Transitional discussions to be made a regular agenda item at team meetings.

Care co-ordinator to be informed and reminded that transitional plans need to be explored with young people.

Following a re-audit of this data 6 months on 100% of cases over the age of 18 were closed and transition was discussed in the remaining 56%.

**Where is my sample? Investigating pre-analytical pathology sampling errors in a psychiatric hospital**

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**Aims.** Errors in the pathology sampling process can be costly for all stakeholders in any clinical setting; however, this process is often overlooked within psychiatry. Over the space of just a few short months at Hollins Park Psychiatric Hospital (HPH) such errors were reported to be numerous with staff raising multiple issues relating to the pathology sampling process. These issues often had a negative impact on patient care, leading to outcomes such as re-bleeding of patients and delays in interventions. Here, we aim to identify the predominant sources of error in this process and suggest possible improvements to minimise these errors in the future.

**Method.** Initially, we mapped and analysed each step of the sampling process as it is currently performed in order to identify areas of possible improvement. We then distributed questionnaires to all junior doctors - who are responsible for the handling of samples within the clinical setting – in order to establish error type and frequency. Questions also assessed individual confidence and familiarity with the sampling process.

**Result.** When mapping the sampling process, we identified all key steps required when sending samples from HPH to Warrington and Halton Hospitals laboratory. This included one pathway for sending routine bloods, and one pathway for urgent bloods. The process for sending routine bloods required more steps and ultimately took longer for samples to reach the laboratory – as expected. Of the issues identified during mapping of the pre-analytical phase, a majority of 77.7% of clinicians reported samples had gone missing or were unreported – with the reasons for this being undetermined in most cases – and 55.5% reported their samples never reached the lab. While on the whole participants were comfortable with the steps involved in sending samples to the laboratory, 77.7% were not aware of the requirement to log samples as they were being sent.

**Conclusion.** The reasons underlying errors in the sampling process at HPH were multifactorial and included a lack of clinician familiarity with correct procedure, poor sample recording/track- ing and lengthy transit times between the patient and laboratory. Here we outline some simple evidence-based recommendations (including education of staff and improved tracking through an electronic requesting system) to help reduce errors and streamline the sampling process in the hopes of improving both efficiency and accuracy, reducing the financial and clinical impact.

**High dose antipsychotic treatment monitoring audit**

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**Aims.** To quantify how many patients were prescribed high dose antipsychotic treatment (HDAT) and establish whether guidance for monitoring HDAT was being followed in an Assertive Outreach Team.

**Background.** Severe mental health disorders are associated with significant premature mortality, predominantly due to physical health conditions. Antipsychotic medications are associated with side effects, including metabolic syndrome and QT prolongation, which increase the risk of serious physical illness. HDAT is defined as when the total dose of antipsychotics prescribed exceeds 100% of the maximum BNF dose, if each dose is expressed a percentage of its maximum dose. There is limited evidence of clinical benefit with HDAT but an increased risk of side effects. Patients prescribed HDAT should therefore be monitored for side effects and clinical benefit. Sussex Partnership NHS Foundation Trust developed a form specifically for this purpose, to be completed in addition to a physical health assessment.

**Method.** All patients on caseload were audited using the electronic notes. Current inpatients were excluded, as inpatient HDAT monitoring forms are attached to paper drug charts and therefore not available for review.

**Result.** A total of 61 patients were audited. Nine were excluded due to being inpatients. 16 were on community treatment orders and 26 were prescribed a long-acting antipsychotic injection. 10 were prescribed clozapine. The median number of medications prescribed was one. Four patients were prescribed HDAT ranging from 117-150% of the maximum BNF dose. Of these, four, one had a HDAT form but this was out of date. 39 of 52 (75%) patients audited had had a physical health assessment in the past 12 months. Two of the 13 missing a physical health assessment were on HDAT.

**Conclusion.** Physical health monitoring should be carried out for all patients on antipsychotics, but is particularly important for patients on HDAT. This audit identified a problem in both general physical health checks and HDAT monitoring. On discussion with the multi-disciplinary team a number of barriers to appropriate physical health monitoring were identified. There was a lack of awareness within the multi-disciplinary team that patients were receiving HDAT and regarding the implications for side effects. A reliable system to highlight the need for physical health checks was also missing and the team did not have sufficient equipment to perform the necessary checks. Identifying these barriers should enable improvements in physical health and HDAT monitoring which can be re-audited.

**Psychiatric liaison team memory pathway: does it achieve the standards set out in NICE clinical guideline 97?**

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Foundation Trust; 9Nottinghamshire Healthcare NHS Foundation Trust;
10 Sheffield Health and Social Care NHS Foundation Trust;
11 Avon and Wiltshire Mental Health Partnership NHS Trust;
12 Hywel Dda University Health Board; 13 Humber Teaching NHS
Foundation Trust; 14 East London NHS Foundation Trust;
15 Cheshire and Wirral NHS Foundation Trust; 16 Birmingham
and Solihull Mental Health Foundation Trust; 17 Barnet, Enfield
and Haringey Mental Health Trust and University College London
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Aims. Early assessment, diagnosis and management for people
living with dementia is essential, both for the patient and their
carers. We recognised delays in established local pathways when
patients had unplanned acute hospital admissions preventing
them from attending memory diagnostic appointments. The
Psychiatric Liaison Team (PLT) Memory Pathway was introduced as
we had the skills and expertise to resume the process and to
find new undetected patients.

Our aim was to determine how well the newly implemented
PLT Memory Pathway follows the standards outlined in the
National Institute of Health & Care Excellence (NICE) Clinical
Guideline 97 (CG97): Assessment, management and support for
people living with dementia and their carers.

Method. A retrospective analysis of all PLT referrals from July
2018 to February 2020 (20 months) was performed to identify
patients on the community memory pathway and those with pos-
sible undetected cognitive impairment. Data were collected from
electronic patient records which included demographics, primary
and collateral history, cognitive testing and imaging, dementia
type among others. Results were analysed using Microsoft Excel.

Result. 41 patients were included (59% female). 80% of patients
were referred for memory problems or confusion. 63% had previ-
ous referrals to a memory service and was on the community
memory pathway at the time of the referral. 34% were on anti-
cholinergic medication but in only 14% were this documented
as reviewed. 100 % were offered and had head imaging. A finding
worthy of note was the absence of any from the ethnic minority
background. 63% of patients were given a memory diagnosis
and 34% had anti-dementia medication started. Patients’ families
were made aware of the diagnosis in 83% of cases, due to the
absence of next of kin details in the patient record. Primary
Care was made aware in 100% of cases; post-diagnostic support
was 100%.

Conclusion. The PLT is well placed to bridge the service gap
between the acute care trust and established community memory
services when dealing with patients with dementia. A dedicated
Memory Pathway has helped to close this gap and adherence to
NICE CG97 standards was good, but there is room for improve-
ment. A particular focus will be on improving documentation of
anticholinergic medication review and exploration for the absence
of ethnic minority patients. Aiming to achieve 100% family
involvement is also recommended.

This study has been submitted to the Royal College of
Psychiatrists’ Faculty of Old Age Annual Conference 2021.

Addiction service changes due to COVID-19
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Aims. Addictions services had to respond rapidly to reduce
COVID-19 transmission to protect patients and staff. Patients
with opioid dependence are particularly vulnerable, with high
risks. Our community addiction service changed practice in line
with COVID-19 guidelines. For patients with opioid dependence;
f ace-to-face contacts were initially reduce and mainly for new
starts, restarts and non-attenders. Prescribing changes were com-
pleted on an individually risk assessed basis to reduce attendance
at the chemist, specifically to reduce transmission, keep patients in
treatment and to ensure chemists could continue to function. We
document some of the service changes during the COVID-19
lockdown.

Method. Service evaluation had approval from Humber Teaching
NHS Foundation Trust. Data retrieved on one Hub of a commu-
nity addictions service in North England, UK. Patients prescribed
opioid substitution treatment for opioid dependence were
assessed, with data retrieval through electronic healthcare records.
Data were analysed by Microsoft Excel anonymously.

Result. In lockdown (March 2020 to June 2020), we identified 112
patients with opioid dependence prescribed opioid substitution
(OST) with methadone or buprenorphine at the Hub. All white
British, mean 42 years, most male (75%) and prescribed metha-
done (78%). Ten were new starts and 8 restarts to OST. Attendance
dates did not change: 91% before and 92% during
lockdown. Appointment format changed from predominantly
face-to-face (92%) to telephone (99%). Most patients (91; n = 88)
were offered take-home naloxone and overdose prevention
training of which 14 refused. Supervision days at the chemist
for OST reduced significantly from 75% collecting daily at the
chemist, reducing to 20% during lockdown. Five patients were
shielding and 7 had covid-related symptoms. There was one
death during lockdown which was not attributed to covid or
overdose.

Conclusion. The addictions service continued to be open and
work productively throughout lockdown, seeing new patients and
continuing treatment interventions safely. Major changes were
made in line with COVID-19 guidelines, to respond to the threat
of transmission. Our service was flexible and able to adapt quickly
to remote working. We maintained excellent attendance rates des-
pite changes to the format of consultations. There were no related
incidents e.g. overdoses linked to prescribed medications, despite
a reduction in supervision, and therefore patients having extra
medications. This important finding may be related to the indi-
vidual risk assessments that we conducted before making chang-
ing to prescribing. This was supported by most patients were
receiving naloxone to prevent overdoses. Some of the changes,
such as telephone consultations, may be beneficial to continue
post COVID-19.

Audit of methods used to contact the duty doctor - Abraham Cowley Unit
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Aims. The aim of this audit was to determine whether the duty
doctor of a 4 ward inpatient psychiatric unit is contacted safely,
effectively and in a manner that can be monitored. This is in
line with trust protocol and the method stated is via switchboard.
Should a deficit be found it was the aim to make an appropriate
intervention.