Appendix B: Communicating for care – quick reference guide

Shared Decisions | Action Plan

- ✓ Speak to the person with disability about their diagnosis using the *Ten top tips for breaking bad news* (Appendix C) and *Tips for communicating with people with intellectual disability* (Appendix L).
- ✓ Request a NDIS plan review to include health and community support for end of life (for example community nursing).
- ✓ Ask the GP or medical specialist to consider completing a medical goals of care plan.
- ✓ File the plan in the person's record and inform all relevant staff including disability support workers of the person's end-of-life goals and wishes.
- ✓ Make the medical goals of care available for sighting by other healthcare professionals such as the Ambulance Service.
- ✓ Develop a palliative care support plan via the GP.
- ✓ Ask the GP to consider a referral to the Specialist Palliative Care Service if indicated.
- ✓ Set up *My hospital passport* (Appendix D) to have available in case the person requires hospitalisation.

Shared Accountability | Action Plan

- ✓ Translate any medical information into easily understood information.
- ✓ Develop and implement a transition of care policy.
- ✓ Develop and implement a transition of care checklist.
- ✓ Document roles and responsibilities for transition of care in relevant position descriptions.
- ✓ Use your organisation's feedback (compliment and complaints) systems to collect, analyse and trend data and information about transitions of care. Share findings with other health providers involved to improve the transition process.

Shared Communication | Action Plan

- ✓ Adopt and use *SUPPORT ISOBAR* (Appendix F) – a communication tool to guide communication at the moment of transition.
- ✓ Adopt and use the *Medical appointment form* to guide conversations with the Doctor (Appendix K).
- ✓ When transferring to hospital provide communication devices to hospital staff along with *My hospital passport* (Appendix D) or the *Care alert kit* (Appendix E).
- ✓ Proactively discuss and plan for hospital or GP visits and ensure everyone understands the best communication methods for the person.
- ✓ Use existing referral pathways to community nursing, specialist palliative care services

Shared Documentation | Action Plan

- ✓ Consider adopting the *My hospital passport* (Appendix D).
- ✓ Include a current medical goals of care or advanced care directive in the transition documentation (if completed).
- ✓ If the person with disability is transitioning to hospital, ensure hospital staff have access to the participant's hospital support plan, list of current medications, allergies, healthcare card, Medicare card, behaviour support plan, communication profiles and any related aids.

Shared Coordination | Action Plan

- ✓ Allocate a 'key' disability support person or lead on coordination of care for the person with disability for specialist palliative care team members, community nurses and medical specialists to speak with about the person who is dying. Ensure this person knows the person well.
- ✓ Incorporate NDIS transitions of care between disability services and hospitals practice alert to guide processes of care.
- ✓ Adopt the *Shared hospital plan* form (Appendix G)
- ✓ Adopt the *Medical appointment form* (Appendix K).
- ✓ Continually review to plan in response to the person's changing needs, goal and wishes.
- ✓ Consider adopting *STOP AND WATCH* (Appendix H) to help disability support workers recognise, report and respond to a person's health and wellbeing.
- ✓ Use the *Navigating end of life* tool (Appendix I) to guide the care pathway