Government of **Western Australia**
Department of **Health**

Hospital Stay Guidelines

A guide for hospital staff

Acknowledgement of Country and People

WA Health acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. It acknowledges the wisdom of Aboriginal Elders both past and present and pays respect to Aboriginal communities of today.

Readers are warned that this document may contain images of people who have deceased since the time of publication.

Suggested citation

Hospital Stay Guidelines, a guide for hospital staff. Western Australian Department of Health.

Important disclaimer

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Our commitment

The Western Australian Department of Health is committed to improving outcomes for people with disability and recognises the many contributions that people with disability make to the Western Australian community.

In WA, around one in 5 people have a disability, which is approximately 411,500 people (State Disability Strategy 2020–2030). While some people with disability live independently, others require some assistance. The department acknowledges the important role that family, friends, carers and disability service providers have in the lives of people with disability and is committed to improving its services and systems so that they are accessible and welcoming for everyone.

The Hospital Stay Guidelines support the State Disability Strategy 2020–2030 and its guiding principles, as outlined in the United Nations Convention on the Rights of Persons with Disabilities.

Visit www.wa.gov.au/government/document-collections/state-disability-strategy-2020-2030 for more information on the State Disability Strategy 2020–2030.

Visit www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html for more information on the United Nations Convention on the Rights of Persons with Disabilities.

The Disability Health Network

The Disability Health Network helped write this guide. The aim of the network is to improve health outcomes for people with disability. The network works together with people with disability, families and carers, health professionals, hospitals, health services, staff from the department and disability service providers.

Disability Health Network Co-Leads Stephanie Coates and Jocelyn Franciscus

The network acknowledges the authors of the original Hospital Stay Guideline for Hospitals and Disability Service Organisations (2016) and the following individuals, groups and organisations for their contributions to this document:

- Meagan White (Author)

Meagan White

- Dr Jacquie Garton-Smith
- Elish Kelly (Fiona Stanley Hospital)
- Ready to Go Home Project (National Disability Services and Department of Health WA, Chief Allied Health Office)

Carer rights

The WA *Carer Recognition Act 2004* recognises the role of carers in the community and how to involve carers in services that impact on them and their caring role. Carer rights are outlined in the Act in the Western Australian Carers Charter, which include:

- carers must be treated with respect and dignity
- the role of carers must be recognised by including carers in the assessment, planning, delivery and review of services that impact on them and their role
- the views and needs of carers must be considered along with the views, needs and best interests of the people receiving care when decisions are made that impact on carers and their role
- complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

About this guide

All WA Health staff and facilities should provide services for people with disability that are inclusive, person-centred, respectful and accessible.

This guide will use the term 'person' when referring to people with disability. This guide acknowledges that the person with disability is referred to as a patient when attending the hospital, and the National Disability Insurance Agency (NDIA) uses the term participant.

This guide provides information for hospital staff on ways to support a person with complex disability support needs during their hospital admission in both the emergency department and ward environments.

This guide is divided into the following sections:

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1 – Gather background information

On admission to hospital, it is important to gather as much information at handover about who the person is, what support needs they have, and who the key contacts in their support network are. This information may be gathered from the person or their nominated representative. It is recommended on admission that a Disability Health Profile form (see Appendix 1 for an example) is used to capture key disability related information about the person for recording in the Patient Medical Record (PMR).

This section includes an overview of the types of information required to best support the person throughout the hospital admission.

Key summary

To optimise the delivery of health care during the person's admission, consider the following:

- identify the key stakeholders involved in the person's community care and document their contact details
- gather a comprehensive understanding of their baseline functional support needs and document in the medical record
- understand how best to communicate with the person and ensure any essential communication aids are available for use. Ask a support person to stay with the person if they have complex communication support needs
- ask if any environmental adaptations need to be implemented
- arrange for any special equipment to be transported to the hospital in a timely manner to support the person during their admission
- ask if the person has a behaviour management plan and get a copy if they do. Ask a support person to stay with the person if required to prevent or minimise behaviour escalation
- identify if the person requires support to make decisions and provide consent. If the person requires assistance, ensure this is available and documented in the medical record
- ensure a copy of the State Administrative Tribunal (SAT) or Guardianship Orders are saved into the PMR if relevant. Visit sat.justice.wa.gov.au for more information.

Identifying the support network

It is important to establish if the person has an essential support network that will assist them during their hospital admission. With the consent of the person, hospital staff should gather key contact details of the support network to enable regular communication throughout admission and effective discharge planning. The support network should be consulted and included throughout the person's hospitalisation only with the consent of the person or their formal guardian.

Examples of who the key support network may include are:

- nominated representative (i.e. family member, friend or legal guardian)
- service provider
- support coordinator / case manager
- General Practitioner (GP)
- NDIS planner
- school
- Department of Communities case worker
- Community Mental Health Team (CMHT) representative
- Child Protection and Family Support (CPFS) case worker.

Document the contact details in the PMR and if appropriate, place a copy in the bedside chart.

Ensure relevant consent forms are completed to enable timely communication and sharing of relevant information between stakeholder groups. For example, www.ndis.gov.au/about-us/policies/access-information/consent-forms the National Disability Insurance Scheme (NDIS) consent form. In the absence of a formal consent form, clearly document that consent was obtained from the person in the PMR.

Establishing functional support needs

If the person is unable to do so themselves, ask their support networks to provide a handover of their baseline functional support needs. They may have a pre-prepared handover document that can be given to staff. This may be in the form of a Disability Health Profile (see Appendix 1 for an example), a health passport (see Appendix 9 for examples), My Health Record, an Advance Health Directive or a Values and Preferences Form. Other examples include access cards, such as the National Access Card and Sunflower Lanyard, or an app, such as Medical ID.

National Access Card

The National Access Card and Lanyard includes a photo and important medical and contact information that a person can show to hospital staff.

Visit www.invisibledisabilities.com.au for more information.

National Assistance Card

The National Assistance Card is a personalised card to assist people with disability and health conditions in the community. The National Assistance Card can be used in everyday or emergency situations where a cardholder needs assistance or support.

Visit www.nationalassistancecard.com.au for more information.

The Sunflower Lanyard

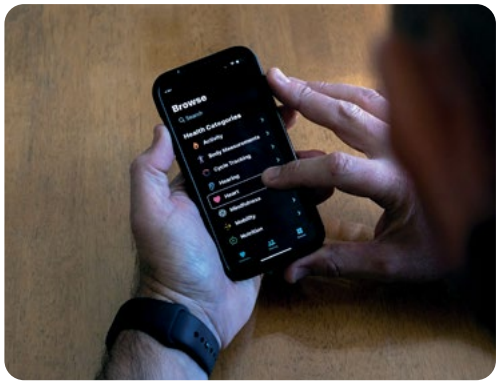
The sunflowers show people the person has a hidden disability. The person may be wearing this as a lanyard, wrist band or some other format indicating a sunflower.

Visit hiddendisabilitiesshop.com.au for more information.

Autism Alert Card

The Autism Alert Card lets emergency services know that the person has autism. It includes the person's photo and name and lists 2 contacts for further help and support.

Visit www.autism.org.au/our-services/fact-sheets-autism-2/autism-alert-card for more information.



Medical ID

Medical ID can be set up on compatible mobile phones. In an emergency other people can access the information from the person's mobile phone without a password. This is helpful if the person has a condition like epilepsy or severe allergies.

To access a person's Medical ID on an iPhone, hold down the lock button and volume up button at the same time.

For an Android, press the lock button and it will show up on the screen if installed.

It is important to gather information about:

- personal care – level of assistance and equipment required
- eating and drinking – modified diet details, ability to swallow, risk of aspiration, ability to feed self, allergies, food preferences
- mobility – level of assistance and equipment required, how the person transfers, distance able to ambulate, falls history
- behaviour/emotional support strategies – triggers, comforters, level of supervision required (i.e. can the person be left unsupervised), environmental needs
- communication needs and preferences – equipment required, how the person expresses pain, hunger or thirst
- cognition – determine level of understanding, ability to read, level of education
- mental health – background information relating to supports required and any comorbidities
- medications and allergies
- assistive technology and special equipment needs – e.g. wheelchair, hoist and sling, communication device.

Any information gathered should be clearly documented in the PMR. See Appendix 2 for a prompt sheet.

Identifying communication needs and preferences

Hospital staff need to be able to communicate directly with the person and include them in any discussions about their care. This includes understanding their usual signs of pain or distress if they don't use words to communicate. The person may have a health passport or similar document that the service provider can give to hospital staff.

There are many important considerations for staff:

- Does the person require any adaptive equipment to support their communication? If yes, ensure it is bought in and accessible for the person. For example, a communication board/device, picture cards, hearing aids, adapted nurse call switch (i.e. head switch), eye gaze devices or hearing impairment identifier sign.
- Does the person have complex communication needs and therefore requires additional support during their inpatient stay from a support worker or communication partner? It may be reasonable to request a support worker to remain with the person during the admission to support effective communication with the person.
- Does the person have a health passport? If yes, request it from the service provider. When was it last updated? Ensure it is in-date and current to the person's needs. Ensure a copy of the passport is in the PMR and a summary is entered in the progress notes.
- Does the person require an Auslan or Tactile Signing interpreter? These services can be booked through the Language Services/Translation and Interpreting Services (TIS) at your site.

Any personal equipment or handover documentation brought from home should be documented in the PMR and clearly labelled to ensure it stays with the person throughout admission, regardless of any ward moves.

Communication boards

People with complex communication access needs may use their own communication boards or may be supported by using a medical signing board. Below are some examples that people can use if required.

Visit www.qld.gov.au/__data/assets/pdf_file/0028/58375/medical-signing-board.pdf for an example medical signing board.

Visit www.patientprovidercommunication.org/userfiles/file/1_1MedicalEncounterCommunicationBoard.pdf for an example pictorial medical encounter communication board.

Identifying environmental adaptations

Are there any environmental design aspects that need to be considered to improve the person's experience and functional capacity whilst they reside in hospital? This may include changes such as:

- moving to a room or area with a quieter environment
- providing a room with low lighting
- allowing space for equipment, for example, hoist, wheelchair or ventilator
- ensuring communication adaptations are in place and accessible, for example, is the head switch for the nurse call bell in the right spot, is the eye gaze technology set up, is the communication device plugged in and charged
- ensuring appropriate equipment is used to meet the person's care needs, for example, providing an air mattress for pressure care during admission if this is what they usually use at home.

Any information or recommendations should be clearly documented in the PMR.

Arranging specialised equipment needs

People may have specific assistive technology or equipment needs, and where appropriate should bring their own items with them from home to ensure continuity of care, function, and comfort. It is important to check if they use any specialised equipment at home. Examples include a wheelchair, ventilator, cough assist machine, communication device, limb prosthesis or splints. If they do use them, request the support network to arrange for these items to be transported to the hospital to be available to the person if they have not already done so.

Other standard equipment, such as air mattresses, commodes, shower chairs, and transfer equipment (e.g. hoists, Sara Stedy or gait aids) should be provided by the hospital for use during admission.

Personal equipment brought into the hospital for use during admission should be documented in the PMR and clearly labelled to ensure it stays with the person throughout admission, regardless of any ward moves. It is preferable that the personal items of equipment remain in the room with the person and not stored in the hospital corridor.

Identifying behavioural management strategies

The hospital setting presents new or unfamiliar environments, different staff and different routines, which may cause distress and be triggers for behavioural escalations or changes. It is important to establish:

- Does the person have a documented behaviour support plan that can be shared with hospital staff?
- Does the person have complex behaviours that will likely require additional support from a support worker during their inpatient stay?
- Does the person need constant monitoring to maintain safety?
- Is the person an absconding risk or do they present risks of harm to themselves or others if their behaviour escalates? If yes, what is the recommended management approach?

Any information gathered should be clearly documented in the PMR and available for all hospital staff. Copies of behaviour management plans should also be easily accessible to hospital staff in the bedside file.

Identifying needs relating to cognitive impairment

Does the person have a cognitive impairment? Does your hospital have a cognitive impairment identifier? If yes, place the cognitive impairment identifier above the person's bed.

Identifying supported decision-making strategies for consent

Hospital staff should always assume the person has capacity to provide consent unless information on guardianship is provided. Not all guardians can make health treatment decisions. An Enduring Guardian with authority or a Plenary Guardian may have this legal capacity.

People with disability have a right to make medical treatment decisions. The person should always be included in decision making in whatever capacity they can participate. Information about the person's ability to participate in decision making may be included on their Disability Health Profile form or health passport, if available.

Some people need to undertake a supported decision-making process with a nominated support person. This may be a family member, friend, legal guardian or support worker. Who this person is should be identified on admission to hospital and clearly documented in the PMR to ensure all hospital staff are aware of who to contact when providing information about the medical care plans or asking for consent to undertake interventions.

Ideally the person will have engaged in Advance Care Planning conversations and have an Advance Health Directive or a Values and Preferences Form. This will include choices about their health care and the name of the person they want to make decisions for them. If they do not have sufficient decision-making capacity, a substitute decision maker with capacity can complete an Advance Care Plan for them. This plan can be used to guide substitute decision makers and clinicians when making medical treatment decisions on behalf of the person.

Visit www.advancecareplanning.org.au/understand-advance-care-planning/health-professionals-roles-and-responsibilities for more information.

If the person does not have an Advance Health Directive or a guardian with authority, hospital staff will need to follow the decision makers list below. The decision maker becomes responsible for the person's health care decisions. The decision maker must be:

- 18 years of age or older
- of full legal capacity
- available
- willing to make the decision.

Decision maker's list:

Advance Health Directive (AHD)
Decisions must be made in accordance with the AHD unless circumstances have changed or could not have been foreseen by the decision maker.

Enduring guardian with authority

Guardian with authority

Spouse or de facto partner (e.g. husband or wife)

Adult son or daughter (over 18 years old)

Mother or father

Brother or sister

Primary unpaid caregiver

Other person with a close personal relationship

Visit www.wa.gov.au/organisation/department-of-justice/office-of-the-public-advocate/making-treatment-decisions-opa-information for information on urgent and non-urgent treatment decisions.

Case study

Samuel, a 43-year-old male, lives in his own unit in the southern suburbs of Perth and has Motor Neurone Disease. Samuel is supported daily by his mother, Janet, and a group of support workers he has known for years. Due to his disability, Samuel has recently commenced use of a Bilevel Positive Airway Pressure (BiPAP) machine at night to assist his breathing whilst sleeping. This was prescribed by a private respiratory consultant. He needs assistance of 2 people to move in bed, transfer via hoist and participate in his personal care activities. He mobilises independently in a customised power wheelchair during the day. Samuel has a mild cognitive impairment. When he requests, his mother supports him with complex decision making. She is not his formally appointed guardian.

Samuel presents to the emergency department via ambulance at 6:00 pm with a 3-day history of worsening shortness of breath, cough, fever and lethargy. He is accompanied by a support worker. This is Samuel's first presentation to the emergency department since he was commenced on BiPAP 6 months prior. Samuel is short of breath and has limited ability to communicate with doctors. He asks his support worker to provide a history to the hospital staff about his symptoms over the past few days. The support worker's shift finishes at 8:00 pm, so she phones Janet to let her know that Samuel is being admitted to hospital and goes home.

Samuel is unable to sleep overnight as he does not have his BiPAP machine and becomes very anxious. The hospital staff find a machine to use, however Samuel cannot remember his settings and both the machine and face mask are different to the one he uses at home. He feels claustrophobic and refuses to use it. Samuel is transferred from the emergency department to the ward at 5:00 am. He requires a 1:1 nurse to remain with him due to his breathing difficulties and anxiety. Janet arrives at 8:00 am to visit and discovers that Samuel has not slept all night and is very anxious. She arranges for a support worker to bring in Samuel's BiPAP machine and wheelchair. Samuel is setup with his BiPAP and instantly falls asleep. He remains asleep throughout the day, leaving his mother to have conversations about his medical care needs with the hospital staff and consent to treatment.

The next day Samuel reports that if the hospital staff had phoned his mother on the night of admission and arranged for the BiPAP to be brought in, he would have been able to sleep overnight and then participate in his health care decision-making the following day. Samuel, his mother and carers were unaware that the hospital did not have the same machine available that Samuel uses at home.

Samuel is discharged home 3 days later. A discharge summary is sent to his GP.

2 – Set expectations early

This section discusses the key actions required to ensure all stakeholders involved in the person's care are working collaboratively to support a successful discharge when medically ready to do so.

Key summary

To optimise the delivery of health care during the person's admission, consider the following:

- Arrange an early stakeholder case conference to set expectations around admission timeframes and outcomes and arrange a communication plan.
- Communicate the estimated length of stay clearly and regularly with stakeholders throughout the admission and notify them as soon as possible if there are any changes to the expected date of discharge.
- Establish a communication plan with the person and key stakeholders to ensure open and transparent information sharing regarding the person's health care needs.
- Discuss with the support network if it is appropriate and feasible to have a support worker in attendance during admission to facilitate communication or optimise behaviour support needs. If appropriate, arrange for a clear roster to be provided and shared with ward staff.

Booking an early stakeholder case conference

Once the person has been admitted to a ward, it is important to setup an early case conference with all stakeholders to discuss the:

- reason for admission
- goals of medical intervention
- anticipated length of admission
- additional supports required during the admission
- potential barriers to discharge that need to be problem-solved.

The treating team should nominate a key staff member to arrange this meeting and be the ongoing central point of contact at the hospital.

Discussing estimated length of stay

It is important to provide the person and their support network with an estimated length of stay and anticipated discharge date. This ensures all stakeholders have adequate time to prepare for the transition back home in a safe and supported way. While this date may be a rough estimate only, ensuring regular communication is established with the person and the support network will allow everyone to be prepared when the final discharge date is confirmed.

Determining frequency of communication

The anticipated length of stay will guide the frequency of communication required. If the person is anticipated to have a long hospital admission, it is recommended that hospital staff set up weekly or fortnightly discussions with the key support network delegates from the outset. These discussions are designed to provide updates regarding ongoing medical care and any changes to estimated length of stay. The discussions also provide the opportunity for early identification of potential discharge barriers and collaborative problem solving.

If the person has an anticipated short length of stay (less than one week), it may be appropriate to only set up an initial case conference on admission and provide direct handover on day of discharge as part of the standard discharge planning process (see below).

Arranging service provider attendance

It is important to identify early if a support worker is required to be present during admission to assist with either communication or behavioural management strategies to optimise the medical care delivered in the hospital environment. This will need to be negotiated with the service provider on an individual case by case basis.

Children of school age should be assisted to participate in ongoing education opportunities wherever possible and practical. This may be provided onsite in person, via virtual attendance, or involve transfer to school for periods of time during the day as negotiated on a case-by-case basis. Support workers can be accessed through negotiation with the service provider to facilitate any of these options.

Some people may be medically ready for discharge but unable to leave hospital due to homelessness and are waiting for suitable accommodation options to be identified to meet their individual needs. In this scenario, it may be appropriate for support workers to attend during the day to take the person out of hospital for social and community activities with the goal of maintaining their functional capacity in preparation to re-enter the community once suitable accommodation is confirmed. Even if a person is medically ready for discharge, disability support workers are unable to replace the care that should be provided in hospital, for example, nursing care, personal care, medication management, and allied health therapy intervention.

Case study

Julia is a 23-year-old woman with autism. She lives in a supported group home environment. Julia is supported by her sister, Susan, who is her formal guardian. She walks independently and participates in daily personal, domestic and community-based activities with supervision from support workers. Julia works part-time in supported employment, 6 hours per week. Julia requires support with her communication and can become easily overwhelmed in new environments or with new routines. In response to these situations, Julia can at times become physically aggressive towards others.

Julia presents to hospital accompanied by a support worker with 2-day history of acute and severe abdominal pain for investigation. Julia is groaning in lots of pain and is unable to communicate effectively with hospital staff. She is not letting hospital staff examine her. Her sister, Susan, is called in to assist with diagnosis and treatment planning. Julia is immediately calmer with her sister present, and hospital staff are able to diagnose her with appendicitis. Hospital staff inform Susan and the support worker that Julia requires surgery and is likely to be in hospital for 48 hours, but they will confirm postoperatively. Her support worker leaves, and Julia is taken to theatre. Susan provides hospital staff with a behaviour management plan and communication support tool to assist in their interactions with Julia. Julia is extremely distressed and her sister requests to accompany her to theatre until she is under anaesthetic.

While Julia is in theatre, Susan arranges a roster of carers between herself and the support workers to support Julia during the daytime throughout her admission. A copy is provided to nursing staff. Julia returns to the ward postoperatively and recovers well.

Julia is discharged home 2 days later without further complications. Her support worker team is ready to assist her transition home and continues to provide supports in her home environment.

3 – Understand hospital staff roles and responsibilities during admission

Hospital staff must always understand that the person and/or their nominated representative are the natural authorities of their own lives and have the right to be involved in decisions about their services and supports. It is the responsibility of hospital staff to include them in every step and decision point throughout the hospital admission.

Key summary

The health system has specific duties and responsibilities to the person during both the admission and following discharge:

- Provide diagnosis and treatment of all health conditions, regardless if acute or chronic, including recovery orientated services such as rehabilitation.
- Communicate regularly and effectively with the person and their support network in an ongoing manner throughout the period of healthcare provision.
- Determine if the person can consent or requires implementation of supported decision-making strategies.
- Understand the National Safety and Quality Health Services (NSQHS) standards and how they govern hospital staff's actions within the hospital setting. Visit www.safetyandquality.gov.au/standards/nsqhs-standards for more information.
- Implement recommended support strategies to optimise the delivery of health care during the admission, including communication tools, behavioural management strategies, cognitive impairment support strategies, environmental adaptations and supported decision-making strategies.
- Identify early if there are any potential barriers to discharge and commence early problem-solving strategies to prevent hospital admissions that are longer than medically necessary.
- Make an application to the NDIA for access (if the person in hospital does not already have an NDIS plan).
- Notify the NDIA that an existing participant is in hospital and has a change of functioning requiring an interim plan or plan variation to facilitate discharge. To notify the NDIA that a change of funded supports is required, email health.liaison.officer@ndis.gov.au as soon as possible.

Providing medical, nursing and allied health interventions

As outlined in the Applied Principles and Tables of Services (APTOS) agreement, the health system is responsible for the following:

- Diagnosis, early intervention and treatment of health conditions, including ongoing or chronic health conditions. This may involve GP services, medical specialist services, dental care, nursing, allied health services, preventive health care, care in public and private hospitals, and pharmaceuticals (available through the Pharmaceutical Benefits Scheme).
- Funding time limited, recovery-oriented services and therapies (rehabilitation) aimed primarily at restoring the person's health and improving the person's functioning after a recent medical or surgical treatment intervention. This includes where treatment and rehabilitation are required episodically.

For mental health services, the health system is responsible for:

- treatment of mental illness, including acute inpatient, ambulatory, rehabilitation/ recovery and early intervention, including clinical support for child and adolescent developmental needs
- residential care where the primary purpose is for time limited follow up linked to treatment or diversion from acute hospital treatment
- the operation of mental health facilities.

This means that hospital staff must meet all the healthcare needs of the person whilst they reside in a hospital setting. Supports related to complex communication needs or behavioural management assistance can be provided by the disability sector as they relate to the underlying disability, not the acute healthcare presentation.

The following resources are available to assist hospital staff to understand which sector is responsible for delivering supports and care as both inpatients and outpatients.

- **Applied Principles and Tables of Support (APTOS) agreement**
  This guideline outlines obligations of different government sectors to provide supports to people with disability. See Appendix 3 for a summary of the responsibilities of the health system.
- **Health vs Disability (NDIS) responsibilities for discharge**
  Developed using the APTOS agreement principles, this decision support tool is designed to assist clinicians to determine if the intervention required falls under the scope of the health system or disability (NDIS) sector. See Appendix 4 for a copy of the tool.

Delivering effective communication

When a person is admitted to hospital, it is the responsibility of all staff members to ensure early, frequent, and effective communication with the person and relevant stakeholders throughout admission and in preparation for discharge. This standard of care is facilitated by maintaining an up-to-date key contacts list in the PMR and/or bedside file and by following the agreed communication schedule. Where possible, the treating team should nominate a key staff member to be the central point of contact at the hospital for the person and their support network.

The following resources and guidelines are available to assist hospital staff to implement effective communication standards and processes throughout admission:

- **Caring for People with Disability**
  ww2.health.wa.gov.au/Articles/A_E/Disability-Health-Network
  A WA Health checklist for hospital staff to support communication and engagement with the person and their support network throughout admission (see Appendix 8 for a copy).
- **Health passport**
  For hospital staff to reference to understand the communication needs and preferences for the person during admission. See Appendix 9 for examples of health passports. It is preferable for the health passport to be completed by the person or their supports prior to admission.
- **NSQHS Standard: Communicating for safety**
  www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard
  This standard outlines the processes required to implement and maintain effective communication with patients, families, friends and carers throughout admission.
- **NSQHS Standard: Partnering with consumers**
  www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard
  This standard outlines the need for hospital staff to actively involve the person in their own care, meet the person's information needs and practice a shared decision-making process.

Any resources in use should be clearly documented in the PMR and included in any patient handover discussions. This will ensure all hospital staff interacting with the person are aware of and have access to relevant resources throughout admission.

When developing new hospital resources, consider using:

- 'Easy Read' formats for people with a cognitive impairment or limited literacy
- web-based information for people with visual impairments who use screen-readers
- alternative formats with all patient hand-outs.

Identifying potential discharge barriers

Through early communication with the person and their support network, clinicians should identify early if there are any potential barriers to discharge. Examples may include:

- accommodation breakdown or homelessness
- informal support network burnout
- lack of adequate funding to meet their new support needs. For example, new diabetes regime, new medication regime, wound management or post-operative orders that impact on mobility
- new carer training needs due to a change in health status. For example, stoma care, wound management or diabetes management
- additional equipment required in the home environment due to a change in their health status. For example, mobility or transfer equipment.

Issues identified should be escalated and actioned early as per the local hospital policy to prevent discharge delay wherever possible.

Implementing supported decision-making strategies

The person should always be included in decision making in whatever capacity they can participate. Some people need to undertake a supported decision-making process with a nominated support person. For example, this may be a family member, friend, legal guardian or support worker. A supported decision-making strategy is a process designed to facilitate the ability of the person to make their own decisions. If a supported decision-making strategy is used in practice for the person, this should be clearly documented in the PMR and included in any patient handover discussions.

Resources exist to support hospital staff to understand how supported decision-making processes can be used and implemented for a person with disability:

- People with Disability and Supported Decision Making and the NDIS
  www.nds.org.au/images/resources/National-SDM-Guide.pdf
- My life, my decision – A handbook for facilitators
  www.facs.nsw.gov.au/download?file=591371

Implementing behavioural management strategies

It is essential to provide additional supports to people who have complex behaviours because of their disability. Consideration when determining implementation strategies must be given to ensuring the least restrictive option is used with the primary goal of maintaining patient and staff safety and preventing harm. Hospital environments can be overwhelming as they are new or unfamiliar environments, there are many different staff and different routines. As a result, the environment itself may cause distress and be triggers for behavioural escalations or changes.

People who have complex behaviours as a result of their disability may already have a behavioural management plan or equivalent which can provide guidance to hospital staff on triggers, de-escalation strategies and safe interventions that are used successfully in the home environment. The needs of the person are highly individualised and should be assessed and implemented on a case-by-case basis.

Regardless of which strategies are implemented during the hospital admission, regular review of any strategies implemented should occur to:

- ensure the least restrictive option is being used
- minimise the use of the restrictive practice wherever possible
- wean the use of restrictive practices over time where safe to do so.

In preparing for discharge, it is important for hospital staff to understand that some practices used in the hospital environment are not able to be automatically transferred to the home environment. There are safeguarding rules in place to protect the individual in relation to restrictive practices.

Restrictive practices fall across 5 domains. These are:

- chemical
- physical
- environment
- mechanical
- seclusion.

There are significant consequences to the implementation of unauthorised use of restrictive practices in the community setting. The need for use of restrictive practices may present a barrier to discharge and hence needs to be discussed early with the service provider receiving the care of the person on discharge to ensure an appropriate safeguarding framework is in place at time of discharge. If the use of restrictive practices is authorised for discharge, it is important to discuss the strategies in use directly with the service providers and if required, provide training to facilitate the discharge.

The following resources and guidelines are available to support hospital staff to implement best-practice behaviour management strategies:

- NSQHS Standard: Comprehensive Care 5.30 – Preventing delirium and managing cognitive impairment
  www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm
  This standard ensures hospital staff collaborate with patients, carers and families to minimise any anxiety or distress whilst they reside in hospital.
- NSQHS Standard: Comprehensive Care 5.35 – Minimising restrictive practices
  www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm
  This standard outlines the need for hospitals to identify where restraint is clinically necessary to prevent harm, and to wherever possible, eliminate or reduce the use of restraint and restrictive practices in accordance with the legislation.

Implementing environmental adaptations

To optimise the delivery of health care to the person in the hospital environment, it is important to implement wherever possible, any adaptations that were identified at time of admission. This should be clearly documented in the PMR and included in any handover discussions between clinicians to ensure consistency of care.

Case study

David is a 62-year-old man with an acquired brain injury. David has lived in a supported group home environment for the past 15 years since the onset of his disability. David requires physical support from one person with all aspects of his daily routine, walks indoors with a frame, and requires support with his communication. David has frequent falls. He also becomes distressed when he is unable to communicate effectively with others or when his routine changes.

David was admitted to hospital following a fall at home and has a fractured leg. He is non-weight bearing for 8 weeks in a cast. As a result, he now requires assistance of 2 people for all transfers and a wheelchair for mobility. Following his surgery, the ward social worker contacts his disability service provider and case manager to arrange discharge home. She is told there is inadequate funding in his support plan to increase his supports from one person to 2 people for the next 8 weeks, and they do not have the newly recommended equipment, therefore he cannot be discharged. The service provider states they would be happy for David to return home following a period of rehabilitation when he has returned to his baseline level or earlier if additional funding and equipment can be arranged. The ward social worker informs the team of the barrier to discharge, and a stakeholder case conference is arranged to discuss David's discharge disposition.

At the case conference, the case manager agrees to submit a request for additional funding to assist with hospital discharge as the fall and subsequent leg fracture are a direct result of the mobility difficulties he has because of his disability. The stakeholders agree to meet weekly to share updates on progress and continue with discharge planning.

At the next meeting, the case manager informs the team that she requires supporting documentation from the medical, nursing and allied health staff about David's new functional support needs and what the long-term healthcare plan will be. The team agree to provide the reports. The allied health team identify that they can arrange outpatient rehabilitation services to improve David's mobility once he is allowed to weight bear again. The allied health staff also advise they can arrange the necessary temporary equipment (hoist and wheelchair) required to support David at home and conduct a home visit to ensure the equipment will be appropriate for his environment. They also offer to provide carer training prior to discharge.

The following week, the case manager confirms additional funding is now available to support David's discharge and a discharge date is set. Hospital staff arrange outpatient services, equipment and carer training as discussed and David is eventually discharged home 4 weeks after he was admitted to hospital.

4 – Understand service provider roles and responsibilities during admission

The person's key stakeholders may include a service provider. In some circumstances, they can provide additional supports during the admission to optimise the delivery of essential health care. Any services they do provide, cannot replace services that are usually expected to be delivered by hospital staff (for example, nursing assistance).

Key summary

Communicating and liaising with service providers through admission will optimise the delivery of essential health care during the hospital admission. With the consent of the person, there are many important actions to consider:

- Exchange the key contact details for the service provider and a key contact at the hospital early during the person's admission.
- Include a service provider representative in any stakeholder or discharge planning discussions.
- Request a service provider to be present to support the person during admission if the person has complex communication or behavioural difficulties as a result of their disability.
- Encourage the service provider to notify hospital staff early of any concerns regarding discharge planning and services that will be required to support the person on discharge from hospital.

Communication

To facilitate timely 2-way communication, hospital staff should provide the nominated service provider with a central point of contact within the hospital. For example, this may be the social worker, nurse unit manager or discharge coordinator.

A nominated service provider representative should be available to attend scheduled meetings at the hospital to discuss the ongoing needs of the person and ensure early discharge planning is commenced. Service providers should be able to provide hospital staff with information about the proposed discharge destination. For example, this may include environmental setup, care support model and equipment already available. Open communication between the service provider and the hospital staff will allow the service provider to undertake regular risk assessments regarding their capacity to safely support the person on discharge, especially if there are changes to the person's health condition and support needs on discharge. This ensures early problem-solving occurs for any potential barriers to discharge that may have been identified.

Service provider attendance

There are several scenarios where service providers are required to provide onsite support during the hospital admission. This would need to be negotiated with the service provider on a case-by-case basis. The service provider cannot provide staff to duplicate or replace hospital responsibilities (as outlined in section 3). However, they can attend for other reasons, such as to:

- provide additional support for people with complex behavioural or communication needs
- enable social / community access support to leave the hospital setting during the day whilst awaiting confirmation of accommodation options
- undertake carer training if the recommended support needs for discharge have changed from baseline
- participate in clinical handover with hospital staff to support medical needs of the person on discharge, such as wound care or diabetes management plan
- attend a case conference to discuss discharge planning.

Identifying potential discharge barriers

Establishing early communication lines between the service provider and hospital staff will enable service providers to notify hospital staff early if they have concerns around their capacity to safely meet the support needs of the person on discharge. Service providers should not wait until the day of discharge to notify hospital staff that they are unable to implement the discharge plan.

Hospital staff may identify that a home environment assessment is required if there have been changes to the person's functional ability. Service providers should be notified of this need and be able to accommodate the request in a reasonable timeframe. The home assessment is generally conducted by hospital staff to ensure the environment is safe for discharge. Any longer-term changes or recommendations should be followed up by the disability community support team.

5 – Collaborative discharge planning

Key summary

To optimise the discharge planning process, consider the following:

- Establish the discharge plan early and communicate the plan with the person and key stakeholders.
- Ensure any essential follow up care is arranged prior to discharge, for example GP appointments, outpatient appointments and referrals to Rehabilitation in the Home (RITH).
- Ensure any new equipment needs have been arranged and provided to the person prior to discharge.
- Complete all relevant documentation and ensure they are provided to the person and key stakeholders at time of discharge to prevent any miscommunication. For example, the medical discharge summary, nursing transfer summary, wound management plan and updated medication list.
- Provide a comprehensive verbal and written handover to the key stakeholders at time of discharge to ensure continuity of care and supports.
- Ensure transport has been arranged to assist the person to leave hospital and return home on the day of discharge.

Coordinating the discharge plan

The discharge plan should be established and communicated to the person and relevant support network as early as possible to enable a smooth and coordinated discharge process. The following information should be shared:

- Date of discharge.
- Time of discharge.
- Transport arrangements.
- Any carer training requirements prior to discharge. For example, if there are new health support needs or a new piece of equipment has been recommended to support functional capacity.

Arranging follow up care

A comprehensive discharge plan should be provided to the person or their nominated representative, and with their consent, handover to their service provider and key support network contacts. It is important to ensure all necessary referrals are made to support the person to return home and manage their recovery from their health condition in the community. Health system supports should sit alongside the regular disability supports.

The handover should include:

- **Medical appointments**
  The medical discharge summary should outline the medical assessment and intervention provided during the hospital admission and detail any follow up appointments required in an outpatient clinic or with the GP. Wherever possible these should be scheduled prior to discharge from hospital. This may also include information about home visiting services that have been arranged, for example, Hospital in the Home (HITH) and Rehabilitation in the Home (RITH).
- **GP appointment**
  If the person needs to attend an appointment with their GP following their hospital discharge, ensure this is clearly communicated to the person and their support network. If appropriate, it may help to book this appointment prior to discharge.
- **Equipment**
  If new equipment is required to support the person in their home environment as result of a deterioration of physical function during their hospital admission, this should be arranged by the hospital staff prior to discharge. Details of equipment hired or loaned should be provided to the person and their support network to ensure follow up and replacement if required in the longer term. This temporary equipment may be arranged through external funding providers such as the NDIS or Insurance Commission of Western Australia (ICWA) if applicable and appropriate.
- **Support workers**
  If the person has additional direct support needs following a deterioration of function during the hospital admission, the hospital staff and support network should have problem-solved how this would be delivered prior to the discharge date. Ensure any plans that have been arranged are clearly documented and handed over at time of discharge. Additional carer training may be required prior to discharge.
- **Medication**
  If the person has commenced new medication and is discharged on a weekend or after-hours, ensure they have an adequate supply of the new medication to facilitate a safe discharge until they can have their script filled in the community.
- **Other concessions and supports**
  The person may be eligible for additional support in the community. Appendix 10 has information listed regarding a range of concessions and supports available to people with disability, which may be of use post discharge.

Completing necessary documentation

Comprehensive documentation is required at time of discharge. This documentation should be provided to the person or their nominated representative, their GP, and with the person's consent, to their service provider or other members of the support network. This will ensure continuity of safe care in the community. The following documentation is recommended:

- **Medical discharge summary**
  Including details of any outpatient medical appointments or appointments scheduled with the GP.
- **Nursing transfer letter**
  If returning to a supported living environment, a transfer letter should be completed that provides information on current functional support needs at time of discharge. It is also important to outline what to monitor post discharge and when to bring the person back to hospital and/or call an ambulance (for example, in the event of elevated temperature, reduction in oxygen saturation levels or high respiratory rate, bring the person back to the emergency department).
- **Wound care plan**
  If applicable, providing a clear handover of current wound management plan and associated care support needs at time of discharge.
- **Outpatient referrals plan**
  The medical discharge summary should include clear and detailed information about any referrals that have been made (including key contact details) to support the person post discharge. For example, HITH, RITH, Silver Chain, Complex Needs Community Team (CoNeCT), NDIS, palliative care and CMHT.
- **Medication list**
  If there have been any changes made to the medication profile during hospital admission, an updated medication list should be provided at time of discharge.
- **Any other resources developed during hospital stay**
  For example, health passport, Disability Health Profile form or behaviour management plan.

Providing comprehensive handover

Best practice care includes a verbal and written handover to be provided by hospital staff to the corresponding community teams. With the consent of the person, this should include the nominated support network contacts and care service providers. For example, their disability service provider, support coordinator or case manager, GP, HITH and RITH.

The following information should be included in the handover:

- Copies of any documentation provided (as listed above).
- Information about the medical care provided during admission, the outcomes and recommendations following discharge, including what to monitor post discharge.
- Identification of any new health issues requiring management in the community setting.
- Any changes to mobility aids or transfer equipment to be used in the community setting.
- Any medication changes made during the hospital admission and reason for the changes.

Arranging transport

Transport plans for discharge should be arranged in advance of the discharge day. Hospital staff should request that a member of the support network arranges to collect the person from hospital at the agreed date and time. If this is unable to be facilitated, the hospital staff should ensure safe travel arrangements are made to facilitate the discharge as planned.

Case study

Jane is a 58-year-old woman with a newly acquired disability. She was admitted to hospital 5 months ago following a stroke that resulted in a severe, permanent brain injury. Jane has completed her rehabilitation and is now in the process of discharge planning. Jane's disability means she is unable to return home. Jane's hospital team have successfully applied for the NDIS and her first plan has now been finalised to support her discharge from hospital to a supported living environment. Her support coordinator has found a suitable accommodation and service provider to support Jane to discharge from hospital to the community. Jane's hospital admission was complicated by a pressure injury to her sacrum that is now healing well.

A discharge planning meeting is conducted with Jane, the support coordinator, a service provider representative, Jane's sister (who is her legal guardian), and representatives from her rehabilitation therapy team. It is identified that several actions from the key stakeholders are required to support Jane's discharge. A tentative discharge date is agreed for 3 weeks' time.

The support coordinator/service provider responsibilities:

- Service provider to ensure adequate staffing available to meet Jane's support needs across the day and confirm availability to meet the scheduled discharge date.
- Support workers will require training to understand how to transfer Jane with the hoist, and available days are to be communicated with hospital staff to arrange training.
- Ensure there is a nurse on staff who can support the management of Jane's sacral pressure injury and oversee her continence management plan.
- Arrange consumables for her continence and wound care through her funding plan.

The hospital responsibilities:

- If required, arrange for temporary equipment to support transfers and mobility including a hoist and wheelchair until permanent equipment can be arranged in the community. This temporary equipment may be arranged through external funding providers such as NDIS or ICWA where appropriate.
- Provide ambulance transport to take her from hospital to the new accommodation facility as Jane cannot transfer into a car.

- Arrange a GP appointment within 3 days of leaving hospital and arrange for her medication scripts to be sent to her new local pharmacy.
- Refer to the neurology outpatient clinic for stroke follow up.
- Refer to ongoing community-based rehabilitation services such RITH and outpatient rehabilitation services.
- Provide documentation to Jane's guardian and service provider, including a medical discharge summary, nursing transfer summary, medication list and wound management plan.
- Provide verbal handover to service provider representative of Jane's functional support needs and nursing care needs.

The following is all arranged within the 3-week time window and Jane is successfully discharged on the planned discharge date. The discharge day is a Monday so that she can visit her GP and pharmacy during the week to ensure continuity of healthcare delivery in the community setting.

Resources

- Easy Read versions of the Hospital Stay Guidelines – A guide for people with disability, families, friends and carers
  www.healthywa.wa.gov.au/Articles/A_E/Disability
- People with Disability and Supported Decision Making and the NDIS
  www.nds.org.au/images/resources/National-SDM-Guide.pdf
- My life, my decision – A handbook for facilitators
  www.facs.nsw.gov.au/download?file=591371
- Easy Read decision maker's list
  www.wa.gov.au/organisation/department-of-justice/office-of-the-public-advocate/making-treatment-decisions-opa-information
- 2016 Hospital Stay Guideline for Hospitals and Disability Service Organisations
  ww2.health.wa.gov.au/Articles/A_E/Disability-Health-Network
- APTOS agreement – Principles to determine the responsibilities of the NDIS and other service systems
  www.dss.gov.au/the-applied-principles-and-tables-of-support-to-determine-responsibilities-ndis-and-other-service
- NSW Health – Responding to the needs of people with disability during hospitalisation
  www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2017_001
- NSQHS standard: Comprehensive Care Action 5.30 – Preventing delirium and managing cognitive impairment
  www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm
- NSQHS standard: Comprehensive Care Action 5.35 – Minimising restrictive practices: restraint
  www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm
- NSQHS standard: Communicating for safety standard
  www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard
- NSQHS standard: Partnering with consumers standard
  www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard
- NDIS consent forms
  www.ndis.gov.au/about-us/policies/access-information/consent-forms
- WA Department of Health – Caring for people with disability
  ww2.health.wa.gov.au/Articles/A_E/Disability-Health-Network

Glossary

Access card: A card that contains important information about the person, their medical needs and contact details.

Assistive technology: Any products, equipment, aids and systems that enhance learning, working, and daily living for persons with disabilities.

Autism Alert Card: A card that that lets emergency services know the person has autism contains important information about the person and contact details.

Carer: Friends or family who support the person with disability. Carers are people who provide support that is unpaid and not part of a paid work or community work arrangement.

Communication partner: A person who provides communication support. Communication partners may include family, friends, carers and trained disability service workers.

Community participation: The process of assisting the person with disability to participate in the community.

Disability-related health supports: Supports relating to the functional impact of a person's disability, such as respiratory and nutritional supports and podiatry.

Disability service organisation: An organisation that provides support for daily living, support coordination for community participation, therapy services and disability-related health supports.

Disability service provider: A person, business or organisation who delivers disability services. These include support workers, support coordinators and therapists.

Disability supports: Personal assistance and equipment to help a person with disability with their daily living, participate in their community and reach their goals.

Easy Read: Clear, everyday language matched with images. People who use Easy Read may include people with learning or developmental disability, people with low literacy levels and people with English as a second language.

Family: A person or persons who provide support to a family member with disability.

Guardian: A person appointed by the State Administrative Tribunal, under the *Guardianship and Administration Act 1990*, to make decisions for a person with limited decision-making ability. There are different types of Guardianship.

Health passport: A document used to outline how an individual wants people to communicate with them and support them when using health and disability services.

Informal support: Another name for an unpaid family member, friend or carer.

NDIA: National Disability Insurance Agency, this is the agency that administers the NDIS.

NDIS: National Disability Insurance Scheme. The NDIS provide funding for people with disability to access support they need in the community.

NDIS Quality and Safeguards Commission: Provides registered NDIS services providers with information and education. The Commission has regulatory powers for ensuring high quality supports in a safe environment.

Support coordinator: A person funded through an NDIS participant's plan. Their role is to coordinate services and assist the person to build their informal support networks.

Supported accommodation: In-home support for people with high support needs. Examples include supported independent living and specialist disability accommodation.

Support worker: A person employed or otherwise engaged to provide disability supports and services for people with disability.

Therapy: A range of therapeutic services such as physiotherapy, occupational therapy and speech pathology.

Appendices

Appendix 1: Disability Health Profile form

EMR317250

Please use I.D. label or block print

DISABILITY HEALTH PROFILE (ADMISSION INFORMATION)

CLINIC _____

CLINICIAN _____

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

Admission Date		**NDIS Number**	
Reason for person attending hospital		NDIS Plan in place: ☐ Yes ☐ No NDIS Plan nominee: ☐ Yes ☐ No	Date of next plan review:
NOK aware of admission	☐ Yes ☐ No	**Support coordinator** Contact details:	
Name of NOK		**Service Provider/s:** *Request copy of care plan for the file*	
NOK Phone			
Is the individual able to make decisions independently? ☐ Yes ☐ No *If no, who supports them with decision making? Complete below:* ☐ Enduring Power of Attorney ☐ Enduring Power of Guardianship ☐ Administration Order ☐ Guardianship Order ☐ SAT in progress Hearing date *(if known):* _____ Other: _____		**Funding source**	☐ NDIS ☐ MyAgedCare ☐ ICWA ☐ Worker's Compensation ☐ CAEP ☐ Other _____
Primary Language		**Interpreter required?**	☐ Yes ☐ No
Residential Status	☐ Own home ☐ Private rental ☐ Public rental ☐ Other: _____ ☐ Lives alone ☐ Lives with others ☐ Formal supports (paid) ☐ Informal supports (unpaid) Details:		
Disability/s	☐ Physical ☐ Sensory ☐ Neurological ☐ Neurodivergent ☐ Intellectual ☐ Developmental ☐ Psychosocial Specify:		
Behaviour/s of Concern		**Positive Behaviour Support Plan** in place:	☐ Yes ☐ No *(if yes, request copy for file)* If yes, PBS practitioner details:
Cognition	Cognitive Impairment: ☐ Yes ☐ No Comments:		
Mental Health	Risk Assessment and Management Plan (RAMP) ☐ Yes ☐ No Treatment Support and Discharge Plan ☐ Yes ☐ No		
Communication	☐ Independent ☐ Assisted If assisted, details:		
Specialised Equipment		**Environmental Requirements** (Eg lighting, noise control and/or other)	

	Independent (tick)	Assisted (tick)	Comments (note level of assistance required and equipment needs)
Mobility			
Personal Care			
Toileting			
Eating / Drinking			

	Continent	Incontinent	Comments (note any equipment / consumables required)
Bladder			
Bowel			

Signature	Name	Designation	Phone / Pager	Date

DO NOT WRITE IN MARGIN

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MR267 DISABILITY HEALTH PROFILE (ADMISSION INFORMATION)

Page 1 of 1

Appendix 2: Checklist for staff – Background information screening questions

- ☐ Who is in the person's support network? What are their contact details?
  - ☐ Family member or friend .....
  - ☐ Legal guardian .....
  - ☐ Service provider .....
  - ☐ Support coordinator/case manager .....
  - ☐ General Practitioner (GP) .....
  - ☐ NDIS planner .....
  - ☐ School .....
  - ☐ Department of Communities case worker .....
  - ☐ Community Mental Health Team (CMHT) representative .....
  - ☐ Child Protection and Family Support (CPFS) case worker .....
- ☐ How much assistance does the person need to complete personal care activities? Is there any special equipment required?

  .....

  .....
- ☐ How much assistance does the person need with eating and drinking? Is there any special equipment needed?

  .....

  .....
- ☐ Does the person need a modified diet? Are they at risk of aspiration? Do they have any food allergies or preferences?

  .....

  .....
- ☐ How much assistance does the person need with transfers and mobility? Is there any special equipment required such as a wheelchair or hoist? Do they have a falls history?

  .....

  .....

- [ ] Does the person have a behaviour support plan? Are there identified triggers/relievers for staff to be aware of? Does the person require a support worker to remain in attendance to assist with behaviour management or emotional regulation?

- [ ] How does the person communicate? Does the person have a health passport? Do they have any special equipment needs to assist their communication? Do they require a support worker to remain in attendance to assist with communication?

- [ ] Is the person's cognition impairment because of their disability? What is their level of understanding? Do they require additional assistance because of their cognitive impairment?

- [ ] What medications does the person usually take?

- [ ] Does the person have any allergies?

Appendix 3: Principles to determine the responsibilities of the NDIS and other service providers

The Applied Principles and Tables of Service (APTOS) guideline outlines obligations of different government sectors to provide supports to people with disabilities. The outline covers the intersection of disability supports across 11 key areas:

1. Health
2. Mental health
3. Early childhood development
4. Child protection and family support
5. School education
6. Higher education and Vocational Education and Training (VET)
7. Employment
8. Housing and community infrastructure
9. Transport
10. Justice
11. Aged care

Visit www.dss.gov.au/the-applied-principles-and-tables-of-support-to-determine-responsibilities-ndis-and-other-service to view the full document.

The interactions of the NDIS with other service systems will reinforce the obligations of other service delivery systems to improve the lives of people with disability, in line with the National Disability Strategy.

Health and Disability Supports Summary

The health system is responsible for:

- Diagnosis, early intervention and treatment of health conditions, including ongoing or chronic health conditions. This may involve general practitioner services, medical specialist services, dental care, nursing, allied health services, preventive health care, care in public and private hospitals, and pharmaceuticals (available through the Pharmaceutical Benefits Scheme (PBS)).
- Funding time limited, recovery-oriented services and therapies (rehabilitation) aimed primarily at restoring the person's health and improving the person's functioning after a recent medical or surgical treatment intervention. This includes where treatment and rehabilitation are required episodically.

In relation to mental health services, the health system is responsible for:

- Treatment of mental illness, including acute inpatient, ambulatory, rehabilitation/ recovery and early intervention, including clinical support for child and adolescent developmental needs;
- Residential care where the primary purpose is for time limited follow up linked to treatment or diversion from acute hospital treatment; and
- The operation of mental health facilities.

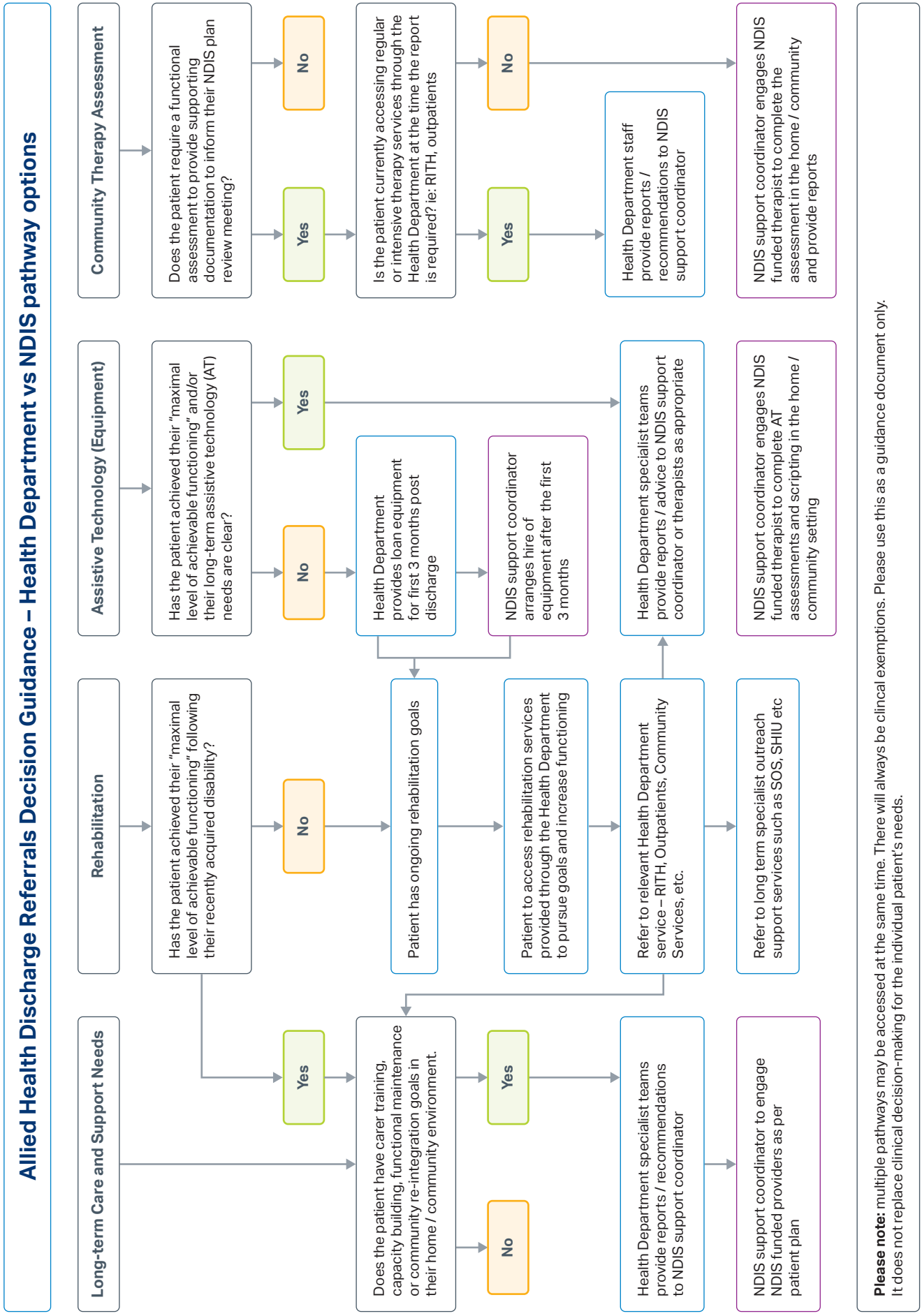
The disability sector (NDIS) is responsible for:

- Supports required due to the impact of a person's impairment/s on their functional capacity and their ability to undertake activities of daily living. This includes "maintenance" supports delivered or supervised by clinically trained or qualified health professionals.
- Ongoing psychosocial recovery supports that focus on a person's functional ability, including those that enable people with mental illness or a psychiatric condition to undertake activities of daily living and participate in the community and in social and economic life. This may also include provision of family and carer supports to support them in their carer role, and family therapy, as they may facilitate the person's ability to participate in the community and in social and economic life.

Visit www.ndis.gov.au/about-us/operational-guidelines/planning-operational-guideline/planning-operational-guideline-appendix-1-table-guidance-whether-support-most-appropriately-funded-ndis for a more detailed comparison of supports provided by NDIS and health/mental health services, including where supports are delivered collaboratively.

See Appendix 4 for a decision support tree to assist in determining which supports are best delivered by which sector.

Appendix 4: Health vs NDIS responsibilities for discharge – Decision support tool



Appendix 5: NDIS community referral pathway – Guidance for staff

If the Multidisciplinary Team (MDT) identifies that the patient is likely to be eligible but does not require staff to action NDIS processes for a safe and/or sustainable discharge from hospital, you may wish to consider the following options. As per standard practice, the MDT should consider these options alongside their usual clinical reasoning processes when discharge planning.

	General Practitioner (GP)	Local Area Coordinator (LAC)	Disability Advocate	RITH	CoNeCT
Service	GPs can support patients with NDIS documentation. The NDIS has developed a resource guide to assist GPs with these processes which can be found here. If after hours functional assessments are required, the GP can access these through the Medicare funded Chronic Disease Management Plan.	NDIS funds APM, Mission Australia and Wanslea as their LAC Partners. A LAC can be the patient's main contact for the NDIS in the community. They can help a person with a disability to understand the NDIS, proceed through planning and make the most of their funding.	A disability advocate's role is to speak, act and write on behalf of a disadvantaged person or group to promote, protect and defend their welfare and justice. This often includes assistance with NDIS related processes.	Rehabilitation in the Home (RITH) provides short to medium term hospital substitution allied health therapy for patients at home. The service aims to facilitate early supported discharge from hospitals or avoidance of hospital admission for patients. This service may include supporting the patient with NDIS processes.	CoNeCT provides care coordination to patients who are at risk of further hospitalisation. This may include support with NDIS processes.
When to Use	• Always, as the treating professional, GPs often need to assist with signing the Access Request Form (ARF) and documenting the medical disability/ diagnosis.	• For patients who require assistance to coordinate the application process. • Socially isolated patients who may struggle obtaining necessary information or follow up processes.	• CALD, ATSI or ESL. • Patients who lack informal supports or who may be socially isolated. • Patients who may be reluctant/ unable to actively follow up processes.	• Patients who have informal supports that can facilitate an early discharge enabling NDIS processes to continue in the community.	• Patients at significant risk of hospital readmission. • Patients who may need support engaging a GP, LAC or advocate.
Required Action	• Print out a copy of the required document (i.e. ARF) and provide it to the patient so it can be given to their GP at their next appointment. • Document what support is needed from the GP within the NACS discharge summary.	• Provide the patient or their representative with contact details for their LAC. Full list of contacts can be found here. • Consider sending a handover to the relevant LAC to advise what support is required.	• Refer the patient to their local disability advocate. • Patients can find an independent advocate in their area here.	• Refer to RITH using standard e-referral and handover processes. • Include details of what actions the patient requires assistance with, for example, access, planning or plan implementation.	• Refer to CoNeCT using standard e- referral and handover processes. • To discuss referrals phone 0404 890 092.

Note: This document is for staff use only, not for distribution to patients and/or families.

Appendix 6: NDIS quick guide

National Disability Insurance Scheme (NDIS) Quick guide on how to get started

Patient Handout

 **NDIS**	• Phone 1800 800 110 and ask for an Access Request Form. • Visit www.ndis.gov.au to download it from the NDIS website. • Filling out the Access Request Form tells NDIS how your disability affects you day to day and what help you need
 **General Practitioner (GP)**	• Book a long appointment with your GP. • Take with you: - Your Access Request Form - Information about how your disability affects you day to day - Copies of recent assessments or reports. • If you haven't been assessed by a therapist, your GP can help you organise this.
 **Local Area Coordinator (LAC)**	• LACs help you understand the NDIS and submit your application. • Go to the NDIS website to find out who your LAC is. • WA LAC contacts include: - APM – 1300 276 522 - Mission Australia – 1800 370 776 - Wanslea – 1300 969 645
 **Disability Advocate**	• A disability advocate can also help you with your application. • Visit askizzy.org.au/disability-advocacy-finder to find your local disability advocate by typing in your postcode.

Appendix 7: Discharge planner

Place patient label here

My WA health system services for discharge

	First Appointment	Location/Contact Details
Rehabilitation in the Home (RITH) ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Pathology ☐ Dietetics ☐ Social Work ☐ Medical	You will be contacted by the RITH team the first day after you leave hospital.	Phone: 08 9431 3898
Outpatient Therapy Services ☐ Physiotherapy ☐ Occupational Therapy ☐ Speech Pathology ☐ Other		
Outpatient Medical Appointments ☐ Rehabilitation Consultant ☐ GP		
Other Services and Referrals ☐ Interim Hospital Package (IHP) ☐ State Head Injury Unit (SHIU) ☐ Spinal Outreach Service (SOS)		

My National Disability Insurance Scheme service supports for discharge

Provider	Contact Person	Contact Details
NDIS Planner ☐ NDIA ☐ Mission Australia ☐ APM		Phone: Email:
Support Coordinator:		Phone: Email:
Service Provider:		Phone: Email:

My NDIS Journey Checklist:

Tick

- ☐ I have received information about the NDIS
- ☐ I have submitted my NDIS Access Request Form
- ☐ I have confirmation that I am now an NDIS participant and my number is:
- ☐ I have a date and time booked for my planning meeting:
- ☐ I have information to provide at my planning meeting about my current functional abilities, my goals and my support needs
- ☐ I have completed my planning meeting
- ☐ My plan has been approved on:
- ☐ I have chosen my service providers
- ☐ I have chosen my support or specialist support coordinator (if funded)
- ☐ My support needs have changed. NDIS have / have not been notified of the need for a review.

Appendix 8: Caring for people with disability

COVID-19

Government of **Western Australia**
Department of **Health**

Caring for people with disability

Clinicians – do you see me?

Remember, I am someone's son or daughter, parent, partner, work colleague or friend.

I matter… My life matters…

People with disability are vulnerable

COVID-19 may present particular risks for people with disability because they may have:

- difficulty practicing hand hygiene
- physical barriers to accessing hygiene facilities
- difficulty performing social distancing because they may need assistance from others and may live in residential settings such as group homes
- the need to touch objects or others, or be touched by others to perform every day activities
- difficulty understanding information or managing change
- co-existing health conditions, and complex comorbidities.

Ways you can help me – a checklist from a person with disability

Communication

- ☐ Find out about how I communicate (e.g. whether I use signs, a book, or a device).
- ☐ Consider whether using pictures or objects may help me understand you better.
- ☐ Talk directly to me, not my supporter.
- ☐ Listen to me – make the time.
- ☐ Know what's normal for me.

Information and decision-making

- ☐ Check whether I have understood when you give me information.
- ☐ Use Easy Read material where possible, this might help my support people too.
- ☐ Include me in decision-making, with support if I need it.
- ☐ Access MyHealthRecord to make sure you have all my information.
- ☐ Ask for information about me from the people who know me best.

Support networks

- ☐ Acknowledge my supporters as a valuable resource.
- ☐ Identify whether my family and carers are a critical part of my support.
- ☐ Identify who else can provide support if needed.
- ☐ Identify a key contact person.
- ☐ Provide my key contact person with information and support about me as things change.

Discharging me from hospital

- ☐ Ensure the supports I need are in place before you discharge me.
- ☐ Ensure I have a written plan and that my support people have a copy.
- ☐ Provide a handover to my GP and disability service provider.
- ☐ Ensure my supporters and I know what to do if I need emergency help.

Further information

Department of Social Services
dss.gov.au/disability-and-carers/information-and-referrals-for-people-with-disability-and-their-supporters-about-coronavirus-covid-19

Department of Health – Health providers
health.wa.gov.au/Coronavirus

Department of Health – General public
healthywa.wa.gov.au

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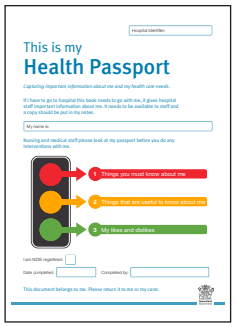
health.wa.gov.au

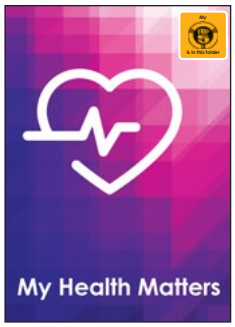
Appendix 9: Health passports

Below are links to examples of health and hospital passports.



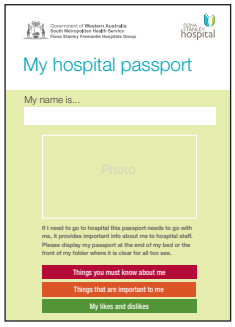
Julian's Key

www.health.qld.gov.au/public-health/groups/disability



My Health Matters (The Council for Intellectual Disability)

cid.org.au/resource/my-health-matters-folder

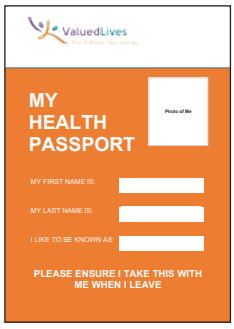


Fiona Stanley Hospital

ddwa.org.au/wp-content/uploads/2021/08/FSH-Paediatric-Passport.pdf

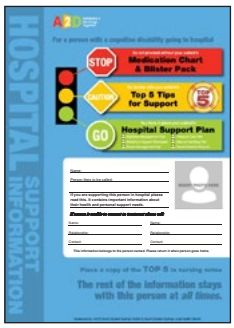
Developmental Disability WA

ddwa.org.au/support-info/health



Valued Lives

valuedlives.org.au/resources



Admission2Discharge

a2d.healthcare/resources

Kiind Emergency Care Plan

Visit www.kiind.com.au/learn/support-for-carers/ for more information.

Appendix 10: Concessions and support

Below are links to information on concessions and supports that may be available for the person on discharge.

ACROD parking permit

For people with mobility and sensory restrictions. This permit allows the holder of the permit (or their driver) to park in an ACROD Parking Bay. Visit www.acrod.org.au/eligibility for more information.

Companion card

For people who require support to get around the community. Where the companion card is accepted, the holder of the card will receive a second ticket for a companion or support person at no extra charge. Companion cards are accepted at many venues including the cinema, leisure centres, sporting and music events, theatres and museums. Visit www.wacompanioncard.org.au/apply-now for more information.

Thermoregulatory Dysfunction Energy Subsidy

Concession card holders with thermoregulation disability may be eligible for support towards the costs of heating and cooling their home. Visit www.wa.gov.au/government/publications/subsidies-thermoregulatory-dysfunction-fs for more information.

Life Support Equipment Electricity Subsidy Scheme

Concession card holders who use life support equipment at home may be eligible for support towards their electricity costs. Visit www.wa.gov.au/government/publications/subsidies-life-support-fs for more information.

National Disability Insurance Scheme (NDIS)

NDIS participants may need to update their plan if their support needs have changed. If the person you support does not have an NDIS plan, but you think they may be eligible, you can phone (with their consent) 1800 800 110 or visit www.ndis.gov.au to find out more information. The hospital may be able to provide supporting information for an NDIS Access Request Form.

Better Access initiative

The Better Access initiative gives Medicare rebates to people living with a diagnosed mental health condition. This includes many conditions, such as depression and anxiety.

Support is available from eligible GPs and other medical practitioners, psychologists, social workers and occupational therapists.

Eligible people can receive up to 10 individual and up to 10 group allied mental health services each year. Visit www.health.gov.au/initiatives-and-programs/better-access-initiative#learn-more for more information.

Support for Seniors

The Disability Support for Older Australians program supports people over the age of 65.

Visit www.health.gov.au/initiatives-and-programs/disability-support-for-older-australians-dsoa-program for more information.

Visit www.myagedcare.gov.au for information on other services available for seniors visit.

Support for carers

Carers WA is the peak body that represents the needs and interests of carers in Western Australia. Carers WA supports carers through the Carer Gateway and other programs.

The Carer Gateway provides a mix of free online, telephone and in-person supports, services and advice, for informal carers in Australia. These services help to reduce stress and build resilience in the caring role.

Call Carers WA on 1800 422 737 or visit www.carerswa.asn.au/our-services/carer-gateway-services for more information.

Closing the Gap

Closing the Gap is a plan to reduce disadvantage among Aboriginal and Torres Strait Islander people. If the person is Aboriginal or Torres Strait Islander, they may be able to get cheaper healthcare services and medications. They can speak with their GP about it.

Visit www.pbs.gov.au/info/publication/factsheets/closing-the-gap-pbs-co-payment-measure and www.servicesaustralia.gov.au/aboriginal-and-torres-strait-islander-health-assessments-and-follow-up-services?context=20 for more information.

Notes

This document can be made available in alternative formats.

Produced by the Health Networks

HEN-014296C SEP'23