

Young Person and Parents/Carers' Experiences of the Transition Into a Child and Adolescent Mental Health Services (CAMHS) Inpatient Unit: What Could Be Improved?

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Aims. To investigate the themes within young people and parents/carers' experiences of the admission process. A focus was placed on potential targets for change to improve experiences of CAMHS admission.

Methods. Young people and parents/carers with an experience of inpatient CAMHS admission within the past two years were approached by the Involvement team of an NHS trust. Focus groups and interviews were conducted capturing the views of 8 young people and two parents/carers. The notes and transcripts from these conversations were analysed using Braun and Clarke thematic analysis.

Results. Two key themes were identified within the data. The first focussed on information provision and communication. This captured young people's experiences of both: what information was available to them, e.g., websites and leaflets, and how this information was conveyed to them. The second theme brought together the young people's interpersonal experiences during the admission process. Within this, the impact of consistent contacts as well as both positive and negative transient encounters was highlighted.

Conclusion. Admission to a psychiatric ward is often a highly distressing time for young people and their families. The provision of easily accessible, clear, and correct information can improve their expectations and initial impressions of a unit. How this information is presented is also important. Consistent staff support and response to distress and difficulties during this time can also shape the perspectives of young people and their parents/carers.

Clear, accurate, and young person friendly information about a unit and the admissions process could be an easily achievable change which units could make to improve young person experiences. Improvements to clinicians' skills and response may represent a more complex and expensive goal.

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Improving Carers' Engagement for Patients Admitted to Psychiatric Intensive Care Unit (PICU): A Quality Improvement Project

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Aims. The project aims to improve carers' engagement for patients admitted to our male Psychiatric Intensive Care Unit

by improving communication between staff and carers; and by involving carers more in patients' care.

Hypothesis:

Among patients admitted to PICU, there is inconsistency in communication with carers and in involving carers in patients' care. We expect an improvement in these parameters with the quality improvement project.

Background:

Within PICUs, patients with severe psychiatric illness face social isolation. Challenges arise when carers are not engaged, impeding patient support and personalised care. Involving carers becomes crucial for informed decision-making, ensuring both patients and carers actively participate in the care process. National Association of PICUs and The Royal College of Psychiatrists' Guidance for PICU sets out recommendations regarding timelines and types of interventions to be offered to carers.

Methods. Initial baseline data was collected by reviewing patient electronic notes.

We then tested interventions to improve carers' engagement by using the Plan-Do-Study-Act (PDSA) methodology over 2 cycles. In the first cycle, we engaged the nursing staff by presenting the baseline data and recommendations to improve carers' engagement. In the second cycle, we introduced an admission protocol to ensure carers were engaged consistently. The parameters assessed were documentation of carers details; contacting carers within 24 hours of admission; documenting carers' views in care plan; inviting carers to Care Plan Approach (CPA) meetings and offer an appointment for carers with staff.

Data was collected after each PDSA cycle to monitor change.

Results. Of the patients admitted to PICU, 29% had their carers' details documented at baseline, 40% after the first PDSA and 80% after the second PDSA. 42% of carers were contacted within 24 hours of admission at baseline; 66% and 30% after the two PDSA. 50% of carers had their views included in the care plan at baseline; 0% and 30% after the interventions. At baseline, 42% of patients' carers were invited to the CPA meeting, 66% and 30% after the two PDSA cycles. 50% of patients' carers were offered an appointment with staff at baseline, 66% and 30% after the two interventions.

Conclusion. As a result of this quality improvement project there has been an improvement in engaging carers of patients admitted to PICU. This was not sustained for the second cycle due to many regular senior staff being on leave during Christmas. The next steps will be to implement this consistently and produce a carers' information pack.

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Improving Trainee Experience of Raising Concerns: Redefining a Representative Structure for Post-Graduate Doctors in Training

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Aims. As part of a wider quality improvement project (QIP) aiming to improve trainees' experiences with 'Raising Concerns' in a large mental health trust, we sought to improve the trainee representative (rep) structure. This would give trainees more transparent processes and provide intermediaries by which to raise concerns. Based on change ideas generated from our driver diagram, roles were created to coordinate meetings and represent specific groups of trainees and on-call rotas.

Methods. Prior to August 2022, there were an undefined number of 'Senior House Officer' (SHO) reps who were recruited informally by the Post-Graduate Medical Education Team. The duties of these reps were not clearly detailed. As part of our first 'Plan, Do, Study, Act' (PDSA) cycle, we identified groups of trainees that needed additional representation (International Medical Graduates [IMGs], Less than Full Time trainees [LTFT]) and introduced a Wellbeing Rep to cover all training grades. Specifically for SHOs, we introduced three core roles (Rota/Placement, Inclusion, and Social) and individual roles for the six on-call rotas. Following the implementation of this rep structure, we gathered quantitative data, including whether trainees had utilised the reps and how effective they were in raising concerns, and qualitative feedback. We gathered data from both the reps and the whole cohort of trainees. We then started another PDSA cycle in August 2023.

Results. On a 1–5 scale (5 = very effective), the average response from trainees for how effective the trust reps were in supporting raising concerns was 3.8 (5 responders), with no trainees who responded feeling that any of the rep roles needed restructuring. However, the rep survey highlighted that the following roles needed restructuring: Rota/Placement rep, Social rep, and Rota reps. The Rota/Placement role was highlighted as being unnecessary due to the existence of individual rota reps, but there was a need for a 'lead' rep to coordinate rep meetings and induction. Unfortunately, a Social rep was not recruited, however it was identified that due to the importance of the role more than one trainee may be required to arrange social events.

Conclusion. Overall, the trainee response to the new rep structure has been neutral/effective, but we hope to obtain more responses in the next PDSA cycle. The rep feedback highlighted the need for coordinator roles to improve cohesion. The results have informed change ideas which we implemented in August 2023. The second PDSA cycle will be completed in July 2024.

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QIP Improving Trainee Confidence in Male Sexual Dysfunction History-Taking in an Acute Inpatient Unit

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Aims. Trainees on the psychiatry on-call rota at a London acute inpatient unit reported a lack of confidence in asking male patients about sexual dysfunction during clerking. Research shows that history-taking barriers include embarrassment, time shortage and task prioritisation. Sexual dysfunction is prevalent amongst the general population, markedly so amongst people with mental health diagnoses.

In response, we designed a quality improvement project (QIP) to improve confidence by addressing the need for good history-taking and the technique for doing so.

Methods. To gauge trainee confidence, we produced and disseminated an online questionnaire with a mixture of qualitative and quantitative questions.

Based on the data collected, we contacted a local sexual health consultant and requested a teaching session on the importance of sexual history-taking, the impact of not doing so, barriers to history-taking and how to ask about sexual dysfunction.

A follow-up questionnaire was produced and disseminated.

Results. The results of the first questionnaire showed that 100% of respondents (n = 10) did not ask male patients questions about their sexual function, on admission. The main reasons for this were embarrassment for themselves (25%) and the patient (66.7%), lack of confidence on how to word these questions (50%), lack of time (58.3%) and feeling that these questions are not relevant (33.3%).

Following the teaching session, 71.4% of respondents said that they would ask male patients questions about symptoms of sexual dysfunction on admission. The majority of responses quoted that the teaching had increased their confidence, decreased their embarrassment in asking these questions, and helped them to understand the relevance of asking these questions. Two respondents queried the appropriateness of asking acutely unwell patients these questions on admission and if these questions could be asked during a patient's admission instead.

Limitations: Small sample size of results; slight drop in responses from first questionnaire to second questionnaire; questionnaire only asking questions about male patients, not female patients.

Conclusion. This QIP shows that a single, simple intervention can improve trainee confidence in the short term. This intervention can be applied across the UK. Online teaching can improve access to the expertise of local sexual health consultants. This QIP also provides a basis for further analysis: whether single interventions can improve trainee confidence in the long term, when is the best time to ask questions about sexual function and applying this intervention to female sexual function history-taking.

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Complex PTSD Pathway for Kingfisher Mother and Baby Unit

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Aims. When Kingfisher Mother and Baby Unit (MBU) opened in 2019 personality disorder and severe self-harming behaviours were exclusion criteria for admission. Complex Post Traumatic Stress Disorder (C-PTSD) with its emotional dysregulation, interpersonal difficulties and common presence of self-harm was similarly categorised.

Currently, C-PTSD presentations are frequently admitted to the MBU, making up around 45.9% of admissions. There is increasing understanding of the importance of effective and trauma informed treatment in admission outcomes, particularly