



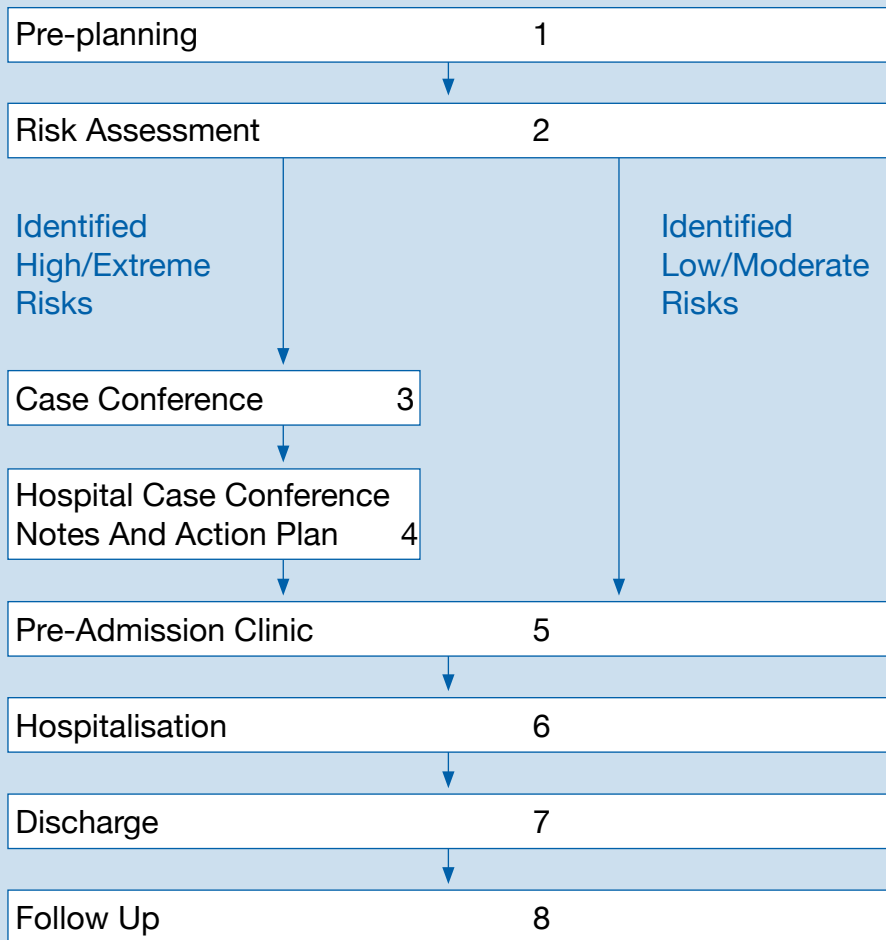
guidelines and procedures manual

for the support of people with
disabilities requiring hospital
treatment

Partnership between
Department of Disability, Housing and Community Services,
and ACT Health



Planned Admission



Disability Support Officer 2, Key Worker or Disability Support Officer on shift in client's house will:

- Notify Network Coordinator of the following **as soon** as a planned procedure is known:
 - Reason for admission
 - Procedure/operation to be undertaken eg: exact procedure/operation site of surgery
 - Date of admission, date of procedure, date of pre-admission clinic appointment
 - Hospital / location
 - Doctor performing procedure (if known)
 - Anticipated discharge date
- Notify hospital staff at the Pre-Admission Clinic contact details of the Network Coordinator as the contact person for discharge of client. **Network Coordinator's Contact details: 6207 1121 (business hours) or 6207 7418 (after hours)**
- Notify Quality, Safety and Risk Manager, Disability ACT.
- Submit anticipated referrals via Intake Officer at Therapy ACT or current treatment therapists relevant to client's anticipated needs after discharge.
- Inform the Guardian of all the information above and ensure they complete hospital paperwork and consent forms, required by the hospital.
- Arrange transport to and from the pre-admission clinic and hospital.

Network Coordinator will:

- Arrange for a Disability Support Officer to stay with a client for the entire period of hospitalisation, if a day Dental procedure is being performed.
- Organise a facilitated risk assessment

REFER TO TEMPLATES & PROCEDURES

- I. Hospital Discharge Policy and Procedures, Disability ACT

Quality, Safety and Risk Manager, Disability ACT will:

- Organise a facilitated risk assessment. The outcome of the assessment to inform what action, if any, is required:
 - If the client has a low/moderate risk rating no extra support arrangements will be needed for hospital admissions.
 - If the client has a high/extreme risk rating intensive supports will be needed for hospital admissions.
- Organise and conduct a Case Conference with Disability ACT and hospital staff if a client has a high/extreme risk rating.

REFER TO TEMPLATES & PROCEDURES

- II. Individual Plan Risk Assessment Template Guidelines, Disability ACT
- III. Individual Risk Assessment Template, Disability ACT

A Case Conference is an opportunity for collaborative decision making amongst key stakeholders regarding the support systems required for identified 'high or extreme risk'^{1,2}, clients of Disability ACT when hospital care is required.

Quality, Safety and Risk Manager, Disability ACT will:

- Identify the need for a Case Conference, during a facilitated risk assessment. If a client has a high/extreme risk rating this is a signal that intensive supports will be needed for hospital admission.
- Organise a Case Conference prior to the pre-admission clinic appointment.
- Invite the following participants for the Case Conference:
 - Disability ACT, Quality, Safety and Risk Manager (Chair)
 - Director, Disability ACT
 - Hospital Team Director
 - Disability ACT, ISS Network Coordinator
 - Disability ACT, Key Worker
 - Client Guardian
 - Other relevant health professionals
- Prepare a report, *Hospital Case Conference and Action Plan*, outlining the roles and responsibilities agreed upon by each of the key stakeholders.
- Distribute copies of the report to all parties involved in the *Hospital Case Conference*.

¹SAA/NZS HB 208:2001 Guidelines for managing risk in healthcare. Standards Australia

²DACTISS Policies and Procedures 2005. Risk Assessment Strategy, Risk Assessment Template, Risk Assessment Template Guidelines, retrieved from DACT Intranet site 8th June 2005

Hospital Case Conference and Action Plan 4

The *Hospital Case Conference and Action Plan* will be developed from issues identified in the *Hospital Case Conference* using an early intervention approach, thereby reducing the risk of adverse outcomes during hospitalisation.

The *Hospital Case Conference and Action Plan* will:

- ensure a smooth transition from home to hospital, hospitalisation and the client's return home based on a person-centered approach in the best interests of the client, Disability ACT and hospital staff; and
- involve financial and in-kind support negotiated between all the key stakeholders involved in the Case Conference.

Disability ACT Quality, Safety and Risk Manager will:

- Prepare and distribute the *Hospital Case Conference Notes and Action Plan* to all participants involved in the *Hospital Case Conference* and other relevant stakeholders.

The Disability Support Officer supporting the client will:

- Ensure the following documentation is taken to the pre-admission clinic and hospital:
 - Copy of client's **Summary of Individual Plan** and if appropriate client's **Seizure Management Plan**.
 - Completed **Treatment Summary Form/s**, from the past 3 months, and **Medication folder**.
 - Copy of the pre-admission **Risk Assessment**.

Leave ONLY a copy of Client's Summary of Individual Plan in hospital.

Do NOT leave Treatment Summaries or Medication Folder.

- **Call** Network Coordinator for assistance in getting paper work to hospital if needed.

REFER TO TEMPLATES & PROCEDURES

Disability ACT:

- IV. Summary of Individual Plan
- V. Seizure Management Plan
- VI. Treatment Summary

The Canberra Hospital:

- VII. Pre-Admission Clinic Forms
- VIII. Client Information & Referral Form

Calvary Hospital:

- IX. Discharge Planning – Disability Clients
- X. Pre-Admission Letter
- XI. Pre-Admission Clinic and Questionnaire
- XII. Day Surgery

Hospitalisation 6

The Disability Support Officer supporting the client will:

- Contact the LINK team **upon arrival** of the client and make relevant arrangements.
- **Notify** Therapy ACT for planned professional support.
- **Notify** on-call manager/s of issues that may arise.
- **Stay with client** as arranged with the Network Coordinator. The Disability Support Officer accompanying a client undergoing DENTAL procedures must stay with the client for the entire period of hospitalisation.
- Contact Network Coordinator if needs change.

Network Coordinator will:

- Arrange for a Disability Support Officer to stay with a client for the entire period of hospitalisation if a day Dental Procedure is being performed.

LINK Team will:

- Ensure Hospital Discharge Treatment Summary includes:
 - Date of follow up visit to General Practitioner (GP) / Specialist
 - Altered physical care needs: bathing, dressing, incontinence management
 - Medication changes
 - Any special conditions
 - Dietary requirements / changes to dietary regime
 - Post-discharge visits to / by Community Nurse, Doctor, or relevant people
 - Degree of mobility and degree of rest
 - Review / end dates for all of the above

REFER TO TEMPLATES & PROCEDURES

- XIII. LINK Discharge Planning Procedures for Disability Clients
- XIV. LINK Team – Discharge Plan

Discharge

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LINK Team / Clinical Nurse Consultant will:

- Notify Network Coordinator of time / date of discharge.
(Business Hours - 6207 1121, After Hours 6207 7418)
- Complete and distribute the clients' Hospital Discharge Treatment Summary:
 - Original copy stays with client
 - Second copy remains with LINK.
 - Third copy given to guardian or given to house staff to provide to guardians.
- Fax a Completed Treatment Summary to Nature Conservation House
(Fax No: 6207 1371)

Network Coordinator will:

- Approve Treatment Summary provided, or contact LINK team to request further information.
- Phone approval to LINK team Nurse in hospital.
- Notify House Disability Support Officer that discharge has been approved.

Key Worker or Disability Support Worker on shift in client's house will:

- Notify guardian of:
 - Client discharge information
 - Client care after discharge
 - Dates of visits from doctor, community nurse and any other relevant persons.
- Pick up client from hospital, with approved Treatment Summary and Summary of Individual Plan copy
- Consult Network Coordinator if changes to transport arrangements are needed.

Client is NOT to be picked up by House Disability Support Officer unless Network Coordinator has given approval.

If transport is unavailable taxi vouchers will be provided by Disability ACT. Taxi vouchers are available from the client's house or On-Call Network Coordinator.

REFER TO TEMPLATES & PROCEDURES

VI. Treatment Summary, Disability ACT

Follow-up

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Disability Support Officer 2, Disability Support Officer 1, Key Worker or Network Coordinator will:

- Immediately place the original of Hospital Discharge Treatment Summary in client's Individual Plan folder.
- Post a copy of Hospital Discharge Treatment Summary to Guardians.
- Review client's Individual Plan within 24 hours of discharge.
- Call Therapy ACT therapists to ensure they are aware of discharge and follow up requirements.
- Notify Network Coordinator and Guardian of client's condition & care immediately after visits by doctors, community nurses or other relevant person.

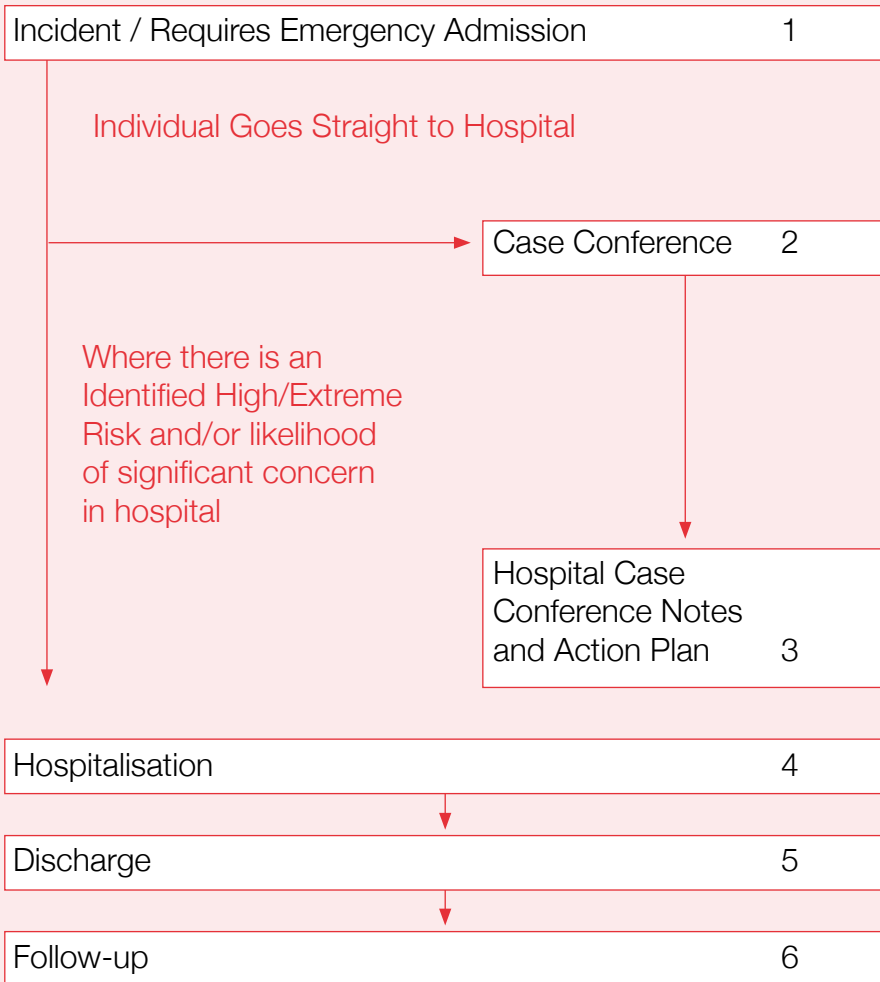
Network Coordinator/ Relevant Professional Officer will:

- Write and distribute procedures for lifting, transferring, feeding etc to staff within 24 hours of visit to house.

REFER TO TEMPLATES & PROCEDURES

VI. Treatment Summary, Disability ACT

Emergency Admission



Incident / Requires Emergency Admission 1

Disability Support Officer 2, Key Worker or Disability Support Officer on shift in client's house will:

- Notify Network Coordinator of the following as soon as possible after an emergency admission:
 - Reason for admission
 - Procedure/operation to be undertaken eg: exact procedure/operation site of surgery
 - Date of admission & date of procedure
 - Hospital / location
 - Doctor performing procedure (if known)
 - Anticipated discharge date
- Notify hospital staff in the Emergency Department contact details of the Network Coordinator as the contact person for discharge of client. **Network Coordinator's Contact details: 6207 1121 (business hours) or 6207 7418 (after hours)**
- Accompany client to hospital, if possible.
- Inform Guardian of all the information above.
- Ensure all client details given to the hospital are correct and the following documentation is taken to hospital:
 - Copy of client's Summary of Individual Plan and if appropriate, the client's Seizure Management Plan.
 - Completed Treatment Summary Form/s, from the past 3 months, and Medication Folder to be taken to the hospital for Doctor / Nurses' reference.

ONLY leave copy of Client Summary of Individual Plan in hospital.

Do NOT leave Treatment Summaries or Medication Folder.

- Call Network Coordinator for assistance in getting paper work to hospital, if needed.

REFER TO TEMPLATES & PROCEDURES

Disability ACT:

- I. Hospital Discharge Policy and Procedures
- IV. Summary of Individual Plan
- V. Seizure Management Plan
- VI. Treatment Summary The Canberra Hospital:
- VII. Client Information & Referral Form Calvary Hospital:
- VIII. Discharge Planning – Disability Clients

Emergency Admission Incident/Requires Emergency Admission 1

Case Conference

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The Case Conference is an opportunity to achieve collaborative decision making amongst key stakeholders regarding the support systems required for identified 'high or extreme risks' clients of Disability ACT when hospital care is required. The purpose of the Case Conference will be to develop *Hospital Case Conference Notes and Action Plan*.

A Case Conference is to be held following an emergency admission as soon as possible if:

- a client has a high/extreme risk rating from a facilitated risk assessment that has identified that intensive supports will be needed for hospital admissions; and/or
- a notification from the hospital has been received by the Network Coordinator that a client related concern has occurred.

Hospital Staff will:

- Notify the Network Coordinator if there has been an increase in significant client related concerns in hospital. **Contact Details for the Network Coordinator: 6207 1121 (business hours) or 6207 7418 (after hours)**

Network Coordinator will:

- Implement the Disability ACT Individual Support Service Critical Incident Process.
- Notify the Quality, Safety and Risk Manager.

Disability ACT Quality, Safety and Risk Manager will:

- Invite the following participants for the Case Conference:
 - Disability ACT, Quality, Safety and Risk Manager (Chair)
 - Director, Disability ACT
 - Hospital Team Director
 - Disability ACT, ISS Network Coordinator
 - Disability ACT, Key Worker
 - Client Guardian
 - Other relevant health professionals
- Prepare a report, Hospital Case Conference Notes and Action Plan, outlining the roles and responsibilities agreed upon by each of the key stakeholders.
- Distribute copies of the report to all parties involved in the Case Conference.

REFER TO TEMPLATES & PROCEDURES

- II. Individual Plan Risk Assessment Template Guidelines, Disability ACT
- III. Individual Risk Assessment Template, Disability ACT
- XV. Critical Incident Flowchart, Disability ACT

Hospital Case Conference and Action Plan 3

The *Hospital Case Conference and Action Plan* will be developed from issues identified in the Case Conference thereby reducing the risk of further concerns during hospitalisation.

The *Hospital Case Conference and Action Plan* will:

- outline a plan for reducing the risk of further concerns during hospitalisation;
- involve financial and in-kind support negotiated between all the key stakeholders involved in the Case Conference; and
- ensure a smooth transition from hospital to the client's home , based on a person-centered approach in the best interests of the client, Disability ACT and hospital staff.

Quality, Safety and Risk Manager, Disability ACT will:

- Prepare and distribute the *Hospital Case Conference and Action Plan* to all participants involved in the *Hospital Case Conference* and other relevant stakeholders.

Hospitalisation

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The Disability Support Officer supporting the client will:

- Request hospital nursing staff to contact the LINK team upon arrival at the hospital
- Notify Therapy ACT of anticipated professional support.
- Notify on call manager/s of issues that may arise.
- Stay with client as arranged with the Network Coordinator. The Disability Support Officer accompanying a client undergoing DENTAL procedures must stay with the client for the entire period of hospitalisation.
- Contact Network Coordinator if needs change.

LINK Team will:

- Ensure Discharge Treatment Summary includes:
 - Date of follow up visit to General Practitioner (GP) / Specialist
 - Altered physical care needs: bathing, dressing, incontinence management
 - Medication changes
 - Any special conditions
 - Dietary requirements / changes to dietary regime
 - Post-discharge visits to / by Community Nurse, Doctor, or relevant people
 - Degree of mobility and degree of rest
 - Review / end dates for all of the above

REFER TO TEMPLATES & PROCEDURES

Disability ACT:

VI. Treatment Summary

The Canberra Hospital:

VIII. Client Information & Referral Form

Calvary Hospital:

IX. Discharge Planning – Disability Clients

LINK Team:

XIII. LINK Discharge Planning Procedures for Disability Clients

XIV. LINK Team – Discharge Plan

Discharge

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LINK Team / Clinical Nurse Consultant will:

- Notify Network Coordinator of time / date of discharge.
(Business Hours - 6207 1121, After Hours - 6207 7418)
- Complete and distribute the clients Treatment Summary:
 - Original copy stays with client
 - Second copy remains with LINK.
 - Third copy given to guardian or given to house staff to provide to guardians.
 - Fax a Completed Treatment Summary to Nature Conservation House
(Fax No: 6207 1371)

Network Coordinator will:

- Approve Treatment Summary provided, or contact LINK team to request further information.
- Phone approval to LINK team Nurse in hospital.
- Notify House Disability Support Officer that discharge has been approved.

Disability Support Officer, Key Worker or Disability Support Worker on shift in client's house will:

- Notify guardian of:
 - Client discharge information
 - Client care after discharge
 - Dates of visits from doctor, community nurse and any other relevant persons.
- Pick up client from hospital, with approved Treatment Summary and Summary of Individual Plan copy
- Consult Network Coordinator if changes to transport arrangements are needed.

Client is NOT to be picked up by House Disability Support Officer unless Network Coordinator has given approval.

If transport is unavailable Disability ACT will provide taxi vouchers. Taxi vouchers are available from the client's house or On-Call Network Coordinator.

REFER TO TEMPLATES & PROCEDURES

VI. Treatment Summary, Disability ACT

Follow-up

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Disability Support Officer 2, Disability Support Officer 1, Key Worker or Network Coordinator will:

- Place immediately the original of Treatment Summary in client's Individual Plan folder.
- Post copy of Treatment Summary to Guardians.
- Review client's Individual Plan within 24 hours of discharge.
- Call Therapy ACT therapists to ensure they are aware of discharge and follow up requirements.
- Notify Network Coordinator and Guardian of client's condition & care immediately after visits by doctors, community nurses or other relevant person.

Network Coordinator/ Relevant Professional Officer will:

- Write and distribute procedures for lifting, transferring, feeding etc to staff within 24 hours of visit to house.

REFER TO TEMPLATES & PROCEDURES

VI. Treatment Summary, Disability ACT

LIST OF TEMPLATES & PROCEDURES

- I. Hospital Discharge Policy and Procedures, Disability ACT
- II. Individual Plan Risk Assessment Template Guidelines, Disability ACT
- III. Individual Risk Assessment Template, Disability ACT
- IV. Summary of Individual Plan, Disability ACT
- V. Seizure Management Plan, Disability ACT
- VI. Treatment Summary, Disability ACT
- VII. Pre-Admission Clinic Forms, The Canberra Hospital
- VIII. Client Information & Referral Form, The Canberra Hospital
- IX. Discharge Planning – Disability Clients, Calvary Hospital
- X. Pre-Admission Letter, Calvary Hospital
- XI. Pre-Admission Clinic and Questionnaire, Calvary Hospital
- XII. Day Surgery, Calvary Hospital
- XIII. LINK Discharge Planning Procedures for Disability Clients
- XIV. LINK Team – Discharge Plan
- XV. Critical Incident Flowchart, Disability ACT

TEMPLATES & PROCEDURES GLOSSARY

<i>Aftercare</i>	This is the plan to guide the carer in the treatments required to optimise the client's health after being released from hospital.
<i>Anticipated discharge date</i>	This is the date on which the client is expected to leave hospital. This date may be changed due to unforeseen circumstances at the hospital, such as multiple emergency admissions to hospital or, the client not being well enough to be discharged from hospital, requiring a longer stay in hospital.
<i>Capacity</i>	See 'Legal Capacity'
<i>Case Conference</i>	A meeting to achieve collaborative decision making amongst key stakeholders regarding the support systems required for identified high or extreme risk clients of Disability ACT when hospital care is required.
<i>Consent</i>	For consent to be valid, the following elements must be satisfied: <ul style="list-style-type: none"> • The person consenting to the treatment must have legal capacity. If the person receiving the treatment lacks capacity, consent must be given by someone with legal capacity, such as a guardian • Patients must be given enough information about the proposed treatment to be able to make an informed choice • Consent must be voluntary • Consent is specific to the procedure being performed.
<i>CNC</i>	The Clinical Nurse Consultant, the nurse in charge of the area or hospital ward.
<i>Critical Incident</i>	High level adverse event.
<i>Degree of mobility</i>	Defines what sort of movement the client can do after they leave hospital, for how long and what help is needed and includes: <ul style="list-style-type: none"> • How often the client can move • What type of movement the client is allowed to do. An example of this is, the client may walk BUT not run or the client may not be allowed out of bed BUT may be allowed to roll over in bed • Any assistance required to move eg walking frame, crutches, special pillows, special positioning.

<i>Degree of rest</i>	<p>Defines the amount of time a client should not be participating in an activity. This may also include:</p> <ul style="list-style-type: none"> • Guidelines for the type of rest eg. Bed rest or bed rest but allowed to walk to the toilet • Guidelines for the length of the rest period. • Guidelines for the frequency of rest.
<i>Dispensing</i>	Distribution of medication from a prescription.
<i>Duty of Care</i>	This is the obligation to take reasonable care to avoid injury or loss to a person whom it can be reasonably foreseen might be injured by an act, or omission. It is the basis for civil (court) action.
<i>Emergency admission</i>	An admission to hospital, which occurs in response to an accident or an unplanned illness. An emergency admission occurs through the Emergency Department.
<i>Guardian</i>	Person identified as having legal status to make decisions in consultation with, and on behalf of, a person with a disability on designated issues. A guardian is appointed under the <i>Guardianship and Management of Property Act 1991</i> where a person over 18 is unable to provide consent for themselves.
<i>Hospital Procedure</i>	This document refers to what is planned to occur when the client goes into hospital. It may be an operation or a test.
<i>Hospital Treatment Summary Sheet Hospital version in triplicate</i>	<p>This form is completed each time a client visits a hospital emergency department or is admitted to hospital. The Link Team/Medical Team completes the form.</p> <p>It summarises:</p> <ul style="list-style-type: none"> The reason for the hospital admission The outcomes of the hospital admission The aftercare required for the client after discharge from hospital. The medication regime Appointment times and venue <p>Medication cannot be dispensed by the hospital, as the hospital does not use blister packs. The prescription is required to be taken to the community pharmacist regularly used by the client.</p> <p>The Treatment Summary Sheet is kept with the Client's records at their residence.</p>

<i>Individual Plan</i>	This is a written plan of action. It specifies client strengths, agreed priorities, goals and strategies designed to meet the needs and ambitions of a person with a disability receiving a service. The Individual Planning process emphasises client participation in the formulation of a plan of action that is based on specific positive outcomes for the client. The Individual Plan is not intended to be a detailed description of every assistance a client can or will receive.
<i>Informed Consent</i>	Required for consent to be valid. For elements of informed consent, see 'Consent.'
<i>Legal capacity</i>	The ability of a person to make decisions that the law will uphold.
<i>LINK Team</i>	The team of nurses whom co-ordinate discharge planning for patients at The Canberra Hospital and Calvary Hospital. The Link Team offers a co-ordinated and planned multi-disciplinary team approach to hospital discharge focusing on clients and their family or significant others.
<i>Medication Folder</i>	This folder contains the paperwork supporting the clients' medication regime.
<i>Medication Signing Sheet</i>	<p>The community pharmacist supplying the Webster-pak must provide a computer generated Medication Signing Sheet for either</p> <ul style="list-style-type: none"> Multi-dose Medication Unit-dose Medication Non-packed Medication <p>Once the medication has been administered the Medication Signing Sheet must be signed as documented evidence of administration.</p>
<i>Multi-dose system</i>	<p>The multi-dose system is used for the dispensing of regular medications into weekly sealed blister sheets. The medication is divided into groups and sealed into a multiple-dose blister package.</p> <p>The multi dose system is dispensed by:</p> <ul style="list-style-type: none"> Client Dosage Time of Day Day of the week <p>Once a medication has been administered the Medication Signing Sheet must be signed as documented evidence of administration.</p>

<i>Planned Admission</i>	Any admission to hospital, which is made in co-operation with the hospital, prior to the date of admission. A planned admission may be organised days, weeks or months in advance and occurs via the hospital admissions office.
<i>Professional Officers</i>	Refers to any professional person eg doctors, nurses, physiotherapist, psychologist etc. involved in the clients care regardless of their place of employment.
<i>Risk Assessment</i>	A process consisting of well-defined steps which, when taken in sequence, support better decision making by contributing to a greater insight into risks and their impacts.
<i>RISKMAN</i>	On-line incident reporting system
<i>Substitute Decision Maker</i>	A substitute decision maker is someone who has legal authority to make decisions on behalf of someone else. In the ACT, the Guardianship and Management of Property Tribunal may appoint a guardian as a substitute decision maker for a person with a decision-making disability.
<i>Treatment Summary</i>	This is a condensed, precise outline of treatment for a client after discharge from hospital. It summarises: <ul style="list-style-type: none"> • The reason for the hospital admission • The outcome of the hospital admission • The aftercare required for the client after discharge from hospital • Follow-up appointment times and venues.
<i>Webster-pak</i>	Commercial packing arrangement of blister sheets.