2025

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

Peacehaven Trust OSV 0003690

1st July to 31st December 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 25th November 2025)
- 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 unannounced RED HIQA Inspection was carried out as part of the ongoing regulatory monitoring of the centre was carried on the 25th November 2025 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 unannounced inspection as required under the legislation as part of the review process undertaken by HIQA in respect of Peacehaven Trust's mid-cycle of their registration certificate period.

Jennifer Deasy was the Inspector.

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 15: Staffing	Compliant		
Regulation 23: Governance and management	Compliant		

Regulation 34: Complaints procedure	Substantially compliant		
Quality and Safety			
Regulation 13: General welfare and development	Compliant		
Regulation 17: Premises	Compliant		
Regulation 28: Fire precautions	Compliant		
Regulation 5: Individual assessment and personal plan	Substantially compliant		
Regulation 7: Positive behavioural support	Substantially compliant		
Regulation 8: Protection	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 34: Complaints procedure	The inspector saw that complaints had been responded to in a timely manner; however, a written response was not provided to the complainant within the timeframe specified by the policy.	Peacehaven Trust will review and where necessary amend their Complaints Policy, to ensure that responses to residents are formatted in an accessible format for each individual; and delivered within the regulated time frames.	New draft in circulation for comment and approval.	New amended policy to be completed and implemented.
		As part of a safeguarding audit and review, Peacehaven Trust will review the complaints reporting system; and the external monitoring system of complaints, to ensure that complaints are being responded to; investigated and resolved within the regulated time lines.	CSW are in the process of appointing a Social Worker to undertake the full review of all CSW services including PHT.	None

Regulation	Reasons for non-compliance	Actions that were taken	Current position	Further recommendations from PPIM
Regulation 5: Individual assessment and personal plan	It was not evident that a specified residents' bedroom was equipped to meet their changed personal care needs and ensure their dignity and well-being. An updated assessment was required to identify any additional supports required to enable staff members to complete tasks in these circumstances. Improvements were also required to the record keeping to ensure that accurate records of the efforts staff took to complete personal care were maintained	The Provider will ensure that as comprehensive as possible personal, medical and environmental assessments of the individual resident are completed, to ensure that their holistic care needs are understood to ensure their dignity and well-being. Findings of these assessments will be discussed with the HSE to seek relevant funding as recommend by such assessments.	SLT, OT and PT assessments have been booked by the key worker – awaiting completion of same.	As changing needs continue (Positively at present) a short term re-assessment of needs will be required – within 3 months of initial date of each assessment.
		The PIC will ensure that annual review of the Individual Care Plan occurs as per legislation including a review when a change of needs occur	Family Annual review not complete – date to be sought with parents	Pic to ensure all MDT review are competed annually

PPIM Unannounced Inspection

The Council for Social Witness' Regional Manager (PPIM/C. Yeomans)) visited Peacehaven Trust services on the following dates: 30th July. C Yeomans was appointed as the Deputy Director of CSW in August '25. During September '25 the (PIC/M Williams) Director of Services of Peacehaven was commissioned to become an Acting Regional Manager and was registered as a PPIM in November '25. A new PIC (G Egan) was appointed as the (Acting) Services Manager. The new PPIM conducted monitoring visits to Peacehaven between the 8th – 12th December 2025.

These visits included supervision of the outing PIC, supervision of the incoming PIC, supervision of the care managers, monitoring against the regulations; being present for HIQA inspection, discussion with the HSE, and commissioning of independent care review reports. These activities evidence the wide ranging and active input the PPIM(s) have within the service, ensuring good governance arrangements are in place.

Health and Safety

Commentary

No recorded meeting of the H&S committee occurred between July and December 2025.

No H&S Audits have been undertaken.

All H&S Safety Statements are in place in each location, and H&S Reps have been appointed in each location.

All H&S Risk assessments are in place and in date – these have been independently reviewed by Peninsula, with no issues identified.

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), via the Service Managers monthly report and also in the Service Manager's Monthly Monitoring report.

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 and/or discuss in supervision if they are responsible for a medication error.

All accidents, incidents and near misses including medication errors are discussed at team meetings and 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).

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. Notification of a Safeguarding incident is made to CHO6 Safeguarding Team (along with a Safeguarding Plan) via the HSE's Safeguarding Portal.

Incidents recorded

69 incidents were recorded between 1st July 2025 – 31st December 2025 for the entire company. This is an increase of 14 on the previous 6 months, where 60 incidents were recorded (Jan – July).

Within the designated centre (OSV 0003690/Peacehaven) 61 incidents occurred between Q3 & Q4 [the remainder belong to the designated centre (OSV 0008999/Grásta House). The majority of incidents were behavioural and occurred in the summer and early autumn months of 2025.

Further analysis of the incidents shows within OSV 0003690/Peacehaven Trust the following

Type of Incident	Q3 Statistics	Q4 Statistics
Uncommunicated Absence	0	0
Resident abuse (by another resident)	0	0
Resident abuse (by staff/third party)	0	0
Resident - slips, trips & falls	3	2
Self-injurious behaviour	0	0
Sexually inappropriate behaviour by a resident	0	0
Potentially sexualised behaviour by a resident	0	0
Resident accident - other than a slip trip or fall	7	4
Theft	1	1
Staff accident - other than a slip, trip or fall	0	0
Infection Control Incident	0	1
Other	1	3
Transport (Car Accident)	2	0
Physically challenging behaviour to an object	0	0
Physically challenging behaviour to another person	5	7
Verbally aggressive behaviour	13	6
Unexplained injury	1	0
Near miss	0	1
Infrastructure (including facilities, environment)	1	1
Q3 Total:	**34**	
Q4 Total:		**27**
Q1 and Q2 Total:	**61**	

breakdown:

Year	Quarter	Total PHT Incidents	Lydia Incidents
2025	1	34	27
2025	2	21	17
2025	3	34	26
2025	4	27	17

The level of incidents compared to Q1+Q2/2025 are 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 that resident's behaviours and finding solutions continues. A planned change of House Manager, and regrouping of residents occurred in Q2. The assessment of the new grouping of residents focused on good compatibility between the resident with high incident data, and the new household i.e. people who were known to the resident, with good self-agency and friendly natures were brought in, with clear and slow transitions. It was anticipated that the same level of incidents would continue for a period (estimate 6 to 12 months), as 'learned behaviour' was being 'un-learned'; however, the increase in intensity of behavioural incidents was not predicted in the assessment. The significant change being that verbal and physical aggressive incidents became focused on fellow residents, were previously, it had been only on staff. This significantly increased the safeguarding data, safeguarding reports and

safety plans. The proactive Stress and Coping plan for the identified resident was revised into a full Positive Behaviour Support Plan, by Psychologist J McGookin. Two further reports were commissioned – one on the affected residents sleep patterns; and the other is a holistic report on the care and provision received by the affected resident within Lydia House – the second report was not completed by the end of Q4. A case conference is planned to review the report in early Q1 of 2026 to seek improvements for the affect resident's care.

Continued efforts to understand a 2nd resident's regression combined with discussions with the HSE on suitable placements is essential; an application to the DSS is underway to enable medical understanding of the regression

Medication Errors for the designated centre OSV 0003690 / Peacehaven Trust

During the period 1st July 2025 and 31st December 2025

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

Incorrect time recorded on MAR sheet	1	
Rational for incorrect time not recorded-MAR sheet		
Total Number of Staff Errors in each Quarter	**7**	**4**
Total Number of Staff Errors in 6- month period	**11**	
Total Number of Errors of Staff and Resident Errors in 6- month period	**17**	

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	8280	7	0.008%
Quarter 4	8466	4	0.005%

A good decrease in the number of staff caused errors in this quarter compared to the first two quarters of 2025. The number of passes reduced by over 40%. Staff errors relate to recording errors, and minor omissions and minor incorrect dosage, all with a low-risk rating, which did not require further action.

Staff always need to work with the utmost accuracy to avoid any errors.

Complaints Log 1st July to 31st December 2025

Month	Number
July	
August	2 LH
September	4 LH
October	
November	
December	4 LH

Compliments Log 1st July to 31st December 2025

Month	Number
July	2 BH
August	
September	2 BH; 1 LH
October	
November	
December	1 BH

Training

A comprehensive training needs analysis is completed at the beginning of each calendar year, by the PIC. The training plan is then targeted at training gaps, and expiring courses. A review of incidents

and changing guidance/regulations/legislation will inform new training needs. The new PIC and new PPIM are committed to delivering a relevant and impactful training schedule for staff, with the ultimate aim of improving service delivery. Most training occurs in the first six months of each calendar year.

Training in the following training has been completed between 1st July and 31st December 2025 to the staff group. A lot of 'two year' courses were completed in 2024, and therefore not due for renewal until 2026.

- Safeguarding Review
- GEARs PBS training

Staff continue to complete online training, with HSELanD.ie and other providers in

- HASSAP
- HIQA Standards Safeguarding training
- HIQA Human Rights Approach 1-4
- HIQA Standards/ Infection Control
- Donning & Doffing PPE Comm & Acute settings
- AMRIC Hand Hygiene
- AMRIC Basics of Infection Prevention and Control

Clinical Input

The progress made during 2024, & Q1+Q2 of 2025 continues to shape Peacehaven today, especially with the development of a new designated centre. Changes in who lives where have opened up new opportunities for relationships and personal development – however this has brought some unexpected challenges which MDT and staff are working to assess and resolve.

A strong emphasis on making reflective practice as a regular part of CRMs, team meetings, and supervision continues. 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. With CORU registration included the aim is to increase the competency of the staff team as a whole.

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. Following on from the HIQA inspection, further PT and OT assessment are needed for the living space as well as the to assess the changing abilities of the individual.

Specific Areas Reviewed

Staff Supervisions – A supervision tracker for 2025 is in place and regularly updated. PPIM reviewed on 20/01/2026 as part of this report. Some supervisions are taking place, however there are some

significant gaps in the tracker, especially in Lydia House, which is experiencing the most behaviour challenges.

Action: The PIC to put in place measures ASAP to ensure effective supervision occurs for all staff, but particularly for those dealing with the more challenging behaviours.

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 - Are in good order.

Concluding comments

Peacehaven has had its challenges within 2025, particularly in relation to the creation of a new designated centre (which involved the discharge of one resident from the existing designated centre into the new. Some staff moved to the new centre, and new recruits were needed. In combination with the vacancies created by the deaths of two residents in the previous year, significant work was undertaken to rebalance the house groups and to admit new residents. This process completed during the summer of 2025. Changes in house managers, then quickly followed by the change of PIC and PPIM have further unsettled the structure which needs some time to re-embed – building effective teams in each of the three houses of this designated centre. The object of the changes was to strengthen governance and improve quality across the service. Q1 and Q2 data of 2026 will determine if this is succeeding.

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. The PIC to ensure Key Work reports are being written by all key workers and submitted with the superseding month, for management review.

2. Timely completion of quarterly supervision for all staff

As noted above supervision is behind policy expectations; and is critically needed in houses dealing with the more challenging behaviours. The PIC to ensure with Care Managers and Deputies that supervision occurs at a minimum for four sessions per staff per year in 2026. The PIC to ensure that all supervisors are adequately trained to deliver good quality supervision by end of Q1 2026. The PPIM to raise cost issues of supervision with the PHT Board in Q1 2026.

3. Renewed PT and OT assessment are needed for the living space as well as the to assess the changing abilities of the individual experiencing regression in LH.

The PIC is to ensure with the Care Manager and Key Worker, that the specified individual receives all PT and OT assessments relating to themselves and also their living environment, within Q1 of 2026.

4. Health and Safety Committee meetings to recommence

This is a statutory function which needs to occur. The PIC to ensure at least four H&S committee meetings per annum.

5. Health and Safety Audits to recommence.

The PIC and PPIM need to ensure that the Admin and Accounts Manager is resourced to complete quarterly H&S audits of each house, or to deputise that function to another member of staff.

Review written by:  Date

Date Approved by Board of Management_____

Actions reviewed by:_____ Date:_____