Hospital Substitution Checklist

1. **Substitutes for an Inpatient bed /ward stay or facilitates an earlier hospital discharge, provided it is clinically safe and the patient can cope at home.**

2. **Complex wound care includes acute surgical wounds with moderate to high exudate, debrided or dehisced wounds, complicated or infected wounds. It also includes wound care such a Negative Pressure Wound Therapy (NPWT) that may not be performed in a GP clinic.**

3. **Hospital substitution does not include routine change of dressings for surgical wounds, routine non-healing chronic wound dressing changes, or routine stoma care.**

For clients requiring negative pressure wound therapy

- ○ Email referral and wound care chart including machine brand (KCI or Smith and nephew), device pressure setting, dressing type and size, canister size, frequency of dressing changes and date of specialist review if known
- ○ Please discharge patient home with at least **1 complete VAC dressing change, including basic consumables,** to provide time for the delivery of ordered supplies and avoid interruptions to wound care
- ○ All sections of the Remedy Healthcare Referral form must be completed.
- ○ Referral form is required to be signed by a clinician.

For patients requiring wound care

- ○ Email referral form, wound care chart including required care regime and products used
- ○ Discharge patient with **3 days of dressing consumables** to provide time for the delivery of supplies ordered and avoid interruptions to wound care
- ○ Send an updated wound care chart if care plan changes prior to discharge home

For patients requiring drain tube care

- ○ Include Type of drain. (please advise if it is to be measured only, measured and emptied, or if bag/bottle needs to be changed)
- ○ Reportable limits/communication to specialist and removal orders/plan
- ○ After hour contact number &plan for after hours management to be advised to us and the patient
- ○ Discharge patient with **all consumables** required for drain tube care
- ○ **Health Funds:** Not all health funds approve Drain tube care – referrals are considered on a case by case basis. If approved, care is usually funded for a maximum of 2 weeks covering only nurse visits (no consumables)

Get in touch

Call 1300 734 224 or email **getbetter@remedyhealthcare.com.au** to speak to nurse on triage

Hospital Substitution Checklist

Remedy
HEALTHCARE IN YOUR HOME

For clients requiring IV antibiotics:

- ○ A Doctor to complete and sign the Medication chart (including flush order)
- ○ Send a copy of the PICC details as listed on the medication chart and X-ray confirmation (date of insertion, location, internal & external length and PICC arm circumference).
- ○ For 24 Hr infusers: connect the first infuser prior to discharge, advise Remedy Healthcare of the connection time and send client with the first batch of infusers
- ○ For short infusions/Push doses: advise Remedy Healthcare the time of the last dose administered. Discharge the patient with medical vials, IV fluid bags and IV lines from the pharmacy
- ○ Discharge patient with 1 spare PICC line dressing and **3 days of all IV consumables eg: syringes and flushes**

Additional requirements or clients requiring IV Vancomycin antibiotics:

(in addition to the above)

- ○ Treating Doctor is aware they are maintaining clinical governance regarding Vancomycin levels and dosing
- ○ Second Doctor contact name and details in case governing Doctor is not available for Vancomycin dosing.
- ○ Send a copy of latest Vancomycin level & renal function tests
- ○ **Pathology days: Monday to Wednesday only.** This is because the company that compounds the 24 hr infusers will not deliver over the weekend and they have a cut off time for ordering
- ○ **Specialist review:** Please advise when the doctor will review results. This is needed for Remedy Healthcare to follow up and order the next lot of Vancomycin baxters

For patients requiring stoma care

- ○ Provide all necessary information regarding stoma care. Email Stoma chart if available
- ○ Please advise if patient is already connected to a Stoma Association
- ○ Discharge patient with **all consumables** required for Stoma care
- ○ After hour contact number & plan for after hours management to be advised to us and the patient
- ○ ***Note:** Remedy Healthcare does not provide a Stomal therapist service. Visits are conducted by RN's experienced in Stoma care and focused on education and support
- ○ **Health Funds:** Not all health funds approve Stoma care – referrals are considered on a case by case basis. If approved, care is usually funded for a maximum of 2 weeks covering only nurse visits (no consumables)

Get in touch

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Hospital Care at Home

HCF Acute Nursing Service Referral Guidelines

- **Complex wounds & IV AB's**
- **Includes nursing home visits ONLY**
- **No allied health & non-clinical services**
- **7 days a week service provision**
- **Member would otherwise remain in hospital**
- **Referral form to include hospital LOS, bed days saved, treating specialist & GP details.**
- **Treating physician remains responsible for medical oversight**
- **Referring hospital to provide 3 days of consumables / dressing supplies**
- **Excludes chronic wounds (no recent debridement) - refer community provider**

Complex Wound meets the following requirements:

- Wound dehisced/debrided during hospital admission
- Depth of wound > 6mm at time of referral
- NPWT – requiring exudate management - refer to the Remedy Hospital Substitution Checklist
- Wound care chart provided with dimensions (including depth) of wound clearly documented on the wound care chart and a photo of the wound (if able).

Intravenous Antibiotics

- IV antibiotic infusion or manual push
- Excludes S.C and oral medication administration
- Refer to Remedy Hospital Substitution Checklist to guide you through referral process
- See below for Referral Form and Medication chart

Please note:

- **Remedy Healthcare will conduct member eligibility and check referral suitability & eligibility criteria prior to confirming referral acceptance**
- **Member not to be discharged home from hospital until referral has been accepted**
- **Member has access to a telephone or mobile phone**

How to refer

Refer via our digital referral form:

refer.remedyhealthcare.com.au

Alternatively, complete our PDF referral form and email to:

getbetter@remedyhealthcare.com.au

If you would like to discuss your referral with a Triage nurse, please call **1300 734 224**.

Get in touch

Call 1300 734 224 or email **getbetter@remedyhealthcare.com.au** to speak to nurse on triage

Hospital Care at Home Referral Form

Remedy HEALTHCARE IN YOUR HOME

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

1. Patient details

First name		Last name	
Date of birth		Gender	
Address for discharge			
State		Postcode	
Phone number		Email	
Cultural/language considerations			

Is the patient of Aboriginal and/or Torres Strait Islander origin?

- ☐ Aboriginal ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Neither Aboriginal nor Torres Strait Islander origin
- ☐ Not stated / inadequately described

Next of Kin

First name		Last name	
Phone number		Relationship	

2. Funding details (PLEASE SELECT HOW THIS PROGRAM WILL BE FUNDED)

☐ **Private health fund** ☐ **Hospital funded**

Health fund name	
Membership number	

☐ **Compensation body/Third party**

Compensation Body Name	
Claim number	
Case manager name	
Case manager phone	
Case manager email	

3. Medical details

Hospital admission date		Anticipated discharge date	
Hospital name			
Primary diagnosis and interventions / surgical procedures (if applicable)			
Past medical history			
Any complications during current admission	☐ Yes ☐ No	Details:	
Any cognitive impairment/delirium	☐ Yes ☐ No	Details:	
Current functional status (mobility, transfers, ADLs)			
Social history			
Allergies			

Infection control alerts: ☐ MRSA ☐ Help B/C ☐ VRE ☐ HIV ☐ COVID-19 ☐ Influenza ☐ None ☐ Other (specify):

Specialist name			
Specialist phone		Specialist email	

SEE OVER TO COMPLETE FORM

Hospital Care at Home Referral Form

Patient name:	
Patient DOB:	
Patient address:	

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

3. Medical details (CONTINUED)

GP name & clinic			
GP phone		GP email	
Second specialist name			
Second specialist phone (if applicable)		Second specialist email (if applicable)	

Home visit staff safety checklist

History of aggression or violence?	☐ Yes ☐ No	History of inappropriate behaviour?	☐ Yes ☐ No
History of illicit substance abuse?	☐ Yes ☐ No	Any other risks for home visiting?	☐ Yes ☐ No
Details:			

4. Hospital Care at Home service requirements

Start date	Frequency or specific days	Program length

The patient would otherwise stay admitted in hospital for _____ day/s without home services

Please select the service/s required:

☐ **IV antibiotics / PICC care**

PICC location		Insertion date	
PICC dressing due date		Length (internal/ external)	
PICC location confirmed by x-ray?	☐ Yes ☐ No (please advise when location confirmed for referral to proceed)	Medication chart attached	☐ Yes ☐ No (please send when available for referral to proceed)

☐ **Complex wound care management**

Wound care details			
Wound care chart attached?	☐ Yes ☐ No (please send when available for referral to proceed)	☐ Patient will be discharged home with **3 days of dressing consumables**	

☐ **Negative pressure wound therapy**

Device brand	☐ KCI ☐ Smith & Nephew ☐ Disposable (e.g. PICO/SNAP)	Device serial number (for KCI/Smith & Nephew)	
Canister and foam size and type		Device pressure setting	☐ Continuous ☐ Intermittent
Wound care chart attached?	☐ Yes ☐ No (please send when available for referral to proceed)	☐ Patient will be discharged home with **1 complete VAC dressing change**	

☐ **Drain management**

Type of drain		**Reportable limits?**	
Drain management plan			
Wound care chart attached?	☐ Yes ☐ No (please send when available for referral to proceed)	☐ Patient will be discharged home with **all consumables** required for drain management	

SEE OVER TO COMPLETE FORM

Hospital Care at Home Referral Form

Patient name:	
Patient DOB:	
Patient address:	

Phone 1300 734 224 | Fax 1300 734 221 | Email getbetter@remedyhealthcare.com.au

4. Hospital Care at Home service requirements (CONTINUED)

☐ **Stoma care**

Stoma details		
Stoma chart	☐ Yes ☐ No (please send when available for referral to proceed)	☐ Patient will be discharged home with **all consumable required** for stoma care.

☐ **Other (specify)**

Specific service requirement details	

5. Additional referral information

6. Authorisation and referrer details

By signing and sending this referral I declare that:

- The hospital treating specialist declares that the patient is medically stable.
- The patient is suitable to safely engage in home-based care.
- The patient has consented to receiving Remedy Healthcare services at home and has consented to their personal and health information being shared with Remedy Healthcare and the health fund nominated in this form, or the health fund's authorised agent.
- The patient has consented to Remedy Healthcare and the health fund nominated in this form contacting the patient, including by electronic means, to ascertain funding eligibility, confirm receipt and facilitate participation of the relevant services.
- The information provided in this form is complete, true and correct to the best of my knowledge.

Referrer name		Referrer organisation	
Referrer role title		Referrer phone	
Referrer email		Additional email	
Referrer signature		Date	

SUBMIT VIA EMAIL

DO NOT WRITE IN THIS BINDING MARGIN

Prescribed Medication Administration Chart

Remedy HEALTHCARE IN YOUR HOME

Attach ADR sticker **Diabetic on insulin**

Medicine (or other)	Reaction / type / date	Initials

Sign ..... Print ..... Date .....

Phone: 1300 734 224 **Email:** getbetter@remedyhealthcare.com.au

URN:

Family name:

Given names:

Address:

Not a valid prescription unless identifiers present

Date of Birth **Sex:** ☐ M ☐ F

Phone Number

Hospital Doctor maintaining Clinical Governance post discharge:

Name: .....

Phone: ..... Pager: .....

Signature: .....

Authority to remove PICC Line (if known at time of referral):

Date of PICC line removal: .....

Name: .....

Signature: .....

Second Doctor for Vancomycin Cases:

Name: .....

Phone: .....

Signature: .....

PICC DETAILS Please provide a copy of the hospital PICC chart and radiology report that includes the following information:

☐ Insertion date
☐ PICC location
☐ Last dressing date/when next due
☐ Xray confirmation of correct PICC location
☐ Length to skin in cms
☐ Upper arm circumference (if available)

Date:	Dose	Date Given																				
Medicine: (print generic name)		Time Given																				
	Route	Nurse Signature																				
Start Date: / Cease Date:		Date Given																				
Doctors Name:	Frequency	Time Given																				
Doctors Signature:		Nurse Signature																				
Date:	Dose	Date Given																				
Medicine: **Normal Saline**	**10-20ml**	Time Given																				
0.9% Sodium Chloride for injection	Route	Nurse Signature																				
Start Date: / Cease Date:	**IV**	Date Given																				
Doctors Name:	Frequency	Time Given																				
Doctors Signature:	**PRN**	Nurse Signature																				

PRESCRIBED MEDICATION ADMINISTRATION CHART

Remedy HEALTHCARE IN YOUR HOME