discernible negative difference from the patient's perspective in the clinical sessions. This may be due to the difficulties in therapeutic alliance using the telehealth platform. We appreciate that there are a number of confounding factors, especially the effect of COVID-19 isolation. Telehealth is a useful addition to our assessment and treatment paradigms and its use should continue; however, we should be aware of the potential negative effect on therapeutic alliance.

What happens to people admitted to a specialist dementia unit in the west of Scotland?

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Aims. Recent local research examined mortality rates following admission to a dementia ward. We wanted to expand on this work and include other important health outcomes for patients admitted to our specialist in-patient dementia unit in the west of Scotland. This would provide a comprehensive overview of our in-patient population, aid service review and improve care. We hypothesised that patients admitted would be physically frail, have a significant mortality rate and would likely require long-term care post discharge.
Method. The clinical notes for each admission to the unit for one year were examined (total 62). We extracted data from a number of different areas such as demographics, mortality rates, discharge destination, readmission rates and prescribed medications.
Result. 60% had an Alzheimer's/mixed dementia diagnosis. Average length of stay was 64 days. 62% were discharged to a care home (50% of this total had lived at home prior to admission), 18% to complex care and 20% to the community. 66% were prescribed an antipsychotic and the average number of medications was 8.4. 35% had a readmission under general medicine within a year of discharge. 19% died whilst an inpatient and a further 30% had died one year post-discharge (total one-year mortality of 44%).
Conclusion. People admitted to our dementia unit are physically frail, with only 20% returning to live in the community, 35% being readmitted to a general medical ward within a year of discharge and 44% dying during the admission or within a year of discharge. We need to bear these results in mind when considering if hospital admission is appropriate and ultimately further develop our skills in palliative and end of life care in order to provide those people admitted to our dementia unit (and those who remain at home) with the highest standard of care.

Audit of pharmacological management of borderline personality disorder as per NICE clinical guidelines CG78

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Aims. To audit the current practice of pharmacological management of Borderline Personality Disorder with NICE Clinical guideline [CG78]: Borderline personality disorder:

Objectives:

23 patient records were analysed in the last 18months with a diagnosis of EUPD to compare current practice against NICE clinical guidance. (2009)

Standards:

When prescribing

1) Use a single drug.
2) Use the minimum effective dose.
3) Agree with the person the target symptoms, monitoring arrangements and anticipated duration of treatment. Antipsychotic drugs should not be used for medium, long term treatment.

Indication:

4) Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated. (Repeated self-harm, marked emotional instability, risk taking behaviour and transient psychotic symptoms).
5) Short-term use of sedative medication may be considered cautiously as part of the overall treatment plan in a crisis. The duration of treatment should be no longer than 1 week.
6) When considering drug treatment, provide the person with written material about the drug. This should include evidence for the drug's effectiveness in the treatment of borderline personality disorder and for any comorbid condition, and potential harm.

Review:

7) Review the effectiveness and tolerability of previous and current treatments.
8) Discontinue ineffective treatments.

Background. Borderline Personality Disorder is common in psychiatric settings with a reported prevalence of 20%.

As per NICE Guidance (CG 78), no medications have been found effective for the longer term treatment of personality difficulties.

This audit was carried out to review if patients were offered psychiatric reviews to discuss the medications they are using, the effectiveness of these, and any potential side effects.
Result. Good practice compliance of 90-100% was noted where >90% compliance was seen in areas where the effectiveness and tolerability of current and previous medication was reviewed by the clinicians under Structured Clinical Management. Also was noted that antipsychotics were not used for medium to long term in patients with Borderline Personality Disorder in the cohort.

The following areas were non-compliant with the NICE recommendations where a compliance <79% has been achieved.

When prescribing, use a single drug (avoid polypharmacy), agree target symptoms, monitoring and duration, provide written information, discuss evidence for effectiveness in treatment of borderline personality disorder.

Partial compliance was achieved (80-89%) with use of sedatives for less than 1 week and discontinuation of ineffective treatment.
Conclusion. Distribute key cards to clinicians.

Provide written information to patients.

Re-audit in 6 months.

An audit on admission clerkings across Lancashire and South Cumbria NHS Foundation Trust (LSCFT)

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