

- There was slight difference for those who were on PRN (77% to 81%). All prescribers informed about results and reminded of recommended guidelines
- Reaudit in 2021-22 to measure change in clinical practice in prescribing HDAT.

A quality improvement project to improve the physical health of people with intellectual disability & severe mental illness in a forensic inpatient ward

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Aims. Review physical health risk factors of service users Co-produce personalised care plans for service users Improve health knowledge and confidence in self-management of health problems Support reduction in risk by improving physical activity levels and supporting healthy dietary choices.

Background. People with intellectual disability have poorer physical health outcomes than those without intellectual disability; there is higher prevalence of obesity, constipation and diabetes in this group of the population, and consistent evidence of premature mortality. Excess mortality in persons with severe mental illness has also been established.

Empowering patients to take an active role in their care, is good practice and encouraged as part of the NHS Long Term Plan.

Quality Improvement methodology was used to design and deliver a multi-disciplinary team (MDT) intervention, on a forensic mental health ward for persons with intellectual disability, to improve physical health in this patient group.

Method. Cardiovascular risk was assessed for 13 patients on a low secure forensic mental health ward. Measures of weight, BMI, blood pressure, resting heart rate, smoking status & status regarding prescription of psychotropic medications were collected.

Together with individual comorbidities and activity levels, a personalised care plan was co-produced by MDT members and patients. Motivational interviewing techniques were adapted to support patients to set personal goals.

Education sessions were designed in 'easy-read' format and delivered by MDT members in a group format. Focus groups were held with service users and with staff members to explore barriers to change. Based on these, specific ideas to increase physical activity and support healthy dietary changes were introduced.

The Patient Activation Measure (PAM) questionnaire was modified and used to assess confidence and knowledge in preventing or reducing health problems, and maintaining changes.

Result. Cardiovascular risk and activity levels were assessed for 13 inpatients. 85% of patients had a BMI in the overweight or obese range. 62% were regular cigarette smokers. 92% were prescribed psychotropic medications. On review of 2 months of opportunities for activity, all patients were categorised as 'inactive'. Patients engaged to varying degrees to co-produce personalised care plans and to engage in group education and physical activity. Of these patients, all showed improvement in measures of Patient Activation and activity level.

Conclusion. An individualised approach is required in exploring physical health problems, considering modifiable risk factors and addressing barriers to change. Co-production, and active participation of MDT members in role-modelling 'healthy habits' was positively reported by patients to facilitate self-management.

The quality of handover on an inpatient psychiatric unit - information is key!

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Aims. To study the quality of handover, between nursing staff and doctors, on an inpatient psychiatric unit.

Effective handover between professionals is vital to ensure the accurate transfer of useful information to enable quality care and patient safety.

Implementation of a handover tool has been shown to improve patient safety, especially when used to structure communication over the phone.

Feedback at trainee doctor forums highlighted insufficient handover from nursing staff whilst on-call, a problem which prompted further exploration.

Method. Standards were developed for the expected quality of handover, consisting of a set of criteria for the minimum information required to ensure a safe and effective handover, stemming from the SBAR (Situation, Background, Assessment, Recommendation) approach, with adequate identification of patients, clear communication of the current situation and relevant details.

In an inpatient psychiatric setting, telephone calls to the on-call doctor were recorded for a two-week period, documenting whether key information was communicated.

Result. Total number of calls to on-call doctor recorded: 68. The patients name was given in 49% and the ID number in just 10%. Both relevant diagnosis/history and NEWS score was provided in 18%. However, the current issue and recommendation was given in 90% and 95% respectively.

Conclusion. The results thus far demonstrate a lack of structure and often limited information delivered in handover from nursing staff to the on-call doctor. This leads to difficulties in prioritisation, identifying the urgency of the situation and inefficiencies, as time is spent requesting further information which is not readily available.

After nursing colleagues were made aware, results from a further two-week period, from 65 total calls, demonstrated some improvement. Patient name given in 51%, ID number in 18%, relevant diagnosis/history in 12%, NEWS score in 17%, current issue in 92% and recommendation in 51%. It is clear that with marginal improvement, there remains a problem which we aim to address by collaborating further with senior nursing leads whilst implementing a succinct handover proforma. It is likely that with COVID-19 as the priority on the agenda this past year, quality improvement projects such as this has not been the main focus. We hope that we will be able to implement these changes in the coming months.

Do you mind if I take your blood pressure? Physical health monitoring of children and young people on ADHD medication amidst a pandemic

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Aims. To establish whether physical health monitoring for CYP on ADHD medication is according to NICE guidance (2018).

To determine the impact of COVID-19 pandemic restrictions on physical health monitoring for CYP on ADHD medication.

Attention deficit hyperactivity disorder (ADHD) is a common neurodevelopmental disorder, characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity, directly impacting on academic, occupational, or social functioning. It affects between 1-5% of children and young people (CYP) most often presenting in early-mid childhood.

Pharmacological treatment can be considered in CYP if certain criteria are met, where licensed medications include methylphenidate, dexamfetamine, lisdexamfetamine, atomoxetine and guanfacine. Stimulant and non-stimulant medications require frequent physical health monitoring due to their side effects including an increase in blood pressure and/or heart rate, loss of appetite, growth restriction and tics.

Method. Standards and criteria were derived from the NICE guidance (2018), whilst local trust policies were reviewed, demonstrating discrepancies. Standards were expected to be met for 100% of patients.

Electronic patient records were reviewed retrospectively from a representative cohort of CYP reviewed by clinicians in a community CAMHS service during March-November 2020. Data were entered manually into a spreadsheet for evaluation.

Result. A total of 27 CYP records were reviewed, average age 13yo, on a range of stimulant/non-stimulant preparations.

5 (19%) had height checked every 6 months, with 4 delayed to 7-8 months.

For those >10yo, only 5 (19%) had weight checked every 6 months.

Only 2 (7%) had their height and weight plotted on a growth chart and reviewed by the healthcare professional responsible for treatment.

Just 4 (15%) had heart rate and blood pressure recorded before and after each dose change, whilst similarly only 4 (not the same) had these parameters recorded every 6 months.

17 patients were reviewed by telephone/video call, where 5 patients provided physical health parameters (measured at home).

Conclusion. Across all parameters, standards are not being met for the required physical health monitoring for CYP on ADHD medication.

The COVID-19 pandemic has significantly changed the working conditions for community teams, impacting face to face reviews, creating challenges for physical health monitoring.

Our ongoing implementations for change include the use of a proforma for physical health measurements, improving psychoeducation for families, exploring potential barriers with senior colleagues and collaborating with pharmacy colleagues to update local guidelines in accordance with the latest NICE recommendations. We aim to re-audit in June 2021.

Are the staff in Heddfan Psychiatric Unit, Wrexham Maelor Hospital, adhering to the personal protective equipment (PPE) guidance as per Public Health Education, England? a QIP

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Aims. The aim of this audit is to assess whether healthcare staff are correctly donning and doffing PPE when entering and leaving the wards (changed to donning and doffing PPE when within 2 metres vicinity of a patient).

Method. Consultants/ Junior doctors/ Ward managers/ Staff nurses/ student nurses/ Health care support workers/ Occupational therapist/ Psychologists/ Student nurses/ Housekeeping staff, were all included in this Audit. None of the staff was aware of this Audit and this was an entirely random observation. We used a standard proforma in order to audit. Followed by the Audit, we trained the staff in the unit and then re-audited.

Result. 98% of them wore mask whilst in the ward and 94% of them washed their hands after doffing. 36% did not wear them appropriately and about 10-14% did not wear PPE at all. A mere 7 out of 50 alone used hand gel. Overall the donning and doffing of PPE was not being followed and adhered to according to the standards from PHE as per the first Audit. In particular, during donning only 1/3rd of them donned the PPE as per guidance. Likewise, the doffing technique was also poor, with only half of them removing the apron and mask correctly. Unfortunately, only 7 of the 50 people were observed to have used hand gel in between the doffing. This could be potentially increasing the risk of the spread of the coronavirus.

We had trained almost 150 staff members in the Heddfan unit with regard to PPE/ donning and doffing.

Handwashing prior to donning was achieved by all the staff. All the staff, that is 100 % of them adhered to the donning technique in line with the guidance in comparison to just 64% during the first Audit. Whilst hardly just 1/2 to 2/3rd of the staff followed the doffing technique adequately, the second audit showed that only 2 of the 50 staff did not follow the guidance. A meagre/ handful of them followed the utilisation of hand gel in between the tasks of doffing during the first Audit. Almost 90% of them followed the technique properly during the second Audit. Thus showing that the PPE training was successful.

Conclusion. Following the PPE training that was provided to them there was a good response from the staff and this went on to show how effectively we have managed the prevention/ contamination of virus in our unit.

Are the rapid tranquilisation nice guidelines adhered to, in patients with agitated/aggressive behavior? a QIP

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Aims. To explore whether the NICE guidelines for rapid tranquilisation are adhered to in the Psychiatric intensive care unit (PICU/ Tryweryn).

Method. Data were collected by core trainees. Standards were taken from NICE guidelines NG10. All patients who had received rapid tranquilisation, that were in PICU from August 2019 to February 2020 were considered in this a.

Result. During the first PDSA, we discussed with the staff in the ward regarding the protocol. Prior to actually starting the second audit, the adherence was noted to be low. However following persistence and having created a protocol jointly with the ward manager, we could see the difference. The staff were appreciated for their efforts in maintaining 100% adherence. The same was intended to be continued with some positive reinforcement from the auditing team. Over the first 2 months, 12 patients received Rapid Tranquilisation. Out of these 12, we randomly selected 4 patients to find the adherence of the NICE guidelines to be 100 per cent. The predictions regarding the adherence to protocol showed that the PDSA was successful.

During the second PDSA, the adherence was 100% again. The adherence to the protocol has been followed for not just the