HOUSING NEEDS AND PREFERENCES TO SUPPORT DISCHARGE

A guide to supporting NDIS participants in hospital to describe the housing and the supports they want and need for discharge

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SUMMER FOUNDATION

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Prepared by:

Summer Foundation Ltd. ABN 90 117 719 516
PO Box 208, Blackburn 3180 VIC Australia
Telephone: +613 9894 7006 info@summerfoundation.org.au www.summerfoundation.org.au

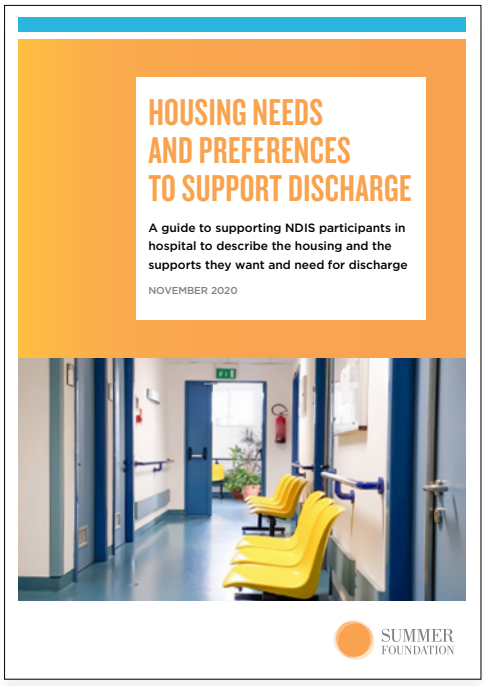
Your feedback:

If you have any comments on this tool, we would be delighted to hear them. Please contact us at: housingbrokerage@summerfoundation.org.au

HOW TO USE THIS GUIDE

This guide and the Housing Needs and Preferences to Support Discharge Template is for health professionals to support a person with disability to describe their housing and support needs and preferences so that they can be discharged to suitable housing.

The guide and the template are designed to be used together. You can type directly into the template, or print it so you can write in the information, using the explanations and advice in the guide.



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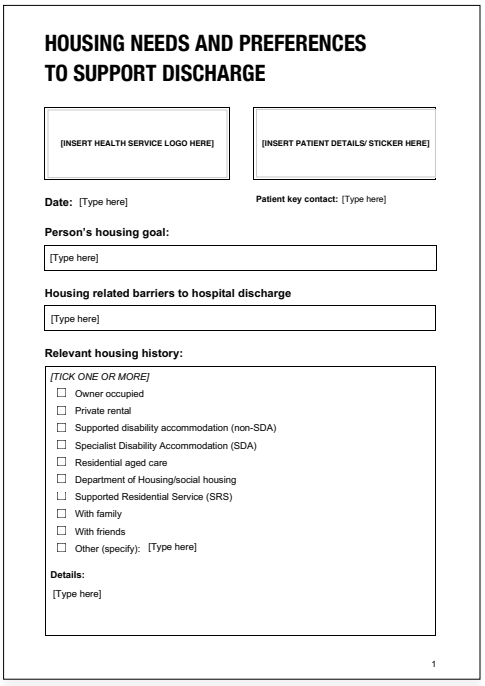


Download the template: Word doc or PDF

INTRODUCTION

If a person with disability cannot be discharged home or to their previous housing, their health team and support coordinator need to work together to find new housing options.

The introduction of the NDIS has brought many new housing options for people with disability. Before the NDIS, health teams and the people they work with had limited housing pathways that could be considered for discharge. Often the 'choice' has been a residential aged care facility or to be 'placed' into a disability group home - so effectively no choice at all.

In 2019, the Australian Government released the ambitious but welcome target to have no young people aged under 65 living in aged care by 2025.

By understanding a person's housing needs and preferences, health teams can facilitate people with disability to exercise real choice and control over the type of housing they live in, where they live, and who they live with. Working in a pressured health system can mean this task feels overwhelming.

The guide and the template assist health teams to have a very important conversation with a person with disability in hospital. It is the first step in finding housing and moving patients along the discharge pathway more efficiently.

What are 'housing needs and preferences'?

Housing needs are features of the built environment that improve function, such as level entry front door, width of doorways and grab rails. Housing needs may also refer to how supports will be provided (such as a second room for support workers). Often housing needs are well considered and articulated.

Housing preferences are how a person wants to live - what is important to the person. You can only know someone's preferences by taking time to ask them or speaking with someone who knows them very well. For example, they may want to live alone, with family, close to sporting facilities or public transport. The person may have pets or enjoy playing loud music or like to smoke.

Often housing preferences are not well considered, may be guessed, assumed or missed altogether.

In order to find appropriate housing, knowing the person's housing needs and preferences is essential. If housing does not meet their needs and preferences, it may not be a sustainable long-term option.

The Summer Foundation has written another resource: **Guide to Developing a Participant's Housing Statement** which can also be used to explore a person's preferences.

Who needs to think about 'housing needs and preferences'?

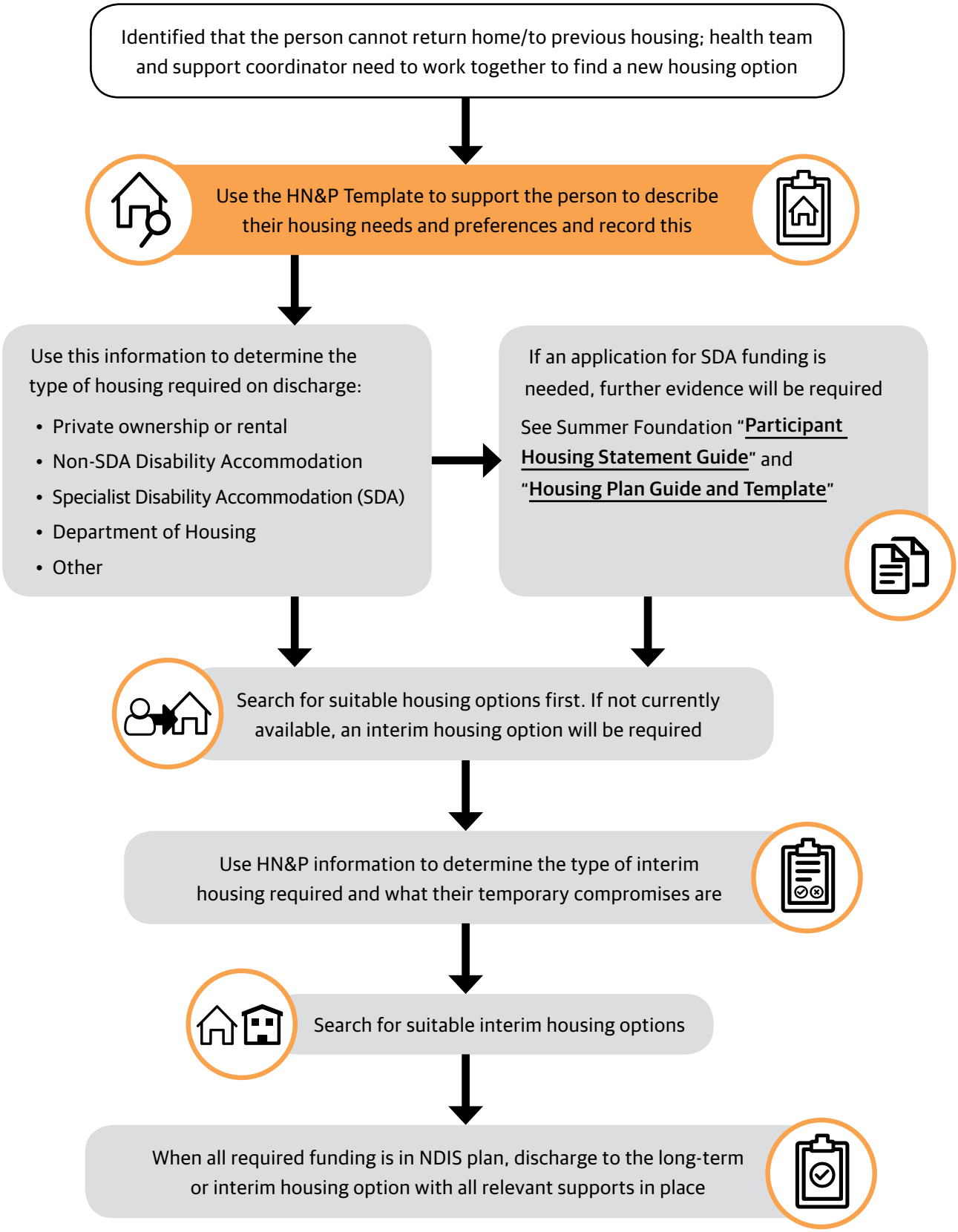
Start this process early, don't wait until a person is ready for discharge

Everyone supporting a person with disability to discharge from hospital needs to think about the person's housing needs and preferences from the point of admission. Along with the person, this includes their informal supports, health team, decision-makers and their support coordinator all being actively involved in the discussion regarding housing.

The health team has specialised skills that are essential when considering housing needs and preferences – they understand the housing features a person needs in order to be their most independent self and achieve what's important to them. The person's health team can determine the person's housing and equipment needs based on current function and by asking the person about their preferences.

It is important to involve all relevant stakeholders when completing the template. Within the Queensland Hospital Discharge and Housing project, 'Housing Needs and Preferences conversations' were established through the facilitation of a joint meeting, to bring together all involved parties. Using the template can be a way to set clear expectations with all involved around what areas need to be discussed.

Where does Housing Needs and Preferences (HN&P) fit in the Housing Pathway?



USING THE TEMPLATE DOCUMENT

A guide to writing in the housing needs and preferences to support discharge template

This Housing Needs and Preferences template alone is not enough for evidence for SDA eligibility. It is the first step, but a detailed Functional Capacity Assessment that talks about housing needs, support needs, housing history and SDA needs requirement is essential for SDA determination

- The template has been developed to help individuals with high and complex support needs to discharge from hospital to appropriate housing.
- The template can be used in its current form or adapted to suit the health team. The Summer Foundation recommends that health teams add their own logos or have it made into a formal medical records document.
- The person's personal information and details have deliberately been left out and a space for a patient medical sticker suggested instead - however, **the template should be adapted to be whatever works for the local health service.**

1. Person's housing goal

- Using this guide and template should ensure a person-led process, where the person's housing goal is essential and forms part of the NDIS funding model.
- The health team may start with one version of the person's housing goal, which may look very different after completing the conversation about a person's housing needs and preferences.
- It's essential that the goal says where the person would like to live, how they would like to live and who they would like to live with.

2. Housing barriers to discharge

Describing what is really stopping the person being discharged helps to create solutions to those problems and guides all the next decisions that are made

List the reason(s) why the person cannot be discharged to their previous housing e.g. previous home is not accessible; home modifications cannot be completed; best support model cannot be achieved; increased support needs not able to be met; increased assistive technology needs cannot be met. The risks associated should be outlined too.

List the housing options you've searched for and the reason(s) why they are not suitable discharge options.

3. Relevant housing history

Detailing the housing options trialled and why they didn't meet the person's needs is great evidence for future housing options

Knowing a person's housing history can help to understand and identify the type of housing they will prefer when they leave hospital. It can indicate what has or has not worked, or what type of housing applications need to be made. Indicate the type of housing the person lived in previously. Additional comments around who they lived with, where they lived, and why they can't return there is useful information.

Write this in the participant's own voice. For example:

I grew up in...I moved to...

I have lived in various housing arrangements, including...

Previous housing arrangements have ended because...

The housing arrangements that worked best for me were...because...

I need to move because...

My current housing puts me at risk of the following...

I have investigated the following mainstream housing options...the outcome was...

4. NDIS status

Even though searching for housing is part of discharge planning, it can start to take up limited public resources when the housing is very hard to find. Support coordinators and NDIS funded OTs can work collaboratively to support health teams in this process

The NDIS is integral to exploring housing and support.

- Use this section to review what the person's NDIS status is currently and to guide what funding you need to request.
- Several scenarios have been included in the template e.g. a person's available funding may be a barrier to discharge, funding may be available but a service hasn't started (e.g. support coordinator).
- Add any information not addressed by the check boxes in the comments section.
- The template prompts aim to highlight:
    - What housing options could be funded with the current NDIS funding in the person's plan?
    - Do health teams need to work with the person's support coordinator to get more/different funding for the right housing option?
    - Do health teams need to work with the person's support coordinator to get more/different funding for the right support model?
    - Is there enough funding for a support coordinator to explore housing, and funding for an OT to review housing options to determine if they meet the person's needs?

5. Person's housing preferences

What are your own personal housing preferences? Do you know your patient's housing preferences? Don't let your knowledge of what is available, what you think is not available or what you have known in the past as housing for people with disability limit your thinking!

- Everyone has a right to voice their housing preferences and we have a responsibility to uphold the rights of people with disability.
- Having a conversation with a person with disability in hospital about where they want to live and who they want to live with promotes choice and control.
- Talk to the person with a 'no limits' approach to explore what really is their BEST long-term housing and individual support model e.g. what types of features would you consider? What are the characteristics you want in a home?
- Helping a person to describe their housing preferences leads the team to search for housing that aligns with these preferences, as well as meeting their needs.

Examples of housing preferences:

My goals and hopes for the future are...

My likes, interests and things I like to do are...

I would like to live in the inner city/inner/outer suburbs/rural/remote area because... It's important that I live close to...because...

I want to live in the one of the following suburbs/LGA/state/territory because...

I need to live near accessible public transport, hospital, community facilities, open space...

I would like to live by myself/with...

If I was to share with others, it's important to me that I live with one other person/ 2-4 other people/males/females/a mix of genders/people I can communicate with...

Living in the right home for me would improve my life in the following ways.....

I want to live in a house/a duplex/townhouse/an apartment/a moveable unit/bungalow...

I would like my home to allow me to do these activities, e.g. having my own accessible bathroom close to my bedroom would enable me to use the toilet without support

The things I like people to know about me...

The things that are most important to me are...

My favourite things are...

I want a pet...

I smoke ...

6. Support model

When going through this section, do not be limited by the support model you think might be available or what you think will be funded. Focus instead on the person's goals, their ideal living environment and the support model for this

- Although challenging, it is essential to think about how a person will 'function' outside of the ward environment. This is because the ideal support model must be identified in order to find the ideal housing.
- Do you have a sense of what an average day would look like for the person when they leave hospital?
- Be creative when talking to the person and together think about the best support model that would meet their needs. It is helpful to break down the support a person needs into different sections, as you will see in the template.

People with high support needs can live alone if they want to! Being able to describe their best support model will ensure a person can do this safely

- 'Planned daytime supports' refers to the 1:1 "hands on" support or right next to the person supports e.g. support workers help a person to have a shower, prepare a meal or transfer out of bed; or continually supervise, prompt or guide a person with cognitive impairments.
- 'Overnight supports' are either inactive support (sleepover model) or active support. Consider if overnight support needs to be in the person's dwelling or on-site nearby.
- 'Unplanned/emergency supports' – think about how far away a support worker needs to be in the case of an emergency. If close by, how quickly do they need to get to the person in an emergency or unplanned event? 2-5 minutes? Or is 10 minutes safe? Is the person able to identify an emergency and call for help?
- Use your expertise and functional assessment reports to answer these questions, and discuss this with the person or other people who know them very well:
    - Can the person be alone, even for a short time, during the day or night in their dwelling?
    - Does the support worker always need to be in the person's dwelling? Or could they be on-site but in a separate dwelling e.g. next door?
    - What does a flexible, individual, person-led, safe, support model look like for the person?
    - Describe a typical day for the person - it's Monday and the person gets up at...

- Tally up the hours in a care plan:
    - Are 1 or 2 support workers needed? How often?

Think about the person in hospital – do they have a staff member by their side every hour of the day? Think about what you really mean when you say "24/7" support

- What's the plan if the person is alone and there is a fire or flood/emergency/the person falls/they have a continence issue? If the person's answer differs from the health team's, just write the facts.
- Is there a temporary compromise? What would work in the interim e.g. would a person accept support workers overnight in their dwelling while awaiting SDA housing with on-site assistance?

Examples to help people describe supports in their own words include:

I need help every day with…

I occasionally need help with…

The things I would like to do more independently are…

The support arrangements that would suit me best are…

I have trouble with thinking before I act/remembering what people tell me/ controlling my anger…

7. Clinical recommendations

What does the functional capacity assessment recommend? Make sure this takes into account the person's housing needs and preferences and paints the whole picture - your professional assessment and the view of the person

This section brings together information from functional assessments as well as discussions with the person. Highlight your clinical recommendations regarding housing features, assistive technology and therapy supports required on discharge.

Consider required housing design features:

- ☐ Wheelchair access (into and around home, including bathroom and kitchen)
- ☐ Stepless/level entry front access
- ☐ Grab rails
- ☐ Non-slip flooring
- ☐ Increased door widths
- ☐ High impact fixtures, strengthened walls, doors, glass
- ☐ Soundproofing
- ☐ Area for staff retreat
- ☐ Separate sensory space/breakout room
- ☐ Luminance contrast (e.g. around doorways and toilet)
- ☐ Lift access
- ☐ Outdoor area (comment if this needs to be fenced)
- ☐ Ensuite bathroom
- ☐ Hobless/level entry shower
- ☐ Study
- ☐ Intercom to entry
- ☐ Automated doors and blinds
- ☐ Type of floor coverings
- ☐ Heating and cooling
- ☐ Vehicle access and whether garage or carport is required
- ☐ List any extra features that relate to work or hobbies that are needed

Consider how would the person call or contact the on-site support worker? Has the person been doing something similar on the ward - using a button or emergency calling system? If not, does the person have the capacity to develop this potential? When? In the next 3-6 months?

Consider required Assistive Technology (and what this means for the built design):

- ☐ Wheelchair: Consider width, turning circle, need to access features from seated position and storage to charge if powered
- ☐ Other gait aid: Consider width and turning circle
- ☐ Bariatric equipment: Consider size and implications of this
- ☐ Showering equipment: Consider space required for use and storage. Does this mean the person cannot share a bathroom with others?
- ☐ Ceiling hoist: Does the person require housing that is able to have a ceiling hoist installed?
- ☐ Mobile hoist: Consider environmental requirements for a safe transfer and for storage
- ☐ Communication device: Consider how the person would call for help. Does this need to be built in?
- ☐ Powered equipment: Consider what would happen if the power went out. Does this require emergency power backup?

Consider essential therapy supports:

- ☐ Ongoing multidisciplinary therapy in the community
- ☐ Positive Behaviour Management Support Plan
- ☐ Mental health supports
- ☐ Ongoing nursing or medical supports

8. Long-term housing needs and preferences

What do you think the person's family would say is the ultimate housing option for their family member?

Health professionals may feel concerned that they will be raising a person's hope, only to then be disappointed due to the huge gap in available housing. To be sensitive to this, you can make sure you set the context of this exploration as a preference and as an important first step, before a 'temporary compromise' is explored to support discharge.

Currently some housing options are:

- Your **own home** with funded home modifications
- **Private rental:** Mainstream
- **Government subsidised rental:** Renting for those with a limited income - public housing/community housing, affordable housing/NRAS
- **Disability group homes:** Public and private - with housing and support provided by same organisation
- **SDA - Specialist Disability Accommodation** where the person will be funded for a particular building type of SDA. This will either be an apartment or a villa/duplex/townhouse or a house or a group home. Once a building has 4 or 5 people living in it, it is classified as a group home. All new build SDA group homes will be for only up to 5 people. Sometimes, SDA housing can be built specifically for the person.
- Level 3 residential accommodation/supported accommodation/Supported Residential Services (SRS) - boarding houses

Be careful of the phrases you use! You can accidentally put a person on to a path of living with many other people, when it's not what they want. By saying someone wants to live in a 'group home', in SDA terms, this automatically means 3 or 4 other housemates. It's also suggested you avoid using the term 'unit' in your reports when talking about SDA, as 'unit' causes confusion between apartments and a villa/duplex/townhouse.

This section is a summary of the best long-term housing option for the person you are working with. Once that option has been described, it's important to aim to put that plan in place, even if it won't be available immediately.

9. Interim housing

Medium Term Accommodation (MTA) funding is usually only for those with a long-term housing plan in place (it is being built or modified or SDA funding has been approved). Short Term Accommodation (STA) funding, which includes the housing and supports, is 'respite'. You will need to plan the long-term option before a person can be discharged to MTA or STA - which is why Housing Needs & Preferences is so important!

- If the person's long-term housing option is not available, consider an *interim housing solution* that may meet some housing needs and preferences, but does not have to meet other less essential ones. This can be referred to as the 'temporary compromise' but should still be safe for the person.
- Interim housing is any housing that can be used for a set period of time until long-term housing can be arranged. Interim housing can often be funded by NDIS Medium Term Accommodation (MTA) funding.
- Discharging to an interim housing option means the person can be out of hospital, their bed can be freed, and it could be a stepping stone to practise independent living skills.
- The person can live in their interim housing until their long-term housing is available.
- List what the person is willing to compromise on in the short to medium term e.g. who they're willing to live with, location, type of home.
- List in your professional assessment any temporary compromises that are safe and acceptable on a short-term basis e.g. a ceiling hoist with 1 support worker may be the best long-term solution, but as a temporary compromise a mobile hoist with 2 support workers is safe.
- Consider different types of interim housing and comment on their suitability. This could include a private rental, living with family, a holiday rental (e.g. hotel or Airbnb), medistays, non-SDA disability accommodation, SDA, Medium Term Accommodation or Short Term Accommodation.

10. Summary of Housing Needs and Preferences and Support Needs for Discharge

This is the most important part of the template. Writing this section in the person's own voice means you can also use this as a 'Participant Housing Statement' as part of an SDA funding application if required. See Summer Foundation's Guide to Developing a Participant Housing Statement for more information

- Summarise all the information you have gathered in the template to describe the person's housing preferences, housing needs and best support model. In a short paragraph, describe the long-term housing option and the interim housing option, including any temporary comprises.
- Discuss this summary with the person to make sure you have it right, then rewrite it using their own voice, with statements such as:

I would like to live by myself/with….in a house/a duplex/townhouse/ an apartment/etc… in [AREA/SUBURB]

The right home for me includes…..[wheelchair access, ceiling hoist, high impact fixtures, etc]

My best support model is….[include details from "summary of support hours"]

As an interim, temporary compromise, I am willing to ….[share with another person, live in a different suburb, etc]

The housing most likely to meet my needs and preferences is…[SDA, non-SDA disability housing, private rental, etc]

Use this summary to articulate a new, more updated and personalised NDIS housing goal. If necessary, re-write the updated housing goal at the top of the template and share that updated goal with the NDIA.

11. Action Plan:

The person or their support person (including a support coordinator) should create a profile on the Housing Hub to assist with the housing search www.housinghub.org.au

Once the person's housing needs and preferences process is completed, the Action Plan guides the next steps.

1. **With the person or Guardian's consent**, share the person's housing needs and preferences with:
    - Guardian
    - Support coordinator
    - Housing providers in a de-identified format
    - Support providers in a de-identified format
2. Save this document in the person's medical record.
3. Use this information to put the person's profile on the Housing Hub to search for housing (**www.housinghub.org.au**) in consultation with their support coordinator.
4. You can also put the person's profile on websites such as Go Nest (**https://gonest.com.au/**)
5. If you have identified an ideal housing or support model and the person agrees, and it requires additional NDIS funding, discuss this with the person's support coordinator. Together, develop a plan to apply for funding. In order to provide evidence about support needs, you may need to supply a daily care plan and additional tailored evidence.
6. If you are unsure whether a person is likely to be eligible for SDA, review these **resources about housing and SDA**.
7. Discuss a housing search plan with the person's support coordinator, which can include:
    - The Housing Hub – **www.housinghub.org.au/**
    - Go Nest – **https://gonest.com.au/**
    - Disability Housing – **www.disabilityhousing.com.au/**
    - Contact housing providers listed on the above websites, who may be open to a custom build for the person if they have SDA funding
    - Private rental housing
    - Holiday rentals/hotels
    - Medistays, interim/short-term housing – **www.medistays.com.au**
    - Department of Housing – if the person is a tenant/waitlisted, check with the Department of Housing for housing options

LIVED EXPERIENCE STORIES

VIDEO STORIES:

Michael's story:

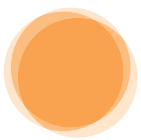
Michael's story about hospital discharge.

www.summerfoundation.org.au/michaels-story/

Trevor's story:

Trevor's story about how he chose where he wants to live.

https://youtu.be/7H3uW-c4_AI



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