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

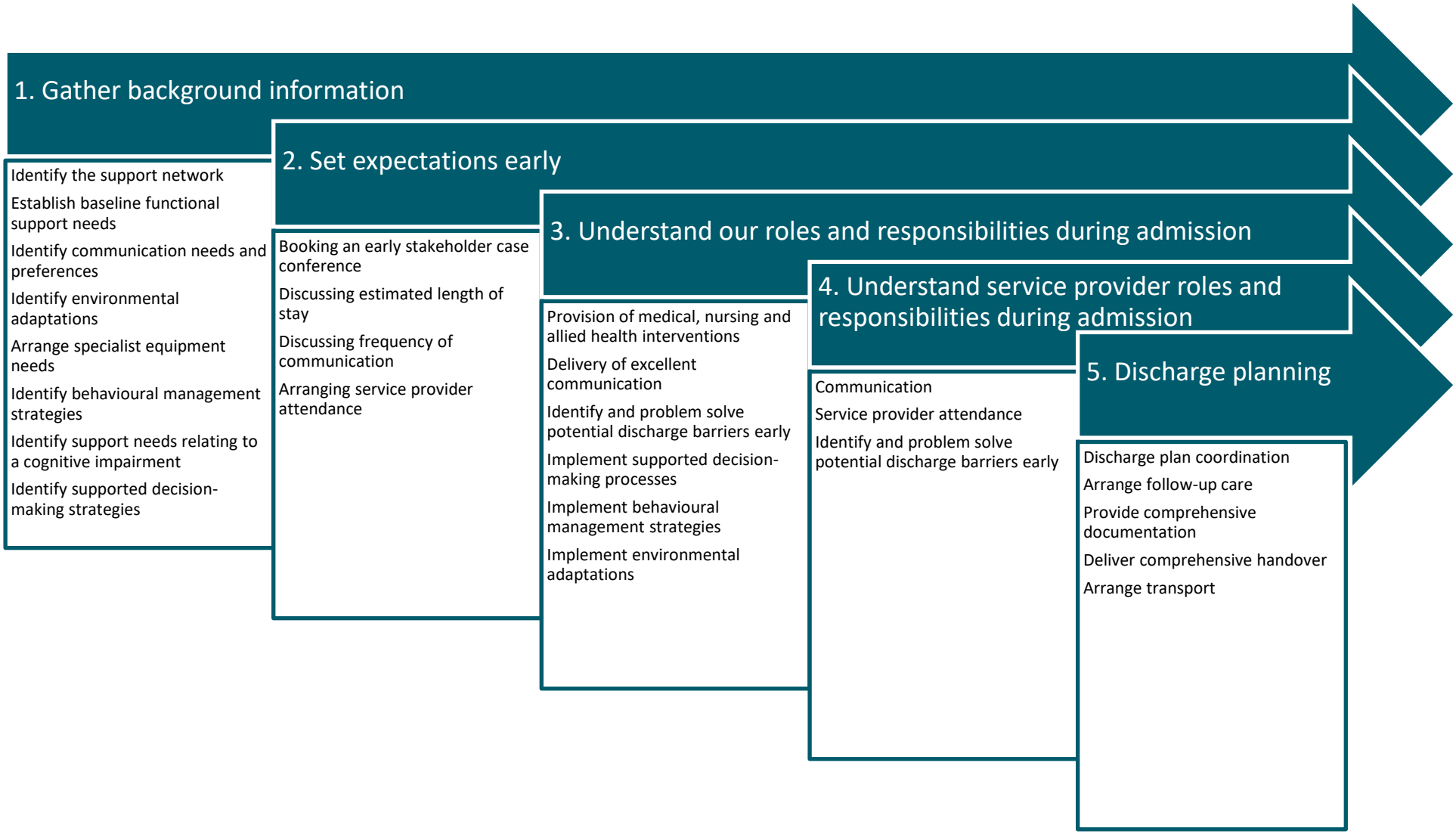
Hospital Stay Guidelines: Part 3

A guide for hospital staff

health.wa.gov.au

Contents

Supporting the Individual during their Hospital Admission – Process Flowchart



Overview:

All WA Health staff and facilities should provide services for people with disabilities that are inclusive, person centred, respectful and accessible. This guideline provides information for hospital staff on ways to support a patient with complex support needs as a result of their disability during their hospital admission in both the emergency department and ward environments.

1: Gather background information

On admission to hospital, it is important to gather as much information at handover about who the patient is, what support needs they have, and who the key contacts in their support network are. This information may be gathered from the individual or their nominated representative. This section includes an overview of the types of information required to best support the individual throughout the hospital admission.

Key Summary

To optimise the delivery of healthcare during the patient'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 patient 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 patient during their admission.
- Ask if the patient has a behaviour management plan and get a copy if they do. Ask a support person to stay with the patient if required to prevent or minimise behaviour escalation.
- Identify if the patient 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 patient medical record if relevant

Identifying the Support Network

It is important to establish if the patient has an essential support network that will assist them during their hospital admission. With the consent of the patient, 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 patient's hospitalisation only with the consent of the patient or their formal guardian.

Examples of who the key support network may include are:

- Nominated representative (ie: family member, 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 Patient Medical Record (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, the National Disability Insurance Scheme (NDIS) consent form. In the absence of a formal consent form, clearly document that consent was obtained from the patient in the PMR.

Establishing Functional Support Needs

If the patient is unable to do so themselves, ask their support workers 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 an 'Individual Health Profile' (See Appendix 1 for example) or via an App. 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 patient transfers; distance able to ambulate; falls history.
- *Behaviour / emotional support strategies* – triggers; comforters; level of supervision required – i.e. can the patient be left unsupervised; environmental needs.
- *Communication needs and preferences* – equipment required; how the patient expresses pain; how the patient expresses 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 & sling; communication device.

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

Identifying Communication Needs and Preferences

Staff need to be able to communicate directly with the patient and include them in any discussions about their care. This includes understanding their usual signs of pain or distress if they are non-verbal. The patient may have a communication passport or similar document that the service provider can give to staff. It is important to consider the following:

- Does the patient require any adaptive equipment to support their communication? If yes, ensure it is bought in and accessible for the patient.
  For example, a communication board / device, picture cards, hearing aids, adapted nurse call switch (ie: head switch), eye gaze devices, hearing impairment identifier sign.
- Does the patient have complex communication needs and therefore requires additional support during their inpatient stay from a support worker?
  It may be reasonable to request a support worker to remain with the patient during the admission to support effective communication with the patient.
- Does the patient have a communication passport tool?
  If yes, request it from the service provider. When was it last updated? Ensure it is in-date and current to the patient's needs. Ensure a copy of the passport is in the PMR and a summary is entered into the progress notes.

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

Identifying Environmental Adaptations

Are there any environmental design aspects that need to be considered to improve the patient'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, 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 patient's care needs. For example, providing an air mattress for pressure care during admission if this is what they usually used at home.

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

Arranging Specialist Equipment Needs

People with disabilities 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. Please check if they use any specialist equipment at home. Examples

include a wheelchair, ventilator, cough assist machine, communication device, limb prosthesis or splints. If they do, request the support worker to arrange for these items to be transported to the hospital to be available to the patient if they have not already done so.

Other standard equipment, such as air mattresses, commodes, shower chairs, and transfer equipment (hoists, sara steady, gait aids etc) 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 patient throughout admission, regardless of any ward moves. It is preferable that the personal items of equipment remain in the room with the patient (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 patient have a documented behaviour management plan that can be shared with hospital staff?
- Does the patient have complex behaviours that will likely require additional support from a support worker during their inpatient stay?
- Does the patient need constant monitoring to maintain safety?
- Is the patient 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 staff. Copies of behaviour management plans should also be easily accessible to staff in the bedside file.

Identifying Needs Relating to Cognitive Impairment

Does the patient have a cognitive impairment? Does your hospital have a Cognitive Impairment identifier? If yes, place Cognitive Impairment identifier above patient bed.

Identifying Supported Decision-Making Strategies for Consent

Staff should always assume that the patient has the capacity to provide consent unless proven otherwise. The individual patient should always be included in decision making in whatever capacity they can participate. Some patients need to undertake a supported decision-making process with a nominated support person. This may be a family member, 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 staff are aware of who to contact when providing information about the medical care plans or asking for consent to undertake interventions.

Patient Story:

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 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 6pm 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 medical staff about his symptoms over the past few days. The support worker's shift finishes at 8pm, 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 5am. He requires a 1:1 nurse to remain with him due to his breathing difficulties and anxiety. Janet arrives at 8am to visit and discovers that Samuel has not slept all night and is very anxious. She arranges for a support worker to bring in Samuels 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 medical staff and consent to treatment.

The next day Samuel reports that if the 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.

Three days later, Samuel is discharged home. 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 patient's care are working collaboratively to support a successful discharge when medically ready to do so.

Key Summary

To optimise the delivery of healthcare during the patient'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 is any changes to the expected date of discharge.
- Establish a communication plan with the patient and key stakeholders to ensure open and transparent information sharing regarding the patient'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 patient has been admitted to a ward, it is important to setup an early case conference with all stakeholders to discuss the following:

- reason for admission
- goals of medical intervention
- anticipated length of admission
- additional supports required during the admission
- identify early if there are any 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 patient 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. Whilst this date may be a rough estimate only, ensuring regular communication is established with the patient 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 patient is anticipated to have a long hospital admission it is recommended that staff setup 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 patient has an anticipated short length of stay (less than one week), it may be appropriate to only setup 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 patients 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 patient 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 patient 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, allied health therapy intervention.

Patient Story:

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 became 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 medical staff. She is not letting medical staff examine her. Her sister is called in to assist with diagnosis and treatment planning. Julia is immediately calmer with her sister present, and medical staff are able to diagnose her with appendicitis. 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 post operatively. Her support worker leaves, and Julia is taken to theatre. Susan provides 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.

Whilst 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 post operatively 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 our roles and responsibilities during admission.

As clinical staff, we must always understand that the individual with the disability 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 our responsibility 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 patient 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 patient and their support network in an ongoing manner throughout the period of health care provision.
- Determine if the patient can consent or requires implementation of supported decision-making strategies.
- Understand the NSQHS standard and how they govern our actions within the hospital setting.
- 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.

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 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 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 is required episodically.

This means that we must meet all the health care needs of the patient 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 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 disabilities. See Appendix 3 for 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).

Delivering excellent communication

When a patient is admitted to hospital, it is the responsibility of all staff members to ensure early, frequent, and effective communication with the patient 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 patient and their support network.

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

- *Caring for People with Disability*
  A WA Health checklist for staff to support communication and engagement with the patient and their support network throughout admission (Appendix 5).
- *Communication passport template.*
  For staff to use to document the communication needs and preferences for the individual during admission (example template available in Appendix 6).
- *NSQHS standard: Communicating for safety*
  This standard outlines the processes required to implement and maintain effective communication with patients, carers, and families throughout admission.
- *NSQHS standard: Partnering with Consumers*
  This standard outlines the need for hospital staff to actively involve the patient in their own care, meet the patient'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 staff interacting with the patient are aware of and have access to relevant resources throughout admission.

When developing new resources at your hospital consider:

- Using "Easy Read" formats for any patient with a cognitive impairment or limited literacy;
- Web-based information for people with visual impairments who use screen-readers; and
- Alternative formats with all patient hand-outs.

Identifying potential discharge barriers

Through early communication with the patient 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, post-operative orders that impact on mobility.
- New carer training needs due to a change in health status. For example, stoma care, wound management, diabetes management etc.
- 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 individual patient should always be included in decision making in whatever capacity they can participate. Some patients need to undertake a supported decision-making process with a nominated support person. For example, this may be a family member, legal guardian or support worker. A supported decision-making strategy is a process designed to facilitate the ability of the individual to make their own decisions. If a supported decision-making strategy is used in practice for the patient, this should be clearly documented in the PMR and included in any patient handover discussions.

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

- *People with Disability and Supported Decision-Making and the NDIS*
- *Supported Decision Making: A handbook for facilitators*

Implementing behavioural management strategies

It is essential to provide additional supports to patients 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.

Patients who have complex behaviours as a result of their disability may already have a behavioural management plan or equivalent which can provide guidance to staff on triggers, de-escalation strategies and safe interventions that are used successfully in the home environment. The needs of the patient 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, and
- Wean the use of restrictive practices over time where safe to do so.

In preparing for discharge, it is important for 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: chemical, physical, environment, mechanical and 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 individual 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 staff to implement best-practice behaviour management strategies:

- *NSQHS Standard: Comprehensive Care 5.30 preventing delirium and managing cognitive impairment*.
  https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-530
  This standard ensures 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.*
  https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-535
  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 individual 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.

Patient Story:

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 two 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 two 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 of, 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 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 health care 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 patient'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 would be generally expected to be delivered by staff in hospital (for example, nursing care).

Key Summary

Communicating and liaising with service providers through admission will optimise the delivery of essential health care during the hospital admission. It is important to consider the following actions with the consent of the patient:

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

Communication

To facilitate timely two-way communication, 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 patient 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, equipment already available etc. 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 patient on discharge, especially if there are changes to the patient'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 may 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, for example:

- To provide additional support for patients with complex behavioural or communication needs.
- To enable social / community access support to leave the hospital setting during the day whilst awaiting confirmation of accommodation options.
- To undertake carer training if the recommended support needs for discharge have changed from baseline.
- To participate in clinical handover with hospital staff to support medical needs of the patient on discharge, such as wound care or diabetes management plan.
- To 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 staff early if they have concerns around their capacity to safely meet the support needs of the patient on discharge. Service providers should not be waiting until day of discharge to notify 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 patient'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 patient and key stakeholders.
- Ensure any essential follow up care is arranged prior to discharge, for example GP appointments, outpatient appointments, referrals to RITH etc.
- Ensure any new equipment needs have been arranged and provided to the patient prior to discharge.
- Complete all relevant documentation and ensure these provided to the patient 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 patient to leave hospital

Coordinating the discharge plan

The discharge plan should be established and communicated to the patient 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 patient 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 patient 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), rehabilitation in the home (RITH).

- *GP appointment*
  If the patient needs to attend an appointment with their GP following their hospital discharge, ensure this is clearly communicated to the patient 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 patient 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 patient 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 NDIS or ICWA if applicable and appropriate.
- *Support workers*
  If the patient 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 patient has been commenced on 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 script filled in the community.

Completing necessary documentation

Comprehensive documentation is required at time of discharge. This documentation should be provided to the patient or their nominated representative, their GP, and with the patient'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 which provides information on current functional support needs at time of discharge.
- *Wound care plan*
  If applicable, providing 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 patient post discharge. For example, to HITH, RITH, Silver Chain, CoNeCT, NDIS, palliative care, Community mental health etc.
- *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, communication passport, behaviour management plan etc.

Providing comprehensive handover

Best practice care includes a verbal and written handover to be provided by health staff to the corresponding community teams. With the consent of the patient, 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, RITH etc.

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
- 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 patient 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.

Patient Story:

Jane is a 58-year-old woman with a newly acquired disability. She was admitted to hospital 5 months ago following a stroke which 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 National Disability Insurance Scheme (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 which 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, available days to be communicated to the 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 to for her continence and wound care through her funding plan.

The hospital responsibilities:

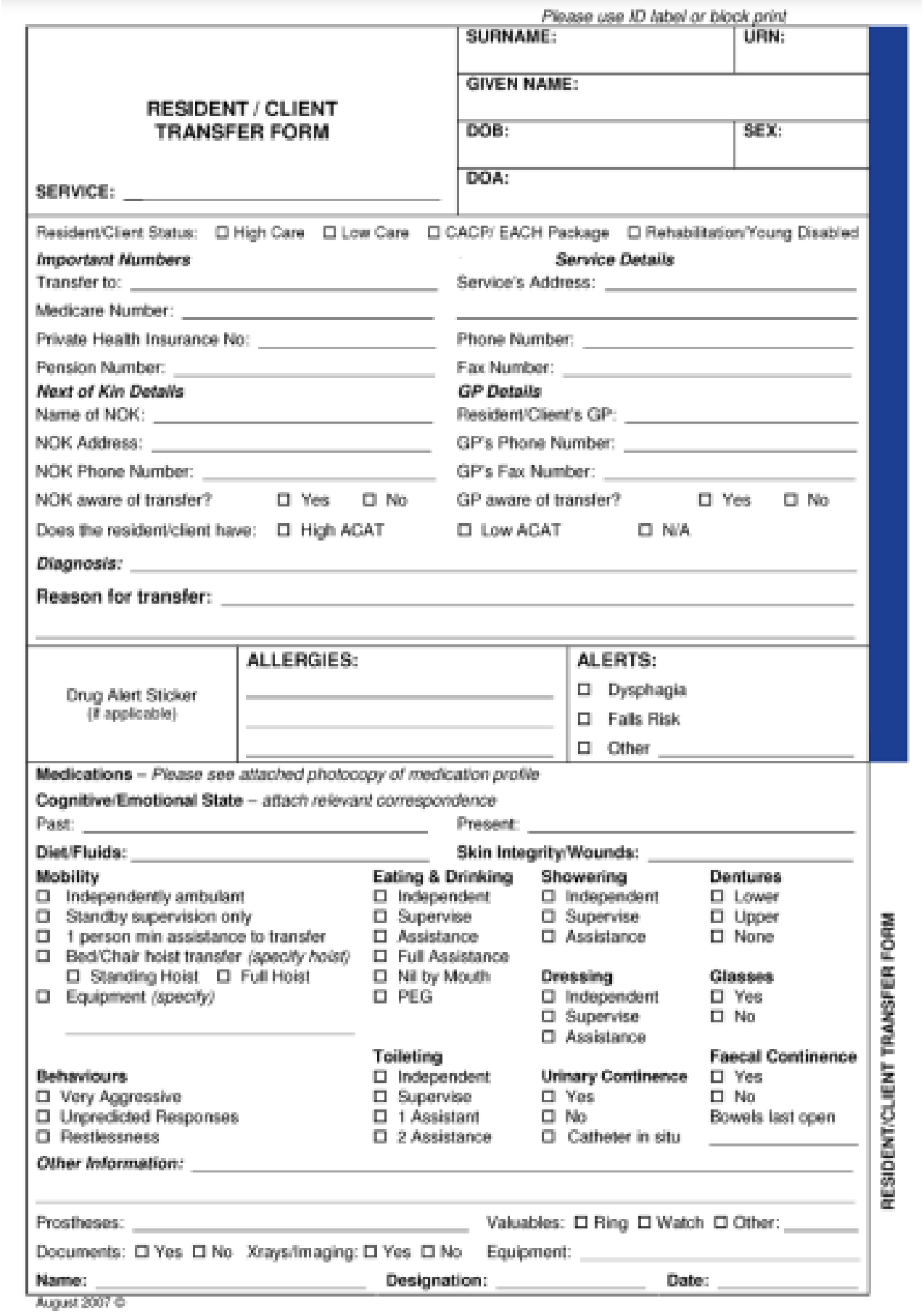
- If required, arrange for temporary equipment to support transfers and mobility including a hoist and wheelchair until permanent equipment can be arranged in the community. This temporary equipment may be arranged through external funding providers such as NDIS or ICWA where appropriate.
- Provide ambulance 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 as Rehabilitation in the Home (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 health care delivery in the community setting.

Resources

- People with Disability and Supported Decision-Making and the NDIS
  https://www.nds.org.au/images/resources/National-SDM-Guide.pdf
  Published by National Disability Services
- Supported Decision Making: A handbook for facilitators
  https://www.facs.nsw.gov.au/download?file=591371
  Published in 2015 by the NSW Government, Family and Community Services
- Original Hospital stay guidelines
  https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Networks/Disability/PDF/Hospital-Stay-Guideline.pdf
- APTOS agreement
  https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf
- NSW health – responding to the needs of people with disability during hospitalisation
  https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2017_001.pdf
- NSQHS Standard: Comprehensive Care 5.30 preventing delirium and managing cognitive impairment.
  https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-530
- NSQHS Standard: Comprehensive Care 5.35 – minimising restrictive practices.
  https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-535
- NSQHS standard: Communicating for safety.
  https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard
- NSQHS standard: Partnering with Consumers.
  https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard
- National Disability Insurance Scheme (NDIS) consent form
  https://www.ndis.gov.au/about-us/policies/access-information/consent-forms
- Caring for People with Disability
  https://www.healthywa.wa.gov.au/~/media/Files/Corporate/general-documents/Infectious-diseases/PDF/Coronavirus/COVID19-Caring-for-People-with-Disability.pdf

Appendix 1: Individual health profile template example



Please use ID label or block print

RESIDENT / CLIENT TRANSFER FORM

SERVICE: _____

SURNAME: | **URN:**

GIVEN NAME:

DOB: | **SEX:**

DOA:

Resident/Client Status: ☐ High Care ☐ Low Care ☐ CACP/ EACH Package ☐ Rehabilitation/Young Disabled

Important Numbers

Transfer to: _____

Medicare Number: _____

Private Health Insurance No: _____

Pension Number: _____

Service Details

Service's Address: _____

Phone Number: _____

Fax Number: _____

Next of Kin Details

Name of NOK: _____

NOK Address: _____

NOK Phone Number: _____

NOK aware of transfer? ☐ Yes ☐ No

GP Details

Resident/Client's GP: _____

GP's Phone Number: _____

GP's Fax Number: _____

GP aware of transfer? ☐ Yes ☐ No

Does the resident/client have: ☐ High ACAT ☐ Low ACAT ☐ N/A

Diagnosis: _____

Reason for transfer: _____

Drug Alert Sticker (if applicable)

ALLERGIES:

ALERTS:

☐ Dysphagia

☐ Falls Risk

☐ Other _____

Medications – *Please see attached photocopy of medication profile*

Cognitive/Emotional State – *attach relevant correspondence*

Past: _____ Present: _____

Diet/Fluids: _____ **Skin Integrity/Wounds:** _____

Mobility
- ☐ Independently ambulant
- ☐ Standby supervision only
- ☐ 1 person min assistance to transfer
- ☐ Bed/Chair hoist transfer *(specify hoist)*
  - ☐ Standing Hoist ☐ Full Hoist
- ☐ Equipment *(specify)*

Eating & Drinking
- ☐ Independent
- ☐ Supervise
- ☐ Assistance
- ☐ Full Assistance
- ☐ Nil by Mouth
- ☐ PEG

Showering
- ☐ Independent
- ☐ Supervise
- ☐ Assistance

Dressing
- ☐ Independent
- ☐ Supervise
- ☐ Assistance

Toileting
- ☐ Independent
- ☐ Supervise
- ☐ 1 Assistant
- ☐ 2 Assistance

Dentures
- ☐ Lower
- ☐ Upper
- ☐ None

Glasses
- ☐ Yes
- ☐ No

Faecal Continence
- ☐ Yes
- ☐ No

Bowels last open _____

Behaviours
- ☐ Very Aggressive
- ☐ Unpredicted Responses
- ☐ Restlessness

Urinary Continence
- ☐ Yes
- ☐ No
- ☐ Catheter in situ

Other Information: _____

Prostheses: _____ Valuables: ☐ Ring ☐ Watch ☐ Other: _____

Documents: ☐ Yes ☐ No Xrays/Imaging: ☐ Yes ☐ No Equipment: _____

Name: _____ **Designation:** _____ **Date:** _____

August 2007 ©

RESIDENT/CLIENT TRANSFER FORM

Appendix 2: CHECKLIST FOR STAFF: Background Information Screening Questions

- ✓ Who is in the patients support network? What are their contact details?
  - ☐ Family member
    _____
  - ☐ 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 patient need to complete personal care activities? Is there any special equipment required?

_____

_____

- ✓ How much assistance does the patient need with eating and drinking? Is there any special equipment needed?

_____

_____

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

_____

_____

- ✓ How much assistance does the patient 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 patient have a behaviour support plan? Are there identified triggers /relievers for staff to be aware of? Does the patient require a support worker to remain in attendance to assist with behaviour management or emotional regulation?

_____

_____

- ✓ How does the patient communicate? Does the patient have a communication 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 patient's cognition impaired as a result of their disability? What is their level of understanding? Do they require additional assistance as a result of their cognitive impairment?

_____

_____

- ✓ What medications does the patient usually take?

_____

_____

- ✓ Does the patient have any allergies?

_____

_____

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

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

The full document is available to view at:

https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf

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 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 is 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.

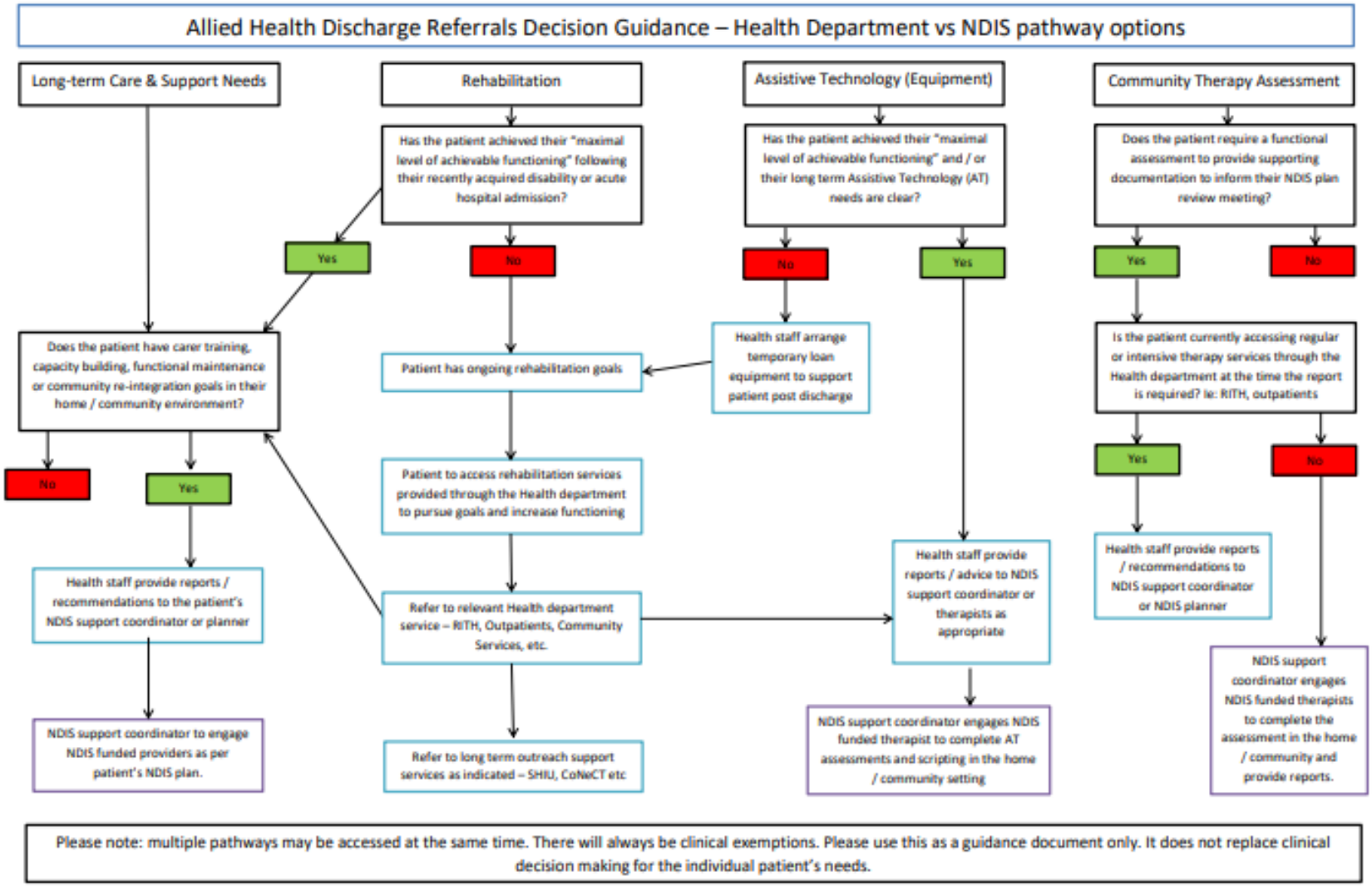
A more detailed comparison of supports provided by NDIS and health/mental health services, including where supports are delivered collaboratively, can be found at https://www.ndis.gov.au/about-us/operational-guidelines/planning-operational-guideline/planning-operational-guideline-appendix-1-table-guidance-whether-support-most-appropriately-funded-ndis

See Appendix 3 for a decision support tree to assist in determining which supports are best delivered by which sector.

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

Government of Western Australia
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Developed by FSFHG NDIS Linkage Team Clinical Project Lead, August 2021



Please note: multiple pathways may be accessed at the same time. There will always be clinical exemptions. Please use this as a guidance document only. It does not replace clinical decision making for the individual patient's needs.

d

Appendix 5: 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

HEN-013728 APR'20

health.wa.gov.au

Appendix 6: Health passports

Note that any Health Passport that the patient chooses to use should be accepted by Hospital staff.

The following may be used:

Julian's Key – Queensland Health

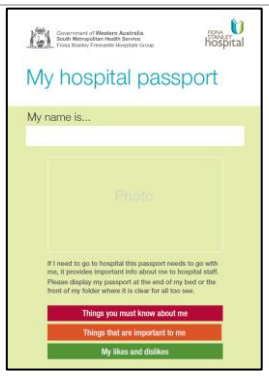
Julian's Key is a patient/carer-controlled tool designed to improve communication and empower people with disability, their families and carers to be more involved in their healthcare.

https://www.health.qld.gov.au/__data/assets/pdf_file/0032/858362/3.-Julians-Key-Health-Passport-100gsm-LHC-staple.pdf

Other options include:

My Health Matters
Council for Intellectual Disability

WA Emergency Care Plan
Kalparrin



My Hospital Passport
Developmental Disability WA and Fiona Stanley Hospital

A2D Together Folder
Admission to Discharge NSW

My Health Information
SA Health

Valued Lives My Health Passport
Health and Disability Commissioner of New Zealand.

This document can be made available in alternative formats on request for a person with disability.