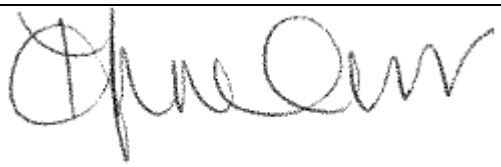
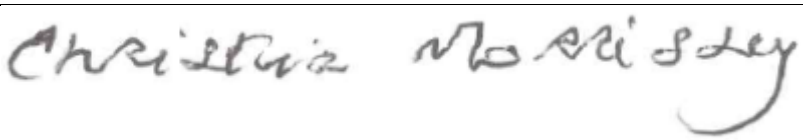
SOS Kilkenny clg

Policy and Procedure for Day/Residential Services Admission, Transfer, Transition, Temporary Absence and Discharge

Revision:	Department: Support Services	
Prepared By: Emma Butler Juli-Ann Lynch Pauline Murray		Date: 21.04. 2021
Signed by CEO on behalf of the Board of Directors:	 _____ Mr Francis Coughlan	Date: 15/06/2021
Policy Number: 037a Version Number: 1	 _____ Mr Francis Coughlan	Date: 15/06/2021

Document Review History			
Review Date:	Reviewed By:	New Revision Date:	Approved by:
15.06.2022		15.06.2025	
15.06.2022		15.06.2025	
25.07.2022		25.07.2025	

Document Change History		
Change to Document:	Date:	Reason for Change:
To include references to Day Service	07.06.2022	Need to include processes for admissions to day services.
Policy Version Number 1 reviewed/approved by the Board of Directors on:	15/06/2021	

Contents

1.0 Introduction 5
2.0 Purpose of Policy 5
3.0 Aims 5
4.0 Scope of Policy 5
5.0 Definitions: 6
6.0 Responsibilities 6
7.0 Admission, Transfer / Transition and Discharge Assessment Committee for SOS Kilkenny clg 6
8.0 Admissions: 7
9.0 Admissions Criteria for SOS Residential Service 7
10.0 HSE CH05 (South Tipperary, Carlow, Kilkenny, Waterford and Wexford) 8
11.0 Admissions to SOS Residential Services 9
12.0 General Admissions Provision 10
13.0 List of persons requesting residential services 10
14.0 Protecting Residents 10
15.0 Responsibilities of the Admission, Transfer, Transition and Discharge Assessment Committee in respect of Transfers and Transitions: 11
16.0 Temporary Absences from an SOS Residential home may include: 11
17.0 Discharge Criteria 11
18.0 Recommendations on Discharge 12
19.0 Access to Service 13
20.0 Approval Procedure 13
21.0 Assessment Procedures 14
22.0 On Admission to SOS Residential Home 14
23.0 Transition Period 14
24.0 Emergency Respite Procedure 15
25.0 Emergency Admissions Procedure 15
26.0 Request for a Transfer 16
27.0 Procedures to be followed: 16
28.0 If the transfer is approved: 17
29.0 Transfer of Files and personal possessions: 17
30.0 If a request is refused: 18
31.0 Additional Responsibilities: 18
32.0 Temporary Absence of a Resident Procedure 18
33.0 Discharge Procedure 19
34.0 This Policy should also be read in conjunction with the following policies: 19
Appendix 1 20
Appendix 2 23
Appendix 3 44

Appendix 4.....46
Staff Signature Sheet 57

1.0 Introduction

SOS Kilkenny clg provides day and residential supports to people with Intellectual Disabilities and Autism in the HSE CHO5 (South Tipperary, Carlow, Kilkenny, Waterford and Wexford) area.

SOS Kilkenny clg will be referred to as SOS throughout this Policy and Procedures.

Throughout the term of this Policy, SOS reserves the right to change the Procedures and associated documentation as necessary at any time pending review of the full Policy every 2 years.

2.0 Purpose of Policy

The purpose of the following document is to inform all relevant Stakeholders of the Policy and Procedures to be followed when an individual:

2.1 Applies to SOS for a Day and/or Residential Placement OR
2.2 Applies for a Transfer within the SOS Residential Service (thus resulting in a Transition Plan) OR
2.3 Is temporarily absent from SOS Residential Service OR
2.4 Is fully discharged from SOS Residential Services.

3.0 Aims

3.1 This document aims to provide clear guidelines for individuals with an Intellectual Disability, their families and SOS staff and other service providers regarding Admission, Transfer/Transition, Temporary Absence and Discharge information and procedures that apply within SOS.

4.0 Scope of Policy

This document applies to:

4.1 All people supported availing of the day services and residential services provided by SOS.
4.2 Adults with an Intellectual disability from HSE CHO-5 (South Tipperary, Carlow, Kilkenny, Waterford and Wexford).

5.0 Definitions:

5.1 Admission — the process of application, acceptance, offer and successful uptake of a Day/Residential placement (home) within SOS.

5.2 Temporary Absence — the process of being absence on a temporary basis from one's Residential placement (home) within SOS.

5.3 Transfer — the process of application, acceptance, offer and successful uptake of a move or relocation from one home to another Residential placement (home) within SOS .

5.4 Transition — the process of being supported to transition from one Residential location to another location either within (or on occasion, external to) SOS Residential Service.

5.5 Discharge — the process of being fully discharged from the SOS Day/Residential Service,

6.0 Responsibilities

6.1 The Chief Executive Officer

6.1.1 The Chief Executive Officer (CEO) has overall responsibility for ensuring that procedures and processes are in place to enable adherence to this policy.

6.1.2 The CEO will ensure that there are systems in place to ensure the efficient management of day and residential services.

6.1.3 The CEO will ensure there is provision of adequate training for all staff.

7.0 Admission, Transfer / Transition and Discharge Assessment Committee for SOS Kilkenny clg

7.1 Decisions on Admission, Transfer/Transition, Temporary Absence and Discharge are made by (and are the responsibility of) the SOS Admission, Transfer/Transition, Temporary Absence and Discharge Committee which is comprised of the:

7.1.1 C.E.O. (or Nominated Person)
7.1.2 Support Services Manager
7.1.3 Social Worker
7.1.4 Residential Operations Managers
7.1.5 Day Operations Manager
7.1.6 Behavioural Therapist
7.1.7 Health Care Nurse / Team (as required)
7.1.8 Residential Manager (as required)
7.1.9 Day services manager (as required)

7.2 The person supported, their key worker, and/or an independent advocate chosen by the person we support shall be represented when necessary (in respect of Transfers, Transitions and Discharge).

7.3 The SOS Admission, Transfer/ Transition, Temporary Discharge and Discharge Committee will meet on a quarterly basis and Minutes of Meetings will be recorded.

8.0 Admissions:

Admissions Criteria for SOS Day Service:

8.1 HSE profiling meeting is completed in the school setting before the person leaves school at age 18.

8.2 SOS is notified of potential new entrants by HSE.

8.3 SOS Social Worker contacts the school to request school reports and any other relevant documentation.

8.4 SOS Social Worker contacts the family to complete an "Assessment of Needs" and to obtain copies of medical/academic assessments and reports.

8.5 SOS Behaviour Support Specialist observes the potential new entrant in their school setting, meets with teachers to gain a deep insight into the person's needs, wishes and future expectations.

8.6 Potential School Leavers may sample the Day Services for 1 week, this is arranged by present school in partnership with the HSE and the Day services manager.

8.7 HSE and SOS agree funding and level of service in advance of any offer of an admission to SOS Kilkenny.

8.8 All admissions are subject to appropriate funding and the subsequent recruitment of suitably qualified staff.

9.0 Admissions Criteria for SOS Residential Service

As a pre-requisite to entering residential services, families are encouraged to register the person on the Kilkenny County Council social housing list.

9.1 The SOS Admission, Transfer/Transition, Temporary Absence and Discharge Committee shall ensure that each application for admission to SOS Residential Service is determined on the basis of the following identified criteria which include:

9.1.1 The individual has an Intellectual Disability;

9.1.2 The individual comes from HSE CH05 (South Tipperary, Carlow, Kilkenny, Waterford and Wexford).

9.1.3 An assessment by the SOS Admission, Transfer / Transition, Temporary Absence and Discharge Committee which will consider who is most need.

9.1.4 This need is assessed (Appendix 2) and prioritized in the following way:

9.1.4.1 Whether the parents are alive or deceased;
9.1.4.2 When parents are alive the age, health and ability of parents to look after their son or daughter;
9.1.4.3 Whether the individual is at risk from abuse or neglect;
9.1.4.4 Whether the individual has additional disabilities which would be better dealt with in a residential setting;
9.1.4.5 Whether the individual is presenting with behaviours that are challenging for families:
9.1.4.6 That a suitable place with staff and resources is available.
9.1.4.7 That the person can benefit from the Residential Services provided by SOS.
9.1.4.8 That provision of a residential service complies with the objectives for which the company was incorporated and sustains the ethos, role and function of the SOS Residential Service.

9.1.5 New admissions are subject to appropriate allocation of funding through submission and subsequent approval of a DSAMT (Disability Supports Application Management Tool) to the HSE.

9.1.6 Where applicable the Facilities Manager will apply for CAS / Housing (Capital Investment Funding for purchase of new Residential properties, green-fields development and/or new builds.

9.1.7 SOS are obliged under agreement with the HSE to complete and return the National Ability Supports System (NASS) for each person availing of services. This will be completed prior to admission and also will be updated as required.

9.1.8 Upon admission to SOS Kilkenny, information, documentation and person details (such as date of birth, next of kin, contacts for contact listing, HIQA unique identifier number, PPS number, daily notes, personal details etc) will be added to our Data Management System.

9.1.9 There will be occasions whereby SOS will be expected to share information with third parties such as HSE, Social Welfare, Public Health etc whom we need to interact with as part of the service we provide.

10.0 HSE CH05 (South Tipperary, Carlow, Kilkenny, Waterford and Wexford)

10.1 The catchment area traditionally comprises of:

10.1.1 Community Healthcare Organisation 5 (CH05).

10.1.2 In exceptional circumstances individual persons with an intellectual disability from outside the catchment area may be admitted to the day/Residential Services where requested by the HSE and with recommendation (if agreed) by the Board of Directors. The recommendation should be from the Admission, Transfer /Transition, Temporary Absence and Discharge Committee.

10.2 The groups in greatest need in the community for residential places are:

10.2.1 Those where one or both parents have died, those with elderly parents or where one or both parents are incapacitated, or where a parent has a permanent and serious medical condition.

10.2.2 Those with multiple physical disabilities.

10.2.3 Those with chronic or serious medical, behavioural or psychiatric disorders.

11.0 Admissions to SOS Residential Services

11.1 When a residential place becomes available for an individual arrangements are made with the person and their next of kin or representatives to assist them in deciding if the place is suitable for them.

11.2 These arrangements include:

11.2.1 Visiting the residential setting;
11.2.2 Meeting the relevant Residential Manager;
11.2.3 Participating in the Transition Process;
11.2.4 Agreeing rent and other charges;
11.2.5 Preparation and/or sharing of an individual's profile or care plan.
11.2.6 Setting up an individual bank/credit union/PO account for the person.

11.3 After a place has been offered to the person and it has been accepted and formal consent or agreement of their next of kin or the person's representatives is obtained, suitable and acceptable arrangements for each person and their families will be agreed and a date set for the admission to take place.

11.4 The Residential Manager will ensure that, as far as is reasonably practicable, the person supported can bring their own furniture and furnishings into their home.

11.5 This agreement (Residential Contract) sets out:

11.5.1 The terms and conditions of the individual's placement;
11.5.2 The nature and extent of the service being provided to meet their assessed needs;
11.5.3 Rent and other charges (costs and contributions).

11.6 In some admission cases considerable adjustment and adaptation is necessary and this may take time and consequently admissions may be planned or phased in over an appropriate period of time.

11.7 Following admission, each individual's settling-in will be monitored and assessed on a regular basis by the Residential Manager with the support of a Residential Operations Manager.

11.8 The person supported will also receive a Welcome Pack that will include information about their new home, useful information and support details.

12.0 General Admissions Provision

12.1 SOS Policy and Procedures for the admission of individuals into the SOS Residential Service will be formally reviewed at least once every two years and adapted where necessary, to ensure that the organisation meets the needs of the person with an intellectual disability and their families in the SOS catchment area.

13.0 List of persons requesting residential services

13.1 The list of persons requesting residential services will be reassessed regularly by the Admissions, Transfer/Transition, Temporary Absence and Discharge Committee, the order of same may change due to changing needs of both the person supported and main carer/s.

14.0 Protecting Residents

14.1 It is imperative that every care is taken to ensure that all people we support in the care of SOS are as far as is reasonably possible protected from all forms of abuse, including abuse from their peers, and can exercise their right to make a complaint and/or seek representation from an independent advocate. The following documentation provide the people we support, their family and/or representative, the procedures and process for ensuring the people we support, safety and wellbeing at all times;

006a	Safeguarding Vulnerable Adults at Risk of Abuse
012a	Complaints Policy
049a	Risk Management Policy
018a	Staff Training, Education and Development Policy
HSE Policy	Trust in Care Policy
063a	Respite Service Policy
073a	Trust in Care Procedures
074a	Open Disclosure Policy

Transfer, Transition And Temporary Absences:

15.0 Responsibilities of the Admission, Transfer, Transition and Discharge Assessment Committee in respect of Transfers and Transitions:

15.1 To respond to all requests for transfers (see Appendix 3) in light of the overall residential needs of the organisation, the possible reasons for the request and the feasibility of the request.
15.2 To ensure a thorough assessment of need is carried out before making a decision on a transfer.
15.3 To consult with respective Residential Line Managers on all requests for transfer.
15.4 To ensure that the person we support, his / her family and staff are informed of the outcome of the request.
15.5 In the case of a person we support requesting to transfer to another residential house, a transition plan must be provided to provide a transition programme (see Appendix 4) taking into account the needs and wishes of the person we support and the needs and wishes of the other people we support in the new house.
15.6 In the case of a person we support requesting a transfer from a residential house to independent living to provide relevant training on the skills needed for independent living.
15.7 To keep written records of all meetings held.
15.8 To keep a centrally held record of all transfers.
15.9 To carry out risk assessments when appropriate and keep a written record of the assessment.
15.10 To submit the request for a transfer or move to the SOS Housing Association (Transfer Request Form to be filled) Appendix 3.
15.11 To notify the SOS Housing Association and Finance Department one month (minimum) in advance of any internal transfer.
15.12 To ensure a one month notice in writing is given by the resident/tenant to end a tenancy agreement with SOS Housing Association.

16.0 Temporary Absences from an SOS Residential home may include:

16.1 Absences which are temporary including a person we support being transferred to a hospital, nursing home, or short term placement are included in this Policy. Please see the "Procedures" for temporary absences in the Procedures section (Section 30.0).

Discharge:

17.0 Discharge Criteria

17.1 A person availing of a residential service with SOS may be discharged from the service when the following conditions apply:

17.1.1 They have vacated their residential placement stating they do not intend to return.
17.1.2 The person or their next of kin inform SOS in writing that they wish to leave their residential placement.
17.1.3 SOS Residential Services are no longer able to meet the needs of the person and alternative accommodation has been secured.

18.0 Recommendations on Discharge

18.1 Recommendations on discharge are made by the SOS Admission, Transfer / Transition, Temporary Absence and Discharge Committee.
18.2 This recommendation is made following consultation with the person and their next of kin.
18.3 The HSE will be notified of any discharges from SOS Residential Services.

Procedures

Admission Procedure for Residential Service:

19.0 Access to Service

19.1 An application on behalf of a person with an intellectual disability to SOS can be made directly to the Social Worker of SOS by individuals already attending SOS, their next of kin or their representatives and by health care professionals.

An application on behalf of a person with an intellectual disability who is not already attending SOS needs to be referred by the HSE Disability Case Manager.

19.2 When an application is received the Social Worker will arrange for an initial clinical assessment of the individual to be undertaken.

19.3 Information for this is compiled by meeting with the individual, their family and others whom know the person well. Reports may be sought from the HSE and other organisations providing services for persons with an intellectual disability.

19.4 If the person is already attending the SOS day service, staff teams working with the person will be consulted also.

20.0 Approval Procedure

20.1 After assessment by the clinical team each individual's assessment will be presented by the social worker to the Admission, Transfer/Transition, Temporary Absence and Discharge Committee.

20.2 Each recommendation for admission to the Residential Service will be supported by the information specified in the attached Appendix 1.

20.3 The Admission, Transfer/Transition, Temporary Absence and Discharge Committee will make recommendations on the referral (considering if the referral complies with the admissions criteria, who is most in need or who can benefit from the service).

20.4 If the Admission, Transfer/Transition, Temporary Absence and Discharge Committee recommend that a person should be offered a residential place with SOS their name is placed on the residential waiting list until a suitable place is available.

20.5 Should the Admission, Transfer/Transition, Temporary Absence and Discharge Committee recommend against admission to the residential service the person, their family and HSE will be notified and explanation given of how this decision was reached.

21.0 Assessment Procedures

21.1 When a residential place is available through vacancies or through a planned expansion of the services, and when the appropriate facilities are in place and the necessary staff and finance are available to meet the assessed needs of the person or will shortly be available the social worker will finalize the assessment and prioritize applications for the service in consultation with their next of kin or their representatives and other health care professionals.

22.0 On Admission to SOS Residential Home

22.1 The Residential Manager for the available residential placement will ensure that each prospective person we support and his / her family or representative are provided with the opportunity to visit the residential home, as far as is reasonably practicable, before admission to view the location.

22.2 The Residential Manager for the available residential placement will ensure that a comprehensive assessment covering the health, personal and social care needs of each person we support is carried out — prior to admission to the residential centre and subsequently as required to reflect changes in need and circumstances, but no less than on an annual basis.

22.3 When it is proposed that a new person is moving in to the SOS Residential Service, the Residential Manager shall ensure that the residential centre is suitable for the purposes of meeting the needs of each person we support (as per their assessed needs through consultation with the MDT and Admission, Transfer/Transition, Temporary Absence and Discharge Committee).

22.4 When it is proposed that anew person is moving in to the SOS Residential Service, the Residential Manager shall ensure that any identified risks are assessed and supports (as outlined in the DSAMT application in addition to those assessed as part of the Admissions Application) are made available to ensure the person's safety and welfare and to ensure the safety and welfare of the existing people we support in the residential centre.

23.0 Transition Period

23.1 Each new person supported being admitted to SOS Residential Service will have a period of transition to the service; this may include the following and will be tailored to meet individual needs.

- 23.1.1 Initially visiting the house for evening tea on a least two occasions to meet the people we support and staff over a one / two week period.
- 23.1.2 Progressing to two evening teas with a recreational activity included, within a one week period
- 23.1.3 On the final week, evening tea on two evenings accompanied by overnight stays.
- 23.1.4 Full admission to the residential home will then occur if the person is happy with the placement, if the person is unhappy, the residential placement will be reviewed.

23.2 The Residential Manager (and key worker where appropriate) s hall no later than 28 days after the person we support is admitted to the residential centre,

prepare a personal plan for the person supported, which reflects the person's needs, outlines the supports required and is developed through a person centred approach with the maximum participation of the person and where appropriate their next of kin or representative, in accordance with the person's wishes, age and the nature of his/her disability.

23.3 The Residential Manager will make this plan available (in an accessible format) to the person we support and their next of kin or representative,

23.4 The CEO will, on admission, agree in writing with each person we support, their representative where the person we support is not capable of giving consent, the terms on which the person we support will reside in the residential home, this will include:

23.5 The support, care and welfare of the person we support in the residential home, and details of the services to be provided for that person we support and costs / contributions to be charged will be clearly outlined.

24.0 Emergency Respite Procedure

24.1 Admissions for emergency respite or crisis care will be assessed individually and approval for emergency respite or crisis care will be at the sole discretion of the CEO considering that a suitable place, staff levels and resources are available.

24.2 Where an individual has been admitted in an emergency, he/she is given time, information and, if necessary, access to an advocate, In order to decide whether or not to stay.

25.0 Emergency Admissions Procedure

25.1 Requests for emergency admissions will be assessed individually and approval for an emergency admission will be at the sole discretion of the CEO considering that a suitable place, staff levels and resources are available.

25.2 Admissions procedures 16.0, 17.0 and 18.0 should be followed for emergencies.

25.3 Temporary emergency respite may be used to allow for a full assessment to be carried out and for the admissions procedures (16.0, 17.0 and 18.0) to be followed.

25.4 Where an individual has been admitted in an emergency, he/she is given time, information and, if necessary, access to an advocate, in order to decide whether or not to stay.

Transfer And Transition Procedure

26.0 Request for a Transfer

26.1 Who can make a request for transfer within the residential service or a move to independent living?

26.1.1 A person we support and/or their family/carer or a chosen advocate, or a member of staff in SOS.

26.2 Who can receive the request?

26.2.1 The request can be made to a frontline staff member in the day or residential service, to a line manager, to a member of the multi-disciplinary team, namely Social Work Department, Health Care Department or Behavioural Support Department.

26.3 What to do if you receive a request to transfer?

26.3.1 Confirm the request with the person we support and/or their advocate.
26.3.2 Put the request in writing to your line manager.
26.3.3 When the line manager receives the request they will establish the grounds for the request.
26.3.4 The line manager will forward the request and their assessment of the request to the Residential Operations Manager.
26.3.5 The Residential Operations Manager will then refer the request and the line manager's assessment to the Transfer Committee for further discussion, recommendation and planning.

27.0 Procedures to be followed:

When the Admission, Transfer/Transition, Temporary Absence and Discharge Committee receives a request for a transfer, or move to independent living:-

25.1 Member(s) of the Admission, Transfer/Transition, Temporary Absence and Discharge Assessment Committee shall meet with the individual who has made the request.

25.2 Member(s) of the Admission, Transfer/Transition, Temporary Absence and Discharge Committee shall assess the needs and wishes of the person we support who made the request or on whose behalf the request was made, and other relevant individuals who may be impacted by the request.

25.3 The Admission, Transfer/Transition, Temporary Absence and Discharge Committee may request further information from:
Residential Line Managers, Day Service Managers, Social Work Department, Health Care Team and/or Behaviour Support Department.

25.4 Where the Transfer is requested due to changing needs of the person supported, a DSAMT will be submitted to the HSE CH05 for additional resources required.

25.5 The Admission, Transfer/Transition, Temporary Absence and Discharge Assessment Committee shall make a decision on the request and communicate this verbally and in writing to the person we support, and their advocates.

28.0 If the transfer is approved:

Follow up:

28.1 The Residential Operations Manager, relevant Residential Manager, and Social Worker will draw up a plan on how and when the transfer will happen and who will inform the person we support, their advocate and the family/families of the other people we support who may be affected by the move and the day and residential staff.

28.2 The Admission, Transfer/Transition, Temporary Absence and Discharge Assessment Committee will assess the financial implications of the transfer in order to ensure that the required resources are feasible.

28.3 The Residential Operations Manager will ensure that all necessary resources to facilitate the person we support' move to their new location are achievable before any transfer/transition is made effective,

28.4 When a person we support has requested a move from one residential house to another an individualized transition programme / plan (see Appendix 4)will be implemented to include meetings with the person we support' family, staff and the other people we support of the house where the individual has requested to move.

28.5 If a person we support is moving from a residential setting to Independent living the Admission, Transfer/Transition, Temporary Absence and Discharge Committee will ensure that they are fully informed of the services and supports available to them and appropriate skills training is provided for independent living.

28.6 The Admission, Transfer/Transition, Temporary Absence and Discharge Committee will ensure that the SOS Housing Association is informed.

28.7 If the person we support /advocate are unhappy with the time frame for the transfer / move they will be advised of the option to appeal it to the CEO.

29.0 Transfer of Files and personal possessions:

29.1 The Residential Manager from where the person we support is moving will ensure that:

29.1.1 All files

29.1.2 All personal information e.g. report books, financial or health records etc.

29.1.3 All personal possessions including own furniture, bed linen, towels etc., are transferred with the person we support to their new accommodation.

30.0 If a request is refused:

Follow up

30.1 The Admission, Transfer/Transition, Temporary Absence and Discharge Committee will meet with the relevant Residential Line Manager and Social Worker to draw up the protocol to inform the person we support, their family and/or their chosen advocate that the request has been refused, and the reasons for the refusal.

30.2 If the person we support, family and/or their chosen advocate are unhappy with the decision they will be advised of the option to appeal this to the CEO.

31.0 Additional Responsibilities:

Note 1

31.1 The Admission, Transfer/Transition, Temporary Absence and Discharge Committee will meet at least once every three months to review the progress of the transfers/transitions which have occurred.

Note 2

31.2 Where the people we support are requested by SOS to move from their residential house, the above procedures are to be followed before any transfer can take place.

32.0 Temporary Absence of a Resident Procedure

32.1 This section applies to when a person we support is temporarily transferred to a hospital, nursing home, or short term placement.

32.2 Where a person we support is temporarily absent from their residential home, the Residential Manager in conjunction with the Social Work Department / Health Care Department will ensure all relevant information pertaining to the person we support is provided to the person taking responsibility for the care, support and wellbeing of the person we support during their absence, i.e. hospital, nursing home etc.

32.3 When a person we support returns from a hospital, nursing home or other short term placement, the Residential Manager of the residential home from which the person we support was absent will take all reasonable actions to ensure that all relevant information pertaining to the person we support is obtained from the person responsible for the care, support and wellbeing of the person we support during their stay in hospital / nursing home etc, The Residential Manager must ensure all information is provided to all appropriate staff prior to the person we support returning

32.4 A temporary absence may require notification to HIQA and / or HSE depending upon the circumstances of the temporary absence.

32.5 Compliance with all necessary protocols (e.g. Infection Prevention and Control Measures during a Pandemic or outbreak of a notifiable disease) must be strictly adhered to in respect of both provisions for the temporary absence and return to the person's SOS Residential home.

33.0 Discharge Procedure

33.1 The people we support may indicate their wish to leave the day/residential service themselves through personal planning or the request may come from their next of kin. A formal written application should be completed by the people we support with the assistance of their key worker or advocate and forwarded to the Social Work Department.

33.2 Alternatively, if identified through a formal assessment that the needs of the person we support cannot be met within the day/ residential service SOS may request for the person to be discharged.

33.3 Whatever the reason for discharge SOS will support the person we support and their next of kin in making the transition from SOS to their next day/ residential placement.

33.4 This could include:

33.4.1 Notifying and / or working in partnership with the HSE ofthe person's wish/need to leave SOS residential services;

33.4.2 Making referrals to alternative residential services;

33.4.3 Supporting the person we support and their next of kin to explore alternative residential options.

33.4.4 Where the person we support is asked to leave the residential service they are given access to an advocate, time to consider their position and an opportunity to state their views at an appropriate forum such as a case review.

33.4.5 Arrangements for the future support of the person we support who leaves a residential service take account of his/ her need for continuity of education, employment, relationships, social contacts and treatment, as appropriate.

33.4.6 Where appropriate, the provision of training in life-skills required for the new living arrangement will be provided to the person we support by SOS,

33.4.7 When a vacancy in the service occurs, or if a person we support is discharged from the residential service the event will be reported to the Admissions, Transfer, Transitions and Discharge Team who may decide to reallocate the place to another person with an intellectual disability after a further suitable individual has been recommended for admission.

33.4.8 If after the person we support is discharged a re-referral, irrespective of the reason for the discharge will be treated as a fresh application and will be subject to normal assessment and approval procedures.

34.0 This Policy should also be read in conjunction with the following policies:

The SOS Data Protection and Privacy Policy (047a)
The SOS Data Breach Management Policy (070a)

Appendix 1

ADMISSIONS ASSESSMENT FORM (037a/001) To be completed in conjunction with the NEEDS ASSESSMENT 037a/002		
SECTION 1		
Name of Admission Applicant:		
Address:		
Referral Agency (if not already in SOS Kilkenny clg):		
Degree / Level of ID — ranges:		
Other factors contribution to care /support needs:		
Dependency / level of care / supervision required:		
Service required:		
Placement / location options:		
Compliance with approved policy / criteria:	Intellectual Disability:	
	HSE CH05: South Tipperary, Carlow, Kilkenny, Waterford and Wexford.	
	Parents living or deceased:	
	Parents living (age, health, ability to look after son / daughter):	
	At risk from abuse or neglect:	
	Additional disabilities which would be better supported in a day/ Residential Setting:	
	Behaviours of Concern:	
	SOS Kilkenny clg has a suitable place with staffing and available resources:	
	Person would benefit from SOS Kilkenny clg	
	Day/Residential Services	

	rovlslono esl enfra Services complies with the objectives for which SOS was incorporated and sustains ethos, role and function of SOS Kilkenny clg Residential Services:	
Day programme / service / activity envisaged:		
SECTION 2		
Residential care required from:		
Outcome of Admissions, Transfer/Transition, Temporary Absence and Discharge Committee Meeting:		
Reason for Recommendation(s):		
Other information:		
Assessment of impact on existing services:		
SECTION 3		
Annual cost of place:		
DSAMT Application submission:		
Funding agreed with HSE:		
NASS Database completed: SOS Database completed:		
Welcome Pack:		
Residential Contract signed:		
Additional Requirements:		
Housing Association Informed:		
Finance Department Informed: Bank/Credit Union/PO Account set up in person's name:		

For Office Use Only .

Appendix 2

NEEDS ASSESSMENT
037a/002

Assessment of Need Template

Type of Assessment	Admission		Discharge		Transition	Review
Date of Assessment						
Name of person supported						
Admission/Discharge/Transition Date						
Referral Date						
Source of Referral						
Current Address						
Date of Birth						
Gender						
PPS Number						
HIQA Number						
Family Contact Name						
Family Contact Number						

Assessments

Any relevant documents, reports, assessments in place at time of admission	Yes	No	Date of Review /document completed and on file
Personal Information			
Health Assessment Checklist for PwID			
Communication Passport			
Dementia Checklist			
Independent Living skills checklist			
Psychiatric Report			
Psychological Assessment Report			
Occupational Report			
Physiotherapy Report			
Dietician Report			
Medical assessment report/Hospital ass. report			
Blood Report			
Speech and Language Report			

Actions

Health and Wellbeing

Discussion	Yes	No
Has this person completed a full course of currently recommended vaccinations?		
Does this person take part in the annual flu vaccination?		
Has this person been vaccinated against Covid-19?		
Is this person continent?		
Double incontinent?		
Urinary incontinent?		
Faecal incontinent?		
Does this person suffer from constipation?		
Does this person suffer from Chronic pain?		
Does this person have Osteoporosis Bone health issues?		
Does this person have endocrine issues (diabetes, hypothyroidism etc)		
Does this person have gastroesophageal issues?		
Does this person have respiratory issues?		
Does this person have cardiovascular issues		

Details

Actions

Mental Health

Item identified	Yes	No
Does this person have input from a mental health professional/behaviour therapist or psychologist?		
Has this person experienced a trauma in the past?		
Does this person warrant further assessment or support regarding trauma-related symptoms?		

Details

Actions

Food and Nutrition/Dietitian		
Item identified	Yes	No
Details		
Actions		

Communication/Swallow Care /Speech and Language

Item identified	Yes	No
Is this person or has this person….?		
Limited Verbal?		
Use of augmented system?		
Non Verbal?		
Can this person communicate needs with no support?		
Can this person eat and drink independently?		
Does this person need limited help		
Does this person need to be fully supported?		
Does this person have a normal diet and fluids?		
Does this person require modified diet and or/fluids? *If yes add grade to details section*		
Does this person require enteral feeding?		
Does this person require input from SLT/Dietician?		

Details

Actions

Physiotherapy/Bone Health/Exercise Plan

Item identified	Yes	No
Is this person fully ambulant?		
Is this person ambulant requiring support or aids?		
Does this person require a wheelchair full time?		
Does this person use a wheelchair transfer and for community access?		
Does this person require hoisting? *If yes add information to details*		
Does this person have reduced function or absence of limb?		

Details

Actions

Epilepsy/Neurology

Item identified	Yes	No
Does this person have epilepsy?		

What type of epilepsy does this person have?	
How regular do they have seizures?	
When was their last seizure?	

Details

Actions

Oral Health/ Dental		
Item identified	Yes	No
Does this person have dental issues?		
Does this person have normal healthy teeth?		
Does this person have minor dental problems?		
Does this person have major dental problems?		

Details

Actions

Eye Health/Optician

Item identified	Yes	No
Does this person have vision difficulties?		
Does this person have normal vision?		
Does this person have minor vision problems?		
Does this person have major vision problems?		
Does this person have cataracts?		

Details

Actions

Ear Care/Audiology

Item identified	Yes	No
Does this person have hearing difficulties?		
Does this person have a hearing aid?		
Does this person suffer recurring ear infections?		
Does this person suffer from wax build up?		

Details

Actions

Equipment/Occupational Therapy/Sensory Programme		
Item identified	Yes	No
Can this person perform personal hygiene?		
Can this person dress independently?		
Does this person have a sensory impairment?		

Details

Actions

Behaviour Support Plan/Recordings Review		
Item identified	Yes	No
Does this person display behavioural issues?		
Does this person engage in Self Injurious behaviour?		
Does this person engage in emotional outbursts?		
Does this person engage in aggression?		
Does this person engage in over activity?		
Does this person engage in sleep disturbance?		
Does this person engage in inappropriate sexual behaviour?		
Does this person engage in destruction of the physical environment?		
Does this person engage in absconding/wandering?		
Details		

Actions

GP

Item identified	Details
Annual Review	
Bloods	
Cholesterol	
Dexa	
Health Screening	
Referrals	

Details

Actions

Medication

Item identified

List of Current Medications

List of PRN Medication and how often they are required

Medication Reviews

Annual Financial Plan

Item identified

Details

Actions

Incidents/Accidents Analysis

Item identified

Details

Actions

Risk Management and Positive Risk Taking

Details

Actions

Fire Evacuation/PEEP/CEEP

Details

Actions

Safeguarding plan/Protection of the person

Item identified

Details

Actions

Advocacy/Human Rights
Item identified
Details
Actions

Actions identified as part of Needs Assessment.	Person Responsible	Completion date

Keyworker/Staff Member		**Date**	
Team Leader/PIC		**Date**	
Operations Manager		**Date**	

Part 3 – Final Report to ADT	The PIC/Manager to complete a final report to Admissions, Discharge & Transition Team 3 months after admission/transition about compatibility & suitability of service to person supported.

PIC Name and Signature
Date

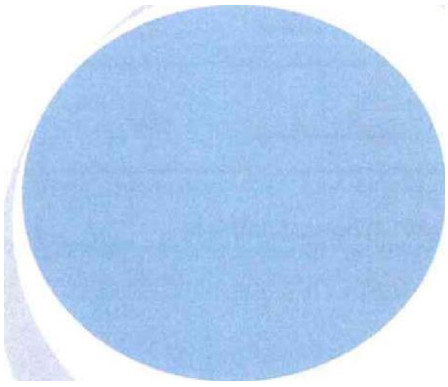
Appendix 3

Transfer Request/Referral Form 037a/003		
Details of Person Supported Requesting / Transferring to a different location		
Name of Person Supported:		
Current Address:		
Date of Birth:		
Contact Number(s):	Landline	
	Mobile	
Is Person Supported aware of the Referral:	Yes	
	No	
Date of Request:		
Type of Transfer Requested:	Permanent	
	Temporary	
	Emergency	
Proposed date of Transfer if application successful:		
Request / Referral Details - Person making Request / Referral:		
Name:		
Current Address:		
	Landline	

Contact Number(s):	Mobile	
Relationship to Person Supported:		
Person Request / Referral was made to:	Name	
	Role	

Request received:	By Phone	
	Letter	
	Email	
	Other	
Rationale for Request / Referral:		
Signed:		
Dated:		
For Office Use Only:		


Transition Plan



Person Requesting/Transferring to a different Location

Name:

_____

Current Address:

_____

_____

_____ _____

Date of Birth:

Contact Number:

Land Line: Mobile:

_____ _____

Is the Person Supported aware of Referral Yes O No O/

Rational_____

_____

_____

_____

_____

Is this requestfora : Permanent Transfer O Temporary Transfer O Emergency Transfer O

Date of Request _/_/ Proposed Datefor Transfer if application is Successful: _/_/

Record of Contact with Person Supported:

Start Date ___/___/___ By Whom:

_____

Contact 1 ___/___/___1 By Whom.

_____

Contact 2 ___/___/___ By Whom:

_____

Contact 3 ___/___/___ By Whom.

_____

Contact 4 ___/___/___ By Whom.

_____

Contact 5 ___/___/___ By

Whom:

_____

Contact 6 ___/___/___ By Whom:

_____

Transition/Transfer Process Complete ___/___/___

Contact Person/Advocate/Keyworker/Family Member

Name:_____

Current Address:

_____

_____

_____

Contact Number:

Land Line: _____ Mobile: _____

Record of Contact with Contact person/Advocate/Keyworker/Family Member

Start Date ___/___/___ To Whom.: _____ By _____

Contact 1 ___/___/___ To Whom, _____ By _____

Contact 2 ___/___/___ To Whom: _____ . _____
By

Contact 3 ___/___/___ To Whom: _____ By _____

Contact 4 ___/___/___ To Whom. _____ . _____
By

Contact 5 ___/___/___ To Whom: _____ . _____
By

Contact 6 ___/___/___ To Whom: _____ By _____

Transition/Transfer Process Complete —/—/

Key-worker

_____

ɔn: _____

Name:

Location:

Designated Centre. _____

Contact Number:

Land Line. Mobile:

_____ _____

2/if Applicable

Name: _____

Location ɔn : _____ .

_____

Designated Centre:

Contact Number:

Land Line: Mobile:

_____ _____

Request/Referral Details

Person Making Request/Referra

Name:

Current
Address.
Contact Number: Land
Line: Mobile.
Relationship:

Person Request/Referral Made to:
Role Date of
Request/Referralv

Received: Verbally O By Phone o Letter O Email o
Other O

Is There a Referral Form on File Yes O No O Date —-/—/— Additional Information:

Transition/Transfer Team

Name: Role: Email Tel

Name: Role: Email Tel

Name: Role: Email Tel

Name: Role: Email Tel

Name. Role: Email Tel

Name: Role: Email Tel

Name: Role: Email Tel

Name: Role: Email Tel

Role:

Name: Role: Email Tel

Name:

Role: Email Tel

Name: Role: Email Tel

Name: Role: Email Tel

Transition/Transfer Coordinator Identified

Name. Role:

Record o Reviews Meetings	

Start Date ___/___/___ Review 1 ___/___/___ Re Review 3 ___/___/___ Transition/Transfer Process Complete -—/—/	Review 4 ___/___/___ Review 5 ___/___/___ Re Review 7 ___/___/___

Other Health Care Professionals Involved:

Role	Name	Referral Date/ By Whom
Speech & Language Therapist		___/___/___
Occupational Therapist		___/___/___
General Practitioner		___/___/___
Doctor [Specialist]		___/___/___
Specialist Nurse		___/___/___
Physiotherapist		___/___/___
Behaviour Support Specialist		___/___/___
Social Worker		___/___/___
Training Officer		___/___/___
Psychiatrist		___/___/___
Dietician		___/___/___
Psychologist		___/___/___

Psychotherapist	_____	__/__/__
_____		
Other:		
_____	_____	__/__/__
_____		
_____	_____	__/__/__
_____		
_____	_____	__/__/__
_____		

Assessment of Needs as carried out by Health Care Professionals Above

Details of Assessments:

Support Intensity Scale Assessment ISIS]- Completed Yes O No O Date —/—/

Type:

By
Whom:
Date: Role:

Please Attach

Report
2/
Type:

By
Whom: Date:
Role:

Please Attach

Report
3/Type:

By
Whom: Date:

Role:

Documentation Checklist	By

IAS Appropriate]

Personal Care Plan updated

Swallow Care Plan Updated

Epilepsy Care Plan Updated

Mobility Care Plan Updated

Health Check Sheet Updated

Personal File Updated

Medical File Updated

Finances Audited / Checked

Property Checklist Updated

Intimate Care Plan Updated

Risk Assessments Completed

Contract of Service Completed

Tenancy Agreement Completed

Additional Information:

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: _____ By

___/___/___ Whom. _____ By

___/___/___ Whom: _____ By

___/___/___ Whom: n:_____ By

___/___/___ _____ Whom:

Staff Signature Sheet

I have read and understand the Admission, Transfer, Transition Absence and Discharge Policy V.I

Print Name:	Signature:	House/ Department:	Date: