



Hartlepool
Borough Council

ADULT SERVICES & PUBLIC HEALTH

Quality Standard Framework

Organisation

HC-One

Home

Brierton Lodge

Responsible Person

Jayne Parkins

Date of Report

15th May 2026

Commissioned Services Team, Adult Services & Public Health

Overview of Home

Brierton Lodge is a nursing home for older people providing residential, nursing and dementia care with 58 en-suite bedrooms over two floors.

All people have a person-centred care plan that is monitored, reviewed and understood by staff and the move to the electronic care record system has had a positive impact on care planning at the home.

People have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so.

People are treated with respect and dignity at all times while they are receiving care and support and they have choice and control over how they spend their days.

Processes for gathering resident and relative feedback could be improved and the home needs to evidence the actions and lessons learned when issues and concerns have been raised.

The home has been following the action plan set by the Medicines Optimisation team, as a range of issues have been identified in relation to good medicines management.

Staff are trained, supported and have effective means of communication which enables them to deliver high standards of care. The service works effectively in partnership with other agencies and professionals.

Staff respond quickly to residents' needs and the care staffing levels within the home are regularly assessed.

There are effective assurance and auditing processes to assess, monitor and drive improvement in the quality and safety of the services provide.

Summary of Outcomes

Brierton Lodge

Date of Report - 15-May-2026

Determination

Person Centred Care

- 1 - Assessment & Review
- 2 - MCA & Consent
- 3 - DoIS
- 4 - Nutrition & Hydration
- 5 - Promoting Dignity, Autonomy & Choice

Outcome "Fully Met" – 15 May 2026
Outcome "Fully Met" – 21 February 2024
Outcome "Fully Met" – 21 February 2024
Outcome "Fully Met" – 15 May 2026
Outcome "Fully Met" – 15 May 2026

Safe Care and Treatment

- 6 - Safeguarding/Understanding Safeguarding
- 7 - Medication
- 8 - Infection Control
- 9 - Premises & Equipment
- 10 - Health & Safety
- 11 - Moving & Handling

Outcome "Fully Met" – 21 February 2024
Outcome "Substantially Met" – 15 May 2026
Outcome "Fully Met" – 21 February 2024
Outcome "Fully Met" – 21 February 2024
Outcome "Fully Met" – 21 February 2024

Governance

- 12 - Leadership & Management
- 13 - Staffing, Recruitment, Support & Learning
- 14 - Quality Assurance
- 15 - Complaints

Outcome "Fully Met" – 15 May 2026
Outcome "Fully Met" - 15 May 2026
Outcome "Fully Met" – 15 May 2026
Outcome "Fully Met" – 21 February 2024

1 - Assessment & Review

Outcome Assessed – Fully Met

The home moved to using electronic care record system 'Nourish' in early 2025. The transfer from paper based to electronic records was well handled and the change has had a positive impact on care planning at the home.

All people receiving the service have a written care plan that is monitored, periodically evaluated and reviews are recorded to ensure the information is up to date and accurate.

People's physical, mental health and social needs holistically are assessed, and their care, treatment and support is delivered in line with relevant legislation and guidance, to achieve effective outcomes.

Generally, people's care records are accurate, complete, legible, up-to-date, securely stored and available to relevant staff so that they support people to stay safe.

The move to an electronic care planning system has help to resolve the previously identified issues around the order, layout, duplication and non-required documentation.

The service ensures that people are provided with the information and understanding about their healthcare and treatment options.

In general, people's health is monitored regularly and professional involvement is sought in a timely manner when required.

People can access care, support and treatment in a timely way and in general, referrals are made quickly to appropriate health services when people's needs change.

People contribute to planning their care and support, with their strengths, levels of independence and quality of life are taken into account.

It was unclear through recording, how much regular involvement and input that families and advocates have in care planning.

In general, people's care plans reflect their physical, mental, emotional and social needs and attempts are made to capture people's personal history, individual preferences, interests and aspirations. Care plans are understood by staff so people have as much choice and control as possible.

People's oral health needs are met and kept under review with professional guidance sought in a timely manner when required. There was no evidence of oral health training viewed on the staff training matrix.

Generally, the service shares appropriate information and assessments with other relevant agencies for the benefit of people who use the service, in a timely manner.

The service attempts to gather people's preferences and choices for their end of life care and these are recorded, reviewed and communicated and acted on where

possible. Family, friends and other representatives are involved in planning, managing and making decisions about their end of life care including advanced decisions made in line with the Mental Capacity Act 2005, however people and families do not always wish to engage in planning in advance.

The service ensures that it quickly identifies people in the last days of life whose condition may be unpredictable and change rapidly and, where required ensures that people have rapid access to support, equipment and medicines including from specialist palliative care professionals.

There was no evidence of end of life training viewed on the staff training matrix, however it showed that four staff members have completed verification of death training.

The service supports people's families when someone dies, however policies and procedures do not state how staff and other residents are supported at this time.

There is an expectation that the home will complete the "Is My Resident Unwell" tool for each referral and that the tool will also include a NEWS2 score.

The service has been inconsistent month by month with NEWS observations during 2025/26 with 3 months over 100% Baseline Observations but overall has a good 12 month average of 81%, see appendix 1.

Data shows that the home have been making good use of the 'Is My Resident Unwell' tool during 2025/26. Improvements are required for the home to increase their % completion of IMRU in comparison to the number of escalations recorded, as the 12 month average was 27%. Further information is provided at appendix 2.

The Home has demonstrated achievement of this outcome.

The move to the Nourish electronic care planning system has helped to resolve the previous issues, where care plans could contained gaps, inconsistencies and incomplete documents. The frequency and quality of daily recordings have also improved. There have been some issues with the home extracting information required from the Nourish system but this appears to be resolved.

2 – Mental Capacity Act & Consent

The findings below are from the Quality Standards Framework Report for Brierton Lodge dated 21 February 2024 at which time the home was assessed as fully achieving the outcome.

Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Source - QSF Report 21ST February 2024

Staff recognise when people need and want support from their carers, advocates or representatives to help them understand and be involved in their care, treatment and support and staff help people to get this support.

The service provides information to people and their families about organisations and advocacy services that can provide independent support and advice about their care, treatment and support.

Staff understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and other relevant national guidance.

People are supported and are given the information and explanations they need to make their own decisions in line with relevant legislation and guidance.

Decisions around a person's possible lack of mental capacity are assessed and recorded.

When people lack the mental capacity to make a decision, staff ensure that best interest decisions are made in accordance with legislation.

The process for seeking consent is monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance.

There are arrangements for people to be involved in decisions about managing risks appropriately including positive risk taking.

Risk management policies and procedures are in place to minimise restrictions on people's freedom, choice and control, in particular for people who lack mental capacity.

Staff are trained to understand, prevent and manage people's behaviour that challenges whilst ensuring the individual is supported appropriately.

The service identifies and meets the information and communication needs of people with a disability or sensory loss. Information is recorded, highlighted and shared with others when required with the consent of the person.

The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

3 - DoLs

The findings below are from the Quality Standards Framework Report for Brierton Lodge dated 21 February 2024 at which time the home was assessed as fully achieving the outcome.

Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Although not all of the elements of this outcome have been assessed for this report, assessments have been undertaken to ensure the home continues to maintain processes and procedures for tracking and recording DOLS applications. The home has

a matrix in place to ensure DOLS are reapplied for as required, in a timely manner. When DOLS applications have been granted, the home generally ensures that these are present within the care plan in a timely manner.

Source - QSF Report 21ST February 2024

The service promotes supportive practice that avoids the need for physical restraint, however where physical restraint is necessary, the service ensures that it is used in a safe, proportionate, and monitored way as part of a person-centred support plan.

Staff recognise when people who lack mental capacity, are being deprived of their liberty and they seek authorisation to do so when considered necessary and proportionate.

Most staff are trained to understand the difference between lawful and unlawful restraint practices. Action is taken to minimise the use of restraint.

There is a system of monitoring to ensure the person's representative maintains regular contact with the person and acts when contact is not maintained.

The service has a system to monitor DoLS authorisations and their review dates however some additional processes have been advised for the service to evidence that DOLS have been reapplied for but the service is awaiting the granted application to be returned from the local authority.

The service must ensure that the DOLS application and authorisation log is accurate and kept up to date to effectively monitor the process.

Management has oversight on the process to ensure where a restriction may actually amount to a deprivation of liberty.

The Home has demonstrated achievement of this outcome.

4 - Nutrition & Hydration

Outcome Assessed – Fully Met

People are involved in decisions about what they eat and drink and any cultural and religious preferences are recorded, reviewed and acted upon.

The home does not always have an advertised food menu and occasionally, the menu does not correspond with the food options available on the day.

People have access to dietary and nutritional specialists to help meet their assessed needs if required.

People receive prompts and encouragement to eat and people appear to enjoy mealtimes and do not feel rushed.

Risks to people with complex needs or lack capacity are identified and managed in relation to their eating and drinking.

Most staff have up to date food hygiene training and the correct procedures are in place and followed wherever food is prepared and stored.

People have accurate nutrition and hydration assessments for eating and drinking which are carried out by trained staff.

People receive support to be independent. Their wishes are recorded, reviewed and acted upon wherever possible. Staff help to ensure that people's dignity is maintained during mealtimes.

The service is aware of specialist diets, allergies, choking risks and lifestyle choices, and these are recorded, kept up to date and shared as appropriate.

People have access to any specialist equipment required, in a timely manner to meet their assessed need.

Drinks are offered throughout the day and when required, people's intake is monitored to ensure their assessed needs are being met.

People can choose the location of where they eat including the dining room, their own room or communal areas and are supported to do so.

The dining rooms were generally observed to be clean and tidy.

People are offered a choice of food and drink, quantities appeared sufficient and food was served at an appropriate temperature. Snacks are offered outside of mealtimes but it was not clear whether residents could make requests any time of day.

People can choose to eat in their own rooms or communal areas and they are checked on regularly.

The Home has demonstrated achievement of this outcome.

5 - Promoting Dignity, Autonomy & Choice **Outcome Assessed – Fully Met**

Staff show concern for people's wellbeing in a caring and meaningful way and respond to their needs in a timely manner on a day to day basis.

The service has processes for people, and those close to them, to feel like they matter, and that staff listen to them and talk to them appropriately and in a way they can understand.

The home could improve how feedback is regularly gathered from residents and relatives. Monthly residents / relative meetings are advertised but can be poorly attended and ineffective. No resident / relative surveys have been completed since 2023 and the previously advertised "you say, we did" initiative, was no longer seen publicised at the home.

There are some examples of people being involved in developing the service including:• deciding how they choose to spend their day• planning activities and outings• decisions around personal care and how and when help is provided devising menus and the timing

and place of meals, and people are consulted when alterations to their living space is planned, when it is possible and appropriate for them to do so.

Staff generally seek accessible ways to communicate with people (when their protected and other characteristics under the Equality Act make this necessary) to reduce or remove barriers.

Staff know the people they are caring for and supporting, including their preferences. Attempts are made to capture people's backgrounds and life histories, in conjunction with families where possible.

Staff make sure that people's privacy and dignity needs are understood and respected including during personal care.

People receive support to be independent as possible. Their wishes are recorded, reviewed and acted upon wherever possible.

People's relatives and friends are made to feel welcome and are able to visit without being unnecessarily restricted. There are arrangements to encourage relatives and friends to provide feedback on the service.

Processes are in place to ensure there is no discrimination when making care and support decisions.

There are some examples of residents being supported to follow their interests and take part in activities that are appropriate.

The home has some links with the local and wider community, but these could be further developed and should include more opportunities for a range of regular planned outings for residents.

The service ensures that people are encouraged and supported to develop and maintain relationships with people that matter to them.

The service has two nominated Dementia champions who oversee standards in the service.

The Home has demonstrated achievement of this outcome

Safe Care & Treatment

6 - Safeguarding

The findings below are from the Quality Standards Framework Report for Brierton Lodge dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Although not all of the elements of this outcome have been assessed for this report, assessments have been undertaken to ensure safeguarding referrals are completed when incidents occur, appropriate investigations take place and the outcome is shared with the resident, families and advocates.

A safeguarding log is maintained to ensure the home and professionals can track progress from start to finish including analysis of lessons learned.

The home continues to have a robust Whistle Blowing Policy and staff are aware of the escalation process should this be required.

Source - QSF Report 21ST February 2024

Safeguarding systems, processes and practices are in place, staff are aware and any updates are communicated to staff.

Systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect.

Staff can recognise signs of potential abuse and know what to do when abuse is suspected. It is unclear if safeguarding is covered as part of staff induction.

Processes are in place to ensure people are protected from discrimination, harassment and abuse, in line with the Equality Act.

People are supported to understand what safeguarding means, and they are encouraged to raise any concerns.

If people are subject to a safeguarding investigation, they are supported during this process.

Staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate.

There are processes for reviewing and investigating safeguarding incidents when they occur. Relevant staff, services, partner organisations and people who use services are involved in reviews and investigations

Safeguarding investigations, reviews and audits ensure lessons can be learned to improve how care, treatment and support is delivered.

The Home has demonstrated achievement of this outcome.

7 – Medication

Outcome Assessed – Substantially Met

It is vitally important that the service ensures the Council are fully informed of all medication incidents and near misses. It is mandated by the Teeswide Safeguarding Adults Board that Councils collect this information from all regulated services. The Council therefore requires homes to provide a monthly schedule of incidents or a statement of “nil return”.

The service has been poor in complying with this requirement having submitted information on only 7 occasions in the last 12 months with none being received since October 2025 – see appendix 3 for further information.

The medication outcome has been assessed by the Medicines Optimisation Service and further information can be found in the Assessment Report dated 29-Sept-25 appended to this report.

The Home has not demonstrated achievement of this outcome.

There have been some examples where administration of medication has not been in-line with requirements as well as some examples of poor documentation and record keeping.

Although some improvements have been made and the home has been following the action plan set by the Medicines Optimisation team, a range of issues have been identified in relation to good medicines management.

The level of impact has been assessed as low – there is no or minimal impact on residents.

The likelihood that the impact will happen or recur has been assessed as possible – the impact may happen/recur but it is not a persistent issue.

The home must continue to work to the action plan to demonstrate further improvements and ensure these improvements are sustained.

8 - Cleanliness and infection control

The findings below are from the Quality Standards Framework Report for Brierton Lodge dated 21 February 2024 at which time the home was assessed as fully achieving the outcome.

Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Although not all of the elements of this outcome have been assessed for this report, evidence has been provided to confirm the home has appointed an Infection Control leads who have undertaken a training course with the Infection Prevention Control

Service from the University Hospital of Hartlepool & North Tees to ensure they fully understand the remit of the role.

The service has completed a self-assessment of their work practices and scored 100% although this has not been verified.

Source - QSF Report 21ST February 2024

There are arrangements for making sure that premises are kept clean and hygienic so that people are protected from infections that could affect both staff and people using services. This includes:- Up to date Policy and procedure- Staff Training, including with the IPC Nurses- Necessary resources- Risk Assessments- Cleaning Records/Schedules- Quality Audits

Staff understand their roles and responsibilities in relation to infection control and hygiene and providers support with this.

Policies and procedures are maintained and followed in line with current relevant national guidance.

The service ensures that it alerts the right external agencies (e.g. HBC, visitors, and professionals) to concerns around infections that affect people's health and wellbeing.

The home has designated IPC Champions.

The service does not complete essential steps or hand hygiene observations but the manager advised that staff complete an IPC compliance log but this was not provided as evidence.

The Service provides and maintains a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

On occasion the service has sought advice and guidance from the Infection control nurse.

The Home has demonstrated achievement of this outcome.

9 - Premises & Equipment

The findings below are from the Quality Standards Framework Report for Brierton Lodge dated 21 February 2024 at which time the home was assessed as fully achieving the outcome. Reports from previous QSF assessments have shown the home has consistently met this outcome since the assessment framework was revised in 2021.

Source - QSF Report 21ST February 2024

Technology is used to support people to receive timely care and support and is easy to use. Equipment, which is owned or used by the provider, is managed to support people to stay safe.

The premises and safety of communal and personal spaces (such as bedrooms) and the living environment are checked and managed to support people to stay safe.

Learning from lessons is shared to make sure that action is taken to improve safety across relevant parts of the service. Staff learn from reviews and investigations by other services and organisations.

The service has arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations and reviews. Information is shared to staff when appropriate.

Examples were provided to demonstration that people are involved in some decisions about the environment but this could be improved to ensure residents and relatives are actively involved in more decisions whenever appropriate.

People have access to appropriate spaces: • in gardens and other outdoor spaces• to see and look after their visitors • for meaningful activities • to spend time together • to be alone.

The signage, decoration and other adaptations to the premises help to meet people's needs and promote their independence. The premises meet people's diverse care, cultural and support needs. Recent improvements have been made to the environment at the home which have been well received. Staff with responsibility for maintaining equipment are appropriately trained to ensure it is fit for purpose. There are plans for responding to emergencies or untoward events, and these are understood by all staff.
The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

10 - Health & Safety

It has not been possible to complete the Health & Safety Assessment and verification this year. The Council will continue to develop the process for further assessment outside of the Quality Standards Framework.

11 - Moving & Handling

The findings below are from the Quality Standards Framework Report for Brierton Lodge dated 21 February 2024 at which time the home was assessed as fully achieving the outcome.

Reports from previous QSF assessments have shown the home has consistently met this outcome since 2021.

The service has evidenced it generally works in partnership with the HBC Falls Prevention Team to analyse trends in falls within the home and to identify preventative measures to protect residents where possible.

Source - QSF Report 21ST February 2024

There is an up to date Moving and Handling Policy in place.

People who use the service are assessed in relation to their mobility needs and referrals are made to specialist agencies in a timely manner. Services using specialist equipment include an OT assessment.

The service ensures that risk assessments are in place where appropriate

There is professional instruction/task guidance detailed in people's support plans, which is in date and followed by staff.

The HBC Falls team have advised that in 2023 the number of falls referrals submitted by the home has increased significantly on the previous year but the quality of the referrals completed still vary depending on the worker completing. It is positive that the home have recently accessed falls training for staff which includes the completion of falls documentation.

People are encouraged to assist, where safe to do so, in their own transfers.

When support is being given to move people, reassurance is given in a compassionate manner by staff.

The service has procedures in place to ensure that staff have skills, competencies, qualifications, experience and knowledge, to meet people's individual needs. The Service can evidence that:(a) Staff have had Moving and Handling Training within the last 12 months.(b) Moving and handling training is provided by a competent trainer.(c) Trained staff monitor staff techniques on a periodic basis.

Equipment is checked, maintained and serviced to ensure it is safe for staff and people to use.

Moving and handling equipment is used in accordance with manufacturer's guidance.

There been no near misses or accidents whilst hoisting in the last 12 months.

The Home has demonstrated achievement of this outcome.

Governance

12 - Leadership & Management

Outcome Assessed – Fully Met

There is a well-established registered home manager, who has been in the post since 2020. A newly appointed deputy manager joined the home in 2025.

There are arrangements including within the rotas, for making sure that staffing levels are sufficient, staff have the right mix of skills, competencies, qualifications, experience and knowledge, to meet people's individual needs and personal preferences are accounted for where possible.

Managers are aware of the day-to-day culture in the service including the attitudes, values and behaviour of staff. They encourage staff to feel positive and proud to work in the organisation

The manager makes sure that staff are supported, respected and valued. Their rights and wellbeing are protected and they are motivated, and caring.

The service shows honesty and transparency from all levels of staff and leadership following an incident. This is shared with people using the service and their families in line with the duty of candour. The service ensures people are supported when incidents occur.

Leaders have the skills, knowledge, experience and integrity they need to lead and inspire staff effectively.

The service has a clear vision and set of values and leaders make sure that these are promoted and understood by staff and embedded into practice.

The organisation promotes equality and inclusion within its workforce and the staff training matrix shows that most staff have up to date equality and diversity training.

All relevant legal requirements are understood and met, including CQC registration requirements, safety and public health related obligations, and the submission of notifications.

During interviews, staff advised that they were encouraged to give feedback and processes were in place to be able to do so and examples were provided of how they were involved in developing the service.

There are some links with the local community but these could be strengthened.

The service works in partnership with key organisations, including the local authority, safeguarding teams and clinical commissioning groups and multidisciplinary teams, to support care provision, service development and joined-up care and does so in an open, honest and transparent way.

The service has clear disciplinary procedures which are followed when it identifies that staff are responsible for unsafe practice.

The Home has demonstrated achievement of this outcome.

13 - Staffing, Recruitment, Support & Learning **Outcome Assessed – Fully Met**

Staff received appropriate induction upon commencement of employment.

Staff receive effective training in safety systems, processes and practices and this is reviewed regularly.

Staff receive feedback from managers in a constructive and motivating way, which enables them to know what action they need to take.

The service makes sure that responsibility and accountability is understood at all levels with clear and transparent processes in place for staff to account for their decisions, actions, behaviours and performance.

Staff are supported and protected when raising concerns and questioning practice including whistle-blowers.

Safety is promoted in recruitment practices, arrangements to support staff, training arrangements, disciplinary procedures and observations.

Staff respond in a compassionate, timely and appropriate way when people experience physical pain, discomfort or emotional distress.

People have their assessed needs, preferences and choices met by staff with the right qualifications, skills, knowledge and experience.

Staff are supported to keep their professional practice and knowledge updated in line with best practice.

Staff teams work collaboratively, share responsibility and resolve conflict quickly and constructively. There are cooperative, supportive and appreciative relationships among staff.

There are effective systems of communication to ensure information is shared timely and appropriately so staff can carry out their roles and responsibilities effectively.

The service gives staff the time, training and support they need to provide care and support in a compassionate and personal way. Staff have time to listen to people, answer their questions, provide information and involve people in decisions

The Home has demonstrated achievement of this outcome.

14 - Quality Assurance **Outcome Assessed –Fully Met**

The service maintains a log of whistleblowing, staff concerns, safeguarding and accidents or incidents and investigates each incident thoroughly. Action plans are developed and monitored to ensure actions are completed.

When incidents occur they are investigated and analysed to look for common themes and trends to ensure lessons are learned. Action is taken to continually drive improvement.

The service ensures that its approach to quality is integral and all staff are aware of potential risks that may compromise quality.

The service enables and encourages accessible open communication with all people who use the service including their family, friends, staff and representatives.

Improvements could be made to how people's views and experiences are gathered.

Resources and support are available to develop staff and teams and drive improvement; examples were provided in discussions with management and staff.

Quality assurance systems enable the service to evaluate and learn from current performance ensuring continuous improvement and to improve future performance.

There are some examples of success being recognised and rewarded, and staff have access to a range of employee benefits.

The service ensures that the delivery of care, treatment and support is inline with current local and national guidance.

The provider is accredited as standards met on the Data Security and Protection Toolkit.

The Home has demonstrated achievement of this outcome.

The home must ensure that the established processes of gathering feedback are implemented regularly with results analysed and shared to evidence changes made and lessons learned.

15 - Complaints

Source - QSF Report 21ST February 2024

People who use the service are provided with information on how to make a complaint or raise concerns and this is regularly promoted.

The complaints process is accessible, is easy for people to raise a concern or complaint and is encouraged.

There is a formal log of complaints which is kept up to date. Complaints are handled effectively with openness, transparency and confidentiality. The complainant receives regular updates, a timely response and an explanation of the outcome including the appeals process.

People who raise concerns or complaints are protected from discrimination, harassment or disadvantage and are supported throughout the process.

Concerns and complaints are used as an opportunity to learn and promote continuous improvement and examples of this were evidenced.

The Home has demonstrated achievement of this outcome.

The requirement to meet the outcome remains and the Council has monitored this throughout the year.

Appendix 1 - NEWS Baseline Observations each month

NEWS usage	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Home	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy	% NEWS by bed occupancy
Brierton Lodge	132	98	53	129	54	91	41	69	29	83	111	80

Appendix 2- Is My Resident Unwell'

IMRU Brierton Lodge 2025/26	Apr-25			May-25			Jun-25			Jul-25			Aug-25			Sep-25		
	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %
	44	0	0	36	9	25	42	8	19	44	13	30	37	9	24	40	10	25
	Oct-25			Nov-25			Dec-25			Jan-26			Feb-26			Mar-26		
	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %	No. of health escalations	Total IMRU completed	Monthly %
	36	10	28	41	25	61	39	9	23	44	17	39	27	6	22	45	12	27

Appendix 3 – Medication logs

Brierton Lodge

