Hartlepool
Borough Council

ADULT SERVICES & PUBLIC HEALTH
Quality Standard Framework

Organisation	Harbour Healthcare
Home	Warrior Park
Responsible Person	Val Halas
Date of Report	15th May 2026

Commissioned Services Team, Adult Services & Public Health

Overview of Home

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

The home has changed provider in the past year, which has required management and staff to learn new systems and processes, as well as the preparation and implementation of a new electronic care record system.

All people have a person-centred care plan that is monitored, reviewed and understood by staff but issues remain around the level of detail, legibility, inconsistencies and how well they reflect the persons current need and ability. The lack of daily care records meant it was not possible to verify that peoples assessed needs were being met by staff on a day to day basis

People have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so but issues remain about the mealtime experience.

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.

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 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.

The home appointed a new deputy manager in the past year and this has helped to address the previous concerns around the lack of leadership at the home when the manager was unavailable.

Quality assurance processes have not always been robustly applied with significant gaps in checks, audits, meetings and observations and limited evidence of lessons learned and developments.

Summary of Outcomes

Warrior Park

Date of Report – 15-May-2026

	Determination
Person Centred Care	
1 - Assessment & Review	Outcome "Partly Met"– 15 May 2026
2 - MCA & Consent	Outcome "Fully Met"– 21 February 2024
3 - DoIS	Outcome "Fully Met"– 21 February 2024
4 - Nutrition & Hydration	Outcome "Substantially Met"– 15 May 2026
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 "Substantially Met"– 15 May 2026
8 - Infection Control	Outcome "Fully Met"– 21 February 2024
9 - Premises & Equipment	Outcome "Fully Met"– 21 February 2024
10 - Health & Safety	
11 - Moving & Handling	Outcome "Fully Met"– 21 February 2024
Governance	
12 - Leadership & Management	Outcome "Fully Met"– 15 May 2026
13 - Staffing, Recruitment, Support & Learning	Outcome "Fully Met"– 14 April 2025
14 - Quality Assurance	Outcome "Substantially Met"– 15 May 2026
15 - Complaints	Outcome "Fully Met"– 21 February 2024

Person Centred Care

1 - Assessment & Review

Outcome Assessed – Partly Met

All people receiving the service have a written care plan that is monitored and regular reviews are recorded, however care plan sections need to be rewritten regularly to ensure the information is up to date and accurate, especially when peoples care needs have changed significantly.

Generally, 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 generally complete, up-to-date, securely stored and available to relevant staff so that they support people to stay safe.

There were examples of some care plan documents which were almost entirely illegible.

As daily care records are not kept, it was not possible to verify that peoples assessed needs were being met by staff on a day to day basis.

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

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.

It is unclear to what extent, people, families and their advocates contribute to planning their care and support.

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 but care plan contents are often basic and could be expanded to provide staff with additional detail were required.

Generally, people's oral health needs are met and kept under review with professional guidance sought in a timely manner when required, however some care plans did not contain an oral health assessment.

Staff training matrix shows that most staff have completed oral health training.

In general, the service shares appropriate information and assessments with other relevant agencies for the benefit of people who use the service.

The home has not had an active NHS mail account for the majority of the year which may have impacted and restricted the homes ability to share and receive information with professionals in a timely manner,

Attempts are made to gather people's preferences and choices for their end of life care and these are recorded, reviewed, communicated and acted on where possible, however on review some people do not have an end of life care plan in place. 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.

Staff training matrix shows that most staff have completed end of life training.

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

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.

Information shows that the service has had consistently poor numbers of NEWS observations during 2025/26 with no months over 100% Baseline Observations and a low 12 month average of 33%, as detailed in appendix 1.

Data shows that the home have not been using the 'Is My Resident Unwell' tool frequently 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 only 6%. Further information is provided at appendix 2.
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The Home has not demonstrated achievement of this outcome.

Care plan issues remain around the level of detail, legibility, inconsistencies and how well they reflect the persons current need and ability. The lack of daily care records meant it was not possible to verify that peoples assessed needs were being met by staff on a day to day basis. There were examples of some care plan documents which were almost entirely illegible.

Once the new electronic care record system is fully implemented, this should help to resolved many of the issues identified and bring many benefits to the home.

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.

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.

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 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 the home continues to maintain processes and procedures for tracking and recording DOLS applications.

During checks several issues relating to DOLS were highlighted, including that they were not always renewed on time, the latest conditions were not always contained within care plans and the DOLS matrix contain inaccuracies. The manager must ensure these issues are resolved going forward.

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 are involved in decisions about what they eat and drink and their cultural and religious preferences are recorded, reviewed and acted upon, examples of this in practice at the home were provided by the home manager.

Show plates were not used by staff during observations and food menus were not present on dining tables. Show plates were not used by staff during observations and food menus were not present on dining tables

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

People appeared to enjoy mealtimes and did not feel rushed. During observations, It was felt that some staff could have prompted and encouraged residents to eat more.

During observations, some residents were escorted to the dining room too early and had to wait a significant time before the meal service had started, causing them to become restless. Food was not always served in a logical order, those seated first could be served last, residents finishing their main meals first, were given desserts last after a long wait.

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

Most staff have completed relevant food safety training and it appeared that 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 help to ensure that peoples 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.

Generally, people have access to specialist equipment in a timely manner to meet their assessed need.

Drinks are offered throughout the day and jugs of water or juice are available in every resident room. When required people's intake is monitored to ensure their assessed needs are being met.

Drinks were not always replenished quickly during the meal service as staff were not always available to do so.

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

The four tables in the dining room were all located at a distance to each other in the corners of the room. Whilst this space brings benefits such as allowing wheelchair users enough space for access, it can feel like some residents are isolated and does not promote social interaction.

People are offered a choice of food and drink and this appeared to be served at an appropriate temperature. Snacks are offered outside of mealtimes and are available any time of day upon request.

Many residents choose to eat in their own rooms and are supported by staff to do so. Some residents require one to one support from staff at mealtimes and this meant that good staffing levels were not always maintained in the dining room to respond to residents needs and provide encouragement or prompts.

The Home has not demonstrated achievement of this outcome.

The mealtime experience for residents could be improved and on occasions staff may not be available to encourage residents to maximise their intake of food and fluids. It may be of consideration, to split the dining service so those eating in rooms and those requiring one to one support are carried out at different times to those eating in the dining room to allow more staff to be present.

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 – 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 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.

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.

During interviews, staff stated that they felt they knew the people they were caring for and supporting well over time, including their preferences but it would be useful to be given specific time to get to know new residents Attempts are made to capture peoples 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 and they were able to describe the processes used during staff interview.

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.

The home are in the process of carrying out resident / relative surveys but the responses have not yet been analysed.

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. The home has some links with the local community but these could be strengthened.

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 champions who oversee standards in the service.

Staff training matrix shows that most staff have completed dementia training.

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 the elements of this outcome have been assessed for this report, checks have been undertaken to confirm safeguarding referrals are completed when incidents occur, appropriate investigations take place and the outcome is shared with the resident, families and advocates.

During safeguarding checks, the home did not maintain a safeguarding log. Some incidents and lessons learned were viewed but it was difficult to confirm that all required processes were followed or that CQC notifications were made when required. Issues were raised with the home management.

The home continues to have a 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. 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 – 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 8 occasions in the last 12 months with 3 of those submissions not in the correct format or the appropriate level of detail required so these could not be recorded– see appendix 3 for further information.

The medication outcome has been assessed by the Medicines Optimisation Service further information can be found in the Assessment Report dated 02-Dec-2025 appended to this report.

The Home has not demonstrated achievement of this outcome.

The action plan set by the Medicines Optimisation team has not been followed and a range of issues have been identified in relation to good medicines management.

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 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 work to the action plan to demonstrate improvements and ensure these improvements are sustained.

8 - Cleanliness and infection control

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, evidence has been provided to confirm the home 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 98% 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.

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 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 – Fully 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.

Managers are aware of the day-to-day culture in the service including the attitudes, values and behaviour of staff.

During interviews, staff felt that could go to their manager with concerns and that this would be dealt with appropriately.

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 appointed a new deputy manager in the past year and this has helped to address the previous concerns around the lack of leadership at the home when the manager was unavailable.

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 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.

There are processes in place for staff to feedback and during interviews staff were able to provide some examples of changes made to develop the service from suggestion put forward.

There are some links with the local community, but these could be strengthened further which would have a positive impact on the service.

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

The Home has demonstrated achievement of this outcome.

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13 - Staffing, Recruitment, Support & Learning

Outcome Assessed – Fully 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.

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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.

There are processes for ensuring that 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.

During staff file checks there were some examples of some missing documents, gaps and inaccuracies.

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 this is reinforced with support, supervision, appraisal and training however during staff interviews, staff did not always feel that formal supervision took place regularly.

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 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 – Substantially Met

The service maintains a log of whistleblowing, staff concerns, safeguarding and accidents or incidents and investigations take place with actions plans developed.

During checks, the homes filing system did not easily allow verification of quality assurance processes, as files often contained historical, inconsistent and disorderly information. it was noted however, that in more recent visits to the home vast improvements had been made to the filing system but these improvements need to be sustained.

When incidents occur, they are investigated and there is some evidence that common themes and trends were identified however it is not always clear how any lessons learned are fed back to staff.

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 promotes accessible open communication with people who use the service including their family, friends, staff and representatives..

There are some processes to gather people's views and experiences but little evidence to confirm these are acted on to shape and improve the services and culture.

Resources and support are available to develop staff and teams and drive improvement.

Supervision documents viewed, made it clear to staff what was expected of them, reinforcing standards but was not a reflective exercise and did not always allow the staff member to outline their concerns, needs or aspirations.

The home has quality assurance systems in place, but these are not robust enough to evidence learning from current performance to enable continuous improvement. Audits, checks and meetings do not always happen regularly or consistently.

The home has changed provider in the last year, which has brought some changes in documentation and processes, which has disrupted the homes quality assurances processes.

The home has been without an allocated area manager for a significant period in the past 12 months so the home has lacked oversight, checks and audits have not always taken place.

The provider has processes to ensure success and innovation is recognised, encouraged and implemented, however there were limited examples to evidence how these have been applied.

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

Due to the change in ownership, the provider will be required to start the process of completing the requirements of the data security and protection toolkit.

The Home has not demonstrated achievement of this outcome.

Quality assurance processes have not always been robustly applied with significant gaps in checks, audits, meetings and observations and limited evidence of lessons learned and improvements. The lack of oversight from an area manager for a significant period has impacted on quality assurance processes at the home.

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.

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.

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
Warrior Park	28	15	40	69	57	43	9	2	10	2	23	51

Appendix 2- Is My Resident Unwell'

IMRU Warrior Park 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 %
	29	1	3	27	1	4	26	2	8	26	4	15	21	0	0	31	2	6
	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 %
	28	3	11	26	0	0	30	1	3	23	0	0	29	2	7	41	4	10

Appendix 3 – Medication logs