**Episode 2, Part 2**

***Supporting a person who needs to leave hospital***

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**Andrea:** Hi, I’m Andrea Lockwood and welcome to Part 2 of Episode 2, focusing on best practice for support coordinators working in hospitals. In Part 2, we’ll talk about establishing a person's housing and support preferences, including exploring short versus long-term housing, the value of short-term NDIS plans in hospital, establishing if the new home is working for the person, and achieving the impossible.

# Establishing housing preferences

**Andrea:** A critical aspect of a person’s discharge from hospital is exploring where they are going to live. We talked to Laura and Alex about their approach to establishing the housing preferences for a person with disability in hospital.

**Laura:**, The first thing that we have to do is make sure that we are establishing the rapport with the participant and communicating in that way that the participant is comfortable with exploring that option. Because it can be quite daunting for someone to think about having to relocate, or having to adjust where they thought they were going to live or who they were going to live with. Particularly if there are other family members or informal supports involved. So we find that being able to provide that safe space for someone to discuss in a very informal manner about what they enjoy about their surroundings, rather than focusing so much on the physical aspect of the house or the dwelling or the location.

So we try to offer that real comfortable setting to just explore what someone wants in their surroundings, and then we step it out. And it also means that we’re also allowing that space to be able to make it a holistic approach, rather than so defined by bricks and mortar. And a lot of the time someone’s preferences will be different based on whether there is an opportunity to choose who someone lives with or what their support model might look like and what their equipment might be. So it’s about establishing what someone wants around them first, and then working out how to build it up, rather than the other way.

**Alex:** Yeah so mainly focusing on the need initially, that will become clear if you’re having really good conversations and trying to get a really good understanding from the inpatient team, what’s been explored already. The hospital teams in my experience will have already done a whole lot of housing exploration or have at least pinpointed why they aren’t able to return home.

I think it's important to have lots of conversations with the allied health team and the participant, getting directives from them really early on, how do they want you to help with the process? Making sure that you are having private conversations with that participant as well because you need to be offering them a space where they’re not feeling like they have to say yes to things just to get out of hospital, people become institutionalised very quickly and it takes away a little bit of their self-advocacy, or people may just need support to build their self-advocacy skills.

Having conversations and also applying it to real life scenarios and helping bring a bit of a future perspective into the scenario and a holistic picture. So it’s not just about having conversations about what the basic housing might look like for somebody but “okay so this is what your life is going to look like, like as in I want to be able to have the kids over or I need to be able to do this or I want to live close to this”. You may need a support coordinator to have those more holistic conversations with people to help paint that picture to then determine maybe what some of those housing priorities are aside from just those basic aspects or the most available aspects.

**Laura:** We try to not cover up the barriers or the risks, but we try and make sure that someone’s got the opportunity to explore every option. Because we always try to make sure that people understand that, in order to make an informed decision, you need to have all of the pieces of the puzzle at least available.

One thing we’re really mindful of, is that you can’t forgo any option, any choice. Even if, as a support coordinator, you're pretty certain that it’s not going to be the best option. And not presenting that and giving someone a choice to explore it, then you're not doing your due diligence with that, and you could actually miss out on a really good opportunity. And I often find that it’s really clear for some people to be able to say, “no, that’s not an option for me”. But if you take a few more moments to just unpack why it’s not an option, you tend to find why – what someone actually really wants and needs.

So if you say, “the aged care facility is not an option for me, full stop”, and then you just let that person move on to the next topic, you've missed this real opportunity to unpack that and say, “okay, why?” “Because I don’t want to be around 30 people.” “Okay, do you prefer to have a bit of downtime to yourself?” “Yeah, I do. I don’t like people in my face.” And then you've just added a bunch more information about what someone’s preferences are, as opposed to what they’ve excluded. That’s – every time that someone eliminates something, it’s actually giving you more answers and more ideas about what is actually going to work.

# Short-term versus long-term housing options

**Andrea:** Short-term or interim housing may become part of a person’s discharge plan from hospital. Laura shares her experience on when and how this has been organised for a person.

**Laura:** Immediately, as soon as someone talks about interim housing, there’s quite a few other barriers that you have to try to navigate around and circumvent. The main concern that people have when talking about interim option is that it’s only temporary. That it’s a lot of effort that isn’t going to be something ongoing. But at the same time you're weighing that up with the participant as opposed to ending up staying in hospital for an extended period, or ending up in an aged care facility as well.

The recent introduction for medium-term accommodation as an option into the scheme, and actually having that flexibility to use that for that step down, step back approach, is just amazing. It’s actually really helped to bridge that gap. The only issue has been with trying to match a suitable accommodation, because there are still similar factors with thin markets. But in terms of – there are a couple of participants who we worked with to try to prevent that interim hospitalisation or transition to an aged care facility, by being able to collaborate with a couple of different service support providers, who also have connections with, and agreements with, medium-term accommodation, accessible facilities. So that the accommodation is happy to negotiate on the price, so that they can fall within what NDIA will fund. And they’re also open and accommodating with having quite a few different support workers in and out, and know that, and understand, and recognise that there may be different equipment that needs to come in, or furniture moved around.

And a lot of that, again, is that relationship building and that rapport that you've got to establish the networks first so that you can build something that didn’t exist before. Because there’s – an interim option generally means that it’s something temporary that’s not a permanent structure. So a lot of the time you're adapting someone’s temporary environment.

**Andrea:** It’s massive, Laura, isn’t it? You're not just really connecting and building rapport and understanding with the person and their family, but also with others; that they need to then connect with themselves. So your example of connecting with medium-term accommodation or housing providers, that’s really interesting.

**Laura:** Particularly when you're talking about – some of these medium-term accommodation providers end up being mainstream hotels and motels. So they’re very interesting conversations that you can have for the first time, when you're having a discussion with a manager at a hotel, and trying to explain what you're asking and whether this is possible. And a lot of the time it’s just about being able to bring that to – bring the possibility to the sector. It’s about being able to say to that mainstream service, “this is possible. We’ve done it before. This is all we need. Are you able to accommodate it?”

And that generally brings out a completely different response than if you contact someone and say, “can you do that?” And then you're putting that responsibility on someone else to come up with a solution that they can’t possibly come up with, because they’re not connected to the scheme, they don’t understand this person’s support needs or how that could possibly work. So being able to have that conversation and bring a solution to the table, and ask someone to work with you on that to make it happen, takes time. And you run into a few brick walls first, but you do need to just, again, have a really clear picture of what you're asking and why.

# Establishing a support model

**Andrea:** Alongside establishing a person’s housing preferences, Alex and Laura also shared how they establish the type of support model that will suit the person’s preferences and needs. First up is Alex.

**Alex:** It’s important to recognise that the hospitals will have done hopefully a lot of work to prepare an understanding for you and the participant of what their basic minimum support needs are. So it’s looking at okay, what is it that if you went home today that you wouldn’t be able to do without support and working backwards from there. “So you want to go home and return to your everyday life, well what is it that you need? What is it that you do in your everyday life?”

Hospitals do a great job now with their preplanning prep and all of that but there’ll still be changes when you get involved that people will one, open up just probably a little bit more with you because you’re the next step. You're closer, you’re that one step closer to freedom so it’s a little bit more of a different conversation as opposed to a clinical conversation that they’ve probably had a number of times and they don’t really know the purpose of it. Whereas with you, the conversation is “okay, we’re going to get you home or we’re going to help you get home, what do we need to do?”

So it’s just that little bit more of a motivational-style conversation and then working from there. You have to listen and you have to be sensitive about it as well.

**Laura:** And it’s a similar approach in that we look at – you've got the hierarchy of needs. So you go through and you acknowledge and validate that someone has a physical or a psychological need for something. And that’s usually easier to define. But how that support is then going to be provided is something that a lot of people, they have never been asked, have never recognised that there is an option. Particularly - and this has come up in recent conversations with someone in hospital, in that we were mapping out whether there were any gaps with what support they were potentially going to need coming home, compared to what they were receiving in hospital. And one of the first things was, “how many hours?” – we were looking at how many hours someone needs for their morning routine.

Like, “oh, you know, by the time that finishes, it’s 10 o’clock,” “Okay, what time do you actually want to get up then?” “What do you mean? I get up at 6.” “Well, that’s what the hospital has to do. When you're at home, and you have supports in place at home, you can choose if you want to wake up at 6 or at 7. What works for you?” And then it opens up a whole new question and answer session about exploring what someone’s day-to-day – not just day-to-day routine and schedule, but how that looks in terms of a lifestyle.

Or set up a support system that actually works at the times that you want it to, and still be supported physically, still go through that process and be safe. But to make it, design it around how your lifestyle is best going to suit yourself and your family. Because a lot of the time we’re having to make sure that the family members are not being – not missing out on their dynamics and on their relationship. And a lot of the time, in stepping out from that, we have to try and acknowledge that when someone has supports come in, generally people are not going to choose to have supports come in, if you could. It’s an intrusion. The majority of the time, it doesn’t matter how fantastic and wonderful, and the support you build with the support worker is, they’re still coming into your home. It’s still intruding on your time and your life and your family. So that’s one of the things we look at, is how we can best support a participant to identify how they want their supports delivered, and then help negotiate through and navigate through that to see how we could help that be set up. Who’s going to complement it?

So what we, as support coordinators, can do, is not be – we’re not the decision-maker. We’re not judging. We’re creating that space so that you can explore it, and we’re there to help prompt and assist and guide and connect.

Another thing that we do in conjunction with that conversation is have different internal templates for ourselves, where we have dot points and prompters to flag and work through what someone’s preferences might be. So we have a housing preference document. It’s like an internal profile. So it builds a profile of what someone wants in their surroundings, but it’s also got little prompters that can help us to collate the information and transfer it across to NDIS speak and housing terminology, and help us to flag and not miss any of those little details that might have a real impact on whether someone’s support needs are met. And we do a similar thing with exploring what someone wants out of their support worker service and preferences.

And what’s really important in that support worker may not be that they can make a bed the best, that they know the difference between 3 different types of hoist. Because there are certain things that can be taught, and people can be upskilled if they’ve got the fundamental priorities in place that someone places more of an emphasis on. You've got to be able to create the space so that someone knows that they have a right to have a choice, so that you can help explore that and help express that choice. But then you've also got to be able to help collate it and apply it to what’s actually going to be put in place. So you've got to be able to translate that across.

**Andrea:** Sally and Jenny both shared their perspective about just how important it is to have the right support team for Sally.

**Sally:** I have to thank the paramedics as living in a country town you become like family and that’s what they are as when they’re not attending me for an emergency they’ll sometimes just drop in and see how I’m going, and when they take me for appointments we will often stop for ice-cream or lunch on the way home. They’ve also organised special outings which I’ve enjoyed and wouldn’t be able to experience if I was in a facility and not at home. So without both my wonderful staff, family, friends, paramedics I think my life would be a lot different.

**Andrea:**  Having the skills that you need to support you, Sally, but also people that you get along with, that you connect with as well. I think I’ve heard from lots of people with disability about the workers that are supporting them and how important it is too, to have people that you do connect with in a personal way.

**Jenny** That’s a really interesting point because sometimes the agency’ll say “oh look, as long as we’ve got a body in the room it doesn’t matter”. But for Sally that’s really, really important because if you don’t connect with the person it doesn’t make the shift very pleasant. I think that is one thing that agencies can lose sight of, is that if Sally’s happy then everything’s going to fall into place and be good for her but when she’s struggling with someone who won’t talk to her then that’s –

**Andrea:** It makes it tough.

**Jenny:**  Makes it very difficult, But yeah, connecting with staff, it’s really vital.

# The impact of short-term plans in a hospital setting

**Andrea:** We talked to Alex and Laura about how they become involved in working with a person in hospital, via a short-term or interim plan, and what impact these plans have on the discharge for a person with disability in hospital. Jenny and Sally also share their experience of how this impacted Sally’s preparation to return home.

**Laura:** Yeah, the difference that they can make is just amazing. Being able to have a short-term or an interim plan put in place at the start of someone’s – before someone’s ready to discharge home, means that you can become involved and help link everything, and help navigate that process, and potentially reduce or fill all the gaps. Line everything up, and make it as smooth as possible, whilst supporting someone to understand what the scheme can do. It just makes such a difference..

The longer that it takes to be able to get you involved as the support coordinator means that the faster you're having to try to action something, so that you're not delaying that discharge home. And having that short-term plan in place means that it’s identifying that someone’s in the middle of a transition period. So you're basically getting a head start, and you're able to trial and test things, that obviously the health system are still providing the support, and the guidance and the service that they need to. But there’s a lot of aspects that run parallel with that.

When an interim plan is put in place and someone’s still in hospital, generally the funding that’s included, or the service that’s identified, are things such as therapy supports to be able to do an assessment for home modifications. There’s identified that there might need to be hire equipment and stuff like that – consumables funding, the low risk aides, and support coordination funding. But one thing that often really gets missed is community access hours, and support worker hours. And often it’s just because, “well, the hospital’s providing the support, why would someone need that?”

But if someone has been in hospital for 12 months, completely isolated and separated from all of their support networks and their peers, their mates, their community, then one of the hardest things to do is be able to try to transition back into that community. To be able to catch up with your mates again and have a chat. Whether it’s a piece of equipment that’s assisting you to mobilise, there’s still that need to have that social connection with someone. And that’s one of the underpinning, fundamental components of the scheme, is to be able to build that social connection.

If someone's in hospital, they’re waiting for their home modifications, and that’s all that’s – and maybe some equipment, and that’s all that’s really required to be able to get out of hospital. Completely safe. Medical wise they’re stable. There’s no reason to actually be in that hospital setting, apart from the fact that there’s nowhere to discharge to physically, then what’s to stop that person from being able to get out and have a couple of hours down the street at a café? Or go to a local event? Supported by staff who can come in and be trained by the nursing staff, and start to help with that re-engagement.

It actually takes time to transition. And it can be really daunting if you're going back to your community as a different person, or with a different piece of equipment or different support needs. So having that time to be able to transition back and be supported to do so can also reduce that isolation, the concern, the frustration. And the psychological benefit of that far outweighs the cost of a few support worker hours, if they get that in place.

**Andrea:** Laura, in your experience, who creates this short-term plan that ensures you're funded to come in and do this work in hospital?

**Laura:** The recent pathway that was established for COVID; the hospital discharge pathway. And then on top of that, or parallel to that, there is also the complex support needs pathway within NDIA.

We’re finding that quite often the complex pathway of a hospital discharge plan is a – it’s recognising that someone’s in a situation where they need to get some support in place now to be able to get the next step moving, but not necessarily be ready to be able to project what is going to be needed across in the next 12 months. And quite often we’re seeing 6-month plans as well as 3-month interim plans. And that can just give enough time to really unpack and dissect where someone’s at, what someone’s going to need, and how we can try to reduce the delay once ready to actually leave hospital.

**Andrea:** Jenny shared her experience of how Sally’s community-based support team learnt from the hospital team before Sally left hospital, and what that meant for her and Sally.

**Jenny:** The girls were paid to come up to learn. I mean it was like a shift, really, they were just doing a normal shift. We had a very big training session just with outreach from the Austin, and all the staff came in and they did a lot of training on the ventilators and trache care and so we had a full day’s – actually it was 2 days. Four days, another of you girls were there. Might have been 2 days’ training so that was all funded also which was very valuable. That was a big part of being able to come home, was that everybody was competent in the trache area and ventilator.

So as we started to build our team, they worked alongside the nursing staff which was wonderful because that really gave them such a good headstart whereas now the girls that are coming on post-hospital, they’ve got a lot more to learn whereas some of the other girls had what, about 6 months? Probably about 6 months in the hospital, it was a phenomenal effort by the staff that drove up the shifts. They’d come up for a few hours and they’d learn the drill and they’d work with the nurses and it was wonderful, it really set us up well. That was initiated by the social worker and she coordinated that with the NUM on the ward.

That’s when Sally would be able to get off the ward. She’d always go with one of the nurses plus our staff so she would get off the ward and she’d maybe just go over to the Olivia John Centre. We went down the street a couple of times, not very often but went out for coffee maybe. But it was one of those things that was trying to help Sally get out from being inside the hospital.

**Sally:** When I was stable enough I was able to spend time off the ward. At the start, it was just very small trips and it took quite a lot of organisation due to my complex needs and if there were enough staff for me to go. Once we were getting closer to me getting discharged, we did do a few bigger outings which included going to the movies and out for lunch near the hospital. But probably the most exciting but also challenging outing was attending my sister’s wedding - but with a lot of planning I managed to attend and enjoy the day.

**Jenny:** You can become very institutionalised and I guess that was the whole idea of breaking that a little bit. You couldn’t do it totally because the move from hospital to home after that amount of time is –

**Andrea :** Enormous.

**Jenny:** A shock to the system.

**Andrea:** Here’s Alex again, sharing her experience of how short-term plans can make a difference.

**Alex:** It really is a collaborative effort . It’s both health and NDIS that are involved in that process and invested in that process. And I think 3-month plans so the hospital identifies somebody’s eligible for NDIS access and automatically they give you a bit of information about what’s needed and automatically a planner is allocated and a short-term plan can be generated. And then the really good work can start together with that participant, helping really clearly map out what’s needed, getting some assistive technology started if that’s going to be more complex and then support workers and external – NDIS OTs, physios, the therapy team all working together for a few months and then they can help the NDIA build a good plan that’s going to be really functional for someone when they’re about to leave.

It takes a minimum of I’d say 4 weeks for someone who's really high support needs or moderate to high support needs, it takes at least 4 weeks to get supports engaged, up and running, ready, potentially started some training. It’s not fair that that participant should miss out on their inpatient team and their support provider being able to have some training and education before they leave. They’ve been in there for 6 months potentially and then to miss that opportunity I think is really unfair so that’s where a short-term plan would be really amazing.

**Using tools**

**Andrea:** We asked Alex and Laura about what type of tools they use to guide their person-centred approach, as well as record-keeping when working in the hospital setting. They shared a few examples.

**Alex:**  I think having like action plans is a really good one, and we have developed a holistic master action plan document that’s inclusive of someone’s details but then it goes through all the elements of their support network, anything that anyone needs to really be aware of and then comes to their day-to-day life and what equipment they might need.

But basically you definitely do as a support coordinator need something that you go off as a basic template for these situations because you’re just doing yourself a disservice if you don’t go in with any sort of preparation. You have to have something to record information on because there is nothing worse than being a person with a new injury or a person in hospital and you've already told your story 50 times and then your support coordinator, every time they see you or speak to you they want to check information with you that you’ve already gone over.

I’m not saying don’t check things with people, but you don’t want to re-traumatise somebody or be insensitive to the fact that they’ve given you this information. They’re sharing something really sensitive with you and that you have a responsibility to be capturing that in a meaningful way so that you can go off and then use it. Also you’re being paid basically – this is billable work so you are not to be charging the participant if you don’t have good record keeping. That’s your responsibility.

Not everyone needs you to do or wants you to do everything for them and they also want to stay on top of things so you might have to leave copies of stuff with them because it’s hard to keep in contact with people in hospitals on a ward. So being mindful that creating resources that are participant-friendly as well, that’s just important and everyone has different needs.

**Laura:** We are unable to have access to the hospital’s files and internal filing system. But to be able to have a joint way of transferring and communicating the information is important. So a lot of the time we’re operating on the “let’s have a key contact for each section”. So whether it be the social worker or the OT for the hospital, and ourselves as support coordination for the community side of it, and that we establish an action plan in an actual document, in a table.

Whatever that looks like is different for each person. It may be quite simple. It may be really complex. It could be a 1-pager or it could be 10 pages. But we will often try to set that out as an action plan that can then be shared via email, generally, with other external agencies and organisations, and people can all just contribute to that if it needs to be updated, and send it back.

# Establishing if a new home is working for a person and continuing to build capacity

**Andrea:** When a person with disability finally leaves hospital after a long time, it’s a significant transition and change in their life. We asked Alex and Laura about how they establish if the new home is working for people they’ve supported to leave hospital.

**Alex:**. It’s very unclear to me what it is that is a successful discharge, however I see it as successful if that person doesn’t go back to hospital very soon after for an unplanned – basically if they’re home that part of it is done, you’ve assisted them to do that. If they can remain at home while you’re working with them, then that’s great if that’s what they want.

But I think the other thing that indicates to me that things are positive, things that I will reflect on and think I think this is going really well is when people – it’s more about the capacity building side of things. So it’s more about when people start to understand what their NDIS funds can help them access and making choices about “well I’ve seen this therapy provider online, this awesome clinic that I want to go to, it’s over the other side of Melbourne but I want to go to it and I'm going to go to it”. Like taking control of their choices as well, like when they start directing me and asking me for things or for help with things, I think that’s when I think at least they know that I can help them and how I can help them, maintaining that connection.

I know it sounds really cliché, we’re always saying it with NDIS, choice and control but honestly when people are exercising choices and feeling more in control of their lives, especially after going through a really traumatic experience, that’s what I see as successful. But I suppose if you look at it medically like we were saying and in terms of the NDIS, if people are able to live where they choose, maybe at home, maybe in an SDA, maybe with their family, maybe in a rental property in an area that they like, whatever it is, if they are living where they want and they have connection to people, the people that they choose –

**Andrea:** Then that’s really key.

**Alex:** Yeah

**Laura:** Yeah, historically discharge home has stopped once someone has exited hospital. Whereas what we try to do is be able to establish and maintain that connection, firstly with the hospital team. But if something has changed or something has been missed when someone comes home, that we can then go back and just double-check something or run something past that person. But to be able to establish that and agree on that expectation, that there will be a follow-up catch-up just to check in and run through a checklist of staff, just to make sure that everything’s okay.

And then obviously one really massive component of our role is to be able to establish the ongoing rapport and contact with the participant and their family, or the other people who are in the housing environment, to make sure it is working. We don’t expect that just because someone’s got out of hospital that that’s all fine, everything’s in place, nothing needs to change. There’ll always be something that you couldn’t predict. And that’s okay, as long as you know at what stage you're going to have to try and review that and monitor it and adapt it.

A transitional period isn’t just the 2 weeks before and the 2 weeks after discharge home. A transitional period can be up to 3 years, in reality. That’s generally the timeframe that we’re seeing, that someone’s into their third or fourth plan, by that time things are starting to settle enough, and really pull out how someone’s lifestyle is going to then be able to support them.

Some people, depending on their situation, circumstance, and how different their environment and support needs are, and what their support network is around them, it may not take quite so long to feel like, “I’m at the next stage now. Okay. I’m safe and settled. I want to start looking at a new job”, or “I want to get back into my community and start exploring study options”. There’s a different timeframe for everything, but it’s about being able to just help someone identify what stage they’re at, and what support they can have through that.

Going home is just the start of it. That’s when it really kicks in. That’s when we start to explore how things could work and what someone’s options are.

**Andrea:** Jenny shared her experience of how Alex and Laura have supported her to apply for funding for Sally’s equipment, and also plan ahead for Sally’s equipment needs in the future.

**Jenny:** The equipment side of things was – there had to be quite a few applications made because they were over the amount that you would have been able to purchase a product so that delayed things a little bit just like suction machines and things like that, they were over the NDIS bracket or cap. So the girls did a phenomenal amount of writing and then they ordered a lot of stuff. Alex worked out that we would need this much for 6 months so she went ahead and purchased about 6 months’ worth of stock and that was really very helpful to get us going upfront. Then they helped me to be able to negotiate how to do that because I always thought oh no, they can just do the ordering, they can keep doing that but they’ve taught me so much that I’ve been able to do. I do all the ordering now and then if there’s anything that we need that’s out of that cap then the girls will do the AT application.

There was not much that they [*NDIA*] said no to. The only time they’ve said no to something is just recent times so 12 months into it and we wanted to get some secondary machines so that Sally wouldn’t end up in hospital. Like we’d asked for another humidifier because if that breaks down then she would have to go back into hospital, there’s no backup. So it had to be applied for and the girls did a phenomenal job in doing that. They’ve seen that it’s reasonable and necessary so we’ve been very grateful for that.

# Establishing if a person’s new home/life is what they imagined

**Andrea:** We talked to Alex about how she supports people with disability beyond their discharge from hospital and living back in the community.

**Alex:**  I think you need to be very mindful you’re not re-traumatising people by feeling like you have the authority or the right, you’re never saying to people “oh well at least you’re home now or this”, just being very, very mindful. Because there may be something that you feel has been successful or has been a good outcome but it will never take away the challenges that that person will likely face for the rest of their lives and also the transition that people are going through, not only physically, mentally as well.

Goals are a really good way to have those conversations in a positive way and I think setting up regular meetings with participants, obviously within the funding and if that’s something that they’re comfortable with and, revisiting those goals, how are we tracking? How do they want to monitor their progress? Is there a system that they like to use to keep track of where they’re – but also I can’t emphasise enough their goals will be different the day they come home because they will potentially finally be home and start thinking again differently.

Like I said there’s a process that people would go through becoming institutionalised and then deinstitutionalised when they get home. And that changes things in terms of what they want, what they want to achieve and also they start doing things and they think okay, now I actually think I can achieve this or that may not be as realistic for me, this is what I’m going to need.

# Achieving the ‘impossible’

**Andrea:** To complete this podcast, Alex and Laura, and Jenny and Sally share their perspective on achieving the impossible through collaboration - empowering Sally to move home with her family, where she wanted to be.

**Alex:**  It was an enormously collaborative effort and just that, just being able to go home and live at home with the supports, the participant – and mainly it’s the informal supports that we communicate with but just thinking it may not have ever been possible for that because of that person’s support needs and whether or not that was ever going to be facilitated and funded. So reflecting on just being able to be a family, not having to live in a hospital for the rest of your life, just being able to use equipment that potentially the hospital system didn’t think that they were able to use and access different tools and socialise and participate in activities in the community and have relationships. Just an entire support model that nobody thought was necessarily ever going to happen or be sustainable and it is.

The work never stops and that’s all part of it and that’s something as a support coordinator to really understand, is that you’re never going to go home at the end of day and be like “oh well that’s done and we’ll never have to work on that again”. It’s just all pieces of a puzzle that you’re along for the ride.

**Laura:** It not only smooths the process for participants, but it also – and it really obviously helps us in our role if we’re feeling comfortable and supported ourselves, and having – maintaining that connection with people. But it also builds the sector. It helps to develop and define what we want that social model to look like, rather than just try to fit within what the expectation would be from a tick box approach. So that’s one thing that we’re always mindful of when we’re working collaboratively with, particularly the health sector, is that, “this is the opportunity. We’ve got all of this scope to be able to define how we want this to look.” We obviously still comply and align with NDIS legislation, and operational guidelines, but the actual delivery of that, and how it looks, and how we can support each other as a society and community, to be able to do that together, that’s where we really do find some amazing outcomes.

And we’ve worked with people to achieve coming home from hospital after years of being stuck there, and adamant that being home in their community, with their family, was the only possibility. And being told that that probably wasn’t likely. “There would be too much to do”, or “it’s going to be too hard”, or “it was too dangerous or too risky”. But having, as a whole community, and all of mainstream and funded supports being able to come together and support a family to make that happen, that’s where you see results.

**Sally:** Without the support of the staff and the paramedics we wouldn’t be able to do what we have achieved, as I didn’t have all of the doctors and nursing staff I was used to if we have an emergency, which we have plenty of. But with the support from everyone we have managed to cope.

It was hard to imagine what my life was going to be like after spending so much time in hospital. But again thanks to my family, staff there made the transition from hospital to home as easy for me as possible, with helping me doing things that I enjoy doing such as cooking, making cards, building Lego and getting outside when I’m well enough. I’ve got a very special dog named Lily who is very special to me and loves spending time having cuddles at night with her.

**Andrea:**  It’s clear from everything that you’ve shared and what Sally has shared too that it’s been an incredible team effort, that SCs are part of that but they’re working within this really cohesive team to achieve this outcome.

**Jenny :** Yeah, absolutely. It’s a team effort, the whole thing, between the agencies and the staff and the support coordination and all the other people that I have on my list. Alex and Laura - they have been an ongoing support weekly. I basically every week have – if it’s not a text message or an email to them I have input for any problems that might happen. I was trying to get on to a third agency mainly because of needing more staff and thought we could draw from another pool and Alex set up a – it was about an hour-and-a-half Zoom meeting just so we’d all talk so she’s involved in a lot of those extra things, anything that crops up. The support coordinators is just so vital. They can do things I can’t do.

There’s nothing that’s too difficult for them and that’s what I really appreciate so much about them. They often just check in to see how I’m going also but there’s so many little bits and pieces that they troubleshoot so much more easily than I can. I couldn’t imagine doing this actually without them. I don’t think I could. They are just such a vital link.

**Andrea**: Thank you for listening to Episode 2 of the *“Best Practice”* series. The Summer Foundation would like to thank Laura Schutz and Alex Foote from Independence Australia as well as Sally and Jenny Messer for their contributions to *“Best Practice”*. And thank you to Linda Hughes, our UpSkill Lead.

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You can find out more about the UpSkill program for support coordinators and allied health professionals on the Summer Foundation website. Tune it to Episode 3 of “*Best Practice”* to hear how others in the workforce have supported people living in Aged Care to benefit from the NDIS.