The Quality Network for Prison Mental Health Services used the findings from this consultation to produce a national guidance document on planning effective mental healthcare in prisons, which can be accessed for free by all prison mental health teams.

Communication in COVID: a quality improvement project into staff communication with family/carers at New Haven Older Adult Mental Health Inpatient Unit

Felicity Jones[1]*, Bhavna Khanna[1], Batool Almoosawi[1], Alex Humm[1], Upjeet Mahon[2] and Rosie Edwards[2]

[1]Hereford and Worcestershire Health and Care NHS Trust and [2]University of Birmingham, Medical School
*Corresponding author.

doi: 10.1192/bjo.2021.534

Aims. In the psychiatric care of patients, family involvement is key to recovery. At the New Haven Unit, there have been a number of complaints regarding poor communication and lack of updates given to families during COVID-19.

The aim is to:

To increase the overall satisfaction of the family with the service received for their loved ones

Ensure effective and timely communication of updates to the families, to prevent further complaints, by assigning a member of staff per patient to be the primary individual responsible for family contact

Create an addition to the weekly ward round MDT proforma on 'Carenotes' where communication can be documented

Method. A standardised questionnaire has been sent to the relatives of inpatients at the New Haven Unit. Qualitative data are being collated, which will lead to quantitative statistical analysis of the satisfaction ratings.

Based on the current bed state on the ward at the time of the project all 32 relatives of current inpatients were contacted and 23 agreed to complete the survey which was sent out either by email or post.

The new MDT proforma will be added, which will be used to record actions needed to be taken involving communication and updating family members on a weekly basis. This opportunity to record communication will improve continuity of care and satisfaction amongst family members.

There will be follow-up via a second questionnaire to identify improvement.

Result. The average results of selected categories so far are shown below (still awaiting further responses):

Frequency of updates regarding loved ones = 4.33/10 (10-excellent)

To what degree were your concerns listened to? 7.33/10

Quality of content discussed with staff members = 3.33/4 (4-excellent)

Other categories scoring below the expected standard, included awareness of visiting guidelines and questions regarding lasting power of attorney, in which 33.3% of participants responded either 'no' or 'not sure' respectively.

Questions addressing formalities of introduction and confidentiality through identity confirmation, scored highly.

Conclusion. We are awaiting more survey responses in order to identify additional areas of improvement; however, it is already clear to see that there are areas that would be advanced through structured, assigned reminders via an MDT amendment.

We will also be introducing set dates for conference calls with the families now involving the whole MDT; one within the first week of admission, one after six weeks and one at the point of discharge as a minimum.

North West London New Model of Care Project (NMOC) – improving inpatient mental health care for children and young people

Dr Jovanka Tolmac[1]*, Alun Lewis[2], Azer Mohammed[3], Elizabeth Fellow-Smith[4], Johan Redelinghuys[5] and Braulio Girelas[6]

[1]Consultant Child and Adolescent Psychiatrist, Harrow CAMHS, Central and North West London NHS Foundation Trust; [2]NMOC Project manager, West London NHS Trust; [3]Consultant Child and Adolescent Psychiatrist, Westminster CAMHS, Central and North West London NHS Foundation Trust; [4]Consultant Child and Adolescent Psychiatrist, West London NHS Trust; [5]CAMHS Clinical Director, West London Trust and [6]Clinical Research Fellow, Centre for Psychiatry, Imperial College, Centre for Paediatrics and Child Health, Faculty of Medicine, Imperial College, Honorary Spr, Harrow CAMHS, Central and North West London NHS Foundation Trust
*Corresponding author.

doi: 10.1192/bjo.2021.535

Aims. Specialised inpatient mental health services for children and young people are commissioned and managed by NHS England (NHSE) and provided by NHS as well as independent sector. The access to beds has been managed nationally with young people admitted far from home. There were capacity issues identified in London. To address these concerns, NHSE invited organisations to work in partnership to co-design and establish new models of care. This is one of the first of such projects, set up to manage the budget for children and young people's beds on behalf of NHSE and change the way of managing and monitoring admissions.

Our aims:

To reduce length of inpatient stay

To enable admission of young people as close to home as possible

To improve resource efficiency, capacity and capability of managing young people in crisis in the community.

Method. A number of changes were introduced, including engagement of community and inpatient clinical staff, repatriation to units closer to home and introduction of CRAFT meetings (early review meetings in inpatient units to enable timely and effective discharge planning and support back to local services). The implementation has been closely monitored by the project manager and clinical group, which included representatives from all organisations involved.

Result. After four years, young people are admitted to hospitals closer to home and the length of inpatient stay has decreased by 18%. The number of admissions has decreased by 28%. Out of area occupied beds days have been decreased by 66%.

Significant recurrent budget savings have been achieved. Over the past three years, these savings have been reinvested in developing crisis community support and more specialist community services within CNWL and West London Trust.

Conclusion. There have been considerable benefits of multiple organisations working in partnership to improve patients care. The success of the project has created further opportunities for the development of services which provide safe and effective alternatives to admission (such as crisis services, home treatment teams and specialized community services). In summary, this collaborative model has improved the quality of care and experience for young people and reduced the need for psychiatric admission.

Improving physical health assessment of old age inpatients on the Oaks Acute Admission Ward

Dr Karen Aus*, Marilia Gougoulaki, Maja Elia and Emily Wall
Barnet, Enfield and Haringey Mental Health Trust
*Corresponding author.

doi: 10.1192/bjo.2021.536

Aims. Old age psychiatry patients are subject to increased frailty, comorbid load and medication adverse events than equivalent older age populations without psychiatric illness. Timely physical health assessment and monitoring is therefore an essential part of treatment provision. The Oaks is a 20-bed old age acute admissions ward in Barnet, Enfield and Haringey Mental Health Trust. With this quality improvement project, we aimed to deliver high-quality assessment and treatment of physical health for our patients.

Method. Using NICE guidelines as a blueprint, we devised a list of parameters essential to the management of old age inpatients. This included blood tests (full blood count, urea and electrolytes, liver function, thyroid function, cholesterol, lipids, iron studies, vitamin D, glycated haemoglobin, prolactin), investigations (imaging, ECG, physical examination, cognitive testing) and assessments (body mass index [BMI], functional review, mobility, Rockwood Frailty Score). The implementation goal was to ensure all parameters were acted on within 24 hours of admission (or 48 hours for patients admitted on weekends).

We initially audited these parameters in patients admitted to the Oaks in October and November 2020 (n = 24). We subsequently collated all parameters into an online spreadsheet, which was distributed to ward medical staff. For each new admission, parameters could be marked as pending or complete. The spreadsheet was reviewed in daily ward handover. Following implementation, we collected data on the parameters for patients admitted in December 2020 and January 2021 (n = 16).

Result. Prior to implementation of the spreadsheet, 42.0% of all parameters had been actioned within 24 hours of admission. Following the implementation of the spreadsheet, 86.2% of parameters had been actioned within 24 hours (mean difference 44.2%, 95% CI 13.5% to 64%, $p = 0.006$).

In detail, there were significant increases in timely actioning of magnesium (increased by 61.7%, $p < 0.001$), cholesterol (61.7%, $p < 0.001$), glycated haemoglobin (65.8%, $p < 0.001$), vitamin D (65.8%. $p < 0.001$), prolactin (61.7% $p < 0.001$), lipids (61.7%, $p < 0.001$), thyroid function (51.7%, $p < 0.01$), iron studies (80.9%, $p < 0.001$), imaging (42.5%, $p = 0.01$), frailty scores (60.0%, $p < 0.01$), BMI measurement (55.9%, $p < 0.001$), and functional review (42.5%, $p = 0.01$).

Conclusion. Implementation of a monitoring spreadsheet with relevant parameters linked to daily ward handover resulted in widespread and significant improvement in the assessment of physical health among old age psychiatry inpatients.

Use of clonidine in the management of opiate withdrawal in community patients

David Kelsey[1]*, Pierre Hoezoo[2] and Pardeep Grewal[3]
[1]North London Forensic Service; [2]Enable - Enfield alcohol and drug service and [3]The Grove Drug Treatment Service
*Corresponding author.

doi: 10.1192/bjo.2021.537

Aims. Clonidine has been used to alleviate symptoms of opiate withdrawal. No validated prescribing schedules exist for the use of Clonidine in opiate detoxification in community patients. We have devised a Clonidine prescribing schedule for adult outpatients seeking opiate detoxification.

Background. Opiate cessation following prolonged use produces a central noradrenergic (NA) response in the locus coeruleus (LC), causing symptoms that can result in reinstatement of use. Pharmacotherapies for withdrawal are thought to work through decreased NA release in the LC by agonising pre-synaptic alpha-2 adrenoceptors. Clonidine has been used since the 1970s. However, it is off-license in the UK, and superseded by Lofexidine. Though both cause hypotension, this is less marked with Lofexidine, which may be anxiolytic and considered better tolerated. Lofexidine is no longer available in the UK. Specialists may need to resort to Clonidine for those seeking opiate detoxification.

Method. We performed a feasibility study with the primary outcome being tolerability of an outpatient clonidine schedule. Patients (n = 7) were aged between 18 and 65 years (mean 32). Six were prescribed buprenorphine as opiate substitution (OST), and one methadone.

Exclusion criteria were in keeping with BNF contraindications.

An ECG was obtained for each patient before treatment. A urine drug screen and Clinical Opiate Withdrawal Scale were taken to confirm opiate dependence and withdrawal. Patients self-monitored withdrawal using the Subjective Opiate Withdrawal Scale and daily blood pressure measurements. Standard adjuvants for withdrawal were prescribed.

A test dose of 100mcg Clonidine was given to assess for hypotension. If tolerant they received 100mcg QDS, reducing over eight days.

Patients were contacted by their recovery worker twice during the period.

Result. Five of the seven completed the course, two dropped out due to hypotension. No other adverse effects warranting discontinuation were encountered. Patients reported fatigue and lightheadedness as their most troublesome side-effects. Of 3 patients who returned SOWS scores, 2 reported decline by 21/64 and 14/64 respectively. One reported an increase of 49/64 over 8 days. 3 of the 5 subjects who completed the course were not abstinent at completion, citing opiate withdrawal symptoms as causative.

Conclusion. There is scope for the safe use of clonidine in the community for motivated individuals. Adequate monitoring of heart rate and blood pressure is required. Starting doses at 100mcg QDS appear well tolerated. Prescribers may wish to reduce this over a longer period to encourage completion and improve tolerability. Further research is needed.

An audit: fitness to drive assessment in inpatients of general adult and old age psychiatry

Ismail Khan[1]*, Nneamaka Asiodu[2], Dr Divyanish[3], Anum Yaqoob[4] and Hasanain Qureshi[4]
[1]Bloxwich Hospital; [2]Bushey Fields Hospital; [3]Heath Lane hospital and [4]Dorothy Pattison Hospital
*Corresponding author.

doi: 10.1192/bjo.2021.538

Aims. To determine if fitness to drive is assessed on admission and discharge, if applicable, and for this to be documented during clerking and on discharge notifications.

To determine if patients are being educated about the impact of their condition on the ability to safely drive.