Methods. This was a retrospective review of patients' files referred to ASD Walsall CAHMS Clinic conducted in February 2021. A random sample size of 44 boys and girls equally distributed from the ASD database was selected randomly from the completed ASD assessment list, the equal distribution between genders was intentional. We looked at presenting symptoms reported on the referral letters, assessments in CAMHS, and interventions outlined from ASD outcome letters of all subjects with completed ASD assessment, in age groups 7–18 years.
Results. Across genders, most patients presented in the teenage years with common age of presentation seen at ages 15 and 17, both at 15.9% and mean age being 13 years. Ninety-five percent of patients were in school at the time of referral. Only 4.5% of patient were referred through crisis and the rest through local GP. A variety of presenting symptoms were seen, with the majority of the patients presenting with social and communication difficulties (77.3%), under /overreaction to sensory stimuli (63.6%) and anxiety (61.4%). 9.1% of patients had a family history of ASD. 100% of assessments included ADOS, SALT and neurodevelopmental assessment. 77.3% of patients were referred to support groups like living with ASD parent support groups. Along with CAMHS, education (97.7%) was the main agency involved in the care of these patients. In 44.2% of patients, EHCP was requested or already in place. The in between gender comparison also showed that although most symptoms were similar in both groups, some such as self-harm were higher among girls (27.3%) as compared to boys (13.6%) as well as obsessional symptoms which were more common in boys (63.3%) as compared to girls (27.3%).
Conclusion. Undiagnosed ASD presents with a wide variety of symptoms amongst boys and girls. Previous UK studies have shown an earlier presentation of ASD and which is contrary to our findings demonstrating a much later presentation. Therefore, we recommend referrers to be aware of the varied presentations and have a lower threshold for referral to secondary services to aid quicker ASD diagnosis and management.

An Audit to Assess the Quality of Ward Referrals Sent to City Hospital Liaison Psychiatry Team From Inpatients Wards D15, D17and D27, Between July 2021 to September 2021

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Aims. Liaison psychiatry provides psychiatric care to medical patients. Patients include those attending emergency departments, general hospital inpatients and outpatients. Liaison teams work hand in hand with several general hospital teams to offer advice, review and manage these patients. Over the last few months, the Liaison service in City Hospital have been receiving many inappropriate referrals. Inappropriate referrals are defined as patients who are referred to services, with one of the following reasons:
1. Insufficient presenting complaint
2. No documented Past psychiatric history
3. Insufficient Mental state Examination (MSE)
4. No risk assessment
5. No documented Drug/alcohol history
6. Patients having not consented to referral.
7. If one or more of the above criteria is not met

Our aim was to evaluate the appropriateness of the referrals received from D15, D17, D27 inpatients wards in City Hospital over a 3-month period from July to September 2021. These wards were chosen as they commonly refer patients to liaison services.
Methods. We collated data retrospectively on the nature of all referrals from D15, D17 and D27 ward over a 3-month period. The patient referral portal was used, and referral content of each patient was analysed. An audit tool was devised to assess whether the referrals followed the liaison referral pathway and guidelines set by NHS England for referral structure to liaison services.
Results. 18 patients were referred to the Liaison psychiatry from the three wards over the three-month period. We observed 77.8% (n = 14) of the referrals having insufficient information for the presenting complaints, whilst 22.2% (n = 4) of them did not state past psychiatric history. Approximately 94.4%(n = 17) did not state sufficient details of MSE. In 83.3% (n = 15) of referrals appropriate detailed risk assessment was not done, 27.8% (n = 5) of them did not have alcohol/ drug use stated and 22.2% (n = 4) of patients referred did not consent to the referral being made.
Conclusion. The results demonstrated that ward referrals lack quality and contain inadequate information to allow for safe screening of patients and for the implementation of appropriate actions by the liaison team. A possible reason for inappropriate referrals may be due an existing knowledge gap and lack of confidence taking detailed psychiatric histories, assessing risk, and performing MSE in non-psychiatric trainees making referrals to liaison services.

Audit Of Psychotropic Prescribing in the Crisis Team at Fieldhead Hospital According to NICE Guidelines

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Aims. To ensure that psychotropic prescribing and monitoring in the Crisis Team is compliant with NICE guidelines and to provide excellent patient care and to practice medicine safely.
Methods. Medication prescribing should be a collaborative decision by the service user and the prescriber. This allows patients to have autonomy to decide their treatment plan. NICE provides guidelines for prescribing medication which includes baseline investigations, reviews of treatment including side effects, and physical health monitoring.

We selected 50 admitted patients for the audit from April 2021 until September 2021, who were prescribed psychotropic medications. We used medication cards and electronic patients' records (System One). Our exclusion criteria were the 72-hour post-discharge follow-up from the inpatient ward.

The audit standards included as follows: age, gender, the indication, the start of medications, dose, within BNF limits, discussion, consent from the patient, comorbidities, physical health monitoring, response to treatment, monitoring of side effects, and other important information.
Results. 100% results for indication, dosage, discussion with the patient, and side effects monitoring.

We had promising results for benefits from the treatment (46 out of 50 patients responded to treatment) and 4/50 did not respond to treatment. Unfortunately, one patient died from an

overdose of illicit drugs, not with prescribed medication and one was admitted, and one felt worse, and one did not have any response.

However, 22 out of 50 patients were prescribed antipsychotic medication.11 out of 22 patients had ECG and blood done by the Crisis Team and 4 done by other parties (hospital and primary care).3 had recent blood tests but no ECG.2 patients did not have physical health monitoring and the reason was not documented.2 patients were started on antipsychotic by the Crisis Team, but the dose was not changed.

In terms of side effects, 8 out of 50 reported some side effects.

6 of them were prescribed antidepressants. They reported difficulty in sleeping and palpitations with Venlafaxine, nausea with Fluoxetine, nonspecific side effects with Citalopram, and sedation with Trazadone. 2 patients felt dizziness, diarrhoea, and muscle spasms with Mirtazapine. One patient had a metallic taste with Zopiclone. For side effects with antipsychotics, only one patient reported side effects with Olanzapine.

Conclusion.

- The Crisis Team is working at excellent standards on most areas of psychotropic prescribing and monitoring
- The Crisis Team needs to improve physical health monitoring of their patients.

Clinical Audit of the Awareness of Safety Guidelines on Lithium Prescribing Within the Acute Hospital-James Cook University Hospital

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Aims. Lithium is a useful drug and is of particular benefit in patients with chronic mood disorders like bipolar affective disorder and recurrent depression. Lithium requires careful monitoring and dose adjustment for safe use due to its narrow therapeutic index and high potential for toxicity. Monitoring must carry on even when mental health patients taking Lithium are admitted to acute hospital. Therefore, the main aim of this clinical audit was to evaluate the level of awareness of the lithium safety guidance amongst medical staff working within the Acute Hospital, James Cook University Hospital. Ideally 100% of staff should have the appropriate knowledge.

Methods. Questionnaire consisted of 6 items which were derived from key points within the Trust guidelines for Lithium. It was designed to highlight the key points in the document and check the level of awareness of the respondents. Respondents were drawn from James Cook University Hospital and South Tees Liaison Psychiatry team. A total of 25 respondents were included in the study.

Results. 96% (24/25) of the respondents were aware that renal and thyroid function should be checked for patients on Lithium. 84% (21/25) were aware of the potential impact of Lithium on Kidney function (eGFR) and 68% (17/25) were aware of signs of Lithium toxicity.

60% (15/25) of acute staff were aware about referring patients with deranged Lithium levels to the Liaison Psychiatry team. 40% (10/25) were aware of the drugs that could potentially increase lithium levels like Diuretics, Non-steroidal anti-inflammatory drugs, ACE (angiotensin converting enzyme) inhibitors. Only 24% (6/25) of acute trust staff were aware about checking lithium levels on admission.

Conclusion. Ideally, a 100% compliance and positive response rate should be achieved as these relate to completion of expected safety checks. Lithium is a potentially high-risk drug with a narrow therapeutic index. Possibility of its acute and chronic side effects, including lithium toxicity, makes it essential to follow safety guidelines on lithium prescribing and hence ensure patient safety.

In view of this, the clinical audit results clearly show that there is significant room for improvement to achieve a 100% positive response rate for awareness of safety guidelines on Lithium prescribing.

Overall, there were an average of 57% positive responses and 42% negative responses for awareness of various aspects of the safety guidelines for Lithium.

A robust action plan which included teaching sessions on creating awareness about lithium monitoring was planned because of this audit.

The Impact of COVID-19 on the Quality of Admission Clerkings on an Old Age Psychiatry Ward – an Audit

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Aims. On 11th February 2020 a novel coronavirus was named SARS-CoV-2, with the World Health Organisation announcing that the associate disease would be known as COVID-19. As doctors providing an inpatient psychiatric service, there were various changes in our daily practice secondary to the pandemic. These included reduced staffing levels due to illness, the need to wear personal protective equipment during all patient contact and high levels of anxiety surrounding transmission. We hypothesised that the resultant pressure on our service might impact the quality of admission clerkings to our ward, (a 17 bed functional Old Age Psychiatry ward), and therefore resolved to audit the data. We determined that "quality" of the clerking should be equated to completeness, i.e. the degree to which all desired information is included.

Methods. Admission clerkings to the ward are to be completed on a pro forma built within the electronic patient record system ("Paris"). This pro forma is based on guidelines for the admission of patients to psychiatric inpatient units produced by the Royal College of Psychiatrists. The standard for the audit was set as 90% compliance with each individual section of the pro forma.

All admissions across three periods were extracted from the electronic record using the inbuilt reporting function. The periods were 1st April to 1st July in 2019 (pre-pandemic, n = 15), 2020 (early pandemic, n = 29) and 2021 (late pandemic, n = 22). Data were extracted manually from each admission clerking and recording anonymously on an excel spreadsheet, with either "yes" or "no" confirming or denying compliance with each domain (e.g. presenting complaint).

Results. All domains showed improved compliance from 2019 to 2021 other than recording of the mental state examination which saw a 9.09% decrease (which is not statistically significant).

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