

- >80 years
- History of low sodium
- AKI during admission
- Relevant comorbidities (see above)
- >1 antidepressant
- Other meds that can cause hyponatraemia
- More frequent monitoring for all those with with multiple risk factors AND who are starting/increasing antidepressant:
 - baseline sodium plus repeat after 2 and 4 weeks
 - Communicate to GP the need for 3-monthly sodium monitoring for those with above risk factors
 - Re-audit in 6-12 months' time

Audit on antipsychotic prescribing in children and young people with a learning disability under the care of mental health services in Surrey

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Aims. To check the extent to which National Institute of Clinical Excellence (NICE) guidelines were being followed in clinical practice with regards to prescribing antipsychotic medication to Child and Adolescent Mental Health Services (CAMHS) patients with a diagnosed learning disability (LD).

Method. A data collection tool (based on a similar Royal College of Psychiatrists [RCPsych] audit) was filled out with retrospective data from patients' clinical records, then analysed using Microsoft Excel and Microsoft Powerpoint.

The agreed standards were the NICE guidelines.

There were no ethical issues as the data were retrospective and anonymised.

Sample size was 13, comprising 7 males and 6 females.

All service users were less than 18 years of age.

Result. 7 out of the 13 patients who were prescribed antipsychotics had a Severe/Profound LD.

Among the 5 patients who had been prescribed antipsychotic medication, 4 were on Risperidone and 2 were on Aripiprazole. The reasons for starting antipsychotic medication were clearly documented for all 5, the most common reasons being overt aggressive behaviour and general agitation/anxiety.

Only 1 patient had antipsychotic medication initiated in the previous 12 months. NICE guidelines had been generally followed for the management of this case, with good documented evidence.

For the other 4 patients, in whom antipsychotic medication was initiated more than 12 months ago, there was a lack of documentation of the subsequent assessment of side effects, extrapyramidal side effects, body weight, blood pressure, glycaemic control and lipid profile. 1 of these patients did not have a documented review of antipsychotic medication in the previous 6 months. For the other 3 patients, their medication reviews did not consider whether to reduce the dose or stop antipsychotic medication.

1 patient had been transferred to primary care, with a clear transfer of prescribing responsibility and documented evidence that written guidance was provided to primary care which addressed all the necessary management details.

Conclusion. Although there was clear documentation of reasons for initiating antipsychotics, there appeared to be a lack of awareness of NICE guidelines for antipsychotic medication

reviews, side effect and metabolic markers assessment, and their documentation. This is an area for potential change in practice to conform better to national guidelines and improve patient care.

Baseline ECGs done in memory clinics in Leicestershire

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Aims. To ascertain the compliance of the Mental Health Service of Older People (MHSOP) memory clinics in obtaining ECGs, based on the agreed criteria.

Background. Cholinesterase inhibitors are a main pharmacological treatment for Alzheimer's dementia (AD). These drugs may worsen pre-existing cardiac conditions or cause significant cardiac side effects. A baseline ECG can be beneficial before starting patients on these medications. Previously in Leicestershire, all memory clinic patients were receiving routine ECGs. However, new standards were set based on the NICE guidelines and criteria outlined in other regions, to reduce the use of this time consuming and expensive investigation for patients who may not require it.

Method. A total of 120 patients attending memory clinics in Leicestershire over a 6 month period (April to September 2019), were randomly selected and their electronic records retrospectively reviewed. The data collection tool was designed to encompass the key aspects of the criteria for obtaining an ECG for those attending the memory clinic. The information was analysed using Microsoft Excel.

Result. Of the 120 patients, 23 (19.2%) were diagnosed with AD, 10 (8.33%) with mixed and 19 (15.8%) with vascular dementia. 68 (56.7%) had a diagnosis of "other" which included mild cognitive impairment or diagnosis still under investigation. 0 patients were diagnosed with Lewy Body Dementia or Parkinson's dementia. Of the total number of patients, only 10 had an ECG done, 2 with a diagnosis of AD, 1 with mixed dementia, 1 with vascular dementia and 6 "other". The 10 ECGs done were all requested by nursing staff.

Although 27 (22.5%) patients were identified to have a diagnosis of AD or mixed dementia, plus at least one of the criteria for an ECG, only 6 (22.2%) were discussed with the Multi-Disciplinary Team (MDT) following which only 3 of the 27 patients (11.1%) had an ECG

Conclusion. Despite having clear criteria for requesting an ECG for those attending the memory clinic, compliance over the 6 month period was low. The following recommendations may be useful in improving compliance:

Displaying the ECG algorithm in the memory service clinic rooms.

Raise awareness amongst memory service clinicians of the criteria for requesting ECGs.

"Are they medically fit?" - clinical audit on the physical assessment of mental health patients in A&E

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Aims. A&E departments are busy places; with quick triage decisions required to prioritise urgent care to those who need it. This requires the use of predictions based on past experiences and probabilities. However, this runs the risk of patients being categorised by the prejudices and stigmas associated with their conditions; particularly in the case of mental health patients and the assumption they are otherwise 'medically fit'. This is especially of concern when considering that mental health often deteriorates during acute physical illness.

Following a number of dangerous 'near misses', this audit was conducted to review the practice of triage and physical assessment of patients presenting to A&E with mental health symptoms. The aim was to compare practice against the Royal College of Emergency Medicine (RCEM) guidelines, to identify repeated issues and systemic vulnerabilities which endangered patients through a lack of appropriate assessment.

Method. Using the online Electronic Patient Record (EPR) system, the notes of 100 patients referred to the Bolton Mental Health Liaison Team (MHLT) from Bolton A&E were reviewed. They were assessed for whether or not the patients had been appropriately physically assessed, according to the RCEM guidelines, before being referred to the MHLT. These results were analysed anonymously.

Result. The findings showed that less than half (44%) of all referred patients had physical observations taken at all, and even fewer (37%) received the full, physical assessment before referral. Out of the patients identified as having abnormal physical observations only 58% were acted on. Many patients had no history or triage assessment completed; with triage referrals consisting of only the words "mental health". Most importantly, the audit identified this lack of adequate physical assessment resulted in a 2% 'near miss' rate, including a missed diabetic ketoacidosis and delayed treatment for a missed overdose.

Conclusion. Following this audit and the above result, it is clear that triage and physical assessment of mental health patients attending A&E is inadequate; with resulting risk of severe consequences to patients. It is therefore recommended to co-develop joint guidelines and teaching to guide A&E and MHLT practitioners on the process of completing the physical assessment prior to referral. It is also recommended to repeat this audit throughout other hospital trusts, in order to review the local referral pathways to ensure adequate physical assessment to avoid any 'near misses' or serious incidents.

Annual physical health checks within a forensic inpatient service

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Aims. Patients prescribed antipsychotics are at risk of ill effects to their physical health. Our aims were to assess whether inpatients within a forensic service, on antipsychotic medications, were receiving annual physical health monitoring in accordance with current NICE and SIGN Guidelines. Based on these Guidelines the following objectives were identified:

- 1: Physical examination, BMI and blood pressure recorded within the past year
- 2: FBC recorded within the past year
- 3: U&Es recorded within past year
- 4: LFTs recorded within the past year

5: HbA1C / random glucose / fasting glucose recorded within the past year

6: Random lipids / fasting lipids recorded within the past year

Method. Inclusion Criteria: Patients admitted for longer than a year currently prescribed an antipsychotic.

Data were collected cross-sectionally on 24/7/20 for all inpatients meeting the inclusion criteria. Medical notes and the blood results system were reviewed for results of any annual physical examinations and blood monitoring over the past year.

Anonymized data were analysed using Excel.

Result. 13 out of 17 inpatients fulfilled the inclusion criteria. Of these 13 inpatients, 9 (69.2%) were prescribed clozapine, 1 (7.7%) zuclopenthixol, 1 (7.7%) paliperidone and 1 (7.7%) amisulpride.

All patients had BMI and blood pressures recorded within the preceding month. Only 1 patient (7.7%) had an annual physical health examination within the past year.

Findings for bloods taken within the past year were as follows:

12 patients (92.3%) had an FBC recorded

9 patients (69.2%) had U + Es recorded

9 patients (69.2%) had LFTs recorded

11 patients (84.6%) had HbA1c recorded

7 patients (53.8%) had lipids recorded

Conclusion. There is scope for improvement with both annual physical examinations and blood monitoring.

All patients had regular BMIs and blood pressure recorded which is largely attributable to nursing staff protocols. Low compliance with full annual physical examination could be explained by there being no local system in place for annual physical health checks and also frequent changes in junior doctor ward cover.

Blood monitoring showed variable compliance with established standards. FBC monitoring had the best compliance, likely because the vast majority of our patients are prescribed clozapine, which necessitates minimal monthly FBC monitoring.

This audit was presented to the Forensic Team and thereafter it was agreed for a local system to be put in place for annual physical health checks in the summer each year. This will improve opportunities to optimise our patients health. We plan to re-audit at this time.

Racial representation of psychological services in a London male remand prison

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Aims. To investigate whether racial groups are proportionally represented in referrals for trauma, hearing voices, emotional regulation and psychological therapy.

To understand the psychological needs across racial groups in HMP Wormwood Scrubs, the UK's 4th-most diverse prison.

To see if the long-established under-representation of Asian males and over-representation of Mixed males in psychological services in the community is also occurring in the prison system.

Method. Psychological referrals were received via the medical notes system (SystmOne), whereby a prisoner's name, age, location, racial group and reason for referral are transferred into the psychology referrals database.

773 referrals were made between October 2018 and May 2020. As the prison's population throughout this time period was fluid, the month of December 2019 was used as a reference for the general prison population.