Hospital discharge pathways for support coordinators

Georgia Matthews, Positive Behaviour Support Practitoner

Lin Holker, Specialist Support Coordinator,

Acknowledgement of Country

We would like to respectfully acknowledge the Traditional Custodians of the lands we are meeting on, the Whudjuk people. We wish to acknowledge and respect their continuing culture and contribution they make to the city and regions of Western Australia and pay our respects to Elders past and present.

Acknowledgements

This webinar is hosted by the NDIA ECSN Program.

Webinar content is informed by a number of people with sector expertise and content knowledge

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Our main speakers for today

Georgia Matthews – Previous experience at NDIA as a Health Liaison Officer, social worker in General Medicine and Mental Health Inpatients, Child Protection Worker.

Lin Holker – Specialist Support Coordinator

Special thanks to Kyla O'Leary and Brenda Smith from the ECSN who are supporting facilitation today.

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Purpose

Support a timely, successful and sustainable hospital discharge for people who we work with

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Focus areas

- Communication and collaboration
- How we do this?
  - Centre the participant
  - Case conferencing
  - Regular and specific communication

HEALTH DEPARTMENT WA

South Metro Health Services (SMHS) Board

Fiona Stanley (inc. state rehab)
Fremantle
Rockingham
Murray District
Peel Health campus

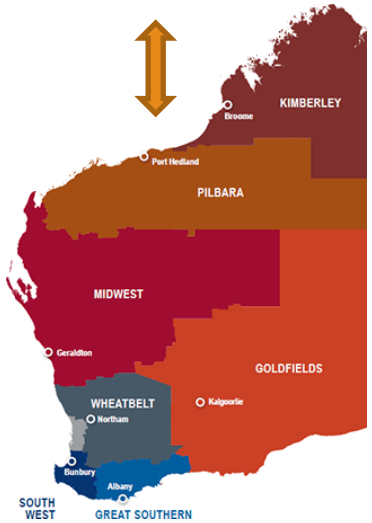
East Metro Health Services (EMHS) Board

Royal Perth (inc. state Trauma)
Bentley Health Service
Armadale Health
Kalamunda
St John of God Midland

North Metro Health Services (NMHS) Board

Sir Charles Gardiner
Osborne Park
King Edward Memorial
Graylands
Joondalup

WA Country Health Services (WACHS) Board



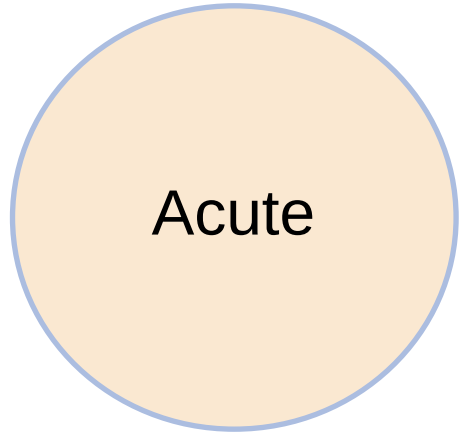
All Community Health Hubs, hospitals, and PATS

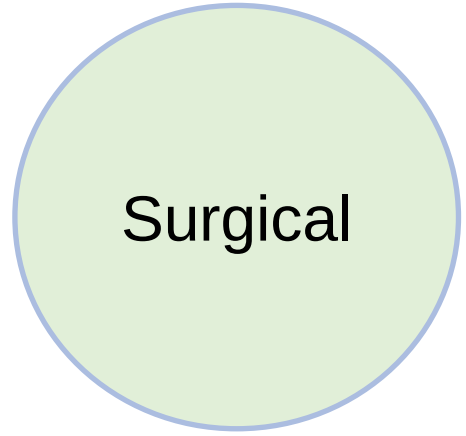
Child and adolescent Health Services (CAHS) Board

Perth Children's Hospital
CAMHS
Midland Community Health Hub

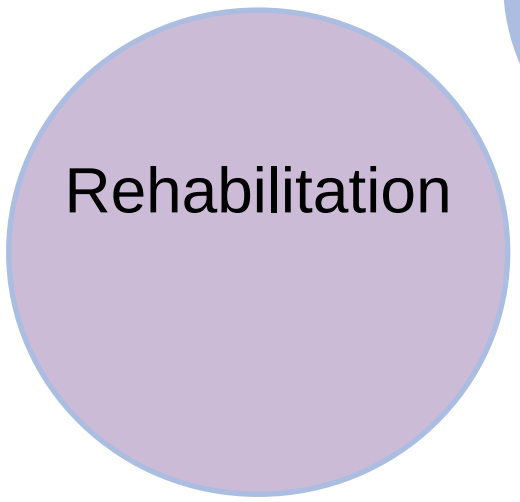
General Medicine
Oncology
Renal

- Voluntary
- Involuntary
- Rehab





Gastroenterology
Day Surgery
General Surgery



Patient journey from admission to discharge

Patient journey through the hospital – very broad breakdown of this journey

a. Admission – may change wards quickly

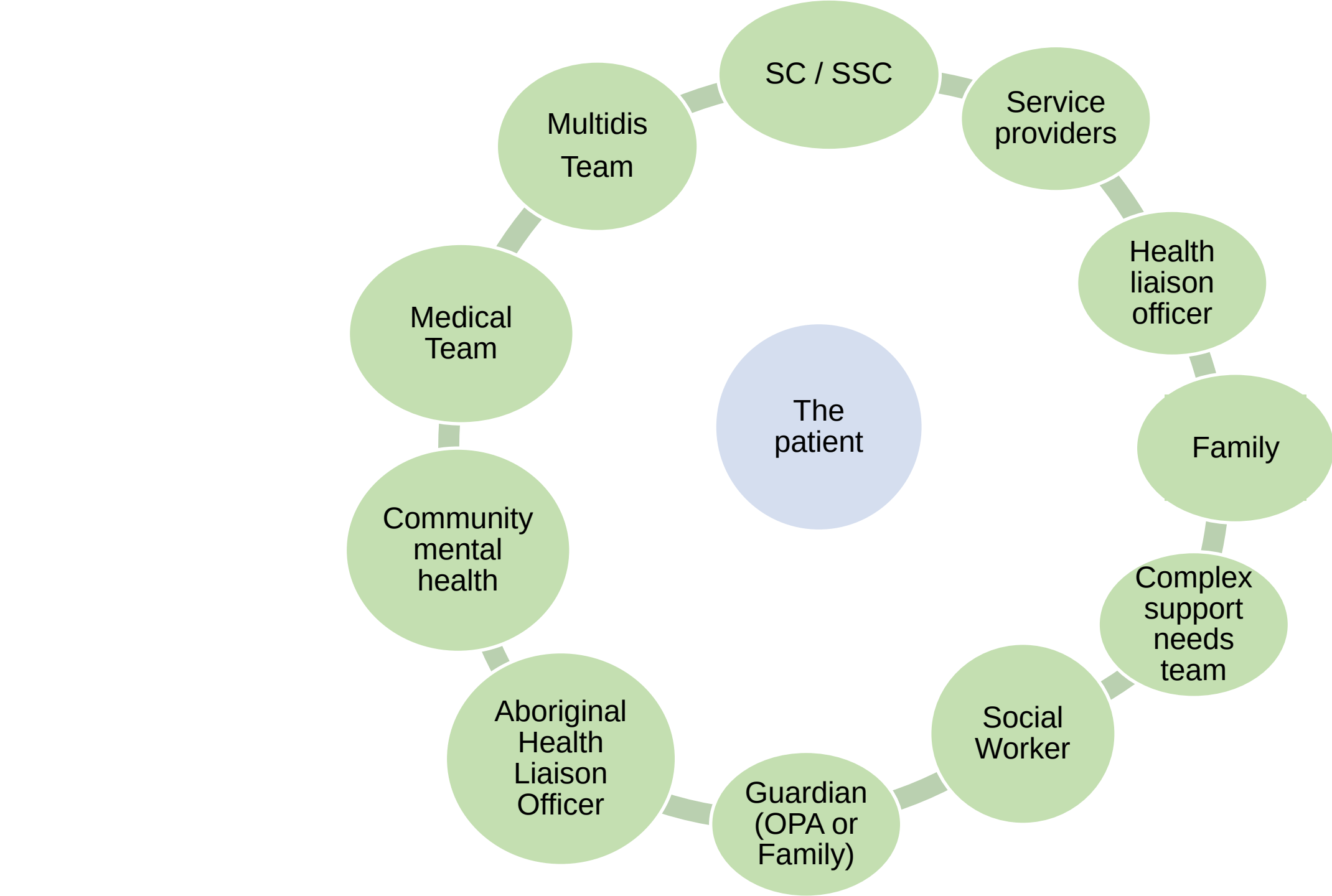
b. Moving wards/hospital

c. Discharge

d. Post discharge

Risks for long-stay patients at hospitals

1. Decline in functional capacity during medium to long admissions
2. Negative impacts on mental health, relationships, spirituality
3. Increased risk of infection and secondary illness (nosocomial infection)
4. Harm from medical/surgical management (Iatrogenic trauma)
5. Board and lodging


SC / SSC
Service providers
Health liaison officer
Family
Complex support needs team
Social Worker
Guardian (OPA or Family)
Aboriginal Health Liaison Officer
Community mental health
Medical Team
Multidis Team
The patient

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Case conferencing

Case Conferences should:

- Have the consent of and involve the Participant
- Have a clear agenda
- Have a clear chairperson: this could be the Support Coordinator
- Have clear outcomes
- Be documented, including all the actions allocated to all involved
- Have clear, agreed time frames for actions and review (this could also include an agreed date for the next Case Conference)

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Case conferencing

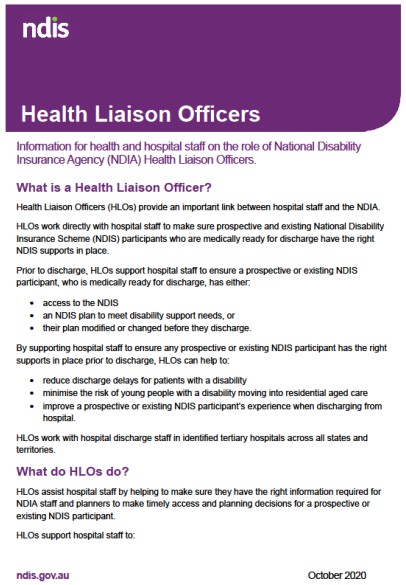
Case Conferences can often have the following attendees:

- The Participant
- Informal support person and/or Guardian
- Social Worker
- OT (inpatient and also possibly NDIS-funded community OT),
- Clinical inpatient medical team
- Nursing Unit Manager
- A representative from the NDIA (such as an NDIS Planner)
- Behaviour Support Practitoner

Case conferencing

Tips for support coordinators:

- ❑ Consent
- ❑ Who and how to collaborate with the hospital
- ❑ Set-up a case conference as soon as possible
- ❑ Request copies of documentation submitted by the hospital to NDIS
- ❑ Request a ‘purpose of medication form’ to be completed by the treating consultant – this will cover any medications which may be considered a restrictive practice
- ❑ Ask if the hospital completed a risk assessment for the participant and if so, request a copy
- ❑ Get confirmation on whether the person is medically ready for discharge or not
- ❑ Contact WA Health Liaison Officers where someone is medically ready for discharge and there are barriers from NDIS on the timeliness of this discharge



ndis

Health Liaison Officers

Information for health and hospital staff on the role of National Disability Insurance Agency (NDIA) Health Liaison Officers.

What is a Health Liaison Officer?

Health Liaison Officers (HLOs) provide an important link between hospital staff and the NDIA.

HLOs work directly with hospital staff to make sure prospective and existing National Disability Insurance Scheme (NDIS) participants who are medically ready for discharge have the right NDIS supports in place.

Prior to discharge, HLOs support hospital staff to ensure a prospective or existing NDIS participant, who is medically ready for discharge, has either:

- access to the NDIS
- an NDIS plan to meet disability support needs, or
- their plan modified or changed before they discharge.

By supporting hospital staff to ensure any prospective or existing NDIS participant has the right supports in place prior to discharge, HLOs can help to:

- reduce discharge delays for patients with a disability
- minimise the risk of young people with a disability moving into residential aged care
- improve a prospective or existing NDIS participant's experience when discharging from hospital.

HLOs work with hospital discharge staff in identified tertiary hospitals across all states and territories.

What do HLOs do?

HLOs assist hospital staff by helping to make sure they have the right information required for NDIA staff and planners to make timely access and planning decisions for a prospective or existing NDIS participant.

HLOs support hospital staff to:

ndis.gov.au October 2020

Interface with NDIA

Health Liaison Officers (HLO)

- Where are they located?
  - Fiona Stanley Hospital
  - Royal Perth Hospital
  - Sir Charles Gardiner Hospital / Perth Children's Hospital
- HLO's service the whole of WA
- The participant is determined to be 'Medically Ready for Discharge'
- Referral to HLO's can be made through support coordinators or the Hospital by emailing participant/potential participant details to wahealthliaison@ndis.gov.au

Internal health escalation pathways

- Each Health service area has an internal escalation pathways to the NDIS (same as other mainstream services)
- This is based on risk factors the hospital identifies
- It will be a different role in each health area

Practice Alert

Transitions of care between disability services and hospitals

November 2020

Key points

- Transitions of care refers to the movement of people between places or services providing care such as people moving between disability support services and hospitals.
- Transitions of care are key points where there is risk of harm to participants. In Australia, problems in transition of care have been associated with risks of harm to people who have a disability.
- Safe transition of care requires clear communication about, and coordination of, participant care between providers, health care staff, participants and their support network.

Background

People with disability have the right to the highest possible standard of health. This includes equitable access to health services that address their individual health needs, as well as access to appropriate supports before, during and after hospital admissions.

Services involved in supporting the health of Australian people with disability are guided by practice standards of safe, high quality health care and disability support.

Australian people with disability commonly access hospital services, with 22% being admitted to hospital and 26% having visited a hospital emergency department in 2015.

Australian reports on the deaths of people with disability outline serious and life-threatening risks if transitions of care are mismanaged. Areas of concern include the management of medications, and lack of necessary follow up care after hospital discharge.

Considerations for discharge

- Housing – where is the person going live after hospital?
  - Visit the home with the person?
  - Hospital to complete a home review?
- Disability related health supports required?
- Positive Behaviour Support (PBS) and restrictive practices
- Procedural considerations
  - Mealtime management?
  - Mobility requirements?
  - Behaviour Support Plan
  - Medication protocol
- Support Worker level requirements
- Health supports required for discharge
  - Rehab – in the home or as an outpatient
  - Hospital in the home
  - Equipment loan
  - Basic and essential modifications
  - Any community requirements? Community Treatment Order?

All of this can be determined at a case conference!

Disability-related health supports

Listen

Print this page

Since 1 October 2019, additional disability-related health supports have been available to purchase using NDIS funding. The typical types of support available can be grouped into eight 'support type' categories.

The following list of fundable supports is not exhaustive, and supports may be delivered in a range of ways.

- **Continence supports** +
- **Diabetic management supports** +
- **Dysphagia supports** +
- **Epilepsy supports** +
- **Nutrition supports** +
- **Podiatry supports** +
- **Respiratory supports** +
- **Wound and pressure care supports** +

TRANSITION PLAN

Participant and logistical details of move			
Participant Name:			
Key contacts: Guardian, Trust, Informal Supports:			
Reason for move:			
Moving **from:**	Address:	Organisation:	Contact:
Moving **to:**	Address:	Organisation:	Contact:
Date of move:		Time of move:	
Support persons to transport participant and belongings arranged for anything prior to and day of move?		Organisation and contact:	
Method of transportations on move day?		Multiple trips required? Hire? Van? Car? Taxi?:	
Trial or permanent move?		Type of accommodation funding (ie SIL, STA, MTA):	
Ratio of supports:		Funding secured? Or waiting on NDIA decision?:	
Change of circumstances submitted (if applicable)?		Date CoC submitted (If applicable)?:	

Transition Action List				
What? (If applicable)	**Additional Information / comments**	**Who?**	**When?**	**Completed**
PRIOR TO MOVE				

Case study

Paul is a street wise 30 year old man who has spent a lot of his adult life in and out of housing and on the streets. He has a good sense of humour and knows how to get his needs met, even if they may be contrary to his good long term physical and mental health. He loves music and taught himself to play the guitar. His goal is to move to Tasmania to be with his parents.

Paul's main supports are his father who lives in Tasmania and his brother who lives in Perth. He mother also lives with his father in Tasmania. Paul's father is currently in Perth in order to assist Paul with his transition out of hospital.

Paul is impacted by a long history of drug and alcohol addiction. He has been known to drink methylated spirits regularly when he can't get alcohol and drugs of any kind. He has thoughts of suicide and self harm on a weekly basis.

He has a health condition of diabetes where he has lost a leg as a result of mismanaged diabetes 6 months ago. He is still getting used to the disability of being an amputee and his wounds have not fully healed. He also has a Psychosocial Disability including drug induced Schizophrenia and a Personality Disorder.

Paul has been in Midland Hospital for the past 3 months as an admitted patient as a result of a deterioration in his physical health where he was not maintaining the wound care for his amputated leg. He was taken to hospital after he lost consciousness as a result of sepsis and was found in an extremely unsanitary condition.

You are referred Paul as he is not deemed as medically fit for discharge and he has acquired his first NDIS plan whilst in hospital. In hospital, staff has reported him to be compliant most of the time but quite headstrong around his treatment where he has not allowed his dressings to be changed when required and demanding around pain killer medication.

He has the following in his NDIS plan:

1. Core Supports total - $55,000
2. Improved Daily Living - $10,000
3. Improved Relationships - $8,000
4. Specialist Support Coordination - $8000
5. Capital – Wheelchair hire - $5000

He has no services currently involved.

Discussion

- Where to with Paul?
- Questions we have?
- First steps?

Open discussion

- Who is supporting someone in hospital now?

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Questions?

Thoughts?

Feelings?

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nulsen group

ADVOCACY KNOWLEDGE COMMUNITY DEVELOPMENTAL DISABILITY wa

https://ecsn.nulsen.com.au/easy-read-resources/

ECSN Hub > Articles > Easy Read Resources

Articles

Easy Read Resources

16 March 2021

Easy read resources are a valuable tool to use when supporting people with complex communication needs, supporting people who have difficulty in reading, and supporting people who English is not their first language.

The ECSN team are avid supporters of the use of these documents to support communication and assist people to understand things they are important for them. I decided to do some research and pull together a list of the different resources out there that are free and readily available.

I hope that you find this information helpful in your line of work.

The **Council for intellectual disability** has the following easy read resources available:

- Manage your money https://cid.org.au/resource/manage-your-money/
- Online meeting checklist https://cid.org.au/resource/online-meetings-checklist/
- Choosing your support worker https://cid.org.au/resource/choosing-your-support-worker/
- Wearing masks during Coronavirus https://cid.org.au/resource/wearing-masks-during-

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disability services

Thank you