2025

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

1st January 2025 – 30th June 2025

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 centrewas 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 3rd July 2025.

Regulation	Reasons for non-compliance	Actions that were taken	Current position	Further recommendations from PPIM
Regulation 26: Risk management procedures	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. *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.*	Risk assessment updated	Resident has moved to Lydia House and monitoring of dementia diagnosis is ongoing.	Further business case submitted to HSE in regards to adequate staffing.

Regulation 28: Fire precautions	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. 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. 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.		Double cover remains in place 24 hours per day to facilitate evacuation.	This issue remains ongoing – business case submitted to HSE for triple cover to ensure 2 staff are available for full evacuation.

PPIM Unannounced Inspection

The Council for Social Witness' Regional Manager (PPIM) visited Peacehaven Trust services on the following dates:

20th March, 8th April, 8th May and 13th May 2025. (It is to be noted the PPIM was on maternity leave until 3rd March 2025, support visits were carried out by CSW's Training Manager/ Clinical Lead January '25 – March '25.

These visits included supervision of the PIC, attendance at meetings with HSE to discuss residents' needs, quality assurance processes, and participation of recruitment. These visits evidence the wide ranging and active input the PPIM has within the service, ensuring good governance arrangements are in place.

Health and Safety

Commentary

A Health and Safety Committee meeting was held on 13th February 2025.

Topics covered included:

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

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	Q1 Statistics	Q2 Statistics
Uncommunicated Absence		
Resident abuse (by another resident)		

Resident abuse (by staff/third party)		
Resident - slips, trips & falls	2	1
Self-injurious behaviour		2
Resident accident - other than a slip trip or fall	6	4
Theft		1
Staff accident - other than a slip, trip or fall		
Infection Control Issue		1
Other	4	1
Transport (Car Accident)		
Physically challenging behaviour to an object	3	3
Physically challenging behaviour to another person	14	6
Verbally aggressive behaviour	5	4
Unexplained injury	1	
Near miss	1	
Infrastructure (including facilities, environment)	1	
Q1 Total:	**37**	
Q2 Total:		**23**
Q1 and Q2 Total:		

Further analysis of the incidents shows the following breakdown:

Year	Quarter	Total Incidents	Lydia Incidents
2025	1	37	27
2024	1	17	7
2025	2	23	
2024	2	30	

The level of incidents compared to Q4/2024 is a nearly 25% higher. Of these 75% are in Lydia House, and nearly of all these are behavioural incidents. Approximately 50% of all incidents involved the same resident with verbal or physical outbursts - Investment in understanding resident's behaviours and finding solutions. The planned change of House Manager, and regrouping of residents is anticipated to help with incident decrease; however, a proactive Stress and Coping plan is needed for the identified resident, which is agreed with Psychologist J McGookin. Continued efforts to understand a 2nd resident's regression combined with discussions with the HSE on suitable placements is essential.

The level of incidents compared to Q1/2025 is a nearly 25% lower. However, of the total incidents 75% remain in Lydia House. Approximately 40% of all incidents are caused by one resident, (reduced from 17 to 9), (with 40 'Issues of Note' recorded as well) with verbal or physical outbursts - Staff have been working hard with psychology to understand same resident's behaviours and finding solutions.

Medication Errors

During the period 1st January 2025 and 30th June 2025

Type of Error	**Q1 Number**	**Q2 Number**
Incidents (Resident Caused)		
Medication vomited		
Refusal to take medication	2	4
Resident missed their medication		1
Adverse Reaction		
Taking with another Substance		
Medication Loss		
Medication Spillage	1	2
Medication Spoilage	2	
Total Number of Resident Errors in Each Quarter	**5**	**7**
Total Number of Resident Errors in 6 – Month Period	**12**	
Incidents (Staff caused)		
To the wrong person		
Wrong medication		
Incorrect dosage	1	
Via the incorrect route		
At the incorrect time		1
Medication omitted by staff	1	2
Medication not restored		
Stock Control	1	
Incorrect form used		
Incorrect code used on Mar Sheet	2	
Medication not recorded on MAR Sheet		4
MAR Sheet is not signed	1	2
PRN rational not entered onto MAR sheet		
Incorrect time recorded on MAR sheet		
Rational for incorrect time not recorded-MAR sheet		
Total Number of Staff Errors in each Quarter	**6**	**9**
Total Number of Staff Errors in 6- month period	**15**	

Total Number of Errors of Staff and Resident Errors in 6- month period	

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 1	7098	6	0.08%
Quarter 2			

A very slight increase in the number of staff caused errors in this quarter compared to the last quarter of 2024. And the same as compared to Q1 of 2024. The number of passes reduced by 12.5%. Staff errors relate to recording errors, and minor omissions and minor incorrect dosage, which did not require further action. Staff always need to work with the utmost accuracy to avoid any errors.

A 50% increase in the number of staff caused errors in this 2nd quarter of 2025 compared to the 1st quarter of 2025. This is the highest error rate since Q1 of 2023. The number of passes increased by 546; as did the total of residents (15 - 18) and the total of the staff team increased from 30 - 35. With Grasta House commencing, as the fourth service and changes to both Blake House and Lydia House (in terms of residents and staffing), an increase in errors can be understood. Staff errors predominately relate to recording errors, however with 2 omissions (ear drops) and 1 minor incorrect dosage, which did not require further action, staff always need to work with the utmost accuracy to avoid any errors. As the new staff and teams settle a significant reduction in errors is expected and required. Resident refusals should also diminish as the Grasta staff gain further expertise in supporting resident, so that 'refusals' become less frequent.

Complaints Log 1st January 2025 – 30th June 2025

Month	Number
January	1 (Lydia House)
March	1 (Lydia House)
May	2 (1x Grasta House, 1x Lydia House)

Compliments Log 1st January 2025 – 30th June 2025

Month	Number
February	2 (Applewood)
April	1 (Lydia House)

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 up until 30th June 2025

- Life story work
- Infection, Prevention and Control
- Manual Handling
- Person Centred Planning/ Key Working
- Safeguarding
- First Aid Refresher
- Anti – Bullying

Clinical Input

The progress made during 2024 continues to shape Peacehaven today. Changes in who lives where have opened up new opportunities for relationships and personal development. Naturally, there have been some periods of adjustment, so we've placed a strong emphasis on making reflective practice a regular part of CRMs, team meetings, and supervision. These spaces allow staff to take stock, learn from what's happening day-to-day, and tweak support where needed—helping us stay emotionally attuned and trauma-informed in our care.

In early 2025, we also took part in a multi-agency case review to propose a tailored new service for a young man whose support needs are shifting. Working closely with HIQA and other professionals, we've been exploring a pathway that's sustainable and clinically sound. This work highlights Peacehaven's ongoing commitment to being flexible, person-led, and always evolving to meet the needs of those we support.

Specific Areas Reviewed

Staff Supervisions – A supervision tracker for 2025 is in place and regularly updated. PPIM reviewed on 04/07/25 as part of this report. Supervisions are taking place, however there are some gaps in the tracker.

Action: Tracker to be updated with most recent supervision for all staff - Care Managers must update this as and when a supervision session is completed to ensure accurate and up to date records.

Emergency Contacts – All In Case of Emergency documentation was updated in March 2025. This is completed annually or as there is a change in contact details etc.

Restrictive Practices Trackers- This appears to be in need of updating.

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 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

Review written by:  Date

Date Approved by Board of Management_____

Actions reviewed by:_____ Date:_____