health

Hospital in the Home
Guidelines

State Government
Victoria

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Guidelines

Contents

Acknowledgements

Purpose

These guidelines are intended to provide information to assist HITH services to administer the HITH service within appropriate governance and funding structures, and to deliver high-quality HITH services to patients. They aim to promote consistency of access and reduce variation of service profiles across the state within the context of a complex service system. Using these guidelines, it is expected that health services develop local structures, models, policies and practices to meet their obligation to the community and the Department of Health.

The guidelines provide supplementary information related specifically to HITH and should be understood in conjunction with the broader existing legislation, frameworks, standards and agreements which were current at the time these guidelines were developed such as:

- *Victorian hospital admission policy, July 2011*
- *Victorian health service policy and funding guidelines 2011–12*
- *Health Independence Program guidelines 2008*
- *Occupational Health and Safety Act 2004 (Vic)*
- professional ethics and guidelines
- Victorian Admitted Episode Data Set
- *Victorian Home and Community Care Program Manual, 2003*
- *Care in your community: A planning framework for integrated ambulatory health care, 2006*
- *Rural directions – for a stronger healthier Victoria, 2009*
- *Victorian service coordination practice manual, 2009*
- *Victorian clinical governance policy framework, 2011*
- *Australian guidelines for the prevention and control of infection in healthcare*
- hospital accreditation resources:
  - The Australian Council on Healthcare Standards' Evaluation and Quality Improvement Program (ACHS EQuIP)
  - The International Organisation for Standardisation's Quality Management System 9000 (ISO 9002)
  - Quality Improvement Council's Health and Community Services Standards (QIC).
- *Victorian Health Priorities Framework 2012–22: Metropolitan Health Plan.*

Hospital in the Home in Victoria

What is HITH?

HITH services provide care in the home that would otherwise need to be delivered within a hospital as an admitted patient. Patients who receive HITH care are classified as admitted patients and their care is funded through a health service's casemix revenue. HITH often provides an alternative to admission to a hospital or an opportunity for earlier relocation to the home than would otherwise be possible. Many HITH patients are elderly and chronically ill, but there is a significant cohort of patients who have an acute event and require short-term, intensive medical treatments, including paediatric and neonatal patients.

HITH services generally are staffed by a multidisciplinary mix of nursing, medical and allied health staff. They have been funded in Victoria since 1994 and are consistently affirmed as being safe and appropriate.

HITH separations represent an important proportion of all admitted patient separations from Victorian health services. In 2010–11, 25,379 of all acute admitted patient separations had a HITH component of care. For metropolitan and regional health services more than one in 20 of all acute multiday separations involve HITH. In 2010–11, almost 500 additional beds would have been required to accommodate patients otherwise treated at home through HITH.

HITH funding

HITH services are financed through the casemix system of activity-based funding at predetermined levels for each separation for a particular diagnostic related group (DRG). HITH services also contribute to the health service's acute throughput target. In cases where a length of stay exceeds the inlier high boundary point, a HITH outlier per diem is payable at a discounted rate (80 per cent) to the usual in-hospital outlier per diem. In addition, all health services have a capped annual throughput target. If the target is exceeded, health services are reimbursed at a discount rate for the first two per cent in excess of the target – beyond that level there is no further reimbursement for services provided. Further detail on the casemix funding system, targets and reimbursement rates for each weighted inlier equivalent separation (WIES) is available at <www.health.vic.gov.au/pfg/>.

HITH has been demonstrated to provide cost-effective services across a wide range of sites and conditions in Victoria within the casemix system. The Department of Health continues to provide funding with the expectation that the range of services and minimum requirements set out in this document are achievable within the resources provided for HITH.

Review of HITH programs in 2009

In 1994 the HITH program was commenced as a pilot program as part of a strategy to provide patients with greater healthcare options by incorporating home-based care in an episode of acute care. Over the decade, the program evolved in policy, practice, activity levels, research and funding mechanisms. By 2008 HITH services had developed to meet local needs, resulting in significant variation between HITH services. DLA Phillips Fox was appointed to undertake a review. The objectives of the review were to:

- use existing information to evaluate key aspects of HITH services including role, referral processes, workforce issues, staff safety, medical leadership and clinical and corporate governance
- develop recommendations to ensure all Victorians have equitable access to patient-centred HITH services
- identify models of substituted care and investigate other technologies that may enhance services
- review the relationship between HITH services and other programs and referral processes
- outline a new service delivery model, if indicated by the findings.

Comprehensive consultation was conducted through: stakeholder and HITH provider forums; patient satisfaction interviews; public calls for submissions; a literature review; and an advisory group process. There was also involvement from a variety of program areas within the department.

The final report of the review confirmed that HITH is a well-established model of care that is safe and effective. There is a core range of conditions for which HITH is the preferred modality. It is highly valued by patients, carers and staff. In particular, the study of Victorian HITH patients and carers conducted for the review demonstrated participants were overwhelmingly supportive of the program, identifying strengths such as less disruption to normal life, greater comfort, keeping families together, being away from the hospital environment and flexibility of service provision.

HITH has been shown both locally and abroad to be cost effective. The report suggested there are significant opportunities to develop the model of service provision further, particularly with respect to enhancing the range and penetration of services and enhancing access to services.

In Victoria HITH is under-utilised and is encouraged to grow. The review also highlighted the need for HITH guidelines, standards and improved data reporting.

The final report, literature review and consumer research report are available at <www.health.vic.gov.au/hith/review09>.

Service delivery

1. Service delivery

1.1 Eligibility

Program guideline

HITH is an acute health program that substitutes admitted care in the home setting. The admission criteria are governed by the department's *Victorian hospital admission policy*.

Context

In Victoria the HITH program is focused exclusively on acute admitted care substitution and does not provide other non-admitted or community-type care. The *Victorian hospital admission policy* (www.health.vic.gov.au/hdss/vaed) provides guidelines to health services to distinguish between admitted and non-admitted patients. Admitted patients in HITH are reported to the Victorian Admitted Episode Dataset (VAED) and attract funding through the admitted patient casemix funding system in the same way as other admitted patients.

Admitted care includes sameday, overnight and multiday ward admissions. The patient's own home (or other residential service not providing admitted care) is the 'virtual ward'. This setting may be the usual place of residence or temporary accommodation.

Minimum requirements

- HITH admissions meet the criteria of the *Victorian hospital admission policy*. Victorian Hospital Admission Policy (see <www.health.vic.gov.au/hdss/vaed/>).
- Develop policy and practice to promote effective patient selection for safe, high-quality acute care in the home setting.
- Develop policy and practice that enables direct admission from Emergency Departments or general practitioners that are safe and appropriate. This will assist in providing earliest definitive care for patients that require HITH.
- Meet the medical record, coding and reporting requirements of the Victorian health service policy and funding guidelines.
- Consent to be treated by the HITH service is documented in the medical record.
- When a patient is admitted to HITH either prior to their in-hospital stay or is transferred from in-hospital-based care, this is considered continuous care.

Interpretation

Patients are eligible for HITH admitted care if they meet any of the following 'criteria for admission' as per the *Victorian hospital admission policy*:

- type O – patient expected to require hospitalisation for a minimum of one night
- type N – qualified newborn
- type E – day-only extended medical treatment
- type B – day-only automatically admitted procedures
- type U – unqualified newborn
- type C – day-only not automatically admitted procedures but with specific reasons for admission documented by the clinician.

To distinguish between type B (day-only automatically admitted procedures) and type C (day-only not automatically admitted procedures) go to <www.health.vic.gov.au/hdss/vaed> and download the *Admission policy procedure code lists – effective 1 July 2011*. This classifies same-day diagnosis and procedure codes into either type B or type C. The health information service department of the health service may assist with accessing the correct code/s.

Interstate patients are eligible for HITH, just as they would be eligible for a hospital admission.

In addition to the *Victorian hospital admission policy*, HITH services develop effective selection criteria such as:

- clinical stability of the patient and appropriateness of HITH treatment
- provision of equivalent care
- safe and appropriate environment
- carer support
- consent to service
- location of care.

Telephone contacts and reviews

It is acknowledged that contacting a patient by telephone when a face-to-face visit is not clinically indicated, or to follow up after separation or a procedure, is good practice. However, in relation to HITH:

- Telephone follow-up after a day case or minor procedure is not eligible as admitted care.
- Telephone contacts must not be reported to the VAED as HITH days when a visit or intervention has not occurred.
- If following an inbound or outbound telephone call the patient has a face-to-face contact with HITH staff, then HITH activity is reportable for that day.
- Telephone contacts must be clearly recorded in the patient's medical records and be identified as a telephone contact and not as a home visit.

Wound care

Wound care that does not require admitted care is ineligible for HITH and should be referred to services such as Post Acute Care (PAC), Home and Community Care (HACC) and general practitioner (GP) primary care. Useful considerations when determining whether a wound requires admitted care include the level of medical governance necessary and the intensity of service provision required.

Negative pressure wound therapy (such as VAC dressings) that would otherwise require admission to a hospital is eligible for HITH.

Drain tube care

Wound/surgical drain tube care may be eligible for HITH if it substitutes admitted care. Care involving medical supervision and service intensity typical of admitted care is eligible for HITH and would involve: assessment, measurement and reporting of drainage; monitoring of suction patency; daily-twice daily visits; or flushing. Drain tube care for free drainage where the care involved is a simple dressing would not be admitted care and is ineligible for HITH.

Venous access device maintenance

Maintenance, flushing, dressing and disconnection of venous access devices such as a peripherally inserted central catheter, central venous catheter and Porta-Cath are not eligible for admission according to the *Not automatically qualified for admission list* (1 July 2010), which includes 'Maintenance alone vascular access device', 'Maintenance alone drug delivery device', 'Removal of venous catheter' and 'Removal of vascular access device'.

Trial of void

Trial of void is not generally considered HITH appropriate because it is not usually admitted care. However, specific exceptions may be acceptable. For example, if a rural hospital needed to admit a remote patient because of distance, this could be considered appropriate HITH, particularly if there is a supporting policy and the reason is well documented in the patient's history.

Alternatives to HITH

If the care type required does not meet the HITH criteria, consider the following:

- PAC services
- HACC
- Community Aged Care Packages (CACP), Extended Care at Home (EACH) Extended Care at Home Dementia (EACHD) and Linkages, Transition Care Program (TCP)
- residential in-reach
- postnatal domiciliary care
- specialist clinics (outpatients)
- GPs
- Hospital Admission Risk Program (HARP)
- Subacute Ambulatory Care Services (SACS)

1.2 Setting of care

Program guideline

HITH is delivered to patients in their home or at a temporary residential address that does not normally provide admitted care. Services delivered in other settings are only eligible to be HITH in specific circumstances.

Context

One of the common features that HITH-type programs share internationally is the provision of service in a place of residence. The department funds other models of care for ambulatory care delivered in a range of locations that aim to ensure treatment in the right place. Accordingly the standards, requirements and funding of these programs reflect the setting.

HITH services are intended to be delivered in the home. Definitions of the home have been tested through the history of the program for inclusion of settings such as the workplace, school, HITH clinic and residential care facility. The principle of person-focused care requires some flexibility in the definition of 'home' in special circumstances.

Minimum requirements

- HITH activity is delivered in the home/residential setting.
- Routine or ad hoc telephone follow-up of investigations or minor procedures may be part of HITH care but does not qualify the patient as HITH eligible in or of itself.
- HITH activity delivered outside of the home/residential setting is accompanied with a documented rationale in the patient's medical record.
- There is provision for medical review to occur in the home as necessary.

Interpretation

HITH 'clinics'

- If a patient is attending a health service for specialist medical review or other diagnostic investigation not appropriate for the home setting, for example an X-ray, then the HITH intervention may also be carried out at that time. This is both cost and time effective. HITH may be reported for this contact.
- It is acknowledged that, particularly in some rural settings, HITH interventions take place in a clinic setting for various reasons, including patient choice. Documentation in the medical record must explain why the contact was not provided in the patient's home.
- Patient choice and patient or staff safety are suitable rationales for delivering HITH services at a health service.
- Victorian Ambulatory Classification and Funding System (VACS) (specialist clinics funding) cannot be claimed for outpatient activity or other non-HITH activity while a patient is an admitted patient in a hospital or admitted under the care of HITH. This also applies for public patients receiving services in Medicare-funded outpatient clinics.

- GPs with patients on HITH cannot claim the Medicare rebate for reviewing public HITH patients. Their services should be invoiced to, and are funded by, the treating health service that receives the HITH episode funding for that patient except in cases such as Transport Accident Commission (TAC), Department of Veterans' Affairs (DVA) or private HITH arrangements.

HITH in the workplace or school

- It is important to reintegrate patients into their normal routines and lifestyle as soon as clinically possible. HITH may offer an advantage in this area to ward-based admissions.
- It is permissible for patients to attend employment/school while admitted to a HITH service, in unusual circumstances. The patient must be clinically stable and not be adversely affected by attending the workplace/school.
- Reduced hours or changes in roles, workload and responsibilities may be required.
- There will need to be a flexible approach from the patient, employer/school and HITH team to enable treatment to be administered safely and effectively in the workplace/school. For example, an appropriate area to undertake the care must be available. The environment should be risk-assessed for the patient and staff visiting, as would occur in the patient's home.
- It remains a local health service decision if HITH in the workplace/school can be safely delivered. The risks and benefits should be carefully considered.
- Patients treated in the workplace/school must participate as per the agreed plan of care. The decision to return to employment should not adversely affect treatment outcomes.
- An example of HITH in the workplace is pre-operative anticoagulation of a patient with high embolic risk.
- Confidentiality must be respected and maintained.

Telemedicine

- The Department of Health encourages the use of telemedicine initiatives. Telemedicine occurs when medical information is transferred through interactive audiovisual media for the purpose of clinical services, such as consulting, and sometimes remote medical procedures or examinations.
- A follow-up phone call does not constitute telemedicine for the purposes of these guidelines.
- Telemedicine consultations may constitute the equivalent of a home visit. Specific initiatives should be presented to the department for consideration of whether the consultation is equivalent to a home visit.

1.3 Range of service

Program guideline

HITH offers a range of services that substitute those available in the acute hospital setting to meet patient needs. The range of services offered is limited by practical and safety aspects and influences patient selection criteria.

Context

HITH literature identifies variation in the composition of staffing of HITH services. The staffing profile relates specifically to the services provided and the diagnostic cohorts that can be managed in HITH.

Other non-clinical services are sometimes required to facilitate acute care in the home setting. Examples of this include home help, personal care, interpreters and the temporary provision of equipment.

Health services use employed staff dedicated to HITH, employed staff shared with other health service programs and contracted providers to deliver the range of HITH services. Volume of service, workforce and service availability contribute to local decisions regarding staffing models.

The benefits of using an interdisciplinary approach to healthcare are recognised in the HITH model. This approach contributes to person-centred care.

Minimum requirements

- Patient selection is limited exclusively to those whose acute treatment and care needs will be safely met by the HITH service.
- Patients are not disadvantaged by transfer to HITH resulting in unmet needs due to limited range of service, or inadequate specialist medical oversight.
- Provision of nursing appropriate to the model of care.
- Provision of medical review.
- Provision of allied health services including physiotherapy, occupational therapy, social work, speech pathology and dietetics.
- 24-hour emergency telephone support and access to a face-to-face review.
- Provision of pharmaceuticals (see *Medication management guideline*), radiology, pathology, transport (including ambulance).
- Hotel services, accommodation and personal care are provided where an unmet need exists and is directly related to the acute admission.
- Use an interdisciplinary approach through collaborative goal setting and shared resources.

1.4 Assessment

Program guideline

Comprehensive assessment is conducted throughout the entry process and supports appropriate patient selection, treatment and planning. Assessment is reviewed throughout the admitted episode.

Context

Significant assessment may precede referral to HITH, particularly for patients who have had investigation and treatment at a hospital. However, direct admissions to HITH from the community or an emergency department may require significant assessment to occur during the HITH episode. Use of available documented assessment information has the potential to reduce duplication or omission. Assessing environmental factors are particularly important in the home setting.

The process of initial needs identification often precedes and informs assessment but does not replace it.

Information for assessment can be gathered from a variety of sources including physical and interview assessment of patient, carers, reports, GP, clinicians, referrers and other service providers.

Minimum requirements

- Systems for initial needs assessment inform the selection process for HITH.
- Assessment is conducted for all HITH patients and is inclusive of clinical, social and environmental elements.
- Assessment informs the selection process for HITH to ensure the safety and quality of the service.
- Policy, practices and tools are developed for assessment.
- Specialised assessment is available to patients consistent with other admitted care.

Resources

HITH programs have identified a number of elements that assist entry and assessment including:

- incorporating HITH intake into centralised intake, resulting in effective streaming of patients and simplified decision making for referrers
- using a risk screening tool to identify areas for more detailed assessment
- using standard hospital documents whenever possible to reduce duplication
- enhancing or developing tools specific to HITH that support good documentation for clinical management and coding purposes
- using discharge planning meetings, patient access meetings and ward case finding to support entry to and assessment for HITH services
- incorporating occupational health and safety assessment into entry processes
- incorporating a check for an advanced care plan and a substitute decision maker, such as a guardian or enduring power of attorney (medical)
- using electronic referral notification
- using system-based clinical assessment to lead to care plans
- developing HITH tools that are consistent with hospital tools

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- avoiding duplicating information collection (using information already collected in hospital such as falls risk and medication alerts)
- sharing documentation with other HITH services. Relevant avenues may be:
  - emailing an enquiry via the HITH Society (Australasia) (email <hithquery@gmail.com>)
  - emailing an enquiry via HITH managers
  - raising an issue for discussion at a HITH forum.

1.5 Pre-hospital or preadmission care

Program guideline

Pre-hospital or preadmission care is eligible for HITH only where the services delivered directly substitute admitted care. HITH admitted services delivered immediately prior to a hospital-based episode form a single continuous episode of care.

Context

It is common for elective patients to require investigations, medical preparation or preliminary treatment prior to the primary reason for admission to a hospital. Most of these services are provided in the community or on an outpatient basis through preadmission clinics, outpatient departments, GPs and diagnostic/pathology services. There are occasions when patients require admitted care in preparation for the primary reason for admission such as before elective surgery.

Generally HACC nursing does not cover services associated with acute needs and would not provide this service type.

Minimum requirements

- The reason for admitted care with HITH must be clearly recognisable in the medical record.
- HITH treatment prior to the primary reason for admission to a hospital must be reported as a continuous part of the episode and as such should be recorded as one type O episode.
- Home-based admitted days where no visit occurs should be recorded as leave days.
- Pre-hospital or preadmission care should be provided by non-admitted services wherever possible.

Interpretation

Where treatment prior to the primary reason for admission to a hospital requires admitted care, HITH can substitute this admitted care.

Anticoagulation

- Preoperative administration of low molecular weight heparin (such as Clexane), suspension of warfarin, INR (international normalised ratio) testing, monitoring and education may be admissible.
- In most cases of high clinical risk where warfarin cannot simply be suspended but requires maintenance of anticoagulants (such as Clexane), admission to a health service for anticoagulation would be justifiable. Concordantly admission to HITH is justifiable.
- If alternative arrangements for preoperative anticoagulation are available the admission to hospital or HITH should not be necessary.

1.6 Mothers and newborns

Program guideline

Mothers and newborns may be admitted to HITH if they meet the criteria for admission, but they must be considered individually for admission criteria.

Context

Earlier business rules deemed that only 'qualified' babies could be treated by HITH and that newborns could not be reported as 'on leave' for days when they were not visited. Both restrictions were removed in 2009 in recognition of the principle that mothers and newborns should be treated in the same place where possible.

The Postnatal Domiciliary Grant (formerly the Variable/Maternity Services Grant) provides for post-discharge visits that cover postnatal domiciliary care to public maternity patients, including basic postnatal health checks and appropriate lactation support.

Several pilot projects are underway trialling home birthing in Victoria. In 2010, home birthing was included as an eligible HITH admission and subsequently eligible for casemix funding and recording within the VAED.

Minimum requirements

- Mothers, unqualified newborns and qualified newborns must be individually considered for HITH.
- In a multiday stay, days that a patient is not visited by HITH staff must be reported as leave days.
- HITH and postnatal domiciliary care are not delivered to a single patient concurrently.
- Home birthing is admissible to HITH and is recorded on the VAED.

Interpretation

The most common cohort of newborns eligible for HITH are those who require admitted care in a hospital and still require treatment at home as a continuation of that care. As for any other patient, there needs to be documentation that the baby would otherwise require admitted care in a hospital.

Early discharge following delivery is not justification for reporting HITH for a newborn or mother.

The Postnatal Domiciliary Grant supports transition to home. The services provided within postnatal domiciliary care should be considered prior to initiating a HITH admission.

Resource

Postnatal domiciliary care
www.health.vic.gov.au/maternitycare/funding2

1.7 Patient journeys and pathways

Program guideline

HITH-amenable conditions are considered within the context of a patient-centred journey or pathway from entry to admitted care through to separation.

Context

Patient pathway in this context refers to any process that streamlines the patient journey.
It is not necessarily a clinical pathway with expected timelines, outcomes and variances.

HITH may provide part of an entire episode of care that links with other elements of care such as GP care or services in an emergency department, outpatients, a ward, diagnostics or a community setting. Initiatives such as Ambulatory Emergency Care and Patient Flow Collaboratives recognise the benefit of examining and refining pathways of care. Locally, development of pathways that include medical management and decision support for the setting of care have been described as useful by HITH services. Inclusion of HITH within relevant health service pathways provides potential to maximise the benefits of HITH and correspondingly consider pathways more broadly than HITH. Involvement of emergency departments in developing pathways supports earliest definitive care in HITH.

The high levels of patient acceptability, patient outcomes and evidence of economic advantage encourage health services to provide access to HITH services for appropriate patients.

Minimum requirements

- Health services consider developing pathways for diagnoses amenable to ambulatory care such as cellulitis, deep vein thrombosis, pulmonary embolus and urosepsis.

- Pathways should be inclusive and be developed according to best available evidence.

- Health services are encouraged to benchmark between services.

Resource

Ambulatory Emergency Care – NHS institute for Innovation and Improvement
https://www.institute.nhs.uk/index.php?option=com_content&task=view&id=1530&Itemid=4010

1.8 Interface with other programs

Program guideline

Service coordination and involvement of community, ambulatory and other health programs maximises access, reduces duplication and increases continuity of care for the patient. Services must operate within relevant criteria and models of care.

Context

Recent reviews of community-based care, of which HITH is an example albeit of higher acuity than other programs, identified a need to provide integrated and equitable access to care and to minimise duplication of services. As a consequence of these reviews, Health Independence Programs (HIP) guidelines, which cover the Post Acute Care (PAC) services, subacute ambulatory care services (SACS) and the Hospital Admission Risk Program (HARP), have been developed. In addition to HIP there is a range of Victorian and Commonwealth programs that provide services in the community including palliative care, HACC, CACP, EACH, EACHD, DVA Home Care and DVA Nursing, TCP, Residential In-Reach and postnatal domiciliary care.

Most of these programs provide services that are complementary to HITH, while others have models of care that may duplicate some aspects provided by HITH. Most of these programs have distinct eligibility and priority-of-access criteria. HITH services must work within the funding and program criteria that direct these programs.

Minimum requirements

- HITH services plan appropriate referral and engagement of other clinical programs and work collaboratively through transfer.
- PAC and HITH enrolment is not concurrent, though PAC assessment can commence during the admitted episode.
- Postnatal domiciliary care and HITH enrolment are not concurrent.
- TCP and HITH enrolment are not concurrent.
- SACS and HITH enrolment are not concurrent.
- HACC services operating concurrently with HITH will be coordinated and avoid duplication.
- HARP services operating concurrently with HITH will be coordinated and avoid duplication.
- Palliative care services operating concurrently with HITH will be coordinated and avoid duplication.
- Residential In-Reach operating concurrently with HITH will be coordinated and avoid duplication.
- HITH services consider integration of intake or access services in broader access services such as HIP defined point of entry.

Interpretation

Home and Community Care

When HITH and HACC services are both providing care to the same client, the HITH service should be the primary care coordinator. The HITH service will contact the HACC service provider to discuss the care plan.

Clients receiving HACC services prior to a HITH episode should continue to receive the HACC services at the same level (particularly for services like home help and meals) during the HITH episode.

The HITH service will provide all nursing care to the patient. This is especially on the days that HITH visit, regardless of whether HACC nursing has been provided prior to the HITH episode. However, on rare occasions HACC nursing may continue to be provided on HITH leave days if the process is coordinated and is in the best interests of the client.

The issue of personal care will need careful clinical assessment by the HITH program to ensure no additional risk is placed on existing HACC providers. If the patient is at the same level of acuity and function as usual then existing HACC personal care can continue. However, if the patient requires a greater level of assistance or competence of staffing during the HITH episode, then the HITH program should provide that care.

If the acute condition requiring HITH admission necessitates an increase in the HACC services then HITH is responsible for planning, funding and monitoring the additional services. Where possible, the HITH service is encouraged to use providers that promote continuity of care.

Where no HACC support services have been in place HITH will arrange and fund the services required during the admitted episode and refer to HACC as appropriate for continuing care at the end of the HITH episode.

This interpretation supersedes the Victorian HACC program manual (2003) and will be referred to in the new online HACC program manual currently under development.

Resources

Community Aged Care Packages (CACP)
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-cacp-guidelines.htm1

Domiciliary midwifery
www.health.vic.gov.au/maternitycare/funding2

Extended Aged Care at Home Dementia Packages (EACHD)
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-eachd.htm

Extended Aged Care at Home Packages (EACH)
www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-comcprov-eachdex.htm

HACC Active Service Model
www.health.vic.gov.au/hacc/projects

Health independence programs guidelines
www.health.vic.gov.au/subacute/hip-manual08.pdf

Victorian HACC program manual
www.health.vic.gov.au/hacc/prog_manual

Victorian Palliative Care Program
www.health.vic.gov.au/palliativecare

1.9 Inter-hospital/HITH transfer

Program guideline

Transfer of admitted patients from a hospital or HITH service to another HITH service should be driven by person-centred care principles. Appropriate governance should support the transfer arrangement.

Context

Person-centred care involves placing the patient at the centre of their own care.
Key principles include:

- *the sharing of responsibility*: planning care and making decisions about care, treatment or outcomes
- *coordination and integration*: this involves teamwork and service providers and systems working 'seamlessly' behind the scenes to maximise patient outcomes and provide them with a positive experience.

Transfer of an admitted patient from a hospital or HITH service to another HITH service involves separation from a hospital/HITH service and admission by another HITH service. It should be planned with the patient and HITH service receiving and admitting the HITH patient. The needs of the patient, capability of the receiving service, clinical governance and risk management are key elements of planning the transfer.

Transfer of HITH care should be distinguished from contracting services for HITH
(see Guideline 3.3 External service providers-contractors).

Minimum requirements

- Separation and subsequent transfer to another HITH service requires acceptance of the referral by an admitting doctor at the receiving HITH service.
- After separation and subsequent transfer, admission to a health service HITH service requires assessment of the patient by medical staff within 24 hours.
- Transfer options to HITH should be considered to maximise access to HITH for the patient.
- Service capability must be considered in determining the appropriate receiving service. In other words, it is incumbent on the health service that is referring out to ensure safe discharge and continuity of service until admission by the receiving HITH service.
- Transfer to small rural hospitals can occur with agreement of the receiving service but only within the receiving service capability and with adequate medical oversight.

1.10 Separation

Program guideline

The separation of a patient from HITH occurs when acute admitted care is no longer required. Appropriate planning and communication enable timely separation and continuity of care.

Context

Patient episodes can involve different accommodation types such as an emergency department, wards and HITH. Appropriate planning for these moves, as well as separation at the end of the episode, is necessary throughout the episode. Improvements in this planning, also known as discharge planning, can have the following outcomes:[1]

- increased patient and carer satisfaction with hospital/HITH care
- reduced length of hospital stay
- reduced length of hospital stay in subsequent admissions
- prevention of unplanned readmissions.

Minimum requirements

- Discharge planning commences on the patient's admission to the health service or HITH, is regularly reviewed and the plan documented.
- Appropriate referral to services is undertaken at the earliest possible opportunity.
- Review regarding the decision to discharge or separate a patient is not delayed.
- Appropriate information is provided to patients, carers, GPs and community services including a discharge summary.

Interpretation

It is acknowledged that certain procedures or interventions may need to be made at the end of an episode prior to separation such as removing a vascular access device. These interventions can be reported as HITH as these tasks are an essential part of the total HITH episode. This is distinguished from admission to HITH solely for the purpose of a non-admitted procedure such as disconnection of an infusion pump, which is ineligible for HITH.

1 *Improving patient transition from hospital to the community: A good practice guide for hospitals*, www.health.vic.gov.au/archive/archive2008/discharge/patrans/patrans_all.pdf

1.11 Medication management

Program guideline

HITH services implement systems to ensure safe and effective medication management
in the home setting.

Context

Evidence shows that significant patient harm and suboptimal use of medicines frequently result
from the discontinuity that occurs when patients move between different healthcare settings and
providers.[2] To assist patients in moving safely among healthcare providers and settings, safe and
effective use of medicines must be realised across the healthcare continuum.

Medication is used by patients in almost all HITH episodes whether as the primary treatment
or maintained as the treatment for comorbid conditions. The home setting presents an array of
variations from the hospital setting that have implications for medications associated with hospital
admission. Hospital practices, policies and procedures may require adaptation for the home setting.

Minimum requirements

- Medication policies, procedures and practices are adapted to promote effectiveness and safety
  in the home setting.
- Medicines are administered by staff with competencies and clinical privileges.
- Medicines are dispensed, transported and stored securely, safely and in accordance with the
  manufacturer's directions, legislation, jurisdictional orders and health service policies.
- Medication incidents and errors are reported into the relevant review mechanism.
- An accurate and complete list of a patient's medicines is documented and maintained throughout
  the episode of care.
- An accurate and complete list of the patient's medicines is provided to the receiving clinician and
  patient when handing over care or changing medicines.
- Health services provide the medication required by patients during a HITH episode, in line with the
  interpretation outlined below.
- Patient self-administered medication is coordinated with HITH staff administered medication.
- Antibiotics are selected responsibly to optimise antimicrobial therapy and improve patient
  outcomes while containing bacterial resistance.
- There are appropriate policies or practice guidelines in place to minimise the risk of (and to
  manage) anaphylaxis.

Interpretation

Where patients choose to administer medications they acquire through usual sources rather than
hospital-provided medications, there is no need for the HITH service to provide duplicate medication.
In fact there may be benefit in patients using familiar brands from usual sources. However, the HITH
service is obliged to provide all medications, as they would for admitted patients in a hospital, when
they are required by a patient.

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2 Australian Pharmaceutical Advisory Council 2005, *Guiding principles to achieve continuity in medication management*,
   Commonwealth of Australia, Canberra. www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guiding

Resources

Australian Commission on Safety and Quality in Health Care: Antimicrobial Stewardship
in Australian Hospitals 2011
www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/Antimicrobial-Stewardship

Australian Council for Safety and Quality in Health Care: *Second national report on patient safety:
Improving medication safety* (now Australian Commission for Safety and Quality in Health Care)
www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894F
F/$File/med_saf_rept.pdf

Drug and poisons controls in Victoria
www.health.vic.gov.au/dpu/reqhealth

Guiding principles to achieve continuity in medication management
www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guiding

1.12 24-hour access

Program guideline

Patients and carers have 24-hour access to appropriate healthcare professionals from the relevant HITH service.

Context

As HITH patients are admitted patients it is expected that there are identified protocols in place for business hours and out-of-hours service provision. Patients with acute health conditions have the potential to deteriorate. Prompt and informed assessment and appropriate action will mitigate risk. Access to current information about patient HITH admission details will support the assessment and planning process. Access to physical reassessment or readmission to bed-based care may be required.

Minimum requirements

- Policies, protocols and practices are in place for patients to access appropriate healthcare advice 24 hours per day from within the HITH service or hospital.
- Patients must be informed of protocols and practices on how to access services or assistance out of hours.
- Telephone advice and face-to-face clinical assessment should be available if required.
- Emergency plans that direct patients to access emergency services directly should be provided where appropriate.
- Where the local GP has admitting rights to the HITH service, they may be the nominated contact if able to provide 24-hour access.

1.13 Privately insured patients in public health services and HITH

Program guideline

Privately insured patients in public health services are eligible for HITH and are entitled to equity of access to HITH.

Context

Prior to 30 June 2008, the Australian Government set a private health insurance default benefit rate for Commonwealth-accredited HITH services. The *Private Health Insurance Act 2007* removed regulation of the default benefit, requiring jurisdictions to negotiate individual HITH service rates with individual private health insurance funds. Now, health services need to have individual agreements with private health insurers to establish rates and terms of services provided. The department is working with a range of private health insurers to minimise the burden of entering into such agreements, with a view to improving access.

Minimum requirements

- HITH services develop agreements with private health insurers to facilitate access to HITH.
- The patient should be reported to VAED as a private HITH patient.
- The patient must provide their consent for transfer to home for their private episode in HITH and this consent must be documented in their medical record.
- Patients cannot be changed from a private account class to a public account class to report HITH. This constitutes a change of patient election and is only permitted in certain exceptional circumstances.

Interpretation

Where public HITH services admit private patients, the private rate of WIES will be attracted (approximately 82 per cent of public WIES rates) and any third-party reimbursement entitlement (such as diagnostics, medical or pharmaceuticals).

Resource

Information on private admission election status
www.health.vic.gov.au/feesman/fees2

Program management

2. Program management

2.1 Records and VAED reporting

Program guideline

HITH records and data are reported to the same coding standards and VAED (Victorian Admitted Episode Data) requirements as those for all admitted care.

Context

The department collects data on all admitted patients from Victorian health services. This data forms the VAED. Among other things, VAED data is used for health service planning, policy formulation, casemix funding and epidemiological research.

Minimum requirements

- All HITH treatment is documented in the patient's medical record.
- The reason for admitted care must be plainly identifiable in the medical record.
- If the care the patient is receiving would not normally be admitted care but this patient would otherwise be in a hospital to receive it, the rationale for admission must be documented in the medical record.
- Where there is a departure from HITH-specific criteria, for example care is not delivered in the home, the rationale for the departure from criteria must be documented in the medical record.
- The patient's consent to be treated under HITH must also be evident in the patient's medical record.
- Health services meet the VAED reporting requirements in relation to HITH.
- Services provided by HITH are recorded as accomodation type 4 on the VAED.
- DRG reporting should be consistent with the practices for admitted patients.
- The requirement for the issue of Acute Care Certificates is applicable in HITH. In Victoria, an admitted patient will automatically become a nursing-home-type patient after 35 days of continuous hospitalisation unless a medical practitioner has certified that acute care needs to continue for a specified period.

Interpretation

- When a patient is in HITH either prior to or after their hospital stay, it is considered a continuous episode. The criteria for admission that applies to the hospital component of their stay is also valid for the HITH component. There is no requirement to code the HITH episode separately.
- There must be sufficient documentation in the patient's medical record to support the admission or transfer of the patient to a HITH service as a substitute for admitted acute care, as outlined in Guideline 1.1 Eligibility, and any interventions undertaken with patients admitted to HITH must be documented, including the type of contact/intervention.
- The patient must have face-to-face contact with HITH staff to qualify for a reported HITH day, therefore services such as telephone calls cannot be reported to the VAED. A leave day should be reported if the patient is not home when HITH staff visit.

Leave days

- In a multiday stay, days that a patient is not visited by HITH staff must be reported as leave days. Where more than seven days occur between visits, the patient must be separated and readmitted.
- A patient admitted to HITH can be put on leave to attend a procedure elsewhere, for example, hyperbaric treatment or other day procedure at another health service. However, if the patient is seen by HITH on the same day that they receive the admitted care elsewhere, the leave day can't be recorded in data systems currently.

Resource

Acute Care Certificates
www.health.vic.gov.au/aims/private-hosps2010/p1_instruct.pdf

2.2 Leadership

Program guideline

Effective leadership of HITH services is implemented within each health service providing HITH services.

Context

Standards for leadership are clearly set out in EQuIP5 to support safety, quality and performance in healthcare. These leadership standards are equally applicable to all areas of the health service, including HITH.

A 2009 review of HITH programs identified that health services may benefit from reviewing their HITH governance and management arrangements to ensure effective delivery and development of HITH services. It specifically noted the need for appropriate medical leadership to be in place as determined by each health service.

The value of leadership in different disciplines is acknowledged and the emergence of advanced professional roles, such as nurse practitioner, provide another platform for leadership in HITH.

Minimum requirements

- Effective structures and processes for managing the service are in place.
- Health services have HITH-focused medical role(s) that provide leadership, advocacy among medical peers, coordination and development of medical aspects of HITH services.
- Roles and responsibilities are understood and there are clear channels of communication and accountability.
- Performance of the HITH service is monitored and acted upon.
- Roles and accountabilities are in place to advocate for HITH to the highest level.
- HITH contributes to the strategic planning of the health service.
- Staff attend relevant forums and meetings held by the department.

Resource

EQuIP5 – The Australian Council on Healthcare Standards.
www.achs.org.au

2.3 Professional development

Program guideline

HITH services have structured, planned and comprehensive learning and development systems. Staff participation in professional development should be encouraged.

Context

Professional development assists staff to achieve the skills, knowledge, behaviour and performance to provide excellence in service delivery. Demonstration of maintenance of competence (continuing professional development) is now mandated for registration as a health professional. Professional development is also an essential component of quality improvement.

Minimum requirements

- Staff have access to and are involved in a professional development program that is adapted to the home setting and includes:
  - a documented learning and development plan
  - internal and external education opportunities
  - compulsory training sessions (for example, cardiopulmonary resuscitation, anaphylaxis management when administering intravenous antibiotcs and occupational health and safety, including managing risks associated with home visits).
- Individual staff members take responsibility for maintaining their skills.

Employers are responsible for ensuring health professionals meet the required professional standards. The *Victorian Charter of Human Rights and Responsibilities* and *With respect to age: 2009 Victorian guidelines for health services and community agencies* to prevent elder abuse are recommended.

Resources

Australian Health Practitioner Regulation Agency
www.ahpra.gov.au

Continuing professional development registration standard (Nursing and Midwifery Board of Australia)
www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx

OHS guidelines for the provision of services into the home for the community care sector
www.health.vic.gov.au/hacc/downloads/pdf/vic_homecare.pdf

The HITH Society of Australasia provides education and promotes networking
www.hithsociety.org.au

Victorian Charter of Human Rights and Responsibilities
www.humanrightscommission.vic.gov.au

With respect to age: 2009 Victorian guidelines for health services and community agencies
to prevent elder abuse
www.health.vic.gov.au/agedcare/policy/elder_abuse.htm

2.4 Staff competence

Program guideline

All staff providing HITH services have suitable competence and credentials to deliver high-quality, safe services in the home setting.

Context

The delivery of acute services in the home setting requires a team with a mix of skills and competencies. The setting itself may require adaptation of usual practices, procedures and policies from those used in the hospital setting. Therefore the range of competencies and skills required by a staff member within HITH may vary from a similar role in the hospital setting and may be different from those required in the hospital setting.

The setting of care does not diminish the standard of care to be delivered.

Professional standards, competencies, codes of ethics, codes of professional conduct and other professional guidelines are now specified by the Australian Health Practitioner Regulation Agency and other relevant professional boards.

Minimum requirements

- A range of staff with skills and competencies to meet the clinical needs of acute patients is provided through each HITH service.
- Position descriptions are developed to define staff responsibilities, accountabilities and activities.
- Staff have relevant qualifications, experience, knowledge and skills.
- Clinical staff are registered with the relevant professional body, for example, Australian Health Practitioner Regulation Agency (AHPRA).
- Relevant police checks and Working with Children Checks are completed.
- Staff participate in a comprehensive orientation program.
- Professional development and staff appraisal systems are used to maintain staff competence.
- Adherence to the health service policy for credentialing and scope of clinical practice.
- All outreach staff should have a current cardiopulmonary resuscitation (one rescuer) competency.
- All staff administering intravenous medication should have a current anaphylaxis competency.

Interpretation

Enrolled nurse (Division 2)

Enrolled nurses (Division 2) have had a number of changes since 1 July 2010 and the commencement of national registration.

The Nurses and Midwifery Board of Australia (NMBA) have transitioned enrolled nurses that previously had medication endorsement to the national register without a notation on their registration; in other words, medicines capability is now part of baseline practice for registration for both divisions of the nursing register. It is envisaged that this would encompass most enrolled nurses working in HITH services. Enrolled nurses who have not completed board-approved training in medicines administration will transition with a notation to that effect on their registration. It is the responsibility of the organisation to consider the appropriateness of the workforce within a given service.

Enrolled nurses working in HITH have their delegation and supervision requirements based on the NMBA *National framework for the development of decision-making tools for nursing and midwifery practice*. These guidelines do not distinguish between enrolled nurses (Division 2) or registered nurses (Division 1) and require that all nurses must work within their scope of practice according to their education, authorisation and their competence to perform. The extent of supervision a practitioner needs should be assessed using this framework.

Police checks

All organisations that are funded by the Department of Health are required to undertake a pre-employment/pre-placement police check when providing services to any aged or infirmed person in the home. Further details are available at the website and within the legislation (see resources below).

Working with children check

Working with Children Checks are required for people working in child-related occupational fields (such as a paediatric ward) or if they are have regular and direct contact with children that is not directly supervised. Further details are available at the website and within the legislation (see resources below).

Mandatory training and competence

Mandatory training/competence provided to all employees to ensure safe staffing and risk management (including safe handling, occupational violence and infection control) may need to be modified to ensure it reflects the context of practice for HITH workers. Education in relation to elder abuse and human rights should be considered.

Paediatrics, midwifery and neonatal

The benefit of specific qualifications/competencies in fields such as paediatrics, midwifery and neonatology is acknowledged. However, it is the responsibility of the health service to define the skills required to meet the needs of its patients. It is recommended that HITH services develop professional links with specialist areas of expertise to support delivery of quality care.

Resources

Australian guidelines for the prevention and control of Infection in healthcare
www.nhmrc.gov.au/guidelines/publications/cd33

Australian Health Practitioner Regulation Agency
www.ahpra.gov.au

Credentialing and scope of clinical practice guidelines
www.health.vic.gov.au/clinicalengagement

Department of Health: *Service agreement information kit,* 5.6 Police records check policy
www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/5.departmental-policies-and-procedures/5.6-police-records-check-policy

Nursing and Midwifery Board of Australia codes and guidelines
www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

Victorian Charter of Human Rights and Responsibilities
www.humanrightscommission.vic.gov.au

Victorian Police – police records check
www.police.vic.gov.au/content.asp?Document_ID=274

With respect to age: 2009 Victorian guidelines for health services and community agencies to prevent elder abuse
www.health.vic.gov.au/agedcare/policy/elder_abuse.htm

Working with Children Check information, publications, helpline and legislation
www.justice.vic.gov.au/workingwithchildren

2.5 Quality improvement

Program guideline

Annual quality improvement plans are developed in line with the health service's quality improvement process.

Context

Quality improvement optimises patient care by providing evidence of outcomes and identification of areas for enhancement. It is essential to delivering a safe and high-quality service, and promotes program development and best practice.

An effective quality program requires a planned approach and the *Victorian clinical governance policy framework* (2009) outlines a strategic overview of the key principles and practices necessary for effectively monitoring, managing and improving health services.

Clinical governance and risk management are two elements of quality improvement that are highlighted in the home setting. Clinical governance is where managers and clinicians share responsibility and are held accountable for patient care, minimising risks, and for continuously monitoring and improving the quality of care. Risk management is essential for good governance and the provision of safe care. It complements business planning, performance reporting, quality improvement and internal and external auditing to support good stewardship and control.

Minimum requirements

- A quality improvement plan is developed and implemented in line with the health service's overall quality plan.
- Staff are informed of the continuous quality improvement system and participate in the ongoing monitoring and analysis in everyday practice.
- Analysis of the outcomes of patient care is consistent over time to allow evaluation of specific indicators and improvement.
- Health services promote a quality improvement culture that involves recognising leaders in quality improvement.
- Systems for incident, adverse event and complaint management are in place.
- Policies and procedures for risk management ensure risk identification and analysis and management is ongoing.
- Conduct ongoing evaluation of the services including patient, staff and stakeholder satisfaction/experience surveys.
- Evaluate the effectiveness of continuous improvement activities regularly.
- Use clinical indicators to monitor and improve services.
- Benchmark against other services.

Resources

Australian Council on Healthcare Standards clinical indicators for Hospital in the Home
www.achs.org.au/ClinicalIndicators/

Victorian clinical governance policy framework – Enhancing clinical care
www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy

2.6 Patient and staff safety

Program guideline

Consider the safety of patients and staff when determining the intervention and setting for service delivery.

Context

The domestic or residential environment is unregulated, informal and can be an unpredictable setting in which to provide healthcare. It lacks the infrastructure and regulation of a hospital setting. Each health service has a duty of care to protect the safety of patients, staff and others. It is the responsibility of health services to:

- provide safe care to all patients and a safe environment for staff, carers and patients
- ensure that efforts are made to reduce the possibility of harm to patients, carers and staff within the service
- identify the risk of harm to patients and develop strategies and safeguards to prevent risk
- determine and address the key components of safety for the services based on the patient mix and known and potential risks.

The *Occupational Health and Safety Act 2004* governs safety in the workplace. The WorkSafe publication *Working safely in visiting health services* is specifically targeted at programs such as HITH and provides a resource to prevent hazards.

Minimum requirements

- Policy, protocols and practice are in place to promote patient and staff safety.
- Risks associated with occupational violence and musculoskeletal disorders are managed – see publications: *Working safely in visiting health services and Preventing occupational violence in Victorian health services: A policy framework and resource kit* (Department of Health).
- Identify risks and manage them in order to minimise adverse events and optimise the safety of patients and staff.
- When conducting an assessment or developing a care plan, assess and document the foreseeable risk to the patient of participating in certain activities.
- At-risk behaviours are clearly communicated with the patient and documented.
- Consider the safety of patients and staff when deciding whether a home-based service is appropriate.
- Patients must have a suitable home environment with safe access and carer support available when required.
- Patients who are assessed as being at risk of harm are referred to the appropriate service for management.
- Bushfire, extreme weather and heat-related illness are considered risks in relation to HITH.

Resources

Bushfire and heat related illness website
www.dhs.vic.gov.au/emergency

Department of Health – *Preventing occupational violence in Victorian health services:
A policy framework and resource kit*
www.health.vic.gov.au/nursing/promoting/noviolence/strategy-1

Victorian Charter of Human Rights and Responsibilities
www.humanrightscommission.vic.gov.au

With respect to age: 2009 Victorian guidelines for health services and community
agencies to prevent elder abuse
www.health.vic.gov.au/agedcare/policy/elder_abuse.htm

WorkSafe: *Working safely in visiting health services*
www.worksafe.vic.gov.au

Corporate services

3. Corporate services

3.1 Clinical governance

Program guideline

Health service boards, management and staff are responsible for ensuring appropriate clinical governance for HITH services.

Context

Clinical governance is defined as the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers/patients/residents.[3]

Clinical governance occurs within the broader governance role of boards and involves financial and corporate functions, setting strategic direction, managing risk, improving performance and ensuring compliance with statutory requirements.[4]

The need for strengthened clinical governance and broader health service governance in relation to HITH is identified in the evaluation of HITH programs in 2009. It notes there are opportunities to further develop HITH and health services need to consider whether their current health service structures are supporting or hindering such development. Regardless of local arrangements, HITH will only develop to its full potential if the characteristics of good clinical governance are in place, including:

- strong clinical leadership and advocacy
- effective delegation and clarity of responsibility
- best practice systems for delivering high-quality care
- effective systems for monitoring, analysing and reporting information
- a strong clinical risk management program
- an effective service-based culture.

Minimum requirements

- HITH services are incorporated into health service implementation of the *Victorian clinical governance policy framework*.
- HITH internal governance and management arrangements ensure strong leadership, clarity of delegated responsibility and effective monitoring and risk management arrangements.
- Each health service identifies a key contact for their HITH service, usually the HITH manager.
- Each HITH patient has an identified admitting doctor and delegation of medical management is clear.
- Health service executives and boards oversee and evaluate HITH service quality and performance.

Resources

Australian Centre for Healthcare Governance provides a range of templates, resources and networks
www.healthcaregovernance.org.au

HITH Review 2009
www.health.vic.gov.au/hith/review09

Victorian clinical governance policy framework – Enhancing clinical care
www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy

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3 Sir Liam Donaldson, NHS Chief Medical Officer Australian Council on *Healthcare Standards 2004*, ACHS News Vol 12, 1-2 Sydney, Clinical governance policy and procedures
4 Department of Health 2008, *Victorian clinical governance framework*, State Government of Victoria, Melbourne

3.2 Infection control

Program guideline

Infection control policies, procedures and practices are adapted and developed to minimise infection risk in the home environment.

Context

The effective prevention, monitoring and control of infections are integral to the quality, safety and clinical risk management operations of any health service. While not all healthcare-acquired infections can be prevented, health services can ensure that systems are in place to minimise their occurrence.

The home or community environment presents a different range of risks to the hospital setting. While the risk of nosocomial infection is reduced in the home setting, the obligation to minimise infection risk is not diminished.

Minimum requirements

- Meet the requirements of the *Australian guidelines for the prevention and control of infection in healthcare*. Use standard (universal) precautions, including hand washing and personal protective equipment.
- Take additional precautions in relation to specific infections identified in the infection control guidelines.

Resource

Australian guidelines for the prevention and control of infection in healthcare
www.nhmrc.gov.au/australian-guidelines-prevention-and-control-infection-healthcare

3.3 External service providers – contractors

Program guideline

External service providers (contractors) are managed to maximise safety, continuity and quality of care.

Context

HITH services engage contractors to provide services to patients for a variety of reasons including different service type, additional same service type, in times of peak demand, overcoming geographical barriers and preferred model of care. HITH services remain accountable for ensuring safety and quality of care for services provided by contractors. The transfer of responsibilities to a third party can create risks that require appropriate management.

Engaging contractors is distinguished from the process of separation and transfer of a patient to another HITH service.

Minimum requirements

- Contracted services are engaged within the terms of appropriate service agreements that ensure safety and quality and address:
  - appropriately credentialed staff
  - service responsiveness and standards
  - occupational health and safety standards
  - mechanisms for review and evaluation of performance
  - risk management processes for patients and service providers
  - dispute resolution mechanisms
  - clear lines of medical governance.
- Appropriate policies and processes are developed for referral, development of a management plan, transfer of information, management of clinical deterioration, provision of supplies and designation of key contact people.

Additional information

Abbreviations

CACP	Community Aged Care Packages
DRG	diagnostic related group
DVA	Department of Veterans' Affairs
EACH	Extended Care at Home
EACHD	Extended Care at Home Dementia
GP	general practitioner
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
HIP	Health Independence Program
PAC	Post Acute Care
SACS	Subacute Ambulatory Care Services
TAC	Transport Accident Commission
TCP	Transition Care Program
VAED	Victorian Admitted Episode Dataset
WIES	weighted inlier equivalent separation

Glossary

Acute care

Care that is appropriately classified by a diagnosis-related classification, as the need for treatment is driven primarily by the patient's medical diagnosis. It is limited to care type 4 'Other care (Acute) including Qualified newborn' and U 'Unqualified newborn'.

Admitted patient

A patient who undergoes a hospital's admission process to receive treatment or care. This treatment or care is provided over a period of time and can occur in a traditional hospital setting or in the person's home (under specified programs such as HITH). An admitted patient must meet the criteria set out in the *Victorian hospital admission policy*.

The patient may be admitted if one or more of the following apply:

- the patient's condition requires clinical management or facilities not available in their usual residential environment
- the patient requires procedures that cannot be performed in a stand-alone facility, such as a doctor's room, without specialised support facilities or expertise available (for example, cardiac catheterisation)
- the patient requires observation in order to be assessed or diagnosed
- a legal requirement for admission exists (for example, under child protection legislation).

The items in the above list, in isolation, may not be sufficient to meet the criteria for admission.

Assessment

A decision-making methodology in which relevant patient-related information is collected, weighed and interpreted. Assessment is an investigative process using professional and interpersonal skills to uncover relevant issues/needs and appropriate actions.

Boundary points, inliers and outliers

Each DRG (diagnostic related group) is assigned two boundary points: a low boundary point and a high boundary point. These boundary points represent the average length of stay. An inpatient stay with a length of stay that falls between or on the two boundary points of the allocation DRG is referred to an inlier. An inpatient separation with a length of stay that falls below the low boundary point is referred to as an low outlier and an inpatient separation with a length of stay that is above the high boundary point is referred to as a high outlier.

Carer

A person who provides unpaid care and support to family members or friends who have a chronic or acute condition, mental illness, disability or who are frail aged.

Casemix

Casemix is defined as an information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. The term may be taken to refer to both (i) the number and types of patients treated, and (ii) the mix of bundles of treatments, procedures and so on provided to patients. In general, the use of resources in treating patients is the key to understanding casemix as a measure of hospital output and activities.

Community service providers

Agencies located in the community whose core business is to provide services to patients living in the community (including but not limited to local government agencies, the Royal District Nursing Service, community health services, general practitioners, HIP services and non-government agencies).

Credentialing

Credentialing is the formal process of verifying the qualifications, experience, professional standing and other relevant professional attributes of health professionals for the purpose of forming a view about their competence and suitability to provide safe, high-quality healthcare services within specific organisational environments.

Discharge

Discharge refers to the transition and exit of a patient from a program or service after a review. Also known as separation.

Episode

The period during which a patient receives services within a defined stream of a program for which activity is being reported. The period between admission and separation.

Evidence-based practice

A process through which professionals use the best available evidence, integrated with professional expertise, to make decisions regarding the care of an individual. It requires practitioners to seek the best available evidence from a variety of sources, critically appraise the evidence, decide what outcome is to be achieved, apply that evidence in professional practice and evaluate the outcome. Consultation with the patient is implicit in the process.

General practitioner

A general practitioner (GP) is a registered medical practitioner who is qualified and competent for general practice in Australia. A GP has the skills and experience to provide holistic, comprehensive, coordinated and continuing medical care and maintains professional competence for general practice.

Governance

There are two main aspects of governance in healthcare:

Corporate governance:

The process by which the organisation is directed, controlled and held to account. It encompasses authority, accountability, stewardship, leadership, direction and control exercises in the organisation.

Clinical governance:

A systematic approach to maintaining and improving the quality of patient care. It encompasses education and training, clinical quality and safety, clinical effectiveness, research and development, openness, risk management, credentialing and scope of practice. Successfully implementing clinical governance requires developing strong and effective partnerships with clinicians and managers for providing safe and effective healthcare. A key component of clinical governance is recognition by managers and clinicians that they share the responsibility for the quality of care delivered by the service.

Health independence programs

Comprises Post-Acute Care Services (PAC), Subacute Ambulatory Care Services (SACS) and Hospital Admission Risk Program (HARP) services.

Health service

For the purpose of this document this term is inclusive of a public health service, public hospital, or denominational hospital and the premises thereof as specified in the Health Services Act 1988.

Hospital Admission Risk Program (HARP)

A Victorian Government initiative established to address sustained increases in demand on the hospital system.

Home

For the purpose of this document the term home is an accommodation type inclusive of a private residence, independent living units, residential aged care, supported accommodation, temporary accommodation and public housing.

Hospital

A physically distinct site owned or occupied by a public health service where treatment and/or care is regularly provided to patients. For the purposes of this document it is exclusive of a patient's home.

Inlier high boundary –
see *Boundary points, inliers and outliers*

Interdisciplinary approach

This approach is characterised by the participation and involvement of two or more health disciplines.

The different disciplines within a team pool their expertise to make team-based treatment decisions based on the identified patient needs. An interdisciplinary approach adopts a patient-centred approach in that the focus shifts from a discipline-specific approach to treatment and towards the different disciplines within a team.

Outlier per diem – see *Boundary points, inliers and outliers*

Paediatric skilled practitioner

A practitioner who has particular skills in paediatrics through training or experience.

Person-centred care

Delivering healthcare configured around the needs of the person.

Post Acute Care (PAC)

Post-acute care services aim to assist patients discharged from a public hospital, including emergency departments, acute services and subacute services, who have been assessed as requiring short-term, community-based supports to assist them to recuperate in the community and to ensure a safe and timely discharge.

Principal diagnosis

The diagnosis established after study (assessment) to be chiefly responsible for occasioning the service event or episode.

Quality use of medicines

Selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safety and effectively.

Separation

The process whereby a same-day patient or an overnight or multiday-stay patient completes an episode of care.

Subacute Ambulatory Care Services (SACS)

Government program that provides person-centred, interdisciplinary care support via flexible service delivery in a range of settings. It aims to improve and maintain a person's functional capacity and maximise independence.

The department (or department)

Department of Health, Victoria

Transfer

Separation from a hospital campus/HITH service and admission to another.

Transition Care Program

Program that provides short-term support and active management for older patients at the interface of the acute/subacute and residential aged care sectors. It is goal-oriented, time-limited and targets older patients at the conclusion of a hospital episode who require more time and support in a non-hospital environment to complete their restorative process, optimise their functional capacity and finalise and access their longer term care arrangements.

VAED

Victorian Admitted Episode Dataset

Resources

This section contains all resources referred to in the guidelines. This section also offers a list of resources and references provided by the sector that may be of assistance to Health Independence Program staff.

Aboriginal and Torres Strait Islanders

Improving care for Aboriginal and Torres Strait Islander patients
www.health.vic.gov.au/koori/icap

The cultural respect framework for Aboriginal health
www.health.vic.gov.au/koori/cultural-respect-framework.pdf

Acts and charters

Health Records Act 2001
www.health.vic.gov.au/healthrecords

Health Services Act 1988
www.austlii.edu.au/au/legis/vic/consol_act/hsa1988161

Mental Health Act 1986
www.austlii.edu.au/au/legis/vic/consol_act/mha1986128

Public hospital patient charter
www.health.vic.gov.au/patientcharter

Working with Children Check
www.justice.vic.gov.au/workingwithchildren

Advance care planning and palliative care

Clinical practice guidelines for communicating prognosis and end-of-life issues
www.mja.com.au/public/issues/186_12_180607/cla11246_fm.html

Office of the Public Advocate
www.publicadvocate.vic.gov.au

Respecting patient choices
www.respectingpatientchoices.org.au

Victoria's Palliative Care Program website
www.health.vic.gov.au/palliativecare/contacts

Ambulatory emergency care

NHS Institute for Innovation and Improvement
www.institute.nhs.uk/index.php?option=com_content&task=view&id=1530&Itemid=4010

Assessment

Centre for Applied Gerontology Bundoora Extended Care Centre, Northern Health; commissioned by Australian Health Ministers' Advisory Council (AHMAC) by the AHMAC Care of Older Australian Working Group 2004, *A guide for assessing older patient in hospitals*. Australian Health Ministers' Advisory Council's Care of Older Australian Working Group, Melbourne. Metropolitan Health and Aged Care Services Division. www.health.vic.gov.au/acute-agedcare

Australian health care agreement

www.health.vic.gov.au/agreement

Australian Health Practitioner Regulation Agency

www.ahpra.gov.au

Cultural and linguistically diverse

Department of Human Services –
Cultural diversity guide
www.dhs.vic.gov.au/multicultural

Department of Human Services –
Language services policy
www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/language-services-policy

Carers Victoria

www.carersvic.org.au or 1800 242 636

Care in your community

www.health.vic.gov.au/archive/archive2010/ambulatorycare/careinyourcommunity

Compliment, incident and complaint management

Officer of the Health Services Commissioner –
Guide to complaint handling in health
care services
www.health.vic.gov.au/hsc/downloads/
complaints_handling.pdf

Casemix funding

www.health.vic.gov.au/casemix

Credentialing and scope of clinical practice guidelines

www.health.vic.gov.au/clinicalengagement

Consent

Consent information brochure
in different languages

www.health.vic.gov.au/pcps/publications/
languages_privacy

Clinical indicators

Australian Council on Healthcare Standards
clinical indicators for Hospital in the Home
www.achs.org.au/ClinicalIndicators/

Consumer involvement

Consumer participation
www.healthissuescentre.org.au/participate/
vicpart.shtml

*Doing it with us not for us participation
policy* (2006–09)
www.health.vic.gov.au/consumer

Continuing professional development registration standard

(Nursing and Midwifery Board of Australia)
www.nursingmidwiferyboard.gov.au/
Registration-Standards.aspx

Cultural diversity

Centre for Cultural Diversity in Ageing
www.culturaldiversity.com.au

Victorian Transcultural Psychiatry Unit

www.vtpu.org.au

Strategic Directions 2010

Achieving the best health and wellbeing
or all Victorians

Department of Health policies and resources

Ambulatory care policy and planning framework
*www.health.vic.gov.au/archive/archive2010/
ambulatorycare/downloads/acf_consult_paper.pdf*

*Care in your community: A planning framework
for integrated ambulatory health care* (2006)
www.health.vic.gov.au/archive/archive2010/
ambulatorycare/downloads/ciyc_update.pdf

Continuous improvement framework
www.health.vic.gov.au/pcps/publications

Disability Services
http://www.dhs.vic.gov.au/for-individuals/
disability

Good practice guide for practitioners
http://www.health.vic.gov.au/pcps/publications/
goodpractice.htm

Health Independence Program guidelines
www.health.vic.gov.au/subacute/hip-manual08.pdf

Health*SMART*
http://www.health.vic.gov.au/healthsmart/

Improving care for older people
www.health.vic.gov.au/older

*Improving care: Hospital Admission Risk
Program public report* (2006)
www.health.vic.gov.au/harp

*Improving patient transition from hospital
to the community: A good practice guide
for hospitals* (2003)
http://www.health.vic.gov.au/archive/
archive2008/discharge/patrans.htm

Occupational Health and Safety Act 2004 (Vic)
www.austlii.edu.au/au/legis/vic/consol_act/ohasa2004273/

Rural directions for a better state of health (2005)
www.health.vic.gov.au/ruralhealth

*Victorian clinical governance policy framework –
Enhancing clinical care*
http://docs.health.vic.gov.au/docs/doc/Victorian-clinical-governance-policy-framework

Victorian HACC program manual
www.health.vic.gov.au/hacc/prog_manual

Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan
http://www.health.vic.gov.au/healthplan2022/

*Victorian health service policy
and funding guidelines*
www.health.vic.gov.au/pfg

Victorian hospital admission policy
www.health.vic.gov.au/hdss/vaed

*Victorian services coordination
practice manual* (2009)
www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm

Early intervention in chronic disease (EIiCD)

EIiCD guidelines
http://www.health.vic.gov.au/pch/icdm/index.htm#doc1

**Evaluation and quality improvement
program (EQuIP)**

EQuIP of the Australian Council
on Healthcare Standards
www.achs.org.au

General practitioners

*Working with general practice – Department
of Human Services position statement*
http://www.health.vic.gov.au/pch/gpp/index.htm

Governance

Australian Centre for Healthcare Governance
provides a range of templates, resources
and networks
www.healthcaregovernance.org.au

HITH Victorian website

www.health.vic.gov.au/hith

HITH review

http://www.health.vic.gov.au/hith/review09.htm

HITH Society of Australasia

www.hithsociety.org.au

Home and Community Care program manual

www.health.vic.gov.au/hacc/prog_manual

Hospital Admission Risk Program (HARP)

http://www.health.vic.gov.au/harp/

Human services directory

humanservicesdirectory.vic.gov.au

Infection control

Infection prevention in health services
www.health.vic.gov.au/infectionprevention/index.htm

Department of Health – Infectious diseases
epidemiology and surveillance website
http://ideas.health.vic.gov.au/

*Australian guidelines for the prevention and
control of infection in healthcare*
www.nhmrc.gov.au/guidelines/publications/cd33

Maternity Services Grant

www.health.vic.gov.au/maternitycare/funding2

Medication management

Australian Commission on Safety and Quality
in Health Care: Antimicrobial stewardship in
Australian Hospitals 2011
http://www.health.gov.au/internet/safety/publishing.nsf/Content/com-pubs_AMS-44471

Australian Council for Safety and Quality in Health Care: *Second national report on patient safety improving medication safety* (Now Australian Commission for Safety and Quality in Health Care)
www.health.gov.au/internet/safety/publishing.nsf/Content/F0FD7442D1F2F8DDCA2571C6000894FF/$File/med_saf_rept.pdf

Drug and poisons controls in Victoria
www.health.vic.gov.au/dpu/reqhealth

Guiding principles to achieve continuity in medication management
http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-guiding

National Health and Medical Research Council (NHMRC) resources

National statement on ethical conduct in human research (2007)
www.unisa.edu.au/res/ethics/nationalstatement.asp

NHMRC & AVCC *Statement and guidelines on research practice: Australian Code for the responsible practice of research*
www.nhmrc.gov.au/_files_nhmrc/publications/attachments/r39.pdf

Values and ethics – G*uidelines for ethical conduct in Aboriginal and Torres Strait Islanders health research*
www.nhmrc.gov.au/guidelines/publications/e52

Nursing and Midwifery Board of Australia codes and guidelines

www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

Quality improvement

Better quality, better health care: a safety and quality improvement framework for Victorian health services
www.health.vic.gov.au/qualitycouncil/pub/improve/framework

Person-centred care

Improving care for older people. What is person-centred health care? A literature review
www.health.vic.gov.au/older/pubs

Post Acute Care services (PAC)

Department of Health – PAC website
www.health.vic.gov.au/pac

Private admission election status

www.health.vic.gov.au/feesman/fees2

Safety in the workplace

Bushfire and heat-related illness website
www.dhs.vic.gov.au/emergency

Department of Health: *Preventing occupational violence in Victorian health services: A policy framework and resource kit*
www.health.vic.gov.au/nursing/promoting/noviolence/strategy-1

WorkSafe Victoria
www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/WorkSafe

Service Coordination Tool Templates (SCTT)

The SCTT is a statewide service coordination template developed by the Department of Human Services that facilitates the sharing of information and assessments among all services including community and acute sectors
www.health.vic.gov.au/pcps/coordination

State-wide equipment program (SWEP)

www.swep.bhs.org.au/

Subacute Ambulatory Care Services (SACS)

Department of Health – SACS website
www.health.vic.gov.au/subacute

Victorian Admitted Episode Dataset

www.health.vic.gov.au/hdss/vaed

Victorian Police — National Police Check

http://www.police.vic.gov.au/content.
asp?Document_ID=274

Victorian public hospital patient charter

www.health.vic.gov.au/patientcharter

**Working with Children Check information,
publications, helpline and legislation**

www.justice.vic.gov.au/workingwithchildren