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. The patient is clinically safe to go home but unable to care for the wound themselves and due to wound complexities unable to visit the GP. It also includes wound care such a VAC/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

- ○ Complete All sections of the Remedy /RC referral form and it must be signed by a clinician
- ○ Email referral and wound care chart including machine brand (KCl 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

For patients requiring wound care

- ○ Complete All sections of the Remedy Healthcare referral form and it must be signed by a clinician
- ○ 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

- ○ Complete All sections of the Remedy Healthcare referral form and it must be signed by a clinician
- ○ 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:

- ○ Complete all sections of the Remedy Healthcare referral form and it must be signed by a clinician
- ○ The Governing 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) Please note other devices used for IV infusions (CVCs, Hickman's and Portacaths) are currently out of scope for Remedy nursing services.
- ○ 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**

For clients requiring vancomycin antibiotic: (same as above for IVAB with a few additional requirements as below)

- ○ Treating Doctor is aware they are maintaining clinical governance regarding Vancomycin levels and dosing
- ○ 2ND Doctor contact name and details incase governing Doctor is not available for Vanc 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 Vanc baxters

For patients requiring stoma care

- ○ Complete All sections of the Remedy Healthcare referral form and it must be signed by a clinician
- ○ 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

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

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
- Referral form and Medication chart can be found at: https://www.remedyhealthcare.com.au/Make-a-referral

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

Referrals are sent via the: getbetter@remedyhealthcare.com.au **OR**

Call **1300 734 224** to discuss your referral requirements

Remedy Healthcare Group ABN 71 079 782 746
GPO Box 2219, Melbourne, Victoria 3001
Phone: 1300 734 224 Fax: 1300 734 221
remedyhealthcare.com.au

Referral to Remedy Healthcare

Remedy HEALTHCARE IN YOUR HOME

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

Remedy always send a receipt of referral correspondence, if you don't receive this please call to check we have the referral.

1. Referrer and hospital details

Referrer (Please tell us about you)

First name

Last name

Role title

Work number

Email

Email (additional)

Hospital name

Hospital number

This number will be used to contact the patient or accounts team if we have an issue with financial eligibility.

2. Specialist and GP details

Treating specialist details

First name

Last name

Phone

Email

Fax (optional)

GPs details

First name

Last name

Phone

Email

Fax (optional)

3. Patient details

Please enter the patients details

First name

Last name

Date of birth dd mm yyyy

Sex ☐ Female ☐ Male ☐ Other/unspecified

Phone

Email

Address for discharge
(No PO Boxes)

Cultural / religious / language considerations (optional)

Name of health fund

Membership number

Hospital funded ☐ Yes

Next of Kin

First name

Last name

Relationship

Phone number

4. Patient's medical details

Admission date dd mm yyyy

Proposed DC date dd mm yyyy

Primary diagnosis and interventions / surgical procedures (if applicable)

PMHx

Current mobility / function / ADL's

Any complications during admission? ☐ Yes ☐ No

Details

Any known allergies? ☐ Yes ☐ No

Details

Social situation / supports ☐ Lives with others ☐ Lives alone ☐ Has a carer ☐ A carer for others

Social situation details (optional)

Any known infections? ☐ Yes ☐ No

Details

Any cognitive impairment/delirium? ☐ Yes ☐ No

Details

Any other community care services? ☐ Yes ☐ No

Details

On more than 5 medications? ☐ Yes ☐ No

Details

Any other wounds unrelated to this admission? ☐ Yes ☐ No

Details

SEE OVER TO COMPLETE FORM

Referral to Remedy Healthcare

Patient name:	
Patient DOB:	
Patient address:	

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

Remedy always send a receipt of referral correspondence, if you don't receive this please call to check we have the referral.

5. Functional status (ONLY FOR REHABILITATION REFERRALS)

Patient goals

Previous functional status (mobility and ADLs)

Current functional status

Mobility ☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile

Distance meters

Transfers ☐ Indep ☐ s/v ☐ 1 Assist ☐ 2 Assist ☐ Immobile

Does the patient use a walking aid? ☐ Yes ☐ No

Walking aid type

Weight bearing restrictions ☐ Full ☐ Partial ☐ Touch ☐ WBAT ☐ Non-Weight bearing

Patient safe to manage stairs/steps? ☐ Yes ☐ No ☐ N/A

Patient has been assessed as a high falls risk? ☐ Yes ☐ No

Number of falls during current admission Fall/s

History of falls in the past 12 months? ☐ Yes ☐ No

History of fall details

Any precautions and/or contra-indication? ☐ Yes ☐ No

Precautions and/or contra-indication details

Any continence issues? ☐ Yes ☐ No

Select all continence issues ☐ Bladder ☐ Bowel

Toileting requirements ☐ Indep ☐ Supervision ☐ Assistance

Showering requirements ☐ Indep ☐ Supervision ☐ Assistance

Additional information

6. Service requirement details

Bed day savings by using home services

Patient from? ☐ Acute ward ☐ In patient rehab

☐ **Rehabilitation at Home - Multidisciplinary Program**

☐ Physiotherapy ☐ Occupational Therapy

☐ Rehab Nursing (Including wound review if required) ☐ Dietetics

☐ Personal Care ☐ Home Help ☐ Meals

☐ **Hospital Care at Home Program**

☐ Wound Management ☐ IV antibiotics/PICC Care

☐ NPWT/VAC ☐ Drain tube care ☐ Stoma/IDC/SPC care

☐ OT ☐ Physio ☐ Personal Care ☐ Meals ☐ Home Help

Service type	Start date	Sessions per week	Duration in weeks	Additional information e.g. Pharmacy contact details

7. Authorisation

☐ Hospital treating doctor/surgeon declares that the patient is medically stable, has suitable social support to safely engage in home-based care and is not being discharged against medical or allied health advice. The patient has consented to Remedy Healthcare disclosing their personal information to the health fund nominated in this form, or its authorised agent (as applicable), to ascertain funding eligibility, confirm receipt of relevant services and facilitate participation.

☐ I will send the patient home with 3 days of consumables for all Hospital care at home referrals.

Referrer name | Role title | Date

Signature

☐ I declare that the information provided by me in the referral is true and correct.

8. Referral checklists

Please provide the following documents Attach to email or fax the applicable documents to the fax number 1300 734 221

☐ I have attached specialist protocol (if applicable)

☐ I have included a wound care chart (if applicable)

☐ I have included a medication and PICC chart (if applicable)

☐ Hospital Care at Home checklist completed

Home visit staff safety checklist

History of aggression or violence? ☐ Yes ☐ No History of inappropriate behaviour? ☐ Yes ☐ No History of substance abuse? ☐ Yes ☐ No

Are there any other risks for home visiting? (behavioural/social issues, domestic violence, infectious diseases) ☐ Yes ☐ No

Precautions and/or contra-indication have been included in this referral? ☐ Yes ☐ No

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