

Transitional discussions to be made a regular agenda item at team meetings.

Care co-ordinator to be informed and reminded that transitional plans need to be explored with young people.

Following a re-audit of this data 6 months on 100% of cases over the age of 18 were closed and transition was discussed in the remaining 56%.

Where is my sample? Investigating pre-analytical pathology sampling errors in a psychiatric hospital

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Aims. Errors in the pathology sampling process can be costly for all stakeholders in any clinical setting; however, this process is often overlooked within psychiatry. Over the space of just a few short months at Hollins Park Psychiatric Hospital (HPH) such errors were reported to be numerous with staff raising multiple issues relating to the pathology sampling process. These issues often had a negative impact on patient care, leading to outcomes such as re-bleeding of patients and delays in interventions. Here, we aim to identify the predominant sources of error in this process and suggest possible improvements to minimise these errors in the future.

Method. Initially, we mapped and analysed each step of the sampling process as it is currently performed in order to identify areas of possible improvement. We then distributed questionnaires to all junior doctors - who are responsible for the handling of samples within the clinical setting - in order to establish error type and frequency. Questions also assessed individual confidence and familiarity with the sampling process.

Result. When mapping the sampling process, we identified all key steps required when sending samples from HPH to Warrington and Halton Hospitals laboratory. This included one pathway for sending routine bloods, and one pathway for urgent bloods. The process for sending routine bloods required more steps and ultimately took longer for samples to reach the laboratory - as expected. Of the issues identified during mapping of the pre-analytical phase, a majority of 77.7% of clinicians reported samples had gone missing or were unreported - with the reasons for this being undetermined in most cases - and 55.5% reported their samples never reached the lab. While on the whole participants were comfortable with the steps involved in sending samples to the laboratory, 77.7% were not aware of the requirement to log samples as they were being sent.

Conclusion. The reasons underlying errors in the sampling process at HPH were multifactorial and included a lack of clinician familiarity with correct procedure, poor sample recording/tracking and lengthy transit times between the patient and laboratory. Here we outline some simple evidence-based recommendations (including education of staff and improved tracking through an electronic requesting system) to help reduce errors and streamline the sampling process in the hopes of improving both efficiency and accuracy, reducing the financial and clinical impact.

High dose antipsychotic treatment monitoring audit

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Aims. To quantify how many patients were prescribed high dose antipsychotic treatment (HDAT) and establish whether guidance for monitoring HDAT was being followed in an Assertive Outreach Team.

Background. Severe mental health disorders are associated with significant premature mortality, predominantly due to physical health conditions. Antipsychotic medications are associated with side effects, including metabolic syndrome and QT prolongation, which increase the risk of serious physical illness. HDAT is defined as when the total dose of antipsychotics prescribed exceeds 100% of the maximum BNF dose, if each dose is expressed a percentage of its maximum dose. There is limited evidence of clinical benefit with HDAT but an increased risk of side effects. Patients prescribed HDAT should therefore be monitored for side effects and clinical benefit. Sussex Partnership NHS Foundation Trust developed a form specifically for this purpose, to be completed in addition to a physical health assessment.

Method. All patients on caseload were audited using the electronic notes. Current inpatients were excluded, as inpatient HDAT monitoring forms are attached to paper drug charts and therefore were not available for review.

Result. A total of 61 patients were audited. Nine were excluded due to being inpatients. 16 were on community treatment orders and 26 were prescribed a long-acting antipsychotic injection. 10 were prescribed clozapine. The median number of medications prescribed was one. Four patients were prescribed HDAT ranging from 117-150% of the maximum BNF dose. Of these four, one had a HDAT form but this was out of date. 39 of 52 (75%) patients audited had had a physical health assessment in the past 12 months. Two of the 13 missing a physical health assessment were on HDAT.

Conclusion. Physical health monitoring should be carried out for all patients on antipsychotics, but is particularly important for patients on HDAT. This audit identified a problem in both general physical health checks and HDAT monitoring. On discussion with the multi-disciplinary team a number of barriers to appropriate physical health monitoring were identified. There was a lack of awareness within the multi-disciplinary team that patients were receiving HDAT and regarding the implications for side effects. A reliable system to highlight the need for physical health checks was also missing and the team did not have sufficient equipment to perform the necessary checks. Identifying these barriers should enable improvements in physical health and HDAT monitoring which can be re-audited.

Psychiatric liaison team memory pathway: does it achieve the standards set out in NICE clinical guideline 97?

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Aims. Early assessment, diagnosis and management for people living with dementia is essential, both for the patient and their carers. We recognised delays in established local pathways when patients had unplanned acute hospital admissions preventing them from attending memory diagnostic appointments. The Psychiatric Liaison Team (PLT) Memory Pathway was introduced

as we had the skills and expertise to resume the process and to find new undetected patients.

Our aim was to determine how well the newly implemented PLT Memory Pathway follows the standards outlined in the National Institute of Health & Care Excellence (NICE) Clinical Guideline 97 (CG97): Assessment, management and support for people living with dementia and their carers.

Method. A retrospective analysis of all PLT referrals from July 2018 to February 2020 (20 months) was performed to identify patients on the community memory pathway and those with possible undetected cognitive impairment. Data were collected from electronic patient records which included demographics, primary and collateral history, cognitive testing and imaging, dementia type among others. Results were analysed using Microsoft Excel. **Result.** 41 patients were included (59% female). 80% of patients were referred for memory problems or confusion. 63% had previous referrals to a memory service and was on the community memory pathway at the time of the referral. 34% were on anticholinergic medication but in only 14% were this documented as reviewed. 100% were offered and had head imaging. A finding worthy of note was the absence of any from the ethnic minority background. 63% of patients were given a memory diagnosis and 34% had anti-dementia medication started. Patients' families were made aware of the diagnosis in 83% of cases, due to the absence of next of kin details in the patient record. Primary Care was made aware in 100% of cases; post-diagnostic support was 100%.

Conclusion. The PLT is well placed to bridge the service gap between the acute care trust and established community memory services when dealing with patients with dementia. A dedicated Memory Pathway has helped to close this gap and adherence to NICE CG97 standards was good, but there is room for improvement. A particular focus will be on improving documentation of anticholinergic medication review and exploration for the absence of ethnic minority patients. Aiming to achieve 100% family involvement is also recommended.

This study has been submitted to the Royal College of Psychiatrists' Faculty of Old Age Annual Conference 2021.

Addiction service changes due to COVID-19

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Aims. Addictions services had to respond rapidly to reduce COVID-19 transmission to protect patients and staff. Patients with opioid dependence are particularly vulnerable, with high risks. Our community addiction service changed practice in line with COVID-19 guidelines. For patients with opioid dependence; face-to-face contacts were initially reduce and mainly for new starts, restarts and non-attenders. Prescribing changes were completed on an individually risk assessed basis to reduce attendance at the chemist, specifically to reduce transmission, keep patients in treatment and to ensure chemists could continue to function. We document some of the service changes during the COVID-19 lockdown.

Method. Service evaluation had approval from Humber Teaching NHS Foundation Trust. Data retrieved on one Hub of a community addictions service in North England, UK. Patients prescribed opioid substitution treatment for opioid dependence were

assessed, with data retrieval through electronic healthcare records. Data were analysed by Microsoft Excel anonymously.

Result. In lockdown (March 2020 to June 2020), we identified 112 patients with opioid dependence prescribed opioid substitution (OST) with methadone or buprenorphine at the Hub. All white British, mean 42 years, most male (75%) and prescribed methadone (78%). Ten were new starts and 8 restarts to OST. Attendance rates did not change: 91% before and 92% during lockdown. Appointment format changed from predominantly face-to-face (92%) to telephone (99%). Most patients (91%;n = 88) were offered take-home naloxone and overdose prevention training of which 14 refused. Supervision days at the chemist for OST reduced significantly from 75% collecting daily at the chemist, reducing to 20% during lockdown. Five patients were shielding and 7 had covid-related symptoms. There was one death during lockdown which was not attributed to covid or overdose.

Conclusion. The addictions service continued to be open and work proactively throughout lockdown, seeing new patients and continuing treatment interventions safely. Major changes were made in line with COVID-19 guidelines, to respond to the threat of transmission. Our service was flexible and able to adapt quickly to remote working. We maintained excellent attendance rates despite changes to the format of consultations. There were no related incidents e.g. overdoses linked to prescribed medications, despite a reduction in supervision, and therefore patients having extra medications. This important finding may be related to the individual risk assessments that we conducted before making changing to prescribing. This was supported by most patients were receiving naloxone to prevent overdoses. Some of the changes, such as telephone consultations, may be beneficial to continue post COVID-19.

Audit of methods used to contact the duty doctor - Abraham Cowley Unit

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Aims. The aim of this audit was to determine whether the duty doctor of a 4 ward inpatient psychiatric unit is contacted safely, effectively and in a manner that can be monitored. This is in line with trust protocol and the method stated is via switchboard. Should a deficit be found it was the aim to make an appropriate intervention.

Background. In the Abraham Cowley Unit, there is a Senior House Officer 'on-call' duty doctor 24/7. The shifts are 2 x 12.5 hours daily and at all times the duty doctor should be contacted via switchboard. Contacting via switchboard is important to ensure there is an audit trail of calls made. Issues that arise from using other methods of contact, e.g. calling direct extensions, include miscommunication and the doctor not being reached in a timely manner. This had been identified as an issue anecdotally by junior doctors on call and also highlighted following an untoward incident.

Method. The method by which the on call doctor was contacted was recorded in Excel for 5 consecutive 12.5 hour shifts in October 2019. The standard set for calls via switchboard was 80%. Following the initial results and the subsequent intervention, a repeat audit was performed using the same method.