peacehaventrust

Bi-Annual Report

July to December 2017

Provider Nominee:	Michael Williams
Director of Services:	Michael Williams
Care Managers:	Salome Murphy
	Sean Kelly
Report Completed by:	Michael Williams
Date:	20th January 2018

Introduction

Peacehaven Trust is a voluntary organisation based in Greystones, County Wicklow. The Trust manages 3 Residential services for people with disabilities, mainly for people with Intellectual Disabilities. 16 people are currently supported in total across the three homes with an office attached to one of the services - Lydia House; Blake House and Applewood Heights are the other two services. Capacity 17 persons.

Peacehaven Trust continued to be governed by a group of Directors. The Council for Social Witness of the Presbyterian Church in Ireland, will continue to work towards a take over, though for a further two/three year period Peacehaven Trust will remain in position, and members of the Presbyterian Church in Ireland will join the Board of Directors.

Core funding continued to be provided by HSE.

Peacehaven Trust has 'assumed registration' by HIQA.

Method

This Bi-Annual report is based on the monthly monitoring reports; plus complaints, incidents, medication incidents and staffing data for the reporting period. The monitoring reports throughout the space of a full year cover all 31 outcomes as listed in SI367. Therefore the reporting period covers approximately half of those outcomes.

The table below outlines the schedule for which outcomes are monitored within which month. The highlighted months indicate a major monitoring inspection, which are unannounced. All other monitoring visits may also be unannounced or may be planned.

January	7	Resident's Rights
	1	Statement of Purpose

February (Unannounced)	6	Protection
	9	Visits
	17	Directory of Residents
	18	Information for Residents
March	5	Positive Behaviour Support
	26	Medicines and Pharmaceutical Support
April	8	Communications
	27	Volunteers
May	16	Food and Nutrition
	28	Notification of Incidents
	29	Notification of Periods when Person in Charge is Absent
	30	Notification of Procedures and Arrangements for Periods when Person in Charge is Absent
June	19	Records
	24	Protection against Infection
	25	Fire Precautions
July	10	Personal Possessions
	31	Complaints Procedures
August	11	General Welfare and Development
	13	Staffing
	14	Training and Staff Development
	23	Risk Management
September	3	Individual Assessment and Personal Plans
	2	Written Policies and Procedures
October	4	Health Care
	12	Person in Charge
November	21	Admission and Contract for the provision of Services
	22	Temporary absence, transition and discharge of resident
December	20	Governance and Management
	15	Premises

Actions Arising from Previous Six Monthly Reports (January – June 2017)

Action to be completed	By Whom	Date for Completion.	Completed? Comment
Health and Safety Committee – to devise better fire drill recording systems	S Kelly	31.12.17	No. New H&S Committee now meeting. New fire drill system not in place.
To complete all mandatory staff	M Williams	31.12.17	Yes. By 14th Dec 17

training			
To review all policies for effectiveness and best practice standards.	M Williams	31.12.17	No. 11 polices remaining that need attention.
Monitoring Visits to continue with actions identified.	M Williams or S Kelly, S Murphy	31.12.17	Yes. In Dec completed by Care Manager.
Management Team meetings to continue with actions identified.	M Williams	31.12.17	Yes – each month – minutes on file.
Continue to work on the reduction of Medication Errors and repeat offenders.	M Williams	31.12.17	Errors rose slightly, by percentage, but types are much less serious.
Continue with planning building works for Blake House with view to complete by end of November	M Williams	30.11.17	Not complete – HSE seeking assurances re State's Interest.

The outcomes monitored in July were '10 Personal Possessions', 'Complaints Procedure', The monitoring reports found that all financial records and resident monies where all healthy and well. Several personal procession lists needed to be completed. In relation to Complaints Procedure, clear notices where displayed in all locations, and staff had discussed procedures with residents. In relation to matters arising from the June audit, staff where still learning the new system. All medication actions had been completed, other actions not yet completed. The July monitoring visit was announced.

The outcomes monitored in August were '11 General Welfare and Development', '13 Staffing', 'Training and Staff Development', and '23 Risk Management'. This was a major monitoring inspection month and all visits were unannounced.

The monitoring reports found that most actions from July were not met – some of these office based and needing significant attention. In resident files some 'Assessments of Need', 'Personal Preferences Forms', 'End of Life Plans', 'Care plans', 'Safety Plans', 'PCPs' were to

be updated; development of community connections to continue; some staff to continue in educational development to attain basic qualification, role of Keyworkers to be clarified; HR files to be completed (as per July audit). Training gaps to be filled ASAP; Supervision for all staff to continue; Copies of Health Act, National Standards and SI 367 to be located in each location, Risk Assessment & Hazard Policy to be reviewed; Motor Policy to be reviewed

The outcomes monitored in September were '3 Individual Assessment and Personal Pans', '2 Written Policies and Procedures'.

The monitoring reports found that the Director needed to complete the review process for 11 policies; and write new policy for CCTV and electronic surveillance. Also to ensure copies of all current policies are in all locations. Some Composite health Plans still needed to be introduced. To increase hours/time for two residents in Lydia House, To established the preferred preference for PCPs for some residents. That not al PCPs were in date (as in August audit); and a new Family Review Form was required to better capture a multi-disciplinary review of each resident.

Most short term actions from the August audit were met. Long term actions were being addressed but not yet resolved.

The outcomes monitored in October were '4 Health Care', '2 Person in Charge'. The monitoring report found that some Composite Health Assessments needed to be completed. All regulatory requirements concerning the Person in Charge were met. Most short term actions from the September audit were met. Some Long term actions were met such as HR files others being addressed but not yet resolved.

The outcomes monitored in November were '21 Admission and Contract for the Provision of Services', '22 Temporary Absence, Transition and discharge of Resident'. The monitoring reports found that a new Admission Policy is in place; one referral active with completed form. Residents present under two years have new contact information. Most residents have been a part of Peacehaven for over five years – such records not in place. One Impact Assessment in place for new referral. That Contract of Care; Tenancy Agreement; Resident's Guide & Tenancy Handbook were in place for most residents; some to be completed. In regard to temporary absence (hospitalisation) or discharge then recorded discussions with HSE, Resident and Family with clear Transition Plans written would be in place. Most short term actions from the October audit were met. Some Long term actions were met such as HR files others being addressed but not yet resolved. Some easier actions not resolved –

keyworkers to be addressed & identify support needs or other. Financial discrepancies in Applewood's residents to be investigated.

The outcomes monitored in December were '20 Governance and Management', '15 Premises'. The monitoring report found that Lydia house is due for redecoration; and an increase in staffing to meet both changing needs and a 6th resident – submissions already with HSE. Blake house to be renovated to provide for Ensuite in each bedroom and then to redecorate; Applewood Heights needs minor re-modelling downstairs to ensure fire safety, and to improve wheelchair accessibility. Staffing hours need to increase by 19.5 hrs to ensure residents needs are met. Appraisals for staff need to recommence. Most short term actions from the November audit were met. Some Long term actions were met such as the training schedule. Some easier actions not resolved – keyworkers to be addressed & identify support needs or other. Financial discrepancies in Applewood's residents to be investigated.

All the reports generally found some errors in the medication storage, and set actions for correction – these were completed on time. Comments form the staff and residents were positive, but had room for improvement regarding personal care.
The general condition of the houses was fine, with tidiness and cleanliness needing small improvement in most areas.

Staffing Issues:
No major changes in staffing. One staff NT resigned in November (19.5hrs post) this has been advertised – interview in Jan.
The staffing structure as of June 17 are;
-1 x Director of Services, full time
-1 x Administration Manager, part time
-2 x Social Care Managers, full time
-Social Care Workers, full time and part time
I staff member returned from maternity leave in this period.
Staff Meetings were generally held weekly.
A new staff training policy was created and a schedule was implemented to ensure mandatory training occurred for Occupational First Aid, Medication Management, Fire Safety, Safe Guarding of Vulnerable Adults and Manual Handling.

Governance:

No changes to the board, which met on the Aug 17th, Nov 17th. The takeover proceedings with the Council for Social Witness of the Presbyterian Church continued.

Complaints:

There were 2 complaints received in this reporting period – both were resolved within the policy and time line.

Incidents and Medication Errors:

There were 40 incidents reported in the reporting period. There were 4 incidents which required report to HIQA and/or the HSE Safe Guarding Team. Safe Guarding plans are in place for one resident in relation to the internet.

56 Medication errors were reported to management, with actions assigned to each. For the third quarter the rate of errors was 0.47%, which increased slightly from the second quarter and then increased slightly again to 0.50% in the fourth quarter – the cause of errors shifted from major categories to minor ones with incorrect documentation being the largest cause - with omissions being the largest error. The volume of medications handled has risen in the year from 5214 per quarter to 6096 per quarter.

The breakdown of medication errors for the reporting period [in both quarters] is as follows below:

July 2017 - September 2017 Statistics		October 2017 - December 2017 Statistics	
Medication Loss	0	Medication Loss	1
Medication Spilage	0	Medication Spilage	4
Medication Spoilage	0	Medication Spoilage	0
Stock Control	1	Stock Control	2
Incorrect Code Used	0	Incorrect Code Used	0
Incorrect Documentation	2	Incorrect Documentation	10
Medication not Recorded	6	Medication not Recorded	3
Medication Vomited	0	Medication Vomited	0
Refusal to take Medication	0	Refusal to take Medication	1
Missed Medication	1	Missed Medication	3
Adverse Reaction	0	Adverse Reaction	0
Taking with another Substance	0	Taking with another Substance	0
Incorrect Person	0	Incorrect Person	0

Incorrect Medicaiton	0	Incorrect Medicaiton	0
Incorrect Dosage	1	Incorrect Dosage	1
Incorrect Route/Form	0	Incorrect Route/Form	0
Incorrect Time	2	Incorrect Time	2
Medication Omission	10	Medication Omission	4
Medication not Restored	2	Medication not Restored	0
Total Number of Errors for Quarter	25	Total Number of Errors for Quarter	31
Total number of Passes for Quarter	5367	Total number of Passes for Quarter	6096
Percentage of medication errors	0.47%	Percentage of medication errors	0.50%

People supported:

No new residents in this reporting period. 5 people supported in Applewood, 6 people supported in Blake House and 5 people supported in Lydia House.

As at 31st December an active referral is being considered for Lydia House– which would require a change to the staffing compliment – with increased HSE funding.

Environmental Issues:

Consideration and planning occurred regarding the physical environment of Blake House with a view to improve lighting on the first floor and facilitate the provision of en suite facilities for all residents. The planning work continued throughout this reporting period.

The Log House Offices were installed at the rear of Lydia House – to free up space in Lydia for potential 6th resident.

Financial:

The 2016 financial audit was completed; an AFS reviewed with the HSE/DPER occurred.

Actions:

Continue the renovation plans for Applewood and Blake House

Action to be completed	By Whom	Date for Completion.
Health and Safety Committee – to devise better fire drill	S Kelly	31.03.18

recording systems		
To review all policies for effectiveness and best practice standards.	M Williams	28.02.18
Monitoring Visits to continue with actions identified.	M Williams or S Kelly, S Murphy	30.06.18
Complete financial investigation into discrepancies in residents money in AW during November 17	L King	28.02.18
Ensure staff read, review monitoring reports and complete actions within set deadlines.	M Williams	31.03.18
Management Team meetings to continue with actions identified.	M Williams	30.06.18
Continue to work on the reduction of Medication Errors and repeat offenders.	M Williams	30.06.18
Continue with planning building works for Blake House and also Applewood height with view to complete by end of May	M Williams	31.05.18
Complete redecoration of Lydia House	M Williams	30.06.18

Michael Williams

Director of Services.