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.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

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.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Reflecting on Episodes of Rapid Tranquilisation in Forensic MDT Settings

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