2022(n = 13) to see documentation, including Consent documents; Form 5(consent) in case of capacity, T4/T6/S62, Documentation of Memory assessment, as well as MADRS assessment before and during the procedure. We started generating ECT discharge summaries in November 2021 and collected data for all patients (13) till 6th February 2022.

Results.

Documentation of Legal Status: 5% in 2020 vs.100% in 2021* and 2022
Written consent /form 5: 95% in 2020 vs. 100% in 2021* and 2022
Documented Mini-ACE: 5% in 2020 vs. 100% in 2021* and 2022
Doc. MADRS assessment; 0% in 2020 vs. 100% in 2021* and 2022
*(excluding patients who did not complete the treatment)

Conclusion. The audit results of 2020 showed improvement however assessments done during treatment were not accessible to referring clinicians or to patients. Introduction of discharge summary helped to give snapshot of patient's weekly progress, weekly objective assessment scores which helped the referring clinicians to get idea about patient's improvement and resulted in improved communication as well as patient and carer satisfaction.

Small actions can have big impact on the way patient care is delivered. We believe that going through process of auditing helped us to improve our practice and make a positive change in terms of delivering better care.

MDT Clinics on a General Adult Acute Psychiatric Ward: Staff's Views and Person-Centred Care

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Aims. Person-Centred Care (PCC) focuses on knowing the person behind the patient, engaging them as an active partner in their treatment, encouraging self-management and shared decisions. Inpatient multidisciplinary (MDT) clinics offer an opportunity for PCC by working collaboratively with service users (SU) in developing care plans. The aims of this project were to explore staff views and levels of satisfaction regarding the running of MDT clinics, to assess the quality and efficacy of changes made to MDT clinics, and to identify areas of practice which need improvement.

Methods. In April 2021, MDT meetings of an acute inpatient clinical team were repurposed to 30-minute clinics with SU and relevant key professionals present, focusing on SU needs. Two staff surveys were completed in June and October 2021. Following the first survey, changes were made to the days clinics were run, attendance schedule, and staff allocation of responsibilities for efficient clinic running. In the second survey, a 14-question questionnaire was sent to all 48 staff members. The questions explored staff experience of MDT clinics. The measures were both qualitative and quantitative.

Results. The overall response rate was 31.25%, of which 40% by medical and 40% by nursing staff. Staff reported there was a positive impact in the collaborative development of care plans, including improved SU involvement, increased involvement of families, improved contribution from different professionals, and formulations providing greater insight. They reported improved task orientation, directed responsibility for task completion within the team, and enhanced role and responsibility of the named nurse. They thought there was less time for 1:1 work, but that the "overall benefits are worth it". Improved relationship with SU was reported by 85%, increased engagement with SU care by 93%, and identifying clear goals for care plans by 93%. Nevertheless, problems with planning and logistics were reported by 77%. Main challenges included time management especially with external visitors or combination of remote and face-to-face attendees, relatively poor attendance of CMHT and family members, difficulties with informing and preparing SU ahead of their clinic times, number of attendees, and dissemination of MDT care plans.

Conclusion. Repurposing MDT meetings to MDT clinics focusing on SU needs has a positive impact in inpatient clinical practice. MDT clinic planning and improving the involvement of community teams and family members can contribute to an optimal purposeful inpatient admission. Conducting inpatient MDT clinics can be a crucial part of working collaboratively with SU and PCC.

Alcohol Related Brain Damage Presentations in an Acute General Hospital

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Aims. Alcohol-related brain damage (ARBD) is used to describe a variety of clinical syndromes associated with excessive intake of alcohol. It can present with cognitive and neurological syndromes, including Wernicke's encephalopathy, Korsakoff's syndrome, alcohol dementia, cerebellar atrophy and frontal lobe dysfunction, Central pontine myelinolysis and Marchiafava Bignami disease. In up to 25% of cases ARBD can be complicated by traumatic head injury and brain blood supply disturbances. In the absence of clear national guidelines, standards or established pathways of care across most of the UK, most patients are unable to access appropriate service provision. The North Derbyshire mental health liaison team (MHLT) provides assessment and diagnosis of acute alcohol related brain injury, assess severity (based on clinical presentation, investigation findings, cognitive assessment) and provide a care plan with follow-up to various community services. Aim and objectives: To find out the discharge outcome for patients with ARBD diagnosis by the north MHLT, help us identify service gaps and look at ways to improve patient's care in this group.

Methods. We retrospectively analysed 300 patients who were referred to liaison team for drug and alcohol problems and were seen by the drug and alcohol lead nurse within the liaison team. Patients who were given a diagnosis of ARBD by the liaison team were included in the study.

We looked at

1. Age and gender distribution
2. Team who gave the initial diagnosis
3. Discharge destination
4. Community follow-up and engagement

Results. We identified 17 patients who were given diagnosis of ARBD. There was relatively equal distribution of male to female patients. Majority of diagnosis' were given by liaison team. The discharge destination was variable with around half referred to ARBD rehabilitation unit and Derbyshire recovery partnership. Engagement was poor with only 20% of patients engaging with services.

Conclusion. Recommendations:

1. Detailed cognitive tests need doing for screening and to establish severity
2. Consideration for which neuroimaging modalities can help aid diagnosis, if any, should be made.
3. ARBD leaflets to be given
4. ARBD diagnosed patients who do not need rehabilitation unit, should be referred for social care assessment as an inpatient and / or be followed up in the community under Care Act
5. Considerations with the Multi Disciplinary Team for ways to improve engagement in the community, perhaps with more frequent and robust follow-ups.

Improving the Quality of Old Age Inpatient Ward Rounds During COVID-19 in NHS Lanarkshire, Scotland

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Aims. To provide a structured Multidisciplinary team (MDT) checklist to improve the quality of ward rounds in Ward 3, Wishaw General hospital. Ward rounds normally involved patient and electronic documentation review during MDT. Feedback from medical and nursing staff indicated inconsistencies in finding up to date Do not resuscitate cardiopulmonary resuscitation (DNACPR)forms/Treatment escalation plans, treatment forms, care plans, thromboembolism prophylaxis during ward rounds. Discussions about who will update the family, make social work referrals needed clear documentation in order to follow up efficiently post MDT. Food, fluid, and weight charts although done regularly there was no single place to keep them together. These charts to be kept in a separate folder for finding easily during ward rounds. The Royal College of Psychiatrists sets standards that managers and practitioners have agreed standards for ward rounds. Structured ward rounds and check lists have shown to prevent omissions in care and improve patient safety.
Methods. Discussions with Ward 3 team, nursing colleagues and ward Quality improvement group were held. A Standard MDT Quality improvement Checklist was devised and used as a Pilot in W3, WGH.

This was first introduced in August 2021. Plan, do, study, act (PDSA) cycle was carried out.

Plan: Trial MDT checklist at Ward 3 ward Round
Do: Use Initially for two Consultant ward rounds
Study: Ask all MDT staff members for feedback on the form
Act: Reformat the checklist for the following ward rounds and distribute among all consultants.

Repeated Revisions of MDT checklist done after feedback from ward staff and final version devised and results audited in Nov 2021 and Jan 2022.

Food, Fluid, and weight charts were put in separate folders.
Results. Before MDT Checklist nil up to date MDT checklist information available, 10% individual food and fluid charts and 0% folders.

After MDT checklist in November 2021, 73% increase in up-to-date checklist items, 100% increase in finding charts in folders.

In January 2022 decrease to 44% of up-to-date MDT checklist items, 100% food and fluid charts in folders.
Conclusion. MDT Checklist provided robust structure to our Ward rounds along with the regular electronic record and has been incorporated in our shared drive. The results in January for up-to-date checklist were down because of staff sickness due to new Omicron variant and less people available to keep documentation up-to-date.

A Pilot Project to Introduce the Compassionate Approach to Living Mindfully for Prevention of Disease (Calmpod) in Weight Management in a Forensic Intellectual Disability Unit

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Aims. About 28% of the UK population are obese and a further 36.2% are overweight. The prevalence of both in those with mental illness and/or intellectual disability (ID) is much higher. Several therapeutic approaches have been tried, with varying efficacy. Recently a three-session intervention which uses mindfulness techniques (The compassionate approach to living mindfully for prevention of disease- CALMPOD) was used in a tertiary obesity service in the West Midlands and shown significant benefits. Our aim was to assess the suitability of this intervention in mental illnesses and/or intellectual disability services.
Methods. Three pre-pilot focus group discussions involving multispecialty professionals and service users were held involving four psychiatrists, three service users, two psychologists, one physician, one endocrinologist, one bariatric surgeon and one pharmacist to identify key aspects of the CALMPOD programme for adaption to psychiatry and/or psychiatry of ID wards. Based on this, CALMPOD was modified by two psychologists with relevant experience. The modified CALMPOD was piloted in a medium secure forensic in-patient unit for people with ID. A post-pilot focus group discussion involving two psychiatrists, one occupational therapist and three service users was held after completion of the pilot to discuss lessons learned.
Results. Invitations sent to 17 in-patients. The mean BMI was 34.76%, 76% were obese, 6% were over-weight and 18% in the normal range of weight. 3 patients attended the three-session programme (17%). All 3 were in the obese category, all had had individual weight management input – i.e. seen by dietician, weight management included in care plans. The post-pilot focus group discussions identified 6 key themes.
Conclusion. Emerging themes from the pilot were (a) Patients and staff recognise that the programme was 'necessary' and 'useful', but the challenge is how to 'start attending regularly'. Once in, participants 'tended to stay on'. (b) A visible publicity campaign is needed to spread awareness of the programme and its 'newness'. This would help with staff 'buy in' from all wards and departments. (c) The key message should be 'living healthily' and 'feeling better', not just weight loss. (d) Staff and/or patients' family members participating in the programme would be more motivating. (e) The content of the programme needs further modifying with an emphasis on shared activities, calories