Co-Production of a Digital Symptom Self-Management Resource for Patients With Functional Neurological Disorder

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Aims. Patients with Functional Neurological Disorder (FND) experience neurological symptoms which may impair motor control, sensory function, or awareness. Long waiting lists before treatment mean the risk of relapse during this period is high. A lack of knowledge around FND also results in a lower quality of life. Therefore, it is important patients with FND receive appropriate psychoeducation to empower them to understand and manage their symptoms. We aimed to strengthen our symptom self-management booklet for patients in a community neuropsychiatry setting, using a co-production model and taking forward improvements into a digital audiovisual format.
Methods. We used co-production as part of a quality improvement project (QIP) at East Kent Neuropsychiatry Service to identify improvements to our existing symptom self-management booklet and apply these in the production of a digital resource. Initially, the symptom self-management booklet was distributed to 10 patients, awaiting further assessment and treatment, chosen by the multidisciplinary team following triage appointments. Two weeks later, 7 patients reviewed the booklet with 4 medical students by phone and qualitative and quantitative feedback was obtained from patients and carers. Quantitative feedback was collected using an adapted 20-point Ensuring Quality Information for Patients (EQIP) tool. Informed by this feedback, scripts were developed for the audiovisual resource. The scripts were further reviewed by a medical student, 2 multidisciplinary team members and 3 Trust Communications Department members.
Results. The first QIP cycle highlighted the importance of the symptom self-management booklet. Most patients had used the booklet. Patients found it a helpful source of information. Two patients noticed a considerable improvement in their quality of life, others did not due to the short length of booklet use. . EQIP tool demonstrated an improved score of 80.51% compared to previous round of feedback (53.33%). Carers identified the booklet as reassuring. Additional links to external information was identified as an area for development.

Patient feedback informed the development of scripts for the audiovisual resource. Consultation with the Trust Communications Department identified three themes of improvement: accessibility to patients, increased clarity and concise language, and an appropriate visual format, therefore scripts were further refined.
Conclusion. Our QIP shows the value of a psychoeducation and symptom self-management tool for FND patients which was positively received by patients and carers. Collaborating with patients in the digitalisation of this information allows for a more accessible resource which effectively addresses patient concerns and empowers symptom self-management.

Quality Improvement Project to Co-Produce Effective Triangulated Communication Between Inpatient Psychiatric Team, Community Mental Health Teams, Patients and Carers to Help Patient Involvement and Positive Step Down Discharge Planning

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Aims. The aim of the QI project was to promote patient involvement, choice and recovery using effective communication and collaborative planning. To achieve this, we aimed to ensure that patient's voice remained central to the decision making process in meetings . Using 5-Why QI methodology, the MDT of Delfryn-House—a private 28-bedded rehabilitation unit, reviewed the communication interruptions between the internal and external CMHT (especially after the pandemic), which in turn was hampering patients' progress towards positive discharge. It was also noticed that patients' attendance was significantly dropped and they were not showing interest in their CPA/CTP meetings, as they were not seeing any benefits of them. The MDT planned the project to improve the communication for continuity of care and to have better involvement of patients, their families and external teams.
Methods. The Intervention project, based on QI model-of-improvement, established that effective communication was the main aim, to be achieved with new change ideas. The outcomes were both qualitatively and quantitatively measured e.g.using feedback questionnaires from CMHT and patients and carers, attendance and discussion of discharge goals for the admitted patients. Driver diagrams were used for change ideas e.g. Microsoft teams invites to all teams for the patient review and care plan review meetings, MDT adding the progress feedback to the patient review meeting proforma to be shared internally and externally prior to the meetings, informing the care coordinators prior to change in Mental health act status, same day email to CCOs about medication changes, incidents, safeguarding, and ensuring discharge goals are discussed at every meeting. Satisfaction surveys to the CMHTs and patients were conducted pre- and post-intervention. Qualitative data were collated, helping to generate quantitative statistical analysis of the satisfaction ratings. The attendance of meetings and positive discharge from the unit were also used to measure the outcomes.
Results. There was significant improvement in both commissioners and CMHT's satisfaction of improved communication from Delfryn House. There was increase in attendance (44% by patients, 20% by carers, 64%by CMHT and 40% by Commissioners). There was increase (45%) in patients reading and signing their care plans. A notable increase in positive step-down discharge plans were noted, however, as the QI project was run in a rehabilitation unit requiring longer admissions, there were not many actual discharges to show a noticeable difference.
Conclusion. The QI-project helped in establishing clearer pathways towards positive discharge and continuity of care, signifying the importance of effective communication between teams and

co-producing the care plans and meeting agendas with the patients and their carers.

Quality Improvement Project to Improve the Implementation of Mental Health Act Code of Practice Guiding Principles and Patient Knowledge About MHA in In-Patient Psychiatric Unit

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Aims. To improve the efficiency of MHA documentation, patient education on MHA and implementation of guidelines of Code of Practice in in-patient unit. We also aimed to involve patients at some stages of the QI project to ensure they remain updated about the legal framework and associated documents and their voice remains central.

Methods. The QI Project was started after an initial audit was conducted which included MHA documentation on admission and during the length of stay, patients' legal rights, section-17 leaves, capacity and treatment forms, tribunal reports, section-117 meetings and arrangement of independent managers hearings prior to Section Renewals. Using 5-Why QI methodology, the medical team and the MHA administrator reviewed the gaps in the initial audit. Using the QI "theory of change" model, three primary drivers of "Responsible Clinician and MHA Administration Liaison", "Patient Education on MHA" and "Policies and Guidelines Implementation" were established. Secondary drivers for "RC and MHA Administration Liaison" required inputs from doctors, secretaries, nurses and MHA Admin. Change ideas of introducing weekly email template for required MHA actions, section paper scrutiny template made for approval by MHA Admin/ RC prior to patient's admission, Introduction of MHA relevant actions section in the morning handover and patient's review record form.

Secondary drivers and change ideas for "Patient Education on MHA" included discussions with MDT, easy- language information leaflets, discussion slots with pharmacists about medications before consenting for treatment forms, discussion slots with the key nurse and RC about MHA related decisions and going through statutory reports together to understand the nature and degree of illness, and risks necessitating the renewal of admission.

Secondary drivers and change ideas for "Policies and Guidelines Implementation" included teaching sessions for nurses on report writing, giving evidence at tribunals, and how to inform patients about legal rights, and liaison with medical management QI committee to ensure capacity and treatment certificates are up to date and filed in the medical folders. The initial audit tool was repeated on quarterly basis in addition to the PDSAs to measure results.

Results. Results showed 100% score in capacity assessments, treatment certificates and timely reports. There was still improvement needed in organising managers hearing prior to section renewal, likely section renewals left till late. A pre-and-post intervention score on patients' knowledge of rights and MHA showed an improvement of 68%.

Conclusion. The QI-project helped in implementing MHA code of practice guiding principles and patients' knowledge about MHA and their rights.

Expeditious multipronged Interventions strike down Geriatric Memory Clinic No Shows in the Department of Geriatrics -a Value Enhancing Initiative via Memory Outreach Program and Telephone Triaging

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Aims/background. One of the biggest challenges faced by the healthcare sector is devising ways of tackling No shows in the Clinics. Patients are classed as no-shows when they fail to attend scheduled appointments without prior notification to the Health Care Provider. Some factors contributing to clinic No shows amongst frail Older Adults include lack of transportation and non-availability of family members to bring them to the clinic. Along with this, forgetfulness and poor insight into their condition also can contribute to No shows. Memory clinics in Rumailah Hospital under Hamad Medical Corporation in Qatar are the leading specialized multidisciplinary clinics that carry out an assessment, diagnosis, and management of people presenting with Memory Concerns.

Implementation of Quality Improvement projects to tackle the No shows in the Geriatric Memory Clinics in Rumailah Hospital under Hamad Medical Corporation in the State of Qatar.

Methods. Various process improvement initiative based on LEAN methodology got implemented from January 2022 to reshape the service and reduce No shows

1. Initial nurse triage contacts with the patients or their family members to identify any inappropriate referrals are signposted to the right service and offer appointments for the appropriate referrals at a date and time convenient for them
2. Telephone triage by the Physician and Case manager of new cases offered a clinic appointment and conduct a brief assessment to agrees risk and order investigations prior to the initial appointment . Patient's requesting rescheduling and cancellations are dealt with immediately. In addition, any new slots which becomes available during this process are offered to other patients and their appointments are brought forward
3. Nurses contact with the patient caregiver of the person with Dementia and remind them of the appointment a day before the appointment.
4. Geriatric Memory Outreach Service to carry out home visits for patients who are unable to attend clinic appointments because of frailty, significant cognitive impairment, and mobility issues.

Results. The No shows rates were as follows
2019 -26%.
2020 -13% (COVID-19 impact).
2021 -13%
Intervention was implemented in January 2022 and No Show reduced to 9% in 2022. This indirectly reduced the waiting time (from referral to Consultation) from three months to 5 weeks.