1. Detailed cognitive tests need doing for screening and to establish severity
2. Consideration for which neuroimaging modalities can help aid diagnosis, if any, should be made.
3. ARBD leaflets to be given
4. ARBD diagnosed patients who do not need rehabilitation unit, should be referred for social care assessment as an inpatient and / or be followed up in the community under Care Act
5. Considerations with the Multi Disciplinary Team for ways to improve engagement in the community, perhaps with more frequent and robust follow-ups.

Improving the Quality of Old Age Inpatient Ward Rounds During COVID-19 in NHS Lanarkshire, Scotland

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Aims. To provide a structured Multidisciplinary team (MDT) checklist to improve the quality of ward rounds in Ward 3, Wishaw General hospital. Ward rounds normally involved patient and electronic documentation review during MDT. Feedback from medical and nursing staff indicated inconsistencies in finding up to date Do not resuscitate cardiopulmonary resuscitation (DNACPR)forms/Treatment escalation plans, treatment forms, care plans, thromboembolism prophylaxis during ward rounds. Discussions about who will update the family, make social work referrals needed clear documentation in order to follow up efficiently post MDT. Food, fluid, and weight charts although done regularly there was no single place to keep them together. These charts to be kept in a separate folder for finding easily during ward rounds. The Royal College of Psychiatrists sets standards that managers and practitioners have agreed standards for ward rounds. Structured ward rounds and check lists have shown to prevent omissions in care and improve patient safety.
Methods. Discussions with Ward 3 team, nursing colleagues and ward Quality improvement group were held. A Standard MDT Quality improvement Checklist was devised and used as a Pilot in W3, WGH.

This was first introduced in August 2021. Plan, do, study, act (PDSA) cycle was carried out.

Plan: Trial MDT checklist at Ward 3 ward Round
Do: Use Initially for two Consultant ward rounds
Study: Ask all MDT staff members for feedback on the form
Act: Reformat the checklist for the following ward rounds and distribute among all consultants.

Repeated Revisions of MDT checklist done after feedback from ward staff and final version devised and results audited in Nov 2021 and Jan 2022.

Food, Fluid, and weight charts were put in separate folders.
Results. Before MDT Checklist nil up to date MDT checklist information available, 10% individual food and fluid charts and 0% folders.

After MDT checklist in November 2021, 73% increase in up-to-date checklist items, 100% increase in finding charts in folders.

In January 2022 decrease to 44% of up-to-date MDT checklist items, 100% food and fluid charts in folders.
Conclusion. MDT Checklist provided robust structure to our Ward rounds along with the regular electronic record and has been incorporated in our shared drive. The results in January for up-to-date checklist were down because of staff sickness due to new Omicron variant and less people available to keep documentation up-to-date.

A Pilot Project to Introduce the Compassionate Approach to Living Mindfully for Prevention of Disease (Calmpod) in Weight Management in a Forensic Intellectual Disability Unit

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Aims. About 28% of the UK population are obese and a further 36.2% are overweight. The prevalence of both in those with mental illness and/or intellectual disability (ID) is much higher. Several therapeutic approaches have been tried, with varying efficacy. Recently a three-session intervention which uses mindfulness techniques (The compassionate approach to living mindfully for prevention of disease- CALMPOD) was used in a tertiary obesity service in the West Midlands and shown significant benefits. Our aim was to assess the suitability of this intervention in mental illnesses and/or intellectual disability services.
Methods. Three pre-pilot focus group discussions involving multispecialty professionals and service users were held involving four psychiatrists, three service users, two psychologists, one physician, one endocrinologist, one bariatric surgeon and one pharmacist to identify key aspects of the CALMPOD programme for adaption to psychiatry and/or psychiatry of ID wards. Based on this, CALMPOD was modified by two psychologists with relevant experience. The modified CALMPOD was piloted in a medium secure forensic in-patient unit for people with ID. A post-pilot focus group discussion involving two psychiatrists, one occupational therapist and three service users was held after completion of the pilot to discuss lessons learned.
Results. Invitations sent to 17 in-patients. The mean BMI was 34.76%, 76% were obese, 6% were over-weight and 18% in the normal range of weight. 3 patients attended the three-session programme (17%). All 3 were in the obese category, all had had individual weight management input – i.e. seen by dietician, weight management included in care plans. The post-pilot focus group discussions identified 6 key themes.
Conclusion. Emerging themes from the pilot were (a) Patients and staff recognise that the programme was 'necessary' and 'useful', but the challenge is how to 'start attending regularly'. Once in, participants 'tended to stay on'. (b) A visible publicity campaign is needed to spread awareness of the programme and its 'newness'. This would help with staff 'buy in' from all wards and departments. (c) The key message should be 'living healthily' and 'feeling better', not just weight loss. (d) Staff and/or patients' family members participating in the programme would be more motivating. (e) The content of the programme needs further modifying with an emphasis on shared activities, calories