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Hospital in the Home

Newsletter No.23 - June 1998

*From the address by **Sister CATHERINE HATTERSLEY, Wangaratta Base Hospital**, to the quarterly meeting of **The IN Group** held 13/5/98, Balwyn Library Meeting Room, 336 Whitehorse Rd.*

When Catherine was Sister in charge of District Nursing at Benalla Hospital, Hospital in the Home (HITH) was added to her portfolio which also included Palliative Care. She then set up last October the Home-Based Nursing Service at the Wangaratta Hospital. This is new in the rural area but is happening in Melbourne.

The state government provided substantial funding to start HITH in 1994 to give health care to patients in their own home. Some reasons for this move were the increasing cost of caring for patients in hospitals, the escalating waiting lists and better home living standards - lots of facilities in homes and people had cars. Another factor was the fact that a long stay in hospital put you at risk of infection.

Canada and the USA had already instituted HITH, calling it Post Acute Care. Thirty nine hospitals agreed to give a two year pilot program a go. It caused some concern; doctors wanted to know how they would still be in charge of their patients and would the nurses know how to care for them. Criteria were set out including that a patient stayed under care of their GP. If a patient was not happy with the nursing, they could go back to their GP or specialist.

In 1995/96 a consultancy were brought in to see how the program was going, particularly whether it was cost effective. There was general consensus that it was working well. A state wide survey showed 97% of the patients said they preferred to be at home. Another finding was that patients were getting better quicker - they were doing their own thing in their own home. A nurse just came, once or twice a day, gave them their injections, their dressings, looked after them. They knew we were on call.

There is still uncertainty about continued funding for the service. The state government will want to know how it will make money, now that Case Mix is the determinant. Funding is presently coming from DRGs (Diagnostic Related Groups). Patients in hospital are put in their related group. For example you might be put under Respiratory - numbers 600 to 700 - and if it is Recurrent Respiratory you could be labelled 601; over 65 with Acute Respiratory problems the number would be 602. Each Group number has a WEV (Weighting of an Estimated Value). This defines a state average. A patient can only have this weighting between Inlyers and Outlyers (the maximum length of stay). The hospital does not get money for a stay longer than this maximum.

Nurses now have to know DRGs, work out WEVs, and to tell patients that they can come on the program but can only be kept for five days, because beyond that you are not providing the hospital

any money. It is awful. Nurses try not to tell patients that; they are humane. Anyway nothing ever goes to plan.

Each year the government has to be advised of the estimated number of patients and total bed days. HITH patients are also listed as Inpatients. For example the estimate for the month of March might be 70 bed days. If this number was exceeded then the hospital got an incentive of say \$55 a bed day. If you gave a high estimate that you didn't meet you were penalised. So while we are treating people we are juggling these figures and competing against other sections - not a healthy scenario. We still don't know, even after three years, what the trends will be.

What patients would be eligible for HITH? Each hospital had its own criteria. Initially there was funding for one nurse at the hospital. So the service boundary had to be kept small say 20km. A HITH patient normally had to have a carer. For those living alone we lent a mobile phone. The environment of the home had to be conducive to good nursing, in particular electric power had to be available. The patient had to have an acceptable DRG. They had to be able to normally look after themselves, such as to shower themselves. The state government prescribed that all people had to be public patients. That was considered discriminatory so we got round this for HITH by discharging a private hospital patient and re-admitting as a public patient. The government now accepts Veteran Affairs and transport accident patients for HITH and is in the process of accepting private patients.

Another government criterion was one had to volunteer for HITH - this is in line with most actions in hospital.

What were the types of diagnosis that we treated? In the beginning it was mainly people with wounds from surgery, but not longterm which go to district nursing. HITH is an acute program or short term (meaning less than 8 weeks). They may have catheters inserted for long term antibiotic therapy. They might need monitoring three times a day, temperature and blood pressure taken, antibiotics and drugs given - all free as they are still regarded as hospital patients, equivalent to being transferred from one ward to another ward.

HITH go out and see these people, make an assessment of their home, see what the environment is like, how they are coping, can they manage at home, are they eating, can they get their meals. If not, Meals on Wheels are paid for. If the carer, looking after someone who is disabled, is the one who is sick, and normally does the housework, someone is paid to clean the house.

Modern technology has changed incredibly. There is gear that the patient wears round the waist that infuses drugs over a period. With this, the nurse only has to go to the home once a day to set up the gear. The rest of the time the patient can go to work, potter in their garden, go visiting, driving, shopping.

As regards gammaglobulin treatment such as for GBS and CIDP patients, it is a blood product for which the chance of an adverse reaction is fairly high. Because every bottle is different you have to take observations every five minutes for the first 15 minutes and every 15 minutes after that. So a nurse could be sitting in the home for a lengthy period. At present HITH doesn't have equipment to monitor that nor the facility for the patient to page if having a reaction.

A new program, the Victorian Ambulatory Centre, is being set up to run through the Alfred Hospital. The chairperson is Jackie Clayton who had set up HITHs in South Australia, then set up HITH at St Vincent's Hospital. She is particularly looking at the research because the future is to get people out of hospitals. The idea is to have people who will go to hospital for their operation, then spend their recovery at home. HITH at Wangaratta already covers as well as HITH, palliative care, post-acute care, District Nursing and therapy. People at HITH see the same nurses but wearing different hats to suit the treatment.

Some Questions & Answers

Q. Vilma Clarke reported how she had used HITH at Wangaratta with methyl prednisolone treatment for CIDP by longline catheter over five days with the nurse coming to her office for about an hour each day.

A. HITH is particularly helpful for disorders like MS where the patients have an acute phase lasting perhaps two days. After the HITH treatment the patient can then resume more normal living rather than being confined in hospital.

Q. How many hospitals have HITH?

A. This list shows 39, now there are 42.

Q. Are children treated in HITH?

A. Not so much because the carer parents are anxious to get hospital care for their children. Also most child ailments are of a few days duration.

Q. What happens to the patient who has no electricity.

A. We suggest the patient move to a more suitable location, say with a relative or friend.

Q. What is the difference in cost between hospital and HITH treatment?

A. Most hospitals say HITH is cheaper. It costs about \$300 per day to keep a patient in hospital. If we only have to make one visit a day for HITH then that is a lot cheaper. From a nursing viewpoint with HITH people get better quicker, and its is nicer and better.

Q. Nurses are able to see more patients per day in hospital than in HITH; isn't HITH less efficient in using nurse expertise?

A. Only a small proportion of hospital patients can be treated in HITH. Also the trend is that hospital patients are increasingly the elderly with multiple disorders who need hospital care.

GBS/CIDP National Awareness Day June 1st

Monday June 1st is the GBS/CIDP National Awareness Day. The Council of GBS/CIDP Support Groups of Australia is encouraging all State Support Groups and their members to endeavour to gain publicity in the media - print, radio, TV - so that the public is aware of these inflammatory neuropathies which can be so traumatic and disabling for some of its victims.

In Victoria, our Secretary **MELVA BEHR**, who is also Secretary of the Council, has been busy contacting such possibilities as TV programs "Midday", "Morning Australia" and "Burke's Back Yard". Committee member **BETTY GERRAND** has written to Geraldine Doogue who has a TV program and a column in the "Melbourne Weekly".

CATHRYN HOPE, Bioplasma Product Manager CSL Limited, has kindly invited members of The In Group to inspect the production of Intragam at their Broadmeadows factory on this Awareness

Day 10.30am - 1pm. **Members wishing to attend please obtain details from Betty Gerrand 98536443 by Saturday 30th May**

Successful Cake Selling

The fine sum of \$503 was raised in some 2 1/2 hours of selling cakes at a stall on Maling Road Canterbury on the morning of Saturday 2nd May.

Thanks must go particularly to **MARGARET LAWRENCE** who masterminded it all, well supported by those who helped man the stall and cooked for it - **MELVA, JOE & AMY BEHR, BETTY GERRAND, BETTY & DAVID GERMANO, DOUG LAWRENCE.**

Thanks too to **DOROTHY BRENNAN, BARBARA CLIFFORD, JAMES GERRAND, IRMA HANNER, ROSEMARY MACQUALTER, RAE MALCOLM & JOYCE MONTGOMERY** who donated cakes.

We hope to have an even bigger success next year with more members and friends contributing goodies.

Raffle of Bear raise \$103

Thanks, **MELVA BEHR**, for raising \$103 by raffling a Talking Bear at her Sunbury Supermarket on a Saturday morning. This is the third successful raffle of this Bear - the two previous winners, **MARJORIE AUSTIN** and **DAVID ASHTON** having generously returned their reward.

Membership

Our membership continues to grow with the total now at 261 which includes 30 interstate (10 NSW, 10 Qld, 4 Tas, 4 SA, 2 WA) and 49 overseas (1 Austria, 2 Canada, 2 Italy, 1 Japan, 5 New Zealand, 1 Philippines, 1 Slovakia, 4 UK, 32 USA).

Membership renewals for 1988/99 are due from 1/7/98 - the renewal form is enclosed.

Good Questionnaire response

Sixty-three members returned filled-in forms which is a most helpful response. The information is being put into a data base to provide a ready means of matching support.

\$3,050 Donation for Research

The IN Group donated \$3,050 to the Royal Children's Hospital Research Foundation to further the research being carried out by Dr Andrew Kornberg into GBS and CIDP. This donation includes \$50 given by Mrs Colleen Hulm of North Sydney in appreciation of help given her recently by The IN Group.

This makes a total of \$9,050 that The In Group has donated to Andrew's research, thanks to the generous support of many members.

Social Get-To-Gethers

- **Film Luncheon Wed 17th June 11am**

See a good film "*The Horse Whisperer*" (Robert Redford directs and stars) and then have a basket luncheon (fresh cut sandwiches, cream cake, tea or coffee) with fellow members and friends, all for \$10 (out of which The IN Group makes \$1.50) at the **Balwyn Cinema 231 Whitehorse Road.**

RSVP Betty Gerrand 9853 6443 by Saturday 13th June.

- **Winter Luncheon Sunday 28th June 12 noon**

For \$10 you and your friends will both enjoy a light luncheon - soup (3 varieties), chunky bread, dessert, tea or coffee - meet up with members and friends and support The IN Group.

The location this year is **Maternal & Child Health & Early Parenting Centre, 22 McArthur St, Malvern.**

RSVP Betty Gerrand 9853 6443 Wednesday 25th June.

Committee Changes

The In Group Committee is sorry to lose Deputy-Director **BARBARA STEFANOWSKI** and Committee member **TED BASARKE** who have resigned from the Committee following Barbara taking up a position in Traralgon. However we are pleased that Barbara will continue being President of the Council of GBS/CIDP Support Groups and still conduct the Dutch Auction at our November Social Luncheon.

We are glad to welcome two new members to the Committee, **JOE BEHR** and **ROSEMARY MACQUALTER**. We are looking for a new Treasurer for 198/99 as **PHYL CAMERON** will not be renominating. Thanks Phyl for helping out.

Booklet Review

Boy is this Guy Sick by **JOHN M. POLLARD**. ppbk 9pp. \$1 (\$2 inc.post).

Review by James Gerrand.

"This is one patient's story of ... Guillain-Barre Syndrome. It is not meant to be totally serious but is truthful. The important thing learnt is that no matter how difficult the experience one can always learn and gain something beneficial out of it."

The above preface to member John Pollard's saga expresses well why it is worth reading, particularly by anyone interested in understanding to some extent the trauma of a severe GBS attack.

Last Updated: 15 Oct 2007 17:49