

pharmacists, hospital manager and hospital director. The committee reviewed the medication errors reported in the last year and planned the Pre-Intervention Phase I and Post Intervention Phase II Audits.

The Intervention project was broadly divided into two domains---Doctors' Prescription led by the Specialty doctor and the Nurses' Medication Administration, led by the Head of care. Using the QI "theory of change" model, three primary drivers of "Safe Prescription and Administration", "Patient Education" and "Policies and Guidelines Implementation" were established. The poster will have a demonstration of the complete drivers' diagram.

Secondary drivers for "Safe prescription and administration" required inputs from doctors, nurses and pharmacists; Change ideas (Interventions) of introducing In-patient depot clinics, Daily 10-Points self-audit by clinic nurse, twice daily information about patients' medication compliance in morning and evening electronic handovers, PDSAs with monthly audits of prescription and administration errors, monthly pharmacists' audits for drug interactions and monitoring of adverse effects and rapid tranquilisations were implemented.

Secondary drivers and change ideas for "Patient Education" included discussions with Multidisciplinary teams, medication information leaflets being available to patients, discussion slots with pharmacists, self-administration of medication, and alternate self-management strategies instead of PRN medications.

Secondary drivers and change ideas for the "Policies and Guidelines Implementation" included steps to ensure all staff were aware of the policies for safe drug administration, rapid tranquilization and PRN utilisation, medication meetings minutes being circulated to all staff, and monthly audits for MHA1983 Section 57 treatment certificates for detained patients.

The medication Management Committee continued to meet on monthly basis to review the interventions, implementation of new strategies, and new recommendations on the basis of monthly mini-audits. A patient satisfaction survey on their knowledge about prescribed psychotropic medication was also conducted pre and post-intervention.

**Result.** Results of Phase I and Phase II were compared. There was a significant reduction in prescription errors by doctors (19% to 3%) and medication administration (34% to 11%). Mental health documentation compliance improved from 77% to 98%. Patient satisfaction survey also demonstrated more knowledge about their prescribed psychotropic medication (15% to 32%). Two areas however did not show satisfactory improvements; There was not a significant improvement in acknowledgment or documentation of potential drug interactions or adverse events raised by pharmacists. Errors related to depot medication administration reduced in the initial two months, but increased again. The introduction of the Weekly Depot Clinic was not found successful by the administering nursing staff, and it was moved back to daily administrations.

**Conclusion.** The formation of the medication management committee and the quality improvement programme showed significant improvement in most areas of effective medication management. The primary and secondary drivers with the change ideas gave structure to the intervention programme. The mini-audits using PDSA methodology helped to test different interventional strategies and to assess their impact and building upon the learning from previous results. This shows that for sustained effective medication management, this should not be a one-off exercise, and we need to continue learning and implementing newer strategies for continued effective medication, taking on-board the advice from MDT, nursing, patients, and carers.

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## Improving remote prescribing in a CAMHS community team during the COVID-19 pandemic

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**Aims.** Prior to the COVID-19 pandemic, prescriptions were usually collected by patients/families in person from the CAMHS community team base. Due to social distancing measures introduced during the pandemic, face-to-face contact between staff and patients had to be minimised. This led to an increase in remote prescribing, including from home. Feedback from team doctors was that the process of following the Remote Prescribing Protocol (RPP) was taking up a significant portion of their day, preventing them from doing other clinical work.

Our aim was to reduce the time taken to complete a remote prescription to pre-pandemic levels (under 15 minutes).

**Method.** We used PDSA methodology in this QI project:

- 1) Plan: Survey sent out to team duty doctors to identify the most time-consuming steps in RPP which could be safely delegated to administrative staff
- 2) Do: Email sent requesting administrative staff clarify several details with patients/families when they request a prescription. This included the names and doses of medication, how many days they had left, where they wanted the prescription sent to (home/pharmacy) and the relevant address. If the patient usually received their repeat prescription from their GP, they were re-directed to their GP
- 3) Study: Following the intervention above, team doctors recorded how long it took to complete a remote prescription

**Result.** The average time taken to complete a prescription fell from 31 minutes (pre-intervention) to 22 minutes (post-intervention). The range of time taken also dropped from 10-241 minutes (pre-intervention) to 0-46 minutes (post-intervention). The medications taking above the average time to complete were more likely to be non-controlled drugs rather than controlled drugs (which one may typically think would be more time-consuming to write out).

**Conclusion.** Whilst we have successfully reduced the time for remote prescribing, we have not reached the target of reducing it down to less than 15 minutes (pre-pandemic timings). As part of the next PDSA cycle, we have carried out a survey to ask what barriers remain. Checking patient's notes and recent prescriptions can still be inefficient. We propose introducing an intervention whereby this can also be safely delegated to administrative staff e.g. including a copy of the most recent prescription in the request.

In the future, we will continue to improve the RPP with further PDSA cycles and carry out an audit on the system on a regular basis to ensure standards are met.

### Treatment resistant depression in the UK: sub-analysis of a European real-world evidence study

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**Aims.** Treatment resistant depression (TRD) affects  $\leq 20\%$  of patients with major depressive disorder and is defined as failure to respond to  $\geq 2$  different antidepressants in the same major depressive episode (MDE). TRD patients' outcomes are poor and real-world data from the UK are limited. The Treatment Resistant Depression in Europe Cohort was established to study patients being treated in local, routine clinical practice. The analysis presented here aimed to compare UK-specific data with data from other European countries included in the study.

**Method.** A prospective, multicentre, observational cohort study of TRD patients in Italy, Germany, Spain, Portugal, the Netherlands, the UK and Belgium was conducted. Patients aged 18–74 years with current TRD, Montgomery-Åsberg Depression Rating Scale (MADRS) score  $\geq 20$ , and initiating a new treatment for depression, were eligible. Data from medical records, clinician assessments and patient-reported questionnaires were collected over time, with follow-up of  $\geq 6$  months.

**Result.** Data from 411 patients were analysed. At baseline, UK patients ( $n = 49$ ) had similar depression severity to the whole European cohort (34.7% vs 32.6% of patients categorised as severe based on MADRS score, respectively). Patients had experienced the current MDE for a mean (standard deviation [SD]) of 6.1 (7.9) years vs 2.6 (3.9) years and 14.3% vs 4.9% had experienced  $\geq 5$  treatment failures during this time in the UK and whole cohort, respectively. Total mean (SD) Sheehan Disability Scale (SDS) scores of 24.5 (5.1) and 22.4 (5.5) were reported for the UK and whole cohort, respectively. Unemployment and long-term sick leave rates were 38.8% and 20.4% in the UK and 30.2% and 19.0% in the whole cohort, respectively. At 6 months, 8.9% of UK patients were in remission, and 82.2% had not responded to treatment, representing the lowest remission and highest non-response rates across all countries.

**Conclusion.** UK patients had been ill for longer and had more prior treatment failures than other countries in the study. They had high work and functional impairment, and the worst treatment outcomes of all the countries studied. UK TRD patients experience high disease burden; there is an unmet need for treatment strategies with better response rates.

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### CAMHS Emergency Assessment Service (EAS): development & implementation during the COVID-19 crisis

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#### Aims.

- To provide emergency psychiatric assessment throughout the COVID-19 pandemic.
- To maintain patient and staff safety by minimising exposure to infection risk by reducing A&E contact.
- To alleviate pressures on the A&E department by enabling CAMHS patients be seen in an alternative setting.
- To provide a more appropriate environment for the assessment of young people in acute distress.

#### Method.

- Service live 8th April 2020 to 8th June 2020.
- Exclusion criteria: 1) confirmed/suspected overdose; 2) self-harm with injuries requiring medical attention; 3) acute psychotic episode; 4) drug/alcohol intoxication; 5) high risk of absconding (ASD/LD/LAC), 6) severe agitation/aggression; 7) eating disorders requiring medical intervention; 8) section 136 of the MHA; 9) break down of a social care placement; 10) medically unexplained symptoms.

Data reviewed of all young people who were referred to A&E during March–April 2020. Each case was assessed as to whether they were then seen within the EAS Service.

These cases were reviewed demographically looking at ethnicity, gender, while also reviewing the reason for referral.

#### Result.

- A total of 90 cases referred to Urgent Care Team
- Nineteen (21%) met criteria for assessment at EAS
- 80% of presentations between 12am and 9am.
- Commonest reasons for referral : low mood with suicidal ideation (42%), anxiety (26%)  
→ 50% service users not previously known to CAMHS
- Majority of service users were female
- Mean age 15 years
- All but one of the young people assessed at the EAS, were discharged home with community follow-up

#### Conclusion.

- Average total no. monthly referrals to CAMHS Urgent Care Team (UCT) fell from approx. 90 to 45.
- Only a small proportion of referrals (21%) could be safely seen by the EAS, suggesting that the majority of young people required a joint assessment by A&E and CAMHS Urgent Care Team.
- When need arises, very rapid reconfiguration and implementation of CAMHS emergency services is achievable.
- EAS diverted a small number of young people from exposure to COVID-19 in A & E.
- The service was set up speedily without evaluation of parent/carer/young people views or evaluation of cost-effectiveness.
- If similar services are to be set up permanently, the balance between safety and the risk of division between mental & physical health services and potential to increase stigmatisation of mental illness should be considered.
- Adaptation to future outbreaks should be informed by this initiative.