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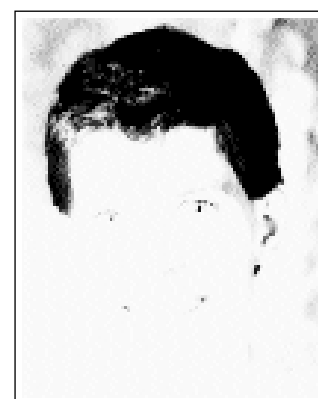
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## EDITORIAL

*Sue Daly*  
*Business Manager*  
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## NEW VCACI MEDICAL DIRECTOR

**W**e are pleased to announce the appointment of the new VCACI Medical Director - Dr Kit Fairley. Kit graduated with his MBBS from the University of Melbourne in 1983 and has since completed a PhD from Monash University in 1995. Kit currently holds appointments as Associate Professor and Head of Infectious Disease Epidemiology Unit, and Deputy Program Coordinator CRC Water Quality and Treatment with the Department of Epidemiology and Preventive Medicine at Monash University. Further to these appointments Kit is an Infectious Disease Physician at the Alfred Hospital and Editor of *Epidemiology and Infection*.



Kit has a strong research focus and has published extensively in the area of Infectious Diseases.

### HITH Staff Safety Guidelines

In this edition of our Newsletter we have included our newly developed guidelines for HITH Staff Safety. These guidelines have been developed in consultation with HITH Coordinators across Victoria and are intended to inform local development of policies and procedures that address staff safety for HITH personnel. We welcome any comments that you have with respect to these guidelines so please let us know what you think.

### HITH Seminars

Staff of the VCACI are coordinating a number of seminars which focus on HITH related topics. Kaylene Fiddes and Robyn Wall in association with staff from Flinders Medical Centre, are conducting a series of rural seminars on the development and implementation of clinical pathways. The first of these seminars was held in Sale on the 25th March 1999. This seminar is to be repeated at the following sites: Warnambool - 22nd April 1999, Bendigo - 29th April 1999 and Wangaratta 30th April 1999.

In celebration of International Nurses' Day we are collaborating with ACCNS to run a one day seminar on HITH from the perspective of hospital based nurses, HITH from the perspective of community nursing providers and the evolving role of the nurse practitioner. This seminar will be held on Saturday the 15th May 1999. For more details on this seminar see inside this Newsletter.

# HOME INTRAVENOUS THERAPY FOR PATIENTS WITH HEART FAILURE

*Summarised by  
Kaylene Fiddes  
Project Officer  
VCACI*

*As presented at:  
Developments in Cardiovascular Disease: Implications for Nursing Practice Conference*

*The Garvan Institute, St. Vincent's Private Hospital, Sydney, Dec 1998*

**D**evelopments in Cardiovascular Disease: Implications for Nursing Practice Conference was held in December 1998 at The Garvan Institute for Medical Research by St. Vincent's Private Hospital. Presentations covered topics relevant to healthcare providers practicing across a range of healthcare settings. Relevant to the home setting was a presentation by Ms. Annemarie Kaan.

Ms. Annemarie Kaan, the Clinical Nurse Consultant with the Heart and Lung Transplant Program at St. Vincent's Public Hospital in Sydney, discussed home intravenous therapy for the patient with heart failure. Before describing their home intravenous therapy practice for patients with heart failure, Ms. Kaan discussed home intravenous therapy in general and outlined the benefits including efficiencies in inpatient bed use, cost efficiency and lowering the incidence of long stay patients.

The advantages and disadvantages of self-administered IV therapy were presented. Advantages included independence, cost effectiveness, that isolated patients can still be discharged home and that possibly there were less errors or "bad" practice with self-administration if the patient is appropriately selected and educated. The disadvantages discussed were the potential to lose track of the patients as there were lots of patients administering their own therapy and the potential to miss sepsis. Ms Kaan also posed "Was self-administration expecting too much?" and stated that some of the patients who they had expected to cope well had not done so, and vice versa.

In general, the selection criteria for patients to self-administer IV therapy include those patients who are medically stable, positive and motivated, have the ability to learn the necessary techniques of IV therapy and have telephone access. Exclusion criteria generally include patients with poor venous access, suspicion of non adherence, any physical limitations such as blindness, emotional limitations and the absence of a support person.

The choice of venous access and the type of administration device selected is dependent on a number of issues which were discussed. An example of this would be in the instance of self-administration of home inotropes. Here, the device is required to have an alarm on it and the usual venous access used is an antibiotic impregnated single lumen catheter or a Vygon nutracath silicone catheter. The pumps used at St. Vincent's were listed: the Graseby MS16A syringe pump, the

Paragon Infusion device by TUTA, the Intermate by Baxter and the CADD by Pharmacia-Upjohn.

One hundred and seventy-seven episodes of home self-administered IV therapy have occurred through St. Vincent's Public Hospital Sydney since 1993. Their practice included two days of intensive education given to the patient while in the hospital. Both hands-on training and education sheets are part of these education sessions. A two minute hand wash is included in the training as gloves were found to provide less dexterity for the majority of patients. Line infections have occurred in 2% of their patients (4 out of 177). These required removal of the line and antibiotics. The incidence of line related problems was also presented. Some of these included patient confusion with a three way tap, blocked line, line dislodged, and blood/air in the line. A nurse is on call twenty four hours a day and step by step instructions are given if problems like these occur. It was concluded that for general home IV therapy, self-administration was safe and reliable for their selected home patients.

The selection criteria normally applied to all other patients may not apply for the Heart Failure group. For example, a patient with heart failure requiring inotropes may not be medically stable. Referral was made to Sindone et al for their article published in the American Heart Journal (1997) 135:5 on St. Vincent's experience from 1990-1995 with inotropic infusions in the home. Some further points regarding home inotropic therapy raised were issues for rural patients and issues for patient carers.

The St Vincent's program has sent a few patients home in rural areas however, accommodation near the hospital has been typically used in this situation. Whilst the patient may reside near a rural hospital it then becomes a matter of asking a rural hospital to take on the responsibility of a patient in the home who has not previously been their inpatient. Issues for the carer include having to change a syringe driver every eight hours and that there may be exhaustion for both patient and carer as the carer is caring for a critically ill person in this situation.

In conclusion, Ms Kaan stated that carefully selected heart failure patients can receive home inotropic therapy as a cost effective alternative to hospital episodes. With the introduction of new medication therapy such as carvedilol for heart failure however, intravenous inotropic therapy may now be less popular and less frequently required.

# VICTORIAN HITH MINIMUM DATA SET PROJECT

**Sharon Moreham**  
**Research Assistant**  
**VCACI**

**J**anuary this year saw the first meeting of the Victorian HITH Minimum Data Set Committee. This multi-disciplinary group has been established to identify and define a minimum set of data elements that are crucial in the management of HITH programs in Victoria. Data elements will be selected for their ability to describe the HITH environment for various audiences and applications. Analysis of these data elements will contribute to business planning, research, benchmarking, trend analysis, management reporting, resource utilisation and management, costing, and policy formation. These items will not include all of the data elements that are critical for the day-to-day clinical management of patients.

Because of the generic and minimalist approach of the project, HITH programs may want to supplement this set of data elements with items they believe are important for the management of their specific program at both a day-to-day clinical

level and business operational and planning level.

The current phase of the project will not attempt to design an information system, only the minimum critical data elements for business analysis to be contained in a HITH information system. The development of a functional specification for an information system will occur after the minimum data set is developed.

The Committee meets monthly and to date has developed a draft generic high level information model for HITH as well as identifying and defining data elements in the areas of demographic characteristics, socio-cultural characteristics, service delivery setting and location, insurance and funding characteristics, health status in terms of physical and functional wellbeing, person roles in terms of carers and recipients of care, organisation roles in terms of service purchaser and provider roles, and outcomes. This project is due to be completed by December 1999.

## International Nurses' Day Seminar

The Australian Council of Community Nursing Services (Inc) Victorian Branch will be jointly hosting a forum with Victorian Centre for Ambulatory Care Innovation to celebrate International Nurses' Day.

*The forum will be held at RDNS, 31 Alma Rd, St Kilda on Saturday 15 May from 9.30am - 4.30pm.*

Topics will include development in the Nurse Practitioner Role, Experiences of Nurse Practitioners, Community Methadone Program, Rural Homelessness, HITH - both rural and city perspectives and the role of VCACI.

*A nominal charge will apply.*

**RSVP to Jane Reilly 9853 4670  
by 1 May 1999.**



May 12, 1820 - August 13, 1910

Florence Nightingale on  
the Millennium

"My view you know is that the ultimate destination of all nursing is the nursing of the sick in their own homes . . . I look to the abolition of all hospitals and workhouse infirmaries. But it is no use to talk about the year 2000"



## A REVISION OF THROMBOTIC COMPLICATIONS IN INTRAVENOUS THERAPY

*Summarised by Kaylene Fiddes, Project Officer, VCACI*

**P**hlebitis, deep vein thrombosis and septic thrombosis are complications of intravenous therapy depending on the access or site used. An article by J Smith in the March/April 1998 issue of the Journal of Intravenous Nursing presents a review of some of the literature on the pathology and treatment of thrombotic complications associated with intravenous therapy. The following is a summary of Smith's review.

## PHLEBITIS

Smith's review advises that the incidence of phlebitis varies from 1% to 10%. It is recognised that the symptoms, which include tenderness, erythema and swelling, may be due to bacteria or mechanical irritation. In the treatment of phlebitis, most cases respond to removal of the catheter and local heat application. Firmness of the vein may persist for 1 to 3 months. In the presentation of an infective component (symptoms of fever and site purulence) an excision of the infected vein may be required. Antibiotic therapy is also initiated in this case.

## DEEP VEIN THROMBOSIS ASSOCIATED WITH IV THERAPY

Smith states that literature shows the range of incidence of deep vein thrombosis (DVT) in IV therapy as 0.02% to 13% (Smith notes, however, that the incidence is difficult to determine and discussion of various studies is provided in the article). The clinical picture of thrombosis is pain and swelling in the arm and neck on the same side as the inserted catheter and a positive venogram. Duplex scanning is now more widely used for diagnosis although venogram remains more reliable to detect stenosis of the superior vena cava (SVC). The actual thrombosis usually involves a short segment in the subclavian vein but can extend into the SVC. Extension peripherally into the axillary vein is not common.

There are two types of thrombosis. The first is a fibrin sleeve thrombosis which usually shows no symptoms except for trouble with aspirating blood and eventually catheter occlusion. The actual catheter itself may be a factor in the development as studies have shown that some materials are more thrombotic than others. For example, polyurethane is cited in studies as more thrombogenic than other materials.

The second type of thrombosis is a vascular mural thrombosis and is more likely to obstruct the vein and cause associated symptoms. Insertion of the catheter is stated as an initiating factor in its development. Difficult insertions and multiple attempts cause damage to the intima of the vessel and are reported to stimulate the thrombosis. Size of the catheter is also identified as a possible factor. Smith reviews a study on patients with haemodialysis catheters which showed 50% to

have stenosis of the SVC on venograms (most had no symptoms). Location of the catheter tip and the disruption in blood flow or stasis which can be associated with the presence of a catheter are described as other factors. Infusions such as high concentration dextrose and some chemotherapy can stimulate thrombosis, while other factors listed include low blood flow, hypovolemia, infection and hypercoagulable states.

Treatment of the thrombosis varies according to the type of access, the need for further access and availability of other sites. Standard treatment is described as removal of the catheter, elevation of the extremity and intravenous anticoagulation followed by oral anticoagulation. Whilst literature generally recommends the removal of lines, one study was able to salvage 87% of the lines by keeping them in place while placing another line to infuse thrombolytic agents. Balloon angioplasty was then used to remove any remaining thrombosis material. Smith acknowledged this was an expensive process but concluded that it may be appropriate if no other access is available.

## SEPTIC THROMBOSIS

Septic thrombosis begins when the thrombosis is colonised by bacteria or fungi, with symptoms of pain and swelling in the neck and arm on the same side as the inserted catheter and fever. Other sources of infection and endocarditis should be excluded. Treatment usually includes removal of the catheter, intravenous anticoagulation, and empirical antibiotics until culture findings are presented. Appropriate antibiotics are administered usually for six to eight weeks once results are available. A Fogarty thrombolectomy was described to be occasionally used in this situation whereby a balloon catheter is passed down to the clot and then pulled back with the clot being removed through a venotomy. Another treatment which may be used is thrombolysis to dissolve the clot in order for the antibiotics to directly attack the bacteria.

## PREVENTIVE MEASURES

Some of the preventive measures presented included meticulous catheter insertion technique and catheter aftercare to prevent intimal damage, and accurate placement of the catheter tip. Ongoing improvement in the catheter materials being developed is also discussed. Some of the studies presented for preventive measures included a study on patients with cystic fibrosis with VADs where low dose of aspirin reduced the incidence of thrombosis. Another study reported low dose heparin in total parental nutrition was associated with a reduction in thrombosis incidence, while other studies described a reduced incidence of thrombosis with the use of low dose heparin and other low dose oral anticoagulation.

# HITH STAFF SAFETY GUIDELINES

*Carole Staley  
Senior Project Officer  
VCACI*

Staff members working in the community are exposed to many risks, which will vary between HITH programs dependent upon the demographics of the area. In an effort to minimize risks to staff, all HITH programs should develop clear precise policies and procedures relating to staff safety whilst care is being provided beyond the hospital campus. These documents should be reviewed, with staff input, at regular intervals to ensure they are relevant to current conditions.

Written policies and procedures should specifically address the following areas:

- Staff recruitment, orientation & ongoing education
- Communication
- Assessment of the patient & environment
- Guidelines for home visits
- Travelling in cars
- Manual handling
- Isolation
- Critical incident management
- Bush fires (if applicable)

Related policies include:

- Infection Control & Waste Disposal
- Management of Chemotherapy in the Home
- Motor Vehicle Policy

Specific requirements for staff safety in a HITH program are summarized below.

## Staff Recruitment, Orientation and Ongoing Education

Prior to accepting employment, all prospective staff members should be made aware of the safety risks involved when working for a HITH program. The orientation program for new staff members must incorporate the Staff Safety Policy and promote a culture where risks to staff safety are easily raised, discussed and solutions developed. Staff need to be encouraged to develop an awareness of personal safety issues, rely upon their own judgement when confronted with a risk, be accountable for their own safety, and consider the risks to their colleagues. Staff members should not put themselves at risk and, if fearful, should never enter into a situation if they assess there is a threat to their safety.

Ongoing education programs should include updates on staff safety and strategies to minimize risks. Consideration should be given to providing sessions on issues such as defensive behaviors, conflict resolution, sexual harassment, self defense, how to work with challenging behaviors and specific training in areas pertinent to the HITH program, for example bush fires, drug and alcohol or psychiatric patients.

## Communication

HITH programs need to develop a 24 hour system by which they are able to identify where staff are, who they are visiting and when they are expected back at the office or home (if business is conducted from a home address). Included in this system should be a process to notify any variation in the expected schedule and the response should a staff member not return at the expected time.

Emergency contact numbers and procedures need to be available to all staff.

HITH programs should provide staff with a method of communication, for example, mobile telephone or two-way radio. The provision of personal "screecher" alarms may be of use in warding off an assailant in populated areas. Also, staff conducting after dark visits need to be provided with a torch.

HITH programs need to decide whether vehicle signage is of benefit or creates a potential risk in their geographic area.

All issues relating to staff safety should be documented in the patient's medical record and raised with senior staff to establish appropriate strategies. Strategies to minimise safety risks, including contracts with patients and withdrawal of home service provision, should be considered if risks to staff safety arise.

If a breach of staff safety occurs, incident reports stating corrective action taken should be completed and forwarded to the appropriate hospital departments.

## Assessment of the Patient and Environment

All patients should be screened prior to acceptance by a HITH program. Part of this screening process needs to focus upon safety issues for staff.

HITH programs need to identify staff safety risks that are exclusion criteria for the program and alternative options for patients who are not accepted for these reasons.

The patient referral or assessment tool should incorporate a "Safety Assessment" to document potential risks, strategies to address these risks, and confirm that safety issues have been considered.

Assessment of the patient should be holistic and include points that may impact upon staff safety such as social circumstances, history of drug and alcohol abuse, psychiatric illnesses and tendency for aggressive or violent behavior.

Assessment should include the environment with particular attention to the type of housing, for example residential house or high rise flat, access to the residence, availability of car parking, street numbering and lighting, household composition including pets for example vicious dogs, other people in the surrounding environment and infection control issues.

Assessment of both the patient and their environment

should include consideration of circumstances after dark, taking into account the increased isolation and subsequent vulnerability that occurs when conducting visits after dark.

### Guidelines for Home Visits

Staff members should familiarize themselves with the patient's medical record, including safety issues before visiting a patient for the first time.

Staff members should ensure that their equipment, for example mobile phone, two-way radio, personal "screecher" alarm and/or torch, are functioning prior to commencing work for the day. The mobile phone and personal "screecher" alarm should be carried at all times throughout the day.

Staff members should program emergency telephone numbers into the mobile phone and select the emergency number prior to entering an unknown situation, for example, a first visit to an unknown address. If contacting emergency services, always begin by giving the address first and then the complaint/report.

Staff members may consider visiting with a colleague if there are safety concerns. This can be a useful strategy and provides an extra pair of eyes to look out for danger or distract a potentially aggressive person. Even so, care must be taken when considering "double" visits as the concept may create a false sense of security. If a situation is truly deemed to be unsafe it is preferable to send no staff at all rather than put two people at risk.

Staff members should employ strategies to increase safety whilst visiting in high risk areas, for example, high rise public housing, boarding houses and areas with known drug or criminal activity, see Table 1, Guidelines for Visiting in High Risk Areas.

Table 1. Guidelines for Visiting in High Risk Areas

- Dress appropriately, for example, avoid expensive jewellery.
- Modify behaviour appropriately for the environment.
- Contact the office or a colleague prior to entering and upon leaving a potential risk situation.
- Use positive body language.
- Develop a good sense of awareness.
- Avoid using stairs, lifts are a preferable option.
- Position yourself near lift buttons.
- If the behaviour of a person in a lift is worrying, get out at the next stop.
- Don't react in a frightened manner.
- Be the verbal aggressor as the offender often works upon the victim's fears.
- Avoid getting into physical contact with the other person.
- If worried about the behaviour of someone in corridors or balconies, scream FIRE, which may alert others who can render assistance.
- When visiting patients in boarding houses, identify yourself to the landlady/man (if there is one) or a reliable resident. They may be of benefit in ensuring your safety.
- Be aware of the location of doors so that you can make a quick exit if required.

Staff members should employ strategies to increase security after dark as appropriate, see Table 2, Guidelines for Evening Visits.

Table 2. Guidelines for Evening Visits

- Carry a torch.
- Always conduct the first visit to an unknown address in daylight hours to assess suitability for after dark visits.
- Instruct the patient/family members to turn on outside lights.
- Ring the patient/family just before visiting to ensure that it is still suitable to visit and arrange for them to meet you if necessary.
- Have the patient/family meet you at the gate/front door/lifts of the apartment building.
- Request the patient/family escort you to the car or wait at the door until you are safely in the car at the completion of the visit.
- Use security guard escorts for visits to potentially dangerous addresses (if available).

### Manual Handling

In HITH programs, staff members often work alone and without the physical support of other staff. All patients and their environments should be carefully assessed and appropriate aids provided to maximize safe care and minimize the potential for back injuries for both staff and carers, for example shower chairs, and bathroom rails.

Staff members often transfer equipment, for example nurse's bag, patient supplies and emergency equipment, from the office to the car and to patients' houses. Efforts should be made to minimize the size and weight of items, the distance between transfers, and the need to carry equipment, for example use carry bags with wheels.

Staff members need to protect themselves from injury by positioning themselves carefully when attending care and getting in and out of the car. It is also important for staff members to be aware of their own fitness level and consider preventative back exercises which promote strength and flexibility.

### Travelling in Cars

Motor vehicles should be regularly serviced and maintained in a roadworthy state. A process for regular checking of tyre pressure, tyre condition, oil and water along with a mechanism for reporting and remedying faults needs to be in place.

Items of equipment within the car should be secured or confined to the boot to prevent injury due to projectiles in the event of sudden braking or a motor vehicle accident. Station wagons should be equipped with either a luggage cover or cargo barrier.

Clear guidelines need to be available for the procedure to follow in the event of a motor vehicle accident.

Staff members need to employ strategies which ensure their safety whilst driving, see Table 3, Guidelines for Safety Whilst Driving.

Table 3. Guidelines for Safety Whilst Driving

**Before Entering the Car:**

- Be aware of weather and road conditions and have adequate maps.
- Have accurate directions to the street, building, and apartment. If the area is unfamiliar to you, check with a colleague for more detailed information. Always know exactly where you are going.
- Always keep in the glove box, a torch, pen, paper and coins for emergency calls.
- When possible, avoid parking in deserted, poorly-lit areas.
- Check inside your vehicle, especially the rear, before getting in.
- Keep car and house keys separate and do not label them with your name or address.

**In the Car:**

- Once inside, lock all doors and roll up windows to within 3cm of the top.
- Be wary of strangers approaching your car while you are stationary. Stay in gear and be prepared to sound the horn if threatened.
- Be alert at all times for potentially dangerous situations. When travelling alone never pick up hitchhikers. If annoyed by another driver, or think you are being followed keep driving and drive to a place where people are visible, for example, petrol station, shop, or police station. Obtain the registration number and report incident to police as soon as possible.

**Leaving Your Car:**

- Always remove the key from the ignition and lock up. Valuables should be out of sight, as should any papers with your name and address.
- Never hide a spare key in the car.

**Isolation**

HITH programs need to recognize the isolation that can be experienced by staff working alone in the community. Opportunities for support through the development of teams, case consultation meetings, social functions, and more formal systems such as debriefing and counseling should be provided.

**Critical Incident Management**

HITH programs need to have access to a psychological support program that encompasses a preventive/educative approach to the management of staff stress and critical incidents. This program should include staff education regarding stress and critical incident management; access to trained staff to facilitate defusing and/or debriefing within 24 hours of a critical incident; and professional counselling.

To enable pro-active intervention, HITH programs should develop a sense of critical incidents that may lead to stress, for example, death or serious injury to a patient, threat or serious injury to a staff member, media attention, staff abuse of patients, case mismanagement, and witness to staff suffering.

**Bush Fires**

For HITH programs based in fire prone areas, the identification of fire evacuation areas and the development of guidelines for how to respond in a bush fire are vital, see Table 4, What to do in Bushfire.

Table 4. What to do in a Bushfire

In the event of a bush fire, do not continue to drive into the fire zone, but do a "U" turn to safety if road conditions permit you to do so.

If caught in a bush fire:

- Do not leave the car.
- Park in a cleared area.
- Leave your headlights on.
- Close all windows.
- Crouch below window level.
- Cover yourself with a woollen blanket and clothing.
- Wait until fire front passes.

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 Safety Guidelines - February, 1999.

# NATIONAL ASSOCIATION FOR HOMECARE

**Nick Santamaria**  
**Research Scientist**  
**VCACI**

## 17TH ANNUAL MEETING

The 1998 National Association for Homecare (NAHC) 17th annual meeting held in Atlanta, Georgia, USA was characterised by the feeling of intense financial pressure on the American homecare industry. Attended by over 4500 delegates (down from 7000 in 1997) the conference was told by the president of the NAHC, Val Halamandaris that without significant funding increases to homecare providers there will be increasing numbers of citizens who would not have access to homecare services in the USA.

To understand this situation it is necessary to review some of the economic and political background of the predominantly private homecare industry in the USA. The current situation has arisen through the convergence of a number of related events. The first of these was the growth in the influence of health management organisations (HMOs) that have had the effect of reducing hospital length of stay. Obviously, reducing hospital length of stay is dependant to a large degree on the availability of homecare services, consequently there had been an increase in the homecare sector of more than 300% over the last four years. More recently the American congress had passed legislation known as the Balanced Budget Bill which required the administration to review all expenditure to bring in a cost neutral budget in 1998. The outcome of these events combined with a high media profile, multi-million dollar fraud case against a private homecare provider resulted in The Health Care Finance Administration (HCFA) reducing the reimbursement amount per homecare visit through the Interim Payment System (IPS) by 15%.

Further to the financial pressures has been the introduction of a requirement for all homecare providers to meet the requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). One of which has been the need to collect and analyse patient outcome data through the Outcome and Assessment Information Set (OASIS). The result of the decrease in funding through the IPS and the

greater regulatory demands made by systems such as OASIS has been that over one thousand private homecare agencies have gone out of business in the last year.

The program at the conference was organised into a number of thematic streams which included; business development, finance, interim payment system, quality improvement, telemedicine, hospital homecare, management, paediatrics and hospice care. Surprisingly, there were relatively few research papers presented at the conference. An area in which a number of interesting papers were presented was that of telemedicine and information systems. Understandably, in an environment of financial pressure, private homecare providers have been attempting to maximise the efficiency of their operations and to minimise cost per patient care episode. The area of chronic heart failure remote monitoring appears to have had a great deal of input from monitoring equipment manufacturers and equipment of differing levels of sophistication was discussed in presentations and demonstrated at the trade display. Of particular interest were the demonstrations of a remote wound assessment system and new disposable electronic infusion devices.

Those of you who met Marjorie Bauman from Johns Hopkins Home Care at a VCACI HITH Seminar last year will be pleased to hear that Marjorie was presented with a lifetime achievement award for her leadership in homecare.

It was heartening for me to see how well the Australian homecare system has developed and that it compares more than favorably to the USA in a number of areas. Many of the delegates that I spoke with during the conference were very interested in the activities in Victorian HITH programs (once they realised that we "did" homecare in Australia). Overall the conference provided a great opportunity to gain an insight into the huge American homecare sector.

Acknowledgment: I would like to thank the Johnson & Johnson Medical Education Foundation for their kind assistance, which enabled me to attend the NAHC conference.

## UPCOMING CONFERENCES

Numerous Educational Programs  
International Diabetes Institute  
Janet Haynes - Training Co-ordinator  
Tel: (03) 9258 5053 Fax: (03) 9258 5090  
e-mail: jhaynes@idi.org.au

Australian Resource Centre for Hospital Innovation  
Hospital in the Home - 1999 Tool Kit Seminar  
Stamford Plaza, Adelaide  
May 14 - 1999, Adelaide  
Tel: (02) 4924 6041 Fax: (02) 4924 6040

ACCNS - VCACI  
Rural and Acute Care at Home  
RDNS Building, St Kilda, Melbourne  
May 15 - 1999, Melbourne  
Tel: (03) 9583 4670

National Home Infusion Association  
8th Annual Conference  
May 19-22, 1999, Fort Lauderdale Convention Centre,  
Fort Lauderdale, Florida  
Fax: 0011 1 703 683 1484  
Email: infusion@vais.net

AHOITA - Annual Scientific Conference  
A Scientific Foundation for Hospital in the Home into the  
21st Century  
Hotel Sofitel  
June 4, 1999, Melbourne, Australia  
Dr Michael Montalto  
Tel: 0419 303 178 Fax: (03) 9784 7242  
Email: m.montalto@gpph.unimelb.edu.au  
Marie O'Brien  
Tel: (03) 9594 4564 Fax: (03) 9594 4533  
Email: marie.obrien@med.monash.edu.au

Health Outcomes Conference 1999  
5th Annual International Conference  
Intergrating the Elements  
Rydges Lakeside, Canberra  
July 21-22, 1999, Canberra  
Tel: (02) 6205 0869 Fax: (02) 6205 2037  
e-mail: jan\_sansoni@dpa.act.gov.au

Post Acute Treatment & Care in the Home (PATCH)  
Hotel Sofitel, Melbourne  
August 20-21, 1999, Melbourne  
Tel: (02) 9818 3344 Fax: (02) 9555 7522  
e-mail: hsansw@ozemail.com.au

3rd Australian Cystic Fibrosis Conference  
The Masonic Centre, Sydney  
August 26-28, 1999, Sydney  
Tel: (02) 9878 5250 Fax: (02) 9878 5058

Medical Case Management  
Catch a Wave into the New Millenium  
San Diego Convention Centre, San Diego, California  
September 22-25, 1999, California  
Tel: 0011 1 760 431 9797 Fax: 0011 1 760 431 8135

The 4th Annual Disease Management Congress  
Innovative Strategies for Total Health Management  
Hynes Conference Centre, Sheraton Boston-Towers  
October 4-6, 1999, Boston, USA  
Web Site: www.nmhcc.org

### Conference Page Proudly Sponsored by

## Smith+Nephew

Smith & Nephew  
Wound Management Seminars  
6th May, 3rd June (Geelong), 15th July,  
2nd Septemeber, 7th October,  
25th November 1999

Registration 8.00am

Commences 8.30am

*Morning Tea*

Lunch 1.00pm

Concludes 3.00pm

***A light lunch will be provided***

***Cost: \$50.00***

(includes the Seminar, a  
comprehensive Wound Care Manual,  
Morning Tea and Lunch)

Smith & Nephew  
Leg Ulcer Management Seminars  
20th April, 5th August 1999

Registration 8.00am

Commences 8.30am

*Morning Tea*

Concludes 12.30pm

***A light lunch will be provided***

***Cost: \$40.00***

(includes the Seminar, a  
comprehensive Leg Ulcer Manual, and  
Morning Tea)

***Presenter: Smith & Nephew Specialist  
Representative***

***All above seminars held at:***

***Sunninghill Receptions***

228 Cotham Road

Kew Victoria

3101

(Melways Ref:45 F6)

Parking on site

***With 3rd June the exception***

***Ambassador Hotel***

Corner Gheringhap & Myers Street

Geelong Victoria

3220

Smith & Nephew Rehabilitation  
Aids to daily living information and/or  
product demonstrations please contact:  
***Emma Ellison (03) 9545 0233***

# HITH SHOWCASE WESTERN HOSPITAL (FOOTSCRAY)

*Elwyn Davies  
HITH Nurse  
Unit Manager*

The Hospital in the Home program at Western Hospital began seeing patients in July 1996. We are a general program, accepting all types of patients with no specific patient focus.

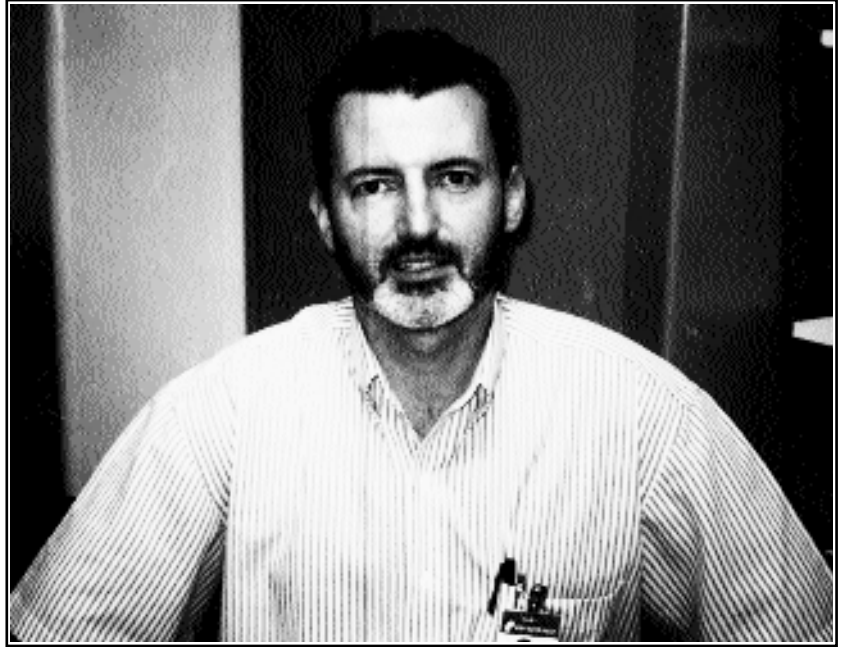
We are based at Western Hospital in Footscray which is part of North Western Health. Western Hospital and Sunshine Hospital now have separate management teams since July 1998. We comprise of a Nurse Unit Manager and 4 part time staff. This enables us to provide coverage from 0800 to 2200, 7 days per week. There is always a nurse on call overnight for patient emergency calls or for new admissions from the Emergency Department. We do not have a medical officer attached to the unit. We liaise with registrars of each unit re problems, reviews and planning.

When the program began we considered that 20 kms would be the boundary limit outside of which patients would be excluded. We found this was too restrictive and now accept patients from Sunbury, Werribee, and Bacchus Marsh (occasionally) which is 35 kms away. We have found that traffic on roads in this area is not too heavy and the network of roads is good.

The staff here include myself, Elwyn Davies, as Unit Manager and Jenny Mackay, Carme Martinez, Agnes Sundram, Kirsten Linn and Vicki Eleftheriadis who are all ACNs. We rarely subcontract work to anyone else. We have established good communications with Royal Melbourne Hospital and Northern HITH, and have enjoyed great support from Joanne Moss and Dr Denise Ruth.

Our main patient groups will be of no surprise to many HITH Coordinators in Victoria. There are a large number of patients with cellulitis, deep vein thrombosis, and those with pneumonia. Over half of patients referred come from the Emergency Department, which has become the de facto HITH treatment unit. The patients referred from the wards are often patients who may not have been well enough to go to HITH directly from the Emergency Department. The use of PICC lines is steadily increasing for patients requiring antibiotics for greater than 2 weeks, but the greater number of our patients are for courses of treatment up to 7 days. We have also been looking at haemorrhoidectomy patients. This group is sent home with a visit from HITH the following day with follow up telephone calls on day 2 and 3. Our Analgesia regimen of Panadol and Indocid with once only Pethidine tablet appears to be satisfactory. It is still early days and there have been only 8 patients so far.

In addition to HITH services we now provide community



*Elwyn Davies HITH Nurse Unit Manager*

support to those patients with percutaneous endoscopic gastrostomy (PEG) tubes. These patients, who more often than not are elderly and confused, were being sent in, unaccompanied, by ambulance to the Emergency Department late at night by nursing homes. In order to provide a better service to these patients and also improve risk management, these patients are visited by HITH. They are not regarded as HITH admissions and are not recorded on the VIMD. We encourage nursing homes to take up this skill themselves and the number of calls relating to these patients is dropping.

The majority of our patients live West of our Hospital and we share a similar catchment area to Royal Melbourne Hospital in part of the region. Some of the Royal Melbourne Hospital patients in this area are logistically too far for them to see. We have cooperated to the extent that many patients are referred to Western for either all or part of the visits required. This allows Royal Melbourne Hospital to accept patients in Laverton, Werribee and Melton and means we are able to work towards a network target of beddays. In 1998-99 we have seen over 30 patients for Royal Melbourne Hospital which equates to over 150 visits. Work like this has allowed us to move towards a seamless HITH program in the network and we will be cooperating with Royal Melbourne Hospital and Northern when Broadmeadows Health Service opens mid-year under Joanne Moss. We have also entered in a service agreement with PACFU which has had benefits such as maintaining continuity to HITH patients after the acute phase of illness is over and generating a small amount of income.

We do not have the ability or budget to provide Allied Health services to patients but with the development of clinical pathways in the hospital, for groups such as hip replacements, we foresee there may be some development here.

In 1996/97 we treated about 187 patients in HITH. In 1997/98 our patient through-put increased to 308 patient episodes with a bedday total of 2,069. Further to this we managed 108 visits to PEG patients which prevented unnecessary visits to the Emergency Department. Our targets for 1998/99 present a new challenge of 2,538 beddays. We are presently 200 beddays behind at this stage but have been extremely busy since Christmas. The activity shown on our Inlier Equivalent Separation reports do not allow us to show visits for other hospitals, work for PACFU and visits to PEG patients which we record separately as part of our Key Performance Indicators.

I think our successes over the last two years or so have come from working cooperatively both within and outside Western Hospital. Having our own dedicated staff has allowed us to maintain good communications with medical units and more importantly patients. We are also co-located with RDNS and sharing the same office has allowed us to identify any potential problems and move patients effortlessly to post acute services when required.

Risk Screening Tools and Assessment and Discharge forms have been adopted at Western as part of a process of effective discharge planning and we have been very actively involved with the development of the forms and the process. Our involvement includes education of medical and nursing staff on effective discharge planning and being part of a team which is attempting to change the culture of the hospital so that we see patient care as a continuum that begins before admission and extends post discharge.

We were successful in 1997 in obtaining a Department of Human Services (DHS) HITH Service Development Grant. This was to look at "Improving Access and Responsiveness of North Western Health HITH programs to patients from culturally and linguistically diverse communities". This area of Melbourne has a large number of patients from a non-English

speaking background. We employed the Centre for Culture Ethnicity and Health (CEH) to undertake a large part of the work for us. We concentrated on the three most used languages in this area, Vietnamese, Greek and Italian. The project has included a 2-day diversity training workshop which was available to all HITH staff throughout North Western Health including Werribee Mercy. There has been development of patient satisfaction surveys and consents in the three key languages, generic patient information booklets and sheets across the network (in three key languages) and publicity through ethnic media (radio and newspapers). Further, we have reviewed and revised our interpreter policy at Western to include all out of hospital services and to recognise that provision of services to non-English speaking patients must not be compromised by lack of knowledge about how to contact and effectively use interpreters. This work will be made available to all HITH programs in Victoria after presentation of the final report to DHS at the end of May this year.

North Western Health has also successfully gained sustainability and service development grants in 1998 to which all HITH programs are contributing.

Patient satisfaction, like all other HITH programs in Victoria appears to be very good. We give a questionnaire to nearly all patients on discharge. Our unplanned return to hospital for each year is about 6%. This is not confined to one particular group and has always been at our instigation rather than patient concern or anxiety.

The last two years or so have been quite challenging but very rewarding also. The contacts made and support from VCACI and Tass Mousaferidis, before he moved from DHS, have been invaluable. The future? I see this as consolidation of what we have so far achieved, greater links with other HITH programs in North Western Health and development of surgical pathways. The synergy gained through working together is our only way to go forward.

(I have been seconded to become Western Hospital Continuity Manager (Y2K etc.) for the next twelve months and will be replaced by Jenny Mackay. I still hope to attend HITH Coordinator's meetings if time allows.)

## CONTACT US

We are keen to receive your feedback so that we can address areas of interest to you.

Please feel free to contact us if you:

- would like more information about the VCACI,
  - wish to be added to our mailing list,
  - have feedback, ideas or items for future Newsletters,
- would like to share details of forthcoming conferences, seminars or workshops,
  - would like more information on HITH/ Acute Care in the Home Issues.

# Victorian HITH Contact Names and Numbers

					Telephone	Fax
Angliss Health Services	Albert Street	Upper F'tree Gully	Mr Wayne	Massuger	(03) 9764 6242	(03) 9764 6114
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Helen	Fithall	(03) 9496 3378	(03) 9496 3359
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Lisa	Hill	(03) 9496 5775	(03) 9496 5772
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Kim	Lumsden	(03) 9496 3603	(03) 9459 0971
Bairnsdale Regnl Health Service	Day Street	Bairnsdale	Ms Gael	Traa	(03) 5152 0274	(03) 5152 6683
Ballarat Health Services	P.O. Box 577	Ballarat	Ms Patricia	Twaits	(03) 5320 4676	(03) 5320 4549
Benalla & District Memorial	P.O. Box 406	Benalla	Ms Margaret	Aldous	(03) 5760 2258	(03) 5760 2246
Bendigo Health Care Group	P.O. 126	Bendigo	Ms Robyne	Fahy	(03) 5441 0222	(03) 5441 0280
Box Hill Hospital	Nelson Road	Box Hill	Ms Helen	Hamilton	(03) 9895 3442	(03) 9895 4901
Central Wellington Health Service	Guthridge Parade	Sale	Ms Paula	Hart	(03) 5144 4111	(03) 5149 6633
Colac Com. Health Svces Hospital	Corangamite Street	Colac	Ms Marie Louise	Tucker	(03) 5230 0275	(03) 5230 1191
Dandenong Hospital	Box 478	Dandenong	Ms Dana	Kiley	(03) 9554 8416	(03) 9554 8453
Djerriwah Health Service	P.O. Box 330	Bacchus Marsh	Ms Jane	Cape	(03) 5367 2000	(03) 5367 4537
East Grampians Health Service	P.O. Box 155	Ararat	Mr Ray	Elsworthy	(03) 5352 2221	(03) 5352 4612
Echuca Regional Health	P.O. Box 25	Echuca	Ms Diane	Egan	(03) 5482 2800	(03) 5482 5478
Geelong Hospital	P.O. Box 281	Geelong	Mrs Helen	Wadsworth	(03) 5226 7108	(03) 5226 7302
Hamilton Base Hospital	P.O. Box 283	Hamilton	Ms Betty	Joosen	(03) 5571 0222	(03) 5571 0240
Goulburn Valley Hospital	102 Corio Street	Shepparton	Ms Christine	Ryan	(03) 5831 6390	(03) 5822 2584
Kyneton District Health Service	P.O. Box 34	Kyneton	Ms Judith	Bloomfield	(03) 5422 1177	(03) 5422 2373
Latrobe Regional Hospital	Locked Bag No 1	Moe	Ms Rosemary	Nation	(03) 5127 0608	(03) 5127 0775
Maroondah Hospital	P.O. Box 135	East Ringwood	Ms Robyn	Kirsch	(03) 9871 3712	(03) 9871 3716
Mercy Public Hospitals Inc	Clarendon Street	East Melbourne	Ms Diana	Morgan	(03) 9270 2569	(03) 9270 2307
Mildura Base Hospital	P.O. Box 306	Mildura	Ms Sheena	Clark	(03) 5022 3333	(03) 5022 3470
Monash Medical Centre	Locked Bag 29	Clayton	Ms Fran	Chambers	(03) 9550 2433	(03) 9550 6925
Monash Medical Centre	246 Clayton Road	Clayton	Dr Lindsay	Grayson	(03) 9550 4564	(03) 9550 4533
Peninsula Health Care Network	P.O. Box 52	Frankston	Dr Michael	Montalto	(03) 9784 7241	(03) 9784 7242
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Dr Guy	Toner	(03) 9656 1190	(03) 9656 1408
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Cathy	Watty	(03) 9656 1055	(03) 9656 1415
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Helen	Fawns	(03) 9656 1312	(03) 9656 1422
Portland & District Hospital	Bentinck Street	Portland	Ms Michelle	Henningsen	(03) 5521 0333	(03) 5521 0358
Royal Children's Hospital	Flemington Road	Parkville	Ms Trish	McDonald	(03) 9345 6548	(03) 9345 6231
Royal Melbourne Hospital	Grattan Street	Parkville	Dr Denise	Ruth	(03) 9342 8549	(03) 9342 8548
Royal Melbourne Hospital	Ward 2 North	Parkville	Ms Ruth	Power	(03) 9342 7720	(03) 9342 7700
Royal Melbourne Hospital	2 Grattan Street	Parkville	Ms Karen	Palmir	(03) 9342 8597	(03) 9342 8268
Royal Women's Hospital	132 Grattan Street	Carlton	Ms Pamela	Bull	(03) 9344 2324	(03) 9348 1840
St Vincent's Hospital	41 Victoria Pde	Fitzroy	Ms Tamara	Rowan	(03) 9288 3818	(03) 9288 3848
Stawell District Hospital	P.O. Box 116	Stawell	Ms Jan	Sherwell	(03) 5358 8572	(03) 5358 4092
Swan Hill District Hospital	P.O. Box 483	Swan Hill	Ms Dallas	Brown	(03) 5033 9375	(03) 5032 9528
The Alfred	P.O. Box 315	Prahran	Ms Dianne	Richards	(03) 9276 3908	(03) 9276 2794
The Northern Hospital	185 Coopers Street	Epping	Ms Anne	Bentley	(03) 9219 8000	(03) 9219 8633
The Williamstown Hospital	P.O. Box 125	Williamstown	Ms Allison	Chircop	(03) 9393 0133	(03) 9393 0178
Wangaratta District Base Hospital	P.O. Box 386	Wangaratta	Ms Cath	Hattersley	(03) 5722 0348	(03) 5721 9526
Warrnambool & District Base Hosp	Ryot Street	Warrnambool	Mr Mark	Johnstone	(03) 5563 1457	(03) 5563 1627
Werribee Mercy	300 Princes Highway	Werribee	Ms Wendy	Dunn	(03) 9216 8691	(03) 9216 8692
West Gippsland Hospital	Landsborough Road	Warragul	Mrs Marie	Young	(03) 5623 0611	(03) 5623 0609
West Wimmera Health Service	P.O. Box 231	Nhill	Ms Lynne	Fraser	(03) 5391 4222	(03) 5391 4228
Western Hospital	Gordon Street	Footscray	Ms Jennifer	MacKay	(03) 9319 4222	(03) 9319 6314
Wimmera Health Care Group	Baillie Street	Horsham	Mrs Pat	Dodson	(03) 5381 9184	(03) 5381 9187
Wodonga District Hospital	Vermont Street	Wodonga	Ms Dianne	Wicks	(02) 6051 7334	(02) 6051 7337



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