Little is known about the prevalence of comorbid ADHD in adults under the care of early intervention for psychosis (EIP) services in the UK. A previous audit and quality improvement project examining all (adolescent and adult) patients (age 14–65 years) conducted in October 2022 showed a prevalence of 3.6% comorbid diagnosed ADHD in our EIP service.

Methods. Audit tools to identify the prevalence of ADHD in patients with First episode psychosis. Re-audit to monitor the the trajectory of the cases.

Measurable: Using EIP caseload cross-sectional data, data of monitoring and management from electronic patient notes system (SystmOne).

A clinical pathway was developed to integrate the diagnostic and treatment pathway to manage ADHD in an early intervention psychosis service.

Service evaluation

We identified all adult patients (between the ages of 18 and 65 years) on the caseload of the EIP service in Northamptonshire Healthcare NHS Foundation Trust, dated 5 September 2023. Data collected included age, gender, ethnicity, primary psychosis diagnosis, psychotropic and ADHD medication prescribed and risk profile that included a history or presence of substance use. Data was anonymised.

Quality improvement

Following from a previous ADHD service evaluation and QIP in EIP (2022) we identified further problem areas that included significant delays in suspected comorbid ADHD in adult patients under EIP care, as well as challenges for those already referred and attempts made by the adult ADHD service for screening and assessment (poor engagement), as well as challenges to patient functional recovery and outcomes in those with comorbid diagnosed and suspected ADHD and psychosis.

Results. 174 of 183 (95%) patients on the caseload at the time of the study review date were adults. Of the adult patients, 5 of 174 (2.9%) patients had a known diagnosis of ADHD, all dating back to childhood/adolescence. An additional 4 patients had been referred for ADHD assessment.

Conclusion. There are treatment challenges, and monitoring of physical health has differences with the Early Intervention Psychosis (EIP) standards following antipsychotic monitoring, hence why we have implemented in a lead-up ADHD in EIP Quality Improvement Project a NICE concordant care plan that includes physical health monitoring content and frequency.

Combined outcomes (symptomatic and functional recovery) may be worse unless ADHD related symptoms and functional impairment are addressed, in addition to psychosis, and addressing substance use is also important, given that in people with substance use disorder, the prevalence of ADHD is estimated to be as high as 21% (Rohner et al. 2023), with a lifetime prevalence of drug use disorder 27.7% (Anker et al. 2020). Of interest, in our cohort, 3/5 (60%) patients had a history of substance use (40% drug-induced psychosis diagnosis).

Our study patient profile included all young Caucasian males, with a mean age of 22 years (range 19–28 years). Of interest is that our current ongoing pilot case for the integrated clinical pathway is a young mixed-race female. Females are more likely to be undiagnosed, and clinical presentation can be different (Attoe & Climie 2023).

There are challenges with suspected ADHD and diagnostic assessment. In our Trust we have a stand-alone adult ADHD diagnostic assessment service for formal diagnosis, using DSM criteria with 3 phases of assessment. However, this service has significant referral rates, and due to capacity and resources, has a very long waiting list (18 months to 2 years).

As part of our quality improvement effort, we have collaboratively (with the adult ADHD service) worked towards an integrated pathway to improve efficiency and time to diagnostic assessment (reduce delays) for patients in EIP suspected with comorbid ADHD, with our first pilot case ongoing. We have developed a clinical pathway to aid clinicians in management of those with confirmed and suspected comorbid ADHD, to improve patient outcomes.

There are further training needs to effectively support and manage ADHD comorbidity in those with psychosis under the care of Early Intervention Psychosis.

Project Whiteboard: A Quality Improvement Project Enhancing Patient Flow in an Acute Mental Health Setting

Dr Ashu Handa*, Ms Terry Harper, Dr Brandon Wong, Dr Kisa Abbas and Ms Olanrewaju Odeyemi

CNWL, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.378

Aims. We are a 17 bedded acute mental health ward in a busy inner-city hospital. A handover of all patients, with the multidisciplinary team, takes place every morning (Whiteboard round). The clinical team felt that the information provided during this meeting needed a review, to ensure relevant patient information is being disseminated, and right clinical decisions are being made in a timely manner.

The team decided to focus on improving links with Community Mental Health Hubs (CMHH) to ensure continuity of care. The challenge the inpatient team faced is the need to interface with community mental health teams from two London boroughs, as the unit became the main admission hospital for Kensington & Chelsea and Westminster (KCW) patients.

The main aim is that 80% of KCW patients' CMHH (including new referrals) will be contacted within 24 hours of them being admitted onto the ward by April 2024.

Methods. As part of this QI project, weekly meetings were commenced, with a team comprising doctors, nursing staff (both inpatient and from local community team) and an Expert by Experience (EbE). A questionnaire was produced and circulated to ward colleagues about their views on the quality of whiteboard. A more focused questionnaire was then sent out around CMHH involvement in a patient's admission journey. We took a deep dive into the structure of the local community teams (at least 10 identified) and how referral processes work, as it was evident that staff were unclear at times on who/how to refer.

From this, the first change idea was formed: "information sheets" were produced showing which GPs correspond to which teams, and that patients can be referred this way. The Plan Do Study Act (PDSA) was applied to make these sheets visible to all staff. The outcome measure used was how many patients had CMHH referral/contact within 24 hours.

Results. Data is being collected daily, by reviewing patients notes to see if CMHHs have been contacted. Since commencement of the first PDSA cycle in December 2023, of the twenty-three patients admitted, nineteen have been eligible. Of these nineteen patients, fifteen patients (79%) have had contact or referrals made to their CMHH within 24 hours.

Conclusion. Results suggest that the aim is on the way to being met. Our next change idea is to obtain formal feedback from staff and patients on this process.

Implementing a Digital Handover System to Improve Safety and Efficacy of Handover Across Acute Psychiatric Inpatient Sites

Dr Aaron Harris*

Oxleas NHS Foundation Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.379

Aims. To implement a digital handover system within Oxleas inpatient sites to improve the visibility of tasks both completed and pending, to reduce the number of tasks missed and to provide a clear audit trail relating to tasks handed over.
Methods. Junior doctors providing on-call cover to acute sites across all 3 boroughs served by Oxleas were invited to complete a questionnaire relating to the efficacy of handover. With this data & information gathered through discussions with the trust's informatics team, a digital handover system, based in Microsoft Teams, was developed. This was piloted and refined through 6 PDSA cycles from September 2022 – August 2023 before being implemented across all Oxleas acute sites from August 2023. Further questionnaires were completed 1 month & 6 months after its roll out to assess the impact of the change.
Results. Doctors were asked to complete a questionnaire at 3 time points: pre-intervention (T0, 20 respondents), 1-month post-intervention (T1, 13 respondents), and 6-months post-intervention (T2, 12 respondents).

- At T0, 92.3% of respondents reported tasks created by the on-call team had been missed due to staff not being aware, this reduced to 11.1% at T1, and 28.6% at T2.
- At T0, 23.1% of respondents agree/strongly agree that it is easy to view tasks that have been done on their ward out-of-hours.
- By comparison, at T1 69.2% reported the digital handover system has made it easier to view what had been done on a ward out-of-hours, rising to 83.3% at T2.
- At T1, 76.9% reported the digital handover system has made it easier to view tasks when on-call, rising to 83.3% at T2.
- At T0, 30% agree/strongly agree that the outgoing on-call doctor leaves a written record of tasks completed and outstanding. This rose to 69.3% at T1, and 41.7% at T2.

Conclusion. There is strong evidence that effective handover is a key aspect of clinical care, and failure of this is a preventable cause of patient harm. The initial questionnaire highlighted issues with the efficacy and safety of the handover process within acute sites at Oxleas, which the digital system sought to address. After implementation of the digital system, the findings demonstrated improvements in the handover process, with visibility increasing for tasks both completed & in progress, and fewer reports of tasks being missed by the ward-based doctors, which was maintained over the 6-month follow up period.

Improving Bone Health Care and Monitoring of Intellectual Disability Patients on a Low Secure Female Unit

Dr Serena Hinze[1]*, Dr Rosie England[2], Dr Ambreen Rashid[1] and Ms Nicole Freeman[1]

[1]Coventry and Warwickshire Partnership NHS Trust, Coventry, United Kingdom and [2]Black Country Healthcare NHS Foundation Trust, Walsall, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.380

Aims.

- To ensure all patients on a low secure female inpatient unit have bone health risk factors assessed, identified and interventions initiated within 3 months of admission.
- The above to be achieved through creation of a Bone Health proforma, integration of a Bone Health checklist into the Intellectual Disability (ID) Annual Health Check and delivery of bone health education for patients and staff.

Background
Intellectual Disability has been shown to be associated with poor bone health, osteoporosis and increased fracture risk. The current NICE guidelines and risk tools (QFRACTURE), do not adequately reflect the true risk within this patient group who present with additional risks of epilepsy, antiepileptic medication and greater likelihood of low vitamin D. Bone health has not routinely been monitored in this population hitherto. This quality improvement project sought to develop a process whereby potential risk factors for poor bone health were identified and managed effectively.
Methods. The project was undertaken between February 2022 – October 2023 on a female low secure unit. All 8 patients on the unit were included. A baseline screening of risk factors was conducted to assess current practice and explore the clinical need for the project. Most patients were found to have multiple risk factors which had not previously been highlighted, indicating the need for formalised monitoring. Based on questionnaire feedback, a Bone Health Care Plan, a risk factor checklist which was integrated with patients' ID Annual Health check and Educational workshops were developed. Primary and secondary drivers were identified at the outset and plan, do, study, act cycles were used to refine change ideas. The changes were evaluated using quantitative and qualitative measures.
Results. Every inpatient has a completed Bone Health Care Plan. Twenty-five percent of patients were identified as having a particularly high risk and have had referrals accepted for Dual-energy X-ray absorptiometry (DEXA) scans. All patients are using a new easy-read ID Annual Health Check form with Bone Health checklist incorporated. All staff and patients were given the opportunity to attend a series of four bone health workshops, 43% of patients attended at least one session. Positive written and verbal feedback was received from both patients and staff.
Conclusion. 100% of service users have had their risk factors for bone health assessed and any necessary interventions applied. There is now an embedded process for reviewing the bone health of these patients annually where previously there was no regular monitoring.