

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 dietitian, 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

counting and less emphasis on definitions. (f)Calorie counts and exercise trackers need 'more fun and interactive elements.

Based on these recommendations a revised CALMPOD-ID programme, co-produced with service users, is now being introduced in the service.

Heard, Valued, Empowered: Utilising a Quality Improvement Framework to Improve Trainee Experience

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Aims. Feedback from doctors in training (DiT) through the Scottish Training Survey has highlighted poor trainee experience within Psychiatry at St. John's Hospital, Livingston. Research suggests that a healthy, happy and engaged workforce experiences lower levels of burnout and provides higher quality patient care. Our aim was to improve the experience of DiT working within the department and thereby improve patient care.

Methods. We utilised the Wellbeing, Conditions and Rota Evaluation (WeCaRE) framework. This is a user-friendly quality improvement (QI) framework designed to improve trainee experience. As part of WeCaRE, questionnaires and 'what matters to you' conversations were undertaken with ten DiT (foundation doctors, GP trainees, and core psychiatry trainees). From the issues raised, trainees were empowered to co-create change ideas and use Plan-Do-Study-Act (PDSA) cycles to address the issues. Finally, the questionnaire was repeated to complete the loop.

This approach created an open, listening environment with clear communication channels from trainees to consultants and management. This allowed us to identify themes for improvement. These included induction, education opportunities, clinical supervision and escalation policies.

In collaboration with trainees, three improvement teams were formed, each of which addressed an issue through a PDSA cycle. These were:

1. Unclear referral pathway to Psychiatry resulting in inefficiency. The team co-created a flowchart identifying how to appropriately refer to Psychiatry, which has reduced the number of inappropriate bleeps.
2. Unclear escalation policies and consultant cover. The trainees worked with the multidisciplinary team to generate a clear escalation pathway.
3. Significant variation in content and documentation of clerking – the data collected helped drive change through the utilisation of an electronic clerking checklist.

Other issues were raised and quickly addressed without requiring a PDSA cycle. Such issues included provision of on-call rooms, parking spaces, improvements to induction, starting a Balint Group for trainees, and changing the mode of administration of Pabrinex.

Results. During the five-month period those who experienced joy in work several times a week or more increased from 0%-86%. Those who always felt a valued member of the team increased from 29%- 86%. Those with overall job satisfaction increased from 0%-75%

Conclusion. DiT experience comprises more than rota compliance. It includes well-being, psychological support, professional development, teamship and more. This project has demonstrated

considerable improvement in trainee experience through utilising the WeCaRE framework. This highlights the power of listening to, valuing and empowering trainees, whilst utilising data as a vehicle to drive change.

Antipsychotic Monitoring Within the Home Treatment Team in the Southern Trust, a Quality Improvement Project

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Aims. The Royal College of Psychiatrists has a specialist group called the Home Treatment Accreditation Scheme (HTAS) that has published a set of best practice recommendations for Home Treatment Crisis Response (HTCR) teams across the UK. As of yet, the HCTR team in the Southern Trust is not accredited. We decided to focus our project on antipsychotic monitoring. SMART aim: All patients (100%) within the HCTR team commenced on antipsychotics are receiving an appropriate level of blood and physical monitoring as recommended by guidelines and these are being documented correctly within 10 days of discharge.

Methods.

PLAN

HTAS standards were reviewed alongside NICE guidelines on antipsychotic monitoring and a pro forma created. We collected baseline data on patients commenced on treatment dose antipsychotics in the HCTR team and assessed completion of bloods/ECGs/physical parameters and documentation.

DO

Our intervention for PSDA cycle 1 was to educate members of the multi-disciplinary team (MDT) via a presentation after the baseline data were analysed. We looked at correct documentation and how to fix common mistakes identified. We asked staff for their input on how to improve outcomes. Posters were printed off for guidance. We collected data after this intervention using the same pro forma.

STUDY

We analysed the results from PSDA cycle 1, comparing them to baseline results.

ACT

Our next step in PSDA cycle 2 would be to focus on continuing to improve poorer results such as prolactin levels and ECGs, with input from the MDT.

Results. Baseline data showed between a 14% and 59% completion rate for various baseline bloods, 68-72% completion rate for heart rate (HR)/blood pressure (BP)/weight and a 36% completion rate for ECGs.

Following PSDA cycle 1, this improved to between a 55-100% completion rate for baseline bloods, a 91% completion rate for HR/BP/weight and a 64% completion rate for ECGs.

Baseline documentation of these parameters was correctly recorded between 9-68% of the time. This overall improved after PSDA cycle 1 to 18-73%.

Conclusion. Our intervention from PSDA cycle 1 improved completion of bloods, physical parameters and ECGs in the HCTR team. Documentation also improved in all domains.

Our next step in PSDA cycle 2 would be to focus on continuing to improve poorer results, looking at altering practicalities that may have affected those areas.