



Challenges of cross-disciplinary management in a DGH OPAT setting

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BSAC OPAT workshop July 2022



Introduction

- Description of our current service
- Hazard points
- Brief case illustration
- Rising to the challenge

Our set up

Nurse practitioner
team
SASH@Home

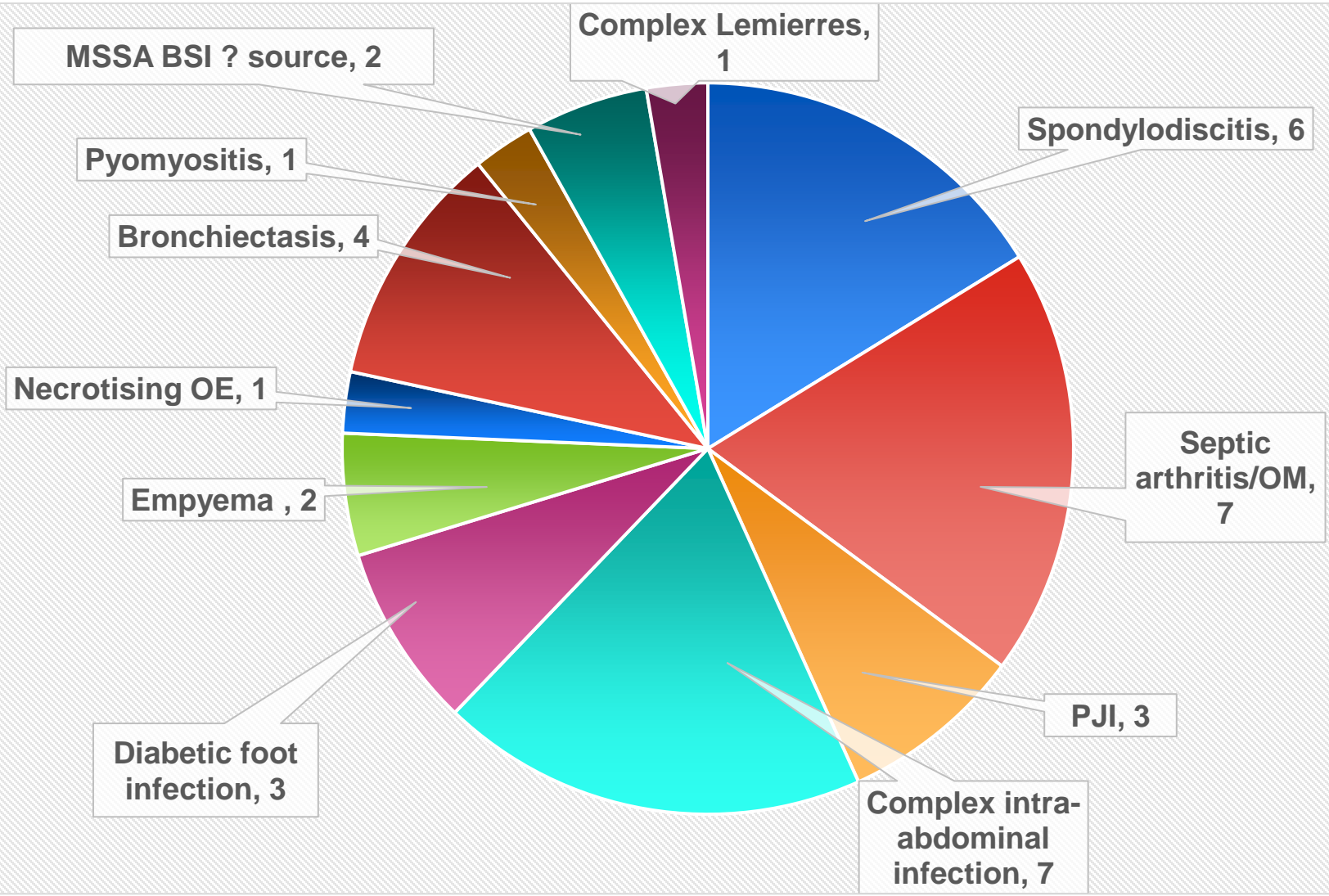


Easy Surrey Hospital
+/- 700 beds acute
secondary care



Consultant
Medical
Microbiologists

Antimicrobial
Pharmacist

Scope of activity 2022



Pathway

- Patient remains under a named hospital Consultant 
- OPAT regimen according to antibiotic policy or as agreed with duty Consultant Medical Microbiologist
- Patient meets referral criteria for SASH@Home
- PICC or midline placement 

- **At point of discharge:**
 - Documented OPAT plan – discharge summary ⚠
 - Follow up arrangements with the appropriate team in place ⚠
- **Weekly virtual review meeting**
 - SASH@Home, CMMs, Antimicrobial Pharmacist, +/- clinical team member
 - Documentation
 - Clinical teams updated with any issues/planned changes – early review arranged if required ⚠
 - Patient informed ⚠

Complexities

- 'Named Consultant' – influenced by working practice on wards and duty rotas
- Operational flow – patient movement/pressures to reduce IP LOS
- Placement of PICC or midline - timing
- Documentation of agreed OPAT regimen
- Clinic follow up/review process - more than one team?

Patient with complex infection

Case 48 yr woman

09/21 Admission 1:

O&G


- Sepsis post endometrial ablation – ESBL-*Klebs* & *E.faecalis* BSI. Also isolated from HVS and CSU sample
- 10/07 IP treatment IV Meropenem

Background

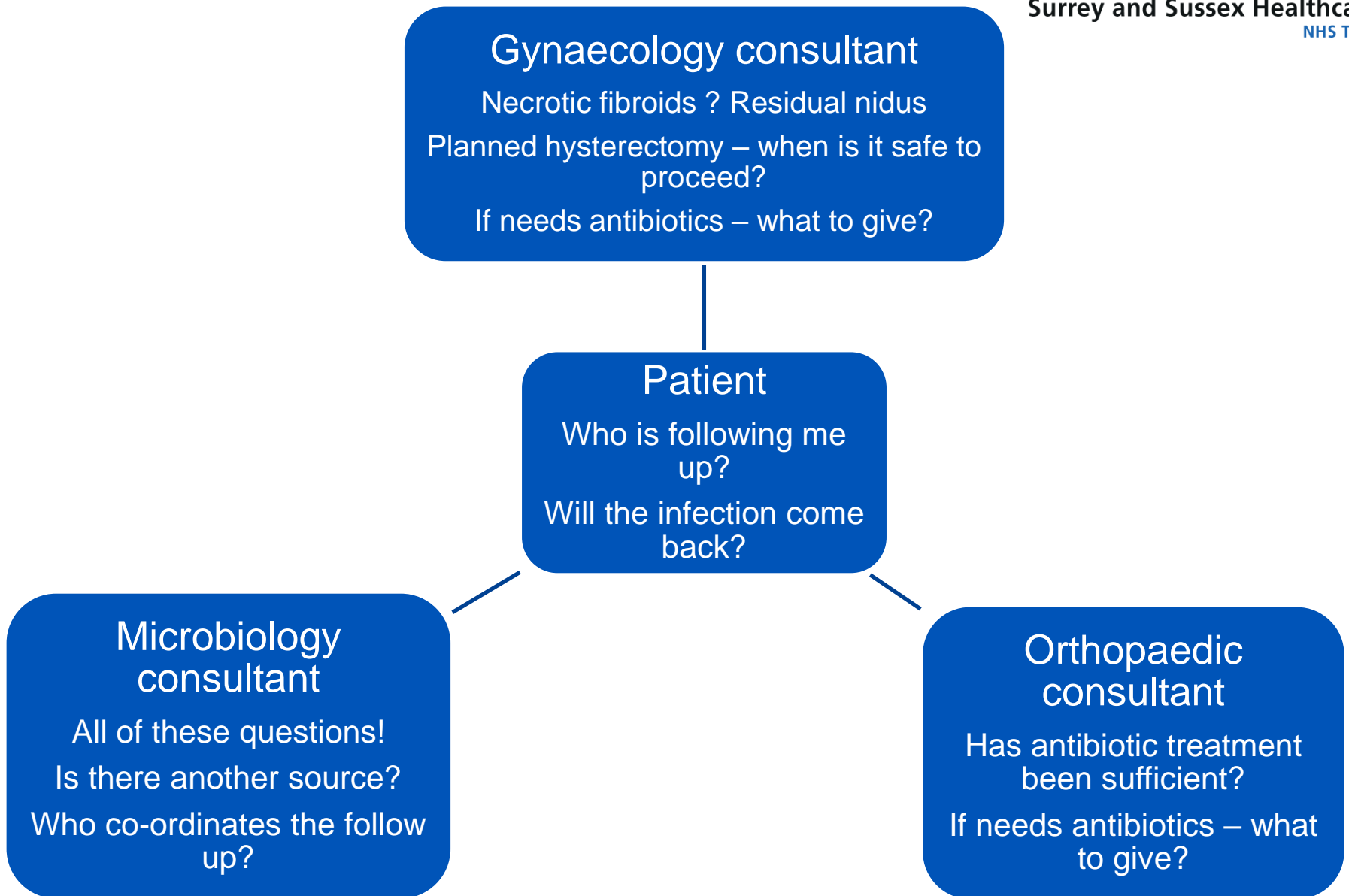
- Complex endometriosis & adenomyosis
- Long COVID
- Chronic back pain – Hx of L5/S1 microdiscectomy 06/20* - required period of ISC post op

11/21 Admission 2:

O&G with Orthopaedic ward consult

- Fever and abdominal pain – recurrent BSI – ESBL-*Klebs* & *E.faecalis*
- Infected necrotic fibroids (?nidus) and clinical/radiological discitis L3/4 with early pre-vertebral collection.
- IP Amoxicillin/Meropenem > OPAT Teicoplanin/Ertapenem
- Plan for elective hysterectomy – when would be optimal timing?
- Follow up with both teams separately – no MDT arranged 

Antibiotics curtailed at 7 weeks due to development of eosinophilia – limited alternative antibiotic options. Active monitoring and follow up



03/22 Admission 3:

O&G

- Elective hysterectomy

04/22 Admission 4:

O&G

- Abdominal and back pain with fever
- ESBL-*Klebs* BSI ?source
- ‘Outlier’ on general surgical ward
- Orthopaedic review – not O&G issue

- CMM arranged MDT discussion with O&G & Orthopaedic Consultants
- Patient updated regularly
- Transferred back under Orthopaedic care – further course of IVAs for unresolved spondylodiscitis
- Antibiotic regimen unfortunately not sustainable with current OPAT arrangements
- Has completed intended regimen – remains well and under continued Orthopaedic follow up

Rising to the challenge – ‘GIRFT’

- Close working relationship with SASH@Home team
- Operational team engagement
- Clinical engagement
 - Reinforce referral protocols
 - Trust induction & during telephonic ward consults
 - Ward Pharmacists
 - IPCNs
 - Electronic referral process – working on it
- Continue to review options – recruitment/skills expansion, collaboration with RAC, MDT arrangements
- Maintain oversight of OPAT (over)use - reviewing regimens etc

Thank you – any questions?