Children

And

Joint

Commissioning

Quality Standard Framework

HARTLEPOOL BOROUGH COUNCIL

Organisation	**Four Seasons**
Home	**Warrior Park**
Responsible Person	**Val Halas**
Date of Report	**14 April 2025**

Commissioned Services Team, Adult & Community Based Services

Overview of Home

Warrior Park provides residential and nursing care over two floors, for up to 48 residents.

All people have a person-centred care plan that is monitored, reviewed and understood by staff but can be contradictory, inconsistent and incomplete and daily recording is basic with significant gaps. The home must ensure it meets the minimum requirements for completing NEWS baseline observations and “Is my resident unwell?” tools so people’s health continue to be monitored and any concerns picked up as soon as possible.

People may not always have choice and control over their meal preferences and the mealtime experience may not encourage people to maximise their intake.

The home is working towards an action plan set by the medication optimisation team, as significant issues around the safe management of medication have been identified.

Staff are generally trained, supported and have good means of communication which enables them to deliver high standards of care, however the home lacks leadership when the manager is unavailable. The home 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.

The home regularly has vacant beds and this may be due to the home not taking advantage of trusted assessors. The process that the home adopts, is for the manager to undertake all assessments before agreeing to a new admission and this could potentially cause delays. The home may wish to consider training additional staff to complete assessments when the manager is unavailable.

Summary of Outcomes

Warrior Park

Date of Report - 14-April-2025

	Determination
Person Centred Care	
1 - Assessment & Review	**Outcome "Substantially Met"– 14 April 2025**
2 - MCA & Consent	**Outcome "Fully Met"– 21 February 2024**
3 - DoIS	**Outcome "Fully Met"– 21 February 2024**
4 - Nutrition & Hydration	**Outcome "Substantially Met"– 14 April 2025**
5 - Promoting Dignity, Autonomy & Choice	**Outcome "Fully Met"– 21 February 2024**
Safe Care and Treatment	
6 - Safeguarding/Understanding Safeguarding	**Outcome "Fully Met"– 21 February 2024**
7 - Medication	**Outcome "Partly Met"– 14 April 2025**
8 - Infection Control	**Outcome "Fully Met"– 21 February 2024**
9 - Premises & Equipment	**Outcome "Fully Met"– 21 February 2024**
10 - Health & Safety	**Outcome "Fully Met"– 21 February 2024**
11 - Moving & Handling	**Outcome "Fully Met"– 21 February 2024**
Governance	
12 - Leadership & Management	**Outcome "Substantially Met"– 14 April 2025**
13 - Staffing, Recruitment, Support & Learning	**Outcome "Fully Met"– 14 April 2025**
14 - Quality Assurance	**Outcome "Fully Met"– 14 April 2025**
15 - Complaints	**Outcome "Fully Met"– 21 February 2024**

Person Centred Care

1 - Assessment & Review

Outcome Assessed – Substantially Met

Care plan sections need to be rewritten regularly to ensure the information is up to date and accurate, especially when people's need change significantly. It was noted that some care plans had not been fully rewritten in several years and therefore some

Care plan sections need to be rewritten regularly to ensure the information is up to date and accurate, especially when people's need change significantly. It was noted that some care plans had not been fully rewritten in several years and therefore some sections had amendments and adaptions which meant sections were untidy and difficult to follow.

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.

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

Daily care notes are very basic and contain significant gaps, when discussed with some staff they were not aware that daily notes recording was a requirement.

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

People are generally involved in monitoring their health.

People can access care, support and treatment in a timely way and referrals are made quickly to appropriate health services when people's needs change. The service has consistently provided less than the required minimum number of NEWS Baseline Observations per month.

It is unclear to what extent, people contribute to planning their care and support, with their strengths, levels of independence and quality of life are taken into account.

Most People's care plans generally reflect their physical, mental, emotional and social needs and incorporate their 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. Staff do not appear to have any specific oral health training although this may form part of another training.

The service shares 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.

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. Staff do not appear to have any specific end of life training although this may form part of another training.

The service supports people's families, other people using the service and staff when someone dies.

The service has consistently provided less than the required minimum number of NEWS Baseline Observations per month, as detailed in appendix 1.

From August 2024, the service has not regularly recorded and completed the 'Is My Resident Unwell' tool if they have had any concerns regarding residents health. Further information is

provided at appendix 1. 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.

Care plans can be contradictory, inconsistent and incomplete and daily recording is basic with significant gaps. The home does regularly does not meet the minimum requirements for completing NEWS and Is my resident unwell so people's health concerns may be unmonitored.
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 - MCA & Consent

The findings below are from the Quality Standards Framework Report for Warrior Park 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. However, a formal process to record when people have been visited, particularly those with RPR's, would make this process more robust. This was recommended to the home last year but has not been implemented.
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 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 Home has demonstrated achievement of this outcome.

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.

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.

Management & staff would generally recognise if someone hadn't been contacted recently but a formal process to record when this has happened, particularly those with RPR's, would make this process more robust.

Care plans contain the most up to date Conditions attached to deprivation of liberty safeguards (DoLS) authorisations.

However, no DoLS matrix was maintained which would make this process more robust.

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 may not always be involved in decisions about what they eat and drink, as it appears staff often make decisions on people's behalf based on their known preferences.

Show plates are not always used to visually inform residents of the choices available.

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

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.

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

Generally, 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. Staff should prompt and encourage residents to eat more and offer alternatives if people do not like the options available.

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.

Generally, 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.
Drinks are not always replenished quickly during the meal service.

People can choose the location of where they eat including the dining room, their own room or communal areas.

Those who are able to do so and show a preference for eating in the dining room should be encouraged to do so whenever possible.

People are offered a choice of food and drink, and this is served at an appropriate temperature.
People are often sat in the dining room for long periods before the mealtime service begins and those sitting together one table are not all served at the same time.
Some residents felt that the portion sizes were too small and they were still hungry after mealtimes.

Residents who choose to eat in their bedroom or a communal area, may not be checked up in a regular or timely manner in line with their assessed needs.

The Home has not demonstrated achievement of this outcome.

People may not always have choice and control over their meal preferences and the mealtime experience may not encourage people to maximise their intake.

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

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, informal resident conversations confirm residents appear happy, feel well cared for, have choice and control over their daily lives and have appropriate stimulation. The service has a programme of activities and events which aims to capture residents' preferences and choices.

Source *- QSF Report 21ST February 2024*

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 makes sure that people, and those close to them, feel like they matter, and that staff listen to them and talk to them appropriately and in a way they can understand.

People are actively 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.

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 know the people they are caring for and supporting, including their preferences, personal histories and backgrounds.

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

People receive support to be independent. 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.

People are supported to follow their interests and take part in activities that are appropriate to them including in the wider community.

The service ensures that 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 has a nominated Dementia champion(s) 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 Warrior Park 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 Whistle Blowing Policy and staff are aware of the escalation process should this be required.
Safeguarding trends have been analysed – see appendix 3 for further information.

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. However, staff training in this area has fallen below what it should be and the manager must ensure all staff safeguarding training is brought up to date as a matter of urgency.

Processes are in place to ensure people are protected from discrimination, harassment and abuse, in line with the Equality Act. However, staff training in this area has fallen below what it should be and the manager must ensure all staff equality & diversity training is brought up to date as a matter of urgency.

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 – Partly 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 2024 – see appendix 4 for further information.

The medication outcome has been assessed by the Medicines Optimisation Service further information can be found in the Assessment Report dated 29-Oct-2024 appended to this report.

The Home has not demonstrated achievement of this outcome.

The home scored poorly on their initial audit and despite intense support from the Medicines Optimisation team and HBC, there continues to be significant issues around the safe management of medication.

The home must work to the action plan set by the Medicines Optimisation team, as the follow up audit showed the home had not completed the actions set previously. Any improvements made need to be sustained going forward.
The Medicines Optimisation team attempted to organise a further follow up audit to check completion against the action plan however this could not be agreed with the home manager.

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.

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 completed Infection Control Workbooks regularly

and has appointed an Infection Control Champion who has 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 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- Necessary resources- Risk Assessments- Cleaning Records/Schedules- Quality Audits
However, staff training in this area has fallen below what it should be and the manager must ensure all staff safeguarding training is brought up to date as a matter of urgency.

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 Warrior Park 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. However, usage of the National Early Warning Score (NEWS) tool remained poor in 2023 and showed no improvement from the previous year. The manager must ensure this improves in 2024.

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.

However, lounge areas are sometimes used to store wheelchairs when they are not in use which could potentially present a safety hazard. The manager needs to ensure that this doesn't happen and explore other options for storing equipment.

There is some evidence that lessons are learned and shared to make sure that action is taken to improve safety across relevant parts of the service.

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: • 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 are now in need of a refresh and update to help to meet people's needs and promote their independence.

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.

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 Warrior Park 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.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 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.

Due to poor record keeping it is not possible to determine how many staff have up to date Moving & Handling Training or who has received practical observation for a competent staff member.

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.

Governance
12- Leadership & Management
Outcome Assessed – Substantially Met

There is a well-established registered home manager, who has been in the post since 2019.

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. Agency staff have been used to recent times to ensure staffing levels are sufficient.

It is unclear whether the managers is always aware of the day-to-day culture in the service including the attitudes, values and behaviour of staff.

The service promotes and supports fairness, transparency and an open culture for staff.

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 home has operated without a deputy manager for the majority of the year, which can mean the home is short of leaders to ensure standards are maintained when the manager is unavailable.

When the home manager is unavailable, staff are not always able to make decisions or provide clarity on processes which can cause unnecessary delays.

The service has a clear vision and set of values on display at the home but it is unclear if these are promoted and understood by staff and embedded into practice.

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

The registered manager understands their responsibilities and are supported by the regional manager and the provider to deliver what is required. The home manager must ensure that requirements for staff training and staff supervision are maintained as these have dipped below required levels in some cases.

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

There are some processes in place for staff to feedback but it is unclear whether any developments have been made as a result of staff input.

There are some links with the local community that have a positive impact on the service but these could be developed further

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 does not always take on board guidance, feedback and adhere to action plans provided by professionals.

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

The Home has not demonstrated achievement of this outcome.

The service lacks leadership when the home manager is unavailable.

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.

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

Staff receive appropriate induction upon commencement of employment.

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

Staff generally receive feedback from managers in a 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 but training levels have dipped below required levels in some areas.

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

Staff know and understand what is expected of them and receive regular supervision and appraisal.

Staff and teams generally work collaboratively, share responsibility and resolve conflict quickly and constructively.

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

The service generally 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

Staff work together to ensure that people receive consistent, timely, coordinated, person-centred care.

The Home has demonstrated achievement of this outcome.

14 - Quality Assurance

Outcome Assessed – 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 encourage accessible open communication with all people who use the service including their family, friends, staff and representatives but the service could further promote and encourage attendance at resident / relative meetings.

People's views and experiences are gathered and acted on to shape and improve the services and culture.

Resources and support is available to develop staff and teams and drive improvement

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

Sometimes success and innovation is recognised, encouraged and implemented.

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 has demonstrated achievement of this outcome.

15 - Complaints

The findings below are from the Quality Standards Framework Report for Warrior Park 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*

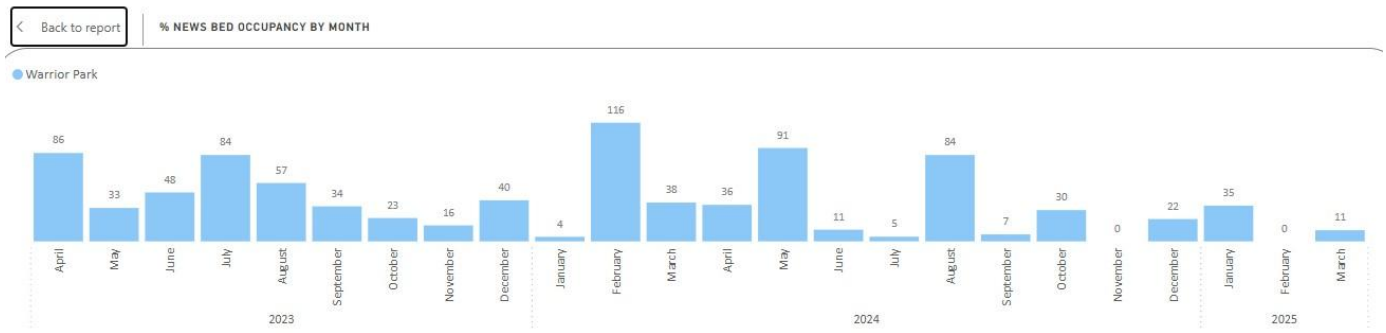
People who use the service are provided with information on how to make a complaint or raise concerns and this is regularly promoted.
The complaints process is accessible, is easy for people to raise a concern or complaint and is encouraged.

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.

Appendix 1 - NEWS Baseline Observations each month

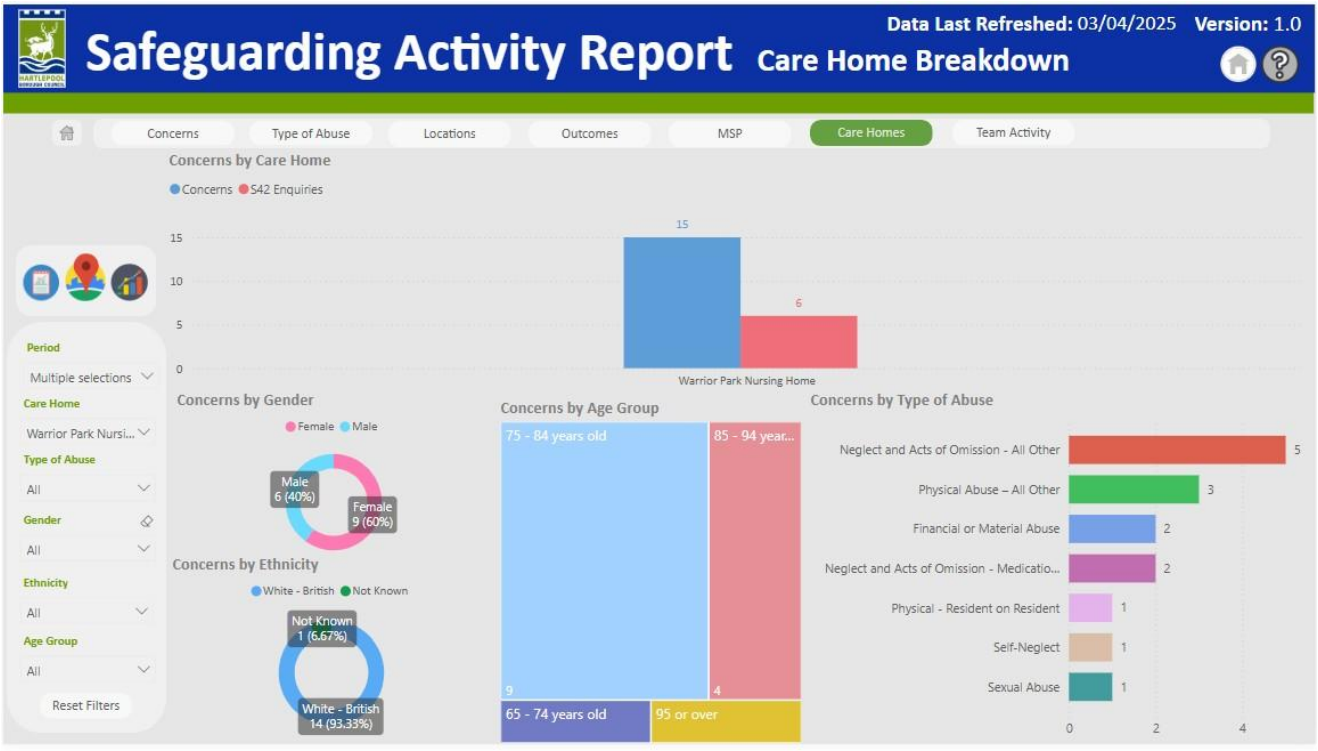


Appendix 2- Is My Resident Unwell'

Is My Resident Unwell (IMRU) Usage April 2024 – March 2025

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
0	0	0	0	0	1	0	0	3	1		

Appendix 3 - Safeguarding trends



Appendix 4 – Medication logs