

avenues need to be sought to ensure prompt treatment and prevent relapse.

A CTO suite designed for recall could be the solution for the future.

Overdose admissions to a district general hospital intensive care unit

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Aims. This audit aimed to analyse the patient population coming into East Surrey Hospital's Intensive Care Unit from 1993 to 2019.

Background. The Office for National Statistics (ONS) published a report in August 2019 on ages most likely to die by suicide and drug poisoning. Their data showed that Generation X were dying by this method in greater numbers than other age groups. This is in contrast with data from 1990s for England and Wales which showed people in their 20s were most likely to die by suicide or poisoning. This audit set out to look at admission data from an intensive care unit (ICU) in a district general hospital in Surrey over a similar period of time.

Method. Patient records from 1993 to September 2019 were accessed using the WardWatcher database. To access the maximum number of admissions qualifying under the aims, the database was accessed by searching under "admission comments" for: overdose, self-harm, poison, suicide. These reports were downloaded and the lists were checked against each other to delete duplicates. This gave a total of 331 patients. The data were analysed by year, according to age, gender, season, psychiatric diagnoses and previous overdose attempts. Their outcomes were checked against recorded deaths. There was not enough information to investigate method of overdose.

Result. A total of 331 patient records were accessed. The youngest patient was 15 years old, the oldest was 84 years old. The age dataset was non-parametrically distributed with the median age of 43 years (IQR 33–51 years). The age distributions for each year appeared symmetrical but total numbers for each year were small. The population was split as 191 female (58%) and 141 male (42%). 16 patients died on the ICU on admission with an overdose, 5% of total numbers, of which 19% had a previous overdose attempts and 44% had a psychiatric diagnosis. The youngest death was 22 and the oldest was 81 years old. The average age was 47 years, with the spread consistent in the 2000s and 2010s.

Conclusion. The results from East Surrey Hospital's ICU do not reflect the analysis from the ONS. The mean age for each year has remained similar. Numbers for the audit were small and admission criteria to the ICU prescribe that the patient be critically unwell and may not be indicative of the total admissions to a district general hospital.

Neuroimaging in an older adult inpatient psychiatric unit

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Aims. This audit aimed to analyse the use of neuroimaging and its effect on treatment in an older adult inpatient psychiatry unit over the period of one year.

Background. Brain imaging can be used as a diagnostic tool in psychiatry. According to NICE guidelines, structural imaging, such as magnetic resonance imaging (MRI) or computed tomography (CT), can be used in the workup for dementia diagnosis in order to exclude non-dementia pathology and identify dementia subtype. This is important in the geriatric population where evidence of small vessel disease has an impact on treatment options and management of polypharmacy.

Method. A list of patients from the past year (January to December 2019) was accessed. Patient records were then analysed to see if neuroimaging had been accessed during their admission at The Meadows Hospital, Surrey and Borders Partnership. This included imaging from prior to admission. Analysis was divided into type of imaging, comments and impact on diagnosis.

Result. Overall numbers for the audit were small. A total of 74 patients were admitted onto the unit, of which 3 were readmissions. There was missing information for 8 patients, giving a total of 63 patients. CT scans were accessed for 35 patients (56% of total); 3 of these were done during the admission. MRI scans were completed for 21 patients (33%), with one requested during admission. A total of 9 patients (14%) had both CT and MRI scans. Neuroimaging results led to a change in diagnosis for 6 patients (10%). In all cases this reflected the finding of small vessel disease and a change of diagnosis to either vascular dementia or mixed dementia.

Diagnoses were also analysed. The Meadows Hospital has 2 dementia wards (male and female) and 1 functional ward (for females). A total of 36 patients (57%) were diagnosed with dementia, of which the biggest groups were: Alzheimer's dementia (13 patients, 36%) and Vascular dementia (11 patients, 31%). **Conclusion.** The majority of the patients were admitted with established diagnoses and so only a small number had changes made following review of imaging. Good imaging results and reports help to differentiate types of dementia. Although neuroimaging is not gold standard in diagnosing dementia syndromes, it is now an important aspect in the diagnostic pathway. Getting the diagnosis correct will help with treating individuals appropriately and avoid unnecessary prescribing.

Implementation of smoking cessation policy at the antelope house in Southern Health NHS Foundation Trust in Southampton

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Aims. To ensure that health care practitioners at Antelope house, Southern Health NHS Foundation Trust in Southampton are providing service users information, advice and stop smoking support in line with smoke free policies in the trust.

Background. Smoking is the single largest preventable cause of ill health and premature death in England. Cigarette smoking causes a wide range of diseases and medical conditions like cancers, heart diseases and stroke.

The prevalence of stroke is extremely high among people with mental health problems especially those admitted to hospital.

Stopping smoking reduces the risk of developing preventable diseases and premature death.

These are the background behind this audit.

Method. Data were collected using the following ways:

Use of desinged questionnaire.

Looking into Rio electronic records

Standard used and compared against was Southern Health NHS Foundation Trust " smoke free trust policies"

20 cases were looked into and examined.

Result. Most staff are not implementing the Trust no smoking policies well and documentation of the informtion given are not complete.

Most service users prefer to use e-cigarettes.

Most people between 30 and 50 years old range do not smoke.

For those of clozapine, the impact of cigarettes smoking not explained.

Conclusion. The trust smoke free policies are not well implemented by health care practitioners at Antelope house mental health unit, Southern Health NHS Foundation Trust in Southampton.

End of life care in a secure hospital setting

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Aims. To measure the standard of care provided to patients who had a natural and expected death whilst in secure care at Roseberry Park Hospital, Middlesbrough.

Mallard ward is a low secure psychiatric ward for older aged men suffering from cognitive difficulties and significant physical comorbidity in addition to a severe and enduring mental illness. The patient population is such that it will remain the most appropriate placement for some patients until their death. It is vital that staff members on Mallard ward and indeed all parts of the Trust are aware of the priorities for care of the dying person and ensure that care is provided in accordance with these priorities.

The Leadership Alliance for the Care of Dying People (LACDP), a coalition of 21 national organisations, published One Chance to get it Right – Improving people's experience of care in the last few days and hours of life in June 2014. This document laid out five priorities for care of the dying person focussing on sensitive communication, involvement of the person and relevant others in decisions and compassionately delivering an individualised care plan.

Method. The data collection tool was adapted from End of Life Care Audit: Dying in Hospital, a national clinical audit commissioned by Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. Data were collected from both electronic and paper records. There were three natural and expected deaths in the last two years.

Result. For all three patients, there was documented evidence that they were likely to die in the coming hours or days.

End of life care discussion was held with the nominated persons and not with the patients due to their lack of mental capacity.

The needs of the patients and their nominated persons were explored in all three cases.

All patients had an individualised care plan which was followed.

The palliative care team supported the staff with the care of these patients.

The care provided was largely consistent with the priorities listed.

Conclusion. The national audit compares performance of only acute NHS Trusts with no data to reflect the performance of mental health hospitals. It is imperative that mental health services work in collaboration with physical health and palliative care services so they are able to continue providing a high level of care to

this patient group. Clinicians and staff involved in the care of dying patients also need to be adequately trained.

Before writing that script: use of antipsychotic medication in patients with dementia in a CMHTOA

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Aims. A 2009 independent review commissioned by the UK government to review the use of antipsychotic medication in patients diagnosed with dementia produced the Time for Action report, often referred to as the Banerjee Report. It highlighted the common practise of using antipsychotics in the treatment of Behavioural and Psychological Symptoms of Dementia (BPSD) and the clinical issues this could raise especially when these medications were not being regularly reviewed. The audit was therefore carried out to determine whether patients with BPSD in a Community Mental Health Team for Older adults (CMHTOA) in Mid Surrey, who had been diagnosed with BPSD, were being adequately assessed and managed in line with the current guidelines.

Method. Patients with a diagnosis of dementia open to one of three teams in the CMHTOA during the months of October and November 2019 were identified, those being prescribed antipsychotic medication were selected and data from their electronic records collected and analysed to determine if clinicians: a) identified and documented the target behaviours, b) carried out a structured assessment using an ABC chart before commencing medication, c) reviewed the antipsychotic medication 6 weeks after it was commenced.

Result. Of the 87 patients with a diagnosis of Dementia from October to November 2019, 18 were on antipsychotic medication. 100% of these had target behaviours identified and clearly documented, a sixth had a structured assessment prior to starting medication and 61% had been reviewed after the first 6 weeks of starting antipsychotics.

Conclusion. The findings showed that a good proportion of patients did not have the required structured assessment before commencement of treatment and that more needed to be done by way of improving regular reviews after antipsychotic treatment is commenced.

Perinatal mental health outcome measures in a mother and baby unit

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Aims. To Audit Perinatal outcome measures and understand better the population served in order to improve care and understand risks. Our audit standards included: paired HoNOS and PBQ recorded on admission and discharge as well as ASQ scores prior to admission.

Method. Health of the Nation Outcome Scales (HoNOS), Postpartum Bonding Questionnaire (PBQ) and Ages and Stages Questionnaires (ASQ) were recorded on Lorenzo and SystmOne. Scores were collected over 20 months within the same MBU and these were analyzed.