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

Contents

About the BSAC OPAT Good Practice Recommendations

The Outpatient Parenteral Antimicrobial Therapy (OPAT) Good Practice Recommendations (GPRs) have been developed by the British Society for Antimicrobial Chemotherapy (BSAC) as part of the BSAC OPAT Initiative. The BSAC OPAT Initiative was established to support the provision of OPAT services wherever the clinical need exists.

For more information about the BSAC OPAT Initiative visit: e-OPAT.com. This site offers a wealth of evidence based and experience-based resources that are openly available to all healthcare professionals to inform, guide and support their practice.

About the OPAT GPR Assessment Tool

The OPAT GPR Assessment tool is intended to enable OPAT service providers to identify the extent of overall compliance with the BSAC OPAT Good Practice recommendations.

Information collected by the tool informs service providers where their service is doing well, where improvements could be made, or where support is required.

The OPAT GPR Assessment Tool is made freely available to help you understand where you are now in your OPAT Service journey, and to plan and implement improvement initiatives.

How to use the OPAT GPR Assessment Tool

The tool should be used in conjunction with the BSAC Outpatient Parenteral Antimicrobial Therapy (OPAT) Good Practice Recommendations (GPRs) 2019.

The tables contain all the recommendations as listed in the current version of the OPAT GPRs.

An Excel version of the assessment tool has also been provided, which can be used as an electronic record (non-printable format) and can be found on the e-OPAT webpage.

In the first instance, record which recommendations are relevant to your OPAT service.

For relevant recommendations, additional information can be entered about current activity, any actions needed to meet the recommendation, deadlines and the names of the responsible leads.

In order to fit the recommendations into a printable word document, each of the GPR sections has been divided into three parts:

- Part 1 - Is the recommendation relevant to your service and what is the current activity/evidence supporting the recommendation?
- Part 2 – Is the recommendation met? What are the reasons if the recommendation is not met or partially met?
- Part 3 – Is there a risk associated if the recommendation is not implemented? Is there a cost or a saving associated with implementing the recommendation?

The number of relevant recommendations should be recorded alongside the number of recommendations met in the table on page 29. This will enable the percentage of recommendations met to be calculated.

It is intended that the assessment tool is completed by the OPAT service team, rather than by a single individual.

Acknowledgement

The OPAT GPR Assessment tool has been modified from a baseline assessment tool produced by NICE.

Disclaimer

This assessment tool should be used alongside the published guidance. The information contained within the tool does not supersede or replace the guidance itself.

Contact

Any questions or comments relating to the assessment tool and/or OPAT GPRs, please email: OPAT@bsac.org.uk.

Abbreviations

- GPR, Good Practice Recommendations
- IV, Intravenous
- RCN, Royal College of Nurses

1. OPAT team and service structure - Part 1

	OPAT recommendation	Is the recommendation relevant? Yes/No/Not sure	Current activity/evidence
1.1	In non-inpatient settings, IV antibiotics should be delivered within a formal OPAT service with clear pathways for early discharge or admission avoidance, in order to ensure patient safety.		
1.2	The OPAT team should have clear managerial and clinical governance lines of responsibility.		
1.3	The OPAT team should have an identifiable lead clinician. All OPAT team members should have identified time for OPAT in their job plans.		
1.4	The OPAT multidisciplinary team should include, as a minimum, a medically qualified clinician (e.g. an infectious diseases physician, internal medicine specialist, cystic fibrosis physician, paediatrician or a surgeon with an infection interest), a medically qualified infection specialist (infectious diseases physician/paediatric infectious diseases specialist or clinical microbiologist), a specialist nurse and a clinical antimicrobial pharmacist.		

	OPAT recommendation	Is the recommendation relevant? Yes/No	Current activity/evidence
1.5	A management plan (including use of standardized treatment regimens or specific patient group directions) should be agreed between the OPAT team and the referring team for each patient and this should be documented. This plan should include other relevant specialists and other possible treatment modalities, e.g. surgical or radiological intervention for source control. It should also state the treatment goal.		
1.6	OPAT teams should develop local algorithms for novel treatment strategies, for example, longer acting antimicrobials, new infusion devices, etc.		
1.7	OPAT services should consider the role of telemedicine for supporting suitably identified patients at home.		
1.8	Lead clinical responsibility for patients receiving OPAT should be agreed between referring clinician and OPAT clinician and documented.		
1.9	There should be communication between the OPAT team, the patient's general practitioner, the community team (when appropriate) and the referring clinician. As a minimum this should include notification of acceptance onto the OPAT programme, notification of completion of therapy and notification of further follow-up/management plan post OPAT.		
1.10	The written communication should be clear, multi-disciplinary (e.g. an integrated care pathway) and available and accessible to all relevant members of the clinical team at all times including out of hours.		

1. OPAT team and service structure - Part 2

	OPAT recommendation	Is the recommendation met? Yes/No/Partial	Reasons if recommendation not met or partially met	Action needed to implement recommendation
1.1	In non-inpatient settings, IV antibiotics should be delivered within a formal OPAT service with clear pathways for early discharge or admission avoidance, in order to ensure patient safety.			
1.2	The OPAT team should have clear managerial and clinical governance lines of responsibility.			
1.3	The OPAT team should have an identifiable lead clinician. All OPAT team members should have identified time for OPAT in their job plans.			
1.4	The OPAT multidisciplinary team should include, as a minimum, a medically qualified clinician (e.g. an infectious diseases physician, internal medicine specialist, cystic fibrosis physician, paediatrician or a surgeon with an infection interest), a medically qualified infection specialist (infectious diseases physician/paediatric infectious diseases specialist or clinical microbiologist), a specialist nurse and a clinical antimicrobial pharmacist.			
	OPAT recommendation	**Is the recommendation met? Yes/No/Partial**	**Reasons if recommendation not met or partially met**	**Action needed to implement recommendation**

1.5	A management plan (including use of standardized treatment regimens or specific patient group directions) should be agreed between the OPAT team and the referring team for each patient and this should be documented. This plan should include other relevant specialists and other possible treatment modalities, e.g. surgical or radiological intervention for source control. It should also state the treatment goal.			
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1. OPAT team and service structure - Part 3

	OPAT recommendation	Details of any associated risk if recommendation is not implemented	Is there a cost or saving?	Deadline	Lead Person Responsible
1.1	In non-inpatient settings, IV antibiotics should be delivered within a formal OPAT service with clear pathways for early discharge or admission avoidance, in order to ensure patient safety.				
1.2	The OPAT team should have clear managerial and clinical governance lines of responsibility.				
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	OPAT recommendation	**Details of any associated risk if recommendation is not implemented**	**Is there a cost or saving?**	**Deadline**	**Lead Person Responsible**

1.5	A management plan (including use of standardized treatment regimens or specific patient group directions) should be agreed between the OPAT team and the referring team for each patient and this should be documented. This plan should include other relevant specialists and other possible treatment modalities, e.g. surgical or radiological intervention for source control. It should also state the treatment goal.				
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1.10	The written communication should be clear, multi-disciplinary (e.g. an integrated care pathway) and available and accessible to all relevant members of the clinical team at all times including out of hours.				

2. Patient Selection – Part 1

	OPAT recommendation	Is the recommendation relevant? Yes/No	Current activity/evidence
2.1	OPAT should be part of a comprehensive infection and antimicrobial stewardship service, in order to maximise opportunities for identification and selection of suitable patients and to optimise appropriate management and minimise unintended consequences of antimicrobial therapy.		
2.2	It is the responsibility of the infection specialist to agree specific infection-related inclusion and exclusion criteria for OPAT. These should incorporate specific infection severity criteria where appropriate.		
2.3	There should be agreed and documented OPAT patient suitability criteria incorporating physical, social and logistic criteria. These should take into account additional risk factors for treatment failure, for example, co-morbidities, lifestyle issues, etc. These should be documented for each patient.		
2.4	Initial assessment for OPAT should be performed by a competent member of the OPAT team.		
2.5	Patients and carers should be fully informed about the nature of OPAT and should be given the opportunity to decline or accept this mode of therapy.		
2.6	All patients who have been assessed as being at risk of venous thrombosis as inpatients should be considered for further prophylaxis during OPAT if assessed as having ongoing risk.		

2. Patient Selection – Part 2

	OPAT recommendation	Is the recommendation met? Yes/No/Partial	Reasons if recommendation not met or partially met	Action needed to implement recommendation
2.1	OPAT should be part of a comprehensive infection and antimicrobial stewardship service, in order to maximise opportunities for identification and selection of suitable patients and to optimise appropriate management and minimise unintended consequences of antimicrobial therapy.			
2.2	It is the responsibility of the infection specialist to agree specific infection-related inclusion and exclusion criteria for OPAT. These should incorporate specific infection severity criteria where appropriate.			
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2. Patient Selection – Part 3

	OPAT recommendation	Is there a risk associated with not implementing this recommendation? Yes/No	Details of any associated risk if recommendation is not implemented	Is there a cost or saving?	Deadline	Lead Person Responsible
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3. Antimicrobial management and drug delivery – Part 1

	OPAT recommendation	Is the recommendation relevant? Yes/No	Current activity/evidence
3.1	Oral antimicrobial therapy should always be used in preference to intravenous therapy where these have equivalent efficacy unless there are other relevant factors, e.g. toxicity, lack of oral route, allergies or drug/drug or drug/patient interactions.		
3.2	The infection treatment plan should be agreed between the OPAT team and the referring clinician before commencement of OPAT.		
3.3	The treatment plan is the responsibility of the OPAT infection specialist, following discussion with the referring clinician. It should include choice and dose of antimicrobial agent, frequency of administration and duration of therapy, and where appropriate should take into account flexibility based on clinical response.		
3.4	Antimicrobial choice within OPAT programmes should be subject to review by the local antimicrobial stewardship programme.		
3.5	It is the responsibility of the OPAT team to ensure correct and continued prescription of antimicrobials during OPAT, but prescriptions may be written by the referring team under the direction of the OPAT team. Pre-agreed drug choice and dosage for certain conditions (e.g. soft tissue sepsis in the context of a patient group direction) is acceptable.		

	OPAT recommendation	Is the recommendation relevant? Yes/No	Current activity/evidence
3.6	It is the responsibility of the OPAT team to advise on appropriate follow up for toxicity, compliance and outcome monitoring for those patients recommended by the OPAT team to receive complex oral antibiotic regimens (in place of IV therapy). Follow up of such patients may be best addressed in the immediate post discharge phase through existing multi-disciplinary OPAT services working within the GPR framework.		
3.7	Prescribing for individuals within OPAT should be assessed by an antimicrobial pharmacist.		
3.8	Storage, reconstitution and administration of antimicrobials must comply with published Royal Pharmaceutical Society/Royal College of Nursing standards and with local hospital clinical pharmacy standards.		
3.9	The OPAT team, in collaboration with the referring team, is responsible for the choice of intravascular access for each patient.		
3.10	Insertion and care of the intravascular access device must comply with published RCN standards, and with local and national infection prevention and control guidance.		
	OPAT recommendation	**Is the recommendation relevant? Yes/No**	**Current activity/evidence**

3.11	A member of the OPAT team with the appropriate competencies is responsible for selection of the drug delivery device; use of these must comply with published RCN standards and local hospital guidelines.		
3.12	Antimicrobial agents should only be used in pumps or elastomeric devices if there are robust stability data meeting the standards of the NHS 'Standard Protocol for Deriving and Assessment of Stability Part 1 - Aseptic Preparations (Small Molecules)'.		
3.13	Training of patients or carers in the administration of intravenous medicines must comply with published RCN standards and should be carried out by a member of the OPAT team with the relevant competencies. Both the OPAT nurse specialist and patient/carer must be satisfied of competence and this should be documented.		
3.14	All administered doses of intravenous antimicrobial therapy should be documented on a medication card or equivalent, including doses administered out of hospital.		
3.15	The first dose of a new antimicrobial should be administered in a supervised setting. This may be the patient's own home if the antimicrobial is administered by a person competent and equipped to identify and manage anaphylaxis.		

3. Antimicrobial management and drug delivery – Part 2

	OPAT recommendation	Is the recommendation met? Yes/No/Partial	Reasons if recommendation not met or partially met	Actions needed to implement recommendation
3.1	Oral antimicrobial therapy should always be used in preference to intravenous therapy where these have equivalent efficacy unless there are other relevant factors, e.g. toxicity, lack of oral route, allergies or drug/drug or drug/patient interactions.			
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3. Antimicrobial management and drug delivery – Part 3

	OPAT recommendation	Is there a risk associated with not implementing this recommendation? Yes/No	Details of any associated risk if recommendation is not implemented	Is there a cost or saving?	Deadline	Lead Person Responsible
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4. Monitoring of the patient during OPAT – Part 1

	OPAT recommendation	Is the recommendation relevant? Yes/No	Current activity/evidence
4.1	Patients with skin and soft tissue infection should be reviewed daily by the OPAT team to optimize speed of intravenous to oral switch.		
4.2	There should be a weekly multidisciplinary meeting/virtual ward round, including as a minimum the OPAT specialist nurse, OPAT physician, infection specialist and antimicrobial pharmacist, to discuss progress (including safety monitoring and outcome) of patients receiving OPAT.		
4.3	Patients receiving in excess of 1 week of antimicrobial therapy should be regularly reviewed by a member of the OPAT team, in addition to discussion at the weekly multi-disciplinary team meeting. The frequency and type of review should be agreed locally.		
4.4	Patients should have blood tests performed at least weekly. Blood tests should include full blood count, renal and liver function, C-reactive protein (CRP) and therapeutic drug monitoring where appropriate. Other tests may be required for specific indications or therapies.		
4.5	The OPAT team is responsible for monitoring clinical response to antimicrobial management and blood investigations, and for reviewing the treatment plan, in conjunction/consultation with the referring specialist as necessary.		
4.6	There should be a mechanism in place for urgent discussion and review of emergent clinical problems during therapy according to clinical need. There should be a clear pathway for 24 h immediate access to advice/review/admission for OPAT patients and this should be communicated to the patient both verbally and in writing.		

4. Monitoring of the patient during OPAT – Part 2

	OPAT recommendation	Is the recommendation met? Yes/No/Partial	Reasons if recommendation not met or partially met	Actions needed to implement recommendation
4.1	Patients with skin and soft tissue infection should be reviewed daily by the OPAT team to optimize speed of intravenous to oral switch.			
4.2	There should be a weekly multidisciplinary meeting/virtual ward round, including as a minimum the OPAT specialist nurse, OPAT physician, infection specialist and antimicrobial pharmacist, to discuss progress (including safety monitoring and outcome) of patients receiving OPAT.			
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4. Monitoring of the patient during OPAT – Part 3

	OPAT recommendation	Is there a risk associated with not implementing this recommendation? Yes/No	Details of any associated risk if recommendation is not implemented	Is there a cost or saving?	Deadline	Lead Person Responsible
4.1	Patients with skin and soft tissue infection should be reviewed daily by the OPAT team to optimize speed of intravenous to oral switch.					
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5. Outcome monitoring and clinical governance – Part 1

	OPAT recommendation	Is the recommendation relevant? Yes/No	Current activity/evidence
5.1	Data on OPAT patients should be recorded prospectively for service improvement and quality assurance including auditing and benchmarking. A local database would facilitate this process. This information should be shared with all relevant stakeholders, including referring clinicians and general practitioners and may contribute to a national registry.		
5.2	Standard outcome criteria should be used on completion of intravenous therapy and these should relate to patient specific aims of therapy. Data on readmissions, death during OPAT, adverse drug reactions, vascular access complications and healthcare-associated infections, e.g. *Clostridioides difficile*-associated diarrhoea and *Staphylococcus aureus* bacteraemia, should also be recorded.		
5.3	Risk assessment and audit of individual processes (particularly new processes) should be undertaken as part of the local clinical governance programme.		
5.4	Regular surveys of patient experience should be undertaken in key patient groups (e.g. short-term treated groups such as those with soft tissue infection and longer-term treatment groups such as those with bone and joint infection).		
5.5	There should be an annual review of the service to ensure compliance with national recommendations.		
5.6	Each member of the OPAT team is responsible for personal continuing professional development relating to best clinical practice.		

5. Outcome monitoring and clinical governance – Part 2

	OPAT recommendation	Is the recommendation met? Yes/No/Partial	Reasons if recommendation not met or partially met	Actions needed to implement recommendation
5.1	Data on OPAT patients should be recorded prospectively for service improvement and quality assurance including auditing and benchmarking. A local database would facilitate this process. This information should be shared with all relevant stakeholders, including referring clinicians and general practitioners and may contribute to a national registry.			
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5. Outcome monitoring and clinical governance – Part 3

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Summary of Assessment

Number of relevant recommendations	
Number of recommendations met	
Percentage of recommendations met	

Date assessment completed:……..

OPAT Service Lead (Name):……

OPAT Service Lead (Signature):……