Northern Sydney Local Health District
Drug and Alcohol Service
Inpatient Drug and Alcohol Service
Model of Care

September 2022

Table of Contents

1. Introduction

The Inpatient Drug and Alcohol Service (IDAS) of the Northern Sydney Local Health District (NSLHD) is located at Royal North Shore Hospital (RNSH) and provides withdrawal management for patients within the NSLHD catchment area. The rationale for providing withdrawal management is to minimise the associated physical and psychological harm associated with withdrawing from the substance(s) (NSW Health, 2008).

The following table shows the number of admissions to IDAS by primary drug of concern, for the year January to December 2019. Data from 2019 has been chosen as it is more consistent with practice over years not affected by the Coronavirus pandemic.

Table 1: Admissions to Inpatient Drug and Alcohol Service by primary drug of concern, January – December 2019

Primary drug of concern	Number of admissions
Alcohol	325
Amphetamines, nfd*	29
Benzodiazepines, nfd*	13
Cannabinoids and related drugs, nfd*	20
Cocaine	5
Heroin	41
MDMA/ecstasy	4
Methadone	2
Methamphetamine	27
Pharmaceutical opioids, nfd*	1
Other, not specified	11
TOTAL	478

*nfd = not further described

2. Aims and Scope

The aim of this model of care is to ensure provision of health services in line with the Agency for Clinical Innovations framework of 'right care, at the right place, at the right time by the right team' (ACI, 2013) as well as the *Clinical Care Standards: Alcohol and Other Drugs*. It broadly describes how assessment and treatment will be provided by DAS to patients with substance use disorders who are admitted for withdrawal management. It outlines evidence-based and best practices for this cohort and aims to ensure safe, patient centric care with efficient use of resources.

11 of the 15 beds within IDAS are available for admissions for withdrawal management, the subject of this model of care. The remaining 4 beds will be occupied by patients being treated under the *NSW Drug and Alcohol Treatment Act 2007*. They are outside the scope of this model of care whose D&A treatment is informed by the NSW Health "*Model of Care Involuntary Drug and Alcohol Treatment Program",* however some aspects are alluded to in this model of care.

3. Guiding Framework

The guiding principles of this model are based on Australian Government policy recommendations outlined the *National Drug Strategy 2017-2026*, and the Australian *Guidelines for Treatment of Alcohol Problems* (Haber, Lintzeris, Proude & Lopatko, 2009).

Harm minimisation is the central tenet of health policy for substance use in Australia. It is a pragmatic approach based on the acceptance that substance use exists and is likely to continue. Harm minimisation comprises three approaches:

- Supply reduction: in relation to licit drugs, controlling, managing and regulating their supply; in relation to illicit drugs, preventing, stopping, disrupting or otherwise reducing their production and supply
- Demand reduction: preventing the uptake and/or delaying the onset of use of substances, reducing the misuse of substances in the community, and supporting people to recover from dependence through evidence-based treatment
- Harm reduction: reducing the adverse health, social and economic consequences of substance use, for the user, their families and the wider community

(Commonwealth of Australia, 2017)

4. Key elements of the Model of Care

The model of care for IDAS describes a comprehensive, multidisciplinary management program for people with substance use disorders. It is structured around a quality framework that is person-centred and evidence-based and which targets reducing harms from substances for the individual and community. The ideal patient journey will include the use of some or all of the following elements:

<u>Multidisciplinary interventions</u>

- Comprehensive assessment
- Brief intervention
- Controlled substance use strategies
- Withdrawal management
- Pharmacotherapy
- Psychosocial support

- Referral pathway

Aims and objectives

- Reduce harms from substance use
- Optimise access and equity of inpatient services
- Reduce hospital utilisation and healthcare costs
- Promote integration of care with other health services e.g. primary care, mental health

Documentation

- Substance use assessment using validated tools
- Documented patient centred management plan
- Withdrawal management scales
- Regular progress notes and review
- Discharge referral plan
- Prescribed pharmacotherapy

5. Difference between IDAS (Inpatient Drug and Alcohol Service) and IDAT (Involuntary Drug and Alcohol Treatment)

IDAS is a voluntary acute withdrawal management service accepting both elective and emergency admissions. It is not structured around any legal framework. In contrast, IDAT is a structured drug and alcohol treatment program provided for under the Involuntary Drug and Alcohol Treatment Act, which comprises an involuntary inpatient residential treatment component and a community based component. The involuntary residential component can last as long as three months, whereas the average length of stay for an admission to IDAS is between five and seven days. The first phase of IDAT focuses on the acute medical management of substance withdrawal and referral to other specialist medical care if required. The second phase provides a range of supportive, structured interventions to address the causes and consequences of substance use.

6. Staffing

IDAS is staffed by 19 nurses, whose grades vary from RN1 to RN8 and CNS1, and 1 health education officer (HEO) who cover three shifts, typically with 4 staff rostered on the morning and afternoon shifts, and 2 overnight. There is a full time occupational therapist, social worker and clinical psychologist, and a peer support worker, who works part time.

IDAS is staffed by 1.0 FTE (full time equivalent) resident medical officer (RMO) and up to 2.0 FTE registrars. Senior medical cover is provided by 1.0 FTE staff specialists. There is always a consultant on call providing phone advice 24 hours a day, 7 days a week.

7. Governance

Oversight of IDAS activity is by the Clinical Director, NSLHD Drug and Alcohol Services, the IDAS Nursing Unit Manager, the Drug and Alcohol Service Executive and the NSLHD Mental Health and Drug and Alcohol Directorate.

8. Referrals and eligibility

IDAS accepts both elective and emergency admissions.

- Elective admissions: patients contact the IDAS Intake Officer and complete an intake assessment, and are then booked by the Intake Officer for admission to IDAS on a specific date. To be eligible for admission, patients must be aged 18 years and over, and reside within the NSLHD catchment area, although the service may accept admissions from outside the area if extenuating circumstances are present.
- Emergency admissions: accepted through the emergency departments or as transfers from other medical teams from NSLHD Hospitals including Royal North Shore, Ryde, Hornsby, Mona Vale, from Northern Beaches Hospital, and hospitals in other Health Districts.
- For eligibility criteria and procedures around interhospital transfers, refer to Appendix 1.

9. Service delivery

Assessment, withdrawal management, post-withdrawal management/discharge planning, and management of special population groups are in line with the *NSLHD Guideline Management of Drug and Alcohol Intoxication and Withdrawal in Inpatient settings – NSLHD, NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008)*, and *NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines (2008)*.

10. Admission and orientation

On arrival to the ward, nursing staff will conduct a nursing assessment as part of the admission process. They will also conduct a search of the patient's belongings for any disallowed items. The patient will then be shown around the ward, and provided with the rules of the unit regarding behavioural expectations, smoking, phone use and expected treatment components. They will be given relevant paperwork including a ward guide.

Each shift, the patient will be given an allocated nurse who assists them with day to day needs such as medication dosing, assist with problem solving and facilitate discharge

planning. In general, this is the nurse who will complete the admission for the patient on arrival. To facilitate continuity of care where possible a primary nurse who is allocated to the same patient each day will be identified. Nurses are responsible for updating handover and documenting in eMR for their allocated patients.

Patients should be seen by either the Registrar or Staff Specialist within the first 24 hours of admission to the ward, unless admitted over the weekend, in which case they should be seen on the next working day. Patients are then seen as required by the medical team during the course of the admission.

11. Assessment

All patients admitted to IDAS should have comprehensive medical and nursing assessments on admission which include a substance use history, medical, psychiatric and psychosocial histories, physical and mental state examination, and laboratory investigations as clinically appropriate (e.g. full blood count, biochemistry, liver function, screening for blood borne viruses and sexually transmitted infections). The eMR D&A Assessment form should be completed in its entirety, which includes screening for domestic violence and child safety concerns, as well as the Australian Treatment Outcomes Profile. Admission Medication Reconciliation and Venous Thromboembolism prophylaxis screening should also be performed as part of the medical admission.

12. Withdrawal management

All patients admitted to IDAS should have regular monitoring and supportive care. Nursing observations are performed at a minimum of every 4 hours on the first day of admission, this may be reviewed as the admission progresses by the medical team as necessary. Appropriate validated scales such as the Alcohol Withdrawal Scale should be used to monitor the progress of withdrawal. A peripherally inserted venous cannula (PIVC) may be required in some instances, this should be inserted by a trained member of staff. PIVCs should be inspected daily by the medical team and on each shift by the nursing team, and removed after 72 hours (NSLHD, 2022). Pharmacotherapy to manage withdrawal such as diazepam may be appropriate and should be guided by the NSLHD and NSW Ministry of Health guidelines. It is recognised, however, that these are intended as general guides and may not be applicable to every clinical situation. The final decision regarding all withdrawal management rests with the medical team.

13. Allied health

Allied Health includes a social worker, psychologist, health education officer, occupational therapy and peer worker. They provide assessment, treatment, care planning, discharge planning and support to families and carers, and individual and group therapy as part of the

therapeutic group program. Allied health receive referrals from the medical team, nursing, from the patient and from each other. They work collaboratively with patients, nursing, the medical team and families and carers to provide patient centred care.

Social Worker

The Social Worker provides psychosocial assessment, treatment, interventions and care planning, specialist care and treatment in domestic violence, child protection, sexual assault and working with families and carers. Social Work liaise closely with the Department of Communities and Justice (DCJ) and the National Disability Insurance Scheme (NDIS), though it should be noted that NDIS related tasks are the responsibility of all staff. The Social Worker provides assessment and interventions to assist with patient's finances, accommodation and linkages with community resources. They provide referrals and advocate for supports for the patient and their family and carers.

Clinical Psychologist

The Clinical Psychologist provides specialised psychotherapy and cognitive assessments for patients accessing the Involuntary Drug and Alcohol Treatment Program (IDAT). The Clinical Psychologist provides psychological assessment, treatment, interventions and care planning. They provide one on one and group therapy sessions, such as anger management, sleep hygiene, how to manage relationships and rebuilding relationships.

Health Education Officer (HEO)

The Health Education Officers facilitate recovery groups such as the morning walk, relapse prevention, treatment options and smoking cessation. The Health Education Officer provides one on one emotional and practical support for patients day to day to complete their Activities of Daily Living.

Occupational Therapist

The Occupational Therapist provides specialist functional assessments, treatment, interventions and care planning. The Occupational Therapist works with patients' one on one and in groups to optimize their activities of daily living. They work with patients to develop meaning and purpose in their lives to live their lives as independently as possible. The Occupational Therapist provides group therapy sessions on discharge planning, implementing recovery into daily life, exploring the 12 steps and exploring emotions.

Peer Worker

The Peer Worker provides lived experience of addiction and works with patients and staff to provide care and treatment that meets the patient's needs, either one on one and in groups. The Peer Worker facilitates group sessions on smoking cessation, art and craft, a weekly BBQ and a peer based recovery group.

IDAT Care Co-ordination

In addition to the above, IDAT patients are allocated to an IDAT care co-ordinator upon their admission. Care co-ordinators include the Social Worker, Occupational Therapist, Psychologist, Clinical Nurse Consultant and Health Education Officer. To ensure continuity of care, the IDAT care co-ordinator (for the inpatient treatment component) becomes the IDAT transfer of care co-ordinator (for the community-based treatment component). The IDAT care co-ordinator provides inpatient services as required, and undertakes transfer of care/discharge planning in consultation with other members of the IDAT team from the first week of admission. The IDAT transfer of care co-ordinator role is an adjunct to local community-based treatment and support providers by following up the patient and their providers by telephone to ensure the discharge plans are being implemented and supporting the patient to make modifications as needed.
The following is a guide to the frequency of phone contact by the IDAT transfer of care co-ordinator:

- Weekly for the first few weeks. During this period, support decreases in intensity and frequency and the patient builds links and relationships with local community-based treatment and support providers.
- Fortnightly for the following two months.
- Monthly for the remaining three months.

Should the patient be lost to contact, staff are required to follow the "Clinician Response for Patients that did not attend" policy. This practice described is applicable to all patients regardless of their home location including NSLHD. Home visits, where appropriate, are to be provided by local services e.g. Mission Australia, Assertive Case Management (ACM), etc.

14. Discharge planning

Withdrawal management provides an opportunity for engagement, planning and coordination of discharge planning. Discussion should commence at the beginning of a patient's admission to IDAS. This may include any of the following:

Within NSLHD DAS

- Medical or nurse-led outpatient service
- Counselling
- Assertive Case Management service

Within NSLHD

- Referring mental health or medical team e.g. Community Mental Health Team, chronic pain

External to NSLHD DAS

- General practitioner
- Private addiction specialist
- Other Local Health District Drug and Alcohol Service, if patient lives outside of NSLHD catchment area
- Private hospital
- Self-help groups e.g. Alcoholics Anonymous, SMART recovery

- Residential rehabilitation
- Day rehabilitation programs

If a patient has had repeated failed attempts at voluntary withdrawal management and is considered appropriate for Involuntary Drug and Alcohol Treatment (IDAT), a referral to the IDAT team could be considered. Reference should be made to the NSW Ministry of Health IDAT Model of Care.

The listed GP on a patient's medical record is sent a discharge summary, which can draw on multidisciplinary input through the eDRS.

15. Special population groups

Intoxicated patients, patients with physical or mental comorbidity, elderly patients, young people, people with an intellectual disability, perinatal patients, and patients who identify as being Aboriginal or Torres Strait Islander, or LGBTQIA+ may require additional care during their admission to IDAS. Clinicians should be guided by the NSW Ministry of Health Clinical Practice Guidelines.

16. Promotion of Service

Relevant stakeholders will be made aware of this service and model of care. Opportunity for feedback will also be provided.

Updates and information on the progress and implementation of this model of care will be provided to the following groups:

- NSLHD Drug and Alcohol Service clinicians
- Staff working in Emergency Departments within NSLHD and at Northern Beaches Hospital
- Staff working in the general hospitals within NSLHD
- Staff working within NSLHD mental health services
- General practitioners
- Primary Health Network
- Drug and Alcohol Services in other Local Health Districts
- Non-government organisations
- Allied health networks and their associations

17. Evaluation, monitoring and data system

There is an expectation that DAS clinicians will collect patient related contact data for all interventions that they deliver in any setting across the service. This data will be recorded in the patient's electronic medical record and continually updated. It will assist ongoing monitoring of service accessibility and efficacy and inform service development and evaluation. To ensure the Drug and Alcohol Minimum Data Set and Australian Treatment Outcomes Profile (ATOP's) are collected, the D&A Assessment form must be completed. ATOP's are to be completed by the IDAT transfer of care co-ordinator 3 months and 6 months post discharge from the IDAS. A clinical note is required prior to discharge to close the Minimum Data Set episode of care. Patients are invited to engage in DAS annual service satisfaction surveys to evaluate the service's acceptability.

18. Risk analysis

A literature search was conducted in May 2022. The Agency for Clinical Innovation's (2013) framework on how to develop a model of care remains the most up to date and relevant. Using this framework, several risks related to implementation have been identified and assessed, along with strategies to mitigate these risks and paths for escalation where required (see Table 2).

Risk #	Description	Consequence	Mitigation strategies	Responsibility
1	Managing expectations of stakeholders regarding agreed scope of Model of Care	Lack of engagement of stakeholders	Consultation with stakeholders during development of Model of Care Ongoing dialogue with stakeholders during implementation and evaluation	Drug and Alcohol Service Executive
2	Service demand exceeding capacity	Lack of accessibility to service for patients	Graded promotion and rollout of services	Drug and Alcohol Service Executive
3	Model of Care is not sustained	Unwanted clinical variation	Ongoing quality improvement and evaluation activities, built into the Model of Care from the outset	Drug and Alcohol Service Executive

19. References

Agency for Clinical Innovation. (2013). *Understanding the process to develop a Model of Care: An ACI Framework.* Sydney: Agency for Clinical Innovation.

Commonwealth of Australia. (2017). *National Drug Strategy 2017-2026*. Canberra: Commonwealth of Australia.

Northern Sydney Local Health District. (2020). *Guideline: Management of Drug and Alcohol Intoxication and Withdrawal in Inpatient settings – NSLHD*. Sydney: Northern Sydney Local Health District.

Northern Sydney Local Health District. (2022). *Procedure: Adult Peripheral Intravenous Cannula (PIVC) Insertion and Management.* Sydney: Northern Sydney Local Health District.

NSW Health. (2008). *Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW*. Sydney: NSW Health.

NSW Health. (2008). *Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines*. Sydney: NSW Health.

NSW Health. (n.d.). *Model of Care Involuntary Drug and Alcohol Treatment Program Version 5*. Retrieved from https://www.health.nsw.gov.au/aod/programs/Documents/idat-mc.pdf

20. Appendix 1: guide to voluntary admissions

GUIDE TO VOLUNTARY ADMISSIONS TO IDAS (INPATIENT DRUG AND ALCOHOL SERVICE)

ADMISSION CRITERIA:

1. Referral from the doctor who has assessed the patient and determined the patient is in or is at risk of severe and/or complicated alcohol and/or drug withdrawal. All transfers should be done by hospital transport and not by private transport e.g. family member, taxi, etc. Patients arriving by private transport will be directed to RNSH ED.

   From Royal North Shore Hospital:
   - Directly into IDAS at any time: any ED Doctor to contact IDAS Consultant on call via RNSH switch on 02 9926 7111.

   From Hornsby Ku-ring-Gai, Ryde and Mona Vale Hospitals:
   - Directly into IDAS: only between Monday and Sunday from 8:30am to 3:00pm; ED Consultant or Senior CMO to contact IDAS Consultant on call via RNSH switch on 02 9926 7111,

   From Northern Beaches Hospital:
   - Directly into IDAS: only between Monday and Friday from 8:30am to 3:00pm to allow time for medical staff to complete admission; contact IDAS Consultant on call via RNSH switch on 02 9926 7111.
   - After hours and on weekends: potential transfers from Northern Beaches Hospital must be discussed with on call psychiatrist for Northern Beaches Hospital, who will then liaise with NSLHD DAS consultant on call via RNSH switch on 02 9926 7111. Transfer must be via RNSH Emergency Department.

   Patients being admitted from other facilities:
   - At any time, transfer via RNSH Emergency Department at the discretion of the IDAS Consultant on call.
2. Unsuitable for outpatient withdrawal management or has recently failed outpatient withdrawal management.

3. If being admitted for alcohol use disorder, blood alcohol level preferably less than 0.1%. However, if the patient's blood alcohol level is 0.1-0.3%, an admission will be considered if the patient is in alcohol withdrawal and meets all other criteria. The DAS consultant on call and RNSH MHDA After Hours Nurse Manager should discuss patient.

4. The patient must:
   - Live in the NSLHD catchment area or be of no fixed address
   - Have no restrictions regarding admission to IDAS. Referrer checks eMR and DAS consultant on call checks frequent flyer list
   - Be able to mobilise and be independent with ADL's (Activities of Daily Living)
   - Agree to an admission for withdrawal management with typical length of stay being 5 to 7 days depending on the nature of the withdrawal
   - Be aware that IDAS is a locked ward, and that smoking, vaping, mobile phones, leave and visitors are not permitted.

5. Comprehensive alcohol and drug history, examination and investigations:
   - Amount of alcohol used per day (in standard drinks), or drug used per day
   - Duration of current episode of use
   - Number of drinking/using days over the past month
   - Time to first drink/use and time of last drink/use

- History of previous complicated withdrawal including withdrawal seizure history
- Other drug use, especially benzodiazepines and opioids (risk of Central Nervous System depression)
- Assessment of current intoxication or withdrawal including relevant withdrawal scale scores e.g. AWS, COWS, and blood or breath alcohol measurement
- Assessment for signs of Wernicke-Korsakoff Syndrome
- Investigations where appropriate including e.g. FBC, EUC, LFT; and if malnutrition suspected then CMP, B12, folate.

6. Medical and surgical history, and medications – IDAS cannot manage acute medical or surgical issues including CoVid positive patients. Patients will require admission to main hospital under medical or surgical team if such issues are present.

7. Psychiatric history and Mental State Examination – IDAS cannot manage acute psychiatric issues and is not safe for aggressive or suicidal patients. The psychiatry CNC or on call psychiatry registrar is not required to review patients who are to be admitted to IDAS unless there is a clear indication of risk e.g. suicidality.

8. IVC inserted if DAS consultant on call determines intravenous thiamine is necessary