Results. A total of 60 records were included from Dorset Healthcare Psychiatry Liaison Services. Only one heading, the "Presenting Situation", was documented in all assessments (100%). Psychiatric headings on the template showed high compliance: "Mental State Examination" and "Risk Summary" were each documented in 98% of assessments, and "Psychiatric Formulation" in 92%. The "Carer/Parent's Understanding of the Assessment" was the least assessed (40%). Other significant headings that showed moderate compliance were, "Safeguarding Concerns" (71%), "Physical Health History" (75%) and "Social Situation" (81%).

Conclusion. Our findings emphasize the need for more comprehensive biopsychosocial assessments in Dorset Healthcare Liaison Psychiatry services. While Liaison Psychiatry practitioners exhibit proficiency in evaluating psychiatric aspects, there is reduced compliance in assessing social aspects, notably in assessing family understanding. Future qualitative analyses will evaluate practical barriers and human factors affecting compliance with specific headings. Moreover, data collection can expand to encompass additional Mental Health services in a wider catchment area, including settings such as community and inpatient facilities.

Improving Pathways for Patients With Disordered Eating in General Acute Hospital, in Accordance With MEED Guidelines

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Aims. Patients with disordered eating in psychiatry are considered highly complex in the acute hospital setting. In Spring 2023 a pilot for a specialised dietitian was introduced to identify and target such patients; aimed at reducing length of stay to the acute medical wards. Hospital admissions for eating disorder increased by 84% between 2015/16 and 2020/21; with increasing complexity of presentations and a demand for Specialist Eating Disorder (SEDU) beds, there are increasing numbers admitted to acute medical beds for initial treatment and management. In 2021 the Royal College of Psychiatrists published its updated guidance, Medical Emergencies in Eating Disorders (MEED). There is recognition that acute trusts must identify care pathways for the management of patients with eating disorders and severe food restriction for psychiatric reasons. This audit aims to show how these guidelines are being implemented locally and where there is a need for improvements in care pathways focusing particularly on length of stay, frequent attenders and avoiding hospital admissions.

Methods. A retrospective audit of 26 patients presenting between 01/03/2023 and 31/12/2023 was completed. Patients were identified from data collated by the specialist dietitian as having presented with an existing diagnosis of eating disorder or disordered eating in the context of psychiatry. Some patients were detained under the Mental Health Act. Some patients presented on multiple occasions to the acute hospital during this period; each inpatient episode was analysed independently. Data was collected retrospectively by analysing PICS documentation (electronic notes system) and entered into a data collection spreadsheet. A Google Form checklist was created to capture whether key points from MEED guidelines were met.

Results. Demographic data, details of initial presentation and admission events were collated including the team initially referred to and how long after the initial admission this occurred. Outcomes of admission were also recorded. Data was quantitatively analysed to understands trends in referral process, MDT working (inclusion of emergency clinicians, acute medicine, psychiatrist, specialist dieticians and nursing colleagues). Average lengths of stay, number of attendances and planned admissions were also captured.

Conclusion. An overall reduction in length of stay for detained patients with dietetic and wider MDT input was noted from 50 days prior to January 2023, to 29 in the period from March 2023 onwards. Frequent attendance for electrolyte abnormalities was significantly improved though implementing MDT working with teams in the community and planned admissions from inpatient units or SEDUs for medical management reduced overall length of stay for those patients.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

A Clinical Audit of ECT Documentation in NHS Grampian

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Aims. Electroconvulsive Therapy (ECT) is a treatment used for patients with severe depression, mania, catatonia, and schizophrenia. National Institute for Clinical Excellence (NICE) guidance for the use of ECT advises that for all patients, a risk/benefit assessment for the treatment should be made and documented with particular reference to anaesthetic risk and the adverse effect of cognitive impairment.

For patients who can consent to treatment, NICE recommends the use of patient information leaflets to help people to make an informed decision about their ECT treatment.

For patients who cannot consent to treatment, psychiatrists can authorise the use of ECT using the Mental Health Act. However, NICE recommends that any advance directive should be fully taken into account, and someone who speaks on behalf of the patient should be consulted.

This project aimed to audit whether the documentation of the consent process of patients undergoing ECT in NHS Grampian was in line with the above NICE Guidance.

Methods. The clinical notes and ECT folders of the six patients undergoing ECT treatment in NHS Grampian in January 2023 were reviewed in reference of the following domains:

1) The clinical indication for ECT.
2) If the patient (or their family/advocate) had the opportunity to receive the RCPsych Patient Information Leaflet for ECT.
3) If a discussion about the risks/benefits of ECT had taken place with a patient, their family or advocate.
4) If specific risks and side effects – namely anaesthetic risk and cognitive impairment – had been discussed with the patient, their family or advocate.

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

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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

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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