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WELCOME MESSAGE

Dear Colleagues

On behalf of The HITH Society Australasia, I would like to extend a warm welcome to the 11th Annual Scientific Conference here in sunny Brisbane, Queensland! We think you will find this to be a welcoming and vibrant city to visit.

Our Conference theme, LEARN: Lead, Engage, Aspire, Research, Negotiate is sure to be engaging and applicable to our respective organisations. We have developed an informative and exciting agenda this year in line with the Conference theme, with our Australian and International keynote speakers, Philip Darbyshire and Karen Titchener, both with vast experience from public and private HITH services. We think you will find a wide variety of topics and workshops on offer this year. The HITH Society welcomes and congratulates those selected to present oral or poster presentations.

Importantly our conferences would not be able to succeed without the support of our sponsors. This year I would like to thank:

Major Supporter - Queensland Health;

Platinum Sponsor - Baxter;

Silver Sponsor - Smith & Nephew;

Gala Dinner Sponsor - Silver Chain Group;

Coffee Barista Sponsor - National Home Nurse; and

Name Badge and Lanyard Sponsor – World Hospital at Home Congress 2019.

Please make sure you circulate throughout the exhibitions during the breaks.

We hope you will join us for the annual Conference Dinner, generously sponsored by Silver Chain at Room 360, QUT, with fabulous views of Brisbane. We cannot wait to see how everyone has interpreted the dinner theme Black and White with a dash of sunshine!

Additionally, I would like to thank the Conference Organising Committee for their time, expertise and dedication for making my role much easier. Thank you!

If you are passionate about providing excellent care in the home and committed to improving and implementing innovations, this 2018 HITH Society Australasia Conference will be inspiring!

So welcome and enjoy the next two days!

Angela Ellis

Chair Conference Organising Committee

WBHHS- Bundaberg, QLD

Angela Ellis

ORGANISING COMMITTEE

Angela Ellis
Conference Chair
Wide Bay Hospital and Health Service – Bundaberg
QLD

Jill Bell
Acute Care @ Home Logan/Metro South
QLD

Ian Campbell
Cabrini Health
VIC

Pauline Dobson
John Hunter Hospital
NSW

Barbara Farrelly
SALHN; Hospital @ Home Service

SA

President, HITH Society Australasia

Narelle Hawkins
Sir Charles Gairdner Hospital
WA

Sue Henning
SilverChain Group
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Austin Health
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Dr James Pollard
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HITH ABSTRACT PRESENTATION PRIZES

To recognise and reward the valuable contribution made by HITH clinicians and managers. These prizes will be awarded for the best oral presentation and best poster presentation at the close of the Annual Scientific Meeting.

KEYNOTE AND INVITED SPEAKERS

Keynote Speakers

Philip Darbyshire

Professor Philip Darbyshire, began nursing nearly 40 years ago. He trained and worked in Intellectual disability and children's nursing before moving into nursing education and child health research. He gained his Masters degree in Glasgow and his PhD in Edinburgh. He is internationally recognised as a leader in nursing & health care research and service development.

For 13 years he led one of Australia's most successful practice-based research departments at Women's & Children's Hospital in Adelaide, described by the Australian Council on Healthcare Standards as, "an example of excellence in research leadership".

He also pioneered the use of innovative arts and literature approaches to help staff and students develop deeper understandings of care and the Patient Experience.

Taking up the late Steve Jobs' challenge of "Don't settle"…… Philip waited until the world's worst global financial crisis in 2008 to leave his secure University Professor post to work with hospitals, health services and universities worldwide as a consultant. He has helped health and education organisations in Australia, New Zealand, UK, Norway, Ireland and Italy.

Philip is also a Professor of Nursing at Monash and Flinders Universities and is a proud ambassador for AWCH (Association for the Wellbeing of Children in Healthcare).

Karen Titchener

A Winston Churchill Fellow Karen is a motivational, enthusiastic and energetic nurse leader who for the past 15 years has been developing innovative services that provided acute hospital at home care within the UK NHS system. Latterly she a director implementing a hospital at home programme for the Huntsman Cancer Institute in the USA

Invited Speakers

- Dr Anna Barker, Medibank Private
- Monique Berger, HCF
- Donal Byrne, nib Health Funds
- Dr John Cass-Verco, Royal Prince Alfred Hospital Sydney
- Natalie Dubrowin, Bupa
- Nicole Marsh, The AVATAR Group
- Adjunct Professor Shelley Nowlan, Queensland Department of Health
- Sean Unwin, Princess Alexandra Hospital
- Michael Walsh, Queensland Health
- Dr Michael Young, The Townsville Hospital

PROGRAM

WEDNESDAY 21 NOVEMBER 2018

Time	Session
10.00 - 17.00	**HITH Society Executive Meeting** Stamford Lounge
17.00 - 18.30	**REGISTRATION OPEN** **Registration Desk, Hotel Foyer**
18.00 - 19.00	**Welcome Reception** Pav Bar, Stamford Plaza Brisbane

THURSDAY 22 NOVEMBER 2018

Time	Session
07.30 - 17.00	**REGISTRATION OPEN - DAY 1** Registration Desk, Conference Floor
08.00 - 15.20	**Exhibition Open & Arrival Tea and Coffee** River Room
08.30 - 10.40	CONFERENCE OPENING **Chair: Barbara Farrelly, President HITH Society Australasia** **Grand Ballroom**
08.30 - 08.40	**Welcome to Brisbane and Conference Opening** *Angela Ellis,* Conference Convenor
08.40 - 09.00	**Opening Address** *Michael Walsh*, Director General, Queensland Health
09.00 - 09.45	**KEYNOTE ADDRESS: The future of Hospital in the Home – is there one?** *Philip Darbyshire*, Internationally Recognised Leader in Nursing & Health Care Research and Service Development
09.45 - 10.15	**DVRS – Everyone's Business** *Dr John Cass-Verco*, Royal Prince Alfred Hospital
10.15 - 10.40	**Optimising Antimicrobial Therapy Delivery for OPAT** *Sean Unwin,* Princess Alexandra Hospital
10.40 - 11.10	**MORNING TEA, EXHIBITION AND POSTER VIEWING** River Room
11.10 - 12.20	PLENARY SESSION **Chair: Angela Ellis, Wide Bay Hospital and Health Service** Grand Ballroom
11.10 - 11.45	**INTERNATIONAL KEYNOTE ADDRESS: Knowledge of HITH in the UK** *Karen Titchener,* Huntsman Cancer Institute, University of Utah (formerly Guys & St Thomas NHS Foundation, London)
11.45 - 12.00	**HITH Society Memorial Oration - Dr Nicholas Collins** *Nicholas Marlow*, HITH Society Executive
12.00 - 12.20	**Nick Collins Fellowship** Introduction by *Barbara Farrelly,* President HITH Society Australasia; Presentation by *Angela Burge*, The Alfred Hospital and LaTrobe University, Melbourne - Nick Collins Fellowship Award Winner 2017 Announcement of 2018 winner by Brendan Cummins, Director, Baxter Compounding & Pharmaceuticals, ANZ Baxter Compounding
12.20 - 13.20	**NETWORKING LUNCH, EXHIBITION AND POSTER VIEWING** River Room

Time	Workshop A	Workshop B	Workshop C	Workshop D
13.20 - 14.30	**STAFF WELLBEING** Raffles 1	**CLINICAL LEADERSHIP** Ballroom 1	**FEISTY FEET** Raffles 2 & 3	**RESEARCH** Ballroom 2
	Dee Loader, The Alfred **Dr Mary O'Reilly,** Austin Health **Michelle Horsnell,** Cabrini Health	**Dr Nicole Hancock,** Princess Alexandra Hospital **Melissa McCusker,** Metro South Health@Home	**Rita Raj,** Browns Plains Community Health Centre, QEII Hospital **Manjeet Sagoo,** Redlands Hospital Physiotherapy and Podiatry, Metro South Health	**Dr Daryl Kroschel,** Silver Chain
14.30 - 15.00	**AFTERNOON TEA, EXHIBITION AND POSTER VIEWING** River Room			

Time	Concurrent Session 1: Presentation of Papers - ENGAGE Chair: Sue Henning, Silver Chain Group Ballroom 1		Concurrent Session 2: Presentation of Papers - RESEARCH Chair: Dee Loader, Alfred HITH Ballroom 2	
15.00 - 16.30				
15.00 - 15.15	Engaging in personalised, innovative, connected health care **Vanessa West & Julie Sturgess, Hospital In Your Home**	**OR01**	The implementation of remote home monitoring within a public Hospital in the Home (HITH) service **Vickie de Jong, QLD Health** **Vickie Irving, Telstra Health**	**OR07**
15.15 - 15.30	An analysis of 890 patients discharged through Out Patient Intravenous Antibiotic (OPIVA) service at Waitemata District Health Board (WDHB) Auckland **Beverley Hopper, Waitemata District Health Board**	**OR02**	Multidisciplinary Clinical Handover for HITH - Quality and Assurance Project **Dr Linda Lin, Royal Melbourne Hospital**	**OR08**
15.30 - 15.45	'Joey' - A new multidisciplinary model to improve feeding support of young children at home **Dr Jye Gard & Dr Joanna Lawrence, Royal Children's Hospital**	**OR03**	Holoportation: 3D Teleconferencing in the Home **Dr Daryl Kroschel, Silver Chain Group**	**OR09**
15.45 - 16.00	Why do our Hospital in the Home (HITH) services have capacity? Driving HITH uptake in Queensland **Laureen Hines, Department of Health - Queensland**	**OR04**	Twice daily cephazolin is effective for treatment of serious methicillin-sensitive Staphylococcus aureus infection in a Hospital in the Home program **Dr Andrew Fuller, Alfred Hospital**	**OR10**
16.00 - 16.15	Applying Habit Psychology and Consumer Tactics to Improve Medication Adherence **Scott Taylor, Perx Health**	**OR05**	Assessing persons who inject substances for suitability for home IV therapy treatment **Pauline Dobson, John Hunter Hospital**	**OR11**
16.15 - 16.30	From less to more – transformational growth of a HITH **Helen Richards, Monash Health**	**OR06**	Learnings from Medibank at Home—services that provide customers with greater choice and flexibility about where they receive their care **Dr Anna Barker, Medibank Private**	**OR12**
16.30 - 17.00	**Hospital in the Home Society Australasia Annual General Meeting** Grand Ballroom 2			
19.00	**Conference Dinner** Room Three Sixty, QUT *Sponsored by Silver Chain* Silver Chain			

FRIDAY 23 NOVEMBER 2018

Time	Session			
07.30 - 17.00	**REGISTRATION OPEN - DAY 2** Registration Desk, Conference Floor			
08.30 - 15.30	**Exhibition Open & Arrival Tea and Coffee** River Room			
09.00 - 10.30	**PLENARY SESSION** **Chair: Angela Ellis, Wide Bay Hospital and Health Service** Grand Ballroom			
09.00 - 09.30	**PICCs at Home - A Retrospective Cohort Study** *Nicole Marsh*, The AVATAR Group			
09.30 - 10.00	**Retrofitting a HiTH Service in an acute care model – from bespoke to BAU** *Dr Michael Young*, The Townsville Hospital			
10.00 - 10.30	**The Move From Acute Hospital Care to Home-Based Acute Care** *Shelley Nowlan*, Queensland - Department of Health			
10.30 - 11.00	**MORNING TEA, EXHIBITION AND POSTER VIEWING** River Room			
11.00 - 12.15	**Concurrent Session 3: Presentation of Papers - LEARN / ENGAGE** Chair: Dr Daryl Kroschel, Silver Chain Group Ballroom 1		**Concurrent Session 4: Presentation of Papers - ASPIRE / NEGOTIATE / RESEARCH** Chair: Dr Mary O'Reilly, Austin Health Ballroom 2	
11.00 - 11.15	Allied Health Led Hospital in the Home **Rachel Thomas, Children's Health Queensland**	**OR13**	Heart failure management utilising Hospital in the Home (HITH) **Debra Gascard, Monash Health**	**OR18**
11.15 - 11.30	Home Improvement – Changing and Challenging HITH with SIM **Rachael Sloane & Pippa Cadwallader, Sydney Children's Hospital Network Randwick**	**OR14**	Instead of thinking outside the box, get rid of the box **Suzanne Harvey & Andrea Keating, Metro North HITH**	**OR19**
11.30 - 11.45	Blood and blood product transfusion in a community setting in South Australia **Parimal Shrimali, RDNS SA**	**OR15**	Avoiding hospital admissions for patients with neuromuscular conditions using a novel CHQatHome Physiotherapy led model of care **Nadia Hawker, Children's Health Queensland**	**OR20**
11.45 - 12.00	Electronic Medication Management at Home **Meaghan Hollamby, Children's Health Queensland**	**OR16**	'Show me the money' – urinary tract infection (UTI)/pyelonephritis in children and Hospital-in-the-Home (HITH) **Dr Barry Scanlan, University of Melbourne**	**OR21**
12.00 - 12.15	Finding our way **Joanna Burdajewicz, NSW Health**	**OR17**	Hospital in the Home Delivery of Conditioning Therapy for Autologous Stem Cell Transplantation: A Novel Single Centre Patient Focused Approach **Dr David Routledge, Peter MacCallum and Royal Melbourne Hospital**	**OR22**
12.15 - 13.15	**NETWORKING LUNCH, EXHIBITION AND POSTER VIEWING** River Room			

Time	Session
13.15 - 15.00	**PLENARY SESSION** **Chair: Dr James Pollard, Barwon Health - University Hospital Geelong** Grand Ballroom
13.15 - 14.15	**The Current & Future Role of Private Health Funds in HITH** Panellists: *Donal Byrne*, Head of Clinical Operations, nib Health Funds *Dr Anna Barker,* Head of Member Health Innovation, Medibank Private *Natalie Dubrowin,* Head of Health Programs & Quality, Health Partnerships & Innovation, Bupa *Monique Berger,* Clinical Advisor, HCF
14.15 - 15.00	**INTERNATIONAL KEYNOTE ADDRESS: Ambulance Clinical Pathway** *Karen Titchener,* Huntsman Cancer Institute, University of Utah
15.00 - 15.25	**AFTERNOON TEA, EXHIBITION AND POSTER VIEWING** River Room
15.25 - 16.30	**PLENARY SESSION** **Chair: Barbara Farrelly, President, HITH Society Australasia** Grand Ballroom
15.25 - 16.00	**KEYNOTE ADDRESS: A Researcher Looks at Leadership** *Philip Darbyshire,* Internationally Recognised Leader in Nursing & Health Care Research and Service Development
16.00 - 16.30	**Awards & Prizes / Conference Handover 2019**
16.30	**Conference Close**

SOCIAL PROGRAM

Welcome Reception

Pav Bar, The Stamford Plaza Brisbane

Wednesday 21 November 2018
18.00 – 19.00

In a break from tradition the Welcome Reception will be held in the Pav Bar which is a French inspired courtyard bar. This will allow delegates to mingle and enjoy the beautiful Queensland weather alongside some great local produce and beverages. Come along and enjoy the relaxed casual setting and atmosphere to kick off the Conference.

Cost
Inclusive for delegates
Accompanying Person(s): $50 (incl GST)

Conference Dinner sponsored by Silver Chain

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Room Three Sixty, Queensland University of Technology

Thursday 22 November 2018
19.00 – 23.00

The Conference Dinner will again be a highlight for delegates. Room Three Sixty provides beautiful views over the river and city beyond. Guests will enjoy a selection of beverages with a two-course meal and great entertainment. This year dance the night away to the sounds of Midnight Groove a local four-piece band who will play all your favourite songs.

Please be sure to bring your Conference Dinner Ticket to ensure entry.

Cost
Inclusive for delegates
Accompanying Person(s): $130 (incl GST)

Dress Code
Black & White with a Dash of sunshine!

GENERAL INFORMATION

Accommodation

Please ensure you settle your conference account directly with the hotel in full upon departure.

The Stamford Plaza Brisbane

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Telephone: (07) 3221 1999

Business Centre

The Stamford Plaza offers a variety of business centre facilities including Internet booths and printing. Internet Booths are available in the hotel lobby and printing can be organised through the staff at the reception desk.

Car Parking

A self-park rate of $45.00 per vehicle, per day is available to Conference attendees. Should guests prefer a valet parking option, the price is $57.00 per vehicle, per day. Please note that all parking is strictly subject to availability at time of arrival in the Hotel car park and is not reserved.

Catering

Catering during the Conference is included in the registration fee for Delegates, Speakers and Exhibitors. The Welcome Reception and Conference Dinner are also complimentary to Delegates. You must register to attend the Welcome Reception and the Conference Dinner. If you have not already done so, please visit the Conference Registration Desk at your earliest convenience.

Certificate of Attendance

A Certificate of Attendance will be emailed to you post Conference.

Conference Registration Desk Hours

The Conference Registration Desk is located outside of the Grand Ballroom on the lobby level. The desk will be open during the following hours:

Wednesday 21 November	17:00 – 18:30
Thursday 22 November	07:30 – 17:00
Friday 23 November	08:30 – 16:30

Dietary Requirements

If you have advised the Conference Secretariat of your dietary requirements, please see the wait staff to receive your special meal. All buffets will cater for vegetarian and gluten free dietary requirements.

Disclaimer

The Conference Committee reserves the right to change the scientific program at any time without notice. Please note the program is correct at time of print.

Dress Code

The dress code for the business sessions and events is business casual.

Exhibition

The Exhibition will be located in River Room and will be open at the following times:

Thursday 22 November 2018	08.30 – 15.20
Friday 23 November 2018	08.30 – 15.30

GENERAL INFORMATION

HITH Society Annual General Meeting

The HITH Society Annual General Meeting will be held in the Grand Ballroom 2 at The Stamford Plaza Brisbane on Thursday 22 November 2018 at 4.30pm. Members are encouraged to attend this meeting.

Mobile Phones

For the convenience of all delegates, please ensure that your mobile phone is switched to silent during all sessions.

Name Badges and Tickets

For security purposes, Delegates, Speakers and Exhibitors must wear their name badges at all times during the Conference. Entrance to the Conference and Exhibition will be limited to name badge holders only. If you misplace your name badge, please see the Registration Desk for a new one. If you have registered for the Conference Dinner, you will have received a ticket in your registration envelope. You must present your ticket for entry to the dinner. To purchase additional dinner tickets (including partner tickets), please see the Conference Registration Desk – places are limited so please do this at your earliest convenience.

Poster Display Times

Please take the time to view the poster presentations which are available for viewing in the foyer areas during Conference hours.

Posters will remain on display from the morning of Thursday 22 November 2018, until close of Conference on Friday 23 November 2018. Please refer to the Conference Program for all catering breaks, during which time delegates may view posters at their leisure.

Poster Presenters

Poster presenters, your poster number can be found by checking the Author Index in this Program Book. Should you require any assistance with your poster, see the staff at the Registration Desk.

Poster Set Up and Pack Down Times

Set up:
Thursday 22 November 2018, 08.30

Pack down:
Friday 23 November 2018, 15.25

Speakers

Please make yourself known at the Conference Registration Desk upon arrival. If you have not sent your presentation in advance, please ensure you download your presentation and confirm your audio visual requirements at least 3 hours prior to the start of your session, or the day prior for morning sessions. Please ensure you are available in your presentation room at least 15 minutes prior to the start of the session.

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Conference Dinner

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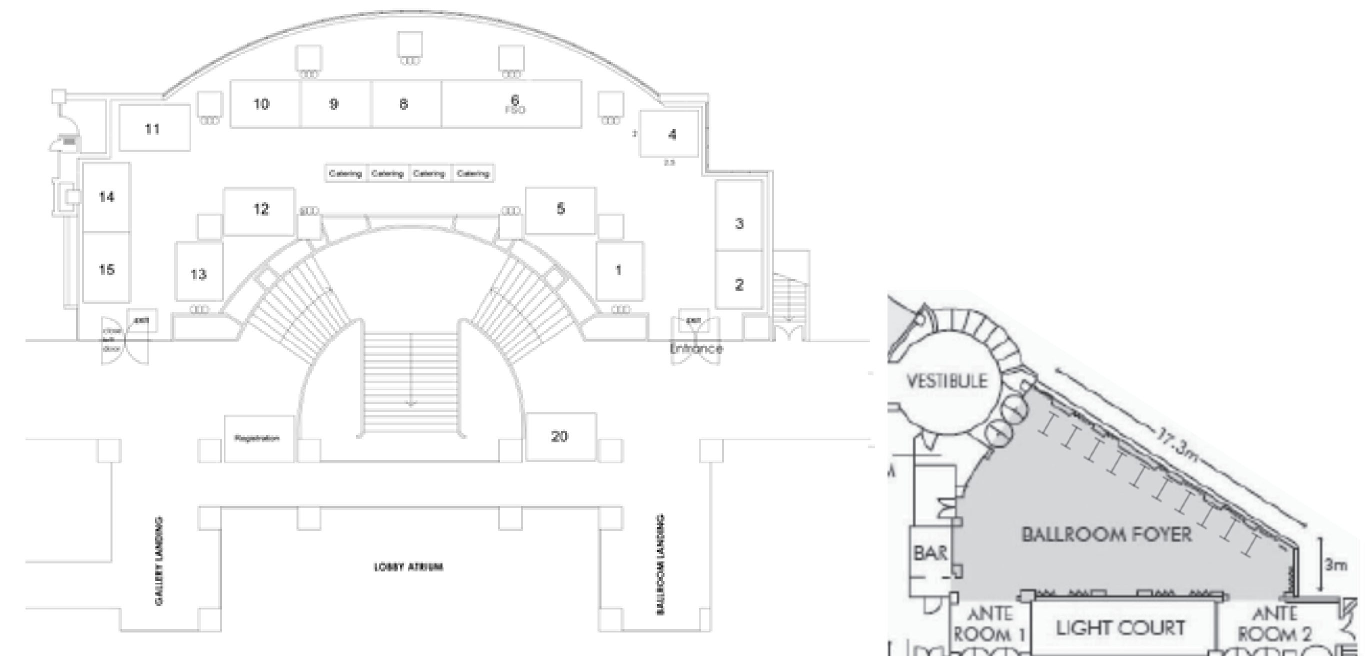

Exhibitor	Booth Number
ADMEDUS	11
Baxter Healthcare	6
KCI Medical	10
Mölnlycke Health Care	4
nib Health Funds	14
Nipro Australia	8
Queensland Health	20
RAPP Australia	2
REM Systems	5
Silver Chain Group	9
Slade Health	12
Smith & Nephew	15
Supagas Australia	1
Sutherland Medical	3
Telstra Health	13

EXHIBITORS

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ABSTRACTS OF ORAL PRESENTATIONS

ORAL ABSTRACTS

Oral Abstract Details	Paper Reference
ENGAGING IN PERSONALISED, INNOVATIVE, CONNECTED HEALTH CARE Vanessa West, Julie Sturgess	OR01
AN ANALYSIS OF 890 PATIENTS DISCHARGED THROUGH OUT PATIENT INTRAVENOUS ANTIBIOTIC (OPIVA) SERVICE AT WAITEMATA DISTRICT HEALTH BOARD (WDHB) AUCKLAND Beverley Hopper, Emilie Corgnet, Dr Kerry Read, Dr Nick Gow, Dr Hasan Bhally, Nicola Davies	OR02
'JOEY' - A NEW MULTIDISCIPLINARY MODEL TO IMPROVE FEEDING SUPPORT OF YOUNG CHILDREN AT HOME Dr Jye Gard, Dr Penelope Bryant, Dr Catherine Simpson, Dr Suzanne Boyce, Dr Joanna Lawrence	OR03
WHY DO OUR HOSPITAL IN THE HOME (HITH) SERVICES HAVE CAPACITY? DRIVING HITH UPTAKE IN QUEENSLAND Sonya Mizzi, Laureen Hines	OR04
APPLYING HABIT PSYCHOLOGY AND CONSUMER TACTICS TO IMPROVE MEDICATION ADHERENCE Dr Jonny Lo, Scott Taylor, Hugo Rourke	OR05
FROM LESS TO MORE – TRANSFORMATIONAL GROWTH OF A HITH Helen Richards	OR06
THE IMPLEMENTATION OF REMOTE HOME MONITORING WITHIN A PUBLIC HOSPITAL IN THE HOME (HITH) SERVICE Vickie de Jong, Melissa McCusker, Vickie Irving, Matt Page	OR07
MULTIDISCIPLINARY CLINICAL HANDOVER FOR HITH - QUALITY AND ASSURANCE PROJECT Dr Linda Lin, Dr Seok Lim	OR08
HOLOPORTATION: 3D TELECONFERENCING IN THE HOME Dr Daryl Kroschel	OR09
TWICE DAILY CEPHAZOLIN IS EFFECTIVE FOR TREATMENT OF SERIOUS METHICILLIN-SENSITIVE STAPHYLOCOCCUS AUREUS INFECTION IN A HOSPITAL IN THE HOME PROGRAM A Fuller, M Birrell, D Loader, N Rousetty, B Wallis, E Bailey, S Lang	OR10
ASSESSING PERSONS WHO INJECT SUBSTANCES FOR SUITABILITY FOR HOME IV THERAPY TREATMENT Pauline Dobson, Dr Sally McKenna, Dr Stacey Weedon	OR11
LEARNINGS FROM MEDIBANK AT HOME—SERVICES THAT PROVIDE CUSTOMERS WITH GREATER CHOICE AND FLEXIBILITY ABOUT WHERE THEY RECEIVE THEIR CARE Associate Professor Anna Barker, Associate Professor Rebecca Bell	OR12
ALLIED HEALTH LED HOSPITAL IN THE HOME Rachel Thomas, Nadia Hawker, Alana Jessop	OR13
HOME IMPROVEMENT – CHANGING AND CHALLENGING HITH WITH SIM Rachael Sloane, Pippa Cadwallader	OR14
BLOOD AND BLOOD PRODUCT TRANSFUSION IN A COMMUNITY SETTING IN SOUTH AUSTRALIA Parimal Shrimali	OR15
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OR01

ENGAGING IN PERSONALISED, INNOVATIVE, CONNECTED HEALTH CARE

Vanessa West, Julie Sturgess

Hospital In Your Home, Townsville, Australia

Aims

This presentation aims to highlight a positive and innovative way forward to give patients and clinicians more personalised, connected care using The Diary CarePro™.

Methods

Through the first Australian health care partnership with Apple™ and The Diary Carepro™ applications, Hospital in your home has engaged in consumer feedback at both the acute and chronic care setting in the practicality of using The Diary Carepro application to have connected, integrated care with health care providers, family and caregivers.

A cohort of random patients and clinicians at both facilities were consented to participate in the feedback. Each participant completed a pre and post survey around their current knowledge of an iPad and if they already used an electronic platform to store, share and monitor their health information.

Participants were introduced to the application, shown how to monitor their vital signs, set up reminders for medication, water intake, document feelings, pain score, and then share the information with their health care provider, in safe and secure environment thus reducing unnecessary visits to the ED/GP and allow secure 24-hour monitoring in liaison with their Hospital in Your Home team.

Results

Participants highlighted the ease of use and the positive attribute of being able to own their health data while having connected, patient-focused care. Clinicians liked that they can create an efficient and productive workflow for members of the care team using the Calendar and Task sharing system, identify patient needs, instantly create priorities, collaborate with colleagues, maintain continuity of care, send reminders to patients (e.g. appointments, medications).

Conclusions

The Diary CarePro™ automates care team workflow while enabling improved care and personal health management, enabling individuals to follow their treatment plans, whilst having the added connectivity to their caregivers and care teams increasing the likelihood of patients achieving their health goals.

OR02

AN ANALYSIS OF 890 PATIENTS DISCHARGED THROUGH OUT PATIENT INTRAVENOUS ANTIBIOTIC (OPIVA) SERVICE AT WAITEMATA DISTRICT HEALTH BOARD (WDHB) AUCKLAND

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Waitemata District Health Board, Auckland, New Zealand

Aims

OPIVA services allowing for patient-centered, home based care have been shown to improve patient satisfaction and reduce hospital length of stay (LOS). The WDHB OPIVA service discharges patients on elastomeric Infusors (60%), intermittent daily dosing by community nursing (20%) or self-administration (15%) and multiple modalities (5%). This presentation will focus on the growth and experience of the WDHB OPIVA service and our vision for the future

Methods

We retrospectively reviewed the electronic records for all patients discharged on OPIVA between 1st May 2015 and 30th April 2018. Variables included discharging services, treatment indications, antibiotics used, readmission rates within 30 days and bed days saved,. Patient satisfaction was determined by a survey at the end of treatment

Results

890 patients were treated through the OPIVA service. Discharging services were Orthopaedics (50%), General Medicine (25%), General Surgery (10%) and others (15%). All patients had appropriate follow-up through community nursing and Infectious Diseases clinics whilst completing their OPIVA treatment. Common indications for OPIVA were bone and joint infections (50%) followed by respiratory (8%) and genitourinary and cardiovascular infections (both 7%). Flucloxacillin (30%), Ceftriaxone (20%) and Benzyl-Penicillin (15%) were the most commonly prescribed antibiotics. During this 3 year period we saved a total of 20,431 bed days. A one year snapshot of readmissions within 30 days of initiating OPIVA was 29%with a 9% readmission rate attributable to PICC lines or antibiotic treatment. Patient response to the satisfaction survey demonstrated that 90% were very satisfied with the service they received.

Conclusions

Waitemata DHB has a high quality, multidisciplinary and efficient home based intravenous antibiotic service with excellent patient satisfaction, a good safety record, resulting in significantly reduced lengths of stay.

OR03

‘JOEY’ - A NEW MULTIDISCIPLINARY MODEL TO IMPROVE FEEDING SUPPORT OF YOUNG CHILDREN AT HOME

Dr Jye Gard, Dr Penelope Bryant, Dr Catherine Simpson, Dr Suzanne Boyce, Dr Joanna Lawrence

Royal Children’s Hospital, Flemington, Australia

Aim

Primary

- To reduce the number of days children with feeding issues spend in-hospital.

Secondary

- To improve carer satisfaction with oral feeding.
- To improve carer satisfaction with oral feeding.
- To reduce the total number of days a child is fed via nasogastric tube (NGT).
- To decrease the total number of hospital representations for feeding issues.

Methods

Multidisciplinary Maternal Child Health Nurse, Speech Pathologist, Dieticians, Occupational Therapist, Paediatricians and Nurses support home

Results

In five months, there were 78 admissions to the accounting for 934 bed days.

The children referred had diverse medical comorbidities, including cardiac (37), respiratory (12) and neuromuscular (8) diseases.

36 patients referred to the program for poor oral feeding or poor weight gainll improved their oral skills improved and most gained weight (86%) during their admission. The average length of admission was 1 days.

39 patients were referred trial NGT weaning. Sixteen of these patients (41%) were orally on discharge. A further two were feeding within two weeks of discharge. The average time until successful NGT wean was 9 days. The average length of admission, regardless of NGT wean, was 15.39 days.

Eleven patients represented to hospital during their Joey admission. Nine (82%) due to a new, or exacerbation of a known, medical condition. Three of the patients that represented to hospital returned to the Joey program within 24 hours. The other eight required further investigation or treatment in-hospital.

Conclusions

The model reduces the burden to families seeking in-hospital care for feeding difficulties.

OR04

WHY DO OUR HOSPITAL IN THE HOME (HITH) SERVICES HAVE CAPACITY? DRIVING HITH UPTAKE IN QUEENSLAND

Sonya Mizzi, Laureen Hines

Department Of Health - Queensland, Herston, Brisbane, Australia

Aim

With the uptake of HITH in Queensland having plateaued in recent years (.69% of acute hospital separations – Queensland HITH 2017-18 FY), Queensland Health engaged HITH services statewide, to identify barriers and enablers to HITH utilisation, and generate solutions for action.

Methods

In 2016 Queensland HITH services and clinicians that refer patients to HITH services, participated in a statewide survey to identify barriers and enablers to HITH referrals. Following this survey, the Taking Healthcare Home Forum, a collaboration between the Australian Centre for Health Services (AusHSI) and Baxter Healthcare, was convened confirming the survey findings. The Department of Health, in partnership with HITH services, utilised these findings to develop a HITH action plan. Through a process of co-design, forums and working groups have been established to inform and support the implementation of prioritised solutions across Queensland.

Results

The results of these investigations identified common issues experienced by HITH services across Queensland. This presents a clear opportunity to develop solutions to maximise impact and reduce duplication of effort. The presentation aims to share the results of the survey, discuss the methodology of co-design and present the artefacts developed to support, better promotion of HITH, purchasing leavers and increased utilisation of technology to support HITH service delivery.

Conclusions

Although Queensland Health promotes HITH as a viable hospital substitution model the survey identified that 62% of Queensland HITH Services had capacity to increase service provision without additional resources. In an environment of increasing demand for health services and finite resources, maximising HITH services utilisation is essential. Through a coordinated co-design approach, services can be supported to enhance service uptake through targeted strategies.

OR05

APPLYING HABIT PSYCHOLOGY AND CONSUMER TACTICS TO IMPROVE MEDICATION ADHERENCE

Dr Jonny Lo[1,2], Scott Taylor[1], Hugo Rourke[1]

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Aim

Medication adherence for chronic illnesses in developed countries, like Australia, averages 50% (World Health Organization, 2003). Addressing adherence has the potential to greatly improve the health of the population and health system effectiveness. This study determined the feasibility of applying habit psychology and consumer tactics (like rewards programs) to medication adherence using a smartphone application (Perx). The effectiveness of different reward programs was also determined.

Methods

A daily-habit forming loop was developed, consisting of a: (i) trigger; (ii) health-related behaviour (of taking the medication); (iii) novel verification method (using the smartphone camera); (iv) motivation. The types of motivations included tailored educational messaging, social challenges of medication streaks, quasi-financial rewards and online games. Patients were recruited from community programs (via online sources and commercial partnerships) as well as outpatients' clinics (via Sydney Local Health District).

Results

Over 2 years, 1,504 Australian patients (age range 18-79) with chronic illness used Perx, averaging overall adherence rates of 87% in outpatients and 77% in community programs. Among specific digital engagement programs, social challenges achieved the highest rate (90%) of patients taking all prescribed medication over 7-days. Engagement in online games during the first week of using Perx increased persistence by 40%, as measured by the total number of adherent days. Providing a single $10 quasi-financial reward created a small (2%) but sustained increase in adherence (over 3-months).

Conclusions

Combining habit psychology with consumer tactics achieved high medication adherence in patients with chronic illness in outpatients and community settings. Social challenges were optimal for strict short-term adherence, while online games improved persistence in the program. Quasi-financial rewards created small but sustained improvements in overall adherence.

References

World Health Organization 2003. Adherence to Long-Term Therapies.

OR06

FROM LESS TO MORE – TRANSFORMATIONAL GROWTH OF A HITH

Helen Richards

Monash Health, Dandenong, Australia

Aim

To redesign an adult HITH service to meet the needs of the community.

Methods

With the support the Health Network a journey of service redevelopment occurred that resulted in transformational change.

The success resulted from many changes including:

- HITH staff culture to a "can do" mindset
- Strong medical and nursing governance
- Executive leadership endorsement
- Workflow redesign
- Improved relationships with stakeholders
- evelopment of trust in the service resulting in significantly expanded cohorts treated under HITH
- Internal negotiation of a funding model to support growth.

This is our story of success

Results

The adult HITH service has expanded from 47 beds to now offer 138 beds, with flex capacity as required up to 160 beds.

This size service provided 46,500 bed days of care to our community in 2017/2018 financial year and resulted in an increase from 4.4% (February 2012) to 13.3% (June 2017) of patients who had a multiday acute inpatient stay who received HITH as part of their episode of care.

Conclusions

It is possible to expand a HITH service in a cost effective and sustainable manner. Successful growth is multifactorial and is dependent on engagement with all parts of the health service.

OR07

THE IMPLEMENTATION OF REMOTE HOME MONITORING WITHIN A PUBLIC HOSPITAL IN THE HOME (HITH) SERVICE

Vicky de Jong[1], Melissa McCusker[1], Vickie Irving[2], Matt Page[3]

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Aim

The application of a home-based telehealth/home monitoring system in HITH will not only allow remote vital sign monitoring, but also increase capacity to allow more patients to be nursed in the community to achieve better outcomes.

Methods

A home monitoring system utilizing Telstra Health's "MyCareManager" app on the patient's existing smart device for all patients wishing to participate. The solution is configurable to allow patients to take a range of clinical measurements in their homes. Additional accessories can be included such as Bluetooth enabled weight, temperature, blood pressure, pulse oximetry, blood glucose devices. In addition a range of health surveys can be setup that relate to their specific DRG. A web-based health portal allows HITH clinicians to view the latest clinical measurement data for patients and displays vital clinical information/alerts by a triage dashboard.

Results

Prerequisite research has indicated a high probability of success with the home monitoring model. Telemedicine technology facilitated the discharge of 10.1% (n=35) of patients considered unsuitable for clinician-led discharge from the HITH service during the trial period. Statistically insignificant differences in rates of readmission between patients discharged in person versus those participating in the telemedicine-supported model suggest that the clinical standards of the service have been maintained1. The evaluated results of the home monitoring implementation along with possible limitations of the analysis and implications of the outcome will be available in early 2019.

Conclusions

the existing clinical standards of the service1, A strong primary health care system is critical to the sustainability of health care systems. Management of conditions in the home of the patient often reduces burden in a hospital-centric public health system. Telehealth services have demonstrated improved management of chronic disease in the community, improved health care outcomes and quality of life.

References

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OR08

MULTIDISCIPLINARY CLINICAL HANDOVER FOR HITH - QUALITY AND ASSURANCE PROJECT

Dr Linda Lin, Dr Seok Lim

Royal Melbourne Hospital, Melbourne, Australia

Aim

Hospital in the Home is increasingly seen as an effective alternative to inpatient care1, 2. Clinical handover becomes crucial, as patients are not in a single location1, 2. A literature review commissioned by the Australian Commission on Quality and Safety in Health Care3 found that 50% of adverse inpatient events occur from communication failures3. In 2018, RMH HITH implemented a daily multi-disciplinary handover meeting which integrated nursing and medical handovers with oversight by senior staff. Here we retrospectively compare its effectiveness.

Methods

100 consecutive HITH admissions that followed separate nursing and medical handovers between July-Aug 2017 was compared with 100 admissions from Dec 2017-Jan 2018 that used a multidisciplinary format. Parameters included average and median length of stay, delays in response time to queries for intervention and unplanned transfers to inpatient care. Delays were measured as 1, 2 and 3+ days, and used to measure clinical outcomes.

Results

There was no statistical difference in length of stay of hospital admissions, with median length of stay at 7 days under both formats. The total number of one-day delays was 48 under the separate handover model in 100 admissions reviewed, and one-day delays were 24 under the multidisciplinary approach. Number of 2-day delays was 18; and 6 for more than 3 days under the separate handover system, while there were no delays beyond a day under the multidisciplinary model. 2 and 3 unexpected transfers into hospital-based care occurred for the separate and multidisciplinary formats respectively for reasons such as sepsis or closer inpatient monitoring.

Conclusions

A multidisciplinary clinical handover system is helpful in reducing response time to clinical queries and potentially leads to better integrated care delivery for HITH inpatients. Interestingly, the number of unplanned admissions was low in either setting.

References

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3. Wong MC, Yee, Kwang Chien, Turner, Paul. Clinical handover literature review. eHealth Services Research Group, University of Tasmania, Australia. Australian Commission on Safety and Quality in Health Care 2008.

OR09

HOLOPORTATION: 3D TELECONFERENCING IN THE HOME

Dr Daryl Kroschel

Silver Chain Group, Perth, Australia

Aim

In a health care system that claims to be 'patient centred' the telemedicine model has not always been an optimal patient experience. At the 2017 conference, the author outlined a world-first 3D platform that puts the patient at the forefront of the telemedicine experience. This presentation will detail the lived experience of implementation in the field

Methods

In the quest for an improved patient experience, an extensive workshop was undertaken at Microsoft Headquarters in the US in order to design a solution to improve telemedicine. Subsequently SAAB technologies, based in Adelaide, were commissioned to build a novel 3D holographic application under the HoloLens Enterprise Acceleration Program to enable holoportation of Doctors into patients' homes. Over the past year, extensive trials have been undertaken in various settings to determine the optimal configuration for fidelity and latency.

Results

For the first time, holoportation has occurred in an Australian health care context. Evaluation from an end user experience will be detailed as well as the best applications of the technology in a community based health care provider.

Conclusions

This technology has moved from concept to field testing and continues to evolve as a novel patient experience of telemedicine in the Australian Hospital in the Home (HITH) model.

OR10

TWICE DAILY CEPHAZOLIN IS EFFECTIVE FOR TREATMENT OF SERIOUS METHICILLIN-SENSITIVE STAPHYLOCOCCUS AUREUS INFECTION IN A HOSPITAL IN THE HOME PROGRAM

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Background

The use of cephazolin for infections caused by Staphylocccus aureus has been demonstrated to be effective, and associated with less adverse effects compared to antistaphylocccal penicillins, however use of cephazolin on hospital in the home (HITH) programs often requires the use of continuous infusions. We report the outcomes of patients with serious infections caused by methicillin-sensitive Staphylococcus aureus (MSSA) treated using twice daily cephazolin by a large tertiary hospital HITH program.

Aim

To evaluate the safety, efficacy and 90 day outcomes of patients with serious infections caused by MSSA treated with twice daily cephazolin by our HITH program.

Methods: A retrospective analysis of clinical outcomes of cases with serious infections caused by MSSA treated with cephazolin monotherapy on the HITH program at a tertiary hospital between January 2010 and July 2016 (6.5 years). Outcome measures included readmission rate, adverse drug reactions and clinical cure.

Results

111 cases of serious MSSA infection were treated with cephazolin by HITH during the study period, including 52 with peripheral or vertebral osteomyelitis and 13 with infective endocarditis. 56 patients had bacteraemia. Median duration of intravenous antibiotic therapy was 41 days, and the median proportion of intravenous therapy administered by HITH was 69%. Two patients had recurrence of infection within 90 days, but were due to retained prosthetic material. 4% of patients experienced an adverse drug reaction. No cases of antibiotic failure were identified.

Conclusions

The use of twice daily cephazolin for serious MSSA infection on a HITH program is safe and effective.

Disclosure of interest statement:

No pharmaceutical grants were received in the development of this study.

OR11

ASSESSING PERSONS WHO INJECT SUBSTANCES FOR SUITABILITY FOR HOME IV THERAPY TREATMENT

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[1]John Hunter Hospital, New Lambton Heights, Australia, [2]Drug & Alcohol Clinical Services, Newcastle Community Health Centre, Newcastle, Australia

Aim

To develop a tool that would have the potential to assist the clinician to determine whether to accept a referral of a patient with a history of injecting substance use onto hospital in the home (HITH) with a central venous access device.

Methods

A literature review was conducted and a draft tool was developed based on the experience of staff with expertise in managing persons who injecting substances (PWIS) in HITH. The criteria included in the tool were clustered under the headings of Compliance Behaviour, Social Circumstances, and Injecting History e.g. substances used, regularity of injecting, and time since last injecting substance use. Each of the items were allocated a score. The higher the score the less likely that the patient would be successful on HITH. To determine a cut off value for acceptance of a PWIS onto HITH, the score was validated from historical referrals of PWIS to the HITH service.

Results

HITH referrals where ten PWIS were accepted and 1 referral where a PWIS were declined were retrospectively reviewed using the assessment tool. The average score of accepted patients was 3 compared to the patient with a score of 9 who was declined admission.

Conclusions

The tool has been validated in a small number of patients within our service and requires replication in multiple HITH services to determine its greater applicability. The tool was further refined with drug & alcohol specialist input. Clinicians have been looking for a solution to guide decision making around PWIS eligibility for HITH for many years. We believe this is a major step forward.

OR12

LEARNINGS FROM MEDIBANK AT HOME—SERVICES THAT PROVIDE CUSTOMERS WITH GREATER CHOICE AND FLEXIBILITY ABOUT WHERE THEY RECEIVE THEIR CARE

Associate Professor Anna Barker[1,2], Associate Professor Rebecca Bell[1,3]

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Aim

To reports on key process, outcome and impact measures of the Medibank at Home program which commenced in 2016. Barriers to, and enablers of, implementation, uptake and growth are explored.

Methods

A mixed methods evaluation including qualitative and quantitative data from customers that have received the service in FY18 (N=936), service providers (n=42), clinicians (15) and peak bodies (n=7).

Results

In 2018, 936 people received Medibank at Home services including rehabilitation following joint replacement surgery, chemotherapy, palliative care and dialysis. Rehabilitation at Home accounts for 87% of enrolments and customers achieve function improvements above those reported for similar patients receiving inpatient rehabilitation. Across all services, customer satisfaction was high (net promotor score >77/100); and treatment costs and readmissions lower than for those receiving inpatient care.

Customers report time, cost and convenience benefits, and feeling empowered to manage their own health. Some report frustration with current lack of geographical coverage for services. Others report satisfaction with in-hospital treatment citing an established routine and relationships with hospital staff.

Among clinicians and peak bodies there is agreement the service aligns with the broader policy direction of out of hospital care. It was also recognised that there is potential for Medibank at Home to support service growth among an ageing population and rising chronic disease rates. Clinicians reported barriers to uptake as a new referral process that is less convenient than for inpatient referrals, concerns about fragmentation of care and lack of established relationships between clinicians and service providers.

Conclusions

Medibank is committed to increasing customer choice and growing its Medibank at Home services. It will consider a range of strategies including technology and telehealth to support future service design and implementation.

OR13

ALLIED HEALTH LED HOSPITAL IN THE HOME

Rachel Thomas, Nadia Hawker, Alana Jessop

Children's Health Queensland, South Brisbane, Australia

Aim

Novel Allied Health led HITH admissions were introduced at CHQatHome in the last 12months to assist with Patient Flow Strategies and appropriate usage of overnight beds acknowledging the benefit of rehabilitation in the community setting.[1]

Methods

Allied Health staff identified patients who were planned to be admitted to an overnight bed specifically for intensive tertiary level allied health therapy interventions. The patients identified were unable to receive the required intervention at their home hospital and were required to stay in local accommodation near the tertiary paediatric referral hospital with the support of the Patient Travel Subsidy Scheme.

Results

Two complex Paediatric Orthopaedic patients and two chronic respiratory patients have successfully utilised this model of care. In one case, the patient attended therapy sessions twice daily for a week to provide intensive intervention and implement a program the family could continue with support upon their return home. The patient successfully achieved the goals of the intensive intervention. The second patient had an extended inpatient admission of greater than 100 days prior to their transfer to HITH for daily clexane and intensive physiotherapy intervention. The four patients who utilised this model of care (MOC) have already saved at total of more than 115 overnight bed days with no serious safety events reported. All patients successfully achieved their proposed HITH goals.

Conclusions

An Allied Health Led HITH MOC has been successfully introduced in to CHQ's paediatric tertiary hospital and health service. This MOC has patient and family centred care at the fore front with optimal clinical outcomes, assisting with patient flow strategies and appropriate utilisation of overnight inpatient beds with nil adverse events. Future directions include utilising this MOC for other patients throughout CHQ.

References

1. WADE, D. (2003). Community rehabilitation, or rehabilitation in the community. Disability and Rehabilitation, 25(15), pp.875-881.

OR14

HOME IMPROVEMENT – CHANGING AND CHALLENGING HITH WITH SIM

Rachael Sloane, Pippa Cadwallader

Sydney Children's Hospital Randwick, Randwick, Australia

Aim

Communicating clinical deterioration in a HITH patient is vital. We created a simulation experience that would illicit the opportunity for the nurse to seek validation for their clinical concerns with the treating medical team at the hospital and decide an appropriate action when the advice received was unsatisfactory. It's well known that children don't suddenly deteriorate, clinicians suddenly notice. Our patients can and do deteriorate at home. This is challenging for the nurse particularly when they are concerned with the medical advice received.

Methods

We developed a simulated clinical scenario in which a HITH nurse could assess and recognise a child who becomes unwell at home. The nurse worked alone during the SIM as this is common practice in our paediatric HITH service. We had independent clinicians playing the roles of mother and registrar. The nurse was given a clinical summary of the patient prior to visiting the 'patient's home' in the hospital simulation unit. The SIM was repeated three times with three different nurses and observed by an unseen audience.

Results

The results where fascinating and varied. The demeanour of the mother played an unforeseen part in the actions of the nurse. It was discovered that apical pulse is not commonly taken and this prevented one nurse from recognising the deterioration. Each nurse took a different course of action. Those involved in playing roles during the SIM were amazed at how isolated the HITH nurse is.

Conclusions

There are many benefits to simulating a HITH clinical scenario. Gaining insight into what happens in the home helps educators guide training and change practice. Our SIM has enabled nurses to reflect on their patient assessment skills, ISBAR techniques and documentation. The scenario must be simulated multiple times to enable a debrief that fosters rigorous discussion and reflection

OR15

BLOOD AND BLOOD PRODUCT TRANSFUSION IN A COMMUNITY SETTING IN SOUTH AUSTRALIA

Parimal Shrimali

RDNS SA, Adelaide, Australia

Aim

To audit blood and blood product transfusion practices in a community setting in South Australia. The Royal District Nursing Service (RDNS) SA is part of the Silver Chain Group (and as an approved provider for SA Health) has been providing services based on sound clinical practice, efficient processes supported by Clinical Governance and strict adherence to cold-chain measures and protocols. The practice provides the client a timely and safe blood/blood product transfusion in the comfort of their home.

Methods

All transfusion provided by RDNS from 2011 to May 2018 were included in the audit. Referral sources (hospital/GP), patient demographics including diagnoses, location, product wastage and transfusion reaction were collected and analysed.

Results

A total of 1345 transfusion episodes (421 patients) were analysed. The patients had a median age of 83 (75-89) with an approximate 50/50 gender split. The service started in 2011 with 136 episodes and had a gradual increase to 301 episodes in 2017. More than half (51%) of the referrals were from public hospitals, 29% from GPs and 16% from residential care facility (RCF). Patient diagnoses were predominantly anaemia, haematological malignancies, blood disorders and other medical conditions. Over the study period, there was minimum blood wastage (1x discarded due to venous access, 2x due to incorrect storage at site), one (1) clinical transfusion reaction (non-haemolytic febrile) and five (5) operational incidents.

Conclusions

This audit has revealed there is an increasing trend in blood transfusion in the home setting. The source of referrals i.e. public hospitals, GPs and RCFs suggests that this clinical partnership assists in reducing the overburden in the public healthcare system. Patients benefit at many levels as they avoid travel to the hospital and remain in the comfort of their normal living surrounds. With correct patient and blood supply processes, this form of blood therapy is ideally suited for certain patient groups.

OR16

ELECTRONIC MEDICATION MANAGEMENT AT HOME

Meaghan Hollamby[1], Molly Blair[1], Shiromi Arora[2]

[1]CHQatHome, Children's Health Queensland, [2]Clinical Informatics, Children's Health Queensland,

Children's Health Queensland (CHQ) has been live with ieMR since 2014, however in April 2018 Electronic Medications Management (EMM) was introduced at Lady Cilento Children's Hospital (LCCH). The transition process from paper to electronic required multidisciplinary consultation with the ieMR project team to ensure a safe and seamless journey for current inpatients[1]. A thorough business continuity plan was required in case of ieMR downtime or access issues when visiting patients offsite. CHQatHome were one of the first locations in LCCH to Go Live with EMM and had the first hospital equivalent inpatients transitioned on Go Live day. Furthermore, CHQatHome was the first Hospital in the Home Service in Queensland to utilise the complete suite of EMM in the community setting.

Aim

The aim of EMM is to provide a real-time record of medication delivery, increasing patient safety and allowing treating teams to review medications at any time, from any computer.

Methods

EMM is performed in the community via Remote Access laptop computers utilising 'Follow Me Desktop', Facetime and where required reverse checking. The downtime business continuity safety plan is followed for all patients transferred to HITH to ensure their safety.

Results

107 inpatients requiring daily medication have been transferred to CHQatHome HITH since EMM commenced in April 2018. There have been zero serious safety events since the Go Live with the only adverse events relating to patients incorrectly discharged within ieMR rather than transferred to HITH virtual ward, resulting in, at times, a need for medical officers to rechart the HITH medications. EMM has allowed timely and efficient modifications to prescribed medications.

Conclusions

EMM within CHQatHome was safely implemented in April 2018 with no serious safety events. Further education has been provided to improve the process for nursing and administration staff when children are transferred from the inpatient ward to the HITH virtual ward.

References

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OR17

FINDING OUR WAY

Joanna Burdajewicz

NSW Health, North Sydney, Australia

Aim

NSW have operated HITH Services for more than two decades under different governance and funding structures. Varying models exists locally which have developed over time to meet patient, resourcing and geographical challenges. With renewed focus over the past five years on standardisation and encouragement, HITH continues to grow in our state. Broadly, the recent programs of work have included improved activity analysis and reporting, purchasing options, policy development and focused investment.

Methods

Prior to 2013, HITH was delivered through daily and intermittent care with a lack of strategic alignment of model of care across the state and nationally. Review of HITH definitions (first edition and second edition guideline) has resulted in greater alignment of services and enabled accurate transparent reporting and HITH activity analysis. A greater focus on governance, escalation and safety and quality has been coupled with $7 million ministerial commitment for investment in the state-wide growth of HITH.

Results

In 2014/15 there were 17,573 overnight HITH separations and in 16/17 this grew to 22,977. We have achieved an increase the number of paediatric specific HITH services and extended the reach of adult HITH services in Far West NSW.

Our focus has extended to sub-acute care including rehabilitation and palliative care. Future directions include evolving telemedicine and tele-monitoring models of care, direct HITH admission models, medication safety and developing a HITH safety and quality framework.

Conclusions

A multipronged strategic investment and redesign of HITH in NSW has achieved growth and increased options for home based care for our patients.

OR18

HEART FAILURE MANAGEMENT UTILISING HOSPITAL IN THE HOME (HITH)

Helen Richards, Debra Gascard

Monash Health, Dandenong, Australia

Aim

To utilise a HITH service to optimise heart failure management in a community setting.

Methods

Utilising knowledge gained through previous service reviews of chronic heart failure management we have identified patient's preference was to receive their treatment and care at home.

For care under HITH two (2) possible cohorts were identified:

- Supportive/palliative care where intravenous frusemide was to manage symptoms of postural nocturnal dyspnoea and orthopnoea
- Patients who have become resistant to oral Frusemide.

These cohorts informed a pilot study for heart failure admissions during financial years 2015-2017.

A care pathway was developed in collaboration between General Medicine, Cardiology, Complex Care and Hospital in the Home; guidelines were written, staff education provided and processes formalised to care for this cohort.

Results

Forty seven (47) patients were admitted to the HITH during the pilot period:

- Twenty five (25) admitted to HITH directly from the community
- Twenty two (22) with facilitated early transfer from an acute bed based service into inpatient community services.

All patients were discharged home, with a corrected readmission rate of 12% (state average 15-33%).

Four (4) patients who were admitted under the supportive care stream were readmitted for palliation with twenty eight (28) days of discharge from HITH.

Conclusions

Utilisation of HITH services - Intravenous Frusemide for management of Heart Failure provided a patient centred alternative to bed based care that was;

- Financially viable
- No additional length of stay
- No increase in 28 day readmission rate
- No increase of death as an end point.

Since the conclusion of the pilot this cohort of patients has been imbedded as standard care for the service.

OR19

INSTEAD OF THINKING OUTSIDE THE BOX, GET RID OF THE BOX

Andrea Keating, Suzanne Harvey

Metro North HITH, Brisbane, Australia

Aim

Metro North HITH displayed how QLD Health's "Values in Action" is more than just words. Through negotiation and engagement with multiple medical teams and clinical units, HITH Metro North could provide an innovative solution to deliver patient-centred care safely and effectively.

Methods

A renal transplant patient's condition required a change in treatment from a daily antiviral infusion of Gancyclovir to a twice daily infusion of Foscarnet. Forscarnet is a more potent antiviral which requires supportive IV hydration pre- and post-infusion and vigilant pathology monitoring. Initially the referral appeared to have limited potential for success however by prioritising patient's needs, the emotional plea to be treated at home could be realised. Negotiation and engagement with many clinical teams and clinical units to share resources, knowledge and clinical care was the key to success.

Results

The patient was enabled to return home and receive her treatment safely and effectively with Metro North HITH. Historically, a twice a day two-hour treatment within the service's operational hours would not have been possible. With her husband's support and the flexibility and adaptability of the HITH team, excellent clinical care was provided to the patient whilst allowing her to be at home. The patient now features in the HITH marketing video, spruiking the benefits of HITH. The effective collaboration with the treating teams and with the patient resulted in a positive achievement for all.

Conclusions

At Metro North HITH we value high performance, teamwork and compassion for our patients. Using our negotiation skills and engaging our key stakeholders we were able to realise the patient's desire to be at home. Instead of thinking outside the box, we got rid of the box.

OR20

AVOIDING HOSPITAL ADMISSIONS FOR PATIENTS WITH NEUROMUSCULAR CONDITIONS USING A NOVEL CHQATHOME PHYSIOTHERAPY LED MODEL OF CARE

Nadia Hawker

Children's Health Queensland Hospital and Health Service, South Brisbane, Australia

Aim

To develop a post-acute care/hospital avoidance (HA) strategy to keep children with Spinal Muscular Atrophy (SMA) in their home environment safely. SMA is a rare genetic neuromuscular disorder identified by loss of motor neurons and progressive muscle wasting. Children with SMA often have frequent and lengthy hospital admissions, averaging 13 days per admission, and require intense respiratory physiotherapy intervention when admitted to hospital.

Methods

Patients were referred to CHQatHome by a member of the multidisciplinary team. A Respiratory Physiotherapy Home Action plan that indicates the parameters for contacting the CHQatHome physiotherapist was developed in collaboration with the family and included in the electronic medical record. Parents could contact the team at any time and a physiotherapy visit was planned within 24hrs.

Results

This HA intervention was utilised by four patients with SMA over a six month period. Thirty-six occasions of service in the home were provided by physiotherapy to these four patients. Two of these patients' required one admission each, 16 days and 11 days, and one patient required two short admissions of six days and two days within this time. Therapists were able to Facetime members of the treating team from the patient's home to ensure timely access to review and facilitate continuity of care. The risk of hospital acquired infections was also reduced by keeping patients at home.

Conclusions

Using a needs based, carer initiated hospital avoidance strategy, patients with SMA have been successfully managed out of hospital. It has reduced hospital admissions by an average of two admissions per patient over the six month period. Due to the success of this model with the current patients, it has now been expanded to other patients with chronic complex respiratory conditions.

OR21

'SHOW ME THE MONEY' – URINARY TRACT INFECTION (UTI)/PYELONEPHRITIS IN CHILDREN AND HOSPITAL-IN-THE-HOME (HITH)

Dr Barry Scanlan[1,2,3], Jessica Wong[1], William Sim[1], Dr Sarah McNab[1,2,3], Prof Andrew Davidson[1,2,3], A/Prof. Franz Babl[1,2,3], A/Prof Penelope Bryant[1,2,3]

[1]University of Melbourne, Melbourne, Australia, [2]The Royal Children Hospital, Melbourne, Australia, [3]The Murdoch Children's Research Institute, Melbourne, Australia

Aim

Having shown that HITH can manage children with acute UTI/pyelonephritis directly from the Emergency Department (ED)1, we aimed to determine the cost implications on management of all children with UTI. We aimed to analyse costs of:

1. Admitting children with UTI to hospital for intravenous (IV) antibiotics compared to HITH
2. Patients admitted to hospital who could have been treated on HITH
3. Patients treated with IV antibiotics who could have received oral antibiotics[2].

Methods

An observational study (May 2016-Mar 2018) of all children (3m-18y) diagnosed in ED with UTI/ pyelonephritis. Data collection included demographics, clinical features, treatment, length of stay (LOS), hospital readmissions. Cost analyses compared the cost of managing a medical patient acutely in hospital (AUD1,297/day) compared to HITH (AUD530/day).

Results

Of 1367 patients with UTI/pyelonephritis, 278 (20%) were admitted to hospital (712 bed-days), 25 (9%) were later transferred to HITH (50 bed-days), and 14 (1%) went directly ED-to-HITH (35 bed-days). The total cost for these three groups was respectively

AUD923,464+AUD26,500+AUD18,550=AUD968,514. The average cost for an admitted patient was AUD3,502 (LOS 2.7d) versus on HITH AUD1,325 (LOS 2.5d).

We then identified alternate strategies: of patients admitted to hospital 134/278 (48%) could have been treated on HITH; of those treated with IV antibiotics 28/292 (10%) could have been treated with oral. The potential cost savings of treating these children at home was AUD301,737 = AUD164,584/year (table).

	Inpatient Bed Days (cost)	HITH Bed Days (cost)	Total Cost
Hospital patients who could have been HITH	335 ($434,495)	-420 (-$222,600)	$211,895
IV patients who could have had oral	66 ($85,602)	8 ($4,240)	$89,842
Total potential savings	$520,097	-$218,360	$301,737 =$164,584/yr

Conclusions

Although being at home is much better for children, HITH is underused in UTI/pyelonephritis management. We have shown the financial benefits of increased HITH use and switch to oral antibiotics.

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OR22

HOSPITAL IN THE HOME DELIVERY OF CONDITIONING THERAPY FOR AUTOLOGOUS STEM CELL TRANSPLANTATION: A NOVEL SINGLE CENTRE PATIENT FOCUSED APPROACH

Dr David Routledge[1,2], Melissa Todd[2], Prof Michael Montalto[3], Dr Seok Ming Lim[2]

[1]Peter MacCallum And Royal Melbourne Hospital, Melbourne, Australia, [2]The Royal Melbourne Hospital, Melbourne, Australia, [3]The Epworth, Melbourne, Australia

Aim

High dose therapy with Autologous Haematopoietic Stem Cell Transplantation (AuHSCT) has traditionally been performed as an inpatient (IP) procedure. However, with improvements in supportive care and patient selection it is possible to safely deliver conditioning chemotherapy in an outpatient (OP) setting on large day units with daily visits.

To reduce these daily visits The Clinical Haematology department of Royal Melbourne Hospital (RMH), Peter MacCallum and Hospital in the Home (HITH) department developed a novel program to deliver supportive care at home as part of Melphalan conditioning for AuHSCT in Myeloma patients. The program was instigated in phases to identify any deficiencies and put strategies in place to rectify them before moving on to the next phase (See Figure 1). Here we report on the safety outcomes of HITH AuSCT, specifically complications and outcomes.

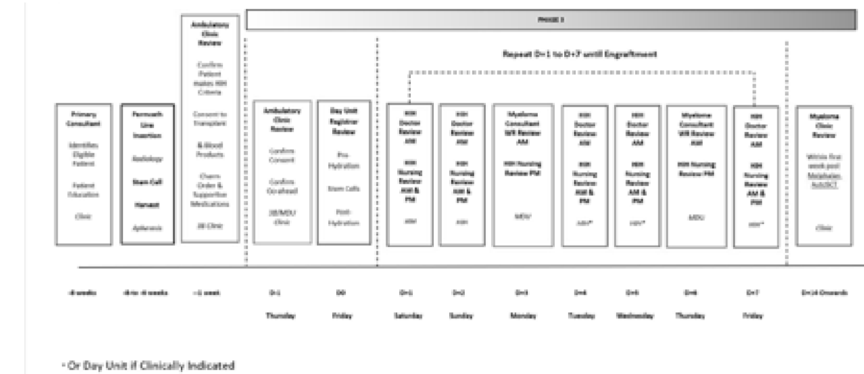

Figure 1 – Timeline Melphan AuSCT under HITH

Methods

A retrospective case note audit identified 16 consecutive AuHSCT patients who received Melphalan conditioning and supportive care between 2017 and 2018 via the HITH Program.

Results

3 patients enrolled in Phase 1 = 6 bed days saved with no unplanned admissions. 1 patient developed a fever at home but failed to inform the team. Phase 2 involved 10 patients, saving 49 bed days. 2 patients were admitted early (fever D+2 and social reasons D+3). Lastly 3 patients have entered phase 3, saving 26 bed days. All were readmitted (2 for diarrhoea at D+7 and 1 for Fever and mucositis at D+8) and this was consistent with known side effects. Overall program resulted in 81 bed days saved.

Conclusions

The HITH delivery of chemotherapy and supportive care as part of conditioning for AuHSCT in the patient's home is both safe and effective. It resulted in a total number of 81 bed days saved and the risk of complications was consistent when AuHSCT performed as an IP.

Hospital in the Home (HITH) in Queensland

With the uptake of HITH in Queensland having plateaued in recent years, and with increasing demand for health services with finite resources, maximising HITH service utilisation is essential in Queensland.

The Clinical Excellence Division is collaborating with HITH services statewide, to optimise and enhance HITH service delivery across Queensland.

improved HITH **promotion**

exploring HITH Model of Care (MoC) expansion

greater utilisation of **technology** in HITH

Clinical Excellence Division

What we do:

The Clinical Excellence Division sits within Queensland's Department of Health. **Our vision focuses on creating solutions for better healthcare in Queensland.** The department is responsible for the overall management of the Queensland public health system. The department and HHSs are collectively referred to as Queensland Health.

We:

- connect and collaborate with the department and Hospital and Health Service (HHS) clinicians to improve health services for our patients
- are the conduit for the Queensland Clinical Senate and clinical networks to engage with the department, and provide professional leadership for clinicians through the Office of the Chief Dental Officer, Office of the Chief Nursing and Midwifery Officer and Allied Health Professions Office of Queensland
- set and support the direction for mental health, alcohol and other drug services in Queensland.

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Partner with HHSs, clinicians and consumers to drive measurable improvements in patient care

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ABSTRACTS OF POSTER PRESENTATIONS

POSTER ABSTRACTS

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A PATIENT'S JOURNEY; AN INTERPROFESSIONAL APPROACH TO PATIENT-FOCUSED CARE Suzanne Blanch, Angela Ellis	PO02
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CI H7CA9G˙=B˙5 ˙D5 H=9BH!; I =898 ˙CI HD5 H=9BH˙=J ˙5 BH=6 =CH=7 ˙DFC; F5 A ˙5 H˙H<9 ˙GI BG<=B9 ˙7 C5 GH˙<CGD=H5 @5 B8 ˙<95 @H< ˙G9 FJ=7 9 ˙fG7 <<GŁ Dr Alexandra Melon, Dr Shradha Subedi, Dr Keat Choong, Ryan Gee	PO04
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PO01

THE PERFORMANCE AND SAFETY OF ELASTOMERIC INFUSORS WITH PERIPHERAL CANNULA FOR CONTINUOUS INFUSION IN THE HOME

Tracey Watson

Bundaberg Hospital, Bundaberg, Australia

Background

Continuous infusion (CI) of suitable antibiotic with elastomeric infusors via peripheral intravenous cannula (PIVC) has recently drawn interest and resulted in increased utilisation by Hospital In The Home (HITH). This infusion modality adds flexibility and capacity to HITH whose service may otherwise be limited by resourcing constraints. Despite increased utilisation, evidence demonstrating device performance and safety using this infusion method has yet to be established.

Aims

To report randomised controlled study findings examining the performance and safety of elastomeric infusors delivering CI of antibiotics via PIVC in adult HITH patients.

Methods

HITH patients prescribed CI of peripherally compatible antibiotics via PIVC (cephazolin, lincomycin, piperacillin-tazobactam), without a pre-existing central catheter, were randomised to receive treatment administered by Baxter LV10 elastomeric infusors (Baxter group) or the CADD-Solis 2120 programmable pump (CADD-Solis group) via a 20 gauge long-line inserted into the forearm. Pre-infusion device weight and time device connected were recorded daily; Post-infusion weight and time device disconnected were recorded during a 22-24-hour follow-up visit. Adverse events were documented as they occurred.

Results

137 infusions (Baxter= 66, CADD-Solis= 71) were recorded from 31 patients between July 2017-June 2018. On average the Baxter delivered 94% of antibiotic infusate over 22-24 hours infusion time, compared to 96% in the CADD-Solis group. Four infusions (Baxter= 2, CADD-Solis= 2) did not deliver the expected proportion of infusate after 22 hours. Minor adverse events relating to the device, infusion line or cannulation site occurred on 4 occasions in the Baxter, and 3 occasions in the CADD-Solis group.

Conclusions

Elastomeric infusors successfully delivered CI of peripherally-compatible antibiotic via PIVC for HITH patients with demonstrated minor adverse events comparable to the programmable pump.

PO02

A PATIENT'S JOURNEY; AN INTERPROFESSIONAL APPROACH TO PATIENT-FOCUSED CARE

Suzanne Blanch, Angela Ellis

WBHHS Bundaberg, Bundaberg, Australia

Aims

To highlight the therapeutic interventions, relationship and trust developed by the patient and family in the interprofessional team.

Methods

A patient's multiple chart review

Results

This presentation will showcase the struggles of Jack (pseudonym), a frail 83-year-old widower with multiple co-morbidities. This case spans several years and it highlights the therapeutic relationship and trust developed by the patient and his family with the team, and advocacy. Additionally, it highlights the linkage between hospital and community services.

Conclusions

Communication and liaison were identified as being the key to the success of our service. From INR and medication monitoring, following a specialist outpatient appointment through to his physical safety in the home the Team performance was underpinned by good communication and interdisciplinary respect.

PO03

DEVELOPMENT AND USE OF A PHYSIOTHERAPY ONCOLOGY SCREENING TOOL FOR A HOSPITAL IN THE HOME SERVICE

Emily Moore

The Royal Children's Hospital, Parkville, Australia

Aims

To develop a screening tool that can be easily used by Hospital in the Home (HITH) health professionals to detect children with cancer who are at risk of developing physical impairments as a result of their cancer treatment. Use of this tool should allow for timely referral to physiotherapy.

Methods

A quantitative prospective and retrospective audit of admissions of oncology patients receiving HITH is being undertaken. Data collected includes child's diagnosis, treatment phase, HITH physiotherapy input and number of physiotherapy visits.

Results

Twenty three oncology patients were admitted to HITH under oncology teams with a diagnosis between 1st July 2017 to 31st December 2017. Nine out of the 23 patients (39%) received physiotherapy during this time. There were two cases each of Pre-B cell acute lymphoblastic leukaemia (ALL), T-cell ALL, and T lymphoblastic lymphoma. One had stage 4 neuroblastoma and one had left thalamic anaplastic astrocytoma. Treatment phases during HITH admission varied and included consolidation, intensification/delayed intensification, interim maintenance and remission. Preliminary audit data following initiation of the tool from the 30th July 2018 indicates an increase in patients reviewed by a physiotherapist. Eleven of the 18 patients (61%) admitted to HITH under oncology teams were reviewed by a physiotherapist. There were three cases of T-cell ALL, five of B-cell ALL and one case each of acute myeloid leukaemia, neuroblastoma and myelodysplastic syndrome. Treatment phases during HITH admission varied and included delayed intensification, consolidation, maintenance and relapse.

Conclusions

Preliminary audit data suggests that the oncology screening tool increased the number of referrals to physiotherapy for children with cancer admitted to a HITH service.

PO04

OUTCOMES IN A PATIENT-GUIDED OUTPATIENT IV ANTIBIOTIC PROGRAM AT THE SUNSHINE COAST HOSPITAL AND HEALTH SERVICE (SCHHS)

Dr Alexandra Melon, Dr Shradha Subedi, Dr Keat Choong, Ryan Gee

Sunshine Coast Hospital and Health Service, Birtinya, Australia

Problem

Describe the epidemiology and define rates and types of complications associated with the SCHHS Home Intravenous Antibiotic Service (HIAS).

Methods

Retrospective cohort study of patients admitted to the SCHHS HIAS from January 2016 - June 2018. Patient demographics were collected on admission to HIAS with further data collected retrospectively from medical records.

Practice Change

Data was analysed to identify trends in patients who experience complications on the HIAS program. This information will be used to refine admission criteria and better select the most suitable patients to receive treatment through HIAS. The goal is to optimise future patient outcomes and improve complication rates.

Evaluation

There were 102 episodes on the HIAS program from December 2016 – June 2018. The average duration of therapy was 24.3 days (range 5-165). The most frequent indications for therapy were bone or joint infection (59%) and bacteraemia (11%). Staphylococcus aureus was the most commonly treated organism (38%) with Coagulase negative Staphylococci being the second commonest (9%).

The total cure rate for the program was 91%, with 9% of patients requiring either source control, re-admission to hospital or treatment change during their HIAS admission. 9% of patients experienced a drug related complication, most commonly to vancomycin. 7% of patients experienced a line related complication. Line related infections were more common in patients who had them inserted by the radiology department or at an out of district hospital, compared to those inserted by the SCHHS vascular access team.

Conclusions

The HIAS program is a safe means to complete treatment of conditions requiring prolonged antibiotic therapy. Outcomes may be improved by ensuring lines are inserted by the vascular access team and closely monitoring patients being treated with vancomycin.

PO05

OXYGEN PATHWAY HITH BRISBANE – METRO NORTH

Anton Nguyen

HITH, Brisbane, Australia

Aims

To provide oxygen therapy and weaning to patients whilst on Hospital in the Home (HITH).

Methods

Patients are referred from hospitals to HITH with their oxygen requirements and saturation levels for oxygen therapy. Oxygen concentrators are set up at the patient's home with education and advice provided to the family as well as discussing problem shooting issues and contact numbers if any concerns. Hospital to set target range for SpO_2 (88-92% for CO_2 retainers, 92-94% with HF or some respiratory concerns, >94% for general patient). Range can be modified for chronically hypoxic patient e.g. >85%.

Physiotherapists to review patients daily, with aim to wean oxygen if applicable. Assess patient on room air if appropriate at rest (supine/sleeping position and sitting), exertion (mobility within home and ADL's). Physiotherapists to provide and practice breathing and clearance exercises to improve lung ventilation as well as set up a reconditioning exercise program to improve demand ventilation, heart rate, thoracic ROM and improve breathing techniques with mobility. After assessment physiotherapy to discuss with medical registrar with regard to concerns and changes to oxygen therapy, liaise with team leader about changes and nursing staff to follow up later in the day where appropriate.

Results

Ensure safe and timely discharge and weaning in the community and provide education and advice to patient/family on signs and symptoms of hypoxia. It can be a stressful time for patient/family to adjust. Patients tend to recondition faster in the community due to incidental exercise and activity, improved mood and compliance. Patients are referred to MASS for home oxygen if oxygen weaning unlikely.

Conclusion

HITH can provide safe and effective oxygen therapy and weaning in the community. HITH is able to address the patient needs holistically.

PO06

SWSLHD COLLABORATED HITH MODEL

Anthony Hecimovic, Vesna Matijesavic

SSWLHD, Berrima, Australia

Aims

To develop and implement a quality Hospital In the Home program combining both Community Health Nurses and Ambulatory Care Services within South Western Sydney Local Health District

Methods

Within SWSLHD the HITH program is undertaken by a combined team. Medical Governance is primarily provided by one of 4 Ambulatory Care Services located within a corresponding hospital with some medical governance also being provided by specialist outside of the LHD. Community Health Nurses either attend to home visits or the client attends a Community Health clinic to receive their prescribed treatments.

Community Health Nurses all have a point of care device (Laptop) which is with them at each client encounter so the client's medical records, including history and current medical reviews are available instantly with the nurse. All documentation occurs electronically so up to date current information is available for both the nurses in the community and the Ambulatory Care Teams within the hospitals.

Communication is maintained with the medical officers by means of regular case reviews and regular telephone contact.

Results

Referrals to the HITH service have increased over the past 12 months to an average of approx. 230/ month. Data collected demonstrate that most of these referrals are for the administration of antibiotics, primarily for cellulitis, chest infections/pneumonia, and osteomyelitis.

Emergency representations are reported on and divided into Avoidable and Non Avoidable representations. Avoidable presentations have decreased over the 12 months to 4 across the LHD. This is primarily the result of the Community Health Nurses developing more acute type skills directly related to HITH clients.

Conclusion

The HITH model within SWSLHD to date is functioning well and is a great example of a collaborative team approach. The partnerships developed between Community Health Nurses and the in-patient Ambulatory Care services can only serve to better the care clients are receiving.

PO07

SAVING MONEY AND RESOURCES THROUGH (SMART) RECYCLING IN HITH

Kirsten Tsang[1], Jillian Hennessy [2], James Branley [2,3], Archana Sud [2,3], Ruby Samson[1]

[1]Departments of Pharmacy, Hospital in the Home and Infectious Diseases, Nepean Hospital, Sydney, Australia, [2]Hospital in the Home and Infectious Diseases, [3]Department of infectious Diseases, Nepean Hospital, Sydney, Australia

The Nepean Hospital in the Home (HITH) provides parenteral antibiotic therapy (OPAT) in the community. For patients on long term antibiotic infusions, a week's worth of infusers are ordered at a time and given to patients to store at home. Whenever there is a change in antibiotic therapy, drug or duration, the infusers stored in patients' homes are disposed of, hence wasted. As a pilot, cost analysis over one month revealed a waste of 2410.00 dollars.

Objective

To reduce cost of providing antibiotic infusers to patients on the HITH service

Methods

Antibiotic infusers for all patients admitted to Nepean HITH between February and August 2018 were kept in the HITH pharmaceutical grade fridge with 24 hour temperature monitoring. These were taken out daily by the nurse visiting the patients' home on the day. Infusers which were not used could then be relabelled for another patient or discarded as appropriate.

Results

During the pilot of one month in January 2018, 22 infusers were disposed of and 13 could be recycled using the old system of dispensing a weeks' worth of infusers for patients to take home. This amounted to a waste of 2410.00 AUD for that month. Over February to August 158 infusers were wasted, average of 19 per month. 140 infusers could be recycled, an average of 18 per month. This amounted to a total saving of 15953.00 dollars (average 2084.00 per month).

Conclusions

Keeping antibiotic infusers in the HITH fridge is an effective way of ensuring adequate cold chain requirements and increasing cost effectiveness. Moving forward, a closer analysis on which antibiotic infusers were least likely to be relabelled (and therefore disposed) would further aid in reducing wastage.

PO08

ASSESSMENT OF AN AMBULATORY CARE PROGRAM FOR PATIENTS WITH LOW RISK FEBRILE NEUTROPENIA IN A REGIONAL CANCER CENTRE

Dr Raquel Cowan

Ballarat Health Services, Ballarat, Australia

Background/Aims

Febrile neutropenia (FN) is a common complication of chemotherapy for solid organ and haematological malignancies. Patients at low risk of medical complications from FN are identified using the validated Multinational Association of Supportive Care in Cancer (MASCC) risk index. Scores ≥21 are considered to be at a <5% risk of a complication, allowing management as an outpatient by the Hospital in the Home (HITH) service.1,2 The aim is to determine if this is a feasible model of care in terms of reduction in inpatient length of stay (LOS) and cost benefit to our regional hospital

Methods

A retrospective audit was undertaken of all FN presentations to the regional centre in 2017. Patients with a MASCC risk score ≥21 were identified as potential Hospital in the Home candidates. The median length of stay was determined for low risk patients and compared to an estimated HITH length of stay. Total costs of inpatient admissions were determined from diagnosis related group (DRG) codes, applied to low risk patients and compared to predicted HITH costs.[1]

Results

Twenty of the 50 FN patients were identified as low risk and appropriate for the HITH service. Patients with low risk FN had a median LOS of 3.8 days at an average cost of $895.14 per patient bed day. Comparatively, the predicted LOS is 3.0 days with HITH at an expected cost of $241.00 per patient bed day. The difference between the two is $654.14 per patient bed day. Therefore, for a 12-month period, the ambulatory program is estimated to result in a nett cost benefit of $238,761.10.

Conclusions

An ambulatory program for low risk FN patients via the HITH service is feasible, with an estimated reduction in hospital LOS with resultant significant cost benefits. This is also likely to lead to an improvement in patient satisfaction.

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PO09

A RETROSPECTIVE AUDIT OF CONTINUOUS VANCOMYCIN INFUSION PRESCRIBING IN PATIENTS DISCHARGED TO HOSPITAL-IN-THE-HOME

Marissa Sakiris[2], Marisol Cincunegui[1], Dr Carl Schneider[2], Kristin Xenos[1], Dr Indy Sandaradura[1], Dr Susan Maddocks[1], Dr Jonathan Penm[2]

[1]Westmead Hospital, Westmead, Australia, [2]University of Sydney, Camperdown, Australia

Aims

To assess a tertiary hospital's compliance with local vancomycin prescribing guidelines for patients on continuous vancomycin infusions and explore the potential link between compliance and delayed discharge to hospital-in-the-home (HITH).

Methods

A retrospective audit was conducted of adult patients discharged on continuous vancomycin infusions over a 2 year period. Target vancomycin levels were defined as 20-25 mg/L. Non-compliance was divided into under dosing and overdosing based on the starting dose and first dose adjustment, based on therapeutic drug monitoring (TDM). Multivariable logistic regression was used to assess the impact of compliance with guidelines on delayed discharge.

Results

In total, 70 patients were discharged on continuous vancomycin infusions. 49% (n=34) of patients received vancomycin compliant with the local prescribing guidelines while 51% (n=36) received vancomycin that was non-compliant. Multivariable logistic regression showed that patients who were under dosed had an odds ratio of 4.6 of having a delayed discharge compared to those that were compliant (95% CI:1.3-13.2). 42% of the non-compliant group experienced delayed discharge resulting in an extra 45 days in hospital and costing $51 975.

Conclusions

The majority of patients receiving continuous vancomycin infusions did not receive guideline-compliant dosing. Patients that had dose adjustments lower than stipulated by local guidelines had a significantly increased odds of having a delayed discharge. Significant costs were associated with delayed discharge from non-compliant prescribing. Targeted clinical interventions by pharmacists and doctors to optimise vancomycin prescribing may reduce length of stay, promote earlier discharge through hospital-in-the-home, and reduce costs to the hospital.

PO10

IMPLEMENTING HOSPITAL IN THE HOME (HITH) SPECIFIC ANTIMICROBIAL PROTOCOLS IN THE ELECTRONIC MEDICATION MANAGEMENT SYSTEM-SUPPORTING OUR CLINICIANS IN BEST PRACTICE

Christine Lo[1], Michelle Horsnell[1], Dr Stephen Dang[1], Lucy Wilson[1], Ian Campbell[1], Dr Amalie Wilke[1], A/Prof Dr Mary O'Reilly[1,2]

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Aims

In response to a medication incident related to inadvertent incorrect antimicrobial dosing, HITH specific antimicrobial protocols were developed in our electronic medication management system (MedChart®).

Methods

The incident involved sub-therapeutic antimicrobial dosing via infusion pump related to an incorrect medication frequency order (daily rather than 6-hourly). Possible contributing factors included prescriber work pressure and distraction. It was decided to review and update HITH specific antimicrobial protocols and include them in our electronic system to reduce this risk.

The protocols were reviewed and updated collaboratively by the HITH and Antimicrobial Stewardship (AMS) teams to reflect current practice and Therapeutic Guidelines: Antibiotic™. The updated protocols were approved by the AMS Committee, then set up by the Clinical Applications Support Pharmacist and double-checked by the Clinical Applications Lead Functional Analyst who is also a pharmacist. The new protocols were trialled before going live. 'How to prescribe' information sheets were developed to support use.

Results

The updated protocols include specific details, including agent, total dose of antibiotic to be administered in 12 or 24 hours, dosing regimen, administration times and instructions. These details are also utilised by pharmacists when dispensing antibiotics. The implementation of HITH electronic protocols supports efficient, accurate and safe prescribing compared with manual transcription from in-patient to HITH orders.

Conclusions

This quality improvement activity supports patient safety with clear dosing instructions for all medical, nursing and pharmacy staff. The protocols eliminate transcription errors, reduce risk of incorrect infusion dosing and promote consistent practices. The implementation and utilisation of protocols were well received by all clinicians and we have also implemented other non-antimicrobial HITH protocols using this principle.

PO11

SUPERVISED SELF-ADMINISTRATION OF OUTPATIENT PARENTERAL ANTIBIOTIC THERAPY IN TAN TOCK SENG HOSPITAL, SINGAPORE

Zhong Lihua

Tan Tock Seng Hospital, Singapore

Aims

Tan Tock Seng was the first hospital to offer Outpatient Parenteral Antibiotic Therapy (OPAT) in Singapore in 2001. The ability to manage patients in the community setting reduces pressure on hospital beds utilization and the risk of developing nosocomial infections, whilst maintaining patient autonomy has led to increasing interest in OPAT services. To facilitate the uptake of OPAT service, patient/ caregiver OPAT(S-OPAT model) was introduced since 2008.The aim of this study was to evaluate the progress, impact and safety of S-OPAT model over the past ten years.

Methods

Selected patients or caregivers would complete training and assessment by OPAT nurses to ensure competency prior to entry into the S-OPAT program. Antibiotic administration for S-OPAT was limited to pharmacy prepared antibiotic elastomeric infusors connected to a peripherally inserted central catheter (PICC). Patients or caregivers were educated on line care, complications and a 24 hour hotline was provided. Change of PICC dressing and medical review were performed weekly at the hospital clinic. From 1 April 2008 to 31 March 2018, data on patients enrolled in S-OPAT were reviewed.

Results

There were 478 patients enrolled in S-OPAT from April 2008 to March 2018 resulting in 13633 bed days saved; median duration of S-OPAT treatment was 28 days. Readmission rate of S-OPAT was 13%, in comparison clinic OPAT was 10% and home OPAT was 18%. Line related complications occurred in 3/1000 catheter days, similar to clinic and home OPAT patients (3.5/1000). With the introduction of S-OPAT service, the total number of bed days saved in OPAT increased from 3649 days in 2007 to 6808 in 2017, an 86.6% increase.

Conclusions

OPAT using S-OPAT model is an effective and safe intervention to increased uptake of OPAT amongst suitable patients.

PO12

PATIENT SATISFACTION OF NURSE CLINICIAN LED FOLLOW-UP AT OUTPATIENT PARENTERAL ANTIBIOTIC THERAPY (OPAT) CLINIC

Zhong Lihua

Tan Tock Seng Hospital, Singapore

Aims

To support the expanding Outpatient Parenteral Antibiotic Therapy (OPAT) service and encourage up-skilling of nursing staff, a trained OPAT nurse clinician (NC) was introduced to assist care delivery with nurse-led outpatient weekly clinic reviews of selected OPAT patients on their second and/or third visit under physician supervision from April 2016.

Methods

Tan Tock Seng Hospital (TTSH) is a university affiliated 1500 bed hospital in Singapore. The TTSH OPAT clinic has been in service since 2001 treating approximately 350 patients per year with weekly clinic reviews of all OPAT patients. From June 2016 to Feb 2017, OPAT patients who had been reviewed at least once in a NC led clinic were given an anonymous questionnaire at the completion of OPAT therapy regarding their satisfaction with this new service.

Results

Of 74 patients given the questionnaire, 64 (86%) completed the survey. All surveyed participants indicated that information was given in an understandable manner and would like or did not mind being seen by NC. Approximately half (36/64; 56%) felt that they were able to discuss additional issues because they had seen a NC rather than doctor. On a scale of one to ten for overall satisfaction with 10 being completely satisfied, 66% rated the service as 10 out of 10, 20% rated 9 out of 10 and 14% rated 8 out of 10.

Conclusions

Our results indicate that in selected patients, follow-up in NC led clinic provides excellent patient satisfaction. This nursing up-skilling effort helps to increase overall manpower productivity and is aligned with Singapore Ministry of Health Nursing Taskforce recommendations on enhancing nursing professional development and career advancement.

PO13

INTRAVENOUS ACCESS IN CHILDREN TREATED IN HOSPITAL-IN-THE-HOME

Dr Grainne Butler[1], Dr Suzanne Boyce[1,2], Dr Joanne Lawrence[1,2], Dr Kate Simpson[1,2], A/Prof Penelope Bryant[1,2,3]

[1]RCH @Home Department, Royal Children's Hospital Melbourne, Melbourne, Australia, [2]Department of General Medicine, Royal Children's Hospital, Melbourne, Australia, [3]Murdoch Children's Research Institute, Royal Children's Hospital, Melbourne, Australia

Aims

The advantages of receiving intravenous antibiotics via Hospital-in-the-Home (HITH) have been previously documented. The optimal choice of intravenous access in children remains unclear. We report our experience of line-associated complications.

Methods

Clinical, demographic and outcome data were prospectively recorded for all patients admitted to HITH for parenteral antibiotics from April 2015-April 2018.

Results

1690 patients were identified, with complete data in 1574.855(54%) were male with a median age of 6.6 years(IQR 2.3-12.2).Median HITH stay was 7 days (IQR 3-12).The most common form of IV access were peripheral cannula (n=420), PICC(n=314) and tunnelled CVC(n=314).Complications associated with IV access occurred in 129 cases(7.6%)(table 1).When divided by access type, complications were greater with peripheral than central access (12.1% vs 6.1%, p<0.0001). Type of peripheral line (cannula vs midline) did not affect rates of complication(p=0.63).

Conclusions

CVCs were associated with few complications and were a reliable method of venous access when compared to peripheral access, and were used frequently in patients requiring longer courses of parenteral antibiotics. Peripheral lines were used for short durations of treatment but had high rates of failure. Factors that should influence choice of intravenous access in children include expected duration of treatment, need for continuous infusions and local expertise and experience.

Complication	ACCESS TYPE						TOTAL
	Peripheral Cannula	Midline	PICC	Port	Tunnelled CVC	Non-Tunnelled CVC	
Dislodged/Leaking/broken - Resited	367	104	344	317	298	15	1445
Dislodged/Leaking/Broken – Not Re-sited	6	1	1	5	4	9	17
Tissued/Blocked – Re-sited	16	0	4	0	3	0	23
Tissued/Blocked – Not Re-sited	8	2	10	2	3	0	25
Nil Tunnel/Site Infection – Re-sited	22	7	9	2	2	1	43
Tunnel/site Infection – Not re-sited	0	1	0	1	1	0	3
Stiff line – Continued	0	0	0	0	0	0	0
Stiff line – Continued	1	1	10	2	4	0	18
TOTAL	420	116	378	329	315	16	1574

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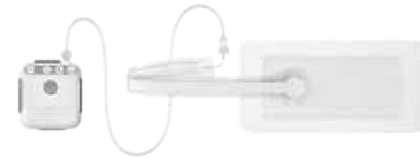

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References

1. Dowsett C, et al. Use of PICO to improve clinical and economic outcomes in hard-to-heal wounds. *Wounds Int* 2017;8(2):53-58. A prospective cohort study of 52 wounds.

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WEDNESDAY 21 NOVEMBER 2018

Time	Session
10.00 -17.00	**HITH Society Executive Meeting** Stamford Lounge
17.00 - 18.30	**REGISTRATION OPEN** **Registration Desk, Hotel Foyer**
18.00 - 19.00	**Welcome Reception** Pav Bar, Stamford Plaza Brisbane

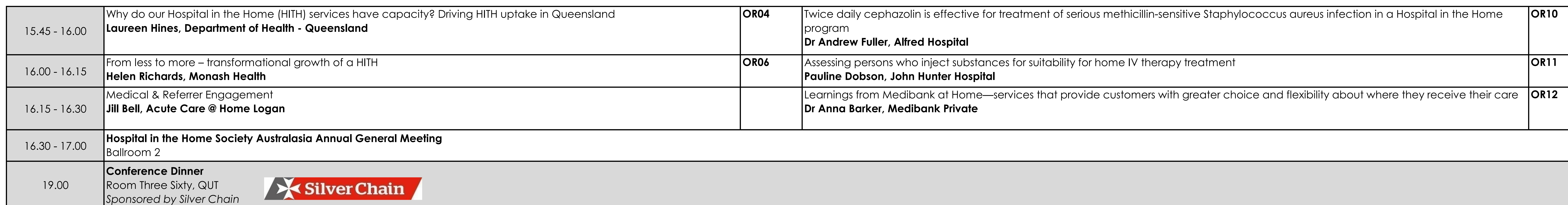
THURSDAY 22 NOVEMBER 2018

Time	Session
07.30 - 17.00	**REGISTRATION OPEN - DAY 1** Registration Desk, Conference Floor
08.00 - 15.20	**Exhibition Open & Arrival Tea and Coffee** River Room
08.30 - 10.40	**CONFERENCE OPENING** **Chair: Barbara Farrelly, President, HITH Society Australasia** **Grand Ballroom**
08.30 - 08.40	**Welcome to Brisbane and Conference Opening** *Angela Ellis* , Conference Convenor
08.40 - 09.00	**Opening Address** *Adjunct Professor Shelley Nowlan* , Chief Nursing and Midwifery Officer, Clinical Excellence Division Department of Health, Queensland
09.00 - 09.45	**KEYNOTE ADDRESS: The future of Hospital in the Home – is there one?** *Philip Darbyshire* , Internationally Recognised Leader in Nursing & Health Care Research and Service Development
09.45 - 10.15	**DVRS – Everyone's Business** *Dr John Cass-Verco* , Royal Prince Alfred Hospital
10.15 - 10.40	**Q&A: Antimicrobials in HITH** Facilitator: Mary O'Reilly, Austin Health Panellists: *Chris Shenton* , PureIV *Dee Loader* , Alfred HITH *James Pollard* , Barwon Health - University Hospital Geelong
10.40 - 11.10	**MORNING TEA, EXHIBITION AND POSTER VIEWING** River Room
11.10 - 12.20	**PLENARY SESSION** **Chair: Angela Ellis, Wide Bay Hospital and Health Service** **Grand Ballroom**
11.10 - 11.45	**INTERNATIONAL KEYNOTE ADDRESS: Knowledge of HITH in the UK** *Karen Titchener,* Huntsman Cancer Institute, University of Utah (formerly Guys & St Thomas NHS Foundation, London)
11.45 - 12.00	**HITH Society Memorial Oration - Dr Nicholas Collins** *Nicholas Marlow* , HITH Society Executive
12.00 - 12.20	**Nick Collins Fellowship** Introduction by *Barbara Farrelly* , President HITH Society Australasia; Presentation by *Angela Burge* , The Alfred Hospital and LaTrobe University, Melbourne - Nick Collins Fellowship Award Winner 2017 Announcement of 2018 winner by *Brendan Cummins,* Director, Baxter Compounding & Pharmaceuticals, ANZ
12.20 - 13.20	**NETWORKING LUNCH, EXHIBITION AND POSTER VIEWING** River Room

Time	Workshop A	Workshop B	Workshop C	Workshop D
13.20 - 14.30	**Workshop A** STAFF WELLBEING **Raffles 1**	**Workshop B** CLINICAL LEADERSHIP **Ballroom 1**	**Workshop C** FEISTY FEET **Raffles 2 & 3**	**Workshop D** RESEARCH **Ballroom 2**
	Dee Loader, The Alfred **Mary O'Reilly** , Austin Health **Michelle Horsnell,** Cabrini Health	**Dr Nicole Hancock,** Princess Alexandra Hospital **Melissa McCusker**, Metro South Health@Home	**Rita Raj,** Browns Plains Community Health Centre, QEII Hospital **Manjeet Sagoo,** Redlands Hospital Physiotherapy and Podiatry, Metro South Health	**Dr Daryl Kroschel,** Silver Chain

Time	Session
14.30 - 15.00	**AFTERNOON TEA, EXHIBITION AND POSTER VIEWING** River Room

Time	Concurrent Session 1		Concurrent Session 2	
15.00 - 16.30	**Concurrent Session 1: Presentation of Papers - ENGAGE** *Chair: Sue Henning, Silver Chain Group* **Ballroom 1**		**Concurrent Session 2: Presentation of Papers - RESEARCH** *Chair: Dee Loader, Alfred HITH* **Ballroom 2**	
15.00 - 15.15	Engaging in personalised, innovative, connected health care **Vanessa West & Julie Sturgess, Hospital In Your Home**	**OR01**	The implementation of remote home monitoring within a public Hospital in the Home (HITH) service **Vickie de Jong, QLD Health** **Vickie Irving, Telstra Health**	**OR07**
15.15 - 15.30	An analysis of 890 patients discharged through Out Patient Intravenous Antibiotic (OPIVA) service at Waitemata District Health Board (WDHB) Auckland **Beverley Hopper, Waitemata District Health Board**	**OR02**	Multidisciplinary Clinical Handover for HITH - Quality and Assurance Project **Dr Linda Lin, Royal Melbourne Hospital**	**OR08**
15.30 - 15.45	'Joey' - A new multidisciplinary model to improve feeding support of young children at home **Dr Jye Gard & Dr Joanna Lawrence, Royal Children's Hospital**	**OR03**	Holoportation: 3D Teleconferencing in the Home **Dr Daryl Kroschel, Silver Chain Group**	**OR09**



Time	Session		Session	
15.45 - 16.00	Why do our Hospital in the Home (HITH) services have capacity? Driving HITH uptake in Queensland **Lauren Hines, Department of Health - Queensland**	**OR04**	Twice daily cephazolin is effective for treatment of serious methicillin-sensitive Staphylococcus aureus infection in a Hospital in the Home program **Dr Andrew Fuller, Alfred Hospital**	**OR10**
16.00 - 16.15	From less to more – transformational growth of a HITH **Helen Richards, Monash Health**	**OR06**	Assessing persons who inject substances for suitability for home IV therapy treatment **Pauline Dobson, John Hunter Hospital**	**OR11**
16.15 - 16.30	Medical & Referrer Engagement **Jill Bell, Acute Care @ Home Logan**		Learnings from Medibank at Home—services that provide customers with greater choice and flexibility about where they receive their care **Dr Anna Barker, Medibank Private**	**OR12**
16.30 - 17.00	**Hospital in the Home Society Australasia Annual General Meeting** Ballroom 2			
19.00	**Conference Dinner** Room Three Sixty, QUT *Sponsored by Silver Chain*			

FRIDAY 23 NOVEMBER 2018

Time	Session		Session	
08.30 - 16.30	**REGISTRATION OPEN - DAY 2** Registration Desk, Conference Floor			
08.30 - 15.30	**Exhibition Open & Arrival Tea and Coffee** River Room			
09.00 - 10.30	**PLENARY SESSION** **Chair: Angela Ellis, Wide Bay Hospital and Health Service** **Grand Ballroom**			
09.00 - 09.30	**PICCs at Home - A Retrospective Cohort Study** *Nicole Marsh* , The AVATAR Group			
09.30 - 10.00	**Retrofitting a HiTH Service in an acute care model – from bespoke to BAU** *Dr Michael Young,* The Townsville Hospital			
10.00 - 10.30	**The Move From Acute Hospital Care to Home-Based Acute Care** *Shelley Nowlan,* Queensland - Department of Health			
10.30 - 11.00	**MORNING TEA, EXHIBITION AND POSTER VIEWING** River Room			
11.00 - 12.15	**Concurrent Session 3: Presentation of Papers - LEARN / ENGAGE** **Chair: *Dr Daryl Kroschel, Silver Chain Group*** **Ballroom 1**		**Concurrent Session 4: Presentation of Papers - ASPIRE / NEGOTIATE / RESEARCH** **Chair: *Mary O'Reilly, Austin Health*** **Ballroom 2**	
11.00 - 11.15	Allied Health Led Hospital in the Home **Rachel Thomas, Children's Health Queensland**	**OR13**	Heart failure management utilising Hospital in the Home (HITH) **Debra Gascard, Monash Health**	**OR18**
11.15 - 11.30	Home Improvement – Changing and Challenging HITH with SIM **Rachael Sloane & Pippa Cadwallader, Sydney Children's Hospital Network Randwick**	**OR14**	Instead of thinking outside the box, get rid of the box **Suzanne Harvey & Andrea Keating, Metro North HITH**	**OR19**
11.30 - 11.45	Blood and blood product transfusion in a community setting in South Australia **Parimal Shrimali, RDNS SA**	**OR15**	Avoiding hospital admissions for patients with neuromuscular conditions using a novel CHQatHome Physiotherapy led model of care **Nadia Hawker, Children's Health Queensland**	**OR20**
11.45 - 12.00	Electronic Medication Management at Home **Meaghan Hollamby, Children's Health Queensland**	**OR16**	'Show me the money' – urinary tract infection (UTI)/pyelonephritis in children and Hospital-in-the-Home (HITH) **Dr Barry Scanlan, University of Melbourne**	**OR21**
12.00 - 12.15	Finding our way **Joanna Burdajewicz, NSW Health**	**OR17**	Hospital in the Home Delivery of Conditioning Therapy for Autologous Stem Cell Transplantation: A Novel Single Centre Patient Focused Approach **Dr David Routledge, Peter MacCallum and Royal Melbourne Hospital**	**OR22**
12.15 - 13.15	**NETWORKING LUNCH, EXHIBITION AND POSTER VIEWING** River Room			
13.15 - 15.00	**PLENARY SESSION** **Chair: Dr James Pollard, Barwon Health - University Hospital Geelong** **Grand Ballroom**			
13.15 - 14.15	**The Current & Future Role of Private Health Funds in HITH** Panellists: *Dr Anna Barker* , Head of Member Health Innovation, Medibank Private *Natalie Dubrowin,* Head of Health Partnership Models, Bupa *Monique Berger* , Clinical Advisor, HCF *Monica Tribe* , RN Coordinator, nib Health Funds			
14.15 - 15.00	**INTERNATIONAL KEYNOTE ADDRESS: Ambulance Clinical Pathway** *Karen Titchener,* Huntsman Cancer Institute, University of Utah			
15.00 - 15.25	**AFTERNOON TEA, EXHIBITION AND POSTER VIEWING** River Room			
15.25 - 16.30	**PLENARY SESSION** **Chair: Barbara Farrelly, President, HITH Society Australasia** **Grand Ballroom**			
15.25 - 16.00	**KEYNOTE ADDRESS: A Researcher Looks at Leadership** *Philip Darbyshire* , Internationally Recognised Leader in Nursing & Health Care Research and Service Development			
16.00 - 16.30	**Awards & Prizes / Conference Handover 2019**			
16.30	**Conference Close**			