Trainees Leading Change: Inaugural National Quality Improvement Conference

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Abstracts
Improving the Quality of Diabetes Management in Community Rehabilitation Psychiatry
Dr Tanya Deb, Dr Roxanne Keynejad, Dr Sri Hari Charan Thiguti and Dr Arsime Demjaha

Overview
Type 2 Diabetes Mellitus (T2DM) is associated with multiple complications in mental health patients. We aimed to assess T2DM care in the Southwark High Support Rehabilitation Team (SHSRT), South London and Maudsley NHS Foundation Trust (SLaM). We compared patient care with NICE guidelines and implemented quality improvement interventions, before reassessment.

Summary of initial findings
Thirty-three patients with T2DM were identified. 58% of patients had poor diabetic control and 9% suffered a diabetic emergency. 39% of patients had annual eye surveillance and 57% had HbA1c surveillance. Structured diabetes education was not routinely offered.

Summary of interventions and reassessment
We presented these findings to the multidisciplinary SHSRT and devised proformas for Care Programme Approach (CPA) reviews, incorporating physical health and education. We also collaborated with a local voluntary group, CoolTan Arts, to run a diabetes community education session for patients.

We reassessed care after 12 months. We found 81% of patients had received structured education (64% improvement). 94% had HbA1c surveillance (37% improvement), 94% had lipids checked (25% improvement) and annual eye surveillance in 50% (11% improvement).

Future directions
We will continue to use the CPA proforma. The team have requested further diabetes education and we recommend offering education to staff at rehabilitation placements. We have found structured education empowered patients to engage, and improved their awareness of healthy eating and exercise. We hope to present these findings at this conference to influence patient care across other UK sites.

Availability of Physical Health Equipment on Psychiatric Inpatient Wards: Quality Improvement Project
Dr Asuka Leslie, Mr Hossein Darzi, Mr Phillip Purcell, Ms Liz Jones, and Mr Chris O’Connor

What needed improving?
In the 2014-15 London School of Psychiatry survey, trainees expressed concerns that they did not always have the equipment they needed to manage the physical health of their patients.

How did I try to improve it?
I conducted an audit which supported these concerns e.g. across wards, 21% did not have a full set of routine blood bottles; 95% did not have working ophthalmoscopes/auroscopes/pen torches. I shared findings with each ward, made recommendations as to how improvements could be made and putting some interventions in place myself e.g. sending ward doctors printable Snellen charts; linking the managers of wards that had surplus equipment with those that were missing items.

Why hadn’t it improved?
Availability of physical health equipment was still an issue so I set about trying to understand why this was the case e.g. exploring how wards were organising inventory. I found that there was no consistent system across the trust.
I couldn't improve it by myself!
It was clear what needed improving and why it had not. Systems needed to change and this was not something I could do by myself! Getting the issue on the trust’s agenda was the key and came out of a combination of:

- Sheer persistence
- Finding good people in/outside my organisation
- Using the levers of influence available to me
- Increased awareness/will to address poor physical health outcomes of patients with mental illness

Examples of changes that are taking place include: a Physical Health Champion for each ward, training for ward staff on procurement/stock systems.

The Experience of a Trainee Working to Improve the Systems’ Capacity for Quality Improvement
Dr Howard Ryland

The Academy of Medical Royal Colleges’ Joint Academy Training Forum commissioned a Task and Finish Group to consider Quality Improvement training as it relates to the medical profession. The group involved key stakeholders from all four UK countries and considered four key aspects:

1. Curriculum development
2. QI training
3. Mapping resources and ways of delivering inter-professional education
4. Supporting infrastructure

The group’s recommendations [http://www.aomrc.org.uk/committees/quality-improvement-training-for-better-outcomes.html](http://www.aomrc.org.uk/committees/quality-improvement-training-for-better-outcomes.html) are designed to provide a robust framework for embedding improvement methodology as a core competence in all doctors. The overarching aim is to create an increased capacity across the workforce in order to allow healthcare teams to have a positive impact on the delivery of safe and effective patient care.

I will describe my own experience of being a trainee who was involved in this work through my role on the Task and Finish Group, representing the Academy of Medical Royal Colleges’ Trainee Doctors’ Group. This afforded me a fascinating insight into the challenges of working at a national level to ensure that systems are in place to allow trainees to gain the necessary skills in quality improvement.

Quality Improvement in Action: developing quality improvement skills in psychiatry
Dr Clare Trevelyan, Dr Liz Ewins, Bridget Kelly, and Dr Steve Arnott

Quality Improvement (QI) is increasingly at the forefront of postgraduate professional skills development, after the 2013 Francis report highlighted a need for a culture of collective leadership, and trainees as important agents of change. In 2014 Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Medical Education team developed a QI programme, offering trainees resources, training, project supervision and coaching. Collaboration with the Trust Quality Academy and Integrated Governance Group has led to coordinated project governance procedures. Prior to this programme, no trainees in AWP were involved in QI projects. Between 2014-2016 76% core trainees and 60% of advanced trainees have now been involved in QI, and it has become embedded in Severn School of Psychiatry ARCPs. Trainee projects have focused on improving safety, efficiency and patient experience, driven both from a grass-roots level and helping address Trust and Deanery level Quality priorities. Trainees have achieved national publication and poster prizes, and feedback indicates high trainee engagement and enjoyment. There has been an impact on culture and senior engagement, with increasing numbers of senior doctors and the MDT involved in QI. It is hoped that this programme will help develop medical leadership with a sound understanding of effective improvement methodologies.
The right result at the right time – Targeting blood sample transport time to optimise timely receipt of blood result
Dr. Adam AJ Al-Diwani, Dr. Daniele Saville-Tucker, Dr. Lisa Ridings and Dr. Gail Critchlow

Introduction
Inpatient psychiatric treatment requires rapid blood result turnaround. For historical reasons psychiatric hospitals are often distant from laboratories, necessitating sample transportation. This is associated with frequent handover of pending blood results. This was not only time consuming, but also put patients at risk of unnecessary further investigations and treatments.

Plan
Quantitative analysis of handover documentation and a qualitative survey of doctors’ experiences concluded that optimising the return of results in working hours was crucial.

Do
Liaison with the Trust works department established that a local provider was transporting samples at 8AM, 10AM, and 3PM, leading to most being transferred at 3PM, causing out-of-hours results.

Feedback from the Trust, matrons, and medical directors, concluded that moving the delivery times was sensible. A timely renegotiation of delivery contract incorporated our recommendations.

Study
A new, more frequent, and appropriately timed delivery schedule is starting. We will repeat quantitative and qualitative analysis after 1 month.

Act
We are optimistic but will likely proceed to a further PDSA cycle reviewing guidelines for urgency of sample review. This project has demonstrated the value of identifying key nodes in a process and involving key stakeholders to improve quality for service providers and users alike.

Completion of physical examination on admission to CAMHS inpatient service
Dr Natalie Ashburner, Dr Manu Padda and Dr Linda Cullen

This re-audit was carried out to review completion of a recently created physical examination tool which should be completed within 2 weeks of admission. The aims and objectives were to review changes made to the physical examination form, assess compliance of form completion and to see if changes made after the first audit have improved completion and recording of physical examination form. The form was created using guidance from the GMC, RCPsych OP67 report and MARSIPAN risk assessment framework. Data was collected on 29 inpatients across 3 CAMHS wards in July 2014. Much improvement was seen in the re-audit, with improved documentation of consent, capacity assessments, inspection, observations and examination including cardiovascular, respiratory, abdominal and neurological in the re-audit compared to the original. Areas identified for improvement were BMI and waist measurements, Gait, Exercise and last menstrual period. Recommendations for improvement were to ensure that all physical examination forms are stored in the same place in each person’s file to ensure easy retrieval. To check that the physical examination form has been completed at the first CPA review. Ensure that all equipment needed is available on each ward and audit the availability of this equipment. Edit the form to include sections for ECG, blood tests and other investigations.
The evolution of the handover list  
*Surg Lt Luke Baker, Dr Matthew Kube-Clare, Dr Natasha Newlands and Dr Tony Davies*

**Background**  
With increasing changeover between medical teams, having an effective means of handover is imperative to maintaining high quality patient care. This quality improvement project is a study of how a combined handover list evolved, and discusses possible future improvements to enhance patient care.

**Objective**  
To design a handover list that would improve patient safety and continuity of care.

**Methods**  
Junior doctors compiled ideas for a handover list based on designs used in other disciplines and adapted them for an acute inpatient psychiatry ward. The design evolved in the two weeks following its introduction. Junior doctors working on the unit were audited before and after the introduction of the handover list.

**Results**  
Our newly developed handover list has led to improved handovers, enhanced patient care, more accurate discharge summaries and reduced workload for the clinical team. 100% of doctors felt that team handovers were more efficient and safer when using the handover list. For example, listing section expiry dates and upcoming tribunal dates has helped with planning further mental health act assessments and with report planning.

**Conclusions**  
A well designed, concise handover list promotes the efficiency of the ward team leading to increased satisfaction of junior doctors and improved patient safety.

Initiation and evaluation of a physical health clinic to improve monitoring of patients receiving antipsychotic medication at the Waltham Forest Home Treatment (Crisis Resolution) Team  
*Dr Tracy Barry, Dr Ken Anakwue, and Dr Bill Travers*

**Background**  
Patients who have serious mental illnesses have increased rates of mortality due to poor physical health. Patients who are receiving antipsychotic medication need physical health monitoring to detect and treat metabolic side effects.

**Method**  
Physical health measures of patients who were receiving antipsychotic medication from the Home Treatment (Crisis Resolution) Team in Waltham Forest as part of North East London Foundation Trust were studied. Physical health measures included vital signs, body mass index (BMI), bloods tests and ECGs, based on recommendations from the Royal College of Psychiatrists. The preliminary recording of measures was conducted in January 2014. A weekly physical health clinic was established, staffed by a nurse and a doctor. Physical health clinic measures were reassessed in January 2016.

**Results**  
Following the establishment of the physical health clinic, physical health measures were recorded more frequently. BMI measurement increased from 15% to 73%. LDL and HDL blood testing improved from 20% to 63%. Monitoring of random blood glucose improved from 30% to 73%. Patients having ECGs completed improved slightly from 55% to 63%. Blood pressure was previously well recorded at 75% and improved further to 93%.

**Discussion**  
There has been an improvement in documentation of physical health measures since the establishment of the physical health clinic. However, the effectiveness in terms of improving patient outcomes is still to be evaluated. The clinic will also need to be evaluated in terms of resources utilization and patient experience.
**Welford Wards “Dragons Den” – A novel multidisciplinary team approach to improving patient care**  
Dr Kirsty Bates and Dr Hari Subramaniam

**Introduction**  
Quality improvement projects are an important part of our role as healthcare professionals, but can often be laborious and mundane. We wanted an innovative project to improve care on our old age psychiatry ward and so held a multidisciplinary team building day, which included a “dragons den” style activity in the afternoon with thanks and acknowledgement to the BBC show.

**Methods**  
We asked patients how they thought their stay on the ward could be improved based on accommodation, activities, services and enjoyment which were then communicated at the event. Staff were split into groups and had to come up with an idea to pitch to the “dragons” (consultant, matron and managers) for “virtual money” so that they could use it to improve an aspect of the ward based on the feelings expressed by the patients.

**Results**  
Ideas pitched targeted mealtimes, sleeping and activities which were the main areas patients would like to see an improvement in. Suggestions included: staff eating with patients at mealtimes to improve therapeutic relationship, monthly “themed” buffet meals, patient/carer suggestions box and soft closing doors to aid sleep disturbance at night.

**Conclusions**  
In one afternoon, using a novel approach to quality improvement, we have come up with simple suggestions which can easily be implemented on the ward in the short term to improve the patient experience which we would need to research further to see if this is sustained in the long term. This activity instilled a sense of ownership, morale and improved engagement of ward staff.

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**Improving handover between triage and treatment wards**  
Dr Louisa Bird, Dr Kate Ordish, Dr Alice Debelle, Dr Thomas Reily, Dr Tony Davies, and Dr Lindsay Solera-Deuchar

**Introduction**  
This project aimed to improve the quality of handover between junior doctors upon transfer of patients from triage to treatment wards. Prior to this project, there was no formal system of handover, with outstanding tasks and patient safety issues not explicitly recorded in patient notes.

**Methods**  
Doctors on recipient wards were surveyed. 100% said that they did not receive handovers for the majority of patient transfers. All rated the adequacy of handover at 3/5 (5 being adequate) and only 33% rated ascertaining which jobs were outstanding at 4/5 or 5/5 (5 being very easy). Information was collected regarding opinions on the ideal format and content of handover.

Using this data, a new system of handover was designed, in which doctors on the triage ward recorded a handover entry on the electronic patient record, using a set template.

**Results**  
3 months following implementation, doctors on the treatment ward were resurveyed. 100% reported receiving handovers for the majority of patients (previously 0%) and 100% rated the adequacy of handover at 4/5 or 5/5 (previously 0%). 100% rated the ease of ascertaining which jobs were outstanding at 4/5 or 5/5 (previously 33%).

**Conclusions**  
We implemented a handover system which promotes better teamwork and safety when patients are transferred. The new handover system was informed by a survey of ward-based doctors and demonstrated a clear improvement in the handover process. This quality improvement project may be beneficial for other hospitals using the triage ward model.
**Are community depot prescriptions regularly reviewed?**

*Dr Susannah Bond and Dr Megan Roberts*

**Introduction**

In Southern Health, community depot prescriptions must be re-prescribed every six months. This audit sought to identify whether they were being appropriately reviewed. A secondary aim was to identify whether physical health monitoring was being carried out, given results may influence the outcome of each review.

**Methods**

All depot prescription cards were reviewed and corresponding electronic record scrutinised. Hampshire Health Records were searched for evidence of physical health monitoring.

**Results**

Regular reviews of medication of patients prescribed depot antipsychotic medications are being carried out for the majority of patients.

The reviewing clinicians usually do not personally re-prescribe or make changes to the depot prescription charts. In most cases the review does not lead to a change in medication and the same prescription is to be continued. Where changes are recommended these are not always being communicated and this has led to prescribing errors.

The recommended physical health monitoring was incomplete in 95% of cases.

**Recommendations**

For improved communication between reviewing clinicians and practitioners administering the depot medications to ensure that changes are noted and reflected on prescription cards.

Physical health monitoring requires closer working between CMHTs and GPs – some monitoring could be completed by the community team themselves.

**‘Pooling resources, Improving care – Service Evaluation of a city-wide pilot scheme centralising referrals across adjacent localities in Bristol, England; reducing waiting-times to input from tertiary Child & Adolescent Mental Health Services in urgently referred patients with self-harm’.*

*Dr James Bowler and Dr Melanie Merricks*

**Background**

In July 2014, House of Commons Health Committee report ‘Future in Mind’ identified ‘serious ... problems with ... commissioning and Provision of Children’s and adolescents’ mental health services...from prevention and early intervention ... to inpatient services ...’

Reducing delay-time between initial referral for urgent assessment following self-harm from Primary and Secondary services and first assessment by tertiary CAMHS service is important in this. We decided to assess impact of a city-wide cross-locality pilot scheme that had just been commissioned on reducing waiting times as aimed and on quality of initial tertiary assessment. The scheme, Central Intake Team (CIT), pooled incoming referrals as first point of triage and contact with CAMHS and offered urgent assessment and management.

**Methodology**

We audited caseload patients in one locality at two time-periods – pre- and post-CIT commencement. One-off review of patient records. We adapted the NICE auditing tool in longer-term management of self-harm against NICE guidelines in Needs Assessment. Clinical auditing done on patient cohort with self-harm as primary reason for referral, marked as urgent by referrer, who were taken on by the locality team and also assessed as urgent by the team. Ten patients referred pre- (January to March 2015); ten post-CIT (April to June 2015) - chosen chronologically. Latter cohort assessed initially by CIT – this being taken as first input by CAMHS. Three patients pre-CIT; 4 post- were reassessed as ineligible – e.g. referral rejection, loss to follow-up, referral to outside service.
Results
Strong clinical evidence of reduction in waiting-time between referral and first appointment after CIT including clear improvement in quality of first assessment. Reduction from median of 36 days to 6.5 days (U score 9; hospital and GP referrals). Reduction from 36 days to 1 day when including only hospital-originating referrals. Evidence of improvement in assessment of physical health (33% to 50%), genogram (50 – 67%) and differential mental disorders (67 to 100%) post-CIT creation.

Conclusions
Evidence shown of clinical efficacy in reducing waiting times between primary/secondary and tertiary assessment in self harm in children. Likely value in assessing with larger cohorts in localities where there is a pre-existing poor performance against waiting list targets to assess improvement further and to support cost-effectiveness of CIT. Sample size and variation in locality waiting list length will need addressing in larger investigations. Study shows the balance of interpreting clinical versus statistical effect in small cohort studies of service evaluation. Evidence as here has contributed to CIT scheme being extended from the pilot due to clear benefit and CIT has been adopted by neighbouring Trust.

Navigating the murky waters of shifting physical health guidelines: Examining the use of QRISK2 and the prescription of statins in Medium Secure Forensic Unit
Dr J D Butler-Meadows and Dr T Barton

Background
The National Audit of Schizophrenia (2014) stated that there are:

"Significant deficiencies in the monitoring and management of physical health problems in people with schizophrenia..."

Cardiovascular risk is reduced using statins. QRISK2 estimates future cardiovascular risk by producing a percentage indicating risk of cardiovascular events in the subsequent 10 years. Guidance from NICE previously stated QRISK2 scores >20% required treatment with statins if risk factors were not addressed by lifestyle changes. This threshold has subsequently been reduced to 10% in 2014.

Objective
Is the current statin prescribing practice at Ravenswood House in keeping with National Guidelines on reduction of cardiovascular risk?

Methods
Data was collected for all patients residing in Ravenswood House Medium Secure Forensic Unit. Data was collected from RiO (electronic notes system), CPA reports, and local hospital pathology databases. The results were compiled in an Excel spreadsheet and the results are as follows:

Results
The number of patients who could have been included in the audit was 74; however 8 patients (11%) did not have sufficient data to be included. Of note in 11% of cases there was no documentary evidence of Chol/HDL ratios being measured. 17 patients (23%) were prescribed Statins. 9 (12%) patients had a QRISK2 score of >10%. 2 patients (2.7%) had QRISK2 scores >20% and both were prescribed Statins. Of the 9 with a QRISK2 score >10%, 5 (66%) were prescribed Statins thus 4 patients (44%) had a QRISK2 score >10% but did not receive a Statin. 12 of the 17 patients (71%) prescribed Statins had a QRISK2 of 6 months old.

Conclusions
Many patients do not smoke as a result of their detention and are therefore coded as ex-smokers which may result in the underestimation of their cardiovascular risk. All patients audited were taking antipsychotic medication, in some cases above BNF limits. QRISK2 lacks stratification for cardiovascular risk associated with antipsychotic use.
A Step Towards Medicine Optimisation—Medicine Reconciliation & Safe Prescribing in Psychiatric Out-patient Clinics
Dr Bushra Butt, ST6 General Adult Psychiatry, Nottinghamshire Healthcare NHS Foundation Trust.
Dr Subodh Dave, Consultant Psychiatrist General Adult Psychiatry, Derbyshire Healthcare NHS Foundation Trust.

NICE guidance (2015) on “Medicine Optimisation— the safe and effective use of medicines to enable the best outcomes” support King’s Fund (2013) and Royal Pharmaceutical Society’s recommendations regarding improved communication amongst clinicians and patient involvement. During the psychiatric out-patient reviews most chronic and severely unwell patients find it difficult to recall the names of all their medication and often have little knowledge of their physical health problems. We audited for the presence of GP Medical Summaries in the case notes of 40 patients attending psychiatric out-patient clinic and compared it with 20 new referrals to the Pathfinders (single point of access).

GP Medical Summaries were present in 30% of case notes in outpatient clinic compared to 75% of new referrals to the Pathfinders.

The findings were discussed in the local Drugs & Therapeutics Committee and along with the recommendations disseminated to the teams. A Re-Audit is planned following implementation of: Letters to GPs requesting medical summaries, Reminders along with the request for Annual Physical Health Checks, Reminder for consultants on reconciliation sheet, Clinical systems to ensure a named slot in e-notes for this information to be uploaded by the Pathfinders/admin.

A Quality Improvement Project Focused on Co-operative Physical Assessment of New Adult Inpatients
Dr Rosalind Dean, Dr Constance Gillman and Dr Anna Richman

Aim
Patients admitted to inpatient psychiatric units often have increased cardiovascular risk and limited access to primary care. Anecdotal evidence suggested information collected was insufficient to allow effective use of the Lester Cardiometabolic Health Resource (LCHR). This project aimed to improve usage of a standardised electric record which encouraged joint assessment between nursing and medical staff.

Method
All patients admitted to adult services in the Merseyside area during two seven-day periods during August 2015 and January 2016 were identified. Data collected included form usage, time to completion, and presence or absence of LCHR measures. Data collection was repeated following an awareness campaign and improvements in laboratory test reporting.

Results
Overall usage improved from 79% to 97%, meeting our target of 90% completion. Nursing staff continued to complete assessments more consistently, however co-operative completion improved from 22% to 72% between 2015 and 2016. Mean time to completion shortened by 2.45 days. Availability of laboratory results improved significantly following implementation of an automated system. Height, weight and waist circumference improved minimally to 88%, 97% and 26% respectively.

Conclusions and recommendations
LCHR guided assessment improved with staff awareness but some information remains limited. We feel equipment availability and a lack of departmental guidance are barriers.

Junior Doctors Handbook
Dr Katherine Farrington and Dr Bebe Fahy

When junior medical staff rotate in their placements they can arrive at an inpatient AMH ward which is very busy and have little or no idea of psychiatry and the running of the ward. The quality of the induction to the ward is vital in influencing continuity of care and patient safety. All medical staff are given a trust induction which covers the general trust policies and workings but it was felt that there was
a need for a more ward specific induction which could continue to provide a reference for the junior doctors as their placement persisted. This led to the creation of a junior doctor’s handbook. The handbook contains information in regards to the working of the ward, psychiatric terms and how to do basic jobs. Outcomes have been measured both subjectively and via more qualitative measures to assess the usefulness of the handbook via using rating scales. The feedback from the junior doctors has on the whole been positive, allowing for a smoother transition period. Any suggested improvements have been assessed and the handbook modified. It is hoped that it will be shared with other wards in the hospital.

The Potential of Learning Healthcare Systems
Dr Tom Foley and Dr Fergus Fairmichael

The Internet and big data analytics have begun to transform other industries. It has been proposed that when this technology is combined with, improved outcomes measurement and systematic behaviour change techniques, true Learning Healthcare Systems could emerge and transform Quality Improvement. This study reviewed the literature and engaged almost 60 experts in seminars and interviews.

Several early examples of Learning Healthcare Systems were identified, including:
- **Comparative Effectiveness Research** in the form of observational studies using routinely collected data to fill gaps in the evidence base more quickly and at lower cost than would be possible with conventional RCTs.
- Real-time **surveillance systems** that track epidemiological phenomena and adverse events related to treatments in near real-time.
- **Predictive models** that identify where low quality or unnecessarily expensive care might occur and ‘impactibility’ modeling that can identify those instances most likely to respond to mitigation.
- **Clinical Decision Support Systems** that aid clinicians in dealing with unfamiliar or high-risk situations.
- Quality Improvement through **positive deviance**. Positive deviants (really good providers) are identified using outcome data, studied and evidence is disseminated to other organizations.

This presentation/poster outlines the implications of these developments for the future of Quality Improvement and suggest what psychiatrists can do to prepare. Final report and source material is available at learninghealthcareproject.org

Shocking Statistics - Getting to the Heart of the Matter
Dr Ruth Freeman

Background
Within West London Mental Health Trust (WLMHT), significant effort has been made to improve Automated External Defibrillator (AED) accessibility, resulting in WLMHT being the first Mental Health Trust to achieve accreditation by London Ambulance Service’s Defibrillator Accreditation Scheme.

Methods
AEDs within WLMHT were audited between April and May 2015 looking at AED accessibility, signage and checks within the previous month. Problems were noted and addressed through distribution of extra AEDs, signage and log books as well as staff re-education. Amendments were also made to the Trust’s Basic Life Support policy. Following these changes, the worst-performing inpatient unit was re-audited in October 2015.

Results
At initial audit, every inpatient ward had an AED and most were accessible, except for those at forensic sites. Lack of signage was common at all but one inpatient site. Checks were performed sporadically across the Trust and one ward had no recorded checks. At re-audit, all inpatient wards had an accessible AED, which was signposted and had a log book. The ward which had no checks performed at initial audit achieved 58% daily checks at re-audit. One ward achieved 100% daily checks.

Conclusions
Marked improvement was demonstrated at re-audit following implementation of the described changes. AEDs are now more accessible, checked more often and staff feel more confident about their use. This
Approach to a sustainable inpatient wards ‘clinic room management’, with respect to maintaining compliance with provision of physical examination and phlebotomy equipment, and disinfection standards within Norfolk and Suffolk NHS Foundation Trust

Dr Reza Ghaderi

People with Mental Health problems are more likely to have significant health risks. Since the compilation of my report of 1st cycle of the clinical audit on *Availability of physical examination and phlebotomy equipment, and the extent the examination tools are accessible and in proper working order* (23 wards) in 2011, gold standards were set and a significant change in awareness and involvement of different disciplines within the trust was brought about.

NSFT took initiative in clinic rooms management, the impact of which are highlighted in 2nd cycle report (25 Wards) in 2013. Despite the improvement in overall compliance from 56% to 75%, it became evident that the practice is not sustainable.

The plans for a trust-wide 3rd audit cycle (34 wards) and a parallel service evaluation study were devised in liaison with Trust management and other allied disciplines. The study questionnaires are received as thought provoking, detailed, and fair by the interviewees.

For the change to commence, a shared vision at all levels along with a structured sustainable system of practice monitored through internal audits and supervision is necessary. A learning cycle for the trust is initiated. The strength of the studies is in bringing a collaborated view of each clinical area into account. The ambition is to bring the trust management to collaboratively speculate about devising new trust guidelines and new policies for this purpose.

Improving physical health monitoring for community patients in Exeter prescribed Clozapine

*Dr Jason Hancock, Dr Charles Dixon, James Lee, and Pam Spencer*

**Background**

People with Schizophrenia have a life expectancy 20 years less than the background population. Despite NICE stating that performing physical health monitoring is the responsibility of Mental Health Trusts baseline audit indicated that in our outpatient population of patients prescribed Clozapine 5% (4/87) had physical health monitoring conducted over the previous year.

**Methods**

Using improvement methodology, core group meetings and patient involvement sessions we planned and made the following changes to our Clozapine clinic:

1. Annual physical health monitoring including lipid, HbA1C blood tests, ECGs and side effects rating scales conducted in Clozapine clinic.
2. Consultants came into the clinic to perform annual psychiatric reviews.
3. All results of physical health monitoring communicated with GPs.

**Results**

Quality and communication of physical health monitoring with patient’s GP improved during pilot studies: 95% (36/38) had all physical health monitoring performed, 89% (34/38) had this communicated with their GP. Patient feedback indicates that patients prefer the Consultant appointment being combined with their monthly clinic appointment.

**Future aims**

It is possible to perform physical health monitoring using the existing Clozapine clinic structure. We will now expand to include all Exeter patients taking Clozapine. A full year of monitoring will be completed by 2016.
A clinician-friendly template for mental health ward rounds  
*Dr Richard Hoile and Dr Henna Qureshi*

**Objectives**
1. To create a template for documenting ward rounds, built into our existing electronic patient record (EPR), that is quick and intuitive to use.
2. To ensure the voices of the multidisciplinary team (MDT) and the patient are routinely recorded in ward round.
3. To encourage more comprehensive documentation, including capacity, risk and physical health monitoring.

**Summary of project**
After concerns were raised about the quality of ward round documentation across the Trust, we emailed every doctor asking them to outline problems with the current system and possible improvements. Based on this feedback, we designed a new ward round template with help from the EPR team.

**Plans for roll-out**
The template has been piloted on a single ward. The template will be rolled out to three further wards in May 2016, and throughout the Trust by September 2016. During this period, we are collecting feedback from the MDT and the patient via questionnaires, as well as auditing the comprehensiveness of documentation before and after the template’s introduction. Continuous improvements are being made to the template throughout these testing stages.

Redesigning the core trainee rota  
*Dr Richard Hoile*

**Objectives**
To create a template for creating and viewing on-call rotas, to ensure 1) transparency (the ability to see how many shifts, and of what type, each trainee is allocated), and 2) an even distribution of shifts among trainees. Additionally, the template should alert trainees if their workload is inappropriate for their banding, and if they are doing more liaison than psychiatric unit on-calls (or vice versa).

**Summary of project**
South London and the Maudsley NHS Foundation Trust has 110 core trainees covering on-calls across seven sites. Trainees complained that the August 2015 rota did not distribute on-calls fairly. Following consultation with Human Resources (HR) and junior doctors, I designed a spreadsheet for creating new rotas, which analysed each trainee’s on-call workload and calculated their mean weekly hours via the Riddell formula. HR used my template to create the February2016 rota.

**Measuring improvement**
The February 2016 rota showed reduced inter-trainee standard deviation in average weekly hours. Additionally, trainees rated the new rota more highly on clarity, transparency, fairness and sensible allocation of shifts, with 68% rating it overall as ‘much better’.

**Future steps**
Updates to the template will accommodate changes to the junior doctors’ contract, and a new Trust-wide section 136 rota.

NHS or UPS: Finding a more efficient way of getting medication to patients under Rotherham Intensive Home Treatment Team – a service evaluation.  
*Dr Jaazzmina Hussain, Dr Sathya Vishawanath, and Mrs Karen Crichton*

In Rotherham Intensive Home Treatment Team (IHTT), patients informed us when repeat prescriptions of their psychotropic medications were required. Frequently, this resulted in urgent requests to prescribe for same day or next day delivery as the medication had run out. A team member was required to make a non-therapeutic visit to deliver medication (“medication drops”), which had cost and time implications for the service.
My hypothesis was that anticipating the due date of repeat prescriptions and prescribing in advance of the patient running out would reduce the number of urgent requests and therefore the number of medication drops. The intervention was an Excel spreadsheet, showing when the last prescription was done and when it was due to be renewed. A reduction in the number of urgent repeats was seen, from 51.8% to 16.8% (18/107) of all prescriptions written. Medication drops reduced from 72.7% to 33% (6/18).

This was my first experience of starting and leading a quality improvement project; I evidenced the existence of the problem, created a potential solution and then tested it, collecting evidence that it was effective. I had to sell the idea to the team who had reservations about the change. It was highly rewarding to apply knowledge and skills gained from the Edward Jenner Programme and do something that benefitted the team in which I worked and the patients I served.

**QIP: Blood Borne Virus Screening of Psychiatric Inpatients**  
*Susannah Johnson and Megan Cooper*

**Project Aims**
Improve parity of care of psychiatric patients through increasing awareness and routine screening of all psychiatric inpatients for blood borne viruses.

**Background**
People with serious mental illness have consistently higher rates of blood borne viruses, including HIV, Hepatitis B and Hepatitis C. All inpatients are offered routine blood tests to establish baseline results and to help rule out undiagnosed, underlying or contributing physical health problems. However, inpatients are rarely offered screening or routinely screened for blood borne viruses, despite being at significantly higher risk than the general population. These infections not only carry a much better prognosis when identified and treated early, but may also present with psychiatric symptoms such as depression, psychosis or cognitive decline.

**Method**
At the start of the project all current inpatients in Wotton Lawn and Charlton Lane Hospital were audited as to whether they were known to have or had been tested for blood borne viruses during their admission. Meetings were then held to educate nursing and medical teams about the importance of blood borne virus testing, alongside updating the admission proforma to include blood borne virus screening with the existing routine blood tests.

**Results**
At the end of the project all current inpatients were audited to compare testing rates and review positive results.

**Improving the Use of Early Warning Scores to recognise and manage physically unwell patients on an Older Adults Inpatient Unit – a Quality Improvement Project**  
*Dr Claire Jones and Dr Sophie Williams*

Working on an older adults’ mental health unit, we noticed that staff were not confident or skilled at recognising patients who were physically unwell and struggled to gain adequate medical review of these patients.

An Early Warning Score chart was already used to record vital signs, but this was done in a non-standardised manner and scores were not used to guide safe clinical management. We carried out an audit to assess the use of the Early Warning Score and found that only 6% of scores were calculated correctly, and of the scores which signified an unwell patient only 1 in 20 had been actioned.

This showed a clear need to improve recognition of physically unwell patients. Our change methods included running interactive teaching sessions with ward staff on calculating Early Warning Scores, standardising the actions taken in response to Early Warning scores, placing guidance
materials in clinical areas, and bringing in standardised telephone handover of scores and concerns about physical health.

Following the interventions, we repeated the audit, showing scores are now calculated 95% of the time. Staff confidence has improved. There have been more timely medical reviews of physically unwell patients and telephone handovers have become more clinically relevant and clear. This project has been a learning curve as to the challenges leading a Quality Improvement Project in a multidisciplinary setting, particularly with respect to changing the culture of the workplace. We continue to work with our team to develop both our own and their ideas for further improving their cognition of physically unwell patients and are rolling out our learning across all the general and older adult wards in our Trust.

Quality Improvement Fellowship
Dr Sukhwinder Kaur

Introduction
I joined the third cohort of QIF (Quality Improvement Fellowship) for 2014/15, delivered by Kings Fund, funded by Health Education East of England and sponsored and supported by my trust.

Key elements of QIF
One year of development as emerging leaders and quality improvement (for all disciplines across NHS). It included three modules over one year and involved taking on a QIF project at your workplace.

My QIF project
The aim of my QIF project was to improve the outcome for person presenting under mental health Section 136 assessed and to reduce the future presentations. Sec 136 allows a police officer to remove a person from a public place if that person must appear to be suffering from mental disorder and to be in immediate need of care or control.

QIF Pilot project
My pilot project was to target the Sec 136 frequent attenders who are presenting with mainly alcohol or illicit drug abuse and to refer to drug and alcohol team after Sec 136 assessments. I conducted pilot project over two months and there was 30% improvement in terms of referral to drug and alcohol team.

Quality Improvement Project for Out of Hours Clinical Handover
Dr. Deepa Krishnan, Dr. Neil Nixon, and Stacey Simon

Background
Inadequate Clinical Handover has been identified as a ‘major cause of preventable harm’. A recent Quality Management visit from the Local Education and Training Board (2014) identified deficiencies in the Nottinghamshire Healthcare Foundation Trust handover recording system, with associated risks for both patients and junior doctors. Here we aimed to assess this concern using a mixed methodology, including local surveys and audit; and secondly to make any necessary quality improvements.

Methods
We developed an audit tool from published guidance and carried out an initial audit of handover recording during a 1-month period. This pre-implementation phase was combined with a survey assessing barriers. Based on this initial work we developed and implemented a new handover recording system in collaboration with the IT department and trained junior doctors in its use. We then re-audited handover recording quality.

Results
A post-implementation audit was carried out using the same tool for a period of 1 month. The quality of documentation improved across all the domains tested.

Conclusions
Significant problems existed in the previous handover recording system that may have affected patient safety. Changes in recording rate were less marked and barriers to utilisation are being addressed,
Audit identifying whether applications for Section 12 and Approved Clinician approval and re-approval have been processed correctly by the London Approval Office

F Lewis, H Blott, J Townell, T Lambert and M Khwaja

Aims and hypothesis
To assess the compliance of the London Section 12/Approved Clinician (S12/AC) approval office, as well as efficiency of the process to identify how it can be improved. The standard has been set as 100% compliance.

Background
An initial audit was conducted in 2013 of compliance with guidelines for approval for S12/AC status, in line with the Harris report recommendations, and changes made to improve the process. Following this the audit cycle was completed in March 2015; the time taken for the various stages of the approval process has now also been examined to identify where improvements can be made.

Methods
Approximately 25% of the applications (n=88) received in the six months to 6/3/15 were audited. Average length of time to approval was compared with 2013 data (n=54). An audit tool ensured that all of the criteria for application were met, and the time taken for each stage of application was recorded. The data were analysed using Microsoft Excel.

Results
In both cycles of audit 100% compliance with approval criteria was demonstrated. The mean time taken to approve applications increased by 21% from 48.6 in 2013 to 58.8 days in the 2015 cycle. The time taken from requesting to receiving references was identified as the rate limiting step for most applications.

Conclusions
The London office remains 100% compliant with guidelines. The increase in mean time taken to process applications is likely due to the increase in number of applications received in the time period assessed due to the large original cohort of ACs requiring renewal in the audit period. Efficiency of the process can be improved by making changes to the reference process, such as them being requested by the candidate prior to application, or electronically. It may be beneficial in the future to establish a national standardised AC/S12 cross-panel audit, with different regions auditing each other.

How well the NICE quality standards for psychosis and schizophrenia in adults are met in forensic mental health services – A local audit

Dr Nicole Lichtblau, Dr Maryna Popova, Dr Charlotte Harrison, and Dr Mary A Harty

Background
In forensic mental health services many of the service users have a diagnosis of schizophrenia or schizo-affective disorder. In 2015, NICE quality standards for psychosis and schizophrenia in adults were published, including among others psychopharmacological and psychological treatment, physical health assessment, promoting healthy lifestyle, and supported employment programmes.

Methods
We analyse how well these quality standards are addressed in forensic in-patient and out-patient services at the Springfield University Hospital, South West London and St. George’s Mental Health Trust, by using a clear structured tool that enables easy data evaluation and covers the applicable quality statements. Therefore, we audit all current service users from one male low secure ward, two male medium secure wards, one female medium secure ward and the forensic outreach team, who have a diagnosis of either schizophrenia or schizo-affective disorder by obtaining the relevant data from the electronic patient records.
Rationale
The aim of this audit is to review the current quality of service provided for service users with schizophrenia or schizo-affective disorder in our forensic mental health service, taking into account the limitations and special needs due to the forensic setting. Eventually, we have therewith a basis to plan any needed improvements that may arise.

Staff knowledge of diabetes care at an acute adult inpatient mental health centre
Dr S Lightbody, Dr J de Boisanger, E Baker, and Dr M L Barnard

Aims
Diabetes is more prevalent among individuals with mental illness and psychiatric co-morbidities can adversely affect diabetes self-care. We aimed to assess the care of patients with diabetes admitted to an acute inpatient mental health centre and to measure staff knowledge of diabetes management.

Methods
A 15-point questionnaire was devised and distributed to staff on four adult inpatient mental health wards. Responses were collected from 15 staff members. Feedback was invited on the need for diabetes training.

Results
There was disparity among staff on how often capillary blood glucose should be monitored and where recorded. Staff had high awareness (>85%) of risk factors for diabetes such as waist circumference, ethnicity and family history. However, there was a lack of knowledge of the association of diabetes with mental illness (25% unaware) and with antipsychotic medication (46% unaware). A significant proportion were unaware of the link between hyperglycaemia and new antipsychotic medication (75% unaware). Alcohol was incorrectly thought to cause hyperglycaemia by 54% of respondents. Feedback was positive regarding further education with 54% wanting training in diabetes management.

Conclusions
There is potential to improve the care of patients with diabetes and mental illness in an inpatient setting. We have presented one trial teaching session to 40 newly qualified nurses, with excellent feedback received, and plan to arrange a regular education programme. We will also provide clear written guidance on diabetes management to ward staff. This could benefit patients’ long-term health and reduce disease burden among the large population living with these two major chronic diseases.

Creating an integrated care pathway for the assessment and management of people with Down’s syndrome at risk of dementia with the London Borough of Waltham Forest (North East London Foundation Trust).
Dr Jack Lindesay, Dr Jason Tsang, Dr Samir Shah, Dr Afia Ali

Background
People with Down’s syndrome are at significantly increased risk of developing dementia compared to the general population. Furthermore, diagnosis of dementia in Down’s syndrome occurs at a much earlier age. Presently, no established care pathway exists between Learning Disability and Memory Services in Waltham Forest.

Aim
By May of 2016, we aim to create and implement a care pathway that integrates the diagnostic expertise within the Learning Disability team, with the directed biopsychosocial management available through the Memory Service. This project will seek to provide equity of care between the two patient groups.

Method
Baseline data from the Trust and Clinical Commissioning Group were collected for patients with a dual diagnosis of Down syndrome and dementia of any type. Referral processes for GPs and mental health access teams were created.
Findings
Currently, there is one person in Waltham Forest with a dual diagnosis accessing the standard post diagnostic care offered through the Memory Service. A further five patients have benefited from the established pathway.

Summary
Cognitive assessment for those with Down’s syndrome is an extensive process, as baseline ability and clinical presentations are variable. For there to be a continued shared care pathway between the two services, a reliable process of diagnostic coding is required, in order to identify those patients requiring continued cognitive monitoring and referral for assessment.

Review of the inpatient psychiatric admission rates of patient’s living in Hounslow.

Dr Amy Love and Dr Jade Laura Sehinson

Background
One of the guiding principles of the Mental Health Act is that care and treatment should be provided in the least restrictive way possible. At an inpatient unit in West London the medical team felt anecdotally that the rates of admission were increasing and we wanted to better understand whether this was reflected in the admissions figures and if so why this was the case.

Aims & Objectives:
To identify whether the number of patients who reside in the London Borough of Hounslow, being admitted to an inpatient mental health unit, had increased from 2014 to 2015. If this was the case, to establish any reasons for this increase and use this information to help understand if there are changes that could be made to reduce admission rates with the aim of treating more patients in the community in the least restrictive way.

Method:
With the help of the informatics department at West London Mental Health Trust we identified the number of patients from the Hounslow CCG who were admitted to an inpatient mental health unit in the months of November 2014 and November 2015. The mental health electronic records of these patients were then used to identify characteristics such as the patients diagnosis, mode of presentation, use of the mental health act, length of stay and plans for follow up after discharge.

Results:
The number of patients from Hounslow who were admitted to an inpatient unit in November 2014 was 26 and in November 2015 was 49; which is an 88% increase. Data collection is still underway.

Mind the gap: Are we providing timely and effective care for adolescents presenting to psychiatric services out of hours?

Dr Amy Love and Dr Yasmin Al-Asady

Background
More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time (1). As the structure of mental health services continues to evolve, a gap in the provision of out-of-hours (OOH) adolescent services is emerging with little clarity as to who is best to provide appropriate out-of-hours emergency care. Anecdotal evidence from a busy West London Emergency Department (ED) has revealed significant difficulties ranging from which professional should be responsible for assessment to where and how soon admission can be offered often leaving vulnerable young people to get stuck in the gap between adult and child mental health services.

Aims & Objectives
To identify and explore the nature of recurring logistical difficulties in providing effective care for adolescents who present OOH with a view to optimising assessment and immediate management and thus the quality of experience of this vulnerable patient group.
Method
The Emergency Department IT system was used to identify all 16 and 17 year old patients presenting with mental health difficulties over a twelve month period. Mental health electronic records of said patients were then used to identify the nature of presentation, time to assess and outcome in addition to qualitative data regarding operational difficulties encountered.

Results
Data collection is on-going.

Reducing Unnecessary Repeated Blood Testing in Psychiatric Inpatients
Dr Alan Mackenzie

Introduction
All NHS SLAM inpatients should have ten baseline blood tests completed during their admission. We noted that some patients underwent venepuncture multiple times before all tests were completed and that some patients never received all required tests.

Aim
The primary aim was to reduce the number of times patients underwent venepuncture. The secondary aim was to increase the percentage of patients who received a complete set of blood tests during their admission.

Method
Consecutive patients admitted to the acute psychosis ward between June and December 2015 were included in the first round of data collection. Following this, various measures were undertaken to raise awareness among the junior doctor cohort. The second round of data collection took place between January and April 2016.

Results
Twenty-five patients were included in the first round of data collection and 20 in the second. The median number of venepuncture episodes fell from 3 (IQR 4) to 2 (IQR 2), \( \chi^2 = 3.375 \) (p=0.066), however, the number of patients receiving a complete set of blood tests fell from 52% to 25%.

Conclusions
Although successful in reducing the total number of venepuncture episodes, fewer patients received a complete set of blood tests during the second round of data collection. Further work is needed to improve compliance with the protocol. This will continue to be monitored regularly as part of an ongoing quality improvement project.

Quality improvement at Belfast Addiction Service: blood tests for patients commencing and continuing naltrexone
Dr Orlagh McCambridge and Dr Helen Toal

Naltrexone is offered for relapse prevention for patients with alcohol and/or opioid dependence syndrome. At Belfast Addiction Service liver functions tests (LFTs) are checked prior to commencement, after 1 month of treatment and 3 monthly thereafter. I noted that urea and electrolytes (U+Es) were also being requested for these patients by nursing staff without clinical indication. This resulted in 2 patients being contacted regarding hyperkalaemia likely secondary to haemolysis. The patients were distressed at this and repeat tests were required-1 patient attended their general practitioner that day and the other attended the accident an emergency department. I used the plan, do, study, act cycle to address this.

Plan
Stop U+Es being requested alongside LFTs for no clinical reason.
Do
I met with the nursing team leader in the Day Hospital where these bloods are taken. We discussed the issue and it was addressed with all nursing staff at a team meeting in December 2015.

Study
From January-March 2016 six patients on naltrexone were chosen at random from the blood book. All had only LFTs taken, which was appropriate.

Act
This project will be presented to staff locally and any new staff will be informed as part of their induction.

POEMS – Physical observations in elderly mental health services
Dr Emma McPhail

Physical healthcare is often overlooked in mental health services, and is especially important in elderly populations due to increased co-morbidity risk. As physical illness is not a staple of mental health care, physical observations are often underestimated and consequently missed. Using the Model for Improvement to identify SMART aims, I conducted a PDSA cycle to implement a change identified through a process map. The aim was to increase the compliance at which physical observations were completed compared to that requested by a physician. The innovation utilised a whiteboard; observation data was displayed in a clearer format, to improve clarity for allied health-professionals.

Baseline measurements showed 100% compliance of observation requests in all patients receiving once-weekly observations. However, in those with high frequency observations, the compliance percentage was 64.4%. Post-intervention, this percentage increased to 73.8%.

From this single intervention, the compliance has increased significantly although there is room for further improvement. Reducing risk of patient harm subsequently reduces the risk of serious illness or death. This intervention suggests that a factor is ease of access of information: frequency and completion of observations are now clearly displayed for all team members. Feedback from team members has shown the intervention is well received, as it has made information more readily available, and has made their jobs more efficient.

Specialty Trainee informal admission screening out-of-hours in Barnet Enfield and Haringey NHS Trust – A Quality Improvement Project
Dr. Benjamin McNeillis and Dr. Anthony Ediae

Introduction
In June 2015, Trust management implemented a policy whereby all informal admissions must be verbally screened by the ST on-call, who may suggest more information gathering, alternatives to admission, or face-to-face assessment of the patient.

Aims
To assess the effectiveness and impact of this policy and perform a cost-benefit analysis.

Methods
For 60 days we sent a questionnaire to STs after their on-call. Information gathered included time of call, referral source, whether the ST saw the patient, whether admission was averted, number of hours work missed the next day.

Results
We achieved a 73% response rate. 39 informal admissions were screened, involving 4 face-to-face ST reviews. 2 admissions were averted (1 by phone, 1 by face-to-face assessment). 47 hours’ work was missed by STs due to the policy.
**Conclusion**
The informal admission screening policy had a low effectiveness (5% of informal admissions were averted), however had a high cost in terms of hours of work missed by doctors as well as added delay and distress for patients awaiting admission.

**Action**
We presented our findings to the Executive Director of Services and Clinical Directors. We changed the policy such that ST screening of informal admissions became discretionary rather than mandatory.

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**Clozapine Titration at the Crisis House: A Quality Improvement Project**
*Andrea Meredith and Rahul Bhattacharya*

**Introduction**
We aim to provide an alternative to hospital admission for patients needing clozapine titration and demonstrate that titration at the local crisis house (CH) would improve patient choice & experience whilst reducing costs and acute bed occupancy.

**Method**
We used QI framework of ‘PDSA cycles’ which stand for; Plan, Do, Study and Act.

P – Decided on opening referral; D – Started necessary training, developing pathway and protocol around referral and initiating clozapine; S – Gathered information from staff, patients and errors. A – Adapted our systems to improve quality. We used outcome measures and a balancing measure.

**Results**
We attempted clozapine titration with 23 patients over 2 years. Titration was successful in 69% of cases and unsuccessful in 22% where the patient was too unwell to be treated at CH or refused treatment. In 9% of cases it was partially successful. There was a significant reduction in medication errors as staff gained experience.

100% of the successful titrations who gave feedback indicated a preference for Crisis House over hospital admission.

CH was felt to be a resource to improve efficiency as the cost of a CH bed is £186/day compared to an adult acute bed that costs £364/day.

**Conclusions**
Clozapine titration at the CH appears to offer a safe, effective, patient centred and efficient alternative to hospital admission. Added benefits included improved partnership work between agencies.

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**Psychiatric Trainee Support through Significant Untoward Incidents (SUIs) and Coroner Inquests**
*Dr Amit D Mistry, Dr Abigail Smith and Dr Petros Lekkos*

**Aims**
To set up an educational workshop to support Psychiatric (core & higher) trainees through Significant Untoward Incidents (SUIs) and Coroner inquests.

**Background**
SUI’s and Coroner Inquests can have a detrimental impact on trainees involved although can be a learning opportunity if supported appropriately. We set up a workshop to support trainees through these processes.

**Methods**
We followed the “Plan, Do, Study, Act cycle” (PDSA) to create workshops that provided information about the investigation process, both practical and psychodynamic. Workshops were delivered across four London Psychiatric trainee academic programs.

Feedback from 35 (n=35) participating trainees were collated through pre and post-workshop questionnaires consisting of statements on a 5-point Likert scale (strongly disagree–strongly agree).
Results
Prior to the workshops 60% (21) and 40% (14) of trainees did not know what an SUI or coroner inquest involved, respectively. Only 33% of trainees knew how to access clinical and personal support during investigations. This figure increased to 100% post-workshop. Of note, 97% (34) wanted this topic taught at induction.

Conclusions:
Workshops provide immediate benefits for trainees who are unfamiliar with SUI and coroner proceedings. We intend to set this up as a regular workshop for junior trainees within our local psychiatry training scheme.

Quality Improvement Project: Psychiatric Junior Doctor Support through performing Patient Seclusion Reviews

Dr Amit D Mistry, Dr Daniel Hughes and Dr Asim Suddle

Aims
To set up a simulation workshop to support junior GP and Psychiatry trainees performing seclusion reviews.

Background
There is a perception that psychiatric trainees are often not formally taught how to perform seclusion reviews. Current literature trends indicate the efficacy of simulation training for psychiatric trainees.

Method
A “Plan, Do, Study, Act cycle “was followed to create workshops that consisted of two components. Part A consisted of a seminar that outlined a 3-stage approach to performing reviews. Part B involved trainee participation in a simulated seclusion scenario.

Feedback from 24 (n=24) participants was collated through pre and post-workshop questionnaires consisting of statements on a 5-point Likert scale.

Results
On Pre-workshop feedback, 13% (3) of trainees had received prior seclusion teaching and54% (13) had already performed reviews.

Only 25 and 50% of trainees agreed that they knew the physical and mental health symptoms that should be assessed, respectively.

Post-workshop, agreement to these statements improved to 100% along with knowing what a review entails, what pre-review nursing information is relevant and at what hourly intervals the Multi-Disciplinary Team should review secluded patients.

Conclusions
Trainees should be offered simulated seclusion review training as part of their induction into psychiatry as agreed by 100% of our workshop participants.

Mental Health Care in Emergency Departments: Qualitative data analysis

Anna Moore, Nicolas Lorenzini, Ruth Davies, Megan Stafford, Alice Wickersham, Tim Harris, Beatrice Tooke, Tamara Ventura and Peter Fonagy

Background
A disproportionate number of mental health (MH) patients breach the four-hour emergency department (ED) target, affecting the functioning of emergency services. This study aims to inform future decision-making about how to best organise ED services for MH patients.

Methods
A case note audit of 632 consecutive patients and a qualitative exploration of the ED experience of a subgroup of them (n=42) was performed.
Results
Most patients perceived the ED as the best place to receive professional help and psychotropic medication quickly. The average wait was 111 minutes for an initial assessment. Most patients considered waiting times too long, but showed awareness of the ED pressures. Patients perceived ED staff as not having a strong knowledge of MH, rating their attitudes low when feeling dismissed or when a lack of empathy was shown. The psychiatric team was scored more highly in attitude and knowledge. 47.62% of patients reported waiting in an uncomfortable place.

Conclusion
Shortening waits, training ED staff in MH and providing comfortable waiting areas may improve MH patient’s experiences in ED.

Smoking cessation – a shortfall in quality of assessment
Dr Anna-Marie Mortlock, Dr Ainslie Boyle, Dr Fintan Larkin Consultant Forensic Psychiatrist

Aim
To evaluate adherence to Trust smoking cessation guidelines and therefore identify areas for improvement.

Background
Smoking prevalence is higher among people with mental disorder. A smoking ban was introduced to Broadmoor hospital in 2008 and to WLMHT in its entirety in 2016. Managing smoking cessation can be a challenge for patients, therefore providing support is vital.

Methods
This retrospective service evaluation involved 17 patients admitted over 4 months to Broadmoor hospital. The electronic record (RiO) physical health (PH) form and RiO nursing and doctor admission notes were assessed for documentation of i. smoking status at admission ii. cigarette numbers smoked and iii. smoking cessation services offered.

Results
There was no smoking status for 3 patients on the PH form. For those recorded, all were by administrative staff. Smoking status was documented for 5 in admission notes. None had a record of cigarette numbers. All 12 ‘Smokers’ referred to the smoking cessation service were entered by non-clinical staff. Some information was conflicting.

Conclusions
Assessment addressing smoking cessation could be improved. It is essential that recording of information is accurate and consistent. The next step is design of a ‘Smoking checklist’ to be completed on admission by a healthcare professional at first point of contact.

Datix Reported Incidents from In-patient Psychiatric Units Pre and Post Implementation of a totally Smoke Free Hospital Site Policy
Dr Barry J Mullan, Paul Jackson, Dr A Kirrane and Dr K McSharry

Background
Smoke free hospital sites have been introduced in Scotland as of March 2015; many hospitals in the rest of the UK already have adopted this policy. This is an admirable approach as it has been well documented the damage that tobacco smokes both first and second hand can cause. Many patients on Psychiatric Units are long term patients and use smoking as a mechanism to cope with their mental illness. Changes in smoking habit can also have considerable effect on several psychiatric medications.

Anecdotally ward staff report more incidents of aggression, confrontation, agitation, smoking on the ward, fire department callouts and an increased use of prn medication since the smoke free site policy was implemented.
Aims
The aim of this project is to evaluate the implementation of smoke free sites identifying if the anecdotal evidence is true that there are increased adverse incidents that need to be addressed.

Methods
Data collected for the six months prior to and following the implementation of the smoke free site policy in the Cheshire East mental health inpatient units.
Data analysed using Quality Surveillance Support Team searches looking at the total number of incidents documented by staff by completing a datix during these time periods that specifically have smoking, smoke, cigarettes or lighter mentioned in their text.

Results
There was a substantial increase in smoking related datix forms in the first and second months after the introduction of the smoke free site policy (over 16 fold), this did substantially decrease in the subsequent months but did still consistently remain over 5 times greater than the previously reported incidents.

Conclusions
There are many obvious benefits to smoke free hospital sites for patients, staff and visitors. This project highlights there is a marked number of adverse incidents reported on inpatient mental health wards following the implementation of this policy. Alternative methods of helping patients adapt to a completely smoke free environment such as education and e-cigarettes needs to be further researched.

Developing a multidisciplinary approach to frequent attenders in the Emergency Department – a pilot project
Dr Marion Geffen, Dr Sunil Dassin and Dr Marcus Hughes

Background
Research shows that frequent attendees (FA) at Emergency Departments often have complex medical, mental health and social care needs.

The aim of this pilot project was to devise and implement a review, assessment and care pathway for frequent attenders.

Methods
At multidisciplinary service development meetings, it was agreed that the top 10 FA during a 3 months period in 2015 were identified and medical / psychiatric records searched. Contact was made with patients and services involved in their care, including GP’s. Some patients were invited for a psychiatric assessment.

Multi-professional care plan meetings were arranged including statutory and voluntary services. Individualised care plans were agreed and attached to medical records to be flagged up at A&E attendance. Referrals to other services were made if necessary.

Results
There was good participation in the review meetings from the Emergency Dept., Drug & Alcohol services, CMHTs and the voluntary sector as well as Liaison Psychiatry. Care plans were agreed for 7FA. 3 were invited for an outpatient assessment prior to meeting, 1 declined assessment.

Referrals were made to alcohol and outreach services, safeguarding/ vulnerable adult. For the other 3 FA, frequent attendance subsided following the index period. A care plan meeting was therefore deemed unnecessary.

Conclusions
- Care plan meetings proved useful for improving joined up care, networking and linking hard to engage patients with services.
- Most frequent presenting problem amongst FA were drug& alcohol disorders (4/10)
- Organising the meetings and finalising care plans proved to belabour intensive
- Effectiveness of implementation and usefulness of care plans for A&E treatment yet to be evaluated
Do Reminder Phone-Calls Reduce ‘Did Not Attend’ Rates

Dr. Thinh Ngo

Patients miss around 20% of scheduled appointments for mental health treatment, mainly in Primary care or Out-patient clinics. The financial cost of missed appointments in the NHS has been estimated at £360 million per year.

This Quality Improvement study in an Outpatient CAMHS unit in Warrington aims to see if a ‘Reminder Phone-call’ has any effect on ‘Did Not Attend’ rates (DNA). A Financial Analysis of DNA’s on the service is also completed.

Three Consultant Child and Adolescent Psychiatrists were studied. Baseline ‘DNA’ rates were calculated retrospectively over the period January-December 2014. An intervention period from October-November 2015 included a ‘Reminder Phone-call’ delivered by administrative staff to Service Users/ carers a week prior to their appointment. ‘DNA’ rates were compared for the equivalent periods October-November 2014 Vs. October-November 2015.

The implementation of the reminder phone call did not reduce ‘DNA’ rates. The study highlighted the logistical difficulties of implementing ‘reminder-phone calls’ by administrative staff, with high levels of ‘no attempts’ and ‘no answer’. The study also showed significant financial implications to the service caused by ‘DNA’.

Recommendations
- An automated SMS text reminder service should be implemented.
- A designated correspondence contact should be agreed when the patient is accepted to CAMHS.
- Information Leaflets about the cost implications of DNA appointments and clear instructions to cancel appointments in advance.
- Further service evaluation to find out reasons why people DNA.

Physical health assessment of new patients to Tasman Ward, Park Royal Secure Services

Dr Emma Padfield and Dr Girija Kottalgi

The Central and North West London NHS Foundation Trust and the National Institute for Clinical Excellence provide guidance on essential physical health monitoring for people admitted to a psychiatric hospital and those prescribed antipsychotics. An audit was done to check compliance with this guidance on a low secure forensic ward. Data were analysed for fourteen male inpatients aged 18-65 admitted during one year period. Our results concluded that majority had their vital signs checked within six hours of admission (80%), 70% had a physical examination done and 65% had a complete set of baseline bloods. Baseline measures such as waist circumference, glycosylated haemoglobin and electrocardiogram were not performed consistently for all patients prior to commencing regular antipsychotic treatment. Appropriate referrals to specialists including further investigations were not done consistently when abnormalities were found. Further review of physical health assessments at the three-month review at first CPA meeting were inadequate and did not fully meet the standards. New procedures have been now introduced which include mandatory use of existing templates for admission assessments and implementation of new templates for reviews, circulating copies of guidelines, simple flow-charts and appropriate monitoring by nursing and medical staff of adherence to physical health policy and guidelines. Re-auditing will be done in 6 months to review the improvement in quality of physical health monitoring.

A pocket of excellence in QI training

Lida Panagiotopoulou and Tim Gill

Quality improvement has recently replaced the concept of auditing in healthcare, claiming higher efficiency. Building improvement capability is one of the main challenges for healthcare providers. It is a new skill and it is important that training in QI is provided and that it gradually becomes business as usual.
I recently came across a QI microsite with a collection of QIP posters, as part of my preparation to attend a QI Conference organised by my Trust. I was impressed by the quality of the work showcased. Going through the posters was one of the best learning experiences I had in QI. Poster presentation is an ideal way of presenting QIPs, as it can include Driver diagrams, figures with multiple PDSAs cycles, run charts indicating baseline measurement over time and of course text explaining the project, challenges and lessons learnt. Attendees were encouraged to review the posters and to vote for the best one prior to attending conference, a strategy that worked very well in motivating professionals to critically appraise the projects.

I later further reviewed the microsite and discovered that it has very good quality learning material on a variety of QI tools, information on current QIs and information on a variety of face to face training opportunities. The microsite has 105,460 views and counting. I feel that sharing my experience of the microsite with fellow trainees would be an excellent opportunity to spread the word about this pocket of excellence in training.

**Improving patients and staff experience of ward rounds**  
*Dr Lida Panagiotopoulou*

Discussions had taken place on whether the way of conducting our ward rounds could be improved. It is well known that the w/e can be a stressful experience for patients and therefore has the potential to hinder recovery. Recent SUIs investigation had indicated space for improvement. An inspiring QIP poster was seen on the ELFT QI microsite on “improving patient and staff experience of ward rounds” in a ward in Newham. An opportunity came up at the ELFT QI conference to attend a workshop on this particular QIP.

A decision was made to initiate a QIP, based on the similar one. The lead started recruiting a team by approaching the Consultant and the ward matron. Patient, carers and staff experience scales cards were designed and started being distributed to all attendees during all ward rounds on a regular basis. The rating on these cards would be used as a baseline measurement. Space was also available for comments/feedback. The ward is due to be converted to a single sex ward, so we expect the experience scale cards to capture the impact of this change. After completion we will look into the feedback collected and implement change ideas. The change ideas that were implemented in the relevant QIP in Newham can be considered. Allocation of a QI coach is to be arranged soon. Service user involvement is to be discussed, via liaising with the people participating lead for our borough.

**Safety first: an audit cycle on safeguarding children and young adults using the Electronic Common Assessment framework (eCAF).**  
*Dr Lida Panagiotopoulou, Dr Esha Abrol, Dr Arisa Harada and Dr GolnarAref-Adib*

One in ten young people deliberately self-harm, which is associated with higher rates of completed suicide. NICE recommends that CAMHS professionals should consider using the eCAF form following a presentation to CAMHS services.

We audited the eCAF completion rate for 6 months. It was 62% with ethnic minorities only 20%. We implemented change ideas. We circulated the audit, updated the intranet with guidelines, updated the changeover handover document and added a reminder on the CAMHS referral forms. Subsequently re-audit was conducted which found a completion rate of 44%. On the positive side the completion rate for ethnic minorities was doubled, reaching 40%.

We proceeded with an interactive presentation at the CAMHS team meeting to explore this result. Awareness on eCAF was found to be satisfactory. However the team often used alternative methods, for instance direct telephone contact.

In conclusion the compliance for children from ethnic minorities improved, however the overall rate didn’t. We noticed that in our QIP, all members of QIP team had left the clinical team by the time the re-audit period started. It was felt that the physical presence of the members of staff who own the project is instrumental for the intervention to yield optimal results.
Improving awareness around the role of the trainee representative
Dr Lida Panagiotopoulou and Dr Radhika Sen

Aims and hypothesis
In our core training programme there was considerable ambiguity regarding the responsibilities of core trainee representatives. We wanted to test this hypothesis and to design an appropriate intervention.

Background
The role of the trainee representative is considered by some trainees to be a good opportunity for gaining experience in management, leadership and medical education.

Method
Using the “plan, do, study, act cycle” we firstly “planned” our quality improvement project and then circulated a survey to trainee representatives a month after they commenced their placement. A “job description” was then written, with site tutors’ assistance, and circulated to all the trainees prior to changeover. We then recirculated the survey to representatives and analysed our survey results.

Results
Prior to our intervention 29% of representatives had full awareness of meetings they were invited to attend, and 42% had partial awareness. After our intervention 66% had full awareness and 44% partial awareness. Initially no trainee had received information regarding rota construction, whereas after our intervention 33% of the representatives received satisfactory information. Prior to our intervention, the level of satisfaction around the info representatives had received averaged 2.14/5, whereas after it averaged 3.5.

Conclusion
Though our intervention was effective there remains scope for improvement as some trainees did not read and assimilate the information in the circulated trainee representative job description. We “acted” by including the role description in the induction package, aiming at sustainability.

Pro re nata (PRN) Lorazepam Prescription and Monitoring: An Audit of Acute General Adult Psychiatric Inpatients.
Dr Shay-Anne Pantall and Dr Gurmukh Chandan

The BNF states that benzodiazepines are indicated for short-term relief of severe or disabling anxiety. Research has found that pro re nata (PRN) lorazepam is overprescribed and inadequately monitored. This audit aimed to: identify the proportion of adult psychiatric inpatients prescribed PRN lorazepam, assess appropriateness of prescriptions and compliance with documentation guidelines, based on standards derived from PRN medication guidelines. Data was collected retrospectively for all adult inpatients of working age admitted on a single day using prescription charts and medical notes. Key results include: 38% patients prescribed PRN lorazepam within the preceding 4 weeks (88% prescribed on admission), 0% prescriptions being reviewed since prescribed and 33% administrations not documented in notes. We made several recommendations including avoiding routine prescription of PRN lorazepam, weekly medical review of PRN prescriptions with review dates documented on drug charts and documentation guidelines to be reissued. Overall we felt this audit had potential to improve patient care and reduce risk associated with medications. However, the recommendations were difficult to implement without support of senior staff and rotational changes made re-audit challenging. This audit is currently being conducted at a different Trust and aims to improve prescribing practice with the support of the multi-disciplinary team.

Spreading the Word: A Quality Improvement Project
Dr Matthew Penn

Problem
The period following discharge is a high risk time for patients necessitating effective communication between mental health services and primary care. A problem was identified with missing information in discharge summaries and a quality improvement project carried out with the aim of addressing this.
Method
Auditing against national standards identified particular deficiencies in the areas of risk assessment, use of ICD-10 codes and follow-up actions. Contributory factors included the unfamiliarity of trainees with the structures and approach of mental health services and a lack of information when writing the discharge summary. An intervention was executed through the production of a prompt form for information gathering. In response to problems generating awareness of the form, extra post-induction training was delivered to the incoming juniors. This included general information on mental health services as well as discharges and the prompt form.

Results
An 11% improvement in risk assessment and a 26% improvement in ICD-10 coding.

Conclusions
The project illustrated the value of a small scale, modifiable intervention. Insight was gained into the difficulties of reconciling diverse managerial and clinical agendas in designing the form. Much was also learnt about the challenges of disseminating information and instigating cultural and process change in disparate groups of staff. The approach was adopted across the Trust and a future modification would more effectively enlist Consultant and Nurse participation.

Drug chart compliance with section 58 treatment certification and Code of Practice 25.75
Dr Alexandra Powell, Dr Clemency Nye and Dr Olivier Dick

Section 58 of the MHA states that treatment cannot be continued for any patient detained longer than three months without certification of capacity and consent by the RC or SOAD authorisation. All psychiatric medications must then be compliant with the T2/T3 certificate. Code of Practice 25.75 states that best practice is to directly attach certificates to the drug chart. The CQC have identified occasional breaches of these requirements.

This pilot study was undertaken to assess local compliance to then assess the need for further investigation and need for improvement trust-wide.

Methodology
Patients subject to s58 MHA with T2/T3 certification were identified by the MHA office. Data collectors reviewed electronic notes, paper notes and drug charts, completing a pre-determined proforma. Driver diagrams and process mapping were utilised to deconstruct the compliance issues noted.

Results
Compliance of drug chart with T2/T3 certificate:
- 60% of patient charts were fully compliant.
- 40% had one or more non-compliance issues.
- In total there were 14 non-compliance issues: 6 instances relating to dose, 2 instances relating to route of administration, 4 instances relating to prescribed drug, and 2 instances of non-compliant stat doses.

Compliance with CoP 25.75:
- 24% of certificates were directly attached to the drug chart.

Conclusions
A trust-wide audit would be of benefit. The methodology has some minor limitations but remains suitable. Possible interventions identified during this audit may be of benefit if trust-wide audit results are consistent with these findings.
Capacity Management in a Community CAMHs Team

Dr Matt Reeves

Background
A CAMHs team wanted to manage the demands on their service better as demand for the service was greater than the capacity. The team used the Choice and Partnership Approach and were overwhelmed by the number of cases and the work required to manage them.

Strategy
The initial investigation involved making a Team Job Plan, which provided the number of potential working hours and types of activity undertaken by the team. This showed a potential surplus of team time for the number of cases, not the experience of the team on the ground. A number of hypotheses were suggested. 1. Cases not turned around in the estimated time and staying in service for longer 2. Unscheduled care time underestimated 3. Administration time underestimated 4. Number of cases seen by case holders was overestimated.

Implementation
Phase 1 was a team caseload review for the last 12 months.
Phase 2 was a monitoring period for team work.
Phase 3 produced a Complexity Scoring System that grouped cases into “Turn Over” or “Ultra Long/Complex”.
Phase 4 combined the results to produce a system that could manage demands on the service.

Results
• Team case load review
30% of cases were Ultra Long/Complex. This reduced capacity and was previously unaccounted for. Turn Over cases took 10hrs face-to-face contact and 20 weeks in service. Ultra Long cases took 32 hrs of face-to-face contact per year and spent on average 113wks in service.

• Monitoring outcome
The same amount of time (25%) spent seeing patients was spent on administration. Emergency unplanned care was 5% of total work. Meetings took up 17% of team time.

• Complexity scoring system
This provided a sensitive guide to case type. The team could now predict the amount of work that each case was likely to “cost” the team after the first meeting.

• Impact
It was now possible to forecast future capacity and reconfigure the team to respond. In addition to this it gave clinicians and managers better overview on current cases and consequently improving patient care and staff morale.

Quality of Side Effect Monitoring in Patients on Depot Antipsychotic Medication

Dr Natasha Rishi and Dr Amitav Narula

Aims
To review the documentation of side-effect monitoring for patients receiving antipsychotic depot injections, in accordance with NICE guidelines.

Background
Antipsychotic related side-effects may compromise physical health, quality of life and lead to non-adherence, a likely determinant of relapse. Research indicates that patients do not spontaneously report side effects.

Methods
A pro-forma was designed to review the details of side-effect documentation within the past year. Electronic records of 35 patients on depot medication were audited and re-audited 8 months later.
Results
The overall sample was 71% male with a mean age of 56. 100% (audit 1) and 97% (audit 2) of patients had been monitored for side effects in the past year. In 37% of cases this had been by a nurse and no doctors. In audit 1: 45% of patients had no side-effects; 28% extra-pyramidal side-effects; 14% injection site complaints; 10% sedation; and 3% weight gain. In audit 2, 71% of the sample reported no side effects.

Conclusions
There was regular enquiry into side-effects, however mostly in the form of generic statements. Side-effects were not always elicited by doctors. Implementing systemic enquiry through use of the Glasgow Antipsychotic Side-effect Scale after audit 1, was unsuccessful. The barriers to this may have been not having a full MDT approach and commitment in action planning.

Improving Quality in a Child and Adolescent Mental Health Service: challenges faced
Dr Elizabeth Robertson

Background
The follow-up of children with Attention Deficit Hyperactivity Disorder (ADHD) in the Child and Adolescent Mental Health Service (CAMHS) was not consistent within the team. Review was conducted by the Consultant Psychiatrist, Specialty Trainees, Core Trainee and a Nurse Prescriber in the Service.

Aims and Purpose
We aimed that prescribers in CAMHS would provide regular follow-up on a defined day in the week. The purpose was to improve the service to patients with ADHD and to free up Consultant time for other clinical tasks.

Method
We proposed compiling a database of patients with a diagnosis of ADHD using medication. The database would be created jointly by the clinicians and administrators and held by the Team administrators. Clinicians would feedback to administration after each clinic to update the database and to generate new appointments.

Results
We faced a number of challenges in the discussion and attempt to initiate the project which have been interesting to explore in order to ascertain if they could be overcome in order to make progress with the project.

Discussion
We will discuss the challenges under the broad headings, technical and adaptive issues and group them in to themes; engagement and ownership, excess ambition, wider context, sustainability.

Improving End of Life Care in an Older Adults Mental Health Hospital
Dr Ross Runciman

“Physicians caring for patients with dementia should formulate a plan for end-of-life care in partnership with patients, families, and caregivers, and be prepared to manage common symptoms at the end of life in dementia, including pain and delirium”1. More patients with dementia were dying on the local older adult psychiatry wards. There was no end of life policy, appropriate training or established links with local services. Together with a multidisciplinary team led by the hospital matron I established contacts with the local palliative care team and wrote a palliative care policy. Soon we will have a medical examiner; we have planned a programme of palliative care education for all colleagues and a new drug card. Parallel to this, is a cultural change, from initial fear amongst the teams, to an acceptance of dying with a team wide endeavour for better standards, supported by debriefing after patient deaths. Families of relatives have passed on their thanks to teams on each ward, recurrently praising nursing colleagues and stating that they wouldn’t have wanted their loved ones to die anywhere else.
Quality Improvement Project on Physical Health in Old Age Psychiatry Inpatients: Improving Monitoring, Escalation and Documentation of Physical Observations
Dr Emma Salter, Dr Samuel Lawton, Dr Neelaveni Subramaniyam, Dr Mohammad Omar and Dr Stefan Kolowski

Background
Physical health co-morbidity is high in elderly psychiatry. National Early Warning score (NEWS) is recommended across UK, aiding prompt response to acute illness. This project aimed to improve physical observation completion, documentation and escalation of deteriorating physical health in elderly inpatient wards.

Method
Electronic notes were reviewed over one week on 2 wards (28 beds). This analysis was repeated monthly, to assess quality and location of documented observations, and appropriate escalation time. Concurrently, quality of 10 inter-disciplinary verbally communicated observations for deteriorating patients was analysed.
Following baseline analysis, each monthly analysis was preceded by the following consecutive interventions: staff teaching; presentation of NEWS guidelines on wards; flowchart for management of unwell patients. An additional data analysis was completed before the flowchart intervention, due to NEWS charts being introduced by the Trust, out with this project.

Results
Baseline results and results following consecutive monthly interventions stated above were as follows:
- Full observations were provided verbally in 20%, 40%, 60%, 50% then 80% cases.
- Full observations were documented in 49%, 45%, 54%, 33% then 65% cases.
- Observations were documented on electronic charts in 65%, 69%, 71%, 69% then 88% cases.
- Concerning observations were escalated in a timely manner in 86%, 71%, 60%, 67% then 82% cases.

Conclusion
Through educational interventions and NEWS guidelines, verbal communication and documentation of a full set of observations improved. Establishing key stakeholders to aid future interventions may further enable us to cement changes and improve patient safety.

What is the purpose of the MRCPsych Course?
Dr Rajiv Shah and Dr Flora Greig

Aims and Method
With the support of the London Deanery, we designed an online London-wide survey open throughout June 2015, to collate trainees experience of their local MRCPsych Course. It covered three domains - effectiveness, structure and teaching. Trainees ranked their course's top strengths and suggested improvements, with space for open comments. We aimed to identify areas of good practice and offer constructive suggestions that could be implemented regionally.

Results
163 (36%) responses were received. The South London and the Maudsley course was rated most favourably and the North West London one was rated the least. Trainees cited the opportunity to network and developing clinical knowledge as strengths of their courses. Suggested improvements focussed on help passing exams.

Discussion
We identified significant confusion amongst trainees regarding their understanding of the purpose of the course. Many feel that the ‘MRCPsych’ course is a misnomer, as it is not specifically designed to pass exams. We suggest that the course organisers provide more information on the intended purpose of the course, establishing measures to evaluate its effectiveness and encourage its continued improvement.
Right person, Right place, Right time – Analysis of a liaison psychiatry follow-up clinic

Dr Roshni Shah and Dr Anna Burnside

**Aims**
The liaison psychiatry service at the Royal London Hospital set up a new follow-up clinic in May 2015. This analysis aims to use did not attend (DNA) and A&E re-attendance rates to assess whether patients are being targeted appropriately to allow maximum benefit from a limited resource.

**Methods**
A retrospective analysis of 3 months’ clinic referral and outcome data.

**Results**
28 patients referred, 13 patients attended ≥ 1 appointment, 16 patients DNA ≥ 1 appointment. 94% reduction at January 2016 follow-up in A&E attendances by patients who attended the clinic (Graph 2).

**Conclusions**
There was a significant impact on re-attendance to A&E after clinic referral. Of patients referred, those in psychosocial crisis had the highest clinic attendance rate. Patients who were already open to other mental health services had lower attendance rates. There were high rates of patients presenting with suicidal thoughts or acts, with high DNA rates.

The findings described above regarding attendance rates will allow the team to better target interventions, for example, not offering appointments to known patients, escalating self-harm patients to secondary care, or trialling a telephone clinic.

Preparing junior doctors for emergency psychiatric experience: a novel peer-led interactive simulation style teaching programme

Dr Krishna Singh, Dr Alex Till, Dr Elizabeth Shaw, Dr Bethan Royles, Dr Malik M. Banat, Dr Peter Wilson and Dr Indira Vinjamuri

**Aims**
To support junior doctors new to psychiatry through a novel peer-led simulation style teaching programme that would improve their knowledge, experience and confidence when managing acute psychiatric emergencies, particularly out of hours. Simultaneously, opportunities to provide and develop the teaching skills of senior trainees were provided.

**Methods**
The project was spearheaded by the Director of Medical Education, led by a trainee-working group and supported by the Medical Education Department. The session lasted 3 hours, initially with 6 scenarios, and was aligned with the Trusts protected pre-existing teaching structure to ensure all junior doctors were able to attend.

**Results**
Following two successful iterations of this teaching programme, junior doctors reported increased confidence and reduced anxiety when managing emergency psychiatric scenarios. Facilitators were similarly positive in their feedback, being able to gain formal teaching experience and appraisal.

**Conclusions**
Incorporated into induction we have introduced a novel, inexpensive and sustainable peer-led teaching programme that could be easily replicable elsewhere. Anecdotally it is improving junior doctors’ practice, their working relationships with each other, and has been proven to improve their confidence and reduce their anxieties about managing acute psychiatric emergencies.
Audit of Adherence to NICE Guidance in the Assessment and Management of Non-Cognitive Symptoms and Behaviour that Challenges in Patients with Dementia on an Inpatient Organic Psychiatric Ward

Dr Clare Smith and Dr Al-Kamil

Aims
To identify whether or not we are compliant with NICE guidance CG42 in assessing patients who present with non-cognitive symptoms and behaviour that challenges (NCSB) in patients with dementia prior to commencing pharmacological interventions and whether delays in treatment effect the duration of admission.

Methods
Paper proforma completed from case notes for 20 inpatients and recent discharges from an organic older age psychiatric ward. Patients were included if they had a diagnosis of dementia, identifiable NCSB and accessible case notes and excluded if they were on antipsychotic or anti-dementia medication prior to admission.

Results
7 patients were excluded giving a final sample size of 13.
Compliance rates for physical health assessments were high (92-100%) except for constipation (69%). Evidence of assessment of psychosocial and environmental factors were more variable (15-85%). There was a mean delay of 33.7 days and 40.5 days between identification of NCSB and significant changes being made to antipsychotic and anti-dementia medication respectively. This was reduced to 6.2 days when significant distress or immediate risk was identified. In the sub-sample who had been discharged, delays in pharmacological interventions accounted for approximately one third of the duration of admission.

Conclusions
Compliance was high for those items included in current admission pathways e.g. Advancing Quality Alliance (AQuA) but more variable for those with no clear area for documentation e.g. environmental. As a result a NCSB care plan was developed and a two week post admission multi-disciplinary meeting introduced to increase compliance with NICE guidance and reduce delays in treatment.

Lonely this Christmas: A Trainee, Advocate and Service User Led Inpatient Christmas Service Evaluation Audit

Dr Alexis Theodorou, Dr Chloe Pickup, Dr Jennifer Townell, Natasha Lobo and Dr Masum Khwaja

Aims and hypothesis
To understand patients’ views and recommendations for improvements on inpatient experiences over the festive period at the Gordon Hospital in Central London.

Background
The psychiatric inpatient experience over the festive period is an area not widely researched. It has been suggested that there may be an increase in depression, anxiety, alcohol poisonings and suicide around this period.

Methods
A questionnaire was devised collaboratively with the local service user involvement group and The Advocacy Project. The questionnaire explored personal views and recommendations for improving the inpatient experience during the Festive period.

Results
The questionnaire was distributed to all inpatients between 7th January and 20th January 2016, with a response rate of 33%.

The results showed patients find Christmas important, rating it 6.65 (on a scale from 1 -10). In 2015 six (30%) received advice from mental health professionals for this period, as opposed to 1 (6.25%) in 2014.
Patients most commonly described Christmas as ‘Depressing’ ‘Joyful’ and ‘lonely’ and the festive period as ‘Depressing’ and ‘fun’. The commonest recommendation was ‘Group walk’, followed by ‘extended visiting hours’ ‘entertainment’ and ‘visiting church’.

**Conclusions**
There have been improvements in updating care plans, with continued work needed. Some changes being made from our results are, highlighting with staff the importance of re-evaluating care plans, distribution of information leaflets and increasing activity availability. This will be re-evaluated to ensure further improvements are made.

**Developing Enhanced 3di Skills for Efficient ASD Assessment and Diagnosis in CYPS Maidstone KENT**
*Dr Chidiebere Uwadoka, Dr Sanaa Saeed and Dr Nigel Ashurst*

**Abstract**
At the course of my CAMHS core training, I identified a huge waiting list, which was approximately 24 calendar months and still increasing demand for ASD assessment which reflected the national picture.

One of the reasons for the long waiting list was due to the use of the traditional ASD assessment tools and technique, which takes 2 trained psychiatrists and or psychologists a minimum of 90-120 minutes in a face-to-face assessment without a full report for one assessment.

I identified an updated evidence based 3di interview skills and software which could aid clinicians to assess and diagnose a child with suspected ASD in no more than 45 minutes with almost a full report.

I sourced funding for relevant clinicians to be trained and was able to secure full funding from health education England for 7 clinicians to be trained. 5 clinicians have been trained and significant difference has been identified in the assessment of ASD.

**Completion of the post-ECT clinical review paperwork at the Royal Edinburgh Hospital. Are we ensuring that patients are adequately monitored and not put at risk from extra ECT treatments?**
*Dr Steven Voy and Dr Pauline McConville*

**Background and Aim**
The risk of death following anesthesia is at least 1 in 100,000. In 2014, 4302 ECT treatments were delivered in Scotland. SEAN standards (2013) and NICE guidelines (2003) state that between each ECT treatment, clinical status and symptomatic response should be assessed. To address this, a T5 form is required after every second treatment to monitor clinical status and response. We wished to assess whether documents were being completed prior to the next treatment.

**Methods**
T5 completion rates for patients undergoing ECT was gathered from 24/8/15 to 25/9/15. Thereafter, I met with the ECT staff and changed the prescription form to include a box which instructed that a T5 be completed before two further treatments could be prescribed. The new form was sent out to all medical staff and uploaded to the intranet. Completion rates were re-audited from the 22/1/16 until the 22/2/16.

**Results**
A total of 54 patients received ECT from 24/8/15 to 25/9/15. Of these, 26 required a T5 but five of these (19%) were not completed. Following the intervention, re-auditing highlighted that of the 51 patients received ECT from the 22/1/16 until the 22/2/16 and of these 24 required a T5 and 23 (95%) were done.

**Conclusions**
The results highlight that a simple amendment of the prescription form has improved T5 completion rates by 14%. Ensuring that patients are reviewed in the recommended timeframe reduces the potential harm of extra ECT treatments.
Physical Health Documentation: A Plight to Get It Right
Dr Tarek Zghoul, Dr Mark Toynbee and Dr Angeliki Tziaka

Information
Individuals afflicted with a severe mental health illness have been shown to have a shorter life-expectancy, with a recent study in high-income countries putting the mortality gap in the range of 15-20 years. The issues are multifactorial and include, amongst others, life-style and poor physical health. On inpatient psychiatric wards, admission procedures for patients include full assessment and documentation of their physical health as per NICE and the Royal College of Psychiatrists guidelines.

Background
Previously, we audited the state of physical health documentation of new inpatients within 72 hours of their admission. This pertained to a set of values, which we expected to have been documented within the first three days of their admission. The results demonstrated overall poor documentation. As a consequence, an admission pack was designed to aid with the process, with a re-audit demonstrating a marked improvement in electronic documentation.

Objective
The aim was to re-assess the state of documentation six months post-intervention of the re-audit.

Results & Conclusion
Our results showed that whilst the documentation was still better than the first audit, it did display a deterioration since the last re-audit, and thus, demonstrating a failure in compliance with the intervention introduced six months earlier.