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Aims. To ensure smooth running of Multidisciplinary team (MDT) in Community mental health team (CMHT) and reviewing MDT structure for better functioning at Parkview Mental health Resource centre.

On a Friday two Multidisciplinary teams (MDTs) were running online on Microsoft teams simultaneously. The same staff was running the two MDTs, so staff input could be limited at times and staff would dip in and out of MDTs. Discussion around ways of improving this so that both MDTs run smoothly. Also, there was no formal structure to MDT meetings. It was decided that improvement in Quality of MDT needs to be addressed.

Methods. Initially numerous discussions held online with Parkview team, nursing colleagues.

CMHT Quality improvement group was set up and a meeting was arranged where everyone's ideas were considered.

A pilot project was first introduced in March 2022 and audited in July 2022. Plan, do, study, act (PDSA) cycle was carried out.

Plan

Two nursing teams to be setup which will feed back into the two MDTs on alternate weeks. This will reduce nursing teams having to come in and out of one MDT to join other MDT, hence increasing the efficacy of the MDT.

Devise a new template to provide formal structure for the MDT presentation.

Do

Trial the new setup of two nursing teams.

Study

Ask all MDT staff members for feedback on the working of MDT.

Act

Reformat the Structured template and distribute to all staff members.

Results. 100% staff felt that new structure of MDT was useful.

84% staff satisfied with the new way of running of MDT.

84% staff satisfied with having designated teams for MDT.

Conclusion. Having Designated MDT teams and a structured format helped in robust functioning of the MDT in the CMHT.

Improving Trainee Doctors' Awareness on How to Refer for Routine Radiological and Cardiac Investigations at a Psychiatric Hospital in South London

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Aims. Psychiatric inpatient hospital, although part of secondary care, is separate from a physical health hospital and therefore does not have access to electronic referral systems, which increases efficiency of referral processes. As part of an admission clerking for all inpatients in psychiatric hospitals, the admitting doctor takes a history of past medical issues, a physical examination, electrocardiogram and bloods. Depending on findings, further radiological and cardiac investigations may be warranted. Not having access to electronic referral systems can cause delay in delivering treatment for psychiatric inpatients, especially when referral pathways is unclear. The aim of this quality improvement project is to increase the knowledge of referrers in order to improve efficiency completing referrals and reduce incorrect referrals. With clinicians able to refer for routine imaging correctly and in an efficient manner, it is hoped that this will correlate with an improved quality of care received by patients.

Methods. Firstly we assessed the knowledge of currently employed trainee doctors, via a web-based survey, on how to refer for routine and commonly ordered radiological and cardiac investigations. Employed referrers included core trainee, GP and foundation year trainee doctors. We then created an electronic referral pack which includes a guidance and referral forms provided to clinicians when they start employment at Lambeth hospital and accessible to current trainees. A follow up survey then reassessed the knowledge of these referrers.

Results. There was a total of 11 responses received from survey prior to sending out the electronic referral guidance pack, of which 100% believed that it would be helpful to have a referral guidance pack. A total of 4 responses were received after sending out the guidance. The surveys showed that there is improved knowledge of how to refer for routine radiological and cardiac investigations after guidance was sent. Prior to sending the guidance, 9.1% referrers were made aware of the referral process, and this increased to 50% after the referral guidance pack was sent out.

Conclusion. Trainee doctors in psychiatric hospitals require more support with physical health management in psychiatric hospitals, including referring for physical health investigations, as referrers cannot access electronic referral systems used in physical health hospitals. Results need to be correlated with clinical outcomes in future. A longer term project could include linking the electronic referral systems between psychiatric and physical health hospitals.

Monitoring of Clozapine-Induced Gastrointestinal Hypomotility

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Aims. Clozapine, a second-generation antipsychotic licensed for treatment-resistant schizophrenia, has a well-documented side effect profile, the most common of which is decreased gastrointestinal motility. Clozapine-induced constipation occurs more frequently than blood dyscrasias and can lead to severe complications such as paralytic ileus and intestinal blockage; in extreme cases, it can be fatal, with a fatality rate of 20–30%. The risk of gastrointestinal hypomotility is most pronounced during the initial four months of treatment; hence, weekly assessments are imperative during this period. According to Lanarkshire's local guidelines, bowel habits should be assessed at baseline, during routine blood sampling, and ideally at every clinical interaction. Our audit aims to determine the frequency of bowel habit monitoring in inpatient settings and to ascertain the prevalence of laxative prescriptions among these patients.

Methods. Data were collected retrospectively from psychiatric inpatient wards in Lanarkshire for patients on Clozapine therapy. The review focused on electronic medical records to evaluate the regularity of bowel habit screening. Additionally, we examined the Hospital Electronic Prescribing and Medicines Administration (HEPMA) system to gather information on laxative prescriptions.
Results. The audit revealed that bowel habit monitoring, which should be a standard practice at each clinical encounter, was found to be inconsistent. Regular assessments were documented for only 40% of patients. Monitoring was most thorough in rehabilitation wards, where patients on Clozapine had their gastrointestinal function assessed routinely through screening questionnaires. Furthermore, 80% of the surveyed patient population was documented as having been prescribed laxatives.
Conclusion. The documentation of bowel movements for inpatients on Clozapine was suboptimal, leading to the potential oversight of critical side effects. The audit highlights a discrepancy in adherence to national and Lanarkshire's local guidelines for the monitoring of inpatients treated with Clozapine. To rectify this, we recommend the implementation of a standardized screening protocol to assess constipation risk systematically. Proactive monitoring should be incorporated into regular clinical evaluations for patients on Clozapine, ensuring that this assessment occurs at every clinical interaction. This approach is crucial not only for patient safety but also for enhancing treatment efficacy and patient quality of life. Moreover, these measures will likely lead to improved documentation and compliance with established guidelines, thereby reducing the incidence of preventable complications associated with Clozapine-induced constipation.

Improving Staff Awareness of Sensory Aid Needs and Dementia Status on an Old Age Ward

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Aims. The aim of our quality improvement project was to explore and improve care for patients who use sensory aids, with or without dementia, on an old age ward at King's College Hospital. We sought to do this by increasing the staff awareness of each patient's sensory needs and dementia status.

Guidelines state that sensory aids (glasses and hearing aids) are important in orientating patients with delirium and dementia, yet these devices frequently go missing during admission or are not being used appropriately. This could affect communication and therefore overall care, both physical and mental. It is widely understood that delirium and dementia are associated with increased morbidity and mortality. In this project we aimed to explore issues around sensory aid use and to identify and implement impactful changes.
Methods. 2 Plan, Do, Study, Act cycles were conducted between October 2022 to February 2023. A driver diagram was created following staff interviews on the ward. The first cycle focused on increasing awareness of a form in electronic patient records (EPR) and the need for documenting each patient's sensory aid possessions and dementia status. This was done through bite-size teaching sessions to the team and monitoring of completion of this form. The second cycle included utilising a new laminated bedside checklist that is manually filled in and was aimed to serve as a visual cue of the patient's sensory impairment/dementia status. A survey was used at baseline and then repeated over the course of both cycles to evaluate awareness of staff (named nurse) of each patient's sensory impairment/dementia status on the ward.
Results. Baseline survey showed that staff were unsure of the sensory aid needs (glasses, hearing aids, dentures) of 25% of patients and 46.7% when it came to dementia status. EPR form completion increased by 14% between 14/12/22 and 25/01/23, however this was not statistically significant. 18% of bedside checklists were filled after 4 weeks. Overall, there was a statistically significant decrease in staff not knowing the sensory impairment status (by 32%) as well as dementia status (by 40%).
Conclusion. Whilst uptake of the forms and bedside checklist was slow, the project did show an improvement in awareness of staff and our hypothesis is that this leads to better use of sensory aids. The next step would be to assess whether this leads to better care through further PDSA cycles.

Early Intervention in Psychosis in Southwark – Bringing Antipsychotic Prescribing Closer to the Gold Standard

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Aims. This quality improvement project was conducted in an Early Intervention in Psychosis CMHT (Community Mental Health Team). We aimed to compare prescribing practices to the RCPsych gold standard for treatment of first episode psychosis. Following an initial audit, intervention was completed aiming to improve adherence to these guidelines and thereby the proportion of patients achieving remission.
Methods. An initial audit of the whole CMHT caseload (with exclusions for patients currently admitted to hospital, under the care of a home treatment team or awaiting assessment) was conducted in June 2021. This was completed from information contained in the electronic patient care record. This recorded for each patient details of whether an antipsychotic was recommended, if one was being taken, the dose, if remission was achieved and the number of previously trialled medications. Following this initial audit interventions were completed through designing a one-page flowchart to empower members of the wider multidisciplinary team (in particular care coordinators) around prompting appropriate medication changes, with an accompanying education session. Following these interventions, a re-audit was completed in March 2023 and the two samples compared through descriptive statistics. In the first audit 269 patients were included (27 exclusions), and in the second 255 (49 exclusions).
Results. The initial pre-intervention audit found that of patients taking medications, 33% (N = 172) hadn't achieved remission. In the follow up audit the proportion of patients taking medication without having achieved remission remained similar at 37%