Improving quality of remote mental health consultations during COVID-19

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Aims. During the first wave of coronavirus pandemic, many Psychiatry outpatient appointments moved rapidly to remote or 'virtual' to protect patients and staff from infection. Telephone consultations do not allow assessment of appearance or other visual aspects of behaviour/affect, yet these are core components of Mental State Examination. Videoconsultation software was unfamiliar to many mental health clinicians, with obstacles including hardware availability, software provision and skills, data security as well as lack of clinican motivation and confidence preventing rapid uptake. I wanted to take advantage of excellent IT support, and NHS England funding of software licence, to drive introduction of Attend Anywhere patient videoconsultation ('telepsychiatry') software within my local ADAPT (Anxiety, Depression and Personality Disorder,Trauma) Community Mental Health Team from April 2020 onwards.
Method. I assembled a small group of clinicans to take part in a local pilot of Attend Anywhere software. One Care Coordinator, a Consultant Psychologist, two Consultant Psychiatrists and myself completed satisfaction and confidience scores throughout an 8 week period. Number of videoconsultation outpatient appointments offered to and accepted by patients were also recorded. Weekly group meetings were deemed impossible to schedule given pandemic workloads, so we used 1:1 quick remote catchups, identifying and troubleshooting obstacles, working with IT implement a work-around when the team hit a technical brick wall.
Result. Clinician confidence and satisfaction increased significantly during this period, as did number of offered & completed video consultations.

Attend Anywhere consultations were used for up to 25% of clinician weekly workload.

Clinicians who manage their own diaries started quickly

It was difficult to successfully engage Administration team to organise Attend Anywhere test calls, leading to slow uptake for Consultant Psychiatrists who do not manage their own diaries.
Conclusion. Patient obstacles to use of Attend Anywhere appeared to be idiosyncratic and multifactorial, including poverty, digital exclusion, lack of privacy at home, and clinical history of online grooming. However, some patients already used Attend Anyhwere software with their physical health teams, while others prefer videocall to phone. Age was not an obstacle.

Once this small group of clinicians began to use software successfully, it had a snowball effect within the team and other clinicians asked to sign up for the service. Full support from Administration teams will be crucial to increasing videocalls within the service. Clinicians suggested offering videoconsultation as an opt-out service and requested additional functionality from the software to widen use.

Bowel monitoring in psychiatry of old age: a quality improvement project

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Aims. This project aims to ensure all patients in the dementia ward 1 in Kingsway Care Centre, Dundee have daily bowel monitoring and achieve a normal bowel habit. The hypothesis is that patients are inadequately screened and substantial undiagnosed constipation exists.
Background. Constipation has a prevalence of 16-50% among individuals over 65 years old in the community. Psychiatric illnesses are known risk factors with older psychiatric patients 3-6 times more likely to be constipated. Untreated constipation may progress to serious complications such as bowel obstruction and bowel perforation. Delirium, often mislabelled as worsening psychiatric symptoms, also may occur leading to additional psychotropic medications being prescribed, further worsening the constipation.
Method. All patients in Ward 1, Kingsway Care Centre Dundee over 4 months were included, amounting to 25 patients. Data were gathered from stool charts weekly. Quality improvement framework was followed with two plan-do-study-act (PDSA) cycles completed. Normal bowel function was assessed against ROME IV constipation criteria and less than 75% of Bristol stool type 6 or 7 due to the risk of overflow diarrhoea and laxative overuse. In the first PDSA cycle, stool charts were modified to account for patients independently mobilising to the bathroom and daily documentation even if bowel movements were uncertain. The second PDSA cycle introduced a sticker on charts folder to "ask the patient" along with a staff education leaflet on the complications of constipation. Data were anonymised and analysed with run charts using Microsoft Excel.
Result. At baselines, 50% of patients had a stool chart. This increased to 90% in cycle 1, 100% in cycle 2. 28% of patients had any stools documented at baselines. This increased to 31% in cycle 1, 59% in cycle 2. At baselines, 0% of patients had a normal bowel habit. This maintained at 0% in cycle 1 but increased to 13% in cycle 2. No serious complications were found in patients assisted with toileting. However, 34% of independently mobile patients developed serious complications.
Conclusion. Poor documentation existed in all patients, particularly those independently mobile. Independently mobile patients were particularly at risk of serious complications of constipation compared to assisted patients. Introduction of new stool charts in the first PDSA cycle resulted in increased documentation but limited benefit for identification of constipation. The second PDSA cycle, targeting staff education and compliance, showed an increase in identification of constipation indicating limited staff knowledge as a key barrier to improvement in patients' bowel habit.

Improving physical health for psychiatric patients detained in a low secure forensic psychiatric unit in the United Kingdom

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Aims. This project aimed to improve physical health and to tackle obesity in patients detained in a low secure forensic psychiatric unit.
Background. People suffering from severe and enduring mental health problems have a life expectancy of 15-20 years less than the general population. The main cause of death is cardiovascular disease due to lifestyle factors, such as smoking, substance misuse and obesity.

Physical health problems such as metabolic syndrome, diabetes and heart disease have a knock on effect on motivation, self-esteem and concordance with treatment.

Over 60% of the general population and up to 80% of patients detained in forensic psychiatric units in the UK are classed as overweight or obese, with serious consequences to physical health.

Southfield Low Secure Unit is a 28 bed unit. Most patients suffer from treatment resistant schizophrenia and are prescribed high doses of antipsychotic medication, some up to 250% of the maximum recommended dose.

Method. Baseline data were collected using Body Mass Index (BMI) and Simple Physical Activity Questionnaire (SPAQ). Following the initial data collection, patients were involved in focus groups, community meetings and a monthly physical health action group. There was input from the care team including psychology, occupational therapy, nursing, catering and security. New activities have been made available such as "physical health and mental health education group", "rambling group", "gym sessions", "patient focus groups" and "walking group".

Result. This project has been running for 9 months and is ongoing.

There has been a modest change in the BMI – initial results ranging from BMI 23.6–42.8kg/m2. Of the initial cohort (n = 14), there has been weight loss (n = 3), weight gain (n = 3) and no change (n = 8).

The initial SPAQ results showed that on average patients spend 19.8 hours per day either in bed or doing sedentary activities and only 1.68 hours per day walking or doing physical activities. This pattern is being reassessed.

The qualitative data from patient focus groups shows increased interest in activities, motivation and desire to contribute to the project.

Conclusion. The preliminary results show an increase in patient motivation and engagement with available activities. There have also been patient-led challenges which were well received. Patients feel positive about the programme and valued for their input. Further support is required to maintain progress.

An analysis of outcome measures in a specialist inpatient eating disorders unit in Aberdeen: changes since 2015 and response to the COVID-19 lockdown

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Aims. Identify differences in outcome measures between inpatient cohorts during the first year of the pandemic compared with preceding years.

Identify key elements in the treatment provided by identifying any trends in the outcome measures between 2015 and 2021.

Background. The Eden Unit at the Royal Cornhill Hospital (RCH) in Aberdeen is a ten-bed specialist centre for the inpatient treatment of eating disorders (ED). Strict measures to control the spread of COVID-19 have meant that important aspects of therapy in the Eden Unit are no longer permissible. It is not known whether handicaps to providing the previous service are reflected in recent outcomes.

Method. Values for age, length of stay (LOS), BMI, HbA1c (diabetic patients) and responses to three questionnaires: Eating Disorder Evaluation Questionnaire (EDE-Q); Depression Anxiety Stress Scale (DASS)-21; and Clinical Outcomes in Routine Evaluation (CORE). This data were collected for April 2020 to February 2021 (Pandemic) and compared with five preceding years, April 2015 to March 2020 (Pre-COVID). The project was registered with NHS Grampian Quality Assurance Team and approved by the MCN Quality Assurance subgroup. Ethical approval was not required. A data collection sheet allowed anonymised data to be entered into a Microsoft Excel TM Spreadsheet for analysis of baseline demographics.

Result. Average age of patients remained similar across the six years. Length of stay in the first year of the pandemic was significantly shortened. BMI on discharge in 2020/21 remained similar to preceding years. If relevant, HbA1c was measured throughout admission and comparison with BMI change reflected a focus on treating both diabetes and ED concurrently. Comparison of admission and discharge questionnaires to determine outcome measures proved difficult due to the small number of responses to both.

Conclusion. Shorter LOS during the pandemic was a significant finding. Despite this, BMI on discharge remained similar, suggesting a shift to weight restoration due to lack of opportunities for an holistic approach due to restrictions. Key elements of treatment include careful monitoring of HbA1c and concurrent management of Type I Diabetes for those patients. The low response rate to questionnaires raises concern regarding their use, in their current format, as effective tools to measure outcomes. Though low numbers of questionnaire responses prevent firm conclusion, it appears that the reduced opportunities for elements of treatment to be undertaken in the community may have contributed to increased anxiety levels on discharge.

Assessing the practice of written referrals to neuroradiology and how this process can be improved and standardised

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Aims. This quality improvement project aims to improve the quality of information provided in the referrals from the older adult psychiatry department to radiology when requesting neuroradiological imaging.

The secondary outcome aims to standardise information on the referral proforma. We hypothesise that this improved referral proforma will lead to improved quality of reporting from the radiology department, which will form the second stage of this quality improvement project.

A further area of interest of this exercise is to establish whether standardised radiological scoring systems are requested in the referral, as these can be utilised as a means to standardise reported information.

Method. Retrospective electronic case analysis was performed on 50 consecutive radiology referrals for a period of 3 months from November 2019 to January 2020. Data were obtained from generic MRI and CT referral proforma and entered into a specifically designed data collection tool. Recorded were patient demographics, provisional diagnosis, modality of imaging, use of ACE-III cognitive score, radiological scoring systems, and inclusion and exclusion criteria.

Result. Results from 50 referrals have shown: 60% were male, 40% female. Average patient age of 74, ranging from 49 to 95. 58% were referred for CT head with 42% for MRI head. More than half of referrals quoted the ACE-III score. 26% of referrals stated exclusion criteria such as space occupying lesions, haemorrhages or infarcts. 10% of referrals requested specific neuro-radiological scoring scales. Specific scales which were requested included GCA (global cortical atrophy), MTA scale (medial temporal atrophy), Koedam scale (evidence of parietal atrophy) and Fazekas (evidence of vascular changes). Only 80% of referrals included the patients GP details on the referral form.