Ready To Go Home

The Ready to Go Home project is funded by the Australian Government Department of Social Services

What is the Ready to Go Home project?

The Ready to Go Home (RTGH) project long -term outcomes are to:

- Reduce long stay patient discharge delays for people with a disability
- Improve the transition experience for people with disability from hospital to community settings.

What are the bumps and blockers?

1. **Discharge planning** within the health system and the interface with external stakeholders – information, education, communication and collaboration
2. **Consumer navigation** of health and NDIS – information, communication and collaboration
3. **Timeframes** – health, NDIS, service providers
4. **Health system NDIS capability** – information, education, resourcing
5. **Workforce** – staffing shortages, capacity (skill sets – specialist supports), time for upskilling and education, who is responsible for what?
6. **Housing** – information, navigation, fit -for-purpose stock / models
7. **Funding** – flexible funding particularly in the short -to-mid term

Discharge Planning

- Early identification of people with disability
- Participant profile shared with consent
- Collaborative discharge planning and meetings
- Develop discharge planning training module for service provider onboarding
- Discharge process protocols – Discharge Checklist
- Understanding and literacy - people with disability, carer and support networks
- Family and carer training funding for health settings
- Establish protocol for hospital access – support workers and other external supports
- Identify and improve process to record guardianship authority at admission
- Guardianship training and resources

NDIS Related Concerns

- Flexibility in transition funding
- Investigate transitional accommodation (short to medium term) models and opportunities
- Establish and maintain list of service providers with accommodation options
- Establish and maintain a whole of sector vacancy register
- Housing pathway resources and capacity building activities for HSPs
- Establish protocol for hospital access – support workers and other external supports
- SIL training and resources

What is the Ready to Go Home project?

1. Develop and implement coordinated, effective discharge planning processes
2. Identify and deliver strategies to understand, communicate and support the individual's specific disability related needs while in hospital
3. Improve the interface for people with disability transitioning from hospital to community

Ready To Go Home Action Framework

Strategy	Actions	Education & Resources
Develop & implement coordinated, effective discharge planning processes	**On Admission:** • Improve HSP systems for early identification of people with disability and supports needed • Develop & implement HSP template to capture service provider information and key contacts • Promote use of My Health record and support WAPHA My Health campaign • Promote use of Health Passport and Hospital Stay Guideline Individual Health Profile form **Discharge Planning** • Document roles and responsibilities of all discharge planning stakeholders • Document and implement HSP discharge planning processes with agreed timelines (initiation, NDIS access and plan reviews, planning meetings, decision-making points) • Deliver collaborative discharge planning meeting education for all stakeholders **Culture** • Support collaboration between NDIS Project Officers at each HSP • Develop and implement communication & engagement strategy **RTGH Pilot Governance** • Establish HSP governance structures that support quality improvement processes for people with disability • Implement HSP quality improvement processes **NDIS Engagement** • Work with NDIA Health Liaison Officers & HSP staff to streamline roles, responsibilities and communications • Facilitate HSP NDIS Health Champions Program	**On Admission** • NDIS Admitted Patient Register • Service provider & contact template documented in patient file **Discharge Planning** • Discharge planning resources • Discharge planning education • Collaborative discharge planning meeting education • Online resource library catalogue **Culture** • Communication & engagement collateral **NDIS Engagement** • Health Liaison Officer Info resource
Identify & implement strategies to understand, communicate & support the individual's specific disability related needs while in hospital	**Person-centred care** • Develop clear, timely and effective disability specific person-centred communication tools for HSPs • Develop and implement strategies to support people with disability to feel included and understood for HSPs • Promote current Peer Support programs for people with disability	**Person-centred care** • Disability specific communication resources • Disability competency education
Improve the interface for people with disability transitioning from hospital to community	**Transitions** • Develop and deliver overnight and weekend discharge process resources for SPs in the community • Deliver education about medication information on discharge for SPs • Develop and maintain online resource library catalogue for SPs (maintained by NDG) • Support & promote WAPHA's HealthPathways Disability and AHCWA's MAPPA tool **Housing** • Map & co-design housing pathways & providers • Develop housing exploration education **People with disability, Carer & Support Networks** • Support & promote Carers WA programs Prepare to Care, counselling support and Carers Gateway • Co-design resources for people with disability	**Transitions** • Discharge process resources • Online resource library catalogue **Housing** • Housing pathway resources • Housing exploration education **People with disability, Carer & Support Network** • Co-design resources for people with disability

Person, Carer, Family, Support Networks

Pilots

Rockingham Health Campus site

- Process mapping & NDIS guideline
- Communications – newsletter & hub
- Sticker trial
- NDIS education
- Disability Connect event – Support coordinators and service coordinators
- Collaborative discharge planning meeting resources
- Your hospital Guide resources

Pilots

Great Southern

- GS RTGH working group
- Improved access to home and living supports
  - Communication & collaboration – information & collaborative discharge planning
  - Skill gaps & workforce – Specialist supports & workforce
  - Housing solutions – data, education, collaboration

Pilots

Joondalup Health Campus site

- Process mapping
- NDIS guideline and hub support
- Collaborative discharge planning meeting resources
- Patient-centred communication resources
- Functional Capacity Report training model
- Disability Health Connect: Information transfer solutions
- Your hospital Guide resources

Pilots

Joondalup Health Campus site

- Disability Health Connect: Information transfer solutions

Additional information

- Book about me: What helps the person feel comfortable, communication strategies, sensory information and triggers. Health passport type information
- Behaviour Support Plan
- Mental Health Plan
- Meal Plan
- Communication aids
- Medications and medication management: prompts, assistance, full control
- Stakeholder planning meeting
- Cultural religious considerations
- Admission form- medical profile and inclusion of consent
- Service provider and primary care provider
- Current general practitioner (GP) details
- Is 1:1 support required
- Transfer plan
- Routine
- Chronic health conditions and comorbidities
- Allergies and risk alerts
- Current restrictive practices
- Any involvement of Department of Justice or Child Protection
- Photo of the person
- Medicare, private health, Department of Veterans Affairs
- Vaccination status

Additional information

- Readmission plan (if what point should a person be readmitted)
- Discharge summary with correct details, GP contacts, destination, etc
- Timely information to leave with the person
- Clarification between health to keep and National Disability Insurance Scheme (NDIS) responsibilities (after hospital stay)
- Clear transport plan communicated prior to discharge, duty of care (who is responsible for what) in transit and on arrival
- Thorough discharge process
- When is person discharging to? What is needed for that setting? There will be different requirements depending on type of discharge and destination. For example: new service providers involved on discharge, short or long hospital stay
- Recommendations for allied health follow including hospital allied health staff contacts s community allied health can contact for follow where required
- Support network details
- Communication with family and relevant people. For example: guardian, GP, service provi
- Medication management and new medication supply. Who is going to manage? Does the person need support? For example insulin management and injections
- Assessment documentations
- Equipment and assistive technology new equipment, training, follow up, use in home suitability
- Alerts - mental health, forensic, alcohol or other drugs, risk
- Confirmation discussion had with medical decision maker re: discharge and discharge documentation
- Acronym free
- Extra supports required

Government of Western Australia
Department of Health

NDS National Disability Services

Co-design Team

Co-design Team

Government of Western Australia
Department of Health

NDS National Disability Services

Your Hospital Guide
Information
Seven information resources for people with disability. Standard, print-friendly, accessible, easy read.

Name to be confirmed
Tool
Information transfer mechanism to support timely and efficient transitions. Envelope, form, card.

Your Hospital Guide
Education
Hospital stay preparedness and education onboarding module for service providers.

Other resources:

- Online resource catalogue
- Service provider onboarding resource
- Office of Public advocate – Guardianship guidelines