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## Improving Medical Handover in the Tyrone and Fermanagh Psychiatric Inpatient Unit

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**Aims.** This project was undertaken in the Tyrone and Fermanagh Hospital, an inpatient Psychiatric Unit in Omagh, Northern Ireland. It was recognised that the previous method of medical handover via anonymised WhatsApp messages had several issues including patient data on personal phones, over-reliance on phone apps which have the potential to crash and short messages with limited details were included. The aim of our project was to improve patient safety by improving communication between medical staff members.
**Methods.** The previous method of medical handover was via text message on messaging platform WhatsApp. A message was sent the morning of handover, to the WhatsApp group.

We continued to use a digital platform, but used Microsoft word, and Western Trust email addresses to record and send the handover. At the start of this project, we allowed free space recording, resulting in variation in the handovers.

We agreed a minimum number of details to be included to ensure quality of handover, and audited the word documents, to assess the adherence to this.

This change, still does not require face to face handover. There have been pros and cons to the change, which will be discussed in this presentation.

We reviewed four months' worth of handovers. They were reviewed for specific elements of essential handover criteria. The areas included Patient Name, H&C, detained or voluntary, admission or review, presenting complaint, patient's history, risks, physical issues, and handover to specific person.

It should be noted that the doctors involved were aware of the changes made, and standards being introduced, and therefore were aware that they would be auditing their own handovers. This might have created bias in the subsequent handovers.

We then analysed each month to see what percentage of handovers had been concordant with the standards. These data were then represented in graphs, as we will show.
**Results.** We identified areas which were performed well when completing handover. The areas which were consistently 100% included the date of handover and patient name or initials. Outstanding jobs were performed in 97.5% of handovers.

Areas for improvement identified when collecting results were the status of admission (i.e. voluntary or detained), the main patient risks and use of the document password.

100% of the shifts used the new digitalised format for handover using Microsoft word and trust email system.
**Conclusion.** We reviewed the results of the data, which highlighted areas for improvement

We hope to implement a standard performa for handovers, reducing the chance of key information being missed, thereby improving patient safety. We aim to collect data following this 2nd intervention in the next rotation and continue to examine handover processes using PDSA cycles.

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## A Trust Wide Audit Evaluating Prescribing Practices in Clients With Emotionally Unstable Personality Disorder (EUPD)

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**Aims.** The aim of this audit was to evaluate prescribing practices in patients with EUPD at South West London and St George's Mental Health NHS Trust and compare these to NICE guidance on the management of EUPD. We are aware that for a multitude of reasons including high levels of distress and long waiting times for psychological therapy, clients with EUPD are often prescribed psychotropic medication. NICE guidance states that drug treatment including antipsychotics should not be used specifically for EUPD or for associated behavioural symptoms. Drug treatment for comorbid conditions and short-term use of sedative medication may be considered as part of a crisis treatment plan. If prescribing, NICE recommends that written material be provided to the client along with regular treatment reviews.
**Methods.** We obtained a list of patients in the trust with a recorded diagnosis of EUPD on their electronic patient record (EPR) system (N=869). 10% of these clients were randomly sampled (N=87).

The notes were assessed for any prescribed psychiatric medication including the documented rationale for prescribing. We also assessed if medication use was consistent with NICE recommended time limited crisis prescribing and whether there was evidence of regular reviews of prescribed medication and of written material being provided to the client.
**Results.** Of the sampled clients, 81.6% (n=71) were prescribed medication. Of these, 39.4%( n=28) had medication use consistent with NICE recommended time limited prescribing, and 57.7%( n=41) had timely reviews of medication. 4.2% (n=3) of those prescribed medication had evidence on their EPR of written material being provided.
**Conclusion.** Our results highlight the extent of drug prescribing for EUPD within the trust. Over half of patients sampled had timely reviews of prescribed medication. However, most were not consistent with NICE recommended time limited prescribing. The results were presented to the trust's Clinical Reference Group. A Working Group has now been formed to help bring prescribing practices better in line with NICE guidance, specifically around the provision and recording of written information of drug treatment to patients and reducing inappropriate prescribing and polypharmacy.

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## Reflecting on Episodes of Rapid Tranquilisation in Forensic MDT Settings

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**Aims.** Rampton Hospital is the High Secure Hospital of Nottinghamshire Healthcare NHS Foundation Trust's Forensic Service. It is one of three such hospitals in England, following Security Directions set out by the Department of Health. Patient management occurs through the implementation of strict policies and procedures. Policy requirements highlight the need for MDT post-incident discussion of restrictive interventions, and in particular, of Rapid Tranquilisation (RT). This primary audit aimed to ascertain current practice and if necessary, suggest interventions to ensure that patient-care remains safe, effective, and well-led.
**Methods.** To establish current practice with regards to the discussion of individual cases of RT in MDT settings, specifically in Ward Round, we commenced a retrospective data collection from electronic notes covering all directorates within the High Secure estate between May and June 2022.

From these notes, we tried to ascertain whether the following policy standards were being met:

- A de-brief with the patient should take place as soon after the incident as is practicable and reasonable, ideally within 72 hours.
- The MDT meeting post RT episode should explicitly discuss the episode, and consider medication and any triggers of periods of acutely disturbed behaviour.
- There were 81 data sets to explore.

**Results.** Not all data sets were viable. Out of those analysed, less than 10% were found to have met the aforementioned ideal policy standards of having had a reflective discussion within 72 hours with both the patient and as an MDT, exploring the episode itself and its antecedents.
**Conclusion.** There are several interesting factors to consider from the results obtained. We postulate that the frequency of episodes of RT makes meeting the policy standard problematic; pragmatically, there is a significant time barrier to exploring these incidents in detail and the various teams, operating in dynamic and high-risk environments, may find it difficult to coalesce in order to debrief appropriately.

Furthermore, the reflections may actually be happening, but the burden of documentation mean that these are not being recorded formally in a way that can be measured.

There are limitations to the searches of electronic notes and we did not have access to Incident Reports, often completed at the time of these episodes; further information may have been uncovered if they were available.

Despite this, there is room for interventions that inform staff of this need and to provoke improvements in current practice.

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## Seclusion on Psychiatric Intensive Care Unit – Is the Trust Medical Review Policy Being Followed?

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**Aims.** Seclusion is a restrictive intervention used in inpatient settings for the safe management of patients who present with severe behavioural disturbance which is likely to cause harm to others. Clinical notes were used to establish if the trust policy of medical reviews for patients in seclusion was being followed on the Psychiatric Intensive Care Unit (PICU).
**Methods.** Patients admitted to male PICU at Springfield Hospital, Southwest London, over a 4 month period (February 2022 to May 2022) were included in this audit. Patients who were secluded outside this time period or prior to admission to PICU were excluded from this audit.

The clinical notes computer system (Rio) was searched using the term "seclusion". The timing of initiation and termination of seclusion were noted as well as the timing and grade of medical professionals present for documented reviews.
**Results.** Over this period, 12 discrete episodes of seclusion were identified. The length of seclusion varied from 8 hours 45 minutes to over 5 days, with a mean length of almost 3 days (2 days, 20 hours, 25 minutes).

As the length of seclusion differed so did the required medical reviews in line with trust policy. This involves Senior House Officer (SHO) review at 30 minutes, Registrar review at 8 hours, Consultant review at 24 hours followed by 2 senior reviews (one Registrar and one Consultant) over each subsequent 24 hour period of continuous seclusion.

10 episodes of seclusion lasted over 24 hours in this audit. Of these 40% had the required medical reviews documented in the clinical notes appropriately for the full period of seclusion. 50% of cases had at least 1 missed or not documented Registrar review. There were 2 incidents of missed Consultant medical reviews for a 24 hour period of continuous seclusion.
**Conclusion.** From these results medical reviews were not being correctly carried out, or were not documented correctly, in the majority (60%) of cases of seclusion over 24 hours. This suggests missed opportunities for patient review to terminate seclusion at the earliest safe opportunity in line with national and trust guidance. These results have informed the update of trust guidelines on seclusion to bring it in line with national guidance with a view to improve patient care and will be re-audited.

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## Clinical Audit Reviewing Compliance With Respective Trust-Based Physical Health Monitoring Guidelines, Amongst Inpatients Prescribed Anti-Psychotic Medication in Two Distinct Secure Care Facilities: A Low Secure Unit and a Prison Personality Disorder Unit

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**Aims.**

1. To review the current level of compliance with CPFT (Cambridge & Peterborough Foundation Trust) guidelines by inpatients prescribed anti-psychotics at George Mackenzie House (GMH) low-secure unit and likewise, with NHFT (Northamptonshire Foundation Trust) guidelines by inmates prescribed anti-psychotics at HMP Whitemoor's Fens Unit.
2. To identify any differences or similarities in compliance rates between both sites.

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