SAMPLE TRANSITION NDIS PLAN

For younger people in residential aged care or who are in hospital, at risk of entering residential aged care

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What is a transition NDIS plan?

A transition NDIS plan aims to facilitate a successful and timely discharge from hospital or exit from residential aged care (RAC) for NDIS participants. It is a 3–6 month plan that acts as a transition to a more extensive plan. It caters for a range of possibilities, including:

- The person needs an interim housing option while awaiting significant modifications to their existing home
- The person cannot go back home and needs alternative housing
- The person may be discharged before their more extensive plan is confirmed and implemented

Who is this for?

- **Patients or NDIS participants in hospital** who are at risk of admission to RAC,or have a life-limiting condition where timely supports are critical
- **NDIS participants in residential aged care** who want to move out
- **Patients who have had a catastrophic or life-changing event** that has resulted in a lifelong disability that requires specialist assessment for their new housing and support needs (includes potential home modifications)
- **NDIS participants with an existing disability** who have experienced a significant change in their circumstances and require specialist assessment for their new housing and support needs (includes potential home modifications)

What does it include?

- **Hours for a support coordinator** to collaborate with the person and health professionals to explore the person's housing needs and preferences, including **medium term accommodation (MTA)** until a person moves into a more permanent home or arrangement
- **Hours for specialist assessments** including home modifications, housing options, and level 3-4 assistive technology
- **Hours to coordinate links** between health and community-based service providers and mainstream systems so that important **training and handover** can support the person to remain in the community and avoid admission or readmission to hospital

Why advocate for a transition plan?

- It aims to prevent NDIS participants getting 'stuck' in hospital or RAC because funded supports are not available
- It enables key supports to start in an effective time frame before discharge, or it may facilitate discharge before a more extensive plan is approved

What are the essential transition supports?

The table on page 3 onwards outlines support items that are essential for a transition plan. Staff need to work with the person to decide if additional supports are needed based on the person's goals.

SAMPLE TRANSITION NDIS PLAN

PARTICIPANT'S GOALS

Clarity on the person's goals is essential for creating an effective early, transition plan. Sample goals may include:

Immediate term goal	"I want to leave the hospital as soon as possible and live back in my community with my partner and family"
Subgoals	"I need to live somewhere temporarily with support, before moving to where I want to stay long-term" "I need equipment to help me with everyday things, so I can do as much for myself as possible" "I want to feel confident in the people who will support me with everyday activities such as showering and dressing, so I don't rely on my partner and [they] can return to work"

PARTICIPANT STATEMENT

1. LIVING ARRANGEMENTS, RELATIONSHIPS AND SUPPORTS

Describing the person's current living arrangements and the informal support they receive is also essential. This highlights potential discharge options and what support is available to facilitate the person's discharge.

"Where I live and the people who support me"	I am currently an inpatient at [X] Hospital. ***Consider commenting on:*** • Reason for admission or person's description of their disability • Living arrangements before hospital admission • Family/friends' proximity to person and frequency of contact • Person's preferences re discharge destination, including location/who to live with • Level of support from family/friends • Reason a transition plan would facilitate discharge from hospital

2. DAILY LIFE – DESCRIBE DAY-TO-DAY LIFE

"My daily life"	***Consider commenting on:*** • How long the person has been in hospital or residential aged care • Previous lifestyle/employment/study/functional ability/what was important to the person • Current functional ability and use of/need for equipment and impact of not receiving supports

PRIORITY SUPPORT ITEMS

Core Supports	
Support Category and Support Item	**Justification – Tailored to participant's goals**
Assistance with Daily Life Assistance with Self-Care Activities	Participant is unable to attend to self-care activities independently due to their disability which has resulted in *[functional impairments/equipment needs/judgement around safety]*. Participant needs their support workers to receive training from health staff to deliver personal care support when they transition from hospital. This will support participant's goal of successfully and sustainably transitioning out of hospital to the community and reduce the risk of readmission caused by inappropriate support practices. This may include training in specific activities such as hoisting, tracheotomy care and pressure care regime. [X] hours recommended *NB. Recommended training hours should correlate to the level of daily support the participant needs (e.g. needs 20 hours support/day, therefore support workers need 20 hours/day training over 2-week period).*
Assistance with Daily Life Medium-Term Accommodation (MTA)	Participant requires a medium-term housing option prior to their preferred long-term housing solution becoming available. This is essential to support the transition from hospital or RAC to the community as soon as possible, to reduce the high risk associated with an extended hospital admission, including the risk of infection and social isolation and to facilitate community participation. *Typically, MTA would be used for periods up to 90 days and is only approved when a participant has a long term housing solution that they can't access quite yet (e.g. the building is not yet complete). The MTA price covers the accommodation component of the care, with the support component of the care to be claimed through the appropriate support line items such as 'assistance with self-care'.*
Assistance with Social and Community Participation Access Community, Social and Rec Activities	Participant requires assistance with re-engaging in their community, reducing isolation, increasing their opportunities for participation and facilitating their socialisation with their support network. This early support will help enable a safe and timely transition from hospital to the community. For example: • Assistance to access social and community activities/events • Assistance with car transfers and wheelchair navigation • Assistance to orientate/navigate the community safely • Assistance with shopping/groceries/errands This support can include assistance for a participant to access the community and engage in activities that facilitate social participation while still in hospital, e.g. going to a dental appointment or participating in leisure activities. 6 hours per week recommended *Recommend requesting 'composite rate' to facilitate flexibility over the whole week.*

Core Supports – continued	
Support Category and Support Item	**Justification – Tailored to participant's goals**
Consumables Low Cost Assistive Technology Continence Supplies	Participant requires low-cost assistive technology to purchase daily adaptive aids and equipment (~less than $1500) that will increase their safety and independence with everyday tasks. This will reduce the need for additional support workers as the participant can actively participate in daily tasks. Additionally, the participant will require XX funding for minor repairs and hire in addition to the capital supports below. This is essential to ensure timely repairs and access to equipment to minimise disruption to their participation in daily life. Participant requires continence supplies that have been recommended in a continence nurse's assessment. These items are essential in supporting their successful transition from hospital to community and promoting the participant's daily hygiene and social and community participation. Having access to recommended continence supplies will promote the participant's skin integrity and wellbeing, while reducing the risk of pressure areas. Continence products are also essential to the participant's confidence in accessing the community – without these, the participant is at risk of being isolated at home. Low Cost AT – min $1500 + XX for repairs and hire Continence Supplies – *Identify package that applies.*
Transport Transport	Participant is unable to use public transport safely or independently due to their [functional impairments/ equipment needs/judgement around safety]. Participant is also currently unable to drive independently. Participant relies on accessing the community for appointments, family and social engagements and employment. Participant also needs transport support to explore housing options for their long-term housing plans. Participant requires transport funding to address the above and support their goal of accessing the community. *This item can be funded as:* • *Fortnightly periodic payment (fixed amount based on transport levels 1, 2, 3)* **OR** • *Flexible amount within core budgets (for this to occur, this category must be agency managed, along with the rest of core supports).*

Capacity Building Support	
Support Category and Support Item	**Justification – Tailored to participant's goals**
Improved Daily Living Skills Assessment, Recommendation, Therapy or Training e.g. occupational therapy, speech pathology	Participant requires occupational therapy assessment, recommendation and therapy to *[support, explore and implement aids and equipment/home modifications/alternate housing options]*. This is essential and in line with the participant's goal of leaving hospital and returning to community living. Participant requires speech pathology assessment, recommendation and therapy to explore communication devices that are essential for their participation in everyday tasks. A speech pathologist is required to ensure that the most reasonable and necessary device is prescribed, which will increase the participant's ability to communicate their needs, reduce their isolation and reduce the amount of support they require during the day. *If necessary, include therapy reports that outline risks and short-term plan recommendations that are not included in this short-term pre-planning document.* 50 hours recommended for interim period (~3 months)
Support Coordination Level 2 - Coordination of Supports	Support coordination is essential to ensure the participant is able to access funded and mainstream supports, understand and explore options in relation to housing and living arrangements, engage and communicate with providers, work towards NDIS plan goals while mitigating barriers and risks, maximise budget to meet required supports, increase use of NDIS portal and strengthen choice and control. Participant requires support coordination to identify a preferred living arrangement, explore available housing options, and prepare a housing plan. Throughout this process, the support coordinator will liaise between multiple providers, ensuring a cohesive plan that facilitates the participant's successful transition from hospital to the community. 52 hours recommended for interim period (~3 months) - 4 hours per week for 3 months *NB. Hours recommended may vary depending on complexity of participant's needs.*

Capacity Building Support – continued	
Support Category and Support Item	**Justification – Tailored to participant's goals**
Support Coordination Level 3 – Specialist Support Coordination	Participant requires specialist support coordination for *[specific time frame]* to support the participant with their complex needs and reduce the risk placed on their participation and their formal and informal supports. These hours of specialist support coordination are required to build the participant's capacity and resilience, so they can be effectively supported by level 2 coordination of supports. The participant has a number of complexities which also indicate the need for a time-limited period of this level of support coordination - they include *(choose/elaborate on what's relevant):* • Involvement with other systems (e.g. justice, child protection, etc) • Requiring 1:1 or 2:1 level of support due to significant physical impairments or behaviours of concern • Risks with current housing (e.g. shared supported housing or RAC) • No existing informal or community supports • Requires input from a team of multiple providers Specialist support coordination is also required for the participant to implement their behavior support plan with the coordination of all supports required to facilitate this.
Improved Relationships Specialist Behavioural Intervention Support Behaviour Management Plan Incl. Training in Behaviour Management Strategies Individual Social Skills Development	Participant needs a specialist assessment to establish a Behaviour Intervention Support (BIS) plan, as the participant has persistent/significant harmful behaviours of concern. This plan is essential in supporting the temporary implementation of restrictive practices that may be recommended and essential, and then reducing these as soon as appropriate. A BIS plan is essential for the participant to achieve their goal of living in the community. Participant requires hours to support training of informal and formal supports in behaviour management strategies that have been identified in the BIS plan. This is essential for an effective and sustainable transition from hospital to the community. 30 hours recommended for a combination of assessment, development and implementation of the BIS plan.

Capital Support	
Support Category and Support Item	**Justification – Tailored to participant's goals**
Assistive Technology Rental Repairs & Maintenance	Participant requires the AT outlined below to be rented to ensure they are able to get out of bed and safely participate in everyday activities. This AT is essential to support the participant's successful and sustainable transition from hospital to community living. Flexible hire equipment funding is essential to ensure the participant's safety and maximise their ability to participate in daily activities while awaiting the outcome of AT trials/submitted applications. In addition, the participant requires major mobility repairs/maintenance funding for current equipment and prescribed equipment once delivered and set up. Participant requires a portable accessible ensuite, linked to the Toilet and Bathroom Equipment Rental support item, as their current bathroom is not accessible and they cannot safely have their hygiene needs met in that space. This is essential to be hired while awaiting home modifications to be completed. Participant requires modular ramping system, linked to the Mobility Equipment Rental support item, as the current access to their home is not safe and a mobility aid does not enable access. Renting this ramping system will support the participant to achieve a timely discharge from hospital and transition to their community as soon as possible. • Major Mobility Repairs (quote required) • Minor Mobility Repairs/Maintenance (funds to be available/accessible) • Hire Equipment - Rental - Composite (funds to be flexibly available/accessible) *NB: It is helpful to include what hire items are required and quotes for minimum 3-month period.*
Assistive Technology – Purchase/Scripted Equipment Delivery – Set-up/Training (apply to relevant option)	Participant requires assistive technology that will facilitate their safety and independence with daily activities, so that they can transition effectively from hospital to home. The items that are required are: • *[item]* • *[item]* Please see attached AT form for each item as completed by the occupational therapist/physiotherapist/speech pathologist etc. with all clinical justifications. Participant also requires equipment delivery, set-up and training. Quotes to be provided for high cost items (over $15,000).

Capital Support – continued	
Support Category and Support Item	**Justification – Tailored to participant's goals**
Home Modifications HM - Certification and Compliance Approval HM - Building Works Project Management CHM - Deposit CHM - Practical Completion CHM - Progress Stage HM - Design Consultation with Builder HM - Bathroom/Toilet - Structural work HM - Ramp - Structural	*NB: include either Home Modifications or SDA, not both.* Participant requires home modifications to their current home to be able to return home. Early planning for modifications to their home will avoid an extended hospital admission, which involves further risk to the participant. This includes their home being accessible and set up to meet their needs for participation in all activities of daily living, while optimising independence in these tasks. The expected home modifications include, but are not limited to: • Accessible front access, requiring ramp installation • Full bathroom modification The support line items listed are required pending OT assessments, quotes and applications that will be completed within this interim plan period, providing complete recommendations and justifications of home modifications required. The participant will require architect/builder fees for complex modifications to include project management and architect fees due to the complex structural modifications involved. Quotes to be provided following OT assessment and recommendations.
Home Modifications Specialist Disability Accommodation	*NB: Ensure that NDIS goals include housing options goal:* Consideration for SDA (if participant is not returning home). This will require capacity building OT assessment (included above) to complete OT report and support coordination hours (included above) to complete the housing plan. *If health has completed SDA application:* OT report and housing plan are attached/have been submitted for prompt assessment and outcome with the aim of reducing the risk of an extended hospital admission through exploring multiple housing options, and supporting participant to achieve their long-term housing goal. *If external OT and support coordinator are completing SDA application:* Participant requires an SDA response. OT report and housing plan to be completed within this interim plan with capacity building supports.

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