Department of Emergency Medicine

Royal Darwin Hospital
Northern Territory Department of Health

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Submission to the 'Ice' Select Committee

Dr James Fordyce

Deputy Director of Emergency Medicine, Royal Darwin Hospital

Wednesday 15 2015

I have been asked to outline what would be required to improve data collection regarding 'Ice' related presentations to the Emergency Department of Royal Darwin Hospital.

Current practice

Data regarding 'Ice' related presentations are currently obtained through data collection by our Alcohol and Other Drugs service and by discharge diagnosis coding.

Our chief mechanism of collecting data regarding Ice related presentations is through audit by our Alcohol and Other Drugs (AOD) unit. The Emergency Department has cover by AOD clinicians during business hours, from 0800 to 1621 hours, Monday to Friday. These clinicians see all patients presenting with issues related to substance abuse during these hours, and perform acute intervention, give advice, and arrange referral and follow-up. Patients who present out of these hours are sometimes kept in the emergency department overnight for subsequent review. Overnight observation is typically used for patients with acute alcohol intoxication requiring a period of observation/sobering up, rather than amphetamine intoxication. A system also exists for telephone follow-up after discharge of appropriate patients. Emergency visits by patients with drug and alcohol issues are considered good opportunities for intervention, so assessment by AOD clinicians during a patients stay in Emergency is our preferred option. Our AOD clinicians document individual patient records on the CCIS electronic system, which includes information on substances used, and also maintain activity databases of presentations, substances involved, and outcomes.

Our other mechanism of data collection is by discharge coding, however this method is significantly limited. Each patient has a diagnosis electronically coded upon discharge from the emergency department. The diagnosis is chosen from an extensive list of all possible illnesses or injuries. Coding is performed by the treating doctor, who chooses the single diagnosis causing presentation to the emergency department. The diagnosis is much more likely to be a consequence of drug and alcohol use, such as injury, psychosis, or other medical condition, rather than pure intoxication. The coded diagnoses, therefore, do not currently form a valid representation of presentations related to Ice or other substances. The codes also do not differentiate between various forms of amphetamine.

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Opportunities for improved data collection

Possible methods of improving data collection in the emergency department include extension of AOD cover and through modification of coding strategies.

Current AOD clinical support for the Emergency Department covers the business week, from Monday to Friday 0800 to 1621, and maintain a database as mentioned above. Patients with Ice or other amphetamine related issues often present in the late afternoon, evening, and weekend, however, limiting the utility of the current AOD service to identify, engage and intervene. Subsequent telephone follow-up is difficult in this group, due to issues with language, phone access, and willingness to engage once acute issue has resolved. Extending AOD hours from the current business hour model to an extended hours model, covering 0800 to 2400 seven day a week, would provide significantly more robust services to patients with substance abuse issues, and would provide far more accurate information regarding numbers of patients presenting, harms incurred, and outcomes.

In the long term there are also major potential benefits from improving discharge coding quality, in terms of identification of ‘Ice’ related presentations and pathology. Improved coding also has implications regarding case based funding of emergency department admissions. Integral to instituting modified coding practice, however, is a modern, flexible medical information system. The current system is effectively obsolete, and has limited utility for further modification to facilitate practice improvement. NT Health is currently undertaking the Core Clinical System Renewal Programme (CCSRP), a major body of work aiming to overhaul and effectively replace a number of currently used patient information systems with one unified system. Improved facility to document multiple diagnoses and associated conditions will be an integral part of the emergency department module of this new system, which will allow greatly improved identification and documentation of substance use and abuse. The time frame is very prolonged, however. The CCSRP commenced this year, and has a planned completion date of 2020. In the meantime achieving improved data collection through coding, using the current obsolete system, would pose major challenges, and I would not advocate this as an avenue to explore.

There has been some discussion regarding the possibility of screening in the Emergency Department for ‘Ice’ and other substances, to obtain data on prevalence of substance use within the community. The chief risk of this strategy lies in patients who need hospital care, but avoid presentation based on the fear of stigmatisation or legal implications. This can potentially lead to delayed presentation, with subsequent adverse outcomes. This is particularly likely in indigenous patients, who often have significant pre-existing reservations about accessing hospital care. Further implications of either admission of use of an illicit substance, or proof of use by body fluid testing, are multiple, involving social,

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employment, and legal reasons. Appropriate consent would be required, involving a large allocation of staff time, with little benefit in terms of emergency department acute management. For these reasons, I would strongly advise that screening in the Emergency Department setting would be an inappropriate approach.

Recommendations

Improved data regarding ‘Ice’ use related to Emergency Department presentations at Royal Darwin Hospital would best be achieved by provision of extended hours AOD clinicians. These clinicians would provide a dual role of extended service provision, and documenting ‘Ice’ related presentations far more accurately than is currently possible.

Modified strategies of diagnostic coding will form a key part of future data gathering regarding substance use, but implementation of this should be done in conjunction with the CCSRP over the next few years. Short term approaches to this problem are unlikely to be effective.

Screening for ‘Ice’ and other substances in an Emergency Department population has significant issues, and should not be performed.

James Fordyce
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