24 (39%) had been involved in an SI. Only half felt adequately supported by the trust at internal investigation. Knowledge of the available internal and external sources of support ranged from 38-71% however these sources were rarely utilised. 12 (60%) trainees did not feel that learning had been facilitated following an SI and almost none had been informed of internal investigation outcomes.

Respondents who gave a low (1-4/10) rating of support from their NHS Trust were more likely to have been informed about the incident in person, been invited to team-based support or been aware of the variety of sources of support available, when compared with respondents who scored their Trust support more highly. Suggestions for improvements made by trainees included opportunities to observe coroners' inquests and a peer support scheme from colleagues with experience of SI involvement.

Conclusion. Unfortunately, trainees did not report much improvement in their experiences compared those in the 2017 survey, and a large proportion continued to feel unsupported. Interventions had not been as widely circulated as intended and only half of trainees had been invited to team-based support. Possible further interventions include increasing email communication to trainees following SIs and setting up a peer support scheme. We are in the process of organising a coroner's inquest observation programme for trainees.

Adherence to Public Health England (PHE) guidance for the use of personal protective equipment (PPE) in north Wales mental health unit- a regional audit

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Aims. To ensure that the PPE guidance is strictly adhered to.

To ensure that patient care is not compromised.

To help us in areas of need in order to educate the staff regarding the techniques of PPE and thus ensure patient and staff safety and care during the pandemic.

Method. Novel coronavirus 2019 was first described in December 2019 in Wuhan in China. Since those initial few cases, it has rapidly proliferated to a global pandemic, putting an inordinate amount of strain on healthcare systems around the world. We believe that the technique of donning and doffing if followed as per PHE guidelines would be of help in both preventing the infection and improve the care and safety of both patients and staff.

This Audit includes both In-patient and Out-patient units in Psychiatric services across North Wales. Data were collected from 19 units out of 39. We observed covertly 325 staff members belonging to various cadres. Apart from the Donning and Doffing techniques, we also observed the availability of designated areas for this purpose and the availability of PPE as well.

Data collection was by junior and senior doctors from various sites of the mental health unit in North Wales. A proforma was provided, the standards were based on PHE guidelines.

Result. It was noted that just about 50% of the staff followed donning as per guidance. Amongst all three sites, the Central team showed a better adherence with 85% of them donning PPE correctly. whereas only 22% adhered to donning in the West team.

Only 21% of them managed to doff PPE as per guidance amongst all 3 centres in North Wales.

It was also noted that there are no designated areas to Don and Doff in outpatient units. Staff, in general, seem to not adhere to the guidance of utilising a mask, especially when within 2 meters distance of other staff.

Conclusion. We will be presenting the Audit at the regional meeting. After discussion with the infection prevention control team and Health and safety lead, we intend to improvise the wards with designated areas for donning and doffing. Teaching sessions for the staff in all three sites, reminders in various areas of the community mental health units and inpatient units.

We are hoping that these recommendations will help us in achieving our aim of health and safety during this pandemic.

A retrospective analysis comparing clinical outcome measures pre- and post- the introduction of telehealth in a community-based psychiatry clinic in a tertiary medical centre

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Aims. The aim of this retrospective analysis was to look at the effect that telehealth had on patient outcomes and the therapeutic alliance.

Method. Clinical outcomes measures were collected prospectively as part of routine clinical care. Outcome measures were administered at patients' initial and final appointment. Information was merged into a single database and imported into IBM SPSS for retrospective analysis. The following measures were administered at the beginning and end of treatment and were used to evaluate patient progress; Health of the Nation Outcome Scale (HoNOS), Life Skills Profile (LSP), Session Rating Scale (SRS), Outcome Rating Scale (ORS).

Result. Two cohorts were derived from the clinic; the first cohort (n = 90; 53 females; 37 males; M = 35.72 years; SD = 12.12 years) comprised of those patients whose care occurred between 23/09/2019 and 22/03/2020 and did not receive telehealth appointments. The second cohort (n = 122; 68 females; 54 males; M = 36.2 years; SD = 12.78 years) were those patients who presented to the clinic and were discharged between 23/03/2020 and 21/09/2020 and received at least one telehealth appointment. In the pre-telehealth cohort, mean HoNOS scores at baseline were 17.87 compared to 13.53 at discharge, mean LSP scores at baseline were 10.76 compared to 9.01 at discharge, mean SRS scores at baseline were 34.17 compared to 36.04 at discharge, and mean ORS scores at baseline were 12.97 compared to 21.28 at discharge. In the post-telehealth cohort, mean HoNOS scores at baseline were 14.45 compared to 10.50 at discharge, mean LSP scores at baseline were 7.85 compared to 7.19 at discharge, mean SRS scores at baseline were 36.04 compared to 35.36 at discharge, and mean ORS scores at baseline were 18.83 compared to 15.85 at discharge.

Conclusion. Results show that telehealth did not impact negatively on the therapeutic effect of clinical sessions, highlighted by similar reductions in HoNOS and LSP scores. It was seen in the post-telehealth cohort that there was worsening in the subject-rated scales (SRS and ORS) which was not seen in the pre-telehealth face-to-face cohort. Thus, there seems to be a

discernible negative difference from the patient's perspective in the clinical sessions. This may be due to the difficulties in therapeutic alliance using the telehealth platform. We appreciate that there are a number of confounding factors, especially the effect of COVID-19 isolation. Telehealth is a useful addition to our assessment and treatment paradigms and its use should continue; however, we should be aware of the potential negative effect on therapeutic alliance.

What happens to people admitted to a specialist dementia unit in the west of Scotland?

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Aims. Recent local research examined mortality rates following admission to a dementia ward. We wanted to expand on this work and include other important health outcomes for patients admitted to our specialist in-patient dementia unit in the west of Scotland. This would provide a comprehensive overview of our in-patient population, aid service review and improve care. We hypothesised that patients admitted would be physically frail, have a significant mortality rate and would likely require long-term care post discharge.
Method. The clinical notes for each admission to the unit for one year were examined (total 62). We extracted data from a number of different areas such as demographics, mortality rates, discharge destination, readmission rates and prescribed medications.
Result. 60% had an Alzheimer's/mixed dementia diagnosis. Average length of stay was 64 days. 62% were discharged to a care home (50% of this total had lived at home prior to admission), 18% to complex care and 20% to the community. 66% were prescribed an antipsychotic and the average number of medications was 8.4. 35% had a readmission under general medicine within a year of discharge. 19% died whilst an inpatient and a further 30% had died one year post-discharge (total one-year mortality of 44%).
Conclusion. People admitted to our dementia unit are physically frail, with only 20% returning to live in the community, 35% being readmitted to a general medical ward within a year of discharge and 44% dying during the admission or within a year of discharge. We need to bear these results in mind when considering if hospital admission is appropriate and ultimately further develop our skills in palliative and end of life care in order to provide those people admitted to our dementia unit (and those who remain at home) with the highest standard of care.

Audit of pharmacological management of borderline personality disorder as per NICE clinical guidelines CG78

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Aims. To audit the current practice of pharmacological management of Borderline Personality Disorder with NICE Clinical guideline [CG78]: Borderline personality disorder:

Objectives:

23 patient records were analysed in the last 18months with a diagnosis of EUPD to compare current practice against NICE clinical guidance. (2009)

Standards:

When prescribing

1) Use a single drug.
2) Use the minimum effective dose.
3) Agree with the person the target symptoms, monitoring arrangements and anticipated duration of treatment. Antipsychotic drugs should not be used for medium, long term treatment.

Indication:

4) Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated. (Repeated self-harm, marked emotional instability, risk taking behaviour and transient psychotic symptoms).
5) Short-term use of sedative medication may be considered cautiously as part of the overall treatment plan in a crisis. The duration of treatment should be no longer than 1 week.
6) When considering drug treatment, provide the person with written material about the drug. This should include evidence for the drug's effectiveness in the treatment of borderline personality disorder and for any comorbid condition, and potential harm.

Review:

7) Review the effectiveness and tolerability of previous and current treatments.
8) Discontinue ineffective treatments.

Background. Borderline Personality Disorder is common in psychiatric settings with a reported prevalence of 20%.

As per NICE Guidance (CG 78), no medications have been found effective for the longer term treatment of personality difficulties.

This audit was carried out to review if patients were offered psychiatric reviews to discuss the medications they are using, the effectiveness of these, and any potential side effects.
Result. Good practice compliance of 90-100% was noted where >90% compliance was seen in areas where the effectiveness and tolerability of current and previous medication was reviewed by the clinicians under Structured Clinical Management. Also was noted that antipsychotics were not used for medium to long term in patients with Borderline Personality Disorder in the cohort.

The following areas were non-compliant with the NICE recommendations where a compliance <79% has been achieved.

When prescribing, use a single drug (avoid polypharmacy), agree target symptoms, monitoring and duration, provide written information, discuss evidence for effectiveness in treatment of borderline personality disorder.

Partial compliance was achieved (80-89%) with use of sedatives for less than 1 week and discontinuation of ineffective treatment.
Conclusion. Distribute key cards to clinicians.

Provide written information to patients.

Re-audit in 6 months.

An audit on admission clerkings across Lancashire and South Cumbria NHS Foundation Trust (LSCFT)

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