

feedback displayed in common areas of the ward which are regularly updated. 4. Mutual Expectations between Staff and Patients: A set of expectations created in co-production with patients displayed in the communal areas of the ward to be followed by both staff and patients. 5. Gardening sessions : One of our newer change ideas during the COVID-19 pandemic was to provide a safe, socially distanced space for patients to be involved in growing and caring for the Nile Ward garden with our activities co-ordinator. 6. Optimisation of Physical Exercise : Focus on physical activity through garden fitness sessions and 1-1 fitness sessions in the gym. This was another change idea commenced during the COVID-19 pandemic. These sessions occur throughout the day with our fitness instructor and enable our patients to focus on their physical health & fitness. 7. Improved Ward Environment : Gym equipment were upgraded and the appearance of the ward gymnasium was enhanced using quality art created in co-production with patients.

Result. There was a 43% reduction in the number of violent incidents in the ward following QI interventions. The details of the results will be depicted in pictorial form in the poster.

Conclusion. Our patients are able to recover in a safe environment with a reduced level of violence and aggression resulting in patients receiving less rapid tranquilisation and restrictive interventions. We have had fewer assaults on staff which has made our staff feel safer to work in a busy PICU. Staff feel more confident in their role through the use of the new risk assessment tool. Patients and staff alike have given positive feedback to the changes implemented in this QI project, with violence being successfully reduced by 43%. We hope that our QI project can be used as an example to show how QI methodology can enable Violence Reduction within mental health services.

Improving cardiometabolic health assessments and interventions at St Charles Hospital, London

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Aims. St Charles is one of the largest inpatient mental health units in London with 8 wards and covers the boroughs of Kensington & Chelsea and Westminster. This project aimed was set up so that 95% of patients in St Charles Mental Health Centre would have a complete cardiometabolic health assessment by December 2020. This would include Weight, Smoking, Alcohol, Substance Use, Hypertension, Cholesterol and Diabetes assessments with necessary interventions recorded. The outcome of the intervention would improve overall physical health and life expectancy.

Method. People with serious mental illness experience significantly worse physical health and shorter life expectancy of up to 10 to 15 years than the general population. CNWL is making Physical Health of patients in Mental Health Services a priority. Performance in this area has been challenging across the Trust because of:

- Buy in from clinicians.
- Staff did not feel empowered to discuss interventions with patients.
- High sickness and absence as a result of COVID was found to directly correlate with reduced physical health monitoring/recording.
- Lack of training in completing the SystemOne physical health template

The following cardiometabolic risk monitoring interventions were recorded on SystemOne (electronic documentation platform) and performance reviewed using Tableau : Weight, Smoking, Alcohol, Substance Use, Hypertension, Cholesterol and Diabetes assessments with necessary interventions recorded.

Result. Prior to the commencement of this project, the wards in St Charles Mental Health Centre completed physical health assessments on roughly 8% of the patients in February 2020. The QI project was implemented in June 2020. By September 2020, physical health recording across 8 wards across St Charles had increased to 89% following successful implementation of the interventions.

Conclusion. The following interventions resulted in a significant improvement in physical health cardiometabolic risk monitoring at a busy inpatient mental health setting:

- Monthly physical health meetings to enable shared learning with ward doctors, nurses and healthcare assistants.
- Ongoing one-to-one and group support to train staff with completing and recording physical health assessments.
- Tableau Physical Health Report regularly reviewed with MDT during ward round meetings.
- Physical health leads given supernumerary days to run physical health clinics on the wards.
- Fortnightly Physical health monitoring meetings with the Director of Nursing and Head of Governance.

Manualising the induction of higher trainees in psychiatry for North Wales: The CiSGC Guide ("Croeso i Seiciatreg Gogledd Cymru")

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Aims. There is a significant period of adjustment for new higher trainees in psychiatry given the presence of inter-trust differences in the National Health Services (NHS). It may take some time for a trainee to become familiar with the new administrative system and workflow of the new environment, which may be even longer for an international medical graduate (IMG). Although there is an existing induction system, having a written structured manual will assist the trainees to get through this process more easily. Hence, this Quality Improvement Project (QIP) outlined the creation of an induction manual that serves as a starter pack to facilitate the settling-in process of new North Wales higher trainees in psychiatry, i.e. the "Croeso i Seiciatreg Gogledd Cymru" (CiSGC) guide (means Welcome to North Wales Psychiatry in Welsh).

Method. The induction manual was initially drafted by the authors based on the available printed policies and information online. Further input and from different stakeholders were obtained to triangulate and enrich the manual. Specific links and further references were included in the manual for the reference of prospective manual users. Authors' contact details were included for any further clarification, suggestions or input.

Result. The manual consisted of four sections: A) General Process before, during and after Reporting Duty, B) Trainees' Duty, 3) Speciality-specific Guidance, and 4) Health Board-related Information. The General Process section covered the visa-related information, post-acceptance paperwork process, access to email

and hospital informative system, medical practice-related issues (including section 12(2) approval and medical indemnity). The Trainees' Duty section briefed on time-tabling and clinical duty. The Specialty-specific Guide provided important information related to training. Lastly, the section of Health Board-related Information highlighted the administrative structure of the NHS Health Board, important contact numbers, link to information. Specialty specific sections were created for general adult psychiatry and old age psychiatry as there is no other higher training of psychiatry in North Wales at the moment. Further sections in the pipeline include substance misuse and liaison psychiatry.

Conclusion. This induction manual is neither prescriptive nor exhaustive. It serves as a generic reference to facilitate new trainees in their adjustment process. Further review and revision will be conducted before every induction process to ensure the information is up-to-date and incorporating new input from the trainees.

Audit of documentation of observations on mental health services for older people (MHSOP) wards following implementation of nervecentre

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Aims. Nervecentre is an application that can be used on mobile devices and desktop computers to record and view physical observations amongst other tools. An audit had been done previously assessing the practice of recording observations using paper documentation. That audit had recommended the use of Nervecentre to improve the recording of observations. This audit was undertaken following the introduction of Nervecentre for documentation of physical observations. The aims were to evaluate if the transition to electronic documentation of NEWS (National Early Warning Score) observations on Nervecentre has improved practice in comparison to paper documentation and to evaluate if our practice could be improved by implementing electronic observations for psychiatric observations in addition.

Method. Data were collected over a 10-day period looking at all the documented observations from all inpatients on the MHSOP wards that met the inclusion criteria. Data were collected on the recording of psychiatric observations (recorded on paper charts) and physical observations (recorded on Nervecentre). The data were collated and analysed. The new data were compared to the original data from prior to the introduction of NerveCentre and the findings were presented at a local meeting.

Result. This audit has highlighted that the documentation of physical observations on MHSOP wards has greatly improved since Nervecentre was introduced. There was an improvement in recording of physical observations in almost all domains measured. NEWS scores were correctly documented 100% of the time compared to 87% previously. Raised NEWS scores were correctly escalated to a senior and reviewed 80% of the time compared to 0% previously. It has also highlighted that the quality of documentation regarding psychiatric observations could be improved as we are not currently meeting local or national guidance.

Conclusion. The most likely cause for the improvement in the recording of the physical observations is the implementation of Nervecentre. Nervecentre prompts users when observations are due, removes the risk of calculation errors and allows for observations to be directly escalated. Implementing Nervecentre for psychiatric observations may similarly improve the quality of these observations therefore improving patient safety.

A pilot to assess the feasibility and potential clinical utility of enhanced sleep management on inpatient wards in a mental health trust

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Aims. To assess the feasibility and utility of introducing the following changes on to in-patient units:

Structural and cultural adaptation to create a sleep friendly ward environment

A "Protected Sleep Time" between midnight and 6am

Routine screening for sleep disorders, including obstructive sleep apnoea and restless leg syndrome

Background. Insomnia and other sleep disturbances are cause, correlate and consequence of psychiatric disorders. Routine hourly night time observations, ward noise, bright lights at night time, sleep disorders, insufficient exercise, insufficient day light exposure, too much caffeine and inappropriate psychotropic use are all causes of disturbed sleep (Horne 2018).

Method. Seven wards participated in a pilot (SleepWell). These consisted of one male and two female Acute Wards (General Adult), a High Dependency Unit, a Neurorehabilitation ward, an in-patient dementia service and one rehabilitation ward. These wards were supported via an existing trust management structure and the pilot was specifically supported by two trust managers (RW and RB) and by a clinical director (PK). The expectation was that each ward would identify a sleep champion from existing staff to facilitate the changes. A "product" was developed which identified core sleep management features but, in addition, wards were not confined to these. The existing policy that all inpatients should be checked each hour over night was suspended for the pilot wards and the patients had protected sleep time (PST) if the MDT agreed that it was clinically appropriate.

Quantitative and qualitative techniques were used to identify facilitators of change, impact on sleep and, outcome.

Result. Protected sleep was viewed positively by all staff and approximately 50% of patients on the pilot wards were able to have PST at some point in their admission. Routine sleep disorder assessments were harder to implement and 33% of patients were screened. There were no deaths or significant events on patients due to PST. Hypnotic use on the pilot wards reduced. It is anticipated that PST where it is safe will be rolled out across all adult and old age wards in the trust.

Conclusion. With support, it has been feasible to change many aspects of sleep management across a breadth of inpatient units in a large NHS trust.

Let's get moving! Improving physical activity amongst rehabilitation patients; a quality improvement project

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