Moving from residential aged care to community living. Implementing a transition approach

For a younger person who has made the decision to either leave residential aged care (RAC) or explore leaving an aged care service, their move to community living involves a dedicated transition process that starts the moment any consideration of current and future living options arises and well before a new accommodation option is chosen.

Employing a transition approach to what can be a momentous change in living circumstances for a younger person, ensures a number of imperatives are in place.

Most importantly, it places the younger person at the centre of all efforts to deliver a healthy, safe and sustainable move to community living. It also brings all of the younger person's formal and informal supports together to work collaboratively as a team; ensures information is kept up to date and shared; and that contributions from all actors are integrated and delivered to ensure the move succeeds.

Finally, a dedicated transition process enables the younger person to be

- supported with choice making about the many decisions they will have to make before, during and after their move to the community;
- directly involved in decisions and actions regarding this change in their living arrangements; and
- supported to regain their agency through this collaborative process.

Change moves at the speed of trust…

For most younger people, considering a move from the known of the RAC service to the greater unknown of community living, brings intense anxiety. This is particularly the case for those individuals who see their placement in aged care as "the system's" failure to support them appropriately and don't want to risk this happening again.

Supporting a younger resident through the challenges of considering options and making informed decisions requires trust to be established between the younger person and the transition process facilitator. Without trust and evident commitment to the younger person's declared choices and preferences, inappropriate options may be considered and/or a decision to move may not happen at all.

Learning about why the younger person has decided to consider their current and future living options or to leave residential aged care, is a good starting point to establishing a

relationship of trust. Involving the younger person in conversations that enable them to share their important life experiences and what has influenced their choices and decisions, is important here. So too is understanding the younger person's journey into residential aged care, including whether they were involved in this decision and what placement in aged care has meant to them as a result.

These conversations can also start to build a sense of the types of support and housing options that might be needed. Discussing 'what makes a house a home' for the younger person; what is needed to meet their individual needs and preferences including what they like or would like to change about where they currently live, will also help articulate a younger person's preferences about where and how they want to live.

Gathering this information in one place can provide the younger person with an important reference point to help with weighing up choices. It will also enable this information to be shared with the younger person's formal and informal support networks and their support team, ensuring that

- the expectations of all involved are managed appropriately;
- risks are identified and addressed; and
- concerns raised by the younger person, their family, or their informal and formal supporters, are managed and addressed effectively.

A number of practical tools are available with this document that provide conversation prompts to help learn as much as possible about the younger person and their current and future living preferences.

Collaboration: a team effort

Achieving a positive transition experience for a younger person depends on collaboration by all involved, a skilled facilitator and a support team committed to the younger person and their transition journey.

For individuals who choose to remain in RAC, the support team ensures integration of services from other programs with those of the aged care sevice and the NDIS.

Bringing the younger person's formal and informal support networks together as a team should occur as soon as possible. The team's role is to support and progress the transition by working collaboratively. As well as the younger person, team members should include their health, housing and disability service providers; the NDIS; the residential aged care service manager; allied health practitioners; and the younger person's family and other informal supporters.

An independent transition facilitator with the leadership skills and working knowledge of the various service systems involved in the transition, is needed to not only bring the team together, but ensure it continues to work in partnership. Maintaining working relationships

of trust and transparency amongst team members and ensuring all actors continue to make the time and resource commitment required, is one of the facilitator's key roles.

Another is convene regular team meetings. These should be established from the outset and will enable team members to

- develop a shared understanding of the younger person's choice making and preferences about where and how they want to live.
- support involved services, supports and support networks to become well versed in how to support the younger person so that a comprehensive integrated service response can be designed and implemented
- ensure accurate information is provided to assist the younger person and their support network to make relevant choices and decisions.

Working together also helps the team's members to recognise the enormity involved in making a decision to leave aged care and the stress and heightened anxiety that making this decision delivers for the younger person. It also ensures the younger person

- is given the time and support needed to consider their choices and preferences and make informed decisions about their living arrangements
- can communicate their wishes and preferences and knows these are acknowledged
- can share who they are now as well as who they were before they entered residential age care and what their journey to enter RAC has entailed
- is at the centre of planning and preparations
- has their confidence built
- has their engagement and participation maintained with that of their trusted supporter/s
- has their agency encouraged and supported
- is confident in the team's support and its coordination of tasks, activities, and timeframes to progress their transition to community living.

Being part of a collaborative team also ensures the younger person is supported to have a comprehensive understanding of what living in the community will look like, including the impact of location and environment, what their routine and support will entail and how they will contribute to and engage in their day-to-day life.

Building an understanding of how their chosen accommodation and support services will meet the younger person's social, emotional, and everyday needs, will also confirm for them that their support team will

- help to build their capacity and 'walk with them' before, during and after they move
- continue to implement and maintain support strategies, resolve service and environmental issues and

- continue to build their capacity to adjust and sustain the new living and support arrangement.

Implementing a positive transition experience

The Alliance has undertaken extensive work with younger people living in residential aged care to develop a transition process that delivers safe, healthy and sustainable moves to community living. The following steps to implement a transition process are the outcome of this work.

1. **Work through the conversation topics** suggested in the *Guide to gathering information through conversations* with the younger person and their trusted decision supporters.

2. **Once this information has been gathered, bring the support team together**.
   It's essential that the team have a shared understanding of the younger person's life experiences, journey into residential aged care, wishes and preferences and their experience with choice making and decisions.

   As well as the information that's been gathered through conversations with the younger person, share any additional information such as allied health reports, disability support worker input, or aged care provider information.

   Having this information not only helps to manage expectations, risks and concerns. It's also essential to translating the support the younger person needs from an aged care context to that of community living.

3. **Develop a schedule of regular meetings with the younger person and their support team.**
   Regular team meetings ensure expectations are managed; problems, risks and concerns are identified and addressed; and the team can maintain its collaboration to achieve the younger person's chosen outcome.

   This not only secures trust and transparency in the work being done. It also ensures team members are kept up to date on progress with transition activities and can contribute to these as needed.

4. **Develop a table of activities and tasks** relevant to the status of the younger person's decision making and identification of an alternative living and support arrangement.

5. **Start assembling a transition story board**
   An adjunct to the younger person's social story that provides background information about the individual, the transition story board documents the younger person's new living arrangements and acts as a focus while they prepare to move.

Transition story boards.

As a depository of information about the younger person's new living and support arrangements, a transition story board provides information for the younger person to have at hand, refer to, reflect on and talk about with those around them, about the decision they have made, where they are moving to and why.

The amount of detail provided in the transition story board will vary according to the individual's need, with the transition story expanding as the younger person and their trusted supporters learn more. It prompts questions and requests for more information and as more is learnt and the story expands, the younger person's reality becomes more visible and tangible, their wishes and preferences more concrete.

Prompting and supporting the younger person to refer to the transition story regularly can help to reduce anxiety about a considered move to community living and build their confidence and capacity. Just as importantly, it can also identify where gaps, barrier, and inconsistencies exist that need address.

Themes to capture in the transition story board can include

- what it means for the younger person to leave RAC
- what will change if they do move to live in the community
- a description of the new living situation and support arrangements including what will be provided, how it works and what support can be expected.

The use of photos, floor plans, lists of items etc can be very useful in showing additional information and reminding the younger person about their new home while they are still living in the RAC.

Sia's transition to community living

Sia worked as a nurse and lived in the community with her partner. While travelling overseas, she was hit by a car and left significantly disabled. Her relationship with her partner subsequently broke down and Sia moved into a Special Residential Service (SRS). Her family's concerns about her vulnerability in the SRS led to permanent placement in RAC where she has lived for the last 8 years.

Following discussions with the project team about her life in the nursing home and what she liked/disliked about living there, Sia indicated she wanted to move out of aged care saying that she wanted to live with others her own age, be able to make her own decisions about living her life and engage in community activities.

Considering options

The project team commenced a series of weekly meetings with Sia to discuss what she was looking for, how she hoped to live in the community, what locations she was interested in, community activities she wanted to pursue, the types of housemates she hoped to live with if a shared setting was an option.

The project team had already had discussions with the facility manager and the RAC's aged care staff about the project's work and established collaborative working relationships with them. The MFMC team engaged the facility's staff and management in its work with Sia and encouraged their engagement in conversations with her as Sia contemplated moving and what this might look like for her.

Subsequent discussions with Sia canvassed the type of living arrangement she was interested in. To give her some idea of what these could be, one of the project team's members supported Sia to look at various options online that included living alone in an apartment with some shared support and living in shared supported settings with others. Following these investigations and exploration of her thoughts about each option, Sia made a considered decision and indicated that her preference was to live in a house with one or two others in a shared supported setting. She also stated that her preference was to live in an area with which she was familiar and where she had already established community connections.

The project team contacted Sia's support coordinator to advise her of Sia's decision to leave aged care and request a Change of Circumstance plan review so that Sia's goal of moving could be listed in her plan. However, in discussion with her support coordinator, the project team was surprised to discover that Sia already had a goal to move in her NDIS plan, had met eligibility for Specialist Disability Accommodation (SDA) and had funding to explore community options in her plan. Her goal to explore community options had been in Sia's previous 2 plans but none of the support coordinators who'd worked with Sia over that time had supported her to pursue her goal or her approved SDA eligibility status. Sia 's current coordinator was about to go on maternity leave and a new coordinator was in the process of beinn appointed.

The project team continued to work with Sia and identified a new SDA property being built close to the area Sia identified as preferable for her. This new property accorded with the SDA status Sia had been approved for. In this new setting, Sia would live with 3 others with onsite support, each NDIS participant having their own bedroom, bathroom and living space as well as shared space on the site. Sia applied to move to this SDA and received a letter of offer for the property.

After discussing this opportunity with the project team and her family, Sia made a considered decision to accept the offer.

Preparing to move

From that point, work on Sia's transition to the community intensified. The project team expanded its work with Sia and her family; the aged care service management and staff; Sia's occupational therapist, physiotherapist and support coordinator; the NDIS; and health, disability and mental health services to ensure the supports Sia needed to live successfully in her new home and be actively connected to the community were in place.

To inform the Roster Of Care (ROC) at her new home and the Supported Independent Living (SIL) funding required to deliver shared care there, Sia's RAC service committed to document the supports Sia received from staff and encourage Sia to have greater input into activities she needed to make decisions about in her new home, such as managing her laundry. Sia was also encouraged to become familiar with her new neighbourhood by making regular visits there and considering such things as how she might shop for food (in a supermarket with wheelchair accessible trolleys or by asking a support worker to push a trolley for example), connect with a local church and get to know the local library. These were all things Sia had indicated she was looking forward to doing.

Sia was also supported to visit her new home, meet and become familiar with the staff providing shared care to all the residents and begin interviewing and selecting her own community support team to enable Sia to access the community.

As it had done from the outset, the project team continued to facilitate the collaborative involvement of all actors engaged in Sia's transition. This included commitments to maintain regular contact with Sia when she moved to her new home to address any concerns and ensure the move went smoothly.

To concentrate efforts, the project team brought Sia's formal and informal supporters together to form a transition support team and convened weekly team meetings. As well as Sia and several members of her family, members of Sia's support team included the RAC manager, allied health practitioners (occupational therapist and physiotherapist), Sia's support coordinator, SDA and SIL provider representatives from Sia's new home, as well as representatives from the disability provider delivering Sia's community support. These regular transition support team meetings began while Sia was still living in the RAC service and have continued after she moved to her new home.

These meetings offered an important opportunity for Sia and any member of the team to raise questions or concerns about Sia's move to the community; identify potential risks and action strategies to mitigate these risks; and provide up to date information on progress to achieve Sia's goal to all involved. They were particularly important in addressing the anxiety Sia's family members expressed about Sia's move from what they perceived as the RAC's safe and secure environment to a community living setting that did not seem as secure or as safe.

Moving from an institutional setting with limited if any opportunity to make decisions to one where decision making is the norm, can be overwhelming, especially if the younger person no longer sees themselves as a decision maker. To avoid this, the project team continued to have weekly meetings with Sia and her support coordinator to discuss the types of decisions she would need to make when she left the RAC. Occurring in a trusted environment, these meetings provided Sia with an opportunity to consider the tasks and activities she would need to undertake in her new home, such as devising a weekly meals menu; organising a shopping list and doing the shopping with

support; preparing her meals with support; and incorporating social activities into her weekly schedule.

Sia had indicated she was especially keen to establish a dedicated rehabilitation program and used these weekly meetings to think about how to organise regular hydrotherapy and physiotherapy sessions. With support, Sia began making inquiries about hydrotherapy pools near her new home and decided to visit one to see if the assistive equipment she would need to access the pool, was in place. Sia also used these discussions to start thinking about the community activities she was interested in joining and together with her family, started to discuss what Sia would need to furnish her home.

The project team continued to convene weekly meetings with Sia and her support coordinator to further develop Sia's social and transition stories, encourage her visits to her new neighbourhood and address any questions Sia had as she became familiar with her new home, the house staff and how they would work with her; and the amenity her new neighbourhood offered.

This was a busy time for Sia as she prepared to interview and engage additional support workers as part of her community team. Sia decided on the criteria she would use to interview applicants; and engage new workers while she was still living in the RAC. As well as becoming familiar with each other, this worker continuity meant that Sia could move to her new home with workers already familiar with her support needs and with whom she felt confident.

As a result of her accident, Sia lives with bipolar disorder. As part of her preparation to move, Sia identified a number of things that she wanted the house staff and her community workers to be aware of in supporting her when she experienced a bipolar episode. Sia and the project team used these weekly conversations to compile a concise description of how staff could best support Sia during these times. With input from the RAC manager, this document was included with Sia's social and transition stories in a folder of information Sia provided to staff for discussion at training sessions with her.

In all these various activities, Sia was supported to consider her wishes and preferences, assess options and make considered decisions. The transition process enabled Sia to regain a sense of her agency as a decision maker and become confident in her ability to make decisions about her health and wellbeing.

As Sia's moving day drew closer, her occupational therapist organised a training session in Sia's support needs with Sia and Sia's house staff. The occupational therapist also completed an environmental scan of Sia's new home to identify any accessibility concerns. Sia's physiotherapist began hydrotherapy sessions with Sia at her local hydrotherapy pool and started training therapy assistants to work with Sia regularly.

Sia's support coordinator was also busier than usual. As well as weekly meetings with Sia and participating in the weekly transition support team meetings, the support

coordinator liaised with Sia's family concerning the whitegoods Sia needed and organising Sia's connection to the internet and utilities. The support coordinator also liaised with the SDA provider regarding automating the doors in Sia's home; activation of the property's IT systems and ensuring these were connected to Sia's smartphone via an app; and ensuring Sia and her family received a copy of the rental agreement for perusal.

The support coordinator also worked with Sia to identify community activities Sia was interested in joining and connected Sia with them. With the assistance of her support coordinator, Sia made enquiries about becoming a patient at a local GP clinic and made an appointment to meet with her new GP and transfer her medical files to their care. Sia and the support coordinator also identified a pharmacy close to Sia's new home along with other health services Sia would need such as podiatry.

Finally, the support coordinator prepared a change of circumstance request for a plan review for Sia and, with the project team's support, contributed to development of Sia's Roster of Care to give to the SIL provider. The project team coordinated information provision from the transition support team's members to ensure Sia's plan review could proceed effectively. As a result, Sia's new plan was approved without delay and her moving date confirmed.

However, just before Sia was about to move, an NDIA 'administrative error' changed Sia's SDA status to one that was not consistent with that of her new home and Sia was unable to go ahead with her planned move. Following the project team's approaches to Sia's local member of parliament and senior NDIA executives, Sia's original SDA status was reinstated and she was able to move, several weeks and a great deal of anxiety for Sia later.

Moving and settling in

Because of the extensive work the project and transition support teams had done to prepare Sia for this move, Sia approached the moving date to her new home with confidence. In saying goodbye to people at the residential aged care service, she invited them to come and visit her and promised to return and tell them how it was going once she'd settled in.

Coordinated by the project team, the detailed information provided to the SIL and SDA providers by Sia's transition support team and the collaborative working relationships team members had established with management and staff at Sia's new home, all worked to secure a successful move for Sia.

Although some outstanding issues remained, such as completing the automation of doors and activation of the NBN, Sia's first night in her new home proceeded without problem.

However, due to a miscommunication with house staff, Sia was unable to reach support staff for assistance early the following morning and called one of the project

team members for help. The project team member contacted the provider's after hours number to resolve the problem. The project team then organised for Sia to meet with the house manager and discuss how they could ensure the problem did not recur.

Sia and the transition support team have continued to meet weekly and have addressed a number of 'teething problems' in Sia settling in to her new home. These have been as varied as installation of additional power points, ensuring the property's front door is automated and providing feedback to staff regarding how to engage with Sia at her direction.

At her request, the project team has also continued to provide direct support to Sia, maintaining bi weekly contact to discuss concerns Sia has regarding the support she receives from house staff and addressing inconsistencies in her home's accessibility. This has included supporting Sia's meetings with the property owner to further adapt the kitchen to enable Sia to use it more independently.

A couple of weeks after moving in to her new home and after her support coordinator had connected Sia with disability art classes and disability gardening groups in her new area, Sia decided that she did not want to join groups that were only for people with disability. Instead, she preferred to attend a local gardening club and a morning tea and conversation group for community members that met at the neighbourhood community hub. Once again, Sia's growing sense of self and her confidence in making her own decisions is evident.

Despite continuing issues with staff recruitment that mirrors similar problems in the broader disability workforce, Sia says the seven weeks since she has moved into her new home have been 'seven weeks of bliss'. Sia is a member of her local library, has explored a range of local farmer's markets and plans and shops for all her meals and domestic needs. Orienting staff to her particular needs continues to be a work in progress, but Sia says she is equal to the task.

Since starting the transition process and being supported to consider her preferences and make decisions again on her own behalf, Sia's confidence in her abilities has grown in equal measure to her independence. The transition process has provided a solid foundation from which Sia could consider moving from her residential aged care service to community living, prepare to do so and make a move to community living that has the support of her family and the wholehearted approval of Sia herself.

The project team member who has been the most closely involved with Sia said

> *"Watching Sia regain her confidence, make decisions about how she wants to live her life and engage as a contributing member of her community again, has been exciting to see. Working with Sia and being a part of her journey to a more independent life in the community has been an absolute privilege…she's taught me a lot!"*

Suggested transition tasks and activities

This table of suggested tasks and activities is intended to ensure the transition process is structured to meet the younger person's needs. Tasks and activities can be undertaken in whatever order the transition support team feels is the most appropriate.

Suggested Transition Activities and Tasks		
Before undertaking any of the following activities/tasks, prepare a summary of the current situation and the status of any decision/s made.	• *Describe the circumstances and reasons for the younger person wanting to leave residential aged care; or consider other living arrangements* • *Briefly describe the time spent in residential care, what this has meant and reasons for entering aged care* • *Indicate what support and other resources are available to assist the younger person with choice making and expressing their wishes and preference.* • *Outline the status of any accommodation and support decisions already made and timeframes for implementing these*	
Activity	**Description of the tasks involved**	**Progress**
Create transition goals	• identify the support required	
Understand chosen accommodation & service preference/s. Has	• Location and amenities of the accommodation • Accessibility to community and service amenities • Style of accommodation • Configuration of the service	

accommodation been chosen or identified?	• Opportunity for residents to design/negotiate service components with SIL providers	
Establish the environment	• Furniture layout, installation of equipment and safety requirements • If required, identify, purchase, and implement aids for sensory needs, diversional activities, visual cueing and orientation and communication	
Establish a support workforce team to support the attributes required by the younger person	• Share information to learn about the younger person. (Social story) • With the support of trusted informal and formal supporters, create opportunities for the younger person to share information through an informal Q&A session with the new accommodation support team • As a team, list the characteristics and attributes that will best work with the younger person. Also create some interview questions to ask during staff recruitment • New service team to meet younger person in their current environment to better understand where they are moving from and begin building rapport • Set up shadow shifts, with opportunities to observe how support is provided • Relevant therapist (OT, PT, BSP, Nursing,) to develop a training & mentoring schedule for support team prior to younger person's move; and during the settling and adjustment phase of transition	

	• Schedule of care team sessions & mentoring with the team to respond to challenges and maintain consistency in the delivery of support • Development of a roster, shift times etc	
Establish daily routines and support practises through an integrated support plan	• Obtain a copy of the Care Plan & Medication chart from the younger person's residential care service • Relevant therapists to assist in creating an integrated support plan that details the strategies used to provide the younger person with a consistent routine. The routine must take a preventative approach to minimise the triggers for behaviour and or health /medical incidents such as seizures, choking, aspiration, falls etc. • Development and implementation of resources for example ○ scripts for self-care activities; mealtime prompts; redirection; and conversations, to minimise identified triggers for behaviours • Medication administration • Nutritional needs and meal preparation & delivery (likes & dislikes) • Incident and emergency management	
Preparing the younger person for their new living arrangements	• Transition story boards and scripts including photo's, floor plan etc • Visits to the property • Meeting the house staff and other residents if sharing • Orientation in the community	

	• Establishing community activities eg joining local library, shopping at local supermarket • With assistance the younger person to make lists ✓ Personal items to take to their new home, ✓ Food/meals they like and recipes ✓ What they are looking forward to most about their new living arrangement and community ✓ Activities, vocations, interests, groups to explore ✓ Budgeting	
SDA, SIL and support service agreement	• Information to explain the tenancy arrangement, cost (utilities, rent), tenant rights, shared arrangements • Household items, cleaning etc • Food shopping, meal preparation & delivery • Money management • Participant contribution to the household i.e. bedding, kitchenware, furniture, whitegoods etc? • Opportunity to negotiate/design service with provider	
Establish connections and referrals with other clinical services	• GP • Pharmacy • Continence supplies • Podiatry • Nursing	
Communication and Collaboration	• Schedule of care team meetings, during and post relocation • Correspondence	

	• Recording activity progress	
Risks and Concerns	• Develop a risk and concerns table (same below)	
Service requirements	• Completion of service intake and tenancy forms • Changes to any Comprehensive Behaviour support plan • Completion of SiL RoC and quote	