1. In 87.5% cases DNA was recorded in patient's records?
2. In 45.45% cases the information (DNA) was shared with GP
3. In 45.45% cases DNA was discussed in MDT meeting
4. In 0% case the referrer was involved in review and decision of next step
5. In 11.36% cases alternative venues was considered for carrying out the assessment to support the person to engage, e.g. GP Surgery.
6. 25 patients DNA appointment twice

Conclusion. We are not adherent to trust policy.

Assessing the Impact of COVID-19 on Overdose Presentations Through the Emergency Department in a Large Tertiary Hospital

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Aims. The outbreak of COVID-19, lockdown and self-isolation has created a lot of additional pressure on the society as a whole. We aim to audit the number of patients presenting to SVUH ED since March 27th 2020 (the date at which the government imposed a stay-at-home order) with an overdose.

Methods. The cohort of cases analysed was identified using ED MAXIMS under the subheading of 'overdose and poisoning' presentations. Data were collected using MAXIMS and clinical portal and stored on the SVUH system and analysed using Microsoft Excel and SPSS.

Results. There were a total of 713 cases in both years (from 27th of March – 31st December), with 353 (49.5%) admitted in 2019 and 360 (50.5%) admitted in 2020. Out of those admitted, 423 patients were females (196 and 227 in 2019 and 2020 respectively). There was a significant increase in the number of female presentations in 2020, with a p value of 0.041.

When stratifying patients based on age, the mean ages were 37.22 (SD 17.04) and 34.18 (SD17.32) in 2019 and 2020 respectively ($p = 0.076$). When dividing age groups in three categories (under 18, over 65 and 19–64), our data showed significant differences. There was a significant increase in numbers in the ≤18 yr and 19–64 age groups in 2020 compared with 2019. In the under 18 groups, there was an increase in numbers by 7.9% in 2020 (11.6% compared with 19.5%). When comparing numbers between Months per year, overall, there were no changes in presentations. Interestingly March 2020 had no presentations compared with March 2019, coinciding with the beginning of the pandemic in Ireland. May showed more than 50% decrease in presentations in 2020. Similar numbers were seen in the rest of the months of both years.

Conclusion. Between 2019 and 2020, there was a 1.9% increase of ED presentations with overdoses, which did not show any significance in increase of numbers or in age demographics. There were three main findings from our analysis:

1. A significant difference between the two years in a rise in female patients admitted with overdose ($p = 0.041$)
2. An increase in presentations in the age groups of under 18 and 19–64. This may allude to increase strain in the younger population with loss of jobs, financial burdens etc.
3. There were no presentations in March 2020, coinciding with the beginning of the pandemic in Ireland.

An Audit on Patient Safety and Prescribing in Patients With a Learning Disability, Autism, or Both at a Scottish GP Practice

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Aims. The aim was to investigate the proportion of patients with a previous diagnosis of learning disability or autism who later successfully underwent an annual review of their prescribed antipsychotic or anti-depressant. This audit was prompted after Public Health England announced that a significant number of adults with a learning disability, autism or both take a prescribed antipsychotic, an antidepressant or both without appropriate clinical indications (psychosis or affective/anxiety disorder).

Methods. The sample included 23 patients from the practice who had received a diagnosis of learning disabilities, autism, or both by 12th October 2020. Of these, 12 patients had a record of at least 5 prescriptions of an anti-psychotic in the last 12 months and 20 patients had a record of at least 5 prescriptions of an anti-depressant within the last 12 months. The notes for these patients were reviewed in May 2021 in an effort to ascertain whether a medication review had been completed for these patients since May 2020. The review process included a phone call between the patient and the prescribing doctor to determine whether there any side effects were being experienced and to assess the need for the continuation of the prescription. The resulting data were recorded and analysed on Microsoft Excel.

Results. Out of the 12 patients who had been prescribed an anti-psychotic, 10 had received a medication review within the last 12 months. From the 20 patients who had been prescribed an anti-depressant, 19 had undergone a review of their medication within the last 12 months.

Conclusion. Review of anti-psychotics and anti-depressants prescribed to patients with a diagnosis of learning disability, autism, or both was overall positive with the majority of these patients receiving a medication review within 12 months. As a further recommendation, another audit can be done to explore whether these patients had an annual blood test done as increased cholesterol is a known side-effect of psychotropic drugs.

Presenting Symptoms of Undiagnosed Autism Spectrum Disorder Among Young Boys and Girls in Community CAMHS Between 2018–2019

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Aims. Though Autism Spectrum Disorder (ASD) is a common childhood neurodevelopmental disorders, the literature on presentation of undiagnosed ASD in Consultant Child and Adolescent Mental Health Services, (CAMHS) is scarce. The aim of the study was to look at symptoms at presentation among boys and girls in CAMHS, compare the symptom profile between the two genders, establish the main referral and assessment pathways and interventions employed after diagnosis

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

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