

$n = 1$ commented that the forms give insight into patient presentations and management

Conclusion. Doctors routinely prescribe Z-drugs and benzodiazepines, and would generally consider Haloperidol as a second line over Promethazine (while nurses had a slight preference for requesting Promethazine over Haloperidol). The role of 12 lead electro-cardiogram monitoring would require further exploration in separate audits, as both Promethazine and Haloperidol can cause QTc interval prolongation [4,5].

Doctors most commonly cited expectations by nursing staff as the main driver for PRN medication prescription. Profound differences were present with regards to rationale behind PRN medication use when comparisons between doctors and nurses self-reports were made. The majority of nurses cited ward atmosphere and patient dependence/expectation as main drivers, whereas a minority of doctors shared those views. This represents a concerning disconnect between professionals, although it can be explained by the higher proportion of time ward nurses spend on mental health wards and in direct patient care. Nursing staff, being the dispensers of medication, would also likely be the main professionals contacted for the request of PRN medication by patients.

Nuanced views were given to the role of psychological redirection. This was shared between doctors and nurses, although many cited concerns about nursing staff shortages leading to a possible overreliance on PRN medication. A minority of doctors ($n = 2$) would recommend psychological redirection after first line rapid tranquilisation was exhausted. The counterargument being that someone admitted onto a ward tacitly implies a high level of acuity and reduced appropriateness of psychological techniques.

Hypnotics most commonly being requested likely reflects the difficult nature to initiate and maintain sleep in an acute ward setting.

On review of the Round 2 results indicate that doctors and nurses agree that the new system is safer although more time consuming. Concerns were raised about rapid tranquilisation and immediate emergencies, although the revised policy would allow for the verbal order policy to be followed with a digital order in these circumstances. This was clarified via further communication with relevant parties.

The changes were more received more positively by doctors than nurses, with some nurses opting for the older system if possible. It was also raised that this may be putting up barriers for out of hours prescriptions, although the required information is arguably succinct and only requests vital information for safe prescribing. Further exploration of these concerns would be indicated. The Round 2 results were limited by the low sample size compared to the first round. Despite the limitations and concerns about the new system, digitising the system allows for further audits and studies to utilize much more robust methods of measuring out of hours prescriptions than self-reported measures employed in the initial rounds. Although they may not be directly compared to findings of this report, future baselines can be established and compared to in an objective manner.

Future Rounds

Proposed: To design and clearly display information on commonly requested medication by patients, empowering them to make more informed decisions on the medications they request. This could be in the form of leaflets patients could take or posters on areas where patients receive medication. One example is that Zopiclone is a very commonly requested medication on an as required basis although patients may not be as aware of the risks associated with chronic use.

Proposed: To design and clearly display information on psychologically informed techniques in patient areas such as distress tolerance and sleep hygiene. This would be on mental health sites which do

not currently display this information. To measure impact on PRN medication dispensation.

Proposed: Further exploration of patient perceived ward environment and measures that can be implemented to reduce anxiety/insomnia associated with inpatient admission.

Proposed: Exploration of proportion of inpatient initiated PRN medication progresses to long term use in the community (largely focused on hypnotics and benzodiazepines).

Dr QI - A quality improvement (QI) approach to designing and delivering QI training

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Aims. To develop and implement a QI training programme for trainees, Trust grade doctors and Consultants in Nottinghamshire Healthcare NHS Trust (NHFT) to enable them to deliver change in practice through acquisition of new knowledge and practical application of skills in QI projects using Model for Improvement.

Background. QI is crucial to improve patient care. Doctors are uniquely placed to input into patient safety and service delivery of healthcare. The skills required to be future clinical leaders and undertake improvement work are not innate and formal teaching and support is required.

What is DrQI?

DrQI is a trainee-led QI teaching programme developed in collaboration with Trainees improving patient safety through QI (TIPSQI) in North West deanery.

Method. A pre-implementation survey amongst doctors in NHFT in February 2019 (33 responses) suggested that 90% of doctors were interested in learning QI and about 48% preferred face-face workshops with support from the QI team.

A list of change ideas were created using a driver diagram with QI education and project support identified as key primary drivers.

PDSA cycles

Nine interactive workshops teaching key QI concepts (based on model for improvement) in NHFT, training more than 100 doctors. A workshop in Derbyshire Healthcare NHS Foundation Trust (70 doctors) and Nottingham University Hospital (20 doctors). Workshops were continually adapted based on qualitative and quantitative feedback. Different formats were tried including virtual sessions, game-based and problem-based learning approaches using small group activities.

Result. Pre-course and post-course questionnaires were used to assess change in understanding of individual components of QI methodology (SMART Aim, Driver diagram, PDSA cycles, outcome and process measures and run charts). Mean pre-course self-assessment score collated from seven QI workshops in NHFT (2019-2020) was 3.3 and mean post-course score was 7.68, showing an improvement in understanding of QI methodology.

Participants were asked to score the relevance (8.4) and quality of teaching (8.4) and the support from the QI team (7.4) on a scale of 1-10 (1 = poor and 10 = excellent). Additional free text feedback was obtained to help us improve the teaching programme.

Conclusion. Collaborative leadership trainee-led initiative to increase the QI capacity. A bottom up approach to complement the top down approach from the Trust QI team. Future steps include further collaboration and expansion of the scheme to other Trusts, Train the trainer sessions and building a network of QI champions.