ADULT SERVICES & PUBLIC HEALTH

Quality Standard Framework

Organisation	Prestige Care
Home	Merlin Manor
Responsible Person	Carole Gibson
Date of Report	15 May 2026

Commissioned Services Team, Adult Services & Public Health

Merlin Manor is a purpose built care home which opened in July 2022. The home provides residential and nursing care for up to 94 residents and is the largest care home in Hartlepool. All rooms are decorated to a high standard and all are equipped with en-suite facilities.

The care home utilises an electronic care plan system which staff are able to update from portable devices. The system is simple to navigate and all staff receive training on how to operate it before starting. All care plans reviewed contained accurate information and were updated in a timely manner.

Although some recent 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.

Summary of Outcomes

There have been actions identified which will need to be worked towards.

Falls, safeguarding referrals and other notifications need to be reported, logged and documented.

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

The home has been identified as a priority visit for the Medicines Optimisation team in the next calendar year.

Summary of Outcomes

Name of Home-Merlin Manor

Date of Report – 15-May-2025

	Determination
Person Centred Care	
1 - Assessment & Review	Outcome “Substantially Met” 15 May 2026
2 - MCA & Consent	Outcome “Fully Met” – 21st February 2024
3 - DoIS	Outcome “Fully Met” – 21st February 2024
4 - Nutrition & Hydration	Outcome “Substantially Met” 15 May 2026
5 - Promoting Dignity, Autonomy & Choice	Outcome “Substantially Met” 15 May 2026
Safe Care and Treatment	
6 - Safeguarding/Understanding Safeguarding	Outcome “Fully Met” – 21st February 2024
7 - Medication	Outcome “Substantially Met” – 15 May 2026
8 - Infection Control	Outcome “Fully Met” – 21st February 2024
9 - Premises & Equipment	Outcome “Fully Met” – 21st February 2024
10 - Health & Safety	Outcome “Fully Met” – 21st February 2024
11 - Moving & Handling	Outcome “Fully Met” – 21st February 2024
Governance	
12 - Leadership & Management	Outcome “Partly Met” 15 May 2026
13 - Staffing, Recruitment, Support & Learning	Outcome “Substantially Met” 15 May 2026
14 - Quality Assurance	Outcome “Substantially Met” 15 May 2026
15 - Complaints	Outcome “Fully Met” – 21st February 2024

Person Centred Care
1 - Assessment & Review
Outcome assessed - Substantially Met

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.

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. On occasions the correct paperwork was not accessible.

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

People can access care, support and treatment in a timely way but referrals are not always made quickly to appropriate health services when people’s needs change. There have been delays in some referrals being made in 2025 and into 2026. The home is working towards improving this.

People do not regularly contribute to planning their care and support, and their strengths, levels of independence and quality of life are not always taken into account. This was highlighted during conversations with residents.

People's care plans reflect their physical, mental, emotional and social needs and incorporate their personal history, individual preferences, interests and aspirations. Care plans are understood by staff.

People’s oral health needs are met and kept under review with professional guidance sought in a timely manner when required on most occasions.

The service does not always share appropriate information and assessments with other relevant agencies for the benefit of people who use the service.

People’s preferences and choices for their end-of-life care 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.

There has been some mixed feedback from families relating to the support they have received from the home when a resident has died.

The service has sometimes provided more than the minimum number of NEWS Baseline Observations each month as detailed in appendix 1. Out of 12 months, they have achieved more than 100% on 6 occasions.

The service has recorded and completed the ‘Is My Resident Unwell’ tool if they have any concerns regarding residents health. Further information is provided at appendix 2. 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. Going forwards the homes performance in relation to this will be measured.

The Home has not demonstrated achievement of this outcome.

Information is not always shared with other agencies for the benefit of people using services.

Correct paperwork should be completed, logged and shared with services and other providers when required.

The use of NEWS can be further utilised within the service.

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.

2 – Mental Capacity Act & Consent

The findings below are from the Quality Standards Framework Report for Merlin Manor dated 21st 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 home opened in 2022.

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. However, a formal process to record when people have been visited, particularly those with RPR's, would make this process more robust.

The service provides information to people, their families and other carers about external bodies, community 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 persons 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 this outcome remains and the Council has monitored this throughout the year.

3 – DoLs

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

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 have a Dols matrix and can evidence applying for Dols 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.

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

There is no formal system of monitoring in place to ensure the person's representative maintains regular contact with the person but the service would act if necessary. This task will become difficult when the service reaches full capacity and it is recommended that a robust system is introduced.

The service has a system to monitor DoLS authorisations and their review dates and this is maintained. Care plans contain the most up to date Conditions attached to deprivation of liberty safeguards (DoLS) authorisations.

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 – Substantially Met

People are involved in decisions about what they eat and drink and their cultural and religious preferences are recorded, reviewed and acted upon. However, residents report they have requested changes to the food offered on occasions which has not improved.

People have access to dietary and nutritional specialists to help meet their assessed needs if required. People do not always have access to a balanced diet and health care professionals have raised concerns.

People receive prompts and encouragement to eat when needed and people 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.

All relevant staff have completed 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 knowledgeable staff.

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

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 specialist equipment 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.

People are offered a choice of food and drink, this is not always served at an appropriate temperature for the whole mealtime. Residents have fed back concerns relating to mealtimes and food content.

Residents can choose to eat in their bedroom or communal area and they are checked on regularly.

The Home has not demonstrated achievement of this outcome.

Sometimes people do not have the choices of food and drink they would like. Residents have raised concerns on more than one occasion which include within the residents meeting and at mealtimes. Resident feedback has been poor relating to food at some mealtimes and have raised that this is not a one-off occurrence.

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.

5 - Promoting Dignity, Autonomy & Choice

Outcome Assessed – Substantially 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. But, on occasions staff have not provided care in a timely manner. This has a negative impact on some residents dignity if residents do not have a timely response to their needs.

The service does not always ensure that people, and those close to them, feel valued. Sometimes, staff do not listen to people or talk to them appropriately in a way they can understand based on their assessed needs. Some family have fed back more positively regarding their experiences.

There are 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. The service will benefit from recording when residents decline to participate in activities.

Staff 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 generally know the people they are caring for and supporting, including their preferences, personal histories, backgrounds. However, there have been occasions when some staff have not have not been equipped with adequate knowledge when attending professional meetings.

Staff make sure that people's privacy and dignity needs are understood and respected including during personal care. Staff speak positively about delivering care with dignity.

Overall people receive support to be independent. However, on occasion some wishes are not recorded, reviewed and acted upon. Documentation and recording information requires some improvement.

Generally, relatives and friends are made to feel welcome and are able to visit without being unnecessarily restricted, however there are some examples where this is not the case and some feel excluded. There are arrangements to encourage relatives and friends to provide feedback on the service but not all feedback is acknowledged and acted upon.

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

People are supported to follow their interests and take part in activities that are appropriate to them including in the wider community. The service would benefit from recording when resident decline to join in these activities.

The service ensures that most people are encouraged and supported to develop and maintain relationships with people that matter to them, both within the service and the wider community to avoid social isolation.

The service ensure that all staff are trained and oversee standards in the service regarding care for people living with Dementia.

The Home has not demonstrated achievement of this outcome.

People are not always informed of the choices they have that are related to their care, treatment and support, or if they are informed the recording of this is not always carried out.

Information is not always shared with other agencies for the benefit of people using services and professionals have raised concerns relating to this.

Residents have commented they often are left for long periods of time when they need support due to low staff.

The level of impact has been assessed as low – there is no or minimal impact on residents. This is due to the home acknowledging that in areas, improvement is needed and beginning steps to improving this.

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.

Safe Care & Treatment

6 - Safeguarding

The findings below are from the Quality Standards Framework Report for Merlin Manor dated 21st 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 home opened in 2022

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 partially maintained to ensure the home and professionals can track progress from start to finish including analysis of lessons learned. The safeguarding log was incomplete in places and some information has not been recorded or has been recorded incorrectly. Staff have advised they have improved this, however the documents were archived and unable to evidence this at the time of the visit. Safeguarding trends have been analysed.
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.

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 incidents occur. All 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 complied with this requirement having submitted information on 8 occasions in the last 12 months. There have been 4 months with no returns.

The medication outcome has been assessed by the Medicines Optimisation Service further information can be found in the Assessment Report dated 27 October 2025 appended to this report.

The home is working towards compliance with the action plan. The home must work to the action plan set by the Medicines Optimisation team to immediately demonstrate improvement and ensure these improvements are sustained.

The Home has not demonstrated achievement of this outcome

Although some recent 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 home must continue to work to the action plan to demonstrate further improvements and ensure these improvements are sustained. The home has been identified as a priority visit for the Medicines Optimisation team in the next calendar year.

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.

8 - Cleanliness and infection control

The findings below are from the Quality Standards Framework Report for Merlin Manor dated 21st 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 home opened in 2022

The service has completed a self-assessment of their work practices and scored 99% 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 Service completes regular Hand Hygiene documentation and has a designated IPC Champion who has attended the IPC Study Day. The Service has up to date IPC workbook/training.

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

The Service engages with and updates the Infection Control Nurses when required.

The Home has demonstrated achievement of this outcome.

9 - Premises & Equipment

The findings below are from the Quality Standards Framework Report for Merlin Manor dated 21st 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 home opened in 2022

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 and themes are identified 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.

People are involved in decisions about the environment. Any changes to the environment are managed to avoid causing distress to people who live there.

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

However, outdoor spaces and in particular the garden area has limited usage due to the elevation.

The signage, decoration and other adaptations to the premises help to meet people's needs and promote their independence. The premises generally meet people's diverse care, cultural and support needs.

However, some areas of the home would benefit from further decoration with increased focus on creating a dementia friendly environment where necessary.

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 this 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 Merlin Manor dated 21st February 2024 at which time the home was assessed as fully achieving the outcome.

The service has evidenced it 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.

During the recent review, it was highlighted that some falls referrals are not being sent through as required. Some some staff may benefit from falls prevention awareness training which has been offered to the home. It is important that the home access this training.

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 robust and appropriate.* *There is professional instruction/task guidance detailed in people's support plans, which is in date and followed by staff.* *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 manufacturers guidance.* *There have been no near misses or accidents whilst hoisting in the last 12 months.* *The Home has demonstrated achievement of this outcome*

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

Governance

12 - Leadership & Management

Outcome Assessed– Partly Met

There is a registered manager in post.

There are some 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. There are occasions when staffing levels and competencies has been questioned by both professionals and families, and that some staff would benefit from further training and support.

The management at the home are not always aware of the day-to-day culture in the service including the attitudes, values and behaviour of staff.

The service does not always show honesty and transparency from all levels of staff and leadership following an incident. The service does not always ensure people are supported when incidents occur. This includes safeguarding reports, medication incidents and falls within the home.

Most staff say leaders have the skills, knowledge, experience and integrity they need to lead and inspire staff effectively, however there have been some staff who do not feel this way and they have suggested a need for improvement.

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

The organisation promotes equality and inclusion within its workforce and all staff have up to date equality and diversity training.

Most relevant legal requirements are understood and met, including CQC registration requirements, safety and public health related obligations, and the submission of notifications, however there have been occasions when notifications have not been sent to CQC. During conversations, staff advised that this has improved, however the log was archived so unable to verify.

Some staff are actively involved in developing the service.

There are links with the local community which have a positive impact on the service. There has been positive feedback relating to the community being welcomed into the home including the Mini Merlin's toddler group.

The service sometimes works in partnership with key organisations, including the local authority, safeguarding teams and Integrated Care Board (ICB) and multidisciplinary teams, to support care provision, service development and joined-up care and does so in an open, honest and transparent way. This has seen some improvement which needs to continue.

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

The Home has not demonstrated achievement of this outcome.

Leadership and management within the home are not consistently effective, with concerns around staffing levels, skills and training. Oversight of day-to-day culture is limited, and communication, transparency and incident reporting are sometimes poor. Not all staff feel supported to raise concerns, and partnership working and regulatory

compliance are inconsistent, highlighting some weaknesses in leadership and governance.

There has been confusion relating to the deputyship within the home when the Manager is not at work. There is an action plan which the home should continue to work towards.

The home have had a change in Deputy Manager during this period of assessment which hopes to help stabilise and support the existing management team.

The level of impact has been assessed as medium – there is a moderate impact but no long-term effects 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.

13 - Staffing, Recruitment, Support & Learning
Outcome Assessed- Substantially Met

Most staff have received appropriate induction upon commencement of employment. Some induction booklets had not been fully completed and signed off.

Most staff receive effective training in safety systems, processes and practices and this is reviewed regularly. Some staff report that they require further training to develop.

Some staff receive feedback from managers in a constructive and motivating way, which enables them to know what action they need to take but other staff have reported that they have received feedback in which is not constructive.

The service sometimes 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.

Not all staff feel supported and protected when raising concerns and questioning practice, including whistle-blowers. This has been brought up in staff conversations.

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

Staff respond in a compassionate and appropriate way when people experience physical pain, discomfort or emotional distress. This is not always in a timely manner and residents have reported waiting for a response often.

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 mostly know and understand what is expected of them and this is reinforced with regular support, supervision, appraisal and training. Some staff have stated that supervisions are a negative experience and do not understand the purpose of these. The service may benefit from group supervisions or more frequent team meetings.

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

There are systems of communication to ensure information is shared timely and appropriately so staff can carry out their roles and responsibilities but these are not always effective. Some communication is not recorded, or is recorded and not picked up efficiently due to a lack of handover time between shifts.

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

The Home has not demonstrated achievement of this outcome.

Staff are not always aware of changes in people's needs because internal communication systems are sometimes ineffective. Some recording and documentation requires improvement and staff would benefit from some time to handover between shifts.

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.

14 - Quality Assurance
Outcome Assessed – Substantially met

The service often maintains a log of whistleblowing, staff concerns, safeguarding and accidents or incidents and investigates each incident thoroughly. Action plans are not always completed. Staff suggest that whistleblowing is not completed due to concerns within the staff team. Safeguarding reporting has possibly improved recently however, the recording of this was not clear or accessible.

When incidents occur it is not always clear if they are investigated and analysed to look for common themes and trends. Lessons learned are not always identified and action is not always taken to drive improvement.

The service approach to quality is not always integral and all staff may not be aware of potential risks that may compromise quality. Whilst some of the service is delivered to a high standard, there are gaps in areas.

The service does not always promote or support accessible open communication with all people who use the service including their family, friends, staff and representatives. Feedback from family members has mentioned some issues with communication with staff.

People's views and experiences are gathered but not always acted on to shape and improve the services and culture. Comments which have included a dementia friendly approach to the aesthetic of the units have not been adopted.

Resources and support is available to develop staff and teams and drive improvement, examples of these were provided by the manager. There have been changes to senior management which has began to support the home and the management within the home.

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

Success and innovation is recognised, encouraged and implemented on occasion. The home have recently implemented staff recognition again which highlights that the management acknowledge good practice.

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 are met or approaching standards in the DPST Toolkit. The home lost some access to NHS mail at the beginning of the assessment period, which meant the home only had one person with access. This has since improved and is used correctly.

The Home has not demonstrated achievement of this outcome.

The service monitors the quality of the service but does not always act on findings.

The level of impact has been assessed as low – there is no or minimal impact on residents. This has been rated as low due to recent developments within the service which have demonstrated some improvements.

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.

15 – Complaints

The findings below are from the Quality Standards Framework Report for Merlin Manor dated 21st 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 home opened in 2022

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 this outcome remains and the Council has monitored this throughout the year.

Appendix 1

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
Merlin Manor	109	111	90	108	114	94	89	112	58	86	101	79

Appendix 2

IMRU Merlin Manor 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 %
	58	6	10	58	2	3	65	12	18	71	14	20	60	9	15	59	15	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 %
	79	16	20	72	16	22	78	7	9	75	10	13	112	17	15	84	5	6

Appendix 3