Our aim was to assess the practicality and impact of making calculation of the QRISK3 score routine practice for new admissions onto our general adult acute male inpatient ward, in order to improve detection of increased cardiovascular risk and offer atorvastatin as primary prevention if indicated.

Methods: Over the course of six months (August 2024–February 2025), we calculated the QRISK3 score for 50 inpatients on a general adult male acute ward. Patients who had a score of 10% or more were counselled on their increased risk of stroke or myocardial infarction, and were offered atorvastatin as primary prevention.

Results: At the start of data collection, only one of the 17 patients on the ward was on a statin and none of the patients had a documented QRISK3 score.

Of the 50 patients included, 10 of them had a QRISK3 score of 10% or more. Of those 10, two were already on a statin. Of the remaining eight, four agreed to start atorvastatin whilst the remaining four declined.

QRISK3 scores were included on the discharge summaries of all patients who they had been calculated for, with a request to the patient's GP to revisit the topic of primary prevention in the future for those patients who had declined a statin.

The average time to acquire the information required to calculate the score for a patient was 6 minutes and 24 seconds.

Conclusion: Calculating the QRISK3 score for psychiatric inpatients is a quick process that can feasibly be a part of a checklist for new psychiatric admissions and may increase the proportion of patients on appropriate treatment with a statin.

In the future, use of a semi-structured interview that includes both statin counselling and lifestyle advice can be implemented, and we will trial this for the second cycle to see if it has an impact on uptake of a statin. Future research could involve longitudinal follow-up of cardiovascular outcomes to assess the impact of primary prevention in this patient population.

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Bridging the Gap – Physical Health Management by Mental Health Nurses in Pendleview: A Quality Improvement Project

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Aims: To reinforce nurses' initial physical health management knowledge on Darwen and Calder wards at Pendleview unit (LSCFT). This quality improvement project attempted to bridge the gap (of physical health knowledge) amongst nursing staff by providing a short teaching course of 3 topics to mental health nurses on Darwen and Calder ward at Pendleview mental health unit, Royal Blackburn Hospital.

Methods: The quality improvement project was conducted using the PDSA (plan, do, study, act) cycle methodology. The sample included 20 mental health nurses across Darwen and Calder wards in Pendleview unit. Three teaching sessions were delivered to nursing staff by doctors on both Darwen and Calder wards (6 in total) covering blood sugar monitoring, EWS and escalation and pain management. Quantitative and qualitative data was collected via pre- and post-teaching feedback forms, assessing nurses' confidence and knowledge in managing physical health conditions. Confidence and knowledge were both scored on Likert scales numbered from 1–5.

Results: 85% of nurses (17 of 20) stated they had not received training on the teaching topics before starting work Data across the three teaching sessions revealed the following;

Blood sugar monitoring (n=8): Mean confidence (1 – not at all confident, 5 – confident) increased from 2.75 95% CI [1.85, 3.65] to 4.75 95% CI [4.45, 5.05] out of 5. Mean knowledge (1 – very poor, 5 – extremely good) increased from 2.75 95% CI [2.292, 3.208] to 4.75 95% CI [4.45, 5.05] out of 5.

EWS and escalation (n=6): Mean confidence increased from 3.5 95% CI [2.493, 4.507] to 4.3 95% CI [3.704, 4.896] out of 5. Mean knowledge increased from 3.5 95% CI [3.1, 3.9] to 4.5 95% CI [4.1, 4.9] out of 5.

Pain management (n=6): Mean confidence increased from 4.33 95% CI [3.953, 4.707] to 4.83 95% CI [4.532, 5.128] out of 5. Mean knowledge increased from 3.5 95% CI [3.1, 3.9] to 4.67 95% CI [4.293, 5.047] out of 5.

Conclusion: Physical health management teaching to mental health nursing staff has shown to increase nurses' confidence and knowledge in physical health. Providing physical health management teaching trust wide can help to eliminate knowledge gaps among the nursing staff, irrespective of their prior knowledge. Flow charts, posters, and providing regular physical health teaching and training to nurses during induction and beyond can all aid to empower nursing staff. A further QI cycle could be explored, looking into new teaching content after determining any additional gaps in physical health knowledge of the nursing staff.

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Psychosis in Neuro-Developmental Disorders: A Phenomenological Approach

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Aims: Psychotic illnesses are more common in people with intellectual disabilities with rates as high as three times what is found in the general population. Making a diagnosis of psychosis in intellectual disability is complicated by various reasons such as communication difficulties, comorbidities, cultural differences, diagnostic overshadowing, and atypical presentation. The presence of comorbid Autism can further complicate the diagnostic process.

The clinical approach in diagnosing psychosis in people with intellectual disabilities must be based on a phenomenological assessment that aims to clarify in the patient, objective reality (that may include the "normal alternate" reality of neurodivergence) and the "loss of reality contact" observed in psychosis, from one another.

Our aim in this article is to illustrate phenomenologically the atypical nature of psychotic symptoms in people with neuro-developmental disorders compared with the general population.

Methods: We analysed features of the mental state examinations of men admitted to the regional medium secure unit for men with neurodevelopmental disorders over the period of June 2021 and

September 2024, identifying atypical descriptions of psychotic phenomena as indicated in the ICD–11 criteria.
Results: Over the study period, 16 men with psychosis and neurodevelopmental conditions were managed. The abnormal phenomena recorded included both classical descriptions similar to the general population and some atypical descriptions also.

In addition to bizarre, persecutory and grandiose ideas, other abnormal beliefs were reported as "bad thoughts", and "paranoia". Somatic, visual, and auditory hallucinations were also documented. Second- and third-person auditory hallucinations were experienced as external, located inside the head, or in some cases unclear. Abnormal thinking processes were described as "muddled thoughts" or "my head is screwed". Clinicians also highlighted muddled conversation, disjointed thoughts, speaking in unfamiliar (non-existent) language, repetitive speech, minimal effective conversation, perplexity and loosening of associations. Negative symptoms were quite common including grossly disorganised behaviours such as agitation, combativeness, physical and sexual violence.
Conclusion: Core features of neurodevelopmental disorders may be misinterpreted as symptoms of psychosis and when psychotic phenomena are described atypically, clinicians may miss the diagnosis often with negative consequences for the patients.

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From Baseline to Recovery: An Audit of Pre- and Post-ECT (Electro Convulsive Therapy) Patient Assessments

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Aims: The audit was conducted to evaluate the effectiveness and procedural compliance of pre- and post-Electroconvulsive Therapy (ECT) assessments in accordance with the Scottish Electroconvulsive Therapy Accreditation Network (SEAN) Standard. Specifically, it assessed whether healthcare professionals are adhering to protocols by conducting the required Montreal Cognitive Assessment (MoCA), Montgomery–Åsberg Depression Rating Scale (MADRS), and Clinical Global Impression (CGI) evaluations. The goal is to enhance patient care and ensure strict adherence to established SEAN standards.
Methods: The audit utilized a retrospective analysis of patient records who received ECT in the two years 2022 and 2023. The focus was on the completeness of the MoCA, MADRS, and CGI assessments pre-ECT, immediately post-ECT, and during follow-ups at three and six months. ECT notes and digital notes were collected, and ECT packs were scrutinized to collect the data of the patients.
Results: Out of 32 patients evaluated, 20 underwent a Montreal Cognitive Assessment (MoCA) prior to electroconvulsive therapy (ECT). It was not feasible to conduct the assessment for 6 patients, and it remains not done for another 6. Post-ECT, only 10 patients have completed MoCA, with none receiving follow-up assessments at 3 or 6 months. Regarding the MADRS (Montgomery–Åsberg Depression Rating Scale), 28 patients were assessed before ECT. Two were unable to undergo this assessment, and it was not performed for another 2 patients. Post-ECT, 11 patients have completed their MADRS, but no follow-ups have been conducted at 3 or 6 months. For the Clinical Global Impression (CGI) scale, assessments were completed pre-ECT for 26 patients, with 2 unable to participate. Post-ECT, the CGI was completed for 13 patients, but there has been no follow-up at 3 or 6 months.
Conclusion: The audit reveals that while the pre-ECT MOCA, MADRS, and CGI assessments met established standards, there were notable gaps in the completion of post-ECT evaluations. Particularly concerning was the poor completion rate of these assessments at both the 3-month and 6-month intervals. To address this, the audit recommends implementing robust processes to ensure the consistent and timely completion of these crucial assessments, which are essential for evaluating not only the therapeutic efficacy of ECT but also its cognitive side effects. Additionally, the audit suggests the establishment of specialized clinics staffed by senior-level specialist nurses to conduct these assessments. This approach would not only facilitate the collection of comprehensive data on the effectiveness of ECT but also enhance research into its cognitive aspects.

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Challenges and Best Practices in Consent to Treatment at University Hospital Wishaw

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Aims: We aimed to assess adherence to the Mental Health Act Code of Practice within University Hospital Wishaw's inpatient psychiatry setting, focusing on the documentation of consent to treatment for patients under Compulsory Treatment Orders (CTO). Compulsory Treatment Orders (CTO) authorize the treatment of mental disorders under specific legal and ethical guidelines, requiring meticulous documentation of consent. Initial reviews highlighted poor electronic documentation standards for patients under CTOs, prompting a proposed practice change to include scanning and filing consent forms electronically.
Methods: An initial review was conducted in December 2022 across three inpatient wards at Wishaw General Hospital, covering 57 patient records to establish the presence and adequacy of T2 and T3 documentation. A follow-up review in January 2025 re-examined 65 records to assess improvements in electronic record-keeping and documentation practices following the implementation of the proposed changes.
Results: The 2024 review showed that all patients under CTOs had their T2B or T3B forms properly documented in physical and electronic formats. However, only 70% had their consent status adequately recorded in the electronic clinical notes. This marked a significant improvement in electronic record-keeping from the initial 2022 review.
Conclusion: The integration of scanned consent forms into electronic records has enhanced the accessibility and quality of documentation, allowing for better coordination of care across multiple units. Despite these improvements, the consistent documentation of patients' capacity and consent status during clinical reviews remains a challenge. Ongoing education for medical staff and further reviews are recommended to ensure continuous adherence to the Mental Health Act Code of Practice and improve documentation practices.

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