The project had been registered with the NHS Grampian Quality Improvement & Assurance Team prior to data collection beginning.

Results. All of the notes reviewed (100%) had the clinical indication for ECT clearly documented.

Three (50%) of the patients had received the RCPsych Patient Information Leaflet for ECT.

A clear risk/benefit assessment discussion was documented in three (50%) of the patients' notes.

Specific discussion of side effects including cognitive impairment and anaesthetic risk was documented in three (50%) of the patients' notes.

Conclusion. There is a clear need for improvement in the documentation of the consent process for ECT in NHS Grampian. While the indication for receiving ECT is being clearly recorded, documentation of the risk/benefit assessment, discussion of specific side effects, and involvement of family or advocacy is less consistent. The introduction of the NHS Grampian standardised consent form is being considered as an option to improve this documentation. The documentation of the consent process for ECT can be re-audited once this form has been introduced.

An Initial Audit of Delirium Detection and Management in an Intensive Care Setting

Dr Yzobelle Barcelos* and Dr Kirthika Mohanathass

East and North Hertfordshire NHS Trust, Stevenage, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.539

Aims. In the intensive care unit (ICU), delirium occurs in up to 80% of patients on mechanical ventilation. Delirium is associated with an increased risk of morbidity and mortality, long-term cognitive decline, and risk of reintubation. This initial audit aims to identify areas of improvement in the early detection, prevention, and management of delirium in the ICU of the general hospital following trust guidelines.

Methods. In this baseline audit, data was collected about all inpatients on admission over a 7-week period (81 patients in total). The parameters audited were in accordance with trust guidance on the management of delirium and compliance to this was recorded. Parameters included: the correct use and documentation of screening tools, type and cause of delirium, pharmacological and non-pharmacological management, and other demographics such as sensory impairment and length of stay. Confused patients handed over verbally during ward rounds were also assessed again at the time, with documentation and parameters reviewed.

Results. Of the 81 inpatients in the ICU, 20 were observed with delirium during their stay. The documentation of delirium via the CAM-ICU screening tool was incorrect in 25% of patients with delirium (PWDs). Furthermore, behaviour (including sleep) was only monitored for 15% of PWDs and 0% had a complete "This is me" document (support tool for patient-centred care).

Sensory aids were not available for 50% of PWDs and 25% of this group had drug/alcohol dependence. A diagnosis of delirium was only formally documented in 40% of PWDs and of these, 15% had the type of delirium documented. Only 8 PWDs received a specific management plan, with 6 PWDs receiving haloperidol or lorazepam for agitation. Non-pharmacological managements were not documented.

The average length of stay in the hospital was 20% longer in PWDs compared with non-delirium patients, with 10 deaths in the ICU; 50% of these being PWDs.

Conclusion. There is a lack of accurate documentation and a lack of medical optimisation for PWDs, which may lead to missed delirium diagnosis, greater risk of mortality and longer hospital stays. The results highlight a need for further education about delirium in the ICU, to increase awareness for better detection, prevention and promotion of appropriate delirium management and formal documentation as per trust guidelines. Furthermore, a need to consider alternative pharmacological management for delirium, specifically in the ICU where lorazepam and haloperidol may not be suitable in consideration of anaesthetic drug interactions and respiratory support requirements.

Audit of the Completion Rate of BPD Admission Checklist for the Hospital Admitted Service Users With EUPD

Dr Ranjan Baruah[1]*, Dr Simon Graham[1], Dr Jehan Elturky[2], Dr Hannah Ruth[1] and Dr Faraaz Abulais[1]

[1]Mersey Care NHS Foundation Trust, Liverpool, United Kingdom and [2]Mersey Care NHS Foundation Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.540

Aims. As admissions have the potential to contribute to iatrogenic harm, Mersey Care NHS Foundation Trust (MCFT) introduced an admission checklist to help the decision-making process around admitting people with Borderline Personality Disorder (BPD).

1. To conduct an audit to review if the admission checklist was being used after its introduction.
2. To provide data on the context of admission including the use of MHA.

Methods. Data from admissions for people with BPD to nine acute care wards in (MCFT) over a three-month period were collected and assessed for 21 parameters.

A total of 60 admissions were identified for 51 patients (9 patients had more than one admission).

Results. None of the recorded 60 admissions had a completed BPD checklist at the time of admission.

36 (60%) of the decisions to admit took place during the Normal Working Hours (NWH), 24 (40%) out of hours (OOH).

33 (55%) informal admissions, 27 (45%) on Section 2 of the MHA.

NWH admissions were associated with a higher number of informal admissions compared with OOH admissions (24 vs 9 respectively).

3 out of 27 OOH admissions requested by Crisis Resolution and Home Treatment (CRHT) resulted in informal admissions. The remaining OOH admissions were following a Mental Health Act Assessment (MHAA) by trainee psychiatrists.

At the point of admission, 9 (15%) patients were not open to secondary mental health team in MCFT prior to their referral for MHAA; 48 (80%) patients were under Community Mental Health Teams and/or the CRHT; 12 (20%) were open to the Personality

Disorder (PD) hub, and 3 (5%) were open to other mental health teams including eating disorders team, Attention Deficit Hyperactivity Disorder (ADHD), Addiction Services and Criminal Justice & Liaison Team (CJLT).

Conclusion. There was no engagement with completing the BPD admission checklist. 40% of ST doctors reported on a separate survey that they cannot locate the Checklist on patient information system.

Admission decisions made during NWH have led to significantly more informal admissions compared with during OOH where the MHA was more likely to be used.

An action plan was designed to improve engagement with the admission checklist:

- Introductory training was provided to CRHT, approved mental health professionals (AMHPs), MHA second opinion doctors and psychiatry ST doctors.
- Inpatient teams were asked to complete the checklist.
- Bed Management to request an updated completed PD admission Checklist prior to admission.
- Re-auditing in 6 months.

An Audit to Assess Nicotine Management on a Mental Health Rehabilitation Unit in Mersey Care NHS Foundation Trust

Dr Ranjan Baruah*, Dr Olusegun Popoola, Dr Sion Gilbey and Dr Oliver Pentz

Mersey Care NHS Foundation Trust, Liverpool, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.541

Aims. Research has found that having a mental health condition is associated with smoking, and difficulties remaining abstinent. It is also evidenced that there is desire to reduce the amount smoked and cease smoking altogether by those with mental health conditions. Smoking can also affect some medications used to treat mental health conditions.

To assess nicotine replacement management in inpatients at Rathbone Rehabilitation Centre (RRC) against Mersey Care NHS foundation Trust (MCFT) Nicotine Management Guidelines (SA20).

Methods. Data of all discharged patients from RRC over a 12-month period was collected following a standardised process and assessed for 6 parameters.

A total of 51 discharges were identified and the whole sample of 51 patients were audited.

Results. 47 (92%) were asked and recorded of their smoking status and 4 (8%) were not at the point of first contact on patient electronic records (Rio).

Of the 28 smokers who were identified on admission, 26 (93%) were offered support to stop smoking at that point. 3 other patients started smoking during admission.

Of the 31 patients who were identified as smokers (including 3 who began smoking during admission), 24 (77%) were offered support to stop smoking at regular intervals throughout their admission and 7(23%) were not.

Of the 28 smokers who did not wish to permanently stop smoking, there was documented evidence that 20 (71%) of these individuals were offered nicotine replacement treatment (NRT) in some form to manage temporary abstinence from smoking.

5 out of 31 smokers were referred to a Nicotine Dependence Treatment Advisor for counselling and support during their inpatient stay.

Conclusion. Below action plan was designed to improve compliance with MCFT Nicotine Management Guidelines (SA20):

Audit leads to communicate with every team member at RRC (Team meetings and emails) to remind them of the following:

- To offer smokers support to stop smoking at regular intervals and document on Rio; via named nurse sessions or opportunistically.
- To offer NRT where appropriate and document on Rio if accepted or declined during MDT reviews/named nurse session.
- Ensure Physical Health Nursing Proforma is always completed on Rio, and if the service user is a smoker, to ensure referral status (referred/declined) to Nicotine management team is documented.
- Increase awareness of referral pathway by putting up posters in relevant clinical areas.

Monitoring of Antipsychotics in CAMHS Intellectual Disability Service in Lancashire and South Cumbria NHS Foundation Trust

Dr Sadia Batool[1]*, Dr Wala Kamal Abbas[1], Dr Abimbola Oyedokun[2] and Dr Mischa Oyed[1]

[1]LSCFT, Preston, United Kingdom and [2]CWP, Cheshire, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.542

Aims. To ascertain the service performance against the standards set by National Institute for Clinical Excellence (NICE) guidelines on physical health monitoring of children and adolescents prescribed antipsychotics.

Methods. Initial audit: April–June 2021.

Re-audit: January–February 2024.

Registered with the Lancashire and South Cumbria NHS Foundation Trust audit department. An audit tool was developed by the investigators. The investigators carried out a review of patient electronic records and clinical letters to gather information pertaining to initiation of antipsychotics and physical health monitoring.

Results. Amongst other variables in this trust-wide audit, we considered age, ethnic background, reason of initiation of antipsychotic, comorbid conditions among which most common is epilepsy, dose of antipsychotic used and distributions across various CCGs. Were they regularly reviewed by medic reviews and side effects monitored? We also looked at choice of antipsychotic used, which was largely aripiprazole and risperidone. Were antipsychotic bloods done or not and were we able to complete children's height and weight measurements whilst they were on antipsychotics? It was important that these are documented as being considered or 'offered' even if could not be successfully completed due to e.g. challenging behaviour from the child. Detailed and comparative results can be shown in final submission along with charts.

https://doi.org/10.1192/bjo.2024.540 Published online by Cambridge University Press