

combination therapy with nicotine lozenges with the goal of smoking cessation.

Conclusion. Patients were open to a brief informal intervention targeting smoking behaviours and readily accepted trying nicotine lozenges and prescription during their inpatient stay. The regular use of nicotine replacement therapy by some patients encouraged other patients to try and accept therapy. In addition to the habitual tobacco sharing among patients, nicotine lozenges were also shared especially with newly admitted patients. The evaluation of the impact of this intervention will require a much longer period of time of implementation.

“The path is smooth that leadeth on to danger”: caffeine and psychosis

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Aims. To review literature on the importance of caffeine intake with regard to psychosis. The need for intervention with regard to caffeine intake hinges on effectively recognizing potential risks.

Background. Caffeine is the most widely consumed psychoactive substance worldwide and as such is generally considered acceptable but as a competitive adenosine antagonist, it affects dopamine transmission. Patients with serious mental illness are known to have higher caffeine intakes than the general population. The hierarchy of needs for this patient population is complex, frequently leaving the intake of caffeine under the radar of clinical priorities.

Method. PubMed and Google Scholar search for caffeine/coffee and psychosis/schizophrenia

Result. Of the 43 articles that were considered relevant for clinical practice, caffeine consumption was associated with 1) appearance of psychotic symptoms and episodes (caffeine-induced psychosis) and chronic psychosis in high intake 2) exacerbation of psychosis in schizophrenic patients even in lower intakes, 3) treatment resistance possibly due to interference with antipsychotics (ex. clozapine), 4) abuse and addiction, 5) comorbidity with tobacco smoking and other addictions. Caffeine in low doses was associated with ameliorating cognitive and extrapyramidal side-effects of medication and as a potential treatment strategy for treatment-resistant schizophrenia.

Conclusion. Caffeine consumption may have a greater impact on psychotic symptoms and episodes than is recognized with negative effects outweighing any potential benefits. Greater awareness of the necessity to quantify caffeine intake and implementation of interventions to curb intake may contribute to better quality of care of serious mental illness. Further research is warranted.

Monitoring lithium therapy in a CMHRS during the COVID-19 pandemic

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Aims. The COVID-19 pandemic has presented a challenge in ensuring that routine monitoring can still be offered and

occur in a safe and effective manner. Our aim was to continue the regular physical health monitoring of North East Hampshire CMHRS patients who are prescribed lithium during the COVID-19 pandemic, and to achieve above 90% compliance for the monitoring standards. Lithium monitoring clinics have been established in our CMHRS since 2017, Lithium is a high-risk medication as recognised by a National Patient Safety Alert in 2009. Previous annual POMH-UK audits have identified suboptimal monitoring of Lithium patients at local and national levels.

Method. The ‘Plan-Do-Study-Act’ (PDSA) approach was utilised and a ‘QI Bundle’ formed. A database of patients who are prescribed lithium has been created and maintained. Synchronised standardised reminder letters are sent to the patients twice yearly. NICE recommends that patients on lithium have their lithium levels checked every 3 months for the first year and then at least every 6 months, plus TFTs, U&Es, calcium and weight every 6 months (or more frequently if impaired). The Specialist Pharmacist Service advise that during the COVID-19 pandemic, if patients are not in the at-risk category then monitoring intervals can be extended by up to 3 months, but that patients in the at-risk category should have their normal monitoring intervals continued.

Lithium clinics have been held every April and October since 2017 by the Junior Doctors allocated to NE Hampshire CMHRS. This year they were conducted via telephone appointment or face to face where safe to do so with clinician in full PPE. An audit was subsequently carried out in December 2020 to assess our patient’s compliance with the aforementioned NICE recommendations for lithium monitoring, the results of which were compared to previous annual audits.

Result. Seventeen patients were currently prescribed lithium within the NE Hampshire CMHRS. Over 90% compliance with monitoring was achieved in December 2020 apart from the checking of calcium levels which was slightly below target at 82%, and weight which was at 88%. There was no significant reduction in monitoring standards obtained compared to data from the previous three years.

Conclusion. Routine monitoring for our patients who are prescribed Lithium was effectively and safely continued during the pandemic. Above 90% compliance with lithium monitoring standards was nearly obtained across all areas. We will continue to offer lithium monitoring twice yearly.

Improving training and support by improving our out of hours handover, Central and North West London NHS Foundation Trust

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Aims. During out of hour handovers at St Charles Hospital – the two duty SHO (senior house officers) cover on site, whereas the on-call registrar and consultant are available to contact by phone. Some trainees may experience difficulties in contacting their seniors for support, or may not feel comfortable doing so. Trainees may also feel like they would benefit from being more informed of the hospital situation, or added learning and educational opportunities from the shift. The aim of this project was to improve the out of hours support for the on-call SHOs – which we hope to have positive short (such as improving confidence and performance) - and longer-term impacts (improving retention in the deanery and specialty).

Method. The project proposed instating a 15-minute Zoom call at the start of each night shift (9:30pm) which involved the on-call team (SHOs, registrar, consultants and ideally bed managers). Firstly – a survey monkey questionnaire was sent to trainees to gain a baseline on how supported/informed/ease and learning opportunities for that shift. The project then piloted three separate Plan Do Study Act cycles of change and collected feedback from trainees after each cycle. Both qualitative feedback and quantitative feedback from trainees were collected in the Likert scale format after each PDSA cycle.

Result. Results showed that a key benefit of this call is that any pressing issues can be brought up and addressed. Furthermore, for the benefit of the trainees, generally trainees felt more supported whilst they are on call, and got to know the fellow on call team. In addition, trainees reported feeling more at ease when calling their senior colleagues.

Conclusion. It is particularly important for doctors to feel supported and informed during their on call shift, especially in the current climate, where there are fast changes and adaptations taking place due to the pandemic. By adding a short meeting at the beginning of each night shift, doctors in the hospital demonstrated an increase in feeling supported, informed and having educational opportunities during their on call shifts. In the long term, by addressing on call issues and making trainees feel more confident and supported during their shift, is likely to benefit and improve recruitment and retention.

Identification of patients with mood disorder following admission with hip fracture with a view to starting treatment and provide advice

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Aims. The aim of this quality improvement project is to improve identification and management of mood disorder in patients over 65 years admitted to Royal Surrey County Hospital (RSCH) with hip fractures by introducing a standardised assessment tool to guide appropriate interventions.

Background. The signs of depression in the elderly can be subtle and often go unnoticed. The multidisciplinary team (MDT) at RSCH observed that low mood could negatively impact on a patient's recovery, affecting pain thresholds and leading to poor engagement with rehabilitation. Proactive identification and management of mood disorder is an important part of Comprehensive Geriatric Assessment but not routinely performed in patients with hip fracture admitted to RSCH.

Method. Notes and discharge summaries of patients with hip fracture admitted over a four-month period were retrospectively reviewed to establish if patients were screened for low mood. A mood screening tool was chosen and implemented prospectively over a four-month period. Occupational therapists and junior doctors completed a Cornell Score for all patients. Those identified with depression or probable depression were issued verbal advice, an information leaflet and follow-up arranged.

Result. Ninety-eight patients were included in the retrospective cohort. No patients were formally identified as having depression or probable depression, and there was no indication that mood was considered or assessed at any point during admission. During the four-month prospective period, 90 patients were

admitted to RSCH with hip fracture and 86 patients (96%) were screened for low mood. Four patients were excluded due to a terminal prognosis. Of the patients screened, 9% had major depression and 16% probable depression. Feedback from our occupational therapists and doctors was positive, with the tool being relatively easy to use in patients with or without cognitive impairment. Much of the assessment could be incorporated into their initial assessment or in gaining collateral history from next of kin. Anecdotally, considering patients psychological well-being had a positive impact on inpatient therapy sessions guided the MDT in supporting the patient appropriately.

Conclusion. Implementation of a standardised and validated mood screening tool enabled us to identify that a quarter (25%) of the patients admitted following a hip fracture had, or probably had depression. This allowed us to intervene with simple measures such as verbal advice and an information leaflet and consider pharmacological intervention where appropriate.

“Beth”: the development of a digital personalised health record and patient portal for use in clinical practice

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Aims. To design & develop a clinically scalable personalised health record and patient portal to;

Improve patient safety through improved communication and information sharing between staff, patients and carers, and improved access to safety plans for patients.

Increase the uptake of virtual appointments and video calls rather than over-reliance on telephone calls for clinical care

Empower patients to access supported self-management and self-directed care using digital resources

Background. Current mental health services often rely on telephone calls, letters, text messages and email, which often repeat information to the detriment of the patient. Likewise, care plans and appointments are given in paper cards, which can be lost or become out-dated. Furthermore, service-users often have no access to curated resources, symptom-tracking tools or ability to document their personal treatment targets in medical notes.

Method. Based on service-user feedback, clinical need and the above aims, a digital personalised health record and online portal was developed for patients to record personal goals & coping strategies, access crisis plans, view appointments, track symptoms, complete clinical assessments, communicate with their care-team and access self-management materials. The tool, ‘Beth’, was named after the Bethlem Royal Hospital and was launched in July 2020 to all patients in the South London and Maudsley Trust. **Result.** Across the Trust, the tool currently has 710 active users. Features used include; accessing care plans and safety plans, communicating with care teams, organising and viewing appointments, undertaking clinical assessments to inform measurement-based care, tracking symptoms and progress, developing a secure diary, and accessing free & trusted self-management resources.

Conclusion. We have developed “Beth,” a digital personalised health record and patient portal for use in widespread clinical practice. The tool allows patients to take an active role in their care-planning, enhances communication between patients, carers and clinical teams and may improve service efficiency and patient safety. Future development may customise the tool further to incorporate new features and optimise usability for patients and clinicians alike.