

**Aims.** To reach 80% adherence to DVANI (Driving and Vehicle Agency Northern Ireland) guidance in acute inpatients ward, T&F Hospital

**Background.** This is a scale-up of a previous successful QI project on driving and Attention Deficit Hyperactivity Disorder in Belfast Trust. According to DVLA's guidance for medical practitioners on the current medical standards of fitness to drive, patients with certain mental health diagnosis are required to inform DVLA of their diagnoses and refrain from driving. Different factors are considered in order to determine patients' fitness to drive. According to DVLA and GMC, it is medical professionals' responsibility to advise patients to inform DVLA/DVANI of their mental health diagnosis. It is the patient's legal duty to notify DVLA/DVANI of their diagnosis. Patients can be fined up to £1000 if they failed to inform DVANI of their medical condition. **Method.** Outcome: Completeness of driving advice given to consecutive patients discharged from T&F hospital from April 2019 to early August 2019 in %

Process: Document clearly in electronic and written notes on following - (1) has driving status been asked (2) has patient been advised to inform DVA if required (3) has patient been advised likely how long he/she is to refrain from driving for

Balancing: increased the time of reviews, increased numbers of consultant reports requested from DVA

**Result.** 4 cycles have been completed. Cycle 1 – baseline and review guidance; Cycle 2 – medical staff education and developed driving advice pathway and patient leaflet; Cycle 3 – admin staff was involved for putting driving advice pathway in admission pack; Cycle 4 – medical staff was educated again regarding importance of documenting electronically. Clear changes were seen after cycle 3 showing an increase of mean of 25% completeness of driving advice to over 90%.

**Conclusion.** It is the legal duty of patients to notify DVANI of mental health diagnosis, however it is the responsibility of medical professionals to advise patients to do so. This QI project has shown improvement in the completeness of driving advice given. Further cycles are to be completed to obtain patient feedback.

## A survey of the use of seclusion and physical restraint at school and at home for children under the care of the NHS Lanarkshire CAMHS – learning disability team

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doi: 10.1192/bjo.2021.592

**Aims.** To attempt to quantify the use of seclusion and restraint for young people managed by the NHS Lanarkshire CAMHS Learning Disability team.

**Background.** There has been increasing interest in the use of seclusion and restraint in children with learning disabilities, reflected by various news reports in the UK and USA. A survey of parents conducted by the Challenging Behaviour Foundation (2019) found that 35% of disabled children (n = 204) had been regularly physically restrained and a further 21% had been regularly secluded. The use of restrictive practice in children is contradictory to the UN Convention on the Rights of the Child as well as the conclusion of a recent report conducted by the Scottish Children's Commissioner titled "No Safe Place" which called on schools to stop using restraint and seclusion until national guidelines and standards were in place. No data were submitted to the Children's Commissioner from Lanarkshire. Anecdotally there

was an impression in the team that restrictive practices were widely used at school and home.

**Method.** The NHS Lanarkshire CAMHS-LD team is a small team caring for children aged 5–18 years with moderate to severe/profound learning disability with mental disorder and/or severe challenging behaviour. The methodology for this retrospective audit relied on reviewing patient case notes and speaking with involved clinicians. We discussed each individual patient on their respective caseload as to whether the child had been restrained or secluded at home or at school.

**Result.** All 108 children from the caseload were included in the audit of whom 52.8% had been either restrained or secluded. 24.1% of children were both restrained and secluded at school, while 15.8% were restrained and secluded at home. These patients were complex. 86.1% had Autistic Spectrum Disorder and 55.6% had another comorbidity, such as ADHD.

**Conclusion.** The figures are broadly similar to those in the Challenging Behaviour Foundation report. The team knew all of the individual patients very well and review them across a variety of settings such as school and home with instances of seclusion and restraint being directly witnessed by clinicians. Nevertheless, there is the issue of recall bias. These findings will be shared with NHS Lanarkshire management for further discussion and dissemination. .

## Testing a computerised tool to improve physical health monitoring in a medium secure forensic setting

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doi: 10.1192/bjo.2021.593

**Aims.** This project aimed to improve adherence to regular monitoring of the physical health of inpatients within a medium secure forensic psychiatric unit. A computerised tool to remind doctors to do checks was created, which was proposed would improve adherence.

**Background.** The physical health of people with mental health problems is of some concern, with higher rates of physical comorbidity and mortality compared to the general population.

The forensic inpatient population has a high burden of both severe mental illness and physical ill health, and a high medication burden with potential adverse effects on physical health.

To support the health of patients in our medium secure unit, each should routinely have three physical health checks done at least every six months. These are 1) an electrocardiogram (ECG), 2) a set of blood tests and 3) a full physical examination.

**Method.** Patient records for 26 patients across two medium secure psychiatric wards were checked for 1) an ECG, 2) a full set of blood tests and 3) a full general physical examination within the past 6 months.

A tool was created that automatically calculated the next due date for each check and colour coded which were overdue (red) or within 30 days of the due date (yellow). This tool was given to the core trainees working on these wards to help them keep track of which checks needed to be done.

The records for patients on the same two wards were rechecked four months later and the adherence rates compared.

**Result.** On both wards, for each of the three physical health checks, a substantial improvement was seen in the proportion completed within the past 6 months.

**Conclusion.** The tool created was a useful means of presenting, in one place, relevant information needed by doctors working in