Safe Medication Prescribing in Halton Memory Services

Dr Divya Jain[1] and Dr Archisha Marya[2]*

[1]Merseycare NHS Trust, Halton, United Kingdom and [2]Liverpool University, Liverpool, United Kingdom
*Presenting author.

Aims.
- To improve safe medication prescribing by achieving a 25% improvement in the number of cases reported in the practice within six months.
- To reduce human factors contributing to medication errors to improve patient safety and quality of care.

Methods.
- Retrospective data collection was done for Halton and Widnes patients from March 2022 to April 2023;
- Retrospective data collection for Re-audit was done for a period between June 2023 to January 2024 to complete the audit cycle;
- Liaised with medicine management team for local practices/policies;
- Reviewed and verified Trust standardised local policies on medicine management;
- Reviewed incident data and checked processes in other teams;
- The findings were presented at the Medicine Management meeting in May 2023;
- Training on safe prescribing was delivered to the Memory team in June 2023.

Results.
- During the first data collection period, 14 incident forms were reported.
- During the second data collection period, 1 incident form was reported which was an administrative error.
- Prescribing errors for the first cycle accounted for 28.6%, administrative errors for 35.7%, dispensing errors for 21.4%, and other errors for 14.3%.
- Specific error types included prescribing the wrong dose/medication, medication not prescribed, medication unavailable and double prescribing.
- No incidents of restraint, seclusion, rapid tranquillisation, ambulance calls, or RIDDOR were reported.

Conclusion.
- Administrative errors accounted for the majority of the total reported incidents (35.7%).
- Recommendations include safe clinical practice of prescribing medication (MDT lead to update medication card and inform GP promptly).
- Other recommendations were medication card updates, aligning clinical systems, avoiding email requests and introducing Community EPMA (Trust objective to introduce EPMA to community teams in 2024/25) and to standardise procedures.
- An improvement of 92.9% in the incident reporting was found in the re-audit following a training session to the team with improved practice of no email requests or chains.
- The audit identified communication difficulties within memory services, primary care and care home.
- It also highlighted challenges related to new staff, post-MDT meetings medication card updates, prescriber preferences, geographical disparities, and doctors' availability.

QI Project Aiming to Reduce the Use of Restrictive Practice in Belfast Trust Psychiatry With the Implementation of a Therapy Cross

Dr Sara McGucken*, Dr Jordan Taylor, Dr Niall Corrigan, Dr Pamela McGucken and Mr Robert Dornan

Belfast Health and Social Care Trust, Belfast, United Kingdom
*Presenting author.

Aims. The aims of the study were to illustrate the number and type of restrictive practices that were used across two inpatient wards within the Acute Mental Health Inpatient Centre in the Belfast trust over a two year period. This initially would highlight the prevalence and use of such practices and allow for comparison against the data collected after the implementation of the therapy cross. We hoped that with the implementation of the therapy cross we would see a decline in the use of physical interventions, use of IM medications and also the number of aggressive or distressing incidents and behaviours would also decrease.

Methods. We utilized a statistical process control to collate and illustrate data. Daily data collection was carried out and compiled over a 2–3 year period and is ongoing with regards to ward incidents of aggressive behaviour, use of physical intervention, use of IM medications. In early October of 2023 the therapy cross was introduced and the run charts and data collection continued allowing for comparison of such behaviours and interventions pre and post intervention.

Results. A percentage decrease of 50% of the weekly average was noted in incidents of aggressive and violent behaviours on one ward in AMHIC following implementation of therapy. A percentage decrease in average weekly use of IM injections was noted to be 13%. A 12% decrease was found in the use of physical intervention on a weekly average following the therapy cross.

Conclusion. The implementation of a therapy cross in early October 2023 indicated improvement in the incidence of use of restrictive measures on two inpatient wards in the Belfast Trust, including the number of physical interventions such as holds that were required and also decreased the incidence of use of IM medications for rapid tranquillization. The data indicates a significant decrease in the number of cases of violent and aggressive behaviour on wards following implementation of a therapy cross.

Let's Talk About Sex: Breaking Down Barriers to Care in a Community Learning Disability Team

Dr Liam Embliss[1], Dr Zoe Melrose[2]* and Dr Laura Dunn[3]

[1]North East London NHS Foundation Trust, London, United Kingdom; [2]South West London and St George's Mental Health NHS Trust, London, United Kingdom and [3]East London NHS Foundation Trust, London, United Kingdom
*Presenting author.

Aims. We aimed to improve the care for people with intellectual disabilities (PWID) presenting to a community learning disability service (CLDT) with health needs relating to sexual wellbeing, sexuality, and/or gender identity (SSGI). A QI framework was used, focussing on staff education and service development.