

# Supporting a Good Transition



Locating a housing option for discharge is only a part of the discharge planning process. Once a housing option is confirmed, planning for a transition from hospital should include frequent communication with both the housing and support providers.

Support providers will seek to understand the person's support needs, and may request documents including OT (occupational therapist) reports, medication charts and continence information. For those needing specialised care, such as behaviour support or specialised manual handling techniques, specific training is recommended and often required by the provider. Participant-led [training videos](#) are a useful way to do this.

Other items regularly associated with moving such as furniture, linen and first food shop also need to be organised. It is important to allocate these tasks to a member of the care team well in advance. When this is left to the last minute, discharge can be delayed several days to ensure the basics are in place.

## Top Tricks and Tips



Include housing and support providers in regular stakeholder meetings leading up to discharge.



Shadow shifts in the hospital are ideal to provide thorough training of new support workers.



The [Moving to a New Home Checklist](#) is a helpful resource for transition planning.

## Case Study

Five days after discharge to a new SDA (Specialist Disability Accommodation), Josh was readmitted to hospital. The reason for admission was because the new support workers found it challenging to provide adequate support, and the support provider complained they had not been fully informed of Josh's specific needs.

An investigation found that prior to discharge, no carer training or comprehensive handover had been completed between the hospital team and the support provider. As a result, the arrangement broke down and Josh returned to the hospital via ED (emergency department). The care coordinator spoke to the provider, who agreed they would be willing to support Josh once carer training and a written handover had been provided. Josh then needed to be admitted to a ward for 5 days so this could be completed.

Overview:  
Discharge  
Planning

Barriers to  
Discharge

Collaborative  
Discharge  
Planning

Making Sense  
of NDIS  
Funding

**Supporting  
a Good  
Transition**

Escalation  
Pathways