NDIS Quality and Safeguards Commission

Transitions of care between home and hospitals

Practice Alert January 2025

Key Points

- Transitions of care refers to the movement of a person between services providing care, such as when a person moves between their home and a hospital.
- Transitions of care are critical points to manage because there is risk of harm to people with disability if they do not receive the support they need.
- Safe transitions of care require clear communication and coordination between the person with disability, their support network, health professionals and providers. Everyone should understand their role to help the transition go well.
- Providers should manage risks to participants by ensuring transitions between their home and the hospital are planned and coordinated in line with the NDIS Practice Standards.
- Providers should ensure they meet their responsibilities under the High Intensity Daily Personal Activities (HIDPA) NDIS Practice Standards when providing HIDPA supports. Providers can refer to the High Intensity Support Skills Descriptors (HISSDs) for guidance on the training and knowledge recommended to deliver these supports.

Why are transitions of care important?

Australian people with disability commonly access hospital services. The Australian Institute of Health and Wellbeing reported that:

- 26% of people with disability visited a hospital emergency department in 2018.
- 22% of people with disability were admitted to hospital in 2018.

Australian reports on the deaths of people with disability have identified serious and life-threatening risks if transitions of care between services and hospitals are mismanaged. Areas of concern include a lack of clear communication resulting in:

- Medication errors
- Failure to follow up with appropriate specialists
- Lack of necessary support services in place after hospital discharge
- Lack of necessary follow up care after hospital discharge

Transitions of care are opportunities for improving medication safety and reducing avoidable harms and death. Safe transitions of care require clear communication and coordination between the person with disability, their support network, health professionals and providers. Clear communication and coordination helps ensure that critical information about the person's health needs, potential risks and current health care are not lost during transitions of care.

Supporting participants going to hospital

Providers should document, communicate and manage a participant's transition between their home and hospital including identifying and managing risks that might arise.

Providers should support participants to prepare for potential hospital admissions by:

- Helping participants understand information about their health in an accessible format. For example, communicating information verbally, Easy Read or visual prompts and provided in a person's preferred language.
- Keeping the participant's health related documentation, such as medication and support plans, accurate and up-to-date in a format that can be readily communicated to hospital staff. See Resources for different options to communicate information during a transition.
- With the participant's consent, including family, supporters and workers who know the person well in the process. This will help to ensure a participant's preferences and needs are communicated and understood by everyone involved.

If a hospital admission is planned (for example, a planned procedure or surgery), consider requesting a pre-admission appointment. This gives participants and family or support workers, and hospital staff time to meet, discuss and plan for any additional supports that may be needed during the participant's admission. This time can be used to discuss any existing health issues, specific needs or support plans.

Information to provide to hospital staff

Providers who are responsible for a participant's medical records and care, or have consent from participants or guardians to share information, should make sure the following are available to hospital staff on admission:

- List of current medications and dosages

- Webster packs and other required medications
- Health care card
- Medicare card
- Support plans related to wellbeing, such as a behaviour support plan or communication plan
- Support plans related to health, such as a mealtime management plan, diabetes management plan, epilepsy management plan or emergency medication management plan
- Details about any assistive technology or devices, if required

See Resources for more about what information may be needed by the hospital.

Supporting participants going home from hospital

Assess provider's capacity to meet the participant's support needs

Providers should understand any changes to the person's ongoing care needs before leaving the hospital. Work with hospital staff to ensure changes to the participant's care or medication are understood. Providers can request written information about follow-up care to avoid miscommunication with the consent of the participant.

Providers will also need to engage with hospital staff and undertake a risk assessment to consider if they can provide care safely. For example, new equipment or medication may be needed and staff may need additional training. Identify any support needs that are classified as 'high intensity daily personal activities' (HIDPA), as they may require additional training in special skills and assessment of specific modules of the Practice Standards. Providers can check the NDIS Commission website for more information on registration. For more details on HIDPA skills, see the High Intensity Support Skills Descriptors.

If a provider cannot provide supports safely or is not registered to do so, this must be clearly communicated to hospital staff as soon as possible. Early and ongoing communication with hospital staff, the participant, and support network can prevent delays in participants being discharged from hospital and reduce risk to participants following discharge.

Information for discharge from hospital

Plan for the participant's discharge from hospital in consultation with hospital staff as early as possible. This information should be made available to the participant in an accessible format.

Providers should check with health care staff as these documents may be called something different in your local area. Some of this information may be coordinated and communicated through services outside the hospital. See support services for transitions of care below.

Documentation and information to request from the hospital may include:

- Discharge summary: a summary of the medical care the person received in hospital, any needed follow-up such as outpatient services or Allied Health services and medication.
- Care plan or discharge plan: a detailed discharge plan for follow-up appointments with medical specialists, care recommendations for the person's regular health care providers such as their GP, and any other required health or social requirements.
- Medication summary: a list of current medications, including information about any new or changed medications and dates for the next medication review.
- Details about equipment or devices, for example, how equipment will be hired or purchased, who will be responsible for coordinating training for new equipment and what maintenance will be required.
- Referrals to outpatient rehabilitation services such as social or support groups and home assessments for equipment or modifications.

Support services for transitions of care

Depending on the circumstance, there may be services and supports that help with coordinating the transition of care.

Support coordinator: If a participant has an NDIS-funded support coordinator, they can help with things such as organising new equipment and training for staff.

Case coordinator or social worker: Some hospitals have dedicated staff to help coordinate complex arrangements. Check with your hospital service to see if these supports are available to you.

Patient advocacy services: Most states have some form of independent patient advocacy service. These services may help to assist in advocating and coordinating care both in hospital and during transitions between hospital and home.

Provider obligations related to transitions of care

Worker Capability

Providers should consider how to increase NDIS workers' training and skills in line with the NDIS Workforce Capability Framework and the High Intensity Support Skills Descriptors.

NDIS Code of Conduct

Providers and workers must comply with the NDIS Code of Conduct when providing supports or services to NDIS participants.

The NDIS Code of Conduct requires all NDIS providers and workers who provide NDIS supports or services to NDIS participants to, among other things:

- Provide supports and services in a safe and competent manner with care and skill,

- Promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports provided to people with disability.

NDIS Practice Standards

If you are a registered NDIS provider, you must comply with the NDIS Practice Standards contained in the National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 as part of your conditions of registration. The NDIS Practice Standards relate to the delivery of safe, quality supports and services, and the management of risks associated with the supports you provide to NDIS participants.

To achieve compliance with the NDIS Practice Standards, registered providers should demonstrate compliance with the National Disability Insurance Scheme (Quality Indicators for NDIS Practice Standards) Guidelines 2018. The NDIS Commission's guidance on the NDIS Practice Standards and Quality Indicators provides a further resource to assist registered NDIS providers to understand their obligations in relation to participants.

The NDIS Practice Standards that are most relevant to this alert include:

- **Risk management:** Risks to participants are identified and managed.
- **Quality management:** Each participant benefits from a quality management system relevant and proportionate to the size and scale of the provider, which promotes continuous improvement of support delivery.
- **Information management:** Management of each participant's information ensures it is identifiable, accurately recorded, current and confidential. Each participant's information is easily accessible to the participant and appropriately utilised by relevant workers.
- **Incident management:** Each participant is safeguarded by the provider's incident management system, ensuring that incidents are acknowledged, respond to, well managed and learned from.
- **Transitions to and from a provider:** Each participant experiences a planned and coordinated transition to or from the provider.
- **Management of medication:** Each participant requiring medication is confident their provider administers, stores and monitors the effects of their medication, and works to prevent errors or incidents.

Resources

Record-keeping and communication resources

- The A2D Together is a tool to improve the hospital experiences of people with a cognitive disability, their carers, families and disability support staff.
- Hospital Stay Guidelines includes a 'Going to Hospital Checklist' to help ensure all important information, medication and personal items are packed when going to hospital and information on discharge plans.

- Manage My Care is a discharge planning app for use across Western Australia.
- My Health My Communication is a set of resources for recording and communicating important health information with hospital staff.
- Say Less Show More (SLSM) initiative seeks to provide this support with a series of simple photo stories (visuals) explaining the steps involved in common medical procedures.
- Health Services fact sheet for adults - Council for Intellectual Disability is an Easy Read fact sheet about different health services, allied health professionals and doctors.

Information about accessing health services for participants, families and providers

- Building capability in NSW health services for people with intellectual disability: the Essentials will guide health services staff and other service providers to better understand and meet the complex and multiple health needs of people with an intellectual disability and their carers.
- Communicating with your healthcare provider when you are in hospital is a fact sheet about ways to communicate with your healthcare provider when in hospital.
- Hospital inclusion are video resources from Latrobe University for people with intellectual disability and their supporters.
- Intellectual Disability Training Videos is a series of training videos designed to help health professionals understand the care needs of a person with intellectual disability.
- A Quick Reference Guide to Hospital Care for People with Disability describes the implications a person's disability may have on their stay in hospital from admission, in-patient care, and discharge.
- Guide to Patient and Family Engagement in Hospital Quality and Safety outlines how to improve communication between patients, families and health professionals in a hospital setting.
  - » Strategy 2: Communicating to Improve Quality helps improve communication among patients, family members, clinicians, and hospital staff from the point of admission.
  - » Strategy 3: Nurse Bedside Shift Report supports the safe handoff of care between nurses by involving the patient and family in the change of shift report for nurses.
  - » Strategy 4: IDEAL Discharge Planning helps reduce preventable readmissions by engaging patients and family members in the transition from hospital to home.
- Top Tips for Safe Health Care is designed to help consumers, their families, carers and other support people get the most out of their health care from a rights perspective.
- User guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium
  - » Chapter 6: Partnering with Consumers Standard includes strategies for effective communication and information on shared decision-making.

» Chapter 9: Communicating for Safety Standard includes strategies and tools for providers involved in transfers between services and hospitals.

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