Governance Structure in OPAT:

Reflections from Homerton

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The Homerton OPAT Service

- Multidisciplinary service:

OPAT/ID consultants, OPAT and Vascular Access CNSs, pharmacists, microbiology, community nursing partners, admin support.

- Covers patients across Hackney and neighbouring boroughs

Picture by Dr Christian Buckingham

Why does governance matter in OPAT?

- Safe, effective care for complex infections outside the hospital
- Balance between autonomy in community settings and robust clinical oversight
- Governance is a framework ensuring accountability, safety, and quality

What do you need to establish an OPAT Governance Framework?

- Needs assessment
- Multidisciplinary governance team
- Policy development
- Risk management strategies
- Define roles and responsibilities
- Communication strategies
- Patient and Caregiver Education
- Monitor and evaluate performance
- Promote a Culture of Continuous Improvement
- Training and Development
- Document the Governance Framework
- Review and Revise as Needed

Governance Structure Overview

- Clinical governance board: overarching oversight

- OPAT steering group: meets quarterly; includes consultants, CNSs, pharmacy, microbiology, management

- Weekly MDT OPAT review: case discussion and escalation forum

- Policies & protocols: based on BSAC guidelines, adapted locally

- Audit & feedback loop: safety incidents, readmissions, line complications, antimicrobial stewardship

Roles in Governance

Pharmacy

- Ensure sufficient supply of prescribed intravenous antimicrobials and diluents until their first follow up appointment in the OPAT clinic
- coordinate further supplies of prescribed intravenous antimicrobials and diluents with the OPAT CNS and microbiology/ID consultant

Administrator

- Book OPAT clinic appointments and transport
- Stock keeping

ID/OPAT Consultants

- Devise management plan
- Prescribe medication
- Clinical monitoring
- Request and review any investigations
- Communicate with the referring consultant/GP and other MDT members

OPAT/Vascular Access CNS

- Gatekeeper for patient selection
- Clinical monitoring
- Escalation
- Data collection
- Patient advocate, provide education and support
- Coordinate care
- Insert appropriate IV line

Challenges in Governance

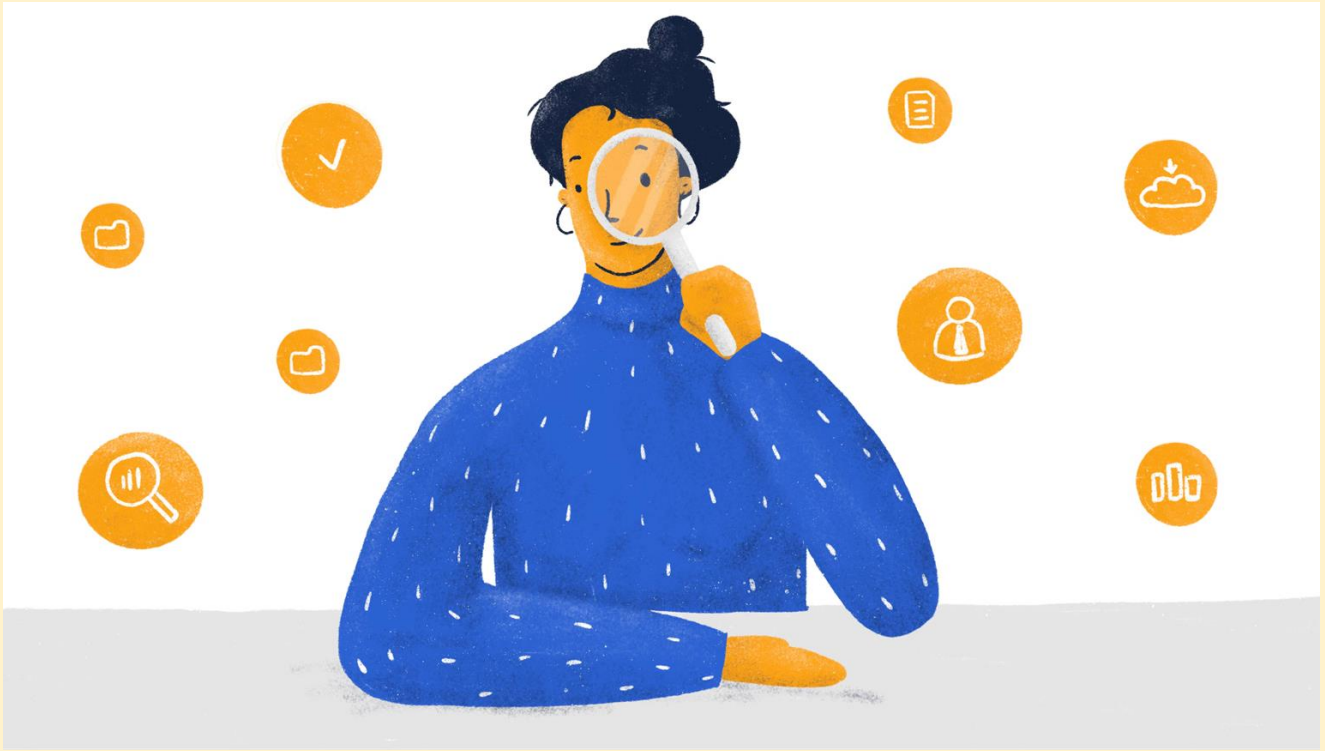
Diverse patient needs in a high-turnover urban population

Balancing autonomy with oversight in community settings

Capacity for audit and data entry vs clinical workload

Communication gaps between acute and community teams

Case Studies



Case Study 1: Medication Non-Adherence

Mr G, 54 yr old, was referred to OPAT by another hospital (Hackney resident) for treatment of for a Right infected hip post hemiarthroplasty (Group B Streptococcus).

Past medical history: Depression, insomnia, delirium, past opioid dependence and alcohol abuse.

Planned treatment: Teicoplanin IV 800 mg OD & PO linezolid for 3 months

He fails to adhere to the prescribed antibiotic regimen. He misses doses and prematurely stops the treatment due to misconceptions about the duration of therapy.

Case Study 1: Reflection

Governance Framework:

- Risk management strategies
- Define roles and responsibilities
- Communication strategies

Reflection/Outcome:

- Establish clear communication channels for external teams – we do not accept patients without a named consultant and their contact details

Case Study 2: Communication Breakdown

Mr S, 72 yr old, was referred to OPAT for treatment of Pulmonary Nontuberculous mycobacterial infection

Planned treatment: IV Amikacin 800mg OD and PO Azithromycin, Clofazimine, Linezolid

Monthly audiometry checks and ECGs arranged

A breakdown in communication occurs between the OPAT team and the patient. The patient experiences side effects (hearing problems: "people speaking with a lisp") but fails to report them promptly, assuming they are unrelated.

Switched to IV Imipenem 500mg BD, whilst being trialled for nebulised amikacin at another facility.

Case Study 2: Reflection

Governance Framework:

- Patient and Caregiver Education
- Training and Development

Reflection/Outcome:

- Patients are counselled on side effects at the beginning of treatment, ?information overload ?how much is retained
- Continuously provide education on common side effects
- Encourage open dialogue and emphasize the importance of reporting any concerns / changes even if they appear unrelated.

Case Study 3: Who is responsible?

Ms M, 84 yr old, septic arthritis of left knee, x2 washouts, declined a further washout

On IV meropenem, CRP slow to settle

Patient frustrated of being in hospital and desperate to leave, tearful.

Not willing to attend OPAT clinic due to reduced mobility.

Converted to IV ertapenem and discharged as distressed on the ward rather than based on medical grounds.

As housebound frailty team agreed to follow up to facilitate discharge with OPAT oversight.

IV line failed, community team unable to recannulate.
Community nurses raised concerns re low mood and suicidal thoughts, which they referred to community mental health team. Low SpO2, tachycardic. Rise in CRP. Missed CT appointment.
Unable to communicate with Frailty team ?had been seen, no documentation

Case Study 3: Reflection

Governance Framework:

- Define roles and responsibilities
- Communication strategies
- Document the Governance Framework

Reflection/Outcome:

- Blurred boundaries
- No longer accept shared care, patients are discharged under frailty team and they contact micro as required

Reflections from Homerton

Governance must be dynamic and adapt to service growth and patient complexity

Success lies in collaboration: consultants, nurses, pharmacists, admin, community partners and patients and their families/carers.

Regular audit and reflection strengthen both patient outcomes and team confidence

References

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Assessment tool for the BSAC Outpatient Parenteral Antimicrobial Therapy (OPAT) Good Practice Recommendations 2019

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Thank you

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