339); Hub 1 (77%; n = 72/93), Hub 2 (73%; n = 97/133), Hub 3 (79%; n = 89/113). For non-attending patients, a medication review was conducted in their absence by the prescriber for most (94%; n = 74/81) patients (see table 1 and Figure 1).

In January 2020, reassessment of attendance rates for Hub 1 (subsample), in January 2020 (n = 91) which showed attendance had increased to 86% (n = 78/91). All (100% n = 13) patients who did not attend for the prescriber review in person, had a medication review in their absence. In addition, the reasons for nonattendance were discussed with the patient and their keyworker, following which they were booked for a subsequent appointment.

Conclusion. Nonattendance at clinical appointments causes a significant financial burden across the NHS. It was fantastic to see that the QIP improved patient attendance rates and this was sustained and improved, over a year later. Serial non-attenders may need an enhanced strategy.

Exploring the views of young people with autism spectrum disorder (ASD) on how to improve medical consultations

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doi: 10.1192/bjo.2021.553

Aims. The aim of this study was to explore experiences of consultations with non-specialist health professionals in a group of young people with ASD and their parents and what they considered would help to improve these interactions.

Background. Research has shown that general awareness around autism is poor among the general medical community and this can result in poor communication during medical consultations.

Method. An opportunistic group of 4 young people with ASD and 8 parents from a local support group in Exeter were interviewed in an informal environment about their experiences of healthcare consultations after seeking verbal consent.

Result. Among the 8 parents interviewed the themes emerging were a deep lack of understanding and awareness among medical staff of the challenges faced by individuals with autism, the importance of the doctor-patient relationship to allow children to open up to healthcare professionals, and the need for all children to be respected as individuals.

Among the 4 young people (13 to 19 years) with ASD interviewed they identified significant anxiety around waiting for appointments and expressed a desire for a distractor to relieve stress, questions posed by clinicians were often vague and should be clearer, 3D models/mannequins could be useful to support understanding of anatomy and physiology, patience and a calm demeanour were vital with a quiet clinical environment to avoid distraction, time for mental preparation is important and efforts should be made to avoid delays or cancellation of appointments where possible.

An interactive website was generated in the light of feedback from the client group and their parents, aiming to educate clinicians regarding the challenges faced by this client group and provide a guide suggesting how to facilitate effective consultation through the use of simple techniques to promote engagement/reduce anxiety in the clinical environment.

Conclusion. Simple changes to the approach to consultation with clients with ASD - a quiet consultation space, no delays and better communication - could reduce stress and promote positive interactions with a beneficial effect on healthcare delivery for this client group.

No time to die: improving response to emergency scenarios in the 136 suite

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doi: 10.1192/bjo.2021.554

Aims. Improve confidence and experience of trainees performing preliminary medical reviews in the 136 suite.

Improve patient safety by increasing trainee's confidence in responding to emergency scenarios, including crash calls of patients in the 136 Suite.

To orientate trainees to the 136 suite and the emergency crash equipment, in order to better prepare trainees for emergency scenarios.

Background. The authors encountered a crash call in the 136 suite, in which a patient had concealed an opiate overdose. The patient was successfully resuscitated but concerns were raised by the junior doctors that they were unaware of what or where the emergency equipment was kept in the 136 suite. Following a debrief session, we established that junior doctors needed more orientation to the 136 suite and more teaching on performing preliminary medical reviews and responding to emergency situations.

Method. Trainees, were asked to complete an anonymous, qualitative questionnaire with 16 questions asking about their confidence to respond to emergency situations in the 136 suite.

Based on the feedback, an interactive teaching session was delivered two weeks later. The session covered a structured approach on how to perform a preliminary medical review and scenario-based teaching on emergency situations. Trainees were then shown the 136 facility, introduced to the lead nurse and shown the emergency crash equipment and drugs stores.

Trainees were then re-consulted, with the same questionnaire to ascertain whether confidence and knowledge had increased.

Result. Following initial induction, only 25% of trainees felt confident performing 136 Suite preliminary reviews. 50% of trainees had encountered crash calls at Park House Hospital, however 93% did not receive orientation of emergency equipment locations. Only 44% of trainees felt confident managing a crash call; reasons included feeling 'rusty, little recent experience, not being familiar with the equipment'.

Post-interactive teaching session, 89% now felt confident performing 136 Suite preliminary reviews. 100% knew where the crash equipment was located in the 136 Suite.

Conclusion. Trainees should receive a robust induction on how to perform 136 preliminary reviews and have orientation of the facility, including crash equipment during induction

Trainees require refresher training in addition to their basic life support training on common emergency scenarios encountered in psychiatric hospitals.

A resuscitation skills training session is being organised for new trainees and hopefully incorporated into each forthcoming rotation.

Dublin's homeless crisis – is this reflected in emergency department psychiatry referrals?

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doi: 10.1192/bjo.2021.555

Aims. This study seeks to explore the prevalence and impact of homelessness in an adult sample of psychiatry referrals over a

one-month period via the Emergency Department at St. James's Hospital.

Background. Homelessness has now reached a crisis point in Ireland. In July 2019, there were 10,275 people documented as homeless nationwide, with the number of homeless families increasing by 178% since June 2015. The majority of individuals registered as homeless are located in Dublin. St. James's Hospital (SJH) provides psychiatric care to a population of 136,704 people across Dublin South-City within areas of significant deprivation according to the most recent social deprivation index.

Method. All Emergency Department psychiatry referrals over a one-month period were recorded. Month of study was randomly generated. Data were collected from electronic records. Socio-demographic information was analysed. Data were anonymised and recorded using Microsoft Excel. Current homelessness statistics were accessed from the Department of Housing, Planning, and Local Government and compared to the data collected.

Result. During the month of the Study (March 2019), 4315 adults accessed emergency homeless accommodation in Dublin. Of the 109 psychiatry referrals received through the Emergency Department at SJH during this time, over a quarter (28%) of those referred reported themselves to be homeless or living in temporary accommodation. An additional 5% were documented as living in residential or sheltered care at time of assessment. All of the referred homeless patients were unemployed (n = 30). 50% of homeless patients were referred to psychiatry following expressed thoughts or acts of self-harm. Illicit drug abuse was associated with 73% of referrals. Alcohol abuse was associated with 47%. Of those who were referred, under a quarter (23%) were assessed as having a major mental illness, and in the majority of these cases, illicit drug and alcohol abuse were compounding factors in exacerbating symptomatology. Of those referred, 66% had previously been reviewed by psychiatry during prior ED presentations and 60% of homeless presenters reported that they had previously been, or were currently linked in with community mental health teams.

Conclusion. Frequently, vulnerable patients most in need of social and psychiatric care, such as homeless people with addiction issues, are eclipsed from accessing supports. The high proportion of patients reporting to be homeless is cause for concern and suggests the need for tailored and integrated multidisciplinary assessments and interventions at an Emergency Department level.

Alcohol hand sanitisers on mental health wards safety risk educational and QI poster

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doi: 10.1192/bjo.2021.556

Aims. To provide awareness of safety concerns around use of alcohol hand sanitiser on a mental health ward, and to consider ways of improving how learning for a serious adverse incident in one trust can better be communicated to other trusts

Background. DD a male patient with history of paranoid schizophrenia alongside historic illicit drug use and current alcohol dependency admitted detained to Bluestone hospital following bizarre behaviour at a wake. Had been non-compliant with medication. Transferred to PICU due to going AWOL and returning under influence of alcohol.

2nd April overnight staff noted him to become over-sedated, presenting with slurred speech and appeared under influence of alcohol – transferred to A + E due to deteriorating GCS – was intubated, and transferred to ICU. Blood alcohol level was 373. Several empty bottles of hand sanitiser from dispensers on ward found in his room and he later disclosed he had accessed further alcohol hand sanitiser in sluice while washing clothes

SAI learning outcomes from one healthcare trust in Northern Ireland not currently routinely shared with other trusts

Method. Literature review carried out to search for reports of similar incidents – 1 previous review article suggesting one death and 11 other major complications from consumption of alcohol hand sanitiser over 5 year period 2005-2009.

Quality improvement steps implemented to address this risk

Ward policy was reviewed to ensure patients no longer had unsupervised access to wash clothes

Liaised with Infection Control to assess the need for alcohol hand sanitiser to be available to patients given the ward is effectively a community setting

Intoxication policy reviewed and education sessions on this provided to all medical and nursing staff

Regional regular PICU staff update seminar launched for purpose of bringing PICU staff from across Northern Ireland together to share learning from SAIs and cases

Result. Infection control agreed alcohol hand sanitiser dispensers could be removed from wards and kept only in locked nursing office with use of visitors.

Learning from this case shared with other trusts locally at newly launched regional PICU update seminar

No further incidents to date

Conclusion. Patient access to alcohol hand sanitisers found to be a significant safety risk in PICU setting

Following implementation of quality improvement steps no further incidents of patients swallowing alcohol hand sanitiser

Improved awareness of risk of alcohol intoxication on ward with nursing staff escalating concerns to on-call doctor more frequently

Improving safety-planning in patients admitted with self-harm

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doi: 10.1192/bjo.2021.557

Aims. Self-harm is a common presentation to acute hospitals, associated with increased risk of completed suicide. Safety plans are increasingly recommended to help patients recognise and prevent escalation of self-harm behaviours.

This project aimed to improve quality and documentation of safety planning for patients admitted at an acute general hospital due to self-harm, who were assessed by Liaison Psychiatry. We aimed to increase the number of patients given written safety plans on discharge by 50%.

Method. The PDSA cycle model of quality improvement was used. A retrospective audit of clinical records was conducted over 3 months to establish baseline documentation of safety planning (n = 51). A template for a self-harm crisis plan, used in other areas of the Trust, was adopted, to be adapted to each patient. A leaflet for sources of crisis support and patient feedback form were developed and distributed to clinicians in the team. Data collection was repeated one month later (n = 48). The second set of interventions involved a training session for clinicians on