

documentation of the discussions had with patients and carers about the risks and benefits of using antipsychotic medications for management of BPSD. A teaching session was held at the team meeting to highlight the risks and benefits. The team will ensure that they provide a health board approved leaflet to each patient and carer following their discussion. Only 73% of the patients had a CAIR form in their notes and the team favour the original version. The team will revert back to using the original version of the CAIR form as it has more space allocated to document ongoing reviews. We will re-audit in 6 months time.

On-call medical seclusion reviews: are we meeting MHA code of practice (COP) requirements?

Oliver Turner^{1*} and David Leung²

¹Leeds and York Partnership NHS Foundation Trust and ²PICU, Newsam Ward 1, Leeds and York Partnership NHS Foundation Trust
*Corresponding author.

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Aims. Are Junior Trainee, Medical Seclusion Reviews complaint with MHA COP Criteria?

Objectives. Are we seeing newly secluded patients on time?

Are we documenting these reviews in clinical notes?

Do documented reviews meet criteria stated by the MHA COP 26.133?

Are we informing Higher Trainees of the need for MDT reviews?

Background. Seclusion is an important aspect of inpatient care. MHA COP Chapter 26 provides guidance for documenting seclusion reviews, ensuring safeguards are in place to protect patient's safety and human rights. Secluded patients require a medical review within 1 hour, and four hourly thereafter, until a higher trainee or Consultant undertake an MDT Review. In our Trust, LYPFT, trainees undertake these reviews. There is noted discrepancy in seclusion review documentation. This audit identifies our compliance with time limits, and whether documentation meets the required criteria in the MHA Code of Practice

Method. Our Sample includes all Out-of-Hour Junior Trainee Medical Seclusion Reviews between 01/01/20 and 01/04/20 at LYPFT. Seclusions were identified from on call logs, and clinical notes were reviewed for a documented seclusion review. The date and time of seclusion are recorded, whether a 1 or 4 hourly review, and the time of review. We recorded any mention of: physical health; mental state; observation levels; recent medication; medication side effects; risk to others; risk to self and the need for ongoing seclusion.

Result. 56 episodes of seclusion were identified; all 56 had a documented medical seclusion review. 49 reviews were on time, 4 were late with a documented reason, and 3 were late without. There was documentation of the Higher Trainee being informed in 53 reviews.

No seclusion reviews mentioned all MHA COP criteria. We more frequently mentioned patients' physical health (51), psychiatric health (52) and need for seclusion (54). 46 seclusion reviews mentioned risk of harm to others; only 3 mentioned risk of self-harm. 25 seclusion reviews mentioned medication, and 5 mentioned review for side effects. 5 seclusion reviews mentioned observation levels.

Conclusion. Our Junior Doctor Seclusion Reviews were not meeting the MHA Code of Practice Criteria, and we believe this to largely be due to lack of awareness of the standards. As such, results have been disseminated to Junior trainees in weekly teaching. We created a medical seclusion review template, adopted by the Trust, to ensure documentation compliance with the MHA COP. Junior doctor inductions now include a presentation regarding Seclusion, the reviews and documentation. We will re-audit in 12 months.

Early intervention in psychosis team (EIT): pathways to care

Chloe Uffendell* and John Stevens

MerseyCare NHS Trust

*Corresponding author.

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Aims. The main aim of this study was to investigate whether the EIT access and waiting time standard (>60% of people experiencing first episode psychosis (FEP) are treated with a NICE-approved care package within two weeks of referral) was being met within Liverpool EIT.

We also wanted to understand the pathway to treatment within EIT services, identify delays in the process of triage/assessment/MDT/medical review and implement changes to reduce delays.

Method. This study was a retrospective cross-sectional audit of all patients accepted on to the FEP pathway following MDT discussion in the Liverpool EIT Teams across May and June 2020.

Case notes were analysed for delays in referral, engagement with assessment and care-coordinators, as well as prescriber review offering medication. The data were collated and analysed before implementing changes.

Result. 40 patients presented as FEP in May and June 2020, 6 were excluded due to an extended inpatient stay.

Within the remaining patient cohort (n = 34), 64.7% of patients were engaged with a care package within 14 days. Only 14.7% of patients received an offer of medication within 14 days, the mean time to be offered medication was 39 days.

26% of patients first contact within MerseyCare Trust was with EIT, 74% presented elsewhere. 24% instead presented to liaison psychiatry from A&E departments, 18% to the single point of access team, 9% to criminal justice liaison team (CJLT) and 9% to North West Ambulance Service triage car.

29% of referrals came from the community (GP and counselling services), 15% from CRHT (crisis resolution and home treatment team), 14% from CJLT, 12% from urgent care team, 9% from liaison psychiatry.

Conclusion. The Access and Waiting time standard was met. However, this study showed that patients were not being referred to EIT at first point of contact. This study shows 26% of service users first presented to liaison psychiatry, yet only 1/3 of those were immediately referred to EIT, the remainder being later referred by other services e.g. CRHT.

In addition to referral delays, lack of medical practitioner availability caused significant delays in arranging medical reviews, delaying patients access to medication.

The changes implemented to address these issues included educating MerseyCare services in the early recognition of psychosis to increase early referral. Non-medical prescribers' roles were developed to perform initial medical reviews in addition to doctors, allowing patients earlier medication access. This allowed 'urgent slots' to be developed, time set aside for emergencies enabling prompt review of urgent cases.

An audit of lithium prescribing practices in an old age psychiatry service highlighting renal impairment in this cohort

Leia Valentine*, John Cannon, Siobhan Marmion, Michelle Corcoran, Marguerite Cryan, Geraldine McCarthy and Catherine Dolan

Liscarney House, Psychiatry of Old Age Service

*Corresponding author.

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Aims. To compare Lithium prescribing practices in a Psychiatry of Old Age (POA) Service in the North-West of Ireland among adults aged 65 years and over with best practice guidelines.

Method. Review of the literature informed development of audit standards for Lithium prescribing. These included National Institute for Clinical Excellence (NICE) 2014 guidelines, The British National Formulary (2019) and Maudsley Prescribing Guidelines (2018). Data were collected retrospectively, using an audit-specific data collection tool, from clinical files of POA team caseload, aged 65 years or more and prescribed Lithium over the past one year.

Result. At the time of the audit in February 2020, 18 patients were prescribed lithium, 67% female, average age 74.6 years. Of those prescribed Lithium; 50% (n=9) had a depression diagnosis, 44% (n=8) had bipolar affective disorder (BPAD) and 6% (n=1) had schizoaffective disorder.

78% (n=14) of patients were on track to meet, or had already met, the NICE standard of 3-monthly serum lithium level. Lithium levels were checked on average 4.5 times in past one year, average lithium level was 0.61mmol/L across the group and 39% (n=7) had lithium level within recommended therapeutic range (0.6-0.8mmol/L).

83% (n=15) of patients met the NICE standards of 3 monthly renal tests, thyroid function test was performed in 89% (n=16) and at least one serum calcium level was documented in 63% (n=15). Taking into consideration most recent blood test results, 100% (n=18) had abnormal renal function, 78% (n=7) had abnormal thyroid function and 60% (n=9) had abnormal serum calcium.

Half (n=9) were initiated on lithium by POA service and of these, 56% (n=5) had documented renal impairment prior to initiation. Of patients on long term lithium therapy at time of referral (n=9), almost half (n=4) had a documented history of lithium toxicity.

Conclusion. The results of this audit highlight room for improvement in lithium monitoring of older adults attending POA service. Furthermore, all patients prescribed lithium had impaired renal function, half had abnormal calcium and two fifths had abnormal thyroid function. This is an important finding given the associations between those admitted to hospital with COVID-19 and comorbid kidney disease and increased risk of inpatient death.

Our findings highlight the need for three monthly renal function monitoring in older adults prescribed lithium given the additive adverse effects of increasing age and lithium on the kidney. Close working with specialised renal services to provide timely advice on renal management for those with renal impairment prescribed lithium is important to minimise adverse patient outcomes.

Improving the patient involvement in research and development on acute psychiatric wards – an audit and quality improvement project

Ioana Varvari^{1*}, Hany El – Sayeh², Shona McIlrae³ and Susan Bonner⁴

¹Psychiatry Registrar, Tees, Esk and Wear Valleys NHS Foundation Trust; ²Consultant Psychiatrist and Director of Medical Education, Tees, Esk and Wear Valleys NHS Foundation Trust; ³Consultant Psychiatrist and Clinical Director, Tees, Esk and Wear Valleys NHS Foundation Trust and ⁴Research nurse, Tees Esk and Wear Valleys NHS foundation Trust

*Corresponding author.

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Aims. The local audit aimed at measuring awareness of research and development policies and implementation of local and national standards. Our findings generated a quality improvement project with two main objectives: first, improving patient approach and recruitment in research and second, improving trainee satisfaction within our trust.

Method. A cohort of new inpatient admissions was identified over a period of 4 weeks, between October 2019 and November 2019, on the two psychiatric wards at the Briary Wing, Harrogate District Hospital. Based on local and national standards, we designed and developed a qualitative (questionnaire) and quantitative (audit tool) approach that was aimed at both staff and patients. Our steps included: assessing awareness and implementation of standards, a retrospective collection of data on the wards, and analysis of the data in Microsoft Excel.

Result. Only one ward implemented the local guidance from which we identified a sample of 14 consecutive new admissions that were currently present on the ward and were able to answer our questions. 13 of those patients were noted as ‘approached’ on our visual board from which only 3 patients remembered reading a leaflet about research options in the admission pack, however, they have not been verbally informed. There was no process in place to assure the re-approaching of initially unwell patients or to follow up on discharge for those interested. Documentation was available in only 9 of the cases and was nonspecific: ‘admission pack done’.

Conclusion. The awareness and understanding of Research and Development policies are poor and they are difficult to apply in practice in a busy inpatient environment without a clear process in place. This results in patients missing the opportunity to learn and understand more about research or to participate in ongoing studies. Quality improvement work needs to be done to improve patient recruitment in research in inpatient settings. Simple flow charts and stepwise processes as exemplified by our action plan have the potential to improve service quality, as well as patient and trainee satisfaction.

Reducing high dose antipsychotic therapy (HDAT) in a community mental health team (CMHT)

Richard Walsh^{1*}, Sonn Patel², Valentina Loddò², Rebecca Fahy³ and Elizabeth Walsh²

¹School of Medicine, University College Dublin; ²Galway University Hospital and ³Semmelweis University

*Corresponding author.

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Aims. The consensus statement (CR190) of The Royal College of Psychiatrists states that the benefit of prescribing HDAT does not outweigh the risk of the increased side effect burden. HDAT is defined as the “daily dose of a single antipsychotic exceeding the upper limit for that drug as stated in the Summary of Product Characteristic (SPC) or British National Formulary (BNF),” and as the cumulative daily dose of two or more antipsychotics (for combined prescription). The prevalence of HDAT has been shown to vary widely and protocols for monitoring poorly implemented. In 2018 we completed a baseline survey of the prevalence of HDAT within our CMHT. We assessed our prescribing practice as compared to seven best practice audit criteria, which were adopted. Our aim is to resurvey closing the audit loop to 1) establish the current prevalence of HDAT and 2) assess the impact the intervention on prescribing practice.