

O0102

Applying the Surgical Checklist Approach for Psychiatric Trainees to a Busy, Time Sensitive Psychiatric Crisis Environment

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Introduction: The Jackson Hospital Crisis (Psychiatric ED) Center serves the entirety of Miami-Dade County in Florida and is considered one of the top three busiest and per capita of clinical staff likely the busiest nationally across the United States. Simultaneously, the management of mental health emergencies has ascended near the top of international priorities driven by multiple trends (e.g., growing social isolation associated with the pandemic, de-stigmatization). The crisis environment presents a uniquely difficult challenge in applying high quality medical care: frequent suicidal gestures, impulsive often intoxicated or psychotic patients, unprecedented demand, diminishing staff capacity, and requirements to consistently apply specific medical and psychiatric protocols. These challenges are specifically difficult for new trainees who are not yet accustomed to the high acuity situations found in psychiatry. Moreover, academic, institutional, and governmental policies change on a monthly, or even weekly basis, often with the objective of improving care. Nevertheless, such constant shifts in workflow result in opportunities for errors that impact patient trajectories.

Objectives: As such we endeavored to apply an evidence-based approach to improving the likelihood of success. One such vetted approach, the use of checklists, benefits from 10+ years of peer-reviewed research in “operational” medical specialties (e.g., surgery, ED, ICU) where work is segmented around interventions or time-shifts which share commonalities with the Psychiatric ED model. Yet the difficulty in implementing such models is typically not in the “hard” aspects of defining the checklist, but in the “soft” implementation dimensions of syndication, distribution, and enablement in the context of the individual unique settings.

Methods: We developed a checklist that will be implemented on the Jackson Crisis emergency department, with the aim of having first year trainees complete the check list on each individual patient. Surveys were administered before implementation of checklist and will be distributed on a quarterly basis to trainees to evaluate for changes in resident confidence and clinical care.

Results: Over six months, we launched this initiative with drivers of adoption focused on accelerating and easing new resident training, safety incident targeting, and in the balancing of “push” top/down and “pull” bottom/up dynamics. Initial learnings include rapidly improving resident satisfaction as well as various other impacts currently being observed throughout the institution.

Conclusions: Overall reception to the checklist has been positive from attendings and new trainees alike, further evidence will be analyzed and presented as the checklist is utilized throughout the psychiatric ED.

Disclosure of Interest: None Declared

O0101

The evaluation of IMR in crisis resolution home treatment, a mixed methods study protocol

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Introduction: In the past years, recovery has become a central concept in psychiatric treatment (Sowers *et al.* Acad Psychiatry 2016; 40 461-467). However, in acute mental health care the concept of recovery is lacking attention (Rabenschlag *et al.* Psychiatry Q 2014; 85 225-239; Jaeger *et al.* Nord J Psychiatry 2015; 69 188-195; Luigi *et al.* Can. Med. Educ. J. 2010; 11 62-73). In 2021 a short version of Illness Management and Recovery (IMR) was implemented at the Psychiatric Emergency Service Amsterdam-Amstelland (SPAA). IMR is an evidence based group intervention for patients with severe mental illness, based on cognitive-behavioral, psychoeducational and motivational components. The aim of IMR is to support participants to manage their mental illness (Mueser *et al.* Schizophr Bull 2006; 32 32-43). To our knowledge this the first time that IMR is implemented within an acute mental health care setting. Therefore the effects of IMR program on recovery in the acute phase of psychiatric illness are unknown.

Objectives: Insight in effects of IMR in acute mental health care.

Methods: We will carry out a mixed method study. In phase 1 the intervention will be carried out. 25 patients who are admitted to acute mental health care and diagnosed with a severe mental illness (SMI) will take part in the shortened version of IMR. Effects will be measured by the client version of the IMR-scale (Salyers *et al.* Community Ment. Health J. 2007; 43 459-480). Phase 2 includes qualitative interviews with a subsample from phase 1 (using maximum variety in diagnosis and demographic characteristics) to gain insight in the mechanisms and impact of the program.

Results: The proposed study will investigate the effects of an adjusted evidenced-based treatment within a population of people who receive treatment in a Psychiatric Emergency Service. The original intervention is shortened in time and topics, to match the needs of people in the acute phase of psychiatric illness. The question that arises is if an existing treatment can be translated to a different group of patients.

Conclusions: The proposed project has some important limitations that we feel deserve mentioning. It is questionable if a person can profit from a recovery program during a phase of acute crisis. Also, can we expect the same effects if the new program is a shortened version of the original evidence based intervention?

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O0102

Medical cannabis use among patients with Post-Traumatic Stress Disorder (PTSD): A nationwide database study

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