The Creation of a MEED Score Calculator to Aid MEED Score Completion in Patients With Eating Disorders

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Aims. The Medical Emergencies in Eating Disorders (MEED) guidelines include a scoring system, the MEED Score, which is an all-age risk assessment of the physical safety and risk to life of patients with eating disorders. Accurate MEED Scores are therefore fundamental for patient safety. However, MEED Scores can be timely and confusing for unfamiliar professionals. The MEED Score Calculator is a spreadsheet consisting of a colour-coded table with each MEED Score category. Red, Amber and Green are selected based on the described parameter and totals are automatically calculated. Additional "Background and Instructions" and "Medical Management" pages explain how to use the calculator and how to manage medical issues arising from MEED Scores. The aims of the MEED Score Calculator project are to: 1) Increase confidence amongst healthcare professionals completing MEED Scores 2) Increase efficiency of completing MEED Scores

Methods.

- A preliminary survey questioning MEED Score confidence and efficiency was sent to healthcare professionals who complete MEED scores
- The MEED Score Calculator was created using Microsoft Excel
- Upon completion of the survey, the MEED Score Calculator was distributed via email
- Three months later, the secondary survey was sent to users, focusing on calculator use and the impact on MEED Scoring efficiency and confidence

Results.

- 20 participants completed the preliminary survey
- 10 participants completed the secondary survey
- 60% of respondents now use the MEED Score Calculator when completing MEED Scores
- 0% prefer not using the calculator (40% haven't completed a MEED Score since having Calculator access)
- 60% of respondents report increased confidence completing MEED Scores
- 89% of respondents report reduced time spent completing MEED Scores
- *Result collection ongoing

Conclusion. The MEED Score Calculator increases confidence and efficiency of MEED scoring amongst healthcare professionals, achieving both aims.

Furthermore, due to positive feedback from eating disorder professionals, the MEED Score Calculator was included in the Kernow Local Medical Committee newsletter to raise awareness amongst Cornwall GPs. It is also due to be added to local clinical referral guidelines for GP referrals to eating disorder services. Additionally, we aim to make further improvements to the Calculator based on user feedback.

We hope for knowledge of this simple tool to spread throughout relevant primary and secondary care settings, making MEED Scoring more accessible and quicker for healthcare professionals. We anticipate that with this, we will see improvement in the robustness of physical monitoring and the quality of referrals. Thus, reducing risk of adverse physical health outcomes in this vulnerable cohort.

Improving the Quality of Valproate Prescribing in Adult Mental Health Services - POMH Topic 20b - Enhanced Community Rehabilitation Service (ECRS), Bognor Regis, West Sussex

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Aims:/Background. The licensed indications for Sodium Valproate are narrow however the medication is commonly prescribed amongst mental health services in the UK. Such practice can be associated with ineffective and poorly tolerated treatment, especially given the limited evidence re efficacy of 'off label' use of Valproate.

Aims and auditable outcomes

- Annual review of risk benefit balance for those on continued Valproate treatment to include asking about adverse effects, medication adherence and therapeutic benefit Any 'off label' prescription of Valproate, should be explained to the patient and documented
- Clinician's reasons for initiating Valproate treatment should be documented in clinical records
- Plasma level monitoring of Valproate treatment should not be used unless there is evidence of concerns about medication adherence, dose related side effects and/or ineffectiveness
- Prior to initiating Valproate, the following should be documented in the clinical records: Full Blood Count (FBC), Liver Function Tests (LFTs) and Weight and/or BMI
- Review within first three months of Valproate treatment should include: Screening for common side effects and assessment of the response of treatment

Methods. Only 7 of 51 patients on the ECRS caseload were eligible for the study i.e. currently prescribed Valproate, irrespective of age.

Audit forms provided by POMH team. Clinical records used to complete included all electronic/paper notes, letters, and other patient information available to clinical team.

Due to nature of information required we involved doctors and nurses from the clinical team.

Results. 6/7 (86%) of patients had clinical reasoning for Valproate prescription documented in their clinical records - 5/7 (71%) were prescribed 'off-label' - mainly as adjunct for refractory Schizophrenia.

7/7 (100%) of patients had a documented review in the past year which included asking about adherence to their Valproate medication.

2/7 (29%) of patients had plasma monitoring of Valproate treatment in the past year as part of routine hospital admission blood tests. No evidence of concerns for the other patients documented otherwise.

5/7 (71%) had treatment initiated with Valproate more than 5 years ago, hence unable to see if prescription initiations were explained to patients due to lack of historical records.

Conclusion. First cycle of this internal audit which forms part of a wider national prescribing audit, demonstrates that the ECRS team are generally meeting current standards for Valproate prescription.

Despite the majority (71%) being initiated >5y ago - 86% of our patients have documented clinical reasons for ongoing prescription, with100% having a documented review in the past year.

Understanding Trainees' Current Likelihood of Raising Concerns

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Aims. Raising concerns is a duty for all doctors. However, a scoping exercise within a large mental health Trust demonstrated that trainees experience difficulties in raising both patient safety and training concerns. As part of a trainee-led quality improvement (QI) project within this Trust, our aim was to develop a pulse survey to capture the current likelihood of trainees raising concerns and factors influencing this.

Methods. An online survey was developed using 'plan do study act' (PDSA) methodology. The initial draft was informed by data from the Autumn 2021 scoping exercise. The survey was refined using a collaborative trainee-led approach. It was tested by trainees involved in the QI project followed by two other trainees and was revised accordingly.

Trainees across all training grades were invited to complete the survey through various communication channels. The pulse survey will be repeated monthly with a two-week response window.

Results. Ten trainees out of 103 responded to the first pulse survey open from 18th to 31st January 2023 (response rate 9.7%). Seven respondents were core trainees and three were higher trainees.

Respondents were more likely to raise patient safety concerns than training concerns (average score of 3.8 out of 5, where 5 equals 'very likely', versus 3.4 out of 5 respectively). Of the three respondents who had experienced a patient safety concern in the past 2 weeks, only two had used any existing process to raise it. These data were replicated for training concerns.

No respondents were confident that effective action would be taken if they raised a training concern, while less than half of respondents were confident that effective action would be taken if it were a patient safety concern.

The reasons for the low response rate are likely varied. However, there may be some similar underlying reasons for low engagement in surveys and low engagement in raising concerns. Given this, a more negative picture of trainees' likelihood of raising concerns may have been portrayed if more trainees engaged in the survey.

Conclusion. Engaging trainees to provide insight into their likelihood of raising concerns is challenging. Despite the low response rate, this initial pulse survey demonstrated that trainees continue to experience barriers to raising concerns. PDSA methodology will continue to be used to optimise the monthly pulse survey response rate. The key QI outcome measures will also be integrated into pre and post intervention surveys as a pragmatic approach to evaluate specific change ideas.

EVALUATION of VIDEO CONSULTATIONS in COMMUNITY MENTAL HEALTH SETTING- Pilot Project of Service Evaluation

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Aims. To evaluate the overall experience and satisfaction with Attend Anywhere video consultations in adult CMHT. The increased use of the digital world is evident via Ofcom Tele Report 2019. UK Government's Five Year Forward View and initiatives, such as 'Digital First', aim to reduce face-to-face consultations. Past reports have shown video consultations to be non-inferior to face-to-face consultations in systematic reviews and qualitative studies.The contagious nature of the COVID-19 outbreak limited face-to-face consultations. This led to video consultations via Attend Anywhere (AA). AA is accessed anywhere via the web on Google or Safari with a good internet connection. It provides a single, consistent entry point with an online waiting area on the service's webpage.

Methods.

1. Two separate questionnaires were designed, one each for service users and staff, to capture relevant information at the end of AA consultation. Additional clinical questions for staff included.
2. Data were collected anonymously for 2 months from 1st April 2020.

Results. Total respondent 44= 20 service users and 24 staff.

1. For Service Users:

The respondents' age range was 19-62 years, 80% females. The majority were follow-ups with three new assessments. About half of them had previous contact with the staff. 15 consultations were carried out by the doctor, four by the psychologist, and one was a joint doctor-psychologist consultation.

95% reported their overall experience to be very good-good. 90% found it easy to use: 95% said they would use it again.

2. For Staff:

The respondents' age range was 30-50 years, 87% females. The majority were follow-up assessments with one-third new. 16/24 respondents were doctors and eight psychologists. 58% had a previous meeting with service users.

83% reported the overall experience as very good to good: one third felt it's time-saving. 100% reported it's easy to use, would re-use and recommend to others.

For clinical questions, the responses were very good-good as Rapport 87%; Risk assessment 83%; care plan 83%; History taking 78%; Mental state/Cognition 66% and providing support 65%.

Conclusion. Overall, the majority of respondents at an Adult CMHT found video consultations easy to use with readiness to use them again. Video consultations offer several advantages