

2024

Bi - Annual review of safety and quality of care and support

1st July 2024 – 31st December 2024

Our commitment to quality and safety

PCI/ Peacehaven aims to safeguard the welfare of its residents by providing the highest possible standard of care and adopting safe working practices to minimise the potential for abuse. Regular reviews and audits provide the organisation with the opportunity to assess and improve performance in order to realise our vision of providing the best quality care possible in a supportive safe and caring home from home environment.

This review is informed by:

- HIQA reports (most recent 10th April 2024)
- Incident log (inc. medication incidents)
- Complaints/ Compliments log
- Care plan audits
- Safeguarding Concerns and Plans
- Health and Safety Committee Information
- RIRC Committee Minutes
- PPIM Unannounced Visit Report
- Training Plans

HIQA report

An announced Inspection was carried out as part of the ongoing regulatory monitoring of the centre was carried out by HIQA on 10th April 2024 under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013-2015 as amended.

This inspection was an announced inspection scheduled to inform decision making in respect of the provider's application to renew the centre's certificate of registration.

Jennifer Deasy was the Lead Inspector, with Michael Muldowney assisting.

The Regulations considered on this inspection and the judgements made were as follows

REGULATION TITLE	JUDGEMENT	RISK RATING	DATE TO BE COMPLIED WITH
Capacity and Capability			
Regulation 14: Persons in charge	Compliant		
Regulation 15: Staffing	Compliant		
Regulation 22: Insurance	Compliant		
Regulation 23: Governance and management	Compliant		
Regulation 3: Statement of purpose	Compliant		

Regulation 34: Complaints procedure	Compliant		
Quality and Safety			
Regulation 10: Communication	Compliant		
Regulation 11: Visits	Compliant		
Regulation 18: Food and nutrition	Compliant		
Regulation 20: Information for residents	Compliant		
Regulation 26: Risk management procedures	Substantially compliant		
Regulation 28: Fire precautions	Not compliant		
Regulation 5: Individual assessment and personal plan	Compliant		
Regulation 8: Protection	Compliant		
Regulation 9: Residents' rights	Compliant		

Reasons for non-compliance, preliminary actions taken and current position report as of January 2025.

Regulation	Reasons for non-compliance	Actions that were taken	Current position	Further recommendations from PPIM
Regulation 26: Risk management procedures	<p>Inspectors saw that the risk assessment in relation to the risk of residents being unexpectedly absent from the designated centre required review. The control measures were not found to be sufficiently detailed to guide staff in consistently responding to this risk.</p> <p><i>For example, there was no time-frame set out for how long staff should wait before contacting the relevant stakeholders or authorities, or what the procedure was that should be followed in this instance. The inspectors reviewed the missing persons' guidance on residents' files and saw that this information was also absent from this guidance.</i></p>	Risk assessment updated	Risk assessment has been updated by PHT staff and reviewed by PPIM, some changes were advised and the risk assessment updated accordingly.	Continued monitoring of the dementia related behaviours of the resident.

Regulation 28: Fire precautions	<p>The evacuation plans for two residents did not demonstrate that they could be safely evacuated from the centre in a reasonable manner. For example, these residents either refused to evacuate or had difficulties in evacuating due to their mobility. Their evacuation plans outlined that they could remain in their bedrooms to await rescue by the fire service if staff efforts to evacuate them were unsuccessful. This arrangement was not appropriate, and required more consideration from the provider.</p> <p>The inspectors also found that although regular fire drills were carried out to test the effectiveness of the fire evacuations plans, the drills did not always include the maximum number of residents and reduced staff levels.</p> <p>The inspectors released a sample of the fire doors in all three houses, including bedroom doors, and found that two doors in the centre did not close fully.</p>	<p>Double cover remains in place 24 hours per day to facilitate evacuation.</p>	
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PPIM Service Visits

The Council for Social Witness’ Training Manager/ Clinical Lead visited Peacehaven on a number of occasions between July 2024 and December 2024 on behalf of the PPIM. On these visits, the well being of residents was considered at length and the quality-of-service delivery assessed.

The dates of visits are as follows:

17th July, 8th August, 10th Sept, 19th Sept, 7th Nov, 21st Nov, 28th Nov and 5th Dec

Health and Safety

Commentary

A Health and Safety Committee meeting was held on 29th August 2024 and 12th December 2024. This total 4 meetings throughout the year, a sustained improvement from 2023, when only 1 meeting was held in 12 months.

Topics covered included:

- Daily/ weekly H&S Checks, PEEPS, Fire Equipment, First Aid Kits, Health and Safety Statements, Vehicle Management, Training, Incidents/ Accidents, PAT testing.

A new Fire Safety Log book was launched in July 2024 covering all weekly, quarterly and annual checks. This has been working well and ensures comprehensive documentation of all fire related safety checks in one place.

Incident log

Commentary

All accidents, incidents and near misses including medication errors are recorded in the incident log, which is collated on a monthly basis and forwarded to the PPIM (Regional Care Manager).

All accidents, incidents and near misses are risk assessed by the Person in Charge and a risk management plan is implemented to minimise risk of further harm.

All medication errors are recorded on a Medication Error report form and actions are put in place relating to that single incident. All staff are expected to complete a reflective practice exercise if they are responsible for a medication error.

All accidents, incidents and near misses including medication errors are discussed at team meetings and fortnightly Care Manager's meeting with a view to encourage reflective practice & shared learning across teams and houses.

The incident log is reviewed quarterly by the registered provider representative and a 6 monthly report given to the Board of Management.

HIQA is informed of any notifiable events and a record kept of this (portal). HSE is informed of quarterly notifications to HIQA.

Any potential safeguarding incident is reviewed by PIC, Regional Care Manager (Deputy Adult Safeguarding Champion) and PCI's Safeguarding Lead (Adult Safeguarding Champion) on receipt of incident form.

Incidents recorded

56 incidents were recorded between 1st July 2024 – 31st December 2024. This is an increase of 70% on the previous 6 months.

Type of Incident	Q3 Statistics	Q4 Statistics
Uncommunicated Absence	1	
Resident abuse (by another resident)		
Resident abuse (by staff/third party)		
Resident - slips, trips & falls	5	3
Self-injurious behaviour	1	1
Resident accident - other than a slip trip or fall	1	3
Theft		
Staff accident - other than a slip, trip or fall		
Infection Control Issue	2	
Other	2	6
Transport (Car Accident)	2	
Physically challenging behaviour to an object	5	2
Physically challenging behaviour to another person	8	7
Verbally aggressive behaviour	2	5
Unexplained injury		
Near miss		
Infrastructure (including facilities, environment)		
Q3 Total:	29	
Q4 Total:		27
Q3 and Q4 Total:	56	

Further analysis of the incidents shows the following breakdown:

Year	Quarter	Total Incidents	Lydia Incidents
2023	Q3	12	6
2024	Q3	29	21
2023	Q4	21	11
2024	Q4	27	19

In Quarter 3, there is a pronounced shift to 'challenging incidents' 14 in all, all of which are in Lydia House. There are a number of residents with emerging complexity of need alongside some deterioration in relationships between some residents. Within Lydia House, the dynamic and structure requires ongoing consideration with the clinical team, to ensure all residents are safe and provided with effective support. The suitability of Lydia House as a placement is under consideration for some residents.

In Quarter 4, the level of incidents compared to Q3 is a little lower. Staff are engaging with all relevant parties to review the needs of individual residents and to provide person-centred care to minimise the risk of further incidents. The PIC continues to work with the HSE in relation to business cases that have been submitted to address the emerging and current needs of residents and associated risks.

Medication Errors

During the period 1st July 2024 and 31st December 2024,

Type of Error	Q3 Number	Q4 Number
Incidents (Resident Caused)		
Medication vomited		
Refusal to take medication	4	
Resident missed their medication	1	1
Adverse Reaction		
Taking with another Substance		
Medication Loss		
Medication Spillage	1	
Medication Spoilage	1	1
Total Number of Resident Errors in Each Quarter	7	2
Total Number of Resident Errors in 6 – Month Period	9	
Incidents (Staff caused)		
To the wrong person		
Wrong medication		
Incorrect dosage	1	
Via the incorrect route	1	
At the incorrect time	1	2
Medication omitted by staff		2
Medication not restored		
Stock Control	1	1
Incorrect form used		
Incorrect code used on Mar Sheet		
Medication not recorded on MAR Sheet	1	
MAR Sheet is not signed	1	
PRN rational not entered onto MAR sheet	1	
Incorrect time recorded on MAR sheet		
Rational for incorrect time not recorded-MAR sheet		
Total Number of Staff Errors in each Quarter	7	5
Total Number of Staff Errors in 6- month period	12	

Total Number of Errors of Staff and Resident Errors in 6- month period	21
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When examined against the back drop of medication administration across both quarters, it evidences the following staff errors:

Quarter	Medication Passes	Errors	Margin of Error
Quarter 3	7644	7	0.09%
Quarter 4	8190	5	0.01%

Complaints Log 1st July 2024 – 31st December 2024

Month	Number
July	4
September	5
October	1
November	1

All recorded complaints are in relation to 2 residents within Lydia House. Work is ongoing with relevant parties to address complaints and manage concerns.

Compliments Log 1st July 2024 – 31st December 2024

Month	Number
July	1 (Applewood)
September	1 (Blake House)
November	2 (Applewood & Blakehouse)
December	3 (Applewood x1 and Lydia House x2)

Training

A comprehensive training plan is designed at the beginning of each year following the review of staff training needs, resident’s needs, incidents and changing guidance/regulations/legislation. The PIC remains committed to delivering a relevant and impactful training schedule for staff, with the ultimate aim of improving service delivery.

Training in the following areas has been completed (in addition to the training completed up to 30th June 2024) up until 31st December 2024

- Life story
- Person Centred Planning
- Epilepsy
- Open Disclosure
- Risk Management
- GEARS

Additionally, staff attend a staff meeting regularly, where the emphasis is on reflection and learning. Concerns, incidents, and needs are discussed at length providing all staff with opportunities to ask questions and share learning and effective approaches. The PPIM has attended a number of team meetings and has observed comprehensive discussion between team members, evidencing a genuine desire to get things right for every resident. The team are observed as being keen to learn and to develop skills.

Clinical Input

In the second half of 2024, Peacehaven continued holding regular monthly Clinical Review Meetings (CRMs), which offered a structured space to reflect, plan, and respond to the needs of those we support.

A big focus during this time was building the team’s confidence and skill in trauma-informed Positive Behaviour Support, particularly around recognising emotional needs and understanding more complex behaviours. Peacehaven also brought in more visual communication tools to support clearer, more personalised ways of connecting—especially helpful for people who communicate differently.

Therapeutic story work became a key part of helping individuals explore and process their experiences in a safe and meaningful way. Alongside this, we worked on improving how people in the service relate to each other—using clinical input and observations to strengthen group dynamics and encourage more supportive peer relationships.

Concluding comments

Peacehaven has had its challenges within 2024, particularly in relation to staff and it has required considered planning by the PIC to ensure adequate shift coverage and effective service delivery. On discussion with residents, feedback has been positive in relation to staff input.

Peacehaven continues to provide person led support with a focus on resident strengths, the development of the positive behaviour support input has been invaluable and has enabled staff to develop their skills and knowledge in this area.

Improvements required

1. Timely completion of monthly reports

As identified above, due to the pressures on staffing levels and the changing needs of residents, the PIC role has diversified and has involved covering shifts and completing additional reports and proposals to HSE to request differentiation of services to ensure continued provision of support for individuals.


Action	Responsible	Date for Completion
A review of content of monthly reports to be completed and template amended if necessary	MW/CY	28/02/24
Completion of monthly reports to be prioritised	MW	Completed

A definite improvement in the timely completion of monthly reports has been noted at the end of 2024.

2. Timely completion of Monthly Key Working Reports

On review of the PIC monthly audit reports, it is noted that there are often delays in the receipt of key working monthly reports. Key working reports are necessary to enable accurate and timely review of changing needs and wishes of a resident and any concerns. They are key in tracking progress/ decline identified areas for each resident.

Action	Person/s responsible	Date for completion
To be addressed with staff at next team meeting	PIC	
To be monitored by Care Managers over the next 3 months	Care Managers	

Review written by:  Date _____

Date Approved by Board of Management _____

Actions reviewed by: _____ Date: _____