**Episode 3, Part 2**

**Supporting a person in aged care to live a better life**

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**Andrea:** Hi, I’m Andrea Lockwood and welcome to Part 2 of Episode 3, where we’re talking about what best practice looks like for support coordinators working with people living in aged care. In Part 2, we’ll talk about how support coordinators support a person to transition out of aged care into their new home, preparing for their move and then establishing if the new home is working for the person

# Inspecting alternative housing options

**Andrea:** First up, Jamie talks about supporting a person to visit the new home.

You mentioned an example of supporting someone to actually go and have a look at an area and get a feel for it. Is that something – is that an important part of the process in the person thinking about moving out, and then making that transition?

**Jamie:** Definitely. Seeing the places, it doesn’t become real until you actually look at the first place, and also it can change a person’s idea of “I’ve just got to get out of here, I’ve just got to get out of here”, but then to actually see a place and go “oh no, I don’t want that”. We all know what we want until we find out that we don’t want it.

It’s important, and it’s done so well in the SDA world, where you actually get – so yes, you make your application. Yes, you have to get your SDA funding first nowadays so you’ve already got your OT report, you put that together, and then you’re finding a place. And basically you can only do a certain amount of research, then it’s important for the participant to go out there, meet the actual residents and staff that are actually there, specifically the staff that are going to help them out in particular and the team leader. Check out the local area, go down to the shops, have a coffee, come back and then jump in a cab. And I’ve never arranged a visit with somebody that doesn’t go down to the shops and have a coffee and come back. If it’s an hour session, we allow another 2 hours for that to actually happen and make it a full day outing so they really get an idea of the surroundings and what it’s like. And that always does help give people an idea of what the opportunities actually are.

And yes I’ve had, in particular, had a participant go “yep, that’s definitely not what I want, definitely don’t want that”. Had another participant get scared off by that model saying “it’s not a variation, it’s not a variation enough from the aged care sector. I need something completely different because I’m just moving from this to that so that’s not – I’m going to need something more”. So it actually helped us structure more of a need for independent living as opposed to going and living with others, which that participant would not have chosen unless they were actually able to have a look at those other options. So it’s definitely vital for a participant to go and have a look at the local areas, and it gives them an idea.

It also puts that mindset, just that change of mindset of like, this could be my home. And that goes on the back of what I was saying earlier is like that literally if you move in here, this will be your home. If you choose to live in here, and it is your choice, this is your home from this point forward. Do you want this to be your home?

**Andrea:** It’s a massive transition, it’s such a big change that people make in their life moving from somewhere like a nursing home into the community. And what you’re saying there, Jamie, in relation to a participant that you supported to actually go and meet other people in the home that they were considering as an option, but realising that actually no, I don’t want to live with other people, that isn’t something that I want to do. So it really highlights the importance of not just looking at the area, but actually meeting the people that you might then live with or interact with, and whether that’s going to work as well.

We talked to Laura about her approach to planning the transition for a person who is leaving a nursing home?

In a post-COVID world do you think for a person that has effectively got a plan in place, a person in RAC has a plan in place to move out, that there’s potential for that person to trial that new environment? To go out overnight, or maybe more than that, but just to have a staged approach to leaving?

**Laura:** Absolutely. Absolutely. And that’s exactly what we had pinpointed prior to COVID occurring. This particular person and a couple of other people who we’ve supported to transition now, and that was the whole concept of it; was to help set up that environment so that they could have an overnight, and then a 2-night. And that’s happened in the hospital setting as well. We’ve organised that transition to a couple of different supported accommodations before as well, so out in the community but still supported, to try overnight, weekend, and then half the week and then ongoing.

So it’s a gradual transition that allows you to have the opportunity to pick up on any potential risks before it’s a permanent thing. And if there is something that’s unsafe then there is still that setting to go back to whilst you fix the stuff that’s unsafe. Because that’s what we’re trying to prevent; is going into an environment that might have an issue that you've got to try to fix while someone’s there, where it becomes unsafe.

You're also asking people in those settings and asking other people who have gone through it what they did, what they should be aware of. We do that with our team. We share – even just ourselves, we share within our team what we’ve come up against and what we’ve recognised and noticed, so that the next person who’s supporting someone to go through it goes, “oh! That’s right, Alex dealt with that. I know where to go, and if I don’t, I’m going to go back to Alex and ask her how she managed to get that outcome. How did she manage to make sure that the RAC followed through with the equipment they were meant to? Because I don’t want to have to read the Aged Care Act and argue with people again 20 times. But she’s got the extract there already, because she got the outcome. So let’s draw from that. Let’s take other people’s skills and other people’s experiences and build on it.”

# Preparing to move

**Andrea:** Laura, can you share how you’re approached preparing someone to move? Are there particular supports to consider for their NDIS plan that make a big difference?

**Laura:** Quite often it’s about helping to not only identify the best option and get it in place, but it’s about designing and developing it, and making sure that it’s suitable, before pulling the pin. And that can be a pretty lengthy transitional period, which is often hard. Because you've got to try to start working through the process before it’s needed; before it becomes critical, and we’ve done that before. We’ve worked within that before to help someone to find a more suitable accommodation in a critical crisis situation, we also made sure that the day-to-day support needs were enhanced as much as possible. We maximised NDIS funding and supports to help make sure that this person was out of that aged care facility as often as possible; in the community, attending events, going on a short holiday.

Things such as making sure that really pushing to increase transport funding, so that they could actually get away from that place and reconnect, as a younger – quite a lot younger person. So looking at if we can’t change the actual housing immediately, then we look at how we can change the surroundings, and adapt the environment so that someone’s at least safe and is supported to stay connected. And then we try to get that housing in place. So it can be a lot more of a lengthy process. But it’s still, again, about managing expectations, being able to resource and find information, and being able to sit in your lane.

**Andrea:** Yep. Just with what you were saying before around accommodation or housing options, does MTA, medium term accommodation, come in, in your experience, to supporting a person to transition out of RAC?

**Laura:** Out of RAC it’s a little bit more of a risk, in – if you're uncertain of timeframes. RAC, again, it’s about whether it’s real or whether it’s a perceived security net. So RAC’s not going anywhere. You're not going to get turfed out. So there’s not generally as much of a push to, “ok, we need to find an interim option.” And often, if you're talking about moving from RAC, which we did explore this with this person I was speaking about before – so we explored MTA as an option. But the reason that that person was in RAC for so long was because they needed an individualised, customised option, both for the environment but also the support network.

And the concept of trying to – and we did explore it, and it was not going to work safely – the concept of trying to explore a setup with an accessible environment, as well as having a support system set up, trained to be able to facilitate that, but also make it a smooth transition. So if we were going to do that, we were going to need to try to find a support worker service who could then continue on in an SDA setting. Because in that circumstance it’s so detrimental to someone to have a whole new support network come in and have to learn about your support needs, and again that whole intrusive nature. But the – it’s unsafe as well to have so many people coming in and learning at the same time, when you're talking about high needs.

So what we weighed up was whether it was going to be more unsafe to have unknown people come in, and then potentially a few weeks later have another bunch of unknown people come into a different environment. And the impact, psychological impact, that was going to have.

But it’s definitely – MTA has definitely supported quite a few people to be able to have that gap reduced, if – particularly if home modifications or an SDA were just being finalised, and they had a timeframe. MTA works quite well if you've got a timeline, you've got a timeframe, and you've also got a way to have that continuity of support and have the staff trained up properly.

But the other thing that we also consider with MTA is whether that interim environment is going to be able to accommodate someone’s equipment needs. So it’s a very big factor, because generally, if a therapist is prescribing equipment, they’re prescribing it for the long-term support need environment, not for a hotel room, which generally doesn’t have that space or the level. So there’s a lot of underlying risk factors associated with that that can cause a lot of concern if you're not catching it. Yeah. A lot of it is just about asking the questions.

**Andrea:** Yeah, and having the right tools to guide those questions too, isn’t it?

**Laura:** Yeah, and they’re – that’s what we do every time. So the template that I said, about the prompts and how we build that profile, and flag things, what we work – because we work through some of those questions directly with the participant, some with the therapist, some with the family member. And we build that profile. And it fits within different categories and topics so that we can translate it across to NDIS speak. But what we do with that is it’s a continuously developing template. Every time we work through the process with someone, we find or think of something different that could have been asked before the other question, or should have been asked, or was completely missed by someone in the process.

So every time that we go through that process with someone, we adapt and adjust that template. So we’re learning all the time, because every situation brings up a new risk or barrier or a challenge or outcome. So we take those little points and we add them in and we learn from that. Instead of just trying to fit that person into our template, we move the template to fit the people.

**Andrea**: We talked to Jamie about how he has approached preparing someone to move?

What I’ve heard from other people, just to share some examples, connecting with other people who have made that transition themselves, with other people with disability who have been in aged care and moved out, has been one really important thing that people have shared with us.

The other thing is actually doing activities that are representative of what your life outside of RAC will be like but doing those while you’re in aged care. So you’re not just waiting until you move and then your life is changing, but actually doing things that are different while you’re in aged care to help prepare for that life outside of the nursing home.

**Jamie:** Yeah, when – with a lot of the participants’ plans we definitely try to get the hours for them that they’re going to get outside of the residency, so with community access supports, so having that kind of support day in, day out. Finding out what their interests are in, whether it be Men’s Shed, whether it be anything, but really focusing on what their main outlet is.

Most of the participants I’ve dealt with have wanted the freedom for themselves to be able to wake up in the morning and choose what they want, which of course is the hardest thing to fight for in regards to hours and funding with NDIS, but perfectly respectable and understanding for what they want.

When people first move out, the first thing they want to do is just have their freedom. And then it’s like finding a routine, what kind of routine actually works and what interests are everyone in? One thing NDIS are good at is giving a lot of community access hours in the first plan when they move out. After that, it’s very, very difficult because you need to find something between that, so you usually have a year to send a participant around to as many places they possibly can and say “what do you think about this? What do you think about that?”

So yeah, as far as preparation is concerned, really, really hard within an aged care facility, but certainly getting the community access to help get out of that residency and go to places is important.

**Andrea:** Yes, yep.

**Jamie:** As I’ve said, probably one of the main things with me is a lot of people I’ve found the first thing they want to do is just they don’t want a schedule, they want that freedom. They want to get out, they don’t want to be around other people because they’re around 30 to 100 people every day because they’re in an aged care, so yes, I found that a little bit harder to bridge.

# Ensuring a new home is working for a person

**Andrea**: We talked to Laura and Jamie about how to establish if the new home is working for the person? First we hear from Laura.

Once you've got everything in place, they’ve had additional support within the RAC environment to help that person transition out, and they’ve moved out, how are you then establishing what that new environment is; how that’s working for the person? And also whether that new home, that new – those new surroundings, whether it’s what the person imagined their life would be like once they’ve moved out of RAC?

**Laura:** Yeah, that resonates so well at the moment. There’s a few people who we’re in the middle of helping to adapt and explore alternative options, now that they’re out of RAC. But it’s similar to how we approach with health, in that we make sure as much as possible that everyone’s connected for that continuity of support, and that we’ve helped establish a realistic timeframe to do just an informal review of where people feel they’re at. But in particular if you – what we find with RAC is that often things are hidden when someone’s been living in a facility for a long time. And until someone’s in an environment where everything’s out in the open, and there’s a bunch of different people coming in and out of from different agencies and providers, you start to unravel it.

And it becomes more apparent what someone’s actual support needs are when they’re trying to access an individual service delivery. So in a RAC obviously it’s determined based on how many people are in there, as to the ratio and the time that they can provide and support someone with. And little things such as – a particular person was, “what do you mean I can choose my clothes? The facility just puts it out, gets them out for me. I don’t get to choose my clothes, what I want to wear.” Because it was quicker and easier, and in a RAC facility with 200 people you don’t have the time to ask every person, “are you sure you don’t prefer the blue shirt?”

In an ideal world you would, but it’s the conditions that the staff are working under as well. So when someone’s living in their own environment, and the support worker or the support staff are asking, “what would you like to wear today?” “I don’t know. What do you mean? I’ve got a choice?” And quite often what we discover is that with more choice comes more decisions, which become more responsibility. So the more opportunities that someone has, the more decisions they have to make. And that can really overwhelm if you haven’t been used to any of that. So to help someone to monitor and review and check in with whereabouts they’re at and how something is working for them can change for months and months on end after moving out of a RAC. Because every single day there’s a new opportunity to make a decision and learn something more about how they want something to happen that wasn’t available before.

So it’s so different and it’s so – such a new experience, that a lot of the time it’s just too much. So you've got to just do it step-by-step: “all right, let’s make sure that your day-to-day support needs are met first. Then work out what activities you want to actually go out and do. And then let’s have a look at what menus you can – what your meal plan could look like. And then let’s focus on how to really get the most out of everything.”

So it’s a gradual approach, but again it’s about making sure that you're keeping that safe space for someone, that you're checking in and not just taking for granted that, if someone’s getting up and going to bed, that all the stuff in-between is okay. Just because someone is not back in hospital every week doesn’t mean that that person feels safe or is supported in the best way possible. And it can – the difference is that, again, RAC is so compartmentalised that you can’t bring in support staff to train up. You can’t have that access to knowing exactly how long it takes someone to have a shower if they were to be supported in their own environment properly. How long it would take for that person to decide what they want to wear, let alone get dressed.

So exploring that, it’s a whole journey in itself once someone’s in their own home. And what you thought might have been someone’s support needs and preferences can often be quite different as soon as someone’s out in the open. And it can often feel like, “oh, why is everything getting worse?” But it’s actually, “why is everything so available now? Why can you see all the detail now? Why couldn’t we see all that stuff that was hidden, and the underlying health issues that someone might have had, that wasn’t picked up because they didn’t have one person connecting with that participant at all times?”

**Andrea:** Jamie, from your perspective, once a person’s moved, how do you establish that this new home is really working for them and is matching up to what they imagined this new life might be before they moved?’

**Jamie:** The hard thing with that is that most people don’t – well, nobody will really – for the participants who have had this as a brand new disability, this is their first time, so they’re going to go through a lot of hardship for it, so as a support coordinator you’re there quite a lot. Either visiting, a bit hard during COVID, but either visiting them or contacting and calling them and checking in with them quite regularly about how things are going, how things are with the staff. Your community access workers, are they turning up on time, are they not turning up on time? Checking in if they do have practitioners, what practitioners are going in? Are they not going in?

Talking with the staff as well and seeing what their points of view are as well, because they get to see the participant 24/7. But really mainly going in and just regularly checking up with them and just going “How are things happening?” What is, a lot of people like anything, if you ask how someone’s going they’re going to go “oh, they’re good”. They’re not going to give you a detailed process, so it’s really about probing that person to find out what is wrong.

You don’t want to do it to the point where they deliberately find things that are wrong that aren’t, but to do it to a point where literally it’s like “Okay, how’s the morning process going? How are things going showering, eating? Have you got the food you want? How’s the money situation going? Do you feel trapped, do you need to go out more? How’s the room, what do we need to do with your room? Do you want us to change the furniture? How do we want to work on that? You need a couch.” “I don’t have any money.” “Oh no problem at all, let’s find you someone, find this – find what we can to actually help you out through this and make this a home for you. Are you bored during any parts of the day? Are your community access workers the right people for you? Are there any of them that aren’t really clicking? Are they doing what they’re supposed to be doing?”

And the same thing with the house. “Do you like the food that’s on there?” There’s so much when you think about our own lives, when we actually wake up, how much – well, we don’t think about our own life, but when you do, are you able to get up in the morning? Do you have time – are you able to freely go to the toilet? Are you able to eat the cereal that you actually want to be able to eat? Do you have all the tools and utensils to be able to do that? get dressed and then get ready of the day. Are you able to head out? Do you know the tram schedules? Just when you actually break down a whole day, there’s a lot of complications.

And depending on the staff, that there are some staff that are just so wonderful in the fact that they’ve done all this stuff and you don’t have to do anything. It’s like well, you’ve already organised that, that’s fine, that’s great. But then you’ll find that there are other instances where you have to literally replan everything.

And I’ve definitely had complications with the way the house runs so that we literally have to start team meetings and have care team meetings on a monthly basis, and organise things so that we can bridge that gap of communication and make sure the participants are actually getting the care they require. In particular the participants, if they are having any complications, that a) the participant has a voice in actually mentioning it to the practitioners or myself. But also that the staff know that they can actually bring that up with the practitioners and myself, because there’s been occasions where we haven’t realised the complication has been of a certain behavioural nature and for that reason the participant is not receiving the level of care that they need, and everyone’s just accepted it as this is the type of person that person is or whatever.

It’s like no, no, no, let’s go bring a practitioner in, and they end up finding out that that person is being sat in the wrong commode. Or that person is – they’re using – they’re getting that person up way too early and that’s not – it scares them. It can even be, depending on the levels of behaviours, it can even be don’t turn the light on when you first walk in the room and just go “hey, how are you going?”

**Andrea**: Yes. It’s really important to work out what’s behind someone’s reaction and understand what’s working or not working for them. Jamie - have you worked with anyone who hasn’t been happy with where they’ve moved to, and then chose to live somewhere else?’

**Jamie:** Definitely.

Looking at a new house is not a problem at all, like for anyone, anyone can choose to move elsewhere.

It’s definitely all within the realm of possibility in the NDIS world, and who’s going to stop them? It’s their choice, their life, and that’s what we’re here to do as well. And as a support coordinator, if they want to move somewhere else, we’re going to be here and we want the best for them and we’re going to keep advocating, especially if something doesn’t meet their needs. That’s what it’s all about.

**Andrea:** We talked to Phi about how his life has changed since leaving the nursing home and living back in the community.

So when you moved to your new home, Phi, I just want to make sure that I heard what you said. When you moved, you got more support?

**Phi:** Yes, yes.

**Andrea:** And you’ve got a physio and OT as well?

**Phi:** Yes.

**Andrea:** More recreation time to do the things that you enjoy?

**Phi:** Yes.

**Andrea:** Yeah. What sort of things are they, Phi? What are you doing now that you’re living in your new home?

**Phi:** Mainly I go on Saturday or Sunday, even Friday, I go to Northland or Greensborough and get my dinner and just go outside. Get some fresh air. Yeah.

**Andrea:** Going out to get fresh air, but going to get dinner at Northland and Greensborough did you say?

**Phi:** Yeah.

**Andrea:** Yeah. Sounds great, Phi. And you couldn’t do those things when you were in the nursing home?

**Phi:** No.

**Andrea:** What kind of support does he provide while you’re living in your new home?

**Phi:** If I got something that I need, I will ring Jamie and I need to speak to him and I can ring him and ask about it.

**Andrea:** So if you need some more physio, Jamie can help you to ask for that in your next plan?

**Phi:** Yeah.

**Phi:** I’m happy where I am from move out of nursing home and you get more carer, that is one. You get coordination, physio, and OT. And then you’ve got extra time to go outside.

**Andrea**: More time with all of those supports from your daily support worker, from Jamie your support coordinator, your physio and OT?

**Phi**: Yes.

**Andrea**: And all of these supports mean you can go out and do what you want to do?

**Phi**: Yes.

**Andrea**: It’s a really big change, Phi, for you?

**Phi**: Yes.

**Andrea:** Thank you for listening to Episode 3 of the  *“Best Practice”* series. The Summer Foundation would like to thank Jamie Woodman from Melbourne City Mission, Laura Schutz from Independence Australia, and also Phi, for their generous contributions to *“Best Practice”*.

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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 4 of “*Best Practice”* to hear Linda Hughes talking about working in a person-centred way.