When OPAT became IPAT
A case study in individualised quality care

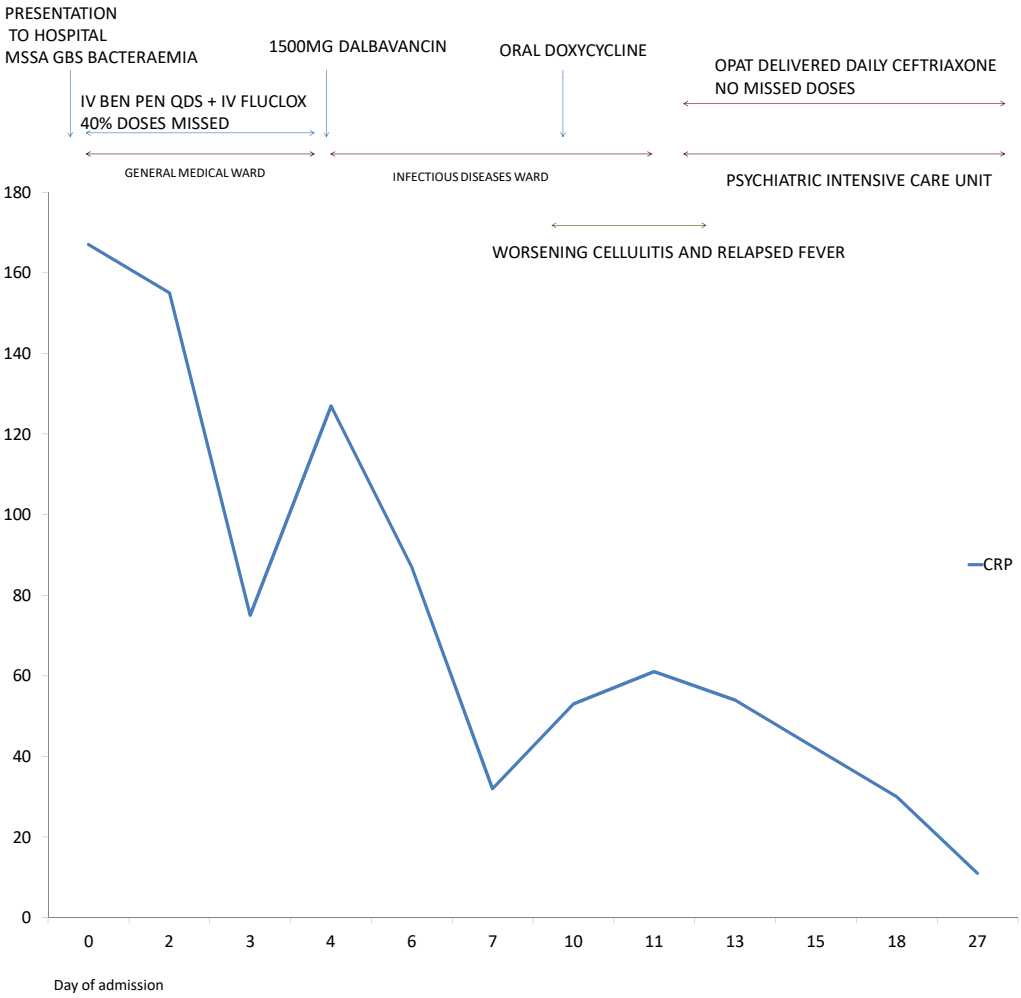
Authors:
Adams D.[1] Burton G.[1] Dickson L. Brown S. Griffin E.[1 2] Perry M. [1 2] and Mackintosh C.L. [1 2]
[1] OPAT and Medical Day Unit, St John's Hospital, Livingston, [2] OPAT Centre, Regional Infectious Diseases Unit, Western General Hospital Edinburgh,

Background

Many people who inject drugs present to acute hospital services, often with complications of drug use [1], including increased risk of hepatitis C virus (HCV) infection[2], bacterial infections, mental health morbidity and complex social backgrounds. We describe a case where despite requiring continued inpatient management of severe mental health morbidity, treatment for co-existent *Staph aureus and GBS* bacteraemia was facilitated by OPAT within the intensive psychiatric care unit in an acute hospital.

Presentation

30 year old patient
Past medical history: polysubstance use including injection drug use, previous episodes of deliberate self harm and suicidal ideation
Presents with severe back pain, fever
Blood cultures – Methicillin sensitive *Staph aureus* and group B streptococci
Evidence of disordered thinking, severe paranoia



Clinical course

Throughout admission patient displayed acute mental health distress with evidence of psychosis.
They were detained under the mental health act but declined most investigations and treatments.
They were transferred to the infectious disease unit for consideration of novel long acting antimicrobials to attempt to facilitate recovery from infection.
Despite this, management on infectious diseases ward was very challenging with worsening of mental health and worsening of clinical infection.
It was decided that ultimately management of their mental health in an appropriate clinical environment was paramount to recovery.

The patient was transferred to the psychiatric intensive care unit (PICU), where, as nursing staff in this unit were not able to administer intravenous therapy, the OPAT clinical nurse specialists attended the PICU daily to administer IV antibiotics. With management occurring in the right place for the patient, trust was gained and treatment was accepted with a good clinical recovery.

What made the difference?

By maintaining flexibility in use of our OPAT team, this complex patient was able to receive care within an environment most suitable to their care needs. By designing a patient-centred, case specific treatment plan we were able to achieve a satisfactory treatment outcome for a patient with complex needs who was unable to attend the OPAT centre or receive appropriate infection related management within the clinical unit best suited to his day to day management. Continual MDT discussion and flexibility in approach allows good clinical outcomes to be obtained in very challenging circumstances.

References
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Contact details
David Adams, OPAT/Medical Day Unit Charge nurse
David.Adams@nhslothian.scot.nhs.uk

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