Mariposa House service evaluation project & co-production: new women's NHS forensic community step-down hostel

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Aims. To understand and learn from patients' views and experiences. Ultimately, to improve quality, safety, and patients' experiences and outcomes.

Service evaluation project of Mariposa House, London, the new women's forensic high support community step-down hostel after hospital admission. Run in partnership with Langley House (charitable) Trust. It is a co-produced, rare and innovative service- to our knowledge the only NHS women's service of its kind in England. In female and forensic community populations: transitions are the highest risk periods; the same treatment as men is unlikely to produce the same outcomes; and performance indicators and outcome measures are poorly understood.

Method. Confidential patient questionnaire and self-reported Recovering Quality of Life (ReQoL) measure. Given to all patients in Mariposa House, before (in hospital) and 2-3 months after transfer to hostel. Themes included "my: care; voice (co-production); transition; & gender". 12 questionnaires were received from 9 patients: 5 completed both pre- & post-; 3 (20%) were given but not received. Analysed by thematic content analysis. Additional focus group feedback session with patients and staff.

Result. Overall, patients had very positive and similar views about both hostel and hospital(s), and similar views about both. Generally, patients feel treated with compassion, dignity and respect, and listened to and understood by staff members. They feel involved in and positive about their care.

There was a huge amount of involvement in co-producing the service and feeding back experiences, which has been very helpful. Co-production activities included: interviewing for staff and tenders; choosing hostel building; stakeholder meetings; and participating in meetings about training, policies and expectations. "I've been in hospital for so long moving was scary! But helping set up the project has given me confidence to move."

There was strong agreement that transitions are difficult. Views on gender-specific needs being met were very positive, for both hostel and hospital. The main area for improvement was having better awareness of local neighbourhood and facilities-booklet now produced. Quality of life measures were at least maintained from hospital to hostel: 80% (n = 4) showed no reliable improvement/ deterioration, and 20% (n = 1) showed reliable improvement.

Conclusion. There are very positive and similar views about the hostel and hospital(s). Co-production and service user involvement has been very helpful. The new hostel has maintained patient satisfaction and quality of life measures compared to established inpatient services. These are positive findings, and crucially: in a less- secure, contained, established, and cheaper new community setting, involving complex and challenging transitions.

Are acute psychiatric units providing adequate inpatient services for borderline personality disorder patients?

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Aims. To assess the adherence to NICE guidelines CG78 (1.4) regarding the inpatient services provided for BPD patients at an acute psychiatric unit (The Oleaster).

Borderline personality disorder (BPD) patients are frequent users of psychiatric inpatient services. However, evidence suggests that inpatient treatment is ineffective in the long-term recovery of such patients. The inpatient services at the Oleaster will be audited against NICE guidelines for BPD. We hope to improve the care of patients with BPD and ensure effective use of psychiatric resources.

Method. Retrospective case notes review of 35 patients admitted into the Oleaster from 1/11/2018–31/10/2019. This was taken from an initial sample of 72. Patients were excluded if they were admitted for other concomitant mental or behavioural problems (except problem use of tobacco, drugs or alcohol).

Result. 69% of patients were referred to other mental health services (e.g CRHT/HTT, other local alternatives, liaison team) prior to admission. There was no evidence of referrals in 31% of the sample population.

The reasons for admission include significant risks to themselves/others (n = 14) and detention under MHA (n = 14). Reasons were not noted in 7 patients.

Advance agreement on the length and purpose of admission took place in 19 and 27 patients respectively. Discussion of potential harms and benefits of admission only took place in 4 patients. Discussion was not applicable in 2 patients who lacked capacity.

Of the patients admitted ≥2 times in the previous 6 months, only 38% had a CPA review arranged. It was not arranged in the remaining 62%.

Conclusion. There is room for improvement in the appropriate admission and documentation of BPD patients. Referral prior to admission was well adhered but documentation was unclear. Implementing a set checklist before admission could be recommended. Active involvement of patients was inadequate. It is especially lacking in regard to informing patients of the potential harms of admission. This can be improved by educating patients and staff on this matter.CPA reviews were not arranged in a timely manner. Placing an alert on patients' records when they are admitted again within the last 6 months would help to reduce this issue. Overall, greater effort is required to ensure patient's most current needs are met and that limited psychiatric resources are used effectively.

Has vitamin D had its day? An audit of vitamin D, prolactin and HBA1C monitoring over one year in an in-patient secure service

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Aims. To ensure that service users in in-patient secure services have prolactin, vitamin D and HbA1c monitoring as per current best practice guidance.
Background. Service users prescribed antipsychotic medication are at risk of developing raised prolactin levels and metabolic syndrome. In both sexes, long-standing hyperprolactinaemia can lead to low bone mineral density with an increased risk of developing osteoporosis.

In recent years there has been increasing controversy on the increase in Vitamin D monitoring despite the poor evidence for complications from vitamin D deficiency in adults. Not undertaking this test in the absence of symptoms will potentially reduce anxiety for service users could save £17 per test and £50 for a 12-week course of Vitamin D supplementation. Local and national guidance indicate Vitamin D monitoring should only be done in symptomatic people.
Method. Fifty-five service users in the five in-patient wards had their electronic records and pathology results reviewed over a one-year period. All service users were expected to have a minimum of an annual HbA1c and prolactin level but to only have vitamin D monitoring if symptomatic for deficiency.
Result. Although 100% of service users in MSU were tested, vitamin D testing was consistently undertaken without documented clinical evidence of deficiency. The ranges across all units were: prolactin (72- 1384mU/L), HbA1c (30–90 mmol/mol) and vitamin D (15–124 nmol/L). Local reference ranges are prolactin (53- 360mU/L), HbA1c (<48 mmol/mol) and Vitamin D (50–120 nmol/L).

Prolactin levels were highest on the male medium secure wards.

The other two units had significantly less testing with prolactin and HbA1c levels being the least measured (18% of service users on male LSU and 23% on the female ward respectively). Vitamin D testing on these two wards were 38% on the female ward and 18% on the male ward for both tests.
Conclusion. Northside House has a dedicated physical health team and this is likely to explain its 100% score. However, vitamin D testing was being undertaking automatically rather than based on symptoms.

The recommendation is to add prolactin and HbA1c to the physical screens done before CPA meetings for all service users prescribed an antipsychotic but to stop Vitamin D testing in the absence of clinical symptoms of vitamin D deficiency.

Advanced nurse practitioners- the missing link on old age pyschiatry inpatient wards?

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Aims. 1. This project aimed to review the medical cover available to an Old Age Psychiatry inpatient ward.

2. To discuss with ward staff their view for potential improvements and areas of clinical development.

3. To review the potential of a Full Time Nurse Practitioner role on the ward.

One junior doctor (CT1 or equivalent) was allocated to cover the ward whilst balancing their other training needs and clinical commitments. The inpatient ward was based in a community hospital with no onsite medical team. The patients mostly had complex medical needs and multiple comorbidities.

Method. The Junior Doctor's timetable and the time allocated to the ward was reviewed. Questionnaires were conducted with nursing staff to assess their views on the support of physical health cover. The patient notes were analysed for the time taken to review patients after falls over a one month period.
Result. There were 14.5hours allocated to ward cover. An additional 4 hours was provided by another visiting junior doctor totalling 18.5hours per week- 11% of the time. This figure does not account for annual leave, on call commitments or study days whereby there was no additional cover.

A short survey completed by ward staff showed- (1 = Very Poor/Difficult 5 = Excellent/Easy)

- They rated medical cover of physical health needs on ward 7 as 1.3.
- They found contacting a Doctor to discuss a physical problem as 1.7- with particular concern for OOH.
- It was rated to be extremely difficult for a same day review of physical health problems- 1.7
- It was rated extremely difficult to get a physical review following a fall on ward 7- 1.4
- Continuity of care for the patients on ward 7 was rated as 1.6.

The patient case files reviewed over a one month period showed x8 falls. These took on average 14 hours before having a review.
Conclusion. Medical cover for the old age psychiatry inpatient ward was inconsistent and a challenge for a single trainee to manage alongside their other clinical commitments and training needs. A case was proposed to management with an SBAR for a Full Time Advanced Nurse Practitioner which has been approved. This role should provide patients with appropriate cover of their physical health needs. It will allow the junior doctor to work alongside them on the ward supporting each other to provide optimal care for the inpatients.

Audit on venous thromboembolism risk assessment in mental health inpatient wards

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Aims. From May 2015 NHS organisations in Wales are expected to report the number of VTE cases associated with hospital admissions which are possible hospital acquired thrombosis (HAT) per calendar month. NICE Quality Standards (QS3) recommend that All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.
Background. VTE is a condition in which a blood clot (thrombus) forms in a vein, most commonly in the deep veins of the legs, known as a deep vein thrombosis (DVT). The thrombus can dislodge from its original site and travel in the blood (embolism). If it becomes lodged in the lungs, a condition known as a pulmonary embolism (PE) arises and can cause sudden death. Hospital acquired thrombosis is avoidable and unfortunately kills patients under our care.
Method. Collected data using a standardised form for 131 patients from 3 inpatient mental health units on documentation of a VTE risk assessment in the inpatient notes. For those patients who had a documented risk assessment, further data were collected on documentation of contraindications, eisk factors, sign and date of prescription and the appropriateness of prescribing.
Conclusion. 8% of patients from one mental health unit (n = 48) had a documented risk assessment in the notes. The subsections of