Enhancing Well-Being: Optimizing Service Delivery in Neighbourhood Mental Health Team (NMHT) for Administrative Staff and Service users

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Aims. Promoting the well-being of staff is paramount within mental health services. However, a common issue arises where administrative personnel, often serving as the primary point of contact for service users, engage in mental health-related interactions without formal training. This deficiency can adversely affect their well-being, leading to diminished team morale and increased staff turnover, consequently impacting the quality of care provided by the Neighborhood Mental Health Team (NMHT). Moreover, it can contribute to dissatisfaction among service users, jeopardizing their rapport with the service. We aim to improve the wellbeing of staff and service users and to optimize service delivery at the local NMHT.
Methods. Data were gathered from a local NMHT catering to 1200 service users in the borough of Tower Hamlets in London. A pre- and post-implementation questionnaire was administered to both service users and six administrative staff members. The questionnaire highlighted several areas for improvement, including a lack of mental health understanding among administrative staff, reported low confidence when handling certain phone inquiries, and service user complaints. Change initiatives were then devised to address these concerns and evaluate their impact on enhancing the experience for both service users and administrative staff.
Results. Administrative staff uniformly expressed the need for increased mental health training prior to commencing their roles. Implementation of targeted change initiatives led to noticeable improvements in service user satisfaction and staff confidence in managing phone interactions. These enhancements culminated in an overall advancement in service delivery.
Conclusion. Through the strategic implementation of change initiatives informed by our initial findings, we not only augmented mental health literacy among administrative staff and service users but also bolstered their well-being. Consequently, this directly translated into an amelioration of local service offerings. Further research is warranted to ascertain the long-term efficacy of these innovative interventions.

7-Day Follow-Up Appointments Following Discharge From a Psychiatric Hospital

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Aims. Following discharge from inpatient to community psychiatric services, the first 7 days is the most vulnerable and associated with an increased risk of suicide. According to the NICE Guideline 53, it is recommended that patients discharged from inpatient psychiatric services should be reviewed within 7 days by the relevant community services. Our aim was to determine how well we are adhering to this recommendation, appropriately documenting the appointment in the patients' discharge documents as well as the number of patients that attended the appointment.
Methods. We collected data on an excel spreadsheet of patients discharged from Huntly ward (a General Adult Psychiatry ward) in the Royal Cornhill Hospital from 01/09/2022 and 14/10/2022 (a period of 6 weeks).

The data collected included name, CHI, date of admission and discharge, community mental health team, follow-up appointment offered, appropriate documentation on Core discharge document and whether the patient attended the appointment.

After the first audit cycle, we had a discussion with the junior doctors on the ward highlighting the importance of 7 day follow up and the need for arranging with the Community mental health team prior to the discharge, documenting a date, time and name of the clinician for the 7 day follow up in the Core discharge document. We also encouraged the use of reminders like using the doctors' diary book on the ward to document anticipated discharges and adequate hand over of patients to the community mental health team at the start of each week's Multidisciplinary Teams meeting.

We subsequently did a re-audit on patients discharged from Huntly ward between 04/04/2023 and 12/05/2023 (6 weeks). We compared the results from the first cycle and the second cycle to identify a change.
Results. First Audit cycle.

Over the 6-week period, 27 patients were admitted into the Huntly ward and 23 patients were discharged.

48% (n = 11/23) of discharged patients were offered a follow up appointment.

91% (n = 10/11) had this appointment documented in the Core discharge document.

100% (n = 7/7) attended the 7 day follow up appointment.

Re-Audit.

Over the 6 week period, 16 patients were admitted and discharged from Huntly ward.

81% (n = 13/16) were offered a 7 day follow up appointment and this was documented in the Core discharge document.

100% (n = 13/13) of the patients attended their 7 day follow up appointment.

The result showed good improvement from 48% to 81%.
Conclusion. Using reminders, properly liaising with the community mental health team, appropriately documenting a named clinician, date and time for the 7 day follow-up ensures that the patient attends.

The importance of offering support during the first week after discharge from psychiatric hospital should continue to be emphasized to prevent adverse outcome during this vulnerable period.

Improving Quality of Multidisciplinary Team Meetings in Our Community Mental Health Team in NHS Greater Glasgow and Clyde, Scotland

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Aims. To ensure smooth running of Multidisciplinary team (MDT) in Community mental health team (CMHT) and reviewing MDT structure for better functioning at Parkview Mental health Resource centre.

On a Friday two Multidisciplinary teams (MDTs) were running online on Microsoft teams simultaneously. The same staff was running the two MDTs, so staff input could be limited at times and staff would dip in and out of MDTs. Discussion around ways of improving this so that both MDTs run smoothly. Also, there was no formal structure to MDT meetings. It was decided that improvement in Quality of MDT needs to be addressed.

Methods. Initially numerous discussions held online with Parkview team, nursing colleagues.

CMHT Quality improvement group was set up and a meeting was arranged where everyone's ideas were considered.

A pilot project was first introduced in March 2022 and audited in July 2022. Plan, do, study, act (PDSA) cycle was carried out.

Plan

Two nursing teams to be setup which will feed back into the two MDTs on alternate weeks. This will reduce nursing teams having to come in and out of one MDT to join other MDT, hence increasing the efficacy of the MDT.

Devise a new template to provide formal structure for the MDT presentation.

Do

Trial the new setup of two nursing teams.

Study

Ask all MDT staff members for feedback on the working of MDT.

Act

Reformat the Structured template and distribute to all staff members.

Results. 100% staff felt that new structure of MDT was useful.

84% staff satisfied with the new way of running of MDT.

84% staff satisfied with having designated teams for MDT.

Conclusion. Having Designated MDT teams and a structured format helped in robust functioning of the MDT in the CMHT.

Improving Trainee Doctors' Awareness on How to Refer for Routine Radiological and Cardiac Investigations at a Psychiatric Hospital in South London

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Aims. Psychiatric inpatient hospital, although part of secondary care, is separate from a physical health hospital and therefore does not have access to electronic referral systems, which increases efficiency of referral processes. As part of an admission clerking for all inpatients in psychiatric hospitals, the admitting doctor takes a history of past medical issues, a physical examination, electrocardiogram and bloods. Depending on findings, further radiological and cardiac investigations may be warranted. Not having access to electronic referral systems can cause delay in delivering treatment for psychiatric inpatients, especially when referral pathways is unclear. The aim of this quality improvement project is to increase the knowledge of referrers in order to improve efficiency completing referrals and reduce incorrect referrals. With clinicians able to refer for routine imaging correctly and in an efficient manner, it is hoped that this will correlate with an improved quality of care received by patients.

Methods. Firstly we assessed the knowledge of currently employed trainee doctors, via a web-based survey, on how to refer for routine and commonly ordered radiological and cardiac investigations. Employed referrers included core trainee, GP and foundation year trainee doctors. We then created an electronic referral pack which includes a guidance and referral forms provided to clinicians when they start employment at Lambeth hospital and accessible to current trainees. A follow up survey then reassessed the knowledge of these referrers.

Results. There was a total of 11 responses received from survey prior to sending out the electronic referral guidance pack, of which 100% believed that it would be helpful to have a referral guidance pack. A total of 4 responses were received after sending out the guidance. The surveys showed that there is improved knowledge of how to refer for routine radiological and cardiac investigations after guidance was sent. Prior to sending the guidance, 9.1% referrers were made aware of the referral process, and this increased to 50% after the referral guidance pack was sent out.

Conclusion. Trainee doctors in psychiatric hospitals require more support with physical health management in psychiatric hospitals, including referring for physical health investigations, as referrers cannot access electronic referral systems used in physical health hospitals. Results need to be correlated with clinical outcomes in future. A longer term project could include linking the electronic referral systems between psychiatric and physical health hospitals.

Monitoring of Clozapine-Induced Gastrointestinal Hypomotility

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Aims. Clozapine, a second-generation antipsychotic licensed for treatment-resistant schizophrenia, has a well-documented side effect profile, the most common of which is decreased gastrointestinal motility. Clozapine-induced constipation occurs more frequently than blood dyscrasias and can lead to severe complications such as paralytic ileus and intestinal blockage; in extreme cases, it can be fatal, with a fatality rate of 20–30%. The risk of gastrointestinal hypomotility is most pronounced during the initial four months of treatment; hence, weekly assessments are imperative during this period. According to Lanarkshire's local guidelines, bowel habits should be assessed at baseline, during routine blood sampling, and ideally at every clinical interaction. Our audit aims to determine the frequency of bowel habit monitoring in inpatient settings and to ascertain the prevalence of laxative prescriptions among these patients.