easy to do PA with patients during their shift, while many reported they were able to encourage exercise but were unable to accompany patients to sessions. Specifically, participants reported lack of time (40%), high level of clinical activity (32%), lack of staff (30%), lack of PA resources inside the wards (20%) and conflicting priorities (18%), stopping them from helping patients to do more exercise. However, they felt more staff (28%), time dedicated to PA (26%), on-ward resources (18%), access to the gym and gardens (18%), staff dedicated to PA (16%) and staff trained in facilitating PA (10%), would help participants promote PA on the ward. Other suggestions to enable PA included a change in ward culture, valuing and promoting PA, daily patient encouragement by all MDT members instead of only occupational therapists, and PA promotion as part of mental health treatment and as physical health strategy. Finally, 70% of participants said they exercised regularly, although some reported lack of time or motivation, work commitments and workload-related exhaustion reducing their ability to exercise.
Conclusion. Participants acknowledged the importance of PA for physical and mental health. Furthermore, they described multiple enablers and barriers. Prioritising PA during admission, providing on-ward activities, educating/training staff, reiterating that PA promotion is within all MDT members' job roles, and offering organisational support can contribute to improved PA provision and regular involvement of patients.An integrative approach to mental health and well-being, promoting PA in inpatient psychiatric settings is required.

Improving accessebility to psychiatry in NHS Tayside

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Aims. Our aim is to improve the accessibility of Psychiatry to other specialties when being contacted for review and advice, both in hours and out of hours.
Background. From clinical contact and informal conversations, other specialties sometimes have difficulties contacting psychiatry for advice/review. The aim of this is quality improvement project is to determine how accessible we are to other specialties and work on improving how we communicate with the general hospital.
Method. We created a questionnaire for colleagues from other specialties to fill in from 26/9/19 for 6 weeks. We gathered information regarding their grade, work site, previous contact with psychiatry, whether they knew where to find our contact information and if they could identify the correct method to ask for advice from general adult psychiatry (GAP), Psychiatry of old age (POA) , and out of hours psychiatry (OOH). We also asked colleagues to put in free text comments regarding their experience in contacting psychiatry. We also asked if our colleagues were aware of how to perform an Emergency Detention Certificate as this is advice we sometimes give which does not always need our input immediately.
Result. There was a total of 39 responses, 29 from Ninewells Hospital (NW) and 10 from Perth Royal Infirmary (PRI). There was a mixture of staff grades from Foundation Doctors to Consultants. 23/39 colleagues knew where to find contact information for Psychiatry, 14/39 colleagues correctly answered how to contact GAP (Phone), 15/39 colleagues correctly answered how to contact POA (Email), 15/39 colleagues correctly identified who to contact OOH, and 16/34 colleagues who could do emergency detentions (FY2+) knew how to do one. Free text comments often referred back to the difficulty of finding the right grade of staff first try, Feedback from PRI where there was no dedicated Liaison Service and relies on a duty doctor system was less positive, with terms 'tricky', 'difficulty', 'awkward' used in majority of responses.
Conclusion. From our results we can conclude that contacting Psychiatry in NHS Tayside can be confusing for other specialties. Taking this forward, we will utilize the 'referral finder' system in NHS Tayside and review the existing information available, and to update the contact information for our subspecialties to make contact ourselves more streamlined and accessible. We will also review appropriate clinical protocols that we can link to our page on referral finder to help save time for our colleagues as well.

Improving the physical healthcare of COVID-19 patients in inpatient psychiatric settings

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Aims. COVID-19 can spread rapidly in psychiatric inpatient settings. Previous studies have found that patients have a higher risk of hospitalisation and death than adults in the community. The aim of this project was to improve the care of patients with COVID-19 in psychiatric inpatient settings.
Method. A baseline audit was conducted of care COVID-19 patients received in wards that experienced outbreaks in January 2021 in a London Mental Health Trust. Clinical notes were reviewed for management plans, including clear documentation of risk of serious illness, frequency of vitals monitoring, and thresholds for escalation to medical teams.

A new protocol was subsequently developed and implemented at one inpatient unit: "COVID-19: Early Identification of Risk and Management". This included an adjusted 4C mortality score to determine risk of deterioration, and schedules for observation monitoring based on this outcome. Each schedule specified separate frequencies of monitoring of critical observations (oxygen saturations, respiratory rate) and routine observations, thus minimising unnecessary staff exposure. It prompted venous thromboembolism (VTE) assessment and documentation of escalation criteria.
Result. 44 patients were identified across three working age (WAA, n = 29) and two older age (OA, n = 15) adult wards. 7.5% of WAA and 33.3% of OA patients were hospitalised. 20% of OA patients died following a positive test. 58% of patients had a documented management plan for COVID-19, but only 56% mentioned observation frequency, 19% escalation criteria, and 9% risk of serious disease. No patient received a repeat VTE assessment following diagnosis. The audit identified inconsistent approaches to COVID-19 management between wards, and found no relationship between risk of deterioration and frequency of observation monitoring. Following implementation of this protocol, 100% (n = 4) of patients had a robust plan for COVID-19 management, and 100% received a VTE assessment.
Conclusion. The audit supported previous findings that psychiatric inpatients are at risk of serious COVID-19 infection. This highlights an urgent clinical and ethical need to optimise COVID-19 care in psychiatric inpatient settings. The results of this audit suggest that risk factors for severe infection and elements of routine care are not widely understood or implemented by clinical staff. Introducing evidence-based protocols to support clinicians in managing the physical healthcare of these patients