

Disability Resource Hub Disclaimer

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Hospitalisation Guideline Tools and templates

Summary: The Hospitalisation Guideline Tools and templates provide resources to be completed when supporting a person with disability before, during and after hospitalisation.



Tools and templates

Hospitalisation

1. Hospital Support Plan Parts 1 and 2
2. TOP5 template

Hospital Support Plan - Part 1

Key information about the person- keep with *My Health record* (if used by the person)

Part 1 of the Hospital Support Plan is completed or updated by disability support staff/nurses at the quarterly review of the person's Health Care Plan, or sooner if there are changes in the person's health and circumstances.

Personal details

Name		Preferred name	
CIS No.		TRIM	
Date of birth	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Address			
Phone number			

Health Care Card number	Name of general practitioner
Medicare number	Phone number
Private health insurance number	
Religion / religious considerations	Language /cultural considerations

This person is AT RISK	ALERT
Examples: Allergic reaction to MEDICATION (e.g. Penicillin) Choking on food and fluids NIL BY MOUTH	

Person who provides consent for medical or dental procedures

Name		Relationship	
Phone number (home)	(work)	(mobile)	
Interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No		Language	

Medication

Does the person require medication to be administered during the admission? (If yes, attach copy of current Medication Chart) <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the person need help with taking medication? (If yes, describe, e.g.: Tom will swallow tablets whole if they are given with a spoon of strawberry yoghurt.) <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical information

<p>Summary of medical conditions: e.g. epilepsy, heart problems, breathing problems, swallowing problems. Please attach Health Care Plan and relevant management plans for more information</p>
<p>Does the person have sight or hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe for example: Mary is short sighted and must have her glasses on or where she can reach them at all times. Mary gets very irritable and frustrated if she can't see properly.</p>
<p>Brief description of common health/medical interventions e.g. how blood is usually taken, injections given, temperature taken, blood pressure measured etc?</p>

Disability service provider contacts

<input type="checkbox"/> ADHC		<input type="checkbox"/> NGO	
Name and position of contact person			
Phone		Mobile	
Name and position of alternative contact person			
Phone		Mobile	
Contact for after hours support (in emergencies if no response on above numbers)			
Name and position			
Phone number		Mobile / Pager	

Communication (attach the person's communication profile or chart)

How does the person communicate?
Can the person make choices?
What is the best way to help the person understand what others are saying to her / him?
Can the person read and comprehend what is written?
How do people know if the person is happy, sad, sick, anxious, confused?
How will the person indicate the following? <ul style="list-style-type: none">▪ Needs assistance to go to the toilet _____ _____▪ Hunger _____ _____▪ Thirst _____ _____▪ Pain _____ _____▪ Menu choice _____ _____

Mobility

<p>Does the person use an aid or require assistance to move around in bed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe e.g. Mary is unable to turn over without help. She has fragile skin and needs to be turned every two hours to avoid developing pressure areas.</p>
<p>Does the person use an aid or require assistance to move around the ward? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe, example 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: Electronic equipment requires a recharge overnight.</p>

Meal time assistance/swallowing, nutritional requirements and menu choice (attach Mealtime Management Plan)

<p>Describe any specific meal time assistance required by the person. For example set up of meal tray, needs full assistance, eats without assistance, uses modified cutlery.</p>	
<p>Meals must be texture modified</p> <p><input type="checkbox"/> Unmodified – Regular Foods</p> <p><input type="checkbox"/> Textured A - Soft</p> <p><input type="checkbox"/> Textured B - Minced & Moist</p> <p><input type="checkbox"/> Textured C - Smooth & Pureed</p> <p><input type="checkbox"/> Fully Liquid Diet</p> <p><i>Australian Standardised Terminology and Definitions for textured modified food and fluids 2007</i></p>	<p>Drinks must be texture modified</p> <p><input type="checkbox"/> Unmodified - Regular Fluids</p> <p><input type="checkbox"/> Level 150 - Mildly Thick</p> <p><input type="checkbox"/> Level 400 - Moderately Thick</p> <p><input type="checkbox"/> Level 900 – Extremely Thick</p>
<p>Does the person require enteral feeds? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach a copy of feeding regimen</p>	

Toileting

<p>Does the person require assistance with toileting or use of continence aids? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe, e.g. Mary has a toilet time routine and needs to be offered to go to the toilet every two hours.</p>

Personal care (attach relevant care plans)

<p>Does the person require assistance with dressing, showering/bathing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe, e.g. Mary requires a shower chair and full assistance with showering, drying off and dressing. Mary must brush her teeth daily. Her tooth brushing routine is described in the attached Oral Care Plan.</p>

Behaviour

Does the person have a behaviour support plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, attach a copy.	
Describe any behaviour that hospital staff need to be aware of, what might trigger the behaviour, and how hospital staff should respond.	
Behaviour	Response

Personal preferences

What makes a good day for	What makes a bad day for
Describe below things that make the person happy, for example: <ul style="list-style-type: none"> ▪ Watching TV, reading, listening to music. ▪ Being spoken to clearly and quietly. ▪ Having favourite foods. ▪ Having personal space honoured. ▪ Being able to follow preferred routines for bathing and mealtimes. 	Describe below things that make the person unhappy, for example: <ul style="list-style-type: none"> ▪ Feeling confused by having too many people in the room at once. ▪ Not understanding what is happening. ▪ Being given fish for dinner. ▪ Being rushed through shower time.

Part 1 completed by:

Position / relationship	Sign and date
Person	
Family / guardian / carer	
Key worker	
Line manager	

Hospital Support Plan – Part 2

Support needs and how they are met

Part 2 of the Hospital Support Plan is **partially completed** by disability support staff/nurses at the quarterly review of the person's Health and Wellbeing Plan, or sooner if there are changes in the person's health and circumstances.

Parts 1 and 2 of the Hospital Support Plan are kept with the person's My Health Record (if used by the person) ready to take to any planned or unplanned hospital admissions.

It is **fully completed jointly** by hospital staff **and** disability support staff/nurses, family members and others who know the person well, either at the pre admission planning meeting for planned admissions, or at the earliest opportunity for unplanned/emergency admissions to hospital.

Its purpose is to:

- identify areas of risk that may compromise the person's ability to achieve the best health outcomes, or that compromise the person's safety and/or dignity during a hospital stay
- agree on what supports are required to reduce identified risks; and
- negotiate responsibility and resources for the provision of agreed additional support.

Assessment completed by:	Name	Signature	Date
Nursing Unit Manager			
Disability support worker/nurse			
Family Member(s)			

Work Health and Safety

The disability support worker/nurse who is providing support to the person in the hospital has been inducted to the hospital site and made aware of Work Health and Safety procedures.

	Name	Signature	Date
Nursing Unit Manager providing induction			
Disability support worker/ nurse who received induction			

How to complete Part 2

When additional support needs are identified the plan uses the following key to identify the level of support the person requires and who provides it.

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 family.
Level 3	Additional on-ward support required. Support to be provided by the hospital (<i>for example: use of equipment loan pool</i>).
Level 4	Additional on-ward support required. Support to be provided by the disability support staff/nurse.

Examples

Communication needs	Needs known	Level of risk	Support level	Agreed action
Can the person communicate needs, including pain?	Yes	Low	1	1. Mary's Communication Plan and Communication Board must always be with her where she can reach it to use 2. Disability support staff/nurse to familiarise hospital nursing staff with the Communication Plan and demonstrate how to use the Communication Board. 3. Nursing Unit Manager to check at every shift change that all nursing staff know how to use Mary's Communication Board.
	Unknown	Medium	2	
	No	High	3	
			4	

Mental Health needs	Needs known	Level of Risk	Support Level	Agreed Action
Is the person likely to self harm?	Yes	Low	1	1. Ensure hospital staff understand/ have access to Mary's Behaviour Support Plan. 2. Key worker to attend 1-2 hours per afternoon to check management of support.
	Unknown	Medium	2	
	No	High	3	
			4	

Communication

Communication needs	Needs known	Level of risk	Support level	Agreed action
	Tick as appropriate	Tick as appropriate	See Key Tick as appropriate	See examples
Can the person communicate needs, including pain?	Yes Unknown No	Low Medium High	1 2 3 4	
Can the person understand a verbal explanation of procedures?	Yes Unknown No	Low Medium High	1 2 3 4	
Summary of additional support needs to be met with identified hours and notes				

Safety

Safety needs	Needs known	Level of risk	Support level	Agreed action
	Tick as appropriate	Tick as appropriate	See key Tick as appropriate	See examples
Can the person maintain her/his privacy and dignity?	Yes Unknown No	Low Medium High	1 2 3 4	
Is the person able to find her/his way around the hospital?	Yes Unknown No	Low Medium High	1 2 3 4	
Can the person maintain her/his own safety in the ward?	Yes Unknown No	Low Medium High	1 2 3 4	
Can the person maintain her/his own safety outside the ward?	Yes Unknown No	Low Medium High	1 2 3 4	
Summary of additional support needs to be met with identified hours and notes				

Mental health

Mental Health needs	Needs known Tick as appropriate	Level of risk Tick as appropriate	Support level <i>See Key</i> Tick as appropriate	Agreed action <i>See examples</i>
Is the person at risk of self harm?	Yes Unknown No	Low Medium High	1 2 3 4	
Is the person violent towards others?	Yes Unknown No	Low Medium High	1 2 3 4	
Is the person destructive of property?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person need to be constantly moving around?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person exhibit behaviours that may offend others?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person get anxious?	Yes Unknown No	Low Medium High	1 2 3 4	
Summary of additional support needs to be met with identified hours and notes				

Health and wellbeing

Health and wellbeing needs	Needs known Tick as appropriate	Level of risk Tick as appropriate	Support level See Key Tick as appropriate	Agreed action See examples
Does the person maintain her/his personal hygiene?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person maintain her/his fluid intake?	Yes Unknown No	Low Medium High	1 2 3 4	
Can the person eat meals and snacks without assistance?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person have dysphagia or is at risk of choking?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person currently experience seizures?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person go to the toilet independently?	Yes Unknown No	Low Medium High	1 2 3 4	
Can the person move around without assistance?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person have a regular sleep pattern?	Yes Unknown No	Low Medium High	1 2 3 4	
Is the person at risk from pressure areas?	Yes Unknown No	Low Medium High	1 2 3 4	
Does the person require any special equipment?	Yes Unknown No	Low Medium High	1 2 3 4	
Summary of additional support needs to be met with identified hours and notes				

Surname:
Given name:
Date of Birth Sex
(Affix patient label here)



Insert photo

Has Intellectual Disability
Extra assistance required
Lives with 24 hour support
Provide care in ALL ADLs

Support Strategies

1.

2.

3.

4.

5.

Compiled by :

Date:

Emergency Contact:

Telephone:

Ageing Disability and Homecare (South East Sydney District) would like to acknowledge Carer Support Unit, Central Coast Local Health District for developing the TOP 5 and supporting our agency to further develop TOP 5 for the people who live in homes run by ADHC.