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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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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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