**Result.** Preliminary analysis of data from November 2019–March 2020 (43 patients) showed that a clearly documented rationale for inpatient detox was recorded in 95% of cases. 100% of cases had a recorded AUDIT score, whilst SADQ scores were recorded in 50% of cases. 33% of cases were admitted to rehab post detox, and 19% were prescribed anti-craving medication. Abstinence at one year was confirmed in 21% of cases. 28% of clients received a second detox within one year. The rationale for inpatient detoxes in this population is to be reported.

**Conclusion.** Preliminary data may highlight an opportunity to improve pre detox decision-making and post detox care, with confirmed abstinence in only 21% of clients at one year after detox. The low proportion of completed SADQ scores before accessing detox could offer an opportunity to improve client assessment, and the small proportion of clients prescribed anti-craving medication highlights an area of post detox care which could also be improved. The main limitation of this study is the lack of linked analysis of outcome to specific predictors, which is something that could be explored in future. It would also be valuable to gain survey data on the experience of accessing detox from a service user perspective.

## A review of patients discharged from Shannon Clinic- are shorter stays in secure hospitals associated with poorer patient outcomes?

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**Aims.** Shannon Clinic was established as the regional secure unit in Northern Ireland in 2005 and provides medium secure care to Northern Ireland's population of 1.8 million. Previous research has shown that inpatient admissions are shorter when compared to other secure units. Northern Ireland has less secure beds per population than the other UK nations, which can be a driver for shorter hospital stays. This review was undertaken to examine if shorter inpatient stays were associated with poorer outcomes.

**Method.** All the discharges from Shannon Clinic to the Southern Health and Social Care Trust were reviewed over a period of 10 years (2009-2019). The outcome measures examined were mortality, readmission rate and reoffending rate. Crude rates for these were calculated. To allow for comparison, these rates were compared to the systematic review findings of Fazel et al (2016), which was an international review examining patient outcomes following discharge from secure hospitals.

DUNDRUM 1 Triage Security scores for the patient group were also reviewed, to ensure a sample representative of patients needing medium secure care.

**Result.** 41 patients had been discharged during this period. DUNDRUM 1 Triage Security scores ranged from 2.44 to 3.2.

The average length of admission was 415.5 days. This is shorter than the average reported by Fazel et al (2016).

The crude rates for all of the variables calculated (mortality, readmission to hospital and reoffending) for patients discharged from Shannon to the trust were less of those reported in the systematic review by Fazel et al (2016).

**Conclusion.** This review suggests that patient outcomes are not negatively impacted by shorter inpatient stays in secure hospitals. A possible reason for this is the regional model of care approach, which helps ensure continuity and safe management of the transition between secure care and the community. In addition, there is close multidisciplinary working with supported living providers in the trust area to ensure patients' needs are met.

Following this initial review, there are now plans to review discharge outcomes for all patients discharged during this period. There are five trust areas in total in Northern Ireland so this will allow for comparison across the region.

The review has also been used within the unit to develop information leaflets for patients at admission and posters for display in the unit. We hope this will provide clarity to patients about secure care and a sense of optimism from the start of their admission.

## Audit of physical health monitoring during initiation and ongoing treatment with antipsychotic medication in a tier 3 outpatient CAMHS service, Belfast

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**Aims.** To evidence that physical health monitoring during antipsychotic initiation and continued treatment within the Child and Family Clinic is current, as per the agreed Antipsychotic Medication Monitoring Schedule for Belfast Trust CAMHS (2015), supporting Quality Network for Community CAMHS (QNCC) accreditation.

**Background.** The Antipsychotic Medication Monitoring Schedule CAMHS(2015) was agreed by a working group of consultant psychiatrists and pharmacists, based on evidence from The Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMSEA), NICE Guidelines CG 185(2014), CG155(2013) and Maudsley Guidelines, and was to be located on the electronic system (PARIS).

**Method.** In January 2019, a list of all children/young people on antipsychotic medication was collated (n = 12). Presence of the monitoring schedule in the clinical notes or PARIS was recorded. The Electronic Care Record was reviewed for blood results and PARIS letters for documentation of physical health parameters (heart rate, blood pressure, height, weight, BMI, extrapyramidal side effects, ECG) and to identify documentation of risk/benefit review where monitoring was declined. Re-audit January 2020 (n = 9). Criteria:

All patients commenced on antipsychotic medication will have baseline blood investigations and other physical health parameters documented as per the monitoring schedule. If monitoring was declined, the reason for this and indications for prescribing must be documented as a risk/benefit analysis.

All patients on antipsychotic medication will be current with their physical health Monitoring Schedule.

All patients will have their Monitoring Schedule completed in clinical notes or on PARIS.

**Result.** First cycle results (n = 12):

Baseline bloods (or documented declined) = 92%, Baseline ECG (or documented declined) = 75%

Complete monitoring bloods = 33%, Physical health monitoring parameters complete = 42%

Monitoring schedule present in the notes and current = 42% (0% on PARIS).

Initial Recommendations: Standardised recording of monitoring using PARIS clinic letters and the schedule in front of clinical notes; Baseline ECG mandatory

Second cycle results (n = 9):

Baseline bloods (or declined) = 89%, Baseline ECG (or declined) = 67%

Complete monitoring bloods = 44%, Physical health monitoring parameters complete = 56%

Monitoring schedule present in notes and current = 38%, Present, not current = 50% (0% on PARIS).

**Conclusion.** Lower numbers at re-audit limit interpretation.

Further recommendations: Antipsychotic initiation checklist; Central bloods diary for clinicians; Antipsychotic care-pathway booklet, co-produced with young people, incorporating the monitoring schedule.

## Characterising a cohort of patients referred to a liaison psychiatry service from the Intensive Care Unit

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**Aims.** This is descriptive study of a cohort of patients referred to a liaison psychiatry service from the intensive care department of a major London teaching hospital and trauma centre. The objective was to characterise key patterns in reasons for referral, nature of input, and gain a general sense of the workload. The rationale for collating this information was the consideration to developing a specific intensive care liaison service given the increasing evidence about the cognitive and mental health impacts of post-intensive care syndrome and the need for a coordinated management approach between stakeholders.

**Method.** A cohort of 80 patients referred to liaison psychiatry service over a 6-month period from May to October 2020 was used. Descriptive statistics were used to characterise the patient's age, referring ward, reason for admission and referral, nature of input, number of reviews, previous engagement with mental health services, whether substance abuse or self-harm were related to the admission, and the destination upon discharge.

**Result.** The age range of patients at point of referral was 25-80 years. For 25% of patients, this admission marked their first engagement with secondary mental health services and for around 50%, not only was a new diagnosis given during the admission, but there was no recorded history of any psychiatric diagnoses. Around 10% of patients were referred for management of delirium. Anxiety disorder accounted for the greatest proportion of diagnoses upon discharge, at 22%. There was much variability in the number of intensive care ward reviews carried out, ranging from one to over 10.

In 24%, self-harm led to presentation and 18% had comorbid substance misuse. Medication review was the single most common reason for referral in 13%, whereas requests for talking therapy and capacity assessments were 5% and 2% respectively. The vast majority of patients required a level of ongoing psychiatric input warranting community involvement or admission.

**Conclusion.** This cohort often required detailed work-ups, new diagnoses and a high level of subsequent psychiatric management following discharge from hospital. The wide age range of patients meant that both working age and older adult liaison teams were involved in assessing referrals. Consideration could be given to a specific intensive-care liaison service due to the workload and complexity of needs, as well as the increasing awareness of the need for family support and early inclusion both for their benefit and that of the patient, particularly when the proportion of new diagnoses in this cohort is considered.

## Clinical audit on possible causes of hospital initiated clinic cancellations and recommendation to improve the service

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**Aims.** The aim of this audit is to explore the possible causes of clinic cancellation in an inner city CMHT and the recommendation to reduce the burden.

**Background.** Cancellations of planned appointments have been a major and long-standing problem for healthcare organisations across the world. It represents a significant loss of revenue and waste of resources, have significant psychological, social and financial implications for patients and their families and represent a significant loss of training opportunities for trainees. Re-scheduling appointment is one of the major issues of inconvenience to the patients. It also increases workload for the patient appointment team.

**Method.** Data have been collected retrospectively from patient appointment booking team regarding clinic cancellation with causes of cancellation recorded in the system (01/07/2019–30/09/2019). The investigators have investigated if the cancellation has been made when it was absolutely necessary to cancel the clinic (Unavailability of doctors due to leave/on calls) and if patients have been informed at least 8 weeks prior to the appointed clinic as per trust protocol.

**Result.** Total number of 193 clinics were booked at the CMHT from July 2019 – September 2019. About 54% clinics were cancelled during the time period. The Clinic Cancellation rate was higher in September (68%) and was lowest in August (30.30%). As the month of July is the changeover period for trainees, the number of clinics booked during August was relatively less than normal. 72% clinics were cancelled by junior doctors and 28% clinics were cancelled by consultants at the CMHT. The major cause of clinic cancellation was unavailability of the junior doctors due to on call (31.58%) which was not communicated to the patient appointment booking team. Due to annual leave, 25% clinics were cancelled and 21% clinics were cancelled due to study leave. In both cases it is evident that, lack of communication between clinicians and patient appointment team are primarily responsible for hospital-initiated clinic cancellations. As per Patient Appointment booking team, around 50% cases, patients were informed 8 weeks in advance before cancelling the clinics.

**Conclusion.** This is evident from this audit that the number of hospital-initiated clinic cancellations can be reduced by improving communication between Patient Appointment booking service, Medical staffing department and clinicians. The findings of the audit have been shared locally with CMHT managers, clinicians and with the patient appointment booking team.

## Management of emotionally unstable personality disorder in an urban Irish setting

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