HOSPITAL IN THE HOME (HITH)

TRANSFER CHECKLIST

Please note:

Bass Coast Health HITH service does not accept sub-contracted patients

Send all referrals with completed documentation to

hith@basscoasthealth.org.au

Contact HITH on (03) 5671 3439 or 0439 956 003

Hospital Service Coordinator (03) 5671 3384 for afterhours information

Transfer checklist:

- ☐ COMPLETED PATIENT DISCHARGE SUMMARY
- ☐ COMPLETED MEDICAL REFERRAL (MR 302)
- ☐ COMPLETED ELEGIBILITY CRITERIA (MR 298)
- ☐ DOCTOR TO DOCTOR HANDOVER BEST CONTACT : HSC (03) 5671 3384
- ☐ CVAD DOCUMENTATION INCLUDING
  - PICC TYPE
  - LENGTH
  - PLACEMENT
  - PLAN FOR REMOVAL
- ☐ DOCUMENTED EVIDENCE FOR WOUND ORDERS AND VAC DRESSING REQUIREMENTS

PATIENT DETAILS			
TITLE		UR	
SURNAME		DOB / AGE	
GIVEN NAMES		SEX	
ADDRESS			
MOBILE NO.		HOME NO.	
MARITAL STATUS		EMAIL	
COUNTRY OF BIRTH		LANGUAGE SPOKEN	
RELIGION		ABORIGINAL / TSI	
LOCAL GP	NAME / CLINIC: CONTACT NO: EMAIL:		
FINANCIAL DETAILS:			
MEDICARE NUMBER		EXPIRY DATE	
DVA NUMBER		WORKERS COMP DETAILS	
PENSION CARD DETAILS		HEALTH CARE CARD DETAILS	
PRIVATE HEALTH FUND		PRIVATE FUND POLICY NUMBER	
OTHER CONTACTS			
NEXT OF KIN		**EMERGENCY CONTACT**	
SURNAME		SURNAME	
GIVEN NAME		GIVEN NAME	
REL TO PT		REL TO PT	
ADDRESS		ADDRESS	
TEL NO		TEL NO	

BCH
Bass Coast Health

Hospital in the Home - Medical Referral

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PLACE LABEL HERE

Date of referral: ____ /____ /____ Contact phone number of patient: _____

Next of Kin: _____ Contact number: _____

REFERRING DOCTOR TO COMPLETE

Diagnosis / reason for admission: _____

_____

_____

_____

Relevant past history: _____

_____

_____

_____

Planned treatment: _____

_____

_____

_____

_____

_____

* HITH patients requiring medications must have anaphylaxis management completed on medication chart in prn section (0.5mg [0.5ml] of 1:1000 adrenaline IM)

Anticipated discharge date from service: ____ /____ /____

Referring Doctors name: _____ Designation: _____

Signature: _____ Date: ____ /____ /____ Time: _____

Treating GP notified: ☐ Yes ☐ No Name of treating doctor: _____

Review date: ___ /___ /___ Doctor: _____ Phone number: _____

Place of appointment: _____ Time of appointment: _____

Please indicated the following has been attended to:

- ☐ Consent form signed
- ☐ Admission criteria met
- ☐ Pharmacy arranged
- ☐ Pathology orders completed
- ☐ Review appointment booked
- ☐ Medication chart completed

Please tick if there is an advanced care plan ☐

Nurses name: _____ Designation: _____

Signature: _____ Date: ____ /____ /____ Time: _____

HOSPITAL IN THE HOME – MEDICAL REFERRAL

MR/302

BCH
Bass Coast Health

Hospital in the Hospital (HITH) Eligibility Criteria

Surname ..... U.R. No. .....

First Name ..... Gender .....

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PATIENT LABEL

PLACE LABEL HERE

To be eligible for HITH the patients must meet the following criteria:

❑ Yes	❑ No	They must require acute in-patient services but are medically stable enough to be treated at home.
❑ Yes	❑ No	They reside within the Bass Coast Region (* see below)
❑ Yes	❑ No	Have a good support network (family/carer) who is available to the patient 24/7
❑ Yes	❑ No	Their home is suitable (a routine risk assessment **MR/947** is carried out with all patients)
❑ Yes	❑ No	The patient has access to a telephone
❑ Yes	❑ No	The care required is clearly defined including a clear diagnosis and full past medical/surgical history
❑ Yes	❑ No	There is a clear end date for the proposed HITH treatment
❑ Yes	❑ No	The patient chooses to enter the program voluntarily
❑ Yes	❑ No	The patient must need a maximum of twice daily visits
❑ Yes	❑ No	Inpatient acceptance to the HITH program will occur via BCH doctor/ with admitting rights.

Patients are ineligible for the HITH program if they meet one or more of the following criteria:

❑ Yes	❑ No	The patient's medical condition is unstable or requires repeated emergency interventions
❑ Yes	❑ No	The patient's medical condition does not require inpatient care
❑ Yes	❑ No	The patient is not willing to follow HITH staff instructions
❑ Yes	❑ No	The patient lacks a readily available support network (family/carer)
❑ Yes	❑ No	The patient declines to give consent to enter the HITH program
❑ Yes	❑ No	The home environment poses a risk to the HITH staff, the patient or carer

Once the patient is deemed eligible for the HITH program, please contact the HITH Coordinator, 0439 956 003.

*Acceptance of patients residing outside the Bass Coast Region will be determined by the HITH coordinator.

Name: _____ Designation: _____

Signature: _____ Date: ____ /____ /____

HOSPITAL IN THE HOME (HITH)
ELIGIBILITY CRITERIA

MR/298

BCH
Bass Coast Health

Transfer Checklist

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ...../...../..... Age .....

Doctor..... Ward.....

PLACE LABEL HERE

Date: ___ /___ /___ Bed Number Allocated: _____

Identity

Nurse giving handover: _____ Nurse receiving handover: _____

From Department: _____ To Department: _____

Patient Name:_____ UR Number:_____

Age: _____ Gender: _____ DOB: ____ /____ /____

Patient ID/Armbands: ☐ Yes ☐ No Admitting Unit: _____

Valuables: ☐ Yes ☐ No Details: _____

Belongings: ☐ Yes ☐ No Details: _____

Situation

Presenting problem / provisional diagnosis / procedure

Background

Circle if relevant

AMI Anxiety Asthma CCF CRF Diabetes IHD PE

Behavioural Issues Pneumonia Smoker Stroke UTI Substance Addiction

Dementia Depression

Other Relevant Past & Medical History: _____

_____

_____

Allergies: _____ **Infection Status:** _____

Alert or Flag completed: ☐ Yes ☐ No

Patient's own Medications brought in: ☐ Yes ☐ No Details: _____

Infection Risk: ☐ Yes ☐ No Details: _____

Living Arrangements:

☐ Home ☐ Lives Alone ☐ With family/carer ☐ SRS

☐ Hostel ☐ Nursing Home ☐ Respite Care

Family aware of admission: ☐ Yes ☐ No NOK: _____

ACP: ☐ Yes ☐ No **NFR:** ☐ Yes ☐ No

Turn over for further ISBAR communications

ISBAR Tools (2010) – developed by Southern Health in partnership with the VMIA

BCH, V7 Jan 2017

TRANSFER CHECKLIST

MR/267

BCH
Bass Coast Health

Transfer Checklist

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

PLACE LABEL HERE

TRANSFER CHECKLIST

Assessment

Vital Observations (most current)

T: _____ P: _____ RR: _____ BP: _____ SpO^2: _____

Neuro vascular obs CWMS _____ Pusle taken by: ☐ Palp ☐ Doppler ☐ Monitor

Conscious State:

☐ Alert ☐ Drowsy ☐ Non-responsive ☐ GCS_____ ☐ Has had sedation in ED

Pain Level: _____/10 Analgesia last given at _____ hrs.

Diabetic Status: ☐ N/A ☐ T1DM ☐ T2DM ☐ Insulin ☐ Medication ☐ Diet Controlled

Latest BGL: _____mmol Time Taken: _____ Action taken: _____ Frequency: _____

Urinary Output:

☐ Continent ☐ Incontinent ☐ IDC insitu Size: _____ Time inserted: _____ Last voided: _____hrs

Invest: ☐ Pathology ☐ Attended ☐ Slip sent to Pathology ☐ Slip with patient to ward

☐ Radiology ☐ Attended ☐ Slip sent to Radiology ☐ Slip with patient to ward ☐ ECG

Medications administed (inc. IV) _____

As per National Medication Chart: ☐ Yes ☐ No

Mobility Aids: ☐ Yes ☐ No Details: _____

Risk Assessment Score: _____ **Falls Risk:** ☐ Yes ☐ No **Wound / PU:** ☐ Yes ☐ No _____

Notes: ☐ Yes ☐ No **Medical Admission Notes:** ☐ Yes ☐ No

Antibiotics Given: ☐ Yes ☐ No Time: _____ **Altered MET Criteria:** ☐ Yes ☐ No

Anti – Emetic Last Given: ☐ Yes ☐ No Time: _____

IV and medications orders checked and signed: ☐ Yes ☐ No

Request

Treatment Plan: _____

_____

_____

Medication Charts: ☐ Yes ☐ No **X-Rays Results:** ☐ Yes ☐ No ☐ N/A ☐ Chase up

Surgical RV: ☐ Yes ☐ No ☐ N/A **Pathology results:** ☐ Yes ☐ No ☐ N/A ☐ Chase up

Care plan commenced & referral sent i.e. COPD: ☐ Yes ☐ No

Patient Fasting: ☐ Yes ☐ No

Type of Diet/Fluid ☐ Normal ☐ Textured ☐ Soft ☐ Thickened ☐ Diabetes

Other: _____

Equipment / Resources required (circle): Oxygen Syringe Driver Pressure mattress

Blood warmer Monitor Single Room Insulin Infusion

PHONE HANDOVER

Given by:

Name: _____ Designation: _____ Date/Time: ____ /____ /____

Received by:

Name: _____ Designation: _____ Date/Time: ____ /____ /____

Signature: _____

MR/267

BCH.V7 Jan 2017

BCH
Bass Coast Health

Pre-Visit Telephone Home Risk Assessment Tool

Surname ..... U.R. No. .....

First Name ..... Gender .....

PATIENT LABEL

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

PLACE LABEL HERE

Access to Property

What type of dwelling is this property?

☐ House ☐ Aged Care Facility (*specify*) _____

☐ Flat/Unit ☐ Other _____

Is the house number clearly visible from the street? ☐ Yes ☐ No

If NO, how can the house be identified? _____

_____

Are there any hazards in relation to the condition of the road, driveway, pathway? ☐ Yes ☐ No

_____

Are there any gateways to open/close on the way to the house? ☐ Yes ☐ No

Which door is to be used for entry? _____

Will a mobile phone work in the area? ☐ Yes ☐ No

Is there operational external lighting? ☐ Yes ☐ No

Are there any pets that would have access to the outside area where staff will be entering or area where service will be delivered? ☐ Yes ☐ No

If, YES, how will the pets be restrained? _____

_____

_____ Can we call ahead first? ☐ Yes ☐ No

Is the residence a smoke-free environment? ☐ Yes ☐ No

Is the client the sole occupant? ☐ Yes ☐ No

If NO, how many live there? _____

Is the client or others at the premises known to be potentially aggressive, violent or disturbed? ☐ Yes ☐ No

Are there any other potential risks? ☐ Yes ☐ No

Is there smoke alarm? ☐ Yes ☐ No

Is it working? ☐ Yes ☐ No ☐ Unsure

If No or Unsure, advise action that has been taken? _____

Staff Name: _____ **Signature:** _____

Designation: _____ **Date of Assessment:** _____

PRE – VISIT TELEPHONE HOME RISK ASSESSMENT

MR/947

BCH
Bass Coast Health

Regional Wound Assessment Chart

Surname ..... U.R. No. .....

First Name ..... Sex .....

Date of Birth ... / ... / ... Age .....

Doctor ..... Ward .....

Address .....

PATIENT LABEL

PLACE LABEL HERE

NEW ASSESSMENT DATE	/ /	**WOUND NO.**		**Previous No. of visits carried**	**Final No. of visits carried forward**
FIRST VISIT DATE	/ /	**HEAL/DISCHARGE DATE**	/ /	**HEALED**	☐ Yes ☐ No

WOUND TYPE / HISTORY (Acute / Chronic / History / Previous treatment if any)

ALLERGIES / SENSITIVITIES

Wound Type

- ☐ Acute – Surgical / Crush / Burn / Trauma
- ☐ Cellulitis / Lymphoedema with no previous ulcer
- ☐ Fistula / Abscess / Pilonidal sinus / Drain tube
- ☐ Malignant
- ☐ Radiation skin reaction – with skin loss

Atypical

- ☐ Mucosal Pressure Injury
- ☐ Incontinence Associated Dermatitis (IAD) with skin loss
- ☐ Not Diagnosed
- ☐ Diagnosed (List)

Pressure Injury Classification

- ☐ Stage I
- ☐ Stage II
- ☐ Stage III
- ☐ Stage IV
- ☐ Unstageable
- ☐ Suspected deep tissue injury (SDTI)

Skin Tear Classification

- ☐ Category 1 (a)
- ☐ Category 1 (b)
- ☐ Category 2 (a)
- ☐ Category 2 (b)
- ☐ Category 3

Lower Limb Ulcer

- ☐ Venous Leg Ulcer
- ☐ Arterial Leg Ulcer
- ☐ Venous / Aterial Ulcer
- ☐ Neuro / Ischaemic Ulcer
- ☐ Neuropathic

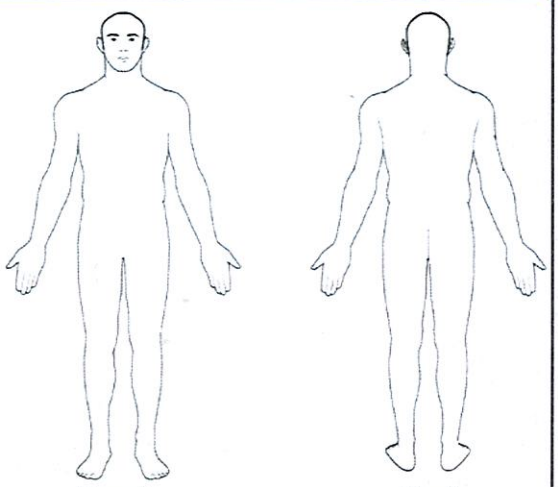
FACTORS AFFECTING HEALING

- ☐ Diabetes
- ☐ Rheumatoid Arthritis / Autoimmune
- ☐ Poor Nutrition
- ☐ Smoking
- ☐ Anaemia
- ☐ Respiratory Disease
- ☐ Cardiovascular disease (CCF /PVD / CVI)
- ☐ Medications
- ☐ Other

WOUND LOCATION

☐ Left	☐ Anterior	☐ Medial	☐ Midline	☐ Proximal
☐ Right	☐ Posterior	☐ Lateral	☐ Circumferential	☐ Distal

☐ Head	☐ Neck	☐ Face	☐ Ears
☐ Arm Upper	☐ Forearm	☐ Hand	☐ Digits
☐ Abdomen Upper		☐ Abdomen lower	
☐ Chest		☐ Breast (s)	
☐ Back Upper	☐ Back Lower	☐ Hip	
☐ Perineum	☐ Sacrum	☐ Buttocks	
☐ Leg Upper	☐ Leg Lower	☐ Knee	
☐ Foot Plantar	☐ Foot Dorsum	☐ Toes	



Front Back

REFERRALS (☑ if required)	**Date**	**INVESTIGATIONS (☑ if required)**	**Date**
☐ Wound Management		☐ HbA1c	
☐ Podiatrist		☐ Wound Swab	
☐ Dietician / Diabetic Ed (circle)		☐ Ankle / Toe Brachial Pressure Index	
☐ Allied Health		☐ Medication review	
☐ Medical (GP / Surgeon / Other)		☐ Radiology	
☐ Other		☐ Other (list)	

Nurse Signature

Name: _____ Designation: _____

Signature: _____ Date: _____ / _____ / _____

REGIONAL WOUND ASSESSMENT CHART MR/599

BCH Bass Coast Health

Regional Wound Assessment Chart

Surname .... U.R. No. ....
First Name .... Sex ....
Date of Birth ..../..../.... Age ....
Doctor .... Ward ....
Address ....

PATIENT LABEL

PLACE LABEL HERE

Allergies/Sensitivities - Describe

Product Selection		**Product Selection**	
Date: / /	Nurse Signature:	Date: / /	Nurse Signature:
Frequency:	Person/ Carer signature:	Frequency:	Person/ Carer signature:
Cleansing Routine		Cleansing Routine	
Debridement	☐ Autolytic ☐ Mechanical ☐ Sharp	Debridement	☐ Autolytic ☐ Mechanical ☐ Sharp
Specify		Specify	
Skin Emollient:		Skin Emollient:	
Primary and secondary Dressing/s:		Primary and secondary Dressing/s:	
Compression System and mmHg:		Compression System and mmHg:	
This Regime was altered because:		This Regime was altered because:	
Nurse Signature at change of Regime		Nurse Signature at change of Regime	

Product Selection		**Product Selection**	
Date: / /	Nurse Signature:	Date: / /	Nurse Signature:
Frequency:	Person/ Carer signature:	Frequency:	Person/ Carer signature:
Cleansing Routine		Cleansing Routine	
Debridement	☐ Autolytic ☐ Mechanical ☐ Sharp	Debridement	☐ Autolytic ☐ Mechanical ☐ Sharp
Specify		Specify	
Skin Emollient:		Skin Emollient:	
Primary and secondary Dressing/s:		Primary and secondary Dressing/s:	
Compression System and mmHg:		Compression System and mmHg:	
This Regime was altered because:		This Regime was altered because:	
Nurse Signature at change of Regime		Nurse Signature at change of Regime	

Product Selection		**Product Selection**	
Date: / /	Nurse Signature:	Date: / /	Nurse Signature:
Frequency:	Person/ Carer signature:	Frequency:	Person/ Carer signature:
Cleansing Routine		Cleansing Routine	
Debridement	☐ Autolytic ☐ Mechanical ☐ Sharp	Debridement	☐ Autolytic ☐ Mechanical ☐ Sharp
Specify		Specify	
Skin Emollient:		Skin Emollient:	
Primary and secondary Dressing/s:		Primary and secondary Dressing/s:	
Compression System and mmHg:		Compression System and mmHg:	
This Regime was altered because:		This Regime was altered because:	
Nurse Signature at change of Regime		Nurse Signature at change of Regime	

MR/599 REGIONAL WOUND ASSESSMENT CHART

BCH
Bass Coast Health

PICC Insertion & Maintenance

Surname ..... U.R. No. .....

First Name ..... Sex .....

PATIENT LABEL

Date of Birth ..../..../.... Age .....

Doctor ..... Ward .....

PLACE LABEL HERE

INSERTION DETAILS

Date | Time | VMO/LMO Inserting | RN Signature

Vein Accessed | Upper arm circumference (pre insertion)

Batch/Lot No. | Device Brand | Lumen Size

Circumference of upper arm (7cm above antecubital fossa | External length (Post Trimming)

Internal Length

COAG Studies: ☐ Dressing applied ☐

Catheter: Aspirate ☐ 10 mL Saline Flush ☐ Heparin lock/ Positive Pressure bung Insitu ☐ Yes ☐ No

X-RAY ☐

Date / Time: ..... Device Tip Location: .....

Placement Confirmed - LMO/VMO Signature: .....

DRESSINGS (Initial Each Box)(24 Hours Post Insertion, then Weekly PRN)

Date/Time							
Site Inspection: document redness, swelling, pain, bleeding							
Stat lock changed							
Injection lock changed							
Flashback obtained. Flush 10 ml Saline							
Dressing / Review attended							
Positive Pressure Bung changed							
External Length from insertion site to hub							
Upper Arm Circumference							
Complications or interventions							
Initial							

COMMENTS .....

PICC - INSERTION & MAINTENANCE

MR/531