# Low Risk Febrile Neutropenia Program: Organisational Readiness Assessment

Successful implementation, evaluation and sustainability of a low risk febrile neutropenia (FN) program requires input and oversite from key stakeholders involved in the care of patients with cancer and FN. The stakeholders include medical and nursing representatives from haematology/oncology, infectious diseases (ID), hospital in the home (HITH), the emergency department (ED) and bed management, as well as pharmacy and quality improvement. Where possible, consumer representation should also be sought. A steering group that includes representatives from each of these departments should be formalised to oversee implementation and evaluation of the program.

The following organisational readiness assessment tool outlines specific items under the four domains of (i) organisation (ii) people (iii) policy and process and (iv) infrastructure that should be considered prior to and during the implementation phase.

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| **On track** | **Improvement required** | **At risk** | **Complete** | **Not applicable** |
| The current organisational state is on target for achieving a state of organisational readiness in this area to support the project effectively. | There is potential for full program benefits not to be achieved without intervention. Opportunities exist to strengthen this area within the organisation to support project activities. | The current organisational state is likely to impact the successful outcome of the project. Significant work required in this area prior to the organisation undertaking project activities in this phase. | Evidence can be provided to support the organisational readiness in this area and for the project to operate effectively. | Outlined requirement is not applicable for this quarter. |

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|  |  | **2019** | **2021** | **2022** |
|  |  | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| **ORGANISATION** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Organisational support | * All phases of the program, including implementation, evaluation and sustainability planning has executive level support
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| Governance | * Activity of the program, including number of patients treated on the program, reductions in in-hospital LOS, number of bed days saved and any adverse events will be reported to the relevant stakeholders as well as hospital executive and quality departments.
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| Specialised departmental support | * All phases of the program, including implementation, evaluation and sustainability planning has departmental support from oncology, infectious diseases (ID), hospital-in-the-home (HITH) (or equivalent), emergency medicine, pharmacy.
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| Existing training programs  | * Existing infection and FN related education provided to all departments involved in care of patients with FN (esp. oncology/haematology and ED) are available to be updated with the low-risk program recommendations.
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|  |  | **2019** | **2021** | **2022** |  |
|  |  | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| PEOPLE |  |
| Leadership team | * A steering group including medical and nursing representatives from oncology, ID, HITH, the ED, bed management, pharmacy and quality improvement has been formalised and are engaged throughout all phases.
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| Key stakeholders | * Stakeholders (including junior and senior medical and nursing staff) from oncology, ID, HITH, ED and pharmacy are aware and supportive of the program.
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| * Consumer representative/s have been identified and is engaged with the program
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| Champions of change  | * A senior nurse specialist (ideally with oncology or HITH background) has been identified that will assist in driving implementation, evaluation and sustainability of the program.
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| * A medical lead has been identified that will oversee implementation, evaluation and sustainability of the program and will supervise the senior nurse specialist.
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| * Additional ward and department champions are allocated to a role (rather than a specific person) to avoid failure of the program in the setting of staff absences
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|  | * Other as required
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| **POLICY AND PROCESS** |  |  |  |  |  |  |  |  |  |  |  |  |
| Policies and procedures  | * The low-risk FN policy and procedure has been adapted for local use

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| * Existing FN pathways and/or guidelines are updated to reflect the new low-risk program
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| * The pathway and/or guideline includes clear recommendations for HITH eligibility (irrespective of risk score), antibiotic options, daily follow up, discharge and readmission criteria.
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| * Pathway/s for readmission to hospital (or transfer from HITH to inpatient ward) are clearly documented and all key stakeholders aware. Consideration is also given to after hours.
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| * The changes are endorsed by the steering group and key stakeholders
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| Access and resources  | * For programs utilising HITH resources, consideration has been given to HITH access at short notice (<1 day) and geographical catchment.
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| * For patients managed at home on IV antibiotics: bolus or infusion antibiotics are available for administration on the same day as discharge
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| Staff education | * The change champions have received appropriate education and are aware of all aspects of the program including implementation, evaluation and sustainability phases
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| * The low-risk FN staff education package for medical and nursing has been adapted for local use
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| * There is a sustainable plan for education of all staff (medical, nursing and pharmacy) from relevant departments (HITH, oncology, ID, ED) that will ensure new/rotating staff are updated.
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| Patient education | * The low risk FN patient/carer education package has been adapted for local use
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| * The low-risk FN patient/carer education package has been reviewed and endorsed by the local consumer representative/s
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| * There is a sustainable plan for patient/carer education about the program including receiving appropriate information prior to transfer to the program
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| * Patients managed at home have clear understanding of how to re-access the hospital in an emergency both in hours and after hours. Similarly, for non-urgent queries patients are provided with clear instructions on who to contact.
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|  | * Other as required
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| **INFRASTRUCTURE** |  |
| Electronic medical record systems  | * Where relevant, electronic medical records (EMR) are updated to reflect the new pathway.
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| * Consideration is given to utilising EMR alerts to notify relevant staff of a patient’s suitability for consideration of the program.
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| * Paper based program instructions are available in all relevant clinical areas for when the EMR is unavailable.
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| Patient review  | * A suitable space has been identified for elective review of patients, as required, as well as for patients that require more urgent medical review.
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| * Consideration has been given to managing low-risk FN patients on a HITH-based program who require urgent in-hospital medical review as per standard HITH procedures
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| Monitoring safety and efficiency | * There is capacity to collect and monitor key performance indicators (KPI) for program safety and efficiency
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| * Where relevant, the EMR systems will be updated to assist in automated collection of these KPIs
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| **EVALUATION AND FEEDBACK** |  |  |  |  |  |  |  |  |  |  |  |  |
| Program safety  | * The following KPIs will be routinely monitored on all patients on the program: hospital representations and reason, hospital readmission and reason, missed infections or adverse events.
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| * A formal root cause analysis will be completed on all hospital readmissions or adverse events and reviewed by the steering group
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| Program efficiency | * The following KPIs will be routinely monitored on all patients on the program: proportion of low-risk patients on the program, in-hospital length of stay (LOS), HITH LOS and total number of bed days saved
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| Program quality of life and economic impact | * Ethics application completed to enable QOL and economic data collection
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| * There is capacity to consent patients and carers for QOL surveys
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| * Relevant patient and clinical data is collected to enable local health information systems to provide costing data
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| Feedback to staff and consumers | * Processes for regular staff and consumer feedback has been identified and program safety and efficiency KPIs are feedback regularly to stakeholders
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| Feedback from staff and consumers | * There is opportunity and process for staff and consumer feedback about the program, in particular any previously unrecognised barriers to safety and efficiency.
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| * Program documents and education are updated as required to maximise safety and efficiency
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