



Trillium
Health Partners
Better Together



The Home Infusion Toolkit is Here! Now What Do We do?

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THP Current Status – SCIG only

Large patient volume for IVIG at 3 sites

- PID, - SID, - Neurology

Patients trained and pick up elsewhere

Hamilton, Burlington, St Mikes

Patients - lost to follow up





Patient – not effective – back to IVIG

Patient – reactions – back to IVIG

Patients – 2 currently in program

THP Current Status for Home Infusion



-  Lab Procedure for Home Infusion
 - product ordering, storage, labelling, issuing, documentation
-  Physician writes order – prescription pad
 - lab gets a copy and orders from CBS
-  Patient picks up product
-  Patient reports any wastage and reaction

How does the toolkit help us?



What are our TM Requirements ?

- Policy, process, procedures
- Consent
- Training and Competency
- Notification
- Product – ordering, storage, labelling issuing, final disposition.
- Adverse Reaction reporting

IQMH VI.3 TM 157

CSA 14.7 Home Administration

IQMH VI.3



TMI57 Facility policies for home transfusion and infusion programs which comply with established standards shall be in place.
[1266]

Policies should include information about the following:

- identification of person picking up product*
- disposition of products not picked up*
- disposition of products returned - both in date and out of date*
- redistribution of products nearing expiration date*
- products received from blood supplier should be documented as received*

What's missing – Formalization!









This is a Hospital Program!

- ✘ Program - Policy & Procedure, Process, Forms
- ✘ Consent for Transfusion
- ✘ Formal Patient Agreement
- ✘ Specific Order Form
- ✘ Responsibilities of Physicians, Clinic Staff, TM
- ✘ Patient Training

What's in the Toolkit?



-  Program - Policy & Procedure, Process, Forms
-  Consent for Transfusion
-  Formal Patient Agreement
-  Specific Order Form
-  Responsibilities of Physicians, Clinic Staff, TM
-  Patient Training



How Do We Make This Toolkit Ours?



1. Draft a THP Integrated Home Infusion Program

- Transfusion Committee, Patient Service Committee, MAC

2. Assign clear responsibilities for all parties

- without any  increase in 
- Clinic bed is going to get filled up with other patients
- get buy in!

3. Revise forms with THP logo & acronyms

#3 is easy...1 & 2 not so much

Step 1

Draft the Program

- TSO
- Clinic RN
- Transfusion Committee



Title:	Master Template for Corporate Policies and Procedures
Folder Name:	//Kernel Root\Trillium Health Partners\Corporate Policies and Procedures\General Administration\Integrated
Date of Issue:	6/6/2014
Policy Sponsor:	
Next Revision:	6/6/2017

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Issues for Hospitals



Is there a specialized Clinic with nurse trainer/ monitor.

Is the Physician writing orders:

- for their patient, as a courtesy, to pick up elsewhere

Who does the monitoring for:

- clinical, infusion issues, product utilization

Patient from elsewhere is just picking up product.

Who “owns” this program?

Who monitors product utilization?



Step 2 Responsibilities



Options Addressed in Toolkit:

- Issuing TM
- MRP – Most Responsible **Person** / Designate
(MD, RN, MLT, TSO)
- RN – Trainer –internal / external
- MRP – Most Responsible **Physician** – specialist/ primary
- Patient -

Activity	Responsibility	Kit
Product pick-up	Patient is recruited, trained, assessed, monitored at a larger site	Lab P&P: -receive orders -Receive, label, store product - Issuing - who reviews log for wastage & reactions? Liaise with larger site about process
MD orders product for their patients, courtesy patients	Patient is Recruited, & monitored - Trained elsewhere. Who is checking for product wastage / reactions?	Hospital P&P (Program) Consent, training, ordering, monitoring Lab P&P product management, product utilization, adverse reactions
Full program	Recruited, trained, assessed, monitored in-house	Hospital P&P (Program) Consent, training, ordering, monitoring Lab P&P product management, product utilization, adverse reactions

Step 3 Documents Consent-Agreement

HOME INFUSION PROGRAM

Subcutaneous Immune Globulin (SCIG) Home Infusion Participation Agreement

I realize that to be successful in home infusion of SCIG I will need to complete a training program. I have read the information provided on SCIG home infusion and I understand the benefits, risks and alternatives to SCIG home infusion.

I am aware that the costs of SCI are covered by the Canadian Blood Services, but that I am responsible for the costs of the infusion supplies (needles, tubing etc)

By signing below, I agree:

1. To attend initial training sessions as required
2. To obtain, transport and store SCIG according to instructions
3. To carry out the infusions as instructed
4. To keep accurate infusion logs and to return completed logs when seeing the physician
5. To contact the Medicine Clinic if there are any concerns with my infusion technique or any questions about technique that I would like clarified
6. To demonstrate knowledge of possible adverse reactions to SCIG and how to manage them should they occur
7. To report any major adverse events immediately to Medicine Clinic nurse
8. To attend annual follow-up appointments with my Immunologist and to undergo periodic laboratory testing as required

I acknowledge that I can be withdrawn from the SCIG Home Infusion Program at any time if I fail to adhere to the above or to any other requirements of the Program. I also understand that I have the right to remove myself from this program at any time.

Patient's signature: _____

Physician's Name: _____ (print)

Physician's Signature: _____ Date: _____

Combined/separate Forms

Toolkit has examples

Product Order

If dosing is 2/week...

vials /infusion

Adjust checklist to fit
your process

Instructions to send

HOME INFUSION PROGRAM

Patient weight: _____ kg Ordering Physician: _____ ext. ____ Date: _____

Initial Request for SCIG (complete information in box below)

If this product is for training please indicate scheduled date: _____

- Primary Immune Deficiency Secondary Immune Deficiency (primary diagnosis: _____)
- Other _____

Currently receiving IVIG? YES NO If yes, monthly dose is: _____ Date of last IVIG : _____

Prescribed dose of SCIG: : _____ grams per week (dose rounded up or down to nearest vial size)

Dispense as: _____ x 5g _____ x 10g _____ x 20g _____ x 50g

Please supply: 1 month _____ 3 months _____ Other _____

CHECKLIST:



- Allergy record reviewed and updated
- SCIG information reviewed and Informed Consent Form completed
- Blood tests ordered and/or reviewed as well as health history of patient
- Training has been completed
- Documents received by the laboratory (not needed if product is for training purposes)

Annual Renewal of SCIG (complete information in box below)

Currently receiving SCIG at a dose of _____ grams per week

- Continue at same dose of _____ grams per week
- Change to _____ grams per week (dose will be rounded up or down to nearest vial size)

Please supply: 1 month _____ 3 months _____ Other _____

CHECKLIST

- Allergy record reviewed and updated
- SCIG information reviewed and any questions / concerns addressed.
- Blood tests ordered and/or reviewed as well as health history of patient
- Consent form completed. Date: _____

Signature of ordering Physician: _____ Date: _____

Send to >>>>> MRP

Pick-up Transfusion Service: _____
 Transfusion Service Phone: _____
 Product Name: _____

Patient's Name: _____
 Date of Birth: _____
 Health Card Number: _____
 Ordering Physician: _____

Date of infusion (mmm dd/yy)	Length of infusion (h = hours, m = minutes)	Site(s) used (see legend)	Volume per site (mL)	Total volume infused (mL)	Lot number(s)	Adverse reaction? (Yes/No) If yes, describe	List any medication(s) taken during infusion	Recent infection? (Yes/No) Fever (°C)

Site Legend	
R	Right
L	Left
U	Upper
Lo	Lower
A	Abdomen
H	Hips
Leg	Leg/thigh

Product Wasted Report						
Complete: If any vial is wasted (broken, contaminated) or expired due to patient error. Record and discard vial in sharps container. If vial has a manufacturer's defect (broken seal, particles or cloudy solution). Record and return vial to transfusion service.						
Date product picked up (mmm dd/yy)	Date wasted (mmm dd/yy)	Lot number	# of vials	Check (✓) one, not both		If wasted, indicate whether returned to Transfusion Service
				Wasted	Expired	

Remember to report ANY Adverse reactions or product defects immediately to _____
 Transfusion Medicine (Phone #)

Toolkit Bonus !!!



Travel letters

C1E Emergency Letter

Nursing P&P

Patient Handbook / Brochure





ORBCoN

**Thank
You**

Mahalo
Kiitos

Tack

Grazie

Obrigado

Toda

Thanks

Takk

Gracias
Merci