LIFE WITHOUT BARRIERS

NDIS LWB 5560 Hospital Support Planning - Procedure

Purpose

We are committed to ensuring that the people we support have access to the necessary health services and maintain a safe environment. Many of the people we support will require hospital admissions at different points in their lives, planned or unplanned. The NDIS refers to these admissions and discharges, as transitions of care. It involves transitioning the responsibility of the person's care between their existing support service/s and the Health System.

This procedure has been developed to ensure safe transitions of care, and assist the people we support to inform hospital staff of their needs and support requirements before or during the admission process. It should be read in conjunction with the NDIS LWB 5563 Providing Hospital Support Procedure, which guides LWB staff on providing hospital support and essential communication during hospital admissions, and the NDIS LWB 5564 Transitions of Care (Discharge) Essentials which helps ensure a safe and timely discharge.

The Importance of Hospital Support

An admission to hospital for the people we support can be a frightening and confusing experience. Hospitals are often busy and overwhelming, and a number of unfamiliar medical staff will assess and talk to the person we support, often using words that they don't understand. The staffing situation is also very different to what is provided in the person's home – hospital staff may be inexperienced in supporting people with disability; have limited time to understand the person's specific support requirements; have a lower staff ratio; and a high turnover can make it difficult to become familiar and build rapport with the person we support.

This places high importance on our ability to ensure smooth transitions of care into and out of hospital so that the people we support are not put at higher risk of harm due to a poorly coordinated admission and discharge.

The NDIS Quality and Safeguarding Commission produced a 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 people with disability and outlines provider obligations.

The people we support may have a variety of support needs that all hospital staff need to be aware of, that we need to ensure are considered if the person is admitted to hospital. Such considerations include:

- **Communication needs** – What do hospital staff need to know to communicate effectively with the person we support? How to use the communication board/aid that the person we support uses? Do hospital staff know who to contact and in what situations?
- **Extra health supports** – e.g. extra support on top of what is usually provided in a hospital such as supervision for seizures, diabetes management, enteral feeding support etc
- **Supported Decision Making** - e.g. does the person require support from a person who knows them well to help make decisions, consent to treatment etc

- **Safeguarding supports** - e.g. positioning, eating and drinking equipment, nutritional needs, allergies, mobility requirements and risk of choking
- **Specific support needs** – e.g. behaviour support response strategies, routines
- **Increased anxiety** – e.g. due to fear, pain, change of routine, unfamiliar environment
- **Behaviour Support** – what do hospital staff need to know to engage appropriately with the person we support? Is training required for hospital staff to effectively use the strategies in the person's Positive Behaviour Support Plan?

The Admission2Discharge (A2D) Together Folder

The Admission2Discharge (A2D) Together Folder is designed to improve the health care experience and safeguarding of the people we support while they are in hospital, by addressing the above considerations. A2D provides the ability to give a clear handover of relevant and current information to hospital staff across three (3) documents:

- **The TOP 5** – a tool developed to provide care tips and unique information about a person with disability that hospital staff need to be aware of first and foremost.
- **Hospital Support Plan Part 1** – captures information that is important to and important for the person, details on their authorised decision maker and support network and specific details on their support needs to allow hospital staff to provide adequate, person-centred care.
- **Hospital Support Plan Part 2** – allows a coordinated transition of care from LWB to hospital staff. It identifies safeguarding and support requirements, and is designed to share LWB disability support expertise with hospital staff, clearly identifying the roles and responsibilities of LWB staff, hospital staff and the person's support network.

Further information on the A2D toolkit can be found on the A2D website.

The A2D Hospital Support Plan is mandatory for people receiving Supported Independent Living (SIL) support. Where LWB is providing support relating to the health of a person we support, for example Lifestyle Supports (LS), or where the person has complex support requirements and, in consultation with the person and their key stakeholders it is deemed appropriate, a Hospital Support Plan should be developed.

Note: A DSL can delegate the development of the A2D Hospital Support Plan to a suitable DSW, however, it remains the responsibility of the DSL to ensure that the task is completed within the allocated timeframe and to the required standard.

Developing an A2D Hospital Support Plan

Hospital Support Plan - TOP 5 TOP 5	**The Disability Support Leader will**: • download the TOP 5 template. • complete the TOP 5 with the person we support and/or their support network. A good time to do this is when completing the Annual Health Assessment. • use the Sample Top 5 Tips on the A2D website to ensure that the TOP 5 tips identify critical risks in a **hospital setting**, with consideration of the person's: – Swallowing risks – Communication challenges – Mobility Risks – Allergy Risks – Hygiene Risks – Behaviour Support Risks – Understanding of and compliance with medical treatment. • save a copy to CIRTS and place several copies in the person's Hospital Support Folder – if it gets misplaced during a hospital admission, or they change wards and it is left behind, another copy is readily available.
Hospital Support Plan - Part 1 1	**The Disability Support Leader will:** • download Part 1 of the A2D Hospital Support Plan. • complete Part 1 of the Hospital Support Plan with the person we support and/or their support network. • provide as much detail as possible, with a view that the person reading the information has never met the person we support and has no prior experience or understanding of their individual support needs. The more informative Part 1 is, the better the person will be supported. • save a copy to CIRTS and place a copy in the person's Hospital Support Folder.
	The Disability Support Leader will: **At the time of completing Part 1 of the A2D Hospital Support Plan:** • download Part 2 of the A2D Hospital Support Plan and place a blank copy into the person's Hospital Support Folder. **At the pre-admission meeting or as soon as possible following an unplanned hospital admission:** • contact the Practice Support Team to ensure they (the DSL) are adequately prepared for the admission. This discussion should include coaching for the DSL on how best to prepare for the completion of Part 2 and focus on what's important to and for the person and how to navigate the discussions with hospital staff.

Hospital Support Plan - Part 2

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- complete Part 2 (as detailed below) with the person we support, their support network, their Support Coordinator and relevant hospital staff (request that the Disability Liaison Officer or equivalent be involved in this discussion).
- provide answers for columns 1 and 2 for each support need question, based on the person's current level of functioning (this may differ from their usual support needs due to the reason they are in hospital).
- complete columns 3 and 4 in partnership with hospital staff and others present to detail what support the person will need (if any) and who will be providing the support.
- use the following key to identify the level of support the person requires and who will provide it**:**

Key to Support Levels	
Level 1	**No additional on-ward support required.** Support can be provided from existing hospital resources.
Level 2	**Additional on-ward support required.** Support to be provided by the person's Support Network (e.g. family & friends)
Level 3	**Additional on-ward support required.** Support to be provided by the hospital (reasonable adjustments put into place)
Level 4	**Additional on-ward support required.** Support to be provided by LWB Disability Support Workers.

- assist the Support Coordinator, as needed, to coordinate informal supports (friends and family) if the hospital requests Level 2 support.
- contact the Client Engagement Team (CET) to discuss:
  - any changes to usual NDIS claiming as a result of the admission
  - any support that will be provided by LWB staff using existing NDIS funding (e.g. DSWs to train hospital staff in understanding the person's complex communication need and/or positive behaviour strategies)
  - anvoicing arrangements for Level 4 supports that will be funded by the hospital (additional on-ward support for personal care etc.).
- request the hospital provide a formal letter such as a "Request for Carer", outlining the support they are requesting (hours and duties) and provide to the CET team. This formal letter facilitates LWB invoicing for support hours provided.

- request additional guidance if at any point during the person's admission to hospital, support cannot be agreed on between LWB and hospital staff. The levels of the decision-making escalation process are:

Levels	Life Without Barriers	Health / Hospital
1	Disability Support Leader	Nurse in Charge / Nurse Unit Manager
2	Regional Operations Manager (ROM)	Director of Nursing and Midwifery
3	State Director	Director, Clinical Operations
Note: The Support Coordinator should be involved at each level		

- consider the following when resolving an agreed Hospital Support Plan:
  - Timeline should be considered – e.g. some issues should be resolved within 24 hours.
  - Escalation from the Line Manager to the next Line Manager should occur within 24 hours.
  - Where matters can't be resolved at each level, details of the relevant managers and contact details should be exchanged prior to escalating the issue.
  - A decision about who provides the support and how it is funded may need to be escalated to the manager with the relevant delegation.
- identify where the hospital's reasonable adjustments (Level 3 supports) are inadequate or cannot be made to ensure the person's safety and wellbeing while in hospital. The NDIA may make exceptions for concurrent supports to be funded in extreme situations on a case by case basis. Assist the Support Coordinator to provide justification to the NDIA to request additional supports by providing the following information:
  1. Description of the person's complex care needs
  2. Description of the disability related reasons why the person requires concurrent supports, including risk to self and others
  3. Outline of the Reasonable Adjustments implemented by the Hospital to address issues identified above – already made by the hospital or in consideration
  4. Description of the concurrent supports requested including: hours, ratio of support and the duration of time the support will be required

	5. Supporting Evidence - attach documentation that supports the request (e.g. Positive Behaviour Support Plan with Restrictive Practice). • discuss with the Support Coordinator the option of using the person's Social and Community Participation funding whilst an inpatient, for LWB staff to take the person out of the hospital for social activities. This is usually considered if it is a social admission (e.g. admitted for social reasons more so than medical issues such as a placement breakdown etc). As per all requests to use NDIS funds, the Support Coordinator will need to gain approval by NDIA for this request. • once complete, provide copies of Part 2 to all people involved, place a copy in the person's Hospital Support Folder and save to CIRTS.
Hospital Support Folder 	**The Disability Support Leader will:** • ensure each person they support who requires a Hospital Support Plan also has a Hospital Support Folder readily available for Ambulance and hospital staff. • ensure the Hospital Support Folder contains the latest versions of the following documents: (as applicable to the person) – Cover Sheet – Review page (see next section) – **A2D Hospital Support Plan** – (The TOP 5 and Part 1 pre-completed, and a blank copy of Part 2, ready to complete on admission). – **Current Medication Summary** – **HIDPA Support Plan/s** – **Any Support Plans** identified in Part 1 of the Hospital Support Plan that will assist hospital staff provide care to the person (e.g. Communication Diary; Personal Care Plan; Transfers, Repositioning and Mobility (TRAM) Plan; Mealtime Management Plan; My Meals My Way Profile; Epilepsy Management Plan; Diabetes Management Plan; Asthma Plan; Allergy Response Plan; Mental Health Plan; Positive Behaviour Support Plan; Palliative Care Plan; End of Life Plan etc). – **Recent Medical Reports** • store the Hospital Support Folder in a location easy to access for planned or unplanned visits to hospital and ensure all DSWs know where to find it. • **Note:** All original documents must be first stored in CIRTS. Only copies should be stored within the Hospital Support folder.
Review	**The Disability Support Leader will:** • download the A2D Reviews Page • place it on the back of the front cover in the same sleeve of the Hospital Support Folder

- review the TOP 5 tips and Part 1 of the A2D Hospital Support Plan monthly or more often if the person's support needs or circumstances change. This review is simply to check that the information is still relevant and up to date and to replace existing support plans, medication summaries etc with current versions as needed.
- complete a progress note with the subject "Hospital Support Plan Review".
- review the folder at least annually after the Annual Health Assessment, and anytime a new health related support plan is implemented, reviewed or ceased, to ensure documents in the Hospital Support Folder are current.

Discharge planning

Planning for the transition of care out of hospital needs to begin at the time of admission to allow time for all necessary arrangements and result in a smooth discharge home. For detailed information on supporting a successful discharge from hospital, refer to the NDIS LWB 5563 Providing Hospital Support Procedure.

The NDIS LWB 5564 Transitions of Care (Discharge) Essentials should be used to prompt Health Services to provide a detailed handover of the person we support in their Transfer of Care summary. This document should include information about why the person was hospitalised, any further support to be provided, indications to call an ambulance and any other direct support modifications required to support their recovery.

Receiving a Transfer of Care Summary

Transfer of Care summary

The Disability Support Leader will:

- provide hospital staff with a copy of the NDIS LWB 5564 Transitions of Care (Discharge) Essentials.
- work with the person's Support Coordinator and Hospital staff to ensure the following requirements have been identified and addressed **before** the person is discharged:
  - Reassessing support risks
  - When to call an ambulance
  - Signs that indicate the person needs immediate review
  - Additional support needs during recovery
  - Ongoing nursing support
  - Checking of and changing dressings
  - Medication – including documented changes
  - Modifications to bedding, environment, usual support
  - Rehabilitation / Therapy
  - Aids and or equipment
  - Transportation
  - Implications to their SIL funding package
  - Change of circumstances with the NDIA.

Storage Pathway

CIRTS:

- **Part 1**: Plans and Assessments > Plans > Add New Plan > Hospital Support Plan > Add New Attachment > Hospital Support Plan SURNAME First Name YYYY.MM.DD

- **Part 2:** Client'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

- **Review:** Add New Review to the Hospital Support Plan.

- **Transfer of Care summary from the Hospital:** Client'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 Discharge Plan SURNAME. First Name YYYY.MM.DD