# Towards Exemplar Hospital Discharge for NDIS Participants
# "Right Supports, Right Time"

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**AIM:** Pilot **streamlined discharge planning** for **NDIS participants** in **Liverpool Hospital**

**5 wards**

**4 months**

**42 paients**

## WHAT DID WE CHANGE?

**START AT ADMISSION**
- **Identify** NDIS participant
- Enter NDIS participant flag on **eMR**
- Refer to **NDIS Health Liaison Officer**

**EARLY CARE AND DISCHARGE PLANNING**
- Multidisciplinary **huddle**
- Stream to 1 of 3 discharge **pathways**

**COORDINATION & COLLABORATION**
- Regular **discharge meetings** with MDT & NDIS providers

## WHAT HELPED?

- **NDIS participant status** displayed on **ward journey board**
- **Collaboration with NDIS Health Liaison Officer** at full scope (not just escalation)
- **Weekly facility NDIS participant meeting** monitoring progress of patients
- **Prompting** by NDIS Health Liaison Officer / Disability Resource Team
- Regular **discharge planning meetings** with **provider stakeholders**
- New **resources** and **education**

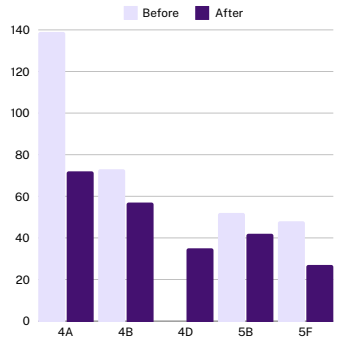
## RESULTS

### EARLIER IDENTIFICATION OF NDIS PARTICIPANTS

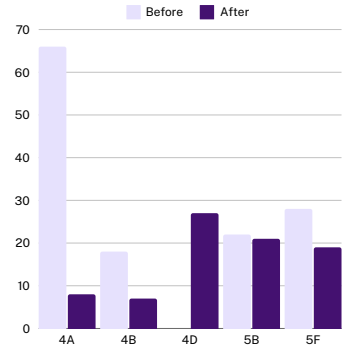
Before **27 days**

After **2 days**

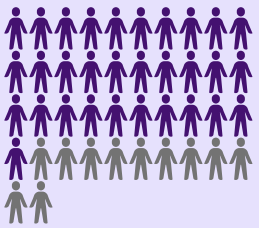
### REDUCED AVERAGE LENGTH OF STAY (Days)




### FEWER DAYS TO START DISCHARGE PATHWAY




**74%** OF PATIENTS ABLE TO LEAVE HOSPITAL **WITHOUT WAITING FOR A FUNDING REVIEW**



## CONCLUSION

Proactive surveillance for NDIS participant status at admission means patients' needs are identified earlier.

Early identification of NDIS participants allows discharge planning to start earlier.

Better coordination between MDT, NDIS HLO and providers makes discharge planning more efficient.

This reduces length of stay.

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