



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Peacehaven Trust
Name of provider:	Peacehaven Trust CLG
Address of centre:	Wicklow
Type of inspection:	Short Notice Announced
Date of inspection:	30 June 2021
Centre ID:	OSV-0003690
Fieldwork ID:	MON-0032234

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Peacehaven trust provides full-time residential care and support for 17 adults with mild or moderate intellectual disabilities across three locations on the east coast of Co. Wicklow. Each house is close to a variety of local amenities and residents have access to private transport to support them to access their community. Each resident has their own bedroom and has access to communal rooms including a choice of sitting area, kitchens, laundry rooms, gardens, private spaces, adequate storage, waste disposal, and private transport. Care and support is provided for residents as required within the context of a 24/7 service. The staffing team consists of a person in charge, care managers, social care workers and relief staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 30 June 2021	09:55hrs to 17:10hrs	Andrew Mooney	Lead
Wednesday 30 June 2021	09:55hrs to 17:10hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

In line with public health guidance, inspectors did not spend extended periods of time with residents. Inspectors visited two of the houses which make up the designated centre and spoke to several residents in both of these houses. Documents and records were reviewed in an office which was located in the garden of one of the houses. Inspectors used observations and discussions with residents as well as a review of records and discussions with key staff to inform judgements on residents' quality of life.

The houses were observed to be large, clean and homely. The walls of one of the sitting rooms was decorated with photographs of residents enjoying outings in the community and of important celebrations. The houses were well maintained. There were several sitting rooms available for residents to access and to have some quiet time alone if they wished. The atmosphere within the houses appeared calm and relaxed. Residents were observed freely accessing and enjoying various parts of their homes. In one house, residents were observed helping themselves to snacks, making tea and sitting at the kitchen table talking to each other and staff. Other residents were observed using their personal tablet devices or reading magazines and relaxing in the various sitting rooms within the house.

Several residents were eager to speak to the inspectors on the day of the inspection. Residents spoke very positively about their experiences of living in their home. They described the choices available to them during their daily routine and the options available to them in accessing their community. Residents described accessing day services, their church and trips out with staff. One resident told the inspectors that they have their own ATM card and can withdraw their money as they needed it. Another resident informed the inspectors that they do their own laundry and that residents choose what to eat for dinner in the house.

Staff facilitated inspectors to speak with residents with alternative communication support needs. This allowed inspectors to engage with this residents in a meaningful way.

Residents described feeling safe in their home. One resident stated that they would like to lock their bedroom door at night but they understand the fire risks that would be associated with this. Another resident described how they can feel stressed at times but that they have strategies to help them to manage their mental health. This resident stated they feel they can always talk to the person in charge and that he listens to what they have to say. Residents generally spoke positively about their relationships with staff.

Residents described finding the last 18 months difficult with managing restrictions during the global pandemic. Residents found it difficult being unable to visit family or go on holidays however they stated they were supported by staff to keep in touch with family over the phone or using personal devices. In one house, two residents

described the plans they are making to go on a holiday in Ireland later in the year which they stated they are very much looking forward to. Residents informed the inspector that some residents do not like going on holidays and that the service provider will support this choice and support residents to stay at home if they wish.

Capacity and capability

The purpose of this inspection was review progress made with the providers last compliance plan response. Overall the inspectors found that improved governance and management arrangements within the centre, had enhanced the centres capacity and capability. These systems ensured residents' quality of life was supported and enhanced. Some improvements were required in the management of medicines.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. Staff spoken with could clearly identify how they would report any concerns about the quality of care and support in the centre and highlighted that they would feel comfortable raising concerns if they arose. Staff reported directly to care managers, who in turn reported to person in charge. A new person participating in management role had been implemented since the last inspection and this was providing appropriate oversight arrangements within the centre, including the completion of six monthly unannounced inspections of quality and safety of care. Where areas of improvement were identified, the person in charge in put appropriate measures in place to address these concerns. This demonstrated that the provider had the ability to self identify issues and the capacity and capability to drive quality improvement.

Inspectors found that there were appropriate staffing levels with the required skill mix to meet the needs and number of resident. Staffing levels were appropriate for the size and layout of the designated centre. A planned and actual rota was maintained, Staffing arrangements within the centre ensured residents needs could be met appropriately. During the inspection, inspectors met with and spoke to staff. Staff demonstrated a detailed understanding of residents needs, including strategies to support residents' with communication and support needs. Inspectors observed staff engaging with residents in a caring and supportive manner and it was clear that residents knew staff well.

A detailed training matrix of mandatory and additional training was maintained by the service provider. The training matrix demonstrated that all staff on duty had up to date mandatory training in fire safety and medication management. Several staff required refresher training, however the person in charge demonstrated that this training was booked for the coming weeks. The person in charge had implemented an individualised training programme to support staff and residents to learn one resident's unique form of sign language and to thereby support that individual to develop effective relationships and to be able to communicate with staff and peers.

This training enabled staff to provide evidence based care and enabled them to support residents with their assessed needs. A review of supervision records for staff and for the person in charge, demonstrated that regular supervision and support meetings were occurring in line with the providers policy. Staff noted they felt supported by this process.

Regulation 15: Staffing

There was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times.

There was a planned and actual roster in place.

Judgment: Compliant

Regulation 16: Training and staff development

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, infection control, fire safety and manual handling. The person in charge maintained a register of what training was completed and what was due.

Staff supervision was provided and the frequency of this supervision was in keeping with providers policy on supervision.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures which identified the lines of authority and accountability within the centre.

Judgment: Compliant

Quality and safety

There were systems and procedures in place to protect residents and promote their welfare. This inspection noted sustained improvements with safeguarding practices and some improvements in the management of behaviours of concern. However, there remained a lack of access to some appropriate allied health care professionals and this required improvement.

The previous inspection in September 2020 found that not all assessments of need were comprehensive in nature, due to a lack of access to appropriate allied health care professionals. Inspectors acknowledge that the provider had enhanced some clinical governance arrangements for positive behaviour support. However, residents continued not to have timely access to other appropriate allied health care professionals. For example residents' assessed as having eating, drinking and swallowing needs did not have timely access for Speech and Language (SLT) assessments, despite this being recommended through their current clinical governance arrangement. The provider had endeavoured to source speech and language therapy however they were not successful in doing so. These arrangements required enhancement.

There were arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life. The service worked together with residents and their representatives to identify and support their strengths, needs and life goals. Residents were supported to access and be part of their community in line with their preferences and assessed needs. Some improvement were required to ensure that personal plans were fully accessible to residents, however the provider had a plan in place to drive this improvement.

Residents received regular and timely review with their General Practitioner (GP) and were supported to attend chiropody, mental health and dental appointments where required, for example residents that required supports in relation to epilepsy management received ongoing regular review with their neurology physician. However, despite being raised as a concern on a previous inspection, some documentation relating to the management of emergency PRN (as required medication), was not consistent and required review. It was noted by inspectors that this documentation had not led to any adverse incidents, however the contradictory information contained in some healthcare related plans required review, to clearly guide staff practice.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Safeguarding plans were developed and safeguards put in place as required. Allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. Staff who spoke with the inspector were knowledgeable in relation to their responsibilities in the event of a suspicion or allegation. Residents also had intimate care plans developed as required which clearly outlined their wishes and preferences. Residents told inspectors that they felt safe in their home.

Medicine records were kept safe and in an accessible place. There were suitable practices in place for ordering, storing, administering and disposing of medicines.

Out of date medicines were stored in a zip locked folder in the medications press. While it was clear that these medicines did not belong to any one individual and were not in use, they were not stored separately to individual residents' medications, it was therefore not clear that these were out of date medications as the folder was not labelled. The provider had recently completed a review of all medication errors and had implemented a new medicines policy and delivered local training to staff in relation to this policy. Staff who were spoken to on the day were knowledgeable with regards to the processes in place for administering medication and for recording and responding to any errors. A system was in place to support staff in reflecting on medication errors and implementing new learning from these. Risk assessments of residents' capacity to self-administer medications were available on files. However, one of these was noted to be out of date. Another risk assessment identified that a resident would like to self-administer medicines and could potentially do so with training, however there was no training plan in place to support the resident with this goal. This process required review to ensure residents preferences regarding self administration could be facilitated, in a safe and effective manner.

Regulation 29: Medicines and pharmaceutical services

Generally there were suitable practices in place for ordering, storing, administering and disposing of medicines. However, improvements were required in how out of date medication was stored. Furthermore, the assessments for residents to self administer medicines required review, for example a risk assessment identified that a resident would like to self-administer medicines and could potentially do so with training, however there was no training plan in place to support the resident with this goal.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There were appropriate arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life. However, not all assessments of need were comprehensive in nature, due to a lack of timely access to appropriate allied health care professionals, such as SLT.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare was generally supported well, with regular and timely engagement with appropriate healthcare professionals, such as their General Practitioners(GP) and hospital consultants. However, documentation relating to the management of certain epilepsy interventions required improvement, to ensure prescribed emergency management interventions were implemented consistently. For example, not all PRN (as required medication) protocols were consistent with residents personal plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The implementation of an enhanced behaviour support planning process had been delayed due to the COVID-19 pandemic. However, in line with public health guidance a clear plan was in place to commence on site behaviour support assessments. Additionally, off site clinical reviews relating to behaviours of concern had been ongoing.

There was evidence of restrictive practices being reviewed in line with the centres policy.

Judgment: Compliant

Regulation 8: Protection

The person in charge initiated and put in place an investigation in relation to any incident,allegation or suspicion of abuse and took appropriate action to safeguard all residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Peacehaven Trust OSV-0003690

Inspection ID: MON-0032234

Date of inspection: 30/06/2021

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <p>The Person in Charge will ensure that each resident has an assessment of their self-medicating abilities (in line with new HSE policy), and those that wish to self-medicate are facilitated to do so – or have a training plan in place to progress to an agreed level of self-medicating – by end of September 2021.</p> <p>The person in Charge will ensure each month that the Peacehaven policy for the storage and retention of medicines is complied with – including clearly labelled separate storage of out of date/out of use medications which are being returned to the pharmacy.</p> <p>All medicines are prescribed, including alternative medicines to ensure compatibility of products.</p> <p>Administration of medicines is kept in line with Peacehaven policy to be person centred, safe and meets the health and medicine needs of each individual resident.</p> <p>The Person in Charge will ensure through bi-monthly supervision that key workers inform residents of their medicines, their purpose and effect according to their cognitive ability.</p> <p>The Person in Charge ensures that no medicine is used as a restraint.</p> <p>Residents continue to choose their GP service, and choose which pharmacy provides their script.</p> <p>All medication errors continue to be recorded, and the Person in Charge along with the PPIM review errors on a monthly basis and work with the staff teams to learn from errors adapt and work to prevent occurrences.</p>	
Regulation 5: Individual assessment and personal plan	Not Compliant

<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>The Person in Charge will work with the Care Managers and the staff team to ensure that each resident’s individual plan (as recorded across assessments, risk assessments, care plans and associated documents) meets the residents preferred way to live, supports their rights; are consistent in information and accurate in detail; kept constantly relevant and updated according to the resident’s needs (and regulation - including any dynamic health regulations as may occur).</p> <p>Through increased file audits (occurring monthly) by the Person in Charge and the Care Managers, the quality and person centeredness of each residents’ plans will be reviewed – with areas of concern promptly addressed.</p> <p>An additional thematic review will be introduced (August 2021) to cross check critical supports, such as Dementia Plans, Dysphagia, Epilepsy, National Screenings, General Medical supports (i.e. dentistry, optician, audiology, chiropody), MHID supports and other areas as deemed necessary by the Provider.</p> <p>The PPIM and Person in Charge will review the auditing system as part of the six-monthly report – which will form part of the quality improvement cycle – and will amend polices as necessary.</p>	
Regulation 6: Health care	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <p>The PPIM will ensure that resident’s rights to timely access to MDT/associated healthcare provision occurs in a timely manner – including access to Dementia Care, SALT, Neurology, Mental Health, Occupational Therapy, Physio Therapy and others.</p> <p>For SALT access the Person in Charge by end of July 2021 will identify all residents in need of SALT access; the PPIM will seek and cost access to private services and ensure urgent and long standing reviews are completed by end of August 31.</p> <p>The Person in Charge will ensure that residents as part of their annual GP/Medical review are informed of National Screenings (as appropriate by age and gender), have opportunity to discuss same with their GP and representatives and make informed choices to engage with the screening programme.</p> <p>The Person in Charge will ensure that engagement with the resident regarding meals/diet preferences occurs with awareness of nutrition, exercise and physical activities occurs through weekly menu planning and activity planning – respecting the resident right to choice.</p> <p>The Person in Charge will develop and deliver training in Advanced Health Care Directives, (by 31st October), and then will work with keyworkers and residents to plan end of life care(as appropriate to the age and health of the resident) – within the abilities of the residential centre. Such plans to be in place by end of December 2021.</p>	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	31/07/2021
Regulation 29(5)	The person in charge shall ensure that following a risk	Substantially Compliant	Yellow	30/09/2021

	assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/08/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/08/2021