

Using Microsoft teams to improve the management of physical health in older age psychiatric inpatients

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Background and Aims

Old age psychiatry patients often have complex physical health needs. Several reports, including those commissioned by the King's fund¹ and the Royal College of Psychiatrists^{1,2}, have highlighted the importance of moving towards an integrated model of care; with a focus on viewing mental health admissions as an opportunity to improve the physical and mental wellbeing of psychiatric patients. Nurses working within old age psychiatry often have limited physical health training and may feel under-equipped to do this. In addition, the doctors overseeing care may have outdated medical knowledge; this in turn could contribute to delays in diagnosis and in accessing care, resulting in poorer treatment outcomes.

During the pandemic we sought to improve the physical health of inpatients within old age psychiatry, utilising Microsoft (MS) Teams, to provide dermatology teaching remotely. Skin disease is common, associated with many systemic diseases, and can cause significant physical and psychological morbidity. The initial session focused on the management of red legs, for which the differential is broad. Bilateral red legs are seldom caused by cellulitis but often misdiagnosed as such; resulting in inappropriate use of antibiotics, delays in correct diagnosis, and risk of causing harm.

Methods

In collaboration with Dr Jonathan Richardson, a consultant old age psychiatrist working on an organic inpatient ward, we agreed to provide focussed physical health teaching to the wards' multidisciplinary team (MDT). Dermatological conditions were identified as a common problem in older inpatients and baseline knowledge was assessed using an MS Teams questionnaire and areas for improvement identified. A PowerPoint teaching session was then delivered virtually, via MS Teams, during the ward's monthly learning and improvement group. The initial session focused on red legs; covering differential diagnoses, pathophysiology, investigation and management. Teaching was provided by a medical trainee, in conjunction with a tissue viability nurse. A post-teaching questionnaire was then sent to the same initial respondents and the pre and post results were compared.

References:

1. Naylor, C., Taggart, H., Charles, A. (2017). *Mental health and new models of care Lessons from the vanguards*. The King's fund and Royal College of Psychiatrists. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/MH_new_models_care_Kings_Fund_May_2017_0.pdf (Accessed 13/09/21)
2. James, A. (2019). *Improving mental health services in systems of integrated and accountable care: emerging lessons and priorities* [online]. Royal college of psychiatrists. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/rcpsych---improving-mental-health-services-in-systems-of-integrated-and-accountable-care-final.pdf?sfvrsn=21848a8d_2 (accessed 13/09/21)

Results

- Number of respondents: 12 for pre-teaching and 10 for post-teaching questionnaire.
- There was increased self-reported confidence in management of common elderly skin conditions (fig. 1).
- Results indicated increased understanding of the common causes of red legs and that bilateral red legs are rarely due to cellulitis (fig. 2).
- We found increased awareness of the role of tissue viability (fig. 3 and 4).
- Staff expressed an interest in knowing more about a range of dermatology topics, most popular were psoriasis, psycho-dermatology and the relationship between psychotropics and the skin.

Figure 1. Graph to show average level of confidence pre and post teaching.



Figure 2. Responses when asked the most likely cause of bilateral red legs (shown as percentage)

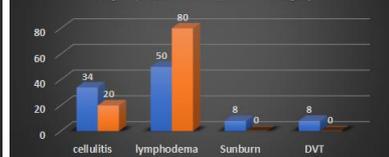


Figure 3. % of staff who were aware of the activities tissue viability CAN help with, pre and post teaching.

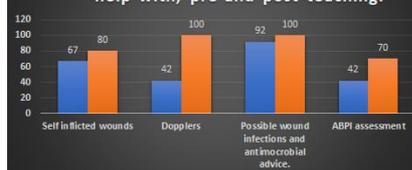
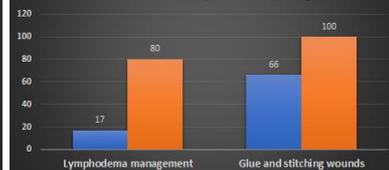


Figure 4. % of staff who were aware of what tissue viability CANNOT help with, Pre and post teaching.



Discussion

Positives:

- **Improved knowledge:** highlighted by pre- and post-teaching questionnaire results.
- **Virtual teaching** allowed the session to be recorded and presented to multiple members of the MDT, which would have been otherwise difficult to coordinate.
- **Quick and easy data capture** was made possible using Microsoft forms.
- **Multidisciplinary teaching:** delivered by both medical and nursing staff to promoted a holistic approach.
- **Teaching appealed to both medical and nursing staff** with a range of professionals in attendance.
- **Identified areas of interest** for future sessions.

Limitations:

- **Difficulty finding protected teaching time:** due to short staffing and ward pressure; a shorter session may have been more accessible. However, recording the session meant staff could watch it at their convenience.
- **No data captured regarding antimicrobial stewardship:** to keep questionnaire brief and to improve completion rates, this data was not collected.
- **No direct quantitative data collected on red legs management or on tissue viability referrals.** Gathering such information would help identify whether improved knowledge and confidence has translated to changed clinical practice.
- **Lack of familiarity with formal teaching sessions:** Some members of the MDT were not used to receiving formal teaching. Further sessions would hopefully encourage engagement by familiarising all staff members with the format of teaching.

Conclusions

- Aim to provide regular MDT teaching for all staff on the ward and involve outside professionals in order to try and improve both physical and mental health of patients during their admission.
- Improve links with tissue viability and make posters to inform staff of what they can help with and how to refer.
- Anti-microbial audits, looking at antibiotic use.
- Further short teaching sessions on other physical health topics would be of value.