

Baseline bloods (or declined) = 89%, Baseline ECG (or declined) = 67%

Complete monitoring bloods = 44%, Physical health monitoring parameters complete = 56%

Monitoring schedule present in notes and current = 38%, Present, not current = 50% (0% on PARIS).

**Conclusion.** Lower numbers at re-audit limit interpretation.

Further recommendations: Antipsychotic initiation checklist; Central bloods diary for clinicians; Antipsychotic care-pathway booklet, co-produced with young people, incorporating the monitoring schedule.

### Characterising a cohort of patients referred to a liaison psychiatry service from the Intensive Care Unit

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**Aims.** This is descriptive study of a cohort of patients referred to a liaison psychiatry service from the intensive care department of a major London teaching hospital and trauma centre. The objective was to characterise key patterns in reasons for referral, nature of input, and gain a general sense of the workload. The rationale for collating this information was the consideration to developing a specific intensive care liaison service given the increasing evidence about the cognitive and mental health impacts of post-intensive care syndrome and the need for a coordinated management approach between stakeholders.

**Method.** A cohort of 80 patients referred to liaison psychiatry service over a 6-month period from May to October 2020 was used. Descriptive statistics were used to characterise the patient's age, referring ward, reason for admission and referral, nature of input, number of reviews, previous engagement with mental health services, whether substance abuse or self-harm were related to the admission, and the destination upon discharge.

**Result.** The age range of patients at point of referral was 25-80 years. For 25% of patients, this admission marked their first engagement with secondary mental health services and for around 50%, not only was a new diagnosis given during the admission, but there was no recorded history of any psychiatric diagnoses. Around 10% of patients were referred for management of delirium. Anxiety disorder accounted for the greatest proportion of diagnoses upon discharge, at 22%. There was much variability in the number of intensive care ward reviews carried out, ranging from one to over 10.

In 24%, self-harm led to presentation and 18% had comorbid substance misuse. Medication review was the single most common reason for referral in 13%, whereas requests for talking therapy and capacity assessments were 5% and 2% respectively. The vast majority of patients required a level of ongoing psychiatric input warranting community involvement or admission.

**Conclusion.** This cohort often required detailed work-ups, new diagnoses and a high level of subsequent psychiatric management following discharge from hospital. The wide age range of patients meant that both working age and older adult liaison teams were involved in assessing referrals. Consideration could be given to a specific intensive-care liaison service due to the workload and complexity of needs, as well as the increasing awareness of the need for family support and early inclusion both for their benefit and that of the patient, particularly when the proportion of new diagnoses in this cohort is considered.

### Clinical audit on possible causes of hospital initiated clinic cancellations and recommendation to improve the service

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**Aims.** The aim of this audit is to explore the possible causes of clinic cancellation in an inner city CMHT and the recommendation to reduce the burden.

**Background.** Cancellations of planned appointments have been a major and long-standing problem for healthcare organisations across the world. It represents a significant loss of revenue and waste of resources, have significant psychological, social and financial implications for patients and their families and represent a significant loss of training opportunities for trainees. Re-scheduling appointment is one of the major issues of inconvenience to the patients. It also increases workload for the patient appointment team.

**Method.** Data have been collected retrospectively from patient appointment booking team regarding clinic cancellation with causes of cancellation recorded in the system (01/07/2019–30/09/2019). The investigators have investigated if the cancellation has been made when it was absolutely necessary to cancel the clinic (Unavailability of doctors due to leave/on calls) and if patients have been informed at least 8 weeks prior to the appointed clinic as per trust protocol.

**Result.** Total number of 193 clinics were booked at the CMHT from July 2019 – September 2019. About 54% clinics were cancelled during the time period. The Clinic Cancellation rate was higher in September (68%) and was lowest in August (30.30%). As the month of July is the changeover period for trainees, the number of clinics booked during August was relatively less than normal. 72% clinics were cancelled by junior doctors and 28% clinics were cancelled by consultants at the CMHT. The major cause of clinic cancellation was unavailability of the junior doctors due to on call (31.58%) which was not communicated to the patient appointment booking team. Due to annual leave, 25% clinics were cancelled and 21% clinics were cancelled due to study leave. In both cases it is evident that, lack of communication between clinicians and patient appointment team are primarily responsible for hospital-initiated clinic cancellations. As per Patient Appointment booking team, around 50% cases, patients were informed 8 weeks in advance before cancelling the clinics.

**Conclusion.** This is evident from this audit that the number of hospital-initiated clinic cancellations can be reduced by improving communication between Patient Appointment booking service, Medical staffing department and clinicians. The findings of the audit have been shared locally with CMHT managers, clinicians and with the patient appointment booking team.

### Management of emotionally unstable personality disorder in an urban Irish setting

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**Aims.** To determine the prevalence of emotionally unstable personality disorder (EUPD) attending a community mental health team (CMHT) in a major Irish city

To describe the current psychiatric care afforded to this cohort of service user

**Method.** Clinical chart review of all 328 patients attending a CMHT outpatient in an urban setting was carried out. Patients diagnosed with EUPD or displayed features of EUPD were identified. Data on the various interventions offered to this cohort of service users were collected and compared against current guidelines.

**Result.** Out of the 328 patients actively attending the service, almost 17% ( $n = 55$ ) were diagnosed with EUPD and further 6% ( $n = 19$ ) were found to display features of EUPD such as emotional dysregulation, self-harming behaviour and cognitive distortions. Comorbid psychiatric disorder such as mood or anxiety spectrum disorder was diagnosed in 23% ( $n = 17$ ) of this cohort. Meanwhile, 8% ( $n = 6$ ) was diagnosed with addiction disorders and 5% ( $n = 4$ ) was diagnosed with a comorbid personality disorder. A significant proportion of 77% ( $n = 57$ ) were prescribed psychotropic medication with 51% ( $n = 29$ ) being on more than one psychotropic medication. Antidepressants, antipsychotics and hypnotics were the three most common medications prescribed at the rate of 89% ( $n = 51$ ), 30% ( $n = 17$ ) and 28% ( $n = 16$ ) respectively. A majority of 66% ( $n = 49$ ) were offered intervention from a multi-disciplinary team (MDT) member with 47% ( $n = 23$ ) being offered more than one type of intervention. Referrals to community mental health nurses and psychology service were the two most common interventions offered with a referral rate of 59% ( $n = 29$ ) and 55% ( $n = 27$ ) respectively. 28% ( $n = 21$ ) of service users with EUPD or EUPD traits has had at least one hospital admission while attending the CMHT and 46% ( $n = 34$ ) have been admitted to the day hospital at least once.

**Conclusion.** The prevalence of EUPD in our outpatient sample corresponds with findings in previous studies. Standard psychiatric care is the most common option available to the majority of general adult patients with EUPD in Ireland due to the lack of any national treatment programme and scarce availability of specialised therapeutic approaches such as dialectical behavioural therapy within community mental health teams. Our CMHT will attempt to integrate mentalization-based treatment into our outpatient management of EUPD patients taking into account current clinical guidelines for management of EUPD and resources needed for training and delivering the intervention.

### Evaluating appropriate use of nicotine replacement therapy on acute adult psychiatric units and adverse events related to smoking bans on wards

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**Aims.** To assess if patients are offered appropriate and adequate NRT (nicotine replacement therapy) upon admission to an acute adult inpatient ward.

To evaluate the number of adverse events occurring which are related to mandatory temporary abstinence from cigarette smoking on inpatient wards.

**Background.** Not all patients are able or willing to quit smoking when admitted to secondary care. In line with NICE Guidance, psychiatric inpatients should not be permitted to smoke inside the hospital building or outside on hospital grounds. NRT is

the most widely used smoking cessation aid. It aims to temporarily replace the nicotine from cigarettes to reduce motivation to smoke and nicotine withdrawal symptoms. NRT should be offered to patients who need support with nicotine withdrawal during an inpatient stay. Trust guidelines state nursing staff are able to administer NRT to patients on admission without prescription, reducing cravings and withdrawal symptoms such as agitation and anxiety which can lead to adverse events such as aggressive behaviour. Cravings may result in the patients self-discharging or absconding from the ward to smoke.

**Method.** A retrospective review of electronic records was conducted of all inpatients admitted to two acute adult units over a three month period (65 patients). Patients were identified as smokers or non-smokers. Search words used included: 'smoking', 'NRT', 'nicotine', 'cig' to search for relevant entries. Data collected included whether NRT was offered and given by nursing staff on admission and adverse events related to smoking.

**Result.** Data from 65 patient admissions were reviewed (31 males, 34 females, mean age 37 years). 37 (57%) patients were identified as smokers. NRT was offered and accepted by 17% of patients on admission and not recorded in 77% of admissions. NRT was declined when offered by 3% of patients.

Adverse events related to smoking occurred in 38% of 'smoking' patients. 40% of these adverse events occurred in first 72 hours of admission. Adverse events include verbal conflicts, physical aggression towards nursing staff and smoking in patient areas.

**Conclusion.** The majority of patients were not offered NRT on admission or this was not accurately documented in clinical notes. When offered NRT, a large proportion of patients accepted it demonstrating its acceptability amongst this patient group. There is a high rate of adverse events related to smoking on wards. More accurate documentation is required to ensure NRT is being sufficiently offered to patients to reduce possible withdrawal symptoms and adverse events.

### Evaluation of paediatric liaison psychiatry services in England 2015-2019

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**Aims.** Liaison psychiatry services (LPSs) provide psychiatric care to general medical patients. This paper aims to evaluate LPS provision for children and young people in England.

**Method.** The annual Liaison Psychiatry Surveys of England (LPSEs) included questions on paediatric services from 2015 (LPSE-2). Questions were developed in consultation with NHS England and the Liaison Faculty of the Royal College of Psychiatrists. We analysed data from LPSE-2 and three subsequent surveys.

LPSs were systematically identified by contacting all acute hospitals with Type 1 emergency departments listed by NHS England. All identified LPSs were emailed a copy of the questionnaire, with follow-up emails and telephone contact for non-responders. Responses by email, post or telephone were accepted.

**Result.** The number of acute hospitals with access to paediatric LPSs increased from 29 (16%) in 2015 to 46 (27%) in 2019; all of these hospitals had access to adult LPSs. The number of paediatric LPSs with at least 11 full time equivalent (FTE) mental