ST. PATRICK'S CENTRE, KELLS ROAD, KILKENNY

Policy Document

POLICY TITLE:

Admission, Transition & Discharge Policy

Prepared by:	Approval Date:	Review Date:
Aine Forde, Breda Hogan	15.11.2015 19.07.2019 23.06.2021	15.11.2017 19.07.2021 23.06.2023
Policy Number 02 – Schedule 5	Approved By: Signed: _____ CEO Signed: _____ Board Member	

Mission Statement

Utilising our resources and skills to provide intentional supports for the people we support; enabling them to live full and inclusive lives by contributing to and enriching the fabric of their local communities.

SPC partners with external agencies and community services to facilitate *'ordinary lives in ordinary places'*

Vision Statement

People supported will live a good life, in their own home, with supports and opportunities to become active, valued and inclusive members of their local communities.

Review Date: June 2021 Revision No: 1	Amendments Required Full review of Policy	New Revision Status 23.06.2023
Reviewed By: Admission, Transition & Discharge Committee	Approved By: Signed: _____ CEO	

Contents

Section 1 Admissions Policy

1.0 Purpose of Policy

1.1. This document details the policy and procedures to be followed when SPC receive an admission application from HSE Disability Services.

2.0 Introduction

2.1. SPC specialises in providing support to people who have severe or profound intellectual disabilities and underlying complex associated health needs.

2.2. People seeking admission to SPC will be considered equally and on the basis of their assessed need and according to the Statement of Purpose of the Designated Centre.

3.0 Aims

3.1. This document outlines clear guidelines for the admission/transition/discharge of Individuals who access SPC services; their Families and Supporters, SPC staff and external stakeholders.

4.0 Scope of this document

4.1. This document applies to:

- All People Supported availing of services provided by SPC.
- All People Supported who wish to avail of services provided by SPC.

5.0 Admissions Criteria

5.1. The SPC Admission, Transition and Discharge Team (ATD Team) shall ensure that each application for admission to SPC Services is determined on the basis of the following criteria: -

- The Person is over the age of 18 or over
- The Person has a severe/profound intellectual disability as their primary disability

5.2. SPC work in partnership with the HSE and will provide supports to a Person who has been suitably assessed and the required revenue and capital funding is confirmed and received from the HSE

5.3. If SPC have a suitable funded vacancy, confirmation of the continued funding for this placement will be secured before allocation of the vacancy takes place. Any uplift of funding will be approved and

secured prior to service provision commencing.

5.4. SPC will endeavor to provide services and supports to a person in their local community.

5.5. Referrals for admission are made in writing via SPC referral form (Appendix 1).

6.0 Catchment Area

6.1. The catchment area of SPC traditionally comprises of:

- Community Healthcare Organisation, South East Area 5 (CHO5)

- In exceptional circumstances Persons with an intellectual disability from outside the catchment area may be admitted to the Residential Community Services where requested by the HSE Disability Manager and with the approval of the SPC Board of Directors.

7.0 Admission and Transitions Team

7.1. The decision to offer a placement at SPC is reviewed and agreed by the ATD team:

- CEO
- Director of Services
- Housing & Facilities Manager
- Assistant Director of Services
- Senior Social Worker
- Behaviour Support Specialist
- CSM Representative

7.2. The ATD Team will consult with the Person in Charge (PIC) and Person Participating in Management (PPIM) of the proposed Designated Centre as part of the assessment process for a residential placement.

Section 2 Admissions Procedures

8.0 Access to Service

8.1. Applications for service provision are accepted from HSE Disability Manager CHO5; such applications will be made in writing to the Director of Services, SPC Kilkenny.

8.2. An application on behalf of a person with an intellectual disability to the SPC Residential Service made directly to the Director of Services by individuals, their immediate family or their representatives and by health care professionals will also be considered. However, approval of such admission applications will only take place once approval for required funding is confirmed in writing from HSE.

8.3. When an application is received by the Director of Services, the Senior Social Worker will arrange an initial psycho-social assessment of the Individual to be undertaken.

8.4. This pre-admissions assessment will be completed by the PIC and PPIM.

8.5. The pre-admissions assessment will identify any health and safety requirements, funding requirements and remedial actions prior to the Person being admitted.

8.6. Information will be sourced from the individual, their family and others who know the person well. Reports may be sought from the HSE, Healthcare professionals and other organisations providing services for the person.

8.7. If the person is already attending SPC Community Supports, the staff teams working with the person will be consulted also.

8.8. Should funding not be secured the Applicant can, if they wish, be placed on a waiting list for SPC Residential Services. This list will be reviewed and updated quarterly at the Admissions and Transitions Team meeting.

9.0 Approval Procedure

9.1. The Social Worker will present the Assessment to the ATD team

9.2. The ATD Team will make one of the following determinations:

- SPC is not an appropriate service to offer the Applicant or

- SPC is an appropriate service to offer the Applicant and it is consistent with the Statement of Purpose for the Designated Centre and can be provided within existing resources or

- SPC is an appropriate service to offer the Applicant, it is consistent with the Statement of Purpose for the Designated Centre, but additional resources would be required before the service can be offered. The ADT will consult with the Finance Manager who will prepare and submit a business case utilising the s38 Support Specification Costing Matrix to the HSE prior to an offer of placement is made.

9.3. Each admission will be subject to a trial period of three months which may be extended by the ATD Team. Parameters of the trial period should include e.g., compatibility with peers, appropriate funding/resources meet needs of person supported, availability of therapeutic supports, views of person supported and/or their representatives. The PIC will submit a comprehensive report to ATD after three months trial period.

9.4. In the event that a determination is made that SPC is deemed unsuitable to the applicant the Admissions and Transitions Team will set out in writing the reasons for this determination.

10.0 Upon Approval of Application

- When a residential place is available and deemed appropriate by the ATD Team in consultation with the PIC and PPIM of the proposed Designated Centre; and when the appropriate facilities are in place and the necessary staff and finances are available to meet the assessed needs of the person;
- the Director of Services or the Social Worker will inform the person as well as their family member or representative and the HSE Disability Manager in writing that their admissions application has been successful.

10.2 When it is proposed that a new person is moving into or within the SPC Residential Service, the relevant PIC 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

11.0 Admission Process

11.1. The PIC for the available Designated Centre 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.

11.2. The PIC 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 (in line with HIQA Regulation 5 – Individual Assessment and Personal Plan) 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.

11.3. When it is proposed that a new person is moving into a SPC Residential Community Home, the relevant PIC shall ensure that the people supported who reside in that home are informed of the potential admission to the residential centre.

11.4. When it is proposed that a new person is moving into a SPC Residential Community Home the relevant PIC shall ensure that any identified risks are assessed and supports 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.

11.5. Each person being admitted to a SPC Designated Centre will have a period of transition to the service and a bespoke transition plan will be developed to ensure a smooth and safe transition.

11.6. The relevant PIC shall, no later than 28 days after the person we support is admitted to the residential centre, prepare a personal plan for the Person Supported outlining the supports required. This plan is to be developed using a person-centred approach with the maximum participation of the Person Supported and where appropriate their family member or representative, in accordance with the person we support wishes, age and the nature of his/her disability.

11.7. Relevant PIC will make this plan available (in an accessible format) to the Person Supported, their family member or representative.

11.8. The CEO will, on admission, agree in writing with each person we support, and their representative where the Person Supported has been shown to lack functional capacity in this instance to make an agreement, the terms

on which the person we support will reside in the residential home, this will be the form of a Provision of Service document which will include:

- The terms and conditions of the individual's placement.
- The nature and extent of the service being provided to meet their assessed needs.
- Rent and other charges.

12.0 Guidance Relating to Admissions

12.1. When a residential place becomes available for an Individual, arrangements are made with the person and their family or representatives to assist them in deciding if the place is suitable for them.

12.2. These arrangements include:

- Visiting the residential setting;
- Meeting the supported people who live in the house
- Meeting the relevant PIC;
- Participating in the Transition Period;
- Agreeing rent and other charges;
- Preparation or sharing of an individual's profile or care plan.

12.3. The PIC shall ensure that, as far as is reasonably practicable, the people we support can bring their own furniture and furnishings into the rooms they occupy. This will not impact on SPC obligations on providing essentials for the person's home.

12.4. In some admission cases considerable adjustment and adaptation is necessary and this may need time and consequently admissions may be planned or phased in over an appropriate period of time to accommodate same.

12.5. Each supported person, following admissions, will be assessed on a regular basis by the PIC with the support of a Community Services Manager in order to ascertain suitability of SPC as the provider.

12.6. SPC Transition Documentation to be used to facilitate all people supported involved in admissions, transitions & discharges (Appendix 1 to 5).

13.0 Emergency Respite Procedure

13.1. Admissions for emergency respite or crisis care will be assessed individually, agreed in writing with the Disability Manager (CHO5) and approval for emergency respite or crisis care will be at the sole discretion of the C.E.O. considering that a suitable place, staff levels and resources are available.

13.2. 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.

14.0 Emergency Admissions Procedure

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

14.2. Admissions procedures 8.0, 9.0 and 10.0 should be followed for emergencies.

14.3. Temporary emergency respite may be used to enable a full assessment to be carried out and/or for the admissions procedures (8.0, 9.0, 10.0) to be followed.

14.4. 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.

14.5. Emergency admissions can be difficult times for all involved. For the Person Supported, their families or representatives, other Persons Supported. SPC is committed to ensuring, in as far as practicable, that resources and strategies are developed to mitigate the impact of transitioning into a new residential environment.

15.0 General Provision

15.1. SPC Policy and Procedures for admission/transition/discharge will be formally reviewed at least once every two years and adapted where necessary, to ensure that the organisation meets the needs of the persons supported and their families within the SPC catchment area.

16.0 Transitions

16.1. There are two types of transition within SPC:

- Internal Transition – from one Designated Centre to another
- External Transition – from SPC to another Service or to a person's home.

16.2. Internal Transition

While an individual can transfer within the SPC residential service from one Designated Centre to another Designated Centre, each transfer, in line with HIQA guidelines, is considered a discharge from the originating Designated Centre and a new admission to the chosen Designated Centre

- Requests for internal transitions may be made by the person supported, representatives of the person supported, a social worker or an appropriate senior person within the Operations Team in SPC.
- When a request for an internal transition has been approved by the ATD in consultation with the relevant PIC and PPIM, the relevant stakeholders shall be informed e.g., family, Office of the Wards of Court, HSE, HIQA, Social Worker (if not already involved) etc.
- The compatibility of the applicant with the existing people supported living in the Designated Centre shall be given due consideration.
- A comprehensive assessment will be completed by the PIC
- All internal transitions shall be person centred and holistic.
- Internal transitions shall be aligned with the relevant established action plan process.
- All personal files, paper and soft copy, are moved with the person supported to their new home.

16.3. External Transitions

- Requests for external transitions may be made by the person supported, their representative(s), advocate, social worker, HSE or an appropriate senior person within the Operations Team in SPC.
- When a request for an external transition has been approved by the ATD, HSE and new service provider, the relevant stakeholders shall be informed e.g. Family, Office of the Ward of Court, HSE, HIQA, Social Worker (if not already involved).
- All transitions shall be person-centred and holistic.
- Transitions shall be aligned with the relevant established action plan process.
- Communication is established between SPC and the new Service.
- Relevant sharing of information takes place at the time of the move.

17.0 Discharge Process

17.1. Requests for discharge shall be received from Director of Services, Senior Manager within the Operations Team or Senior Social Worker.

17.2. The discharge process will be formally activated when the ATD Team receive an application for discharge with supporting documentation from the relevant senior manager.

17.3. Each person's discharge will be person-centred and managed in a planned and safe manner based on their assessed needs.

17.4. Discharges are discussed and planned with key stakeholders involved in supporting the person.

18.0 Criteria for Discharge

18.1. If the Person Supported has not attended the Service for a prolonged period of time.

18.2. If the person supported or representatives indicate they no longer wish to avail of the service in the designated centre and/or Community Hub.

18.3. If other People Supported are put at risk due to repeated safeguarding concerns. In this case, documentary evidence of the range of interventions, supports and programs which have been considered and implemented must be presented to the ATD.

19.0 References

- Health Information and Quality Authority (2013) National Standards for Residential Services for Children and Adults with Disabilities, Ireland.
- Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

20.0 Appendices

- SPC Referral form for admissions
- Letter to request discharge
- SPC Assessment of Needs Template
- SPC ADT Action Plan Template
- SPC Transition Plan Template
- My moving story Template
- Person supported moving in/out of my home Template

Referral for Admission to SPC Residential Community Services

Name Of Person Being Referred	
Date Of Birth	
Current Address	
Date Of Referral	
Brief Description of The Person Being Referred	
Reason For Referral	
Name of Person Completing Referral	
Role of Person Completing Referral	

Please forward the completed form to: The Director of Services, SPC (St Patricks Centre, Kilkenny), Unit 11/12 Danville Business Park, Kilkenny or send the completed form via email to Annette.Ryan@StPatricksKilkenny.ie

Supporting People in Communities
St Patrick's Centre

Saint Patrick's Centre (Kilkenny) Registered Number 6349663B
A: Unit 11-12, Danville Business Park, Kilkenny, Ireland R95 KD32 **T:** 056 772 2170 **E**: info@stpatrickskilkenny.ie

Date

To: SPC Admission, Transition & Discharge Committee

Ref: Request for internal transition

Dear ADT Committee,

I am (Person Supported Name), currently residing in (SPC designated centre Name).

I am supported by my staff team to request an internal transition to another community home within St. Patrick's Centre Kilkenny.

Please liaise with my support team/circle of support to request further detail and information regarding my request.

Kind Regards

_____

Signed by Person supported or
PIC on behalf of Person Supported

Assessment of Need Template – Foundation for Personal Plan

Date of Assessment	
Name of Person Supported	
Date of Admission to Designated Centre	
Address	
Date of Birth	
Name of Assessor	

In line with Regulation 5 and Regulation 24, this Assessment is to be completed by the PIC post admission of person supported within 1 month of admission and will be used as the foundation of the person's Personal Plan.

This Assessment can also be used pre admission and/or discharge of a person supported to gather information and inform the transition process.

Part 1 – Assessment Documentation	Please document all relevant historical and recent information for the person supported. Detail the person's health & wellbeing and other relevant information, to include also hospital admissions and appointments, etc.

Item	Any relevant documents, reports, assessments in place at time of admission	Yes	No	Date of Review /document completed and on file
1. Assessments	Biography			
	My profile			
	Ok Health Check			
	Medical Data Sheet			
	Briefing Document			
	Dis Dat			
	Cognitive changes Check list (If appropriate)			
	Independent Living skills checklist			
	Psychiatric Report			
	Psychological Assessment Report			
	Occupational Report			
	Physiotherapy Report			
	Dietician Report			
	Medical assessment report			
	Blood Reports			
	Speech and Language Report			

Item	Discussion	Action to be completed
2. Health and Well being	*A brief synopsis of how the person has been doing for the past year. Hospital Admissions and appointments etc*	•
3. Mental Health		•
4. Food and Nutrition/Dietitian		•
5. Communication/ Swallow Care /Speech and Language		
6. Physiotherapy/Bone Health/Exercise Plan		•

7. Epilepsy/Neurology		•
8. Oral Health/ Dental		•
9. Eye Health/Optician		•
10. Equipment/Occupational Therapy/Sensory Programme		•
11. Behaviour Support Plan/Recordings Review		•

12. GP/	*Annual Review/ Bloods/ Cholesterol/ Dexa/ Health Screening/Referrals*	•
13. Medication Reviews		•
14. Ear care/Audiology		•
15. Annual Financial Plan		•
16. Incidents/Accidents Analysis		•
17. Risk Management		•

and Positive Risk Taking		
18. Fire Evacuation/PEEP /CEEP		•
19. Safeguarding Plan/Protection of the person		•
20. Advocacy/Human Rights		•

Part 2 – Visioning Meeting	Please document all current information that is available about the person supported to inform future planning.

Item Discussed	**Interests:** *For example, hobbies, things the person enjoys doing*
What are the person's Interests	

Item Discussed	**Talents:** *For example, personality, skills, qualities, attributes*
What are the person's Talents and Skills?	

Item Discussed	What supports does the person need in relation to their Health & Wellbeing?
Health, wellbeing and previous medical history	
Current Health Care concerns	

Item Discussed	**What does this person supported day look like:** *How I like to spend my day/Meaningful day*
What does this person day look like now?	
How can we support this person to have a more meaningful day?	

Item Discussed	**What does this person supported home look like:** *Compared to a person of similar age living in KK*
What does this person's home look like now?	
How can we support this person to make their house a home?	

Item Discussed	What does this person's relationships look like now? *Compared to a person of similar age living in KK*
What does this person's relationships look like now?	
How can we support this person to strengthen their current relationships and create new lasting ones?	

Item Discussed	**Conditions for success:** *what has to be in place to support the person to have a successful day*
What does the person need to make their day/life/activity/role successful?	

Roles and Goals identified with the person

Actions identified as part of annual review and visioning	Person Responsible	Completion date

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

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

PIC Name and Signature	
Date	

Action Plan for Admissions, Discharges & Transitions

Name of Designated centre: **Date:**

Present:

Apologies:

Key:

Task	Detail	Actions identified	Person Responsible	Completion Date	Completed Yes/No
Environment	➢ Environmental assessment/check to identify any needs for person supported. ➢ Necessary amendments to be discussed and completed.				
Person Supported	➢ **Personal Plan** (follow Index of Personal Plan File) ➢ **Assessments** Biography, Profile, Ok Health Check, Medical Data Sheet, DIS DAT, additional: any relevant MDT reports and completed assessments ➢ **Risk Management** • Relevant Risk Assessments • Incident and accident report/analysis • Positive risk taking				

Action Plan for Admissions, Discharges & Transitions

Name of Designated centre: **Date:**

Task	Detail	Actions identified	Person Responsible	Completion Date	Completed Yes/No
	➢ **Restrictive Practices** • Assessments and logs ➢ **Health & Wellbeing** • GP o Registration with GP o Medical needs • Behaviour Support plans • Mental health • Food/Nutrition/Dietitian • OT/Sensory Support and Equipment • Communication/Swallow Care/SLT • Physiotherapy/Mobility/Bone Health • Epilepsy/Neurology • Oral/Dental/Eyes/Ears ➢ **Medication/Pharmacy** • Registration with local community Pharmacy • Kardex, Prescriptions • Move of medication • Medication audit completed				

Action Plan for Admissions, Discharges & Transitions

Name of Designated centre: **Date:**

Task	Detail	Actions identified	Person Responsible	Completion Date	Completed Yes/No
	➢ **Safeguarding** ➢ **Financial Plans/Inventory** ➢ **Service relevant information** • Provision of Service Agreement • Tenancy Agreement ➢ **Vehicle** • ➢ **Fire Safety/PEEP/CEEP** •				
Transition Planning	➢ Transition documentation (transition plan template, moving story) ➢ Information of all people supported involved ➢ Information of all relatives involved ➢ Visits to the new home				

Action Plan for Admissions, Discharges & Transitions

Name of Designated centre: **Date:**

Task	Detail	Actions identified	Person Responsible	Completion Date	Completed Yes/No
Staffing	➢ Staffing Hours/Rosters ➢ Training & Development ➢ Change of Status				
House Relevant Documentation	➢ Statement of Purpose ➢ Directory of Residents ➢ House folder system				
Next Meeting	➢				

SPC Transition Plan

Name	
Commencement date	

About me	
Name	
Date of Birth	
PPS number	
Contact Number	
Current home address	
Admission Date	
Discharge Date	

About my future home		
Proposed home address		
Proposed date for moving		
Is my future home a	Long Term Living Arrangement?	☐
	Interim living arrangement?	☐
	Private rental arrangement?	☐
	Emergency living arrangement?	☐

About my Advocate, and my request and referral details		
Person making request/referral		
Contact Numbers	Landline	
	Mobile	
Relationship to me		
Request or referral made to		
Role of the above person		
Date of request or referral		
Reason for Request or Referral		
Received	Verbally	☐
	By phone	☐
	Letter	☐
	Email	☐
	Other:	

My Transition Team currently supporting the community Move					
Name	Role	Transitioning with me?			
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐
		Yes	☐	No	☐

People who I am currently living with				
Name	Transitioning with me?			
	Yes	☐	No	☐
	Yes	☐	No	☐
	Yes	☐	No	☐
	Yes	☐	No	☐

My Additional Documents	Yes	No	In progress
Has My Moving Story been completed	☐	☐	☐
Has A person moving in/out of my house been completed	☐	☐	☐

My Action Planning/transition meetings were held on			
Start Date		Review 6 Date	
Review 1 Date		Review 7 Date	
Review 2 Date		Review 8 Date	
Review 3 Date		Review 9 Date	
Review 4 Date		Review 10 Date	
Review 5 Date		Review 11 Date	

I visited my new home and the local area on		
Date	Supported by	Purpose

Other Departments and key people involved in my transition		
Department	Name	Actions to follow up on
Speech & Language Therapist		
Occupational Therapist		
Doctor [Specialist]		
Physiotherapist		
Behaviour Support Specialist		
Social Worker		
Psychiatrist		
Dietician		
Psychologist		
Psychotherapist		

Additional Resources/equipment my transition				
Details				
Has an inventory list been created and kept live on file?	Yes	☐	No	☐
Any outstanding actions				

Resource Forms				
Have resource forms been completed and sent to the finance department for new purchases for my home?	Yes	☐	No	☐
How have I been supported to be active in my move (*e.g purchasing new house items, curtains, curtain poles, soft furnishings for the house?)*				

Insert photograph
of me here

This booklet belongs to: _____

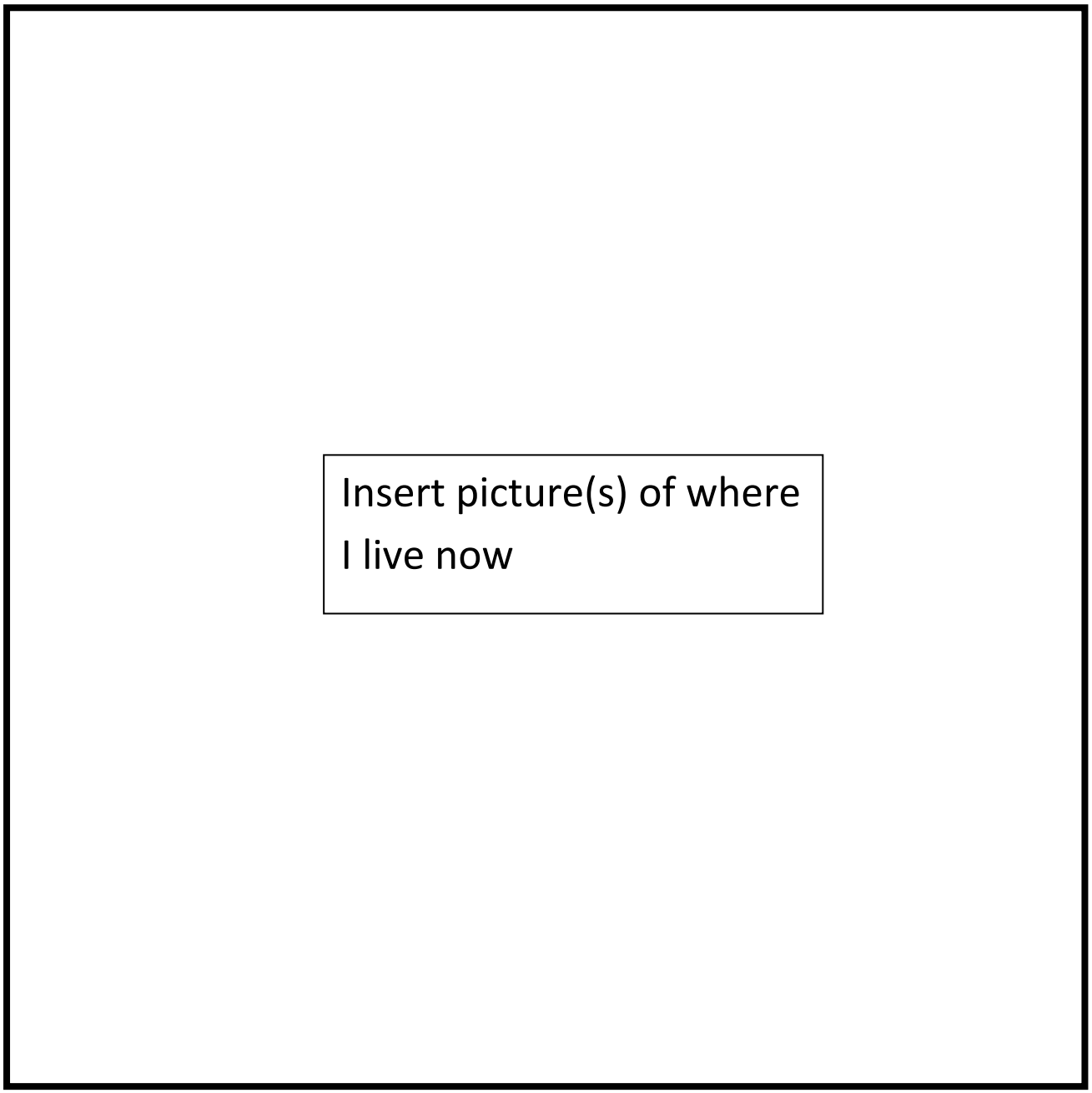
Please read this booklet with me to help me get ready for, and think about moving to my new house.

Let me look at the pictures on each page for as long or as short as I like.

Contents

Getting ready to move

19. I planned my move with support. I had meetings/visits.
20. I visited my new home on _____ _____ _____ _____
21. This is me shopping for things for my new home.
22. This is me packing my bags for the move.
23. I helped with moving.
24. Things I will miss about St. Patrick's centre.
25. I can visit St Patrick's centre after I move.
26. I will still go to Deans Gate after I move.
27. I can talk to staff about the move. I can ask questions whenever I want. I can look at this booklet whenever I want.



I am moving house.

This is where I live now.

Insert picture(s) of the people I live with now

These are some of the people I live with now.

Insert pictures of the people who support me now

These are some of the people who support me now.

Insert picture of my current bedroom

This is my bedroom now.

Insert picture(s) of my favourite place in my current house

This is my favourite place in my house now.

Insert calendar/ visual supports

I will be moving to a new house on _____.

Insert pictures of the outside of my new house

This is the outside of my new house.

Insert pictures of the inside of my new house

This is the inside of my new house.

Insert photographs of the people I will live with in my new house

These are some of the people I will live with in my new house. I know these people already.

Insert photographs of the new people I will live with in my new house

These are some new people I will live with in my new house. I don’t know them.

Insert photographs of the staff who will support me in my new house

These are some of the people who will support me in my new house.

Insert map of my new house

This is a map of my new house.

My new address: _____

_____

_____

_____

My new house phone number: _____

This is the address and phone number of my new house.

Insert photographs of things/places near my new house e.g. cinema/shop/cafe/ park etc

My new house is beside _____

_____

Insert photographs of my family visiting my new house

My family can visit me at my new house

Insert photograph of my new bedroom and some of my things I can put in my new bedroom

This is my bedroom in my new house. I can put my things in my bedroom.

Insert photographs of my favourite things about my new house

These are my favourite things about my new house.

Insert picture(s) of me/others attending meetings about my new house

I planned my move to my new house with support. I had meetings.

Insert picture(s) of me visiting other houses/my new house

I visited a few different houses. I visited my new house before I moved in. I visited my new house on _____ _____

_____ _____ _____

Insert pictures of me buying things for my new house

This is me shopping for _____

and _____ for my new house.

Insert pictures of me packing my bag for my move to my new house

This is me packing my bags for the move to my new house.

Insert pictures of me moving things into my new house

I helped with moving. I moved _____ to my new house.

Insert photographs of my favourite things about my new house

These are my favourite things about my new house.

Insert photographs of the things/people I will miss from Saint Patrick's Centre

Things I will miss about Saint Patrick's Centre: _____

Insert photographs of places in Saint Patrick's

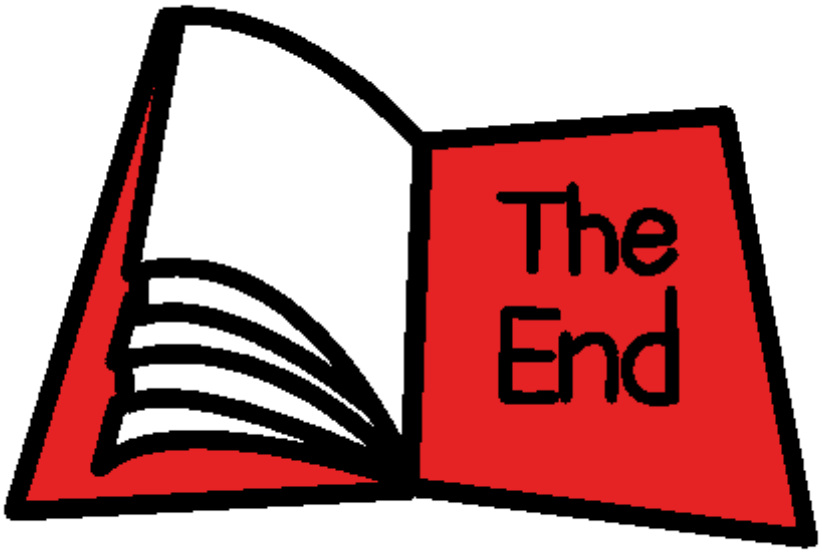
I can visit Saint Patrick's Centre after I move to my new house.

Insert pictures of places and people in Deans Gate important to me

I will still go to Deans Gate on _____ when I move house. These are some pictures of places and people in Deans Gate important to me.

Insert photographs of me looking at this booklet

I can look at this booklet whenever I want.



The end

This booklet belongs to: _____

Please read this booklet with me to support me for when the people I live with move out of my home or if a new person moves into my home.

Let me look at the pictures on each page for as long or as short as I like

Supporting people whose housemates and/or friends are moving to a new home and if a new person moves into their home

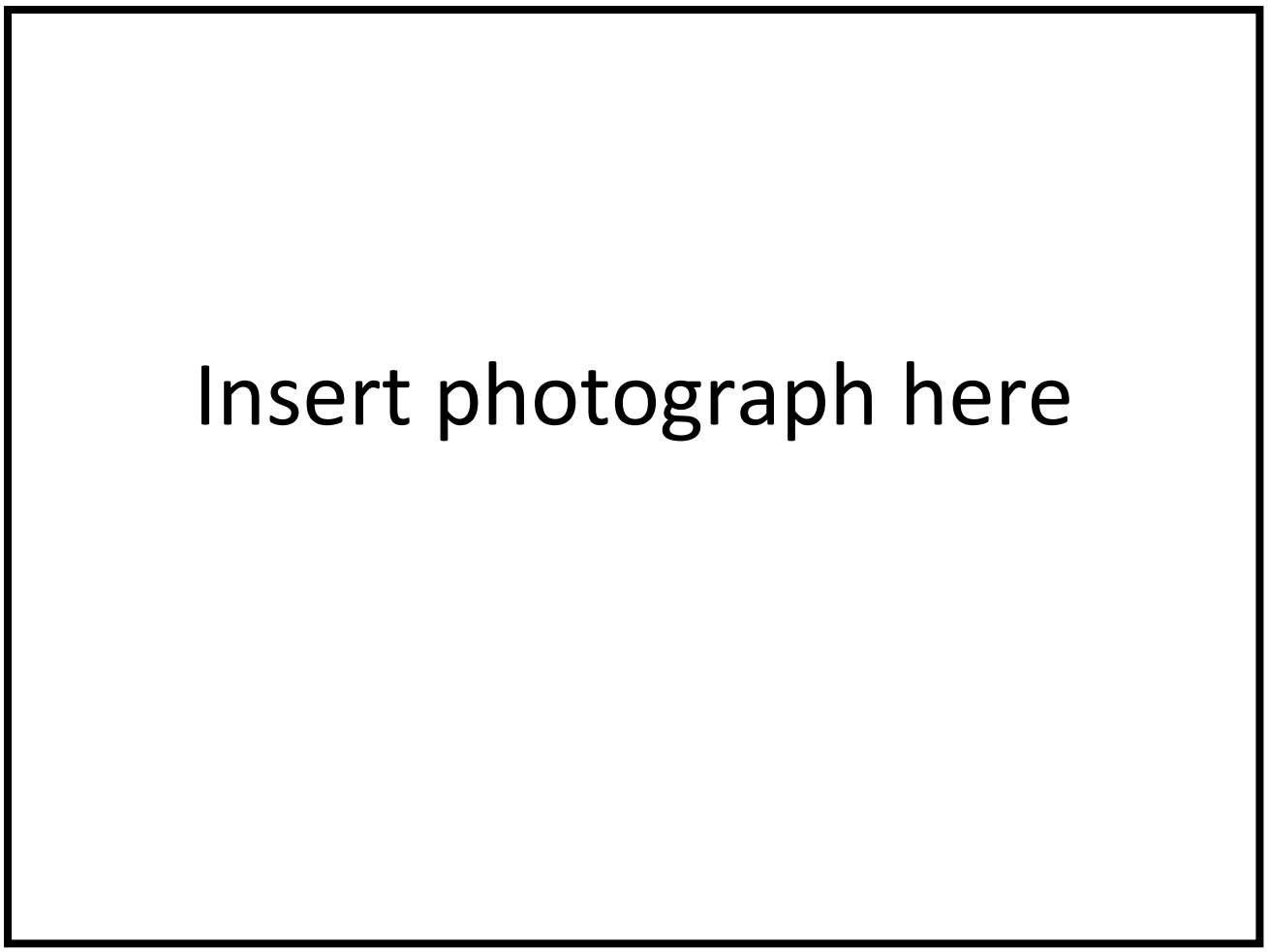
Support needed before the move occurs:

- Support people to prepare for their friends and/or housemates leaving by talking openly about the move in a calm and positive way once a definite move date has been established. Provide reassurance that people will be able to connect with their friends and housemates as they choose.
- You may choose to use a visual calendar to identify move and other move related dates for people (visiting the new house, shopping for the new house etc).
- Use photographs of the house the person is moving to as a way of explaining where the person is moving to their friends in a calm and positive conversation. Provide 1:1 time and preferred activities after this conversation and monitor peoples' responses to same.
- Plan a party to mark the occasion of someone moving out of their home and into a new home.
- Develop a 'friendship' book of photographs (of people spending time together and doing their favourite things together) and mementos (CDs of favourite songs, souvenirs and items from trips and events that people participated in together) for people who have a close relationship and that you think might be likely to miss each other once a move happens. Ensure there is a copy for the person who is moving and their friends they are moving away from.
- Alternatively, you might develop a DVD of people spending time together and doing their favourite things together for people who have a close relationship and that you think might be likely to miss each other once a move happens

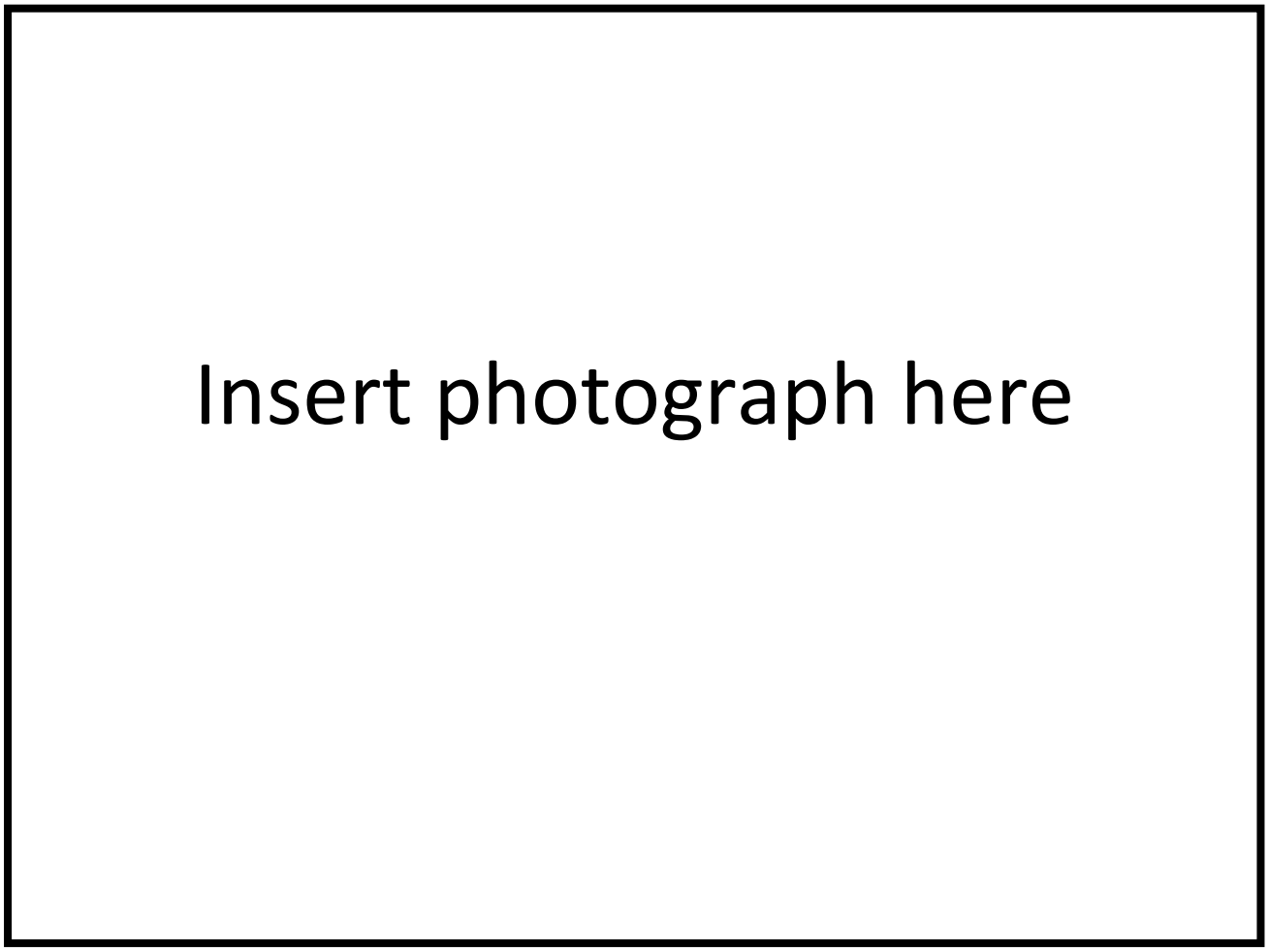
Support needed after the move has occurred

- Support people to buy housewarming cards and presents for each other and support people to attend housewarming parties as appropriate.
- Support people to read through their 'friendship' books or watch their DVDs as they choose.
- Some people may like to get photographs of their friends printed and framed for their house/bedroom.
- Monitor people for signs of distress, discuss any concerns at clinical house meetings and/or contact psychology/psychiatry/play therapy as appropriate

It is important that all staff remember that this booklet is a guide, pages can be added to it or taken out depending on the individual and their needs.



This is _____, he/she is moving out of your home on the _____.



This is _____, he/she is moving into your home on _____.

_____, is moving on the.

_____, new address is:

_____,

_____,

_____,

_____,

I can visit _____, on _____, _____, once I ring ahead and ensure they are free to have visitors.