

Aims. High Dose Antipsychotic Therapy (HDAT) prescriptions and combinations of antipsychotic agents are not currently recommended as standard practice by the RCPsych. College guidance (RCPsych, CR 190) advises that there is “little convincing evidence that off-label prescription of doses of antipsychotic medication above the licensed dosage range has any therapeutic advantage in any clinical setting” and that “any prescription of high-dose antipsychotic medication should be seen as an explicit, time-limited individual trial with a distinct treatment target”. Despite this, both national and local data demonstrate that HDAT has continued to be used regularly across psychiatric inpatient settings, often out of hours and often secondary to the use of PRN Antipsychotics, without a clear treatment plan or rationale. My aim was to create a simple, accessible, online tool that would allow prescribers to quickly and efficiently calculate the BNF percentage of any antipsychotic prescription and that this will enable safer prescribing.

Methods. With the support of a web-developer, I developed an online tool quickly and easily calculate antipsychotic BNF percentages. The tool can be found here: www.hdat.co.uk

Results. The HDAT Helper has been well received at local presentations and I have recently gained the support of senior management at Southern Health NHS Foundation Trust to develop an education programme on HDAT and the HDAT Helper to expand use of the tool across Southern Health.

Conclusion. The current expert guidance, clinical research and my own audit work demonstrates that there are ongoing issues with the prescription of high dose antipsychotics and that at times this occurs inadvertently when different agents are combined.

I believe that the HDAT Helper can make prescribing of antipsychotic agents clearer and more efficient and as a result significantly improve patient safety.

Antipsychotic Cardiometabolic Monitoring: Systemic Gaps and Hidden Groups

Dr Tanya Ansari¹, Dr Zafrina Majid^{1*}, Dr Ashma Mohamed¹ and Dr Martin Schmidt^{1,2}

¹Surrey and Borders Partnership NHS Foundation Trust, Surrey, United Kingdom and ²Head of School of Psychiatry, Surrey, United Kingdom

*Presenting author.

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Aims. To determine whether there are any gaps in cardiometabolic monitoring within primary or secondary care for people prescribed antipsychotic medication. A well-established system of cardiometabolic monitoring and checks has been implemented for patients with psychosis and bipolar in secondary care. It was unclear whether patients without these diagnoses were receiving the same level of monitoring.

Methods. Data were collected retrospectively from case notes of service users under CMHRS Reigate. We included all patients from three GP practices (100 patients) and identified all who were prescribed antipsychotics and their diagnoses. The GP practices were contacted to determine whether a system was in place to flag physical health monitoring requirements for service users on antipsychotics regardless of diagnosis. The results were used to calculate the potential number of patients across the entire trust who were at risk of not receiving cardiometabolic monitoring.

Results. 24/100 patients were prescribed antipsychotics without a diagnosis of psychosis or bipolar. 11/24 had a diagnosis of Emotionally Unstable Personality Disorder. Quetiapine was the commonest antipsychotic. None received routine cardiometabolic monitoring.

The total caseload for all 11 adult community teams in the Trust is 2434. If prescribing and monitoring practices are similar 584 individuals may be affected.

2/3 GP practices responded. Both confirmed that they would only conduct cardiometabolic monitoring when taking over prescribing/on discharge from secondary care if specifically requested to do so.

Conclusion. This service improvement project has identified a significant group of patients who aren't automatically offered cardiometabolic monitoring in secondary care.

Private correspondence from Professor David Taylor confirms that these patients would also benefit from monitoring when prescribed doses that are more likely to cause adverse effects (Quetiapine > 150mg/Olanzapine >5 mg Risperidone >2mg)

Secondary services need to identify these patients and include them in routine cardiometabolic monitoring.

Secondary services need to work closely with primary care to ensure that responsibility for checks is agreed and handed over when necessary.

Do We Know if You Drive? a Quality Improvement Project Improving Compliance With DVLA Guidelines

Dr Mia McDade-Kumar^{1,2*}, Dr Zainab Bashir^{1,2}, Dr Humaira Aziz^{1,2}, Ms Kealy Hughes^{1,2} and Dr Sara Ormerod^{1,2}

¹University Hospitals Birmingham NHS Foundation Trust, Birmingham, United Kingdom and ²Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, United Kingdom

*Presenting author.

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Aims. Background: The Driving & Vehicle Licensing Agency (DVLA) states: “Doctors and other healthcare professionals should: advise individuals on the impact of their medical condition for safe driving ability and also advise the individual on their legal requirement to notify DVLA of any relevant condition”. Within mental health, the guidance states that depression or anxiety associated with “Significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts” must be reported to the DVLA. Aims: Identify whether information was collected on driving status of patients presenting with depression/anxiety and self harm. Identify whether accurate advice was provided and documented. Implement changes that would improve compliance with guidance.

Methods. We reviewed notes to collect baseline data for 3 weeks prior to commencing interventions, then weekly for 2 months from November 2021. Cases were defined as: those presenting to Liaison Psychiatry (LP) with an act of self-harm either on antidepressants or with a confirmed diagnosis of depression/anxiety on their record. Each week, the notes of 10 cases were reviewed for evidence of documentation of driving status and advice regarding DVLA guidelines.

Weekly Interventions.

Week 1: Email communication to team highlighting the guidance, responsibilities and where to document.

Week 2: Driving status discussed in handover daily to increase awareness and identify/address concerns.

Week 3: Repeat email to team.

Week 4: DVLA guidance posters placed in LP office.

Week 12: Teaching session by Occupational therapist from regional driving assessment centre.

Results. Data were analysed for 90 patients over 9 weeks. 52% were female, and average age was 33 years. Relevant documentation was only made on week 1 (10%) and week 4 (20%). No documentation of either driving status or advice given were made in any of the other weeks analysed.

Conclusion. Achieving compliance with guidance was difficult. Email communication was the most effective intervention. A group discussion to identify drivers of poor compliance found that clinicians failed to ask as the questions were not routine practice, and some voiced concerns about the potential implications of advice (worsening therapeutic relationship or increasing social isolation/implications for employment). Future plans include adding a prompt about driving on the electronic risk assessment, and specific training in the staff induction.

“Inside Out”: A Regional Inpatient Joy in Work Project

Dr Tammy Morgan* and Dr Claire Kelly

Beechcroft, Belfast, United Kingdom

*Presenting author.

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Aims. Inpatient admissions during the COVID-19 pandemic went up in the regional unit by 18%. This included a 50% increase in Eating Disorder Presentations and more complex SMI requiring admission to Beechcroft. Beechcroft is the regional inpatient unit for CAMHS in Northern Ireland. This project aimed to improve staff joy in work by 30% by June 2021, following what was one of the most difficult years to be a health professional with the COVID-19 pandemic.

Methods. We used the IHI Joy in Work methodology along with our own rating scales in the inpatient unit.

Several PSDA cycles were carried out including focus groups, gathering baseline data from different wards, and our change ideas- Beechcroft stars nominations, Virtual Quizzes and Staff recognition certificates.

Results. Baseline data on our run chart demonstrated a bad day median in Beechcroft with 4.3 being the score.

With the PSDA cycle we demonstrated a 33% improvement in good day scores with a median of 1.4.

We have learnt that Joy in work comes from recognising the work already being done and rewarding the efforts our staff go to.

Spread and scale with Beechcroft stars now part of fortnightly MDT meeting and management meeting. Also rolled out to a community mental health team.

Conclusion. Joy in Work comes from the team. Recognising the efforts of the team is central to this. In particular during a pandemic.

A Quality Improvement Project to Improve Experiences of Audio Quality for Remote Attendees of a Ward Round at a London Acute Adult Mixed Psychiatric Inpatient Ward

Dr Hamilton Morrin^{1,2*}, Dr Vinitha Soundararajan¹, Dr Rupa Ramesh¹ and Dr James Woollard¹

¹Oxleas NHS Foundation Trust, London, United Kingdom and

²King’s College London, London, United Kingdom

*Presenting author.

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Aims. We sought to assess the degree, nature and impact of poor audio quality during ward rounds for individuals attending

remotely using Microsoft Teams. We aimed to evaluate attendee experiences of audio quality against our expectation that due to the existing ward microphone system using a cardioid polar pickup pattern that attendees would have difficulty hearing all members of the multidisciplinary team, as well as the patient, gathered in the conference room. We also hypothesised that after switching to an omnidirectional sound recording system, we would observe an improvement in attendee satisfaction with audio quality during ward rounds.

Methods. Individuals who had remotely attended ward rounds at Lesney Ward, Oxleas NHS Trust between 01/11/21 and 01/01/22, mainly patient family members and community care co-ordinators, completed a digital feedback questionnaire regarding audio quality. There was no exclusion criteria. Data from Likert scale questions were analysed with descriptive statistical tests (mode and distribution of responses). As minimal demographic data were obtained, inferential statistical tests were not used. Qualitative data were analysed using thematic sorting based on prevalence of themes in the data.

Results. Feedback was provided by three family members, one ward team member and six members of the community mental health team prior to the intervention. Pre-intervention feedback indicated high levels of dissatisfaction with 6/10 respondents reporting they were “dissatisfied” and 1/10 “very dissatisfied”. Only 3/10 of attendees reported being able to hear and understand all individuals physically present in the room. In addition, respondents agreed that the audio quality was poor (modal response “bad”, 6/10), and that the sound quality impacted upon their experience of the ward round (modal response “yes, greatly”, 6/10).

The three most common main issues reported by respondents were: people speaking too far from the microphone (7/10), voices sounding muffled (6/10), and too much background noise (4/10). Using their own words, respondents described how the ward round sound quality made them feel. Common themes identified through thematic sorting included: distress, difficulty in understanding information / management plan, ward round prolongation and inability to comprehend the patient or staff.

Conclusion. In conclusion, we found that when using an in-built laptop microphone with unidirectional pick-up remote ward round attendee satisfaction was poor, though this improved with the introduction of an omnidirectional system. Key areas for improvement include assessment of optimal positioning for adequate audio pick-up, and the introduction of automatic transcription for individuals with hearing impairments.

Improving Physical Health Data Provided on Discharge Summaries From Sheffield Home Treatment Team

Dr Ross Nieuwoudt*, Dr Alex Bradwell and Dr Gaelle Slater
Sheffield Health and Social Care, Sheffield, United Kingdom

*Presenting author.

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Aims. The aim of this QIP was to identify whether the information obtained during routine physical health reviews was being adequately handed over during discharge from the Sheffield Home Treatment Team within discharge summaries. Individuals with serious mental illness have a significantly higher all-cause mortality rate than those without, much of which is due to preventable physical health conditions. Due to this, the Home Treatment Team aims to complete a Physical Health Review (PHR) for every patient under their care as per guidelines. It is important that these examinations are performed, however, it is