

Background. The majority of emphasis lies in ensuring the QTc interval is within range for our patients before initiation of psychotropic medication and as part of monitoring during the maintenance phase. The main dread for most psychiatrists is a prolonged QTc interval, however, a short QTc is equally important to identify and manage.

Method. A literature search was performed using the key words “QTc, psychotropics, and ECG”. Results revealed extensive data on long QTc, but very few articles on prescribing psychotropics and short QTc. Most psychotropics are known to prolong QTc interval, which is what clinicians are worried about most when deciding to prescribe medications in mental health services. However, short QTc is also an equally important ECG finding which should not be ignored. We conducted a survey amongst core trainees in the South Yorkshire training scheme to gauge trainees’ knowledge of QTc and its implications when prescribing psychotropic medications. The survey was designed with SurveyMonkey and had seven questions to keep it user friendly.

Result. The survey was distributed to 47 core trainees working in the South Yorkshire region with a response rate of 42.5%. CT1s comprised 30%, CT2s comprised 40% and CT3s comprised 30% of the total number of responders. 60% trainees reported performing and reviewing ECGs as an integral part of their jobs. 50% trainees believed both a short and long QTc interval were life threatening with 50% considering only long QTc as being fatal. 95% of the responders reported not knowing any medications causing QTc shortening; however 100% reported knowing medications causing QTc prolongation.

Conclusion. The results clearly show that we need to increase awareness regarding short QTc interval and its implications on patient health. Review of literature also highlights the challenges in treating patients with QTc abnormalities. In such situations, it’s advised to seek advice from Cardiology colleagues to ensure safe and effective patient care. It would also be beneficial to arrange refresher workshops to help psychiatrists brush on their ECG skills.

The blues, and an almost shocking surprise – Unexpected PE in a catatonic patient, that almost had ECT

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doi: 10.1192/bjo.2021.373

Aims. To present a case of a near-miss, where an unexpected Pulmonary Embolism (PE) was identified in a patient with psychotic depression and catatonia, who almost had Electroconvulsive Therapy (ECT). Our aim is to highlight the importance of Venous-Thrombo Embolism (VTE) risk assessment in all psychiatric inpatients, particularly those with catatonia, and those about to undergo ECT.

Method. A 53-year-old female admitted with her first presentation of psychotic depression, catatonia, poor oral intake, and significant weight loss in the community for months prior to admission. She was recommended for emergency ECT as the severity of her self-neglect was becoming life threatening. Her first ECT session was cancelled due to low potassium levels prior to ECT, which proved to be a fortunate event. She developed sudden onset chest pain the next day, and following further medical investigations; was diagnosed to have a bilateral PE, and subsequently treated with Apixaban. Due to the potential risk of ECT dislodging the clots, treatment was done by optimising medication alone; Venlafaxine 300 mg, Mirtazapine 45 mg, Haloperidol 6 mg. She made a slow

but successful recovery, and was discharged home, with ongoing support from Early Intervention in Psychosis services.

Result. We conducted a literature search, and it is well known that there is an increased risk of VTE in catatonic patients, as well as other psychiatric inpatients; due to anti-psychotic medication. Furthermore, cases have been reported where ECT was associated with increased risk of death in patients with known VTE/PE.

On retrospective review of the patient’s risks of developing VTE in the community, it was clear, that she was at very high risk of developing VTE. It was also noted that she should have had a VTE risk assessment on admission, in accordance with NICE guidelines; where all acute psychiatric inpatients should have this assessed as soon as possible.

Conclusion. Through a process of assessment and treatment, VTE is often preventable. Identification of high-risk patients on admission to hospital is therefore crucial. It is thus, imperative that a comprehensive VTE risk assessment is completed on admission and regularly reviewed.

This case highlights the risk of missing VTE assessments in WAA Inpatients, particularly those with catatonia, about to undergo ECT, which could have been fatal. As such, VTE/PE risk assessment in such patients, about to undergo ECT, is particularly crucial.

Clinicians need to have a high index of suspicion of VTE/PE, particularly in patients with catatonia.

An enquiry into my use of supervised clinical assessments in the supervision of junior trainees

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doi: 10.1192/bjo.2021.374

Aims. As a particular example of action research, to enquire into my use of Assessments of Clinical Expertise in my supervision of junior trainees, with the intention of further developing my own practice as an educator.

Background. Work-Place Based Assessments (WPBAs) play an established role currently in the assessment of trainee doctors (tenCate, 2017). In psychiatry, supervised clinical assessments (ACE/mini-ACE) assess a trainee’s proficiency in various areas. As part of my PGCert in Medical Education, I was inspired to examine how I conduct and utilise this form of assessment, and indeed the underpinning values and beliefs, about learning, and developing professional wisdom.

Method. This enquiry was situated within the interpretivist tradition. I interrogated my views about the epistemology of knowledge, and how they had changed from pre-university. I made clear my influences from Coles (Fish & Coles, 1998) on professional practice. I investigated my values in performing an assessment, comparing them to those of the wider community. I examined the literature on the validity of this as a tool. I then performed an assessment of a junior, with a consultant observing, before interviewing them separately.

Result. There has been a paradigm shift in how I view assessments, from pre-university in Singapore, to medical training in the UK. The history of WPBAs and the values espoused is intriguing. Consultants and experts may view assessments differently from trainees, but a core value of developing professional judgement is common.

In my interview with the consultant, there were themes around having a clear focus for an assessment, and provision of feedback; the rating scales and how they used them to stimulate feedback; and our shared values in performing an assessment. With the junior, the themes were around the delivery of feedback (including non-verbal), an

appreciation of my encouraging self-reflection and understanding, and the observable values in my carrying out of the assessment, which could be compared to those of other assessors.

Conclusion. WPBAs have their merits, and shortfalls. I am aware of my values and beliefs when utilising them, and have identified a plan to further develop my own practice. This case study is particular, but possibly not unique, in how WPBAs are used in medical education.

SW Neuronet – neuroscience for psychiatrists update day

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doi: 10.1192/bjo.2021.375

Aims. The Royal College of Psychiatrists Neuroscience Project was established to promote greater integration of modern neuroscience into psychiatric training and practice. Regional “Neuronets” are being established to develop local learning opportunities. As the Southwest Neuronet, we sought to establish a high quality and sustainable regional educational event promoting modern neuroscience in psychiatry.

Method. We developed and ran two events in collaboration with the Neuroscience Project, a whole day in-person event in September 2019 and a half day online event in January 2021. Attendees were invited from the Southwest with the latter event being shared more widely through other “Neuronets”. Both featured talks by leading experts in the neuroscience of psychiatry. The first was themed around “Neuroscience from the lab to the clinic”, building on basic research methodologies to their applications in clinical psychiatry. Our pandemic era online event, “Neuroscience of psychosis”, was structured around an evolving clinical case. Both featured interactive elements using audience polling technology to gather views and collate questions. Feedback was gathered through an online survey with individual session ratings and event ratings.

Result. 154 people attended the in-person event from across the South West Division. This included psychiatry trainees, consultants and a small number of other mental health professionals. 382 people signed up to our online event with 262 attending live and others watching recorded sessions. Feedback response rates were 42% and 33% respectively. Feedback on the practical arrangements was highly positive, particularly highlighting pre-event communication. Attendees valued the high calibre of speakers and particularly rated topics of psychiatric genetics, novel antidepressants, and autoimmune psychosis. Environmental sustainability was a prominent theme in our first event with support for our paperless approach but highlighted further potential to reduce waste associated with catering. Overall, attendees valued the opportunity to build on knowledge of basic research techniques but also wished to see greater focus on clinical applications of neuroscience, which we had responded to with the inclusion of a clinical case to frame our online event.

Conclusion. These events provide a prototype for low-cost regional neuroscience in psychiatry education events, in-person or online. Sustainability in terms of cost, human resources for organisation, and environmental impact are all important considerations for such events. We plan to continue to run these annually, forming part of the legacy of the Neuroscience Project. In line with feedback received, we seek to maximise the clinical relevance but also share novel research techniques encountered in the literature.

Evaluating adult forensic staff knowledge of olanzapine long-acting injection post injection syndrome: a service improvement project

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doi: 10.1192/bjo.2021.376

Aims. Post injection syndrome (PIS) is a serious complication that can occur after Olanzapine Long Acting Injection (LAI). It can occur without any derangement in physical observations. It is important that patients are monitored appropriately following administration of Olanzapine LAI to ensure that symptoms of PIS are appropriately identified and managed. This project aimed to evaluate the current level of knowledge about PIS in two staff groups within an Adult Forensic Service – in-patient nursing staff and junior doctors and advanced practitioners (APs) providing medical cover to inpatient wards.

Method. Electronic surveys evaluating knowledge about the symptoms of PIS, monitoring requirements and management of possible PIS were circulated to inpatient nursing staff, junior doctors and APs working within an Adult Forensic Service in the North West of England.

Result. 1) Nursing staff knowledge – 26 nursing staff completed the survey. 4.5% of nurses correctly identified all symptoms of PIS and 72.7% believed that tachycardia or hypotension occur in PIS. 22.7% of nurses identified the correct management plan if a patient feels unwell following Olanzapine LAI. 40.9% would only request a medical review if physical observations were abnormal. 2) Junior doctor and AP knowledge – 6 doctors and 6 advanced practitioners completed the survey. 17% of doctors and APs correctly identified all symptoms of PIS. 50% believed hypotension or tachycardia were symptoms of PIS. 25% of doctors and APs identified correct management of PIS and 16.7% believed that the patient should be managed on the psychiatric ward unless physical observations became abnormal.

Conclusion. Levels of knowledge about the symptoms and management of PIS are low within this Adult Forensic Service. Knowledge of PIS and management of suspected PIS needs to be improved in nursing staff, junior doctors and advanced practitioners to ensure correct identification and safe management. In response to these findings, a care plan for monitoring of patients after Olanzapine LAI was developed. This included a structured monitoring proforma for completion post depot administration and instructions for managing suspected PIS. This care plan is kept in the front of the drug chart of all patients prescribed Olanzapine LAI. One-page educational summaries on PIS were written and circulated to nursing staff, junior doctors and APs. Information on Olanzapine LAI use and PIS were included in junior doctor induction materials and on-call handbook, to improve trainee awareness and knowledge.

Supporting general adult psychiatry higher trainees to develop research competencies: a training improvement project

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doi: 10.1192/bjo.2021.377