Instructions

The purpose of this plan is to support a safe transition of care and ensure hospital staff understand the needs of the person we support while they are hospitalised – and the person is well supported and safeguarded while in hospital.

For in-depth instructions on how to complete this Hospital Support Plan, refer to the NDIS LWB 5560 Hospital Support – Procedure.

There are 4 sections that need to be completed:

1. Hospital Support Information - this should be the first page of the person's Hospital Support Folder.

2. TOP 5 provides information about the 5 most important things hospital staff should know about the person we support.

3. Part 1 of the Hospital Support Plan is completed by LWB staff in detail prior to hospitalisation - to ensure hospital staff understand the person's support and communication needs without having any prior knowledge of them - the more detail the better.

4. Part 2 of the Hospital Support Plan is completed jointly by LWB staff and hospital staff at the time of admission and outlines any additional support that may be provided by LWB staff while the person we support is hospitalised.

Admission Checklist

Ideally, a copy of each plan listed (as relevant to the person we support) in addition to the partially completed NDIS LWB 5661 Hospital Support Plan should go with the person at the time of admission, or as soon as possible afterwards. Original plans must be saved in CIRTS.

The below documents (relevant to the person we support) can be stored in a ready-to-go Hospital Support Folder in the name of the person, however, they must be replaced or added anytime a plan is updated/developed.

HIDPA Support Protocol(s) including:

- ☐ Autonomic Dysreflexia Management Protocol
- ☐ Complex Bowel Management Protocol
- ☐ Enteral Feeding Management Protocol
- ☐ Tracheostomy Management Protocol
- ☐ Urinary Catheter Management Protocol
- ☐ Ventilation Management Protocol
- ☐ Complex Wound Care and Pressure Injury Protocol

Health Support Plan including:

- ☐ Health and Wellbeing Plan
- ☐ Asthma Action Plan
- ☐ Mealtime Management Plan
- ☐ Allergy Response Plan

☐ Transferring, Repositioning and Mobility (TRAM) Plan

☐ Behaviour Support Plan

☐ Recent Medical Reports

☐ Any other health related documents that nursing / medical staff should be aware of.

☐ Epilepsy Management Plan

Also take:

☐ Compact Medication Chart

☐ *Webster Pak(s) including PRN medications

☐ Incontinence Aids

☐ *Non-packed Medications

☐ Pyjamas, slippers, dressing gown (as relevant)

☐ Toiletries

☐ Items that will enable the person we support to stay calm and comfortable e.g. personal items, photos of important people, written phone numbers of family members/ friends, magazines, books, colouring in book as relevant to the person.

☐ Portable aids and equipment e.g. specialised eating and drinking equipment, positioning aids, walking frame, wheelchair, walking stick, cane, CPAP machine

*Medications may be administered via hospital medication supply instead of Webster Packs. Take medications initially and await further instruction.

Note: Please remove Instructions and Admission Checklist page prior to admission.

Hospital Support Information

Name:		
Preferred Name:		
If you are supporting this person in hospital, please read this. It contains important information about their health and personal support needs.		
If the person is unable to consent to treatment, please call the below		

Name:		Name:	
Relationship:		Relationship:	
Contact:		Contact:	

Place a copy of the TOP 5 (next page) in nursing notes.
The rest of the information stays with this person at all times.

	Surname: **Given Name:** **Date of Birth:** **Sex:** **(Affix patient label here)**	**Support Strategies** **H**as Intellectual Disability **E**xtra assistance required **L**ives with 24-hour support **P**rovide care in ALL ADLs
1		
2		
3		
4		
5		

Date:		**Emergency Contact:**		**Telephone:**	
Completed by – (LWB Staff member name:				**Role:**	

Hospital Support Plan Part 1

Completed by LWB staff prior to hospitalisation

Personal Details						
Name:			Preferred Name:			
Date of Birth:		Age:			Gender:	
Address:					Phone:	
NDIS Participant Number:					CIRTS:	
Is the person Aboriginal or Torres Strait Islander:			☐ Yes	☐ No	☐ Unknown	
Language/Cultural Considerations:						
Religious Considerations:						

Authorised Decision Maker for medical or dental procedures:			
N/A ☐ The person we support provides their own consent			
OR			
Name:		Relationship:	
Phone: (Mob)		Phone: (W)	
Interpreter Required?	☐ No ☐ Yes ➔	Language:	

This person is AT RISK	**ALERT**
Examples: • Allergies (e.g. Medications, nuts, dressings) • Choking Risk – (e.g. foods & fluids) • NIL BY MOUTH (Enteral nutrition only)	

General Practitioner Details			
Name:		Telephone:	
Practice address:		Fax:	

Specialist Doctors Details					
Name:		Title:		Contact:	
Name:		Title:		Contact:	

Accommodation Details - This person resides in a Supported Independent Living (SIL) House supported by Life Without Barriers (LWB)			
Team Leader Name:			
SIL House Phone:		SIL Mobile Phone:	
Name of next Line Manager: (9am-5pm M-F)			
Phone:		Mobile Phone:	
After Hours Support Contact: 24hr, 7 days		Mobile Phone:	

Health Details – bring the person's Medicare Card to all Hospital visits	
Medicare Number:	
Private Health Insurance Membership Number:	
Health Care Card Number:	

Medication		
Does the person require Medication to be administered during their admission?	☐ No	☐ Yes ➔
If Yes, attach the person's current Medication Chart and ensure they bring medications to hospital.		
Does the person require support to take medication?	☐ No	☐ Yes ➔
Describe:		
Medical Information		
Diagnosed medical conditions e.g. Epilepsy, Heart conditions, breathing difficulties, dysphagia. Include all relevant plans for more information - e.g. Epilepsy Management Plan, Asthma Action Plan, Mealtime Management Plan.		
Does the person have difficulty with their hearing or sight?	☐ No	☐ Yes ➔
If Yes, describe below how it affects the person and what they need to assist them to see e.g. glasses placed nearby.		

Describe strategies to enable the following health interventions for this person	
Taking blood:	
Giving injections:	
Taking the temperature:	
Measuring blood pressure:	

Communication	
How does the person communicate to others?	
Do they use a communication aid, device or system?	
What is the best way to communicate with the person?	
Does the person require an interpreter / translator?	
How can the person make choices?	
Can the person read and comprehend what is written?	
Can the person write / sign their name?	
Describe how people will know if the person is feeling:	
Sick	
In pain	
Happy	
Sad	
Confused	
Anxious	
Thirsty	
Hungry	
Describe how the person will indicate the below and how to support them:	
Need to use the toilet	
Menu choices	

Mobility

Does the person use an aid or require assistance to move around in bed?	☐ No	☐ Yes ➔
If yes, describe below e.g. Mary is unable to turn over in bed without help. She has fragile skin and needs to be turned every two hours to avoid developing pressure areas.		
Does the person use an aid or require assistance to move around the ward?	☐ No	☐ Yes ➔
If yes, describe below e.g. Tom uses a wheelchair and once he is assisted into the chair he can move around the ward without assistance. For his safety, he should be shown where he can and can't go. **Note:** Any Electronic equipment that requires a recharge overnight.		
Toileting		
Does the person use an aid or require assistance with toileting or use of continence aids?	☐ No	☐ Yes ➔
Does the person require assistance with use of menstrual sanitary pads?	☐ No	☐ Yes ➔
If yes, describe below: e.g. Mary has a toilet time routine and needs to be offered to go every 2 hours		
Personal Care – attach a copy of the person's Personal Care Plan if they have one		
Does the person require assistance with dressing/undressing?	☐ No	☐ Yes ➔
If yes, describe:		
Does the person require assistance with showering/bathing	☐ No	☐ Yes ➔
If yes, describe:		
Does the person person require assistance with brushing their teeth?	☐ No	☐ Yes ➔
If yes, describe:		
Does the person require assistance with grooming?	☐ No	☐ Yes ➔
If yes, describe:		

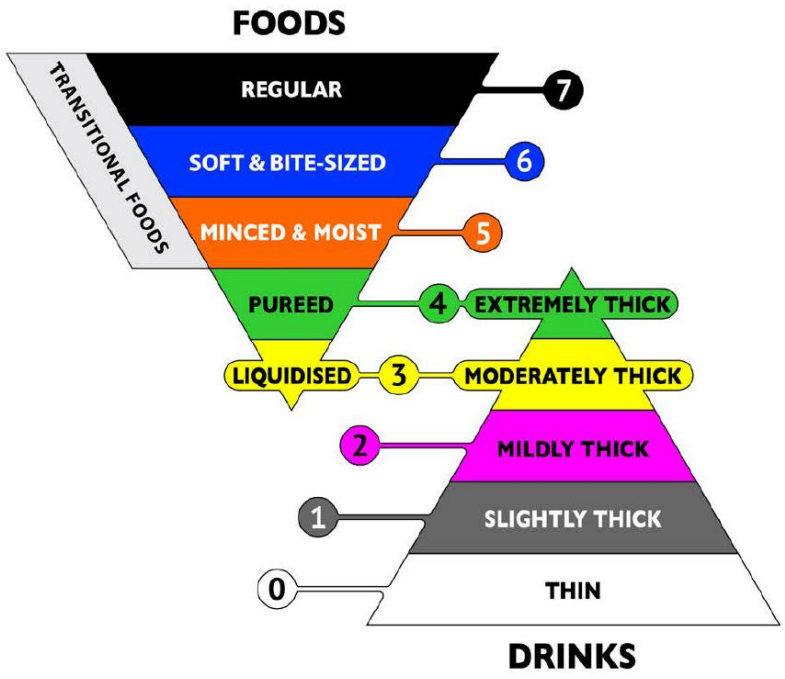
Behaviour Support Requirements

Does the person have a Behaviour Support Plan?	☐ No	☐ Yes ➔
If yes, attach a copy of the plan including PRN Protocols and describe any behaviour that hospital staff need to be aware of below. Include who to contact when the person fails to regain control of themselves.		
Describe the Behaviour(s):		
Triggers to be aware of:		
How to respond:		
Who to contact for advice:		

Personal Preferences	
☐ Their own room (if private health insurance / where availability permits)	
A good day in hospital	**A bad day in hospital**
Indicate things that make the person happy/relaxed: ☐ watching TV ☐ reading ☐ listening to Music ☐ craft e.g. colouring in / drawing / crochet ☐ snacks ☐ walks (if possible) ☐ talking with others ☐ Other – describe:	Indicate the things that make the person unhappy: ☐ too many visitors/ people in the room ☐ sensory related – noise, light, coughing, crying, being touched in certain areas (describe): ☐ particular foods (describe): ☐ confusion (describe what could cause this) ☐ anxiety (describe what would cause this) ☐ Other – describe:
Being able to	**Not being able to**
Mealtime Assistance, Swallowing, Nutritional Requirements and Menu Choice	

★ *Attach the person's Mealtime Management Plan (MMP) (or Nutrition and Swallowing Checklist if an MMP is required but not yet complete) and their My Meals My Way Profile*	
☐ The person has a mealtime Management Plan – *this must be followed explicitly.*	
☐ Setup of meal tray	
☐ Physical assistance with eating/ drinking	
☐ Use of modified equipment – (describe)	
☐ Require clothing protection	
☐ Other:	

Food or Drinks need to be texture modified



	Food Level:	
	Drink Level:	
Does the person require Enteral Feeds?	☐ No	☐ Yes ➔
If yes, attach a copy of feeding regimen.		

Position/Relationship	Signature	Date
Person We Support (if they can sign)		
Family / Authorised Decision Maker		
Disability Support Worker		
Team Leader / Line Manager		

Reviews – Hospital Support Plan Part 1 and Top 5

Month	Update required and completed Yes / No	Date of Review DD/MM/YYYY	Team Leader Signature
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

CIRTS:

Initially upload the completed Part 1, Top 5 and partially completed Part 2 as follows:

Plans and Assessments > Plans > Add New Plan > Hospital Support Plan > Add New Attachment > Hospital Support Plan SURNAME First Name YYYY.MM.DD

When Part 2 has been fully completed (column 4) with the assistance from hospital staff during an admission, upload as follows:

The person's Record > Plans and Assessments > select > Hospital Support Plan > Double click on 'Original Plan' or the latest review (if there is one) in the Review Records grid > Click Edit > Add New Attachment > Hospital Support Plan Part 2 Admission (insert dates of admission) SURNAME. First Name YYYY.MM.DD

Where the Hospital Support Plan has been reviewed Add New Review to the Hospital Support Plan.

Refer to NDIS LWB 5560 Hospital Support – Procedure for instructions if required.

Hospital Support Plan Part 2 - Hospital Support Requirements

Completed jointly by LWB staff and hospital staff at the time of admission

Key to Support Levels	
Level 1	No additional on-ward support required. Support can be provided from existing disability or hospital resources.
Level 2	Additional on-ward support required. Support to be provided by the person's Support Network i.e. family & friends.
Level 3	Additional on-ward support required. Support to be provided by the hospital (*for example, use of equipment loan pool*).
Level 4	Additional on-ward support required. Support to be provided by LWB Disability Support Workers.

For each area, circle the appropriate level of support and describe the agreed actions LWB and hospital staff will undertake.

Communication Needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Can the person communicate needs, including pain?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
	Also refer to Part 1, Page 3 of this Hospital Support Plan.		☐ 4	
Can the person understand a verbal explanation of procedures?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person make loud vocalisations that may impact on others?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	

Safety needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Can the person maintain his / her privacy and dignity?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Is the person able to find her / his way around the hospital?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Can the person maintain his / her own safety in the ward?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Can the person maintain her / his own safety outside the ward?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	

Behaviour related needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Is the person at risk of self-harm?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Is the person violent towards others?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	

Behaviour related needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Is the person destructive of property?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person need to be constantly moving around?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person exhibit behaviours that may offend others?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person get anxious?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person have sensory related difficulties e.g. scared of loud noises, flashing lights	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person require PRN medication for Behaviour(s) of Concern?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person require Behaviour Support Strategies to be implemented to manage Behaviour(s) of Concern?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	

Behaviour related needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Does the person require Restrictive practices to be implemented to manage Behaviours of Concern?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Health and Wellbeing Needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Does the person maintain her/his personal hygiene?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person maintain her/his fluid intake?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Can the person eat meals and snacks without assistance?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person have dysphagia or are they at risk of choking?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
	*If **Yes,** ensure the person's Mealtime Management Plan, and any utensils and equipment are provided.*		☐ 4	
Does the person currently experience seizures?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	

Behaviour related needs	1. Needs known	2. Level of risk	3. Support Level	4. Agreed Support / Actions
Does the person go to the toilet independently?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Can the person move around without assistance?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person have a regular sleep pattern?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Is the person at risk from pressure areas?	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	
Does the person require any special equipment? e.g. shower chair, bedrail, walker	☐ Yes	☐ Low	☐ 1	
	☐ Unknown	☐ Medium	☐ 2	
	☐ No	☐ High	☐ 3	
			☐ 4	

High Intensity Daily Personal Activity (HIDPA) Support Required	
Describe HIDPA support required:	Relevant Support Protocol(s) must be attached, and hospital staff briefed on support required.

Assessment			
Assessment completed by:	Name:	Signature:	Date:
Nursing Unit Manager			
LWB DSW / TL			
Authorised Decision Maker			

Summary of support to be provided by LWB Disability Support Worker(s)			
Summarise the support LWB Disability Support Workers will be providing to the person in addition to support provided by hospital nursing staff.			
Time of day	What support will be provided	Start time	End time
Morning			
Afternoon			
Evening			
Overnight			

Work Health and Safety			
The LWB DSW providing support to the person in the hospital has been inducted to the Hospital Site and made aware of Work Health and Safety Procedures.			
Assessment completed by:	Name:	Signature:	Date:
Nursing Unit Manager providing induction			
LWB staff member who received induction			

Hospital Staff - Please Note: A Discharge Plan is required for people who LWB support when they are leaving hospital.
The NDIS LWB 5562 Hospital Support – Discharge Plan will be provided via email/ electronically for completion prior to discharge.

CIRTS: Upload Part 1, the TOP 5 and partially completed Part 2 when first completed as follows

Plans and Assessments > Plans > Add New Plan > Hospital Support Plan > Add New Attachment > Hospital Support Plan SURNAME First Name YYYY.MM.D

When Part 2 has been fully completed (column 4) with the assistance from hospital staff during an admission, upload as follows

The person's Record > Plans and Assessments > select > Hospital Support Plan > Double click on 'Original Plan' or the latest review (if there is one) in the Review Records grid > Click Edit > Add New Attachment > Hospital Support Plan Part 2 Admission (insert dates of admission) SURNAME. First Name YYYY.MM.DD

Where the Hospital Support Plan has been reviewed Add New Review to the Hospital Support Plan.

Further advice

The NDIS Quality and Safeguarding Commission produced a Practice Alert - Practice Alert: Transitions of care between disability services and hospitals, that explains the risks associated with transitions of care between disability services and hospitals, how to reduce potential risks and support safe transitions of care for the people we support and outlines provider obligations.