



Government of **Western Australia**  
Department of **Health**

# Hospital Stay Guideline for Hospitals and Disability Service Organisations

**Disability Health Network**

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## Purpose of the Guideline

The *Hospital Stay Guideline for Hospitals and Disability Service Organisations* (the *Guideline*) was developed by the Disability Health Network and outlines a best practice approach for disability service organisations and hospitals when managing the hospital experience of individuals with disability.

The *Guideline* outlines opportunities for all areas of the health system (including non-hospital based services) and the disability sector to enable better engagement and planning when an individual with disability is:

- attending the emergency department
- being admitted to hospital
- being discharged from hospital back into the community.

For individuals with disability to maintain and achieve good health outcomes, the hospital system and disability service organisations must maintain effective partnerships. Through developing these partnerships, Health Service Providers and Disability Service Organisations (DSOs) can more appropriately and effectively support individuals with disability when there is a need for emergency or planned health intervention. A partnership also enables the hospital to gain a better understanding of the needs of individuals with disability and the disability sector.

The *Guideline* was developed through collaboration between health service providers and Disability Service organisations and is shaped by the following principles from the *WA Disability Health Framework: Improving the health care of people with disability 2015–25*:

- responsible and flexible
- respect and dignity
- person-centred
- collaboration
- continuous improvement.

This *Guideline* is intended to share expertise to ensure that individuals with disability achieve the best health care outcomes. Establishing collaborative and respectful partnerships between hospital staff and DSO staff in the context of a multidisciplinary approach is critical to improving the patient journey.

## Critical factors for consideration

As an individual moves from their home environment into a hospital the responsibility support may change as well. In some cases additional support may be required in hospital to enable the individual to access the care they need. The extent and arrangements for that support should be planned and agreed to by both those who provide the support in the home environment and the hospital. At the time of a health emergency this is difficult, so anticipatory planning is critical.

It should be noted that the family, friends and carers of an individual may still be providing a caring role when the individual they care for is in supported accommodation. There may be some cases where the family, friend or carer (where present) have the longest relationship with the individual and are ideally placed to provide valuable information about the individual, particularly where the individual has limited communication or decision making ability. The

family or a carer may be the decision-maker for an individual or there may be a Guardian in place. These are both important considerations.

It is the responsibility of both DSO staff and hospital staffs to have a clear understanding of the role of the family, friend or carer (where present) in the individual's care and to keep them informed and involved as appropriate. This responsibility is implied throughout the following sections wherever there is reference to communication between the DSO staff and hospital staffs.

Please note for simplicity, the term 'individual' has been used throughout the Guideline to refer to the 'individual with disability'. This also includes their family and/or carer, as appropriate.

Refer to the [Glossary](#) for further clarification of the terms used in this *Guideline*.

## How to use the *Guideline*

This *Guideline* is presented in two parts:

- **Part 1** consists of four sections, providing practical advice for hospital and disability service organisation staff in managing the individual's hospital stay from admission to discharge
- **Part 2** covers the background information of the guideline, associated policies and frameworks, and information on the Disability Health Network working group who developed the document.

### Section 1: Emergency Department Admission (with flowchart)

Attendance at a hospital Emergency Department, either via the DSOs transport or by ambulance. The individual may be treated in the Emergency Department (ED) and discharged, or a decision to admit may be made. Consideration should be given as to whether attendance at the ED is the best possible treatment option, or whether it is more appropriate to attend a General Practitioner (GP) or other primary health care provider.

### Section 2: Planned admission to ward (with flowchart)

A planned admission occurs following the identification of a health care need that requires non-urgent hospitalisation. This process will occur through the GP or specialist initiating the admission process. It is imperative that from this early stage the identification of hospital type and location is considered. This may be influenced by previous hospital stays, whether or not the individual has private health insurance and the referring doctor.

### Section 3: The hospital stay

During the hospital stay, the support needs of the individual will require negotiation between DSO and hospital staff. At this time, planning for discharge needs to begin, especially if there will be changes to care and support requirements once the individual leaves the hospital.

### Section 4: Discharge from hospital

The aim of discharge is to return the individual to the environment they left, and to ensure the appropriate supports are in place to protect both the individual and the facility. If an individual's support needs have changed significantly as a result of the hospital admission, the discharge plan will require revision.

## Who should use the *Guideline*

This guideline has been developed with the needs of front-line staff in mind, to enable the best possible experience for the person with disability. It is our hope that clinical staff, carers, and all others involved in supporting a person with disability through their hospital stay will utilise sections of this guideline as applicable to their situation.

Whilst the *Guideline* focuses on action to be taken by DSOs that provide supported accommodation and hospitals, it may also be used by DSOs that provide different services, as well as by individuals, families and carers. The principles and strategies can be applied to individuals at any age, not just adults living in supported accommodation settings. Non-accommodation provider DSOs, individuals, families and carers who look to use the *Guideline* should be aware that it is written to provide guidance for the role of the DSOs described here. This may mean that not all aspects of this guideline are applicable to their specific situation.

The *Guideline* may also be used for people living in rural or remote areas who require a hospital stay, however additional anticipatory planning by DSOs and hospitals should be undertaken, especially in situations requiring transfer to a metropolitan health service.

## Guiding Principles

The *Guideline* has been written in conjunction with the Guiding Principles of the WA Disability Health Framework:

- Person Centred – Individuals with disability, their families and carers are supported to make informed decisions about and to successfully manage their own health and care.
- Responsive and Flexible – Services and strategies will be responsive to the needs of individuals with disability.
- Respect and Dignity – Individuals with disability have the right to be respected, to make their own decisions, to feel safe, and to have opportunities to live a meaningful life.
- Collaboration – Collaboration between people with disability, their families and carers and service providers will benefit positive health outcomes.
- Continuous Improvement – programs and services will undertake continuous improvement processes to achieve best practice results.

Please refer to page 30 for further information on the [Guiding Principles](#).

## Documentation to be included

Clear, accurate and up-to-date documentation facilitates communication between the hospital and DSO and is vital for effective clinical handover during both emergency and planned hospital admissions. This should include information regarding the individual's:

- demographics
- health profile
- decision-making capacity
- individuals representative (where applicable)
- family or carer contacts.

[Appendix 1](#) provides a list of recommended information to be exchanged between DSOs and hospital system.

To ensure this information is available at the time of emergency presentation or admissions, DSO staff should keep the following documentation up-to-date and readily accessible at all times:

- Personally Controlled eHealth Record (PCEHR) - if used by the individual
- Hospital support plan – the range of management and support plans to be included in the hospital support plan will depend on specific needs and requirements of each individual.
- Dose administration aids (e.g. blister packs, asthma spacers, insulin pen) and other required medications
- Medication chart
- Copy of Guardianship Order
- Advance Health Directive, if one exists
- Health Care Card
- Medicare Card
- Department of Veterans Affairs (DVA) health card
- Private health insurance details.

It is also important that the information provided to the hospital is in a suitable format that is easy to use and is consistent with other record keeping procedures. A client transfer form used by an aged care provider is provided in [Appendix 2](#) as an example of how this information may be recorded and presented.

All relevant documentation should accompany the individual throughout their hospital stay; this includes at the emergency presentation, pre-admission clinic, during the hospital stay and after discharge.

A copy of this *Guideline* should be available for DSO staff to take with them to hospital if accompanying an individual



# Characteristics of Service Providers

The disability sector	The hospital system
<p><b>Characteristics</b></p> <ul style="list-style-type: none"> <li>• Provides services to assist individuals with disability to engage in everyday life.</li> <li>• Some DSOs may have health care staff. Those that do may or may not provide 24 hour health support service.</li> <li>• Individuals who are in supported accommodation may only be supported by support workers with no medical training.</li> <li>• The role of the DSO staff is vital in ensuring the individual has a safe and comfortable journey through ED and during admission.</li> <li>• The capacity for DSOs to support individuals with disability whilst they are in hospital varies considerably.</li> </ul>	<p><b>Characteristics</b></p> <ul style="list-style-type: none"> <li>• Provides types of health services that generally can't be provided in the community (e.g. by GPs).</li> <li>• Emergency departments are very busy places with lots of noise, activity and a variety of people with differing roles.</li> <li>• An individual may be moved multiple times within the ED area and may have contact with many different hospital staff.</li> <li>• Staff in hospitals care for a number of individuals with differing health care needs that can change dramatically in a short space of time.</li> <li>• Individuals will be discharged when their health care needs no longer require hospitalisation.</li> </ul>
<p><b>Considerations for DSOs:</b></p> <ul style="list-style-type: none"> <li>• the appropriate healthcare setting for the individual: primary care or hospital</li> <li>• strategies and actions that the DSO can take to prevent a hospital stay</li> <li>• the impact that the hospital stay has on the individual, during and after discharge</li> <li>• the history of hospital stays for the individual and how they were managed</li> <li>• what responsibility the DSO has to ensure the hospital stay goes well</li> <li>• whether the individual's health needs will be able to be met at their existing accommodation option post-discharge</li> <li>• acknowledge that the priority of hospital staff is the medical issue the individual presents with upon admission, not the disability-related needs of the individual</li> <li>• occasionally hospitals will not have capacity to admit an individual or may seek to discharge an individual earlier than anticipated - this may result in the individual being returned to their accommodation or transported to an alternative hospital.</li> </ul>	<p><b>Considerations for hospitals:</b></p> <ul style="list-style-type: none"> <li>• the appropriate healthcare setting for the individual: primary care or hospital</li> <li>• alternative services to hospital admissions such as Hospital in the Home, Rehabilitation in the Home, Silver Chain</li> <li>• review the hospital 'environment' to ensure it is disability friendly and welcoming</li> <li>• consider the support needs of the individual in planning and delivering hospital care</li> <li>• strategies and actions that the hospital can take to ensure the individual's hospital stay goes well and provides the best health outcome</li> <li>• the impact that the hospital stay has on the individual, during and after discharge</li> <li>• the history of hospital stays for the individual and how they were managed</li> <li>• type of healthcare, if any, which can be provided in the individual's supported accommodation or home setting</li> <li>• what other DSOs exist and what healthcare services they provide</li> </ul>

The disability sector	The hospital system
	<ul style="list-style-type: none"><li>• individuals with disability may have a large team of people who support them in the community, but those people may be unavailable in the hospital setting</li><li>• communication with the individual and their representative is critical to ensure that consent for healthcare is informed and legal and planning and delivery of hospital care is person-centred</li><li>• DSO staff can provide crucial information about the individual's support needs to assist the delivery of healthcare.</li></ul>

# Part 1

## Flowchart – Going to the emergency department

- Call ambulance
- Keep individual safe and comfortable

- Gather information relevant to the individual

- Pass documentation to ambulance staff
- Alert ambulance staff to key items

- Contact person and confirm their attendance. Ensure individuals representative is also contacted, if required.

- Alert triage staff of individual attending by ambulance and documentation with ambulance staff

- Wait times will vary on the state of the individual's health and those who are also presenting to the emergency department at the same time

- Hospital staff will assess health needs of individual
- Keep individual safe and comfortable

- Support individual to participate in investigation or treatment

- Medical staff assess health care need

- Support individual to return to accommodation
- **Transport**
  - Ensure individual has suitable transport
  - Arrange support for individual in accommodation

- Alert medical staff to individual's support needs
- **Admission to hospital ward**
  - Wait times will vary according to bed availability and stability of individual's health (see planned hospital stay flowchart)

- Communicate outcome of emergency department assessment to relevant staff and family
- Document outcome in individual's records

## Section 1: Emergency Admission – Going to the emergency department

Going to emergency department	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Transport to emergency department</b></p>	<p>Ensure relevant documentation and required aids/ equipment (see <a href="#">Appendix 3</a> for list) are collected and taken with the individual to hospital.</p> <p>If the individual is transported by ambulance ensure:</p> <ul style="list-style-type: none"> <li>• the individual’s documentation and required aids/ equipment go in the ambulance</li> <li>• the attending paramedics are briefed on: <ul style="list-style-type: none"> <li>▪ the presenting circumstances that required the ambulance call-out</li> <li>▪ any characteristics that may impact on the individual’s ambulance journey and presentation to ED.</li> </ul> </li> </ul> <p>If the individual is transported by ambulance but the DSO staff does not accompany the individual ensure:</p> <ul style="list-style-type: none"> <li>• the paramedics have the DSO provider’s contact details</li> <li>• the DSO staff is advised which hospital the individual is being transported to.</li> </ul> <p>It is essential that the DSO provider ensures an appropriate person attends ED to support the individual. This may be a staff and/or a family member or carer.</p> <p>Consider taking a copy of this <i>Hospital Stay Guideline</i> when accompanying an individual to hospital.</p>	<p>Ensure relevant documentation and aids/ equipment (see <a href="#">Appendix 3</a> for list) are collected when the individual presents at hospital.</p> <p>If the individual is transported by ambulance ensure:</p> <ul style="list-style-type: none"> <li>• the individual’s documentation and required aids/ equipment are in the ambulance and stay with the individual upon arrival at the hospital.</li> </ul> <p>If the individual is transported by ambulance but the DSO staff does not accompany the individual ensure:</p> <ul style="list-style-type: none"> <li>• the DSO staff is contacted upon the individual’s arrival at the hospital.</li> </ul>

Going to emergency department	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>At the emergency department</b></p>	<p>In the ED:</p> <ul style="list-style-type: none"> <li>• support the individual with information and assistance to reduce fear and anxiety and to make them as comfortable as possible</li> <li>• assist the hospital staff with any required information</li> <li>• ensure the individual's relevant documentation is passed on to hospital staff</li> <li>• report to hospital staff any observations of behaviour that may be difficult to interpret or any other responses by the individual</li> <li>• familiarise hospital staff with, and demonstrate if necessary, the individual's method of communication</li> <li>• remain with the individual during admission until decisions are made about the individual's care coordination and treatment plans</li> <li>• participate in any other care coordination discussions as required</li> <li>• communicate care coordination and transfer of care discussions to the individual and/ or their representative.</li> </ul>	<p>In the ED:</p> <ul style="list-style-type: none"> <li>• discuss the requirements of the individual with the individual and the DSO staff</li> <li>• alert the DSO staff if the individual exhibits behaviour that is difficult to interpret</li> <li>• engage in care coordination discussions with the DSO staff as required</li> <li>• communicate care coordination and transfer of care discussions to the individual and/ or their representative (or DSO worker if others are unavailable).</li> </ul>

Going to emergency department	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Triage</b></p> <p>Triage is a system of assessment which identifies those of greater need to be treated first. This occurs before any admission to ED.</p> <p>Individuals are rated in priority (1-5) by case severity of health needs. Rankings can fluctuate according to other ED presentations.</p>	<p>At triage:</p> <ul style="list-style-type: none"> <li>• be prepared for a possible lengthy wait</li> <li>• keep the individual comfortable and ensure they do not become distressed</li> <li>• support the individual to participate in the triage process</li> <li>• be available to answer any questions from hospital staff</li> <li>• support the individual to participate in the triage process</li> <li>• be prepared to advocate for the individual if required.</li> </ul>	<p>At triage:</p> <ul style="list-style-type: none"> <li>• assess the individual's health condition within a short period of time and assign a ranking (1-5) according to i) case severity, and ii) other ED presentations</li> <li>• keep the individual and DSO staff informed of changes in the individual's triage rating and estimated time</li> <li>• consider the emotional needs of the individual regarding waiting times, environmental conditions, noise levels and other issues that may impact on the wellbeing of the patient.</li> </ul>
<p><b>Post-triage</b></p> <p>Triage will result in the individual being:</p> <ol style="list-style-type: none"> <li>admitted to the Emergency Department immediately or,</li> <li>asked to wait due to the ranking assigned in Triage.</li> </ol>	<p>The activities undertaken by the DSO staff will vary according to the nature of the individual's case. The DSO staff accompanying the individual to ED needs to be prepared for either an admission to hospital or their being discharged home – a discharge decision may be made within as little as two hours from presentation.</p> <p>If the individual is to be admitted to hospital then DSO staff and relevant hospital staff to ensure that risks to the safety and wellbeing of the individual while in hospital are identified and communicated to hospital staff.</p>	<p>When the individual is admitted to ED, the hospital staff should communicate to the DSO staff if any further assessments and investigation – such as blood test, x-ray, ultra-sound – are to be undertaken. Some procedures may result in additional waiting time as medical staff await results or consider treatment options.</p> <p>If the individual is to be admitted to hospital then the hospital staff need to ensure that risks to the safety and wellbeing of the individual while in hospital are identified and documented (in clinical and nursing handover documents).</p>
<p><b>Case conference</b></p>	<p>The DSO staff should be aware that they may be included in a case conference around the health care management plan for the individual.</p>	<p>The hospital staff should contact the DSO staff to arrange the case conference, enabling the DSO staff to identify who should attend.</p>

Going to emergency department	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Transport back from the emergency department</b></p> <p>Attendance at ED does not automatically lead to admission or an overnight stay in ED – only 40% of people are admitted from ED to ward.</p>	<p>When the individual is discharged from hospital:</p> <ul style="list-style-type: none"> <li>• have transport prepared in advance – discharge will occur regardless of whether or not transport is available</li> <li>• ensure transport strategies are available at any time as discharge can occur at any time (e.g. 2am)</li> <li>• ensure the individual's medication and any aids/ equipment are with them</li> <li>• monitor the individual for a period of time after discharge in case the individual's condition deteriorates necessitating readmission to ED.</li> </ul>	<p>When the individual is discharged from the hospital:</p> <ul style="list-style-type: none"> <li>• offer to assist in organising transport options</li> <li>• ensure that a discharge letter accompanies the individual upon discharge</li> <li>• ensure all equipment belonging to the individual is transported with them.</li> </ul>

## Planned admission process

- Pre admission clinic or other referral pathway
- Ensure all relevant documentation is up to date and brought to the appointment
- Ensure appropriate communication between referring GP or specialist and DSO staff and/or individual's representative. Continue communication throughout process.

- Arrange transport for individual to hospital.

- Contact person and confirm their attendance.

- Keep individual safe and comfortable.

- Ensure all relevant documentation is up to date and bring to admission
- Alert admission clerk or ward staff to key items.

- Support individual to participate in investigation or treatment.

- Medical staff provide health care needs
- Provide appropriate support during hospital stay to individual
- Ensure all appropriate aids/ equipment are available to the individual.

- Support individual to return to accommodation.

- Arrange transport for individual
- Arrange appropriate support for individual in accommodation.

- Communicate outcome of hospital admission to relevant staff and family
- Document outcome in the individual's records.



## Section 2: Planned admission to ward

A planned admission occurs following the identification of a health care need that requires non-urgent hospitalisation. This process will occur through the general practitioner (GP) or specialist initiating the admission process. It is imperative that from this early stage the identification of hospital type and location is considered. This may be influenced by previous hospital stays, whether or not the individual has private health insurance and the referring doctor.

Planned admission to ward	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Admission via regular GP</b> A potential health issue is identified by the DSO staff requiring GP referral.</p>	<p>Refer the individual to his/her GP as the first point of contact – the GP will then determine the required need and admission.</p> <p>Ensure that communication between the GP and the DSO staff and/or the individual's representative occurs.</p> <p>Where required the GP will then commence the process either through planning this admission directly (if admitting rights are present) or referring to the appropriate specialist.</p>	<ul style="list-style-type: none"> <li>• Liaise with the individual's GP and the DSO staff (or individual's representative) to facilitate admission of the individual to hospital.</li> </ul>
<p><b>Admission via specialist (if applicable)</b></p> <p>Following identification of a potential health issue by the DSO staff, the individual is referred to a Specialist (also via GP referral).</p>	<ul style="list-style-type: none"> <li>• Accompany the individual to their appointment (if appropriate) or organise their representative to accompany them.</li> <li>• Support the individual to participate in the consultation.</li> <li>• Ensure that communication between the specialist and the individual's representative occurs if the Representative is unable to accompany the individual to their appointment.</li> <li>• Either attend or ensure the individual's representative attends this consultation to ensure the needs of the individual are identified and planning commences.</li> <li>• Ensure that discharge planning will be suitable and appropriate to the facility or identify the need for alternative accommodation.</li> </ul>	<ul style="list-style-type: none"> <li>• Liaise with the specialist and the DSO staff (or individual's representative) to facilitate admission of the individual to hospital.</li> </ul>

Planned admission to ward	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Pre admission clinic</b> Pre admission clinic appointments are critical to ensure optimal patient care occurs at admission and at discharge.</p> <p>The individual who has legal responsibility for consent should accompany the individual to this appointment – if this is not possible the DSO staff should attend.</p> <p>If the clinic <u>does not</u> occur then pre-admission planning with the specialist will still require appropriate communication.</p>	<p>At the pre-admission clinic:</p> <ul style="list-style-type: none"> <li>• ensure all documentation is collected and taken to the hospital at the point of admission</li> <li>• ensure that discharge planning occurs and that the individual, their representative and the DSO are all aware of the process</li> <li>• ensure that adequate time is allowed for the required needs to be actioned for the hospital stay – i.e. appropriate bed, equipment, consent</li> <li>• communicate admission plan details to the individual’s representative</li> <li>• ensure discharge planning is appropriate to the individual’s DSO – this may require someone with decision-making authority from the DSO to be available/present.</li> </ul>	<p>At the pre-admission clinic:</p> <ul style="list-style-type: none"> <li>• meet with the DSO staff to help plan discharge</li> <li>• ensure that the individual’s hospital notes and admission details are ‘flagged’ as requiring additional or specific needs</li> <li>• advise the individual and their representative or DSO staff of the outcome of the pre admission clinic which may be: <ul style="list-style-type: none"> <li>▪ cancellation</li> <li>▪ postponement</li> <li>▪ re-schedule</li> <li>▪ admission as planned.</li> </ul> </li> </ul>

### Section 3: Admission into hospital

Admission into hospital	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Planning and preparation for admission to hospital</b></p>	<ul style="list-style-type: none"> <li>• provide contact details of the individuals' representative to hospital admissions staff once the decision is made to admit the individual to hospital (if the individual is unable to provide consent)</li> <li>• inform and involve the individual's representative in planning for the admission, where appropriate</li> <li>• attend a pre admission process meeting (arranged by the hospital) to include relevant hospital staff, DSO staff, the individual and their representative, if possible</li> <li>• arrange a hospital stay planning meeting with the DSO staff, individual and individual's representative – this is scheduled by the DSO</li> <li>• ensure that information about the hospital admission, hospital routines and procedures are communicated to the individual in the individual's own communication style</li> <li>• prepare the individual's documentation, as per the Appendix 3, to be up to date and ready to go with the individual on the day of admission</li> <li>• identify the support needs of the individual whilst in hospital and clarify the availability of DSO staff to meet needs during the admission</li> <li>• ensure that equipment needs are identified, these may include mobility aids, communication aids and medical and therapeutic devices</li> <li>• take a copy of the Hospital Stay Guideline with them if accompanying an individual to hospital.</li> </ul>	<ul style="list-style-type: none"> <li>• ensure that effective communication between key stakeholders involved in the admission is maintained including clear communication of medical consent and decision-making protocol – this includes the individual, their representative, GP, DSO, specialist, pre admission clinic</li> <li>• clarify support roles with the DSO staff, e.g. the need for special nurses</li> <li>• arrange a pre admission process meeting to include relevant hospital staff, DSO staff, the individual and their representative, if possible</li> </ul>
<p><b>Providing equipment</b></p>	<ul style="list-style-type: none"> <li>• Continuously update the individual's property list</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure all property that enters the hospital with the</li> </ul>

Admission into hospital	Disability service organisation roles and responsibilities	Hospital staff roles and responsibilities
<p>Ensure all equipment that is provided by the DSO is labelled (property bag and list)</p>	<p>as required to ensure no equipment goes missing.</p>	<p>individual is labelled and returned to the individual upon discharge.</p>
<p><b>Period of admission</b> 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 individual for the admission and ensure their safety and wellbeing during the hospital stay.</p>	<p>Consider the support the individual will require during his/her hospital stay, including:</p> <ul style="list-style-type: none"> <li>• re-clarifying medical consent and decision making protocol</li> <li>• liaising with the hospital staff around possible behaviour support issues and assistance required with individual care e.g. meals, bathing, equipment</li> <li>• considering support to be provided by the DSO</li> <li>• clarifying support roles between the hospital staff and the DSO staff, e.g. the need for special nurses</li> <li>• considering information required from the hospital to the DSO provider at the time of discharge</li> <li>• adequate planning around discharge timing to ensure the necessary supports are in place at the disability facility</li> <li>• jointly agreeing and document supports to meet the individual's needs - this should be done as soon as practicable either prior to transfer to the ward, or once the individual is settled in the ward.</li> </ul>	<p>Consider the support that can be provided in order to deliver optimal patient care, including:</p> <ul style="list-style-type: none"> <li>• liaising with DSO staff around possible behaviour support issues and assistance required with individual care e.g. meals, bathing, equipment</li> <li>• negotiating the supports required by individual with the DSO staff and maintain accurate documentation of these needs</li> <li>• clarifying communication points with the DSO</li> <li>• ensuring that the medication profile is reviewed by the regular pharmacist and that the medication administration system is up to date (this may include medication blister packs and medication charts and signing sheet)</li> <li>• ensuring the hospital pharmacist consults with DSO staff regarding medication history</li> <li>• reviewing discharge plans (timelines, bed movement).</li> </ul>

## Section 4: Discharge from hospital

### Optimising care

An effective discharge from hospital is reliant on good discharge planning; this requires partnership between the individual, the DSO and hospital system.

- discharge coordination for individuals with complex needs requires a holistic focus on the needs of the individual and the capacity of the DSO to meet those needs. "Key information that hospital staff need to know about the individual and their support needs should be provided in a universally consistent format and travel with the individual around the hospital so that any health care professional can access it."<sup>23</sup> Key considerations regarding the discharge process include:
- individuals with disability and/or their representative are the natural authorities of their own lives and have the right to be involved in decisions about their services and supports.
- planning for discharge should commence at the time of admission and should include all stakeholders.
- Individuals presenting with acute health issues may incur changes to their disability support needs due to that health incident. These changes should be considered in accordance with their original accommodation circumstances and its ongoing ability to support those changes.
- the hospital system and the DSO have a shared accountability for the individual's ultimate discharge outcome.
- discharge planning needs to consider the long term sustainability and suitability of the discharge option with a view to preventing readmission and/or discharge to inappropriate accommodation options.
- the hospital staff sharing the appropriate information with the DSO will help enable a safe and timely discharge.

Discharge from hospital	Disability service organisations roles and responsibilities	Hospital staff roles and responsibilities
<p><b>Planning discharge</b></p>	<ul style="list-style-type: none"> <li>• ensure the hospital has all documentation regarding confidentiality and release of information back to the DSO so that all relevant discharge information can be provided</li> <li>• obtain regular updates, preferably daily, on the individual's progress and treatment to understand their current and future support needs</li> <li>• communicate information regarding changes to health and care needs and the impact on long term support requirements to the individual and their representative</li> <li>• communicate information to the relevant funding agency regarding possible changes to long term care and support</li> <li>• support the individual during any transfer across health services to ensure continuity of support and carry-over of essential discharge information</li> <li>• participate in planning for the individual's care coordination in hospital and transfer of care out of hospital</li> <li>• determine if the individual's mobility has changed as an inpatient and if they require any mobility aids and/or additional rehabilitation, or referral to a community physiotherapist</li> <li>• facilitate participation in discharge planning of the individual and significant others</li> <li>• reassess the individual prior to the proposed discharge date to ensure that the individual is now able to be supported within their current accommodation option</li> <li>• ensure that the individual has appropriate transport on the day of discharge</li> </ul>	<ul style="list-style-type: none"> <li>• advise the DSO of planned time of discharge and arrangements available if immediate transport is unavailable</li> <li>• obtain and consider all relevant information regarding the individual's disability and the impact of that disability and their current health issues on long term care and support</li> <li>• provide appropriate documentation (discharge summary, typically sent to GP and next of kin) to the DSO on discharge to ensure continuity of care and ongoing management of new or existing health issues</li> <li>• advise of any changes in mobility aids and/or equipment required by the individual</li> <li>• identify if the staff at the DSO require education and training regarding ongoing care of new health issues and liaise with the contact individual at the DSO to arrange for that to be provided</li> <li>• refer to relevant primary/community based health providers</li> <li>• liaise with the individual's GP to ensure continuity of care from hospital to home</li> <li>• provide relevant information regarding that referral and the associated program to the DSO and the individual and significant others</li> <li>• ascertain if education is required from the hospital pharmacist/asthma educator/diabetic educator e.g. warfarin education, insulin education, inhaler administration technique, and who that education should be provided to</li> <li>• liaise with the individual's pharmacist to ensure that medication will be dispensed and packaged on</li> </ul>

Discharge from hospital	Disability service organisations roles and responsibilities	Hospital staff roles and responsibilities
	<ul style="list-style-type: none"> <li>• where possible, ensure time of discharge allows for someone at the accommodation to receive the individual and has a full understanding of any changes to care requirements.</li> </ul>	<p>discharge - arrange for the hospital pharmacy to provide five days of medication for medication that is not readily available or where the individual will be discharged after hours or on a weekend.</p>
<p><b>Considerations for successful discharge</b></p>	<ul style="list-style-type: none"> <li>• the individual's usual ability</li> <li>• the individual's current level of functioning and whether it is the same as their usual ability pre-admission or if their care needs have changed since their hospital admission</li> <li>• if the discharge care plan provides a guide/criteria of what support can be accessed in the community to support changes in care needs</li> <li>• who makes the decision that the individual can return to their original accommodation option and/or who is responsible for planning and decision making if the individual will require alternative accommodation</li> <li>• who the hospital liaises with to explore alternative accommodation options</li> <li>• what services the individual is eligible for, whether they are able to access services in their area to support changed care needs and if they connected into those services. Examples of services: <ul style="list-style-type: none"> <li>▪ Silver Chain Priority Response Assessment Team (PRA), nurse or medical referred or St John Ambulance</li> <li>▪ Hospital in the Home (HITH)</li> <li>▪ Rehabilitation in the Home (RITH)</li> <li>▪ Complex Needs Coordination Team (CoNeCT)</li> <li>▪ Community Mental Health Services</li> </ul> </li> <li>• if the individual requires new services or if pre-existing services on hold and need to be reinstated (e.g. Home and Community Care (HACC), Silver</li> </ul>	<p>The hospital should provide the following information as part of the individuals discharge information pack (where applicable):</p> <ul style="list-style-type: none"> <li>• discharge summary for the GP with a copy for the DSO</li> <li>• nursing transfer letter</li> <li>• wound care plan</li> <li>• contacts for referrals to community services</li> <li>• contact GP follow up visit booking</li> <li>• outpatient appointments for individual specialties with date/time/location</li> <li>• phone contacts for arranged service providers e.g. HITH, RITH, Silver Chain, CoNeCT, palliative care</li> <li>• access to Community Mental Health</li> <li>• nurse or GP referral to Silver Chain Service Priority Response Assessment Team (PRA)</li> <li>• The hospital worker should consider if a meeting needs to be arranged with the individual and DSO staff to formalise ongoing care requirements, i.e. establishing who takes responsibility for each task</li> <li>• identify the individual's representative to invite and assist in coordinating the meeting.</li> </ul>

Discharge from hospital	Disability service organisations roles and responsibilities	Hospital staff roles and responsibilities
	<p>Chain)</p> <ul style="list-style-type: none"> <li>• if the individual requires completion of funding applications for access to new services</li> <li>• if there are any services that are already being provided to a housemate of the individual and can they be coordinated to be delivered at the same time to create efficiencies (e.g. Silver Chain)</li> <li>• if the individual's living environment has been assessed to support changes to physical and cognitive function</li> <li>• if a home visit is required and if home modification needs to be arranged</li> <li>• if the individual's dietary requirements have changed including swallowing ability and can that change be supported in their current living environment</li> <li>• if the DSO staff requires education/training before the individual's discharge</li> <li>• the individual's new medication profile and who supervises/administers their medication - is all medication able to be packaged to allow for administration by the DSO staff and if not what other arrangements are required</li> <li>• if the individual requires palliative care and if this be provided in their current accommodation option.</li> </ul>	
<p><b>Proposed long term accommodation options</b></p>	<p>Consider:</p> <ul style="list-style-type: none"> <li>• who the key contact people are at the DSO, what their contact details are and when they are available</li> <li>• how information should be received by the DSO and whether information can be entered by the hospital health care workers into the service organisation's records on the individual</li> </ul>	<p>Consider:</p> <ul style="list-style-type: none"> <li>• arranging a meeting with the DSO, the individual and their representative to formalise ongoing care requirements including: <ul style="list-style-type: none"> <li>▪ who the key contact people are</li> <li>▪ how information should be received by the DSO</li> <li>▪ what capacity the accommodation care provider has to cater to the care needs of the individual</li> </ul> </li> </ul>



Discharge from hospital	Disability service organisations roles and responsibilities	Hospital staff roles and responsibilities
	<ul style="list-style-type: none"> <li>• where the individual's care plan is held in the facility and what format is it held in e.g. electronic or hand written</li> <li>• what the qualifications and capabilities of staff at the individuals home are</li> <li>• if nursing staff are available at the facility and if they can continue to provide current treatment required.</li> <li>• if the facility is legally able to manage the individuals health requirements</li> <li>• what the physical environment within the home is and if it is suitable to accommodate any changes in the individual's equipment requirements</li> <li>• if the individual's nursing staff are at the home and/or whether staff are able to provide health management including: <ul style="list-style-type: none"> <li>▪ wound management and dressings</li> <li>▪ catheters</li> <li>▪ Percutaneous Endoscopic Gastrostomy (PEG) meals</li> <li>▪ tracheostomy care</li> <li>▪ respiratory devices – Continuous positive airway pressure (CPAP), ventilator, nebuliser, suctioning, oxygen</li> <li>▪ Peripherally Inserted Central Catheters (PICC lines) lines – intravenous antibiotics</li> <li>▪ injections</li> <li>▪ medications – Schedule 8, Warfarin</li> <li>▪ blood sugar levels and insulin administration</li> <li>▪ pain management</li> <li>▪ ostomy management</li> </ul> </li> <li>• if the home is no longer suitable for providing long term care and support what other options the DSO may be able to provide in the short and long term</li> </ul>	<ul style="list-style-type: none"> <li>▪ booking the individual in for future appointments</li> <li>• maintaining constant and transparent communication with the individuals and all relevant members involved in their care about the potential long term placement and providing support in finding the right place</li> <li>• liaising with the receiving facility and providing all necessary documentation and information required prior to day of discharge including providing clinical handover, faxing medication scripts, setting up services like Residential Care Line (RCL) for wound care advice or trial of void.</li> </ul>

Discharge from hospital	Disability service organisations roles and responsibilities	Hospital staff roles and responsibilities
	<ul style="list-style-type: none"> <li>• If the individual is from rural/remote area whether they can they be transferred (step-down) to a country hospital and would that be for ongoing medical treatment or rehabilitation</li> <li>• how long the individual would need to stay in the country hospital and what the long term plan will be</li> <li>• whether the individual be able to return to their previous support accommodation or whether there is another option that they can relocate to in the same regional area.</li> </ul>	

## Part 2 – Background information

### Partnerships between disability services organisations and the hospital system

For individuals with disability to maintain and achieve good health outcomes, the hospital system and disability service organisations must maintain effective partnerships. Through partnering with Health Service Providers, DSOs can more appropriately and effectively support individuals with disability when there is a need for emergency or planned health intervention. A partnership also enables the hospital staff and services to gain a better understanding of the needs of individuals with disability and the disability sector.

This *Guideline* has been developed to assist DSOs and the hospital system to understand and interact more effectively. It provides information to enhance interaction with and support of, an individual with disability.

This *Guideline* is intended to share expertise to ensure that individuals with disability achieve the best health care outcomes. Establishing collaborative and respectful partnerships between hospital staff and DSO staff in the context of a multidisciplinary approach is critical to improving the patient journey

The *Guideline* will facilitate opportunities to:

- identify areas for action to be undertaken by WA Health and DSOs
- inform service development and improvement initiatives for WA Health and DSOs to improve health outcomes for individuals with disability by enhancing their hospital experience
- create meaningful partnerships and collaboration between WA Health and DSOs
- provide opportunities for other parts of the health system to partner with the disability sector
- undertake research and evaluation with respect to the health and disability system interface.

### Why is the Hospital Stay Guideline important to individuals with disability and disability service organisations?

There is clear evidence that adults with disability have relatively poor access to health interventions and health promotion programs. In addition, compared to the non-disabled population in WA, adults with disability have a significantly higher incidence of long-term health conditions and higher use of health services, including hospitalisation.<sup>1</sup> These inequities reinforce the importance of the [United Nations Convention on the Rights of Persons with Disabilities](#).<sup>2</sup>

In addition to this, it has been found that people with disability regularly present to hospital for primary care issues that are more appropriate for a GP consultation. There were 2.2 million GP-type presentations to WA public hospital Emergency Departments in 2013-14<sup>3</sup> On average, only 22% of ED presentations are admitted. Whilst data is not collected on how many of these presentations were by a person with disability, it is likely that some were. By increasing community understanding and support of the health care coordination of individuals with disability, it is anticipated that hospital presentations not resulting in admission will be limited.

The importance of ongoing, coordinated health care between services was highlighted by the Australian Institute of Health and Welfare *Access to health services by Australians with disability 2012 report*<sup>4</sup>. The report found that approximately 13% of individuals with disability who reported a need for ongoing help or supervision with health-care activities (such as taking medication, manipulating or exercising muscles or limbs) had no source of assistance.

At the local level, the key findings of the [WA Study of Health and Intellectual Disability 2013](#)<sup>5</sup> strongly support the need for the development of strategies to improve health and wellbeing for individuals with intellectual disability. The findings include:

- participants reported high rates of chronic and long-term health conditions
- medication use was high, as was the use of multiple medications
- health services usage, including mental health and hospital based services, was high
- many participants lived a sedentary lifestyle
- substance use was low in the study group when compared to the general population
- generally insufficient health screening/prevention for participants.

Furthermore, feedback from a range of stakeholder consultations including [Clinical Senate debate on disability and health](#)<sup>6</sup>; the Disability Health Consultative Group; Disability Health Network Executive Advisory Group and the [Ministerial Advisory Council on Disability](#)<sup>7</sup>, indicates that potential health outcomes and effective engagement with the hospital system can sometimes be diminished by:

- poor communication between hospital staff, DSO staff, the individual and their family or carer
- information provided that is not fit for purpose
- the lack of an appropriate representative for the individual, or the inability to identify the individual's representative, to assist the hospital to understand the needs of the individual.

The Disability Health Network has identified that the interaction and engagement of both individuals with disability and DSOs with the hospital system is varied and there is an opportunity to improve the overall experience for all parties. The *WA Disability Health Framework: Improving the health care of people with disability 2015–2025*<sup>8</sup> lists four priority areas as identified through stakeholder consultations. The four priority areas align with international and national areas for action and include:

1. Understanding and recognition
2. Health and wellbeing
3. Workforce capability
4. Inclusive healthcare.

This *Guideline* is one strategy to address the health disparities for individuals with disability in the priority areas mentioned above.

### **Taking a quality approach**

The disability sector is made up of individuals with disability, their families and carers, who may be supported by a diverse range of DSOs. Support to individuals is provided through a range of community based options including independent living, in-home support and group home accommodation.

Currently, the disability sector does not have a mandated clinical governance framework. Consequently, responses to and support of the health needs of individual varies, based on:

- their individual health needs
- their capacity to make informed decisions about the management of their own health requirements
- their personal living arrangement
- the identification, recognition and involvement of the family and/ or carer
- the capacity of the DSO
- the skills of the DSO staff.

The *Guideline* is an opportunity for DSOs and the hospital system to collaborate in the development of a clinical governance framework that supports the health needs of individuals.

It is the responsibility of DSOs to translate the information contained within the *guideline* to enhance their current health related policies and practices. Likewise it is the responsibility of the hospital system to translate the information contained in this *Guideline* to improve their services to individuals. This may also require both sectors to provide training for staff to implement the strategies outlined.

### **What the Guideline should do**

The *Guideline* provides a shared understanding of the roles and responsibilities of the DSOs and hospital system in enabling safety and quality health care to be provided in a hospital setting.

The *Guideline* clearly defines the responsibilities of the DSO staff and the hospital staff in the individual's hospital stay and covers the individual's journey from pre-admission to discharge.

### **Policy linkages**

The *Disability Hospital Stay Guideline* aligns with the [WA Health Strategic Intent 2015-2020](#)<sup>9</sup> vision to "deliver a safe, high quality, sustainable health system for all Western Australians".

Other government frameworks and policies that complement and support the *Guideline* are:

- the *WA Disability Health Framework: Improving the health care of people with disability 2015-2025*<sup>8</sup> which articulates system-wide priorities for health and disability service providers to address. The aim is for individuals with disability in WA to be able to achieve the best possible health and wellbeing outcomes throughout their lives
- the [National Disability Strategy](#)<sup>10</sup> - a ten-year national policy framework for improving life for Australians with disability, their families and carers. It aims to create change in all mainstream services and programs as well as community infrastructure by ensuring the principles underpinning the United Nations Convention on the Rights of Persons with Disabilities are incorporated into public policy across governments
- [Count Me In: Disability Future Directions](#)<sup>11</sup>, developed by the Disability Services Commission, sets out a long term strategy designed to guide all Western Australians when responding to individuals with disability
- the [Carers Recognition Act 2004](#)<sup>12</sup> and the [Carers Charter](#)<sup>13</sup> provide clear direction on how carers are to be treated and how carers should be involved in the decision making and delivery of services
- the [Policy Framework on Substantive Equality](#)<sup>14</sup> which recognises that specific needs of certain groups in the community can only be met by adjusting government policies, procedures and practices.

- the [WA Health Disability Access and Inclusion Policy](#)<sup>15</sup> which outlines WA Health's commitment to ensuring that individuals with disability, their families and carers are able to fully access the range of health services, facilities and information available in the public health system
- the [WA Health Promotion Strategic Framework 2012-2016](#)<sup>16</sup> provides direction for primary prevention of health conditions in WA. It recognises individuals with disability as a vulnerable population and acknowledges they are a difficult population to access for the provision of health promotion activities
- other WA Health specific policies include:
  - [WA Health Consent to Treatment Policy](#)<sup>17</sup>
  - [WA Health Clinical Handover Policy, January 2014](#)<sup>18</sup>
  - [WA Health Language Services Policy, September 2011](#)<sup>19</sup>
  - [Operational Directive: Borders, 1 November 2007](#)<sup>20</sup>.

## Standards

There are Standards that apply to the aspect of service delivery outlined by this *Guideline*.

The [National Safety and Quality Health Service Standards](#)<sup>21</sup> aim to protect the public from harm and to improve the quality of health service provision.

Implementation of the *Guideline* supports the actions required to achieve Standard 2: Partnering with Consumers and Standard 6: Clinical Handover.

There are six [National Standards for Disability Services](#)<sup>22</sup> that apply to DSOs. Standards 1, 2, 3 and 4 are relevant to the *Guideline*.

1. Rights: The service promotes individual rights to freedom of expression, self-determination and decision making and actively prevents abuse, harm, neglect and violence.
2. Participation and inclusion: The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.
3. Individual outcomes: Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.
4. Feedback and complaints: Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.

## Guiding principles

The *WA Disability Health Framework: Improving the health care of people with disability 2015-25*<sup>8</sup> contains guiding principles that equally apply to this *Guideline*. This *Guideline* identifies how DSOs and the hospital system can use the *Framework's* guiding principles with respect to hospital stays for individuals in supported accommodation. Examples of the application of the *Framework* principles for hospital stays are provided as dot points under each principle.

### Person centred

Individuals with disability, their families and carers are supported to make informed decisions about, and to successfully manage, their own health and care. They are able to make informed decisions and choose when to invite others to act on their behalf. This may require partnerships to deliver care responsive to people's individual abilities, preferences, lifestyles and goals.

- Promoting an understanding amongst the services that not all individuals are able to make autonomous decisions, and ensuring that the appropriate mechanisms are in place to support them.
- The health service and disability service organisation have a shared accountability for the individual's healthcare.

### Responsive and flexible

Services and strategies will be responsive to the needs of individuals with disability including those from all cultural and linguistic backgrounds residing in communities across WA, including rural and remote locations.

- Individualised support strategies should be flexible, forward thinking and evidence based to meet the changing needs of the individual.
- Recognising that systems exist in both the health and the disability sector and that they both must be responsive and flexible to improve the health outcomes of individuals.
- Planning for hospital stays for individuals should take place before a health emergency.
- Hospital stay planning should include all stakeholders including the hospital, disability service organisation, the individual and their representative.
- Discharge planning needs to consider the long term sustainability and suitability of the discharge option with view to preventing readmission and/or discharge to inappropriate accommodation options.
- Culturally specific needs (e.g. interpreters, female staff for female patients of Muslim faith) should be identified when planning for hospital stays.

### Respect and dignity

Individuals with disability have the same rights as everyone else – to be respected, to make their own decisions, to feel safe and have opportunities to live a meaningful life.

- Individuals with disability have the right to an inclusive disability and health support system that enables them to enjoy the highest attainable standard of health and wellbeing.
- Individual's information when shared will be done in a manner that respects privacy and dignity.
- Individual's right to exercise self-determination in decision-making will be promoted where possible.

## Collaboration

Through collaborating, sharing an understanding of roles and responsibilities, and building partnerships, positive health outcomes for individuals with disability can be obtained more efficiently and sustainably.

- The unique expertise of the individual, their families and carer will be recognised and valued by the health and disability system.
- The unique expertise of both the health system and disability service organisations is recognised and valued.
- The individual and their representative, the health service and disability service organisation have a responsibility for collaborating in the interests of the individual with disability.
- Effective collaboration will be achieved in an environment of mutual respect and clear communication as well as an understanding of the responsibilities, capacities and constraints of the health and disability system.
- Disability service providers have a responsibility to provide appropriate information and support to enable an individual to effectively interface with the health system and ensure that their representatives, families and carers are appropriately informed.

## Continuous improvement

Programs and services are involved in continuous improvement processes to achieve best-practice. Services delivered meet best standards of practice based on best available evidence.

- Learnings should be applied to improve the relationship and collaboration interface practices.
- Recognise that the sectors, their relationships and interface are evolving
- The *Guideline* provides a foundation for continuous improvement.
- Having clear feedback processes will enable both the health system and disability service organisations to receive important information that can help them continuously improve their service.



## Reviewing the *Guideline*

The *Guideline* will be reviewed at intervals no longer than five years, or sooner if required.

Date of last review: N.A

Supersedes: N.A

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22. Department of Social Services. National Standards for Disability Services. Canberra: Australian Government; 2013.
23. NSW Ministry of Health. NSW Health & Ageing and Disability and Home Care (ADHC) Joint *Guideline*. Sydney: NSW Ministry of Health; 2013; p. 3-5.
24. Carers Recognition Act 2004. Government of Western Australia, ed. 01-b0-00 ed. Perth, WA.
25. Guardianship and Administration Act 1990. Government of Western Australia, ed. 05-i0-00 ed. Perth, WA.

# Glossary

## Carers

People who provide ongoing (unpaid) care and support to family members and friends who have disability, a mental illness, chronic condition, terminal illness or are frail aged ([Carers Recognition Act](#)<sup>24</sup>).

## Consent

See Informed Consent.

## Disability service organisation staff

Any staff member employed by the disability service organisation to contribute to the care and wellbeing of the individual with disability.

## Individual with disability

Referred to as the individual within this document. Use of the term individual includes the individual's family and/or carer, if appropriate.

## Individual's representative

Any person who has recognised decision making capacity/authority on behalf of the individual as identified in the [Guardianship and Administration Act 1990 hierarchy of treatment decision-makers](#)<sup>25</sup> – this may include a family member or carer or a person appointed in accordance with the Act.

## Informed consent

A process of communication between the individual with disability and their health care worker that results in the individual's authorisation or agreement to receive health care. This communication should ensure the individual has an understanding of all the available options and the expected outcomes.

## Hospital staff

All persons employed to provide services for the purpose of improving an individual's health and well-being in a hospital. This includes but is not limited to doctors, nurses and allied health care workers.

## Policy

A set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

## Service provider

A person or organisation who receives remuneration for providing support services to individuals with disability.

## Services

Products of the organisation delivered to people or units of the organisation that deliver products to people.

## Acronyms

<b>CPAP</b>	Continuous positive airway pressure
<b>CoNeCT</b>	Complex Needs Coordination Team
<b>DSO</b>	Disability service organisation
<b>DVA</b>	Department of Veterans' Affairs
<b>ED</b>	Emergency department
<b>GP</b>	General Practitioner
<b>HACC</b>	Home and Community Care
<b>HITH</b>	Hospital in the Home
<b>PEG</b>	Percutaneous Endoscopic Gastrostomy
<b>PRA</b>	Silver Chain Priority Response Assessment Team
<b>RITH</b>	Rehabilitation in the Home
<b>WA</b>	Western Australia

# Appendices

## Appendix 1: Recommended information to be provided between the disability service organisation and hospital settings

### Information provided by the disability service organisation to the hospital

#### Demographics

- Photo
- Name/known by
- Date of birth
- DSO accommodation provider name, address and phone numbers (including after hours)
- DSO accommodation provider key personnel names and phone numbers (including after hours)
- DSO accommodation provider description (including what health care facilities and nursing care is available)
- Next of kin (relationship, contact details, level of involvement - contact in emergency only or involve in all decision making)
- Family/ carer (relationship, contact details, desired level of involvement -)
- Communication needs
- Personal profile (likes dislikes, concerns etc)

#### Health profile

- Atypical signs and symptoms
- Health implications of disability type
- Pain profile
- Relevant medical/ surgical history
- Alerts and allergies
- Medication chart (including contact number of pharmacy)
- Support needs
- Transportation requirements
- Mobility needs
- Allied health needs
- Aids accompanying individual (e.g. glasses, hearing aids, alternative augmentative communication (AAC) device, other)
- Dietary needs
- Advance Health Directive
- Hospital Support Plan

#### Consents and notification

- Person with legal decision-making authority (including out-of-hours phone number)
- Person to contact for information regarding medical history (including out-of-hours phone number)
- Copy of Enduring Power of Attorney / Guardianship Order and/or next of kin/family members/carers including any legal restrictions

### Information provided by hospital to disability service organisation

- Discharge summary
- Nursing summary
- Medication scripts
- Allied health documents

## Appendix 2: Example of individual health profile

*Please use ID label or block print*

<b>RESIDENT / CLIENT TRANSFER FORM</b>	<b>SURNAME:</b> _____		<b>URN:</b> _____
	<b>GIVEN NAME:</b> _____		
	<b>DOB:</b> _____		<b>SEX:</b> _____
	<b>DOA:</b> _____		
<b>SERVICE:</b> _____			
Resident/Client Status: <input type="checkbox"/> High Care <input type="checkbox"/> Low Care <input type="checkbox"/> CACP/ EACH Package <input type="checkbox"/> Rehabilitation/Young Disabled			
<b>Important Numbers</b>		<b>Service Details</b>	
Transfer to: _____		Service's Address: _____	
Medicare Number: _____		Phone Number: _____	
Private Health Insurance No: _____		Fax Number: _____	
Pension Number: _____		<b>GP Details</b>	
<b>Next of Kin Details</b>		Resident/Client's GP: _____	
Name of NOK: _____		GP's Phone Number: _____	
NOK Address: _____		GP's Fax Number: _____	
NOK Phone Number: _____		GP aware of transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NOK aware of transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the resident/client have: <input type="checkbox"/> High ACAT <input type="checkbox"/> Low ACAT <input type="checkbox"/> N/A	
<b>Diagnosis:</b> _____			
<b>Reason for transfer:</b> _____			
Drug Alert Sticker (if applicable)	<b>ALLERGIES:</b>		<b>ALERTS:</b>
	_____		<input type="checkbox"/> Dysphagia
_____		<input type="checkbox"/> Falls Risk	
_____		<input type="checkbox"/> Other _____	
<b>Medications</b> – Please see attached photocopy of medication profile			
<b>Cognitive/Emotional State</b> – attach relevant correspondence			
Past: _____		Present: _____	
<b>Diet/Fluids:</b> _____		<b>Skin Integrity/Wounds:</b> _____	
<b>Mobility</b>	<b>Eating &amp; Drinking</b>	<b>Showering</b>	<b>Dentures</b>
<input type="checkbox"/> Independently ambulant	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Lower
<input type="checkbox"/> Standby supervision only	<input type="checkbox"/> Supervise	<input type="checkbox"/> Supervise	<input type="checkbox"/> Upper
<input type="checkbox"/> 1 person min assistance to transfer	<input type="checkbox"/> Assistance	<input type="checkbox"/> Assistance	<input type="checkbox"/> None
<input type="checkbox"/> Bed/Chair hoist transfer ( <i>specify hoist</i> )	<input type="checkbox"/> Full Assistance	<b>Dressing</b>	<b>Glasses</b>
<input type="checkbox"/> Standing Hoist <input type="checkbox"/> Full Hoist	<input type="checkbox"/> Nil by Mouth	<input type="checkbox"/> Independent	<input type="checkbox"/> Yes
<input type="checkbox"/> Equipment ( <i>specify</i> )	<input type="checkbox"/> PEG	<input type="checkbox"/> Supervise	<input type="checkbox"/> No
_____	<b>Toileting</b>	<input type="checkbox"/> Assistance	<b>Faecal Continence</b>
<b>Behaviours</b>	<input type="checkbox"/> Independent	<b>Urinary Continence</b>	<input type="checkbox"/> Yes
<input type="checkbox"/> Very Aggressive	<input type="checkbox"/> Supervise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Unpredicted Responses	<input type="checkbox"/> 1 Assistant	<input type="checkbox"/> No	Bowels last open _____
<input type="checkbox"/> Restlessness	<input type="checkbox"/> 2 Assistance	<input type="checkbox"/> Catheter in situ	
<b>Other Information:</b> _____			
Prostheses: _____		Valuables: <input type="checkbox"/> Ring <input type="checkbox"/> Watch <input type="checkbox"/> Other: _____	
Documents: <input type="checkbox"/> Yes <input type="checkbox"/> No		Xrays/Imaging: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Equipment: _____			
<b>Name:</b> _____		<b>Designation:</b> _____	
<b>Date:</b> _____			

RESIDENT/CLIENT TRANSFER FORM

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### Appendix 3: Hospital Stay Guideline Project Group membership

The Disability Health Network acknowledges the individuals, groups and organisations who contributed their time and experience into shaping the *Hospital Stay Guideline*, in particular the Hospital Stay Guideline Project Group.

#### Hospital Stay Guideline Project Group membership

First name	Position and organisation
AJ Rajagopal	Discharge Coordinator, Patient Flow Unit, Royal Perth Hospital
Amanda Crook	Health Services Manager, 360 Health + Community
Nicole Depraizer / Jenny Howson	Senior Development Officers, Health Networks, WA Department of Health
Tricia Dewar	Principal Disability Health Coordinator , Disability Services Commission
Carol Franklin	Carer representative
Robyn Lieblich	Sir Charles Gairdner, Long Stay Young Disabled/SW Manager, Sir Charles Gairdner Hospital
Merinda March	Health Services Manager, 360 Health + Community
Sue Morrison	Nursing Services Manager, Disability Services Commission
Helen Nys	Director, Local Area Coordinator, Disability Services Commission
Gail Palmer	Manager of Community Programs, MS Society WA
Sue Shapland	General Manager, Member Services, MS Society WA
Gordon Trewern (Chair)	Chief Executive Officer, Nulsen
Janet Wagland	Manager, Services for Younger People, Brightwater Group
Emma Williams	Development Officer, Health Networks, WA Department of Health



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