

Aims. The older adult is more likely to be prescribed a lot of medications (polypharmacy) on account of multi-morbidity and being under the care of several specialists. Adverse drug events and reactions account for a significant number of acute hospital presentations in this population group with increased risks of delirium, lasting cognitive impairment, falls and death.

Medications are not routinely reviewed or rationalised in the elderly, often contributing to preventable harm.

We sought to estimate the prevalence of polypharmacy and potentially inappropriate medications, anticholinergics in particular, in patients (65 years and older) referred to the St Mary's Hospital Liaison Psychiatry Department over a 3-month period.

Method. Between 01/06/2019 and 31/08/2019 all referral forms (from in-patient wards and A&E) for patients aged 65+ years were screened for medications currently prescribed and administered. The medications were confirmed via the St. Mary's Hospital electronic records, pharmacists' completed Medicines Reconciliation and GP Summary Care Records. Polypharmacy was defined as patients prescribed 5 or more medications. Drugs with anticholinergic properties were considered as an example of Potentially Inappropriate Medication (PIMs) using the Anticholinergic Burden Scale. 77 patients were referred in the time period. 9 were excluded due to incomplete/unreconciled medication information.

Result. 77.94% (n = 53) were prescribed 5 or more medications.

38.24% (n = 26) were prescribed over 10 medications.

10.29% (n = 7) prescribed over 15 medications.

69% of (n = 47) prescribed an anticholinergic.

42.65% (n = 29) prescribed more than 1 anticholinergic.

Conclusion. Polypharmacy and potentially inappropriate prescribing remain widespread within the older adult population.

Increased anticholinergic burden further compounds risks of cognitive impairment, delirium and death.

Other categories of Potentially Inappropriate Medications, including those no longer needed, ought to be identified and reviewed. Over-the-counter medications also need to be screened for.

Elimination or reduction of anticholinergic burden may improve quality of life for patients, as well as cost burden on services.

Pharmacovigilance, collaborative working, regular and systematic medication reviews, and on-going training are needed across services providing care for the older adult.

Utilisation of mental health transfer checklist proforma from acute physical health hospitals (Liverpool University Hospitals NHS Foundation Trust) to mental health hospitals (Mersey Care NHS Foundation Trust)

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Aims. Testing the compliance and completion rate of a transfer checklist (proforma) created in accordance with local hospital policies.

Background. The proforma was developed following serious incidents where medically unstable patients were inappropriately discharged to mental health hospitals, requiring readmission to acute medical hospitals. Frequently these events reported an inadequate

handover from medical to mental health teams and patients were often prematurely deemed medically fit with evidence to the contrary.

Although parity of esteem between mental and physical health has been a high profile political issue in the UK since 2011, evidence indicates that parity is far from being achieved. This first ever checklist was designed to improve safety of patient transfer from acute physical health hospitals to mental health hospitals by ensuring patients are medically fit and better communication between the two trusts.

Method. Data were collected retrospectively over a six-month period between August 2018 and January 2019 and retrieved from patient notes available at relevant trusts. Electronic notes were obtained from medical wards, accident and emergency and Mersey Care electronic systems. Notes were specifically scrutinised for presence of the proforma, quality of completion and, number and reasons for readmission from mental health hospitals to acute physical health hospitals following their medical optimization. Readmissions were considered as admissions to physical health hospitals up to one month following discharge with evidence of ongoing concerns.

Result. 6597 referrals were made to liaison services from Liverpool University Hospitals, of which 5–6 % were admitted to inpatient mental health units. 31% of admissions from Liverpool University Hospitals were readmitted to a physical health hospital within one month of discharge indicating inappropriate and unsafe discharges. Of all those readmitted, 10% had ongoing acute medical concerns prior to admission to a mental health hospital. The proforma was filled in 13% of admissions from Liverpool University Hospitals. None of the forms were fully complete.

Conclusion. 10% of patient admissions to mental health hospitals were identified as inappropriate due to ongoing acute medical concerns. The proforma served as structured guidance and evidence of medical fitness at time of transfer. However poor compliance was observed, which could be secondary to lack of awareness of the proforma and inadequate dissemination of the policy. Findings were shared and discussed with the appropriate teams both in acute physical health and mental health hospitals and steps will be taken to raise awareness of the proforma before completing a second audit.

The organization of a mental health phonenumber in Buenos Aires City: its role to minimize the impact of mental health services disruption amidst COVID-19 pandemic

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Aims. The main concern of this research is to evaluate the performance of a new Mental Health Phonenumber Programme, developed to facilitate access to Mental Health Services and to lower the impact of Mental Health Services disruption due to COVID-19 lockdown. Crisis resolution, new referrals, and patients' reconnection with their former Mental Health Teams were recorded.

Method. The data obtained from 11,406 calls made to the Mental Health Phone Line from April 14th, 2020 to March 1st, 2021 were analysed. Crisis resolutions, new referrals, and patients' reconnection with their former Mental Health Teams were calculated.

Result. Of the 11,406 calls registered, 72.2% of them were made by women. Mean age was 50.13 years, SD 18.51; median: 50.

There was a significant difference between gender regarding age (males: mean 43.91 years, SD 18.88; females: mean 52.48 years, SD: 15.9), being the males who used the phoneline younger ($t:23.75$; $p < 0.000$). 54.2 % of the users lived with a significant other. Crisis resolution represented 12.6 % of the sample, request for information 34.4%, psychosocial interventions 47.6% and, reconnection with former Mental Health Team 4.3%. New referrals for treatment were 2.9% of the total calls. Two main negative affects the 74.2% of the total affect reported. Anxiety-Fear accounts for 49.3% of reported feelings and depression a 24.9 %.

Conclusion.

Coping with and management of COVID-19 restrictions within the secure and forensic inpatient setting - a patients' and carers' perspective

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Aims. To seek patients' feedback on their wellbeing and the service adaptations during the COVID-19 pandemic

To obtain carers' views on service adaptations during the COVID-19 pandemic.

To establish impact on patients' wellbeing and progress in the context of COVID-19

Background. The COVID-19 pandemic resulted in unprecedented challenges faced by healthcare systems worldwide. Public Health England (PHE) provided guidance to manage the spread of the virus. In response to the national lockdown, the Forensic Healthcare Service part of Sussex Partnership NHS Foundation Trust (SPFT) took measures that were considered necessary to prevent the risk of spread to patients and staff.

Restrictions necessary to contain the virus included immediate suspension of all patients leave except emergency leave, suspension of visits by family members and professionals including legal visits and restrictions on multidisciplinary (MDT) members physically present on the wards. It was necessary to adapt our existing model of care to reflect and represent the challenges faced by such restrictions.

A service evaluation project was undertaken to ascertain the patients' and carers' perspectives of the management of restrictions.

Method. Standards

It is noteworthy that no service standards in the context of this unique global pandemic were available internationally, nationally or regionally at the time of undertaking the project.

Methodology / Data collection

An anonymous patient feedback questionnaire was developed to collect data on voluntary basis from all the inpatients within the secure and forensic CDS. Patients' feedback was broadly divided in to three sections 1) personal factors, 2) satisfaction with access to information and 3) satisfaction with services to include mental and physical well-being.

Patients' feedback was collected during a 6-week period. For observation purposes, risk comparison anonymous data were also collected. Informal Carers' feedback was collected with regard to virtual visits.

Result. During the data collection period 99 out of 105 beds were occupied. The response rate was 49% (49 responders).

Overall 73% of responders expressed that their mental health was affected. Approximately 51% of responders expressed that progress towards their discharge was very much affected. 91% of responders were not coping well with the new circumstances

Overall, carers' feedback was positive in regard to provision of virtual visits.

Conclusion. Our survey has shown that the necessary COVID-19 pandemic restrictions have in some domains resulted in a negative impact on patients' mental wellbeing and progression. However, it also identifies positive areas of new practice, which have been maintained by the service.

Reviewing suitability of Essex Partnership University Foundation NHS Trust out of area locked rehab placements

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Aims. To look at 14 EPUT out of area patient profiles, map their journey to the current locked rehab placements -To review the appropriateness of placement of 14 patients through reviewing whether the care provided is achieving the rehabilitation goals.

To look at patients' needs and whether the local alternatives can provide the care

Background. Rehabilitation services aim to help complex General Adult Mental health patients reintegrate in the community by promoting independent living skills. Some complex mental health patient's care needs mandate a specialist rehabilitation services. Currently there has been a nationwide shortage of local rehabilitation services. This resulted in placing complex needs patients out of area in locked rehabilitation hospitals and miles away from their local community connections. Families and local community team providers travel miles to keep in contact with their complex need persons. The NHS five year plan includes minimizing the current out of area placements and for local services to work together as per CQC recommendations to work together and bring those individuals closer to home.

Method. We designed a tool and examined the electronic records for all 14 out of area placed patient profiles, mapping their clinical journey and reviewing whether the care provided is achieving the rehabilitation goals.

Result. (N = 14), Patient profiles: 78.5% had residual symptoms (Psychotic symptoms 85%). Patient's illness profile; treatment resistant with residual symptoms in 71.4% and 7% had comorbid illicit substance misuse, other illness profiles 21.4%. History of alcohol and illicit drug misuse was present in 78.5% and 45% of them were using illicit substances more than 5 years. Patients' risk profile revealed 86.7% had history of non-compliance. Attempted suicide 21.4% has attempted suicide at list once in which 1/3 of them had more than one attempt. 64.3% Had positive history of offending behavior. All patients in the sample had history of violence 85.7% had risk of vulnerability and self-neglect, 28.5% has history of carrying weapons, 35.7 had a previous Custodial sentence. Average Duration of illness average 16.7 years, average distance from home was 149 miles though clozapine was considered in 92.8% only 35.7% of sample was on clozapine, and the other 64.3% were on combinations. Only 35.7% were on depot.

Conclusion. There is a need for expert input for advice regarding complex Management of residual symptoms and rehabilitation needs in the community. Health and social care joint working is needed.