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Wednesday 16th March 2011

Management of medical emergencies in old age psychiatry: Focus on ECG and lab results  
Dr Atef Michael, Consultant in Geriatric Medicine, Dudley

An introduction to coaching skills for psychiatrists  
Dr Alan Swann, Newcastle General Hospital, Newcastle-upon-Tyne and Dr Steve Blades  
Coaching skills can be useful in a wide range of consultant roles and activities. Educational supervision, team development, consultant appraisal and clinical work can all be enhanced in their effectiveness with the skillful use of coaching.

This three hour workshop is run by two formally trained executive coaches. Alan Swann is a consultant old age psychiatrist in Newcastle and Steve Blades, a GP and freelance executive coach.

The workshop will introduce and outline a practical model of coaching. Participants will have an opportunity to use this approach to help them with a current issue.

DoLS: Induction course for mental health assessors  
Dr Jonathan Waite, Nottingham

Leadership and Management skills for Consultant Psychiatrists  
Kate Phipps, Birmingham and Solihull Mental Health Foundation Trust and Dr Asif Atta, Manor, Nuneaton  
The aim of the workshop will be to discuss the concepts of management and leadership with reference to the expectations from Consultant Psychiatrists as senior clinicians in the context of current challenges facing the national health service. There will be opportunity to participate in group work as well.

Update on neuroimaging for old age psychiatrists  
Dr Swarup Chavda, Consultant Neuro-radiologist, Queen Elizabeth Hospital, Birmingham

Thursday 17th March 2001

Clinical update on psychosis in later life  
Professor Robert Howard, Dean, The Royal College of Psychiatrists, London

Spirituality in later life: the contribution of spirituality to well being in dementia  
Rev Professor Elizabeth MacKinlay, Centre for Ageing and Pastoral Studies, St Mark’s National Theological Centre, Canberra and University of Canberra, Australia  
Matters of the spiritual dimension become more important to many older people. For some this is an issue largely associated with life meaning, for others, it has a specific religious dimension. Over the last two decades this has become an area of great interest, and anecdotes of spirituality in older adults are being replaced with research findings. While it seems there is a common spiritual core that works across different religious faiths in pastoral care, there are certainly different religious and cultural beliefs and practices. The importance of understanding how this dimension is lived out in individual lives in multi-faith and multicultural twenty-first century western countries is an important challenge for those who work with older adults.

This paper will briefly describe a model of spiritual tasks and process of ageing developed as part of doctoral studies that mapped the spiritual dimension of independent living older people. The model recognises a central core of life meaning from which the person responds to life, this is affected by and influences the person’s sense of self-sufficiency and vulnerability, their life story, the importance of relationship and finding hope in later life. The model was tested in further studies of frail older people in residential care, then with people who have dementia.

The second part of the paper will outline research conducted using a framework of spiritual reminiscence with people who have dementia to examine ways of more deeply connecting with them and their search for meaning in the midst of dementia.
Alcohol problems in the elderly
Dr Tony Rao, North Southwark CMHT, London

Although alcohol use and misuse traditionally diminishes with age, changing demographics have seen
differences in the epidemiology of alcohol problems in the elderly. The combination of a ‘baby boomer’
population with different drinking patterns and a growing older population has now brought older alcohol
problems in the elderly into sharper focus. This presentation summarises current knowledge and looks at
future challenges for old age psychiatry services in meeting the needs of older people with alcohol misuse
and dual diagnosis.

Sexuality, ageing and dementia
Professor Susan Benbow, Staffordshire University

The future of Old Age psychiatry in area of the new commissioning GPs
Professor Steve Field, The Royal College of GPs

Working age dementia: needs and barriers
Dr Peter Bentham, Queen Elizabeth Psychiatric Hospital, Birmingham and Dr Jo Allen

Mental Capacity Assessment: dealing with complex issues
Dr Andy Barker, Becton Centre, New Milton and Dr Jonathan Waite, Nottingham

Dementia and spirituality: widening the scope
Prof Elizabeth MacKinlay, St Mark’s National Theological Centre and University of Canberra, Australia

How can I develop my own career in old age psychiatry?
Dr Hugh Series, Townlands Hospital, Henley-on-Thames

Safeguarding older people: practical approach
Prof Paul Kingston, Staffordshire University, Stoke-on-Trent

Memory clinics; meeting the current challenges
Professor David Jolley, Gnosall Health Centre, Stafford

Liaison old age psychiatry: the RAID experience
Dr Paul Boston, Longley Centre, Sheffield and Professor George Tadros, City Hospital, University of Stafford-
shire

Mental health of older gay and lesbian people
Dr Sandra Evans, St. Bartholomew’s Hospital, London and Dave Richards
Management of depression in older people: bridging the primary / secondary care interface

Professor Carolyn Chew-Graham, University of Manchester, Manchester

Up to one in four older people have symptoms of depression that may require treatment, yet fewer than one in six older people with depression discuss their symptoms with their GP, and only half of these receive adequate management1. Evidence will be presented that depression may be ‘normalized’ by both clinicians and patients contributing to under-detection and management.

There is good evidence for the effectiveness of psychological interventions and anti-depressants for the treatment of depression in older people, but social interventions, and working with the third sector are also thought to be important. A new approach to improving access to care will be discussed.

NICE guidelines should support clinicians’ decision-making in management and referral, although adequate resources need to be available in order to implement the guidance. Initial data suggests older people are under-represented in referrals to Improving Access to Psychological Therapy (IAPT) services, and reasons for this will be presented.

Historically, referral to an Old Age Mental Health Team would be considered when there is diagnostic difficulty, risk of self-harm or suicide, neglect or poor response to two anti-depressants or psychological therapy. There remains regional variation in criteria for referral to secondary care, and dialogue across the primary/secondary interface may be limited; data from a relevant study will be used to illustrate the tensions.

The ‘Collaborative care’ model, integral to which is liaison across the primary/secondary interface, has been shown to improve outcomes for older people with depression. The place of collaborative care in the NICE guideline (Depression) will be discussed.

How current policy directives including the Mental Health Strategy and the White paper, Equity and Excellence Liberating the NHS, offer opportunities to commission and deliver care in innovative ways will be suggested for debate.


The use of clinical dashboard in OAP services

Dr Krishnan, Newcastle General Hospital, Newcastle-upon-Tyne

Gaps and spaces: representation of dementia in contemporary poetry

Dr Hannah Zeilig, Institute of Gerontology, King’s College London

Living with dementia: the role of the Faculty Consumer Group

Clive Evers, Alzheimer’s Society; Barbara Hodkinson and Peter Ashley

This presentation will explain the purpose and function of the Royal College of Psychiatrists Faculty of Old Age Patient and Carer Involvement Steering Group.

We will outline the role, reporting lines, membership and responsibilities of the group and explain its origin.

A brief summary of the topics it has discussed will be given along with an account of achievements and influence on the wider faculty activities.

Members of the group will describe their personal experiences of dementia and their stimulus to join and contribute to the group.

The presentation will also draw on the wider experiences of present and past members of the group and invite discussion about its future role and the issues that it needs to consider.
Update on technological aids for dementia patients
Professor Chris Nugent, University of Ulster, Newtownabbey

One of the key challenges facing society as our population continues to grow is the demands being placed on health and social care provision. This is coupled with the need to develop new approaches to allow the general public to take more control of their own health and lifestyle management. The increased prevalence of technology usage, its reduced costs and improved processing and communication speeds are all key factors which have resulted in new technology based solutions being investigated to address these challenges. Through a consolidation of sensing technology with the ability to record data, intelligent data analysis techniques which may be used to interpret the data collected and personalised interfaces to support interaction with users it has now become possible to deliver support when it is required, where it is required.

Based on these advances a new range of technological aids and intelligent environments for dementia patients are currently being investigated. It is no longer unrealistic to consider that a person’s activities within their own home can be remotely monitored, nor is it unrealistic to consider that the home environment can offer levels of autonomy and adapt to its inhabitant’s changing needs. More recently, developments have targeted the continuum of service delivery to ensure that technological aids can offer support both within the home and the community. The introduction of a technological aid can, if deployed in the optimal circumstances with appropriate levels of support, provide a positive impact.

This talk aims to discuss the recent evolution of technological solutions which have been developed to support dementia patients. The topics covered will address advances which have been made in the area of technological aids from the perspective of supporting memory, social contact, supporting activities of pleasure and safety. A number of case studies will be highlighted and used as the basis to demonstrate how the technological aids have been embedded within the lives of dementia patients.

Recent studies have demonstrated the utility of the introduction of technological based aids and intelligent environments through alleviating some of the challenges associated with dementia along with reducing carer burden. Nevertheless, there are a number of technical and usability challenges which are being recognised as major hindering factors to a wider scale uptake of these solutions. The challenges associated with introducing new technological solutions will be discussed along with the consideration being given towards what the future holds for both the pragmatic use of technological aids along with anticipated future developmental trends.

Old age psychiatry in Egypt (need, services and training)
Dr Osama Refaat, winner of the Faculty of Old Age Overseas Bursary

Information from demographic studies of populations has necessitated the priority of focusing on elderly age. Worldwide the proportion of people aged 60 and over is growing faster than any age group. In Egypt, it is expected that by the year 2025, the percentage of the population over the age of 60 will reach 11.5% of the general population and this will increase to 20.5% by the year of 2050. Health planners direct their attention now to this age population, putting in consideration that service needs of this category are not sufficiently met.

The increase in the proportion of people over 75 is likely to have the greatest impact upon mental health service delivery, as the effects of population ageing are amplified by a disproportionate increase in dementia. Depression is also common in old-age with reported rates ranging from 2% to 15% in those over 65. Other mental disorders of major concern in old-age include anxiety, delirium, substance abuse disorders and schizophrenia.

Most of the educational courses in the medical faculties in Egypt are lacking any significant reference to the elderly population as a special age group with specific medical and mental health problems. Also the one year basic training for the newly graduated physician (house officer), is significantly lacking the geriatric psychiatry core competencies needed for assessment and service delivery.

The department of psychiatry in Cairo University has developed a special unit for old age psychiatry. The role of the unit has extended beyond research and clinical services delivery. The unit carries out basic training on the geriatric psychiatry core competencies. It is involved in training of psychiatrists and other members of the multidisciplinary team dealing with elderly population, such as general practitioners, nurses, psychologists and social workers. The team is concerned with developing culturally sensitive tools for assessment and therapeutic modalities.
Old Age Psychiatry in Chile: why development is needed?
Dr Rommy Von Bernhardi, Pontificia Universidad Catolica de Chile

Chile has experienced an accelerated demographic and epidemiologic transition generating various challenges for the design of policies, plans and socio-sanitary programs. The global improvement of life condition together with the social and sanitary improvement and the success of public health policies, have elevated life expectancy in Chile over 78 years for the general population. However, at the same time, whereas in 1970, people older than 60 years represented 8% of Chilean population, by 2002 they increased to 11.4% and on the next 20 years we estimate a growth ratio of 3.7% per year, projecting for the year 2025, a population of near 4 million of elderly adults (representing 20% of the country population). This phenomenon, associated with the low personal income (compared with the quality of health index of Chile), and the country’s many social needs, constitute a problem for its effects on the social security and health system of the country, emphasizing the need to increase the quality of life of elderly adults.

One of the focuses of new health policies are dementiaing diseases and psychiatric disorders of elderly adults. These problems include a series of chronic conditions presenting a decrease of cognitive functions, and changes on personality and behaviour that significantly affect life quality of patients and their families. Little attention has been given to the prevalence of mental illness among elderly adults. Screening studies with the Geriatric Depression Scale (5-GDS) reveal that up to 47% of elderly adults (77 years mean age: range, 60-92 years), consulting in a geriatric unit has scores suggesting depression. Other reports suggest that of the geriatric patients showing symptoms of depression, psychiatric evaluation confirmed depression on 53.8% of them, with 22.9% showing organic brain problems, 12.7% neurotic problems and 11% others. In contrast, dysthymia, some phobias, and alcohol dependence disorders have been noted to be less common among elderly subjects than in younger population. Nevertheless, a sizable proportion of psychiatric disorders among older adults begin after the age of 59, and one third of elders with major depression has a late onset disorder.

More studied, the National Health Census of 2003 and 2010 screened cognitive impairment of elderly adults with the Folstein Mini Mental State Examination. Those with cognitive impairment also answered a Pfeffer test, which explored autonomy on everyday life activities. Prevalence of cognitive impairment compatible with clinical dementia was observed in 15% of elderly adults. Prevalence increased with age, from 5-8% between 60 and 70 years old to affecting up to 43% of elders older than 80 years. Interestingly, on the 2010 census the prevalence of dementia on the older group decreased to 30%. Prevalence of impairment shows a clear social gradient, increasing from 2% on the high socioeconomic status group to a 32% for elders of low income. The same tendency is observed for educational level, with a 7-fold higher prevalence of impairment for the less educated group. It is important that 10% of elderly adults were bellow poverty line and a 13.2 % of them were illiterate at the 2003 census. Moreover, around a third of elderly adults (representing 50% of the disable population of the country) present at least some level of impairment of their functional capabilities affecting everyday life activities, resulting in a dependency or institutionalization, and an increasing demand on social and health services.

Impairment on around a third of dependent elders depends on psychiatric or cognitive/behavioural problems. Besides their high prevalence, these pathologies have a high direct and indirect cost. Indirect cost depends, among others, on the impact of the care of the patients on a family member. Near 60% of the patients are cared by a family member, care that extends for several years, greatly affecting the caregivers mental health and their possibility of working outside home. Around 75% of them receive no practical help on their work. At present times, there are not specific proposals for the integral management of psychiatric problems of elderly adults. In contrast, for dementia of elderly patients, there are 3 main aims for the health service for the next 5 years: improved awareness of dementia through public information and professional training; early diagnosis and intervention; and provision of high-quality hospital, home, and institutional care. Of these aims, rapid specialist assessment to attain an accurate diagnosis is possibly the most radical, as it will require extensive reforms of the current model of health care. To simplify dementia care, it is proposed that specialized memory clinics also deliver continuous patient-centred support and advice, incorporating also services for the caregivers and family members by a multidisciplinary team.

Work partly supported by grant FONDECYT 1090353.
Royal College of Psychiatrists
Faculty of Old Age

PATIENT AND CARER INVOLVEMENT STEERING GROUP

TERMS OF REFERENCE

Name
The group shall be known as Royal College of Psychiatrists Faculty of Old Age Patient and Carer Involvement Steering Group.

Role
The Patient and Carer Involvement Steering Group of the Royal College of Psychiatrists aims

• to ensure that the interests of patients, carers and the general public are fully taken into account within the work of the Faculty and the College.
• to provide an opportunity for the Faculty to share its plans for developing services and improving training of doctors and for members to influence this development
• to allow group members to be able to disseminate this thinking amongst their own groups or organisations and contribute further feedback to the development process

The Steering Group will operate at a strategic level and assist with the development of Faculty policy and practice in respect of improving clinical psychiatric services for the benefit of patients, carers and the public.

Reporting
The Patient and Carer Involvement Steering Group will report to Council through the Faculty Board.

Membership
The Steering Group will have a maximum membership of 12, as follows:

• RCPsych Chair of the Faculty
• RCPsych Secretary of the Faculty
• RCPsych Treasurer of the Faculty
• Nine lay members, including at least one person with dementia, one active carer and one other person representing older people with mental health problems other than dementia.
• Deputies for each role are acceptable but not mandatory

Lay members: A lay member of the Steering Group is normally defined as an individual who is not currently practicing as a health or social care professional. All lay members will be invited to act as individuals rather than on behalf of outside organisations.

Chairperson: The Chairperson for each meeting will alternate between Faculty and lay members.

Term of office
All lay members will be appointed for between two and three years, with the option of extending their appointment for a further 12 months.

Responsibilities
1. To highlight areas of patient and carer concern to the Faculty and Council and advise on appropriate action.
2. To ensure that patient, carer and public views and experiences inform the work of the Faculty and College.
3. To ensure that the Faculty and the College takes into account the patient, carer and public perspective in all appropriate activities.
4. To be a resource for the Faculty and College to enable the delivery of a professional service that meets the needs and aspirations of patients, carers and the public.
5. To work in association with other patient and carer committees in the College.

6. To ensure that Patient and Carer committee members are supported in their role.

7. Where possible to attend by invitation induction days and workshops held that are relevant to the work of the committee.

8. To contribute to connecting patients with information and including them in educational aspects such as the training and assessment of psychiatrists and publications produced by the Faculty and the College.

9. To contribute to the Faculty’s policy proposals including a full part in the strategic development of the Old Age Faculty through contributing to our Strategy Day.

10. To ensure that decisions are made in the best interests of the College’s role in protecting the public interest, and in promoting high professional standards.

11. To respond to requests for comment from the Faculty and the College Boards and Committees.

12. To reduce stigma by disseminating the work of the Faculty locally and nationally.

Frequency of meetings
There shall be a minimum of three meetings of the Patient and Carer Involvement Steering Group per year, not including working parties or conferences. Meetings will normally be held at the Royal College of Psychiatrists in London.

If a member of the Steering Group does not attend for three consecutive meetings, enquiries shall be made as to whether the member wishes to resign.

Clive Evers /Peter Connelly
November 2009
New Research Presentations

The development of old age psychiatry services in England until 1989
Dr Claire Hilton, Consultant old age psychiatrist, Central and North West London NHS Foundation Trust

Aims
One way of understanding how an aspect of modern life has developed is by exploring its history. This paper outlines the development of old age psychiatry until it was recognised as a specialty by the Department of Health in 1989. Understanding the challenges, successes and failures of the past can stimulate debate and may contribute to decision making for future planning. This paper explores some themes – social, political, economic, medical and psychiatric – which contributed to the specialty’s early development.

Method
Standard methodology for contemporary history has been used including oral history, and a witness seminar, and the study of written archives and published work.

Results
A critical history of our specialty is beginning to emerge.

The demographic ageing of the population and its effect on mental health services were clearly recognised in the 1940s. Although geriatric medicine began to expand clinically at that time, for older mentally ill people there were only a few sporadic developments until the 1970s. Negative attitudes, towards old people and their potential to respond to treatment, have influenced social policy and hence funding to provide resources. Much clinical, epidemiological and relevant scientific research took place in the intervening years, notably led by Felix Post and Martin Roth. Government support was often lacking, and at times geriatricians and the Royal College of Physicians were more supportive than other psychiatrists.

The turning point for old age psychiatry was probably the late 1960s with several hospital scandals, and then the appointment of Tom Arie to a consultant post at Goodmayes Hospital serving parts of east London. He was central to initiating links between clinicians and the Department of Health and Social Security which led to the development of a blueprint for providing old age mental health services and subsequent changes.

Until official recognition of the specialty, relevant and specific clinical and service related data were inadequate. Such data were needed to ensure the development of sufficient senior registrar training, provision of realistic resources and evaluation of emerging services.

Does Intervening Early in Alzheimer’s Disease Delay Institutionalisation?
Dr Jerry Seymour, Consultant in Old Age Psychiatry, Rotherham; Dr Claire Littlewood, Consultant in Old Age Psychiatry, Sheffield and Ms Victoria Owen, Statistician, University of Nottingham

The National Dementia Strategy promotes early diagnosis of dementia, though there is little hard evidence that early diagnosis improves outcome.

The financial cost of residential/nursing home care is high, and as older people do not wish to live in care homes, any intervention that prevents or delays institutionalisation is desirable.

Aims
To investigate whether a specific Memory Clinic intervention, early in the course of Alzheimer’s Dementia (AD), delays institutionalisation.

Method
A retrospective case note study was performed on randomly selected AD patients diagnosed by Sheffield Elderly Mental Health Services, and scoring > 20/30 on Mini Mental State Examination at diagnosis. Two groups were identified; “treatment as usual”; and “Memory Clinic patients”. Both groups had access to cognitive enhancers and the usual range of services. In addition, the Memory Clinic group had access to post-diagnostic counselling, cognitive rehabilitation and carer support, in follow up from a Memory Clinic specialist nurse.

Results
30 Memory Clinic patients were compared with 30 “treatment as usual” controls, matched for age, sex and severity of dementia at diagnosis, and use of cognitive enhancers. The intervention group had institutionalisation delayed by a median time of 10 months, compared to controls.

Implications
Despite methodological limitations, this is the first study to show that a psychosocial intervention early in the course of AD subsequently delays institutionalisation.
New Research Competition for Mohsen Naguib Prize

New for old: old-age psychiatry education in a time of service reform
Dr Alex Bailey and Dr James Warner, CNWL NHS Foundation Trust, Imperial College London

Old-age psychiatric services, in tandem with the rest of the healthcare system in the UK, are changing. Whilst managers and clinicians are grappling with the potential impact of the NHS White Paper reforms, age discrimination legislation and GP commissioning on service provision, it is imperative that education does not get left by the wayside. This paper sets out some of the potential difficulties for education and training provision in the new world of the NHS and offers some potential solutions.

Old-age psychiatry training and education brings with it unique challenges and opportunities. Recently the profile of dementia has increased but it has long been recognised that diagnosis and management of older people with mental illness is often sub-optimal within primary and acute secondary care. Part of the solution for this is improved recognition of the importance of these issues, coupled with a privileging of education and training across undergraduate curricula, specialist training and continuing professional development.

There are also more immediate concerns regarding training of specialists in old-age psychiatry. The introduction of service line management entrains increasing super-specialisation of clinicians. In old-age psychiatry this may include ‘dementia only’ service lines. There is therefore the potential for the emergence of ‘dementia psychiatrists’ with a resultant deskilling in more generic skills in management of older people with mental health problems. This will also have implications for the sufficient training of psychiatry trainees as well as placement of medical students during their psychiatric attachments. This is in the context of falling numbers of applicants to psychiatry training posts.

So what is to be done? It is a sine qua non that we cannot do nothing, or we risk losing the significant gains we have made in improving mental health for older people. This paper will provide avenues for action, from the option of ‘modular’ CCTs (certificate of completion of training), to competency based exit exams, to novel ways of introducing mental health issues for older people into curricula, through, for example, primary care. The solutions will inevitably not be acceptable to all, but the consequence of inertia on this issue will inevitably not be in the best interest of our patients.

Whilst the profile of old-age psychiatry as a specialty has arguably never been better, changes to healthcare structures and systems mean we must ensure that we do not end up sidelined. The importance of training and education in managing mental health problems in older age goes way beyond sub-specialty training and it is incumbent on all clinicians to ensure that standards and excellence in our field are maintained. This paper acts as a stimulus for debate so that as a specialty we can begin to navigate the difficult times ahead.

Cognitive impairment/dementia as a risk factor for delirium in elderly hospitalised patients: A systematic review and meta-analysis.
Dr Apparao Biradar, ST6, Aneurin Bevan Health Board

Background
Delirium is a common disorder seen in the hospitals and is highly prevalent among the elderly. Amongst the many risk factors associated with delirium, previous meta-analytic evidence suggests cognitive impairment/dementia is the most significant.

Objective
The aim of the study was to confirm the association between cognitive impairment/dementia and delirium in elderly hospitalised patients through a systematic review of the literature.

Method
A comprehensive search strategy was used to identify relevant studies: seven electronic databases, checking the references and contacting researchers.

The articles were selected if they met the following inclusion criteria: 1) prospective cohort studies; 2) patients aged over 50; 3) At least 30 cases of delirium; 4) Studies published in English, between January 1996 and March 2010.

The quality of the studies was assessed by using the following quality scales: “Newcastle-Ottawa scale for cohort studies” and “Quality assessment scale for studies examining risk factors”. All analyses were performed by using Statsdirect statistical software version 2.7.8. The combined relative risk was calculated by using both a fixed effect model and a random effect model. The P statistic was used to measure heterogeneity among the studies. A series of subgroup analyses were performed to explore the source of heterogeneity. Finally, the robustness of the results was tested by the sensitivity analysis.
Results
Eleven studies met the inclusion criteria. Cognitive impairment / dementia was significantly associated with delirium in ten studies. The included studies were of low to moderate quality. The pooled relative risk was 3.63 (95% CI 2.56-5.16, P < 0.0001) using a random effect model (figure.1). However, the high I^2 (81.6%, 95% CI = 66.4% to 88.2%) value indicated that variability between studies was due to heterogeneity. The statistical heterogeneity was reduced by excluding the outlier studies and by performing a subgroup analysis of studies that excluded cases of delirium on admission (figure.2). The sensitivity analysis confirmed that the findings of this meta-analysis were robust to publication bias and poor quality studies.

Conclusion
This study confirms that the elderly hospitalised patients with cognitive impairment/ dementia are at least three and a half times more likely to develop delirium compared to patients without cognitive impairment/ dementia. The association is significant, consistent and biologically plausible. Though the included studies had methodological limitations, the strength of association between cognitive impairment/dementia and delirium should not be ignored.

Prevalence of Undiagnosed Dementia and Inappropriate Use of Antipsychotics Within Care Homes.
Dr Craig Gordon, Dr Paul Brown, Ms Lynn Kirkwood, Ms Margaret Hollinger, Ms Judith Logan, Mr Ian MacQuarrie and Dr Ajay Macharouthu, NHS Dumfries and Galloway

Introduction
Dementia is a national priority. There are an estimated 683,597 people with dementia in the UK, representing roughly one person in every 88 (1.1%). Dementia is a significant cause of disability in later life, being third in the world health organisation’s global burden of disease report. By 2025 one million people in the UK will have dementia. Surprisingly, only 1.4% of research papers since 2002 have investigated dementia resulting in limited exploration of how dementia is recognised and managed in care homes. Previous studies have confirmed that 2/3 of residents within care homes suffer from dementia. Dementia has recently attracted a high media profile, particularly in relation to antipsychotic prescribing.

Aims and objectives
Our primary aim was to explore dementia diagnoses within care homes. The objectives included quantifying prevalence rates of undiagnosed dementia within residents of care homes throughout Dumfries and Galloway. This included examining rates of psychotropic prescribing for behavioural and psychological symptoms of dementia in those without a formal diagnosis.

Methods
All care homes within Dumfries and Galloway were invited to participate. Participants were randomly selected from a list supplied by the home and consented. An MMSE was performed on each participant along with a CAM scale and a FAST. Exclusion criteria included current antibiotic use, delirium and sensory difficulties. Care home staff were interviewed to obtain a cognitive history and the participants’ notes were scrutinised for a dementia diagnosis.

Results
Our preliminary results demonstrate that 86% of the patients recruited to date would meet the criteria for dementia. Of those, a statistically significant 27% (p=0.016) had no previous history of dementia.

Conclusions
Our initial results suggest a higher prevalence rate of dementia within care homes than previously thought. Furthermore, they suggest a significant proportion of dementia cases remain undiagnosed. This emphasises the importance of further study and debate to determine how dementia should be managed within care homes, including whether or not acetylcholinesterase inhibitors should be prescribed within this group. Additionally, we identified antipsychotic prescribing for individuals with dementia who lacked a formal diagnosis. Given the scale of unrecognised dementia identified here, a legitimate concern would be an associated high rate of inappropriate antipsychotic prescription. The study is ongoing and our completed results will be available during presentation.
“The eyes have it!” A longitudinal retrospective cohort study identifying potential for Glaucoma treatment as neuroprotection in Alzheimer’s Dementia
Dr Ranjit Mahant, Central & North West London NHS Foundation Trust

Aim
To test the effect of glaucoma medication use on the age of onset (AOO) of Alzheimer’s dementia (AD) compared to control subjects. Supplementary analysis looked at the effect of common systemic medication on AOO of AD.

Background
There is growing evidence of associations of AD with several other conditions. Focusing on one such association, several studies have convincingly revealed higher rates of glaucoma in neurodegenerative disease. Further study has revealed similar models of degeneration of retinal ganglion cells in glaucoma in relation to neurons in AD. Wide opinion has suggested that treatments for AD or glaucoma could potentially offer neuroprotection for the other. In 2009, Lupton et al. published robust evidence linking a later age of retirement to a delay in onset of cognitive problems and AD. Unpublished within their data was the discovery that a subset of patients with glaucoma may also have had a causal relationship with a delay in the AOO of AD.

Method
Data was collected retrospectively from the South London and the Maudsley Trust electronic patient database using their new CRIS data analysis tool generating 55 cases and 198 controls. Using STATA 10, regression analysis was undertaken comparing medication variables against the patients’ age and AOO of AD. In addition to the analysis of my collected data, I obtained the unpublished data from Lupton et al. 2009 in order to generate further results for discussion.

Results
Following analysis, I did not find a statistically significant effect of glaucoma treatment on AOO of cognitive problems in AD (P>0.816). Furthermore, there was no significant correlation with glaucoma medication subclasses or certain systemic medication on the AOO of AD. Interestingly, re-analysis of the Lupton et al. data alone did demonstrate a statistically significant effect of glaucoma treatment on the AOO of AD (P> 0.005), confirming the results of their original analysis. Combining the Lupton et al data to my study data did not demonstrate a statistically significant (P> 0.055).

Discussion
Overall, allowing for study limitations including sample size, I cannot unequivocally conclude that glaucoma treatments do not have an effect on AOO of AD. This study raises important questions, and demonstrates potential for alternative sources and delivery in treatment for AD. It also demonstrates potential for SLaM’s new CRIS data analysis tool. This study highlights the need for further work, and focuses interest in this intriguing area of non-mainstream research.

Diagnosis and outcomes over 12 months following referral for depression to an old age psychiatry service: Should we reconsider a functional – organic division in old age services?
Dr Amy Manley – CT2 North West Deanery

Background
Increasingly there has been a move to divide the management of old age psychiatric patients down a functional-organic line. However this delineation is far from clear. Depression has been implicated as a prodromal symptom to dementia, with a possible causative role. Division of services has the potential to cause misdirection of such patients to functional services.

Aim
This audit aims to assess how many patients referred with depression actually have dementia, in order to quantify the likely incidence of misdirection of patients should functional-organic division be implemented.

Methods
This study reviews all 41 patients referred by their GP with depression to old age psychiatry service in 2009. It looks at final diagnosis, follow up and outcomes over 12 months in order to determine whether GPs would refer to the appropriate service should they be split between functional and organic and to review the degree of comorbidity in this population.
Results
17% of patients referred with depression were given a diagnosis of dementia. 78% of these diagnoses were made at the first appointment. Only 51% of the sample had a primary diagnosis of depression following old age psychiatry review. A further 10% had a comorbid dementia or anxiety disorder. The rest of the sample had adjustment disorder, anxiety disorder or no psychiatric diagnosis. Of the patients referred 22% had had previous contact with psychiatric services with regards to depression. Of these, 33% received a diagnosis of dementia at this referral. In the twelve months following initial assessment 63% of those with depression showed improvement. A diagnosis of dementia predicted a move to residential care (p=0.01). At 12 months 34% continued to be followed up and 16% had died.

Discussion
This audit demonstrates that over 1 in 6 patients referred with depression actually had a dementia for which they required psychiatric input. This remained true when only looking at patients re-referred with a history of previous depression. Moving towards dementia-only old age services may delay appropriate care for this group who would be likely to be first referred to functional services. This may lead to unnecessary assessments and frustration for the patient and healthcare providers. It is important that this group are not overlooked when planning old-age services in the future.

Musical Hallucinations: An internet based survey of sufferers.
Dr Richard McCollum, ST6 Old Age Psychiatry, West Midlands Deanery

Aims
The internet offers healthcare professionals a relatively quick and easy way to gather information about their patients. This technology is perhaps more relevant when considering rare conditions, where the sufferer commonly experiences feelings of stigma or embarrassment, such that they may feel more comfortable sharing information in an anonymous manner.
A musical hallucination is a symptom that matches this profile and this survey aims to identify sufferers and gather information about their experience.

Methods
Recognising the difficulties in collecting data on such a rare symptom, I contacted Dr Neil Baumann, who operates the popular website www.hearinglosshelp.com. The website offers sufferers the opportunity to seek help and advice in an anonymous manner, thus avoiding any feelings of stigma. Dr Baumann has coined the term ‘musical ear syndrome’ (MES) to describe the experience of musical hallucinations. He agreed to add an internet survey to his website, which could be completed by sufferers of musical hallucinations (MH’s), or the relatives of sufferers. The survey includes 22 questions and can be viewed at the bottom of the page www.hearinglosshelp.com/articles/mes.htm.

Results
This paper provides the results from the first 137 respondents who completed the online survey between 7/10/2009 and 28/12/2009.
• 46% of respondents were over 60 years old; 31% between 40 and 60; 16% were under 40 years old.
• 76% of respondents were female.
• 72.5% reported having hearing loss and 58% reported suffering from tinnitus.
• 62% reported the onset of their symptoms as being sudden.
• At the time of onset of their symptoms, 37% of respondents reported suffering from anxiety; 55% reported stress and 28% reported depression. 32% reported having a memory problem, but only 4% had a diagnosis of dementia.
• 36% of respondents reported living alone, while 33% lived with their spouse or partner and 27% lived with their family.
• With regard to the effect MH’s have on the lives of sufferers, the most common problem was interference with sleep, reported by 25%. 33% reported that MES had little or no effect on their life.
• Only 16% reported trying a treatment and of these, the only treatment reported as having helped was using background noise (3%). Only 15% reported seeking professional advice.
• Since the survey began, well over 500 responses have been submitted.

Discussion
The results are broadly in line with previous research findings. Notable exceptions are that the survey suggests musical hallucinations (MH’s) can occur at any age and symptom onset is usually sudden. Most sufferers reported not experiencing significant distress or disruption to their lives as a result of their experience. Insomnia was the most common complaint.
Although there are obvious disadvantages to collecting data via internet surveys, it is a relatively easy and time efficient method of acquiring basic data sets, especially for rare conditions. This survey demonstrates how the internet can improve our knowledge of the subjective experience of a rare and often embarrassing symptom.
A Comparative Survey of very late onset Schizophrenia like Psychosis in Ethnic and Indiginous Elders in Leicester City East

Nisha Mokashi, SpR Old Age Psychiatry

Aims
Leicester is a city with an unusually high proportion of ethnic minorities also reflected in its growing elderly population. Data documenting the demographics of this population diagnosed with Very Late Onset Schizophrenia like Psychosis (VLOSP) is very limited. This study is designed to compare indigenous elders and those from ethnic minority backgrounds who have been diagnosed with VLOSP.

Methods
All referrals to Leicester city east Old Age Psychiatry service with a documented diagnosis of ICD10 F22-29 over a 2 year period (JAN 2006-JAN 2008) were identified and selected for the study. This information is available on a computerised coding system within the directorate. I have pre-designed a schedule to detail the information gained from the case notes.

Results
46 case notes were identified to fall within the selection criteria. Of these, 19 had no previous psychiatric history and were diagnosed with VLOSP. Of these 9 were of an Indian Subcontinent ethnic background compared to only 7 who were of indigenous background. The other 3 were from the Caribbean or Eastern Europe.

Both the indigenous and the Indian Subcontinent groups had a high proportion of females, good social network, were mostly referred by their GP with a high or urgent priority referral. There were no significant visual or auditory problems in both groups and the presence of psychotic symptoms and delusional beliefs was similar.

The indigenous group had a higher proportion of cases that were single or divorced, lived alone and had depressive symptoms.

The Indian Subcontinent group had a higher number of cases living at home and a MMSE was not done in the majority due to language problems.

Conclusion
Elders from the Indian Subcontinent minority group have the highest proportion of presentations of VLOSP. However, the nature of these presentations is similar across all backgrounds. The high priority of these presentations highlights the importance of functional services for older people with mental health problems.

Comparison of Adenbrooke Cognitive Examination-Revised and Mini Mental State Examination

Introduction
The National Dementia Strategy states early identification of Dementia as one of its three key strategies. Memory Clinics have traditionally been using Mini Mental State Examination as their main screening instrument in assessing for cognition. However, some services use additional screening tools, like Adenbrooke Cognitive Examination-Revised.

Aims
To compare and contrast the Adenbrooke Cognitive Examination-Revised with Mini Mental State Examination, in the context of early and accurate diagnosis of dementia.

Methods
Although there is no single specific cut off score for Mini Mental State Examination, 24/30 has been traditionally accepted as the usual cut off score. Hence in this study, we compared those who are scoring 25 or more in their Mini-Mental State Examination.

We examined all consecutive new referrals to the Memory Services. We screened those who were scoring 25 or more on the Mini Mental State Examination and selected the first 50 of these patients.

A data collection sheet was devised to collect the data comparing the two cognitive instruments.
Results
33 out of 50 people despite scoring 25 or more in the Mini-Mental State Examination scored less than 82 (cut off score for dementia) in the Adenbrooke Cognitive Examination-Revised. Out of these 33 people, 13 were diagnosed with early stages of different forms of dementia. 5 people were diagnosed to have functional illness. Only 1 person was discharged after detailed assessment did not find any evidence for cognitive impairment.

Normal or above cut off scores on dementia for Adenbrooke Cognitive Examination-Revised were matched by excellent scores of 28 or above on Mini-Mental State Examination for 14 out of 17 patients. Adenbrooke Cognitive Examination-Revised examines memory aspect of cognition in detail. For over half of the 33 patients scoring less on the Adenbrooke Cognitive Examination-Revised -R, the memory score was 13 or less out of 26 on the Adenbrooke Cognitive Examination-Revised.
Interestingly none of the patients refused Adenbrooke Cognitive Examination-Revised examination.

Conclusion
The above survey raises the question as to whether Adenbrooke Cognitive Examination-Revised should be used routinely in all initial memory assessments, given its significant advantage in detecting early dementia.

Homocysteine in Alzheimer’s Disease: role of dietary folate, vitamin B6 and B12
Dr Ramin Nilforooshan, Cognitive Treatment and Research Unit, Uckfield Community Hospital; David Broadbent, Dietetics Department, East Sussex; Dr Gary Weaving, Clinical Chemistry and Immunology Department, Royal Sussex County Hospital; Jill Gurton, Dietetics Department, East Sussex; Vanessa Moore, Dietetics Department, East Sussex; Lesley Houston, Dietetics Department, East Sussex; Dr Naji Tabet, Institute of Postgraduate Medicine, Brighton & Sussex Medical School and Cognitive Treatment & Research Unit

Aims
Studies assessing plasma Homocysteine (Hcy) in Alzheimer’s disease (AD) have produced conflicting results and may have been influenced by dietary factors. Therefore, we quantitatively assessed whether relevant dietary intake differed significantly in AD patients when compared to controls to account for reported differences in Hcy concentration.

Methods
AD and control participants recruited through a memory clinic completed a 4-day diet intake record. Blood Hcy, B12 and folate were also measured.

Results
No significant difference was obtained between the two groups in the daily intake of folate (p=0.71), vitamin B6 (p=0.60) and vitamin B12 (p=0.65), and in plasma Hcy (p=0.28). In the control group, and as expected, Hcy was significantly and negatively correlated with serum folate (p=0.02) and vitamin B12 (p<0.001), but not with intake levels. In the AD group, significant and negative correlation was obtained only between Hcy and serum folate (p=0.01).

Conclusion
Hence in AD patients with normal dietary and plasma vitamin concentrations, Hcy does not seem to differ significantly from what is expected for the control group. The contradictory reported results for Hcy in AD may in part be related to variation in dietary intake, but other mechanisms cannot be ruled out.
Dying with dementia, what are patients' needs and how do we identify the need for a more palliative approach: an audit of forty-eight deaths.

Dr Olutade Olajitan, Associate Specialist, Oxleas NHS Trust; Dr Thomas Gilberthorpe, Oxleas NHS Trust; Dr Monica Crugel, ST6 in Old Age Psychiatry Oxleas NHS Trust; Dr Adrian Treloar, Consultant and Senior Lecturer in Old Age Psychiatry, Oxleas NHS Trust, Memorial Hospital

Objective
To explore the needs of people who are dying with dementia in the community, how they die, the feasibility of dying well and how to identify the need for a more palliative approach to care.

Sample and Method
Audit of last 48 consecutive deaths from Greenwich Advanced Dementia Service (GADS), a specialist service which sets out to provide care for people with dementia (PWD) at home until they die.

Results
48 PWD died between 2006 and 2010. Mean time in GADS = 379 days (range 6 – 2099). 47 lived at home with a key carer and one lived alone with family carers coming in on a rota to support. 15 (31%) were male. Mean age at death = 82.9 (range 59.6 – 96.8).
All had advanced disability requiring 24 hour care. 39 (81%) were provided with hospital beds and a number also had hoists at home.
The Gold Standards Framework (GSF) “Surprise Question” failed to identify 31% (n=15) of those who required a more palliative approach because of substantial mental distress. The GSF “Prognostic Indicator Guidance” showed similar difficulties, it failed to identify 5% (n=17).
A National Council for Palliative Care (NCPC) algorhythm that includes severe distress as an indicator for a more palliative approach worked much better, identifying 100% of those thought to need a more palliative approach.
Most patients had ongoing needs for psychotropic treatment to reduce distress psychosis and agitation in the last six month of life. Despite care to reduce and avoid unnecessary use, 69% (n= 33) received anti-psychotics and some were treated with other psychotropic agents such as antidepressants.
Pain management was also important with 50% receiving opiates.
77% (n=37) died at home with a small number requiring brief hospital admissions towards the very end of life due to sudden changes and a lack of any 24 hour service to support them. The large majority died peacefully and well at home without the need for artificial nutrition or hydration. Feedbacks from bereaved relatives were extremely positive.

Conclusion
Severe mental distress in advancing dementia is a key and common indicator for a more palliative approach. Tools designed to identify the need for palliative care should recognise this. Most people can die peacefully with dementia but psychiatric needs continue through to death in the majority. Advanced dementia care is very well received by carers.
Survey of the old age psychiatry liaison service in Hairmyres Hospital, NHS Lanarkshire
Dr Julie Langan, Dr Ashling Mooney, Dr Damian Lynch & Mr Kenny Cushley, NHS Lanarkshire

Aims
NHS Lanarkshire has no dedicated Liaison Psychiatry team. Adults over 65 who require inpatient psychiatric assessment are referred centrally. Referrals are screened by an associate specialist who works with a specialist nurse. Two sessions of associate specialist time per week are allocated to liaison work. We aimed to review the reasons for referrals and to determine their outcome. We also aimed to capture the attitudes of the referrers to the existing service and to collect their views on their ability to manage common mental health problems.

Method
A retrospective review of referrals over a 6 month period was undertaken. From the central log a list of patients was generated. The electronic patient psychiatric record was searched. Those in whom the electronic or paper record was incomplete were excluded.

To survey the service, an electronic questionnaire was sent to the Care of the Elderly Department consultants, staff grades and ward managers. Our survey was adapted from the ‘Liaison Mental Health Services for Older People: A literature review, service mapping and in-depth review of service models, research report June 2010’. A 2 week response period was given and a reminder email sent.

Results
82 referrals were made. After exclusions, 66 remained.

The most common reasons for referral were: ‘assessment of confusion and memory impairment’ (38%) and ‘advice on management of behavioural issues’ (23%). Other reasons included ‘assessment of low mood’ (18%) and ‘assessment after deliberate self harm/for individuals voicing suicidal ideation’ (8%). 3% were referred for ‘assessment of capacity’.

Specialist advice was the primary outcome in 48% of cases. 44% of referrals underwent medication changes. 8% were transferred to a psychiatry bed.

Of our 13 surveys, 10 (77%) were completed - 6 by medical staff and 4 by senior nurses. Respondents identified ‘behavioural issues’ as the most common reason for referral, followed by ‘advice on dementia’ and ‘depression’. Most respondents felt comfortable assessing low mood, confusion and capacity. However, were much less comfortable assessing patients who may have self harmed or who were presenting after a suicide attempt. 90% of respondents indicated that further training would be helpful.

70% of respondents indicated that a routine referral should be seen in less than 5 working days. 80% rated the current response time as ‘adequate’. 60% either ‘agreed’ or ‘strongly agreed’ with the statement that ‘mental ill health in the over 65s is adequately managed’. 90% thought that a dedicated liaison consultant psychiatrist post would be beneficial.
Poster Abstracts
Thursday 17th March 2011

1. Evaluation of admissions under Section 2 of the Mental Health Act to the Old Age Psychiatry Ward in North Staffordshire
Dr Olubukola Adeyemo and Dr Jalema Saveiko

Aim
To evaluate the use of section 2 of the Mental Health in detention of older people within North Staffordshire

Method
The medical records of all older people (aged 65 years and over) under Section 2 of the Mental Health Act between 1st of September 2009 and 1st of March 2010 was obtained from Mental Health Law (n=41). Data collected from the notes was recorded onto a data collection form. Each case notes were studied individually and information about their socio-demographic and clinical background collected, e.g. gender, area and type of residency, time and date of admission, duration of section 2, source of referral, presenting symptoms, admitting consultant.

Results
The main findings revealed that there were more patients admitted from their own homes (fifty nine perent) than from care homes and also more admissions occured during working hours. More admissions occured during the week than it did over the weekend. Fifty six percent as opposed to forty four percent of admissions occured during working hours. Thirty six percent of the patients were regraded to informal within three weeks of being detained under section 2 of the mental health act. Majority of patients however, did have behavioural difficulties secondary to dementia. These were contrary to the widely held belief of the local team.

2. Length of stay and service provision for older adults in the acute hospital: The Rapid Assessment, Interface and Discharge model (RAID)
Ms Selina Balloo, Prof George Tadros; Mr Rafik Salama; Rapid Assessment, Interface and Discharge Team (RAID), Birmingham and Solihull Mental Health Foundation Trust; Dr Nageen Mustafa, Staffordshire University; Ms Rachel Pannell, Sandwell and West Birmingham Hospitals NHS Trust and Dr Emma Kelson, Birmingham and Solihull Mental Health Foundation Trust

Aim
It has been well documented that older adults, particularly those with dementia have longer hospital stays leading to poorer outcomes for patients. The aim was to examine length of stay after RAID intervention and the service provided by a liaison psychiatry team for older adults in an acute hospital.

Method
ICD 10 diagnosis, length of stay, outcomes and interventions provided for all older adult referrals was collected. External data from the information technology department was requested regarding diagnosis of dementia in the hospital in general, admission and discharge dates.

Length of stay was compared across three groups; patients seen by RAID, a RAID influence group (not directly seen by RAID but managed by acute colleagues that had received training/support from RAID) and retrospective control group (prior to the launch of RAID). The groups were matched for; age, sex, period of admission, HRG code, main diagnosis and ICD-10 codes.

Results
Mean length of stay for the RAID group patients was 25 days compared with 31 days for the retrospective control group, a difference of 6 days. The mean length of stay for the RAID influence group was 10 days compared with 22 days for the matched retrospective control group, a difference of 12 days. An increase in the diagnoses of vascular and unspecified dementia was observed, with a 22% increase compared with the number of patients diagnosed in the same month in 2008/09, before RAID. Of the patients diagnosed with dementia, 27% of patients, carers, family or staff were given education regarding dementia and 60% of patients were either signposted or directly referred onto other services in the community by the RAID team.
Conclusion
Early detection and diagnosis of dementia has been highlighted as a key area where improvements are needed. RAID has increased awareness and diagnosis of dementia in the acute hospital through providing education, referral and outpatient clinics to patients over the age of 65 years. Length of stay was shorter in the RAID group, suggesting that with intervention from the RAID team patients efficient and effective discharges were facilitated. The influence group length of stay was also shorter than the retrospective group, suggesting that with teaching, training and supervision on other cases RAID was able to impact on the length of stay of patients in this group. As well as the reductions in length of stay being positive for patients there are obviously cost savings associated with these reductions.

3. Assessment and Prevention of Falls in Old Age Psychiatry
Dr Paul Brown, Dr Ajay Macarouthu, Dumfries and Galloway Royal Infirmary

Introduction
Falls are a critically important clinical field in older patients. Falls in these patients are a major cause of disability and the leading cause of mortality from injury in the over-65 population with the royal society for the prevention of accidents (ROSPA) estimating 1 in 3 older people over the age of 65 will have a fall. Incident rates for falls in hospitals are 2-3 times greater than in the community with high rates of physical and psychological complications in the patient as well as a major cost burden to health services. Locally there is no agreed, unified approach for the assessment and management of a psychogeriatric patient who has fallen. This study examines current standards of assessment and care in this crucial field.

Aims/objectives
To examine current clinical care and standards given to an older patient who has fallen against locally approved standards.

To produce a unified and agreed assessment/management protocol for medical/nursing staff based on existing recommendations.

Methods
Case identification achieved via analysing the datix system for all falls since November 2004 (NICE guidelines implemented). Subsequently medical case-notes were collected for applicable patients and resources were scrutinised to determine standard of care given to the fallen patient against criteria.

This is a baseline preliminary study. It is acknowledged that current NICE guidelines do not have a sufficient evidence base to reinforce their recommendations in reducing falls risk in elderly patients who fall in hospital. Nonetheless the recommendations are easily applicable and indicated in older hospitalised patients who fall and will contribute to reducing falls risk over the individual's lifetime.

Results
This study is ongoing. Nonetheless, important trends can be reported on the 33 falls analysed thus far from a sample of the criteria recorded. For example, the proportion of falls prompting a medical review is at 48%. Thus far no osteoporotic risk assessment has been done for any of the falls. Additionally only 15% of falls patients have a subsequent medication review.

Discussion
It is evident there are many readily implemented strategies to reduce the falls risk to an older patient over their lifetime. Falls assessment and prevention could be more coherent, standardised and thorough through the application of locally approved assessment plans thereby aiming to lower morbidity and mortality as well as economical cost.

4. Establishing a Memory Clinic register of patients with dementia who are prescribed antipsychotic medication
Dr Azad Cadinouche, ST6 and Dr Hilary Kinsler, Consultant, NELFT

Aims
Antipsychotic drugs are used for the behavioural and psychiatric symptoms in dementia. Concerns have intensified since October 2002 when the manufacturer of risperidone disclosed the increased risks of stroke and mortality.

We set out to establish a register of an ‘at risk’ group of patients in agreement with the 2009 ‘Time for action’ recommendation that “systems and services are put in place to ensure good practice in the initiation, maintenance and cessation of these drugs for people with dementia”.

Method
A retrospective review of paper and electronic records of patients attending the Memory Clinic between October 2010 and November 2010 was performed.
Results
188 patients were included from a total of 219 outpatient episodes. There were 112 females and 76 males, aged between 57 and 98 years old, predominantly White 88%, Asian 11% and other BME 1%.

Alzheimer’s disease with 90 patients (134 including mixed dementia) was the leading type of dementia, vascular dementia 12 patients (56 with mixed dementia), mixed dementia 44 patients, unspecified type 35 patients, one patient with Parkinson’s disease dementia, one with Korsakoff’s dementia and one Dementia with Lewy Bodies. 187 patients (99.5%) did not have a concomitant primary functional psychosis except for one female White patient with a Fronto Temporal Dementia.

Eleven patients were prescribed a second generation antipsychotic medication. Of the six who were prescribed risperidone one was for a functional delusional disorder, four were given quetiapine and one aripiprazole.

Conclusions
600 patients are under the care of the Memory Clinic; from an estimated 2645 people aged over 65 with dementia in the London Borough of Redbridge. The number of patients who are concurrently prescribed antipsychotic medication is unknown.

Eleven patients on antipsychotic medications were identified following scrutiny of a third of the total patients’ records. They are now on an ‘at risk’ register as will newly detected patients.

The register will be on target with the ‘Time for Action’ recommendation that “reducing the use of antipsychotic drugs or assuring good practice when they are needed should be made a clinical governance priority across the NHS” and the 2010 NICE ‘Quality standard for dementia’ recommendation that the ultimate goal is to reduce to 0% the use of antipsychotic medication for people with dementia.

5. Inpatient prescribing on 3 Old Age Psychiatry units in East London
Dr Azad Cadinouche, ST5, North East London NHS Foundation Trust and Dr Sandra Evans, Consultant, East London NHS Foundation Trust

Aims
Prescribing errors in inpatient settings are more frequent in older adults (63%) compared with working age adults (37%). The NPSA highlighted that 15.7% of medication-related errors were associated with the prescribing process while the GMC reported that 10% of all prescriptions issued by doctors contained errors. The Department of Health warns that the legal responsibility for prescribing lies with the doctor who signs the prescription.

Method
An audit of inpatient prescribing on three units in East London was compared to two similar audits published in The Psychiatrist. The Trust’s audit tool which implements the BNF guidelines was the set standard.

Results
The name, dose, route and frequency of administration of a prescribed medication were duly recorded. Patients’ names were identified in every case (Onajala et al 100%; Ved et al 96-98%) and charts were all signed (similar to Onajala et al and Ved et al). The allergy box completion rate was 100% (14 - 52%, Onajala et al and 10 and 19%, Ved et al). Approved or generic names of medications were always used. Both domains of ‘patient identification’ and ‘completeness of prescription’ were 100% legible (93 - 99%, Ved et al). Advances in junior doctors’ training on prescribing and prompts at induction could explain the higher scores in our sample.

Conclusions
Preventable harm from medicines could cost more than £750 million each year in England (NPSA). Medication errors result in people being admitted or readmitted to hospital, delay discharge, increase the risk of litigation for clinical negligence, impact on staff confidence and morale.

Our recommendations reflect the NPSA’s priority areas for action for NHS organisations, the WHO Quality in Prescribing guidelines, the joint Medical Schools Council and the British Pharmacological Society’s view on training on prescribing and the conclusions of the 2009 GMC report:
1. Improve individual competence of junior doctors – training programme, induction, prescribing skills assessment.
2. Training for nurses – pivotal in identifying medication errors.
3. Pharmacists - training doctors, nurses; attending ward rounds.
4. Interprofessional team-based education.
5. Access to prescribing modules – Royal College of Psychiatrists' website.
6. Regular audits.
7. Reporting medication incidents - ‘no blame culture’.
8. A standard Trust wide or national prescribing chart.
9. Implement the medicines reconciliation policy.

6. An audit of the documentation on advance decisions for new patients seen by the Nottinghamshire City North, West and Hucknall Community Mental Health Team for older people

*Dr Rosemary Elizabeth Cameron, ST6 old age psychiatry and Dr Ruchika Dhar, GP trainee*

**Aims**
Over the past several decades, there has been increasing emphasis on individual autonomy. This has lead to expanded opportunities for patients to be able to express preferences and make choices around their health care decisions. In England and Wales statutory recognition has been given to an advance decision to refuse treatment by terms of the Mental Capacity Act 2005. Advance decisions recognise that a competent person is best situated to identify the future interests of their incompetent self. This is a precious freedom that law and policy should protect to ensure that an advance refusal of treatment has the same legal status as contemporaneous refusal and that it is binding on the medical profession. Therefore, in an attempt to ensure this, accessibility for healthcare professionals to advance decisions is extremely important. The aim of the audit was to establish if new patients seen by the Nottinghamshire City North, West and Hucknall Community Mental Health Team for older people were having the section of their assessment documentation completed which recorded if they had an advance decision, written statement and if their lead clinician had been informed.

**Method**
30 patients open to the Nottinghamshire City North, West and Hucknall Community Mental Health Team for older people were randomly selected and their case notes reviewed.

**Results**
1. 12 out of the 30 patients had the advance decision section completed. No patients had an advance decision.
2. 6 out of the 30 patients had the written statement section completed. All of the 6 patients had no written statements.
3. 27 out of the 30 patients did not have the section relating to if the lead clinician had been informed completed.

**Conclusion**
The low number of new patients with completed documentation regarding advance decisions/written statements/lead clinician being informed may be that the community mental health team does not have a full understanding of Mental Capacity Act 2005 and the relevance of having this information documented. It is therefore important that the results of this audit be fed back to the community mental health team and if necessary relevant education provided. A re-audit following this work is planned in approximately 6 months.
7. Leaping The Gate – An Open Access Memory Assessment Service  
Dr Peter Connelly, Royal Hospital, Perth

Although the vast majority of people with dementia wish to know their diagnosis only 30-50% of people with dementia ever receive a diagnosis. Contributing factors include inadequate recognition of key symptoms by people developing dementia, reluctance to discuss symptoms with their GP, reluctance of GPs to refer to specialist services or minimisation of the value of those services by GPs and reluctance of Secondary Care services to extend access for fear of being overwhelmed.

Following the closure of a dementia admission unit we offered three days of open access memory assessment, one in association with a flu vaccination day and two in association with the patient’s normal appointment with their GP.

A total of 156 patients attended across the three days. A flow chart is presented demonstrating the pathway of these patients from presentation to diagnosis. Their characteristics are compared with 12 patients referred over the same timescale through normal channels and 11 patients already “in the system” with a diagnosis of MCI. Initial results (87 patients) found 8 people with dementia (7 expected from demographics), one of whom had been referred by their GP, and 11 with mild cognitive impairment.

Pros and cons of the service are discussed.

8. Assessment of healthcare and placement needs in an older Forensic Psychiatric population in Comparison to a younger Forensic Psychiatric population
Dr Kavita Das, ST5, Old Age Psychiatry, Farnham Rd Hospital, Surrey and Borders Partnership NHS Foundation Trust; Dr Kevin Murray, Consultant & Clinical Director, Broadmoor Hospital, West London Mental Health Trust; Dr Rick Driscoll, Medical Director, Thornford Park Hospital, Newbury, Priory Group and Dr S.Rao Nimmagadda, Consultant Psychiatrist, Thornford Park Hospital, Newbury, Priory Group

Background
An area in health care provision which is under-researched and suffers from lack of adequate facilities in the UK are services for older patients with history of serious offending.

Available research on older forensic patients in the UK has reported high psychiatric morbidity and physical health problems. Similar studies on older offenders have concluded that they have more mental and physical health needs. Earlier studies on similar populations in healthcare settings have methodologically shortcomings. Recent studies however conclude that assessment of healthcare and placement needs in older forensic patients are possible, using standardised needs assessment scales.

Aims, Objectives, Material and Methods
This is an exploratory study with an aim to compare healthcare and placement needs of older forensic patients (over 60 years) with younger forensic (under 45 years) patients from a High and a Medium/Low Secure Hospitals. An additional objective was to assist in service planning for the older forensic patients. A part of the study (15 patients each in the older & younger group from High secure Hospital Setting) was presented as poster in Faculty of Forensic Psychiatry Annual Meeting, Barcelona 2009.

Thirty patients in the older and 26 in the younger group were examined using the Camberwell Assessment of Needs (Forensic and Elderly version). Placement options were also compared using Forensic adaptation of Alternatives to Acute Psychiatric care Questionnaire (NABUS). Socio-demographic and clinical data was collected from the medical notes.

Results and Conclusions
The older population had more unmet needs in the areas of complex physical health problems, and also reported more psychotic symptoms and treatment as unmet needs than the younger group. The younger group had more met needs than the older group. The two groups were significantly different in placement needs in that more of the older forensic patients were deemed not requiring continued high secure placements in comparison to the younger forensic patients.

This study supports the hypotheses that there are significant differences in healthcare and placement needs of the older forensic patients in comparison to the younger forensic patients. The findings call for careful evaluation of medical histories & physical health monitoring in older patients in forensic settings. Patients in secure setting may be prescribed one or more classes of psychotropic & in higher doses. Appropriate screening tools to identify ‘metabolic syndrome’ should be put in place, to plan & monitor treatment.

In keeping with the significant findings, it is also important to train staff who look after older people in identifying and monitoring needs using standardised measures and the study highlights the requirement for age specific services.
9. Teaching and Training of acute hospital staff in mental health in older adults
Kathy Geelan, Dr Eliza Johnson, Prof George Tadros, Nabila Khan, Selina Balloo; Rapid Assessment, Interface and Discharge team (RAID), Birmingham and Solihull Mental Health Foundation Trust

Aim
As part of a new way of working in mental health in an acute hospital a liaison psychiatry team has provided teaching to acute colleagues. Aiming to improve understanding and reduce stigma of mental health conditions. Teaching has been provided on dementia, delirium, depression, dignity, person centred care, challenging behaviour, anxiety and psychosis. The aim of this evaluation was to examine staff satisfaction with the training and the impact they feel it will have on their future practice.

Method
Training was evaluated using questionnaires, which were completed and returned by staff trained after each session. The questionnaire included three open ended questions, two questions which required a response on a 5 point likert scale and two questions requiring yes, no or neutral responses.

Results
95 completed questionnaires were collected from staff trained, with the largest percentage trained being from nursing backgrounds (22%). 83% felt that the training enhanced their knowledge, 91% felt that it was highly relevant and 92% felt that it would improve their practice. The mean rating was 4.7 (with 5 being excellent), with responses ranging from 3 (neutral) to 5 (excellent). Staff commented that the training was ‘interesting’, ‘informative’ and ‘enjoyable’. Staff felt that their practice would be improved through having more confidence, awareness, understanding and willingness to deal with mental health difficulties.

Conclusion
Training provided to acute staff regarding mental health was well received, they felt that it was relevant, enhanced their knowledge and would improve their practice. Training such as this is beneficial both to staff dealing with patients with mental health difficulties and to the patients themselves, hopefully reducing the associated stigma and fear that has been reported by staff in previous research.

10. An audit of time to receive treatment and review with cholinesterase inhibitors in a memory clinic
Dr Catherine Gordon and Dr Rosemary Cameron, Notts Healthcare NHS Trust

Aim
This audit looks at assessment and reviews in a memory clinic in Broxtowe, Nottinghamshire for patients with a new diagnosis of Alzheimer’s Disease. The clinic had exceeded its capacity, with many patients not being reviewed within 6 months of starting treatment with cholinesterase inhibitors, and some patients waiting many weeks for diagnosis. Patients and carers had separate Mini-Mental State Examinations (MMSE) and Bristol Activities of Daily Living (BADL) six monthly.

Method
We audited 41 patients between June and November 2010 and have re-audited 29 more at the time of writing. Our standards were that patients should receive a diagnosis and be offered treatment within 6 months of presentation to our service, and should be reviewed within 6 months of their treatment initiation and titration.

Results
The mean starting MMSE between the 2 groups was no different at 20.8 and 19.9 (range 6-29). The mean BADL score was also no different at 10 (range 0-41).

The results showed that the mean wait for diagnosis and treatment was 22.4 weeks. This decreased to 14.3 weeks (P<0.043) in the next 29 patients seen. This was well below the standard of 6 months we had set.

22/41 patients missed the target of a 6 month review before the audit. Re-audit showed only 4 out of 29 had missed this target (P<0.009). This shows a significantly reduced time for formal review.

Conclusion
Following the results of the initial audit we reorganized the clinic. We relocated 12 clinics a year 10 miles to the north of the sector. We offered more flexible appointments for those who didn’t need separate assessments of BADL or MMSE who were highly functioning, and offered some yearly follow ups instead of 6 monthly.

Patients waited longer for treatment if they had further investigations. Increased waits were found if patients needed further neuro-imaging or psychometric tests to confirm diagnosis. These tests increase diagnostic sensitivity but often delay treatment. The mean wait for those not receiving a neuropsychological assessment was 13 weeks but 42 weeks for those that did (p<0.0006). Patients sometimes started treatment before results were available, and a presumptive diagnosis was made with the option to discontinue treatment if not appropriate. We are confident that patients can now be offered more local, prompter assessments with review within 6 months.
11. Patients Rights Of Voting in the Election (PROVE) Study
Dr Rachel L Gore (CT2 Psychiatry); Dr Xanthe M Barkla (CT2 Psychiatry); Dr Lois R Carey (CT2 Psychiatry); Dr A Mishra (Consultant Psychiatrist); Dr A Singh (SpR in Old Age Psychiatry)

Background
There has recently been a General Election in the United Kingdom on 6th May 2010. There has also been parliamentary focus of late regarding voting rights. Following some background research it emerged that there is a lack of awareness amongst mental health professionals and service users as to whether or not patients detained under the Mental Health Act 1983 have the right to vote. This raised the question as to whether both voluntary and detained inpatients on working age adult and older adult psychiatric wards were given opportunities to vote in the recent general election in May 2010.

Aims
Our aims were to determine whether inpatients on working age adult and older adult psychiatric wards were given the opportunity to vote in the recent general election on 6th May 2010, whether they actually voted and whether mental health professionals were aware of this issue.

Methods
A survey of 64 inpatients on 5 working age adult psychiatric wards, 1 functional old age psychiatry ward and 1 rehabilitation psychiatric ward within Northumberland Tyne and Wear Foundation (NTW) NHS Trust was carried out by means of an assessor administrated questionnaire. In a separate survey of Consultant Psychiatrists working within NTW trust, a questionnaire on their knowledge of this issue was sent via Trust email. Results were analysed using Microsoft Excel®.

Results
Only 18% of psychiatric inpatients had voted as opposed to 65% of the general population in the general election on 6th May 2010. The remaining patients did not cast a vote, and of these 56% said that if they had not been in hospital they would have voted. There was lack of clarity amongst consultant psychiatrists and other mental health professionals about the voting rights of patients.

Conclusions
The NHS must actively encourage and promote awareness of patients’ rights to vote in the election at both a local and national level. This will add to patient empowerment and help towards promoting patient choice in the NHS.

12. Audit of neuroimaging in a specialist Memory Assessment Service
Dr Sarah Greef, ST4 Psychiatry, 2gether NHS Foundation Trust and Dr Tarun Kuruvilla, Consultant Old Age Psychiatrist, 2gether NHS Foundation Trust

Background
Neuroimaging is often used as a first-line investigation for memory problems to rule out potentially reversible causes and, increasingly, to inform sub-type dementia diagnosis. Existing national & international guidelines are ambiguous as to when to request imaging, when it may not be necessary, and what type of imaging to request. The decision is usually made by individual clinicians with wide variations in practice. Further, local availability and resource constraints may affect neuroimaging requests.

With the national dementia strategy endorsing specialist memory assessment services across the country and with rapid advances in neuroimaging modalities, standardisation of practice is increasingly important.

In Gloucestershire, a specialist memory assessment service (MAS) was set up by 2gether NHS Foundation Trust in November 2009. The MAS clinicians in the five sectors identified a need for clear guidance on neuroimaging requests.

Aims
• To assess what neuroimaging occurred for patients referred to MAS across the county in one month.
• To compare this to NICE (National Institute of Health and Clinical Excellence), SIGN (Scottish Intercollegiate Guidelines Network) & EFNS (European Federation of the Neurological Societies) guidelines.
• To present the data to the MAS consultants, MAS steering group, and radiologists in order to agree on local guidelines.
Methods
- We developed an audit tool and piloted its use on a couple of patient case notes.
- All the patients referred to MAS in January 2010 were identified.
- Dr Greef collected data from the case notes using the audit tool.
- The Trust audit department analysed the data using SPSS.

Key findings
- There were 89 patients referred to MAS in Gloucestershire during January 2010. 82 notes were located and used in data collection.
- 69% of these had neuroimaging (59% requested through MAS, 10% prior to MAS).
- There was wide variation in practice with one sector having 100% and another only 33% neuroimaging.
- Of the patients who had neuroimaging requested through MAS, 88% had a CT scan, 8% had an MRI and 2% had SPECT.
- The length of time between the request for the scan and when the patient received the scan varied from 6 days to 42. The average wait was 22 days.

Recommendations
Local neuroimaging guidelines (details in main poster) were developed from NICE and EFNS guidelines, after consultation with MAS consultants and radiologists. A re-audit will be carried out after a year of implementation of these guidelines.

13. Memory Clinic Audit
Dr Kirsty Halliday, Psychiatry SHO (LAS post); Dr Alka Gupta, GP VTS ST2

Aims
- To investigate whether the Royal Oldham Hospital Memory Clinic is providing the best quality care to its patients.
- Whether this care is within the criteria set by NICE dementia guidelines.
- Whether improvements have been made compared to previous audits.

Methods
It is a retrospective audit covering the 3 months of September, October and November 2010. During these 3 months there were 43 new patients of which we obtained 30 sets of notes to collect data from. Standards were taken from the NICE guidelines on dementia, Nov 2006.

Results
Referral times- 96% of patients saw a memory clinic nurse within 3 months, however 36% of patients waited 6 months or longer to see a consultant.

History- At least 90% of all parts of each patient’s history were taken.

Physical examination- No physical examinations were performed in clinic.

MMSE- 100% of patients had an MMSE performed. MMSE scores were generally higher than in the 2001 audit.

Investigations- 97% of patients had blood tests and 93% had CT head scans performed (compared to 20% in 2001 and 40% in 2004).

Only 1 patient had an MSU and 67% had an ECG performed. However the NICE guidelines state these are not always required.

Diagnosis- Almost 50% Alzheimer’s disease, 13% mild cognitive impairment (none diagnosed in previous audits). No LBD or FTD diagnosed.

Prescribing- 70% donepezil, 18% galantamine, 6% rivastigmine, 6% memantine. (Mainly donepezil- similar to previous audits)

NICE guidelines- 41% of prescribing done within NICE guidelines. That not done within NICE guidelines was due to MMSE scores >20.

Non-pharmacological interventions- 9 patients received an intervention however no patients were offered cognitive stimulation as recommended in the guidelines.

Information on dementia- It was only recorded in the notes for 10 patients that verbal or written information on dementia was given.

Carers assessment- Information on care requirements was recorded for 29 of 30 patients.

Recommendations
1. Try to shorten waiting times to see a consultant.
2. Need to start doing physical examinations or ensure GPs to do this before referral.
3. When prescribing for patients with an MMSE over 20 there should be justification of this recorded in the notes.
4. Improve the documentation of information given.
5. Offer patients and carers non-pharmalogical interventions.
6. Re-audit in 1 year.
Nottinghamshire has a tertiary multidisciplinary service accepting referrals from the entire county and adjacent areas for people under 65 presenting with cognitive impairment.

The symptoms may include memory problems, altered orientation, or personality changes. They are assessed for mild cognitive impairment or a dementia, with an appropriate management plan then being put into place.

All referrals are initially assessed by a member of the diagnostic team which includes a neurologist, psycho-geriatrician, neuropsychologist and an occupational therapy consultant. Investigations ordered following the initial assessment usually involve the use of neuroimaging in the form of Single Photon Emission Computed Tomography [SPECT], or 2-(F) Fluoro -2-deoxy-D-glucose Positron Emission Tomography [FDG PET], or Magnetic Resonance Imaging [MRI] usually of the 3 Tesla variety.

NICE Guidance on the assessment and investigation of dementias [clinical guidance 42], states that structural imaging should be used in the assessment of people with suspected dementia. This is to exclude cerebral pathology, as well as to establish the particular sub-type of dementia. MRI scanning has been described in this document as the preferred modality for this purpose, although CT scans, SPECT and FDG PET can also be used. The latter two are described as being of particular value in differentiating between Alzheimer’s dementia, Vascular dementia, and Frontotemporal dementias. FP Cit Scans [also known as DAT] should be used to establish a diagnosis of Dementia with Lewy Bodies if suspected.

In the NHS as a result of the current economic climate, there is increasing pressure on limited resources. We considered whether the use of multiple forms of neuroimaging [both structural and functional], had a significant impact on the clinical management or altered it in any way.

We looked at 50 consecutive referrals to our working age dementia service and in this paper we will present brief demographic data, diagnostic details and results of the brain scans ordered. An analysis of the short term clinical outcomes and how these were affected by the brain scan results is described. Recommendations will be discussed on the basis of the findings highlighted. We believe that our findings may have important implications for practising clinicians.

15. Audit on End of Life Care Pathway
Dr Tariq Khan, Dr Lathika Weerasena, Annette Banner and Dr Afrin Ahmed, Worcestershire Mental health Partnership Trust

Aims
Was to ascertain whether we were providing End of Life Care as per Trust policy and whether we were implementing the Supportive Care Pathway appropriately to patients identified as ‘near end of life’. This Audit explores the care given during this period of their life and provides a basis to review and develop the current Supportive Care Pathway.

Method
This audit was carried out in the Worcestershire Mental Health Partnership Trust. Data covered all expected deaths between January and December 2009 in Inpatient Units. A retrospective audit of the documentation was carried out to enable the trust to identify the quality of care pathway delivery and documentation, for service users at the end of their life.

The Audit tool was prepared in line with the gold standard Liverpool Care Pathway.

Results
There were a total of 9 (nine) expected deaths during this period and all of whom were placed on the Supportive Care Pathway. The mean age was 83 years.
There were 5 cases with a diagnosis of Vascular dementia, 2 with a diagnosis of Alzheimer’s disease, 1 with a diagnosis of Lewy Body dementia and 1 case with a diagnosis of Mixed Depression and Dementia.

The audit showed that the psychological needs of the patients were satisfactorily met.
There was room for improvement in:
physical health care monitoring,
meeting spiritual and religious needs,
the need for more accurate documentation,
Staff training on documentation of the Supportive Care Pathway.
Conclusions
The ‘dying’ patients were identified appropriately in the In-patient units and the holistic care as prescribed per this pathway has been provided to some extent.

The results however note that although there are many areas of care being successfully addressed, there are some other areas which require significant improvement. It is felt as a result of this audit that the areas highlighted for improvement will enable appropriate teams to address the areas for recommendation. These may include:
- providing the right information and support in a timely manner,
- improving the tool and the staff awareness of the pathway and policy.

It is believed that by using the information obtained from this audit, that the care of the dying patients in the Worcestershire Mental Health Partnership will improve.

16. Rapid tranquilisation in the elderly
Dr Swapna Kongara, CT2 psychiatry trainee

Background
Rapid tranquilisation is frequently used in psychiatry but often there appears to be some confusion among nursing staff and doctors regarding the accurate definition, guidelines and risks of rapid tranquilisation. There seems to be a misconception that guidelines for rapid tranquilisation are to be followed only in parenteral medication use, but not in oral medication use. Due to this, guidelines are often overlooked when oral medication (especially oral Lorazepam) is used for management of agitation.

Aims
I have conducted an audit in 2007-08 to find out if the guidelines for rapid tranquilisation are being followed in the elderly patients. Recommendations from this audit included among others, educating the staff regarding the guidelines of rapid tranquilisation and reaudit at a later time. Consequently, I reaudited the same in 2010 to find out if improvements have been made and to highlight areas for further improvement.

Methods
The audit in 2007-08 was a retrospective case note review of all the patients in old age wards in the hospital who received rapid tranquilisation during a three month period. Total 32 patients were identified. The audit tool looked at 12 aspects of the rapid tranquilisation practice including, the guidelines to be followed before, during and after rapid tranquilisation. The data collected is compared against the NICE guidance and Trust guidelines for rapid tranquilisation.

The re-audit in 2010 is also a retrospective case note review of old age patients who received rapid tranquilisation during a three month period. Total 7 patients were identified. The same audit tool and standards were used.

Results
Results in 2007 highlighted among others, poor use of de escalation techniques prior to administering medication and failure to monitor vital signs (pulse, blood pressure, respiratory rate and temperature) after administering the medication, especially in cases where oral Lorazepam was used.

Results in 2010 showed improvement in the aspects like documentation of the indication for rapid tranquilisation, appropriate use of de escalation techniques and monitoring of vital signs after IM/IV medication. However the adherence to guidelines was poor where oral Lorazepam was used.

These results highlight the ongoing uncertainty among the staff and doctors regarding the need to follow the rapid tranquilisation guidelines when oral medication (especially Lorazepam) is used. This may be applicable to other psychiatric units as well.
17. Role of environmental factors in Behavioural and Psychological Symptoms of Dementia
Dr Prashant Kukkadapu; ST6 Trainee; Knockbracken Healthcare Park; Belfast

Background and Aims
Behavioural and Psychological symptoms in Dementia (BPSD) are common and distressing to both patients and carers. Prevalence of BPSD varies depending on setting and is estimated to be about 80% in care homes. Antipsychotic medication is used commonly to address these behaviours often with poor outcomes and increased risk of cerebrovascular events, falls and mortality. NICE guidelines recommend use of non-pharmacological interventions prior to using these agents. Modifying environment with cues, signage, colour and proper lighting can help with orientation and has been shown to reduce agitation, aggression and unwanted behaviours. The study tried to identify if care homes in a sector of Mental Health Team for Older People (MHTOP) were suitably designed, if the residents had opportunities for social interaction and if these are related to behavioural symptoms in dementia. It was hypothesised that care homes that are poorly designed would refer the most to the team.

Method
A checklist was designed following a literature review of environmental factors felt appropriate for care homes with dementia residents. The checklist had items for various rooms focusing on the layout, signage, lighting, noise, colours and adaptations to minimise for impairments. Activities for social interaction and staff to residents ratio was also included. Five care homes across a sector of MHTOP (Larne and Carrickfergus) were surveyed. The scores on the checklist was then compared against the number of referrals received from each of the care homes over a 4 month period. All the referrals were only accepted after the GP had ruled out physical health problems.

Results
Only one of the care homes scored >60% of the criteria on the checklist. The number of referrals from each care home varied from 20–34 over a 4 month period. The maximum number of referrals was from a care home that scored least on the checklist. All the care homes had activities for social interaction but engagement of residents with dementia varied. Staff : Resident ratio was 1:5 during the day time dropping to 1:8 at night times across all the care homes.

Conclusion
Design of care home buildings and environmental factors can be an associated factor for behavioural symptoms in dementia. Appropriate design of care homes with proper cues, signage, colour and contrasts, effective engagement of residents with meaningful activities can improve orientation to the environment and reduce confusion, agitation, wandering and other behavioural symptoms in dementia.

18. A new liaison psychiatry service for older adults in Sheffield: service evaluation
Dr Aparna Mordekar, Specialty Doctor in Old Age Psychiatry; Dr Gautam Bal, Staff Grade in Old Age Psychiatry; Dr Justin Marley, SpR in Old Age Psychiatry, Dr Paul Boston, Consultant in Old Age Psychiatry, Sheffield Health and Social Care NHS Foundation Trust

Aim
To evaluate the first twelve months of a new liaison service for older people within the university hospitals of Sheffield, which replaced the sector based consultation model psychiatric liaison service in April 2008.

Background review
Older people occupy two-thirds of general hospital beds. Presence of a mental disorder has proved to be an independent predictor of poor outcome in this population. The publication ‘Who cares wins’ by the Royal College of Psychiatrists (2005) recommends that the development of liaison mental health services for older people in general hospitals should be clearly identified as a priority in business planning for the mental health trusts.

Methods
Retrospective analysis of all the 716 referrals received by the service between the 4 month period 15th April 2008 to 14th April 2009. Information collected include demographic data, rate of acceptance of referrals, average waiting time, medical or surgical specialty referring the patients, diagnoses (according to ICD-10) and the outcomes including arrangements for follow-up.
Results
Of the 716 referrals during this period, there were 330 male and 386 female. The average waiting time for the referrals to be seen is 1.9 working days. The most common psychiatric diagnoses were Dementia (30%), Depression (23%), Delirium superimposed on Dementia (14%) and Delirium (12%). Other ICD-10 diagnoses were Schizophrenia and Bipolar Affective disorder. 9 patients had been referred to services with deliberate self harm.

309 patients (43%) did not require any Psychiatric follow up and were discharged back to the care of their GP’s. 136 patients (20%) required follow up from CMHT and 126 (18%) from memory services. 43 patients (6%) required inpatient treatment in a Psychiatric ward.

Conclusions
Dementia, Depression and Delirium represent the main diagnoses in referrals to the service. Patients were seen promptly and nearly 40% patients referred required Psychiatric follow up after discharge from the General hospital showing the need for mental health liaison services for elderly patients in acute hospitals.

19. Survey on prevalence of alcohol use in elderly population in Sheffield
Dr Aparna Mordekar, Specialty Doctor in Old Age Psychiatry, Dr Subha Thyagesh, Consultant, Sheffield Health and Social Care NHS Foundation Trust

Aim
To identify the prevalence of alcohol usage in over 65 year old population in the city of Sheffield over a 6 month period.

Background
Alcohol is significant but less well known problem in older adult. The number of elderly people drinking above the recommended limit has gone up to 17% in men and 7% in women (ONS, 2009).

Method
Data was collected from community mental health teams and memory services across the city between May 2010 and October 2010. The Short Michigan Alcoholism Screening Instrument – Geriatric Version (SMAST-G) is well known alcoholism screening instrument for older adults and was used to collect the information for this survey. A score of 2 or more “yes” responses suggests an alcohol problem.

The information about alcohol was gathered from patients and carers. The psychiatric notes were reviewed retrospectively in the patients identified by SMAST-G.

Results
The data was collected in 102 patients. There were 43 patients from North, 28 from Southwest, 17 from Southeast sector and 14 from West team sector teams, across the city.

Out of 102 patients, 48 were males and 54 were females, age ranging from 61 years to 90 years. 14 patients, 10 males and 4 females scored more than 2 on SMAST-G. Out of 14 patients 12 (8 males and 4 females) drank alcohol above the recommended safe limits. We also had a look at the co-morbid psychiatric conditions present. 8 patients had a diagnosis of depressive disorder, 7 had diagnosis of dementia (4 with Alzheimer’s dementia, 1 with vascular dementia and 2 with alcohol dementia) and 2 patients had a diagnosis of mild cognitive impairment. Other diagnoses included were PTSD and alcoholic hallucinosis.

Conclusion
There are a growing number of older adults having problem with alcohol. We found about 8% males and 4% females had alcohol use disorder in Sheffield which shows similar results to the national demographics known.

The older adults drinking at high levels have a range of psychiatric co-morbid conditions.
20. Discharge destination for older adults after general hospital admission: the impact of the Rapid Assessment, Interface and Discharge (RAID) model in an acute setting

Dr Nageen Mustafa, Staffordshire University. Prof George Tadros, Mr Rafik Salama, Dr Alison Gray, Mr Bokani M Vundhla; Rapid Assessment, Interface and Discharge Team (RAID), Birmingham and Solihull Mental Health Foundation Trust

Aim

Previous research has suggested that over a third of people with dementia who go into hospital from living in their own homes are discharged to a care home, leading to poorer outcome for patients. A key aim of the RAID model is to facilitate early but effective discharge from hospital for patients seen by the team. The aim of this analysis was to examine the discharge destination of patients over the age of 65 who had originally come from their own home and the impact of the RAID intervention.

Method

Data was collected regarding discharge destination of patients over the age of 65 who had originally come from their own home. Three groups were compared, a group of patients that had received intervention from the RAID team, a retrospective control group from the same time period last year and an influence group made up of patients that have been managed by the acute staff who have been trained by RAID.

Results

In the RAID group 708 (80%) patients out of 884 were discharged back to their homes, compared with 1247 (47%) of 2654 patients in the influence group and 1350 (47%) out of the 2873 in the control group.

Conclusion

A greater percentage of patients seen by the RAID team were able to go back to their own home (80%), improving outcomes for the patients. Although the savings to the wider health economy have not been calculated, this is an area where further analysis is currently being undertaken.

21. Audit of adherence to NICE Guidance for prescribing Cholinesterase Inhibitors in Alzheimer’s Dementia

Dr Ejaz Nazir, Consultant Old Age Psychiatrist; Dr. S. K. Kshemendran, Associate Specialist; Professor Tony Elliott, Clinical Director; Dr. S. Lyle, Consultant Psychiatrist. Shelton Hospital, Shrewsbury

Introduction

NICE, UK (National Institute of Clinical Excellence) recommends that

1. The three acetyl cholinesterase inhibitors donepezil, galantamine and rivastigmine are recommended as options in the management of patients with Alzheimer’s disease (AD) of moderate severity only, (those with a Mini Mental State Examination [MMSE] score of between 10 and 20 points)

2. In determining whether a patient has AD of moderate severity for the purpose of section 1 above, healthcare professionals should not rely, or rely solely, upon the patient’s MMSE score in circumstances where it would be inappropriate to do so. These situations are
   (a) A MMSE score greater than 20, who have moderate dementia as judged by significant impairments in functional ability and personal and social functions compared with premorbid ability,
   (b) A MMSE score less than 10 because of a low premorbid attainment or ability or linguistic difficulties, who have moderate dementia as judged by an assessment tool sensitive to their level of competence,
   (c) In people who have linguistic or other communication difficulties or are not fluent in the language applied in MMSE itself.

3. In such cases professionals should make use of another appropriate method of assessment. Patients who continue on the drug should be reviewed every 6 months by MMSE score and global, functional and behavioural assessment. Carers’ views on the patient’s condition should be sought.

4. Memantine is not recommended as a treatment option for people with moderately severe to severe Alzheimer’s disease except as part of well-designed clinical studies.

Aim

We aimed to assess current practice of prescribing cholinesterase inhibitors in patients with AD in Shropshire and its compliance to the recommendations laid down by the NICE guidance in UK.

Method

After designing an audit tool based on NICE Guidance, we did retrospective review of case notes of 102 patients in our service who were started on anti-dementia treatment, over a period from Sept 2009 to August 2010. Our sample comprised of 66 % male and 34 % female patients, with age range of 51-98 years (median 79 years).
Main domains of NICE guidance assessed: Data was collected to answer following questions based on NICE guidance:

1. What was the type of dementia at the time of initiation of anticholinesterases treatment?
2. What was the degree of severity of dementia on initiation?
3. What was the type of cholinesterase inhibitor prescribed?
4. Was MMSE score recorded at the time of initiation and 6 months?
5. Was functional assessment documented using a structured tool as Bristol Activities of Daily Living Score (BADLS) at 6 months follow ups?
6. Was Global assessment documented at 6 months follow ups?
7. Was behavioural assessment documented at 6 months follow ups?
8. Was carers’ views sought on the patient’s condition at the time of initiation?
9. Was the patient reviewed every 6 months?

Results
1. 100% of patients had diagnosis of Alzheimer’s dementia.
2. On initiation of treatment, 11% patients had mild dementia, 61% had moderate and 18% patient had moderately severe AD, 3% had severe dementia and 8% was not recorded.
3. Type of acetyl-cholinesterase inhibitor prescribed was donepezil (42%), galantamine (14%), rivastigmine (37%) and blank 7%. No memantine was prescribed to any client. (100% adherence to guidance).
4. MMSE was documented in 91% patients at the time of initiation and in 79% patients at 6 months follow up.
5. Bristol Activities of Daily Living Score was recorded only in 61% cases at 6 months follow ups.
6. Global assessment done only in 40% of cases at 6 months follow ups.
7. Behavioural assessment done only in 61% of cases at 6 months follow ups.
8. Carers views were sought in 98% of cases at the time of initiation.
9. 80% of patients been reviewed at 6 months.

Discussion
1. Major deviation from NICE guidance were recorded in initiating the treatment for mild dementia in 10% of cases and severe dementia in 3% of cases.
2. Documentation of MMSE at 6 months follow up was not done in 21% of cases.
3. The documentation of BADL, global assessment and behavioural assessment at 6 months was not done in more than 40% of cases.
4. Memantine was not prescribed.
5. Rivastigmine was the second highest prescribed dementia drug.
6. In our practice the prescribing of cholinesterase inhibitor was fully compliant with nice guidance but not with nice guidelines.
7. Although our results are encouraging in many domains assessed, there is still potential of further improvement.

Recommendations:
1. MMSE should be performed and recorded in 100% cases at both initiation and subsequent follow ups.
2. Functional assessment, using structured tool as Bristol Activities of Daily Living Score (BADLS), Global assessment and behavioural assessment should be done and recorded in 100% cases.
3. Carers view on the patient’s condition should be documented in 100% of cases, otherwise the reason should be documented.
4. Where applicable, any shortfall from NICE guidance should be documented clearly; such as, reasons for starting treatment in mild/severe dementia, not using functional assessment tools etc.
5. To improve communication between community mental team and memory clinic for patients on anti-dementia treatment.
22. Neuro imaging in suspected dementia - ? National Institute for Health and Clinical Excellence (NICE) compliance
Dr Kayode I Osanaiye and Dr Balaji Wuntakal, St. James Hospital, Portsmouth

Aims
To ascertain the percentage of people with suspected dementia for whom imaging (CT/ MRI/SPECT) has been undertaken as part of assessment and diagnosis in keeping with NICE guidelines.

Method
A structured audit data collection tool in keeping with NICE guidelines and the clinical experience of responsible consultant psychiatrist was drawn.

This structured collection tool was completed with data electronically retrieved from the initial two assessment letters and respective neuro imaging results of all new patients with suspected dementia referred to the older persons mental health teams, St. James Hospital Portsmouth between January 2009 and December 2009. Sample size was not predetermined but was guided by available number of patients who met the inclusion criteria. All patients with confirmed diagnosis of dementia or diagnosis due to other functional illness were excluded. All data was collated by a psychiatrist.

Results
Data was obtained from a total of 393 patients out of which 31% were males and 14 were less than 65 years old. A diagnosis of Alzheimer's disease was made in about 41% followed by vascular and mixed dementia (i.e. 30.1 and 19.3%) respectively. Just 20% of the patients had a family history of dementia while 134 (34%) were reported to show one or more behavioural and psychological symptom of dementia (BPSD) at the time of first presentation.

Altogether, 122(31%) of sample size had some form of Neuroimaging (structural and/or functional). In 15% of those who had neuroimaging, the clinical diagnosis was not completely in keeping with diagnosis suggested by neuroimaging.

Anti cholinesterase inhibitor was prescribed in 160 (60%) of all patients with Alzheimer’s dementia.

Conclusion
A standard older persons catchment area like Portsmouth with a older population of 30,000 and a total of 393 patients with suspected dementia per year would require at least the sum of about £49,125 per annum for all these patients to have a basic structural imaging (CT scan) at a rate of £125 per patient in keeping with NICE guideline. Would our present (PCTs) and future (GP consortiums) be able to fund this?

23. Driving in Dementia: An audit of patients attending the Memory clinic
Dr Sobia Rafi (CT-3), Dr Chandra Mohan (Associate Specialist), Dr Pravir Sharma (Consultant); Reservoir Court, Birmingham and Solihull Mental Health Foundation Trust

Aims
The evidence suggests that people with dementia do have a higher risk of being involved in an accident. In the UK the law requires anyone who has been given a diagnosis of dementia to inform the medical branch of the DVLA. Failure to do so can result in a fine.

The aim of our audit was to examine the following in patients being assessed in the memory clinic at Reservoir court
- driving is discussed with patients attending the memory clinic for dementia
- driving status is documented in the notes by clinicians
- driving questionnaire is filled
- Appropriate action is taken accordingly

Methods
A retrospective review of case notes of 100 new assessments in the memory clinic between September 2009-Feb 2010 was carried out to gather the required information.

Results
In our sample of 100 patients, 89% patients had the diagnosis of Alzheimer’s dementia. There was equal gender distribution with mean age of 82 years. The mean MMSE score was 20 (SD + 5). Thirteen patients were driving at the time of assessment with 10 males and 3 females, with a mean MMSE score of 23(16-28). 8/13 patients were asked to contact DVLA, written information was provided to 4/13 and driving issue was re-discussed with the 4/13 patients. Further action where appropriate was taken in 4/13 patients. The driving status was documented in 68% of all assessments and 85% for those who were driving.
Conclusion and recommendation
All Clinicians must ask and record driving status of patients attending the memory clinic. We recommend adding the driving screening question on the MMSE form to increase convenience of documenting. All dementia patients who are driving should be advised to inform DVLA and provided with written information. In order to increase the awareness of the importance of discussion about driving issue with dementia patients we organized a training day for Memory clinic staff and Clinicians to develop better understanding of the DVLA guidelines. We aim to perform a re-audit in 6 months time after implementation of the recommendations.

24. Is Problem Based Learning (PBL) an effective teaching method for medical students?- A report on using the PBL approach for medical students during their placement in Old Age Psychiatry, Leicestershire Partnership Trust
Dr Aniruddha Rajkonwar, ST-6; Dr Sandhya Gaur, ST-5; Dr Nicholas Bramble, Staff Grade; Dr Erik VanDiepen, Consultant; Dr Deborah Chaloner, Consultant, Old Age Psychiatry, Leicestershire Partnership Trust

Background
Problem based learning is used in many medical schools in the UK and worldwide. In PBL, students use “triggers” from a problem case or scenario to do independent, self-directed study. It is reported that PBL can enable students to become autonomous problem solvers, to be reflective, self-aware and motivated regarding their own learning.

Method
A PBL scenario was introduced in 2009 for Medical students during their placement in Old Age Psychiatry, Leicestershire Partnership Trust. Medical students from Leicester Medical School, in groups of about 8-10, are placed in Old Age Psychiatry for a week. A case scenario, about a person presenting with cognitive difficulties, is introduced at the beginning of the week. Students are then asked to work in four groups to look up questions based on the case scenario. These questions relate to differential diagnosis, investigations, management and looking at the role of the Community Mental Health Team (CMHT). These questions are linked to learning objectives in the curriculum. Each group presents its findings at the end of the week.

Results
Students were asked to fill in an evaluation form which consists of five questions based on learning objectives. They were encouraged to leave open comments. A total of 209 responses were collected between March-2009 and October-2010. 97 % (203/209) of students agreed/strongly agreed that they had developed an understanding about how a person with cognitive difficulties could present to services. 99.5 % (208/209) of students agreed/strongly agreed they had developed an understanding about the differential diagnosis of a person presenting with cognitive difficulties. 99 % (207/209) of students agreed/strongly agreed they had developed an understanding of the investigations undertaken for a person presenting with cognitive difficulties. 99 % (207/209) agreed/strongly agreed they had developed an understanding about how people with cognitive difficulties are managed using a bio-psycho-social approach. 98.5 % (206/209) students agreed/strongly agreed that the tutorial had enabled them to understand the role of different professionals in the CMHT

Conclusion
PBL appears to be an effective method to enhance the learning experience of medical students. The evaluation shows that a very high proportion of students felt that the learning objectives had been met. Open comments that had been invited were positive. Students remarked that it had been useful to work in groups and the tutorial had helped to put things in perspective. Thus, PBL appears to be a useful method by which self-learning is facilitated.
25. Psychiatric Doctors’ attitude towards receiving ECT if they were to need it themselves
Dr Rehan Ahmed Siddiquee, Consultant Psychiatrist in Acute Care, Birmingham and Solihull Mental Health NHS Foundation Trust; Dr Rinki Ray, ST4, Old Age Psychiatry, Northamptonshire Healthcare NHS Foundation Trust and Dr Iyas Assalman, ST5, General Adult Psychiatry, East London NHS Foundation Trust

Introduction
The use of ECT has declined as a treatment option. The reason for this is multi-factorial ranging from the attitudes of patients and psychiatrists towards ECT, the recommended guidelines from organizations like NICE, the popular media’s portrayal of the treatment and the subsequent effect this has on the perception of the general public.

In this survey the authors have tried to ascertain if the decline in use has also resulted in a decline in psychiatrists’ belief in the effectiveness of ECT. This was tested by a questionnaire formulated around 3 themes:

• Opinion on the effectiveness of ECT
• The psychiatric conditions one would consider using it for
• If psychiatrists would consider it as a treatment if they were to develop a depressive illness themselves.

There has been no study conducted recently looking exclusively at the psychiatrists’ attitudes and whether they choose ECT as a treatment option for themselves if they were to suffer from depression.

Method
A questionnaire was prepared, distributed personally and collected on completion between August and December 2008. This face to face contact ensured a 100% response and none of those approached declined to participate.

This was distributed amongst 122 psychiatrists in Birmingham and North East London. A dual centered approach minimized any bias due to local practice or training in a particular centre and covered a larger sample.

Results
122 responses were received from Birmingham and London. 53 (43%) were junior trainees, 33 (27%) career psychiatrists, 7 (6%) were senior trainees and 29 (24%) were consultants. A wide range of specialties within Psychiatry responded- General Adult (56%), Old Age (16%), Psychotherapy (5%), CAMHS (5%), Forensic (3.2%) and Learning Disability Services (0.8%). 14% of participants did not mention their specialty.

Conclusion
The majority of responding doctors have a positive attitude towards ECT and would consider it as a treatment option for themselves, despite a third of the responders not using ECT regularly in their practice. Most will go for a combination of pharmacological and psychological interventions before considering ECT. This is in line with the NICE guidelines on depression. There were no significant differences between the responses from Birmingham and London.

All junior doctors believe ECT is effective although a few of them would consider having it as a treatment if indicated. This shows that the proportion of psychiatrists who would opt for ECT themselves increases as they become more senior and gain more experience in Psychiatry.
26 An Evaluation Project of Memory Clinic Neuroradiology requests
Dr Larissa Ryan, ST4 Old Age Psychiatry, Prospect Park Hospital, Reading

Aims
NICE guidelines suggest that all patients being investigated for suspected dementia should have some form of neuroimaging, usually a CT scan. Local feedback from radiology suggests that information provided on request forms is not always sufficient to provide a full and accurate report. The radiologists identified that vascular history and risk factors, differential diagnosis and reason for scan were particularly important. Under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000), referrers for imaging are required to supply ‘sufficient medical data relevant to the medical exposure requested to enable the practitioner to decide whether the exposure can be justified’. This project aimed to review memory clinic neuroradiology requests, with an aim to establish a baseline of what information was being provided on the request form. This was also part of a larger project which also included reviewing what was included in radiology reports, and whether the Hachinski Ischaemic Scale was useful in a real world clinical setting.

Methods
It was requested for a copy of all memory clinic radiology forms over the period November – December 2010 inclusive to be sent to the investigator (LR). Data was collected on these forms including demographics and text included in request. These were analysed for items of information included.

Results
77 requests were collected. The average age of patients was 81.5 with range 64-94. 47% were male. The average number of words in a request was 18.7 with range 6-62. 92% of requests included general information on cognition while 45% included more specific information. 18% of requests gave information on vascular history and 50% gave information on vascular risk factors. 24% gave information on other medical history. Only 5% of requests included any findings from physical examination. 39% included a differential diagnosis and 60% included a reason for requesting the CT scan.

27. The Rapid Assessment, Interface and Discharge (RAID) model: Re-admission rates for older adults in an acute hospital after intervention
Mr Rafik Salama; Prof George Tadros; Ms Selina Balloo, Rapid Assessment, Interface and Discharge Team (RAID), Birmingham and Solihull Mental Health Foundation Trust; Dr Nageen Mustafa, Staffordshire University; Ms Rachel Pannell, Sandwell and West Birmingham Hospitals NHS Trust and Dr Emma Kelson; Birmingham and Solihull Mental Health Foundation Trust

Aim
The aim was to examine re-admission rates of older adults referred to the RAID team comparing this group with patients not seen by RAID but influenced by staff training and a retrospective group.

Method
External data from the information technology department was requested regarding the re-admission of patients. An independent statistician used survival analysis to compare re-admissions across three groups: patients seen by RAID, a RAID influence group (managed by acute colleagues that had received training/support from RAID) and retrospective control group (patients admitted prior to the launch of RAID). The groups were matched for; age, sex, period of admission, HRG code, main diagnosis and ICD-10 codes. Further analysis looking at re-admissions was also carried out regarding older adults seen with self harm or alcohol misuse issues.

Results
Readmission rates for the groups were as follows; for the RAID group there were 15 readmissions of 320 patients (4.7%), for the influence group there were 214 out of 970 (22.1%) and for the retrospective control group there were 211 out of 1088 (19.4%). Specifically for alcohol admissions in older adults, in the RAID group there were 0 readmissions of 21 patients (0.0%), for the influence group there was 48 out of 224 (21.4%) and for the control group there were 43 out of 186 patients (23.1%). For older adults with self harm in the RAID group there were 5 readmissions of 54 patients (9.3%), for the influence group there were 16 out of 90 patients (17.8%) and for the control group there were 27 readmissions out of 113 (23.9%).

Conclusion
Findings suggest that RAID intervention improved readmission rates for older adults. Analysis for older adults admitted with alcohol misuse issues and self harm also illustrated reductions in readmissions after RAID intervention. RAID lead to better outcomes for patients through appropriate signposting, referral and facilitating management of mental health issues in the community. As well as a direct effect, RAID was able to influence readmission rates through education, teaching and support of acute staff helping them to manage less complex cases.
28. The Rapid Assessment, Interface and Discharge model (RAID): Can quality improvement lead to cost savings?
Prof George Tadros; Dr Mahnaz Hashmi; Dr Eliza Johnson; Mr Rafik Salama; Ms Selina Balloo, Rapid Assessment, Interface and Discharge Team (RAID), Birmingham and Solihull Mental Health Foundation Trust; Dr Nageen Mustafa, Staffordshire University; Ms Rachel Pannell, Sandwell and West Birmingham Hospitals NHS Trust and Dr George Georgiou, Birmingham and Solihull Mental Health Foundation Trust

Outline of the RAID model
• £1.2 million pounds was made available for an 18 month pilot Liaison Psychiatry service, launched in December 2009.
• The service consists of a 24 hour, single point of contact, multidisciplinary, multi-subspeciality, team operating under a single management and clinical structure.
• The aim was to demonstrate that comprehensive, rapid response Liaison Psychiatry can reduce costs by improving quality of care and service delivery.
• The team provides specialist assessment and management of mental health, substance misuse and psychological needs in all patients over 16yrs.
• The future funding of the team is dependent upon research and evaluation demonstrating cost reduction and quality improvement.

Method
Quality was measured through questionnaires, training evaluation and team functioning e.g. response time targets using a ‘Discharge Outcome Form’.
Cost was examined in terms of length of stay, re-admissions and admission avoidance for three subject groups:

1. Patients directly seen by RAID.
2. RAID influence patients (not directly seen by RAID but managed by acute colleagues that had received training/support from RAID)
3. A retrospective control group

The groups were matched for; age, sex, period of admission, HRG code, main diagnosis and ICD-10 codes

Results
External validators of quality within the pilot period included PLAN accreditation and RAID winning the Health Service Journal award for innovation in mental health 2010. Length of stay was reduced by 14,156 bed days over an 8 month period equivalent to 60 beds per day (or 3 wards). Estimated cost savings £4.5 million over 12 months. In terms of older adults with dementia RAID saved 7.5 bed days per admission in each quarter, equivalent to 16.4 beds per day and over 12 months this would be a saving of 6000 bed days. Results showed a decrease in re-admissions from 15 per 100 (controls) to only 4 per 100 for the RAID group. 1200 readmissions were saved over an 8 month period, estimated cost savings of £5.4 million over a 12 month period. Admission avoidance was significantly increased with 202 patients discharged at the point of MAU after RAID involvement, saving £454,500.

Conclusion
The RAID model has demonstrated substantial improvements in quality and cost.

29. Service evaluation of Yardley and Hodge Hill Older Adults Community Mental Health Team
Dr Shaffiullah, Dr Bhagrath, Dr Manikoth. Supervised by Dr Dhariwal, Consultant Psychiatrist

Introduction
Functionalisation of Older Adult Services has been introduced in Birmingham and Solihull Mental Health Foundation Trust from October 2010. This reorganization, aims at providing effective, person-centered services through ‘new ways of working’. The older adult consultants became community or in patients consultants. Our survey aims to establish benchmark data from pre-functionalisation period, available for future comparison.

Yardley and Hodge Hill area is in East Birmingham and the older adult population over 65 years for a functionalized team here approached 40,000. The use of LEAN methodology led to the development of new practice models to enable such a large population to be serviced effectively, including the introduction of Primary Care based Memory Assessment teams and Community Rehabilitation and Recovery teams.

Aims
Map service demands of Older Adults Community Mental Health Team at Yardley and Hodge hill area prior to the advent of functionalisation of services.
Method
Study period: 1st of August 2009 to 31st of July 2010.
Factors analyzed: a) Total number of referrals, b) Source, c) Health professional providing first point of contact, and d) Waiting period from receipt of referral to first patient contact.

Results
1. A total number of 952 referrals were received of whom 781 (82%) were accepted.
2. Sources of referrals were as follows: 630 (62%) - General Practitioners, 146 (15%) - Acute hospitals and liaison services, 39 (4%) - social services and the remaining 137 (14%) - others (including Psychiatrists, Community Psychiatric Nurses, Day Hospital, Nursing Homes, self referrals and geriatricians).
3. 92% of the referrals were seen within the standard waiting times. 2% of the patients were seen after 6 weeks but the reasons were not stated.
4. 54% of the patients were first seen by doctors and 22% first seen by the Community Psychiatric Nurse.

Conclusions
Prior to the introduction of Functionalisation, the service was predominantly doctor and clinic based. The ‘new ways of working’ which include larger populations served by community consultants, the development of primary care based memory services, the introduction of community rehabilitation and recovery teams in older adults, as well as a result of LEAN methodology a model of first response practitioners, multi disciplinary duty system and their impact on the service will be evaluated in further re audits.

Dr Laura Taylor, CT1 Psychiatry Trainee, West Midlands Deanery; Dr Jennifer Longstaffe, Foundation Year Two, West Yorkshire Deanery and Dr Alison Cracknell, Consultant in Medicine for the Elderly, Leeds Teaching Hospitals Trust
Background
68% of men and 45% of women over the age of 65 in the UK consume alcohol at least once a week. Between 1988 and 2000, the number of men >65 years old exceeding 21 units of alcohol per week increased by 31% and the number of women exceeding 14 units per week increased by 75%. Alcohol use disorders in older people are under-detected and often misdiagnosed resulting in increased morbidity and mortality in this age group.

Aim
Guidelines for the assessment and management of alcohol intake and related complications were introduced at Leeds Teaching Hospital Trust in 2009. This was audited shortly after the introduction of these guidelines and re-audited one year later with the aim of increasing awareness of issues around alcohol consumption in elderly populations and assessing adherence to new guidelines.

Method
The notes of patients over the age of 80 on five elderly medicine wards at Leeds General Infirmary were reviewed at a single point in time. Documentation of alcohol consumption, risk of withdrawal, random capillary glucose, nutritional status and an osteoporosis/ falls risk assessment was evaluated along with management instigated as a result of the assessment. The results were compared with those of the initial audit.

Results
52 sets of case notes were reviewed (67 in the original audit). Alcohol intake was documented in 69% (43% in the original audit). This was recorded in units per week in 63% (39%). Of those with alcohol intake documented, 10 drank alcohol (range 7- 175, median 17.5 units/week). Only 3 patients in the sample drank over the recommended limits. Of these 3 patients, one received pabrinex and all had oral vitamins and thiamine prescribed (appropriate management in all cases). One of these patients had a documented discussion about alcohol intake (33%, 0% in original audit) and none had further questioning regarding dependence (0%). All of the patients drinking over the recommended limits had an assessment of osteoporosis risk and nutritional status (72%).

Discussion
Alcohol consumption is an important problem in older adults, associated with many health issues. This audit demonstrated that with the introduction of specific guidelines, there was an increased awareness of the necessary aspects of assessment and management of alcohol consumption and management. Alcohol dependence cannot be treated correctly if it is not recognised. It appears that when detected, alcohol related problems are appropriately managed medically. However, although improved, there are still problems with the assessment of alcohol intake and subsequent screening for dependence in the elderly.

1 all percentages in brackets denote percentages from the original audit.
Background
The management of clinical psychiatric services is in its third wave of implementation of key performance indicators: we have moved from simple recording of demographic data and diagnostic codes through collecting of routine clinical outcomes (HoNOS) to more complex service delivery analysis and setting of subsequent targets (CQUINs). This caseload-based assessment of an inner-city older adults service relates to the latter; and, in particular, encouragement from the PCT to conceive for ourselves meaningful CQUIN targets for mental health services.

Aims
The study looks into a cross-sectional breakdown (July 2010) of the caseload of a patch-based CMHT by defined variables; to analyse the findings; and to report them numerically and graphically. We planned to explore areas of perceived interest to commissioners, and to test observations the team had speculated about regarding the catchment area. These included factors such as potential caseload differences in ethnic groups compared to the borough norms, and differences in diagnosis by area (e.g. are there fewer patients with dementia from the more deprived Northwest patch than the wealthier Northeast patch?).

Methods
Caseload data for the North Westminster CMHT were extracted from the Trust’s electronic information system. Variables recorded included: age, gender, ethnicity, marital status, GP practice and diagnosis. The graphics and design department of Social Services represented chosen data of interest visually superimposed on a map of the borough of Westminster.

Results
Results to our specific questions were as follows:
1. The ethnicity profile of the caseload was broadly representative of the borough. Out of 229 patients 79% (74%) were white, 11.3% (7%) black, 7.4% (9%) Asian and others 2.3% (10%) (Borough average in parenthesis).
2. Westminster is ranked as the 9th most deprived district when compared with London’s 33 boroughs. Deprivation is most concentrated in Church Street/Northwest wards. Contrary to our expectations, there were fewer patients with dementia in the Northeast (19.6%) as compared to Northwest (23.2%).
3. There were more people widowed or unmarried compared to the national average for those over 65. Out of 229 patients 22.1% were married, 40.6% single, 8.6% divorced, 2.1% separated and 26.6% widowed.

Conclusions
This ‘mapping and tracking’ exercise provided useful information to help in planning to improve service provision to the patch’s population, e.g. social inclusion work for the high rates of people living on their own. Furthermore, the data were useful for considering potential CQUIN targets to recommend to the commissioners to set for the Trust; for example it transpired that the caseload is representative of the borough’s ethnic profile.

32. Sexual Function and Dysfunction in Older Women: the Implications for Old Age Psychiatry. A Review of Recent Literature
Dr Alison Wood, ST 4, North Trent Rotational Training Scheme in Old Age Psychiatry, Beighton Hospital, Sheffield; Ross Runciman, Medical Student, Sheffield University, Sheffield; Professor Kevan Wylie, Porterbrook Clinic, Osborne Road, Sheffield.

Aims
Female sexual dysfunction has been much discussed of late and there has been a thought-provoking article on this subject in the BMJ, within the last 6 months. In Old Age Psychiatry, our patients’ illnesses as well as their treatments can have a considerable impact on their sexual functioning.

This review aims to examine the topic of sexual function and dysfunction in older women, in the context of Old Age Psychiatry.

Method
A review of recent literature was carried out through ‘Healthcare Databases Advanced Search’ via Athens, on the NHS Health Information Resources Website. We accessed “MEDLINE” and “PsycINFO” databases.
Results
Many older women enjoy active sexual lives but increased physical health problems in old age often impair sexual functioning.
Mental health problems in old age adversely affect women’s sexual lives. In particular, depression and its treatment can diminish sexual functioning. Dementia can be very challenging within a close sexual relationship. Also, long-term effects of antipsychotic treatments can impair functioning. Increasing numbers of our patients are developing diabetes. This significantly affects female sexual functioning.

Comments
Commonly, older women unnecessarily just accept deterioration in their sexual functioning.

Our older women patients have more physical health problems, which may be affecting their sexual functioning.

Prominent amongst drugs which adversely affect female sexual functioning are SSRIs. Recent literature suggests that Old Age Psychiatrists should enquire about this common side-effect in older women patients.
Dementia complicates sexual lives but help is available.
We would suggest that, as Old Age Psychiatrists, we should be aware of available treatments for female sexual dysfunction, from psychosexual therapy to clitoral vacuum pumps. Then we can offer hope and appropriately direct our patients for further specialist advice.

Poster Abstracts

Friday 18th March 2011

1. Physical Health in Mental Health? A survey of current practice
Dr Hayley Andrews, The Bradgate Unit, Leicester; Dr Rachel Cowan, The Bennion Centre, Leicester; Dr Ann Boyle, The Bennion Centre, Leicester; Leicester Partnership Trust

Aims
To establish whether the physical health needs of patients on Old Age mental health wards are adequately assessed on admission to hospital.

Background
The Royal College of Psychiatrists in their scoping report stated there is a ‘need for good-quality general healthcare for psychiatry patients’. The National Dementia Strategy recommends the provision of ‘good-quality health and social care’ for all patients with dementia. In view of the increased complexity of the medical needs of elderly people particularly those with dementia, along with the challenge of decreased bed numbers, a survey of the medical assessment of this group was suggested.

Method
A trustwide (Leicester Partnership Trust) review of the notes of all (125) inpatients on Old Age wards was carried out over a 24 hour period. Their admission date, physical examination date and level of completion of this were recorded. When blood tests had been done, which ones were done and whether they were documented in the case notes was also recorded.

Results
Approximately 75% of physical examinations were done at the time of admission, however, only 50% of these were complete (i.e. full systems examination). Often neurological examinations were omitted, which was of concern in view of the morbidity of the patient group. Only 60% of patients had their blood tested by the end of the day following admission. Of note, blood tests had also been done but never documented, including some with abnormalities.

Conclusions
In order to ensure that the physical health needs of the elderly patients within this trust are being met, modifications of the admission proforma are being considered, which will stipulate the necessity for a full neurological examination and a standardised battery of blood tests. The importance of this will also be emphasised to ward Doctors at their induction. The improvements noted from these modifications will be described.
2. A Review of Gynaecological problems in elderly women with mental illness, during an inpatient stay in Edward Street Hospital
Dr Samina Azeem, Associate Specialist and Dr Valerie Curran, Consultant Psychiatrist

Background
The prevalence of dementia has been increasing along with the aging population: 0.8% of women above the age of 65 have dementia. Admission into psychiatric hospitals with co-morbid gynaecological illnesses is also increasing, but due to a lack of awareness about these problems, patients are not receiving adequate care.

Aims
To explore the extent of Gynaecological problems in elderly women admitted to Edward Street Hospital from August 2008 to December 2010
The impact of these problems on their mental health
The response of any interventions offered
To find ways of improving mental health & quality of life

Method
A prospective study was carried out. Data was collected from all female patients who were admitted to Edward Street Hospital from August 2008 to December 2010, and had some form of gynaecological problem.

The data was collected by a Performa, developed to ascertain: reasons of admission, co-morbid gynaecological problems, impact of these problems on mental health, nursing interventions and psychotropic medication. Post-treatment, effects of any gynaecological interventions on mental health were recorded.

Results
In total, 55% of admissions were female. 11.5% of these presented with gynaecological problems; of these, 66.7% with dementia and 33.3% with depression. The most common gynaecological problems identified were utero-vaginal prolapse (33.3%), post menopausal bleeding (16.7%), vaginal thrush (20.8%) and atrophic vaginitis (8.3%).

It was observed that these patients experienced increased agitation and aggression. Restlessness, screaming upon intervention, depression, low self esteem and increased paranoia were also noted. A third of patients required extra psychotropic medication and an extra staffing level, whilst a third of patients experienced a direct impact of these problems on their social and sexual life.

41% of patients underwent gynaecological interventions. Post-treatment, a 50% reduction in (as required) psychotropic medication was reported. In 37.5% of cases, a reduced number of staff was required on intervention/observation level. There was a noticeable reduction of agitation in two thirds of patients, whilst a quarter showed reduced aggression, screaming and shouting. 8.1% of patients were discharged from services.

Conclusion
The findings highlight that a considerable number of female patients present with co-morbid gynaecological problems, which can directly influence their mental health. Appropriate attention and treatment of these comorbid problems is beneficial in improving quality of life, reduction in use of psychotropic medication and a reduced staffing level.

3. Anxiety, a hidden element in dementia: review
Dr Vellingiri Badrakalimuthu, ST5 Registrar – Old Age Psychiatry, Cambridgeshire & Peterborough Foundation Trust, Fulbourn Hospital, Cambridge and Dr Andrew Tarbuck, Consultant – Old Age Psychiatry, Norfolk & Waveney Mental Health Foundation Trust, The Julian Hospital, Bowthorpe Road, Norwich and Honorary Senior Lecturer, University of East Anglia & Director, DeNDRoN East Anglia

Aim & Method
The aim of this review is to explore the prevalence, presentation and diagnosis of anxiety in dementia and discuss the available therapeutic options as well as provide a structured guide to pharmacological treatments.

Results
Anxiety has a prevalence rate between 38% and 72% amongst patients with dementia. Anxiety in dementia is associated with race, vascular, fronto-temporal and Parkinson’s disease dementias and retention of insight and poor quality of life.
Although there is a relationship between anxiety and cognitive impairment, 4 studies have reported an association between severity of anxiety and decline in learning, memory and executive function as well as impacting on behavioural and psychological symptoms including agitation. Making the diagnosis of anxiety in the presence of dementia is a complex process and it requires a comprehensive assessment including physical health, prescribed medications and behavioural analysis. Worry Scale has a good correlation with trait and state anxiety and RAID (Rating of Anxiety In Dementia) has a good inter-rater reliability, sensitivity and specificity and correlates highly with DSM-IV diagnosis of generalised anxiety disorder. There is a high correlation between the anxiety domains in the BEHAVE-AD and Neuro-Psychiatric Inventory.

Success of CBT is dependent on the absence of executive dysfunction at the start of treatment or executive dysfunction that improves with treatment. Supportive group therapy alongside CBT, learning and memory aids, delivery in patients' own home and cognitive rehabilitation are reported to overcome barriers in psychological treatment. Problem-solving therapy can be beneficial in treating depression associated with anxiety in dementia. Although there is a lack of specific social interventions targeting anxiety in dementia, the association of anxiety with symptoms such as agitation suggests the need for social interventions. There is a lack of pharmacological trials specifically exploring anxiety in dementia. However, citalopram has been reported to reduce scores on neurobehavioural rating scale including agitation and trazadone has been reported to be effective in reducing agitation in dementia. Mirtazapine and venlafaxine have evidence for treating anxiety disorder in the elderly. Benzodiazepines can be useful as short-term remedies for agitation and Z-drugs where insomnia is a manifestation of anxiety. Secondary analysis of cholinesterase inhibitors have suggested their benefits on neuropsychiatric symptoms including anxiety. Buspirone and very recently, pregabalin have shown to be effective in treating anxiety in the elderly.

Conclusion
We provide a structured guide for pharmacological management and recommend citalopram, sertraline and fluoxetine as first line agents. Clinicians have to be proactive in exploring and treating for an anxiety disorder when patients present with behavioural and psychological symptoms.

4. Dementia: Place of Death. Where do patients die? Where do they want to die? Preliminary report from a systematic review

Dr Vellingiri Badrakalimuthu, ST5 Registrar in Old Age Psychiatry, Cambridgeshire & Peterborough Foundation Trust, Cambridge and Dr Stephen Barclay, General Practice and Primary Care Research Unit, Department of Public Health and Primary Care, Institute of Public Health, Cambridge

Aim
Between 2001 and 2009, there were 631,078 deaths in England for which one or more of the conditions Alzheimer’s disease, dementia or senility were mentioned in the death certificates. Place of death is an important determinant of the quality of a person’s death. The place where someone dies is influenced by the nature of their final condition and its implications, their age and their personal circumstances. The aim of this study is to conduct a systematic review of place of death of patients with dementia and to produce a narrative synthesis of patient’s opinion on preferred place of death.

Method
Searches of Medline, PsycINFO, EMBASE, CINAHL and Social Sciences databases from January 1987 to December 2010 were conducted, with citation and journal hand searches. The search terms included ‘dementia’, ‘death’ & ‘decision making’. Studies of patients with dementia where place of death was mentioned was included. Extracted data were analysed with a narrative synthesis of emergent themes.

Results
The studies on place of death are limited by dementia being not always recorded as one of the cause for death. The following is the result on place of death: home (3-42%), care home (20-92%), hospital (3-56%) and hospice (1-7%). One European wide study contributed to the wide-variations in range and reported that place of death was related to age, sex, available hospital and nursing home beds, and country of residence. One cost analysis study reported that in that study 51% patients with dementia die at the most expensive option, hospital. Patient’s participation depends upon either the patient’s cognitive capability or the healthcare professionals’ competence to communicate and provide adequate documentation regarding patients’ participation at end-of-life. A study comparing patient’s with dementia and heart failure (HF) reports that although patients with HF participated more in their advance planning, their involvement was not significant in predicting end-of-life preferences. One study reported that enrolment in hospice was a significant factor to patient dying at preferred location. A systematic review suggested that significantly higher proportions of patients dying in the nursing home had specific advance directive of do not hospitalize.
Conclusion

A large proportion of patients with dementia die in a hospital or in care. There is very little evidence of conversation with patients on their preferred place of death. Such a conversation will be an important factor towards quality of death and will have enormous implications on end-of-life care policies.

5. Implementing the National Dementia Strategy Locally - Descriptive Survey of New Service Provision
Dr Wasan Bajallan CT3 and Dr Ann Boyle, Consultant Old Age Psychiatry, Leicester Partnership Trust

Introduction and aims

Shortcomings have been identified in the current provision of dementia services in the UK. The National Dementia Strategy aims to ensure that significant improvements are made to dementia services. In order to make improvements locally and implement this strategy - Blaby and Lutterworth CMHT set up an outpatient service that has been established in partnership with Age Concern. After consultant review and diagnosis, a selected subgroups of patients/carers are referred to this clinic run by the Age Concern Worker. Issues of carer strain, psycho education and sign posting to other relevant services were discussed.

The aim of this study was to review this clinic which presents a first attempt to develop a care pathway for patients/carers post diagnosis.

Methods

This study is a retrospective case note review of the patients seen in this clinic and the themes that are discussed. A descriptive survey of the notes was undertaken to obtain this information. Data was collected then collated from the survey to produce the results.

Results

The case notes of all patients seen were reviewed from the clinics inception till October 2011.

Two thirds of the patients were male and a third female.

The average age of the male patients was 76 and the female was 83.

A review of patient’s diagnosis showed - 44% had Alzheimers, 44% vascular dementia, 6% mixed Alzheimers/Vascular dementia and 6% had other mental health diagnosis.

Of the carers seen, 44% were the spouse, 25% were the children of the patient and 31% had both child and spouse present.

Of the themes discussed with carers - the diagnosis was discussed 94% of the time, eligibility for benefits was discussed 88% of the time, lasting power of attorney 50%, educational talk 75%, carers group 56%, follow-up arranged 41%, community care assessment 25%, a sitting service 18%, and other 13%.

This work highlights how a shared-care protocol could be used effectively for this patient group.

This study is currently only used by Blaby and Lutterworth CMHT and could be spread throughout the Trust.

Further work needs to be done obtaining formal feedback from patients attending the clinic. We are currently in the process of obtaining this information which I also hope to present in this poster.

6. Companions on the journey: old age and learning disability psychiatry
Professor Susan Mary Benbow and Prof Paul Kingston, Centre for Ageing and Mental Health, Staffordshire University, Stafford; Dr Sabyasachi Bhauamik, Leicestershire Partnership NHS Trust and Dr Sarah Black, Devon Partnership NHS Trust

Aims

There is no clarity on how services should be provided to older people with a learning disability who develop a mental health problem in later life. This poster aims to highlight the recommendations of a survey of old age and learning disability psychiatrists and to foster further debate.

Methods

A postal survey of learning disability and old age psychiatrists was carried out to investigate their experience of working across the boundary between the two specialities. The findings were set out in a report to both Faculties.

Results: The findings of the survey led to eight recommendations regarding work at the interface between the two specialities.
Discussion
We found a wide variation across the UK in how services are provided to this group and the psychiatrists who reported working with patients who fall into this interface area generally fed back that their experience had been positive and rewarding. Nevertheless we found a clear need to raise awareness of the service requirements of older adults with a learning disability who have a mental health problem. This is particularly urgent in the current financial climate. The interface population includes not only people with a learning disability and a dementia, but also people with a range of mental health problems of later life in association with an existing learning disability.

Service providers and commissioners need to be aware of significant gaps in service provision for older people with a learning disability who have a mental health problem, and a lack of consensus about how services are best provided. One of the most important issues is how to promote collaboration between staff in older people’s mental health services and in learning disability services. In order that older people with a learning disability who have a mental health problem are able to access the services they require, clear guidelines on interface working and agreed care pathways are also required.

7. Hearing the quiet voices: how can YOUR dementia service learn from patients and their carers?
Professor Susan Mary Benbow, Ms Donna Doherty, Ms Lou Taylor and Professor Paul Kingston, Centre for Ageing and Mental Health, Staffordshire University, Stafford

Aims
The aim of this poster is to highlight some ways in which organisations and individuals can learn from (and be influenced by) people with dementia and their families and to ask conference delegates to consider how their dementia services could learn from the people using them.

Methods
To present in outline ways in which organisations, services, professional groups and individuals have learned from people with dementia and their carers by drawing on the authors’ involvement in the following pieces of work: the Faculty Consumer group, the West Midlands Older People’s Mental Health Collaborative, the MSc module ‘In our Shoes’, an ongoing research project on the narratives of people with dementia and their carers funded by the British Medical Association Dawkins Strutt Grant.

Results
The poster will offer a range of models for consideration.

Discussion
We have shown in the ‘In our Shoes’ project how people with dementia and their carers can be involved in teaching at a number of levels (design, delivery and evaluation) and students have reported how powerful the experience of users and carers as teachers can be. We believe that education offers one way in which people with dementia and their carers can influence the system, but it is important to recognise and develop other ways of learning from patients and carers. The Consumer Group has influenced the work of the Faculty of Old Age Psychiatry nationally and offers a model which could be employed in other settings. The Collaborative project involved staff from a variety of health and social care organisations working with people using their services to learn about how their services and the experience of using them could be improved, sometimes by identifying simple changes to practice.

The challenge we leave with delegates is to reflect on how people with dementia and their carers influence them as individual practitioners and the services they are involved in, and to consider whether there are changes they themselves could make which would increase the learning at an organisational and/ or personal level.
8. Learning and the mental health of older adults
Professor Susan Mary Benbow and Ms Louise M Taylor, Centre for Ageing and Mental Health, Staffordshire University, Stafford

Aims and Methods
Older adults with mental health problems (including dementia and depression) may benefit from involvement in learning. They may also have a role in delivering, designing and assessing education and training for professional staff. We have reviewed research studies and other literature that explores the value of actively involving older adults in different aspects of learning in order to start to address the importance of learning in relation to older adults’ mental health.

Results
The benefits of learning for older adults can be considered in three main areas focussed on mental health: practical (developing life skills/adjusting to illness); psychological (maintaining/developing self-confidence and setting personal goals); and social (social contact, avoiding isolation and engaging with the community). These areas can be related to the prevention of illness (or health promotion), the treatment of illness, and the prevention of relapse and promotion of mental health amongst people known to have existing or previous mental health problems. With an educational focus we can consider two main areas: educational interventions aimed at specific mental health problems; and non-health based educational experiences. The latter encompasses models for involving older people with mental health problems in delivering, designing and assessing education and training.

Discussion
Older adults with dementia, depression and other mental health problems are likely to benefit from involvement in learning as consumers. This will include both learning relevant to their mental health problems and other non mental health based learning opportunities. In addition this group has a potential role in delivering, designing and assessing education and training for others, particularly professional staff in health and social care. Involvement in education enables them to continue to learn and to contribute to the learning of others. We have identified models of involvement in all these areas and research suggesting benefits. However, with the growth of the older population and concern about the increasing numbers of people with dementia and depression requiring mental health services, there is a pressing need for a greater focus on the role of learning in relation to older adults with mental health problems and its implications for practice.

9. Comparison of Older Adults vs Working Adults presenting with overdose at City Hospital
Dr Farooq Khan, Specialist Registrar in Old Age Psychiatry, South Staffordshire & Shropshire Healthcare NHS Foundation Trust, Hon Lecturer in Old Age Psychiatry, Centre for Ageing and Mental Health, Staffordshire University; Dr Tarun Sehgal, Specialist Registrar in General Adult Psychiatry, South Essex Partnership NHS Foundation Trust; Charlotte Street, Sister and Amy Wooldridge, Sister, City Hospital, Birmingham; Maria Garcia, Medical Student, Birmingham Medical School, University of Birmingham; Prof George Tadros, Consultant in Old Age Psychiatry, Birmingham & Solihull Mental Health NHS Foundation Trust, Professor at Centre for Ageing & Mental Health Staffordshire University

Aims
To compare the profile of older adults with working adults who attend the poisons unit after overdose.

Methods
The data was collected retrospectively from the patient case notes, all patients of 50 years or older admitted to poisons unit from April 2009 to March 2010 were compared with people younger than 50 years. The data collection tool was designed to cover three aspects: socio-demographic details, overdose/suicide related themes, assessments and record keeping in case notes. While collecting the data attention was given to intent to die, accidental/deliberate, presence of psychiatric disorder, previous suicidal attempts, referral to psychiatric services and cognitive impairment. Case notes were also checked for precipitants, circumstances and potential reasons for overdose. We also included similar number of younger adults who were admitted to poisons unit during the specified time.

Results
It was found that 87% of patients have taken deliberate overdose, 63% have a clear intent to die of which 75% were among 50 years and above and 50% were among 50 years and below, though 63% were discharged within one day of admission. All 14 out of 14 (100%) under 50 year olds and 11 out of 16 (69%) above 50 year olds have taken deliberate overdose. Reasons for overdose as given by patients were recorded and multiple reasons were found in 40% of patients followed by other reasons (23%).
Multiple reasons included relationship difficulties, pain, debts, feeling low / depressed, argument, bereavement and stress. Other reasons included low mood, accidental / by mistake, unemployment, housing issues, bereavement, alcohol issues, feeling low / depressed, argument, family issues and work issues. Past history of suicide attempt and overdose was found in 40% and 37% of patients respectively. Paracetamol was the most common medication for overdose (26.6%), psychiatrists saw 67% of cases after referral, psychiatric diagnosis was recorded in 67%, psychiatric history and mental state examination (MSE) was recorded in 70%. Cognitive impairment was found in 13% of cases but in 47% it wasn’t recorded. 63% cases were just observed without any medical treatment and 30% were provided with medical treatment and observation as a part of management plan for overdose. Older adults will attempt overdose deliberately and would have clear intent to die. There is a need to understand the overdose pattern in the elderly with respect to types of medications used and prescription given to them.

10. Hard Economic Times and Dementia Care by Families – Cross Cultural Perspective

Dr Farooq Khan, Specialist Registrar in Old age Psychiatry, South Staffordshire & Shropshire Healthcare NHS Foundation Trust and Hon Lecturer in Old age Psychiatry, Centre for Ageing and Mental Health, Staffordshire University and Prof George Tadros, Consultant in Old Age Psychiatry, Birmingham & Solihull Mental Health NHS Foundation Trust, Professor at Centre for Ageing & Mental Health, Staffordshire University

Aims

To find out whether providing quality dementia care in patient’s homes with the help of families and informal carers would be much cheaper in these hard economic times.

Methods

The authors searched the journals electronically for phrases like dementia and family care, community support and economic burden of dementia. We searched the journals with the help of NHS library; articles, which were only abstracts were manually searched at the Library and if, not found were not included in the study. The authors then identified 33 articles, which were relevant to the aims of the review. After carefully reviewing all of them 23 were selected to be included in the review. The authors then subdivided the articles into epidemiological studies, economic studies and social care studies.

Results

The total cost of dementia care to the UK economy is £17.03 billion, which equates to £25,472 per person per year. Annual cost of dementia care per patients is: Community (mild dementia – £16,689, moderate – £25,877, severe – £37,473) and Care home – £31,296. If patients with dementia are kept in a home environment it will lead to lesser public and private expenditure on institutional care due to a possible delay in the need for it. It has been estimated that informal carers save the state between £15 and £24 billion per year by supporting dependents who would otherwise be institutionalized. There are a number of reasons why people in some countries provide care for elderly: Joint family system, sense of responsibility, social norms of respecting and caring for elderly, economic strains and lack of resources. ‘Job satisfaction’ and ‘Companionship’ were the two very positive aspects to caring their spouses with Alzheimer’s disease in a cross-national study. They gained satisfaction from making their spouse as comfortable as possible. They had to learn new skills to deal with difficult situations and were happy with the achievement. 16% were satisfied for ‘doing their best’ for their partners. 12% felt that they can make a return for care and affection given in the past and this played a major part in the motivations. Staying together was the most rewarding aspect for 15% of spouses, 16% patients appreciated the effort that their spouses are putting for the care and that was the motivation for the carers to go on. Singing, playing jokes and any other pleasurable activity was found to be cherishing.
11. Review of Pharmacological Vs Non-Pharmacological Management of Behavioral and Psychological Symptoms of Dementia (Bpsd) in Care Homes - Experiences From Care Home Inreach Program (Chip) Project
Dr Farooq Khan, Specialist Registrar in Old age Psychiatry, South Staffordshire & Shropshire Healthcare NHS Foundation Trust and Hon Lecturer in Old age Psychiatry, Centre for Ageing and Mental Health, Staffordshire University, and Dr Martin Curtice, Consultant Old age Psychiatrist, Dr Nusrath Ali Baig, Staff grade Psychiatrist and Trish McCreedy, Team Manager, Birmingham and Solihull NHS Mental Health Foundation Trust

Aims
1. To provide an in-reach service to care homes and to analyze the impact of this service at the end of six months.
2. Review the literature for care of dementia in care homes with respect to antipsychotic use and non-pharmacological approach in management of BPSD.

Methods
Three doctors – Consultant, Specialist Registrar and Staff Grade were part of the Multi Disciplinary Team (MDT) providing the inputs in four care homes. All doctors had more than 5 years experience of working in Psychiatric services. All four Community Psychiatric Nurses (CPN) from the CMHT taking part in the project were qualified, well trained and experienced in dealing with dementia and BPSD. The team Psychologist was the part of this project and was actively involved in training staff members in management of BPSD. A two / three member team provided the service which included a doctor, Community Psychiatric Nurse (CPN) and Psychologist.

Results
The knowledge of common mental health problems and dementia increased in care home staff at the end of CHIP Project by a margin of 7% and 11%. Confidence in managing behavioural problems increased by 9% among cares home staff at the end of project. 65% of care home staff felt a need for education and awareness, practical problem solving and counselling in managing BPSD. Care home managers pointed at four themes regarding the weakness in managing behavioural problems of dementia: 1. Lack of training, need of regular psychiatric input. 2. Not able to cater for more challenging patients. 3. Management of physically aggressive patients. 4. Delay in medication management by professionals in crisis. CHIP achieved regular monitoring of psychotropic medications, were able to discharge 14 out of 63 existing patients in four care homes, psychoeducation was provided for staff and families. CHIP provided guidance on following non-pharmacological techniques: relaxation techniques, distraction techniques, reality orientation, reminiscence work, needs led therapy, music therapy, person centered approach, behavior therapy: Antecedent Behavior Consequence (ABC), dolls therapy and snozelen therapy.

Some staff comments:
“Valued the service, CHIP is a much needed service in all care homes”.
“Training component was liked by all the staff who attended, more such formal training sessions are needed”.
“Staff felt more confident in dealing with behavioral issues in dementia patients, they felt more supported by the regular follow up visits”.
“Continuity of patient care is maintained and regular follow ups will keep a check on medication specially anti psychotics”.

12. A Comparative Survey of very late onset Schizophrenia like Psychosis in Ethnic and Indiginous Elders in Leicester City East
Nisha Mokashi, SpR Old Age Psychiatry

Aims
Leicester is a city with an unusually high proportion of ethnic minorities also reflected in its growing elderly population. Data documenting the demographics of this population diagnosed with Very Late Onset Schizophrenia like Psychosis (VLOSP) is very limited. This study is designed to compare indigenous elders and those from ethnic minority backgrounds who have been diagnosed with VLOSP.

Methods
All referrals to Leicester city east Old Age Psychiatry service with a documented diagnosis of ICD10 F22-29 over a 2 year period (JAN 2006-JAN 2008) were identified and selected for the study. This information is available on a computerised coding system within the directorate. I have pre-designed a schedule to detail the information gained from the case notes.

Results
46 case notes were identified to fall within the selection criteria. Of these, 19 had no previous psychiatric history and were diagnosed with VLOSP. Of these 9 were of an Indian Subcontinent ethnic background compared to only 7 who were of indigenous background. The other 3 were from the Caribbean or Eastern Europe.
Both the indigenous and the Indian Subcontinent groups had a high proportion of females, good social network, were mostly referred by their GP with a high or urgent priority referral. There were no significant visual or auditory problems in both groups and the presence of psychotic symptoms and delusional beliefs was similar.

The indigenous group had a higher proportion of cases that were single or divorced, lived alone and had depressive symptoms.

The Indian Subcontinent group had a higher number of cases living at home and a MMSE was not done in the majority due to language problems.

Conclusions
Elders from the Indian Subcontinent minority group have the highest proportion of presentations of VLOSP. However, the nature of these presentations is similar across all backgrounds. The high priority of these presentations highlights the importance of functional services for older people with mental health problems.

13. Assessment of Crisis Resolution Home Treatment Teams (CRHT) in Mental Health Services for Older People (MHSOP) – A Clinical Project in Gloucestershire from June 2009- February 2010
Dr Adam Moliver, Project Lead and Consultant Old age Psychiatrist, Cirencester; Dr Sabarigirivasan Muthukrishnan, ST6 in Old age Psychiatry in Severn Training Scheme

Aims
1. To assess the existing CRHT’s input into MHSOP in Gloucestershire
2. To assess if the input does benefit the MHSOP in terms of preventing hospital admissions and enabling early discharge
3. To improve the existing service provision

Method
The last 5-15 referrals to the CRHT in each team were collected and the primary data for the project, the referrals and discharge summaries were studied. The CRHT managers were contacted and asked structured questions about their involvement in supporting the MHSOP. 30 referrals were included in the project. Based on the data, data analysis and information from CRHT managers, project recommendations were made.

Results
The project was able to identify that many admissions were prevented as a result of the involvement of CRHT with MHSOP and few patients were discharged early. This could be a positive thing but only a gold standard randomised control study [RCT] could see if this is a positive and statistically significant outcome. Ideally the patients can be randomized to a control group who meet the acceptance criteria of CRHT but not treated by them and an intervention group which is treated by them. This can then followed by the use of multivariate regression analysis to account for the effects of confounding variables. The RCT is often not possible due to feasibility implications. There was room for improvement in this service provision which has been included in the recommendations.

Summary of recommendations for improving the service provision
• Clear definition of crisis and early discharge
• Clearer referral criteria for the MHSOP and more clearer accepting criteria for CRHT.
• Induction Pack for staff to include these criteria and related policies.
• Regular training for CRHT staff on mental health issues of the elderly.
• Better liaison between CRHT and Inpatient Ward managers
• Consideration needs to be given in the CRHT review meeting about the bed keeping role of CRHT.
• Consideration to be given to staffing levels and support for CRHT supporting MHSOP.
14 Anaemia in Elderly In-Patients in Psychiatric Hospital: A serious problem or an innocent finding?
Dr Yasir Hameed, CT1, Dr Mark Everard, FY2 and Dr Julian Beezhold, consultant psychiatrist, Norfolk and Waveney Mental Health Partnership, Norwich

Background
Anemia (and especially mild forms) is a frequent laboratory finding in the elderly and is usually regarded in our everyday practice in psychiatry as an incidental innocent finding. However, the growing body of literature proves otherwise. Recent literature shows that anemia in the elderly has serious negative impact on mortality, morbidity and quality of life in this age group. Despite the importance of this topic in mental health care, there is paucity or even lack of studies aiming to examine the magnitude of this problem in psychiatric hospitals and to suggest potential solutions for it.

Aims
In this small study, we aim to examine the prevalence of anemia in an inpatient psychiatric hospital, the types of anemia found, the investigations done and if any treatment was given.

Design and Method
20 inpatient case notes were examined retrospectively for patients admitted to the Julian hospital from June 2010 to December 2010. Anemia was defined according to the WHO criteria as a hemoglobin concentration lower than 12 g/dL in women and 13 g/dL in men.

Results
The mean age of patients was 76 with slight male predominance (55% males, 45% females). Dementia in its various types was the main reason of admission for most patients (9/20, 45%). Based on WHO criteria, 30% of our patients (6/20) had anaemia. Four of those patients were suffering from dementia; the other two were bipolar affective disorder. The most common type of anaemia was anaemia of chronic disease. Two of the anaemic patients were not on any form of treatment despite the need for this.

Conclusions
While the association of anemia and adverse outcomes in the elderly is generally acknowledged, it is noteworthy that no guidelines or recommendations for screening and identifying anemia in the elderly exist (whether in general or mental hospitals). Anemia in elderly is a frequent, underappreciated and potentially morbid condition accounting for significant morbidity and mortality in this population.

As mental health professionals, we need to work with our colleagues in medicine to translate awareness into action.

15. Use of antipsychotics in patients with dementia
Dr Kakali Pal, Dr Abigail Smith and Dr Leah Wooster, Core Trainees, Barnet, Enfield and Haringey Mental Health Trust

Background
Recent media interest has highlighted risks associated with the use of antipsychotic medication to manage behavioural and psychological symptoms in dementia (BPSD), such as increased risk of cerebrovascular events. NICE have published guidelines to help minimise prescriptions and a report produced for the National Dementia Strategy recommends reducing total use by a third.

Aim
To evaluate the use of antipsychotics for management of BPSD in the London Borough of Barnet and compare with previous results.

Method
Data was collected from notes of a randomly selected sample of 10% (n=87) of patients known to local Memory Treatment Services with a diagnosis of dementia. Results were compared with national guidelines.
Results
40 patients had evidence of BPSD (46% of cases reviewed): 7 severe (8%), 20 moderate (23%) and 13 mild (15%). Of these, only 7 cases were prescribed antipsychotics (8% of total patients reviewed). Drugs prescribed were quetiapine and amisulpride. Reasons for prescription were clearly documented in 5 of the 7 cases with evidence of discussion with the carer in 6 cases.

6 prescriptions had been started at low doses and titrated accordingly. Target symptoms were monitored in all patients, but only 3 had review plans in place. There was no documented evidence of consideration of non-pharmacological measures for any of the 7 patients.

A previous audit of patients from the same service in 2008 showed 10% of patients were prescribed antipsychotics (12 out of 120) indicating a reduction of 2% in 2 years. These results compare well with the estimated number of patients with dementia prescribed antipsychotics nationally (around 25%).

Conclusion
Results showed that 8% of our patient group had current prescriptions of antipsychotics for management of BPSD. All of these had moderate or severe non-cognitive symptoms of dementia which were being monitored. Reviewing the relevant notes highlighted a need to improve documenting consideration of non-pharmacological methods of management and to ensure clear review plans are in place.

Overall, the prescription rate in the borough was lower than that predicted nationally, and has reduced by 2% compared to 2008. This suggests that local mental health services are already minimising use of these drugs and casts doubt over the need to further reduce prescriptions by a third. Dogmatic compliance with an arbitrary target such as this risks under-treating patients with severe complications of their dementia.

16. Detection and Management of Hypertension in Elderly Psychiatric Inpatients on Woodbury Unit
Dr Gagan Preeti, CT3, South West London and St George’s Mental Health Trust
Supervised by Dr Shakil Khawaja, Consultant Psychiatrist, North East London Foundation Trust

Background
There is considerable and increasing evidence linking vascular risk factors in elderly patients to an increased risk of cognitive decline and depression. There is also evidence that patients with mood disorders, especially depression, are more likely to suffer from hypertension

Standards
NICE Guidelines, North East London Foundation Trust Physical Health Policy

Method
37 patients admitted to Woodbury Unit between 16/4/09 and 16/7/09 were included. Data was collected retrospectively using electronic notes (Rio) and paper notes. The items in the audit tool were: blood pressure checked within 24 hours of admission, blood pressure reading documented, blood pressure monitored as requested, discussion about lifestyle changes, assessing cardiovascular risks and seeking specialist opinion.

Results
Significant findings were: blood pressure was checked and recorded for 97% of patients within 24 hours of admission, 37% were diagnosed with hypertension who were previously not known to have high blood pressure, for 47% of patients with high blood pressure further monitoring was not requested, lifestyle changes were not discussed with any of the patients, cardiovascular risk was assessed in only 50% of patients with persistently high blood pressure and specialist opinion was requested for only 14% of patients

Recommendations
Blood pressure monitoring to be made part of the care plan, discussion about lifestyle changes to be discussed during patient protected time, cardiovascular risk factors to be assessed and specialist opinion requested for patients with persistently high blood pressure, primary care to be informed to arrange appropriate follow-up of hypertension following discharge.

Follow-up from recommendations
The results of the audit were presented to the team and at the academic meeting. This led to the plan of recording blood pressure readings in the relevant section of electronic patient records (Rio). The ward staff were given a talk by one of the team doctors about the importance of blood pressure monitoring, informing the doctors when readings are not within normal range, significance of discussing lifestyle changes with patients, encouraging and helping patients to make those changes.
17 How effective is a crisis resolution and home treatment team for older people with medical input at reducing the number of admissions and length of stay to hospital?
Dr Raghavakurup Radhakrishnan; Dr Jayaram Ramaswamy; Dr Rob Butler, Suffolk Mental Health NHS Partnership (SMHPT)

Aims
To compare the number of admissions to hospital and length of stay before and after the introduction of a crisis resolution and home treatment team for older people.
To compare the differences in admissions and length of stay to the functional and dementia older people team over the same time period.

Background
Crisis resolution and home treatment teams are widely considered to be helpful in managing people at home and reducing the number of unnecessary admissions. However, there are relatively few crisis teams that offer a specialist service for older people. The development of a new team for older people in East Suffolk offered the opportunity to see if the service had an impact on the number of admissions.

Method
We collected data from the Trust’s electronic record system (ePEX) for 12 month and 30 month periods before and after the introduction of the new team.

Results
In the older people’s service, there were 32.8 admissions a month during the time period before the new team and 30.0 admissions a month in the following time period. The lengths of stay were 29.9 days and 38.2 days.
In the general adult service over the same time periods there were admissions a month and 97.5 and 122.0 admissions respectively. Their lengths of stay were 15.2 days and 18.9 days. While the average admission in functional service decreased the average admissions in dementia services increased.

Conclusions
The introduction of a specialist crisis resolution and home treatment team for older people was associated with a reduction in the number of admissions but a significant increase in the average length of stay. Over the same time period the adult service did see a similar change. Specialist crisis teams for older people may offer an effective way at improving the use of inpatient beds.

18. What are the differences between a later life and an adult crisis resolution and home treatment team?
Dr Raghavakurup Radhakrishnan, Dr Rob Butler, Dr Jayaram Ramaswamy Dr Shafy Muthalif, Dr Laura Head, and Dr Vivian Peeler; Suffolk Mental Health Partnership NHS Trust (SMHPT)

Aim
To compare later life and adult crisis and home treatment teams in terms of team composition, patient characteristics, interventions and the outcome in number of admissions and lengths of stay.

Background
Crisis resolution and home treatment teams are considered to be helpful in managing people at home, reducing the number of unnecessary admissions and speeding up discharges. However, there are relatively few crisis teams that offer a specialist service for older people. The development of such a team in East Suffolk offered the opportunity to examine its impact and compare it with an adult team.

Methods
We collected data about team composition in the later life and adult crisis teams. We used a semi-structured tool to perform a retrospective electronic file review of 80 patients referred to the crisis teams. From the electronic record system (ePEX) we examined routine referral data for the 12 month period of Jan 2005 to Jan 2006 and the 30 month period Jan 2007 to June 2009.

Results
The teams differed in team composition, patient characteristics, interventions and the outcome in number of admissions and lengths of stay. The number of admissions to the later life wards was 394 in the first period and 913 in the second period. This showed a 9% average monthly reduction between the time periods (from 33 to 30, t-test not significant). Admissions to the adult wards were 1452 in the first period and 2932 in the second period. This showed a 19% reduction (from 121 to 98 per month, t-test p<0.001). The reduction to the adult wards was significantly greater than to the later life wards (chi-squared, p<0.05).
Conclusions
Both services saw a reduction in admissions over the study period but despite more interventions by the later life team there was a significantly greater reduction in the number admissions to adult wards than to later life wards. Our results suggest the difference is mainly due to differences in patient groups and not due to a lack of interventions by the later life crisis team. This has important implications for service redesign.

19. Can the Commissioning for Quality and Innovation Payment framework improve the quality of care for patients? A report on the Falls Assessment Screening and Implementation of the Falls Pathway within Old Age Services in a Mental Health Trust
Dr Aniruddha Rajkonwar, ST-6, Old Age Psychiatry, Helen Ainsworth, Head of Physiotherapy, Dr Sandhya Gaur, ST-5, Old Age Psychiatry, Dr Deborah Chaloner, Consultant Psychiatrist, Dr Farhan Khan, GPVTS, Dr Anna Karageorge, FY1 and Dr Vaux Cairns, FY1, Leicestershire Partnership Trust

Introduction
The CQUIN (Commissioning for Quality and Innovation) framework is a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by paying a quality increment to providers using NHS Standard Contracts if they achieve agreed quality improvement goals.

Preventing and reducing falls in the elderly is an important target which comes under a CQUIN scheme within Leicestershire Partnership Trust. Patients with dementia are at an increased risk of falls resulting in increased morbidity, mortality and cost. A falls pathway has been produced in order to reduce patient falls and prevent fractures. The pathway is evidence-based, follows national standards and guidelines. It was developed by a multi-disciplinary team and has been in operation since 2008.

Criteria
With any CQUIN project, clinical audit is one of the key ways of gathering evidence of performance against existing quality standards. The following criteria are audited on a yearly basis as part of the monitoring process.
All patients will receive an initial screen.
Full screens in all high risk cases and they will have preventative measures instigated.

Criteria are based upon the Integrated Falls and Bone Health Strategy and NICE Guidelines on the assessment and prevention of falls in older people. In 2010, the criteria for retaining the funding provided under the CQUIN Framework was at least 95% compliance in initial falls risk assessment and 95% in instigating preventative measures in people at high risk.

Method
A trust wide Audit of current inpatient case notes was performed in December 2010. Previous Audits had been done in 2008, 2009. Data on falls and fractures obtained on a yearly basis.

Results
107 patients included in audit. 99.1% of patients had an initial falls risk assessment. A multi-factorial falls risk assessment had been completed and onward referrals had been completed in all 34 patients identified as at high risk.

The number of falls per 100 occupied bed days fell from 13.7 to 10.1 and the number of fractures per 100 occupied bed days fell from 0.35 to 0.28 between 2008 and 2009.

Conclusion
It has seen that there is high compliance with the falls risk assessment pathway. The need for a high level of compliance to hold on to funding is clearly an incentive for better performance. Incidence data shows that falls and fractures in the service have reduced since the pathway was introduced. This translates into better outcomes for patients.
20. Extension of home treatment towards an ageless service
Sally Woodward, Dr Karim Rajput, Karen Ingram. Worcestershire Mental Health Partnership NHS Trust

Introduction
Crisis resolution and home treatment teams (CRHTT) often provide input till the age of 65, few take on 65+ patients. Worcestershire CRHTT recently decided to accept certain patients 65+. Functional clients of working age are generally considered for home treatment (HT). For this reason it is possible that functional patients age 65+ may also be appropriate. Severe organic conditions such as dementia are generally not taken onto HT.
There is pressure for equity for all and HT teams are increasingly encouraged to offer their services to all patients regardless of their age.
It is widely thought that the nature of patients conditions should be matched to an appropriate service, hence HT could manage some cases over 65 similarly early onset dementia may be better managed by an older adults service.
Pressures on inpatient beds and the current financial climate has made the development of new pathways inevitable. Our CRHTT formally took on 65+ patients from June 2010.

Aims
We wanted to evaluate the impact of home treatment team on patients age 65+. We wanted to understand what types of patients were referred for what reason as well as measure the length of HT involvement.

Methods
We designed an excel spread sheet to capture various aspects of the patient journey parameters included age diagnosis reason for referral, time with HT and outcome. We used the electronic case notes to capture data of patients in North Worcestershire from June 2010 to December 2010.

Results
There was a total of 176 computerised entries recorded, of which 31% were assessments, 20% follow ups, the remainder were referrals only. This included 86 individual patients of which 62% were female. The age range was 65-89 (with median =74). 47% were seen in their own home. There were 20 admissions of which 75% were informal. 21 were taken on to HTT as alternative to admission and a further 8 for early discharge. 21 were referred back to own local team.

Average HTT episode was 21 days duration (range 1-56) and most frequent diagnosis was depression 53%, There were 27 episodes of HT, for 20 different patients.

Conclusions/ Discussion
HT has a valuable role in managing a portion of 65+ patients. It can effectively help certain patients to be managed at home in their own environment, which is often their preference. Further study of data such as patient satisfaction in this group would be helpful.

21. Older adult liaison, a study of referral and outcomes
Dr Karim Rajput, Dr Swathi Sanagapati, Helen Istifan, Worcestershire Mental Health Partnership NHS Trust

Aims
Liaison services in acute hospital settings sometimes include specialist provision for older adult clients. The demographic of patients in acute hospitals typically show 60+% of patients in this age group. The typical mental health issues affecting this demographic are dementia, delirium and depression. The Royal College of Psychiatrists and Alzheimer Society have produced compelling reasons for liaison services to be funded.
In Worcestershire there are two main hospitals with specialist older adult liaison provision based in the north and south of the county.
We wanted to evaluate the nature of referrals and outcomes in patients referred to our service.

Methods
We retrospectively collected data for patients referred to our liaison service at Alexandra Hospital and Worcestershire Royal Infirmary. We utilised patient records, the referral book and the computerised records (NCRS). We determined parameters including age, sex, past psychiatric contact, diagnosis, date of referral, date actually seen and outcome.
All patients who were referred in months August, September and October 2010 were included. Furthermore referrals of 65+ clients to the self harm liaison services were also included.
Results:
There were a total of 165 referrals made over the three month period. Most referrals were received in September. Dementia was the most common mental health diagnosis (85%) with depression and delirium being present in 15% each. The mean age was 85 with a range of 65-103. 75% were known to mental health services. 26% were referred to social services, 24% to CMHT, 21% discharged back to home, 4% to rehabilitation, 25% referred to residential/care homes.

Comments/ Conclusion:
The role and importance of a dedicated older adult liaison service is evident in this study. The prevalence of dementia and delirium and depression in this population has a profound effect on the length of stay. The involvement of specialist mental health teams can reduce length of stay and improve the patient journey.

22. A Service Evaluation to Assess the Use of Antipsychotics in Patients with Dementia.
Dr Fozia Roked, Foundation year one trainee Queen Elizabeth Hospital Birmingham; Dr Asha Omar, Foundation year one trainee Watford Hospital London; Kimya Razavi, Final year medical student University of Birmingham and Sandeep Kaur, Final year medical student University of Birmingham

Background
Behavioural and psychological symptoms of dementia (BPSD) include psychotic symptoms such as delusions and aberrant behaviours such as aggression. The cumulative risk of BPSD is 90% across the course of the illness. Antipsychotics are licensed to treat the psychotic symptoms of mental illness. They are being used off-license for the treatment of behavioural symptoms of dementia. There is a general consensus among healthcare professionals that antipsychotics are over-prescribed in the treatment of dementia.

There are concerns around the safety of prescribing antipsychotic drugs to people with dementia (CSM) as they can prolong the QT interval, doubling mortality and risk of sudden death and increase the risk of stroke 3 fold.

Aims
To compare antipsychotic prescribing in dementia over a duration of 4 years. The first sample was taken between August 2006 to 2007 and the second between August 2008 to 2009. Prescribing was assessed in terms of indications, duration, review of use, and adherence to NICE guidelines.

Methods
Patients referred to an old age psychiatric team based at The Queen Elizabeth Psychiatric Hospital were identified using medical and electronic records. Medical notes were reviewed to obtain: age; gender; type of dementia; MMSE score; presenting symptoms; presence of BPSD; treatment offered, including antipsychotics; duration of pharmacological treatment; mean follow-up. Samples were obtained from August 2006 to 2007 and data collection was repeated for comparison from August 2008 to 2009.

Results
From August 2006 to 2007, 70 patients were referred to the psychiatric team, 71% of whom had BPSD. From 2008 to 2009, 90 patients were referred to the team, 69% of whom had BPSD. From August 2006 to 2007, 28% of patients with BPSD were prescribed antipsychotics, from August 2008 to 2009, 36% of patients with BPSD were prescribed antipsychotics (p=0.399). More patients were prescribed typical antipsychotics in 2006 to 2007 (79%) compared to 2008 to 2009 (p=0.03). Fewer patients were on antipsychotics for greater than 6 months in 2008 to 2009 (32%) compared to 2006 to 2007 (36%) (p=0.28).

Conclusions
Results from both sets of data (August 2006 to 2007 and August 2008 to 2009) show that the old age psychiatric team were adhering to NICE guidelines. Although more patients were treated with antipsychotics for BPSD in 2008 to 2009, more patients were on antipsychotics for less than 3 months. A greater number of patients were treated with atypical antipsychotics from 2008 to 2009.
23. Elderly Forensic referrals to a Medium Secure Forensic Mental Health Service in Bristol: A two year survey and a detailed descriptive study.
Dr Suchitra Sabarigirivasan,ST6 in Forensic Psychiatry, Wessex Deanery; Dr Sabarigirivasan Muthukrishnan,ST6 in Old Age Psychiatry, Severn Deanery

Aims
1. To generate data to understand the characteristics of elderly forensic referrals to a South West regional medium secure unit based in Bristol, Fromeside.
2. To generate auditable guidelines and standards for use within Fromeside for the assessment of future elderly forensic referrals.
3. To provide data as a focus for initiating dialogue between local forensic and old age psychiatric services regarding the care of, and the development of services for, elderly offenders.

Methods
The criteria for inclusion for the study were agreed locally and the elderly forensic referrals to Fromeside from 1 January 2009 to 31 December 2010 were included. The cases were identified from the Mental Health Information Management System (MHIS) and they were studied in detail with reference to a data collection tool. The data collection tool was devised to collect data about referral; location of assessment, socio demographic characteristics; diagnosis; sensory and cognitive assessment; comprehensive medical, psychiatric and forensic history; drug and alcohol history.
A similar study was done in the old Fromeside including referrals made between 1988 and 1999. The findings of both the studies were compared and analysed.

Results
There were 24 referrals and all of them met the inclusive criteria of the study. There were in average 2 referrals a month made to the service. This included referrals to the community forensic personality disorder service-The Pathfinder. The study showed the offences committed varied and included homicides, attempted murder, actual bodily harm, arson, stalking and sex offences. Personality disorder and in particular borderline and anti social personality disorder were particularly noted in elderly female patients.
Auditable guidelines and standards were developed for local use for the assessment of future referrals to the service.
It is very interesting to note that the previous study had only 38 cases in an 11 year period whereas this study had 24 referrals in 2 years.
The data gained from this study will be used to develop a NHS business model for secure mental health service for elderly men in the South West region with integrated local Old age Psychiatry and Forensic Psychiatry service.

24. Audit on Memantine use in Hampshire Partnership Trust
Dr Feena Sebastian, Dr Darren Cotterell and Professor Clive Holmes

Introduction
Memantine is a non-competitive NMDA receptor antagonist which is licensed in Europe for the treatment of moderately severe to severe Alzheimer’s disease. In November 2007 Shared Care Guidelines for the Management of Patients receiving Memantine produced by Professor Clive Holmes were released in Hampshire partnership Trust. These guidelines advised that Memantine could be utilised in patients with moderately severe to severe Alzheimer’s disease with signs of agitation/aggression if a trial of Risperidone (the only licensed agent for the short term treatment of aggression in dementia) has been ineffective or is contraindicated.
The primary aims of this audit were to assess whether the prescription of Memantine across Hampshire Partnership Trust followed trust guidelines and to establish whether a robust communication was occurring with Primary Care to ensure complete and safe shared care prescribing.

Method
The first phase of the audit consisted of auditing letters to General Practitioners. This was carried out by pharmacy technicians based in surgeries across Hampshire. All letters to GP’s on patients commenced on Memantine after November 2007 were audited using an audit tool developed by Professor Holmes. 59 cases were eligible.
The second phase consisted of Dr.Cotterell and Dr.Sebastian auditing a random selection of case notes of patients who had been actively prescribed Memantine since November 2007 in all the community mental health teams in Hampshire Partnership NHS Foundation Trust.
77 cases prescribed Memantine were audited using the same audit tool.
Results
The main results were that in 70% of CMHT cases Memantine was prescribed in people suffering from Alzheimer’s disease and 63% were prescribed in severe cases. In 88% of cases the main indication for the prescription was agitation/aggression. Only 41% of letters to general practitioners had a documented diagnosis of Alzheimer’s dementia. In 22% of cases the type of dementia was unspecified. In 55% of the letters to primary care the severity of dementia was not documented. There was inadequate documented evidence that medical cautions of renal impairment 6% (CMHT data) and epilepsy 5% (CMHT) were assessed.

Following our audit we recommended that Clinicians need to be clearer about prescribing appropriately and highlighted the need for documented consideration of contraindications to, and side effects of, Memantine use. Correspondence to GPs should include precise diagnosis, reasons for prescribing and advice regarding the monitoring of renal function. There should be clearer documentation regarding the absence of effect, or contra-indication to, the use of atypical antipsychotics in this cohort.

We also recommended that the current Trust Guidance on the prescription of Memantine may need to be updated according to the Trusts application of reviewed NICE guidance.

25. Antipsychotic prescribing for people with Dementia – A survey of prescribing practice
Dr Namrta Sinha, ST6 Old Age Psychiatry, Morpeth and Dr Robert Barber, Consultant Old Age Psychiatrist, Newcastle General Hospital, Newcastle Upon Tyne

Objective
In recent years clinicians have received guidance from a variety of sources about the safety of antipsychotic medications in people with dementia. The report by Professor Sube Banerjee (Time for Action, Nov 2009) on the use of antipsychotics for people with dementia called for making a reduction in such use a clinical governance priority for the NHS. In view of this, we conducted an electronic survey of Old Age Psychiatrists in the Northeast of England in order to find out about the current prescribing patterns and factors that have influenced prescribing.

Method
The survey included questions about the symptoms for which antipsychotics are used, preferred antipsychotic of a clinician, reason for the preference, duration of use before discontinuation, any changes in prescribing habits and main national drivers that have influenced their prescribing. The survey was sent three times between May-July 2010 to the Old Age Psychiatrists. The responses were then analysed and concluded.

Result
The response rate was 57% (36/63 responses). More than 50% responded that an antipsychotic is often used to treat psychotic symptoms and also occasionally used for agitation and physical aggression. Clinicians prefer to usequetiapine as their first choice (39%), followed by risperidone (33%) and haloperidol (28%). Tolerability and efficacy influence the preference for a particular antipsychotic most with cost-related factors exerting the least influence. Nearly 70% responder would consider discontinuing the antipsychotic after 3 months on treatment and 20% after 6 months. CSM/MHRA advice (75%) followed by the NICE guidance on dementia (50%) commonly influenced the prescribing practice. Approximately 50% of respondents had never audited their prescribing practice, and a similar number had limited access to in-reach services.

Conclusion
Our survey highlighted interested differences in clinical practice when comparing the choice of antipsychotic – particularly that quetiapine was more often chosen compared to risperidone, the only antipsychotic licensed for the short-term treatment (up to six weeks) of persistent aggression in patients with moderate to severe Alzheimer’s dementia. This difference may reflect similar prescribing patterns in primary care. Most clinicians favored short-tem use of treatment (around 3 months) and anticipated future prescribing will reduce. However, in line with the National Strategy for Dementia, we would support the need for a series of local and regional audits on the use of antipsychotic medication for people with dementia, along with clear and realistic goals agreed locally in order to reduce and improve their use in clinical practice.
26. Study of the use of prescription hypnotics/sedatives and other psychotropic medications in the elderly population attending a community mental health team

Dr Narayanan Subramanian, Registrar in Psychiatry, Kildare Mental Health Services, Ireland, Dr Tom Reynolds, Consultant Psychiatrist, Clare Mental Health Services, Ireland, Dr Kyle Dyer, Consultant Psychopharmacologist, South London & Maudsley NHS Trust, London

Aim
The primary aim of the study is to find the prevalence of overuse of hypnotic/sedatives and polypharmacy of psychotropic medications in patients attending a community mental health team for older people in Ireland over a one year period and the self perception of patients about their psychotropic medication use.

Method
Ethical approval was obtained from the local ethical approval committee prior to the commencement of the study. Patients attending a community old age mental health team (n=183) during 2009 were included in the study and their files reviewed in the first stage of the study. Among them, 18 patients were interviewed in the second stage of the study to get their perceptions on their own prescription medication use.

For the purpose of the study, those who were using hypnotic/sedatives for more than eight weeks were defined as ‘over using the hypnotic/sedatives’. Furthermore, those who were on more than one antidepressant, antipsychotic, hypnotic/sedative or mood stabiliser at the same time were defined as being on ‘polypharmacy for either an antidepressant, antipsychotic, hypnotic/sedative or mood stabiliser’.

Results
Prevalence of hypnotic/sedative overuse was 45.9% and the prevalence of polypharmacy of psychotropic medications was 17.5%. The average number of psychotropic medications and total number of medications used were two and six respectively. In the qualitative part of the study, 14 out of 18 patients wanted to continue their overuse of hypnotic/sedatives in spite of advice against same for fear of relapse of their condition. SPSS Version 15 was used in further analysis of the data of this study.

Conclusions
Hypnotic/sedatives are often overused in elderly patients and this poses significant risk of adverse effects due to falls and other adverse effects. Depression is the most common diagnosis in elderly population which puts them at increased risk of suicide and also the need to use antidepressant polypharmacy on occasions to treat them. Psycho education is the need of the hour to reduce overuse of hypnotic/sedatives and polypharmacy of psychotropics in elderly due to the risks associated with such overuse and polypharmacy.

27. Perception of Physician Assisted Suicide among Egyptian Psychiatrists: Elderly Care Prospective.

Dr Mona Y. Rakhawy, Associate Professor of Psychiatry, Cairo University, Egypt; Prof George Tadros, Consultant in Old Age Psychiatry, Birmingham and Solihull Mental Health Foundation Trust, Professor of Mental Health and Ageing, Staffordshire University, UK; Dr Aref Khoweiled, Associate Professor of Psychiatry, Cairo University, Egypt; Dr Ahmed Mahmoud El-Houssini, Resident Psychiatrist, Dar El Mokattam for Mental Health Hospital, Cairo, Egypt; Dr Farooq Khan, Specialist registrar in Old Age Psychiatry, Birmingham, West Midlands Scheme

Aim
To survey the views of Egyptian psychiatrists on physician assisted suicide (PAS) focusing on demographical, spiritual, legal and clinical domains. In this study we also looked into psychiatrists’ opinion in relation to ageing and dementia.

Background
Inadequate attention has been given to the cultural, religious and socio-economic backgrounds underlying the different views of physicians on assisted suicide. These factors could affect the clinical decisions. Views on ageing and dementia also vary in different cultures.

Method
We surveyed the views of psychiatrists in four Egyptian counties (Cairo, Giza, Helwan and Alexandria) using structured questionnaire utilizing 5-points Likert response scale. The questionnaire consisted of 3 sections; Section (I) covered demographic data, section (II) explored the psychiatrists’ views on PAS while section (III) investigated views on a given related vignette. The project was approved by Cairo University Ethical process.
Results
160 psychiatrists completed the questionnaire (response rate was 82%); 70% were males and 30% females. The majority (84%) were Muslims while 14% were Christians and 2% not disclosed. Almost 17.5% described the influence of their religious believes on their medical practice as very strong, while 32.5% described it as strong, 37.5% as neutral, 5% as weak and only 7.5% as nil.

The majority (75%) said they would disagree/strongly disagree to support PAS for a terminally ill patient while only 15% said they would currently support it. However, in response to a given vignette which describes the case of a patient who suffers with Alzheimer’s disease as well as terminal cancer, there was an increased majority (82%) who were against PAS, while only 10% felt PAS would be appropriate; the difference was statistically significant (Chi square, df=16, P<0.0001). Also, 64% said they would still oppose PAS even if it was legalized. However, 62% believed that legalizing PAS would lead to a record increase in patients/families’ request.

A similar proportion to those who disagree to PAS (76%) was also against passive euthanasia. The majority (77%) felt PAS was against their religious believes, there was no significant difference between Muslims and Christians (Chi-square, d.f=2, P= 0.463).

Conclusion
The majority of Egyptian psychiatrists are against physician assisted suicide and passive euthanasia. On specifying patients with Alzheimer’s disease and terminal illness, psychiatrists’ views were more polarized against PAS. The absence of significant difference between the views of Muslim and Christian psychiatrists suggests that future studies should explore the influence of possible culture differences rather than religious believes.

28. Survival Analysis following Multiple Suicide Attempts: Another Call to Consider Younger Adults and Older People Differently.
Prof George Tadros, Consultant in Old Age Psychiatry, Birmingham and Solihull Mental Health Foundation Trust; Professor of Mental Health and Ageing, Staffordshire University; Rafik Salama, PhD student, Center of Systems Biology, University of Birmingham; Dr Mona Y. Rakhawy, Associate Professor of Psychiatry, Cairo University; Dr Osama Refaat, Lecturer of Psychiatry, Cairo University

Background
Suicide in younger people attracts a lot of research and effort while suicide in older people remains a neglected area. It was claimed that suicide in the elderly is different, in some aspects, from suicide in younger people. Previous researches argued that there are two different syndromes of suicide; the first include those who were successful in killing themselves at the first attempt and the second includes those who had multiple attempts before they eventually kill themselves. But, others argued that suicide in the elderly falls under one syndrome as the same difference did not appear to exist.

Aim
The aim of this study is to examine survival rates for both older people and younger adults after single and multiple attempts.

Method
All suicide cases from Birmingham and Solihull Coroner’s Office over 5 years period were included in the study. The total number of cases was 471 among whom 103 had Multiple Suicide Attempts (MSA). The number of suicidal attempts versus the time line of such attempts was collected. We have grouped the deceased persons by age into two groups; under 60 and 60+.

Results
We measured the survival rate of the patients after their last suicidal attempts. The study has shown that the patient’s survival increases with time. We have also shown that the survival curve stabilizes after almost six months of the last suicidal attempt.

We have also studied the survival rates in relation to the number of suicidal attempts; in this study we have divided the patients into two groups, over and under 60. The survival rates of the patients appear to be inversely proportional to the number of attempts committed. The survival of the patients over 60 is lower than that of those under 60.

Conclusion
Using survival analysis technique, it appears that survival rates in older people and younger adults were different. Older people are more likely to die after suicide attempts. Older people appear to be more serious and successful regarding their suicide attempts. We like to stress the need for full psychiatric examination and support to the elderly who attempt suicide especially over the following 6 months.
Hospice patients are at risk of developing or of having pre-existing cognitive impairment, including delirium and dementia. Patients with delirium and dementia experience increased morbidity and mortality. Despite the high prevalence of cognitive impairment in this population it is often not recognised. NICE guidelines for diagnosis, prevention and management of delirium require that patients at risk of developing delirium should be assessed for its presence using a standardized valid instrument within 24 hours of admission.

Aims
1. To determine whether cognitive impairment is assessed routinely on admission to hospices in the UK.
2. To identify which methods/tools are used.

Objectives
1. Contact all UK hospices with an adult inpatient unit to determine if they use a Cognitive Assessment Tool (CAT) in routine admission assessments.
2. If NICE Guidance is not being met, to understand why this might be.
3. Suggest improvements and re-audit.

Criteria/Standards
A A cognitive assessment tool (CAT) should be available (95%).
B Hospices with a CAT should use it for all patients on admission (75%).

Method
212 UK hospices were identified from the 2009/2010 Directory. They were contacted by email or fax and asked:
1. Is a cognitive assessment tool used in your hospice?
2. If so, is it used routinely to screen all patients?
3. Which tool or tools do you use?
18 did not fulfill criteria: thus 194 hospices were approached.

Results
Fifty-seven (29%) replied.
41 (72%) use a recognized tool, the remaining 16 (28%) depend on clinical description only.
Only 8 (14%) assess all patients by CAT on admission, 33 (58%) use them when clinically indicated.
MMSE was available in 29 (51%), AMTS in 9 (16%) and other named scales in 3 (5%).

Discussion
Neither criterion A or B are being met. Most UK hospices do not use a CAT routinely to assess cognitive impairment on admission. Many said they felt this was unnecessarily intrusive. This may be so but the risk is that cognitive impairment is not recognised, contributing to unresolved symptoms and earlier death.

Limitations of the Audit: The response rate was only 29%, limiting generalisability, although the sample size was reasonable.

Conclusions
Despite new national guidelines most UK hospices do not use standardized, validated CAT scales routinely. This may mean that treatment opportunities are missed.
Recommendations: These findings will be shared with all UK hospices and improvements to practice encouraged. The use of CATs will be re-audited in one year.
30. Discharge Delays in the Elderly from Birmingham City Hospital

Mr Abbas Tejani, 5th year medical student, Mrs. Israh Al-Taei, 5th year medical student, Ms Selina Balloo, Clinical psychologist, Ms Emma Parry, Specialist Registrar in Old Age Psychiatry, Professor George Tadros, Professor of Old Age Psychiatry

Background
Elderly people (over 65 years old) are the major users of the NHS. There has been much concern since the inception of the NHS that elderly people occupy hospital beds inappropriately and this may be related to a number of factors. Due to the sustained pressure on the NHS from the rising numbers of hospital admissions, efforts are being made to understand and reduce costly discharge delays.

Aims
To survey the reasons for delayed discharge in elderly patients in hospital. Also aim to look at the correlation between patient demographics, social circumstances, admission and medical care.

Method
An unblinded randomised selection of patients aged over 65 was obtained at City hospital, Birmingham over one day. Information concerning patient demographics, reasons for admission, current medical status and discharge plan were obtained from electronic and paper patient documentation.

Results
Altogether, the details of 96 in-patients were collated. Majority of the patients were 81-85 years old (33%) and male (55%). Majority of them were located on two non-acute elderly care wards in the hospital (35%). The vast majority of them were transferred from Accident and Emergency (83%) and were self-referred. Most of them were admitted to hospital because of a neurological condition (23%) mainly constituting of stroke and worsening confusion. However, 9% of patients were admitted with unspecific complaints, for example, inability to cope. Only 40% of the patients were still present in the hospital because they were not medically fit to go home. Of the rest of the patients, 33% were awaiting assessment from other healthcare professionals, 10% were awaiting transfer to a rehabilitation ward, 10% of patients were awaiting a social support package, 5% were awaiting transfer to a care home, and 2% were due to be discharged later in the day. A spearman’s correlation showed a significant positive correlation between gender and reason for being in hospital (r (96) =0.17, p<0.05). Significant correlations were also observed between age and speciality (r (96) = 0.18, p<0.04) and as would be expected reason for admission and diagnosis (r (96) =0.44, p< 0.00), route and time of admission (r (91) = -0.26, p<0.01) and diagnosis and speciality (r (96) =0.59, p<0.00).

Conclusions
A staggering 60% of patients were medically fit for discharge, yet were still within hospital. This has been shown to correlate with poor patient outcomes and poor patient satisfaction. It was also interesting to note that 9% of patients were admitted with non-specific complaints.
Aims
The All-Party Parliamentary Group on Dementia released a report in 2008 entitled “Always a Last Resort”. They recommended the introduction of protocols for prescribing, monitoring and reviewing antipsychotic medication for people with dementia. This audit looked at the community follow-up of people with dementia who have been commenced on antipsychotics whilst in hospital, ensuring prescriptions are reviewed appropriately.

Methods
This audit combines retrospective and prospective methods, looking at discharges and following them up over six months. Patients were identified from the Rio electronic patient record system, and information was gathered from patients’ case records and filed discharge letters. Available literature was reviewed to look for standards on the follow-up of dementia patients prescribed antipsychotics in the community. The following standards were then set:

• All patients with dementia on antipsychotics should be followed up within 3 months and every 3 months subsequently with a view to taper or stop the antipsychotic if appropriate.
• If antipsychotic are not tapered or stopped the reason should be documented in the patients’ notes.

Patients from two community sectors who were discharged from their local dementia ward between April 2009 to October 2009 and April 2010 to October 2010 were identified.

Results
At the baseline audit in 2009, 26 patients were discharged and 9 (34%) were prescribed antipsychotics. Following discharge, 5 patients were seen at 3 months and 6 were seen at 6 months. 1 patient died less than 3 months after discharge and 1 died between 3 and 6 months. The reason for continuing antipsychotics was clearly documented in 3 cases.

When the audit was repeated in 2010, 24 patients were discharged and 7 (29%) were prescribed antipsychotics. Following discharge, 5 patients were reviewed at 3 months and 2 were seen at 6 months. 1 patient died less than 3 months after discharge and 3 had been discharged less than 6 months at the time of data collection (this data will be available for the poster). In all cases the reason for continuing antipsychotics was clearly documented.