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In this issue of the HITH Review we have included commentaries on two Australian studies, several interesting abstracts from published articles and a listing of many recent publications that are relevant to acute home care.

Most of the articles listed in this review are available either from libraries in Australia or journal websites. Copies of articles with an asterisk (★) can be requested from ACA if required for educational or research purposes by using the order form available on the website.

We hope you find the HITH Review to be a valuable resource and we would welcome any contributions or any feedback.

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## Stability of Flucloxacillin Infusions

Lisa Demos

Carroll JA. Stability of Flucloxacillin in elastomeric infusion devices. *J Pharm Pract Res* 2005; 35:90-2. ★

The aim of the study was to determine the stability of high-dose flucloxacillin infusions in 10ml/h elastomeric infusion devices after storage for 6 days at 2-8°C and then temperatures expected during administration.

Three infusers were prepared for each arm of the study. Each contained 12g flucloxacillin diluted to 240ml with 0.9% sodium chloride. Flucloxacillin concentrations were determined after storage at 2-8°C for 6 days, 2-8°C for 6 days then 31°C for up to 24 hours and 2-8°C for 6 days 31°C for 17 hours and then 37°C for 7 hours.

Flucloxacillin retained 94% of the initial concentration after 6 days at 2-8°C and at 31°C for up to 24 hours but only 87% when the temperature was raised to 37°C for 7 hours.

Flucloxacillin at nominal concentration of 50g/L is stable in elastomeric infusion devices at 2-8°C for 6 days and then at 31°C for up to 24 hours.

### comment

There has been ongoing interest in the stability of flucloxacillin infusions with the "HITH Line" receiving several requests for information. In this study the authors simulated the highest likely skin temperature reached by a solution worn in a waste pouch (i.e. 31°C) and used the acceptable stability cut-off of 90% of the initial concentration at the end of the dosing interval. Based on their results refrigerated 'in-house' flucloxacillin infusions were stable for at least 6 days (98% of initial concentration) and were considered stable under normal administration conditions (94% of initial concentration). Although the study did not determine the longest expiry for an 'in-house' refrigerated solution it was able to provide evidence to support the stability during administration when the temperatures reached were no greater than 31°C. Higher temperatures appear to compromise the stability. Note commercial flucloxacillin solutions have longer expiry dates.

## Pulmonary Embolism

Lisa Demos

Ong BS, Karr MA, Chan DKY et al. Management of pulmonary embolism in the home. *Med J Aust* 2005; 183:239-42. ★

This retrospective study of an ambulatory care unit and medical record data describes the characteristics, outcomes and treatment complications of patients with pulmonary embolism (PE) treated at home and as outpatients in an ambulatory care program during 2003. The data collected included demographic and clinical data, standard clinical indicators of unplanned admission during treatment program, incidence of major bleeding, recurrent venous thromboembolism (VTE), and death within 3 months of admission into the ambulatory care program.

130 patients (67%) with PE were treated by the ambulatory care program: 46% totally as outpatients and 54% as early discharge patients. Mean age was 66.4 years; 61% were women. The program was successfully completed for 89% of patients; one patient was lost to follow-up. There were three episodes of major bleeding (2%; 95% CI, 0.5%-7%), all in patients aged >70 years. Four patients died (3%; 95% CI, 0.8%-8%) within 3 months of admission into the program, but none in the first week, no death being directly attributable to PE. There were seven episodes of recurrent VTE (5%; 95% CI, 2%-11%).

Appropriately selected patients with sub-massive PE can be treated as outpatients or at home. Although the outcome is good in most patients, a significant proportion will require admission, emphasising the need for a well defined protocol and close medical supervision. Further study will more closely define at-risk patients and refine the care pathways.

### comment

Despite the limitations of this study it is useful as it presents data on the out of hospital management of PE in an Australian setting. The results highlight that although most patients who meet the criteria to be accepted into the ambulatory care program can be managed successfully, there are some who require regular medical review.

## Relevant abstracts from Medline and Cinahl

### Community-acquired Pneumonia

Richards DA, Toop LJ, Epton MJ et al. Home management of mild to moderately severe community-acquired pneumonia: a randomised controlled trial. *Med J Aust* 2005; 183:235-8. ★

This randomised controlled trial from Christchurch, New Zealand determined whether community management of mild to moderate community-acquired pneumonia (CAP) is as effective and acceptable as standard hospital management.

From July 2002 to October 2003 55 patients presenting at the Christchurch Hospital emergency department with mild to moderately severe pneumonia were randomised to usual Hospital treatment or comprehensive home care delivered by primary care teams. The main outcome measures were days to discharge, days on intravenous (IV) antibiotics, patient-rated symptom scores, health status measured using level of functioning at 2 and 6 weeks and patient satisfaction.

The median number of days to discharge was higher in the home care than the hospital group (4 days, range 1-14 vs. 2 days, range 0-10;  $P = 0.004$ ). There was no difference in the number of days on IV antibiotics or on subsequent oral antibiotics. Patient-rated symptom scores at 2 and 6 weeks, median change in symptom severity from baseline to 6 weeks, and general functioning at 2 and 6 weeks did not differ between the groups. Patients in both groups were satisfied with their treatment, with a clear preference for community treatment ( $P < 0.001$ ).

Mild to moderately severe CAP can be managed effectively in the community by primary care teams. This model of comprehensive care at home can be implemented by primary care teams with suitable funding structures.

### Duration of Anticoagulation

Ost D, Tepper J, Mihara H et al. Duration of anticoagulation following venous thromboembolism. *JAMA* 2005; 294:706-13. ★

Patients with venous thromboembolism (VTE) are susceptible to recurrent events, but whether prolonging anticoagulation is warranted in patients with VTE remains controversial. The objective of this study was to review the available evidence from randomized controlled trials with results published from 1969 through 2004 and quantify the risks and benefits of extending the duration of anticoagulation in patients with VTE. Data sources searched included PubMed, EMBase Pharmacology, the Cochrane database, clinical trial Web sites and reference lists. Studies that enrolled only pure populations of high-risk patients were excluded. Each article was assessed for inclusion and exclusion criteria by 2 independent reviewers, with adjudication by a third reviewer in cases of disagreement.

Fifteen of 67 studies were included in the analysis. Two independent reviewers extracted the data regarding recurrent VTE, major bleeding, person-time at risk, and study quality using a standardized form, with adjudication by the remainder of the investigators in cases of disagreement.

If patients in the long-term therapy group remained receiving anticoagulation, the risk of recurrent VTE with long- vs short-term therapy was reduced (weighted incidence rate, 0.020 vs 0.126 events/person-year; rate difference, -0.106 [95% confidence interval {CI}, -0.145 to -0.067];  $P < .001$ ; pooled incidence rate ratio [IRR], 0.21 [95% CI, 0.14 to 0.31];  $P < .001$ ). If anticoagulation in the long-term therapy group was discontinued, the risk reduction was less pronounced (weighted incidence rate, 0.052 vs 0.072 events/person-year; rate difference, -0.020 [95% CI, -0.039 to -0.001];  $P = .04$ ; pooled IRR, 0.69 [95% CI, 0.53 to 0.91];  $P = .009$ ). The risk of major bleeding with long- vs short-term therapy was similar (weighted incidence rate, 0.011 vs 0.006 events/person-year; rate difference, 0.005 [95% CI, -0.002 to 0.011];  $P = .14$ ; pooled IRR, 1.80 [95% CI, 0.72 to 4.51];  $P = .21$ ).

Therefore patients who receive extended anticoagulation are protected from recurrent VTE while receiving long-term therapy. The clinical benefit is

maintained after anticoagulation is discontinued, but the magnitude of the benefit is less pronounced.

## Cystic Fibrosis

Thornton J, Elliott R, Tully MP et al. Long term clinical outcome of home and hospital intravenous antibiotic treatment in adults with cystic fibrosis. *Thorax* 2005; 59: 242-6. ★

A retrospective longitudinal study was performed to compare the clinical outcome over a period of 1 year of all patients attending the Manchester Adult CF Unit who received i.v antibiotics at home or in hospital. The primary outcome measure was percentage change in forced expiratory volume in 1 second (FEV(1)) at the end of the 1 year period. Baseline "best" and "average" FEV(1) values were established for each patient for the year before the study. The secondary outcome measures were percentage changes in forced vital capacity (FVC) and body weight.

A total of 116 patients received 454 courses of i.v. antibiotics. At the end of 1 year there had been a mean percentage decline in FEV(1) compared with the baseline "average" for patients treated mostly at home but an improvement in patients treated mostly in hospital (Tukey's HSD mean difference 10.1%, 95% CI 2.9 to 17.2,  $p = 0.003$ ). For all patients there was a mean percentage decline in FEV(1) from the baseline "best" value. For each course of treatment the mean percentage improvements in FEV(1) at the end of the course from the start of the course were significantly higher for patients treated in hospital than for those treated at home.

Clinical outcome, as defined by spirometric parameters and body weight, was better after a course of treatment in hospital than after home treatment, and this benefit was maintained over 1 year of treatment. The results suggest that patients treated at home need closer supervision.

## RCT of Home Intravenous Antibiotic Therapy

Wolter JM, Cagney RA, McCormack JG. A randomised trial of home vs hospital intravenous antibiotic therapy in adults with infectious diseases. *J Infection* 2004; 48: 263-8. ★

A prospective, randomised trial was undertaken of home versus hospital therapy in adults receiving intravenous (IV) antibiotics to show that home care is a feasible alternative to hospitalisation over a broad range of infections, without compromise to quality of life (QOL) or clinical outcomes. Consenting adults requiring IV antibiotics were randomised to complete therapy at home or in hospital. Short Form 36 (SF36) and Perceived Health Competence Scale (PHCS) were used for assessment of QOL. Statistical analysis used unpaired t-tests, Mann-Whitney tests and ANOVA.

One hundred and twenty-nine admissions were referred. Recruitment was hampered by patient preference for one therapy over another. 82 (62%) were included and randomised: 44 to home, 38 to hospital; the two groups had comparable characteristics. There were no differences in improvements in QOL and PHCS scores between the two groups after treatment. Treatment duration was median 11.5 days (range 3-57) and 11 days (range 4-126) for home and hospital groups, respectively. Home therapy costs, approximately, half that of hospital therapy. Time to readmission was longer after hospital therapy.

This study showed that home IV therapy is well tolerated, is less costly, is not associated with any major disadvantage to QOL or clinical outcomes compared to hospital therapy, and is an appropriate treatment option for selected patients.

## Cancer treatment

Remonnay R, Devaux Y, Chvetzoff G et al. Cancer treatment at home or in the hospital: what are the costs for French public health insurance? Findings of a comprehensive-cancer centre. *Health Policy*. 2005; 72:141-8. ★

The objective of this study was to evaluate the cost of home-cancer-healthcare programs and their potential interest for public health insurance as compared to inpatient cancer care. The study was conducted at the Centre Leon Berard (CLB), a comprehensive cancer centre in Lyon, France. Hospitals at home patients were monitored by nurses and oncologists from the CLB. All patients, who received home treatment over a 15-day period in 2001, were included in the study.

Patients were broken down into groups according to the type of healthcare required and the corresponding impact on health insurance expenditure. For each of these patients, a fictive-hospital stay was then reconstructed, which corresponded to the inpatient hospital care that would have been required during the observation period, had hospital at home not been available.

The average cost of hospital at home was significantly lower than the corresponding estimated cost for treatment at the hospital (776.6 vs. 2012.5,  $P < 0.001$ ). This difference was particularly high for patients in the "palliative care" group ( $N = 33$ ) (1201.7 vs. 3489.7,  $P < 0.001$ ), whereas in the "chemotherapy" group, results were not significantly different ( $N = 34$ ) (225.5 vs. 318).

This study suggests that hospitalisation alternatives can generate substantial savings for public health insurance in France.

### Febrile Neutropenia

Cosler LE, Sivasubramaniam V, Agboola O et al. Effect of outpatient treatment of febrile neutropenia on the risk threshold for the use of CSF in patients with cancer treated with chemotherapy. *Value in Health* 2005; 8:47-52. ★

Febrile neutropenia (FN) in patients with cancer treated with chemotherapy has traditionally been managed with inpatient broad-spectrum antibiotics until the infection and neutropenia resolved. A newer strategy is outpatient oral or intravenous antibiotics in selected patients after an initial hospitalization. This study sought to determine these costs, both overall and relative to those of traditional management, and the optimal role of prophylactic colony-stimulating factor (CSF) in patients at greatest risk for FN.

Existing economic decision models were modified by incorporating a treatment strategy for FN in which patients are classified as high- and low-risk according to criteria described by Talcott. Low-risk patients were assumed to be treated as outpatients. Overall costs with the revised economic model were assessed and sensitivity analyses were performed.

The costs of an episode of FN were estimated as 1) no CSF: \$13,355; 2) CSF with hospitalization for FN: \$8677; and 3) CSF with risk stratification and

outpatient management in low-risk patients: \$8188. The risk threshold for the cost-effective use of CSF was only slightly lower with outpatient treatment. When all patients with FN are treated as inpatients and the cost of hospitalization is \$1750/day the risk threshold for FN at which prophylactic CSF becomes cost-effective is 16%. It is 15% when low-risk patients are treated as outpatients.

Outpatient treatment slightly decreases the risk threshold for FN at which prophylactic CSF becomes cost-effective. The limited economic effect of this strategy may be because the patients who were at greatest risk of complications had significantly longer lengths of stay and accounted for most of the hospitalization costs.

### Mental Health

Kalucy R, Thomas L, Lia B et al. Managing increased demand for mental health services in a public hospital emergency department: A trial of "Hospital in the Home" for mental health consumers. *Internat J Mental Health Nursing* 2004; 13:275-81. ★

Increasing demand from mental health consumers for crisis assessment and intervention in public Emergency Departments (ED) has placed considerable strain on ED resources and long delays in admission. At Flinders Medical Centre in South Australia, the Psychiatry Department trialed a 'hospital-in-the-home' service to relieve the pressure on the ED and enhance inpatient capacity. The trial has been successful in diverting mental health consumers directly to intensive home-based services from the ED and freeing up beds in the inpatient unit. Evaluation showed that both consumers and their carers were highly satisfied with the hospital-at-home service.

### Improving IV drug Administration Safety

Adachi W, Lodolce AE. Use of failure mode and effects analysis in improving the safety of i.v. drug administration. *Am J Health-Syst Pharm* 2005; 62:917-20. ★

Failure mode and effects analysis (FMEA) was used to identify dosing and administration errors associated

with intravenous (i.v.) medications and evaluate the effectiveness of subsequent system improvements.

A multidisciplinary medication safety team conducted an FMEA to identify and reduce common medication errors and selected wrong-dose errors for process improvement. In 2002, wrong-dose errors comprised 17% of all medication errors at the hospital (59 of 347 errors). The most common reason for administering the wrong dose was error in programming the i.v. infusion pump (41%). Potential errors (i.e., failures) identified were misinterpretation of the order, removing the wrong medication or wrong concentration of the correct medication, using the wrong diluent or drug to prepare the drip, and entering the wrong concentration or infusion rate on the pump. Errors in programming the i.v. infusion pump was the step in the medication-use process associated with the highest criticality index. Based on the results of the FMEA, two main interventions were performed. First, standard order sets were revised after streamlining the formulary and eliminating the use of unapproved abbreviations. Second, an i.v. pump with enhanced safety features was implemented. One-year follow-up data revealed that the number of medication errors related to dosing (wrong dose or incorrect infusion rate) had decreased slightly (from 59 in 2002 to 46 in 2003); however, a dramatic reduction was noted in the percentage of pump-related errors. In 2003, pump-related errors accounted for 22% of dosing errors, compared with 41% in 2002.

Medication errors related to i.v. infusion pumps were reduced by conducting an FMEA and implementing the process changes needed.

## List of Medline, Cinahl and other relevant published articles

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### Cost

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## Stability

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