

Women of childbearing age were deemed to be those between the ages of 15 and 45, based on the World Health Organization's definition. However, the sample for this audit includes females aged 18–45 years due to the minimum age restrictions of the ward.

All eligible female inpatients had their physical health forms and progress notes screened for documentation of whether a) the possibility of them being pregnant was explored b) if a pregnancy test was done and c) if a contraceptive history was taken.

Result. Only 57% of female patients admitted during this period were asked about their contraceptive habits. Furthermore, exploration into the possibility of pregnancy occurred in less than half of admitted patients.

Further analysis was done by age; 18–26, 27–35 and 36–45, but showed minimal variation.

Conclusion. This audit revealed that Royal College of Psychiatrists and local guidelines are not being met, with women not receiving the recommended assessment and counseling in regard to pregnancy and contraception.

Inpatient admissions provide a valuable opportunity for identifying and preventing potential harm in the case of unplanned and undetected pregnancies. All health care professionals need to be aware of the importance of asking the above questions and ensure they are explored at some point during a patient's admission.

The audit will be discussed at forthcoming Clinical Governance meeting for further recommendations followed by re-audit.

It's a risky business: use of the QCovid risk calculator in a psychiatric rehabilitation population to enhance prevention

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Aims. Serious mental illness (SMI) is now accepted as a significant risk factor for contracting COVID-19, increasing the rates of adverse outcomes, including hospitalisation and mortality. Risk assessments are the cornerstone of protecting vulnerable groups of individuals. The QCovid risk calculator is a newly developed tool to predict the risk of death or hospitalisation from COVID-19. It has not been applied in SMI populations. We aimed to use the QCovid risk calculator in an inpatient rehabilitation setting to identify and mitigate risk for people with SMI with personalised COVID-19 prevention plans.

Method. Clinical and sociodemographic characteristics were obtained for 22 inpatients. Firstly, the QCovid risk calculator was used to ascertain the absolute and relative risks to patients (Odds Ratios (OR) of mortality and/or hospitalisation) from COVID-19. Patients were stratified as high ($OR > 10$), moderate ($OR 5-10$) and low ($OR < 5$) risk. Secondly, personalised COVID-19 prevention plans were coproduced by patients and clinicians addressing 1) risk factors contributing to increased QCovid risk, 2) patient's personal goals, concerns, and preferences 3) maximizing patient engagement in COVID-19 infection prevention strategies. Finally, uptake of personalised COVID-19 prevention plans was evaluated after four weeks using a customised patient feedback questionnaire.

Result. Of the 22 inpatients (68% male), 14 patients (64%) had schizophrenia and 3 patients (14%) had schizoaffective disorder as primary diagnosis. 13 (59%) patients were prescribed clozapine. QCovid risk stratification showed 10% of patients as high

risk, 29% as moderate risk, and 61% as low risk. Apart from SMI in all 22 inpatients, the most common QCovid risk factors were increased body mass index (64%, $n = 14$; 23% overweight and 41% obese), diabetes mellitus type 1 or 2 (27%, $n = 6$) and epilepsy ($n = 4$, 18%). 19 of the 22 patients provided feedback on their personalised COVID-19 prevention plans. Most patients (79%) felt they had "contributed significantly" to their COVID-19 prevention plans, and their individual goals and concerns were valued. 79% were "satisfied" with their COVID-19 prevention plans. Subjective perception of safety from COVID-19 was high, with 95% of patients feeling "safe and well-protected from COVID-19".

Conclusion. Comprehensive assessment of COVID-19 risks in vulnerable groups enables personalised risk mitigation, both at an individual and service level. Our findings show the importance of applying current knowledge to protect vulnerable patients with SMI through personalised prevention plans. This approach can be scaled up to understand risks for services and teams, while allowing clinicians to adapt their use for individualised COVID-19 prevention.

The impact of the COVID-19 pandemic on referrals to liaison psychiatry services at University Hospital Hairmyres, NHS Lanarkshire

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Aims. The COVID-19 pandemic has led to sweeping public health restrictions with predictable impact on mental health. In Scotland, lockdown measures during the first wave of the pandemic commenced on 23rd March 2020 and only began to ease after 29th May 2020. The aim of this study was to evaluate the impact of the first wave of the COVID-19 pandemic on the number and type of referrals made to the adult psychiatric liaison nursing service (PLNS) at University Hospital Hairmyres, NHS Lanarkshire.

Method. We collated all of the archived referrals made by our local emergency department to the PLNS at University Hospital Hairmyres for adults (aged 18–65 years) during the period of the first COVID-19 national lockdown (April–July 2020) and the corresponding period one-year prior (April–July 2019) to analyse differences in referral numbers and demographics. Additionally, for referrals made during 2020, we conducted a qualitative review of electronic records to determine the reason for referral, contributory stressors to presentation, and in particular any effect from COVID-19.

Result. A total of 549 referrals were made over the study period, with 320 in 2019 and 229 in 2020, a decrease of almost 30%. In 2019, referrals fell each month from April ($n = 89$) to July ($n = 74$), while this trend was reversed in 2020, rising from April ($n = 45$) to near-usual levels by July ($n = 68$). Compared to baseline, referrals in April 2020 were for a higher proportion of men (62.2%). On qualitative analysis, 26 records (11.3%) could not be found. Otherwise, the most common reasons for referral were suicidal ideation (43.3%) and/or deliberate self-harm (39.9%). Many patients presented with comorbid substance misuse (54.2%) and the majority were not known to community services (64.5%). COVID-19 was implicated in 48 referrals (23.6%), but only 2 of these arose as a direct result of infection.

Conclusion. We have observed clear differences in the pattern of referrals made to the adult PLNS during the first COVID-19 national lockdown. COVID-19 was implicated in a minority of referrals, but most were related to secondary effects of lockdown restrictions rather than COVID-19 infection. Possible reasons for fewer referrals during this time could be non-presentation through fears of contracting COVID-19 or altruistic avoidance of putting “pressure on the NHS”. Further studies would be insightful; in particular, equivalent analysis of contacts with community services; and qualitative patient perspectives regarding reasons for non-presentation during this time.

Longterm cognitive dysfunction in paediatric brain tumour survivors - the need for multifactorial risk screening

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Aims. Identify common risk factors for longterm cognitive dysfunction in PBTS (paediatric brain tumour survivors) Examine how various paediatric cancer treatment modalities affect cognitive outcomes Consider baseline features which may increase the risk of cognitive dysfunction in PBTS

Method. Current research into the neuropsychiatric sequelae of childhood brain tumours is limited, therefore review of the literature was conducted to identify research within this field.

Databases

Google Scholar - papers accessed via the University of Brighton or Sussex online library

NICE HDAS - HMIC, AMED, MEDLINE, BNI, PsycINFO, CINAHL, Pubmed, EMBASE & EMCARE

Mendeley reference manager - papers for background reading
Search terms

PICO(T) method - Population (Cancer Survivors), Intervention (Cancer Treatment), Comparison (Brain tumour), Outcome (Cognitive dysfunction) & Time (Childhood & adolescence) Boolean operators (AND/OR), truncation and wildcard search functions were also utilised.

Inclusion criteria; no limits on date, study type or gender, however, study results were limited by age - as the research focus was restricted to children and adolescents.

Excluded results; papers which did not meet inclusion criteria, duplicate studies, studies measuring non-cognitive cancer outcomes or investigating non-cortical tumours, non-English language studies with no available English translations.

Result. Common risk factors - certain tumour types (glioneuronal tumours or gliomas) or inner cortical tumour sites e.g. were more vulnerable to epileptogenesis. In particular, seizures which were prolonged and treatment-resistant were associated with a greater degree of cognitive dysfunction.

Impact of various cancer treatment modalities - overall results understandably suggested that patients are more likely to develop cognitive deficits following brain tumour treatment. In particular, partial tumour resection (especially if epileptogenic), whole-brain irradiation, cranial radiotherapy and chemotherapy were more likely to impact cognitive function.

Baseline features that may increase likelihood of cognitive dysfunction e.g. intellectual disability or education level were not noted in the reviewed literature.

Conclusion. Cancer is one of the leading causes of global child mortality, and younger populations often present to paediatric oncology services with brain tumour involvement. Current

childhood brain tumour research has begun to recognise that many young survivors develop into adulthood with cognitive sequelae impacting quality of life measures. However, existing evidence is also limited and requires further research to produce a standardised clinical tool for screening various risk factors which may increase longterm risk of cognitive dysfunction and subsequent difficulties with daily life.

Sexual and reproductive health needs assessment & interventions in a female psychiatric intensive care unit

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Aims. To assess the sexual and reproductive health (SRH) needs of women admitted to a psychiatric intensive care unit (PICU), and acceptability of delivering specialist SRH assessments/interventions in this setting. Secondary aims were to explore the barriers to access and the feasibility of providing SRH assessments and interventions in the PICU.

Method. A retrospective analysis of fifteen months' activity data found that only 25 SRH referrals had been made across 205 PICU admissions. This low referral rate of 12% likely reflected pathway barriers and was unlikely to represent the actual clinical need in female PICU patients. A bi-monthly SRH in-reach clinic and a nurse led SRH referral pathway were implemented on the PICU over a seven-month period. Within a quality improvement framework, a staff training needs assessment was performed, training delivered, a protocol developed, staff attitudes explored, and patient and carer engagement sought.

Result. A quality improvement approach streamlined SRH assessments on the PICU and resulted in 42% of women being assessed and a 3.5-fold increase in uptake. At least 30% of the women in the PICU had unmet SRH needs identified and proceeded to a specialist appointment. This amounts to a minimum 2.5-fold increase in SRH unmet need detection.

The most common SRH needs were complex gynaecological issues (such as period problems, pelvic pain, vaginal discharge), STI advice/testing and contraception advice/options. 21% of women initiated SRH interventions, and 14% completed all the interventions required for their needs. The most common interventions were in the areas of contraception advice/family planning and STI advice/testing.

Staff confidence on assessing SRH topics was identified as a barrier to access with a positive shift noted after bespoke SRH training was implemented and a protocol introduced: on a scale of 0-10 (with 10 being high), 81.3% of staff rated their confidence 8 or above in relation to discussing contraception/sexually transmitted infections (pre-training: 25.0%), and 93.8% in relation to discussing risky behaviours (pre-training: 18.8%). All 11 patient and carer participants felt it was important to have a forum to talk about SRH and 8 (72.7%) agreed it was important in the PICU.

Conclusion. Results identify that SRH needs for PICU admissions are greater than previously realised. Staff highlighted the acceptability and importance of SRH care, if interventions are appropriately timed and the patient's individual risk profile considered.