St. Michael's House

ADMISSIONS, TRANFERS AND DISCHARGES FOR RESIDENTIAL SERVICES

Written By:	**….**	Maureen Hefferon, Deirdre Bolton, Tracey McKenna, Caitríona Redmond and Elaine Teague
Reviewed By:	**….**	E.M.T.
Approved By:	**….**	E.M.T.
		Signed: ***Patricia Doherty, C.E.O.***
Policy and Planning Approval:		
Effective From:	**….**	November 2014
Reviewed:	**….**	June 2016
		Signed: ***Anna Shakespeare, C.E.O.***
Next Review Date:	**….**	June 2019
Distributed To:	**….**	All Organisation
Monitoring Mechanism:	**….**	Residential Approvals Team

CONTENTS

Admissions Policy for Residential Services
October 2015

St. Michael's House seeks to support people who use services to live their lives to the full, by striving to develop and provide the best models of service.

Scope of the Policy

This policy covers admission to residential services provided by St. Michael's House. It details the admission process for people who use services, their families and St. Michael's House staff.

Access Criteria

Residential services can be accessed by individuals with a moderate, severe or profound level of intellectual disability who attend St. Michael's House services or live within the St. Michael's House catchment area.

The purpose of this policy is:

- To ensure fair, equitable and timely management of referrals.
- To promote the transparency of the process.
- To inform the applicant, their family members, other residents and staff about the process.
- To standardise the process.

Principles underpinning the policy:

- That the process takes account of people's rights
- Access to residential services are based on need
- People have a right to visit a service before making a decision
- Criteria for decisions to provide a residential place are fair and transparent
- Each person is entitled to a letter of offer
- Each person will receive a written, signed Contract of Care
- Commencement of placement is within the agreed timeframe set out in the policy.
- People living in the residential service are consulted with in relation to the admission of a new resident.

RESPONSIBILTIIES:

St. Michael's House is committed to ensuring that this policy and procedures are available to staff to inform the management of admissions to residential services.

The Residential Approvals Team is responsible for:

- Ensuring that this policy is implemented.
- The review of the policy every three years or more frequently if required.

Heads of Department are responsible for:

- Ensuring that all Staff have read and understand the policy.

The Service Manager is responsible for:

- Ensuring all Persons in Charge and staff are aware of the policy and that they carry out their specific tasks as outlined in the policy.

All staff are responsible for:

- Ensuring that they understand and familiarise themselves with the content of the policy and procedure.

Admissions Procedures for Residential Services
October 2015

1) Referrals

If an Individual is interested in applying for a residential service in St. Michael's House or transferring from one residential service to another, they can self refer, be referred by a family member or by another agency.

Where the individual is already attending St. Michael's House services, a Social Worker will follow up on this referral and fill out the residential waitlist application form. Where the individual is new to St. Michael's House, but lives within the catchment area, the referral for residential services is processed under the New Referrals, Admissions and Discharges Policy and Procedures. A clinician/s will be assigned to assess whether St Michael's House can meet the needs of the person requiring residential placement and following this the social worker will process the referral for a residential service.

Individuals and families are free to visit a residential service in St. Michael's House before proceeding with a referral for this service.

- All referrals for a residential service in St. Michael's House go to the residential waitlist committee[1] using the standard referral form. This can include referrals from people living at home (Appendix 1) and requests for internal transfer from an existing residential service (Appendix 2).

- For referrals from people living at home[1], the service user is listed on the Client Information System in one of two categories - Priority or Contingency.

- In all situations where an Individual is applying for a residential service is St Michael's House, they must also make a formal application to the County Council Housing list for the area that they are living in. The Social Worker will advise the family of the steps involved in this process.

2) Planning:

Where a vacancy exists, the following must happen within the **first week** of the vacancy becoming available:

- The Person in Charge or Service Manager will link with the Head of Social Work/ Principal Social Worker in the region to advise them of the vacancy.

- The Person in Charge or Service Manager will provide a profile of the vacancy, which is in line with the statement of purpose for the house. Each application for admission to the residential house is determined on the basis of transparent criteria in accordance with the statement of purpose.

[1] The membership comprises the Head of Social Work Department (chair), Principal Social Workers from each region

- The Head of Social Work/Principal Social Worker will request a detailed profile of the person, requiring placement. This will be organised by the Social Worker using the standard form, and includes clinical opinion regarding the persons support needs (e.g. medical, nursing, mental health needs, level of dependency etc) – (Appendix 3).

The Head of Social Work/Principal Social Worker or a person assigned by them in consultation with the other members of the residential waitlist committee and the Service Manager for the house where the vacancy exists will propose an individual for the vacancy. In some situations, more than one individual may be proposed. The Head of Social Work/Principal Social Worker or a person assigned by them will request the residential Approvals team to issue a consultation document. This initiates an assessment/consultation process during which the Person in Charge can consider whether, in line with the statement of purpose, the service can meet the assessed needs of the individual proposed for the vacancy.

3) Assessment Process/Consultation Process:

The Person in Charge, with the support of the Service Manager and clinicians will carry out an assessment of need of the individual proposed for placement. This assessment should be completed and a decision made on whether the house can meet the individual's assessed need as outlined in the statement of purpose. This decision should be made no later than **four weeks** from the date of issue of the consultation document. This assessment should include the following:

1) An initial meeting with the individual in a setting they are familiar with.

2) A review of all relevant documentation pertaining to the individual including personal plans, guidelines and assessments.

3) A request to complete any outstanding assessments needed to enable the Person in Charge to determine if the assessed needs of the person proposed can be met within the vacancy.

4) Complete the relevant Health and Safety assessment and risk profile (Appendix 4).

Throughout the consultation process the views of the proposed Individual and their family will be sought and considered.

5) A period of respite will be facilitated so that the PIC can observe the individual in situ.

6) Following the period of respite the views of existing residents **must be** actively sought with the assistance of their key workers and an appropriate member of the clinical team. The Person in Charge must be sensitive to the manner in which they seek this information having regard to the person's ability to understand and process complex information. Where an individual is not in a position to communicate their views, the Person in charge must demonstrate an accurate representation of their views through e.g. key worker information, family information and clinical opinion.

Following the assessment process, the Person in Charge with the support of the Service Manager and clinicians **must provide a report** detailing the outcome of the assessment process and their recommendation on whether the residential service can meet the needs of the person proposed in line with the statement of purpose. This report must go to the relevant Regional Director and to the Head of Social Work or person assigned by them to bring to the Residential Approvals Team for consideration.

When recommending a person for a vacancy the Person in Charge must be satisfied that the designated centre can provide a safe and effective service to the individual.

In the event that the Person in Charge concludes that the proposed individual's needs, can not be met within the residential setting they must clearly outline the reasons why and whether or not they can identify any additional support/resource requirements that could make the placement suitable for the individual.

4) Approval of Placement:

The Residential Approvals Team[2] must be satisfied that the proposed individual's needs, can be safely and effectively met within the residential unit. In reaching this decision they will consider the report and recommendation of the Person in Charge.

Where the Residential Approvals Team approves the placement, an approvals document will be issued to the Person in Charge and the team and a letter of offer to the individual and their family. This document confirms the offer of a place.

The Residential Approvals Team will issue a Contract of Care (Appendix 6) which outlines the terms and conditions upon which the placement is offered. The Contract of Care is signed by all parties.

The Person in Charge informs the existing residents and their families of the new placement.

Where the Residential Approvals Team uphold the recommendation of the Person in Charge not to proceed with the offer of a placement, the details of this decision are outlined and communicated to the key stakeholders including the individual and their family.

5) Admission Procedures

Once the offer of a placement has been made the Person in Charge will:

- With the support of the Social Worker, arrange for the individual and their family to visit the residential house.

[2] Currently CEO, DOO, RD's, HSW & Project Lead for Residential.

- With the support of their clinic cluster team, develop a transition plan for the new resident.

- Ensure there is a signed copy of the contract of care for each new resident prior to their admission to the centre.

- Ensure that a comprehensive assessment of the individual's needs using the *St. Michael's House Assessment template* (available on the intranet) is fully completed, prior to admission.

- Ensure that the individual's Personal Plan is developed within 28 days of admission.

- With the support of their Service Manager & Lead Clinician, organise a formal review of the placement no later than 3 months after the individual moves in. This review will take into account: the effectiveness of the transition plan, feedback from the new resident and from existing residents, and any additional support requirements.

- At this three month review the PIC must ensure that the individual has opened a bank account and a standing order should be set up to pay the person's rent.

6) Appeals:

Individuals, their family members or advocates may appeal against a decision of the CEO, the Chair of the Residential Approvals Team by notifying the Board of Directors of St. Michael's House in writing. If they remain dissatisfied following this they can appeal to the National Executive of the HSE.

7) Short-term Admissions for Respite: (Appendix 8).

Where a vacancy in a residential house is being used for respite, the protocol for short-term respite admissions must be followed.

For admissions to respite houses only, please refer to the St Michael's House procedures for respite admissions.

8) Discharges and Re-admissions:

Discharge from a residential house can be

- Short term discharge: This type of discharge occurs when the person is discharged and is expected to return to the residential house. Typically this involves discharge to family, discharge to another service for holidays or other short tem location. The Directory of Residents is updated to reflect short term discharges.

Note: St. Michael's House supports service users to spend time with their family to maintain and build family relationships. If a service user spends an overnight with his/her family this is recorded on the directory of residents but is not treated as a discharge.

- Transfers to another St. Michael's House residential service: Transfers to another residential service occur when the existing residential service can no longer meet the assessed needs of the service user or when requested by the service user (and/or their representative). The process of admitting the service user to the new St. Michael's House residential service follows the Policy and Procedures set out in this document. It involves consultation with the service user (and/or their representative) and with service users from the new residential service. The discharge from the existing service occurs when the service user moves permanently to their new house. The directory of residents is updated to reflect the move and the PIC from the new service updates the CIS to reflect the changes.

9) Discharges to Hospital (Appendix 9)

The protocol on managing short-term discharges to hospital and re-admissions provides guidance to all staff on the management of this process.

10) Emergencies:

- An emergency situation is considered to exist when a person who uses services cannot continue to reside in the carer/family household in the short or long-term.
- St. Michael's House will seek to respond positively and flexibly to emergency situations as they arise. Our capacity to respond to emergencies will be limited by the availability of residential vacancies at the time the emergency occurs.
- Where a vacancy does exist the protocol for short-term respite admissions will be followed.
- In the event that no vacancy exists, St. Michael's House will work actively with the person, their family and the HSE to develop an Individual Support Plan as an interim support measure. A clear understanding between St. Michael's House and the HSE is required in the co-ordination and management of funds necessary to respond to the emergency.
- The Director of Operations is the key decision maker in relation to emergency situations and must be notified immediately of any emergency requests by the Regional Director.
- The Social Worker will be the main contact person for the family in emergencies while the person is supported by their key worker and psychologist, if required.

11) Discharge to external Services: (Please refer to Policy)

Discharges to external agencies occur infrequently and only when St. Michael's House is unable to provide safe and effective care for the service user. Discharges to other agencies must follow the Policy for Transferring Clients from St Michael's House to Private (for Profit) Provided Services. Discharges to other agencies involve consultation with service users (and/or their representatives).

APPENDIX 1

RESIDENTIAL WAIT LISTING

Name: _____ **D.O.B.** _____

Address: _____

Unit: _____ **North Region** ☐ **North East Region** ☐ **South Region** ☐

Type of Residential wait listing required ***(****Please tick as appropriate)*

Contingency	☐		
5-year wait list	☐	Indicate year required	☐
Priority	☐	Give info for prioritising	_____

If Priority listing required – give information based on the prioritisation system.

Issues for Service User:

.....

.....

.....

Issues for Carer:

.....

.....

.....

.....

Signed: _____ **Date:** _____

Date Received by PSW _____

Copy to Head Social Worker ☐

Copy to Data Base ☐

Note: Individual profile will be sought by the Principal Social Worker when required.

APPENDIX 2

Residential Transfer Request

Name of Service User: _____

D.O.B. _____

Residential House: _____

Where the needs of a service user have changed and it is the opinion of the Service Manager, Lead Clinician, Person in Charge and cluster team that these issues can no longer be resolved within the present environment, the residential planning team need t be informed.

KEY ISSUES:

- **Health / Medical Needs:**
  Difficulties in meeting needs in present setting.

- **Safety: e.g.** Health & Safety, Safeguarding, Challenging behaviour incidents, Suitability of premises

- **Quality of Life:** Expressed desire to move, outcome of well-being review or IP.

- **Type of accommodation / staffing that would best suit the person's needs:**

- **Other:** Group Mix; Skills mix.

- **Has the service user made the request?**

- **Is the service user's family aware of this request?**

Signed: _____

Date: _____

Forward to Principal Social Worker in your region

APPENDIX 3

Individual Profile Form

To be completed by Social Worker in Consultation with Clinic Team

Name: _____ **D.O.B.** _____

Level of Intellectual Disability:
Status / Family Circumstances:
Significant People in the Person's Life:
Reasons for Residential Placement:
Current Living Arrangements:
Current Day Placement:
Reports Received: ☐ **Social Work** ☐ **Psychology** ☐ **Occupational Therapy** ☐ **Medical/Nursing** ☐ **Psychiatry** ☐ **Physiotherapy** ☐ **Other**

APPENDIX 3

Individual Profile Form continued …

Name: _____ **D.O.B.** _____

SPECIFIC SUPPORT NEEDS:

Challenging Behaviour:
Communication:
Autism Spectrum Disorder:
Medical Issues:
Does this Service User require Nursing staff?

APPENDIX 3

Individual Profile Form continued …

Name: _____ **D.O.B.** _____

SPECIFIC SUPPORT NEEDS:

Mobility:
Daily Living Skills
Feeding:
Washing:
Dressing:

APPENDIX 3

Individual Profile Form continued …

Name: _____ **D.O.B.** _____

SPECIFIC SUPPORT NEEDS:

Other Personal Care:
Interests and Goals:
Physical and Sexual Development:
Socialisation Skills:

APPENDIX 3

Individual Profile Form continued …

Name: _____ **D.O.B.** _____

TYPE OF RESIDENTIAL SERVICE REQUIRED:

Essential Features:
House (type):
Staffing:
Staff Skills Mix:
Location / Type of House:
Costs of Providing this Service:

Completed By: _____ **Date:** _____

APPENDIX 4

HEALTH AND SAFETY CONSIDERATIONS FOR SERVICE USERS PLACEMENTS (RESIDENTIAL & DAY SERVICE)

Purpose:

This checklist is to be used to ensure the main health and safety aspects are considered when assessing potential new service user placements. The list is not exhaustive however the checklist allows site-specific issues to be captured.

Guidance on how to use the Checklist:

This checklist is to be completed for each prospective service user by the Person in Charge and Service Manager with the input of multidisciplinary team as per ***the Admissions Policy and Procedures for Residential services.*** It will help identify if there are any limitations/challenges to the prospective resident taking up the placement from a health and safety perspective. It will also identify what interventions/corrective actions are required before they do take up the placement.

Where 'no' is answered in any of the questions, further consultation and guidance is to be obtained from relevant support staff including, clinicians, service managers and the health and safety department where required.

The checklist and other relevant documentation should be submitted as part of the Consultation document to the Residential & Day Approvals Group as part of the selection process, which identifies the best-fit person for the vacancy.

APPENDIX 4

HEALTH & SAFETY CONSIDERATIONS FOR SERVICE USER PLACEMENTS

Service User's Name: _____ **Number:** _____

Is the Service user? (please circle) **Non Ambulant** **Semi Ambulant** **Ambulant**

Health and Safety Considerations	Yes	No	N/A
Location			
• Is the terrain in the locality suitable for non-ambulant service users?			
• Does the unit have a bus to access the community if terrain is difficult to navigate with wheelchairs?			
• Does the driveway have a ramp with the specified gradient 1:20?			
• Are suitable railings in place if needed?			
• Is the driveway suitable for a non-ambulant SU i.e. steep driveway risk of SU rolling onto a busy road?			
• Is the locality/access/egress to the unit suitable for the Service User's levels of ability to take up the vacancy?			
• If no is answered to any of the above questions or you wish to include additional info in relation to the above section please detail below.			

APPENDIX 4

Health and Safety Considerations	Yes	No	N/A
Unit facilities			
• Do you have to use stairs to access the vacant bedroom?			
• Is there a lift available in the unit?			
• Is the flooring suitable for manoeuvring assistive equipment?			
• Is the bedroom location suitable for a non-ambulant or person with impaired mobility?			
• Is the size of the bedroom sufficient to accommodate and manoeuvre the assistive equipment if needed taking into consideration the number of staff needed in the room to support also?			
• Is the size of communal areas suitable for a person who is non-ambulant and their assistive equipment needs without overcrowding, or affecting access to and from the space?			
• Is the size of the bathroom sufficient to accommodate and manoeuvre the assistive equipment (if needed) taking into consideration the number of staff needed in the room to support?			
• Is there appropriate supports in the bathroom i.e. wall or floor mounted rails, wall mounted shower seats, level access facilities?			
• **Is there adequate storage space to house any assistive equipment required?**			
• If no is answered to any of the above or you wish to include additional info in relation to the above section please detail below.			

APPENDIX 4

Health and Safety Considerations	Yes	No	N/A
Transport			
• Do you have a suitably sized bus to accommodate a wheelchair user?			
• Does the bus have a mechanically operated tail lift to get the non-ambulant person on/off the bus?			
• Would you consider the bus to be suitable for any potential service user? Will wheelchair fit onto the tail lift of the bus?			
• Is there a storage compartment on the bus for the service users loose assistive equipment i.e. power pack, tray?			
• For mobile, independent Service Users, are there public transport options for them to travel?			
• If no is answered to any of the above or you wish to include additional info in relation to the above section please detail below.			
Safe Evacuation			
• Will the evacuation plan for the unit be suitable to accommodate this potential resident?			
• Would you consider the unit environment to be suitable to evacuate this service user?			
• Are appropriate supports available day and night to support evacuation of the potential resident?			
• If no is answered to any of the above or you wish to include additional info in relation to the above section please detail below.			

APPENDIX 4

Health and Safety Considerations	Yes	No	N/A
General			
• Does the potential resident have requirements for assistive equipment for any of the following: Seating, Sleeping, Toileting, Bathing, Dressing, Feeding, Transfers, and Mobility / Standing? • If so - will the person be able to bring their equipment with them or will new equipment be required? If new equipment is required, have you contacted the relevant OT/Physio to assess and prescribe same?			
• Are there any future considerations that need to be considered now, as it will affect the suitability of the potential resident to the unit? i.e. if the proposed service user's physical profile changes in the future, is there the possibility of adapting or extending the current unit's environment to meet their needs? If so please state them below.			
• Are there any other health and safety considerations that have not been included above? If so please state them below?			
• Do you think the unit will be suited to the potential resident from a H&S perspective? If not are there changes required to make it suitable?			
• Have you discussed needs/requirements of potential resident with other services he/she accesses?			

APPENDIX 4

Action Plan Table:

The action plan table below should be completed if additional action is required including environmental adaptations or consultations with clinicians in order to finalise the suitability of the unit for the perspective service user.

Details of action required	Who by?	When by?	Completed

- Ensure that the responsible person completes all sections of the action plan above.

Person in Charge: _____ **Date:** _____

Service Manger: _____

APPENDIX 5

RESIDENTIAL WAITLIST – CRITERIA:	**LEVELS OF INTERVENTION:**
Out of Home – Crisis Point: 5 The following criteria will be used to categorise situations where a service user may not be able to remain at home. All relevant clinical information and opinions must be gathered to enable such a decision to be made. 1) Death of the sole carer and no others are available to care for the service user 2) Death of primary care-giver where the other carer is unable to care for the service user 3) Serious Illness of sole carer 4) Illness of primary care-giver where the other carer is unable to care for the service user Untenable situations where the service user and/or carer are experiencing ongoing difficulties. These situations need to be monitored by the individual Social Worker working with the family in conjunction with the Principal Social Worker.	Fourth – Level 5 Social Breakdown / In care *This level covers immediate family breakdown, service users in crisis residential care, death of a caregiver, serious ill health of the caregiver, or where there are concerns that a service user is at serious risk.* [1] Hardiker Model (1993)
At Risk of Breakdown: 4 ***Issues for Carer*** • Hospitalisation, terminal illness, death in family, elderly lone carer ***Issues for Service User*** • Serious challenging behaviour, abuse, significant mental health problems, significant dependency needs *Any combination of above*	Third – Level 4 Severe stresses *This level identifies families with serious stresses severely impacting, on their ability to care for the service user, including the risk of imminent family breakdown and entry into crisis respite care. e.g. ill health, death of one carer, behaviour of the service user. Difficulties may be acute or well established. The aim is to mitigate the effects and to restore family functioning*. [1] Hardiker Model (1993)

APPENDIX 6: Contract of Care

Contract of Care Agreement between: St.Michael's House &

Name of Person: _____ **D.O.B.** _____

Date of Admission to the Centre: _____

Type of Placement: **Full Time** ☐ **Part Time** ☐ **Time Share** ☐

1.0 Introduction:

The purpose of this document is to agree the terms on which you shall reside in a St. Michael's House residential service. It will set out the support and services offered to you and will give specific details of the fees to be charged.

1.1 The Accommodation: In St. Michael's House you will have a single room with storage for your personal belongings. A key to your room can be provided if you wish. You will share a kitchen, dining area and living room with the other residents in the house.

In St. Michael's House we welcome visitors/ family and friends at times that are mutually acceptable. There are no set visiting hours. There is a private space for you to meet with visitors/ family/ friends if you wish. You will receive support to visit family and friends in their home. You have access to the centre telephone to make and receive calls.

1.2 Staff: In St. Michael's House the Person in Charge of the residential centre is the manager of the house and they will make sure that there are enough staff to provide support to you.

1.3: Other Agencies: St. Michael's House will inform the Health Services Executive when you move into the residential service. We will also update the National Intellectual Disability Database (NIDD) to reflect that you now live in St. Michael's House.

2.0 Charges:

The charges for residing in St. Michael's House are informed by the HSE Long Stay Charge. In St. Michael's House this charge is sometimes rent.

The charges are **** this needs to be personalised****

€ XXX per month/ per week is paid by standing order on the (insert date) from your bank account. A statement about the money you have paid is sent by the accounts department to the Person in Charge each month.

*****Insert here if there are specific arrangements in place for service users not paying by standing order/not paying the full amount/ have alternate arrangements for paying the charges. *********

If you do not pay the charge or don't pay the full amount then you will owe arrears. The accounts department will let you know how much you owe.

If you have any questions about the charge the Person in Charge or accounts department will help to answer them.

2.1 Included in the charges are:

- Electricity, Gas and Oil, Telephone (landline in the centre), basic television package, television licence, bin charges, property tax and water charges.
- All food and drinks are supplied. If you have personal preferences these can be added to the weekly shopping list. If you have specific dietary requirements we will provide you with the food you need to keep healthy.
- Personal incontinence wear is supplied by the HSE using your medical card number.
- St. Michael's House will endeavour to provide you with transport supports where possible. Where transport is not provided you will be supported to access public transport.
- Maintenance of the centre including gardening, painting and general upkeep is included in the monthly cost.
- From Jan 1st 2016 all prescription charges and costs of medication not included on the medical card will be funded from the unit budget through petty cash.
- Insurance for contents, rebuild and public liability.
- Personal care items including hand soap, shower gel and shampoo will be provided for general use.
- Support to get new personal equipment from using your medical card (eg new wheelchair/ new profiling bed)

Not included in the Charge

- Mobile phones are not included in the charge. If you wish to have a mobile phone and/or internet access we will support you to purchase the necessary equipment and set up an account with a provider.
- Subscriptions to SKY TV or enhanced TV subscriptions are not included in the charge. You will be supported to set up an account with a provider if you wish.
- You will be supported to buy any additional food such as extra biscuits, chocolate, sugary drinks or alcohol that you wish to purchase.
- If you wish to attend activities such as shows and concerts or go on holidays and need support from staff you may be asked to pay something towards staff costs. We will agree the amount you will pay with you or your family member before you spend your money. We will follow the 'Guidelines Regarding Expenses Incurred by Members of Staff in Supporting Activities of Service Users'. The PIC can give you a copy of the policy if you wish.

- Furniture for your bedroom is provided. If you wish to redecorate your room and buy new furniture you will be supported to do so. The new furniture will belong to you and will be listed as your possessions. We will follow the St. Michael's House Policy and Procedure for the Management of Service Users Money. The PIC can give you a copy of the policy if you wish.
- If you need new personal equipment (eg new wheelchair/ new specialised bed/ sleep system) and there is a delay with the HSE in providing it you will be supported to purchase it if you have the money available. Clinicians like Occupational Therapists or Physiotherapists will give you (and your family if necessary) advice before any new equipment is ordered. We will follow the St. Michael's House Policy and Procedure for the Management of Service Users Money. The PIC can give you a copy of the policy if you wish.
- If you wish to use taxi's for transport you will be supported to make the payment directly to the taxi driver.
- If you have specific things that you would like to insure separately we will support you to do so.
- If you have a preference for additional/ different personal care items, separate to the items provided we will support you to purchase these yourself and we will record on your money management support plan that we are doing this.

2.2: Care and Support Needs: All care and support needs are assessed on or before admission to a St. Michael's House residential service. The assessment of need is repeated annually or if your needs change. You will be involved in agreeing what your support needs are and developing plans to meet these needs. If your needs change and can no longer be met in the residential house you live in we will work with you and your family to make alternate arrangements.

Confidentiality and data protection is of the utmost importance. We will follow the St. Michael's House policy on Record Keeping to ensure your private information is shared only with those who need to know and with your consent. The PIC will give you a copy of the policy if you would like to see it.

You will be allocated a key worker who will help you to decide what is important to you and what goals you would like to work on.

In St. Michael's House we will help you to be as independent as possible in the following task:

- Take part in making decisions about the running of the house.
- Be involved in cooking, cleaning, shopping, doing laundry and tidying your room
- Personal care and grooming.
- Communicate with others by providing you with the tools and support you need.
- Take care of your money and buy things that you need (as per the St. Michael's House Policy).
- Stay in touch with your family and friends.

- Express your spirituality.
- Keep healthy by having regular checkups (including dental, optician and GP checkups)
- Take any medicines that the doctor prescribes for you (as per the St. Michael's House Policy).
- Eat healthy and nutritious food (as per the St. Michael's House Policy).
- Take part in hobbies, activities, and classes that you choose.
- All of the policies are in the residential centre and the PIC can show them to you if you would like to see them.

2.3: Allied Health Care Professionals: In St. Michael's House if you need help from specialists we will help you to access it. There are no additional charges for St. Michael's House clinical services including:

Doctors, Psychiatrist, Psychologists, Occupational therapists, Speech and language therapists, Physiotherapists, Dieticians, Social worker

Services provided under the medical card are:

GP, Consultants, Accident and Emergency, Radiology, Dentist, Optician.

If you need to be admitted to hospital in an emergency we will call an ambulance and we let your family/ next of kin know. If there is no staff to go with you in the ambulance we will ask your family to meet you at the hospital. We will give important information to the hospital so they know a important things about you. This is called a hospital passport.

Services not provided under the medical card are:

Swift Care clinics are not covered under the medical card. If you wish to attend a Swift Care Clinics there is a charge for this service and we will support you to settle your account with them.

If you require advocacy services we will support you to make contact with the National Advocacy Service. There is no charge for this service.

2.4 Suggestions, Complaints and Concerns: If things go wrong and you want to complain or raise a concern we will try to resolve the issue. In St. Michael's House we have a complaints Policy and Procedure. The PIC will give you a copy if you would like. It outlines how to make a complaint and who to make it to.

If you wish to raise a concern with the HSE, the Confidential Recipient or with HIQA we will provide you with the relevant phone numbers.

3.0 Termination of this Agreement:

If you wish to leave the designated centre, or if the centre can no longer meet your needs we will support you to find suitable alternative accommodation in St. Michael's House or in another service. We can do this in consultation with your family in line with your wishes. We will follow the St. Michael's House Admissions and Discharge policy. The PIC will give you a copy if you would like to see it.

We hope you enjoy living in St. Michael's House. If you have any questions or concerns please talk to your keyworker, the Person in Charge or any staff member.

The PIC will explain this document to you and/ or your family.

Signed: _____ **Date:** _____

Person in Charge on Behalf of St. Michael's House

Signed: _____ **Date:** _____

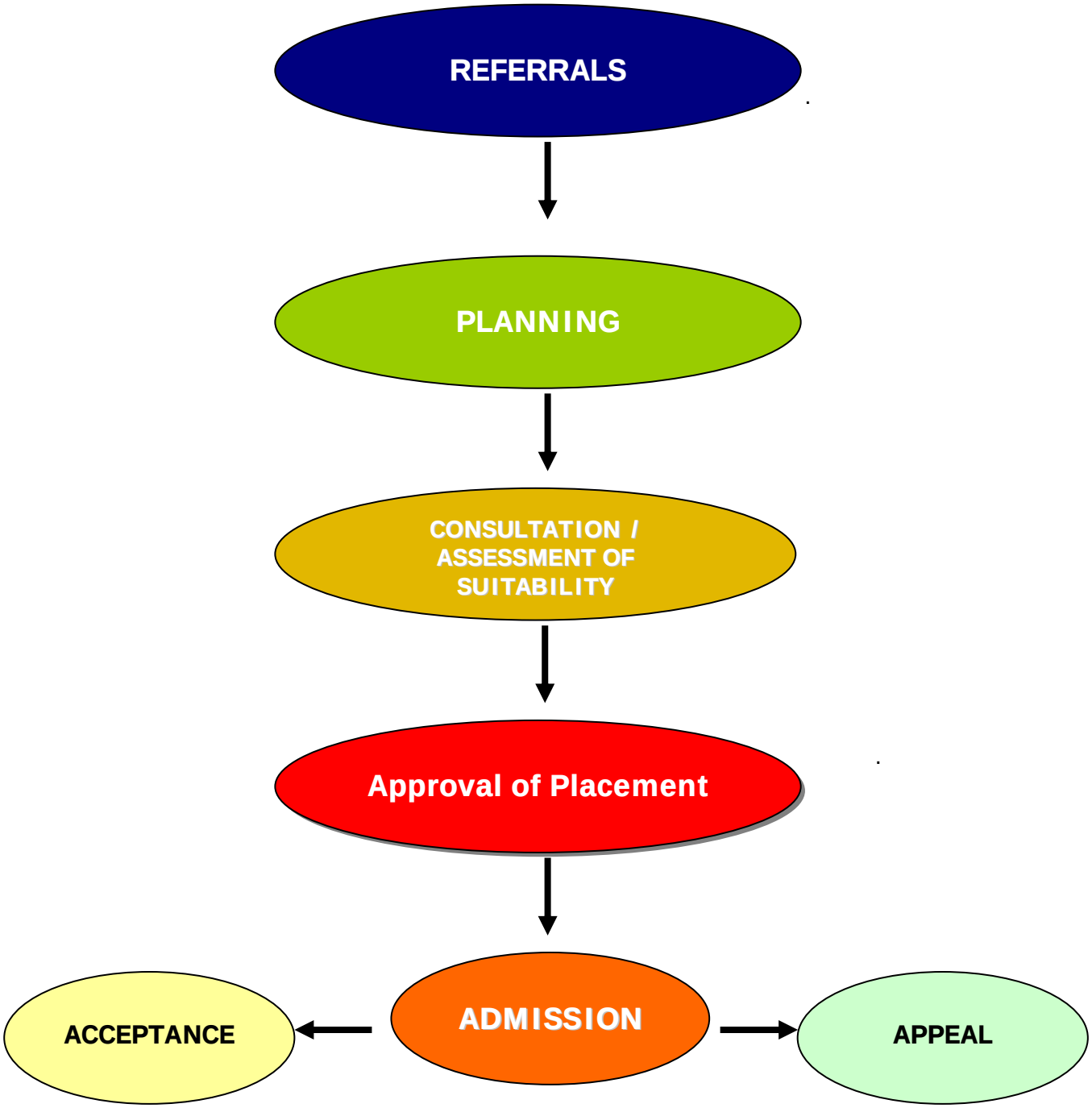
Resident and/or signed by family member as having been explained to them

---

This document is due for review annually.

The next review date is: **Insert Date:** | |

APPENDIX 7: Flow Chart For Admission



APPENDIX 8:

Protocol for short-term respite admissions, Checklist, feedback & Goal Monitoring Form

PROTOCOL FOR SHORT-TERM RESPITE ADMISSIONS

SCOPE:

Utilising of short -term vacant beds to support people who are living at home and who need support.

The Social Work Department identifies individuals needing support.

SUPPORT OPTIONS:

Regular overnight breaks which could be as regular as one week per month. For overnight breaks, it is not advisable for any one house to support more than three people.

Per the organisations admission's process, the Person in charge for the residential house co-ordinates the following with support from key stakeholders.

- Request profile information from the Social Work Department **(See Appendix 3)**
- Complete the standard Assessment template on the individuals coming for respite to ensure that the house can meet the individuals assessed needs in line with their statement of purpose.
- Complete the relevant Health & Safety checklist (See Appendix 4).
- Consult with the service users living in the house about the fact that the bed is to be used for respite.
- If the house cannot meet the assessed needs of the individual for respite, in line with their statement of purpose, the person in charge must relay this information to the social work department.
- Before each break, the person in charge must complete the respite checklist. (See attached).
- After each break the Person In Charge will support the individual to complete an Individual evaluation form for the break and forward this relevant Social Worker. (See attached).
- The person in charge must consult with the residents in the house at regular intervals and record feedback from the residents in the house meeting minutes.

Where respite is required in an emergency and it is necessary to use an existing vacancy, the Person in charge will endeavour to co-ordinate as much of the above information as possible before the person comes in for the break. Any outstanding pieces will be completed as soon as possible post admission.

RESPITE ADMISSION CHECKLIST
(updated December 2015)

NOTE: This checklist must be completed by the commencement of each break.
Please ensure that <u>all</u> sections are completed and that clarifications are noted in the comments section below.

NAME: _____ **DATE OF BREAK** _____

1.	Has the file been fully reviewed?	**Yes** ☐	**No** ☐	**Initials:**		**Date**	
2.	Have parents/families been contacted?	**Yes** ☐	**No** ☐	**Initials:**		**Date**	
3.	Has feedback been received from Day Service?	**Yes** ☐	**No** ☐	**Initials:**		**Date**	
4.	Is the Medication Administration Sheet up to date?	**Yes** ☐	**No** ☐	**Initials:**		**Date**	

5. If applicable, have the following guidelines been reviewed within the past year?

(a) Behavioural	**Yes** ☐	**No** ☐	**N/A:** ☐
(b) Sensory	**Yes** ☐	**No** ☐	**N/A:** ☐
(c) Communication Support Plan	**Yes** ☐	**No** ☐	**N/A:** ☐
(d) Feeding / Dietary	**Yes** ☐	**No** ☐	**N/A:** ☐
(e) Sleeping	**Yes** ☐	**No** ☐	**N/A:** ☐
(f) Medical, e.g. Diabetes *	**Yes** ☐	**No** ☐	**N/A:** ☐

* If "Yes", please specify medical condition _____

6.	Is the Service User's Personal Assessment Support Plan up-to-date?	**Yes** ☐	**No** ☐	**N/A:** ☐
7.	Are Risk Assessments (where applicable) up-to-date?	**Yes** ☐	**No** ☐	**N/A:** ☐
8.	Are the "Person Handling Guidelines" up-to-date?	**Yes** ☐	**No** ☐	**N/A:** ☐
9.	Is the Individual Fire Evacuation plan up-to-date?	**Yes** ☐	**No** ☐	**N/A:** ☐
10.	Are all toys, equipment, sensory items in good repair and available for use, including batteries, etc.?	**Yes** ☐	**No** ☐	
11.	Have relief staff on shift been fully briefed regarding the needs of this Service-User?	**Yes** ☐	**No** ☐	
12.	Are there any restrictive practises in place for this Service-User?	**Yes** ☐	**No** ☐	
	If "yes" is the sanctioning documentation up to date?	**Yes** ☐	**No** ☐	
	(Insert next renewal date)			
13.	Are there Personal Emergency Support Plans in place for this Service User, e.g., Missing Person Plan?	**Yes** ☐	**No** ☐	

If "yes" please specify _____

List the Service User's Current Priority Goals:

Goal 1) _____

Goal 2) _____

Goal 3) _____

Can one or more of these goals be supported in the Respite Service?

Goal 1) **Yes** ☐ **No** ☐

Goal 2) **Yes** ☐ **No** ☐

Goal 3) **Yes** ☐ **No** ☐

Where goals are supported, a goal progression form will be completed.

Additional Comments:

_____

_____

_____

_____

Signed: _____ **Signed:** _____

Print Name: ***Signature***

Date: _____

RESPITE GOAL MONITERING FORM

Service User's Name: _____

Unit: _____

Date of Break: _____

GOAL 1) _____
SPECIFY GOAL: _____
_____

UPDATES:

DATE:	**ACTION:**	**BY WHOM** *(staff signature)*	**SERVICE-USER EXPERIENCE**

GOAL 2)	
SPECIFY GOAL:	

UPDATES:

DATE:	**ACTION:**	**BY WHOM** ***(staff signature)***	**SERVICE-USER EXPERIENCE**

GOAL 3)	
SPECIFY GOAL:	

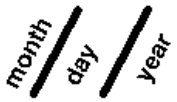
UPDATES:

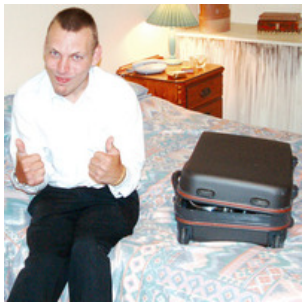
DATE:	**ACTION:**	**BY WHOM** *(staff signature)*	**SERVICE-USER EXPERIENCE**

St. Michael's House

Going to Respite

Have your Say

 Name:	
 Date of Visit:	

	Did you enjoy your break?

	Did you choose what you wanted to do?

	Did you like being with the group?

	Would you like to come back?

	Was there anything you didn’t like?

Appendix 9:

Protocol For Discharge From Hospital And Re-Admission To A Residential Centre

Per the organisations admission's process, the Person in charge for the residential house co-ordinates the following with support from key stakeholders.

- Request profile information from the Social Work Department **(See Appendix 3)**

St. Michael's House aims to work in partnership with the service user, their family and the general hospital to support an individual who is admitted to hospital.

We recognise that when someone is admitted to hospital (as an emergency or in a planned way) it can be a significant and worrying time for the service user and their family members. St. Michael's House endeavour to communicate with the person and their families at all times during a hospital admission to ensure they have all of the information about the support the person is getting.

Admission to Hospital:

Once a person is admitted to hospital the hospital is fully responsible to meet all care and support needs. The PIC or shift leader must inform the service manager, lead clinician and doctor for the cluster that someone has been admitted to hospital. Nurse Manager on Call is notified of an admission to hospital by the relevant Service Manager as soon as possible. If the admission occurs out of hours Nurse Manager on Call will inform the service manager.

St. Michael's House use a Transfer Information Booklet to provide hospital staff with key information about service users. A MAS (Medication Administration Sheet) is also provided with information on prescribed medication.

It is important that the PIC from St. Michael's House request that hospital staff remain in contact with the residential house as well as family members with any updates on the person's condition and wellbeing. This helps to avoid the situation where family members are provide with an update but St. Michael's House staff are not.

St Michael's House staff will link with hospital staff and in some circumstances will provide practical supports to the person. This will be based on the following criteria:

A) Service User Clinical Complexity
B) Level of service user vulnerability and advocacy support needs
C) Level of family resources

The level of support from St. Michael's House staff will be agreed by the PIC and Service Manager, on a case by case basis and is subject to ongoing review. Approval for additional resources to support someone in hospital must follow the 72 hour escalation process. The level and amount of support provided each day should be documented in the daily report in the residential service. It may be appropriate to have a communication sheet that is retained in the hospital and can be completed by St. Michael's House staff who visit. These communication sheets should be kept in addition to daily records in the residential house as they may go missing or be lost in the hospital. An example of what might be included in the daily records or communication notes: 3 hours St. Michael's House staff support provided on 3/1/2016. Service user supported to have a shower and have dinner.

On admission St. Michael's House residential staff should establish who the named CNM2 for the ward is. The CNM2 becomes the point of contact, in the hospital with responsibility for the resident. The PIC/ PPIM or shift leader should keep in regular contact with the CNM2 from the hospital to ensure continuity of care and good communication.

An update should be sought from a nurse or CNM2 for the ward at least once per day (more often if needed). This can be done directly in the hospital or by phone from the residential house. This update should be recorded in the daily reports and should include the name of the nurse who provided the update.

The Directory of Residents should be updated daily to identify that the person is temporarily discharged to another healthcare environment.
Patient

Discharge from Hospital and readmission to St. Michael's House:

St Michael's House is committed to supporting service users to return to their residential place on discharge from a general hospital. We recognise that Service Users often wish to return to their residential centre as it familiar to them and they know the staff supporting them. While we recognise that there are high demands for beds in acute hospital settings this protocol is to ensure that the person's return to their residential setting is planned, safe and that they are returning to a service that can meet their needs.

Planning for discharge should begin soon after admission or in the cases of planned surgery should begin before admission. This must be co-ordinated in conjunction with hospital staff. If the hospital has a Patient Flow department or service St. Michael's House staff will link with this department to plan for discharge. This may require a St. Michael's House doctor to be included in the discussion if the service user has deteriorated since admission. If they do not have a named department then St. Michael's House staff will link with the CNM2 for the ward to plan for discharge. Planning for discharge may include booking respite or a step down facility (such as Clontarf or Caritas) which will need to be done in advance.

A discharge letter should be provided by the hospital in advance of discharge. The letter should contain the necessary information as set out in The National Standard for Patient Discharge 2013. The details should include patient details, primary care healthcare professional details, admission and discharge information, clinical information, medication information, follow up and future management, and person completing discharge summary. This letter should be given to residential staff taking responsibility for the person on discharge and a copy sent to the relevant GP.

If the person needs have changed the readmission process may require multi-disciplinarily consultation. The PIC and/or Service Manager will coordinate this. If they are unavailable a nominated staff member will co-ordinate this. Out of Hours Nurse Manager on Call are available to support this process if necessary. Readmission in this regard may also require staff to have new training or refresher training provided. It is important that this is considered when planning for discharge.

Discharge from hospital on a Friday or over weekends can be difficult to facilitate and may not always be possible.

The following steps should be followed for all discharges from hospital.

1) Review of the person's Assessment of Need and update any sections which have changed (if any) following their admission to hospital. This should be carried out in consultation with the service user and their family. It is completed by a staff member nominated by the PIC/ PPIM and should be completed in conjunction with the multi-disciplinary team (as necessary) to take account of changing needs. The purpose of the review is to consider if there are changes to the persons needs. This may include a review of the:

   - Mobility
   - Feeding, eating, drinking, nutrition,
   - A new or changing diagnosis,
   - Additional equipment needs,
   - Support needs at night and during the day

   Support plans must be developed or updated as necessary following the review of the assessment of need.

   The review of the assessment of need will include a review of medication and will require medication reconciliation:

   St. Michael's House staff must follow the SAM policy in relation to medication reconciliation on admission and discharge from hospital. Medication Reconciliation is the process of gathering the most accurate and complete list of current medications prescribed to a person. It is an essential component of transitions from one care setting to another. It is also an important tool in reducing medication errors, as it ensures medications are checked on admission and discharge to a service.

   St. Michael's House staff should seek a copy of the discharge prescription 24hrs prior to discharge. This is to review any new medications/ changes in medications and to request an update to the MAS.

   St. Michael's House staff must ensure any newly prescribed medication is available and obtained. It is worth noting that hospitals have their own pharmacies if obtaining medications is difficult in community based pharmacies.

2) When the assessment of need is reviewed and updated the PIC/ PPIM/ shift leader and service manager (if available) will consider if the person can safely return to the residential centre. Nurse Manager on Call is available to support this discussion if required. If they conclude that it is safe for the person to return then a Discharge Support Plan will be developed based on the information and instruction issued from the hospital in their discharge letter. The person will to their residential centre within an agreed timeframe. .

OR

If the PIC/ PPIM/ shift leader and Service Manager (or Nurse Manager on Call) are concerned that the person can not return safely to live in their residential centre, based on the updated assessment of need, a referral for an ICM (Individual Co-ordination Meeting) will be made via the service manager to the lead clinician. The purpose is to consider how best to support the person and their changing needs and what additional support and resources will be required. This group will consider if St. Michael's House can meet these support needs in the current centre or if a new residential centre/ new service provider is required. The ICM will make recommendations about the supports required.

St. Michael's House Chief Executive Officer / Director of Operations will discuss and agree resources required from the recommendations of the ICM with the HSE Disability Manager before the person is discharged from the hospital.

Appendix 10: Discharge Checklist:

Discharge Checklist (To be completed if a person is being discharged from hospital or other care facility)	**Date**	**Time**	**Name / Grade / Skillset of Person Spoken to.**	**Comments**	**Signature of St. Michael's House staff Completing Form**	**Must be countersigned by Pic/ppim or in the event Of both being Unavailable service Manager**
Service User Name _____ **Date of Birth**: _____ Discharging hospital : _____ Date admitted to hospital: _____ Date discharged : _____						
Shift leader to contact ward and get handover from CNM/Nurse in charge or Doctor on team discharging service user. This should be done if possible the day prior to discharge and if possible should be done in person. NB discharges on Fridays or at the weekend Should be avoided if changes to MAS as no GP available						
Transfer of Patient form Received and any queries/discrepancies followed up						
Patient Discharge Letter received and any queries/discrepancies followed up. A copy sent to St. Michael's House DR and to GP						

Discharge Checklist (To be completed if a person is being discharged from hospital or other care facility)	**Date**	**Time**	**Name / Grade / Skillset of Person Spoken to.**	**Comments**	**Signature of St. Michael's House staff Completing Form**	**Must be countersigned by Pic/ppim or in the event Of both being Unavailable service Manager**
If medication changes, copy of prescription to be faxed to unit day prior to discharge: Medication ordered from pharmacy:						
Has the service user been informed of discharge Plan:						
Have the SU family been informed of discharge plan						
Transport of SU home form hospital arranged and Details						
Fire Evacuation plan reviewed dated and signed:						
Support Plans reviewed dated and signed : List Support plans amended:						
Have physio guidelines changed in hospital Y / N Arrange St Michael's house review						
Have SALT guidelines changed in hospital Y / N Arrange St Michael's house review						
Have OT guidelines changed in hospital Y / N Arrange St Michael's house review						

Discharge Checklist (To be completed if a person is being discharged from hospital or other care facility)	**Date**	**Time**	**Name / Grade / Skillset of Person Spoken to.**	**Comments**	**Signature of St. Michael's House staff Completing Form**	**Must be countersigned by Pic/ppim or in the event Of both being Unavailable service Manager**
Have Psychiatric guidelines changed in hospital Y / N Arrange St Michael's house review						
Have Dietician guidelines changed in hospital Y / N Arrange St Michael's house review						
Have any other relevant guidelines changed Y / N						
Ensure body check completed on day of Re admission and follow up any possible areas of concern						
OPD appointment given						
Service Manager informed						
NMOC informed						

Once all items are completed this form should be filed with Patient discharge letter, Transfer of patient letter, copy of discharge prescription. And any other relevant documents in SU's Green file.