Environmental factors

We identified and implemented a number of change ideas, using Plan-Do-Study- Act methodology, regularly meeting to review progress and plotting our data on a run chart.

Key patient interventions included a "Mutual Respect" exercise and regular "Community Meetings".

Staff interventions included use of Safety Crosses, Daily Safety Briefings and the Broset Violence Checklist (BVC).

Environmental factors were continually assessed and escalated as appropriate.

We raised awareness of our project and gained feedback by creating a dedicated notice board, providing a staff information session and including it as an agenda item at ward meetings.

Our project measures were identified as:

Outcome: Number of level 1 violent incidents occurring per week

Balancing: Number of incidents in other categories; Patient satisfaction

Process: Staff safety rating; Engagement with interventions

Result. Unfortunately, we were unable to meet our initial goal and there continued to be considerable variation in the number of weekly incidents.

We believe this was attributable to several factors, including the level of acuity within the ward during the project timeframe. It was noted that a relatively small number of patients contributed to a large proportion of the total incidents. Our results, therefore, did not reflect the success of interventions with other patients on the ward.

Despite this, we noted improvements in terms of patient and staff engagement with the project, including subjective reports of staff safety during shifts.

Conclusion. The unpredictable and complex nature of the PICU setting cannot be under-estimated and this ultimately impacted on achieving our intended outcome.

We do feel, however, that the project has had a positive impact and we hope we can build on this progress over the coming months.

Further interventions are being explored, including personalised daily activity schedules and attempts to reduce levels of continuous observations.

A quality improvement project on nicotine replacement therapy in Shannon Clinic (Northern Ireland)

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Aims. The aims of this quality improvement project were to determine if Nicotine Replacement Therapy was being prescribed correctly in Shannon Clinic in Northern Ireland and also to improve the rates of correct prescribing of Nicotine Replacement Therapy in the aforementioned unit.

Background. There are several different types of Nicotine Replacement Therapy currently available. Shannon Clinic is a smoke-free clinical environment therefore patients who smoke are offered Nicotine Replacement Therapy on admission. When I was working at Shannon Clinic I became aware that there was no clear guidance available to medical staff on the wards regarding prescribing Nicotine Replacement Therapy and therefore I decided to carry out this quality improvement project.

Method. An audit of drug charts was done on the patients who were under the care of the consultant that I worked with. In total nine drug charts were included in the audit. After the audit was complete, I produced a poster to show how to correctly prescribe Nicotine Replacement Therapy. A copy of this poster was placed on each ward in Shannon Clinic. After a period of time the drug charts were re-audited to see if there had been an improvement in the rates of correct prescribing of Nicotine Replacement Therapy.

Result. In total, 22% of the drug charts which were included in the audit had Nicotine Replacement Therapy prescribed incorrectly on them. After the inclusion of a poster outlining how to prescribe Nicotine correctly on each ward in Shannon Clinic, 0% of drug charts had Nicotine Replacement Therapy prescribed incorrectly on them. This was an improvement of 22%.

Conclusion. This quality improvement project was successful at reducing the rates of incorrect Nicotine Replacement Therapy in Shannon Clinic. In the future it is my hope that this quality improvement project should lead to the correct prescribing of Nicotine Replacement Therapy for all patients in Shannon Clinic. It should also lead to an increased awareness regarding the different types of Nicotine Replacement Therapy for medical staff working in this clinical unit.

A study to improve the quality of writing clinic letters to patients attending the outpatient clinic

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Aims. In many countries (including the UK and Australia) it is still common practice for hospital doctors to write letters to patients' general practitioners (GPs) following outpatient consultations, and for patients to receive copies of these letters. However, experience suggests that hospital doctors who have changed their practice to include writing letters directly to patients have more patient centred consultations and experience smoother handovers with other members of their multidisciplinary teams. (Rayner et al, BMJ 2020)

The aim of the study was to obtain patient's views to improve the quality of clinical letters sent to them, hence the level of communication and standards of care.

Method. An anonymous questionnaire was designed and posted to collect information from patients attending one of the South County Mental Health outpatient clinic in Derbyshire. 50 random patients were selected between March to November 2020. Patients were asked to provide suggestions to improve the quality of their clinic letters written directly to them and copies sent to their GPs.

Result. Out of 50 patients 48% (n = 24) responded. Majority of patients (92%) expressed their wish to receive their clinic letters written directly to them and 79% preferred to be addressed as a second person in the letters. More than half (54%, N = 13) of them would like to have letter by post. Majority of them (92%, N = 22) wished to have their letter within a week of their consultations.

Patients attending clinics felt that the communication could be better improved through writing clearly: a) reflection of what was discussed during the consultation b) updated diagnosis c) a clear follow-up plan d) current level of support e) medication change f) emergency contact numbers g) actions to be carried out by their GP and further referrals should there be any.

Conclusion. Patients in community prefer to have their clinic letters directly addressing them in second person. It was noted that the letters needed to reflect accurately on what was discussed during the consultation in order to have patient centered consultations. This in turn would improve communication and thus rapport, trust and overall therapeutic relationship.

Quality improvement by introduction of 72-hour admission pathway in Forest House Adolescent Unit (FHAU) for young people in crisis

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Aims. Short admissions for crisis management among young people suffering with Emotionally Unstable Personality Disorder (EUPD) as recommended in National Institute for Health and Care Excellence (NICE) 2009 guidelines are not routinely offered in the United Kingdom (UK). Our aim was to introduce crisis admissions lasting for 72 hours. During this brief admission the families of young people presenting with suicidal behaviour are offered an assessment and diagnosis of young person's difficulties, psychoeducation, and safety plan for future risky behaviour, in addition to respite.

Background. Three-day Crisis admission was set up with the aim of reducing inappropriate long admissions in people who may have more negative effects from admission than positive ones. A need was felt for a brief admission pathway in order to be able to provide treatment for patients suffering from EUPD traits in keeping with NICE guidelines. NICE guidelines suggest that people with borderline personality disorder should be considered for acute psychiatric inpatient admission only for the management of crises involving significant risk to self or others that cannot be managed by other services. The guidelines also recommend ensuring that the decision is based on an explicit and joint understanding of the potential benefits and likely harm that may result from admission and agreeing to the length and purpose of the admission in advance.

Method. A retrospective study comparing length of hospital stay in the 2018 (when this model was introduced) with previous years, the number of serious incidents was carried out to assess the impact of this new admission model. The rate of readmissions in the same year was also assessed. For qualitative feedback regarding the effectiveness of the crisis admission as an intervention, a survey was carried out to assess parent satisfaction and the nursing staff was asked for their views.

Result. There was a marked reduction in the number of serious incidents linked to suicide and length of hospital stay was reduced to half in the year when the crisis admissions were introduced as compared to the previous year. Only about 10-15% of patients required re-admission in the same year. About 90% of parents gave a positive feedback confirming the effectiveness of this intervention.

Conclusion. 72-hour crisis admissions for adolescents are effective, appropriate, clinically indicated alternative to routine admissions with a high parent satisfaction.

Bridging the gap: improving liaison psychiatry documentation quality to meet the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) treat as one recommendations at newcastle hospitals

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Aims. This project aimed to assess and improve the quality and frequency of documentation from Psychiatric Liaison Team (PLT) to ward-based medical colleagues against the Treat as One recommendations. From experience, we hypothesised that written documentation of information crucial to patient care is not consistently meeting standards. This communication breakdown directly affects patient safety, potentially introducing additional risks to our already vulnerable patient group.

Effective communication between PLT and our medical colleagues bridges the gap in providing continuity of care and ensures patients' mental and physical health needs are met in acute trusts. The NCEPOD found that there remains many barriers to high quality mental healthcare provided to patients in general hospitals and recommended 7 elements that PLT documentations should encompass.

Method. We audited initial PLT assessments and the resulting documentation to determine if these met the 7 standards set by NCEPOD. Baseline audit undertaken from 21-27/09/2020 encompassing 130 patient referrals to PLT.

A period of time was allotted to implement robust changes to improve the service. This included a streamlined e-template that automatically populates in the acute hospital eRecord system which prompts clinicians to document according to the NCEPOD standards, structured clinician training and education, and the nomination of "Treat as One Guardians" in the team to ensure that acute trust documentations are present during daily multidisciplinary meetings.

The cycle was then completed on 22-28/02/2021 with a re-audit capturing 55 referrals.

Result. Implementation of our recommended changes saw an increase from 58% of documentations with ≥50% NCEPOD elements to 98% in the re-audit.

We also saw an increase in number of the NCEPOD 7 elements included following intervention: formulation (0% to 8%), legal status and capacity (47% to 79%), risk assessment (2% to 28%), risk management (18% to 53%), and discharge plan (2% to 29%).

Completion rate of acute trust documentation increased from 74% to 96%.

Our interventions also led to more contemporaneous communication, significantly reducing mean time from assessment to documentation in both acute trust and mental health records from 6.02 to 3.53 hours, ($p = 0.04$) and 6.12 to 3.50 hours, ($p = 0.05$) respectively.

Conclusion. Following our interventions, the results showed improving trends in the frequency and quality of our documentation with secondary outcomes showing increased documenting efficiency. Our current practice is not yet optimal and retains potential to adversely affect our patients. We propose further investigating barriers to change using the quality improvement PDSA (Plan, Do, Study, Act) methodology to continue innovating.

Remote psychotropic medication advice for general practitioners: a quality improvement project

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Aims. Our first aim was to first find out how confident general practitioners were about referring in to the Gloucester Recovery Team and managing psychotropic medications. Our second aim was to then improve general practitioner's self-rated scores of confidence in managing psychotropic medication