Conclusion. Results suggest that the aim is on the way to being met. Our next change idea is to obtain formal feedback from staff and patients on this process.

Implementing a Digital Handover System to Improve Safety and Efficacy of Handover Across Acute Psychiatric Inpatient Sites

Dr Aaron Harris*

Oxleas NHS Foundation Trust, London, United Kingdom
*Presenting author.

Aims. To implement a digital handover system within Oxleas inpatient sites to improve the visibility of tasks both completed and pending, to reduce the number of tasks missed and to provide a clear audit trail relating to tasks handed over.

Methods. Junior doctors providing on-call cover to acute sites across all 3 boroughs served by Oxleas were invited to complete a questionnaire relating to the efficacy of handover. With this data & information gathered through discussions with the trust's informatics team, a digital handover system, based in Microsoft Teams, was developed. This was piloted and refined through 6 PDSA cycles from September 2022 – August 2023 before being implemented across all Oxleas acute sites from August 2023. Further questionnaires were completed 1 month & 6 months after its roll out to assess the impact of the change.

Results. Doctors were asked to complete a questionnaire at 3 time points: pre-intervention (T0, 20 respondents), 1-month post-intervention (T1, 13 respondents), and 6-months post-intervention (T2, 12 respondents).

- At T0, 92.3% of respondents reported tasks created by the on-call team had been missed due to staff not being aware, this reduced to 11.1% at T1, and 28.6% at T2.
- At T0, 23.1% of respondents agree/strongly agree that it is easy to view tasks that have been done on their ward out-of-hours.
- By comparison, at T1 69.2% reported the digital handover system has made it easier to view what had been done on a ward out-of-hours, rising to 83.3% at T2.
- At T1, 76.9% reported the digital handover system has made it easier to view tasks when on-call, rising to 83.3% at T2.
- At T0, 30% agree/strongly agree that the outgoing on-call doctor leaves a written record of tasks completed and outstanding. This rose to 69.3% at T1, and 41.7% at T2.

Conclusion. There is strong evidence that effective handover is a key aspect of clinical care, and failure of this is a preventable cause of patient harm. The initial questionnaire highlighted issues with the efficacy and safety of the handover process within acute sites at Oxleas, which the digital system sought to address. After implementation of the digital system, the findings demonstrated improvements in the handover process, with visibility increasing for tasks both completed & in progress, and fewer reports of tasks being missed by the ward-based doctors, which was maintained over the 6-month follow up period.

Improving Bone Health Care and Monitoring of Intellectual Disability Patients on a Low Secure Female Unit

Dr Serena Hinze[1]*, Dr Rosie England[2], Dr Ambreen Rashid[1] and Ms Nicole Freeman[1]

[1]Coventry and Warwickshire Partnership NHS Trust, Coventry, United Kingdom and [2]Black Country Healthcare NHS Foundation Trust, Walsall, United Kingdom
*Presenting author.

Aims.
- To ensure all patients on a low secure female inpatient unit have bone health risk factors assessed, identified and interventions initiated within 3 months of admission.
- The above to be achieved through creation of a Bone Health proforma, integration of a Bone Health checklist into the Intellectual Disability (ID) Annual Health Check and delivery of bone health education for patients and staff.

Background
Intellectual Disability has been shown to be associated with poor bone health, osteoporosis and increased fracture risk. The current NICE guidelines and risk tools (QFRACTURE), do not adequately reflect the true risk within this patient group who present with additional risks of epilepsy, antiepileptic medication and greater likelihood of low vitamin D. Bone health has not routinely been monitored in this population hitherto. This quality improvement project sought to develop a process whereby potential risk factors for poor bone health were identified and managed effectively.

Methods. The project was undertaken between February 2022 – October 2023 on a female low secure unit. All 8 patients on the unit were included. A baseline screening of risk factors was conducted to assess current practice and explore the clinical need for the project. Most patients were found to have multiple risk factors which had not previously been highlighted, indicating the need for formalised monitoring. Based on questionnaire feedback, a Bone Health Care Plan, a risk factor checklist which was integrated with patients' ID Annual Health check and Educational workshops were developed. Primary and secondary drivers were identified at the outset and plan, do, study, act cycles were used to refine change ideas. The changes were evaluated using quantitative and qualitative measures.

Results. Every inpatient has a completed Bone Health Care Plan. Twenty-five percent of patients were identified as having a particularly high risk and have had referrals accepted for Dual-energy X-ray absorptiometry (DEXA) scans. All patients are using a new easy-read ID Annual Health Check form with Bone Health checklist incorporated. All staff and patients were given the opportunity to attend a series of four bone health workshops, 43% of patients attended at least one session. Positive written and verbal feedback was received from both patients and staff.

Conclusion. 100% of service users have had their risk factors for bone health assessed and any necessary interventions applied. There is now an embedded process for reviewing the bone health of these patients annually where previously there was no regular monitoring.

Young Person and Parents/Carers' Experiences of the Transition Into a Child and Adolescent Mental Health Services (CAMHS) Inpatient Unit: What Could Be Improved?

Miss Georgina Shajan[1], Miss Ashika Shah[1], Dr Paul Briley[1], Dr Pallab Majumder[2,1] and Dr Josephine Holland[1,2]*

[1]University of Nottingham, Nottingham, United Kingdom and [2]Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, United Kingdom
*Presenting author.

Aims. To investigate the themes within young people and parents/carers' experiences of the admission process. A focus was placed on potential targets for change to improve experiences of CAMHS admission.

Methods. Young people and parents/carers with an experience of inpatient CAMHS admission within the past two years were approached by the Involvement team of an NHS trust. Focus groups and interviews were conducted capturing the views of 8 young people and two parents/carers. The notes and transcripts from these conversations were analysed using Braun and Clarke thematic analysis.

Results. Two key themes were identified within the data. The first focussed on information provision and communication. This captured young people's experiences of both: what information was available to them, e.g., websites and leaflets, and how this information was conveyed to them. The second theme brought together the young people's interpersonal experiences during the admission process. Within this, the impact of consistent contacts as well as both positive and negative transient encounters was highlighted.

Conclusion. Admission to a psychiatric ward is often a highly distressing time for young people and their families. The provision of easily accessible, clear, and correct information can improve their expectations and initial impressions of a unit. How this information is presented is also important. Consistent staff support and response to distress and difficulties during this time can also shape the perspectives of young people and their parents/carers.

Clear, accurate, and young person friendly information about a unit and the admissions process could be an easily achievable change which units could make to improve young person experiences. Improvements to clinicians' skills and response may represent a more complex and expensive goal.

Improving Carers' Engagement for Patients Admitted to Psychiatric Intensive Care Unit (PICU): A Quality Improvement Project

Miss Simona Hossain*, Miss Lois Clark, Dr Emily Pettifor, Dr Shantala Satisha and Miss Sua Youn

Willow Suite Psychiatric Intensive Care Unit, Littlebrook Hospital, Dartford, United Kingdom
*Presenting author.

Aims. The project aims to improve carers' engagement for patients admitted to our male Psychiatric Intensive Care Unit by improving communication between staff and carers; and by involving carers more in patients' care.

Hypothesis:
Among patients admitted to PICU, there is inconsistency in communication with carers and in involving carers in patients' care. We expect an improvement in these parameters with the quality improvement project.

Background:
Within PICUs, patients with severe psychiatric illness face social isolation. Challenges arise when carers are not engaged, impeding patient support and personalised care. Involving carers becomes crucial for informed decision-making, ensuring both patients and carers actively participate in the care process. National Association of PICUs and The Royal College of Psychiatrists' Guidance for PICU sets out recommendations regarding timelines and types of interventions to be offered to carers.

Methods. Initial baseline data was collected by reviewing patient electronic notes.

We then tested interventions to improve carers' engagement by using the Plan-Do-Study-Act (PDSA) methodology over 2 cycles. In the first cycle, we engaged the nursing staff by presenting the baseline data and recommendations to improve carers' engagement. In the second cycle, we introduced an admission protocol to ensure carers were engaged consistently. The parameters assessed were documentation of carers details; contacting carers within 24 hours of admission; documenting carers' views in care plan; inviting carers to Care Plan Approach (CPA) meetings and offer an appointment for carers with staff.

Data was collected after each PDSA cycle to monitor change.

Results. Of the patients admitted to PICU, 29% had their carers' details documented at baseline, 40% after the first PDSA and 80% after the second PDSA. 42% of carers were contacted within 24 hours of admission at baseline; 66% and 30% after the two PDSA. 50% of carers had their views included in the care plan at baseline; 0% and 30% after the interventions. At baseline, 42% of patients' carers were invited to the CPA meeting, 66% and 30% after the two PDSA cycles. 50% of patients' carers were offered an appointment with staff at baseline, 66% and 30% after the two interventions.

Conclusion. As a result of this quality improvement project there has been an improvement in engaging carers of patients admitted to PICU. This was not sustained for the second cycle due to many regular senior staff being on leave during Christmas. The next steps will be to implement this consistently and produce a carers' information pack.

Improving Trainee Experience of Raising Concerns: Redefining a Representative Structure for Post-Graduate Doctors in Training

Dr Katherine Hubbard*, Dr Sian Davies, Dr Vicki Ibbett, Dr Shay-Anne Pantall and Dr Ruth Scally

Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham, United Kingdom
*Presenting author.