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.