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NSW GOVERNMENT | Family & Community Services

Hospitalisation Guideline

Summary: The Hospitalisation Guidelines were developed by NSW Health and ADHC. They are designed to assist staff of the two agencies to establish and implement support arrangements for people with disability before, during and after hospitalisation.

Family & Community Services
Ageing, Disability & Home Care

Hospitalisation Guideline

Document name	NSW Health and ADHC Joint Guideline to support residents of ADHC operated and funded accommodation support services who attend or are admitted to a NSW Public Hospital (The Joint Guideline)
Policy	Health and Wellbeing Policy
Version number	1.1
Approval date	April 2013
Policy manual	Health and Wellbeing Policy and Practice Manual Volume 2
Approved by	Chief Executive, ADHC & Deputy Director-General Strategy & Resources Div., NSW Ministry of Health
Summary	The Hospitalisation Guidelines were developed by NSW Health and ADHC. They are designed to assist staff of the two agencies to establish and implement support arrangements for people with disability before, during and after hospitalisation.
Replaces document	-
Authoring unit	Contemporary Residential Options Directorate
Applies to	People who are being supported in ADHC operated and funded accommodation support services.
Review date	2016

Version control

The first and final version of a document is version 1.0.

The subsequent final version of the first revision of a document becomes version 1.1.

Each subsequent revision of the final document increases by 0.1, for example version 1.2, version 1.3 etc.

Revision history

Version	Amendment date	Amendment notes
1.0	April 2013	Original version signed off by NSW Ministry of Health and ADHC
1.1	January 2016	Formatted for Health and Wellbeing Policy and Practice Manual Volume 2

NSW HEALTH

AND

AGEING DISABILITY AND HOME CARE (ADHC)

JOINT GUIDELINE

TO SUPPORT RESIDENTS OF ADHC OPERATED AND FUNDED

ACCOMMODATION SUPPORT SERVICES

WHO ATTEND OR ARE ADMITTED TO A NSW PUBLIC HOSPITAL

(THE JOINT GUIDELINE)

Table of contents

1 Introduction

1.1 Background

NSW Health and NSW Department of Family and Community Services, Ageing, Disability and Home Care, (ADHC) have policies in place that require ADHC services and either Local Health Districts (LHD) or local hospitals to establish protocols which detail agreed support arrangements for people with disability living in ADHC operated and funded accommodation support services throughout their hospitalisation.

The NSW Health policy is the Policy Directive 2008_010: Disability: People with a disability: responding to their needs during hospitalisation, revised and reissued in February 2008. ADHC's policy is Health and Wellbeing and was reviewed in January 2016.

Following recommendations made by the NSW Ombudsman regarding the appropriate support of people with disability during hospitalisation, NSW Health and ADHC agreed to develop joint guidelines to assist the staff of respective agencies to establish and implement agreed local arrangements.

This Joint Guideline (the Guideline) was developed through the findings of an audit and in consultation with key stakeholders across health and disability sectors.

Some LHD and ADHC Districts have already developed local protocols which provide the framework for effective support of ADHC clients during a hospital stay. The Guideline aims to facilitate a higher level of compliance with existing NSW Health and AHDC policies.

As a minimum requirement, all local protocols need to comply with the general principles set out in this Guideline. Providing these principles are included in local protocols, all other protocol features can be negotiated, expanded and adapted to meet existing local needs.

The Guideline does not apply to people who access ADHC operated and funded centre based respite services.

1.2 Aims of the Joint Guideline

1. To ensure that staff working in hospitals and disability accommodation support services are aware of their respective roles and responsibilities to people with disability before, during and after transfer of care from hospital.
2. To provide a framework for best practice for health care staff and disability support staff/nurses so together they can:
    - ***identify areas of risk that could compromise a person with disability's capacity to achieve the best health outcomes and their safety and/or dignity during a hospital stay;***
    - ***agree on what additional supports are required to reduce identified risks; and***

- ***negotiate responsibility and resources for the provision of agreed additional support.***

3. To link and reference each agency's policies rather than replicating them. (Staff should refer to relevant policies where indicated in this Guideline.)

2 Principles

2.1 Person-centred approach

Person centred approaches share a common philosophical background based on the values of human rights, independence, choice and social inclusion. They place the person at the centre of decision making, and treat family, natural networks of support, and service providers as partners.

Person centred approaches underpin the way people with disability are supported in ADHC operated and funded accommodation support services and reflect a different way of thinking about a person. Person centred thinking places the person at the centre and looks at the whole of someone's life from their own perspective to discover their preferred lifestyle and what is important to them, and what is important for their health and wellbeing and how they can be supported to achieve these.

For the person to be at the centre of decision making he or she needs to be well informed about the hospital experience. Refer to the NSW Council for Intellectual Disability website for information about going to hospital in easy English[1].

2.2 Patient centred care

Patient centred care is geared toward using resources to develop a culture where the patient is both the heart of the system, and the driver behind every change.

2.3 Communication

Good communication between the person, their family/guardian, medical/hospital staff and disability support staff/nurses, and sharing information about the person's health and disability support needs, understanding, expectations and feelings, make a positive difference to a person's health outcomes.

The NSW Health Policy Directive Disability: People with a Disability: Responding to needs during hospitalisation PD 2008_010, emphasises the need for hospital staff to communicate directly with the person with disability, and include the person's family/guardian and/or disability support staff/nurses.

Disability support staff/nurses have a responsibility to ensure that hospital staff are aware of how the person communicates. This requires inclusion of communication needs and preferences in the Hospital Support Plan, as well as providing a

[1] http://www.nswcid.org.au/health/ee-health-pages/easy-fact-sheets.html

Communication Plan if available, demonstrating the use of communication aids, interpreting gestures, signs and behaviours which people may use to convey their needs and responses.

Severe communication difficulties create particular challenges for the person and hospital staff. Diagnosis, assessment of pain and responses to treatment plans, including medications, may depend on picking up subtle changes in the person's behaviour. Disability support staff/nurses and the person's family are in the best position to provide information to hospital staff about what is 'usual behaviour 'for that person.

The '10 Tips for Safer Health Care'[2] (see Other resources) advises patients to take part in decisions, learn about their condition and treatment, understand their medication, and discuss treatment options with their health care givers. This flyer may be a useful tool for improving communication between people with disability, disability support workers/nurses and health care providers. It is available at: http://www.health.gov.au/internet/safety/publishing.nsf/Content/BE79FB82644728ABCA2571C0000330FB/$File/10tipsumbwnbx.pdf

The NSW Health Policy Directive *Your Health Rights and Responsibilities* PD2011_022 outlines the rights and responsibilities of NSW Health services and staff, and patients and carers. Basic rights are detailed in the policy, including; Access, Safety, Respect, Communication, Participation, Privacy, and the Right to Comment. The Policy Directive sets out NSW Health's Public Patients' Hospital Charter and Commitment to Service. The publication incorporates the principles of the Australian Charter of Healthcare Rights and is consistent with the National Healthcare Agreement (NHCA) 2009.

2.4 Sharing information

Key information that hospital staff need to know about the person and their support needs should be provided in a universally consistent format and travel with the person around the hospital so that any health care professional can access it.

Part 1 of the Hospital Support Plan contains all relevant personal, consent, health/medical and disability support information necessary to help hospital staff provide safe and effective health care. The Hospital Support Plan is completed or updated by disability support staff/nurses as part of the quarterly review of the person's Health Care Plan.

The Hospital Support Plan may be inserted into the plastic sleeve of My Health Record, if it is used by the person, and presented to hospital staff at every pre admission/admission. The Hospital Support Plan is kept with the person at all times including all transfers of care.

[2] The flyer was produced originally by the Australian Council for Safety and Quality in Health Care (now the Australian Commission on Safety and Quality in Health Care) to encourage patients throughout Australia to become more actively involved in their health care.

2.5 Sharing expertise

Sharing expertise to ensure that people with disability achieve the best health care outcomes is central to this Guideline.

Establishing collaborative and respectful partnerships between hospital staff and disability support staff/nurses in the context of a multidisciplinary approach with clinical, nursing, medical and disability support expertise. The partnership respects and listens to the contribution of each stakeholder and collaborates as a team to support the person at the centre.

Part 2 of the Hospital Support Plan is designed to facilitate the sharing of clinical and disability support expertise. It provides the framework to negotiate the range and level of support the person will require during hospitalisation to ensure they achieve the best health outcomes and maintain their safety and dignity.

Part 2 of the Hospital Support Plan is completed in partnership with disability support staff/nurses, the nurse in charge of the unit/ward, the person and, if the person agrees, the family/guardian, at a pre admission meeting or as soon as the person is settled following an unplanned admission to hospital.

Disability support staff/nurses and the person should be involved in any review of the Hospital Support Plan. A person's support needs may change rapidly during a hospital stay due to changes in treatment or condition.

2.6 Capacity to Consent

It is the responsibility of the treating practitioner to determine if the person is able to give consent for medical or dental treatment. Disability support staff/nurses cannot provide consent for medical treatment under any circumstance but must ensure that the person responsible for giving consent is recorded in the Hospital Support Plan. Further information is available in the ADHC *Decision Making and Consent Policy*.

Consent requirements will vary depending on the capacity of the person with disability to give informed consent about medical treatment. Some people will be able to give consent themselves, but if they are incapable of providing informed consent, the responsibility will fall to the person responsible. If the person is to have 'special medical treatment', or the person is objecting to 'major' or 'minor' treatment as defined by the *Guardianship Act 1987*, the consent of the Guardianship Tribunal or the Supreme Court must be sought. For further information see the website of the Guardianship Tribunal[3].

Further information is available in the NSW Health *Consent to Medical Treatment – Patient Information* (PD2005_406). This policy also addresses the escalation process needed if a guardian is not available.

[3] www.gt.nsw.gov.au

3 Workforce

3.1 Role of disability support staff/nurses in the hospital/acute care

In general, the role of disability support staff/nurses is to support the person to navigate the care co-ordination and transfer of care pathways in the hospital system including:

- ***staying with the person until they are settled and comfortable following admission to hospital or transfer of care movements within the hospital***
- ***completing Part 2 of the Hospital Support Plan jointly with the relevant nursing/hospital staff, and participating in any subsequent reviews of the Hospital Support Plan***
- ***assisting hospital staff to communicate with the person***
- ***ensuring that hospital staff are aware of, and act on, the information provided in the Hospital Support Plan***
- ***obtaining regular updates, preferably daily, on the person's progress and treatment***
- ***visiting regularly to ensure the person is settled and comfortable***
- ***communicating care coordination and transfer of care discussions to the person's family, person responsible or guardian***
- ***supporting the person during any transfer of care movements within the hospital***
- ***participating in planning for the person's care co-ordination in hospital and transfer of care out of hospital.***

The level of support will depend on the needs of each person. Unless it is negotiated and agreed in the Hospital Support Plan, it is not the role of disability support staff/nurses to stay with the person once they are settled in the hospital ward.

Disability support staff/nurses should **not** provide the following support:

- ***bathing or showering***
- ***administering medications***
- ***assistance with PEG feeding***
- ***assistance with feeding unless otherwise agreed in the Hospital Support Plan, Part 2***
- ***performance of specific health procedures e.g. pressure care***
- ***assistance to other patients***
- ***write in hospital files***
- ***provide clinical notes on the person***

3.2 Work Health and Safety for disability support staff/nurses in hospital/acute care setting[4]

Part 2 of the Hospital Support Plan must be completed by both hospital and disability support staff/nurses to determine if any additional on-ward assistance is required from disability support staff/nurses to support the person while they are in hospital. It will identify:

- ***risk areas that may impact on the person's health and safety during their hospital stay***
- ***agreed support arrangements and duties and responsibilities of disability support staff/nurses in relation to those arrangements***
- ***how additional support arrangements will be resourced***
- ***clear reporting requirements for both parties as disability support staff/nurses are required to accept direction from hospital staff in regard to their conduct and agreed duties.***

The hospital is required to induct disability support staff/nurses, who are supporting the person in hospital, to the hospital site and its health and safety policies and procedures.

In general, the Person Conducting a Business or Undertaking (PCBU) or the workplace, of the disability support worker, is responsible for any injury incurred in the course of their employment. Injuries should be reported by injured disability support staff to their workplace as soon as possible.

In normal circumstances, the NSW Treasury Managed Fund (TMF) will cover disability support staff/nurses employed by ADHC, as an entity of NSW Health, for all associated liabilities when they accompany a person from their accommodation support service to hospital.

Where a disability support worker/nurse is employed by a Non Government Organisation (NGO), NSW Health requires a copy of the NGO Workers Compensation, Professional Indemnity and Public Liability Certificates of Currency, before allowing them to provide support to the person on hospital premises.

If a disability support worker/nurse injures the person they are supporting whilst they are a patient in a hospital, the appropriate insurance would respond to any claim made by the person against the disability support worker/nurse, ADHC or the NGO, whichever is relevant. Should it be proven that the hospital contributed to the injury, NSW Health, through TMF, would respond to any claim.

If a disability support worker/nurse is injured while assisting the person they are supporting they are covered by their employer's workers compensation policy. If it can be proven that the hospital contributed to the injury, NSW Health would be joined in the claim and answer this under its own insurance.

[4] Refer to Work Health and Safety Act 2011 (NSW)

4 Care Coordination and Transfer of Care

Care Coordination and Transfer of Care arrangements for people covered by this Guideline should be made in accordance with NSW Health Policy Directive – *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals (PD2011_015)* and *Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals, Reference Manual* and *Care Coordination Patient Brochure* and *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals – Staff Booklet*

This Policy Directive (PD) requires that every admitted patient in an acute setting will transition through five stages of care coordination:

1. Pre Admission/ Admission
2. Multidisciplinary Team Meetings
3. Estimated Date of Transfer (EDT)
4. Referrals & Liaison to meet all patient needs
5. Transfer of care out of the hospital

Local Health Districts are responsible for establishing mechanisms to ensure that the essential stages of care coordination are applied in each facility and are sustained as part of the normal care coordination and transfer of care planning.

This Guideline provides additional guidance about how people with disability should be supported at each of the following five stages and what adjustments need to be made to ensure that the health care and additional support needs of people with disability are adequately met while in hospital.

Local Health Districts should use this Guideline in conjunction with the NSW Health Policy Directive – *Care Coordination: Planning for Admission to Transfer of Care in Public Hospitals (PD2011_015)*.

The five stages of care coordination should be implemented through:

- ***Development and use of an admitted patient 'Transfer of Care Risk Assessment (TCRA) Tool'***
- ***NSW Health staff should complete the Transfer of Care Risk Assessment (TCRA) to identify a person 'at risk'. The person with disability attending hospital may come with a My Health Record and Hospital Support Plan (HSP) which will guide how the person is to be supported at all stages of care co-ordination. As described in sections 1.4 and 1.5 of this Guideline, the HSP provides essential information about the person and should be considered by hospital staff when completing the TCRA.***
- ***All departments (including emergency) must have a guideline for care transfer of 'at risk' patients especially between the hours of 10pm and 8am. Where guidelines and checklists already exist (including in paediatrics) it should be confirmed that they comply with the requirements of this guideline.***

- ***The guidelines should have provision for identifying the 'at risk' patients' requirements prior to, during and following transfer of care to home or community and documenting strategies to meet those requirements.***
- Structured (set time and duration) multidisciplinary team meetings in each ward/unit with an allocated responsible person for the administration/ coordination of the meetings. Outcomes for people with disability are enhanced by close liaison between the members of the multidisciplinary team, Disability Support Workers/nurses, the person and, with the person's agreement, the family or guardian.
- Ensuring that the Estimated Date of Transfer (EDT) is allocated, documented, displayed near the bedside and on electronic patient management tools where appropriate, and reviewed for each patient at a multidisciplinary meeting.
- Monitoring of clinical EDT changes, and investigation of reasons for delay for patients staying longer than the EDT.
- Ensuring the Transfer of Care Checklist or equivalent is completed for all patients before they return to the community.
- ***The inclusion of a transfer of care checklist or equivalent information in the patient's medical record is mandatory.***
- ***Processes must be in place to ensure the formal results of tests performed in wards, units and EDTs are reviewed as soon as possible and within 48 hours of their availability, and are actioned appropriately.***
- ***All referrals, appointments, and follow-up information is discussed and provided to the patient, carer or appropriate service in writing, prior to transfer of care.***
- ***The aids, equipment or supports that the person requires on discharge are included in the checklist.***
- ***Notice of transfer of care is given to the person who will be providing the care, with enough notice to allow the provision of sufficient resources to support the person who is receiving care.***
- Development of standards for the quality and legibility of medical and nursing transfer summaries and a transfer of care plan for the patient.
- ***It is essential that separate papers used in wards, units and the EDT are processed and filed in a timely and efficient manner.***
- ***A process whereby the most commonly occurring procedures and conditions are included with plain language advice as part of the transfer of care plan.***
- ***Inclusion of the 'After hours GP Helpline' phone number with this information.***

5 Key Stages

5.1 Be prepared for hospital admissions

Disability support staff/nurses should ensure that the following documentation is up to date and readily accessible to take with the person to any planned or emergency hospital admission:

- My Health Record (if used by the person)
- Hospital Support Plan– the range of other management and support plans to be included in the Hospital Support Plan will depend on specific needs and requirements of each person.
- Medication Chart
- Webster packs and other required medications
- Health Care Card
- Medicare Card
- Communication Plan/Profiles and any related communication aids/tools

5.2 Emergency admission to hospital

In the case of an emergency or unplanned admission, a disability support worker/nurse familiar to the person should accompany them to hospital unless s/he is the only staff member on duty.

If s/he is the only staff member on duty, the Line Manager should be contacted to either organise back up staff for the disability support worker/nurse who is accompanying the person with disability to hospital, or to organise for another staff member or agency staff familiar to the person to go to the hospital. At this stage, if the person is able to agree, the family/guardian is also informed that the person is being taken to hospital.

The documentation listed above in 4.1 (“Be prepared for hospital admissions”) is collected and taken with the person to the hospital.

At the Emergency Department the disability support worker/nurse will:

- support the person with information and assistance to reduce fear and anxiety and to make them as comfortable as possible
- report to hospital staff any observations of behaviour that may be difficult to interpret or any other responses by the person
- introduce hospital staff to the person’s Hospital Support Plan, and ensure that hospital staff know that they should act on the information provided in the Hospital Support Plan
- familiarise hospital staff with, and demonstrate if necessary, the person’s method of communication

- assist hospital staff to develop the TCRA and participate in any other care co-ordination discussions as required
- communicate care coordination and transfer of care discussions to the person's family, person responsible or guardian.

The disability support worker/nurse will remain with the person during admission until decisions are made about the person's care co-ordination and treatment plans.

If the person is to be admitted to hospital then Part 2 of the Hospital Support Plan needs to be completed jointly with the disability support staff/nurse and relevant hospital staff to ensure that risks to the safety and wellbeing of the person while in hospital are identified, and appropriate supports to meet the person's needs are jointly agreed and documented. This should be done as soon as practicable either prior to transfer to the ward, or once the person is settled in the ward.

5.3 Pre admission/planned admission

The period of admission can range from a few hours (for day surgery) to several weeks. Planning should start as soon as the admission is scheduled in order to prepare the person for the admission and ensure their safety and wellbeing during the hospital stay. This process is described in detail in NSW Health Policy Directive – *Care Coordination: Planning for Admission to Transfer of Care in Public Hospitals (PD2011_015)*.

Disability support staff/nurses should:

- If the person is unable to provide consent, provide contact details of the 'person responsible' to hospital admissions staff once the decision is made to admit the person to hospital.
- Inform and involve the person's family/guardian in planning for the admission with the person's consent.
- Arrange a pre admission meeting to include, if possible, the person, and, with the person's consent the family/guardian, disability support staff/nurses and relevant hospital staff.
- Ensure that information about the hospital admission, hospital routines and procedures are communicated to the person in the person's own communication style.
- Prepare the person's documentation, as nominated in Section 4.1 above, to be up to date and ready to go with the person on the day of admission.

5.3.1 Pre admission meeting

The range of issues to be covered during the meeting will depend on the reason for the admission and the particular health and support needs of each person. The Hospital Support Plan should be used as the framework for the discussion and Part 2 of the Hospital Support Plan should be completed during the meeting.

The range and level of support that the person may require during their stay in hospital and responsibility for meeting identified support needs should be agreed to and documented in Part 2 of the Hospital Support Plan during the meeting.

The pre-admission meeting can also be used by hospital staff to identify:

- a key hospital contact person, if available, whose role is to facilitate a smooth and co-ordinated patient journey throughout the entire hospital stay and transfer out of hospital
- adjustments that could be made in the hospital environment and care co-ordination pathway to minimise stress and discomfort and facilitate safety and wellbeing of the person while in hospital for example:
- ***allocating first appointment times for people who have been fasting in preparation for tests***
- ***arranging in advance, priority access to other departments within the hospital if further tests and investigations are going to be conducted as part of the hospital admission***
- ***ensuring ward facilities are accessible and arranged to better accommodate the needs of the person prior to admission such as communication resources, mobility devices and functional aids.***
- ***any training or familiarisation for hospital staff that could be done either, prior to the person arriving or, during their stay to better prepare staff to support the person while in hospital.***

Planning for the transfer out of hospital back home should also commence at the pre admission/admission stage. As far as possible, the person's likely post-transfer medical/ treatment plans and support needs and arrangements to meet these additional or changed needs should also be discussed at the meeting.

5.4 During the hospital stay

Where there are agreed support arrangements as documented in Part 2 of the person's Hospital Support Plan, these will be implemented during the person's stay in hospital. The Hospital Support Plan should be reviewed jointly if the person's care is transferred to other units within the hospital, and if the person's treatment plan is changed.

Otherwise, during the hospital stay the general responsibilities of disability support staff/nurses are to:

- ***visit regularly to ensure the person is settled and comfortable***
- ***remind hospital staff to act on the information provided in the person's Hospital Support Plan***
- ***obtain regular updates, preferably daily, on the person's progress and treatment plan***
- ***communicate with the person's family, or guardian, to ensure consistent information is being provided about the person's progress, treatment plan and any transfer of care within the hospital***
- ***if a key hospital contact person was identified and agreed to at the pre admission meeting, maintain contact with the key person, particularly if the person is moved between wards/units***

- ***if the person is moved between wards/units ensure My Health Record (if used by the person) and the Hospital Support Plan have accompanied the person to the new ward/unit, and that hospital staff know they are to act on the information they contain.***

Refer to Section 2.1 for further information about the role of disability support staff/nurses.

5.5 Transfer of Care out of hospital

Planning for transfer back home should commence at pre admission/admission, when the person's post-transfer support needs are identified during the pre admission planning meeting or, following an unplanned admission, when Part 2 of the Hospital Support Plan is being completed.

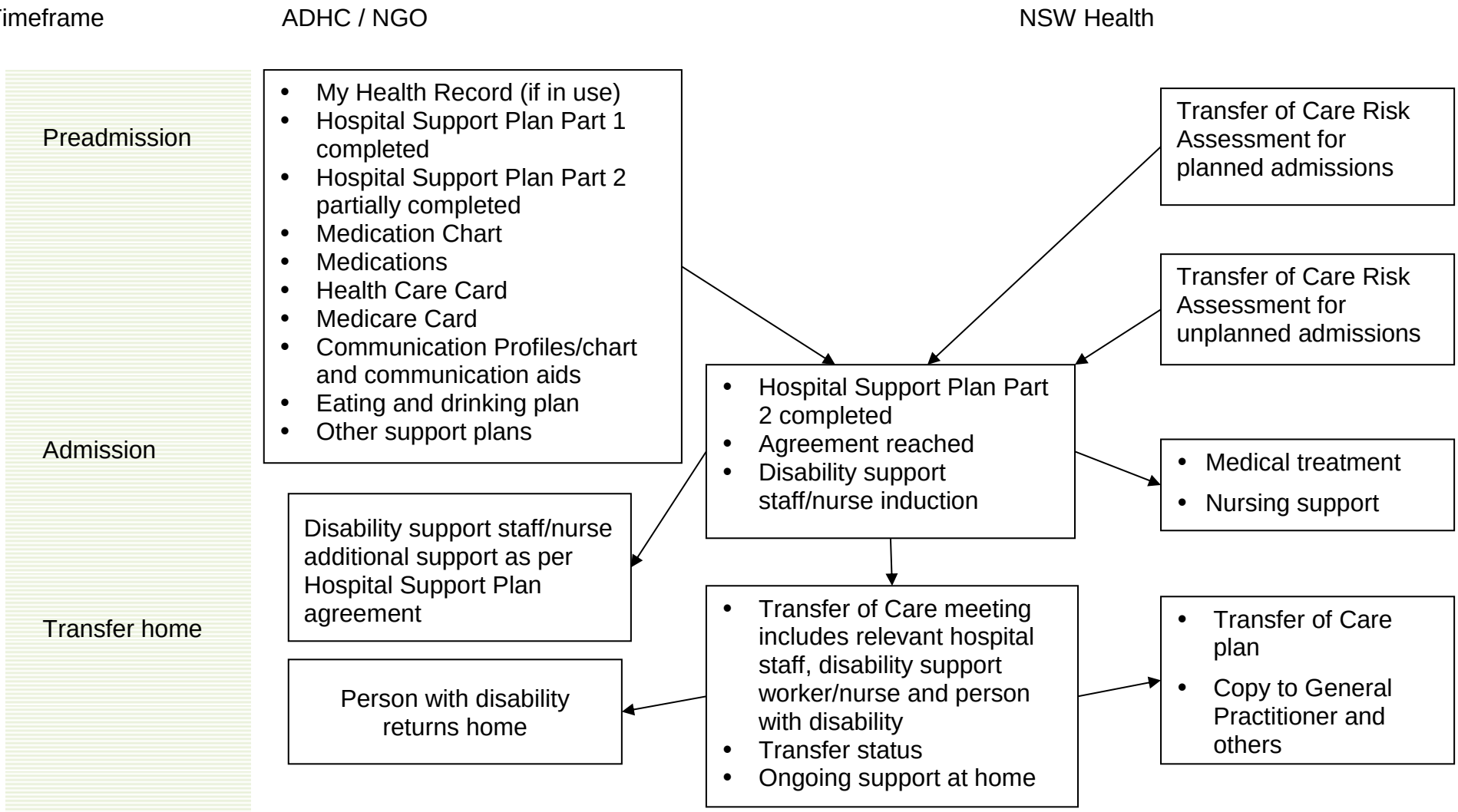
Transfer of care is carried out in accordance with Section 5.1 of the NSW Health Policy Directive: *Care Coordination: Planning for Admission to Transfer of Care in Public Hospitals (PD2011_015).* This requires completion of a Transfer of Care Checklist by hospital staff that contains the following information:

- Estimated date of transfer
- Destination of transfer
- Notification/transport booked
- Personal items returned
- Referral services booked
- Care plan
- Transfer of Care Summary provided to patient that includes medication information, community and GP referral information and follow up appointments. This should be provided in plain language and explained to the patient.

Disability support staff/nurses should familiarise themselves with what the Policy Directive requires to transfer the care of the person out of hospital and back home safely and with optimum health outcomes. They should participate in and contribute to the formulation of the person's Transfer of Care Summary in collaboration with the hospital's Nurse Unit Manager.

Disability support staff/nurses should ensure that the Transfer of Care Summary has been developed and is available at the time the person is discharged.

ADHC / NGO / NSW Health - Planning for people with disability



6 Resolution of issues arising during the hospital stay

The Guideline promotes sharing of information and expertise and a collaborative approach to the care and support of people who require hospitalisation.

If concerns arise about the wellbeing of the person, or the arrangements agreed to in the Transfer of Care Summary cannot be clarified with the Nurse Unit Manager, the escalation process at Appendix 1 should be followed.

7 Local liaison mechanisms

The NSW Health Policy Directive *PD 2008_010: Disability: People with a disability: responding to their needs during hospitalisation* identifies that education of hospital staff regarding the particular needs of people with disability should be a priority.

Local liaison between agencies can occur in a number of ways and provide a useful vehicle for exchange of information, identifying training needs, continuous quality improvement and issue resolution. Where there are no established mechanisms for local liaison, these should be established to provide members with the opportunity to discuss respective training needs and to identify and implement solutions to issues which may arise in the operation of local joint protocols.

The composition of liaison committees and the frequency of meetings can be determined at the local level.

Issues may be identified through a range of sources, including:

- people with disability, their carers and families;
- Disability Support Workers/nurses;
- healthcare professionals;
- local complaint handling processes;
- specialised disability health units
- patient safety and clinical quality programs;
- Health Care Complaints Commission; and
- NSW Ombudsman.

8 Implementation and Monitoring

For NSW Health the implementation of this guideline should be included as part of the Local Health District's disability action plans.

As detailed the NSW Health Policy Directive *Disability: People with a Disability: Responding to needs during hospitalisation PD 2008_010*, it is suggested that a senior staff member of the Local Health District be allocated responsibility for leadership in coordinating disability issues and facilitating the development of

ongoing staff education and training within the area or as stated in relevant disability action plans.

It is expected that all Health professionals be familiar with relevant disability action plans.

In most Local Health Districts (LHD) there are existing patient safety and quality monitoring processes that can be used to identify any issues in the quality of health care provided to and received by patients with disabilities and associated outcomes. These Include:

- Incident Information Management System (IMMS)
- Complaints mechanism
- Consumer/patient satisfaction surveys and interviews
- Accreditation processes
- Periodic medical record audits
- Length of stay reporting

9 Policy and Practice Unit contact details

You can get advice and support about this Policy from the Policy and Practice Unit, Contemporary Residential Options Directorate.

Policy and Practice, Service Improvement

Contemporary Residential Options Directorate

ADHC

policyandpracticefeedback@facs.nsw.gov.au

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10 Glossary

Term	Explanation
'At-risk' criteria	Can include patients who are/have: Elderly (65 and over), developmental delay, disability, debilitation; mental illness; paediatric; presented with a head injury, post-ictal or with significant mechanism of injury and blunt trauma; a carer; intoxicated or has had recent drug ingestion; culturally or linguistically diverse; transferred home between 10pm and 8am. NSWH *Care Coordination: From Admission to Transfer of Care in NSW Public Hospitals, Reference Manual*.
Children and young people	Young people (16 or 17 years old) can consent to medical and dental treatment if they have the capacity to provide it, otherwise consent is provided by the person who has parental responsibility for the young person. Consent for a child to receive ordinary treatments is required from the person who has parental responsibility for the child. No consent is required to provide emergency treatment. Consent for a child or young person to receive special treatments is provided by the Guardianship Tribunal and in some cases by the Chief Executive of Community Services or a delegated officer. ADHC Maximising Health and Wellbeing for Children and Young People Living in Out-of-Home Placements Policy.
Disability Support Staff	Disability support staff includes: • Disability Support Workers/Team Leaders in ADHC group homes • Nurses/Residential Nurse Unit Manager in ADHC Large Residential Centres • equivalent positions in ADHC funded accommodation support services
Disability Support Worker	The Disability Support Workers are staff who provide direct support to persons with disability who reside in ADHC operated and funded accommodation support services. Support is provided for daily activities and life experiences to facilitate the development and enhancement of independent living and social skills.
Discharge/ Transfer of Care	The term discharge has historically referred to transfer from an acute care facility to any other service (including a patient's home). The term 'discharge' has been replaced by 'transfer of care' in PD 2011_015 Care Coordination:

Term	Explanation
	Planning from Admission to Transfer of Care in Acute NSW Health Services. This is because patient health care does not end when they leave hospital. 'Transfer of care' demonstrates that a patient's care continues beyond hospital as they receive care from another service/ facility/ or in the community. This could be by a patient's General Practitioner, community health, other organisation or independently by the patient. *PD 2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.*
Large Residential Centre (LRC)	An older style and existing model that provides 24 hour residential support for people with a disability in a congregate setting of more than 20 beds, built on a hospital service model and functional design. Stronger Together commits the NSW Government to gradually replacing LRCs with contemporary accommodation services.
Multidisciplinary Health Team	A multidisciplinary health team is usually led by a senior clinician. • A multidisciplinary team involves a range of health professionals, from one or more organisations, working together to deliver comprehensive patient care. The ideal multidisciplinary team includes: • General practitioners • Practice nurses • Community health nurses • Allied health professionals (may be a mix of state funded community health and private professionals) such as physiotherapists, occupational therapists, dieticians, psychologists, social workers, podiatrists and Aboriginal Health Workers • Health educators – such as diabetes educators Outcomes for people with disability are enhanced by close liaison between the members of the multidisciplinary team and Disability Support Workers/nurses.
Nurse	Nurses working in ADHC operated and funded accommodation support services, include registered nurses, enrolled nurses and assistants in nursing.
Patient centred approach	Patient centred care is geared toward using the resources we have to develop a culture where the patient is both the heart of the system, and the driver behind every change. We want to improve patient safety and build on compassion and care in our hospitals

Term	Explanation
	http://www.health.nsw.gov.au/pubs/2009/caring_together_hap.html
Patient / person	A patient is a person receipt of medical treatment in a health care facility/hospital. In this document people with disability may fulfil the role of a patient. Reference has been made to ADHC clients to refer to people with disability in receipt of support from an ADHC operated or funded accommodation support service.
Person centred	Person centred approaches to providing support, focus on the person's abilities. They involve listening to the person and learning what the person wants and needs, and supporting the person to make important decisions. Engagement with others who are important to the person, who will provide support to achieve the dreams and aspirations the person has identified, is fundamental to a person centred approach. ADHC Lifestyle Planning Policy (ADHC Lifestyle Policy and Practice Manual)
Person Responsible	A 'person responsible' is not necessarily the patient's next of kin. A 'person responsible' is either: • A guardian (including an enduring guardian) who has the function to consent to medical, dental and health care treatments or, if there is no guardian: • the most recent spouse or de facto spouse with whom the person has a close, continuing relationship. 'De facto spouse' includes same sex partners or, if there is no spouse or de facto spouse: • an unpaid carer who is now providing support to the person or provided this support before the person entered residential care or, if there is no carer: • a relative or friend who has a close personal relationship with the person. *http://www.gt.nsw.gov.au/information/publications.cfm#Consent%20to%20Medical/Dental%20Treatment)*
Request for Admission form	The Request for Admission form is filled out by a treating specialist requesting admission to hospital (usually for surgery).
Specialist Supported Living	Provide care to people with complex needs such as complex behaviour, complex health, or complex support needs relating

Term	Explanation
Services (SSL)	to ageing. The services are provided in contemporary forms of specialist supported living accommodation models which support the principles of the Disability Inclusion Act 2014 and the United Nations Convention on the Rights of Persons with Disabilities (the UN Convention).

Appendix 1

Decision making escalation process

In a case where the Hospital Support Plan cannot be successfully negotiated between the Nurse Unit Managers and Group Home Team Leader/Residential Nurse Unit Manager and/or Coordinator Accommodation and Respite/Nurse Manager Accommodation and Nursing Services or NGO equivalent staff, the following escalation process should apply:

ADHC / NGO	NSW Health
• Manager, Accommodation and Respite • NGO Manager • Nurse Manager Accommodation and Nursing Services	• Nursing/Midwifery Unit Manager (N/MUM) • (or equivalent – person in charge of shift)
• Director Disability and Home Care • NGO Senior Manager • CEO Large Residences • Manager Riverside	• Director of Nursing and Midwifery (DON/M)
• FACS District Director • NGO Director • Executive Director LRC SSL	• LHD Director, Clinical Operations
• Deputy Chief Executive • NGO CE	• CE, LHD

In resolving an agreed Hospital Support Plan, the following should be considered:

- Time line should be considered. For example some issues should be resolved within 24 hours.
- Escalation from line manager to 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 this support and how this support is funded may need to be escalated to Manager, Accommodation and Respite and NSW Health representative (with relevant delegation).