

and hospital informative system, medical practice-related issues (including section 12(2) approval and medical indemnity). The Trainees' Duty section briefed on time-tabling and clinical duty. The Specialty-specific Guide provided important information related to training. Lastly, the section of Health Board-related Information highlighted the administrative structure of the NHS Health Board, important contact numbers, link to information. Specialty specific sections were created for general adult psychiatry and old age psychiatry as there is no other higher training of psychiatry in North Wales at the moment. Further sections in the pipeline include substance misuse and liaison psychiatry.

Conclusion. This induction manual is neither prescriptive nor exhaustive. It serves as a generic reference to facilitate new trainees in their adjustment process. Further review and revision will be conducted before every induction process to ensure the information is up-to-date and incorporating new input from the trainees.

Audit of documentation of observations on mental health services for older people (MHSOP) wards following implementation of nervecentre

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Aims. Nervecentre is an application that can be used on mobile devices and desktop computers to record and view physical observations amongst other tools. An audit had been done previously assessing the practice of recording observations using paper documentation. That audit had recommended the use of Nervecentre to improve the recording of observations. This audit was undertaken following the introduction of Nervecentre for documentation of physical observations. The aims were to evaluate if the transition to electronic documentation of NEWS (National Early Warning Score) observations on Nervecentre has improved practice in comparison to paper documentation and to evaluate if our practice could be improved by implementing electronic observations for psychiatric observations in addition.

Method. Data were collected over a 10-day period looking at all the documented observations from all inpatients on the MHSOP wards that met the inclusion criteria. Data were collected on the recording of psychiatric observations (recorded on paper charts) and physical observations (recorded on Nervecentre). The data were collated and analysed. The new data were compared to the original data from prior to the introduction of NerveCentre and the findings were presented at a local meeting.

Result. This audit has highlighted that the documentation of physical observations on MHSOP wards has greatly improved since Nervecentre was introduced. There was an improvement in recording of physical observations in almost all domains measured. NEWS scores were correctly documented 100% of the time compared to 87% previously. Raised NEWS scores were correctly escalated to a senior and reviewed 80% of the time compared to 0% previously. It has also highlighted that the quality of documentation regarding psychiatric observations could be improved as we are not currently meeting local or national guidance.

Conclusion. The most likely cause for the improvement in the recording of the physical observations is the implementation of Nervecentre. Nervecentre prompts users when observations are due, removes the risk of calculation errors and allows for observations to be directly escalated. Implementing Nervecentre for psychiatric observations may similarly improve the quality of these observations therefore improving patient safety.

A pilot to assess the feasibility and potential clinical utility of enhanced sleep management on inpatient wards in a mental health trust

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Aims. To assess the feasibility and utility of introducing the following changes on to in-patient units:

Structural and cultural adaptation to create a sleep friendly ward environment

A "Protected Sleep Time" between midnight and 6am

Routine screening for sleep disorders, including obstructive sleep apnoea and restless leg syndrome

Background. Insomnia and other sleep disturbances are cause, correlate and consequence of psychiatric disorders. Routine hourly night time observations, ward noise, bright lights at night time, sleep disorders, insufficient exercise, insufficient day light exposure, too much caffeine and inappropriate psychotropic use are all causes of disturbed sleep (Horne 2018).

Method. Seven wards participated in a pilot (SleepWell). These consisted of one male and two female Acute Wards (General Adult), a High Dependency Unit, a Neurorehabilitation ward, an in-patient dementia service and one rehabilitation ward. These wards were supported via an existing trust management structure and the pilot was specifically supported by two trust managers (RW and RB) and by a clinical director (PK). The expectation was that each ward would identify a sleep champion from existing staff to facilitate the changes. A "product" was developed which identified core sleep management features but, in addition, wards were not confined to these. The existing policy that all inpatients should be checked each hour over night was suspended for the pilot wards and the patients had protected sleep time (PST) if the MDT agreed that it was clinically appropriate.

Quantitative and qualitative techniques were used to identify facilitators of change, impact on sleep and, outcome.

Result. Protected sleep was viewed positively by all staff and approximately 50% of patients on the pilot wards were able to have PST at some point in their admission. Routine sleep disorder assessments were harder to implement and 33% of patients were screened. There were no deaths or significant events on patients due to PST. Hypnotic use on the pilot wards reduced. It is anticipated that PST where it is safe will be rolled out across all adult and old age wards in the trust.

Conclusion. With support, it has been feasible to change many aspects of sleep management across a breadth of inpatient units in a large NHS trust.

Let's get moving! Improving physical activity amongst rehabilitation patients; a quality improvement project

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