Fact Sheet: Disability Support Work vs Nursing Support in Hospital

The distinction in one sentence:

> **A nurse assesses and treats illness under clinical accountability; a disability support worker (DSW) supplies continuous, person-specific functional support so the disabled person can communicate, remain safe, exercise choice and actually receive that treatment.**

Disability support work workers play an important role in hospitals, which are not the same as the roles that are carried out by hospital staff. These roles can overlap at the level of an activity, for example, both may assist a person to drink, without duplicating one another in **purpose, expertise, continuity or accountability**. Health systems are responsible for diagnosis, treatment and clinical care; disability support workers provide the personalised, continuous, relationship-based assistance that is not any health system's universal-service or reasonable-adjustment responsibility. In the past, Queensland health guidance has expressly contemplates a paid support person in hospital assisting with communication, advocacy and aspects of personal support while hospital staff remain responsible for healthcare (Queensland Government[1]).

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[1]Queensland Government, https://www.qld.gov.au/health/support/people-with-disability-support-workers-andcarers/healthcare-settings[1]Australian Commission on Safety and Quality in Health Care (ACSQHC), https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/nsqhs_standards_user_guide_for_the_health_care_of_people_with_intellectual_disability.pdf

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It is unclear what will happen now that the National Disability Insurance Scheme has decided that disabled people must ‘leave their supports at the hospital door’.

In July 2026, DPAC consulted with community about why disability support was different from medical support. The themes raised align with national safety guidance that health services must make reasonable adjustments, communicate effectively and partner with the person and their supporters (Australian Commission on Safety and Quality in Health Care (ACSQHC)[2]).

The worker must not be used to transfer the hospital's legal duties or clinical risk to the NDIS. Nor should the worker be excluded merely because a task has a clinical analogue. The correct question is: **what support is being delivered, for what disability-related purpose, by whom, under whose authority, and what would happen without it?**

The chart on the next page outlines the delineations between clinical and disability supports.

Role-boundary guardrails

Disability support worker contribution	Hospital/nursing responsibility that remains
Explains the person's usual communication, baseline, routines, equipment, distress signals and preferences.	Assesses symptoms, makes clinical judgements, documents care and escalates deterioration.
Helps the person use AAC, understand information, ask questions and express consent or refusal.	Provides accessible information, obtains valid consent and arranges qualified interpreters or other reasonable adjustments.
Performs disability-related daily support within competence, training, the person's plan and hospital agreement.	Provides nursing and clinical care, including tasks requiring professional registration or hospital authorisation.
Observes changes and promptly alerts clinicians; supplies an individual baseline and history.	Measures, interprets and responds to clinical observations.
Prompts staff about the person's established medicines and reports discrepancies.	Prescribes, charts, supplies, administers and clinically monitors hospital medicines.
Implements an agreed positive behaviour or sensory-support strategy and uses rapport to prevent escalation.	Assesses and treats medical or psychiatric causes of distress and complies with legal safeguards governing restraint, seclusion and treatment.
Helps follow an existing allied-health programme where safe and authorised.	Assesses new impairment and prescribes or changes rehabilitation, swallowing, respiratory and mobility plans.

1. Communication, AAC, Deafblind communication and supported decision-making

What the DSW contributes

- Sets up, charges, positions and supports use of the person's established augmentative and alternative communication (AAC): eye-gaze devices, PODD books, communication boards, switches, symbols, spelling boards, text-to-speech devices or yes/no systems.
- Interprets highly individual non-verbal communication: facial change, eye movement, vocalisation, body tension, stimming, withdrawal, altered movement or behaviour that may signal pain, breathlessness, nausea, fear, hunger, toileting need or consent/refusal.
- Uses the communication pace and method the person already knows; allows processing time; reduces language; checks understanding; repeats or reframes questions without changing their meaning.
- Supports Deaf, Deafblind and vision-impaired people through Auslan, tactile Auslan, hand-over-hand communication, sighted guiding, environmental description and identification of who is speaking. A DSW or communication guide does not remove the hospital's duty to arrange a suitably qualified interpreter.
- Helps the person prepare questions, take notes, remember ward rounds, retain information after anaesthesia or medication, and communicate their own goals and treatment preferences.

- Supports decision-making without substituting the worker's decision for the person's. This includes presenting options accessibly, identifying the person's established will and preferences, and making space for assent, refusal or a request for more information.
- Hands over communication passports and alerts staff when an apparently simple “yes” is acquiescence, echolalia or a misunderstood question rather than informed agreement.

Why this is not nursing

Nurses must communicate safely, but a rotating clinical team cannot instantly acquire years of knowledge about an individual's idiosyncratic language. The NSQHS Communicating for Safety Standard recognises communication with patients, carers and families as integral to safe care, and its intellectual-disability guidance specifically treats supporters as partners (ACSQHC Communicating for Safety[3]). The DSW supplies the person's established communication infrastructure; clinicians remain responsible for accessible explanations, informed consent and clinical decisions.

Risk if absent

Pain or deterioration may go unreported; consent may be invalid or poorly supported; history may be incomplete; and disability-related communication can be misread as confusion, intoxication, aggression or lack of capacity. A systematic review found patients with communication disability experienced approximately three times the risk of preventable adverse events in hospital (Hemsley and Balandin review, PubMed[4]).

[3]ACSQHC Communicating for Safety, https://www.safetyandquality.gov.au/publications-and-resources/resource-library/nsqhs-standards-user-guide-health-care-people-intellectual-disability/communicating-safety-standard
[4]Hemsley and Balandin review, PubMed, https://pubmed.ncbi.nlm.nih.gov/30876524/

2. Personal care, continence, bowel, stoma, hygiene and dignity

What the DSW contributes

- Provides or assists with timely toileting, urinal positioning, continence-pad changes, clothing management, wiping and hygiene using the person's known prompts and safe technique.
- Supports established bowel routines, including timing, positioning, equipment set-up and recognition of the person's warning signs. Any invasive bowel intervention must remain within the worker's verified training, authorisation and the hospital's clinical agreement.
- Supports person-specific stoma, catheter or urodome routines where the worker is trained, while reporting abnormalities to clinical staff.
- Assists with showering, bed bathing, oral care, hair care, shaving, dressing, menstrual care, skin moisturising and personal presentation in the person's preferred, trauma-informed manner.
- Keeps the call bell, drink, phone, AAC and mobility aids within reach; presses or adapts the call bell where the person cannot operate it.
- Preserves privacy, gender preferences and dignity and avoids rushed handling that can trigger pain, spasm, trauma or distress.

Why this is not duplication

A hospital has responsibility for safe inpatient care and reasonable adjustments, but the DSW brings the individual's established technique, timing and consent cues. The contribution is particularly distinct where personal care requires continual prompting, a specialised routine or a trusted relationship. The NDIS Commission's transition-of-care alert requires disability providers to plan and coordinate hospital transitions and manage

high-intensity daily personal-activity risks rather than treating admission as a complete cessation of provider responsibility (NDIS Quality and Safeguards Commission[5]).

Risk if absent

The consultation reports delayed toileting, people being told to use a pad, missed showers, inaccessible call bells and unmet oral-care needs. Plausible consequences include incontinence-related skin damage, infection, constipation or impaction, falls from attempting to toilet alone, loss of dignity, withdrawal and refusal of further care. These are risk pathways, not claims that every hospital or admission produces them.

3. Eating, drinking, dysphagia, PEG and mealtime management

What the DSW contributes

- Positions the person in their established safe eating posture and ensures required upright time before or after feeds.
- Follows the existing mealtime-management plan: prescribed texture, bite size, pace, utensils, straw or cup, level of supervision, cues, fatigue monitoring and response to coughing or distress.
- Opens packaging, cuts food, loads utensils, physically assists eating or drinking where trained, and remains for the time required rather than leaving a tray out of reach.
- Identifies safe, tolerated and culturally appropriate foods; obtains alternatives where hospital food cannot meet disability-related needs; monitors accessible fluids and records intake where agreed.
- Sets up familiar enteral-feed equipment and routines within competence and hospital authorisation; alerts nurses to medicines that must be separated from feeds or given by a specified route.

[5]NDIS Quality and Safeguards Commission, https://www.ndiscommission.gov.au/sites/default/files/2025-01/Practice%20Alert%20-%20Transitions%20of%20care%20between%20home%20and%20hospitals%20UPDATED%20Jan%202025.pdf

- Recognises the person's early, atypical signs of choking, aspiration, reflux, autonomic change or feed intolerance and immediately escalates.

Why this is not nursing

Speech pathology, dietetics, medicine and nursing retain responsibility for clinical swallowing assessment, prescription and inpatient monitoring. The DSW implements the person's established disability-support routine with continuous, individual attention and reports change. Australian coronial research identifies choking and aspiration pneumonia as prominent preventable causes of death among people in disability residential services, underscoring the need for strict adherence to individual plans (Australian coronial review, PubMed[6]).

Risk if absent

Food or drink can be inaccessible, the wrong texture or delivered without supervision; medication-feed timing can be disrupted; intake can fall; and choking or aspiration signals can be missed. The result may be dehydration, malnutrition, aspiration pneumonia, prolonged admission or death.

4. Mobility, transfers, hoisting and access to equipment

What the DSW contributes

- Explains and assists with the person's established standing, slide-board, sling, hoist or two-person transfer method, including pain, spasticity, joint, fracture and post-operative precautions.
- Checks that the correct sling, wheelchair, cushion, headrest, belt, footplate and mobility aid are available, correctly fitted, charged and within reach.

[6]Australian coronial review, PubMed, https://pubmed.ncbi.nlm.nih.gov/35819380/

- Accompanies the person between departments, supports orientation and wayfinding, and prevents unsafe abandonment in an inaccessible chair or corridor.
- Helps the person get out of bed and into their wheelchair for safe feeding, respiratory function, pressure management and participation, where clinically authorised.
- Teaches unfamiliar staff the person's non-clinical transfer cues and reports any deviation or new pain.

Why this is not nursing

The hospital is responsible for assessing post-operative mobility and supplying safe equipment and staffing. The DSW's distinct value is embodied knowledge of the person's body, equipment, fear cues and successful technique. The worker should not proceed where acute illness, surgery or new injury has changed the risk; clinicians and physiotherapists must reassess first.

Risk if absent

The consultation describes delayed transfers, missed showers, unsuitable beds, incorrect slings and failures to account for wheelchair belts. Potential consequences include falls, fractures, skin injury, shoulder injury, pain, staff injury, fear-driven resistance, prolonged bed rest and avoidable loss of function.

5. Positioning, pressure care, contracture and spasticity management

What the DSW contributes

- Implements the person's established turn schedule, sleep system, limb support, splinting, cushion and posture plan when consistent with current clinical advice.
- Recognises subtle discomfort, autonomic dysreflexia, spasm, developing redness or the person's non-verbal request to be moved.
- Maintains alignment for breathing, swallowing, pain control and contracture prevention; ensures the bed and mattress suit the person's height and pressure risk.
- Completes familiar range-of-motion or stretching routines prescribed before admission, if the treating team confirms they remain safe.
- Records and escalates skin or functional changes rather than treating them as routine disability.

Why this is not nursing

Nurses assess pressure-injury risk and deliver inpatient skin care; allied-health clinicians prescribe positioning and rehabilitation. The DSW supplies frequency, continuity and person-specific handling knowledge. The ACSQHC intellectual-disability guide calls for individualised assessment and reasonable adjustments rather than assumptions based on diagnosis (ACSQHC guide[7]).

Risk if absent

Delayed repositioning and unsuitable bedding can contribute to pressure injury, pain, respiratory compromise, contracture, spasm and deconditioning. A DSW's presence does not excuse the hospital from prevention, documentation and treatment.

[7]ACSQHC guide, https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/nsqhs_standards_user_guide_for_the_health_care_of_people_with_intellectual_disability.pdf

6. Respiratory support: cough assist, BiPAP, ventilation, suction and mucus plugging

What the DSW contributes

- Brings, assembles and positions familiar disability equipment such as a BiPAP mask, non-invasive ventilator interface, cough-assist device or suction equipment where permitted.
- Explains the person's established mask ritual, tolerance strategies, settings record, communication method while masked and signs of fatigue or distress.
- Performs only those high-intensity support tasks for which the worker is specifically trained, assessed as competent, authorised and accepted under the hospital's clinical governance.
- Recognises deviation from the person's baseline breathing, cough strength, secretions, colour, alertness or equipment tolerance and immediately summons clinical staff.
- Maintains access to the call system and communication when the person's mask or weakness prevents speech.

Why this is not nursing

Respiratory assessment, oxygen prescription, ventilator-setting changes, acute suction decisions and response to deterioration are clinical responsibilities. A worker's familiarity can make an established device usable and can identify change earlier; it cannot replace respiratory nursing, physiotherapy or medical care.

Risk if absent

Poor mask fit, delayed access to cough assist or suction, missed secretion change, inability to call for help or failure to recognise an atypical baseline can allow mucus plugging, aspiration, hypoventilation, panic or respiratory deterioration. Campaign material should describe these as foreseeable risks and avoid suggesting every DSW is qualified to perform respiratory procedures.

7. Medicines, timing, routes and person-specific regimes

What the DSW contributes

- Supplies an accurate medication list, pharmacy packs or unavailable home medicines through the approved hospital process.
- Reminds staff about exact timing relationships: anticonvulsants, antispasmodics, Parkinsonian medicines, psychotropics, analgesia, bowel medicines, feeds and sleep routines.
- Alerts staff to established routes, formulation issues, allergies, adverse reactions and known behavioural or communication changes after a medicine.
- Checks the medicine offered against the person's understanding and promptly queries an apparent wrong patient, medicine, dose, time or route.
- Observes and communicates effects in terms of the person's baseline, for example, unusual sedation, increased seizures, dystonia, pain or loss of function.

Why this is not nursing

Hospital clinicians prescribe, chart, dispense, administer and monitor inpatient medicines. The DSW is a second source of individual history and a safety advocate, not an independent medication authority. National safety standards require accurate

medication histories and communication at transitions (ACSQHC Medication Safety Standard[8]).

Risk if absent

Late or omitted doses, incorrect routes, feed interactions and loss of baseline information may produce breakthrough seizures, spasticity, pain, withdrawal, delirium, over-sedation or behavioural change. Any discrepancy must be escalated rather than unilaterally corrected by the worker.

8. Observations, vital signs, seizure patterns and deterioration

What the DSW contributes

- Describes baseline temperature tolerance, blood pressure method, oxygen saturation, alertness, movement, breathing, seizure semiology, pain expression and usual behaviour.
- Helps staff obtain observations with the person's safest positioning, sensory preparation and communication method.
- Maintains line-of-sight support where separately funded and clinically agreed, watching for seizure onset, aspiration, line pulling, attempts to stand, autonomic change or inability to call.
- Distinguishes “different from usual” and urgently escalates, while avoiding diagnosis.
- Keeps a contemporaneous record of observed events and what was communicated to staff.

[8]ACSQHC Medication Safety Standard, https://www.safetyandquality.gov.au/standards/nsqhs-standards/medication-safety-standard

Why this is not nursing

Taking, interpreting and responding to clinical observations is a nursing responsibility. The DSW supplies the comparator, what “normal for this person” looks like, and the continuous presence that a ward roster may not provide. The Coroners Court's Finlay Browne findings identified failures including inadequate observations, delayed recognition of critical illness and the need to consider disability without allowing it to obscure deterioration (Coroners Court of NSW[9]).

Risk if absent

Distress or deterioration can be attributed to disability, a behaviour or “non-compliance”. This is diagnostic overshadowing: the ACSQHC directs clinicians to investigate new symptoms and understand what behaviour means for that individual rather than attributing it to intellectual disability (ACSQHC clinician fact sheet[10]).

9. Behaviour support, safety plans and reduction of restrictive practices

What the DSW contributes

- Brings and explains the person's positive behaviour support plan, hospital profile, safety plan and any authorised restrictive-practice documentation.
- Identifies triggers, precursor signs, trauma responses, communication breakdown, pain behaviours and effective prevention or de-escalation strategies.
- Uses familiar rapport, choice, predictability, distraction, movement, preferred activity, sensory regulation, food or communication to reduce distress.
- Supports safety around wandering, absconding, lines, drains or other patients without defaulting to force.

[9]Coroners Court of NSW, https://coroners.nsw.gov.au/documents/findings/2024/Inquest_into_the_death_of_Finlay_Browne_.pdf
[10]ACSQHC clinician fact sheet, https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/intellectual_disability_actions_for_clinicians_fact_sheet.pdf

- Challenges the label “aggressive”, “combative” or “non-compliant” where behaviour is communicating pain, fear, overload, misunderstanding or unmet need.
- Requests clinical review where behaviour could indicate delirium, seizure, hypoxia, infection, adverse medicine effect or pain.

Why this is not nursing

Clinical staff must assess medical causes, manage the environment and comply with mental-health, guardianship and restraint law. The DSW contributes the prevention plan and person-specific meaning. Restrictive practices include chemical, physical, mechanical and environmental restraint and seclusion (NDIS Commission regulated restrictive-practice guide[11]). Queensland's Public Advocate warns that inappropriate restraint in health settings can cause physical and psychological harm and engage human-rights and legal obligations (Office of the Public Advocate Queensland[12]).

Risk if absent

Loss of the person's interpreter and co-regulator can turn preventable distress into security attendance, sedation, restraint or seclusion. This is a risk pathway, not proof that DSW exclusion inevitably causes restraint.

10. Sensory processing, predictability and environmental access

What the DSW contributes

- Identifies light, noise, smell, touch, crowding, alarms, food, fabric and interruption triggers.
- Sets up sunglasses, headphones, weighted or familiar items, visual schedules, timers and predictable sequencing where safe.

[11]NDIS Commission regulated restrictive-practice guide, https://www.ndiscommission.gov.au/sites/default/files/2022-02/regulated-restrictive-practice-guide-rrp-20200_0.pdf
[12]Office of the Public Advocate Queensland, https://www.publicadvocate.qld.gov.au/our-advocacy/health/restrictive-practices-in-health-settings

- Prepares the person before touch, needles, observations, theatre transfer or staff change; negotiates a quieter waiting area or reduced lighting.
- Maintains routine, rest, sleep and access to preferred activity to prevent cumulative overload.
- Interprets shutdown, mutism, dissociation, stimming or meltdown as communication rather than wilful obstruction.

Why this is not nursing

Hospitals must make reasonable adjustments; the DSW knows which adjustments actually work for the individual and can apply them continuously. Queensland's hospital guidance lists support people as a legitimate part of communication and care, while ACSQHC guidance requires person-centred adjustments (Queensland Government[13]; ACSQHC[14]).

Risk if absent

Sensory overload may reduce communication, consent and cooperation; increase pain and exhaustion; and precipitate panic, shutdown, absconding or conflict. Sedating the visible response without removing the trigger can worsen harm.

11. Familiarity, rapport, emotional support and prevention of isolation

What the DSW contributes

- Provides a trusted face across rotating shifts and explains what will happen next.
- Offers co-regulation, reassurance, conversation, activity, fresh air where authorised and connection with family, community and identity.
- Recognises subtle baseline change and knows what comforts or frightens the person.

[13]Queensland Government, https://www.qld.gov.au/health/support/people-with-disability-support-workers-and-carers/healthcare-settings
[14]ACSQHC, https://www.safetyandquality.gov.au/clinical-topics/intellectual-disability-and-inclusive-health-care

- Supports grief, fear, medical trauma and the loss of control associated with admission.
- Enables family members to remain partners, parents or spouses rather than being forced into unpaid 24-hour care.

Why this is not nursing

Therapeutic nursing relationships remain essential, but a ward nurse cannot usually provide exclusive companionship and long-standing relational knowledge. The value of the DSW is continuity and disability expertise, not substitution for clinical care.

Risk if absent

Isolation and fear can increase refusal, distress, sleep disruption, delirium risk, self-harm thoughts or premature self-discharge. The worker must escalate acute mental-health or safeguarding concerns to clinicians rather than managing them alone.

12. Physical therapy routines and prevention of deconditioning

What the DSW contributes

- Continues established stretches, assisted movement, standing, splinting, walking practice or functional routines after the treating team confirms they remain safe.
- Helps the person practise exercises prescribed by hospital physiotherapy or occupational therapy with the correct cues and equipment.
- Supports access to the wheelchair and ordinary activity instead of prolonged bed rest.
- Reports loss of function and prepares the home, equipment and support team for discharge.

Why this is not nursing

Allied-health clinicians assess and prescribe; nurses support inpatient mobilisation; the DSW provides repetition, familiarity and carry-over into the person's ordinary environment. The worker must not continue a pre-admission routine automatically after surgery or acute deterioration.

Risk if absent

Prolonged inactivity can worsen strength, contracture, spasticity, pressure risk, respiratory clearance and confidence, increasing discharge support needs.

13. Advocacy, safeguarding and continuity across teams

What the DSW contributes

- Repeats the person's history and disability adjustments at each handover, ward move, scan, procedure, pre-operative area, recovery unit and discharge meeting.
- Keeps a record of questions, decisions, incidents and unresolved requests; helps the person use complaints or patient-liaison pathways.
- Identifies neglect, rough handling, inaccessible consent, discriminatory assumptions or unsafe equipment and escalates through the nurse in charge, medical team, disability liaison service or executive.
- Maintains the person's phone, wheelchair, communication device and essential belongings, and guards against loss or inaccessibility.
- Supports the person to communicate abuse or mistreatment without speaking over them.

Why this is not nursing

Staff remain professionally and legally accountable for safe care. The DSW is an independent continuity and safeguarding layer for a person who may be unable to report or prove what occurred. Australian disability-health safety guidance emphasises partnership and respectful communication rather than passive reliance on records (ACSQHC[15]).

Risk if absent

Critical disability information may be lost between teams; the person may be unable to complain; and discriminatory assumptions can go unchallenged. The elevated rate of potentially avoidable hospital or emergency-department deaths among people receiving disability supports makes this continuity a patient-safety issue, not merely companionship (Australian Institute of Health and Welfare[16]).

14. Discharge, home continuity, pets and practical life administration

What the DSW contributes

- Attends discharge planning, records instructions and tests whether the person understands and can implement them.
- Brings clothes, equipment, chargers and communication aids; packs belongings; arranges accessible transport and entry to the home.
- Prepares the home, checks food and utilities, collects prescriptions, coordinates the roster and communicates changed needs to the support team.

[15]ACSQHC, https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/nsqhs_standards_user_guide_for_the_health_care_of_people_with_intellectual_disability.pdf
[16]Australian Institute of Health and Welfare, https://www.aihw.gov.au/australias-disability-strategy/outcomes/health-and-wellbeing/potentially-avoidable-deaths

- Maintains essential practical supports during a long admission: mail, laundry, bills, home security, assistance-animal or pet care and essential errands, where the plan and funding rules permit.
- Monitors the first days home and escalates deterioration or mismatch between the discharge plan and available support.

Why this is not nursing

The hospital must make a safe clinical discharge and the NDIA has a process for reassessing or varying supports where disability needs change during admission (NDIA hospital discharge guidance[17]). The DSW makes the plan operational in the person's real environment.

Risk if absent

The person may be stranded without equipment, food, medication, transport, entry to the home or a trained roster; discharge can fail and lead to readmission. Support delivered outside the hospital during admission is especially clearly distinguishable from bedside nursing, although it still must be authorised and claimable under the plan.

15. Mental health settings, explicitly not an exception

What the DSW contributes in an inpatient psychiatric unit

- Describes the person's usual mental state, speech, sleep, thought process, affect, self-care, risk signals and disability baseline so staff can identify genuine change.
- Distinguishes, without diagnosing, autistic shutdown or overload, dissociation, trauma response, intellectual-disability communication, acquired-brain-injury effects, psychosis, mania, depression, medication effects and ordinary distress.

[17]NDIA hospital discharge guidance, https://www.ndis.gov.au/participants/how-planning-process-works/support-discharge-hospital

- Supports accessible participation in ward rounds, tribunal or legal-rights discussions, care planning, medication conversations and discharge meetings.
- Helps the person remember events, formulate questions, communicate values and preferences and use supported decision-making.
- Maintains grounding, sensory supports, routines, communication systems, cultural connection and trusted relationships.
- Supports authorised leave, short community outings and graded reintegration where the treating team approves.
- Identifies escalating self-harm thoughts, absconding risk, adverse psychotropic effects or increased fear and immediately informs clinical staff.
- Advocates against disability-related behaviour being treated automatically as aggression and promotes less restrictive, trauma-informed alternatives.
- Provides continuity after discharge with appointments, medication routines, housing, daily living and early-warning plans.

What remains the mental-health service's responsibility

Psychiatric assessment, diagnosis, observation level, treatment, medication, leave approval, capacity and legal-status decisions, suicide-risk management and use of seclusion or restraint remain with authorised clinicians and the service. A DSW must never be treated as ward security or made solely responsible for acute risk.

The ACSQHC's psychotropic-medicines standard promotes safe and appropriate psychotropic use for people with cognitive disability or impairment, including review and attention to non-drug approaches (ACSQHC Cognitive Care[18]). Restrictive-practice safeguards remain relevant in mental-health settings because distress can otherwise be answered with chemical restraint, physical restraint, mechanical restraint or seclusion (NDIS Commission guide[19]).

[18]ACSQHC Cognitive Care, https://cognitivecare.gov.au/resources/a-better-way-to-care/
[19]NDIS Commission guide, https://www.ndiscommission.gov.au/sites/default/files/2022-02/regulated-restrictive-practice-guide-rrp-20200_0.pdf

Risk if absent

The person's baseline may be mistaken for acute illness, or acute illness may be dismissed as “just disability”. Communication failure can affect legal rights, consent and treatment. Loss of trusted co-regulation may increase shutdown, self-harm risk, absconding, conflict and reliance on restrictive interventions.

NDIS funded disability support workers should be regarded as concurrent rather than duplicate.

Prior to any support provided within a hospital environment, the NDIS should collect (during the planning process or prior to a scheduled admission):

1. The person's disability-related need and what happens without support.
2. The precise activity the DSW performs.
3. The worker's person-specific knowledge, training and competency.
4. Why ordinary ward staffing or a generic reasonable adjustment cannot supply the same continuity or intensity.
5. Which clinical duties remain with the hospital.
6. The person's consent and preferred communication.
7. The existing plan, behaviour support plan, mealtime plan, respiratory plan or allied-health instruction.
8. Hospital agreement, infection-control requirements and escalation arrangements.
9. Start and finish times and contemporaneous progress notes.
10. Any NDIA approval or advice, because operational rules are presently inconsistent.

The argument is not “nurses cannot care for disabled people”. It is:

> **Nurses need the time and disability expertise around them to provide safe clinical care. A familiar DSW does not replace the nurse; the worker makes the nurse's care accessible, intelligible and safe for this particular person.**