Home-based cancer care

Framework and toolkit

VICTORIA State Government | Health and Human Services

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-1-76069-411-1 **(pdf/online/MS word)**

Available at https://www2.health.vic.gov.au/about/health-strategies/cancer-care

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Acknowledgements

We gratefully acknowledge the work of the project steering committee and the many health professionals within the Victorian Hospital in the Home and cancer sectors (public and private) who have actively engaged in the development of this document.

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Introduction

An increasing incidence in cancer diagnoses and scientific developments in biological therapies has resulted in an increased demand for limited day oncology services. The use of biologic therapies to treat cancer is expected to grow, exceeding capacity of health services to meet demand.

Systemic anti-cancer therapies (SACT) encompass all pharmacological therapies administered intravenously, subcutaneously, intramuscularly or orally to treat cancer. They are typically delivered in the ambulatory care setting and always by specialist cancer nurses. An alternative to hospital-based cancer care is delivering SACT in the patient's home or close to home. Delivering SACT in homes is an established, safe, equivalent and acceptable alternative to delivering SACT in the hospital setting (Cool et al. 2018). In addition to relieving pressure on ambulatory care services, home based cancer care (HBCC) enhances patient-centredness by offering eligible patients more choice about how, when and where they are treated (Borras et al. 2001).

Home-based cancer care: framework and toolkit outlines governance, models of care and funding structures to assist Victorian health services to establish and deliver safe, high-quality cancer treatment in the home. The framework contains a set of evidence-based, best practice tools and templates to assist in the implementation of a HBCC program.

The aims of the framework are to:

- facilitate home-based options for cancer patients receiving active treatment
- provide evidence-based treatment and patient eligibility criteria
- promote consistency of access and reduce variation of service across the state
- provide a program monitoring and evaluation structure.

Alignment

Department of Health and Human Services

Strategic Direction 2: Local solutions – Access to services closer to home (Department of Health and Human Services 2019b).

Victorian cancer plan 2016–2020

Long-term goal: Ensure Victorians have the best possible experience of the cancer treatment and care system

Cancer plan priority: Improve patients' experience of care

System support: Innovation: supporting and systematic scaling-up of innovative practice

Care plan principle: Person-centred care with equitable access

National Safety and Quality Health Service Standards

The document is designed to align with the Australia's National Safety and Quality Health Service (NSQHS) Standards. The aim of the NSQHS Standards are to protect the public from harm and improve the quality of health care. The NSQHS Standards form the structure of the HBCC framework.[1]

[1] NSQHS Standards (second edition) icons used throughout this document with permission National Standards Program. Australian Commission on Safety and Quality in Health Care

Background

The delivery of acute health care to people in their homes is well established in Victorian health services and provided by a variety of service programs depending on the type of care needed.

Service delivery programs are divided broadly into two: admitted care and non-admitted care.

Admitted care

Hospital in the Home (HiTH) services provide care in the home that would otherwise be delivered within a hospital as an admitted patient. In Victoria, the HiTH program focuses exclusively on acute admitted care substitution and does not provide other non-admitted or community-type care (Department of Health 2011). Admitted services, such as HiTH, are funded by WIES (weighted inlier equivalent separation). Admitted care includes same day, overnight and multiday ward admissions. The patient's own home (or other residential service not providing admitted care) is the virtual ward.

Non-admitted care

Non-admitted home care was previously delivered by Home and Community Care (HACC) or the Health Independence Program.

The introduction of the National Disability Insurance Scheme (NDIS) from July 2015 led to significant changes to HACC. During the transition to the NDIS, HACC services continue to be available for people aged 0–64 (HACC PYP – Program for Younger People) until full implementation of the NDIS (Department of Health 2013). People aged over 65 are eligible for home care services provided by the federally funded Community Home Support Program via 'My Aged Care'. The Health Independence Program focuses on improving and optimising people's function and participation in activities of daily living to allow them to maximise their independence and return to or remain in their usual place of residence (Department of Health and Human Services 2019a).

Home-based non-admitted care is also available under the Victorian Specialist Clinics Program. Services are classified using the national tier 2 classification (Independent Hospital Pricing Authority 2019). model and funded by WASE (weighted ambulatory service event).

Type of care

Cancer care at home can mean and incorporate many things. Broadly it can include health care delivered to a patient at home with a diagnosis of cancer such as wound care, intravenous antibiotics, palliative care, pain management and parenteral antineoplastic therapies.

Day oncology units

Most SACT in Australia are delivered in an outpatient or day oncology setting (Australian Institute of Health and Welfare 2019).

Patients attending day oncology units for treatment are booked according to the treatment they are receiving. Patients receiving intravenous systemic anticancer therapies or intravenous supportive care therapies are registered as admitted. Patients receiving subcutaneous or intramuscular therapies, central line care or education are registered as non-admitted. Day oncology units attract both WASE and WIES funding.

HiTH and cancer care

A high proportion of patients who receive care in Victorian HiTH services have a cancer diagnosis; however, most of this care is not SACT.

Of the 45 Victorian HiTH services,[2] seven deliver SACT in the home. One HiTH service delivers cancer treatment that would usually require a multiday admission in a hospital bed – for example, hybrid consolidation treatment for acute myeloid leukaemia. The other six HiTH services deliver therapies that would otherwise be delivered in a day oncology unit. Another health service delivers SACT to patients in the home from their day oncology unit rather than the HiTH department. In 2017–18, 3 per cent of intravenous SACT was delivered in people's homes in Victoria.

[2] Sourced from the department's contact list of Victorian HiTH programs

Defining home-based cancer care

HBCC is the delivery of SACT and associated care to adults by nurses in the patient's home or close to their home.

Scope – inclusions

Systemic anti-cancer therapies

SACT refers to all pharmacological therapies administered intravenously, subcutaneously, intramuscularly or orally to treat cancer. SACT are administered by specialist cancer nurses.

Associated care

Associated care refers to central venous access devices (CVAD) care, ambulatory infusion disconnects, monitoring and patient education.

Close to home

In alignment with the *Victorian cancer plan 2016–2020* to deliver cancer care close to home (Department of Health and Human Services 2016), the HBCC framework includes an option to deliver chemotherapy in a community centre or GP clinic closer to the patient's home.

With the implementation of an HBCC eligibility criteria for the safe delivery of treatments at home, SACT can also be delivered in an outreach centre, limiting the need for investment in infrastructure and human resources required for day oncology units. There may be economies of scale to be made, particularly in regional and rural Victoria, by delivering the HBCC model within a community health service or GP clinic closer to a person's homes rather than in each person's home. For example, a cancer nurse specialist from Ballarat could attend Skipton Medical Practice once a week to deliver treatment to patients who live in or around Skipton (Skipton is 45 minutes from Ballarat).

Scope – exclusions

Post-acute care

The Health Independence Program, incorporating post-acute care, delivers short-term care at home to patients post an acute hospital admission to facilitate early discharge. Services commonly provided include community nursing, personal care and home care. As such, post-acute care is out of scope of the HBCC framework.

Supportive care

Supportive care in cancer is an umbrella term used to describe services that may be required by those affected by cancer. It includes self-help and support, information, psychological support, symptom control, social support, rehabilitation, spiritual support, palliative care and bereavement care (Department of Health and Human Services 2018b).

Supportive care is provided by all members of the multidisciplinary team and it is essential that the HBCC framework incorporates patient access to the full suite of supportive care services. Since the term 'supportive care' refers to such a wide range of care delivered by nursing, medical and allied health professionals, it is recommended that the term 'associated care' rather than 'supportive care' be used in the definition of HBCC.

Palliative care and paediatrics

A statewide Community Palliative Care program (Department of Health and Human Services 2017) is in place in Victoria and is therefore excluded from this project; however, patients may access HBCC for the administration of SACT with palliative intent.

A home-based paediatric cancer care service has been trialled and implemented by the Paediatric Integrated Cancer Service in Victoria. Paediatric cancer care is therefore excluded from the scope of the HBCC framework.

Intravesical therapies

Bladder intravesical therapy is used to treat urothelial carcinoma of the bladder. Therapies include bacillus Calmette-Guérin – a live, attenuated strain of bovine tuberculosis and the cytotoxic drug mitomycin, administered via a urethral catheter.

Bacillus Calmette-Guérin is a biohazard and does not meet the drug stability criteria for home delivery. Mitomycin is a vesicant and is most commonly administered immediately following a transurethral resection of bladder tumour.

Intravesical therapies are not recommended for delivery in the home.

Cytotoxic treatments other than cancer

Cytotoxic and biotherapy treatments prescribed for treating diseases other than cancer are out of scope for the framework.

Summary

HBCC refers to the delivery by nurses of Systemic Anti-Cancer Therapies and associated care to adult patients in their home or close to home.

Inclusions

- Intravenous/intramuscular/subcutaneous therapies
- Central venous access device (CVAD) management
- Ambulatory infusion pump changes and disconnections
- Oral chemotherapy support
- Correction centres

Exclusions

- End-of-life/palliative care
- Pain management
- Delivery of HiTH or post-acute care to patients with a cancer diagnosis following an acute or palliative inpatient admission
- Paediatrics
- Allied health services
- Cytotoxic and biotherapies for diseases other than cancer
- Intravesical therapies

Governance

Quality governance roles and responsibilities

High-quality services and outcomes for every Victorian require everyone at every level in HBCC services to play a role (Department of Health and Human Services 2018a). Everyone from support staff to practice leaders, CEOs and department staff should focus on:

- partnering with patients, families and carers
- regular review, evaluation and identifying areas for improvement
- ownership and accountability for the quality of services provided.

Patients and families

People are the central focus of quality governance. Their experiences of and participation in community services are fundamental indicators of quality and safety. Patients and families:

- participate to their desired extent in the services they receive
- participate in system-wide service improvement
- advocate for safety to support the best possible outcomes for themselves and other clients
- share their experience, provide feedback and offer suggestions to support improvement.

Frontline staff

The people who have direct contact with, and deliver services to, our patients are the face of service quality. Frontline staff:

- support patients to share their experience
- work within relevant standards, protocols and guidelines
- speak up and raise concerns about quality and safety for their colleagues and clients
- share information and learnings regarding safety
- monitor and review their services and focus on continuous improvement
- work collaboratively as part of coordinated teams and services
- work with and support clients to exercise their voice, recognising clients may be hesitant to do this for a range of reasons
- go beyond the bare minimum to pursue excellence for clients
- regularly update their skills and knowledge to provide the best service possible.

Operational managers and team leaders

Operational managers and team leaders:

- provide a safe environment for staff and patients that supports a culture of collaboration, teamwork and transparency
- ensure staff are clear about their roles and responsibilities
- support and develop staff to deliver the best possible service
- proactively identify and manages risks
- lead and model behaviour that supports continuous learning and speaking up about quality and safety concerns
- promote a culture of continuous improvement through sharing information and supporting and enabling staff and clients to contribute to and lead improvement efforts
- support staff to seek out client voices in a way that responds to power imbalances.

Executive

The executive and CEO:

- provide visible leadership and demonstrate a commitment to delivering the organisation's strategic direction
- create and promote a safe and open culture that empowers staff to speak up and raise quality and safety concerns
- foster a 'just' culture of safety, fairness, transparency, learning and improvement in which staff are empowered and supported to deliver their roles and responsibilities
- proactively seek information from qualitative and quantitative sources including staff and clients to test and understand the quality of all areas of service delivery
- drive a culture that is committed to supporting clients to exercise their voice
- maintain focus on the quality of services, ensuring that listening to and acting on the client voice is at the centre of the business and the organisation remains focused on continuous improvement
- regularly report to the board or committee of management on risks, outcomes, areas for improvement and progress on achieving the best service across all areas of service delivery.

Boards, directors and committees of management

Governance bodies have specific responsibilities for quality and safety in their service. These should be specified in their constitution, strategic plan or other governing charter.

Governing bodies have ultimate responsibility to ensure the services delivered within their organisation are safe and high quality. Governing bodies must also take the necessary steps to assure themselves that the services within their organisations are safe.

Governing bodies must ensure they have appropriate subcommittees with suitably skilled members, including a subcommittee dedicated to quality and safety.

Governing bodies:

- set a clear vision, strategic direction and 'just' organisational culture to drive consistently high-quality services and to facilitate effective employee and client engagement and participation
- ensure they have clear and regular reporting on the quality and safety of their service via a dedicated subcommittee
- stay engaged, visible and accessible to staff
- ensure they have the necessary skill set, composition, knowledge and training to actively lead and pursue quality and excellence in service delivery
- understand key risks and ensure controls and strategies are in place to mitigate them
- monitor and evaluate all aspects of services provided through regular and rigorous reviews of benchmarked performance data and information
- ensure robust quality governance structures and systems across the service effectively support and empower staff to provide high-quality services that are designed in collaboration with staff expectations
- delegate responsibility for implementing, monitoring and evaluating improvement to their executive
- regularly seek information from the executive, staff and clients about the status of quality and safety in all areas of service delivery.

Department of Health and Human Services

The department has a number of key quality governance functions including to:

- set the expectations and accountability requirements for quality and safety
- ensure community services have the relevant data and information to support and oversee quality and safety
- provide leadership, support and direction to community services
- monitor quality governance implementation by regularly reviewing key quality and safety data
- monitor the quality governance system to identify concerns early and to take appropriate, timely action to address system failings.

Clinical governance

Good clinical governance leads to safe, effective, person-centred care. Clear lines of responsibility for the clinical management of patients are essential to ensure a medical management plan is established and appropriate management and coordination of care is achieved.

Recommended requirements (Department of Health 2011; Department of Health Queensland 2017) include the following:

- HBCC services are incorporated into health service implementation of the *Victorian clinical governance policy framework*.
- HBCC internal governance and management arrangements ensure strong leadership, clarity of delegated responsibility and effective monitoring and risk management arrangements.
- Each health service identifies a key contact for their HBCC service – for example, a day oncology manager or HBCC coordinator.
- Each HBCC patient has an identified treating oncologist/haematologist and delegation of medical management is clear.
- The patient's treating oncologist/haematologist approves the patient's participation in the HBCC program.
- Patient review periods are set by the treating oncologist/haematologist and depend on the patient's requirements. The treating oncologist/haematologist has access to nursing assessments and treatment notes at the time of review.
- Communication between the HBCC team and the treating oncologist/haematologist is clearly defined to ensure coordination of care for the patient.
- A clear referral pathway is established from the referral source to the HBCC team.
- The treating oncologist/haematologist with responsibility for the patient receives a regular clinical update.
- Each HBCC service participates in the health service strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients.
- Health service executives and boards oversee and evaluate HBCC service quality and performance.

Service delivery models

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

Model A: Oncology HBCC

Under model A, the oncology department manages all aspects and responsibility for the care of the patient participating in the HBCC program. Patients are admitted under the oncologist/haematologist bed card. The HBCC team is responsible for maintaining an up-to-date care plan and for taking the lead in coordinating access to additional services as required.

Model B: HiTH HBCC

Under model B, the HBCC program is managed by the HiTH department. The oncology team refers the patient to the HiTH service for HBCC. The HiTH medical director takes responsibility for all care planning and treatment regimens. Patients for admission are admitted under the HiTH medical director bed card. The HiTH team is responsible for maintaining an up-to-date care plan and for taking the lead in coordinating access to additional services as required.

Model C: Oncology/HiTH HBCC

The oncology/HiTH model is the combination of models A and B. This model of care requires the HiTH team to be in communication with the oncology team during patient participation in HBCC. The HBCC HiTH team escalates any concerns or adverse events to the oncology team and consults with them regarding any changes to the clinical management plan before any changes are made. Patients are admitted under the oncologist/haematologist bed card. The HBCC HiTH team is responsible for maintaining an up-to-date care plan and for taking the lead in coordinating access to additional services as required.

Risk management

Effective risk management requires a commitment to health and safety from all those involved in delivering HBCC (Department of Health and Human Services 2018a; Safe Work Australia 2018).

Both safeguarding and minimising risks to patients requires a structured approach to safety that is both reactive and proactive – that both repair and prevent harm. Safe services rely on staff and their awareness of systems that prioritise safety for all. Safe services are supported by mechanisms that identify issues early and respond when things go wrong.

Risk management for patients and staff should be approached systematically and be integrated within broader risk management systems that scan for, monitor, review and manage risk. This includes early identification of risks and defined escalation processes with clear pathways, processes, accountabilities and oversight.

A robust HBCC risk register, assessment and management plan requires input from nursing, pharmacy and medical staff, as well as the health service executive.

Risk management process

- Identify hazards – find out what could cause harm.
- Assess risks – understand the nature of the harm that could be caused by the hazard, how serious the harm could be and the likelihood of it happening.
- Control risks – implement the most effective control measure that is reasonably practicable in the circumstances and ensure it remains effective over time.
- Review hazards and control measures to ensure they are working as planned.

For more information and guidelines for completing a risk assessment for HBCC refer to Safe Work Australia's *Code of practice: How to manage work health and safety risks*.

Key performance indicators

Measures of success

Monitoring processes help assess the effectiveness of approaches, identify areas of risk and support continuous improvement. Measures should be set to reflect the goals for service excellence and encompass safety, effectiveness, person-centredness and connectedness dimensions (Department of Health and Human Services 2018a, p. 24).

HBCC services should be incorporated into health service planning and demand management strategies. Data and key performance indicators (KPI) are to be monitored, analysed and reported within the health service processes and regularly communicated to all stakeholders (Department of Health Queensland 2017). HBCC services should review their data and identify ways that it can be connected to give enhanced insights into issues and trends within their service.

Clinical incidents, near-misses and adverse events should be reviewed, investigated and managed by a multidisciplinary quality and safety team to drive ongoing improvements in quality and safety.

An open disclosure process should be in place to enable the workforce to communicate openly with patients in the event of an unexpected outcome. Open disclosure training and support should be provided to HBCC nurses in line with the *Australian open disclosure framework* (Australian Commission on Safety and Quality in Health Care 2013).

Levels of HBCC

The HBCC program has been categorised into three levels to reflect the complexity of patient care provided in the home and degree of medical support required (Table 1).

Level 1 HBCC manages the highest level of patient complexity including autologous and allogeneic transplant care and requires daily medical review. Level 2 includes SACT typically delivered in the ambulatory setting, with medical review if clinically indicated. Level 3 HBCC are procedures outsourced to a district nursing service.

Table 1: The three levels of hospital-based cancer care

Level	Definition	Service design
Level 1	The administration of SACT and monitoring typically requiring an acute inpatient admission	• Requires at least daily HiTH visits until discharge • Patient remains admitted for the duration of HiTH visits • Daily medical review • Admitted to HiTH with daily patient oversight from a haematology or medical oncology unit • Admitted under the bed card of an oncologist/haematologist or HiTH medical director
Level 2	The delivery of SACT and associated care typically delivered in a day oncology unit	• Medical oversight provided by the oncology team • Delivered by either HiTH nurses or day oncology nurses • Admitted and non-admitted care • Therapies include chemotherapy, targeted therapy and monoclonal therapy • Central line care, monitoring
Level 3	Disconnection of ambulatory infusion devices, central venous access care	• Non-admitted services only

Workforce

Staff must have the appropriate skills and knowledge to effectively fulfil their roles and responsibilities. Systems must support a skilled, competent and proactive workforce, which is essential for a safe, effective, quality HBCC service.

All staff require access to information and training on effective approaches to continuous service improvement and how they can contribute to delivering high-quality services. Human resource systems must support staff to develop and consolidate their skills, work within their roles and responsibilities and, where appropriate, manage performance.

Staffing models

There are three main models of staffing for HBCC services (Department of Health Queensland 2017).

These include:

- dedicated HBCC team – staff are recruited to provide HBCC care only
- dual model of care – staff are recruited to provide both HiTH and HBCC
- shared model – staff work in a hospital or day oncology unit and provide HBCC care within their scope of practice.

All models will need to include:

- a medical lead
- an HBCC coordinator
- home visit nurses
- a pharmacist.

Delivering HBCC in the community setting requires specialist qualifications and competencies to ensure the care is of the highest standard. Continuous professional development is necessary to maintain patient and staff safety.

- Clinical staff in positions requiring registration must meet standards set by AHPRA.
- All staff are to meet organisational code of conduct standards.
- Staff must be recruited at the appropriate level to reflect the autonomy of providing care in a community setting.
- Mandatory training is set by the health service in line with inpatient requirements and completed by the HBCC as required (for example, basic life support). HBCC 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.
- Staff must participate in Aboriginal and Torres Strait Islander ongoing cultural awareness and competency activities.
- Staff must attend voluntary assisted dying education.
- Staff training and competencies are to be tailored to the community setting. Training is to include management and response to aggression and work-related violence.

Funding

This section details the Commonwealth and state government funding arrangements that are available for delivering a HBCC program.

Admitted and non-admitted funding programs outlined in the Department of Health and Human Services *Policy and funding guidelines 2019–20* fund most HBCC services. Commonwealth-funded services are

those funded by the Medical Benefits Scheme. HBCC services are included in the health service's acute throughput targets and specialist clinic grants.

HBCC funded by private health insurance companies depends on the policies of insurance companies and is currently not widely available. Health services will need to negotiate including an HBCC program with each insurance company.

Funding opportunities

- Admitted services – WIES (Weighted Inlier Equivalent Separation)
- Non-admitted services – WASE tier 2 classification system
- MBS (Medicare Benefits Schedule) – clinics, case conference, chemotherapeutic procedures, nurse practitioners
- Subcutaneous immunoglobulin (SCIg) access program

Admitted services – levels 1 and 2

WIES – Multiday admitted – Intravenous infusions / monitoring / daily medical review (Department of Health and Human Services 2019d)

Code:	Multiple
Weight:	Dependent on diagnostic-related group (DRG) code
Criteria for admission:	O
Definition of service:	The patient is expected to require overnight or multi-day hospitalisation. Criteria for admission (CFA) 'O' should be used where there is an expectation that the patient will require ongoing admitted care

WIES – Same day – Admitted – Intravenous infusions (Department of Health and Human Services 2019d)

Code:	R63Z
Weight:	0.1884 (Department of Health and Human Services 2019a)
Criteria for admission:	B
Definition of service	Receive treatment on a day-only basis
Code 9619900	Treatment listed on the Automatically Admitted Procedures List (AAPL) (Department of Health and Human Services 2019c) Intravenous administration of pharmacological agent, antineoplastic agent

Reporting

Admitted services that meet criteria for admission 'O' or 'B' are reported to the Victorian Admission Episodes Dataset (VAED). The treatments delivered must be listed on the Automatically Admitted Procedures List (AAPL).

Specifications for data items submitted to the VAED for admitted HBCC

Accommodation type on separation (b) (Department of Health and Human Services 2019e)

Code set	Code	Descriptor
	4	In the Home (Hospital – HiTH)

Non-admitted services – HBCC levels 2 and 3

Public or MBS-billed specialist clinics WASE (or tier 2) – Non-admitted (Department of Health and Human Services 2019a)

Code:	10.11 – Chemotherapy treatment
Weight:	1.62 (Department of Health and Human Services 2019a)
Definition of service	Specialist clinic dedicated to the administration of chemotherapy for the treatment of abnormal cells
Inclusions	(Solid tumours / haematological)
	Chemotherapy
	Adjuvant hormonal treatment
	Palliative chemotherapy

Code:	40.52 – Oncology
Weight:	0.82 (Department of Health and Human Services 2019a)
Definition of service	Assessment, management and treatment of malignancy and neoplasm-related conditions
Inclusions	Central venous access device maintenance
	Maintenance of peripherally inserted central catheter (PICC) lines
	Chemotherapy education and patient education on self-administration of subcutaneous medications
	Self-care strategies and supportive care needs assessments
	Education and counselling

Tier 2 specialist clinic classification

The *Tier 2 non-admitted services definitions manual* provides a national framework for classifying non-admitted service events and is updated annually.

The most recent version of the *Tier 2 non-admitted services definitions manual* can be found on the Independent Hospital Pricing Authority (IHPA) website <https://www.ihpa.gov.au/publications/tier-2-non-admitted-services-2019-20>.

Specialist clinic registration

Services funded by WASE are registered as a specialist clinic in the Non-Admitted Clinic Management System with the Department of Health and Human Services.

See the *Non-Admitted Clinic Management System manual 2018–19* <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/nacms-manual-2018-19> for registration instructions.

Reporting

Reporting of public and MBS-billed specialist clinic data to the Department of Health and Human Services is via the Health Portal to both the Agency Information Management System (AIMS) and Victorian Integrated Non-Admitted Health dataset (VINAH) reporting of WASE clinics delivered at home or in another community setting.

Care delivered at home funded by tier 2 non-admitted clinics – WASE – is reported in VINAH (see Table 2).

To report WASE clinics delivered in the home/community setting in VINAH:

Part 1. Business data elements (Department of Health and Human Services 2019e)

Contact delivery setting

Definition: The type of setting in which the contact is experienced by the patient/client

Reported by: Specialist clinics (outpatients)

Select one of the following domain values:

Code	Descriptor
21	Community-based health facility
31	Home

Table 2: WIES and WASE values 2019–20

Payment	All health services	Metropolitan and regional	Subregional and local
Public WIES26	–	$5,029	$5,295
Specialist clinic (public) WASE3	$283.88	–	–
Specialist clinic (MBS-billed) WASE3	$227.10		

Source: Department of Health and Human Services 2019a

Case conferencing

Patients participating in HBCC with complex needs may be referred to a case conference for multidisciplinary care. The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

Case conferences by consultant physician (AN.0.51) (Australian Government Department of Health 2019)

Eligibility

A community case conference is organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from *at least one medical condition* that has been (or is likely to be) present for at least six months, or that is terminal, and has complex needs requiring care from a multidisciplinary team.

Case conference requirements

(a) Attendees

Must include a minimum of four formal care providers from different disciplines including a consultant physician. A patient and/or their carer may attend a case conference; however, they cannot be counted in the four.

In addition to the consultant physician, formal care providers may include:

- Aboriginal health worker
- Aboriginal or Torres Strait Islander health practitioner
- asthma educator

- audiologist
- dentist
- diabetes educator
- dietician
- mental health worker
- occupational therapist
- optometrist
- orthotist and prosthetist
- pharmacist
- physiotherapist
- podiatrist
- psychologist
- registered nurse
- social worker
- speech pathologist
- the patient's GP.

(b) Patient consent

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants. The patient may wish some personal information to be withheld or included in the case conference.
- Inform the patient that they will incur a Medicare charge for which a Medicare rebate is payable (no cost to patient).
- Invite the patient or carer to attend if they wish.
- Record the patient's consent in their medical record.

(c) Documentation

- Patient consent
- Day on which the conference was held, and the times at which the conference started and ended
- Record the names of the participants in the patient's medical records
- Provide a summary of the conference to:
  - the patient or the patient's agent
  - each member of the team the conference
  - the patient's usual GP
- Discuss the outcomes of the patient or the patient's agent.

Subcutaneous immunoglobulin (SCIg) access program

Home-based funding is available to oncology patients who require regular immunoglobulin infusions (Department of Health and Human Services 2019a).

The National Blood Authority has made available immunoglobulin products, which can be delivered at home to treat:

- primary immunodeficiency with antibody deficiency
- specific antibody deficiency
- acquired hypogammaglobulinaemia secondary to haematological malignancy (chronic lymphocytic leukaemia, multiple myeloma, non-Hodgkin lymphoma and other relevant malignancies, and post-haemopoietic stem cell transplantation)
- secondary hypogammaglobulinaemia (including iatrogenic immunodeficiency).

The department provides $680 per quarter for each patient who is being supplied SCIg.

Find out more about the SCIg program <https://www.blood.gov.au/SCIg> from the National Blood Authority website.

Link to toolkit

HBCC planning and decision making p. 33	p.39	Legislative compliance p. 49
Key performance indicators p. 50	Source: Department of **Health Queensland 2017 Workforce competency and training** p. 51	Personal protective equipment / cytotoxic spill kit p. 53
First aid kit for remote nurses p. 53	Case conference MBS item numbers p. 53	HBCC referral template p.65
HBCC consent template p. 66		Error! Not a valid result for table. **p.67**


HBCC Consent template.docx


Case Conference template.docx


HBCC Implementation Checklist.docx


HBCC Referral template.docx


HBCC Home Risk Assessment template.

Partnering with consumers

Patient and consumer participation in service design and delivery is a recognised pillar of person-centred care and is needed to achieve the best patient outcomes.

HBCC requires a trusting and mutually respectful relationship between the patient and health professional.

It is recommended that HBCC provide the following:

- an HBCC program designed, implemented and reviewed in consultation with patients and carers
- information about a patient's healthcare rights
- informed consent
- encouragement for a patient to be actively involved in the decisions about care.

Health literacy should be considered in the design and delivery of patient information and education. Patient information includes ongoing care needs, health service contact details and feedback avenues. The HBCC should consider patients' domestic cultural practices and discuss these during the home assessment.

Link to toolkit

Patient eligibility criteria p. 25

SACT consent example p. 55

HBCC consent template p. 66

HBCC referral template p. 65

Patient information template p. 78

HBCC pathway p. 75

HBCC Patient Experience Survey p. 73

HBCC patient experience template.d

HBCC Consent template.docx

Your Cancer treatment at home ter

HBCC Referral template.docx

Preventing and controlling healthcare-associated infection

Delivering health care in the home has been demonstrated to reduces the risk of patients acquiring a healthcare-associated infection (HAI); however, the principles of preventing and controlling prevention to prevent the risk and effectively manage infections apply.

Cancer, cancer treatments and the use of central lines place cancer patients at high risk of acquiring an HAI. Surveillance of HAI and HBCC-acquired central line-associated blood stream infections (CLABSI) should be included in the broad health service HAI surveillance program.

Screening for patients in home care

The use of standard precautions in accordance with best-practice guidelines as part of routine practice assist in minimising the risks of infection. Guidelines need to be adapted to the home environment.

Standard precautions include (Department of Health and Human Services 2019a):

- hand hygiene, as consistent with the 'five moments for hand hygiene'
- using appropriate personal protective equipment when there is a risk of blood or body fluid exposure
- the safe use and disposal of sharps
- cleaning surfaces prior to setting up for a procedure in the home
- cleaning equipment between patient visits
- practising respiratory hygiene and cough etiquette
- employing proper aseptic technique
- sound waste management.

Immunisation

Due to disease or treatment, many cancer patients are immunocompromised and have an increased risk of morbidity and mortality from many vaccine-preventable diseases. The HBCC workforce should be fully vaccinated according to health service immunisation policy to protect themselves and patients (Australian Government Department of Health 2018).

Recommended vaccinations are (Australian Government Department of Health 2018):

- hepatitis A (if providing health care in Aboriginal and Torres Strait Islander communities, and in some jurisdictions)
- hepatitis B
- influenza
- MMR (if non-immune)
- pertussis (as dTpa)
- varicella (if non-immune)
- bacillus Calmette-Guérin (if working with drug-resistant cases of tuberculosis).

Link to toolkit

Source: Cancer Institute NSW 2019 Clinical procedures and assessment tools p. 62

First aid kit for remote nurses p. 53

Error! Not a valid result for table. p. 72

HBCC HH audit tool template.docx

Link to toolkit

HBCC HH audit tool template.docx

Medication safety

The Australian Commission on Safety and Quality in Health Care includes chemotherapy in its list of medications associated with high potential for medication-related harm. Health services must identify high-risk medications and ensure chemotherapy is stored, prescribed, dispensed and administered safely.

The following are recommendations for the safe storage, prescription, dispensing and administration of chemotherapy in the home environment and should form part of the health service's medication safety strategy (Clinical Excellence Commission 2015).

Medication orders

- Current protocols, administration guidelines, dosing scales (including maximum doses) and checklists for SACT must be readily accessible at the point of care.
- A clear process must be in place for resolution in the event of a prescribing discrepancy.
- Verbal and telephone orders for SACT should never be accepted.
- if (in an extenuating circumstance) telephone orders must be taken, the nurse must write them down immediately and then read them back to the prescriber for verification.

Medication verification

In the hospital

- A registered nurse (qualified in SACT administration) or pharmacist must document (with initials or electronically) an independent double-check of the calculated dose, compatible fluids, medication and pathology results against the medication order before leaving the health service.
- Settings of ambulatory infusion devices must be independently verified by a pharmacist or nurse in the hospital and checked again with the patient at the point of care.

In the home

- An antineoplastic or immunotherapy drug patient assessment must be completed using the Common Terminology Criteria for Adverse Events (CTCAE) (US Department of Health and Human Services 2017).
- Nurses must complete a 'time out' before administering SACT.
- Nurses must check the patient's identification details and medication with the patient.
- Nurses must electronically access and check pathology results in the home.
- Lighting must be adequate to clearly read all labels, medication orders and pump settings.

Administration

- A closed intravenous administration system is used for the administration of SACT

- Burettes must not be used for administering cytotoxic therapies.
- No more than two types of electronic administration pumps can be used to maximise competence with their use.

Adverse reaction

- Accurate adverse drug reaction history must be readily available at the point of care.
- Adverse drug reaction management guidelines, including escalation of care process must be available at the point of care.
- Emergency medication specific to the medication being administered must be clearly prescribed for each patient.
- Emergency medications must be readily available at the point of care.

SACT transport

- SACT must be transported to the home in hard-walled secure containers and secured in the vehicle during transit.
- The temperature inside the transport container must be monitored and recorded to ensure cold chain requirements are met.
- Light-sensitive SACT must have appropriate packaging.
- No more than one patient's medication should be taken into each home.
- At the completion of therapy, all cytotoxic waste should be secured safely in a designated cytotoxic waste container and secured in the vehicle during transit.

Unused SACT

- A process must be in place for the return and disposal of any unused SACT.
- Any incidence of unused SACT returned to the health service must be reported and monitored.

Patient education

- Patients need to be educated to assist staff in the proper patient identification process and understand the importance of the process.
- Patients must be provided with written information about the medications they are receiving.
- During each medication administration, nurses must routinely educate patients and their carers about the medication and potential side effects.
- Patients and carers should be encouraged to ask questions about their medications.
- Patients must be instructed about who and when to call with concerns or questions about their medication.

Incident management

- All staff must report any medication errors or near misses. There should be no embarrassment or fear of reprisal associated with incident reporting.
- Open disclosure must be practised in the event of a medication error.
- Reporting of medication errors and near misses are to be encouraged to ensure continuous system review and error reduction strategies are in place.
- Incidents must be investigated, reviewed and analysed by a multidisciplinary team.

Medication selection

Eligibility of medications for the HBCC program must be overseen by a multidisciplinary team including:

- medical oncologist/haematologist

- pharmacy
- cancer nurse specialists
- occupational health and safety representative
- HiTH manager.

Medication eligibility criteria

Level 1

SACT inclusion criteria for administration in the home

- Intravenous infusions ≤ 120 minutes
- 12 or 24-hour infusions that require twice daily or daily replacement
- Once reconstituted the solution remains stable for 24 hours

SACT exclusion criteria for administration in the home

- A high risk of requiring urgent acute medical intervention
- Require extended observation time > 3 hours (operational decision)
- Vesicant (unless CVAD in place)
- SACT that do not remain stable following reconstitution

Examples of level 1 HBCC protocols

- Monitoring post-hyper-CVAD chemotherapy treatment for acute lymphoblastic leukaemia
- Consolidation treatment for acute myeloid leukaemia – 5+2+5 (cytarabine, idarubicin and etoposide)
- Early discharge and management of intermediate risk neutropenic patients post chemotherapy or bone marrow transplant with pyrexia

Level 2

SACT inclusion criteria for administration in the home (Corbett et al. 2015)

- Intravenous infusion, subcutaneous or intramuscular injections
- Infusion ≤ 60 minutes
- Once reconstituted the solution remains stable for 24 hours

SACT exclusion criteria for administration in the home

- Infusion > 60 minutes
- Require extended observation time post-infusion
- Infrequent ≥ 3 months between treatments
- Multiple agents (unless therapies can be safely delivered within a 90-minute timeframe)
- SACT that require pre/post hydration
- High risk of infusion-related reaction
- Vesicant (unless CVAD in place)
- SACT that do not remain stable following reconstitution

Additional considerations

- It is expected that at least the first infusion of a SACT will be delivered in a hospital setting without complication before administration in the home (Evans et al. 2016) to ensure drug tolerance, education and orientation to the oncology service is provided.
- On the occasion a SACT is not a drug that carries a high risk of infusion-related reaction and patient education is not required, the oncology/haematology physician may decide that this recommended precaution is not required.
- Ensure drug stability and cold chain requirements of SACT are followed.
- SACT is approved by the Therapeutic Goods Administration (TGA) and funded by the Pharmaceutical Benefits Scheme (PBS).
- Consider the line of treatment.
- Consider neoadjuvant/adjuvant versus primary treatment.

Clinical trials

Victoria is the premier location for medical research and clinical trials in Australia.[3] Clinical trials are an important way to improve treatment for people with cancer – and the only way to thoroughly evaluate the effects of a clinical intervention.[4]

To participate in a clinical trial, patients often need to travel to a metropolitan location, costing time and money.[5]

Patients with cancer living in regional locations in particular experience the disadvantage of limited access to clinical trials.

HBCC has the potential to improve access to cancer clinical trials for patients living in regional and rural Victoria and to relieve some of the financial and travel burden experienced by patients enrolled.

Including a provision for home-based care in developing a clinical trial protocol is one strategy that trial sponsors could use to increase accrual for study trials and reduce the travel/costs as a barrier to participation (Borno et al. 2018).

The suitability of a clinical trial for HBCC will depend on:

- the phase of the clinical trial
- inclusion of home-based interventions in the study trial protocol
- the trial medication meeting the HBCC medication eligibility criteria
- patients participating in the trial meeting the HBCC patient eligibility criteria.

Link to toolkit

[3] See Department of Health and Human Services – Clinical Trials <https://www2.health.vic.gov.au/about/clinical-trials-and-research/clinical-trial-research>.

[4] See Cancer Council Australia – Clinical trials <https://www.cancer.org.au/about-cancer/treatment/clinical-trials.html>.

[5] See Victorian Comprehensive Cancer Centre – Accessing Clinical Trials Locally <https://www.viccompcancerctr.org/newsletter/2019-may/accessing-clinical-trials-locally/>.

Link to toolkit

Suggested SACT p. 60

Medication transport – levels 1 and 2 p.61

Anaphylaxis and extravasation kit – levels p. 61

Comprehensive care

Comprehensive care is the screening, assessment and risk identification processes for developing an individualised care plan to prevent and reduce the risk of harm (Australian Commission on Safety and Quality in Health Care 2017).

Comprehensive care plans should be designed in partnership with patients and carers.

- Screening identifies that patients receive their care in the setting that best meets there clinical needs.
- Patient eligibility and home assessments are conducted prior to enrolment in the HBCC program.
- Clinical SACT (chemotherapy and immunotherapy) utilising the CTCAE and supportive care assessments are completed before each treatment.
- Decision algorithms, clear escalation structures and referral processes support the timely and appropriate management of patient and medication issues.
- Ensure the doctor who is accountable for a patient's care is clearly identifiable at the point of care at all times.

Patient eligibility criteria

Levels 1 and 2

A patient is eligible for adult HBCC if the following criteria are met (Corbet et al. 2015; Evans et al. 2016).

Initial

- The treating oncologist/haematologist approves the patient's participation.
- Patients prescribed treatment meet the HBCC SACT eligibility requirement.
- The patient is aware of risk factors and agrees to participate.
- The patient has given consent to SACT or immunotherapy.
- The patient has given consent to HBCC.

Clinical requirements

- The first treatment is delivered within the hospital setting without complication.
- The patient has not had an allergic or anaphylactic reaction during any previous SACT.
- The patient has no cognitive or behavioural barrier to participation.
- The patient is medically stable and has an ECOG performance score of ≤ 2.
- Intravenous access has been assessed and a CVAD is in place if required.

Home and environment assessment criteria

- The patient and family have been educated and understand their role in HBCC
- The patient is able to attend or has access to a pathology service before each treatment.
- The home is suitable for safe administration of SACT.
- The home has a phone, electricity and running water.
- The patient resides within the radius of the HBCC service area.
- Pets can be secured during the home visit.
- Children who are present are cared for by another adult during the home visit.
- Patient characteristics and the home environment do not pose a threat to patient or staff safety.
- Level 2 HBCC – It is preferred that a patient have a caregiver present during treatment; however, living alone should not exclude a patient from the HBCC program.

Additional eligibility criteria considerations for level 1 (Melbourne Health 2018)

- Patients treated at home in a level 1 HBCC program are at a high risk of neutropenia. Since febrile neutropenia is an oncological emergency, it is recommended that patients participating in this program live within 40 minutes of the health service throughout the admission.
- The patient's treatment has not been previously complicated by an admission to an intensive care unit.
- The patient has been clinically stable for the past 24 hours (asymptomatic; no MET call criteria; blood cultures negative).
- A full-time carer is present during admission.
- The patient has adequate home support and agrees to remain at home and not drive.
- The patient has no history of non-compliance.

Additional eligibility criteria considerations for level 2

- There is an appropriate frequency of medical review
- The patient has taken oral premedications ahead of the nurse's visit.
- The patient has access to supportive care needs.

Level 3

Initial assessment

- The treating oncologist/haematologist approves the patient's participation.
- The patient is aware of risk factors and agrees to participate.
- The patient has given consent to HBCC.

Clinical requirements

- The patient has no cognitive or behavioural barrier to participation.

Home and environment assessment criteria

- The patient and family have been educated and understand their role in HBCC.
- The home has a phone, electricity and running water.
- The patient lives within the radius of the HBCC service area.
- Pets can be secured during the home visit.
- Children who are present are cared for by another adult during the home visit.

- A validated emergency procedure is in the patient's home, including emergency contacts and telephone numbers.
- Patient characteristics and the home environment do not pose a threat to patient or staff safety.
- A home visiting safety screen is completed prior to acceptance by HBCC and is reviewed at the first home visit.

Supportive care

To identify and manage psychosocial concerns and the need for support, it is essential that patients within the HBCC program have access to a full suite of supportive care services. It is recommended that a validated supportive care assessment tool be used in the home and referral algorithms to appropriate supportive care provided.

Referrals may lead patients back to the referring hospital or supportive care services closer to home. We*Can* is an Australian supportive care website that helps people affected by cancer find the information, resources and support services they may need following a diagnosis of cancer. The site provides easy access to the many excellent resources, services and information developed by other organisations that specialise in cancer and community support close to home. HBCC programs may assist patients to access supportive care close to home via We*Can* <https://wecan.org.au/>.

Voluntary assisted dying

The Victorian Parliament passed the *Voluntary Assisted Dying Act* in 2017 and it came into effect in June 2019. Under a strict eligibility criterion, the Act allows a person who is already at the end of their life to take medication prescribed by a medical practitioner that will bring about their death (Legislative Council Legal and Social Issues Committee 2016).

The person must also have decision-making capacity and a request cannot be included as part of an advance care directive (Legislative Council Legal and Social Issues Committee 2016).

A registered health practitioner must not – in the course of providing health or professional care services – either initiate a discussion about voluntary assisted dying or suggest voluntary assisted dying to a patient (Department of Health and Human Services 2019f).

It is recommended that health services provide voluntary assisted dying education and training to all staff. Staff are encouraged to refer any questions to the statewide voluntary assisted dying care navigators.

Link to toolkit

Source: Cancer Institute NSW 2019

Clinical procedures and assessment tools p. 62

Supportive care template p. 69

Medication eligibility criteria p. 23

Case Conference template.docx

Patient eligibility criteria p. 25	Oncology/haematology triage tool p. 76	HBCC pathway p. 78

Communicating for safety

Communication is critical to the safe delivery of patient care and occurs across the continuum of care.

Three points in an HBCC program at which clear communication is critical are:

- patient identification and medication verification
- the transition of care between the hospital and HBCC program
- the handover of critical clinical information or risks that emerge during the course of care.

Clinical handover is the 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.

Recommendations for communication

The health service and HBCC

- There are established formal communication pathways between departments and clinicians.
- A comprehensive referral form to HBCC is used.
- There is a structured clinical handover tool for the transfer of patient responsibility and care.
- An escalation of care protocol is in place covering what is expected and required (roles and responsibilities) of each member of the HBCC and health service involved in the handover process.
- The doctor accountable for a patient's care is identifiable at the point of care at all times; health services may allocate an HBCC on-call doctor.

Patients and carers

- The patient and carers participate in treatment decisions and receive clear written and verbal information about their care.
- Patients and carers understand how and when to communicate critical information.
- Patients and carers receive written and verbal information about how to directly escalate care.

Documentation

- Clinicians have access to the patient medical record at the point of care.
- The medical record is current and complete.
- Critical information, alerts and risks are clearly accessible.
- Clinicians have access to contemporary pathology reports at the point of care.
- Policies and procedures are available at the point of care.

Link to toolkit

ISoBAR HBCC minimum dataset – clinical handover p. 62

HBCC referral template p. 65

Patient information template p. 81

Supportive care tool template.docx

HBCC Referral template.docx

HBCC patient experience template.d

Case Conference template.docx

Your Cancer Treatment at Home.jp

Recognising and responding to acute deterioration

Early recognition of clinical deterioration, followed by prompt and effective action, can improve clinical outcomes. Systems should be developed to recognise deterioration early and to respond appropriately in the home (Australian Commission on Safety and Quality in Healthcare 2010).

Elements that describe the essential features of the systems of care for recognising and responding to clinical deterioration include clinical process and organisational requirements.

Clinical processes

Measurement and documentation of observations

- Observations and antineoplastic or immunotherapy drug patient assessment are completed before each treatment in the home using CTCAE (US Department of Health and Human Services 2017).
- Observations include:
  - respiratory rate
  - oxygen saturation
  - heart rate
  - blood pressure
  - temperature.
- The frequency of monitoring during and after treatment is established for each treatment.
- Observations from previous treatments are available at the point of care to identify changes in the patient's condition.

Escalation of care

- The escalation protocol should include:
  - increased monitoring requirements
  - reporting to the HBCC on-call or the patient's medical oncologist or haematologist
  - indications for calling triple zero (000)
  - management of a patient transfer.

Clinical communication

- A formal communication protocol such as ISoBAR should be adopted.
- Discuss the wishes of the patient regarding advance care planning, resuscitation and other active treatment.

Organisational requirements

Organisational supports

- HBCC is incorporated into health services' formal policy framework regarding recognition and response systems.

Education

Nurses should receive annual education about the HBCC escalation protocol. They should know who to call for emergency assistance if they have any concerns about a patient and know that they should call under these circumstances.

Nurses should be able to:

- systematically assess a patient
- understand and interpret abnormal physiological parameters and other abnormal observations
- identify and manage infusion-related reactions
- initiate appropriate early interventions for patients who are deteriorating
- respond with basic life support in the event of severe or rapid deterioration, pending the arrival of emergency assistance
- communicate information about clinical deterioration in a structured and effective way to the medical officer, paramedics and to patients, families and carers.

Evaluation, audit and feedback

- Evaluate HBCC recognition and response systems.
- Conduct a clinical debrief with clinicians involved following each incident.
- Review incidents of patient deterioration including current policies and procedures and compliance with the policy.
- Feed clinical review findings back to the HBCC team.

Technological systems and solutions

- The inclusion of new technological solutions should be considered based on evidence of efficacy and cost, as well as consideration of possible additional safety and quality risks.

Link to toolkit

Medication eligibility criteria p. 23

Anaphylaxis and extravasation kit – levels 1 and 2 p. 61

Oncology/haematology triage tool p. 76

Toolkit

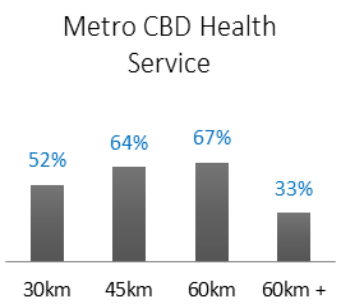
HBCC planning and decision making

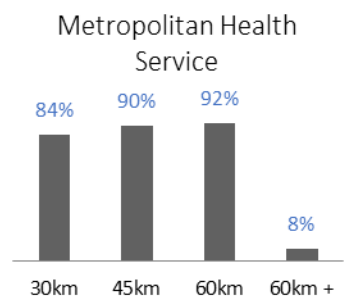
Why deliver an HBCC program?		
Align with department's cancer plan to deliver cancer treatment closer to home	Increase patient choice and reduce the burden of treatment on patients and families	Increase capacity without investment in infrastructure
What governance structure is appropriate? (page 14)		
HBCC delivered by oncology service	Dual service –HBCC delivered by both HITH and oncology	HBCC delivered by HiTH
What type of HBCC service? (page 16)		
Level 1 – Acute inpatient care	**Level 2** – Same day cancer treatment	**Level 3** – Central line care and disconnects only (no treatment)
Funding available (page 18)		
Level 1 WIES	**Level 2** WIES – R63Z – Infusional therapies WASE 10.11 – SC and IM injections WASE 40.52 – CVAD care MBS – Case conference SCIg program	**Level 3** WASE 40.52 – CVAD care

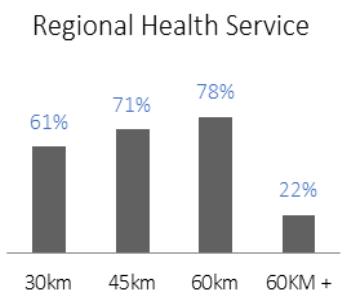
Data review

Step 1. How far do our patients travel?

Measure episodes of care (EOC) rather than patients. What percentages of EOC of care are delivered to patients who live within 30 km, within 45 km, etc. Examples below.







Step 2. How many of our treatments are suitable for HBCC? (see tool below)

Step 3. What percentage of EOC within a 30 km zone are eligible for HBCC?

Summary of a metropolitan CBD ambulatory oncology service:

- Total EOC for 4 weeks = 536
- Average EOC per week = 134
- Average clinical trials (ineligible for HBCC) per week = 51 (38%)
- Average EOC per week eligible for HBCC = 30 (22%)
- Percentage of EOC delivered to patients living within 30 km zone = 52%

Average EOC per week eligible for HBCC and within 30 km zone = 15 (11% of day oncology activity)

Summary of a large metropolitan ambulatory oncology service:

- Total EOC for 4 weeks = 990
- Average EOC per week = 247
- Average EOC per week eligible for HBCC = 97 (39%)
- Percentage of EOC delivered to patients living within 30 km zone = 84%

Average EOC per week eligible for HBCC and within 30 km zone = 81 (32% of day oncology activity)

Summary of a regional ambulatory oncology service:

- Total EOC for 4 weeks = 527
- Average EOC per week = 132
- Average EOC per week eligible for HBCC = 51 (38%)
- Percentage of EOC delivered to patients living within 30 km zone = 61%

Average EOC per week eligible for HBCC and within 30 km zone = 31 (23% of day oncology activity)

Service delivery design

Based on the data and our purpose for HBCC, what is the most feasible way to deliver an HBCC program?

A strategic goal of the *Victorian cancer plan* is to reduce variation in service options to cancer patients across state. HBCC presents a challenge to deliver care to those patients who travel the furthest for treatment and would likely benefit most from an HBCC or close-to-home program.

Health service HBCC	Health service HBCC **plus** outreach service	Health service HBCC **plus** subcontracted service beyond HBCC boundary	Subcontract entire HBCC service
The health service offers HBCC to all patients within a specified kilometre boundary.	The health service delivers an HBCC program within 30 km boundary and establishes outreach service 1 day a week beyond the boundary. For example: Ballarat Health Services may choose to use the HBCC framework to deliver cancer treatment 1 day a week to patients who live in and around Skipton (45 km from Ballarat). One oncology nurse could attend the Skipton Medical Clinic 1 day each week, using the HBCC framework and treat 6–7 patients per day, reducing the patient travel time.	The health service delivers the service up to 30 km and subcontracts the remainder of HBCC to an external home oncology service provider.	The health service subcontracts the entire HBCC program to an external home oncology service provider.

Example A: Two nurses 4 days per week				
Aim: To deliver 40 EOC in the home per week				
Estimate	Infusion	= 80 min per visit		
	IM/SC injection	= 30 min per visit		
	CVAD	= 40 min per visit		
	Travel	= 20 min b/w visits and back to base		
	Medication pick up and coordination	= 60 min per day per nurse		
		No. per week	Time per visit	Total time
IV		22	8 0min	1,760 min
IM/SC		13	30 min	390 min
CVAD		5	40 min	200 min
Travel b/w visits and back to base		48	20 min	960 min
Coordination		x 8 days	60 min	480 min
Total minutes				3,790 min
Total hours per week				63 hours

Costs			
Item	Details	Capital	Annual operational
EFT 1.8 RN	RN G3B Y1/2 HITH/PAC YU15/16 Victorian nurse EBA 2016–20		$175,968
	On-costs 15%		$26,395
Fleet car	× 2, lease + operational cost		$20,000
Mobile phone	Purchase × 2 smartphone @ $1,200 each	$2,400	
	Plan × 2 @ $40 per month		$960
Tablet/laptop	Purchase × 2	$3,000	
Clinical kit	× 2 @ $800 each incl. equipment box, portable IV pole, BP monitoring, thermometer, esky	$1,600	
Consumables	Establishment cost × 2 CVAD and cannulation kits, IV fluids and lines, anaphylaxis and extravasation kits, cytotoxic spill kit, PPE	$600	
	Per infusion (variables – type of peripheral access – CVAD vs cannulation, prime and flush fluid, type of line, filters, waste ~$47		$53,768
	Per injection – PPE ~$3		$2,028
	Per dressing – CVAD dressing kit, PORT access needles, Caps, flush, waste $30 each visit		$7,800
OHS	First aid kit and Blanket per car × 2 @$50	$100	
Annual costs		$7,700	$286,919

Revenue – *based on 2019–20 departmental funding guidelines*		
1 × WIES R63Z	$947 × 22 =	$20,834
1 × WASE 10.11	$458 × 13 =	$5,954
1 × WASE 40.52	$232 × 5 =	$1,160

Total per week	$27,948
Annual	$1,453,296

Example B: One nurse 5 days per week – HBCC 4 days / 1 day outreach clinic

AIM: To deliver 18 EOC – in the home + 6 EOC – 1 outreach day per week

Estimate	Infusion	= 80 min per visit
	IM/SC injection	= 30 min per visit
	CVAD	= 40 min per visit
	Travel – home visits	= 20 min b/w visits and back to base
	Travel – outreach	= 45 min each way
	Medication pick up and coordination	= 60 min per day per nurse

	Per week	Time per visit	Total time
IV	14	80 min	1120 min
IM/SC	4	30 min	120 min
Travel b/w visits and back to base	22	20 min	440 min
Outreach clinic	4 infusions + 2 injections	N/A	320 min
Travel to clinic and back to base	2	45min	90 min
Coordination	x 5 days	60 min / day	300 min
Total minutes			2,390 min
Total hours			40 hours

Costs

Item	Details	Capital	Annual operational
EFT 1 fulltime RN	RN G3B Y1/2 HITH/PAC YU15/16 Victorian nurse EBA 2016–20		$93,600
	On-costs 15%		$14,040
Fleet car	× 1, lease + operational cost		$10,000
Mobile phone	Purchase × 1 smartphone @ $1,200	$1,200	
	Plan × 1 @ $40 /month		$480
Tablet/laptop	Purchase	$1,500	
Clinical kit	Equipment box, portable IV pole, BP monitoring, thermometer, esky	$800	
Consumables	Establishment cost × 1; CVAD and cannulation kits, IV fluids and lines, anaphylaxis and extravasation kits, cytotoxic spill kit, PPE	$300	
	Per infusion (variables – type of peripheral access – CVAD vs cannulation, prime and flush fluid, type of line, filters, waste ~ $47 per visit		$43,992
	Per injection ~$3		$936
OHS	First aid kit and blanket per car	$50	
Room rental (outreach)	Room with 2 chairs, 1 day per week @ $120 per week		$6,240

Annual	$4250	$169,288
Revenue *based on 2019–20 departmental funding guidelines*		
1 × WIES R63Z	$947 × 18 =	$17,046
1 × WASE 10.11	$458 × 6 =	$2,748
Total per week		$19,794
Annual		$1,029,288

Indirect costs and revenue

If the purpose of starting an HBCC program is to increase capacity, the costs and revenue of treating additional patients will include additional medical and pharmacy revenue and costs. However, if the intention of the HBCC program is to provide patients with an alternative to hospital-based care and not increase capacity, there will be little change in the medical and pharmacy costs and revenue.

Tool to measure the number of EOC eligible for HBCC over four weeks

Calculate the number of EOC in the health service that meet the HBCC medication eligibility criteria (this includes infusions, injections and central line care). Compare four weeks of day oncology unit EOC appointments against the medication criteria in the HBCC toolkit. Do not include C1 or day 1 appointments or clinical trials (unless there is provision for home-based care in the clinical trial protocol).

Treatment	Route	Week 1	Week 2	Week 3	Week 4	Total
Atezolizumab	IV					
Avelumab	IV					
Bevacizumab (Avastin)	IV					
Cabazitaxel	IV					
Carboplatin	IV					
Cetuximab (Erbitux)	IV					
Docetaxel (Taxotere)	IV					
Eribulin mesilate (Halaven)	IV					
Etoposide	IV					
Flourouracil	IV					
Gemcitabine	IV					
Maintenance Rituximab – Rapid	IV					
Mitozantrone*	IV					
nab-PACLItaxel (Abraxane)	IV					
Nivolumab (Opdivo)	IV					
Panitumumab (Vectibix)	IV					
Pralatrexate	IV					
Pembrolizumab (Keytruda)	IV					
Pemetrexed (Alimta)	IV					
Raltitrexed (Tomudex)	IV					
Topotecan	IV					
Temsirolimus	IV					
Trastuzumab (Herceptin)	IV					
Trastuzumab emtansine (Kadcyla)	IV					
Zoledronic acid (Zometa)	IV					
Total WIES						
Trastuzumab (Herceptin)	SC					
Denosumab (Xgeva, Prolia)	SC					
Goserelin (Zoladex)	SC					

Treatment	Route	Week 1	Week 2	Week 3	Week 4	Total
Azacitidine (Vidaza)	SC					
Pegfilgrastim (Neulasta)	SC					
Low-dose Cytarabine (Ara-C)	SC					
Lanreotide	SC					
Bortezomib (Velcade)	SC					
Fulvestrant	IM					
Octreotide	IM					
Degarelix (Firmagon)	IM					
Total WASE 10.11						
Ambulatory device disconnects	Support					
CVAD maintenance	Support					
Total WASE 40.52						
Total treatments per week						
Total treatments eligible for HBCC per week						

Non-oncology infusions suitable for home-based care

Disease	Treatment	Route	Frequency
Multiple sclerosis	Natalizumab (Tysabri®)	IV	4 weeks
Crohn's disease	Infliximab (Remicade®)	IV	6–8 weeks
Rheumatoid arthritis	Abatacept	IV	4 weekly
	Tocilizumab (Actemra®)	IV	4 weekly
	Infliximab (Remicade®)	IV	6–8 weeks
Lupus	Pamidronate	IV/PO	3 months to annual
	Denosumab	SC	28 day
	Infliximab (Remicade®)	IV	6–8 weeks
	Secukinumab	IM	Monthly

Life Saving Drugs Program (LSDP)

Disease	Treatment	Route	Frequency
Gaucher's disease	Imiglucerase (Cerezyme®)	IV	2 weekly
	Velaglucerase (VPRIV®)	IV	2 weekly
	Taliglucerase (Elelyso®)	IV	2 weekly
Paroxysmal nocturnal hemoglobinuria	Eculizumab (Soliris®)	IV	2 weekly
Fabry's disease	Agalsidase beta (Fabrazyme®)	IV	2 weekly
	Agalsidase alfa (Replagal®)	IV	2 weekly

HBCC implementation checklist

The implementation checklist has been developed to help health services identify policies and procedures required to safely establish an HBCC program and to ensure the program meets the NSQHS Standards (2nd edition).

The list includes suggested audits to provide evidence to support actions for each standard.

Standard 1: Governance

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Clinical governance	✪			
Consent to treatment	✪			
Privacy	✪			
Financial management	✪			
Quality management	✪			
Risk management	✪			
Clinical performance and effectiveness	✪			
Open disclosure policy	✪			
Workforce	✪			
Health information management	✪			
Legislative compliance	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Voluntary assisted dying	✪			
Clinical incident reporting and management	✪			
OHS incident reporting and management	✪	✪		
Open disclosure procedure	✪			
Complaints management procedure	✪			
Special clinics establishment and access	✪			
Escalation procedure in response to a risk to staff safety in the home or during transit		✪		
Motor vehicle procedure	✪	✪		
Safety in the community	✪	✪		
Home risk assessment procedure	✪	✪	★	
Management of cytotoxic drug exposures	✪		eviQ	

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Staff immunisation	✪			
Health monitoring	✪			
Working with children	✪			

Guidelines/frameworks	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Organisational structure	✪			
Committee structure	✪			
HBCC roles and responsibilities		✪		
Medical records and documentation	✪			
HBCC workforce competency and training		✪	★	

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Referral to HBCC		✪	T	
Consent to HBCC		✪	T	
Consent to SACT		✪	★	
Home risk assessment and control plan	✪	✪	T	
Australian charter of patient rights and responsibilities	✪		T	
Health service feedback form	✪			

Standard 2: Partnering with consumers

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Partnering with consumers	✪			
Patient identification	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
HBCC consent		As above – AA	★	
SACT consent	AA		★	
Complaints management procedure	AA			
Respecting patient domestic cultural practices		✪		

Guidelines	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Patient eligibility criteria for HBCC		✪	★	
Patient treatment pathway		✪	★	
Frequency of medical review		✪		

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Referral to HBCC		AA	T	
Consent to HBCC		AA	T	
Consent to SACT	AA		T	
HBCC patient information		✪	T	
Health service feedback form	AA			

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Patient/carers satisfaction level – HBCC		✪	T	

Standard 3: Preventing and controlling healthcare associated infection

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Preventing and controlling healthcare-associated infections policy	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Hand hygiene	✪	✪		
Escalation of clinical care procedure	✪	✪		
Aseptic technique	✪	✪		
Central line management procedures	✪		eviQ	
Venepuncture and Intravenous cannulation	✪			
Safe handling and disposal of sharps	✪	✪		
Management of occupational exposures for healthcare workers procedure	✪	✪		
Spillages of blood and body substances	✪	✪		
First aid procedure	✪	✪	★	
Personal protective equipment (infection)	✪	✪		
Staff immunisation	✪			

Guidelines	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Standard and transmission-based precautions	✪			

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Occupational exposure form	✪			

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Hand hygiene at home		✪	T	
Central line infections		✪		

Standard 4: Medication safety

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Medication management	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Medication orders management		✪	★	
Administration of SACT procedure	✪	✪		
Resolution in the event of a prescribing discrepancy		✪		
Patient Identification and medication verification in the home		✪	★	
Treatment delay / cancellation process		✪		
Management of anaphylaxis / hypersensitivity reaction in the home		✪		
Management of extravasation in the home		✪		
Management of a cytotoxic spill in the home		✪		
Cytotoxic waste management in the home and during transit		✪		
Personal protective equipment, use and disposal (cytotoxic)		✪		
Cytotoxic contaminated laundry management		✪		

Guidelines	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Administration of SACT guideline	✪	✪	eviQ	
HBCC medication eligibility criteria		✪	★	
SACT cold chain management and transport requirements		✪	★	
Anaphylaxis guideline	✪	✪		
Extravasation guideline	✪	✪		

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Antineoplastic/immunotherapy assessment form	✪		eviQ	

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
SACT temperature during transport				
Medication incidents and near-misses				
Extravasation				
Cancellation of treatment at the point of delivery (drug wastage)				
Cytotoxic spill				

Standard 5: Comprehensive care

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Evidence-based clinical practice	✪			
Preventing falls and harm from falls	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
SACT assessment	✪	✪	eviQ	
Clinical procedures	✪	✪	eviQ	
Preventing falls and harm from falls procedure	✪			
Advance care planning	✪			
Pressure injury surveillance	✪			
Malnutrition screening	✪		T	
Nursing assessment, planning, documentation and communication	✪			

Guidelines	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
HBCC medication eligibility criteria		AA	★	
Patient eligibility criteria for HBCC		AA	★	
Supportive care screening assessment	✪	✪	★	
Oncology/haematology triage tool	✪	✪	eviQ/★	
Case conference guide	✪	✪	★	
HBCC pathway		AA	★	

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Supportive care screening tool	✪		T	
Assessment tools	✪		eviQ	
Case conference tool	✪		T	

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Supportive care screening	✪			
SACT assessment completion	✪			
Falls, pressure injury surveillance	✪			

Standard 6: Communicating for safety

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Clinical handover	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Clinician to clinician handover procedure	✪		★	
Patient and carer escalation process	✪	✪		
Critical alerts	✪			

Guidelines	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Case conference guide	✪		★	

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
ISoBAR	✪		★	
HBCC referral		AA	T	
HBCC patient information		AA	T	
Supportive care screening tool	AA		T	

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Compliance with clinical handover procedure				

Standard 8: Recognising and responding to acute deterioration

Policies	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Responding appropriately to patients in deterioration	✪			

Procedures	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Escalation of clinical care criteria and procedure	AA	AA		
Management of anaphylaxis/hypersensitivity reaction in the home	AA	AA		
Management of extravasation in the home	AA	AA		

Guidelines	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
HBCC medication eligibility criteria		AA	★	
Anaphylaxis guideline	AA	AA	eviQ	
Extravasation guideline	AA	AA	eviQ	
Oncology/haematology triage tool	AA	AA	eviQ/★	

Forms	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Telephone triage log sheet			eviQ/★	

Audits	Organisation wide	Specific to HBCC	★ = see toolkit T = template eviQ – link in toolkit	Documents developed or already in place
Percentage of transfers back to hospital of patients during an episode of care				
Percentage of presentations to SURC/ED of HBCC patients				
Percentage of deaths during the HBCC episode of care				
Percentage unplanned readmissions within 28 days				
Intravenous cannulation complications				
Central venous access device complications				

Legislative compliance

Legislation that applies to HBCC includes, but is not limited to the following:

- *Work Health and Safety Act 2011*
- Work Health and Safety Regulation 2011
- *Therapeutic Goods Act 1989*
- Poisons Standard, February 2019
- *Environment Protection Act 2017*
- Environment Protection (Industrial Waste Resource) Regulations 2009
- *Dangerous Goods Act 1985*
- *Transport Operations (Road Use Management) Act 1995*
- Transport Operations (Road Use Management – Dangerous Goods) Regulation 2008
- *Health Records Act 2001*
- *Health Services Act 1988*.

Australian Standards

- AS/NZS ISO 14644.5:2006 – Cleanrooms and associated controlled environments – Operations
- AS/NZS 1715:2009 – Selection, use and maintenance of respiratory protective equipment
- AS/NZS 1716:2012 – Respiratory protective devices
- AS 1807.0:2000 – Cleanrooms, workstations, safety cabinets and pharmaceutical isolators – Methods of test – List of methods and apparatus
- AS 4031:1992 – Non-reusable containers for the collection of sharp medical items used in health care areas

Safe Work Australia

- *Labelling of workplace hazardous chemicals – code of practice*, October 2018
- *Workplace exposure standards for airborne contaminants*, April 2018
- *Health monitoring for exposure to hazardous chemicals: guide for persons conducting a business or undertaking*, February 2013
- *Hazardous chemicals requiring health monitoring*, March 2013
- *Managing the work environment and facilities – code of practice*, May 2018 (remote worker)
- *First aid in the workplace – code of practice*, May 2018
- *How to manage work health and safety risks – code of practice*, May 2018
- *Preparation of safety data sheets for hazardous chemicals – code of practice*, May 2018

Victorian legislation

Access Victorian Worksafe Acts and Regulations <https://www.worksafe.vic.gov.au/all-acts-and-regulations>.

Key performance indicators

Length of stay (level 1 only)	**DRG groups – HBCC vs hospital** HBCC length of stay is comparable to the hospital length of stay for the same DRG group	**DRG groups – HBCC v hospital** **Denominator** – Total number of patients with an HBCC component of care DRG Z51.1[6] **Numerator** – Total cumulative length of stay DRG Z51.1 of patients with an HBCC component of care ***Compared with ...*** **Denominator** – Total number of patients treated in HBCC program DRG Z51.1 without an HBCC component in the episode of care **Numerator** – Total length of stay for DRG Z51.1 for hospital admissions of patients with no HBCC component of care
Percentage unplanned readmissions within 28 days	**Readmissions for same condition – HBCC v HBCC** Similar or reduced re-admission rates for HBCC care compared with HBCC statewide average.	**Readmissions – HBCC v HBCC** **Denominator** – Total number of patients managed in the HBCC program (DRG Z51.1) **Numerator** – Total number of unplanned readmissions of patients with an HBCC component to hospital for any condition within 28 days ***Compared with ...*** **Denominator** – Average statewide total cancer patients with HBCC component to their episode of care (DRG Z51.1) **Numerator** – Total number of patients with unplanned readmissions to hospital for same condition within 28 days of patients with HBCC component
Percentage of transfers back to hospital under the care of HBCC	Low numbers of unplanned transfers back to day oncology	**Total number of transfers to hospital during HBCC episode of care** **Denominator –** Total number of patients managed in the HBCC program **Numerator** – Total number of unplanned transfers back to hospital during the episode of HBCC care
Percentage of presentations to SURC/ED	Equivalent numbers of patients from HBCC V day oncology present at SURC/ED	**Presentations to SURC/ED** **Denominator** – Total number of patients managed in the HBCC program **Numerator** – Total number of presentations to

[6] ICD-10-CM Code Z51.1 Encounter for antineoplastic chemotherapy and immunotherapy <https://icd.codes/icd10cm/Z511> viewed May 1, 2019

		SURC/ED – HBCC care ***Compared with ...*** **Denominator** – Total number of patients managed in the day oncology **Numerator** – Total number of presentations to SURC/ED – day oncology
Percentage of deaths during the HBCC episode of care	Zero deaths during or following an HBCC episode of care	**Death during/following HBCC care** **Denominator** – Total number of patients managed in the HBCC program **Numerator** – Total number of deaths during the episode of HBCC care
Adverse events, near-misses and incidents – HBCC v day oncology unit	Similar or reduced adverse events, near-misses and incidents compared with inpatient treatment Key areas include adverse events, near-misses and incidents related to the following: • medication • failure to comply with clinical handover procedure • central line infections • extravasation • cytotoxic spill • cancellation of treatment at the point of delivery (drug wastage)	**Total incidents** **Denominator** – Total number of patients managed in the HBCC program **Numerator** – Total number of reported adverse events, near-misses and incidents ***Compared with ...*** **Denominator** – Total day oncology patients with no HBCC component to their episode of care **Numerator** – Total number of reported adverse events, near-misses and incidents
Patient carers/satisfaction levels – HBCC	High levels of patient satisfaction with their HBCC model of care	**HBCC patient satisfaction surveys**
Auditing processes	Similar standard of care to that which is provided in the acute hospital facilities is to be provided by HBCC services	See HBCC implementation template for suggested audits

Source: Department of Health Queensland 2017

Workforce competency and training

Hospital in the Home Society Australasia recommends that nurses employed to work in the home environment are advanced clinicians and have achieved, at minimum, the level of a proficient nurse. According to Benner's stages of clinical competence, proficient nurses learn from experience about what to typically expect in a given situation and how plans need to be modified in response to these events. Proficient nurses can recognise when the expected normal picture does not materialise (Benner 1984). It is also recognised that a nurse who changes practice areas may revert to earlier stages of expertise. For example, an expert nurse in the coronary care unit would not be able to immediately function as an expert in the operating theatre (although the nurse's expertise is valuable). Similarly, a

proficient HiTH nurse new to the delivery of SACT would not immediately function at a proficient or expert nurse level.

Nurses delivering cancer treatment must demonstrate competence, knowledge and proficiency in the administration of cancer therapy and related aspects of cancer care (Brown-West 2019).

It is recommended that nurses employed to deliver HBCC are working, at minimum, at the level of a proficient nurse in relation to both the home setting and the administration of SACT.

Levels 1 and 2

- Advanced clinician with broad experience and skills (Hospital in the Home Society Australasia).
- Five years of postgraduate experience unless previously employed as an enrolled nurse (Australian Commission on Safety and Quality in Health Care 2017)
- Nurses must demonstrate competence, knowledge and proficiency in the administration of cancer therapy and related aspects of cancer care. Competencies to be completed include:
  - evidence-based education program in the delivery of cancer chemotherapy via different routes – for example, eviQ Cancer Education Online – Antineoplastic Drug Administration Course(ADAC)
  - evidence-based education program in the management and maintenance of CVAD – for example, eviQ Cancer Education Online – Central Venous Access Device Course (COSA 2008)
- Management of infusion-related reactions
- Age-appropriate basic life support
- Proficient in intravenous cannulation
- Specialised education and training specific to the home to safely and effectively deliver chemotherapy including risk assessment of the delivery environment, personal safety, chemotherapy transportation, handling, administration and disposal, verification/checking systems and emergency management (Evans et al. 2016).

Level 3

- Advanced clinician with broad experience and skills (Australian Commission on Safety and Quality in Health Care 2017)
- Complete training and demonstrate competence in the safe handling of chemotherapy, including potential cytotoxic spills and CVAD care
  - evidence-based education program in the management and maintenance of CVAD
  - evidence-based education program in the management of patients in the community receiving antineoplastic drugs (Australian Commission on Safety and Quality in Health Care 2017)
- Age-appropriate basic life support
- Specialised education and training specific to the home to safely and effectively handle chemotherapy including risk assessment of the environment, personal safety, chemotherapy handling and disposal.

Mandatory HBCC employment requirements

- Registered nurse, division 1
- Police check
- Working with Children Check
- Victorian driver's licence

Personal protective equipment / cytotoxic spill kit

Personal protective equipment – levels 1, 2 and 3

- Safety goggles
- Purpose-manufactured protective gloves
- Impermeable gowns with closed front and long sleeves with elastic or knit cuffs
- Respiratory protective equipment with a particulate filter (P2) based on risk assessment

Sources: SafeWork NSW 2017; Workplace Health and Safety Queensland 2018

Cytotoxic spill kit – levels 1, 2 and 3

A cytotoxic spill kit should include:

- instructions on how to use the kit
- personal protective equipment (for example, P2 respirator mask, two pairs of gloves, gown/apron)
- adequate quantities of absorbent materials (for example, swabs, absorbent towels, spill pillow, chemical absorbent pads, protective mats (bluey or 'chemo mat'))
- a small scoop to collect any glass fragments
- two purple plastic waste bags, clearly identified as cytotoxic
- incident report forms
- purple plastic, rigid-walled, wide-necked, sharps disposal containers labelled 'Cytotoxic Waste' on both sides of the container (Environment Protection Authority Victoria 2009).

WorkSafe

- Lone worker duress alarm

First aid kit for remote nurses

Health services are required to provide first aid equipment to each worker at the workplace.
It is recommended that HBCC nurses carry a first aid kit in their vehicle (Country Fire Authority Victoria 2019; Safe Work Australia 2019).

Refer to Safe Work Australia's (2019) *First aid in the workplace code of practice* for a detailed list of what to include in the first aid kit.

For health services delivering care in regional and rural locations refer to the Country Fire Authority's *Guide to staying safe in the car during a bushfire*.

Case conference MBS item numbers

Items 820, 822, 823

Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to *organise and coordinate* a community case conference with a multidisciplinary team of at least 3 other formal care providers of different disciplines of:

820	at least 15 minutes but less than 30 minutes	Fee: $143.45 Benefit: 75% = $107.60 85% = $121.95
822	at least 30 minutes but less than 45 minutes	Fee: $215.25 Benefit: 75% = $161.45 85% = $183.00
823	at least 45 minutes	Fee: $286.80 Benefit: 75% = $215.10

		85% = $243.80

Items 825, 826,828

Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to *participate* in a community case conference with a multidisciplinary team of at least 3 other formal care providers of different disciplines of:

825	at least 15 minutes but less than 30 minutes	Fee: $103.00 Benefit: 75% = $77.25 85% = $87.55
826	at least 30 minutes but less than 45 minutes	Fee: $164.30 Benefit: 75% = $123.25 85% = $139.70
828	at least 45 minutes	Fee: $225.60 Benefit: 75% = $169.20 85% = $191.80

Refer to the Medicare Benefits Schedule Book <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/E45D240FB9C1C74FCA2583DD00074EC3/$File/201907-MBS%201Jul2019.pdf> for more information.

SACT consent example

PATIENT AGREEMENT TO SYSTEMIC ANTI-CANCER THERAPY:

(add name of regimen/protocol)

HOSPITAL NAME/STAMP:

RESPONSIBLE HEALTH PROFESSIONAL:

Name:

Job title:

PATIENT DETAILS

PATIENT'S SURNAME/FAMILY NAME:

PATIENT'S FIRST NAME(S):

DATE OF BIRTH:

NHS NUMBER:
(or other identifier)

☐ MALE ☐ FEMALE

SPECIAL REQUIREMENTS:
(e.g. other language/other communication method)

NAME OF PROPOSED COURSE OF TREATMENT

(include brief explanation if medical term not clear. Include regimen/protocol name and list drug names in full. Specify the indication, route, schedule of administration, and location of treatment.)

☐ REGIMEN:

☐ INDICATION FOR TREATMENT (i.e. tumour site):

ROUTE(S) OF ADMINISTRATION:

☐ Intravenous ☐ Subcutaneous ☐ Oral ☐ other:

☐ FREQUENCY (TREATMENT DAYS & LENGTH OF CYCLE):

☐ DURATION OF TREATMENT (number of cycles):

☐ PARTICIPATION IN A CLINICAL TRIAL (trial name):

WHERE THE TREATMENT WILL BE GIVEN:

☐ outpatient ☐ day unit/case ☐ inpatient ☐ other:

TO BE RETAINED IN PATIENT NOTES
Prepared by: Rena Chauhan
Approved by: Janine Mansi (National Chemotherapy Board)

Date of issue and version: September 2016; Version 2;
Review date: September 2019
Check www.cancerresearchuk.org for latest version

Page 1 of 5

Example used with permission Cancer Research United Kingdom and Guy's and ST Thomas' NHS Foundation Trust. Check the Cancer Research UK website <www.cancerresearchuk.org> for the latest version.

STATEMENT OF HEALTH PROFESSIONAL

(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in the hospital/Trust's consent policy)

Patient identifier/label

I have explained the procedure/treatment to the patient. In particular, I have explained:

☑ all relevant boxes

THE INTENDED BENEFITS

- ☐ **CURATIVE** – to give you the best possible chance of being cured.
- ☐ **DISEASE CONTROL/PALLIATIVE** – the aim is not to cure but to control or shrink the disease. The aim is to improve both quality of life and survival.
- ☐ **ADJUVANT** – therapy given after surgery to reduce the risk of the cancer coming back.
- ☐ **NEO-ADJUVANT** – therapy given before surgery/radiotherapy to shrink the cancer, allow radical treatment and reduce the risk of the cancer coming back.

SIGNIFICANT, UNAVOIDABLE OR FREQUENTLY OCCURRING RISKS (INDICATE ALL THAT APPLY):

- ☐ Tiredness and feeling weak (fatigue)
- ☐ An increased risk of getting an infection from a drop in white blood cells – it is harder to fight infections and you can become very ill.

  If you have a severe infection this can be life threatening. Contact you doctor or hospital straight away if:

  - **your temperature goes over 37.5°C (99.5°F) or over 38°C (100.4°F), depending on the advice given by your chemotherapy team**
  - **you suddenly feel unwell (even with a normal temperature)**
- ☐ Anaemia (low number of red blood cells)
- ☐ Bruising or bleeding
- ☐ Feeling sick (nausea) or being sick (vomiting)
- ☐ Sore mouth and ulcers
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Taste changes
- ☐ Loss of appetite
- ☐ Hair loss
- ☐ Skin rashes
- ☐ Nail changes
- ☐ Chemotherapy may leak outside of the vein while it is being given; this is called extravasation. If this happens when you're having chemotherapy it can damage the tissue around the vein. Tell the nurse straight away if you have any stinging, pain, redness or swelling around the vein. Extravasation is not common but if it happens it's important that it's dealt with quickly.
- ☐ Inflammation of the hands and feet
- ☐ Numbness or tingling in hands or feet
- ☐ Impaired hearing or ringing in the ears
- ☐ Problems with the eyes
- ☐ Allergic reactions
- ☐ Impaired heart function
- ☐ Impaired lung function
- ☐ Impaired kidney function
- ☐ Impaired liver function
- ☐ Fluid retention
- ☐ Tumour lysis syndrome
- ☐ Problems with sleep
- ☐ Flu-like symptoms
- ☐ Unstable blood sugars
- ☐ Risk of a second cancer
- ☐ Cancer can increase your risk of developing a blood clot (thrombosis), and having treatment with anti-cancer medicines may increase this risk further. A blood clot may cause pain, redness and swelling in a leg, or breathlessness and chest pain – you must tell your doctor straight away if you have any of these symptoms.
- ☐ Some anti-cancer medicines can damage women's ovaries and men's sperm. This may lead to infertility in men and women and/or early menopause in women.
- ☐ Some anti-cancer medicines may damage the development of a baby in the womb. It is important not to become pregnant or father a child while you are having treatment and for a few months afterwards. It is important to use effective contraception during and for several months after treatment. You can talk to your doctor or nurse about this.
- ☐ Very rarely complications of treatment with anti-cancer medicines can be life-threatening or even result in death. The risks are different for every individual. You can talk to your doctor or nurse about what this means for you.

STATEMENT OF HEALTH PROFESSIONAL (continued)

Patient identifier/label

OTHER RISKS AND INFORMATION:

_____

_____

_____

_____

☐ **I have discussed what the treatment is likely to involve (including inpatient / outpatient treatment, timing of the treatment, blood and any additional tests, follow-up appointments etc) and location.**

☐ **I have discussed the intended benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.**

THE FOLLOWING LEAFLET HAS BEEN PROVIDED:

☐ Information leaflets for: _____

_____

☐ Unlicensed medicine use information (when relevant)

☐ 24 hour chemotherapy service contact details

☐ Other, please state: _____

_____

_____

Signed: _____ Date: _____

Name (PRINT): _____

Job title: _____

STATEMENT OF INTERPRETER (where appropriate)

INTERPRETER BOOKING REFERENCE (if applicable): _____

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed: _____ Date: _____

Name (PRINT): _____

Job title: _____

Patient identifier/label

STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of the form which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure and course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate training and experience.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion:

Patient's signature: _____ Date: _____

Name (PRINT): _____

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Parent's/Witness' signature: _____ Date: _____

Name (PRINT): _____

COPY ACCEPTED BY PATIENT: YES / NO

(please circle)

CONFIRMATION OF CONSENT

(health professional to complete when the patient attends for treatment, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed: _____

Date: _____

Name (PRINT): _____

Job title: _____

IMPORTANT NOTES: (tick if applicable)

☐ See also advance decision to refuse treatment

☐ Patient has withdrawn consent
(ask patient to sign /date here)

Signed: _____

Date: _____

FURTHER INFORMATION FOR PATIENTS

CONTACT DETAILS (if patient wishes to discuss options later):

Contact your hospital team if you have any questions about cancer and treatment.

Cancer Research UK can also help answer your questions about cancer and treatment. If you want to talk in confidence, call our information nurses on freephone **0808 800 4040**, Monday to Friday, 9am to 5pm. Alternatively visit **www.cruk.org** for more information.

These forms have been produced by Guy's and St. Thomas' NHS Foundation Trust as part of a national project to support clinicians in ensuring all patients are fully informed when consenting to SACT. The project is supported by Cancer Research UK. This does not mean you are taking part in a clinical trial.

CANCER RESEARCH UK

TO BE RETAINED IN PATIENT NOTES
Prepared by: Rena Chauhan
Approved by: Janine Mansi (National Chemotherapy Board)

Date of issue and version: September 2016; Version 2;
Review date: September 2019
Check www.cancerresearchuk.org for latest version

GUIDANCE FOR HEALTH PROFESSIONALS

(to be read in conjunction with the hospital's consent policy)

Patient identifier/label

WHAT A CONSENT FORM IS FOR

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoir to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

THE LAW ON CONSENT

See the Department of Health's Reference guide to consent for examination or treatment 2nd Edition for a comprehensive summary of the law on consent (also available at **www.doh.gov.uk**).

WHO CAN GIVE CONSENT

Everyone aged 16 or over is presumed to have the capacity to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will have capacity to give consent for himself or herself. Young people aged 16 and 17, and younger children with capacity, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient has the capacity to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

WHEN NOT TO USE THIS FORM

If the patient is 18 or over and lacks the capacity to give consent, you should use an alternative form (form for adults who lack the capacity to consent to investigation or treatment) instead of this form. A patient lacks capacity if they have an impairment of the mind or brain or disturbance affecting the way their mind or brain works and they cannot:

- understand information about the decision to be made
- retain that information in their mind
- use or weigh this information as a part of their decision making process, or
- communicate their decision (by talking, using sign language or any other means)

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

Relatives cannot be asked to sign a form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to do so under a Lasting Power of Attorney or as a court deputy.

INFORMATION

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'significant, unavoidable or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on the consent form or in the patient's notes.

REFERENCES

1. Summary of Product Characteristics (SPCs) for individual drugs: https://www.medicines.org.uk/emc/
2. Cancer Research UK: http://www.cancerresearchuk.org/about-cancer/cancers-in-general/treatment/cancer-drugs/
3. Macmillan Cancer Support, Cancer Information: http://www.macmillan.org.uk/Cancerinformation/Cancertreatment/Treatmenttypes/Chemotherapy/Chemotherapy.aspx
4. Guy's and St. Thomas' NHS Foundation Trust, Chemotherapy consent forms.

TO BE RETAINED IN PATIENT NOTES
Prepared by: Rena Chauhan
Approved by: Janine Mansi (National Chemotherapy Board)

Date of issue and version: September 2016; Version 2;
Review date: September 2019
Check www.cancerresearchuk.org for latest version

Suggested SACT suitable for HBCC

Drug	Route	Risk	Cytotoxic	Cold chain 2–8°	Cold chain < 28°
Atezolizumab	IV			✓	
Avelumab	IV	Infusion-related reaction (IRR)		✓	
Bevacizumab (Avastin)	IV	IRR		✓	
Cabazitaxel	IV	Extravasation/IRR	✓		✓
Carboplatin	IV	IRR	✓	✓	
Cetuximab (Erbitux)	IV	IRR		✓	
Docetaxel (Taxotere)	IV	Extravasation/IRR	✓	✓	
Eribulin mesilate (Halaven)	IV		✓	✓	
Etoposide (etoposide phosphate)	IV	IRR	✓	✓	
Fluorouracil	IV		✓		✓
Gemcitabine	IV		✓		✓
Maintenance Rituximab – Rapid	IV	IRR		✓	
nab-PACLItaxel (Abraxane)	IV	Extravasation	✓	✓	
Nivolumab (Opdivo)	IV	IRR		✓	
Panitumumab (Vectibix)	IV	IRR		✓	
Pralatrexate	IV		✓	✓	
Pembrolizumab (Keytruda)	IV	IRR		✓	
Pemetrexed (Alimta)	IV		✓	✓	
Raltitrexed (Tomudex)	IV		✓		✓
Topotecan	IV	IRR	✓	✓	
Temsirolimus	IV	IRR	✓		✓
Trastuzumab (Herceptin)	IV	IRR		✓	
Trastuzumab emtansine (Kadcyla)	IV	Extravasation/IRR	✓	✓	
Zoledronic acid (Zometa)	IV				✓
Trastuzumab (Herceptin)	SC	IRR		✓	
Denosumab (Xgeva, Prolia)	SC				✓
Goserelin (Zoladex)	SC				✓
Azacitidine (Vidaza)	SC	IRR	✓	✓	
Pegfilgrastim (Neulasta)	SC			✓	
Low-dose Cytarabine (Ara-C)	SC		✓	✓	
Lanreotide (Somatuline autogel)	SC			✓	
Bortezomib (Velcade)	SC		✓	✓	
Fulvestrant*	IM			✓	
Octreotide	IM				✓
Degarelix (Firmagon)	IM				✓

Medication transport – levels 1 and 2

Cytotoxic drugs must be transported so as to provide adequate physical and chemical protection for the drug (Society of Hospital Pharmacists of Australia 2007). The transport container must be relatively impervious to the atmosphere, robust, secured, have the ability to maintain the cold chain, provide adequate protection to the handler, minimise the risk of damage to the product, ensure containment of cytotoxic material in the event of spillage and allow easy identification of the contained drugs. Cytotoxic drug spill kits must be readily available to personnel involved in transporting cytotoxic drugs.

To ensure cold chain requirements are met, the temperature of the transport container should be monitored. The Department of Health and Human Services recommends using TagAlert temperature indicators.

Labelling of cytotoxic drugs for transport outside an institution must contain the name and address of the institution and a direct contact in the pharmacy department in case of an emergency. Labelling must comply with state and federal transport codes. Instructions in the event of spillage should also be attached.

Sample label for use when transporting cytotoxic drugs outside the institution

Cytotoxic drugs – handle with care

Avoid contact with the skin.

This item has been packaged in accordance with approved guidelines and is safe for transport.

In the event of accidental breakage or spillage:

- do not touch spilt contents or contaminated item
- avoid any contact with skin and clothes
- if spillage has occurred onto unprotected skin or in the eye, immediately wash the area with large amounts of water
- remove any contaminated clothing
- contact [name of contact person] on [telephone number] during normal business hours or on [telephone number] after hours.

Name of institution

Address of institution

Anaphylaxis and extravasation kit – levels 1 and 2

Anaphylaxis/hypersensitivity

Equipment

- Laerdal re-breathing bag and mask (adult)
- Guedel airway × 2 (adult)
- 2 × intravenous giving sets
- Syringes and needles

Drugs

- Adrenaline (epinephrine) 1:1000 (1 mg/1 mL) amps × 5
- Hydrocortisone 100 mg × 2

- Promethazine IV 12.5 mg × 2
- 2 × 1 L bags of sodium chloride 0.9%
- 2 × 10 mL water for injection
- 2 × 10 mL normal saline sodium chloride 0.9%

Extravasation kit – levels 1 and 2

- 10 mL syringes
- Gauze squares
- Disposable paper tape measure
- Permanent marker pen
- Personal protective equipment
- Protective cloth or gauze covering
- Cold pack
- Medication chart
- Camera

Source: Cancer Institute NSW 2019

ISoBAR HBCC minimum dataset – clinical handover

I	Identification	Introduce or identify patient, self and team
S	Situation	Provide current working diagnosis, specific clinical problems, concerns and critical laboratory results
o	Observation	Check and update and discuss recent vital signs
B	Background history	Update and discuss relevant medical and support information
A	Agree to plan (Actions)	Outline plan for assessment, treatment and discharge
R	Responsibility and risk management	Confirm shared understanding, clarify tasks (read back critical information to check understanding), timing and responsibility transferred

Source: Cancer Institute NSW 2019

Clinical procedures and assessment tools

The following list of documents are linked to the Cancer Institute of New South Wales – eviQ website. eviQ resources reflect current best practice and are a useful reference point. Resources are available for use with written permission.

eviQ assessment tools

- Antineoplastic drug patient assessment tool <https://www.eviq.org.au/clinical-resources/assessment-tools/4-antineoplastic-drug-patient-assessment-tool>
- Chemotherapy induced peripheral neuropathy screening tool <https://www.eviq.org.au/clinical-resources/assessment-tools/8-chemotherapy-induced-peripheral-neuropathy-scree>
- Cytarabine cerebellar neurotoxicity assessment chart <https://www.eviq.org.au/clinical-resources/assessment-tools/475-cytarabine-cerebellar-neurotoxicity-assessment>

- Immunotherapy patient assessment tool <https://www.eviq.org.au/clinical-resources/assessment-tools/3533-immunotherapy-patient-assessment-tool>
- Oral mucositis assessment tool <https://www.eviq.org.au/clinical-resources/assessment-tools/10-oral-mucositis-assessment-tool>
- Patient evaluation, risk assessment and initial management of febrile neutropenia <https://www.eviq.org.au/clinical-resources/assessment-tools/875-patient-evaluation-risk-assessment-and-initia>

eviQ administration of antineoplastic therapies

- Antineoplastic drug time out checklist <https://www.eviq.org.au/clinical-resources/assessment-tools/6-antineoplastic-drug-time-out-checklist>
- Clinical procedure – administration of antineoplastic drugs – central venous access device (CVAD) <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/1127-administration-of-antineoplastic-drugs-cent>
- Clinical procedure – administration of antineoplastic drugs – intramuscular and subcutaneous <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/457-administration-of-antineoplastic-drugs-intra>
- Clinical procedure – administration of antineoplastic drugs – intravenous cannula (IVC) <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/1087-administration-of-antineoplastic-drugs-intra>
- Clinical procedure – administration of antineoplastic drugs – oral <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/450-administration-of-antineoplastic-drugs-oral>
- Clinical procedure – hazardous drug spill management <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/919-hazardous-drug-spill-management>
- Hazardous drugs table <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/909-hazardous-drugs-table>
- Safe administration of antineoplastic drugs <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/5-safe-administration-of-antineoplastic-drugs>
- Safe handling and waste management of hazardous drugs <https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/188-safe-handling-and-waste-management-of-hazardou>

eviQ central line (CVAD) care

- Clinical procedure – central venous access device – dressing and needleless injection cap change <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/900-central-venous-access-device-dressing-and-n>
- Clinical procedure – central venous catheter – accessing <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/1161-central-venous-catheter-accessing>
- Clinical procedure – central venous catheter – blood sampling <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/903-central-venous-catheter-blood-sampling>
- Clinical procedure – central venous catheter – deaccessing <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/1163-central-venous-catheter-deaccessing>
- Clinical procedure – implanted venous port (IVP) – accessing and locking <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/898-implanted-venous-port-ivp-accessing-and-lo>
- Clinical procedure – implanted venous port (IVP) – blood sampling <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/911-implanted-venous-port-ivp-blood-sampling>

- Clinical procedure – implanted venous port (IVP) – deaccessing and locking <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/899-implanted-venous-port-ivp-deaccessing-and>
- Clinical procedure – restoring patency to a central venous access device (CVAD) – partial and complete occlusion <https://www.eviq.org.au/clinical-resources/central-venous-access-devices-cvads/771-central-venous-access-device-cvad-restoring>

eviQ extravasation

- Clinical procedure – extravasation management – irritants with vesicant properties general care <https://www.eviq.org.au/clinical-resources/extravasation/1193-extravasation-management-irritants-with-ves>
- Extravasation management – immediate management flow chart <https://www.eviq.org.au/clinical-resources/extravasation/1078-extravasation-management-immediate-manageme>
- Care at home after an extravasation injury – cold or warm compress <https://www.eviq.org.au/Patients-and-carers/Patient-information-sheets/3027-Care-at-home-after-an-extravasation-injury>

HBCC referral template

Health service
Home-based cancer care
Referral

Affix Patient Identification Label

Unit Record Number:_____

Surname _____

Given name: _____

DOB:_____Age:____ Sex:_____

Address: _____

Referring doctor			Date	
Diagnosis				
Treatment care plan				
Relevant medical history				
Previous adverse reactions/hypersensitivity				
Allergies/alerts				
Referral for:	Infusion ☐	Injection ☐	CVAD Care ☐	Monitoring ☐
Details:				
Proposed HBCC commencement date:				
Next medical review date:				
Venous access				
IV cannulation ☐	CVAD	No ☐	Yes ☐	Please specify:
Pathology				
Pre-treatment bloods required	Yes ☐	No ☐	Pathology service provider:	
Patient details				
Usual GP			Phone:	
Language			Interpreter required Yes ☐ No ☐	
Alternate contact name			Phone:	
Does the patient identify as Aboriginal or Torres Strait Islander?			Yes☐ No☐	Rather not say ☐
If yes, would they like to be referred to the Aboriginal Health liaison officer?			Yes☐ No☐	
Clinician name			Signature	Date
Referral received by				Date

HBCC consent template

Health service

Home-based cancer care

Patient responsibilities and consent

Affix Patient Identification Label

Unit Record Number:_____

Surname _____

Given name: _____

DOB: _____ Age:____ Sex:_____

Address: _____

Patient		
I will		
Provide a safe environment for the nurse to work	Yes ☐	No☐
Tell the nurse if there is something or someone in or around the home that might harm them	Yes ☐	No ☐
Ensure no one smokes in my home during the home visit	Yes ☐	No ☐
Keep my pets securely in another room or outside during my treatment	Yes ☐	No ☐
Pay the cost of an ambulance if I need to travel to hospital during my treatment and I do not have ambulance cover (Ambulance Victoria Cover)	Yes ☐	No ☐
I agree:		
The Home-based Cancer Care program has been explained to me in a language I understand.	Yes ☐	No ☐
I have received written information about Home-based Cancer Care.	Yes ☐	No ☐
I understand the risks associated with Home-based Cancer Care.	Yes ☐	No ☐
I understand that information about my health and treatment may be shared with other health providers when needed – for example, my GP.	Yes ☐	No ☐
I understand that if my treatment or home situation changes I may need to return to the hospital for future treatment.	Yes ☐	No ☐

I, consent to having my cancer treatment at home.

Signature Date

Witness

Clinician		
The patient has the capacity to make a decision.	Yes ☐	No ☐
The patient has an advance care directive.	Yes ☐	No ☐
The advance care directive is documented in the medical record.	Yes ☐	No ☐
I have provided written information about Home-based Cancer Care.	Yes ☐	No ☐
I have discussed Home-based Cancer Care and associated risks with the patient.	Yes ☐	No ☐

Clinician name Signature Date

HBCC home risk assessment and control plan template

Health service

Home-based Cancer Care

Home risk assessment and control plan

Affix Patient Identification Label

Unit Record Number:_____

Surname _____

Given name: _____

DOB:_____Age:____ Sex:_____

Address: _____

Assessment completed by clinician:				Date:			
Assessment completed with:				Patient/family/carer			
HBCC referral complete	Yes☐	No☐		HBCC consent complete	Yes ☐	No ☐	
Access	Pre visit Yes	Pre visit No		Comment/action	First visit Yes	First visit No	
Is the property remote or isolated?				If yes, complete a *Home risk control plan* (see reverse side)			
Are road surfaces in good condition?				If no, complete a *Home risk control plan*			
Is roadside assistance available?				If no, complete a *Home risk control plan*			
Is the home in a bushfire-prone area?				If yes, complete a *Home risk control plan*			
Is the house number visible from the street?							
Can the nurse park in the driveway?							
What type of pathway do you have? Is it sloping, are there steps?							
Which door should the nurse come to? Front, side, back							
Do you have any pets?				If yes, complete a *Home risk control plan*			
Inside the home							
Is there adequate workspace?							
Is there a suitable benchtop or table to set up equipment?							
Is there adequate lighting?							
Is the toilet indoors and accessible?							
Is there suitable hand-washing facilities?							
Is there electricity?							
Is there a landline or mobile phone reception?				If no, complete a *Home risk control plan*			
Is the floor surface suitable?							
Is there a smoke detector in working order?				If no, complete a *Home risk control plan*			
Living arrangements							
Are there other people living at home?							
Who will be home during the visit?							
Are there any cultural considerations we need to be aware of (e.g. no shoes in the house)?							
Do you need an interpreter?							
Is there anyone in or around the home who may cause concern for staff safety?				If yes, complete a *Home risk control plan*			
Is there evidence that anyone in or around the home may be under the influence of alcohol or drugs? Are there any firearms on the premises?				If yes, complete a *Home risk control plan*			
Does the patient have any relevant medical history that may pose a potential risk to staff?				If yes, complete a *Home risk control plan*			

Step 1. Home risk control plan

Identified hazard	Likelihood of injury occurring	Control	Responsible person

Control effectiveness	Effective	Partially effective	Ineffective

Step 2. Reassess risk with controls in place

		Consequence				
		Insignificant	Minor	Moderate	Major	Severe
Likelihood	Almost certain	Medium	High	Extreme	Extreme	Extreme
	Likely	Medium	Medium	High	Extreme	Extreme
	Possible	Low	Low	Medium	High	Extreme
	Unlikely	Low	Low	Medium	Medium	High
	Rare	Low	Low	Low	Medium	High

Levels	Risk escalation	Response (Actions)
Extreme	Unable to deliver service at home	As per health service policy
High		
Medium	Escalate to manager	
Low	Acceptable	

Risk control plan completed by:

Reported to:

Action taken:

Notes:

Supportive care template

Health service

Oncology supportive care screening and referral form

Affix Patient Identification Label

Unit Record Number:_____

Surname _____

Given mame: _____

DOB:_____Age:____ Sex:_____

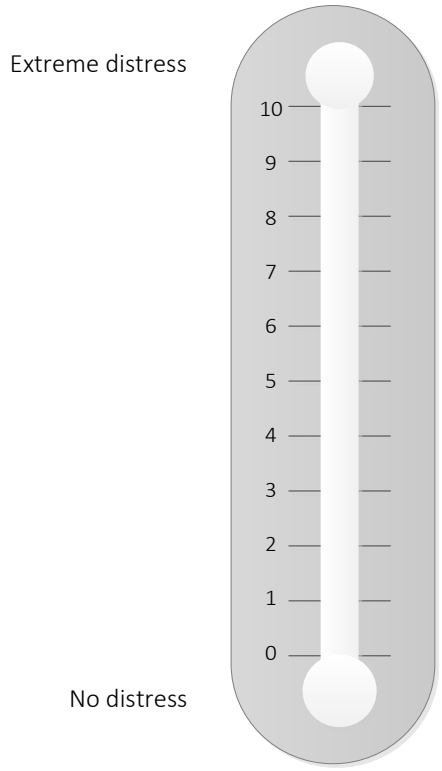
Address: _____

This screening tool is used to identify services, information and resources you may need following a diagnosis of cancer.

Patient to complete

NCCN distress thermometer

Please circle the number (0-10) that best describes the how much distress you have felt in the past week including today.



Problem list

Please tick any of the following that has been a problem for you in the past week including today. Please tick YES or NO

Yes	No	Practical problems
☐	☐	Child care
☐	☐	Housing
☐	☐	Insurance/finances
☐	☐	Transport
☐	☐	Work/school
☐	☐	Treatment decisions
		Family problems
☐	☐	Dealing with children
☐	☐	Dealing with partner
☐	☐	Ability to have children
☐	☐	Family health Issues
		Emotional problems
☐	☐	Depression
☐	☐	Fears
☐	☐	Sadness
☐	☐	Nervousness
☐	☐	Worry
☐	☐	Loss of interest in usual activities
☐	☐	**Spiritual/religious concerns**

Other:

Yes	No	Physical problems
☐	☐	Appearance
☐	☐	Bathing/dressing
☐	☐	Breathing
☐	☐	Changes in urination
☐	☐	Constipation
☐	☐	Diarrhoea
☐	☐	Eating
☐	☐	Fatigue
☐	☐	Feeling swollen
☐	☐	Fevers
☐	☐	Getting around
☐	☐	Indigestion
☐	☐	Memory/concentration
☐	☐	Mouth sores
☐	☐	Nausea
☐	☐	Nose dry / congested
☐	☐	Pain
☐	☐	Skin dry/itchy
☐	☐	Sleep
☐	☐	Tingling hands/feet
☐	☐	Sexual
☐	☐	Substance use

Malnutrition screening tool (MST)

To help the dietician assess your weight and diet, please CIRCLE your answer to the following questions.

Have you lost weight recently without trying?	No	0
	Unsure	2
	Yes	
If yes, how much weight (in kilograms) have you lost?	1–5 kg	1
	6–10 kg	2
	11–15 kg	3
	More than 15 kg	4
Have you been eating poorly because of decreased appetite?	No	0
	Yes	1
	Total	

Have you had a fall in the past 6 months?	Yes	No	Yes – Refer / Assess
When walking, do you lose your balance or feel unsteady?	Yes	No	Yes – Refer / Assess

Comments

Completed by:

Staff signature and designation: Date:

This page is to be completed by a health professional

Patient name:			**URN:**
Diagnosis: Screening completed by:		Patient / health professional / both	Date of diagnosis: Screening offered but declined ☐
Screening point			
Diagnosis ☐ During follow-up ☐	Commencement of treatment ☐ At recurrence ☐	During treatment ☐ During palliative care ☐	At conclusion of treatment ☐ Other ☐

Supportive care referral algorithm

Patient need/concern	Refer to	Date referral complete
• **Physical problem** – urination, constipation, diarrhoea, feeling swollen, fevers, indigestion, mouth sores, nausea, nose dry/congested, pain, skin itchy/dry, tingling hands/feet • Specialist care e.g. wound, breast, stoma • Newly diagnosed – navigating treatment pathway	Cancer nurse consultant/practitioner	
• **MST score ≥ 2** • **Physical problems** – eating • Dietary concerns	Dietitian	
• Falls risk • **Physical problems** – fatigue, bathing/dressing, getting around, sleep • Home management	Occupational therapist	
• Falls risk • **Physical problems** – fatigue, breathing • Strengthening/exercising, lymphoedema	Physiotherapist	
• **Distress thermometer score ≥ 4** • **Practical problems**, family problems, legal issues • **Physical problems** – substance use • **Emotional problems**	Social worker	
• **Physical problems** – difficulty swallowing / speaking	Speech pathologist	
• **Distress thermometer score ≥ 4** • **Physical problems** – appearance, memory concentration, sexual, substance use. • **Emotional problems**	Psychologist	
• **Emotional problems** • **Physical problems** – pain, complex symptom management • End of life	Palliative care worker	
• **Spiritual/religious needs**	Pastoral care worker	

Other service / community service			
Information provided:		Written information ☐	Verbal ☐
Referral required:	Yes ☐	No ☐	Patient consented / declined referral
Treating doctor aware of referrals made:	Yes ☐	No ☐	
Notes			
Staff member:			Ward/unit:

Case conference template

Health service

Home-based Cancer Care

Case conference

AN 0.51

Affix Patient Identification Label

Unit Record Number:_____

Surname _____

Given name: _____

DOB:_____Age:____ Sex:_____

Address: _____

Date: Time commenced: Complete:

Lead consultant:

Patient consent obtained and recorded in medical record Yes ☐ No ☐

Diagnosis:

Discussion

Multidisciplinary care needs:

Intervention goals:

Intervention tasks:

Intervention responsibility:

Previous case conference goals met:

Attendees	Present	Telephone	Video link
1.			
2.			
3.			
4.			
5.			
6.			

Claimable MBS items

Item 820 – Organising consultant – between 15–30 minutes		Item 825 – Participating consultant – between 15–30 minutes	
Item 822 – Organising consultant between 30–45 minutes		Item 826 – Participating consultant between 30–45 minutes	
Item 823 – Organising consultant at least 45 minutes		Item 828 – Participating consultant at least 45 minutes	

Hand hygiene home audit template

Health Service

Home Based Cancer Care

Hand Hygiene Feedback

Hand Hygiene Patient feedback form.

Hand hygiene is hand washing and is very important in preventing the spread of infection.

This form is for you to provide feedback to us about the hand hygiene of the *[Health Service Home Based Cancer Care team.]*
You can return this form to the hospital by post or hand to your nurse in an envelope at the end of the visit.

As a patient of *[Health Service]* you can provide feedback on whether or not our nurses performed hand hygiene during your care. Please observe your nurse during their visit and note if you see them wash their hands ***OR*** use the hand rub during your care.

Date of visit: _____

Before providing my care I saw the Nurse:	After providing my care I saw the Nurse:
☐ Use Hand Rub	☐ Use Hand Rub
☐ Wash with soap and water	☐ Wash with soap and water
☐ They did not clean their hands	☐ They did not clean their hands

If you would like to make any comments about the hand hygiene you observed today, please feel free to provide them here:

_____

_____

_____

_____

If you have any questions or concerns, please contact our Consumer Liaison Officer on:
Telephone: xxxx xxxx Email: feedback@healthservice.com
Mail: Health service, Victoria

HBCC Patient Experience Survey

Thank you for taking the time to complete this survey about the care you have received during your Home-based Cancer Care treatment.
Taking part in this survey is voluntary. Your responses are confidential. We will use your responses to improve our Home-based Cancer Care Program.

I am a Patient ○ Family member / carer ○

The HBCC nurses treat me with respect and dignity.	Yes, always ○	Yes, most of the time ○	Sometimes ○	No ○	Not sure ○
The nurses are on time.	Yes, always ○	Yes, most of the time ○	Sometimes ○	Never ○	Not sure ○
The nurses help me manage the side effects of my treatment.	Yes, always ○	Yes, most of the time ○	Sometimes ○	Never ○	I don't have side effects ○
I feel included in the decisions about my cancer treatment.	Yes, always ○	Yes, most of the time ○	Sometimes ○	Never ○	Not sure ○
My treatment is explained to me in a way I understand.	Yes, always ○	Yes, most of the time ○	Sometimes ○	Never ○	Not sure ○
The nurses and the doctors involved in my care communicate well with each other.	Yes, always ○	Yes, most of the time ○	Sometimes ○	Not at all ○	Not sure ○
How do you rate the clinical skill of the nurses who visit you at home?	Very good ○	Good ○	Satisfactory ○	Poor ○	Very poor ○
I know who to call if I am unwell between home visits.	Yes ○	No ○	Not sure ○		
I get the help I need, when I call the HBCC contact number.	Yes, always ○	Yes, most of the time ○	Sometimes ○	Never ○	I have never called ○
Overall, how satisfied are you with the Home-based Cancer Care team?	Very satisfied ○	Satisfied ○	Neither satisfied or dissatisfied ○	Dissatisfied ○	Very dissatisfied ○

What do you we do well?

What could we do better?

If you would like to make any other comments about your care experiences during your treatment, please use the space below. We would like to know about them.

Please return your survey in the envelope provided.
If you have any questions or concerns, please contact our consumer liaison officer on:
Telephone: [insert phone number]
Email: [insert email address]
Mail: [insert postal address]

Oncology/haematology triage tool

ONCOLOGY/HAEMATOLOGY ADVICE LINE
TRIAGE TOOL, AUSTRALIAN VERSION 1 (2018)

UKONS Oncology Nursing Society

All Green = self care advice
1 Amber = review within 24 hours
2 or more amber = escalate to red
Red = attend for assessment as soon as possible

Patients may present with problems other than those listed below, these would be captured as "other" on the log sheet checklist. Practitioners are advised to refer to the NCI-CTCAE common toxicity criteria v.5 to assess the severity of the problem and/or seek further clinical advice regarding management.

CAUTION! Please note patients who are receiving or have received IMMUNOTHERAPY may present with treatment related problems at anytime during treatment or up to 12 months afterwards. If you are unsure about the patient's regimen, be cautious and follow triage symptom assessment.

Toxicity/Symptom	0	1	2	3	4
Fever - receiving or has received Systemic Anti Cancer Treatment (SACT) within the last 6-8 weeks or immunocompromised.	None.	IF TEMPERATURE 37.5'c or ABOVE or BELOW 36.0'c or GENERALLY UNWELL - URGENT assessment and medical review - Follow neutropenia pathway. ALERT - patients who have taken analgesia or steroids or who may be dehydrated may not present with an abnormal temperature but may still have an infection and be at risk of sepsis - if in doubt do a count.			
Chest pain STOP oral and intravenous Systemic Anti Cancer Treatment until reviewed by oncology or haematology team.	None.	Advise URGENT ED for medical assessment- 000 NB if infusional SACT in place arrange for disconnection.			
Dyspnoea/shortness of breath Is this a new symptom? How long for? Is it getting worse? Do you have a cough? How long for? Is it productive? If yes, what colour is your phlegm/sputum? Is there any chest pain or tightness? - if yes refer to chest pain Consider: SVCO / Anaemia / Pulmonary embolism / Pneumonitis / Infection.	None or no change from normal.	New onset shortness of breath with moderate exertion.	New onset shortness of breath with minimal exertion.	Shortness of breath at rest.	Life threatening symptoms.
Performance Status Has there been a recent change in performance status?	No change to pre-treatment normal - or fully active, able to carry on all pre-disease performance without restriction.	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, such as light housework or office work.	Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours.	Capable of only limited self care, confined to bed or chair for more than 50% of waking hours.	Completely disabled. Cannot carry out any self care. Totally confined to bed or chair.
Diarrhoea How many days has this occurred for? How many times in a 24 hour period? Is there any abdominal pain or discomfort? Is there any blood or mucus in the stool? Has the patient taken any antidiarrhoeal medication? Is there any change in urine output? Is the patient drinking and eating normally? Consider: Infection / Colitis / Constipation. N.B. Patients receiving immunotherapy or Capecitabine should be managed according to the drug specific pathway and assessment arranged as required.	None or no change from normal.	Increase of up to 3 bowel movements a day over pre-treatment normal or mild increase in ostomy output. Drink more fluids Obtain stool sample. Commence regimen specific antidiarrhoeal.	Increase of up to 4-6 episodes a day or moderate increase in ostomy output or nocturnal movement or moderate cramping. Drink plenty of fluids Obtain stool sample. Commence regimen specific antidiarrhoeal. If diarrhoea persists after taking regimen specific antidiarrhoeal escalate to red. If patient is or has been on immunotherapy escalate to red.	Increase of up to 7-9 episodes a day or severe increase in ostomy output or incontinence / severe cramping /bloody diarrhoea.	Increase>10 episodes a day or grossly bloody diarrhoea.
Constipation How long since bowels opened? What is normal? Is there any abdominal pain and/or vomiting? Has the patient taken any medication? Assess the patients urinary output and colour.	None or no change from normal.	Mild - no bowel movement for 24 hours over pre-treatment normal. Dietary advice, increase fluid intake, review supportive medications.	Moderate - no bowel movement for 48 hours over pre-treatment normal. If associated with pain / vomiting move to red. Review fluid and dietary intake. Recommend a laxative.	Severe - no bowel movement for 72 hours over pre-treatment normal.	No bowel movement for >96 hours - consider paralytic ileus.
Urinary Disorder Are you passing urine normally? Is this a new problem or is this normal for you? Is there any change in the urine colour? Is there any blood in the urine? Is there any incontinence, frequency or urgency? Are you passing your normal amount? Are you drinking normally, are you thirsty? Consider: Infection	None or no change from normal.	Mild symptoms. Minimal increase in frequency, urgency, dysuria nocturia. Slight reduction in output. Drink more fluids. Obtain urine sample for analysis.	Moderate symptoms. Moderate increase in frequency, urgency, dysuria nocturia. Moderate reduction in output. Obtain urine sample for analysis.	Severe symptoms. Possible obstruction/retention New incontinence New or increasing haematuria Severe reduction in output	Little or no urine output.
Fever NOT receiving Systemic Anti Cancer Treatment (SACT) and NOT at risk of immunosuppression.	Normal.		< 36.0'c or > 37.5'c - 38.0'c	>38.0'c - 40.0'c	> 40.0'c
Infection Has the patient taken their temperature? If so when? What is it? - if febrile see fever toxicity. Are there any specific symptoms, such as: • pain, burning / stinging or difficulty passing urine? • cough, any sputum, if so what colour? • any shivering, chills or shaking episodes?	None.	Localised signs of infection otherwise generally well.	Signs of infection and generally unwell - If on active SACT treatment follow neutropenic sepsis pathway. * If not on active treatment arrange urgent local review.	Signs of severe symptomatic infection.	Life threatening sepsis.
Nausea How many days? What is the patient's oral intake? Is the patient taking antiemetics as prescribed? Assess patient's urinary output and colour.	None.	Able to eat/drink reasonable intake. Review anti emetics according to local policy.	Able to eat/drink but intake is significantly decreased. Review anti emetics according to local policy.	No significant intake.	
Vomiting How many days? How many episodes? What is the patient's oral intake? Is there any constipation or diarrhoea? - if yes see specific toxicity. Assess patient's urinary output and colour	None.	1-2 episodes in 24 hours. Review anti emetics according to local policy.	3-5 episodes in 24 hours. Review anti emetics according to local policy.	6-10 episodes in 24 hours.	>10 episodes in 24 hours.
Mucositis How many days? Are there any mouth ulcers? Is there evidence of infection? Are they able to eat and drink? Assess patient's urinary output and colour.	None.	Painless ulcers and/or erythema, mild soreness but able to eat and drink normally. Use mouthwash as directed.	Painful ulcers and/or erythema, mild soreness but able to eat and drink normally. Continue with mouthwash as directed, drink plenty of fluids. Use painkillers either as a tablet or mouthwash.	Painful erythema, difficulty eating and drinking.	Significant pain, minimal intake and/or reduced urinary output.
Anorexia What is appetite like? Has this recently changed? Any recent weight loss? Any contributory factors, such as dehydration, nausea, vomiting, mucositis, diarrhoea or constipation - if yes refer to specific problem/symptom.	None or no change from normal.	Loss of appetite without alteration in eating habits. Dietary advice.	Oral intake altered without significant weight loss or malnutrition. Dietary advice.	Oral intake altered in association with significant weight loss/malnutrition.	Life threatening complications, such as collapse.
Pain Is it a new problem? Where is it? How long have you had it? Have you taken any pain killers? Is there any swelling or redness? If pain associated with swelling or redness consider thrombosis or cellulitis. Back pain consider metastatic spinal cord compression (MSCC).	None or no change from normal.	Mild pain not interfering with daily activities. Advise appropriate analgesia.	Moderate pain interfering with daily activities. Advise appropriate analgesia.	Severe pain interfering with daily activities.	Severe disabling pain.
Neurosensory / motor When did the problem start? Is it continuous? Is it getting worse? Is it affecting mobility/function? Any perineal or buttock numbness (Saddle paresthesia)? Any constipation? Any urinary or faecal incontinence? Any visual disturbances? Is there any pain? If yes refer to specific problem / symptom. Consider - Metastatic spinal cord compression, cerebral metastases or cerebral event.	None or no change from normal.	Mild paresthesia, subjective weakness. No loss of function. Contact the advice line immediately if deterioration.	Mild or moderate sensory loss, moderate paresthesia, mild weakness with no loss of function.	Severe sensory loss, paresthesia or weakness that interferes with function.	Paralysis.
Confusion/cognitive disturbance Is this a new symptom? How long have you had this symptom? Is it getting worse? Is it constant? Any recent change in medication?	None or no change from normal.	Mild disorientation not interfering with activities of daily living. Slight decrease in level of alertness.	Moderate cognitive disability and/or disorientation limiting activities of daily living.	Severe cognitive disability and/or severe confusion; severely limiting activities of daily living. Altered level of consciousness. 000 - Urgent assessment in ED.	Life threatening consequences. Loss of consciousness/unrousable. 000 - Urgent assessment in ED.
Fatigue Is this a new problem? Is it getting worse? How many days? Any other associated symptoms? Do you feel exhausted?	None or no change from normal.	Increased fatigue but not affecting normal level of activity. Rest accompanied with intermittent mild activity / exercise.	Moderate or interfering with some normal activities.	Severe or loss of ability to perform some activities.	Bedridden or disabling.
Rash Where is it? Is it localised or generalised? How long have you had it? Is it getting worse? Is it itchy? Are you feeling generally unwell? Any signs of infection, such as pus, pyrexia Moderate = 10-30% of the body surface area (BSA) Severe = greater than 30% of the body surface area (BSA) NB Haematology, follow local guidelines.	None or no change from normal.	Rash covering <10% BSA with or without symptoms, such as pruritus, burning, tightness.	Rash covering 10 - 30% BSA that is limiting normal activities of daily living with or without symptoms, such as pruritus, burning, tightness. Or bleeding with trauma or signs of associated infection.	Rash covering >30% BSA with or without associated symptoms; limiting self care activities. Spontaneous bleeding or signs of associated infection.	
Bleeding Is it a new problem? Is it continuous? What amount? Where from? Are you taking anticoagulants? NB Haematology, follow local guidelines.	None or no change from normal.	Mild, self limited controlled by conservative measures. Consider arranging a full blood count.	Moderate bleeding. 000 - Urgent assessment in ED.	Severe bleeding. 000 - Urgent assessment in ED.	Massive bleed. 000 - Urgent assessment in ED.
Bruising Is it a new problem? Is it localised or generalised? Is there any trauma involved?	None or no change from normal.	Localised - single bruise in only one area.	Multiple sites of bruising or one large site.		
Ocular/eye problems Is this a new problem? Any associated pain? Any visual disturbance? Any discharge/sticky eyes?	None or no change from normal.	Mild symptoms not interfering with function.	Moderate to severe symptoms interfering with function and/or any visual distrubance.		
Palmar Plantar syndrome If on active oral SACT therapies follow drug specific pathways. Drug may need to be suspended and medical review arranged.	None.	Mild numbness, tingling, swelling of hands and/or feet with or without pain or redness. Rest hands and feet, use emollient cream.	Painful redness and/or swelling of hands and/or feet. Follow drug specific pathway - may require dose reduction or treatment deferral. Advise painkillers.	Moist desquamation, ulceration, blistering and severe pain. Follow drug specific pathway - arrange urgent appointment for review by specialist team within 24 hours. May require dose reduction or treatment deferral. Advise painkillers.	
Extravasation Any problems after administration of treatment? When did the problem start? Is the problem around or along the injection site? Has the patient got a central line in place? Describe the problem.	None.	Non Vesicant. Review the next day.	Vesicant or drug not known. Arrange urgent review.		

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Clinical resource: United Kingdom Oncology Nursing Society (UKONS) (2018) Oncology Haematology 24-Hour Helpline, Rapid Assessment and Access Tool Kit – Australia, eviQ Cancer Treatments Online, Cancer Institute NSW, viewed 12 September 2019, <eviq.org.au>. Used with permission

Telephone triage log sheet

HOSPITAL NAME / DEPT:	UKONS/AUS 24 HOUR TRIAGE LOG SHEET (V1 2018)

Patient Details	Patient History	Enquiry Details
Name: Hospital no..... DOB..... Tel no.....	Diagnosis: Male ☐ Female ☐ Consultant..... Has the caller contacted the advice line previously Yes ☐ No ☐	Date..... Time..... Who is calling? ..... Contact no..... Drop in Yes ☐ No ☐

Reason for call
(in patients own words)

Is the patient on active treatment? SACT ☐ Immunotherapy ☐ Radiotherapy ☐ Other ☐ Supportive ☐ No ☐

State regimen..... Are they part of a clinical trial Yes ☐ No ☐

When did the patient last receive treatment? 1-7 days ☐ 8-14 days ☐ 15-28 days ☐ Over 4 weeks ☐

What is the patient's temperature? ☐ °C (Please note that hypothermia is a significant indicator of sepsis)

Has the patient taken any anti-pyretic medication in the previous 4-6 hours Yes ☐ No ☐

Does the patient have a central line? Yes ☐ No ☐ Infusional pump in situ Yes ☐ No ☐

CAUTION! Please note patients who are receiving or have received IMMUNOTHERAPY may present with treatment related problems at anytime during treatment or up to 12 months afterwards. If you are unsure about the patient's regimen, be cautious and follow triage symptom assessment.

Advise	24 hour follow up	Assess
Remember: two ambers equal red!		
Fever - on SACT		
Chest Pain		
Dyspnoea/shortness of breath		
Performance Status		
Diarrhoea		
Constipation		
Urinary disorder		
Fever		
Infection		
Nausea		
Vomiting		
Mucositis		
Anorexia		
Pain		
Neurosensory/motor		
Confusion/cognitive disturbance		
Fatigue		
Rash		
Bleeding		
Bruising		
Ocular/eye problems		
Palmar Plantar syndrome		
Extravasation		
Other, please state:		

Significant medical history	Current medication

Action Taken

Attending for assessment, receiving team contacted Yes ☐ No ☐

Triage practitioner

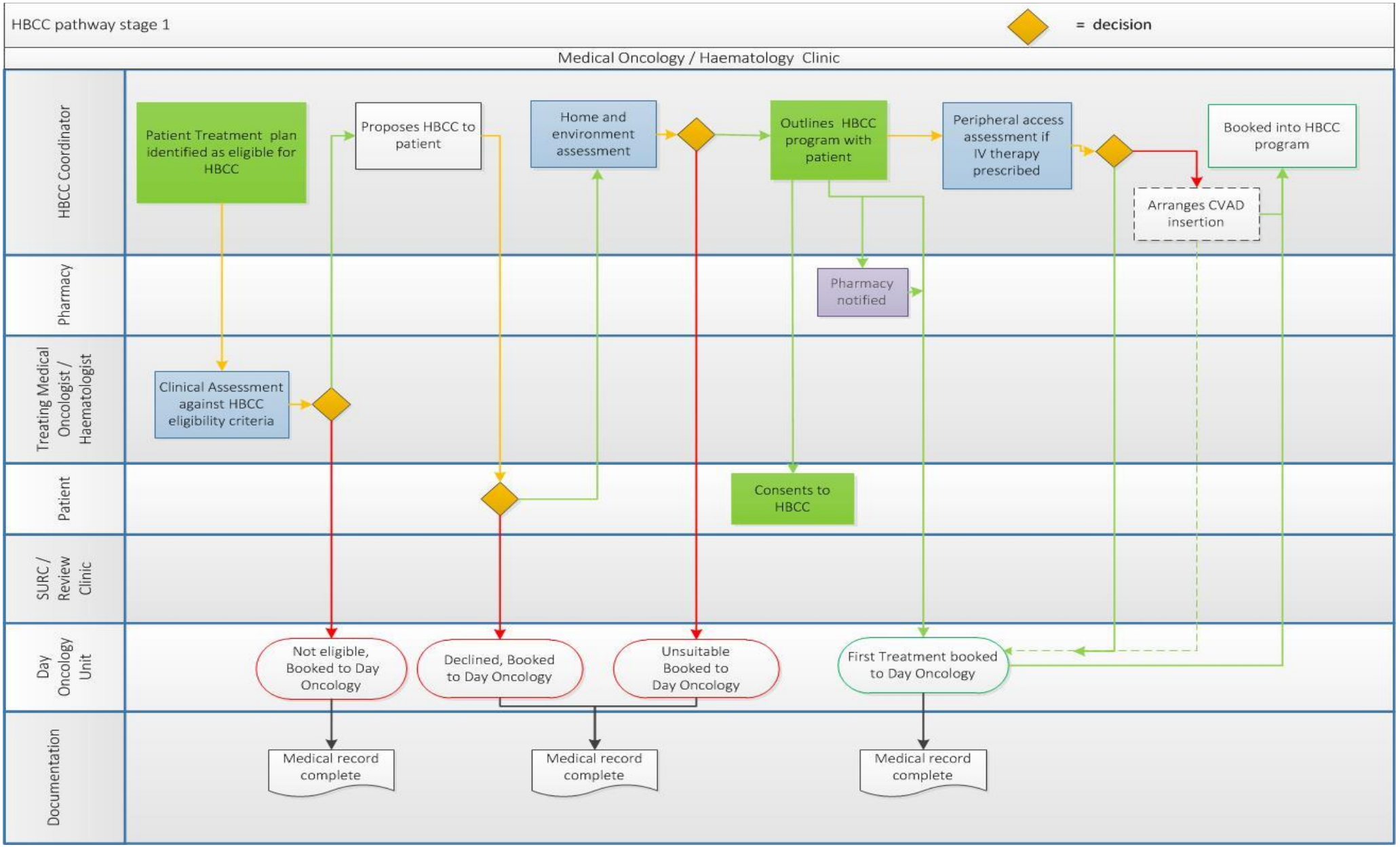
Signature..... Print..... Designation..... Date / /

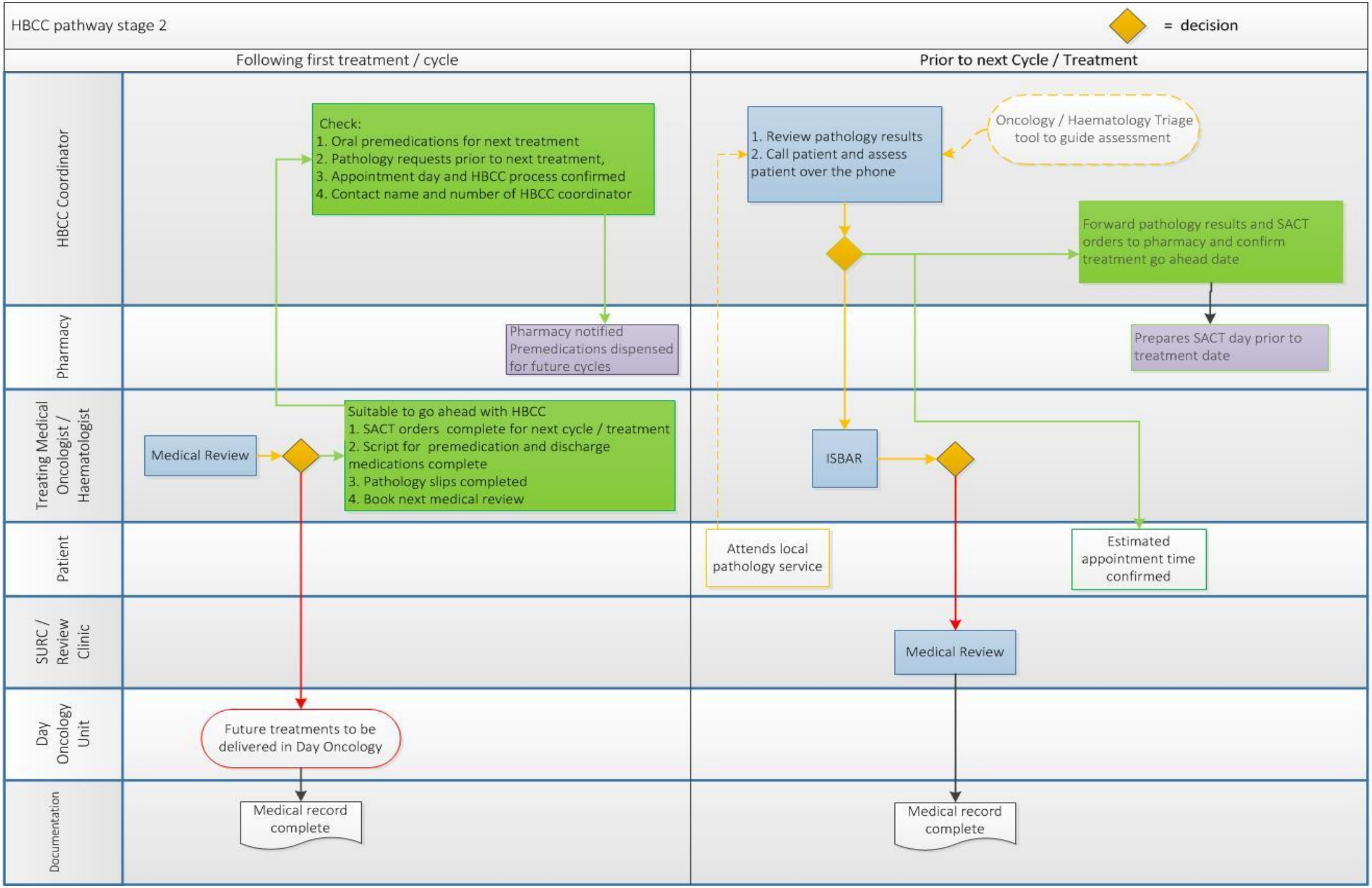
Follow Up Action Taken:

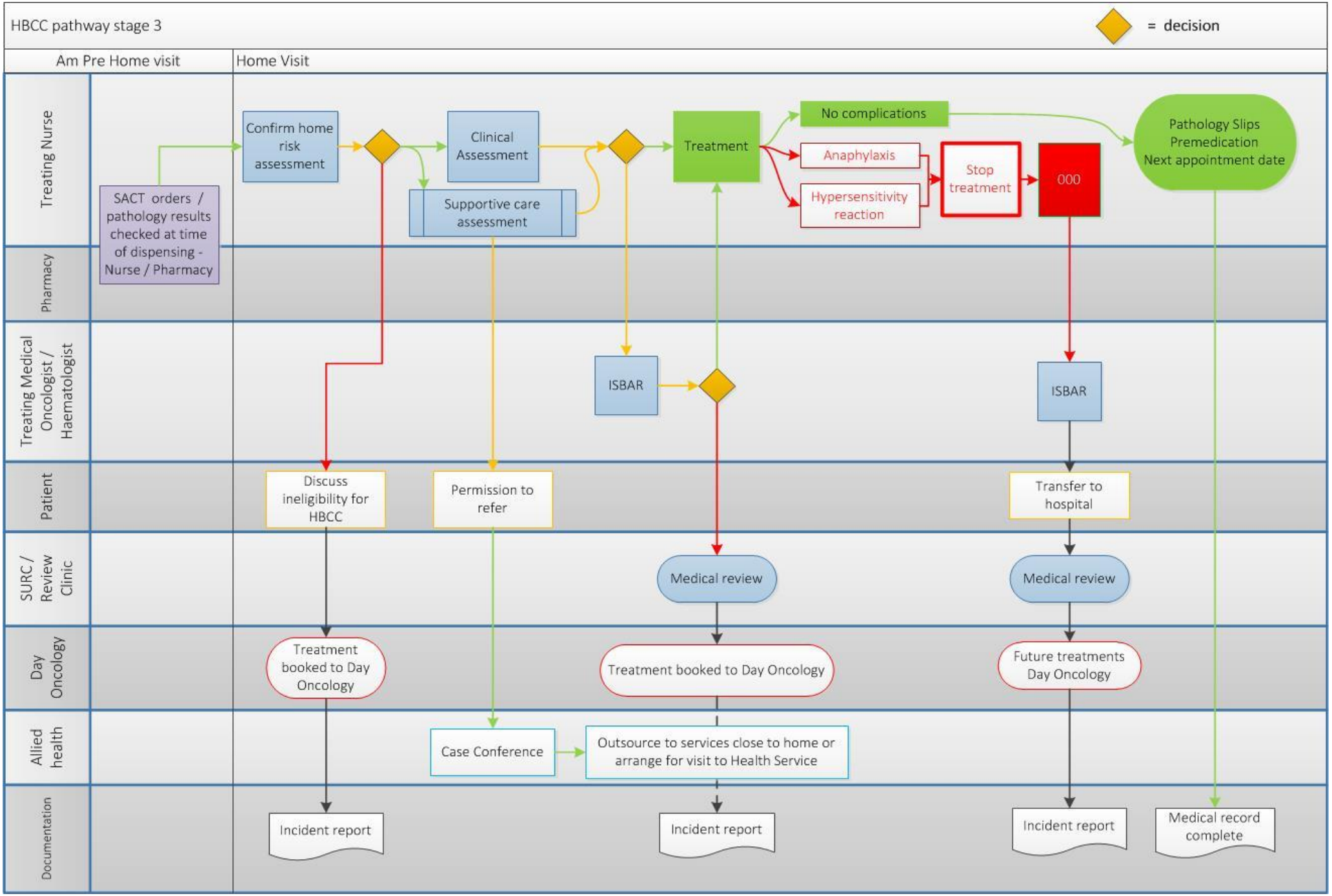
Consultants team contacted Yes ☐ No ☐ Date / /

Signature..... Print..... Designation..... Date / / Time:

HBCC pathway




HBCC pathway stage 2
= decision
Following first treatment / cycle
Prior to next Cycle / Treatment
HBCC Coordinator
Pharmacy
Treating Medical Oncologist / Haematologist
Patient
SURC / Review Clinic
Day Oncology Unit
Documentation
Check:
1. Oral premedications for next treatment
2. Pathology requests prior to next treatment,
3. Appointment day and HBCC process confirmed
4. Contact name and number of HBCC coordinator
Pharmacy notified
Premedications dispensed
for future cycles
Medical Review
Suitable to go ahead with HBCC
1. SACT orders complete for next cycle / treatment
2. Script for premedication and discharge medications complete
3. Pathology slips completed
4. Book next medical review
Future treatments to be delivered in Day Oncology
Medical record complete
1. Review pathology results
2. Call patient and assess patient over the phone
Oncology / Haematology Triage tool to guide assessment
Forward pathology results and SACT orders to pharmacy and confirm treatment go ahead date
Prepares SACT day prior to treatment date
ISBAR
Attends local pathology service
Estimated appointment time confirmed
Medical Review
Medical record complete


HBCC pathway stage 3
= decision
Am Pre Home visit
Home Visit
Treating Nurse
Pharmacy
Treating Medical Oncologist / Haematologist
Patient
SURC / Review Clinic
Day Oncology
Allied health
Documentation
SACT orders / pathology results checked at time of dispensing - Nurse / Pharmacy
Confirm home risk assessment
Clinical Assessment
Supportive care assessment
Treatment
No complications
Anaphylaxis
Hypersensitivity reaction
Stop treatment
000
Pathology Slips
Premedication
Next appointment date
ISBAR
ISBAR
Discuss ineligibility for HBCC
Permission to refer
Transfer to hospital
Medical review
Medical review
Treatment booked to Day Oncology
Treatment booked to Day Oncology
Future treatments Day Oncology
Case Conference
Outsource to services close to home or arrange for visit to Health Service
Incident report
Incident report
Incident report
Medical record complete

If you would like to know more about our Home Based Cancer Care program, please speak to your doctor or nurse.

How to contact us

To speak to a Cancer Nurse about your appointment or treatment

Phone: 03 xxxx xxxxx
After hours: 03 xxxx xxxx

How are we going?

We want to hear from you to help us improve our service.

Please call xxxx xxxx or send us a feedback form with your thoughts and suggestions.

Email: feedback@healthservice.com
Post: Health service, Victoria

HEALTH SERVICE

VICTORIA State Government

Your health care rights

The Australian Charter of Healthcare Rights is to ensure that patients and people providing care can work together to provide a safe and high quality health system.

You have the right:

◊ To health care that meets your needs.

◊ To receive safe and high quality health services, provided with expert care and skill.

◊ To receive care that respects you and your culture, beliefs and values.

◊ To be told about your treatment and to help make decisions about your care and treatment plan.

◊ To be told about any treatment costs.

◊ To expect your personal information be kept private and secure.

◊ To comment on or complain about your care and have your concerns dealt with properly and quickly.

For further information, please visit www.safetyandquality.gov.au

Your chemotherapy at home

Home Based Cancer Care (HBCC) is cancer treatment given to you at home so you do not need to travel to hospital for treatment.

Your cancer treatment might be a chemotherapy infusion or an injection. You might need a pump disconnected or have a PICC or PORT dressing.

You will continue to see your cancer doctor between treatments.

You may to choose to have all your treatment at home or have some at home and some in hospital.

How Home Based Cancer Care works

Your cancer doctor checks that it is safe for you to have treatment at home.*

Your cancer doctor will order your treatment.

A cancer nurse will coordinate your treatment appointments and visit you at home.

You can continue to attend other appointments at the hospital as you need them.

If you try HBCC and do not like it, you can return to hospital for treatment.

*It might be suitable for you to have your treatment at work or at a medical centre closer to home

What our nurse will do

- Check your blood results.
- Call you before your treatment to arrange the time for the home visit.
- Stay with you during your treatment.
- Talk to your cancer doctor if you are unwell during the home visit

What you need to do

- Give your consent to have cancer treatment at home.
- Have a blood test close to home before your treatment if needed.
- Take medication before your appointment if needed.
- A safe environment for the nurse to visit you.
- Tell the nurse if there is anything or anyone in or around your home that may harm them.
- A mobile phone or landline.
- Keep your pets in another room during treatment.
- If you have young children, ask another adult to help care for them during treatment.

Is it safe?

Yes. Cancer treatment has been safely given to patients at home since 1984.

In between visits

Cancer treatment can cause a range of side effects.

If you are unwell or are worried, please call

Phone: 03 xxxx xxxxx

After hours: 03 xxxx xxxx

The nurse may

- Give you help over the phone to manage your symptoms.
- Ask you to come into the Day Oncology Unit.
- Ask you to see your GP or go to an Emergency Department.

The nurse will also tell your cancer doctor that you called.

How much does it cost?

There are no additional costs for Home Based Cancer Care.

Abbreviations

Abbreviation	Definition
AIMS	Agency Information Management System
BD	Twice daily
Clinician	Clinician refers to health professionals who diagnoses and treats patients
CHSP	Community Home Support Program
CLABSI	Central line associated blood stream infection
CVAD	Central venous access device
DRG	Diagnosis-related group
ECOG	Eastern Cooperative Oncology Group Performance Status
eviQ	Online resource of cancer treatment protocols developed by multidisciplinary teams of cancer specialists Australia
HACC	Home and Community Care
HACC PYP	Home and Community Care – Program for Younger People
HIA	Healthcare Associated Infection
HBCC	Home-based Cancer Care
HiTH	Hospital in the Home
MBS	Medical Benefits Scheme
NACMS	Non Admitted Clinic Management System
NDIS	National Disability Insurance Scheme
Neoadjuvant chemotherapy	Chemotherapy given prior to primary treatment of surgery or radiation
PICC	Peripherally inserted central catheter
SACT	Systemic anti-cancer therapies
Specialist clinics	Acute non-admitted medical clinics regardless of the actual funding source
SURC	Symptom and Urgent Review Clinic
Tier 2	Tier 2 non-admitted service classification – national non-admitted classification system
VAED	Victorian Admission Episodes Dataset
VINAH	Victorian Integrated Non Admitted Health dataset
WASE	Weighted ambulatory service event – financial value per service provision
WIES	Weighted inlier equivalent separation – financial value per admission

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