NDIS LWB 5562 Hospital Support – Discharge Plan

This Hospital Discharge Plan **must be completed by hospital staff** prior to discharging the person we support. Health services should have their own transfer of care risk assessment process (or similar) to complete the discharge process. It is critical to the health of the person we support that they are not discharged until LWB can adequately provide support for their recovery.

This plan documents information to assist LWB staff support the person to recover whilst remaining alert to any signs that their health is deteriorating.

LWB staff will provide this plan to the person's usual GP / Health Professionals to inform them of any required changes to support plans currently in place.

Name of person:		**Date of Birth:**	
Reason for hospitalisation:			
Treatment provided:			
Indications urgent review is required:			
Who should review:			
Location:			
Indications to call an Ambulance:			

Referrals for follow up: Have referrals been provided? No: ☐ Yes: ☐ ➔ list names / professions.	
Nursing support	N/A ☐
Describe any support to be provided by qualified nursing staff (sourced via nursing agencies or LWB nurses). **Timeframe:** ☐ Permanent	
New health support requirements	N/A ☐
Describe any health support prescribed for this person (in addition to what was already in place). **Timeframe:** ☐ Permanent	
Personal Care / Bathing / Showering	N/A ☐
Describe any requirements for personal care, bathing or showering. **Timeframe:** ☐ Permanent	
Eating and drinking	N/A ☐
Describe any changes to the person's eating and drinking. **Note:** Mealtime Management Plan must be updated. **Timeframe:** ☐ Permanent	

Physical assistance	N/A ☐
Describe support to be provided by LWB staff for this person on their return to LWB Supported Independent Living home. **Timeframe:** ☐ Permanent	
Aids and equipment	N/A ☐
Describe any new aids or equipment the person must use following hospitalisation. **Timeframe:** ☐ Permanent	
Modifications to bedding / Environment	N/A ☐
Describe any modifications required to environment including bed, chair. **Timeframe:** ☐ Permanent	
Support / modifications needed for transportation:	N/A ☐
Describe any support or modifications for transporting this person. **Timeframe:** ☐ Permanent	
Rehabilitation	N/A ☐
Describe any rehabilitation required by the person. **Timeframe:** ☐ Permanent	

Medication changes	N/A ☐
Describe changes and side effects to watch for. **Note:** the person's Compact Medication Chart & Medication Record <u>must</u> be updated.	

This person's support needs have changed significantly as a result of this hospital admission and they may require a plan review with the NDIS?	☐ Yes	☐ N/A

Describe any other disability support requirements not captured above:

Health Professional sign off		
Name:	Contact No.:	Date:
Profession:	Signature:	
Hospital & Health District:		

LWB Staff Declaration *(All staff who work with this person following hospitalisation to sign)*					
I have read and understood this Hospital Discharge Plan and understand my responsibility in providing support and monitoring the person's health as they recover.					
Staff Name		Signature		Date	
Staff Name		Signature		Date	
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Upload to CIRTS as follows:

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