - Transfer method & number of persons required					
To/from chair					
To/from bed					
To/from toilet					
Hoist type		Sling size			
Bed type		Bedrails/bumpers			
Shower chair		Bath support			
Crash mats		Other			
Conditions e.g. bariatric/MS etc					
Falls, Accidents, or Incidents					
History of Falls?	☐Yes ☐ No				
If yes, give details and reasons for falls (dizziness, activities, environment, unknown etc)	.....				
Risk Factors i.e., osteoporosis, fractures, anorexia/bulimia/ excessive exercise/ hormones	.....				
Unsteady when standing/walking?	☐Yes ☐ No				
If yes, give details	.....				
Known to Falls Team?	☐Yes ☐ No	Referrals made?	☐Yes ☐ No	Risk Assessment available?	☐Yes ☐ No
Fire Evacuation Factors Include smoking, mobility, capacity etc	.....				

Communication and Sensory Loss - *Include how needs are expressed and any sensory aids*	
Speech and Language	.....
Sensory Aids	
Sight	.....
Sensory Aids	
Hearing	.....
Sensory Aids	
Reproductive Needs	
Last Menstrual Period and any Menstrual Issues	.....
Use of Birth Control / HRT / Hormonal Issues	.....
Reproductive Health History including Cancer – Ovarian, Breast, Testicular, Prostrate etc	.....
Current Investigations / Awaiting Results	.....

Infection Control	
Any Infections e.g. MRSA, C Diff, TB, Hepatitis, HIV, Skin Infections, etc	.....
Seizures / TIAs	
Conditions affecting Consciousness – History of Vasa Vagal, Passing Out, Brain Lesions or Abnormalities	.....
Neurological Conditions	
Huntington's Disease, Traumatic and/or acquired Brain Injuries, Strokes etc	.....
End of Life / Palliative Care	
End of Life Care Details	.....

Legal Documents	In Place	Copy Available	Original on Discharge
Advance Directive	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
Living Will	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
DNACPR	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No

Mental Health, Cognition, and Behaviours

Has Mental Capacity been assessed?	☐Yes ☐ No		
If yes, by whom?		Date assessed:	
Give outcome	.....		
Has best interest decision been made?	☐Yes ☐ No		
If yes, give details	.....		
Any known MHS Tribunal Dates?	☐Yes ☐ No		
If yes, give details	.....		
DoLS?	☐Yes ☐ No		
If yes, give details			
Court of Protection – H&W?	☐Yes ☐ No	Court of Protection – Finance?	☐Yes ☐ No
Incapacity Order?	☐Yes ☐ No	Guardianship?	☐Yes ☐ No

POA	**Health & Welfare**	**Property & Finance**
Name		
Relationship		
Address		
Tel No		
Mobile		
Email		
Copy?	☐Yes ☐ No	☐Yes ☐ No

Past and Current history of any cognitive disorders / conditions / mental health	.....

Cognition – Impression of cognitive ability during assessment	.....
To support, you can ask an appropriate question to assess levels of cognition. Ensure question is asked within the general flow of any conversation so as to not be judged as an assessment and they are at ease whilst doing so – see prompts: Prompts: age, time, home address, current year/location, recognise 2 people, date of birth, well known historical dates, well known current facts such as name of present Prime Minister/Monarch etc	
One to One Needs and any Funding	.....
Safeguarding?	☐Yes ☐ No
If yes, give details	.....
Past Trauma / History of PTSD and other Stress/Anxiety Disorders i.e., OCD	.....
Vocal or other Disruptive Periods likely to affect Others	.....
Physical or Verbal Attacks on Others or Interference with Other's Property	.....
Ability to Manage Diet, Hygiene, or Appearance	.....

Compliance to Participate with Prescribed Care (Non Compliance)	.....
Self-Injurious Behaviour / False Allegations / Suicide Ideation	.....
Wandering and any history of absconsion	.....
Sexual Disinhibition	.....
Night Disturbances	.....
Repetitive Behaviour	.....
Signs and Triggers	.....
Describe Current Behaviour Management – and how can this be managed	.....

Teams	Contact	Tel	Email
CPN			
Consultant			

Personal Care Needs and Activities of Daily Living Skills

Record ability to make choices and perform without supervision or assistance

Washing Body, Hands and Face	.....
Bathing/ Showering	.....
Grooming (including shaving, hair, make up etc)	.....
Dressing/ Undressing	.....
Oral Health	.....
	☐ Dentures If yes, please indicate type: ☐ Top ☐ Bottom ☐ Full Set
	Dentist required: ☐Yes ☐ No
Foot Care	.....
	Chiropodist required: ☐Yes ☐ No Podiatrist required: ☐Yes ☐ No
Sleeping Pattern Restlessness Difficulties Disorders (apnoea/walking/ night terrors) and how to manage	.....
Resting / Naps	.....

Enrichment *If possible, give some details on the following. Explain full assessment taken during and after admission.*	
Their life story so far	.....
Significant things about them (personality, major achievements, etc)	.....
Things important to them including dislikes	.....
Hobbies and interests	.....
Religious Cultural Spiritual Info	.....
Practising	☐Yes ☐ No

Family Involvement / Support Network	.....
Consultation with carers/reps/ relatives - how they would like to remain involved?	.....

Any Other Factors / Additional Information

Any other factors that may influence the decision to admit	.....
Any other comments/ Additional Information	.....

Name of Assessor:		**Position:**	
Signature:		**Date:**	