

## Hospital in the Home (HITH) Guideline

### 1. Purpose

This Guideline provides recommendations regarding best practice for Hospital in the Home (HITH) models of care in Queensland. The purpose of the guideline is to support the standardisation of HITH services to maximise patient safety and to support efficient service delivery.

### 2. Scope

This Guideline provides information for all Queensland Health employees (permanent, temporary and casual) and all organisations and individuals acting as agents for Queensland Health (including Visiting Authorised practitioners and other partners, contractors and Senior Authorised practitioners).

### 3. Related documents

#### Authorising Policy and Standard/s:

- Patient Centred Emergency Access Health Service Directive # QH-HSD-025:2015
- *Workplace Health and Safety Act 2011*
- National Safety and Quality Health Service Standards 2012

#### Procedures, Guidelines and Protocols:

- Healthcare Purchasing Framework 2016-17 Hospital in the Home Specification Sheet
- Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2016-2017 Version 1.0

#### Forms and templates:

- Children's Early Warning Tool for Hospital in the Home (CEWT HITH) <1 year
- Children's Early Warning Tool for Hospital in the Home (CEWT HITH) 1-4 YEARS
- Children's Early Warning Tool for Hospital in the Home (CEWT HITH) 5-11 YEARS
- Children's Early Warning Tool for Hospital in the Home (CEWT HITH) 12+ YEARS
- Adult Deterioration Detection System for (Q-ADDS HITH)
- Anticoagulation Therapy Management - Hospital In The Home (HITH) SAMPLE work Instruction
- Hospital In The Home Patient Handout

## 4. Review

This Guideline is due for review in: June 2019 (for completion by January 2020)

**Date of Last Review:** February 2017

**Supersedes:** Hospital in the Home Guidelines v2.2

## 5. Business Area Contact

Healthcare Improvement Unit (HIU)

## 6. Definitions of terms used in the guideline

Term	Definition / Explanation / Details	Source
Acute care	<p>This care type is care in which the principal clinical purpose or treatment goal is to:</p> <ul style="list-style-type: none"> <li>• manage labour (obstetric)</li> <li>• cure illness or provide definitive treatment of injury</li> <li>• perform surgery</li> <li>• relieve symptoms of illness or injury (excluding palliative care)</li> <li>• reduce severity of an illness or injury</li> <li>• protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function</li> <li>• perform diagnostic or therapeutic procedures.</li> </ul> <p>Acute care excludes care which meets the definition of mental health care.</p>	Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2016-2017
Authorised Practitioner	A clinician (for example, a nurse practitioner or Senior Medical Officer - SMO) credentialed to admit patients and retain clinical governance.	HITH Guidelines 2013
Care Setting	<p>Location in which the HITH service provides care to the patient.</p> <p>HITH services are designed and funded to deliver care in the home. The decision regarding HITH treatment is to be patient-focused, taking into consideration the psychological, physical and environmental needs of the patient and not influenced by the funding models.</p> <p>Care settings can include, but are not exclusive to, patient's permanent or temporary residence, Residential Aged Care Facility, hotel, prison and boarding house.</p>	HITH Guidelines 2012
Clinical Governance	The mechanism under which a patient is appointed a healthcare team to assume clinical	HITH Guidelines 2012

Term	Definition / Explanation / Details	Source
	responsibility for the patient's treatment plan and oversee the patient's clinical care.	
Clinical handover	Transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.	National Safety and Quality Health Service Standards (2012)
Consumables	Equipment required by the patient and HITH team to provide care.	HITH Guidelines 2012
Coordination	The structured organisation of the care including communication and role delineation between services.	HITH Guidelines 2012
Contracting of External Service Providers	When the Queensland Health HITH service or Hospital and Health Service (HHS) requests and funds another service (non-government) to provide the HITH care.	HITH Guidelines 2012
Dedicated HITH Team	Team is recruited to provide HITH care only.	HITH Guidelines 2012
Dual Model of Care	Team recruited to provide both HITH and post-acute care.	HITH Guidelines 2012
HITH	HITH provides care in a patient's permanent or temporary residence for conditions requiring clinical governance, monitoring and/or input that would otherwise require treatment in the traditional inpatient hospital bed. The admission criterion is governed by the authorising officer and as such the HITH program is focused exclusively on admitted care substitution.	(Adapted from) HITH Guidelines 2012
Inpatient Shared Model	Staff that work in an acute facility and also provide HITH care within their scope of practice.	HITH Guidelines 2012
Interface	The interaction HITH services have with other service providers during the HITH episode of care.	HITH Guidelines 2012
Inter-HITH transfer	When the care of a HITH patient is moved from the responsibility of one site to another HITH service.	HITH Guidelines 2012
Medication Management	Process whereby the medication requirements of HITH patients are met.	HITH Guidelines 2012
Pathways	Standardised, evidence-based multidisciplinary management plans, which identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes	Queensland Health Clinical Pathways Board

Term	Definition / Explanation / Details	Source
	for a homogenous patient group.	
Patient Journey	Defined as the flow of the patient through the HITH service from time of admission / transfer to HITH until discharge of care to the primary provider, or transfer to another inpatient team.	HITH Guidelines 2012
Record Management	The practice of maintaining patient information while the patient is admitted to the HITH service.	HITH Guidelines 2013
Separation	The point in which the patient can be discharged from the service into the care of the primary care provider (e.g. General Practitioner).	HITH Guidelines 2012
Service Evaluation	The ongoing monitoring and evaluation of service level data to ensure key performance indicators are met.	HITH Guidelines 2012
Sub-acute care	This care type is a collective term for the following types of care: rehabilitation, palliative, geriatric evaluation and management, psychogeriatric and maintenance.	QHAPDC Manual 2016-2017

## 7.0 Approval and Implementation

### Document Custodian:

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### Approval Officer:

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### Version Control

Version	Date	Prepared by	Comments
1.0	29/11/2012	HSIB	New document
2.0	31/12/2013	L. Hines	In partnership with NMOQ and the HITH Advisory Committee
2.1	21/02/2014	L. Hines	In partnership with Health Statistics Unit, Data Collection Unit
2.2	29/02/2016	L. Hines	In partnership with Revenue Strategy and Support Unit and Statistical Collections and Integration Unit
3.0	21/2/2017	S. Mizzi	In partnership with the HITH Guideline Review Working Group

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## 8.0 Context

Over the last 10 years, there has been a rising interest in increasing the provision of HITH, prompted by the outcomes of several national and international reviews in relation to the HITH model of care. These studies identified that:

- patients have better or equal clinical health outcomes compared to a traditional inpatient admission;
- patients and their carers report increased satisfaction when treated via HITH models; and
- healthcare expenditure relating to service provision is lower.

HITH is a priority commitment for the Queensland Government. HITH has the potential to provide patients with greater choice in their care, improve access to health services, equal or better patient care outcomes, and improve efficiencies in service delivery. For these reasons, Queensland Health is keen to promote the ongoing development of HITH for suitable patient cohorts to meet increasing demand for hospital care as the population continues to grow and age.

## 9.0 Corporate and Clinical Governance

### 9.1 Corporate Governance

Corporate governance of HITH services is essential for both patient safety and the viability of HITH services. The establishment of a comprehensive corporate governance structure will provide transparent monitoring/reporting systems, strong clinical leadership, advocacy and clinical risk management.

#### Recommended Requirements

- The corporate governance structure is to be developed to include representation from all relevant clinical levels and professionals within the Hospital and Health Service (HHS) and any external providers (if relevant).
- HITH services are to be incorporated into the HHS planning and demand management strategies.
- Data and key performance indicators (KPI) are to be monitored, analysed and reported via local HHS processes and communicated to all stakeholders on a regular basis. Refer HITH KPIs at [https://www.health.qld.gov.au/\\_data/assets/pdf\\_file/0018/641313/qh-gdl-379-att2.pdf](https://www.health.qld.gov.au/_data/assets/pdf_file/0018/641313/qh-gdl-379-att2.pdf)

### 9.2 Clinical Governance

Clear lines of responsibility for the clinical management of the patient are essential to ensure a treatment plan (medical management plan) is established and appropriate management and coordination of care is achieved. A variety of models of care can be implemented by the HHS to meet local need and should be reflected in the HHS admission policy. Examples include:

### **1. Inpatient Admitting Team Clinical Governance Model**

In the 'Inpatient Admitting Team' clinical governance model, the treating hospital inpatient authorised practitioner (e.g. Emergency Department or inpatient Senior Authorised practitioner SMO, Nurse Practitioner) retains responsibility for the care of the patient admitted to HITH throughout the episode of care. The model of care requires the HITH team to be in communication with the admitting hospital inpatient team during the episode of care. The HITH team shall consult with the admitting inpatient team regarding any changes required to the set clinical management plan prior to those changes being made.

### **2. HITH authorised practitioner or Authorised Practitioner Governance Model**

The 'HITH Authorised Practitioner' or 'Authorised Practitioner Model' is where the care is transferred from the admitting hospital inpatient team to a Queensland Health approved HITH authorised practitioner. The HITH authorised practitioner then takes on the responsibility for all care planning and treatment regimes.

### **3. Combination Clinical Governance Model**

The 'Combination Model' is any combination of the above models. Whilst this model allows for flexibility in service delivery, it is essential that clear clinical governance, reporting lines and guidelines are available.

## **Recommended Requirements**

- Patients are admitted by an authorised practitioner working within their recognised scope of practice.
- Independent HITH authorised practitioners need to be appropriately credentialed as per HHS policy.
- A patient is transferred to a virtual ward (i.e.HOMEXX) with the treating authorised practitioner recognised in HBCIS as per the QHAPDC manual.
- Two-way communication between HITH team and the admitting authorised practitioner is essential to ensure coordination of care for the inpatient.
- Patient review periods are set by the admitting team and are dependent on the patient's requirements.
- The HHS, in collaboration with the direct referral source, is responsible for identifying the pathway for direct referral to the HITH service.
- The authorised practitioner who has responsibility for the patient is to receive a regular clinical update from the HITH service as nominated by the authorised practitioner.

- The HITH team is to notify the authorising practitioner of any changes to the patient's condition.
- Public private partnerships may be considered by the HHS to meet local requirements. There are two methods:
  - ✓ Total clinical care is contracted to the external service provider.
  - ✓ A component of care is transferred to the external service provider (for example physiotherapy).

## 10.0 HITH Inclusion and Exclusion Criteria

### 10.1 Inclusion Criteria

- Home care replaces full hospital admission or a component of a hospital admission. Without a HITH service, the patient would be admitted to hospital for treatment in a traditional hospital bed.
- Each patient is identified as requiring clinical governance, active treatment and / or monitoring during the HITH episode of care.
- All patients require a minimum daily intervention or assessment by the HITH service.
- A comparable level of care to that provided in the inpatient setting is to be provided by the HITH service to meet all patient needs.
- A treating authorised practitioner agrees that the care for the patient can be safely provided and managed in the patient's permanent or temporary residence.
- The patient/approved guardian/carer consents to transfer of care. This is to be documented and evidenced in the patient medical record.
- Patient has no known allergy to medication prescribed during the HITH episode of care.
- Care location must have a telephone with dial out facilities.
- Care location must have a working refrigerator with suitable storage room (if required to store medications).
- For paediatric patients, the approved guardian must nominate an adult to be present during treatment of minors.
- Public eligible patients.
- Acute and sub-acute public eligible patients.
- Acute compensable patients. Include;
  - Department of Veterans' Affairs (DVA) funded patients.
  - Third party compensable funded patients.



- Motor vehicle accident insurance funded patients.
- Workers compensation funded patients.
- Acute non-compensable ineligible (e.g. overseas visitors) patients.
- The HITH service is skilled to provide the care required.
- The HITH service has adequate staff to provide the required number of visits and the timing of the visits required.
- The patient has understanding of the care that will be provided to them while under the HITH.

## 10.2 Exclusion Criteria

- Complex care needs not amenable to a HITH service. These include physical, cognitive and/or social care needs that exceed the capability of available support networks (including carers and health care providers).
- Public hospital Medicare eligible private patients whose accommodation charges are funded by private health insurance.
  - NB: Public hospital patients who elect to receive admitted patient care as private and who are subsequently treated by HITH services will be required to change their election to public from the point at which the HITH service commences.
- Patients who are in hospital for a continuous period exceeding 35 days and not in receipt of an Acute Care Certificate.
  - NB: The continuous period may accrue in more than one hospital (public, private or both). For details see the QHAPDC Manual section 4.14.
- Sub- and non-acute compensable patients. Includes;
  - Department of Veterans' Affairs (DVA) funded patients.
  - Third party compensable funded patients.
  - Motor vehicle accident insurance funded patients.
  - Workers Compensation funded patients.
- Sub- and non-acute non-compensable ineligible patients.
  - For example, overseas visitors including but not limited to international students and persons holding working visas such as 457 visa.
- Sub- and non-acute private eligible non-compensable patients.
- Venous access device maintenance only.
- Wound care and drain management which does not require daily intervention, ongoing clinical intervention and clinical governance.

- Preadmission care for planned or elective admissions that can be managed by the primary care provider.
- Follow-up telephone calls post discharge is not counted as HITH activity.

### 10.3 Specialty areas requiring further consideration for inclusion/exclusion

**Sub-Acute Care:** Sub-acute care can only be provided where it substitutes a traditional hospital bed admission. The HHS is to have clear guidelines in relation to the difference between substitution and post-acute care. Sub-acute HITH cannot replace existing community based services.

**Acute Mental Health:** Acute mental health conditions are not traditionally managed through HITH. Patients with acute mental health conditions can be referred to a HHS Mental Health Acute Care Team for assessment and management of care.. For mental health patients that are admitted to general HITH services for the treatment of an acute or sub-acute medical/surgical condition, care is to be coordinated with the mental health case manager for the patient, to ensure all of the patient's needs are met.

**Paediatric Patient Care:** The HHS is to design services to meet the needs of paediatric patients where applicable. Patient appropriateness is to be governed by the HHS and is dependent on the skill mix and experience of the HITH service. All services providing care to paediatric patients are to adhere to the National Standard of Care for Children and Adolescents.

**Women and Newborn HITH:** These services also require the 'inpatient admitting team' model of care. Home births require obstetrician clinical responsibility and paediatrician clinical responsibility for the neonate. The mother and the baby require assessment against the Hospital and Health Service Admission Policy and as such need to meet the admission guidelines in order to be admitted to HITH. Post-natal follow up care, that would otherwise be provided in the community setting, is not provided by HITH services (e.g. early discharge programs). If preadmission care is provided by HITH, there needs to be clear documentation regarding the reason for the patient admission.

## 11.0 Patient Care

### 11.1 Screening of eligible patients

Consideration of patient and staff safety is an essential part of patient selection. Due to the unpredictable nature of the home environment it is essential that a home visiting safety screen of the patient and their home (or other environment where treatment is planned to occur) is completed prior to acceptance by a HITH service. The assessment needs to identify any potential treatment and environmental risks, e.g. environment hazards, infection control or personal threat.

- A home visiting safety screen is completed prior to acceptance by a HITH service and is reviewed at the first home visit <http://qheps.health.qld.gov.au/caru/hith/resources.htm>
- Patients/carers are assessed as competent to provide self-care health interventions for example: administration of medications, suctioning, and percussion as prescribed prior to acceptance to HITH.
- Residential Aged Care Facilities (RACF) are notified of intent for HITH care prior to HITH referral being made and have capacity to manage the patient's acuity of care.
- Patients are capable of complying with treatment within the care setting.

### 11.2 Admission/ transfer of care

The patient journey through the HITH service should be seamless. Tools such as clinical pathways and Criteria Led Discharge support patient flow and are frequently adopted by HITH services.

Formal clinical pathways are not mandatory for HITH services, however, it is essential that care of the HITH patient is planned and coordinated from admission to separation.

- Direct referral pathways are recommended to be developed in partnership with the hospital staff via referrers to HITH, HHS, Primary Care and the HITH service to maximise efficiency and minimise the risk of inappropriate referrals (e.g. patients that would not normally be admitted).
- Patients meet the admission requirement as stated in the relevant HHS Admission policy.
- Receiving authorised practitioner must accept responsibility.
- Patients are admitted by an authorised practitioner working within their recognised scope of practice.
- The patient/carer consents to transfer of care. This is to be documented and evidenced in the patient medical record.
- Ensure the receiving service has capacity, can meet the patient's needs and agrees to the transfer of clinical care.

- Patients are transferred to HITH as part of a continuous episode of care.
- Handovers meet the National Safety and Quality Standards and includes a clinical treatment plan to be approved by the referring authorised practitioner.
- Handover should be minimised, where possible, by the use of optimal continuity of care models.
- HITH patients require access to multi-disciplinary services as needed.
- Conditions that have a defined treatment plan and Estimated Discharge Date (EDD). This is provided by the referring authorised practitioner to the HITH service.
- If patients do not have daily face to face contact then clear documentation of the reason why needs to be evidenced in the inpatient medical record. For this patient cohort HITH services need to consider whether the patient still requires admission.

### **11.3 Clinical Assessment, Treatment, Monitoring and Documentation**

Comprehensive assessment of the patient's care needs is required during patient selection and while the patient is receiving care from the HITH service. Assessment of the patient is to be documented and updated throughout the episode of care. To assist in the minimisation of duplication, inpatient medical records and information gathered by the hospital is to be utilised by the HITH service.

- HITH services shall have daily access to the hospital inpatient medical record during the episode of care.
- All documentation shall be collated and form a part of the hospital inpatient medical record. All documentation is to be integrated into the inpatient medical record on discharge from HITH.
- Comprehensive assessment should include the clinical, physical, social, environmental and cultural needs of the patient.
- Reason for admission and care location are to be clearly documented in the progress notes.
- The care plan is to be developed collaboratively with the patient and based on the assessment.
- The HHS shall develop local processes for the patient to return to hospital as required.
- The manual handling requirements of the patient are to be assessed and documented.
- Care is to be reviewed in a multidisciplinary handover (daily, at minimum), and documented, as appropriate to patient needs.

- Handovers are to have a holistic approach and are to focus on patient goals and discharge requirements.
- Adequate venous access can be maintained for the duration of treatment (if applicable).
- 24 hour telephone support shall be provided to patients while on HITH. The ability to provide face to face review of patients out of hours is a HHS decision.
- Advance Health Care Directives and Acute Resuscitation Plans are to be recorded in the inpatient medical record (if applicable).
- The patient's length of stay is to be monitored with the use of discharge criteria to ensure timely discharge against accepted benchmarks.
- A discharge summary is to be sent to the General Practitioner and referring authorised practitioner within the timeframes set by the HHS and following local process.
- Acute care certificates are to be provided for acute care patients if the patient's admission is longer than 35 days (as per the QHAPDC manual).
- Home visits and phone calls are to be documented clearly in the progress notes.
- Telephone consultations are considered HITH activity only when delivered in combination with face-to-face clinical care.
- Patient 'leave' management should comply with HHS admission policy guidelines.

#### **11.4 Patient Education and Health Literacy**

Patient education is essential for HITH services to achieve the requirement of providing equivalent care in the community setting. Appropriate education will provide the patient with the strategies and tools to manage in the home setting, resulting in positive patient outcomes and preventing unnecessary transfer back to the acute facility.

The patient must be provided with multi-modal education/information on the following;

- Their rights and responsibilities - <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/17501-ConsumerGuide.pdf>.
- How to contact the HITH service.
- Early recognition and management of deterioration.
- What to do in an emergency.
- Their presenting condition.
- The treatment plan and expected date of discharge.
- Chronic disease self-management (where applicable).
- Self-care measures.

- Medication management including the safe use and storage.
- Consumer Medicines Information (CMI) - <https://www.tga.gov.au/consumer-medicines-information-cmi>

## 12.0 Quality and Safety

### 12.1 Patient Safety and Quality

- Meet the National Safety and Quality Health Service Standards  
<https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf>
- Pressure injury surveillance, malnutrition screening and falls risk assessment shall be completed on all patients in HITH as per the National Safety and Quality Standards.
- Meet the infection control requirements in the Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010) [http://www.nhmrc.gov.au/files\\_nhmrc/publications/attachments/cd33\\_infection\\_control\\_healthcare.pdf](http://www.nhmrc.gov.au/files_nhmrc/publications/attachments/cd33_infection_control_healthcare.pdf).
- Infection control procedures, practices and guidelines are developed to meet the community setting.
- A HITH service has processes in place to manage emergencies, adverse events and other patient complications.
- Collaboration and forward planning between all parties involved in an incident focuses on implementing strategies to minimise the likelihood of incidents reoccurring.
- All clinical and non-clinical incidents/near misses are managed in accordance with related HHS health and safety processes, to ensure all incidents/near misses are reported and recorded.
- HITH services are to be involved in all clinical incident analyses (including Root Cause Analysis and Human Error and Patient Safety (HEAPS) review) for patients that have had part of their care provided by the HITH service.
- At risk behaviours are documented, monitored, risk assessed and reported by the HITH team, as per HHS health and safety processes.
- Where the community setting is not safe for care provision, care may be provided in a clinic environment. This should be used as a last resort and clear documentation stating the reason for clinic based care must be provided in the patient's clinical notes.
- There is a local escalation process in place for HITH staff to manage the deteriorating patient.

- Work instructions are to be implemented for the early identification of the Deteriorating Patient Adult Deterioration Detection system (ADDS) and Children's Early Warning tool (CEWT). <http://gheps.health.qld.gov.au/caru/hith/resources.htm>
- HHS shall have an action plan for extreme weather events to ensure HITH patients and staff members are not put at risk.
- Medical records are to be audited as per HHS requirements.
- Inpatient medical records utilised by HITH are to be maintained to the same standard set for hospital inpatient care and meet HHS guidelines.

## 12.2 Medication Management

Evidence identifies that patients have a higher than average risk of medication error when care is transferred from one setting to another. Due to this risk, HITH services require diligence to ensure patient risk is minimised, and should seek to obtain and verify the best possible medication history for patients.

- HITH services shall meet the National Safety and Quality Standards for medication safety. National Safety and Quality Health Service Standards <https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf>
- Medication management (e.g. ordering, supply, administration) must comply with legislative requirements as documented in the Health (Drugs and Poisons) Regulation 1996. This can be found at: <https://www.legislation.qld.gov.au/OQPChome.htm>.
- Medication policies, guidelines and practices need to be adapted for the home environment.
- HITH service providers antimicrobial stewardship guidelines must be adhered to, ensuring appropriate selection and use of antibiotics. <http://www.safetyandquality.gov.au/publications/antimicrobial-stewardship/>.
- Antibiotic prescribing should be consistent with the [Therapeutic Guidelines: Antibiotic and local formulary restrictions](#), including the Queensland Health List of Approved Medicines.
- A standing order or practice guideline for the management of anaphylaxis is in place.
- Patient and carer education regarding the signs, symptoms and management of anaphylaxis takes place. Regarding the administration of any medication, before the patient leaves the appropriately supervised clinical setting, the clinical staff must ensure the patient and/or carers understand the signs and symptoms of anaphylaxis and adverse

reactions. The patient and/or carers must be informed of the actions to be taken should an adverse event arise.

- Clinical handover to HITH service must include a list of the patient's current medications. This list must include information on any changes to regular medications that have occurred during the episode of care immediately preceding the HITH service.
- Medications are only to be administered by staff with relevant competencies and clinical privileges.
- Medication documentation meets Queensland Health standards.  
<http://qheps.health.qld.gov.au/hsq/medicines/home.htm>.
- Intervention medications are to be provided by HITH from the inpatient funding allocation.
- A patient's own medications can be used for conditions other than the admission condition as per the Use of Patient's Own Medication Guideline.  
<http://qheps.health.qld.gov.au/hssa/medicines/docs/guidelines/patients-own-meds.pdf>.
- Medications are dispensed, stored and transported according to the national standards.
- HITH service providers to develop work place instructions for telephone orders and documentation.
- Coordination and communication of care is to be negotiated with the patient and all other service providers who are administering oral medications to maximise safety (e.g. Residential Aged Care facility staff).
- Medication incidents and near misses are to be recorded, monitored and reported through PRIME.
- A Pharmacist is to reconcile medications on admission to HITH highlighting any medications that require specific monitoring (therapeutic drug monitoring, high risk medications) to medical and nursing staff and again at the end of the episode of care ensuring an accurate list of the patients medications are provided to the patient, General Practitioner and community pharmacy if required.
- A Pharmaceutical Benefits Scheme (PBS) script is to be completed at point of discharge for ongoing medication requirements.
- Process for the management of S8 medications is to be developed by the HHS to meet local and regulatory requirements.



### 12.3 Death during a HITH admission

It is essential that the morbidity and mortality of patients is monitored and that appropriate processes are followed and should include regular, multidisciplinary morbidity, mortality and quality audit and review.

- Meet the requirements stated in the Queensland Health document: Management of the Deceased Patient Practice Manual <http://qheps.health.qld.gov.au/psu/coronial/docs/mdp-manual.pdf>.
- HHSs are to develop local workplace instructions for death during a HITH admission.
- Clinical incident analysis of Severity Assessment Code 1 (SAC 1) unexpected deaths of patients that have had a component of care in HITH are to be conducted with HITH service involvement.

## 13.0 Integrated Service Delivery Model

Clear and concise communication between the HITH team, hospital service, primary care provider and other relevant people will enhance care delivery and positively impact the patient journey.

- The primary care provider is notified of the HITH admission within 24 – 48 hours of transfer of care as per HHS guidelines.
- Patients that receive services from the : Commonwealth Home Support Program (CHSP), Commonwealth Home Care Packages (HCP), Queensland Community Care Services (QCCS), National Disability Insurance Scheme (NDIS) or palliative care prior to admission can continue to receive these services while on HITH; however HITH must take a lead in coordinating care. If the patient's needs during the HITH admission are greater than preadmission, HITH is to increase and fund the increased services.
- Whilst on HITH, CHSP, HCP, QCCS, NDIS and palliative care service providers may review the client to ensure that their Care Plan is updated and that the service provider has adequate resources to provide and maintain a basic level of support for the client.
- All service providers are required to have appropriate policies and procedures in place to manage legislative and regulatory requirements in relation to police checks.
- Patients in RACFs are permitted to receive HITH care substitution; however the HITH service needs to work closely with the RACF to ensure clear communication.
- If personal care is being provided by an external provider, HITH should assess that there is no increased risk to the patient or healthcare worker, prior to continuing this service.

- If no other services are involved and HITH identifies the patient requires assistance to meet their Activities of Daily Living (ADL), it is the HITH responsibility to arrange and fund services for the duration of the HITH episode of care.
- If a patient requires additional support following discharge, it is the HITH responsibility to ensure appropriate referrals are made. These may include My Aged Care for people older than 65 years old or the Access Register for people younger than 65 years old.
- Post-Acute Care and Transition Care Program cannot run concurrently with HITH as this breaches funding agreements.

## 14.0 Corporate Functions

### 14.1 Staffing models

There are three main models of staffing HITH services. These include:

1. 'Dedicated HITH Team' – Team is recruited to provide HITH care only.
2. 'Dual Model of Care' – Team recruited to provide both HITH and Post-Acute Care.
3. 'Inpatient Shared Model' – Staff that work in a hospital and also provide HITH care within their scope of practice.

### 14.2 Staff Training and Competencies

The provision of care in the community setting requires acute and sub-acute specialist skills to ensure the care provided is of the highest standard. Continuous professional development is required to maintain patient and staff safety.

- Clinical staff in positions requiring registration must meet standards set by National Health Boards.
- All staff are to meet organisational Code of Conduct Standards.
- Staff are to be recruited at the appropriate level to reflect the autonomy of providing care in a community setting.
- Mandatory training is set by the HHS in line with inpatient requirements and completed by the HITH service as required (for example Basic Life Support). HITH staff are responsible for ensuring they meet these requirements.
- Staff are to work within their scope of practice and professional frameworks and delegate according to their professional standards.
- Specialty services, for example paediatric HITH, require specialist qualifications and competencies. The HHS shall identify and mandate requirements for the local area.
- Staff training and competencies are to be tailored to the community setting.

### 14.3 Staffing requirements

As per organisational requirements, HITH staff may be required to:

- Complete a criminal history check.
- Have a Blue Card (if non-regulated staff, and work directly with children).
- Complete an Aged Care Police Check, if HITH staff are entering RACFs to provide treatment to HITH patients.

### 14.4 Activity Based Funding

HITH patients are considered inpatients of the hospital facility and are funded through Activity Based Funding (ABF).

While patients remain under the HITH model of care, the below items/services are funded within the ABF funding allocation;

- Consumables (e.g. wound care products)
- Clinical services (Medical, Allied Health, Nursing and support services)
- Clinical investigations
- Intervention medications
- Equipment

Alternative models for an outside provider option will be developed through separate negotiations. Irrespective of service provider, no treatment cost is to be transferred to the patient.

Healthcare Purchasing Initiatives related to HITH are available at:

[http://qheps.health.qld.gov.au/hpfp/html/purchasing\\_framework.htm](http://qheps.health.qld.gov.au/hpfp/html/purchasing_framework.htm)

Further detail is available in the Key Performance Indicator (KPI) Attribute sheets:

- Operational Manual identifies the funding structure for HITH.  
<http://qheps.health.qld.gov.au/abf/html/015-abf-model.htm>
- Data meets QHAPDC reporting requirements.
- Charts are to be coded as a continuous episode of care in accordance with inpatient coding practice.
- All HITH care and Diagnosis Related Groups (DRG) reporting is to be coded in line with inpatient care.
- Care location is to meet QHAPDC requirements.

### 14.5 Revenue

HITH services are also able to accept compensable patients including (refer 'Fees and Charges Register' - <https://www.health.qld.gov.au/directives/html/a#f>):

- DVA funded patients.
- 3rd party insurance funded patients.
- Workers compensation funded patients.
- Non-Medicare eligible patients.

#### 14.6 Service Evaluation

Data and KPIs are to be monitored, analysed and reported via local HHS processes. Service evaluation is important for the ongoing monitoring and evaluation of service level data to ensure key performance indicators are met.

- Minimum data set for reporting is outlined as published on the HITH website <http://qheps.health.qld.gov.au/car/hith/>.
- To ensure transparency of HITH service delivery practice, all data (including clinical incident data) is to be made available to key stakeholders.

### 15.0 Abbreviations

ABF	Activity Based Funding
ADL	Activities of Daily Living
ADDS	Adult Deterioration Detection system
CEWT	Children's Early Warning tool
CHSP	Commonwealth Home Support Program
CMI	Consumer Medicines Information
DRG	Diagnosis related group
DVA	Department of Veteran Affairs
EDD	Estimated Date of Discharge/Estimated Discharge Date (both used)
HBCIS	Hospital-based corporate information system
HCP	Home Care Packages
HEAPS	Human Error and Patient Safety
HHS	Hospital and Health Service
HITH	Hospital in the Home
HIU	Healthcare Improvement Unit
KPI	Data and key performance indicators
NDIS	National Disability Insurance Scheme
NMOQ	Nursing and Midwifery Office Queensland
PBS	Pharmaceutical Benefits Scheme
QCCS	Queensland Community Care Services
QHAPDC	Queensland Hospital Admitted Patient Data Collection Manual
RACF	Residential Aged Care Facilities
SAC	Severity Assessment Code
SMO	Senior Medical Officer

## 16.0 References

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- Health care Policy Relating to Children and Families  
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  - Victorian Hospital In The Home Guidelines  
<https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/acute-care/hospital-in-the-home>
  - NSW Hospital In The Home (HITH) Guideline  
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<http://www.hithsociety.org.au/>
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