Pathway in Perth

Dr Amanda Stafford
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Royal Perth Hospital

Components of the Perth Pathway Project

- Royal Perth Hospital
- Homeless Healthcare GP practice
- Ruah Community Services

Royal Perth Hospital

- Perth's only central city hospital
- First hospital established in Perth in 1855
- Currently have ~450 beds (downsized 2015)
- ED sees 75,000 patients annually


Royal Perth Hospital
Emergency Department
ENTRANCE


SERVIO
Royal Perth
Hospital

Homeless Healthcare GP practice


Homeless
HEALTHCARE
www.homelesshealthcare.org.

- **homelesshealthcare**.org.au

- 5 GPs
- 4 Practice Nurses
- Expanding services currently
- -RPH
- -Street Health evening service 7/7

Ruah Community Services


LIVES
HOMES
A campaign to house
and support Perth's
most vulnerable
homeless people


PERTH
REGISTRY
WEEK 2016
LESS HOMELESS.

Perth Pathway

RUAH COMMUNITY SERVICES

Homeless HEALTHCARE Mobile GP

SERVIO

Royal Perth Hospital

Patient Management Plans

- Aims:
- Improve patient care
- Improve staff safety and ability to manage
- Improve use of health resources

What types?

- Previous violence/aggression/weapons
- Complex medical problems
- Complex psychosocial problems
- Drug seeking/Munchausen
- Difficult airway
- Guardianship considerations
- Vulnerable patient
- "Frequent Flyers" (over ~8 presentations in 3/12)

How do they work?

- Staff member asks for a PMP
- I review file/case manage/write/checked
- Activates at ED triage – printed out
- Background and management information
- Yearly review minimum
- Feedback
- Removed if no longer applicable/useful

PATIENT MANAGEMENT PLAN

UMRN:B******
NAME: ****** ********
ADDRESS: no fixed address
DOB: **/**/1967**

PROBLEM:

1. Frequent presentations to RPH ED: twelve between 18/12/2015- 10/01/2016.
2. Repeated episodes of aggressive, intimidating behaviour towards RPH ED staff in December 2015/January 2016 requiring removal from ED by security on multiple occasions.
3. Seeking opiate analgesia. He claims it is due to a hip injury but more likely because his MS Contin was cut off by Busy Bee pharmacy (doing daily dispensing) because of repeated episodes of presenting intoxicated and behaving aggressively. His prescriber, Homeless Healthcare GP practice will no longer prescribe opiates for him.
4. Has misused prescribed MS Contin – crushing and injecting tablets.

ACTION:

1. Alert security on arrival.
2. If he is agitated or aggressive, security staff should remain present while he is being interviewed.
3. To be seen only by senior ED medical staff. **NO RMOs**.
4. **NOT** to be prescribed, dispensed or given scripts for any opiates or benzodiazepines.
5. Refer back to Homeless Healthcare GP practice for any medication requests or non-emergency issues.
6. Not suitable for QUAC.
7. Any decision to admit him to EMW requires a risk assessment given his history of aggressive behaviour towards staff.
8. To be charged by the police for any offences committed against person or property while in the RPH ED.

CONSULTANT:

Reviewed by Dr Amanda Stafford (ED Staff Specialist) .....

Date: .....

CLINICAL NURSE SPECIALIST:

Reviewed by: Sarah Louise Moyes (NUM), Jo Wilson (CNS), Vanessa Wheeler (A/CNS)

.....

Date: .....

TOPAS ☐

PATIENT MANAGEMENT PLAN

UMRN:L*******

NAME: ***** ******
ADDRESS: No fixed address
DOB: **/**/**85

PROBLEM:

1. Drug induced psychosis.
2. Polysubstance abuse.
3. Antisocial personality Disorder.
4. Extensive forensic history including assault, robbery and sexual assault, including of his two sisters.
5. Known to carry concealed weapons.
6. Aggressive and threatening behaviour to others including family members and ED staff.

ACTION:

1. Inform security on presentation to ED.
2. To be searched for weapons by security before being allowed into ED.
3. Security to remain with patient while in ED and agitated.
4. To be cared for by male staff only in view of risk to female staff.
5. Not to be interviewed by single staff members in an enclosed environment for safety reasons. Security will normally need to be present.
6. To be reviewed early by senior staff to expedite assessment and minimise time in ED.
7. If requires ongoing care in ED, he needs to be heavily sedated to reduce the risk to staff. Liberal oral sedation eg lorazepam 5mg doses, repeated prn and a single dose of olanzepine 20mg is a good starting point. If requires forceable IV sedation will require the presence of 4 security guards.
8. NOT to be admitted to EMW because of risk to staff and other patients.

CONSULTANT:

Reviewed by Dr Amanda Stafford (ED Staff Specialist) .....

Date: .....

CLINICAL NURSE SPECIALIST:

Reviewed by: Kelly-Ann Hahn (CNS), Sarah Moyes (CNS), Gillian Wilson (CNS)

.....

Date: .....

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PATIENT MANAGEMENT PLAN

UMRN:C*******
NAME: ****** ******
ADDRESS: **********
DOB: **/**/1995

PROBLEM:

1. ****** has a complex metabolic disorder (OTC deficiency) resulting in frequent, severe decompensations into a hyperammonaemic encephalopathy.
2. Transferred from long term PMH care to RPH care on 22/04/2014.
3. Has intellectual impairment with a developmental age of 3-6 yrs old.
4. A detailed management protocol has been put in place to assist in her care and is attached.
5. Her inpatient management will be by endocrinology, AAU +-/ ICU.

ACTION:

1. Recognise the potential for rapid deterioration and the need for rapid institution of treatment as this may prevent the need for ICU care.
2. It is essential to institute treatment simply on the suspicion of her parents/carers than wait for confirmation by laboratory or deteriorating clinical status.
3. The medications required for treatment and a copy of her treatment protocol are held in boxes in the Emergency Assessment Drug Room locked cupboard marked SAS medications (below the pharmacist's computer).
4. There is a simple guide to making up the infusions on the last page of the protocol.
5. She will be for admission under AAU if well and ICU if not well.

CONSULTANT:

Reviewed by Dr Amanda Stafford (ED Staff Specialist) .....

Date: .....

CLINICAL NURSE SPECIALIST:

Reviewed by: Jo Wilson (CNS), Sarah Louise Moyes (NUM), Rachel O'Sullivan (A/CNS)

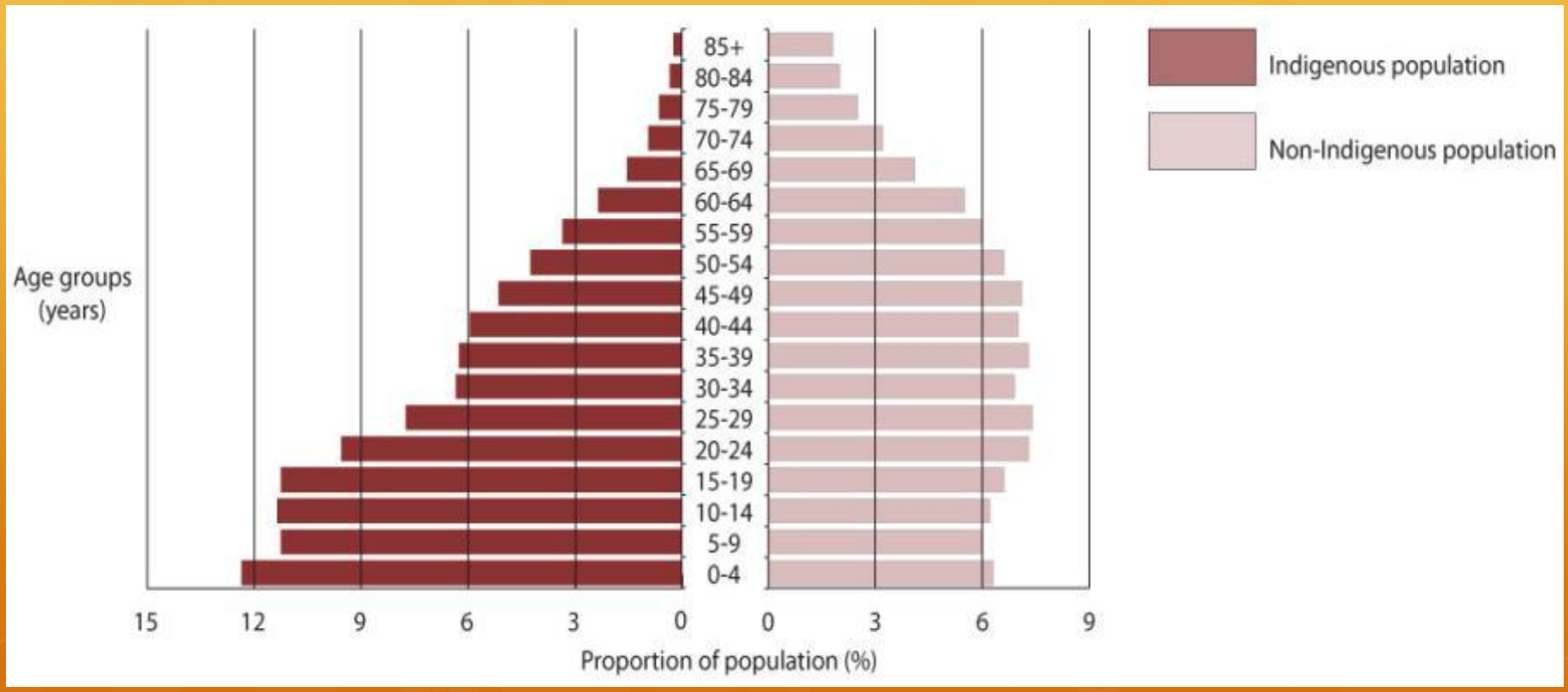
.....

Date: .....

TOPAS ☐

Aboriginal Australians


Waljen
Ngurlu
Amangu
Kalamaia
Maduwongo
CIRCUMCISION LINE
Tjeraradjal
Juat
Balardong
Whadjuk
Njakinjaki
Kalaakga
Ngadjanmaia
Pindjarup
Wilman
Njunga
Wudjari
Koreng
Kaneang
Noongar Groups


Age groups (years)
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
15
12
9
6
3
0
0
3
6
9
Proportion of population (%)
Indigenous population
Non-Indigenous population

Homeless

- Aboriginality carries a major risk of ill health, premature death, social disadvantage, contact with the justice system and homelessness

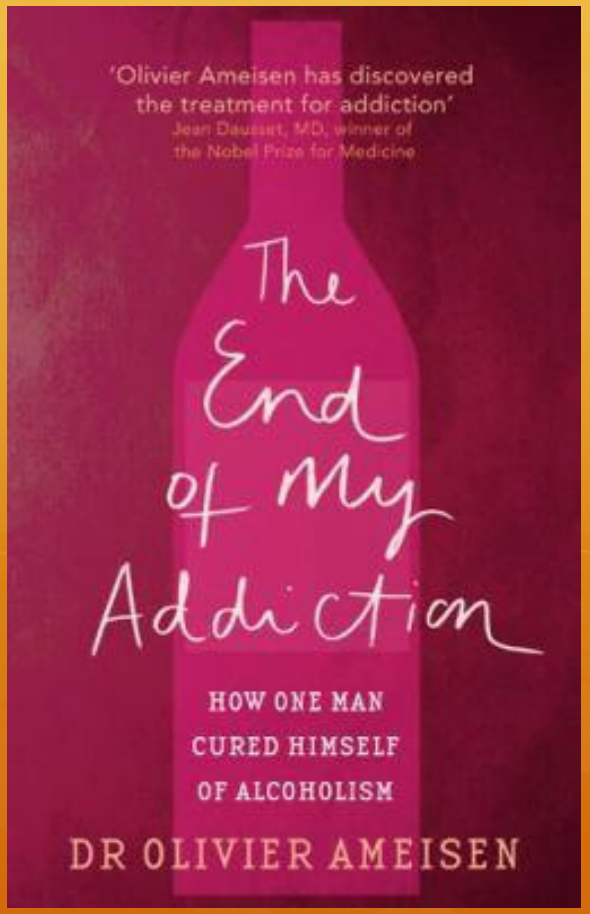
- Most disadvantaged have the trifecta:
- Homeless, Aboriginal, Alcoholic

Alcoholics

Who's drinking a lot?

	Males	Females	Both sexes
In the year 2010: In **Australia**			
Alcohol use disorders (% of 15+ population)	5.0%	2.1%	3.5%
Alcohol dependence (% of 15+ population)	2.2%	0.8%	1.5%
In the year 2010: In **United Kingdom**			
Alcohol use disorders (% of 15+ population)	16.3%	6.0%	11.1%
Alcohol dependence (% of 15+ population)	8.7%	3.2%	5.9%
In the year 2010: In **Russia**			
Alcohol use disorders (% of 15+ population)	31%	6.2%	17.4%
Alcohol dependence (% of 15+ population)	16.5%	3.3%	9.3%

Baclofen for alcoholism



- : 03 December 2012 **PSYCHIATRY** doi: 10.3389/fpsyt.2012.00103
- Suppression of alcohol dependence using baclofen: a 2-year observational study of 100 patients
- ***Renaud de Beaurepaire****
- *Groupe Hospitalier Paul-Guiraud, Villejuif, France*

	baseline	3 months	6 months	1 year	2 years
Total patients	132	100	97*	92*	87*
High risk drinking	132	**100**	27	29	25
Number on baclofen	132	100	(11/27)	(3/29)	(0/25)
Medium risk drinking	0	0	18	15	12
Number on baclofen			(13/18)	(5/15)	(10/12)
Low risk drinking	0	0	**52**	**48**	**50**
Number on baclofen			(51/52)	(41/48)	(40/50)
			*3 lost	* 6 lost * 2 died	*11 lost *2 died

BACLAD

Eur Neuropsychopharmacol. 2015 Apr 14. pii: S0924-977X(15)00102-9. doi: 10.1016/j.euroneuro.2015.04.002. [Epub ahead of print]

High-dose baclofen for the treatment of alcohol dependence (BACLAD study): A randomized, placebo-controlled trial.

Müller CA1, Geisel O2, Pelz P2, Higl V2, Krüger J2, Stickel A2, Beck A2, Wernecke KD3, Hellweg R2, Heinz A2.

More patients of the baclofen group maintained total abstinence during the 3 month high-dose phase than those receiving placebo

Baclofen 15/22, **68.2%** vs. placebo 5/21, **23.8%**

My baclofen treatment stats:

- Total Patients started on baclofen : 57
- Total patients still in treatment: 33 (58%)
- % achieving stability with baclofen : 85% (23)
- % over 6/12 Rx and not stable: 9% (3)
- % under 6/12 Rx and not stable: 6% (2)
- Reasons for not responding: brief duration treatment 38%, unable to stabilise although cravings down 17%, side effects 12%, died 12%

My website

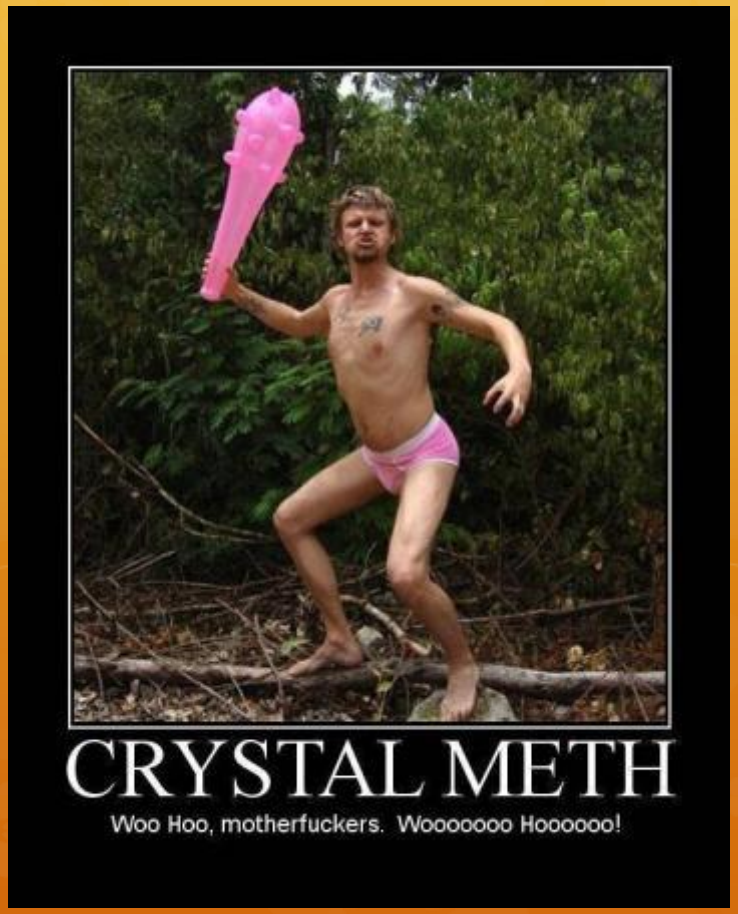
- Baclofentreatment.com

(under construction)

Search Vimeo Amanda Stafford

-webinars for the website

The menace of Meth



- Thank you
- Questions?