as we had the skills and expertise to resume the process and to find new undetected patients.

Our aim was to determine how well the newly implemented PLT Memory Pathway follows the standards outlined in the National Institute of Health & Care Excellence (NICE) Clinical Guideline 97 (CG97): Assessment, management and support for people living with dementia and their carers.

Method. A retrospective analysis of all PLT referrals from July 2018 to February 2020 (20 months) was performed to identify patients on the community memory pathway and those with possible undetected cognitive impairment. Data were collected from electronic patient records which included demographics, primary and collateral history, cognitive testing and imaging, dementia type among others. Results were analysed using Microsoft Excel.

Result. 41 patients were included (59% female). 80% of patients were referred for memory problems or confusion. 63% had previous referrals to a memory service and was on the community memory pathway at the time of the referral. 34% were on anticholinergic medication but in only 14% were this documented as reviewed. 100 % were offered and had head imaging. A finding worthy of note was the absence of any from the ethnic minority background. 63% of patients were given a memory diagnosis and 34% had anti-dementia medication started. Patients' families were made aware of the diagnosis in 83% of cases, due to the absence of next of kin details in the patient record. Primary Care was made aware in 100% of cases; post-diagnostic support was 100%.

Conclusion. The PLT is well placed to bridge the service gap between the acute care trust and established community memory services when dealing with patients with dementia. A dedicated Memory Pathway has helped to close this gap and adherence to NICE CG97 standards was good, but there is room for improvement. A particular focus will be on improving documentation of anticholinergic medication review and exploration for the absence of ethnic minority patients. Aiming to achieve 100% family involvement is also recommended.

This study has been submitted to the Royal College of Psychiatrists' Faculty of Old Age Annual Conference 2021.

Addiction service changes due to COVID-19

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Aims. Addictions services had to respond rapidly to reduce COVID-19 transmission to protect patients and staff. Patients with opioid dependence are particularly vulnerable, with high risks. Our community addiction service changed practice in line with COVID-19 guidelines. For patients with opioid dependence; face-to-face contacts were initially reduce and mainly for new starts, restarts and non-attenders. Prescribing changes were completed on an individually risk assessed basis to reduce attendance at the chemist, specifically to reduce transmission, keep patients in treatment and to ensure chemists could continue to function. We document some of the service changes during the COVID-19 lockdown.

Method. Service evaluation had approval from Humber Teaching NHS Foundation Trust. Data retrieved on one Hub of a community addictions service in North England, UK. Patients prescribed opioid substitution treatment for opioid dependence were assessed, with data retrieval through electronic healthcare records. Data were analysed by Microsoft Excel anonymously.

Result. In lockdown (March 2020 to June 2020), we identified 112 patients with opioid dependence prescribed opioid substitution (OST) with methadone or buprenorphine at the Hub. All white British, mean 42 years, most male (75%) and prescribed methadone (78%). Ten were new starts and 8 restarts to OST. Attendance rates did not change: 91% before and 92% during lockdown. Appointment format changed from predominantly face-to-face (92%) to telephone (99%). Most patients (91%;n = 88) were offered take-home naloxone and overdose prevention training of which 14 refused. Supervision days at the chemist for OST reduced significantly from 75% collecting daily at the chemist, reducing to 20% during lockdown. Five patients were shielding and 7 had covid-related symptoms. There was one death during lockdown which was not attributed to covid or overdose.

Conclusion. The addictions service continued to be open and work proactively throughout lockdown, seeing new patients and continuing treatment interventions safely. Major changes were made in line with COVID-19 guidelines, to respond to the threat of transmission. Our service was flexible and able to adapt quickly to remote working. We maintained excellent attendance rates despite changes to the format of consultations. There were no related incidents e.g. overdoses linked to prescribed medications, despite a reduction in supervision, and therefore patients having extra medications. This important finding may be related to the individual risk assessments that we conducted before making changing to prescribing. This was supported by most patients were receiving naloxone to prevent overdoses. Some of the changes, such as telephone consultations, may be beneficial to continue post COVID-19.

Audit of methods used to contact the duty doctor - Abraham Cowley Unit

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Aims. The aim of this audit was to determine whether the duty doctor of a 4 ward inpatient psychiatric unit is contacted safely, effectively and in a manner that can be monitored. This is in line with trust protocol and the method stated is via switchboard. Should a deficit be found it was the aim to make an appropriate intervention.

Background. In the Abraham Cowley Unit, there is a Senior House Officer 'on-call' duty doctor 24/7. The shifts are 2 x 12.5 hours daily and at all times the duty doctor should be contacted via switchboard. Contacting via switchboard is important to ensure there is an audit trail of calls made. Issues that arise from using other methods of contact, e.g. calling direct extensions, include miscommunication and the doctor not being reached in a timely manner. This had been identified as an issue anecdotally by junior doctors on call and also highlighted following an untoward incident.

Method. The method by which the on call doctor was contacted was recorded in Excel for 5 consecutive 12.5 hour shifts in October 2019. The standard set for calls via switchboard was 80%. Following the initial results and the subsequent intervention, a repeat audit was performed using the same method.

Result. Initial Outcome

Initially it was found that only 25% of calls received where through the appropriate channel (5 out of 20 calls). This fell far below the 80% standard and an intervention was therefore devised.

Intervention

In order to ensure that all ward staff were aware of the trust policy posters were created and placed above all ward telephones and the telephone in the assessment suite office. This information was also handed over to the nurses in charge directly in order for it to be filtered through to other staff during handover.

Post Intervention Outcome

Following the intervention 88% of calls received where through the appropriate channels (7 out of 8 calls) and the 80% standard was achieved.

Conclusion. There has been a demonstrable improvement in the adherence to trust policy when contacting the duty doctor, with the percentage of calls made through the appropriate channel rising from 25% to 88%. This has now met the agreed standard of 80% and will improve the trust's ability to monitor contact of the duty doctor effectively.

A service evaluation of the healthy lifestyle groups in a female medium secure unit- what do our patients know about nutrition?

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Aims. To assess whether patients have a good knowledge of basic nutrition compared to a group of staff. We hypothesise that the patient's knowledge will show deficits compared to the staff despite the group interventions.

Background. The Royal College of Psychiatrist's core standards for inpatient physical health outlines that patients should be engaged in healthy lifestyle groups. The women's secure service at Ardenleigh has developed healthy lifestyles groups to promote a better understanding of nutrition.

Method. An adapted University College London general knowledge nutrition questionnaire was used to investigate nutritional knowledge.

All 22 inpatients and a random selection of staff were offered the chance to complete the questionnaire. As the groups run on a regular basis, it was presumed all patients had attended at least one group session. The staff are the comparator group.

18 staff responses and 12 inpatient responses were obtained (54.5% response rate for inpatients).

Result. No participant in either group scored 100%. Both groups had a good awareness of what foods they should be eating more and less of. 83.3% of patients were aware that they should be eating breakfast everyday as opposed to 100% of staff.

Poor areas of knowledge included knowledge of the number of oily fish servings per week. Staff and patients also performed poorly when estimating their recommended daily salt intake. 1/3 of patients were unable to provide an example of a serving of fruit and vegetables.

The knowledge of the structure of the Eat-Well plate was poor in both groups. Only 16% of patients and 22% of staff were aware that starchy foods should make up 1/3 of the Eat-well plate. Knowledge of protein sources was poor. 25% of patients and 16.6% of staff thought that fruit and butter were good sources of protein

Furthermore, only 50% of patients were able to choose the healthiest evening meal choice from a list of 3 options compared to 100% of staff.

Conclusion. In conclusion staff had better knowledge of nutrition than patients but knowledge was poor in areas amongst both groups. We conclude that groups should have more focus around practical applications of nutritional knowledge to everyday life.

An audit of the use of psychotropic medications over the course of admission to a specialist dementia ward

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Aims. The aim of this audit project was to establish the practices in prescribing and de-prescribing of psychotropic medications for patients on a specialist dementia ward.

Background. There is a great deal of evidence demonstration high rates of polypharmacy, defined as ≥5 drugs, in older adults in general and in those with dementia more specifically. NICE guidelines recommend a structured assessment of a patient with dementia to exclude other potential causes, e.g. pain or delirium. Psychosocial interventions are recommended as first line. Antipsychotics should only be offered second line who present a risk to themselves or others. These should only be used for the shortest time possible and reassessed at least every 6 weeks.

Method. Data were collected for patients (n = 20) discharged from a specialist dementia ward between September 2018 and March 2019. The unit has 14 beds caring for patients with predominantly severe behavioural and psychological symptoms associated with dementia (BPSD). The team is comprised of doctors, nurses, a clinical psychologist, occupational therapists, physiotherapists and pharmacists who meet twice a week to review patients. Data were coded by drug class and counts of medication on admission, at the midpoint and at discharge were conducted. Antipsychotic and benzodiazepine dosages were converted into haloperidol and diazepam equivalence.

Result. Of the 20 patients, 70% were male and 30% female. 95% of the patient (n = 19) were admitted under the Mental Health Act (1983). 20% were managed on 1 to 1 observations and 80% were on 15 min observations. In general, the results show little change in the overall rate of psychotropic prescribing. The mean number of psychotropic medications prescribed per patient on admission was 2.30, at the mid-point of admission it was 2.30 and at discharge it was 2.05. Mean benzodiazepine dosage in diazepam equivalence reduced between admission and discharge from 3.20 mg to 2.10 mg. Mean haloperidol equivalent dosages increased at the midpoint of admission from 1.11 mg to 2.27 mg before reducing to 0.78 mg at discharge.

Conclusion. The results demonstrate minimal change in the overall average number and composition of drugs prescribed. There are differences in the use of regular antipsychotics and benzodiazepines between admission and discharge which are consistent with NICE guidelines. Patients had a structured assessment with regular medicines reconciliation supervised by the team pharmacist. Therefore, the ward environment did allow for detailed discussions about de-prescribing which may not be the case elsewhere.