SHARED TRANSFER OF CARE

Client Record Baseline Audit (Page 1 of 2)

CLIENT DETAILS			
Client ID		Audit No.	
Client DOB		Audit Date	
Reason for entry to organisation			
Relevant History			
Pre-transfer residence	☐ Home ☐ Other, Please specify:		
Post-transfer residence	☐ Home ☐ Subacute care (e.g. rehab) ☐ Aged/Residential Facility ☐ Other Please specify:		

TRANSFER PLANNING				
Entry Date		Length of stay (days)		
Name of organisation where transfer planning commenced				
Were the client's goals identified on entry to organisation?	☐ Yes	☐ No		
Transfer Risk Assessment Tool completed and documentation in medical record	☐ Yes	☐ No		
Who was involved in creating the transfer plan?	☐ Client	☐ Relative	☐ Carer	☐ Other
Was a Shared Information Record commenced?	☐ Yes	☐ No	Date commenced:	
Were time lines discussed? (i.e. Expected length of stay in the organisation)	☐ Yes	☐ No	Date:	
	Discussed with Client		☐ Yes	☐ No
	Discussed with Family/carer		☐ Yes	☐ No
Did the client have prior community services and have they been documented?	☐ Yes	☐ No	Comment	
Were the above community services involved in planning the client's transfer?	☐ Yes	☐ No	Comment	
Other transfer information (i.e. from conversation with referrer or other)				

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Client Record Baseline Audit (Page 2 of 2)

TRANSFER IMPLEMENTATION			
Were home and community services advised of the client's transfer?	☐ Yes	☐ No	☐ N/A
If yes, which services were referred and how was this communicated?			

Name of Service	Date of Referral	Follow up phone call	Client aware
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

If there was more than one provider, were others notified of their involvement?	☐ Yes	☐ No	☐ Not documented
Was the client or family/carer given a copy of the plan?	☐ Yes	☐ No	☐ N/A
How is this demonstrated?	☐ Signature on Plan ☐ Documented in Client Record ☐ Other		

WERE THE FOLLOWING CLIENT DETAILS DOCUMENTED?				
Appointments	Provider Name	☐ Yes	☐ No	☐ N/A
	Contact Details	☐ Yes	☐ No	☐ N/A
	Time/date	☐ Yes	☐ No	☐ N/A
Emergency Contact	☐ Yes	☐ No		
Ongoing Care Information	☐ Yes	☐ No		
Medication Information	☐ Yes	☐ No		
Was the client's general practice home notified of: (tick all that apply)	☐ Yes	☐ No	☐ N/A	
Were home and community services advised of the client's transfer?	☐ Entry to service ☐ Ongoing health care needs ☐ Final Transfer Plan Comment			
Was the client provided with a point of contact after transfer?	☐ Yes	☐ No		