Royal College of Psychiatrists Faculty of Old Age Psychiatry
Annual Scientific Meeting

Wednesday 25th - Friday 27th March 2015
Hilton Hotel Glasgow, UK

ABSTRACTS & BIOGRAPHIES
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Please note a presentation link (with non-editable pdf versions) will be sent shortly after the conference to all delegates after obtaining the authorisation of the authors of the presentations. Unfortunately, it is not always possible to supply presentations due to some items being unpublished and copyright issues.
 Parallel Masterclass Workshops 
 13:00 – 15:00

Workshop A
Tips for successful careers in academia
Craig Ritchie and Tom Russ

Workshop B
Clinical Neurology for psychiatrists
Richard Davenport, Consultant Neurologist, and Maria Oto

Workshop C
Substance Misuse in Older People
Ilana Crome and Tony Rao

The aim of Masterclass is to improve knowledge, skills and attitudes in the assessment, diagnosis, treatment and care of older people with substance misuse. The Masterclass will also improve awareness of age sensitive approaches to the assessment of substance misuse in older people; provide clinicians with the skills to conduct a thorough systematic assessment of Substance Misuse; to identify physical and psychiatric co-morbidity and to be aware of distinctive factors that are particular to older people’s Substance Misuse. Screening, Treatment and Policy aspects of substance misuse will also be covered in some detail.

Handout available within workshop

Workshop D
Polypharmacy and side effects
Jacqueline Wiggins and Kerry McMurray

Parallel Workshops - (Repeat of earlier workshops) 
15:30 – 17:30

Workshop E
Tips for successful careers in academia
Craig Ritchie and Tom Russ

Workshop F
Clinical Neurology for psychiatrists
Richard Davenport, Consultant Neurologist, and Maria Oto

Workshop G
Substance Misuse in Older People
Ilana Crome and Tony Rao

Workshop H
Polypharmacy and side effects
Jacqueline Wiggins and Kerry McMurray

(see above Workshops A-D for full description, if listed)
Thursday, 26 March 2015

Session 1
09:30 – 10:00

Aetiology, mechanisms and treatment of neuropsychiatric symptoms
Clive Ballard

10:00 – 11:00

Innovative drug trial design for dementia prevention: The European Prevention of Alzheimer’s Dementia (EPAD) Project
Professor Craig Ritchie

Session 2
11:00 – 11:30

Update from the Dean
Wendy Burn

11:30 – 12:00

Recruitment into psychiatry: what the Royal College of Psychiatrists is doing
Tom Brown

12:00 - 12:30

Recruitment into Old Age Psychiatry training
Clare Hilton and Debbie Browne

The first half of this presentation takes a historical perspective on recruitment into psychiatry generally and old age psychiatry in particular and considers some quantitative data. What challenges for recruitment were faced by our predecessors? What did they do about it? What was achieved? We face challenges today, such as those outlined in the Centre for Workforce Intelligence report (2014). What can we do draw people into the specialty?

The second half of the presentation looks at current factors influencing training and recruitment. It will ask: Is old age psychiatry an appealing career pathway? Do we have job satisfaction, and is this influencing career choices by junior doctors? It will draw on qualitative data from junior doctors considering their future careers and those currently working in the speciality.

12:30 - 13:00

Foundation Training and Old Age Psychiatry
Ann Boyle

14:00 – 15:15

Debate

Science has little place in the practice of old age psychiatry
Proposer: Dave Anderson
Opposer: Alistair Burns; Seconder: Tony McElveen

Parallel Workshops
15:45 – 17:15
Workshop 1
The nooks and crannies of drug-induced parkinsonism
David Owens and trainee colleague

“There is a view, successfully promoted by the marketing departments of pharmaceutical organisations, that drug-induced extrapyramidal side-effects (EPS) are a thing of the past. This sessions aims to put forward the alternative view – that not only have EPS NOT gone away but that their development is an inevitable consequence of antidopaminergic drug use – a conditio sine qua non. Focusing on drug-induced parkinsonism, the session will illustrate the extensive boundaries of this disorder and challenge some preconceptions about its treatment and outcome, particularly in older populations.”

Workshop 2
Surviving my first year as a consultant
Erum Nomani

Workshop 3
Preparing for the healthcare regulator
James Warner

This interactive workshop will prepare delegates for a visit from a healthcare regulator. It will outline
1. the format of visits,
2. essential preparation in advance
3. what to do on the day and
4. what to do after a critical inspection.

Led by a clinician who has experience from both sides, and is National professional Advisor at the CQC, this will be particularly useful for delegates who have yet to experience a visit, or those who were inspected before the new wave of inspections.

Workshop 4
Liaison service development
John Holmes

Liaison psychiatry services have undergone significant expansion in the last few years, and there are services of widely different maturity operating around the country. Working in small groups, this workshop will help you to understand how you can use quality improvement techniques to refine and enhance your existing service, and share knowledge with others about your barriers and successes.

Workshop 5
Delirium
Anna Sobel

Workshop 6
Talking Therapies/IAPT and accessibility to older people
Marie-Claire Shankland, Noel Collins and Sandra Evans

17:30 – 18:30
Faculty Business Meeting, and Presentation of Lifetime Achievement Award to Dave Anderson

19:30
Conference dinner: After dinner speaker – Baroness Murphy
Friday, 27 March 2015

08:00 - 09:00
Trainees Breakfast and presentations
Tom Russ

Session 3
09:00 – 9:30

Life Begins at 50- The Psychiatric Aspect of Middle Age
Jane Casey

It is 50 years since Sir Martin Roth, Founder of Old Age Psychiatry, wrote the seminal paper “Psychiatric Aspect of Middle Age”. Middle age in the 1960s was defined as the span between 50 and 65 and both philosophy and science had already established that maximum satisfaction and gratification in life begins at 50. This dictum now pervades the media despite recent studies that demonstrate a U-shaped curve of psychological well-being from 18-85 with the rock-bottom happening in middle age.

There may well be a paradox of ageing with community studies demonstrating an increase in happiness, mental well-being and interpersonal relationships occurring after age 50 even as physical health and cognitive function decline. Despite these optimistic findings old-age services are struggling to meet the needs in mental health care after 65. The foundations of physical and mental health in old age are laid down to a considerable extent in the middle years. Sir Martin opined that if we want to intervene effectively we therefore “need to take action long before senescence”. A review of this original paper will be the starting point to provide an evaluation of how far we have come in the last 50 years in the “logical approach of prophylaxis”. Age-related wellbeing and the place for a preventative integrative model for psychiatry in middle age will be explored.

09:30 -10:00

Update on Delirium
Alasdair MacLullich

10:00 – 10:30

Substance Misuse in Older People
Tony Rao

This presentation will outline epidemiological aspects of substance misuse in older people, highlighting the clinical and public health burden of substance misuse. It will also provide an overview of the 2011 Policy document Our Invisible Addicts, together with a summary of the first outcome study in the UK of older people with alcohol misuse

Session 4
11:00 – 12:00

Keynote address – Prevention of dementia – myth or reality
Charles Alessi

12:00 – 13:15

New Science: Presentations by shortlisted Mohsen Naguib & prize winners

1. A survey of the characteristics and outcomes of older adults subject to tribunal hearings within the framework of the Mental Health (Care and Treatment)(Scotland) Act 2003
Dr Paul Brown

Introduction
The use of antipsychotic medication in the management of Behavioural and Psychological Symptoms of Dementia (BPSD) has steadily increased in profile over recent years, attracting strong media attention. Recent evidence reveals a large proportion of inappropriate antipsychotic prescriptions and the hazards of antipsychotic use combined with the commitment in the Scottish Dementia Strategy to reduce inappropriate prescribing served as an impetus for this project.

**Aims and Hypothesis**

To examine psychotropic prescribing in people with dementia across NHS Dumfries and Galloway. To incorporate elements of audit, referring to both local and national standards for use of pharmacological agents in dementia. We hypothesise that there will be a reduction in overall antipsychotic prescribing. **METHODS** This cross sectional survey encompasses elements of audit. There was a fixed sampling period with data collection occurring from April 2012 to December 2012. A letter was sent to every GP practice in Dumfries and Galloway (n=34). We received an excellent response with 32 practices submitting the requested anonymised medication summaries for patients on the dementia register of each practice. Psychotropic prescribing information including current and previous antipsychotic use, cholinesterase inhibitor usage and potentially hazardous medication interactions was obtained. **RESULTS** Currently, psychotropic prescribing has been examined in 10 GP practices, comprising 396 patient records. Our results at this stage are revealing important trends including that 13.4% of patients are currently receiving an antipsychotic compared with 37.9% between 2004-2012. There was an ongoing predominance of quetiapine prescribing representing 7.3% of antipsychotic prescriptions although this too is reducing when compared to a previous prescription rate of 12.4%.

**Discussion**

We believe the general reduction in antipsychotic prescribing is related to a number of factors including increased awareness of MHRA (Medicines and Healthcare Products Regulatory Agency) warnings and respected clinical guidelines. Additionally, there is increased availability and awareness of the range of non-pharmacological approaches available for managing BPSD symptoms. Reasons for the ongoing undesirable predominance of quetiapine prescribing include perceived tolerability and low incidence of EPSE’s and the absence of this medication from the initial MHRA warnings. Risperidone is currently the second most common antipsychotic prescribed indicating an increasing awareness of the risperidone license for treating BPSD in Alzheimer’s dementia.

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**Living life to the full over 65 : A one year evaluation of a community based Guided Self Help Cognitive Behavioural Therapy group for patients aged over 65 with mild to moderate depression and/or anxiety symptoms**

Dr Robert Clafferty

**Background**

Although guided self help cognitive behavioural therapy (GSH-CBT) is recommended in national expert guidelines as an evidence based intervention for the treatment of mild to moderate depression1, there is limited evidence for its use in people over 652 or advice on practical issues of how it can be best delivered within a standard clinical setting3. **Aim** To examine the effectiveness of a GSH-CBT intervention for patients over 65 with mild to moderate depression / anxiety symptoms from a standard clinical sample.

**Methods**

A naturalistic study. Patients identified from an existing sector consultant psychiatrist outpatient clinic service, referred by their GP for assessment during a 12 month period (Aug 2013 – July 2014). No significant psychotropic medication changes during study period. Inclusion criteria: age >65 with mild to moderate depression determined on clinical interview by consultant psychiatrist based on standard ICD-10 diagnostic criteria, able to attend a clinic setting for treatment and no psychotropic drug changes occurring within one month of group start date. Exclusion criteria: any significant cognitive impairment or current severe depression symptoms (e.g. suicidal ideation or psychotic symptoms). Outcome measures Baseline Hospital Anxiety and Depression Scale5 (HADS) depression and anxiety scores compared with final HADS score on completion of group. Results Of the 55 patients identified as eligible to participate, 35 (64%, 27F:8M, age range 66-87, average age = 75) patients accepted an invitation to join the group. 25 patients completed baseline and endpoint HADS questionnaires and their results were included in data analysis. Average baseline anxiety score 9.7 (range 0-20) declined to endpoint 8.3 (range 0-18) This represents an overall 1.4 reduction in average anxiety scores. Average baseline depression score 6.5 (range 0-17) declined to endpoint 5.5 (range 0-12) This represents an overall 1 point reduction in average depression scores. Assuming a significant marker to be a change of >1 on the HADS subset scale this suggests significant improvement for anxiety scores and depression scores between start and end of intervention.

**Conclusions**

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GSH – CBT was effective in reducing mild to moderate anxiety and depression symptoms in this group of community based patients from a standard consultant psychiatrist out patient service for people aged over 65. A collaborative service model with joint working between NHS and voluntary sector may provide an economical and clinically effective intervention

3. The natural course of Anxiety Disorders in the elderly: A Systematic Review of Longitudinal Trials
Dr Ramin Nilforooshan

Background
The anxiety disorders are a prevalent mental health problem in older age with a considerable impact on quality of life. Until recently there have been few longitudinal studies on anxiety in this age group, consequently most of the evidence to date has been cross-sectional in nature. Methods: We undertook a literature search of Medline, PsycINFO, the Cochrane trials database and the TRIP medical database to identify longitudinal studies which would help elucidate natural history and prognosis of anxiety disorders in the elderly.

Results
We identified 12 papers of 10 longitudinal studies in our Review. This represented 34,691 older age participants with 5,199 with anxiety disorders including anxious depression and 3,532 individuals with depression without anxiety. Relapse rates of anxiety disorders are high over 6 year follow-up with considerable migration to mixed anxiety-depression and pure depressive mood episodes. Mixed anxiety-depression appears to be a poorer prognostic state than pure anxiety or pure depression with higher relapse rates across studies. In community settings treatment rates are low with 7-44% of the anxious elderly treated on antidepressant medications. Conclusion: To our knowledge this is the first Systematic Review of longitudinal trials of anxiety disorders in older people. Major longitudinal studies of the anxious elderly are establishing the high risk of relapse and persistence alongside the progression to depression and anxiety depression states. There remains considerable under-treatment in community studies. Specialist assessment and treatment and major public health awareness of the challenges of anxiety disorders in the elderly are required.
Published in International Psychogeriatrics; Sept 2014 http://journals.cambridge.org/action/displayJournal?jid=IPG

4. Detecting alcohol problems in older adults: can we do better?
Dr Christine Taylor

Alcohol problems in older adults have risen steadily over the past decade. For various reasons they are often under detected. This abstract is based on an editorial article for which I am lead author, shortly due to be published in International Psychogeriatrics entitled “Detecting alcohol problems in older adults: can we do better?”. The paper reviews the literature on detection of alcohol problems in older adults including the extent of the problem and risk factors, benefits of detecting and treating alcohol use disorders in older people and barriers to detection. Current screening tools are reviewed in terms of their key features, advantages and disadvantages and suitability for use in older people. Despite assumptions of poor outcome in this population, in fact, research evidence suggests that appropriate treatment can be highly beneficial. Existing instruments for screening and diagnosis specifically for older adults are available but have their limitations and are not widely used. Finally consideration is given to future opportunities for improving detection of alcohol use disorders in older people and providing appropriate interventions. A more active approach to case finding is advocated and more realistic approaches to treatment based upon good research. In order to improve the situation there needs to be a change in societal attitudes, leading to reduced stigma around drinking in late life: a public health response: age-appropriate models of treatment; and higher priority for research in this age group. This is a subject area which has not received much attention within many Old Age Psychiatry services and thus presents a valuable opportunity for raising awareness and knowledge in this area hopefully resulting in improvements in quality of care.

5. Development and launch of the Dementia Friendly Technology Charter
Dr Amanda Thompsell

Aims and Hypothesis
As part of the Prime Minister’s Dementia-Friendly Communities initiative, a sub group was formed with the goal of enabling all people with dementia to have the opportunity to benefit from technology that is appropriate to their needs and to improve the accessibility and usability of technology.
**Background**

Assistive technology can greatly benefit for people with dementia and their carers. However those with dementia and their carers, and even professionals often do not know what is available.

**Method**

The sub-group, comprising some 33 different stakeholders (including representatives of the Alzheimer’s Society) met in November 2013 to discuss the best way to frame and meet its objectives. Direct feedback from the Alzheimer’s Society service users review panels was highlighted and referred to in the discussions. It was decided to develop a “Dementia-Friendly Technology Charter” (available at [www.alzheimers.org.uk/technologycharter](http://www.alzheimers.org.uk/technologycharter)) that would both set out responsibilities for service-providers adopting the Charter to promote appropriate technology to benefit their clients with dementia and also highlight the range of technologies available. The Charter uses case studies to show the practical applications of technology, defines the components of a good quality technology service to aid with service evaluation and suggests questions commissioners of services and most importantly individuals (carers and those with dementia and care home managers) should ask before buying any technology.

The Charter was given a high-profile launch at the Alzheimer’s Show in July, after a media publicity campaign in June 2014.

**Results**

The feedback on the charter has been positive and the Charter has formed the basis for presentations at various conferences including both technology conferences and dementia conferences.

The Charter however is still not all that widely known about and whilst the aim is to work towards having all Clinical commissioning groups, local authority and housing commissioners along with service providers signed up to the charter this still is remaining difficult to achieve. At present only some 27 organisations are believed to have formally adopted the Charter.

**Conclusion**

The Charter has enjoyed some success in raising awareness of the topic, but perhaps more than enthusiasm and commitment will be needed to make this something that service-providers will routinely adopt and pay proper attention to. This is much to be desired as the Charter does demonstrate that there are many benefits to be had from an appropriate implementation of technology to the needs of people with dementia and their carers.

Dr Amanda Thompsell is a member of the sub group that developed the Dementia-Friendly Technology Charter and is a member of clinical advisory group on Telehealth for Good Governance Institute

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**6. Mark Making: The role and value of the arts for people living with dementia**

**Dr Hannah Zeilig**

In the last decade, there has been increasing interest in the participative arts for people who are living with a dementia in Europe and the US. Similarly, there has been a burgeoning of arts initiatives targeting this population; these initiatives are diverse and include: music and drama groups, creative writing programmes, dance groups, painting classes and visits to art galleries. The flourishing of the participative arts for those with a dementia can be understood in the context of a widespread awareness that in the absence of cures for dementia, non-pharmacological interventions are important. Participative arts activities and the possibilities that these present for enhancing and enriching the lives of those with a dementia have thus been attracting increasing attention as representing beneficial interventions. The growth in understanding about residual creative ability that exists in people living with a dementia has added to interest in researching and initiating arts projects for this group of people. This paper will present original data from Mark Making. Mark Making is an AHRC funded UK based study exploring the role and value of the arts for people with a dementia. The project was truly interdisciplinary and involved collaboration with Dr Chris Fox (UEA Medical School consultant old age psychiatrist), John Killick (Poet and innovator in dementia care) and Dr Hannah Zeilig (social gerontologist). Above all, the team worked closely with a group of people with dementia to ascertain their views and opinions. The presentation will concentrate on the complex ways in which arts projects may contribute to a sense of identity for people with a dementia. The ways in which the arts may facilitate unique interactions will be addressed. In addition, notions of inclusivity and participation will be discussed: which groups tend to participate in arts projects? Are arts projects able to engage with those living with a more advanced dementia? The paper will conclude by tentatively suggesting some of the ways in which the arts may have value for people with dementia, some of the gaps in our current evidence base and future directions for research in this important but nascent area.
Prizewinner Presentation
Dr Rishikesh Behere, Bursary for Psychiatrists From Developing Countries Prize Winner

Development and validation of a brief instrument for Cognitive assessment - Indian instrument for cognitive Examination (IICE)
Rishikesh V Behere, Bhargavi Nagendra, Nita Thomas
1 - Department of Psychiatry, Kasturba Medical College, Manipal University, 2 - Department of Clinical Psychology, School of Allied Health Sciences, Manipal University.

Introduction
Dementia is widely prevalent in India and is an important cause of global disease burden. Bedside tests for cognitive assessment include the MMSE, ACE-R, RUDAS, ADAS-COG and Indian adaptations include HMSE and Kannada and Malayalam translations of ACE. However these tests may not assess all domains of cognitive functions and may be limited in their utility in Indian settings due to cultural variations, lack of norms. There is a felt need for brief cognitive assessment instruments which can be used clinically and is applicable to the Indian setting.

Aims and Objectives
To develop and validate brief instrument for cognitive assessment applicable in clinical setting on Indian population.

Methodology
A review of existing scales and instruments available for cognitive assessment was performed. The items were assessed for relevance and applicability in the Indian setting. The instrument was then given to 5 experts from field of psychiatry, psychology, Neurology. They were asked to rate the scale on clinical utility, ease of administration, applicability to Indian context. Specific suggestions and changes were incorporated into the instrument. The instrument was then administered on a group of 180 healthy subjects to obtain normative data on test performance. Cut off scores for each education and age group was estimated by calculating Mean – 2SD rounded off to the nearest whole number. To demonstrate the utility the instrument was administered on subjects who were referred for neuropsychological assessment.

Result
Normative data was obtained for each group (Education - <5yrs, 5-10yrs,>10yrs and age – 20to50yrs, >50yrs) and for each domain (orientation, memory, visuo-spatial orientation, language function tests). Reliability statistics- Cronbach’s alpha a measure of internal consistency was 0.5. The total score on IICE showed strong positive correlation with MMSE/HMSE (r = 0.6 and p < 0.001). Applying the cutoff scores obtained from normative data 12 out of 14 subjects assessed were detected to have cognitive impairment on the IICE yielding a detection rate of 86%.

Conclusion
The Indian Instrument for Cognitive Examination is a brief culturally valid scale that assess comprehensively all domains of cognitive functioning with normative data for Indian population including illiterate subjects.

Philip Davis Prize Essay 2014
Lying to people with dementia: treacherous act or beneficial therapy?
Dr Tony McElveen, ST5 Old Age Psychiatry, NHS Greater Glasgow and Clyde

Introduction
We may like to convince ourselves otherwise, but lies and deception are commonplace in “caring” for people with dementia. This moral dilemma is an area of considerable difficulty for many clinicians and caregivers. It needs to be addressed and brought out into the open for a frank and ‘honest’ examination. It is clear that a culture of lies and deception is rife in many residential and nursing home settings and in NHS Elderly mental health wards. Members of the public may be surprised that this culture of deception and lies is essentially unregulated in relation to people with dementia. Little or no guidance or training is given to staff in relation to the acceptability and use of therapeutic lies or other techniques to deceive vulnerable adults. There is the potential for abuse of vulnerable people which could start out as a therapeutic lie, but there is also the case that it may alleviate distress and hurt for a person with dementia.

Before we plunge deeper into this quagmire, let me first make clear what we are considering to be a therapeutic lie.
Some may think this is obvious and requires little clarification. However, there is much debate and disagreement around the definition of lies, deception and withholding the truth. We have probably all lied at some point in our lives and may justify it as a little white lie, bending the truth or being economical with the truth. Cunningham ² has shown that professionals often use euphemisms for lying such as “bending the truth” to ease their conscience and rationalise their actions. For the purposes of our discussion we shall consider any lie or deception to be grouped together. The term “therapeutic lie” is a false statement or deception with the best interests of the patient at heart. Backhurst ³ stated that “all of these concepts are morally equivalent as they infringe a person’s right to autonomy”. This essay intends to explore some of the situations which may arise in caring for a person with dementia where a lie or deception is used in the person’s best interests as deemed by the caregiver. The clinical and ethical arguments for and against therapeutic lies, as presented from a review of the literature, are then examined. It should be noted that patients who are assessed not to have mental capacity to make decisions related to the situations in question are those to whom we are referring in this discourse and who are referred to in the literature reviewed generally. This will be primarily patients with relatively advanced dementia. There is no suggestion that lies in any form are acceptable practice for a clinician to use in dealing with a person who has capacity to make a decision about the issue in question. The issue of determining capacity can however be extremely complex in some cases.

Discussion
Picture, if you will, a demented widow frantically hammering on the locked ward door trying to go to meet her husband Charles, believing that he will be worried about her. She has been informed that Charles is dead on many occasions and this has caused her severe distress and upset. A nursing assistant tells her ‘Charles is at the shop and will be here soon. Let’s get a cup of tea just now while we’re waiting’.

Or imagine an elderly man with moderately advanced Alzheimer’s type dementia asking his wife if she has seen the car keys. She has hidden them as she knows he is a danger to himself and others on the road. The doctor and DVLA have informed him he is not safe to drive. She now tells him she hasn’t seen them because he became angry and slapped her for the first time in their 58 year marriage when she previously told him he was unsafe to drive. Anyone who has experience of working with people with dementia will recognise these scenarios and the hundreds of variations of them which are a challenging reality for caregivers across the country. If we take the view that lying is prima facie wrong, then justification is required to support the use of therapeutic lies in the scenarios above and in similar situations. The arguments in support of therapeutic lies are that they can prevent distress and agitation, can prevent harm and keep individuals safe, and may indeed enhance the overall well-being of the person with dementia. This may arise from being spared hurt, shock and sadness from a truth which adds nothing but emotional pain and confusion. The patient’s self respect and dignity may also in part be protected. There can also be a beneficial effect to the person’s social relationships and non-expert opinion and some qualitative studies. This was not meant to be an exhaustive critique of all literature on this subject. The aim was to assess what has been examined and commented upon within the last two decades.

Literature Search
The following resources were searched as part of the literature review on therapeutic lies in dementia care: CINAHL, Psychology & Behavioral Sciences Collection, PsycINFO, Medline, Embase, Cochrane Library, ProQuest, NICE, SIGN. The search terms dementia, Alzheimer’s disease, senile dementia, vascular dementia, semantic dementia, dementia with Lewy bodies, and dementia complex, were used. The search terms were combined using the Boolean term ‘or’. Another search included the terms, lies, lie, lying, therapeutic lies, deception, faking, fraud, cheating, malingering, and untruths. Again these terms were combined using the Boolean term ‘or’.

The search results were combined using the Boolean term ‘and’. Only English language articles were included and a time period of 1994 to 2014 was set. The 335 articles were then reviewed by hand to remove those where the search terms were only subtext and not the subject of the main article. Articles out-with the time period set which frequently were referenced in the review articles were then sought and examined. 38 articles were then fully reviewed. The search found the articles to be mainly expert and non-expert opinion and some qualitative studies. This was not meant to be an exhaustive critique of all literature on this subject. The aim was to assess what has been examined and commented upon within the last two decades.
Understandably some hold the view that any form of lying to patients with dementia who lack the relevant capacity is an abuse of that person and a path which exposes the person with dementia to be seen as a non-person. Their person-hood and human dignity is disrespected and demeaned. Kitwood commented on a ‘malignant social psychology’ which can arise from the practice of lying leading to the erosion of person-hood for the person with dementia. Kitwood discusses the ethics related to interacting with dementia sufferers and describes a variety of different interactions such as infantilisation and disempowerment which can result in loss of person-hood. Jones points out that with the erosion of person-hood there is the possibility that people with dementia may no longer be given the consideration and dignity given to other humans. As a consequence, significant neglect and ill-treatment become more likely.

Treolar examined the use of covert medication; at the time of the study 79% of patients in long stay care settings for the elderly had medication administered via deception. This study highlights the lack of transparency and inadequate documentation around this practice. This situation is arguably a breach of a person's human rights and Treolar does recommend that capacity is assessed, and if absent, that a transparent procedure and locally agreed policy is followed, including discussion with all relevant parties. This view is later echoed by James in a 12 item guideline for use when considering therapeutic lies (Table 1).

Table 1: 12 Item set of guidelines on therapeutic lies

1) Lies should only be told if they are in the best interests of the resident, e.g. to ease distress.
2) Specific areas, such as covert medication and aggressive behaviour, require individualised policies that are documented in the care plan.
3) A clear definition of what constitutes a lie should be agreed within each setting.
4) Mental capacity assessments should be performed on each patient prior to use of therapeutic lies.
5) Communication with family should be required and family consent gained if a lie is to be told to the patient.
6) Once a lie has been agreed it must be used consistently across people and settings.
7) All lies told should be documented to ensure lies are being told in patients' best interests.
8) An individualised approach should be adopted towards each case – the relative costs and benefits established relating to the lie.
9) Staff should feel supported by their manager and the patient’s family. They should not feel at risk of being accused of misconduct by telling lies if they have been agreed using these guidelines.
10) Circumstances in which lies should not be told need to be outlined and documented.
11) The act of telling lies should not lead to staff disrespecting the patient. The lies should be seen as a strategy to enhance the patient’s well being, rather than an infringement of their basic rights.
12) Staff should receive training and supervision on the potential problems of lying, and taught alternative strategies to use when lies are not appropriate.

Table from James et al, 2006.

In a study by Culley, Old Age psychiatrists’ views on the use of these guidelines and their views on therapeutic lies were surveyed. Point number 5 was widely considered unhelpful in terms of the family needing to consent to the use of a therapeutic lie. Whilst it would be good practice to consult and involve all relevant stakeholders it is not a legal requirement that family members with no powers as legal proxy consent to lying to a patient, or that they have a veto over such a decision.

Interestingly, there was a marked discrepancy between the psychiatrists’ views on key issues. When asked if they had ever lied to a patient who lacked capacity when judged to be in the patient’s best interests, 69% answered yes. Moreover, when asked if they had sanctioned the use of lies by carers when judged to be in the patient’s best interests, 66% answered yes. Yet when asked if lying to a person with dementia could be therapeutic, 65% disagreed. The majority of respondents also stated that the guidelines from James et al would be unhelpful to carers. They stated the guidance would not improve communication, and would not make therapeutic lies ethical practice.

Proponents of therapeutic lies may state that dementia slowly diminishes the mental capacities required to differentiate between what is truth and falsehood. Schermer comments that "once patients reach a state in which concepts such as..."
true and false, reality and illusion, or fact and fantasy do not mean anything to them anymore it becomes logically impossible to deceive them or to lie to them”. He likens it to lying to a baby or a comatose person. The issue of delineating when the capacity to be lied to is lost is no easy matter. However, this argument does negate the autonomy principle trumping all others if, as Jones 12 states, the person “is incapable of making a valid choice and that the duty of care suggests deception as a reasonable means of relieving suffering in the least restrictive way.”

The moral arguments that lying is wrong, invariably lead to reference to Kantian moral philosophy. Immanuel Kant, the German philosopher 19, viewed lying, alongside coercion, as the root of evil and fundamentally wrong. Lying violates the autonomy of the person being lied to. If you make choices based on the facts or information you have available to you and it is false, then your autonomy and ability to self determine is eroded. In our society, and in particular in the field of medical practice, respect for autonomy is a pillar of good ethical behaviour. Schermer 9 argues that once we come to know a painful truth, we can start dealing with it – mourning it, accepting it, struggling with it, 'giving it a place in our lives'. For the person with advanced dementia a painful truth, such as the fact that their spouse has died, is new every time and hence “they cannot even start to 'deal with it' since they do not remember”. This suggests that those with advanced dementia are not able to utilize, and so are not affected by, new information in terms of their future plans or goals. In turn Schermer, and Jones (as previously stated), highlights the view that the autonomy debate loses some of its relevance against therapeutic lying in moderate to advanced dementia.

One approach advocated by several papers in this literature review is validation therapy. Proponents of validation methods would state they do not believe that any form of lying can be therapeutic 20. The rudiments of this approach are that one would acknowledge the dementing person’s reality in order to enter their world with empathy. ”The validation worker does not agree that the 90 year old woman's mother is alive and say, 'She will be here soon'. The validation worker does not divert or redirect the woman, nor does he argue or admonish her.” 20

Using a validation technique, a person would try to gather the facts and background to what the person with dementia is saying, speak back in the same tense and take the conversation in the direction in which the person is going. Speaking to the person with dementia in the present tense about an event or person from their past as if it is current reality is perceived by some as a form of lying or deception. Feil 20 and other advocates of validation therapy would rebuke such an assertion: “This is not lying; rather it is accepting that the person has returned to the past and sees his or her mother/spouse/etc clearly in the mind's eye”. 20

However, by this logic the carer is colluding with the person in a false reality which the carer is aware is not true. It could be likened to colluding with a psychotic patient in their delusional beliefs. Furthermore, a Cochrane review 21 showed there is insufficient evidence at present to support this approach as being effective. Walker and Dale 22 describe “fancy footwork” as a technique to skirt around the issue of lies, distraction, ignoring the person’s question, and truth telling. They suggest “talking with care and sensitivity in the past tense about someone who has died. Being very vague – the aim is to allow two differing realities to co-exist without contradiction”. In essence this appears to be closely related to validation therapy. These techniques undoubtedly have their merits but they also highlight communication techniques in which family members and care home staff often have no training. It is learning on the job for most family carers in the UK. Often they will look to healthcare professional to validate their actions. Most caregivers are initially uncomfortable about lying to their loved one with dementia. The relationship is built on trust, love and respect over many years. Caregivers of people with dementia struggle with the dilemma of how to treat the person with respect and dignity as well as being able to continue to care for them in the home 23,24. Blum 25 concludes that caregivers typically come to accept and justify that their use of deceptive practices is ultimately in everyone’s best interest. Most people with dementia live at home and are supported by family members, who are at the coalface of dementia care. With the number of people in the UK with dementia set to double within the next 30 years there will be increasing strain on carers to deal with distressed behaviour 26. As clinicians diagnosing and managing patients with dementia, we need to give clear practical advice to our patients and their carers on all aspects of managing distressed behaviour. As distressed behaviour—also referred to as behavioural and psychological symptoms in dementia (BPSD) – increases in frequency, so does the likelihood of the person with dementia moving from home into a nursing home 27.

Whilst lying is often used in daily life as a way of controlling flow of information, in the dementia situation it is utilized as an informal social control mechanism. Zarit et al 28 describe the families of people with dementia as “the hidden victims” of the disease. In this analysis of the pros and cons of therapeutic lies, we must not lose sight of the millions of family members worldwide who endeavour to care for dementia sufferers at home in the face of significant resistance and distress from the insight-less sufferer. Blum 25 articulates the challenges carers face in maintaining a semblance of normal life and order in the household. The article focuses on the experiences of caregivers and the deceptive strategies employed by them. Blum illustrates that as dementia progresses and strategies such as negotiation with the person with dementia fail many careers resort to deception. One caregiver stated “I was working in the dark...I just came up with it out of the air (a therapeutic lie)...it was survival”.

Clinicians and academics can debate the ethics of lying to a person with dementia but we are often far removed from the situations caregivers endure and need to keep in mind that this condition is often managed by those who generally
have a longstanding trusting relationship with the dementia sufferer. “Deception guilt” is a phrase coined to describe the caregiver feeling guilt when the deception is not “authorized” 23, 29. It is well documented 23, 25, 28, 29 that many caregivers experience increasing distress at having to lie and deceive those for whom they care. Justification for the use of lies is that it calms the person down, and therefore it has helped alleviate distress. Moreover, many carers use lies to successfully protect the dementia sufferer from potential risks such as wandering across town in the dark when the person lacks capacity to safeguard their own personal welfare.

The views of those with dementia have been canvassed by Day et al. 30 in regard to the use of lies in dementia care. This study has a small sample size but it does highlight that most participants considered lies to be acceptable if it was perceived to be in the person’s best interests. The best interest decision was determined by three key factors: the person being lied to, the carer and the nature of the lie. See figure 1.

![Figure 1; Adapted from Day et al. Conceptual model depicting people with dementia’s perspectives towards lies in dementia care.](image)

This illustrates that each situation needs to be judged on a case by case basis. Where there was more consensus was that lies were unacceptable if the person with dementia had awareness of being lied to. The sample in Day’s study was people with early stage Alzheimer’s. They “consistently described lying as patronising or demeaning.” They expressed the view that being lied to reduced their autonomy and could impact negatively on their self worth and person-hood. Lies were considered more acceptable in the later stages of dementia when awareness of lies was less likely and lies were deemed more acceptable if no alternatives were available to the carer. There is clearly always an alternative to lying: to tell the truth regardless of the extreme distress which may ensue. Interestingly Day et al. 30 stated that people with mild dementia in their study felt “Overall, there was a feeling that if the truth was explained in a kind way, it would not be as distressing for people with dementia”. It does raise the philosophical question of whether they are lying to themselves to protect themselves from the painful reality of the truth?

The Nursing and Midwifery Council (NMC) 2008 31 standards and code of practice state that all nurses must be open and honest and act with integrity. Guidance from the General Medical Council (GMC) 32 espouses similar virtues. The Department of Health has said there are no plans to issue guidance on therapeutic lying, adding that healthcare professionals should decide whether to use it on a “case-by-case basis” 33. The Alzheimer’s Society has stated “Good quality care should be about identifying and addressing the causes rather than encouraging people with dementia to live in a false reality. It’s important to give people with dementia choice and control over their life whenever possible” 34. In essence there is no clear guidance and the issue is open to personal interpretation. Yet we know lying to people with dementia is endemic within care homes.1

Moreover, training for caregivers in managing challenging behaviour is lacking 22, 35. Pool 35 comments that people with dementia have “special needs and they deserve to be cared for by highly trained carers who have been given the skills and support necessary for this demanding and rewarding work”. The situation is being addressed in part via post-diagnostic support, organisations such as Alzheimer’s Scotland, and access to information more widely available through the internet. However, with limited financial resources and increasing demand being experienced in services for people with dementia across the UK, we must examine all potential therapeutic options we have available. The aim to decrease
antipsychotic prescribing for distressed behaviour in dementia further encourages clinicians to explore all potentially beneficial therapies to alleviate distress and improve well-being.  

Conclusion

The topic of lying to patients does not sit easily with most healthcare professionals – and rightly so, as there are very few situations in which it should ever be considered. However, the practice of lying is widespread in care settings for people with dementia. The literature in this area is still sparse and there is a dearth of high quality research. Philosophers and ethicists have had much to say on the issue of truth telling and lies but this is often of little practical help to the person with dementia and those assisting in their care. That said, to merely conclude with the statement that more research needs to be conducted on the topic would be evading the issue. I believe we need to have a framework to help people with dementia and their caregivers, whether family or paid carers, to ensure best practice is adopted and care is tailored to suit each individual.

There has been a positive attempt by James et al ¹ to produce guidelines to aid clinicians and carers. Some psychiatrists have found this guidance bureaucratic and far from ideal but it is a good starting point for ensuring a consistent and considered approach to the use of therapeutic lies within a nursing home setting. It also provides a framework to ensure that lies and deception do not spiral out of control and become an abusive means of social control rather than a therapeutic intervention to alleviate distress.

Can a lie ever be considered therapeutic? I believe it can. I find that a difficult sentence to write because it does not fit with the deontological view that I would have espoused less than a year ago. Yet if the function of truth in a situation is to bring nothing but pain and distress to a confused, demented fellow human being, then its utilisation in that instance is at best futile, at worst cruel. When we have exhausted all other possible therapeutic options – including truth-telling – and only when it is likely to enhance the person’s well-being, should a “best interests lie” be trialled and then benefit reassessed.

“The unexamined life is not worth living” ³⁷. This is an issue that is worthy of proper examination and thought. Pause and consider whether therapeutic lies are something you actively or passively condone. If this issue affects your practice (and considering the evidence discussed, it is likely that it does), what checks and balances are in place firstly to assess whether it alleviates distress and secondly to prevent misuse and outright abuse of the vulnerable people to whom lies are told? Is this the time to adopt improved training, guidance and documentation in this area?

“For what a tangled web we weave when first we practice to deceive.” Sir Walter Scott. ³⁸

Session 5

14:15 – 14:45

Are the elderly any more of less capable in Scotland than the rest of the UK? - The Adults with Incapacity (Scotland) Act 2000

Professor Lindsay Thomson

14:45 – 15:15

Deprivation of Liberty Safeguards - Update on Mental Health Law

Jonathan Waite, Nottinghamshire Healthcare NHS Trust

In the past year there have been two significant developments in England and Wales Mental Capacity Law: the publication of the House of Lords’ Review of the Mental Capacity Act 2005 and the judgement of the Supreme Court on Deprivation of Liberty. These matters will be considered in some detail with an assessment on their impact on clinical practice.

In Scotland the Scottish Law Commission has produced a Report on Adults with Incapacity (Scot Law Com No240) which lays out proposals on amending Scottish legislation to provide new protections to adults with incapacity who are deprived of their liberty. In Northern Ireland a Draft Mental Capacity is before the Stormont assembly. This is designed
to replace existing mental health legislation as well introducing mental capacity legislation to the province for the first
time.

The UK is a signatory to the UN Convention on the Rights of People with Disabilities. A recent review commissioned by
the Ministry of Justice has concluded that the Mental Capacity Act in its present form is incompatible with the
Convention. There is also a consensus that the Mental Health Act will also require to be amended.

These legal developments will impact on all UK old age psychiatrists, the presentation will aim to bring unify common
themes across the British Isles.

15:15 - 15:45

Closing comments
Alistair Cook

Medical Student Essay Competition Prize Winner

Depressive Disorder and Suicide in the Elderly Population: A Literature Review of Suicide Prevention in this Age
Group
Miss Jane Leadbetter, University of Liverpool, 5th year medical student

Introduction
Depression is a common disorder affecting 8-12% of the population. It is estimated that 1 in 5 elderly people are
depressed. This figure is set to increase with the number of elderly people worldwide rising. Risk factors for depression
in the elderly include: social isolation, poverty and bereavement, amongst others.
On a worldwide level the highest rate of suicide is seen in those over the age of 75. The elderly population have been
shown to have a higher chance of completing a suicide attempt than the young, and opt for more violent methods.
The aim of this report is to compare the success seen from different elderly suicide prevention programs.
Method- a literature review was carried out in November 2014. Studies researching the success of various different
types of intervention, with suicide rate as the primary outcome were deemed suitable.
Results- three main elderly suicide prevention programs were compared. One used a telecommunication intervention,
one a community based approach and the last was a multifaceted suicide prevention program with GP’s acting as
‘gatekeepers’, referring appropriate patients to the service. All the studies proved to be successful, reducing suicide
rates by 74% on average. However the success in each was very much limited to females.
Discussion- elderly females are described as being more open to such interventions and more likely to seek help than
males, hence reflecting the increased success in this gender category. More research is needed to find out how best to
target high risk males.
Suicide prevention in the elderly is a much neglected area. The Department of Health’s suicide prevention strategy,
published in 2012, continues to focus on suicide prevention in younger age groups.
The media’s role in preventing suicide in the elderly has not been researched and is perhaps worthy of exploration. It
could help to reduce the stigma of mental health in this age group.
More training may be needed in order for physicians to identify high risk individuals and refer on to appropriate
services. The somatic manifestations of depression may be misread as ageing and hence patients not appropriately
identified.

Introduction
Depressive disorder in the elderly
Depression is a disorder affecting 8-12% of the population in any year, and the World Health Organisation (WHO)
predicts that by 2020 depression will be the second leading contributor to the global burden of disease1.
The proportion of the world’s population that is elderly has been increasing due to prolonged life expectancy and
decreasing birth rates2. The rates of depression amongst the older population are higher than that of the general
population. In the UK it is currently estimated that 1 in 5 of those over the age of 65, and up to 2 in 5 of those in care
homes are depressed1. Cultural bias may suggest depression to be a natural feature of ageing, thus hindering
the diagnosis of depression in the older age group by physicians; yet later life depression is a pathological condition that
warrants treatment3.
There are many factors that may contribute to the high levels of depression amongst the elderly; these include the
bereavement of loved ones, worsening physical health, social isolation and poverty 4, 5, 6, 7, 8. It is suggested that men

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in particular have somewhat unrealistic expectations and limited strategies in place to deal with difficulties they may encounter as they enter later life. Furthermore, the elderly grew up in an age in which mental health received even more stigmatisation than it does today, often being viewed as a ‘forbidden topic’. These ingrained attitudes remain, meaning many older people are more reluctant than their younger counterparts to admit feelings of depression and seek help.

Depression in the older age group can be difficult to identify due to the wide overlap between symptoms associated with ageing and poor physical health, and the somatic manifestations of depression such as low energy, reduced appetite and a disturbed sleep cycle. The Geriatric Depression Scale (GDS) is a 30 item questionnaire often used to diagnose depression in the elderly population. The creators of the GDS have adapted the questions in order to make it more appropriate for an older audience. Examples of this include, removing any questions related to feelings of hopefulness about the future. These may not warrant the same response in someone nearing the end of their life compared to what would be expected in a younger person. Furthermore, to accommodate for a degree of cognitive decline, answers to the questions require a simple yes or no response. Sheik and Yesavage have also adapted the Jane Leadbetter GDS to a 15 item short form (GDS-15) which correlates well with the 30 item scale, to compensate for fatigue and poor concentration.

Suicide in the elderly
Suicide is a complex thought process, beginning as an initial idea and progressing through planning behaviour up to an attempt; importantly however, this pathway can be interrupted at any stage and suicidal ideation does not inevitably result in suicidal actions. Each year over one million people worldwide will die by suicide, and in England the suicide rate is 10 per 100,000 people (equating to 4,513 suicides in England in 2012). Suicide is the most common cause of death for males under the age of 35 in England. However WHO claims on a worldwide level, the highest rates of suicide are seen in those over the age of 75. With the number of seniors in the world’s population increasing significantly, by 2020 suicide is expected to be the tenth most common cause of death in the older population.

A further worrying point regarding suicide in the older age category surrounds the ratio between attempts to completed suicides. The ratio of attempts to completions in the elderly is worryingly high, estimated at around 4:1 respectively, compared to the much lower ratios seen in the general population of 8-15:1, down to only 200:1 for the young. Studies have also shown that the elderly population often use more lethal and violent methods than the young, which is in keeping with their high attempt to completion ratio. Data from the United States (US) displayed graphically provides a comparison of the different methods of suicide used by different age groups.

![Figure 1- model of suicidality](image)
As the graphs show, for both sexes, the use of firearms, the most violent of the methods listed, increases with age. The figure for men over the age of 65 is most shocking, with firearms used as a means of suicide for 79.1% of this category. This could represent the fact that many of these men will have been involved in the Vietnam War and hence are likely to be comfortable with operation and ownership of such equipment. Yet nevertheless, as shown in other studies, it demonstrates an increased tendency towards the use of more lethal methods, than younger age groups.

As the rate of suicide in the elderly is set to increase in the coming years, research into how best to prevent later life suicide is needed. This study aims to review the available literature regarding suicide prevention programs in the elderly and compare the success seen from different interventions. The aim is to enable conclusions to be drawn regarding suicide prevention programs, and produce clinically relevant results.

**Method**

A literature review was carried out in order to find studies suitable for inclusion in this report. The University of Liverpool’s online database provided access to articles from sources including: The British Journal of Psychiatry, Science Direct, PsycARTICLES and Wiley Online Library, all of which provided useful results.

The search was carried out in November 2014. The terms used to carry out this search were: ‘elderly’, ‘depression’, ‘suicide’ and ‘prevention’. All language and years of publication were included, and articles must have been published in peer reviewed journals in order to be deemed suitable.

In order to have been used in this report, studies must have focused on suicide prevention specifically in the elderly population. 65 years and older was used as the arbitrary cut off for inclusion in this review. The primary outcome of the trial must be reductions in actual number of suicides, as opposed to a reduction in suicidal ideation, for example. This is so as to make comparison between the successfullness of different interventions clearer and less subjective.

The search yielded a number of results, and the relevant articles were reviewed to assess their suitability for inclusion.

**Results**

Three articles in particular fitted wholly with the specified criteria. Each presented different and interesting approaches to elderly suicide prevention programs (ESPP).

De Leo et al carried out a study on an ESPP in Northern Italy. This study centred on a telecommunications service provided to 18,461 participants over an eleven year period. This service was referred to as ‘Tele Help-Tele Check’. Participants were recruited via referrals from General Practitioners (GPs) or social workers. Service users were provided with an alarm device, which triggered a pre-established support network- ‘Tele Help’. The ‘Tele Check’ element of the service consisted of welfare monitoring and emotional support provided from trained, paid staff via twice weekly telephone conversations. Furthermore, users were able to initiate a telephone conversation at any time via the 24 hour
The study compares the observed suicide rates seen in the users of the ‘Tele Help-Tele Check’ service, compared to the suicide rates seen in a corresponding general population in the Vaneto population. For this study, in the intervention cohort there were 6 suicides observed over the eleven years. This is significantly fewer than the expected figure of 20.86, meaning the mortality was only 28.8% of expected. As a secondary outcome, the researchers also noted how users of the service for over six months, saw a significant reduction in the requests for home visits by GPs and also hospital admissions. It was the female gender category in which the greatest success was seen, with the observed rate being 5.99 times lower than expected, however females were overrepresented in this study, making up 84% of the population.

Chan et al carried out a study on suicide prevention in Hong Kong. The ESPP was a government funded scheme and patients were enrolled from October 2002 to May 2007. It consisted of a multifaceted model that operated at two levels: primary care and old age psychiatry services. The pathway involved a ‘gatekeeper’ e.g. GPs, who were trained in identifying at risk cases. Each patient was then assigned a care manager, who arranged an urgent psychogeriatric appointment, and offered follow up as clinically indicated. The care manager is in phone contact with the patient and is contactable in an emergency. The study compares the suicide rate seen in the ESPP cohort to a pre-intervention cohort, both of which consist of patients with an index suicide attempt. Each patient is followed over a two year period.

This study also had a second part comprising analysis of population mortality statistics. The authors collected data on the number of suicides occurring in those over the age of 65 from 1986-2007 using Hong Kong Government’s mortality statistics derived from the Coroner’s Court. On analysis they separated results by gender and also into age categories: ‘young-old’ (65-84 years), and ‘old-old’ (85 years and over).

The intervention group consisted of 351 suicide attempters, and the pre-intervention group were a historical cohort from a previous study on late life suicide consisting of 66 suicide attempters aged over 6521. The pre-intervention group had no liaison with ‘gate keepers’ and did not have the care management component seen in the intervention group. In the pre-intervention group there were 5 observed suicides equating to 7.58%, and in the ESPP cohort there were 7 suicides equating to 1.99%, meaning the two year mortality was much lower in the intervention group. The authors also looked at the rates of attempted suicides between the two groups and found no significant difference. They however acknowledged that if suicide attempts are not worthy of clinical attention, then in both cohorts they are likely to be underreported, unlike the completed suicide rates.

The second part of the study, looking at population level data, found that the suicide rate only dropped significantly in women aged 85 and over from 2002 onwards. No statistically meaningful downward trend was observed in any of the other age or gender categories.

As the pre-intervention cohort was historical, in this study there was limited control of baseline characteristics. The pre-intervention group were recorded to have consisted of significantly more people with risk factors for suicide such as: living alone, GDS score ≥8 and an ICD-10 diagnosis of depressive disorder. The authors state however that the baseline differences were not significant when analysed via Poisson regression, and that the difference in rate of suicide between the two cohorts was in fact significant.

Oyama et al researched the success of an ESPP in Yuri Town, situated in rural Japan. Asian communities such as Japan and Hong Kong have ageing populations and high rates of elderly suicide, making them ideal populations for such research. The study was based on a very community orientated approach to suicide prevention. It consisted of three separate components: mental health workshops, group activity programs and encouragement of self-screening for depression using GDS-15. Participants were shown how to identify signs of low mood and when to consult services. The group activity programs also meant they were encouraged to meet and interact with people in similar situations to themselves. The results of the study were compared to a local area chosen for its similar rates of unemployment and income levels as to Yuri Town.

Success in this study was seen exclusively in females. In this gender category there was a 76% reduced rate of suicide compared to that of the similar population. The results for males remained almost completely unchanged.

Discussion
The three interventions described all proved to be successful, with reductions in the rate of suicide on average around 74%. The telecommunications study also noted a reduction in the need for hospital admissions and GP visits. This is important to take account of when considering the economic viability these interventions. The study by Chan et al, looking at the success of the intervention on a population level, did however note that the only significant reduction was seen in females over 8521. This shows that the ESPP would need to widen in order to have impact across all age and gender categories on a larger scale.

This literature review did produce studies that met the inclusion criteria for this report, and which interestingly studied elderly suicide prevention from different angles. However research specifically on old age suicide prevention is a much neglected area. Had this search been carried out on suicide prevention in adults, a much higher number of results would have been yielded. There needs to be more research focusing on elderly suicide prevention on larger scales. This
would mean more conclusions could be drawn from a wider evidence base and old age psychiatry services would be better equipped to prevent elderly suicides in the future.

The Department of Health’s strategy for suicide prevention in England published in 2012, acknowledges elderly suicide to be a problem, particularly in men over the age of 75. It also states how the problem is set to increase in the future. The first suicide prevention strategy in England, published a decade earlier, had notable success and suicide rates were at their lowest level for 150 years in 2007, prior to the economic difficulties. Following on from the first suicide prevention strategy, despite the rates for men under 35 years having fallen, the Department of Health plan to keep their efforts focused predominately on this age group. This is due to the number of life years lost with each suicide in a young person.

Across the board, the suicide prevention strategies discussed all seemed to have notably more success with females. Haste et al, 1996, stated high risk women are more likely than males to consult their GP before committing suicide. A study by Canetto et al, 1997, also found that women with personal difficulties often employ a self reflective coping style, whereas males are more likely to opt for distraction techniques. This suggests women would be more receptive and open to services such as those used in the suicide prevention programs. The programs required strong elements of active participation and a willingness to engage with services, this is likely to reflect why the greatest success was seen in women. Unfortunately none of the results allow any assumptions to be made about the success of such schemes in males. In England, of the older population, it is males over 75 with the highest rates of suicide. More research is needed to identify how best to target and engage specifically with older males.

The ESPPs mentioned, on the whole focus mostly on reducing the risk factors for suicide. The development of positive ageing, coping and resilience strategies are relatively unexplored potentials for elderly suicide prevention interventions.

There is little in the literature about the correlation between how the media report suicide in the elderly or elderly suicide prevention campaigns, and the effect this has on the target audience. This would be an interesting area for future research. It could be beneficial to see mental health discussed more openly amongst this age group, who place particular stigmatisation on the topic. Removing this taboo and encouraging media platforms that target this age group to openly discuss issues such as depression or suicide could be valuable in encouraging the older generation to admit feeling low in mood or having suicidal ideations, and seek help.

One study of elderly suicides in the US found that 70% of victims did present to primary care services within one month of their death. This suggests primary care providers may be somewhat insufficient at identifying depression and suicidal ideation in the elderly. The study by Chan et al with trained ‘gatekeepers’ e.g. GPs identifying at risk cases proved to be successful, and it was the gatekeepers that initiated enrolment on this suicide prevention program. Hence if more formal training was available for physicians, in particular GPs, then this opportunity to prevent suicide could be better utilised and in need patients referred quickly to the most appropriate service.

Little is documented in the literature about substance misuse and its link to suicide in the older age group. Substance misuse was seldom given as a risk factor for suicide in the elderly population, as it was often stated to be more of concern in younger people. However alcohol and substance misuse, particularly in the high risk male category, is a concern. Often overlooked and underreported, it would be beneficial for more research to be carried out in this area to clarify the strength of the correlation.

Conclusion
Depression is very common in the older age group and the problem is set to increase in the future. Worldwide, suicide is most common in the over 75s. Older people who attempt suicide have much higher attempt to completion ratios than the general population, often using more violent methods.

The three different elderly suicide prevention programs discussed all attempted to reduce rates of elderly suicide in different ways. All the ESPPs produced promising results, particularly in the female gender category.

When considering the number of life years lost and the reaction of society to the news an untimely death, it is justified that the Department of Health continue their efforts to further reduce suicide in the younger age groups. However, it is important that this is not at the neglect of the care the older members of our society; many of who are dealing with severe depression, poverty and bereavement, and very often coping alone. There is certainly a lack of research in this area and much scope for more work to be done. This report has however shown that suicide prevention strategies in the elderly can produce very successful outcomes.

References


Appendix

Personal reflection on old age psychiatry

I completed this report whilst on a seven week placement in old age psychiatry at Mossley Hill Hospital in Liverpool, as part of the final year of my studies. During our final year we have two seven week placements in self-selected areas in order to gain more experience and help with future career planning. I have very much enjoyed the placement and feel I have gained a lot from the experience.

I know I would like to pursue a career in psychiatry however I am unsure of the area I would like to specialise in. After this placement however, I would certainly consider old age psychiatry. I very much enjoy spending time with the older age group and I like the medical component of old age psychiatry.

During this placement I was able to complete an audit on the use of memantine at the hospital. I found it interesting researching the pharmacology of the drug and reading the NICE guidelines regarding dementia treatment. The audit produced results that were helpful for the department and I hope to re-audit memantine use in a year’s time.

During my time in old age psychiatry it was the functional mental disorders in the old age that I found most interesting. There were many patients on the functional ward with depression, and I met a few male patients who were hospitalised following suicide attempts. This led to the idea for my report. My placement highlighted to me the prevalence of depression in the older age group, and how it is set to become more of a problem in the future. This is why I considered the topic to be very relevant and important, and I enjoyed writing the report.

Case study on elderly suicide

This patient was interviewed as an inpatient at Mossley Hill Hospital

Mr A is a 70 year old male who has never been known to mental health services. He was admitted to A&E following a lethal overdose of oxycodone tablets. He left a suicide note describing how he could no longer cope with his deteriorating physical health and loneliness. His suicide note was posted through his neighbour’s letter box; his neighbour however uncharacteristically returned back to the house late that evening and found the note that Mr. A had intended her discovering the following morning. The neighbour contacted the emergency services and Mr. A was taken to A&E in a state of reduced consciousness.

He was reluctant to accept medical help; he refused observations and became aggressive when staff tried to administer intravenous medication. There was debate over his capacity, but it was eventually deemed he lacked capacity due to suicidal ideations and to treat against his will should he request to leave hospital.

When told the overdose could have been lethal he responded saying, ‘I know I will die, leave me alone, I want to die’. Mr. A stated he was not regretful of his actions and wished it had have been successful. He said ‘I am in pain; I am failing all over the place. I have just had enough. I am 70, all my friends are gone’.

Mr. A has type 2 diabetes and suffers with diabetic neuropathy which causes him a great deal of pain. He is concerned that he has recently gained weight and claims all of his friends have passed away. There are no protective factors identified for Mr. A. He had contact with his GP a year previously regarding low mood but received no treatment for this.

Mr. A was assessed under the Mental Health act and detained under section 2 due to risk to self and brought into Mossley Hill Hospital for further assessment.

This is a very sad story and highlights how isolated the older population can feel. For some suicide must feel like the only way to escape such feelings of sadness and loneliness. If we knew the best way to engage with these high risk males that are suffering with depression, perhaps this suicide attempt, or more importantly in this case any future attempts, could be prevented.
Poster Presentations
(Listed alphabetically by main author’s surname indicated by bold italics)

1 Health Care Service Needs Of The Dementia Patients In Designated Health Care Homes For Dementia in Wolverhampton
Dr Muhammad Asghar, Dr Qusai Bharmal, Dr Neilmudhub Kar, Dr Jayashree Viswanathan; Black Country Partnership NHS Foundation Trust

Patients with advanced dementia and challenging behavior are taken care of in two designated health care homes in Wolverhampton. It is essential to evaluate various kinds of needs, which may enable to reflect and provide for appropriate services. Objective: It was intended to evaluate the health care service needs of the dementia patients based on their clinical profile.

Method
We designed a semi-structured questionnaire to collect data, which included socio-demographic and clinical variables. Data were gathered from medical and nursing records. Information for all patients (N=30) in two health care homes was collected.

Results
Most of people were above 80 years of age and belonged to white British ethnicity. Gender was equally distributed. Median duration of stay in the care home was 7.5 years. Most common mode of admission to these care homes was via psychiatric hospital. Most common physical diagnoses were hypertension followed by diabetes mellitus. In addition most had sensoryneural deficit in the form of hearing and or vision impairment; 87% of population had difficulty in imbibing nutrition on their own; 2/3rd has swallowing problems; 90% were incontinent; more than 2/3rd (70%) had speech problems; and a large proportion (56.6%) was immobile and hoisted. A small proportion (16.6%) was on palliative care pathway and 40 % had DNR status. Mixed dementia was commonest psychiatric diagnosis followed by vascular dementia. It was not possible to conduct Standardized Mini Mental State Examination on half population. A small proportion (30%) had psychotic symptoms; however majority (66%) exhibited aggressive and violent behaviour. Majority (96.7%) lacked insight and capacity (93.4%) to make meaningful decisions. Almost 2/3rd of clients were on psychotropic medication, including antidepressants. antipsychotics and benzodiazepines. While all clients were unable to perform ADLS on their own and needed some degree of assistance from carers, majority (66.6%) needed high level of support. It was heartening to see that most of population (56.6%) had good amount of family input. Conclusion: The patients in dementia care homes had multiple. complex health related care needs. It is envisaged that needs can only be met through a well-coordinated multidisciplinary system. The results of this study suggest extent of the problems and needs in this population.

2 Communicating Dementia Diagnoses in Memory Clinics: Preliminary Observations from the ShareD Study
Dr Cate Bailey, East London NHS Foundation Trust, Queen Mary University, London and NIHR funded Academic Clinical Fellow in Old Age Psychiatry, Ms Jemima Dooley, Exeter University, Prof. Rose McCabe, Exeter University

Aims and Hypothesis
This study used video to observe and analyse triadic interactions between patients, companions and doctors during memory clinic diagnostic feedback consultations.

Background
There has been recent governmental and societal drive to facilitate prompt dementia diagnosis and treatment. Although an established culture of disclosure exists, there is little research informing clinicians how best to communicate a diagnosis. Despite growing literature exploring breaking bad news in other medical contexts, memory clinic consultations present certain challenges. These interactions tend to be multi-party; including participants with varying degrees of cognitive impairment. Previous studies found clinicians exhibit anxiety, use mitigating language and spend little time explaining diagnoses before moving to treatment. This may contribute to patients and companions misinterpreting information, which could negate the advantages afforded by early dementia diagnosis with regards to informed decision making. Methods: These findings represent initial analyses from the ShareD* study. The Shared Decision Making in Dementia Study uses video to explore triadic interactions in memory clinics over multiple UK sites. These preliminary results describe 25 diagnostic feedback consultations observing 25 patients, 27 companions and 11 doctors. Recordings were evaluated quantitatively and thematically analysed.
Results
Mean total length of consultations was 28:34 (11:44 – 1:05:00). Mean initial time spent on delivery of dementia diagnosis was 2:08 (00:45 – 9:10). The average proportion of time spent explaining the diagnosis was 15% (4.5% to 39%). In 88% of the initial discussions the doctor moves the conversation on; 55% of the time to medication and in 20% to more general support available. In 22/25 consultations discussions return to dementia at least once, with a median of two additional discussions of dementia. Doctors and companions initiate returns more than patients. Companions are primarily concerned with cause and prognosis of dementia, and the doctor with summarising diagnostic information, explaining treatment and prognosis. Patients seek clarification of what the diagnosis means, requesting diagnostic evidence and verbalising emotional reactions.

Conclusions
Preliminary findings confirm relatively little time is spent explaining the diagnosis and doctors move quickly to discussing treatment, with patients and companions returning to clarify diagnosis and prognosis. There are clearly challenges in managing the differing needs, abilities and expectations of both parties. Future work will explore the impact of different forms of diagnosis delivery on participant satisfaction and understanding in order to advise clinicians in this challenging and important task. *ShareD Study is NIHR funded.

3 Are the standards met for the physical health monitoring when prescribing antipsychotics in Old Age Psychiatry, Gateshead?
Dr Priya Bandi, Northumberland Tyne and Wear NHS Foundation Trust, Dr Laura Catanescu, Northumberland Tyne and Wear NHS Foundation Trust, Dr Richard Harrison, Gateshead Health NHS Foundation Trust

Background
It is well-known that some antipsychotic medications have metabolic consequences. Atypical antipsychotics can cause weight gain and have a negative impact on lipid profile. They may have a direct effect on insulin function, independent of weight gain. An association between diabetes and schizophrenia is also well recognised.

Aims
To determine the current compliance of Old Age psychiatric wards in Gateshead locality with the standards on physical health monitoring when prescribing antipsychotic medication. To ensure that all medical and nursing staff are aware of this Policy. To highlight the need for a trust policy with this regard. To ensure best practice is provided on a daily basis and any areas of concern to be addressed. Standard: NTW Document(C) 29 – This policy follows recommendations from the Maudsley Prescribing Guidelines 2011, BNF 64 (September 2012) Royal College of Psychiatrists Consensus Statement on high dose antipsychotic prescribing May 2006 and other relevant standards.

Method
This was a retrospective initial clinical audit covering the 3 Old Age psychiatric wards over a 6 month period. We used paper files, electronic pathology systems to collect our data. Out of a total of 60 patients admitted, only 24 were prescribed antipsychotic medication and 22 cases were audited. Results: 54% of patients were already on antipsychotic medication at time of admission. There no cases of patients on high dose of antipsychotics. Weight and BMI, blood pressure were 100%. Less checked: lipids, fasting blood glucose, prolactin levels. Physical health is being monitored appropriately, but with regards to co-morbid medical conditions. Baseline prolactin level was checked in only 2 out of 22 patients. At 1 month: There were 13 patients prescribed Olanzapine at 1 month following admission and only 1 had glucose level checked. 100% of the patients had blood pressure and weight checked. At 3 months: Only a third of patients had lipids monitored at 3 months. 100% had blood pressure and weight monitored. At 6 months: Only 2 cases identified at 6 months. They had blood pressure and weight checked, but none had prolactin level monitored, as per current guidelines. Only 1 patient was discharged from the ward with an appropriate shared care plan.

Recommendations
Need for local policy to be implemented. Increasing awareness by improving the weekly ward round sheets. We developed a monitoring form/table that can be easily used by staff members. Future SHO contacted and information passed on for re audit.
Empowering family carers – a role for assistive technology
Prof. Susan Mary Benbow, University of Chester, Dr Sarmishtha Bhattacharyya, University of Chester

Background
One of the developments in dementia care over recent years has been the introduction of assistive technologies (AT). The use of AT brings both advantages and disadvantages and has not revolutionised dementia care in the way that might have been hoped. Nevertheless AT have a growing role in helping people with dementia and their family carers.

Aims and hypothesis
1. AT may empower family carers.
2. AT may increase the disconnection between people with dementia and others.

Method
We carried out a narrative review of the use of AT by family carers of people with dementia and applied a model derived from Arnstein’s ladder of participation (Arnstein, 1969) to the learning derived. Results: We set the learning from identified papers on the use of AT in dementia into the context of a modified carer empowerment ladder, developed from Arnstein’s ladder of participation, and relate it to a conceptual framework developed from the work of Wahl and coworkers. Wahl and colleagues looked at ageing well and the environment, and described connection and empowerment as processes, which contribute to identity, autonomy and well-being. We found evidence that AT can empower family carers but that this could potentially occur at the expense of loss of connection with people with dementia.

Conclusion
AT have an increasing role in maintaining the independence, wellbeing and quality of life of both people with dementia and their carers. The ethical dilemmas involved in the use of technology are challenging and need to be addressed in order that assistive technology might fulfil its potential and humanely contribute to care. It is important to recognise that empowerment alone is not enough. Technological interventions might be used as an alternative to human contact and enhance the disconnection between people with dementia and others. Relationship-centred care is valued by both family carers and people with dementia: health and social care professionals should be alert to the possible use of AT as an alternative to connection. The emphasis in practice should be on empowering and connecting with both family carers and people with dementia.

Understanding and applying health promotion in old age psychiatry practice
Prof. Susan Mary Benbow, University of Chester, Dr Sarmishtha Bhattacharyya, University of Chester

Aims and hypothesis
We hypothesize that health promotion could contribute to old age psychiatry practice and improve physical and mental health outcomes for patients and their families. We aimed to develop a model, which could offer a basis for understanding how to incorporate health promotion in an old age psychiatry service. Background The World Health Organisation (WHO) defines mental health promotion as “actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health”. Prevention can be divided into primary, secondary and tertiary, and may be universal, selective or indicated. How often is health promotion considered in old age psychiatry practice? Is there a model of understanding health promotion that we could usefully apply in old age psychiatry? Methods We carried out a systematic review on mental health promotion in elders from black and minority ethnic communities. The review identified a small number of papers with little common ground, so, following the review, we searched for a model that would enable health promotion to be applied to practice and allow us to make sense of the fragmented evidence we had collected. Results The Revised Health Promotion Model developed from the work of Pender sets out two domains, which influence health-related behaviour: these are individual characteristics and experiences, and behaviour specific factors. Individual characteristics and experiences may suggest groups to target for health promotion in relation to particular conditions. There might be specific risks associated with belonging to a particular community, which are relevant in this domain. Behaviour specific factors suggest ways in which influence might be brought to bear: eg interpersonal factors act here. Barriers and contextual factors are also addressed in this domain. Some studies in health promotion in BME groups have used peer champions (or similar) – this can be understood as an interpersonal intervention sensitive to individual characteristics.

Conclusions
There is little literature to guide mental health promotion for BME elders. The Revised Health Promotion Model offers a structure for understanding how to approach the topic and the evidence that is currently available. It also offers a possible approach to applying health promotion in old age psychiatry practice.

6
Clinical audit of hypnotic medications on an old age inpatient ward
Dr Sophia Bennett, NTW

Background
Risks associated with the long-term use of hypnotic drugs are well recognised and in older people there are additional hazards. NICE has Guidance on the use of hypnotic medication for the short-term management of insomnia. This audit aimed to look at adherence to these guidelines on a functional old age ward.

Method
Information was gathered by reviewing the ward admission and discharge records, patient’s electronic records and paper records, drug Cardexes and sleep charts. Data was analysed using the data collection tool. Patients prescribed a hypnotic during their inpatient stay were identified from electronic records of all patients discharged between January 2013 and January 2014.

Results
The number of admissions was 55. The number of patients on hypnotics was 16. 0% had non pharmacological approaches tried first but 82% had non pharmacological approaches tried at the same time. 67% were prescribed hypnotics for less than 4 weeks. 75% were prescribed the hypnotic with the lowest acquisition cost. 0% were switched to a hypnotic in the same class if the first hypnotic had no effect. Conclusions There was very little evidence that when patients request hypnotic medication or complain of poor sleep, they are being given suitable advice regarding sleep hygiene and lifestyle advice as a method of improving sleep in the first instance. There is a lack of structured activities and physical exercise available to patients on the ward. There needs to be more emphasis on trying non pharmacological approaches first prior to initiating hypnotic medication. This will require introduction of more structured activities to be available including engagement with OT. Patients on hypnotic medication should have their sleep monitored using the sleep chart and if no insomnia found, a review of medication and attempt to withdraw/stop the hypnotic medication.

7
Depression and dementia: cause, consequence or coincidence?
Dr Sophia Bennett, NTW, Prof. Alan Thomas, Newcastle University

Background
The relationship between depression and dementia is complex and still not well understood. A number of different views exist regarding how the two conditions are linked as well as the underlying neurobiological mechanisms at work. This narrative review aimed to examine longitudinal and cross sectional studies in the existing literature and determines the evidence supporting depression being a risk factor, a prodrome, a consequence, or an independent co morbidity in dementia.

Method
A search of the electronic databases MEDLINE(R) and EMBASE was conducted using the keywords: depression OR depressive* AND (dementia OR Cognitive Dis* OR Vascular OR Multi-Infarct OR Alzheimer*). Limits were set to include all articles from the year 2005 to current and those published in English language. Manual searches of other relevant journals and reference lists of primary articles found from initial searches were also conducted. Titles and abstracts were reviewed for relevance. Meta-analyses, systematic reviews as well as individual longitudinal and cross sectional studies were included. Articles were not included if they focused on just one type of dementia, if they focused only on mild cognitive impairment, or if the methodology did not give an indication of how depressive symptoms and cognitive symptoms were defined and classified. Results Overall there is convincing evidence to support both the notion that early life depression can act as a risk factor for later life dementia, and that later life depression can be seen as a prodrome to dementia. There is also evidence to support both conditions showing similar neuropathological changes, particularly white matter disease, either indicating shared risk factors or a shared contribution to neuronal damage.

Conclusions
These findings highlight the need to examine if effective treatment of depressive episodes has any effect in reducing the prevalence of dementia, as well as clinicians being vigilant for late life depression indicating the incipient development
8 Validation of plasma apolipoprotein E as a biomarker for Alzheimer’s disease
Dr Manraj Bhamra, Sandwell and West Birmingham Hospitals NHS Trust, Dr Blaine Roberts, Mental Health Research Institute, University of Melbourne

Aim
To validate changes in plasma apolipoprotein E (ApoE) as a potential biomarker for Alzheimer’s disease (AD).

Background
AD is a progressive age-related neurodegenerative disorder affecting approximately 34 million people worldwide, a figure which is expected to quadruple by 2050. Definitive diagnosis still relies on a post-mortem brain examination, and neurodegenerative and cognitive changes begin years before clinical manifestations. The field is therefore in critical need of a reliable biomarker to aid in early diagnosis and identification of preclinical disease. The Australian Imaging, Biomarker and Lifestyle (AIBL) Study of Ageing aims to address this [7]. ApoE is an abundant plasma protein with a central role in lipid transport and metabolism. There is mounting evidence for its contribution to the pathophysiology of AD, with likely involvement in processes of neuronal repair, remodelling and degeneration by interaction with numerous factors and pathways. There is hence growing support for the investigation of ApoE protein expression as a potential biomarker for AD.

Methods
One dimensional (1D) and two dimensional (2D) western blot validation were carried out for plasma ApoE and APP proteins discovered from 2D gel electrophoresis. Samples of serum were obtained from 6 individuals with a diagnosis of probable AD and 6 healthy age matched elderly controls. Protein concentration was determined using a 2D Quant kit. Analysis of 2D gel films was performed using Multigage analysis software. RESULTS We found a significant decrease in both 34 kDa and 43 kDa plasma ApoE subtypes in in AD compared to controls.

Conclusions
These results demonstrate that alterations in plasma ApoE protein levels occur in AD and implicate plasma ApoE protein expression as a potential biomarker of AD, with possible diagnostic value. This study further suggests the utility of a cost effective, non-invasive blood-based biomarker. Further validation studies are required in a large population to improve the reliability and variability of these results. These results have facilitated an expansion of the project and development of assays to assess plasma levels of ApoE and APP, with the overall aim of developing a peripheral biomarker for early AD.

9 Genetic testing in Dementias and old age psychiatry
Dr Sarmishtha Bhattacharyya, BCUHB, Prof. Susan Mary Benbow, Chester University

Background
Memory clinics are the hub of dementia diagnosis, and old age psychiatrists may face questions from patients and families about whether dementia runs in their family. Predictive genetic testing is available in Early Onset Alzheimer’s and Fronto-temporal dementias (FTD) to estimate the likelihood of disease in siblings and children of those affected. A positive predictive test in Alzheimer’s disease indicates an increased risk of susceptibility for the disease, without certainty that the illness will ever develop. At least five genes are associated with FTD and its subtypes: even more if the overlap with Alzheimer’s disease and motor neuron disease is considered. Aims: To investigate the impact of genetic testing on patients and family members; to consider the ethical and moral dilemmas associated with such testing versus the clinician’s duty of care and to reflect on the implications for old age psychiatrists.

Methods
A systematic literature search was conducted using pubmed and medline to identify research on impact of genetic testing in neurodegenerative conditions such as dementias. Results: Although there is much research available in relation to Huntingtons disease, very little is available concerning FTD or Alzheimer’s dementias. For patients and families making a decision about genetic testing is complicated and may lead to conflict. Informed consent is vital. For clinicians there are dilemmas involved in referring and assessing for genetic testing which may lead to conflict between preserving autonomy and respecting a patient’s confidentiality.
Conclusion
Predictive genetic testing carries potential psychological, social, familial and financial impacts for patients and families involved. Old age psychiatrists need to be alert to the possibility of familial forms of FTD and Alzheimer’s disease and to ensure that careful histories are taken including significant family history. They need to be prepared to discuss the possibility of a familial condition in a sensitive and thoughtful manner with appropriate families. Before advising or proceeding to genetic testing careful thought, support and time needs to be given to families, ensuring that thoughts and wishes of individual patients as well as families are considered: pretesting counselling is very important. Old age psychiatrists have an important role in providing relevant and proper information pre and post testing in order that patients and families are in a position to decide whether to go ahead with testing or not.

10
Perceptions of Use of CTOs in Older people- is it good for care?
Dr Sarmishtha Bhattacharyya, BCUHB, North Wales, Dr Jan Bailey, Chester University, Dr Farooq Khan, Birmingham & Solihull Mental Health NHS Foundation Trust, Prof. George Tadros, Birmingham & Solihull Mental Health NHS Foundation Trust, Prof. Paul Kingston, Chester University

Aims
To explore the use of CTOs by Old Age Psychiatrists, to ascertain their beliefs regarding its suitability for use with older people, and whether they perceive CTOs as beneficial in the delivery of their care. Background: In U.K., Community Treatment Orders (CTO) were introduced in 2008 as a process of reforming the mental health law in England and Wales. CTOs allow people to be treated under the Mental Health Act and subject to conditions whilst residing in their own homes. In UK, psychiatrists generally decide on using a CTO based on the potential benefits of treatment adherence, authority to treat the patient and ensuring early identification of relapse. Research shows that CTOs have not resulted in better outcomes for patients with relapsing illness. There are also indications that CTOs are not effective when caring for older people and their use is limited; however previously evidence was anecdotal.

Methods
Participants were old age psychiatrists working in England and Wales. A mixed method approach was adopted with a quantitative stage using a questionnaire and a qualitative stage involving a series of one-to-one interviews conducted via telephone. The quantitative data was analysed using Qualitrics software. The recorded interviews were transcribed for data analysis and the transcripts were analysed thematically. Results: About half of respondents had used a CTO with an older adult and more than half reported feeling comfortable using CTO with older adults. Both quantitative and qualitative analysis of data showed that CTOs were mainly used with patients diagnosed with relapsing illness and many respondents would not consider using CTOs in people with dementias. There was also evidence that older people were viewed as being compliant.

Conclusion
There was strong evidence that Old Age Psychiatrists perceived CTOs as having limited efficacy with older people and that other legislation was more appropriate to their care. This mirrored a recent study which failed to find any benefit between Section 17 leave and CTO. The perception of older people as being compliant is interesting as it may reflect reality or be a manifestation of stereotypes of older people; both explanations are concerning. It must be considered that compliance may be a cohort effect associated with specific generations of older people. If this is accurate, old age psychiatrists may need to revisit their perceptions of the efficacy of CTOs in the care of older people and translate this into their practice.

11
DNAR application, discussion and documentation for organic and functional older adult psychiatry patients on psychiatry inpatient units.
Dr Charlotte Blewett, Derbyshire Healthcare Trust, Dr Michael Ludlam Derbyshire Healthcare Trust, Dr Gemma McConnon, Derbyshire Healthcare Trust, Dr John Sykes, Derbyshire Healthcare Trust

Background
Clinical guidance suggests guidelines should be set for resus status decisions on all inpatient psychiatric units and appropriate documentation used. Despite this documentation of resus decisions and use of DNAR forms is low within Derbyshire Healthcare Trust.

Standards/Guidelines/Policy
There are no formal guidelines regarding DNAR discussion and currently medics in the trust receive no formal training on DNAR decisions. However standardised trust DNAR forms are to be used when a decision regarding DNAR has taken place. These include patient’s details, DNAR reason, whom was involved in the discussion including the patient, or
where patients’ deem to lack capacity the relative. A review date must be documented on the form and countersigned by a senior medical clinician, with form being placed in the front of the patient’s notes.

Aims and Objectives
To conduct a clinical audit to measure rates of resus discussion and DNAR form completion for all older adult patients within Chesterfield inpatient psychiatric units. Practitioners would be made aware of the results and implementations suggested if required. A re-audit would be carried out six months later to see how the results compared.

Methodology
A retrospective audit of medical notes was completed on all medical notes on both organic and functional wards for older adults within Chesterfield in November 2014. If a DNAR form was completed within the notes we then examined if there was evidence of discussion of the DNAR status within the medical notes, whom made the discussion, was a relative present, was this reviewed by a senior clinician and was a further DNAR review date set.

Results
Five DNAR forms had been completed using the trust DNAR form out of thirty-six older adult patients. Three had been implemented during the admission and two in the community prior to admission. There was 100% completion of patient identifiers, reason for DNAR and signature of the person completing the form. However 60% of DNAR decisions had taken place with family member present and only 20% had a review date.

Conclusion
DNAR discussion is still underperformed within our trust for older adult patients. Whilst appropriate documentation is used there is evidence the decision is not discussed with a family member. We plan to re-audit in six months after the following implementations are made: DNAR training for medics during induction including whom should be completing the discussion and decision and appropriate documentation to use.

12
Improving care for people with Lewy body dementia in care homes
Dr Kimberley Boyle, University of West of Scotland, Prof. Graham Jackson, University of West of Scotland

Aims/Hypothesis
To determine the prevalence of possible Lewy Body Dementia (LBD) and Parkinson’s disease dementia (PDD) in care homes and care home staffs knowledge and therefore management of these dementia subtypes.

Background
It is estimated that there will be 42 million dementia sufferers worldwide in 2020. Its subtypes including LBD/PDD will increase in prevalence over the next few years. However due to the lack of knowledge around these, they are not recognised in the long-term care population leading to a poor quality of life and carer burden.

Methods
Literature review
prevalence of PDD/LBD in care homes Care home staff survey/discussions conducted in Lanarkshire and Yorkshire addressing: The prevalence of possible LBD/PDD and associated symptoms amongst care home residents The challenges that caring for a person with PDD/LBD present for staff groups and care homes What knowledge/skills do care home staff have to care for residents with PDD/LBD The sources of advice/training they have used or would use if they needed support.

Results
PDD prevalence: general population 0.2-0.5%, dementia population 3-4%, Parkinson’s disease population 23-31%. LBD prevalence: 0-5% general population, 0-30.5% dementia population Care home residents: 37% - 54% have dementia however care home staff report only 31-38% highlighting their lack of awareness. PDD/LBD studies showed that the severity of non-motor symptoms is associated with a poor quality of life for the patient and a higher carer burden. Patients under report these possibly due to them not relating these to Parkinson’s disease or being embarrassed. It has also been shown that carer education improves the quality of life of both resident and carer.

Conclusions
Prevalence studies highlight the disease burden of PDD/ LBD. There are known predictors of patients developing dementia which are an important part of care home staff education. We intend to undertake a project to improve the care and support for care home residents who show the symptoms of PDD/ LBD. We will investigate the likely care home prevalence of these and identify the care home staffs knowledge of these. We will then give recommendations to
Acute and Long-term Management of Physical Health in 2 Older Peoples Mental Health Inpatient Units
Dr Alice Brooke, Sussex Partnership NHS Foundation Trust, Dr Amit Kuruvila, Sussex Partnership NHS Foundation Trust, Dr Leonard Atiku Sussex Partnership NHS Foundation Trust

Aims and hypothesis
An audit to investigate physical health monitoring in the inpatient environment, in two key areas; the assessment of the acutely unwell, deteriorating patient, and the management of chronic conditions.

Background
Psychiatric patients suffer from significant co-morbidities; this is most pertinent in Older Peoples Mental Health, where patients are frail and often in poor physical health upon admission. Recognising an acutely medically unwell inpatient is extremely important. Modified Early Warning Score (MEWS) systems, designed to aid early detection of clinical deterioration, are commonplace in General Hospitals. However, they have only recently been introduced within Sussex Partnership Psychiatric Services. Through this audit we hope to assess whether they are being used appropriately and safely.

Methods
Data collection took place in October 2014; the sample was of all current inpatients, in both a Functional and Organic unit. 26 sets of patient notes were audited. 2 patients who were Working Age were excluded. All paper notes and all MEWS charts completed since admission were reviewed. The standard was 100% documentation in all areas.

Results
A High MEWS score was recorded 27 times in total. There was corresponding documentation in the clinical notes of the On-call Doctor being called at this point on 10 occasions (37%). There were 43 changes from baseline recording of observations (recommended 1x weekly) documented on MEWS charts. The rationale for this was only documented 19 times (44%). Out of the 10 times that an On-call Doctor was notified of a high MEWS score, a plan for further frequency of observations was made only 6 times (60%). Out of 4 changes made to the once-weekly MEWS regime due to an isolated observation being abnormal, none were in line with NICE Guidance.

Conclusions
This audit shows that the MEWS chart is not being used effectively. The on-call doctor is not being called appropriately at all moments of a potential deterioration. Documentation of frequency of observations and rationale behind decision-making is poor. Monitoring and diagnosing hypertension in line with NICE guidance needs improvement. Several recommendations have now been made. A teaching session has been delivered to junior doctors on a local level. We have encouraged updated MEWS chart training for nursing teams, and implemented Posters on the ward. We can hope to see a sustained improvement in practice, with the aim of improved patient safety. A re-audit will be performed in 6 months.

Survey of Psychotropic Prescribing in Dementia
Dr Pau Brown, NHS Greater Glasgow and Clyde, Dr Ajay Macharouthu, Dr Marisa Linnney

Introduction
The use of antipsychotic medication in the management of Behavioural and Psychological Symptoms of Dementia (BPSD) has steadily increased in profile over recent years, attracting strong media attention. Recent evidence reveals a large proportion of inappropriate antipsychotic prescriptions and the hazards of antipsychotic use combined with the commitment in the Scottish Dementia Strategy to reduce inappropriate prescribing served as an impetus for this project

Aims and Hypothesis
To examine psychotropic prescribing in people with dementia across NHS Dumfries and Galloway. To incorporate elements of audit, referring to both local and national standards for use of pharmacological agents in dementia. We hypothesise that there will be a reduction in overall antipsychotic prescribing.

Methods
This cross sectional survey encompasses elements of audit. There was a fixed sampling period with data collection
occurring from April 2012 to December 2012. A letter was sent to every GP practice in Dumfries and Galloway (n=34). We received an excellent response with 32 practices submitting the requested anonymised medication summaries for patients on the dementia register of each practice. Psychotropic prescribing information including current and previous antipsychotic use, cholinesterase inhibitor usage and potentially hazardous medication interactions was obtained.

Results
Currently, psychotropic prescribing has been examined in 10 GP practices, comprising 396 patient records. Our results at this stage are revealing important trends including that 13.4% of patients are currently receiving an antipsychotic compared with 37.9% between 2004-2012. There was an ongoing predominance of quetiapine prescribing representing 7.3% of antipsychotic prescriptions although this too is reducing when compared to a previous prescription rate of 12.4%.

Discussion
We believe the general reduction in antipsychotic prescribing is related to a number of factors including increased awareness of MHRA (Medicines and Healthcare Products Regulatory Agency) warnings and respected clinical guidelines. Additionally, there is increased availability and awareness of the range of non-pharmacological approaches available for managing BPSD symptoms. Reasons for the ongoing undesirable predominance of quetiapine prescribing include perceived tolerability and low incidence of EPSE’s and the absence of this medication from the initial MHRA warnings. Risperidone is currently the second most common antipsychotic prescribed indicating an increasing awareness of the risperidone license for treating BPSD in Alzheimer’s dementia.

15
Memory assessment & referral. A clinical audit based on the National Dementia Strategy (2009).
Dr Margaret Butler, Imperial NHS Trust

Introduction
Dementia currently affects over 800 000 people in the UK, 1.3% of the population and 20% of those over 80, these figures are expected to double in the next 30 years. Dementia has huge devastating health and social and financial impacts, it costs the UK economy £23 billion pounds per year. Dementia is more common in those with neurological conditions, making this a vulnerable group, with prevalence rates of 30% in Parkinson’s disease, 50% in multiple sclerosis, 2 to 15% in motor neurone disease and 6 to 30% in those who have had a stroke. There have been longstanding nationwide concerns that the health needs of people with dementia and their carers are not adequately addressed from referral to end of life care, where an estimated third of patients never receive a diagnosis. The National Dementia Strategy and the Memory Services National Accreditation Programme (MSNAP) standards have provided standards to address these concerns and enhance clinical care.

Aims and objectives of audit
1) To evaluate current practice of neurology outpatients at an East Anglian hospital, against the MSNAP standards in relation to assessment of patients with suspected dementia. 2) To evaluate how frequently patients with suspected dementia attending neurology outpatients at the hospital are referred to memory clinics where appropriate in accordance with the National Dementia Strategy recommendations.

Methods
A retrospective audit was conducted of a sample of patients (N=55) referred to the neurology outpatients department at the East Anglian hospital from 2008 to 2012 with cognitive problems. Data was gathered from September 2011-January 2012, from the individual patient notes and hospital two electronic databases namely ICE and electronic template.

Results
Activities of daily living and risk were assessed in 60% of the sample of patients, psychiatric symptoms were assessed in 15- 60%, whilst 36% of patients did not have formal cognitive testing and 67% of all patients less exceptions did not have a memory clinic referral.

Discussion
It is essential that improvements are made in the cognitive and psychiatric assessment of patients with cognitive problems and referral to mental health services for early intervention, diagnosis and to optimise care for patients with dementia. Resource issues have prevented specific action plans and re-auditing to date.
Antipsychotic Use in Dementia

Dr Stephanie Campbell, Southern Trust, Dr Aimee Durkin, Belfast Trust

Background

Around 800,000 people in the UK have dementia, 80% of whom will be expected to have behavioural changes/psychological symptoms. In 2006 NICE published guidelines on the treatment of behavioural problems in patients with dementia. Currently only short term use of Risperidone is licensed for these indications.

Aims

The aims of this audit were to look at the use of and documentation surrounding antipsychotic medication in patients with dementia in both inpatient and outpatient settings in Holywell Hospital to determine whether it complied with current guidelines. It also aimed to determine a need for further training and re-audit.

Methods

Using NICE guidelines standards were created with regard to the documentation of antipsychotic prescribing for patients with dementia. A standard of 100% was set. Notes were collected from all inpatients residing in the acute ward between the months of October-December 2013 as well as those who had been transferred from the acute ward to the rehab ward during this time period. Notes from all SHO outpatient home visits during the month of October were also reviewed. Those patients with a diagnosis of dementia who had been commenced on antipsychotic medications by their Psychiatry team were identified and analysed. The proportion of case notes with appropriate documentation was noted. A computerised table was used to tabulate and analyse the data.

Results

19 patients with dementia on antipsychotics commenced by their Psychiatry team were identified during the time period. 100% compliance was not achieved. The main areas for improvement were:

- Co-morbidities considered
- Rationale for commencing treatment discussed with patient/carer
- Potential adverse effects discussed with patient/carer

The results were discussed with the Pharmacy Department who have begun showing trainees how to access guidance on antipsychotics at induction. The teams have now introduced regular zoning and family meetings as part of addressing the issue of medication earlier during the admission. Providing patient information leaflets/information evenings for patients and carers has been suggested and is being developed, which could help improve compliance in discussing medications with patients and their families. A re-audit in June 2014 showed significant improvement in the above areas, but full compliance has still not been achieved. Conclusion: This audit identified a need for providing further training on antipsychotic use to medical staff. Further development of the ward rounds and information evenings could also be useful, as would re-audit to ensure standards have been met.

Integrating and Implementing Old Age Psychiatry into the Undergraduate Medical Curriculum – University of Glasgow

Dr Martin Carlin, Leverndale Hospital, Glasgow, Dr Ajay Macharouthu, NHS Ayrshire and Arran

Aims and Hypothesis

The need to improve opportunities in Old Age Psychiatry for Medical Students is unequivocal. Establishing a Student Selected Component (SSC) for medical students has facilitated integration between Psychiatry and other medical specialties. This SSC exposes students to organic and functional mental disorders, multidisciplinary team working and offers experience of the law as applied to medicine. The SSC has enhanced the spiral approach adopted by the undergraduate curriculum, aims to utilise a range of teaching methodologies and provide students with opportunities to network with Old Age Psychiatrists. The SSC also aims to improve recruitment into CT1 posts and higher training posts in Old Age Psychiatry.

Background

SSCs allow an extended depth of study in an area of interest to the student. SSCs support evidence based medicine, enhance professional development and broaden knowledge of the specialty. The SSC facilitates the delivery of teaching and exposure to core areas of the specialty which may not be experienced otherwise as an undergraduate. There has been a fall in recent years in the number of UK graduates recruited into Psychiatry and Old Age Psychiatry, requiring initiatives to improve recruitment. SSCs are recommended by the General Medical Council and the Royal College of Psychiatrists.

Methods

The structure and components of the SSC will be outlined in poster format, but will represent the spread of activity in medical student learning.
undertaken by the Old Age Psychiatrist. Students attend tutorials on a range of topics and are issued with learning objectives. Students undertake written and clinical assessment, and there is a specific focus on evidence based management within the written assessment. Results The results of student evaluations will be represented in graphical format, as will student comments about the block. Students who undertake the block will be followed up to determine future career destination and the pilot block has highlighted the need for further work focusing on attitudes to Old Age Psychiatry pre and post block. Specific refinements which have been made to the block will be outlined.

Conclusions
This SSC is in its infancy, but has already proven a popular addition to the undergraduate curriculum and is a growing initiative to improve recruitment. Early anecdotal evidence suggests the block may contribute to tackling common myths about the specialty and the stigma associated with Psychiatry more generally. The block offers clinical and academic opportunities and offers students a chance to compete for medical student essay prizes.

18 Mental Health Problems in Parkinson’s Disease
Dr Antonio D’Costa, Merseycare NHS Trust, Dr Peter Metcalfe, Merseycare NHS Trust, Dr Dave Anderson, Merseycare NHS Trust, Dr Salwan Al-Kubaisi, Merseycare NHS Trust

Parkinson’s disease is a well-known progressive neurological condition that affects 1 in 500 people worldwide. There are several millions spend annually to look at newer research that can help, and even aim to cure people from this crippling disease. Until a cure is found for Parkinson’s, we need to find better ways of managing the many and varied symptoms of the condition. And while neurologist continue their efforts in facilitating a better morbid life, psychiatrist find themselves frequently in the limelight of the treatment process. A commonly known dictum of 'a balance between motion and emotions' highlights the role of psychiatry in the midst of the growing attention. Mental health problems like depression, dementia and psychosis are frequent reason for referral to a psychiatry team, although there are many others like sleep, anxiety disorders that are not far behind. In this service evaluation we look at the general figures of these comorbidity in the Mersey region and also compare the practice against standard guidelines. Our aim is to impress on the general psychiatry community that while research continues to develop in looking at newer advances; it’s important to pay attention to current best practice.

19 Non-Drug Therapies in Old Age Mental Health Services
Dr Sunita Deshmukh, Academic Unit of Psychiatry and Behavioural Sciences, Leeds Institute of Health Sciences, University of Leeds, Dr Nick Venters, St. Mary’s Hospital, Leeds and York Partnership NHS Foundation Trust, Dr Wendy Neil, St. Mary’s Hospital, Leeds and York Partnership NHS Foundation Trust

Aims and hypothesis
Evaluating awareness and accessibility of nondrug therapies for people with dementia, in Old Age Psychiatry (OAP) services across the Royal College of Psychiatrists (RCPsych) Northern & Yorkshire regions. Clinical experience and anecdotal evidence suggested possible lacking awareness and availability. Background National Institute for Health and Care Excellence (NICE) guidance recommends nonpharmacological interventions for cognitive symptoms in mild-to-moderate dementia and for noncognitive symptoms in dementia (all types and severities). Patients should be given opportunities to participate in cognitive stimulation (CS). Individually tailored interventions should be considered for comorbid agitation including aromatherapy, multisensory stimulation, music or dance therapy, animal-assisted therapy and massage. There is some evidence of clinical effectiveness and National Health Service (NHS) staff have a role in ensuring availability. Psychological interventions may be considered for comorbid depression and/or anxiety. There is variable evidence for other nondrug interventions. Methods Cross-sectional service evaluation, using online questionnaire software for survey design, data collection and analysis, over 2–3 weeks. RCPsych members specialising or a main interest in OAP were invited to participate, subsequently extended.

Results
In total, 205 members were invited and 10% responded. The majority, 13 of 20 respondents, were Consultants (65%), six Core Trainees (30%), one Higher Trainee (5%); based in the community (65%), inpatients (30%), liaison (5%); mostly from NHS Foundation Trusts — Leeds and York Partnership (35%), Southwest Yorkshire Partnership (25%), Tees, Esk and Wear Valleys (15%). The top three therapies respondents were aware of in their locality were: psychological therapy (50%), CS (45%), music therapy (30%). The same were the top three recommended to service users. 16% had also recommended cognitive training (CT). 12 of 19 respondents had referred patients to psychological therapy (63%), five to CS (26%), two (11%) to CT, dance-movement therapy, music therapy. 3 of 20 (15%) weren’t aware of any locally available nondrug therapies, and 4 of 19 (21%) had recommended or referred none, including Consultants and Core
Trainees. Proportions of respondents with ‘Difficult’ or ‘Very Difficult’ experiences of referring were: cognitive behavioural therapy (CBT) (33%), CT (24%), dance-movement therapy (24%), multisensory stimulation (24%), CS (22%), music therapy (18%). Respondents based their views on: NICE guidelines for CS (35%); published expert opinion for CT (35%), dance-movement therapy (29%) and CBT (28%); professional experience for music therapy (24%).

Conclusions
Potential implications of response rates were considered. Raising awareness and accessibility of nondrug therapies are recommended.

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Should an electrocardiogram (ECG) be performed on all patients admitted to the acute old age psychiatry ward?
Dr Hannah Driver, NHS Greater Glasgow & Clyde

Aims
This review discusses the advantages and disadvantages of routinely performing an electrocardiogram (ECG) on admission to the old age psychiatric ward. It incorporates a case example of current practice in one ward in addition to exploring current guidelines and the relevant literature.

Hypothesis
All patients admitted to an old age psychiatry ward should have an ECG performed. Background: It is well documented that psychiatric patients have high rates of physical illness, and those with severe mental illness a reduced life expectancy and higher mortality rate. The commonest cause of death is from cardiovascular disease and whilst lifestyle factors likely contribute to this there is growing concern as to the role that psychotropics may play. There have been calls for health professionals to do more to seek out undetected disease especially in those at a higher risk. This is of particular relevance in the elderly population whose propensity to develop side effects from medications coupled with often multiple comorbidities increase the risk of this disease. The routine admission clark provides us with an opportunity to do this, and the usual history, physical examination, blood tests and baseline observations may well help detect any underlying cardiovascular disease. An ECG is not usually performed routinely but would provide a more comprehensive cardiovascular assessment in addition to detecting any unknown arrhythmias, something of particular importance for those on psychotropics.

Methods
A review of current guidelines and literature on the topic was performed to see if an ECG should be routine. To gain insight into current practice, the notes of twenty four inpatients on an old age ward were reviewed to see how many had an ECG at admission or during their stay. The notes were also examined to see whether an ECG was indicated based upon existing medical history, underlying cardiovascular risk factors or medication prescribed.

Results
A literature search offered little guidance. Overall it was suggested to perform an ECG ‘if concerned’ but it remains unclear what this actually means. In the case example, 21% of patients had an ECG at admission and a further 25% during admission. Of those without an ECG, 85% had indications for one, such as a previous myocardial infarction or being on psychotropics. Conclusions: The case example highlighted how the numbers of patients having an admission ECG is low but indications in this patient group are high. The advantages and disadvantages of an admission ECG are discussed.

21
Towards an understanding of why undergraduate teaching about delirium does not guarantee gold-standard practice – results from a UK national survey
Dr Robert Field, Newcastle University Medical School, Dr James Fisher, Northumbria Healthcare NHS Foundation Trust, Dr Adam Gordon, Division of Rehabilitation and Ageing, University of Nottingham, Prof. Alasdair MacLullich, Edinburgh Delirium Research Group, Geriatric Medicine Unit, University of Edinburgh, Edinburgh, Dr Andrew Teodorczuk. School of Medical Education, Newcastle University, Newcastle Upon Tyne, Dr Daniel Davis, Institute of Public Health, University of Cambridge; University College London Hospitals NHS Foundation Trust, Prof Adrian Blundell, Division of Rehabilitation and Ageing, University of Nottingham

Aims & Hypothesis
To survey UK undergraduate medical teaching about delirium and outline how teaching is delivered. Furthermore, we sought to highlight, and share, examples of gold-standard delirium teaching. This is the first detailed analysis of undergraduate teaching about delirium in education and was supported by the British Geriatrics Society, European
Delirium Association and Royal College of Psychiatrists.

Background
Delirium is an acute, severe neuropsychiatric disturbance that remains poorly understood and under-recognised despite its high prevalence amongst older people. It is highly distressing for both patient and carers. Being both preventable and treatable, early recognition and adequate management is essential. A prior survey of junior doctors demonstrated a lack of basic knowledge about diagnosis and management of delirium. As yet, the extent to which delirium is taught at undergraduate level is unknown.

Methods
All UK undergraduate medical schools (31) were invited to complete an electronic questionnaire. Questions were developed following an iterative process amongst delirium experts from the fields of old-age psychiatry and geriatric medicine. Schools were asked to describe methods of delirium teaching and to provide learning outcomes related to delirium. Outcomes were mapped to the three overarching themes outlined in the Tomorrow’s Doctors guidance (2009) for undergraduate teaching (knowledge, skills and attitudes).

Results
77% of medical schools (24/31) responded. Delirium was widely taught (100%) and examined (96%), with teaching predominantly delivered by geriatricians and old-age psychiatrists. The most common method employed was clinical placement (92%), although some schools supported this with innovative methods including e-learning (38%), inter-professional learning (25%) and simulation (21%). Only two medical schools (8%) covered all three Tomorrow’s Doctors domains. Teaching focused on knowledge (75%) and skills (79%) with attitudes frequently overlooked (8%). Only 13% schools incorporated patient/public involvement in delirium teaching and 17% assessed impact of teaching sessions.

Conclusions
This study identified a widespread failure to address attitudes to delirium within undergraduate teaching. Given known negative attitudes of healthcare professionals towards patients with delirium, this is concerning. Future teaching interventions on delirium should address this teaching gap. Furthermore, a synthesis of clinical experience with multidisciplinary interaction and supportive technologies, such as simulation and e-learning, is advocated. Ultimately, this may equip tomorrow’s doctors to adequately recognise and manage the highly prevalent yet difficult area of delirium.

Audit cycle on the quality of request forms and the reports of Brain CT scans of the patients attending the Memory Clinic in Southend
Dr Kumari Galboda Liyanage, South Essex Partnership NHS Trust, DrAmit Sharma, South Essex Partnership NHS Trust, Dr Joshua Asubiaro, South Essex Partnership NHS Trust

Aims
1. To develop audit standards for; a) reporting Brain CT scans (by the radiologists) for the diagnosis of dementia b) information in the request forms of Brain CT scans (by the Memory nurses) 2. To improve the quality of Brain CT scan reports and request forms at the Memory service

Background
We have noticed that the CT brain scan reports we receive from our radiology colleagues are not always giving us the information we need to facilitate diagnosis of dementia. We were also not certain if we give adequate information on the request forms to facilitate their reporting. There is a vast variation in reporting and mostly the information is minimal. Newer CT Scanners could give more information on specific brain changes in dementia cutting down the cost and time delay in requesting MRI brain scans.

Methods
By consulting Old age psychiatrists in the service and Radiology consultant colleagues at Southend general hospital, and by literature search we formulated standards of information for the request forms and standards for reporting of brain CT scans for people presenting with memory impairment. We collected data from 40 consecutive CT brain scan reports and their request forms and analysed for the presence or absence of standards in 2013. After reviewing the results, we introduced an action plan including joint learning between Psychiatrists and Radiologists, introducing paper post on the request form giving the required information. We re-audited after a year by collecting data on 40 consecutive CT brain scan reports and their request forms in 2014.

Results
Standards for brain CT scans were reference to cortical atrophy including the degree and localization, ventricular enlargement, and white matter / vascular changes including the quantification or degree. Standards for request forms
were reference to cognitive impairment, presence or absence of vascular risk factors and probable or differential diagnoses. First audit showed unsatisfactory figures on both reporting and request forms on the standards. In the re-audit after a year, there was a remarkable improvement in brain CT reports including reference to cortical atrophy 45% vs 85%, localization 67% vs 91%, white matter changes 40% vs 65%.

Conclusions
This audit brought about a significant improvement to our memory service in facilitating diagnosis of dementia. Quality of brain CT scan reports in the diagnosis of dementia, can be improved by joint working/learning between two specialties.

23 Dementia- Compliance And Accuracy Of Diagnostic Assessment Tool Following Commission For Quality And Innovation (CQUIN) Recommendations
Mr Saad Ghaus, University of Birmingham, Dr Niall Fergusson, Heartlands Hospital, Prof. George Tadros, Heartlands Hospital

To audit the practice of CQUIN dementia assessment in patients aged 75 or over at Heartlands Hospital. I hypothesise that this is performed in less than 90% of cases. Elderly care represents a growing burden on the health system. Almost half of hospitalised elderly patients suffer from dementia or cognitive impairment, costing £17 billion annually. It has been suggested that dementia screening should be carried out in individuals over 75. Known diagnosis of dementia is undocumented in nearly one third of hospital admissions, according to the CQC. Lack of consideration for the enhanced care needs of these patients increases mortality. In order to improve hospital performance regarding dementia, the Department of Health (DoH) 2014/15 CQUIN initiative requires that trusts assess at least 90% of admitted individuals aged 75 and above for dementia. Data collection for the audit took place during two weeks in November 2014, using patient notes on two elderly medical wards and acute medical unit. Patient ID, gender, place of residence, date of admission and dementia status were recorded from the notes. Patient ID was entered onto the iCare electronic system to evaluate whether the CQUIN dementia diagnostic assessment (DDA) was carried out, and its finding was compared to the notes to determine accuracy. In cases where dementia was not mentioned in the notes, it was concluded that the patient did not have dementia, irrespective of the DDA finding. DDA finding could not be ascertained in patients who had been discharged or who were deceased, hence 17 such patients were discarded. Dementia CQUIN assessment was carried out in 89.8% of patients over 75 (total 59 patients). When the CQUIN finding was "Yes" (patient has dementia), this was accurate in 92.9% of cases. An answer of “No” was accurate in 82.4% of cases. 22.7% with a finding of “Don’t know” were shown to have dementia. There is a significant difference in accuracy of a CQUIN answer of “No” depending on whether patients are admitted from their own home, nursing homes or supervised accommodation (p=0.001). All other differences are non-significant. The audited wards are marginally below the DoH requirement of 90%. DDA is good at identifying dementia but not as effective in excluding dementia. Increased staff training is required to improve compliance and foster more careful assessment to eliminate false negatives. Wider reaudit of a longer timescale is required to cover.

24 Parity of Esteem in Practice? Audit of Physical Health Assessments for Community Patients accepted into Mental Health Services for Older People
Dr Amelia Gledhill, Birmingham Children's Hospital NHS Foundation Trust, Dr Pravir Sharma, Birmingham and Solihull Mental Health NHS Foundation Trust

Aims and hypothesis
The aim of the initial audit was to investigate whether physical health assessments were being carried out when new patients were referred to the Mental Health Services for Older People (MHSOP) service in the Birmingham and Solihull Mental Health Foundation NHS Trust (BSMHFT) North Hub. From discussions in the team it was suspected they were not, and a number of reasons for this were suggested by the staff members. The aim of the reaudit was therefore to take one of the suggestions as a prompt for intervention to see if rates improved. Background Physical health monitoring in the mental healthcare setting is an essential part of assessment and treatment, and an area which the Royal College of Psychiatrists and the NHS is promoting in the recent focus on Parity of Esteem. Additionally, BSMHFT use the Commissioning for Quality and Innovation payment framework to encourage physical healthcare monitoring. From speaking to the Service User Development Worker, it was clear that patients value this aspect of care. Therefore we undertook this audit to understand and attempt to address the barriers to achieving parity of esteem in our practice.

Methods
The initial audit in May 2013 reviewed all 87 new referrals into the BSMHFT North Hub’s Community MHSOP service for the month. Data were collected from the electronic records to see whether patients were having physical assessments
carried out to the standard required by the Trust. The results were then discussed with the team and a simplified paper version of the assessment was made available in the hope of improving assessment rates. The reaudit post intervention took place in February 2014 and reviewed the records of all 59 new patients that month. Results In May 2013, of the 87 new patients referred, 15 had a physical assessment carried out (16%). In the post intervention reaudit in February 2014, of the 59 new patients referred, 10 had a physical assessment carried out (17%).

Conclusions
It was interesting to see that there was little improvement in the number of physical health assessments performed despite the intervention. This may reflect issues raised by staff which are more challenging to change, and should be explored further: limited time and equipment resources; lack of confidence in carrying out assessments; concerns about physical monitoring affecting the therapeutic relationship; and most challenging of all, whether the paths of mental and physical health should cross at all.

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Cardiovascular monitoring of Cholinesterase Inhibitors
Dr Rachel Gore, Northern Deanery

Background
Changes to shared care arrangements for dementia drugs in Northumberland allowed GPs to take over prescribing Acetylcholinesterase inhibitors (ACHEIs) earlier. Feedback was obtained from clinicians on the implications. There was concern regarding cardiovascular monitoring of ACHEIs due to differences in individual practice and uncertainty regarding guidance. A survey was conducted to explore this issue.

Aims
1) To review the literature on cardiovascular effects of ACHEI. 2) To determine the current guidelines for cardiovascular monitoring of ACHEI, the current practice in Northumberland and adherence to existing guidelines.

Methods
A literature review was conducted in April 2013 and a clinician focus group held the same month. A questionnaire was designed to explore individual practice. 14 questionnaires were sent to senior medical staff in the local Old Age Psychiatry service in May 2013.

Results
Rates of cardiovascular adverse effects (CVAE) with ACHEIs are low. Rarely they may cause or unmask bradycardias. There are no national guidelines on cardiovascular monitoring of ACHEIs. 79% (11/14) responded to the survey. All clinicians thought there were guidelines on cardiovascular monitoring of ACHEIs. 46% referred to a published review article and 36% thought there was NICE guidance. 9/11 check a pulse before starting an ACHEI. 10/11 do an ECG, but 4/10 only do so if clinically indicated. 91% contact patients one month after starting an ACHEI. At this appointment 8/10 check pulse and 3/10 do a follow up ECG. Half of clinicians received some training in ECG training in their current post, but a quarter had received no training since university. 45% felt neither confident/unconfident or unconfident in ECG interpretation. 81% had first hand experience of CVAE of ACHEI. Of 24 CVAEs reported, the most common were bradycardia (29.1%) and 1st degree heart block (25%). 67% said that this experience made them more likely carry out physical checks or investigations.

Conclusions
ACHEI are relatively safe drugs and serious side effects are rare. There are no national guidelines regarding cardiovascular monitoring of ACHEIs. A clinician survey revealed that pulse checks and ECGs are often done before commencing the drug and during follow up, but these investigations have unclear value and ECG interpretation may be an issue. Prior clinical experience of adverse effects impacted on individual practice. There is a need for guidance based on these results to avoid unnecessary and costly investigations and for more effective use of clinical time.
Comparing the quality and profile of patients referred to Memory Services from Primary Care and Acute Hospitals
Dr Duncan Gray, Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Navdeep Jagra, Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Venkatesh Muthukrishnan, Tees, Esk and Wear Valleys NHS Foundation Trust

Aims
1. To examine quality of referrals being received by Memory Services. 2. To compare and contrast profile of patients being referred by primary care with that of patients being referred by Acute Hospitals including the Hospital Mental Health liaison team. Background The Memory Services at the Friarage Hospital in Northallerton have achieved excellent accreditation from the MSNAP. The Memory services were also receiving increasing number of referrals from Primary care as well as Acute Hospitals as a result of increased awareness. One of the key objectives of Memory services is to be able to complete assessment and give diagnosis on the same day, wherever possible. This relies on the referrer providing all the pre-assessment information.

Methods
45 patients were provided along with a copy of their referral proforma. We used the information to identify the referrals on the electronic case note system (PARIS) and to retrospectively review these against the proforma. Results We were able to collect data from 40 of the 45 referrals from PARIS. The remaining five patients had not attended the Memory clinic appointment. Of the 40 referrals examined, 33 referrals were from General practice, 1 referral from the Clinical decisions unit, 1 referral from the Care Home liaison team and 5 from the Acute Hospital mental health liaison team. The referrals were nearly equally split between males and females with 19 and 21 referrals respectively. 33 out of 45 referrals had screening bloods done. 32 of the referrals had evidence of a CT scan request. Only 29 had a list of current medication. Only one referral had all the information required from the referral proforma. This was a referral from Primary care. There was no noticeable difference in age profile between Primary Care and Acute Hospital referrals. The quality of referrals from Primary care was consistently better than quality of referral from Acute Hospitals.

Conclusions
It was interesting to note that a huge majority of referrals come from Primary care despite the fact that elderly people constitute nearly two third of acute hospital inpatients. The quality of referrals from Primary care, despite the time limitations was consistently better than referrals from Acute Hospitals. The above survey highlights the importance of the need to work with other healthcare professionals in improving early detection and making appropriate referrals to Memory services.

Dementia and Driving; an Audit
Dr Flora Greig, East London Foundation Trust

Aims and Hypothesis
To audit the documentation of patients’ driving status and subsequent advice given to them during their assessment by the Waltham Forest Memory Service. Following the audit recommendations would be made dependent on the results the clinic re-audited.

Background
Approximately 850000 people are currently living with dementia in the UK. Dementia impairs the ability of people to drive in a number of ways and a discussion around driving is an important component of any dementia assessment. People diagnosed with dementia are legally obliged to inform the Driving Vehicle Licence Authority (DVLA) of their diagnosis. The General Medical Council and Royal College of Psychiatrists have advised that it is the responsibility of doctors to advise when patients are unfit to drive and to recommend that they inform the DVLA. The Memory Services National Accreditation Programme provides guidelines and standards for memory services in the UK. It requires that ‘People who drive are informed of the necessity to report the diagnosis to the DVLA (or equivalent vehicle licensing authority)’.

Methods
New referrals to the memory clinic between 1st July and 31st of December 2012 were audited. The following criteria were set: 1. Driving status should be documented on the first assessment 2. For patients diagnosed with dementia, still driving, there should be documentation that they were advised to inform the DVLA 3. It should be documented whether the patient has or hasn’t informed the DVLA 4. There should be documentation of action taken by the team if the patient has not acted on the advice to inform the DVLA. The standard was set at 100% for all criteria. Results: The clinic had 138 new appointments between 1st July and 31st December 2012 of which 134 notes were reviewed. Driving status...
was documented in 20.9% of patients. 100% of patients with dementia were informed to tell the DVLA, but documentation regarding the outcome of this advice was below standard. Following the audit Assessment and Post Diagnostic Checklists were introduced. The audit was repeated between October and December 2013 when 43 sets of notes were reviewed. The number of patients with their driving status documented had improved to 46.21%. Information regarding informing the DVLA and the outcome of this remained below standard.

Conclusions
Discussions around diving during dementia assessments are often inadequate. The introduction of checklists to the process prompts discussion, improving this aspect of the assessment.

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MEWS Audit on Old Age Psychiatry Wards, Rochford Hospital
Dr Sri Gunanathan, SEPT Trust, DrFeena Sebastian, SEPT, Old Age Consultant

Background
Physical observations are done in hospitals to ensure any deterioration in patients is recognised early and treated by trained staff which is recommended by NICE guidelines. The modified early warning score (MEWS) is a multi-parameter physiological scoring system which is used to identify patients who are becoming ill early. It is a colour coded chart for documenting patients pulse rate, respiratory rate, saturations, temperature and blood pressure. Rochford hospital started using MEWS from 2013 in its new format with adaptation post NHQUIPP (Quality, Innovation, Productivity and Prevention) recommendations. Royal College of psychiatrists summarized a whole person care which discussed the importance of parity between mental and physical health care.

Aims
To assess the use of MEWS on old age psychiatric wards. We are looking to see if MEWS is being used appropriately and according to trust guidelines. -Survey is the second part looking at perception of user’s experience of MEWs.

Method
It is a retrospective data collection, 49 inpatients MEWS chart were accessed and analysed from 29/09/14 till 5/10/14 in the wards. For each patient 7 days observations were analysed X 49 (inpatients) = 343 observations analysed. Standards of the audit • All patients have full set of observations done and recorded on MEWS chart every day, • If observations not done, a reason to be recorded. • Check for missing parameters that are not recorded from bp, hr, rr, sats and temp. • All MEWs score is documented and correctly calculated. • If Mews is ≥2, there should be evidence of documentation of escalation in patient’s electronic notes (Mobius). Part 2- Survey Questionnaires were handed out to junior doctors, nurses and healthcare workers.

Results
Audit It was found that not every patient had their observations done every day. On average 3 sets of observation were done per patient per week. 89% had no records as to why MEWs was not done. 94% of MEWS were calculated correctly. All MEWS 2 ≥ had no documentation of escalation on mobius, however on discussion with nursing staff, they reassured me that they reviewed the MEWS but their documentation was poor. Survey All the nurses said they were trained in using MEWS however the doctors who receive calls from nurses felt they require prompting in order to get the MEWs scores.

Conclusions
MEWs is a useful tool, used effectively however it still requires regular training and further audits to improve the standard.
An Overview of New Referrals to Old Age Psychiatry Services in a Central City Catchment Area
Dr Joel Handley, Cefn Coed Hospital, Abertawe Bro Morgannwg University Health Board, Dr Falak Khattak, Cefn Coed Hospital, Abertawe Bro Morgannwg University Health Board, Dr Lionel Peter, Cefn Coed Hospital, Abertawe Bro Morgannwg University Health Board

Aims and hypothesis
To review and evaluate all new referrals to old age psychiatry services for a central city population of 12,000 individuals over the age of sixty five.

Background
Old age psychiatry covers a diverse group of patients with a variety of complex needs both psychological, social and medical. Appropriately evaluating this case load may help in the effective allocation of resources and also allow for comparison with similar services in comparable areas.

Methods
Using patient records we established the primary diagnosis for 103 new referrals between April and October 2014. Additional data collected included the source of referral, the patient’s age, whether any treatment was started and the level of follow up required.

Results
Out of 103 new referrals over a seven month period between April 2014 and October 2014, a total of 90 were from primary care and 13 were from secondary services. 10 were under the age of 65. The primary psychiatric diagnoses listed were as follows; 11 patients with depression, 3 with an anxiety disorder, 5 with mixed anxiety and depression, 3 with a psychotic episode, 2 with schizophrenia and one with bipolar disorder. A total of 67 patients presented with memory problems of which 18 were classed as having cognitive impairment but no diagnosis of dementia, 15 with mixed type dementia, 11 with vascular dementia, 4 with Alzheimer's Disease, one with Parkinson's disease dementia and 18 with a diagnosis of dementia otherwise unspecified. A further 9 patients were referred for symptoms of an organic cause and a further 4 had symptoms directly relating to a previous stroke. 7 patients did not attend any appointments and 9 were diagnosed with more than one psychiatric disorder. Following the first consultation 33 patients were started on a new medication. Overall 28 patients also required CPN input and 25 were discharged following their first appointment.

Conclusions
From this data it is apparent that 27% of new referrals required CPN input, 65% were for problems with memory and also that overall 32% required the introduction of a new medication. These findings may help in the more effective analysis of demand on local services and will also allow for the observation of any changes over time should this process be repeated. It would be useful to further compare this data with referrals from similar areas in order to make accurate comparisons and identify any notable variations.

Monitoring Physical Health: An Audit of Older People with Chronic Mental Illnesses
Dr Alexander Hartley, Devon Partnership NHS Trust, Dr Arun Devasahayam, Devon Partnership NHS Trust

Background
Physical health of patients with chronic mental illnesses on antipsychotics is often neglected. It is important to routinely monitor their physical health as antipsychotics can have a profound impact on numerous areas of physical health, especially diabetes, cardiovascular disease and stroke. There is significant evidence that people with mental illnesses have greater rates of morbidity and mortality from physical illnesses compared to the general population. The physical health should be monitored through the combination of blood tests, ECGs and physical observations such as weight and blood pressure checks.

Aims
To assess the robustness of physical health monitoring of patients on antipsychotics under the care of older people community mental health team in North Devon.

Method
Patient care records were searched to identify the patients on the CMHT case load who are on antipsychotic treatment between September 2013 and September 2014. Of the 39 patients records retrieved, 7 patients were excluded as they
were not actually on antipsychotic treatment. A further 16 patients were excluded due to their inpatient admission during the audit period as physical health assessment was part of the admission protocol. 16 patients were included in this audit. The audit tool was devised using the NICE Guideline CG178, Trust guidelines on physical health monitoring and Maudsley prescribing guidelines on monitoring requirements for those receiving antipsychotic therapy. Patients’ records were audited to check if their physical health were monitored at baseline, 6 months and annually.

Results
30% of patients had physical health checks at baseline. 20% did not have baseline blood tests. The most frequently missed investigation was Prolactin. Regarding annual monitoring, 64% of patients were monitored as per guidelines. 27% of patients did not have blood tests. Again, the most frequently missed investigation was prolactin.

Conclusions
Reasons for non-compliance to guidelines and protocols are likely to be multi-factorial. Lack of knowledge with regards to monitoring requirements might explain why some but not all investigations were undertaken. Educating nurses, junior doctors and Consultants will lead to better monitoring and ultimately help deliver safe and effective patient care. Patient-targeted strategies such as providing literature on the importance of physical health monitoring would also help. Routinely stating on clinic letters, when and what investigations are due could provide a useful reference tool for GPs.

Bed Utilisation for Old Age Psychiatry in West Lothian
Dr Chris Haxton, NHS Lothian, Dr Suzanne Roscrow, NHS Lothian

Aims and Hypothesis
This project aimed to review admissions to the old age psychiatry ward in West Lothian (ward 3) over 6 months, to assess whether any additional services could have prevented admissions, or facilitated earlier discharge.

Background
The occupation of hospital beds is an increasingly important issue within the NHS. Reducing the amount of time patients spend in hospital is a key priority for NHS Boards as shorter admissions are recognised as having better outcomes for patients. Psychiatric beds have been reduced significantly over the last decade, with overall numbers in Scotland reducing by 33%. Old Age Psychiatry throughout Scotland has had the largest reduction in beds. Within West Lothian, the number of beds on ward 3 has halved. This has put significant strain on the ward. This is compounded by the fact that it is very difficult to find other old age psychiatry beds locally.

Methods
All patients admitted 01/10/13 - 31/03/14 were identified. At 1-2 month intervals a panel would meet to discuss each admission. The panel consisted of a consultant in old age psychiatry, a charge nurse, and an ST5 doctor. Each patient’s notes were brought to the meeting and the circumstances leading to admission were discussed. The panel considered whether the admission could have been prevented if certain requirements were met. This may have involved hypothetical services or additional uses for existing services. The panel also discussed whether patients could have been discharged or transferred from the ward sooner.

Results
There were 38 admissions in this period
4 patients admitted were from outside West Lothian, and used a total of 165 bed/days on ward 3 before being transferred or discharged.
2 patients admitted were admitted first to another hospital outside West Lothian due to lack of beds. They used a total of 21 bed days in other hospitals before being transferred.
39 patients were discharged from the ward with a mean length of stay of 43.9 days (range 1-225)
13 were discharged home, 15 to NHS continuing care, and 6 to care homes. The remaining patients were either transferred to another hospital or died.
Two beds were occupied throughout this period by patients awaiting guardianship.

Conclusion
Increased liaison input to medical wards may benefit patients.
Several patients may have been transferred directly to continuing care
More input to care homes may reduce admissions
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An Audit of care plans sent to patients under Lead Professional Care (LPC).
Dr Oliver Hill, CNWL-K&C OPHA CMHT

Aims
To investigate whether patients under the care of an older adult Community Mental Health Team (CMHT) and under Lead Professional Care (LPC) were receiving a care plan.

Background
The government white paper ‘Equity and Excellence: Liberating the NHS’ emphasizes empowering patients through provision of information and greater choice and control. Their motto no decision about me without me places shared decision making at the heart of the NHS. In line with this all patients should receive a care plan outlining their treatment and treatment goals. This is a mandatory requirement for all patients under CPA but not under LPC. An audit was undertaken to determine whether patients with the CMHT under CPA were receiving a care plan and if not what the reason was for this.

Method
A randomized sample of electronic medical records of 35 patients currently under LPC was reviewed. The initial assessment letter to the GP was evaluated to ascertain whether a copy was sent to the patient. All correspondence was reviewed to identify whether the patient or carer was sent information on their treatment. Their notes were assessed to identify whether there was a reason for this. The time taken from initial assessment until the letter was sent to the GP was also reviewed and the findings collated.

Conclusions
The audit showed 52% of service users were receiving a copy of their care plan, and in 2 cases, no care plan was formulated. The most common reasons for not sending a care plan were because the content would upset/distress the patient or the patient lacked capacity to understand their treatment plan. The majority of the care plans were sent out within 10 days of a patient review, with 2 cases being greater than 3 months. The results were presented to the CMHT and a simple care plan letter was formulated to be sent to those patients not being included in correspondence with the GP. There will be a re-audit in February 2015.

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Is there a case for an outreach liaison team to nursing and residential homes in Barnet?
Dr Fawziya Huq, Barnet, Enfield and Haringey Mental Health Trust, Dr Fawziya Huq, Barnet, Enfield and Haringey Mental Health Trust, Dr Gareth Garrett, Barnet, Enfield and Haringey Mental Health Trust

Aims and Hypothesis
To examine referrals to Barnet Community Mental Health Team (CMHT) for older adults; specifically from nursing and residential homes. This would provide useful information to propose a liaison outreach team to these homes.

Background
Barnet has seen increasing growth in the population of those aged 65 years and over, over the last decade. Barnet has a significantly higher proportion of older adults compared with other London Boroughs. The older adults CMHT in Barnet is seeing nearly 2000 patients a year; a quarter of whom are residing in nursing and residential homes. Providing care for these patients can be costly and time inefficient for the CMHT.

Method
Computerised data on patients referred to Barnet CMHT for older adults were collected for an eleven month period using a retrospective design. The sample was divided into nursing home and residential home patients. The case notes of a 50% randomised sample of patients living in nursing and residential homes were examined to establish reasons for referral and the subsequent resources allocated.

Results
A total of 1911 referrals were made during the study period. Of these, 433 (23%) were made for patients residing in institutional care. The mean number of days spent on the caseload was 61 for patients living in institutional care. For the 50% randomised sample of patients in nursing and residential homes, the most common reasons for referral were behavioural and psychological symptoms of dementia (BPSD) (46%). Cognitive assessment was the next most common (22%), followed by low mood (13%). A significant proportion were discharged following one doctor review (53%). A community psychiatric nurse (CPN) was necessary to follow up 26% of patients. Of those patients presenting with BPSD,
Conclusions
There is a paucity of UK studies that investigate the cost effectiveness of specialist mental health teams working within nursing and residential homes. Our results show such teams are likely to require a doctor and CPN, and given the large amount of referrals received for BPSD, would also benefit from a psychologist or behavioural therapist. We propose a pilot study to examine the effect such a team may have on referrals to the CMHT in Barnet.

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Reviewing mental state on a dementia ward: Do the notes tell the story?
Dr Zoe Isaacson, Sussex Partnership Trust, Dr Ruckshana Azeez, Sussex Partnership Trust

Aims and hypothesis
We audited the daily documentation of mental state in the progress notes on our dementia ward to see if patients were having their psychiatric symptoms reviewed regularly enough. Our hypothesis was that although notes are written each day about the patients, the content of these notes tends to be practical rather than focused on mental health. This could lead to difficulty assessing mental state over time, especially in the dementia patient group where changes are often subtle.

Background
Our ward conducts weekly MDT reviews. We noted a problem was that each team member would have a different opinion of patient progress. The notes would often have no mention of key aspects of the mental state such as mood and so assessing whether medication changes were successful was reliant on oral hand over and subjective opinion. When care homes came to assess patients there was no clear record of psychiatric symptoms over time.

Method
We audited against the standard: Each aspect of mental state should be commented upon on at least 80% of the time. We based our audit tool on the standard psychiatric mental state examination. We audited the notes of all patients present on the ward during a one month period giving a total of 33 patients with a collective total of 410 days on the ward. We read each entry noting whether each aspect of mental state had been commented on.

Results
Results expressed as % of days documented: Behaviour 78% Mood 43% Thoughts/anxieties 33% Perceptions 26% cognition 18% Our standards were not met

Conclusion
The case notes did not give an adequate impression of a patients psychiatric symptoms.

Service Improvement
We carried out a multidisciplinary consultation over two weeks to design a new tool to be used for daily documentation and assessment of mental state. We trialled the tool and re audited using the same method and time period Using the tool we achieved over 80% compliance across the mental state categories. The qualitative benefits have been: Improved nursing input, upskilling and satisfaction; Monitoring the effects of medication easily; Improved assessment for placement; The ability to track patient progress easily over time and quickly respond to changes in mental state.

Conclusion
Our new tool for daily mental state review is now a permanent part of our patient documentation We believe that it has significant benefits for patients and enhances our MDT communications.
Audit Of Use Citalopram And ECG in Older Adult Community Patients
Dr Adnan Khan, Betsi Cadwaladar University Health Board, Dr Sarmistha Bhattacharyya, Betsi Cadwaladar University Health Board

Background
In Old Age Psychiatry, Citalopram is used as a common antidepressant for those over the age of 65 years. Citalopram, is a selective serotonin reuptake inhibitor (SSRI) indicated for the treatment of major depressive disorder, panic disorder, and obsessive compulsive disorder. MHRA introduced new guidelines in 2011 regarding use of Citalopram and Escitalopram. Citalopram and escitalopram are associated with dose-dependent QT interval prolongation and should not be used in those with: congenital long QT syndrome; known pre-existing QT interval prolongation; or in combination with other medicines that prolong the QT interval. ECG measurements should be considered for patients with cardiac disease, and electrolyte disturbances should be corrected before starting treatment. For citalopram, new restrictions on the maximum daily doses now apply: 40 mg for adults; 20 mg for patients older than 65 years; and 20 mg for those with hepatic impairment. For escitalopram, the maximum daily dose for patients older than 65 years is now reduced to 10 mg/day; other doses remain unchanged.

Aims of The audit
To look if best practice is being followed in community patients being treated in Secondary care in West Wrexham and over 65 years of age in the prescribing Citalopram and Escitalopram Standards 1. 100% of those over 65 being prescribed Citalopram are on doses of Citalopram 20mg once daily or less and for escitalopram 10mg once daily. 2. To see that ECG monitoring is done to look at QTC interval either at baseline or during course of treatment for 100% of patients Method Patients who are open to the Community Mental Health Team and on Citalopram were identified between January to March 2014 and a retrospective data collection was done and analysed to see how far the standards are met.

Results
Only 18 patients were identified of whom 3 were deceased hence data was collected for the 15 patients. None of the patients were prescribed with Escitalopram. 60% of patients had a dementia and rest were treated for depression. Guidelines and standards were followed in 93% patients as doses were 20mg or less. The sample size was very small. Conclusions It was highlighted that educating the multidisciplinary team on guidelines for Citalopram use and regularly reviewing patients on Citalopram may improve practice. Involvement of GPs and Pharmacy was essential to alert clinicians for timely review. No Financial sponsorship was received for the Audit.

The Care Homes Liaison Service in Cardiff and the Vale of Glamorgan (Wales) – Are we getting it right?
Dr Sugandha Kumar, Cardiff and Vale LHB, Dr Jeshoor Jebadurai Cardiff and Vale NHS Trust

Aims and hypothesis
The Care Home Liaison Service (CHLS) prevents break down of care home placement and subsequent hospital admission by providing psychiatric assessments, treatment and support within care homes. It improves the quality of care and management of difficult behaviours by providing training and education to the care home staff. This audit aims to identify the number of new assessments and follow up reviews undertaken by the CHLS in addition to breakdown of placements between August and October 2014.

Background
By 2015, there will be approximately 850,000 people living with dementia in the UK with approximately one third of this number residing in a care home. In Wales, the number of people with dementia is estimated to be 45,321. There are currently 67 dementia registered care homes in Cardiff and Vale of Glamorgan area of Wales. Numerous other care homes have residents with undiagnosed cognitive impairment, dementia or other mental health issues. Two thirds of all people living in care homes have dementia or cognitive impairment. It is estimated that 50% of all care home residents have a depressive disorder that warrants intervention. The CHLS is a primary care service which aims to provide comprehensive mental health assessment and follow up, staff training and education within care homes to prevent the breakdown of care home placement and avoid hospital admission. This service includes a consultant psychiatrist, speciality Doctor, specialist nurses, Dementia Care Advisor and Health Care Advisor. A more acute response is provided by the Community Response Enhanced Assessment Crisis and Treatment (REACT) team which is a separate service.

Methods
All individuals, seen by the Care Home Liaison Service (Cardiff and the Vale of Glamorgan LHB) between August 2014
and October 2014, were included in the audit. The number of new referrals, follow-ups, and placements that broke down were recorded. The main reasons for referral and sources of referral were explored.

Results
The total number of assessments and reviews was 220 of which 104 were new assessments and 116 were follow-up reviews. The main reason for referral was BPSD. The main source of referral was care home staff. 4 individuals were referred to REACT and 4 required psychiatric admission.

Conclusions
The CHLS is working well to manage the mental health issues of elderly residents in Care homes. Early diagnosis and prompt intervention with staff education and training have prevented hospital admission in most cases.

37 Intermediate Care Service for Dementia (ICSD): A specialist mental health service for people with behavioural and psychological symptoms of dementia in East Dorset
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Aims and Hypothesis
Evidence suggests that for people with dementia, hospitalisation can exacerbate their confusion, leading to further loss of independence and possibly admissions to residential homes (RH) and that an alternative may be preferable. The aims of the service are to prevent breakdown of care, avoid unnecessary hospitalisation or institutionalisation and facilitate smooth transition between places of care and timely discharge from hospital.

Background
In line with national and local strategy, supporting people outside hospitals, a restructuring of our local dementia services led to a 54% reduction in our organic assessment and treatment beds (71 beds to 33 beds) and the setting up of the Intermediate Care Service for Dementia (ICSD) in April 2013.

Method
ICSD: multidisciplinary team consisting of 12 qualified mental health nurses, 16 health care support workers, an occupational therapist and input from 3 consultant psychiatrists (1 WTE). The service provides intensive, tailored interventions up to six weeks in the patient’s home or RH, holding a budget to bridge delays in accessing care packages. Hours; daily from 7.30 am to 7.30 pm for patients with dementia in East Dorset already accessing the Trust’s secondary care services. Patients have access to a day hospital for ongoing assessment and for urgent respite to carers in crisis. The team is gatekeeper to the organic inpatient beds at Alderney hospital and facilitates discharges from these units.

Results (1st 12 months):
- 212/261 (81%) of referrals accepted.
- Discharge location:
  - Of those living at home: 55% stay at home, 12% moved to RH, 29% admitted to ward.
  - Of those living in RH: 64% remain in same RH, 19% moved to alternative RH, 16% admitted to ward.
- 18% patients referred admitted to organic ward.
- Overall original home/RH: 60%.

Patient and Carer satisfaction questionnaires: 47% rating the overall care as excellent, 27% as very good and 20% as good.

Conclusion
The ICSD team has had a positive impact in keeping people with dementia in crisis out of hospital and predominantly in their own care environment. Having the same psychiatrists providing input to both the ICSD team and organic wards, improves continuity of care and facilitates movement of patients between community and inpatient care. Patients and carers were highly satisfied with the service.
Clinical outcomes in non-institutionalised Alzheimer’s patients – Results from an 18-month observational study in the UK
Dr Alan Lenox-Smith, Lilly, Ms Catherine Reed, Lilly, UK, Mr Jeremie Lebrec, Lilly, Germany, Mr Mark Belger, Lilly, UK, Prof. Roy Jones, RICE, Bath

Background
Observational studies are important for collecting real world data to complement clinical trial results. We describe the decline in cognition and rates of institutionalisation and death of Alzheimer’s disease (AD) patients over 18 months, stratified by disease severity at baseline.

Methods
The GERAS study is a prospective, multicentre, non-interventional, cohort study in the UK. Patients presenting within the normal course of care who were ≥55 years, diagnosed with probable AD, not institutionalised and with an informal caregiver were stratified according to Mini Mental State Examination (MMSE) score as mild (26-21), moderate (20-15) or moderately severe/severe (14 or less) AD. Data collected included demographic characteristics, current medications, clinical measures of cognition, function and behaviour of the patient and resource use on both patient and caregiver. Change in MMSE score from baseline was analysed using repeated measures analysis.

Results
526 patients (200 mild, 180 moderate and 146 moderately severe/severe) from 24 centres across the UK were recruited. At 18 months, data was collected on 341 (64.8%) patients remaining in the study after 17.9% patients were institutionalised, 7.6% had died and 9.7% discontinued for other reasons. In the mild group 11% patients were institutionalised and 5% died; in the moderate group 19% were institutionalised and 7% died and in the moderately severe/severe group 27% were institutionalised and 12% died. The MMSE declined by 3.6 points in the mild AD patients, 3.5 points in the moderate AD patients and 4.7 points in the moderately severe/severe AD patients over 18 months. There was no significant difference in MMSE deterioration between severity levels (p=0.244). Of those patients with a completed MMSE at the end of the study, in the mild cohort 43% patients remained as mild, 37% had transitioned to moderate and 12% had become moderate severe/severe. In addition, 8% of mild patients had improved with a MMSE score of >26. In the moderate group, 6% had improved to mild, 53% remained as moderate and 41% had progressed to moderate severe/severe. In the moderately severe/severe group, only 2 patients improved to moderate with the remaining (97%) stayed as moderate severe/severe.

Summary
In this large observational study, overall mean cognition showed a linear deterioration over the 18 month period across all severity levels. Different patterns of institutionalisation and death were associated with AD severity.

Potential effect of amyloid imaging on diagnosis and intended management of patients with cognitive decline: Impact of appropriate use criterion.
Alan Lenox-Smith, Grazia Dell’Agnello, Michael J. Pontecorvo, Andrew Siderowf, Ming Lu, Craig Hunter, Anupa K. Arora, Mark A. Mintun. All the above are employed by Eli Lilly and Company or a wholly owned subsidiary, Indianapolis, IN, USA.

Background
Appropriate use criteria (AUC; Johnson et al, 2013), provide guidelines for selecting patients for whom amyloid PET could be useful. This study evaluated the impact of amyloid PET on diagnosis and intended management in patients likely to meet AUC.

Methods
We examined 229 cases from a completed study of florbetapir amyloid PET (FBP-PET) in patients either undergoing or recently completed a cognitive decline evaluation. In these cases, Alzheimer’s Disease (AD) was suspected and there was uncertainty (<85% confidence) in the clinical diagnosis. All cases received a provisional diagnosis, and an intended treatment/management plan prior to FBP-PET. Three month follow-up period information for 172 cases were also available to determine actual diagnosis and management post-FBP-PET. Based on the retrospective review of prescan diagnosis/demographics, cases were classified as likely meeting AUC (AUC-like) or not.

Results: 125/229 (55%) subjects were AUC-like. NonAUC cases included typical AD, Mild Cognitive Impairment (MCI) due to AD, Cognitive Decline without objective evidence of impairment (CD) and dementia or cognitive impairment with specific nonAD diagnosis (e.g., Fronto-Temporal Dementia). 59/125 (47%) AUC-like cases were amyloid positive (Aβ+). Among nonAUC cases, 29% (CD), 49% (MCI due to AD), 53% (non-AD) and 73% (typical AD) were Aβ+. Of 172 cases with...
follow-up information, diagnosis/management changed after FBP-PET in 58%/88% and 45%/77% of AUC-like and nonAUC, respectively.

**Conclusions**

FBP-PET altered diagnosis and management in patients selected according to AUC. Additionally, AUC exclude patients with a relatively high (typical AD) or low (CD) probability of Aβ+ scan in most cases. However, in two groups of patients classified as nonAUC by the strictest interpretation of the criteria the proportion of Aβ+ scans was close to chance. Importantly the actual changes in diagnosis and management after FBP-PET as recorded in clinical records were similar to the previously reported intended changes in all cases.

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**Prognostic Value of 18F-Florbetapir Scan: A 36-Month Follow Up Analysis Using ADNI Data**


**Background**

The Alzheimer's Disease Neuroimaging Initiative (ADNI) provides a unique opportunity to investigate the relationship between β-Amyloid neuropathology and patients’ long-term cognitive function change. We examined baseline 18F-florbetapir PET amyloid imaging status and 36-months change from baseline in cognitive performance in subjects with mild cognitive impairment (MCI).

**Method**

All ADNI subjects who underwent PET-imaging with 18F-florbetapir and had a clinical diagnosis of MCI at the visit closest to florbetapir imaging, were included. β-Amyloid deposition was measured by florbetapir standard uptake value ratio (SUVR), and dichotomized as Aβ+ (SUVR>1.1) or Aβ− (SUVR≤1.1). The change of cognitive scores including ADAS11, MMSE and CDR sum of boxes (CDR-SB) were evaluated every 6 months. Mixed-effect Model Repeated Measures (MMRM) was applied to detect the difference between Aβ+ and Aβ− subjects’ cognitive score change from baseline, adjusting for baseline age and cognitive scores. Clinically significant cognitive change (4 point decline on the ADAS 11) was also evaluated using a multivariate-logistic-regression-model with general estimating equation (GEE) to account for within-subjects correlation. Marginal Odds Ratio was used to evaluate the risk difference for a clinically significant cognitive change among Aβ+ participants vs. Aβ− participants. Results: Of 478 MCI-subjects who had at least one florbetapir scan, 153 had a cognitive evaluation at 36-month follow up. Of those, 79 were Aβ− and 74 Aβ+. At 36-month visit, the Aβ+ vs. Aβ− group score changed from baseline (LS means 4.03 vs. 0.26 for ADAS11; -2.61 vs.-0.40 for MMSE; 1.53 vs. -0.11 for CDR-SB [p< 0.0001 all comparisons]). GEE analysis on clinically significant cognitive change showed a marginal Odds Ratio=2.18 (95% CI: 1.47–3.21) for Aβ+ vs. Aβ− groups.

**Conclusion**

MCI subjects with higher β-Amyloid deposition, had greater deterioration in cognitive function over the 36-month follow up, while subjects with no β Amyloid accumulation tended to be stable on these measurements. This finding is consistent with previously published studies.

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**Pre-death grief in dementia carers: Does it exist in the Asian population?**

Dr Tau Ming Liew, Department of Geriatric Psychiatry, Institute of Mental Health, Singapore

**Aims & Hypothesis**

We explored the presence and the nature of pre-death grief (PDG) in a multi-ethnic Asian population using an established PDG scale – the Marwit-Meuser Caregiver Grief Inventory (MMCGI).

**Background**

PDG includes emotional burdens such as mourning for the psychologically absent patient and anticipating impending losses. In the western population, PDG is prevalent among dementia family carers. It burdens the carers and causes premature institutionalization. However, the expression of grief varies with culture. We cannot assume the same existence in the distinct Asian population.
Methods
Spouses or children of non-nursing home dementia patients were recruited from a tertiary hospital. They completed questionnaires containing demographic information and the following scales: MMCGI, Prolonged Grief scale (PG12), Zarit Burden Interview (ZBI) and Centre for Epidemiologic Studies Depression scale (CESD). Correlation between MMCGI and the other scales (along with their subscales) demonstrated construct validity. Cronbach’s alpha measured the internal consistency. Using one-sample T test, mean scores of MMCGI and its subscales were compared with those from the original United States (US) study. Variables selected from univariate linear regression (p < .075) were entered into multivariate regression to identify factors associated with MMCGI (p < .05). RESULTS We recruited 72 participants. As hypothesized, MMCGI correlated strongly with its own subscales of Personal Sacrifice Burden (PSB), Heartfelt Sadness & Longing (HSL), and Worry & Felt Isolation (WFI) (Spearman’s rho = .88 – .94); moderately with PG12, ZBI and CESD (rho = .69 – .79); and poorly with Finances subscale of ZBI and Positive Affect subscale of CESD (rho = .37 & -.33 respectively). Subscales of MMCGI correlated moderately with their related scales (PSB & ZBI; HSL & PG12; WFI & CESD) (rho = .72 – .76). Cronbach’s alpha for MMCGI and its subscales were .89 – .97. Only WFI was significantly different from that of the US (46.2 & 40.6 respectively; p < .001). In multivariate regression, factors associated with MMCGI were severe stage of dementia (p < .001) and carers with the following characteristics: Malay ethnic (p = .025), secondary or below education (p = .011) and spousal relationship (p = .021).

Conclusions
PDG could be validly and reliably measured in the Asian context using MMCGI. PDG in Asia and US seem more similar than dissimilar, suggesting the universality of emotions. However, the influence of culture is palpable – Asian carers show more worries and felt isolation; certain ethnicity experiences higher PDG. Other risk factors of PDG include carers of lower education, spousal relationship and advanced dementia patient.

42 Development of Decision Support Tool (DST) for Physical Frailty Unit (PFU) in Coventry and Warwickshire Partnership Trust (CWPT).
Dr Anna Lukaszewska, Coventry and Warwickshire Partnership Trust, Dr Rafi Arif, Coventry and Warwickshire Partnership Trust

Aims and hypothesis
We aim to assess the development of DST to aid the admission process to PFU.

Background
The Faculty of Old Age Psychiatry of the Royal College of Psychiatrists has recently revised the definition of ‘old age’ and criteria for appropriate services. The revised definition includes: people of any age with a primary dementia, people with mental disorder and physical illness or frailty which contribute(s) to, or complicate(s) the management of their mental illness. This may include people under 65; with psychological or social difficulties related to the ageing process, or end of life issues, or whose needs may be best met by a service for older people. This would normally include people over 70. CWPT has been in a transition to an age independent service based on identifying thresholds for physical health complexities since 17th July 2014. Existing functional ‘old age’ wards are being transformed into Physical Frailty Units (PFU).

Methods
A pilot tool audit to assess the nature and appropriateness of admissions to all psychiatric wards in the Trust took place in May 2014 before DST was introduced. Data was collected from notes and electronic data systems. A DST was developed following several Multidisciplinary Team discussions involving consultant psychiatrists, psychologists, matrons and nurses. DST is an innovative model.

Results
Audit revealed that physical comorbidity increased in complexity with age and there was a significant percentage that experienced physical complexity in age group 40-50 (males) and age group 50-60 (females). DST criteria involved: checking if physical health screening had been done prior to admission; whether patient has got one or more physical comorbidities that are currently unstable; and whether there are any other needs which could cause instability. We are planning to audit the process of admission to PFU against the criteria of DST in the next 3 months.

Conclusions
Physical Frailty Units will continue to be psychiatric units. However, it is expected that proportion of patients with complex physical needs will be larger at these units. Based on the findings of the recent audit, it is clear that age restricted services may not meet the needs of all patients especially with comorbid physical conditions and of younger age. DST will enable the process of safe admission to psychiatric units based on patients’ complex needs, not age alone.
Clinical audit cycle to review standards of lithium monitoring in Mental Health Services for Older People (MHSOP) in Northampton and South Northamptonshire and the utility of a lithium register.

Dr Aye Ma Lwin, Northamptonshire Healthcare Foundation Trust, Dr Jai Sinha, Langham Place Surgery, Northampton, Dr Jaiker Jani, Northamptonshire Foundation Trust

Aim
Clinical audit cycle to review standards of lithium monitoring in Mental Health Services for Older People (MHSOP) in Northampton and South Northamptonshire and the utility of a lithium register.

Background
Lithium is licensed for management of bipolar disorder and augmentation in treatment resistant depression. Its narrow therapeutic index dictates close monitoring. NICE (National Institute for Clinical Excellence) guidelines recommend monitoring of lithium levels every 3 months, and renal and thyroid function every 6 months.

Methods
Clinicians working in the MHSOP were requested to compile a list of patients who were on lithium treatment, and this was cross-referenced with data collected from case notes on the EPEX electronic system, and the electronic pathology laboratory results data base (ICE) at the Northampton General Hospital. Patients who were not under the care of the MHSOP were excluded. Demographic data, primary psychiatric diagnosis, and dates of blood tests for serum lithium levels, renal and thyroid function tests were collected. The first part of the audit cycle was completed in February 2013, and the second part in October 2014. The results of the audit were widely circulated to all clinicians, and following the initial audit a lithium register was set-up and maintained by a nominated medical staff. Results 92% of patients were monitored according to guidelines initially. The re-audit showed an improvement to 95%. 11% of patients had impaired renal function tests and 5% had impaired thyroid function tests.

Conclusion
The audit raised awareness of the clinical guidelines for lithium monitoring in this locality but fell short of the goal of 100% of patients being monitored. Prevalence of renal and thyroid impairment in the elderly underscores the importance of close monitoring. The development and maintenance of the lithium register provoked continued awareness of lithium monitoring, and greatly aided in identification of patients for the repeat audit cycle.

Delirium education program - A collaborative approach in Ayrshire & Arran

Dr Ajay Macharouthu, NHS Ayrshire & Arran, Dr Claire Copeland NHS Ayrshire & Arran

Aim
In September 2013 a collaborative, multidisciplinary team was formed from within Care of the Elderly and Elderly Mental Health Directorates to deliver the Delirium Pathway in NHS Ayrshire and Arran. Prior to this date there was no defined pathway for the identification and management of older people with delirium. Delirium is defined as an acute, fluctuating confusion that can occur on a background of dementia, if unrecognized is associated with a worsening of cognitive function, increased mortality, increased rate of institutionalization and increased length of stay. Local data would suggest 40-60% of people >65yrs are admitted with symptoms suggestive of delirium. An audit highlighted the lack of awareness of delirium and its management. An education program was created for all Healthcare Professionals prior to the roll out of the Delirium Pathway.

Methodology
To ensure consistency between trainers the course content and objectives were agreed. Traditional methods included access to LearnPro modules. There are twice monthly, Consultant lead, drop in sessions for all staff on both sites. Cases are used to facilitate the learning. The most successful modality has been the use of social media in particular the NHS A&A Delirium Facebook page. There are over 300 members. It is a closed group with no patient identifiable material allowed. There are posts about all aspects of delirium and dementia. These were also posted on Vine, Wordeo, Twitter, Scoopit and Google+.

Results
A local audit carried out since the introduction of the delirium pathway has shown encouraging results. There is an increased documentation of delirium in medical notes, medico legal paperwork (Adults With Incapacity) has improved. Over the past 10 months 241 Healthcare professionals have passed the LearnPro module on Adults with Incapacity. 94 people have passed the module on delirium. To date ~150 people have attended the Consultant lead drop in sessions.
An additional 140 referrals were made to our local Elderly Mental Health team suggesting increased awareness of delirium. The Older Persons Acute Care (OPAC) team a division of Health Improvement Scotland (HIS) rated our work very highly on a recent visit.

Conclusion
A change in culture is happening with the majority of healthcare professionals in NHS Ayrshire & Arran aware of delirium and will actively screen people for it. Also our training program supports us to ensure staff have the necessary knowledge and skills to meet the needs of people with delirium and dementia, their families and carers.

45 Frail older people pathway project, NHS Ayrshire & Arran
Dr Ajay Macharouthu, NHS Ayrshire & Arran, Ms Maryann McEwen, NHS Ayrshire & Arran, Dr Rowan Wallace, NHS Ayrshire & Arran

Background
Public consultations inform us that, given the option, people want to stay in their own homes for as long as possible, that prolonged hospital stays are not good for frail elderly patients, and that some admissions could be avoided if services and supports were available closer to people, in their own communities.

Aims and Hypothesis
A comprehensive, collaborative, integrated, multi-disciplinary team assessment in the Accident and Emergency (A&E) department results in improved care for elderly patients with the following outcomes • Avoiding inappropriate hospital admissions • Early identification and management of delirium/cognitive impairment. • Increase in Adults with Incapacity (AWI) assessments • Reducing A&E waiting times, mortality, institutionalization, psychotropic prescriptions and readmission rates • Improved patient and carer satisfaction.

Methodology
A multidisciplinary team (MDT) based in the A&E of Crosshouse Hospital, Kilmarnock, included a Consultant geriatrician, Elderly Mental Health (EMH) liaison psychiatry team, Pharmacist, Intermediate Care and Enablement Service (IC&ES) team with referral on to appropriate services depending on person’s needs. All patients over 65 years attending A&E are included with exceptions of patients with acute needs. After initial A&E triage, a comprehensive MDT assessment was followed by 4AT screening and medication reconciliation. Over 3000 patients have been involved in this study to date.

Results
Interim results show admissions have reduced significantly, with a good impact in reducing the waiting time for all age groups in A&E. Documented diagnosis of delirium has increased with 4AT screening. Patients, carers and staff report improved satisfaction with the service provided. More detailed results and analysis shall be available in the next few months.

Conclusions
Multidisciplinary integrated service for frail elderly people in A&E improves the patient journey and experience. Delirium/cognitive impairment is identified and treated earlier. Hospital admissions are significantly reduced with associated cost reduction.

46 An audit of the compliance of Malnutrition Screening
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Aims and hypothesis
The aim of this audit was to find out the compliance with the Malnutrition Universal Screening Tool (MUST) in the Old Age Psychiatry wards. Every patient who is admitted to a hospital should undergo this screening according to our trust policy and NICE guideline QS 24 published in 2012. Further screening depends on the findings at the admission. Our hypothesis was that the patients admitted in Old Age Psychiatry are not being monitored according to the MUST protocol and therefore the care is being compromised. This is particularly important in old age ward and dementia patients who have poor communication and multiple co-morbidities. Malnutrition can adversely affect their physical and mental health.
Background
The British Association for Parenteral and Enteral Nutrition’s Malnutrition Advisory Group launched the Malnutrition Universal Screening Tool (MUST) in 2003. It is a five-step screening tool to identify adults who are malnourished. Patients who are malnourished, stay in hospital for longer, are three times more likely to develop complications during admission and have a higher mortality rate. Report by Royal College of Physicians,(2002) found that 40% of patients admitted to hospital and 10% of patients cared for in the community are undernourished. It was a wake-up call to clinicians to take clinical nutrition seriously. Methods: It is a retrospective audit which considered all patients on a particular day in the two Old Age Psychiatry wards in the hospital. To collect this snapshot of the MUST screening, the audit was registered with clinical audit department and a data collection tool was designed.

Results
There were 37 patients, 24 males and 13 females with mean age of 80 years for males and 75 years for females. Only 29 patients underwent screening on admission. There were 24 patients identified who needed weekly screening, only 7 had this done every week. Three patients out five underwent dietary monitoring as needed with a further care plan and monitoring. Two patients needed dietician review. However just one got it.

Conclusions
Our conclusion is that there is poor compliance with MUST. This can have dire consequences for patients. Lack of awareness among doctors puts vulnerable patients at risk. We suggest wide circulation of the audit findings among staff. Re-audit at a later stage after ensuring staff awareness and training should be done. This should target a wider clinical area.

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The Delirium Recovery Programme: Pilot Study of Cognitive Enablement Following Hospital Admission
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Background
Delirium is common in frail older adults in hospital. Patients present to hospital with an acute confusional state or develop this during admission. Patients are assessed to identify and treat any intercurrent medical illness. Some recover physically but cognitively and functionally remain impaired and professionals are reluctant to discharge home due to safety concerns. Normally this group of patients wait in hospital for their confusional state to improve, and a proportion are discharged to residential care. A 21 day pathway was designed to provide cognitive enablement at home with 24 hour live in carer.

Methods
Patients with delirium who were medically stable for discharge were identified by consultant physician and psychiatrist. An individual care plan was produced by the occupational therapist after discussion with patient and family. The patients were then discharged onto a virtual ward with a 24 hour live in carer and reviewed at day 4 by OT and day 7 by OT and social worker. Day 10 patients attended ambulatory care for joint review of physical and mental health.

Results
20 patients have been discharged onto the DRP: all have improved functionally. 16 have remained at home; 4 have required residential home placement. All were given the opportunity to receive a shorter hospital stay and return to a familiar home environment much earlier in the course of their treatment. It is felt by the multidisciplinary team that 12 residential care placements have been avoided.

Conclusion
Highly supported early discharge from hospital for patients with delirium is effective and enables patients to regain cognitive function within a familiar environment. It is cost effective to provide short periods of 24 hour live-in care as patients experience a reduced hospital length of stay and reduced level of ongoing residential placement.
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit
Dr Craig Marsh, NHS Greater Glasgow and Clyde

There has been recent public attention and controversy surrounding the use of DNACPR policy in the United Kingdom, highlighted by the case brought to the court of appeal in England on the 17th June 2014 against Cambridge University Hospitals NHS Foundation Trust. This is particularly relevant in Old Age Psychiatry within the area of Dementia Inpatient Care, given poor outcomes in Resuscitation attempts. This audit set out to measure service compliance across an inpatient Old Age Organic ward with the current NHS Scotland Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy. A retrospective case note audit examined a number of criteria including: 1. Presence of DNACPR form. 2. Number of Copies of DNACPR form (if present). 3. Admission Length. 4. Nursing staff beliefs on DNACPR status. 5. If DNACPR present: a. Completed in past year b. Filed in front of the notes c. Decision ‘1’ (CPR unlikely to be successful due to....) d. Decision ‘2’ (The likely outcome of successful CPR would not be of overall benefit to the patient) e. Decision ‘3’ (CPR is not in accord with a valid advance healthcare directive/decision (living will) which is applicable to the current circumstances) f. Countersigned (Senior clinician) g. Review time frame h. Completion before/after admission i. Reviewed on Transfer 6. DNACPR decision in notes (documented). The results demonstrated that 30% of inpatients in an ‘organic’ old age ward had a DNACPR form in place. There was a large variation between individual Consultant practices, with some Consultants having 7% of patients under DNACPR verses 70% at another site, demonstrating no evidence on consensus of approach. Only 40% of patients notes had any reference to any discussion on resuscitation status being made. Where forms were present they were largely completed appropriately by the relevant team. The results were fed back to the relevant teams and changes recommended to current practice, and re-audit if planned. This raised a heated debate in the role of DNACPR in Old Age Dementia Care and our current local practices.

Frail Older Persons Pathway
Ms Maryann McEwen, NHS Ayrshire and Arran Dr Rowan Wallace, NHS Ayrshire and Arran, Mrs Lesley Herd, NHS Ayrshire and Arran, Dr Ajay Macharouthu, NHS Ayrshire and Arran, Mr Stuart Gaw, NHS Ayrshire and Arran, Mr Stuart Cardwell, NHS Ayrshire and Arran

The Frail Older Peoples Pathway (FOPP) is a unique pilot, the only one of its kind in Scotland, within the Emergency Department (ED) of University Hospital Crosshouse. The team screens all people attending the ED who are over 65 years of age and identify those with frailty using an index designed in NHS Ayrshire and Arran. Dementia is a key indicator of frailty. The team philosophy is ‘nothing about me without me’ and ensures relatives are also included in decision making, in keeping with the key themes of the Dementia Strategy 2013. Analysis of data over 10 days in 2012 uncovered a significant burden of frailty within University Hospital Crosshouse. Higher frailty meant longer length of stay and delays in senior medical and multidisciplinary review. People over 65 and those with a dementia diagnosis, represent the minority of ED attendances but are the majority of those admitted to hospital. The data demonstrated a clear need to reduce unplanned admissions and improve the flow of patients through the front door. There was an ‘admit then decide’ action within the hospital. We needed to design a system around the needs of frail old people. When frailty was indicated a Comprehensive Geriatric Assessment was then completed. The interdisciplinary team within ED included a Consultant Geriatrician, Elderly Mental Health Liaison Nurse, Pharmacist, Allied Health Professional from the Intermediate Care and Enablement Service (ICES) and an Advanced Nurse Practitioner. Patients received medical and mental health assessments, delirium screening (using 4AT), medicine reconciliation and functional screening. Appropriate patients were admitted direct to specialty beds, including step-down beds, or discharged home with ICES follow-up if required. Cognitive screening identified people with potentially undiagnosed dementia. Input from Mental Health Liaison ensured seamless referrals to the CMHTe or general hospital Mental Health Liaison Nurses for follow-up. The Mental Health Liaison Nurse and pharmacist worked closely to review and /or reduce psychoactive medications with input from the Liaison Psychiatrist if required. Any prescribed anti-dementia drugs were documented. Patients’ were actively identified for the delirium pathway if they were admitted to hospital. Results showed a reduction in admissions to hospital, alternatives to hospital admission increased, reduced length of stay, reduced waiting time in ED, improved flow for all patients within hospital and direct admission to speciality areas increased. Longer term data analysis revealed improved mortality rates and a reduction in readmission rates. Quantitative results have been positive.
Outcomes after self harm in older people: a five year follow-up study
Dr Caroline McGechaen, NHS Lothian, Dr Tracy Ryan, NHS Lothian, Dr Roger Smythe, NHS Lothian

Aims and Hypothesis
We feel that in older people, there are often psychosocial problems which can respond to intervention and that suicide attempts are not always representative of an underlying mental illness. We sought to examine outcomes following self harm in older people.

Background
Traditionally suicide rates in older people are thought to be higher than in younger age groups and self-harm is often considered to be more diagnostic of mental illness. This view contrasts with recent UK suicide data that show lower suicide rates in older people and our clinical experience.

Methods
Following Caldicott Guardian approval, electronic records were reviewed for all patients over the age of 65 presenting with self harm to a teaching hospital emergency department from 2007-8. Information was collected on demographic factors, method of self harm, psychiatric diagnosis and subsequent presentations with self harm in the following five years. Information on cause of death was obtained from public health records and linked securely to clinical history using the Community Health Index (CHI) number.

Results
99 patients over 65 years presented with self harm between January 2007 and December 2008, of which 72 patients met criteria for inclusion. The mean age was 74 (range 66 - 95) and female: male ratio was 3:2. Of the 72 presentations, 67 were poisoning and the remainder physical methods. 27 (38%) repeated self-harm in the following five-year period, 17 (63%) occurring within the first year. Affective disorder and harmful use of alcohol/ alcohol dependence were common diagnoses both in those who present with self harm and who go on to complete suicide. Many of those who presented after self harm were not felt to have a mental illness (n=15). 32 patients (44%) were dead at five year follow up. In six cases (8%) the cause of death was flagged as suicide, the majority of which were male.

Conclusion
The rate of completed suicide in this cohort was in keeping with previous research. Many of those who present after self harm are not felt to have a mental disorder and much of the neurosis in this cohort represents adjustment disorder to social stressors, life events or physical illness The results reinforce that being male, over the age of 65, with a history of self harm and depression or alcohol use are significant risk factors for completed suicide.

Integrated Care; what does it mean for Services for Older Adults with Mental Illness?
Dr Sujoy Mukherjee, West London MH NHS Trust, Dr Helen McCormack, Southern Health NHS Foundation Trust

Introduction
Across the UK there is a range of different emerging models of health and social care for Older Adults. In order to help positively influence the future, a survey was conducted in which Old Age Psychiatrists were asked for their views on Integrated Care for Older Adults with Mental Illness. A questionnaire was sent electronically and 74 responses were received. The number of responses was low, and not necessarily representative of all Old Age Psychiatrists’ views.

Key findings
Access to services is impeded by the complex and poorly understood service delivery system in which we are operating, where maintaining effective communication, professional expertise and adequate funding is highly challenging. There is agreement for a unified, patient centred approach to integrated care, with Old Age Psychiatrists working across general practice, elderly medicine, the local authority and secondary care. However, models of service delivery currently vary markedly across the UK. Factors influencing the success of service integration for older adults include stigma, levels of funding, inter-organisational communication, both personal and technological, and the lack of well documented evidence. The complex and time consuming process of organisational mergers and acquisitions seems to further divert resources from front line services, and distance the effect of integration from patient care. There is agreement that demonstrating success of service models is important, although there is lack of consensus about the most effective outcome measures to use.
Conclusion
There is strong support for jointly commissioned and provided services for older adults with mental illness, led by the needs of the individual and their carers and involving, at all stages, the full range of professionals with expertise in this field. Adequate funding and the establishment of a strong evidence base is vital to success.

Recommendations
We are recommending that the qualities and components of an effective integrated service is described in more detail, through detailed interviews with those who report that successful models in their area. This would be further informed by the use of a similar survey across a broader range of bodies, including other Royal Colleges, Local Authorities, and Commissioners. It is further recommended that a resource of national and international evidence be established, and that a network is created whereby Psychiatrists can readily access this evidence and support from colleagues across the UK.

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Assessing Adherence to an Antipsychotic Care Pathway: An Audit
Ms Mahum Naeem, St George's University of London, Dr David Lawley, Humber NHS Trust

Aims and Hypothesis
The quality of adherence to an antipsychotic care pathway was examined, for an older adult in patient unit in Humber NHS Foundation Trust (HFT). This also involved the examination of case notes for evidence of communication with patients and their General Practitioners about the need for on-going medical monitoring.

Background
There is comprehensive evidence to suggest that people with mental health problems have higher levels of physical morbidity, which may contribute to premature mortality, and that antipsychotic drugs may contribute to this. This has led to the development of good practice guidelines and care pathways, though it is unclear how well these are being adhered to. Older adults frequently have pre-existing medical co-morbidities, meaning that good medical care is essential.

Methods
The case notes of patients who were discharged from an older adult psychiatric inpatient unit in Hull, between November 2011 - January 2013, were examined retrospectively for evidence of adherence to an antipsychotic care pathway produced by the Humber NHS Foundation Trust (HFT) These guidelines stipulate assessment of a variety of physical health parameters and a range of blood tests. Case notes were also reviewed for any record of communication with the patient and GP about the need for continued health checks whilst on antipsychotic treatment.

Results
56 patients met the inclusion criteria, of which 40 case notes were examined. Weight, BMI, blood pressure, full blood count, thyroid function test and urea and electrolytes were all monitored in above 70% of patients. Compliance rates for the remaining parameters were as follows: Waist measurement (5%), blood lipids (40%), fasting plasma glucose/glycosylated haemoglobin (53%), ECG (53%) and serum prolactin (43%). Only 10% of case notes recorded evidence of a discussion between the clinician and patient about the need for physical health monitoring. In 60% of patients there was evidence of communication with the GP about the need to actively monitor these parameters.

Conclusion
The quality of adherence to an antipsychotic care pathway in the HFT clearly needs improvement. This is likely to reflect the national picture. Despite the availability of guidelines, implementation has been inconsistent. There is particular need for greater engagement with patients and more effective communication with GP’s. These shortcomings in care need to be addressed in order to reduce morbidity and mortality rates in this vulnerable patient group.
An Unusual Case of Familial Vascular Dementia

Dr Ejaz Nazir, South Staffordshire and Shropshire NHS Foundation Trust, Dr Ayesha Bangash, South Staffordshire and Shropshire NHS Foundation Trust

Introduction
Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leucoencephalopathy (also known as CADASIL) is an autosomal dominant condition mainly affecting the vasculature of the deep matter within the brain. It is caused by a mutation in the NOTCH 3 gene on chromosome 19. The progressive degeneration of the smooth muscle cells in blood vessels and consequently the reduction in blood supply to the brain can result in the symptoms experienced in CADASIL such as headaches, transient ischemic attacks and strokes. We present a case of a gentleman who presented with typical features of CADASIL.

Case Report
A 45 year old retired teacher presented to the Younger People with Dementia (YPwD) Service, Shropshire with progressive cognitive decline, functional impairment, and a significant change in his personality. He was also suffering from recurrent seizures, recurrent strokes and spastic paraparesis. The MRI scan of the brain showed multiple confluent white matter lesions of various sizes concentrated around the basal ganglia and periventricular white matter and the pons. A genetic blood test was positive for the NOTCH 3 gene. This condition was also diagnosed in his older brother after the family underwent genetic testing. A placement was found for him in a local nursing home where he is settled with continued specialist input from the multidisciplinary team i.e YPwD Service, general practitioner, neurologist, social services, physiotherapists, occupational therapists and speech therapists.

Conclusion
There is no cure for CADASIL and it is treated via secondary prevention. The mainstay treatment is to target and manage any risk factors for stroke and the psychiatric management is dependent upon the presentation. The European and NICE guidelines suggest that non-pharmacological methods such as behavioural and psychosocial therapies to manage symptoms should be tried first. Thus the importance of the multidisciplinary team working in close partnership for achieving the best possible outcome is highlighted.

Patient Centred Referral Pathway: Perspective of Younger People with Dementia Service in Shropshire

Dr Ejaz Nazir, Consultant Old Age Psychiatrist, South Staffordshire and Shropshire NHS FoundationTrust, Honorary Senior Lecturer at the University of Chester, Visiting Lecturer at Staffordshire University, Dr Ayesha Bangash, South Staffordshire and Shropshire NHS FoundationTrust

Background
A care pathway was devised by Dr Ejaz Nazir for Shropshire's Younger People with Dementia Service in 2009. This pathway was based on the “Integrated Pathway for Young Onset Dementia in the West Midlands” which had been introduced in 2006 by the West Midlands Early Onset Dementia Forum.

Aims
To evaluate the outcomes of the referral pathway as well as inform the development of the service. METHODOLOGY The referrals made to the service during January-December 2013 were recorded by the outreach nurse. RESULTS AND

Conclusions
During January-December 2013, 147 patients were referred to the service out of which 74 were males and 73 were females. 51 patients were in the 60-65 year age range. The majority of patients i.e 130 were referred by their General Practitioners. The remainder were referred by in-patient and out-patient mental health teams, social services, neurology teams and psychiatric liaison team . 21 patients were diagnosed with dementia out of which the majority (8) were diagnosed with Alzheimer's dementia. 5 were diagnosed with the frontal variant of Alzheimer's dementia, 4 were diagnosed with mixed dementia (Alzheimer's dementia and vascular dementia), 3 were diagnosed with alcohol-related dementia and 1 received a diagnosis of frontotemporal dementia. 107 patients were discharged from the service due to not receiving a dementia diagnosis. Due to inconclusive evidence 19 underwent neuropsychometric testing with follow-ups arranged within 6 months.

Recommendations
It was felt that the various aspects of the care pathway should be audited to help inform the service's development. The service will undergo re-evaluation in a year's time.
A qualitative research on mental health staffs' confidence and knowledge in assessing suicide risk in older adults: focus on suicide risk assessment using psychological formulations; screening tools and clinical judgement

Dr Victoria Nzekwe, Tees, Esk and Wear Valleys NHS Foundation Trust, Dr Sarah Dexter-Smith, Tees, Esk and Wear Valleys NHS Foundation Trust

Background
Although many patients are reluctant to seek and actively engage in mental health treatment, up to 75% of those who complete suicide have seen a primary care clinician in the previous 30 days (Luoma JB and Pearson 2002). Having a severe and enduring mental illness is a known risk factor for suicide, therefore an effective risk management and continuity of care is very important (NIMHE 2005).

Aims and Objectives
The aim of this study is to assess how able, confident and knowledgeable mental health nursing staff feel in assessing patients who are suicidal as this will ultimately affect outcome of care.

Methodology
The researcher employed a qualitative descriptive design for the research to allow the researcher to provide a description of staffs' responses. The sample consisted of 10 nursing staff specifically working with mentally unwell Older Persons. Inclusion criteria - Nursing staff with practical experience in looking after suicidal patients - More than 1 year experience in working with older people who have a mental illness - Participants must speak and read English fluently
Exclusion criteria - participants with less than 1 year’s experience working with older people who are mentally unwell, including agency staffs on the ward at the time of the study - more senior nurses who carry out more managerial than clinical work

Data collection entailed the researcher conducting an hour-long audio-taped semi-structured interview, which will be analysed by a qualitative content analysis. A written report indicating the various themes emerging from analysed data will be written up at the end of the study. Measures to validate transferability, dependability, confirmability and credibility will be set up in order to establish trustworthiness and rigour of the research.

Result and Discussion
Data is being currently analysed and will be detailed in the poster. The expectation is that the study will provide insight into the experience of nursing staff whilst caring for suicidal patients. This will also give nursing staff an opportunity to reflect on the care they provide for suicidal patients. The researcher hopes to make the following recommendations based on the outcome of the study: - increased training and education around caring for suicidal patients - more research into the roles of nursing staff in order to establish best practice - contribution to local and national policies on suicide prevention - set up a support system for staff who look after suicidal patients.

Re-Audit of Healthcare Professionals' Knowledge of the Mental Capacity Act (MCA)

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Background
The mental capacity act is an important piece of legislation that affects any medical and allied professional delivering care to patients. The MCA code of practice states that all healthcare professionals should have knowledge of the mental capacity act and be able to perform basic capacity assessments. An initial audit was conducted in 2012 using a questionnaire-based audit tool distributed to 50 staff members of varying grades at North Durham Tees, Esk and Wear Valleys NHS Foundation Trust. The audit cycle was completed with the same questionnaire redistributed to 35 similar ranges of staff within the same locality 8 months later, after some training around Mental Health Legislation was delivered to staffs across the Trust.

Aim
The aim of the re-audit was to identify areas of improvement in knowledge and confidence levels in staffs as regards application of the MCA.

Methods
The questionnaire used was based on the MCA code of practice, which combined both Likert and true/false type questions. This was distributed to varying types of health care professional including nurses, doctors, occupational therapists, psychologists, and social workers, medical and nursing students. Questionnaires were collated and data analyzed using Microsoft excel.
Results
Generally, the more experienced staff members remained more confident as in the initial audit but curiously not necessarily more knowledgeable about the MCA compared to less experienced staff. Confidence and knowledge about the MCA had improved in the more junior staff members in this re-audit. Discussion and implications: It appeared that the training regarding the MCA delivered across the Trust had a direct impact on especially the more junior staff members who performed better in terms of their confidence and knowledge in the re-audit. Conversely, the more experienced senior staff did not necessarily perform better on knowledge regarding the MCA even though their level of confidence would indicate otherwise. There still seemed to be a lack of confidence amongst staff with regards to complex issues like Power of Attorney; Advance Decisions and Conflict Resolution. It would be beneficial if training around Mental Health Legislation were made mandatory for all healthcare staff as requisite in the Mental Capacity Code of Practice. All staff should be encouraged to attend refresher courses in appropriate Mental Health Legislation every few years. Staff dealing with more complex decision making issues affecting patients should be required to attend necessary training to enable them do their jobs properly.

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Delirium and depression: Inter-relationship and overlap in elderly people
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Aim
The aim of this review was to examine the literature relevant to the overlap of delirium and depression; to describe the existing knowledge and generate ideas for further research. Background: Delirium and depression are complex neuropsychiatric syndromes that are common in the elderly and associated with a variety of poor healthcare outcomes. Accurate detection is key to providing optimal care for these conditions but is complicated by their considerable overlap; the exact nature and significance of which is unclear.

Methods
We conducted a systematic review of the literature relevant to delirium and mood disturbance in order to examine possible phenomenological, aetiological, pathophysiological, therapeutic and prognostic implications of reported overlap.

Results
A total of 31 articles were identified. Over 50% (n=17) addressed the relationship between depression and delirium, with fifteen reporting positive evidence that depression is a risk factor for delirium. Seven studies, with follow up periods ranging from two weeks to two years, found varying evidence that delirium may be a risk factor for depression. Four studies highlighted how delirium (especially hypoactive) is commonly misdiagnosed as depression in referrals to consultation-liaison psychiatry services. The remaining four studies addressed the overlap of depression and delirium and the presence of depressive symptoms as part of delirium. Affective disturbance is reported in 43-86% of episodes of delirium. Two studies have identified poorer prognosis in patients with so-called ‘overlap syndrome’ where features of both depression and delirium are evident.

Conclusions
There is significant overlap between delirium and depression that may have important implications for our understanding of these conditions as well as everyday clinical detection and management. Detailed longitudinal studies can further clarify the relationship. No financial sponsorship to declare. Published in The Lancet Psychiatry, August 11th 2014 (online).
A re-audit of discharge summaries from an old age psychiatry unit: completion of the audit cycle
Dr Dipen Patel, Leicestershire Partnership NHS Trust, Dr Hari Subramaniam, Leicestershire Partnership NHS Trust

Background
The discharge summary is a useful medical record used by all members of the multi-disciplinary team in the community which theoretically ensures continuity of care for service users following their transfer from ward to community. This audit evaluated discharge letters at a mental health unit in Leicester. Given no local or national guidelines specifically for psychiatric discharge letters were available, a consensus on standards was gained from 3 consultant psychiatrists resulting in a total of 16 criteria being identified. The content of 50 consecutive discharge summaries from 5 old age psychiatry wards were assessed against these 16 standards. Discharge summaries fell well below the standards expected in many areas. One-third of the discharge summaries did not provide any information to the GP regarding ongoing care plans. Only 1 in 3 discharge letters contained a past psychiatric history and details of investigation results. Only 1 in 4 letters documented a mental state examination and only 1 in 10 provided a patient’s current physical health state.

Methods
Given that poor continuity of care is associated with poorer outcomes, such as increased risk of re-admission, an action plan was implemented to improve standards. Each new cohort of junior doctors were provided with written guidance on minimum standards for discharge letters. 50 discharge letters from the same wards were re-audited against the same 16 standards the following year. Results The re-audit showed significant improvements in many of the standards. 88% (previously 62%) of letters provided information to GP regarding ongoing care plans. 78% (previously 34%) gave inpatient investigation results, 64% (previously 36%) gave a past psychiatry history and 72% (previously 44%) provided a past medical history. However, as in the previous audit, only 1 in 10 letters provided a mental state examination or physical examination findings.

Conclusions
Providing junior doctors with written guidance on psychiatric discharge letters significantly improved standards overall, although letters continued to lack information in areas such as mental state examination. A longer term solution is ongoing and involves amending the current discharge letter software so that specific prompts are present on screen. On a national level, work is underway on a joint online collaboration between the Royal Colleges of Psychiatrists, General Practitioners and Physicians with the aim of reaching a consensus on mental health discharge summaries. Once completed, these guidelines could then potentially be implemented at trust level nationwide in future.

Does screening for depression in older adults improve clinical outcome? A systematic review
Dr Claire Pocklington, The University of York, Dr Dean McMillan, The University of York, Dr Simon Gilbody, The University of York

Background
Depression in older adults is under-recognised and under-treated, despite its association with higher rates of morbidity and mortality, increased healthcare utilization and economic costs. Screening for depression could be a solution to improve rates of detection and avert poor consequences of failings in diagnosis. Screening for depression is a datable issue. Currently evidence regarding screening is lacking. The aim of this systematic review was to establish the clinical effectiveness of screening for depression in older adults.

Methods
Seven electronic databases, with unpublished and grey literature, were searched from inception to May 2014. Study design was limited to randomised controlled trials but there were no other limitations on search strategy. The population of interest was older adults who underwent depression screening. Results of screening for the intervention group directed treatment whereas results of screening for the control group did not influence treatment in anyway. The Cochrane Collaboration’s Tool for assessing the risk of bias was utilised. Meta-analysis of standardised mean difference in change on depression rating scale was performed.

Results
9482 records were identified with only 7 studies fulfilling inclusion and exclusion criteria. The seven studies amounted to 693 patients with an average age of 75.9 years. Four studies were based in secondary care whilst three were in primary care. The studies reported outcome measures at different follow-up time periods; therefore three separate meta-analyses were performed. Meta-analyses favoured the control group; findings however were only significant (p
Assessment of falls intervention in Old age Organic Inpatient(Dementia) wards --Comparison to Local trust Policy

Dr Girish Rao, Tees,Esk & Wear Valley Trust, Dr Martina Esisi, Monkwearmouth Hospital, Sunderland

The annual incidence of falls in people with dementia is 40-60%, twice the rate of the equivalent cognitively normal older population. They are less likely to make a satisfactory recovery from injury, five times more likely to be institutionalised and after fracture neck of femur have a 6 month mortality of 72% more than three times that of cognitively intact patients.

Aims of Audit
To assess the falls intervention done in Dementia patients admitted in Organic Inpatient ward. This will include all of the patients admitted as inpatient between 01/01/14 -31/03/14 as it will allow for comparison of the practice of the service against standards set out in the NTW Trust Policy: “Falls prevention/Risk Reduction & Management policy –NTW (0) 40.

The standards reviewed are as follows: To determine whether initial risk assessment tool documentation was carried out whilst as an inpatient as indicated in trust policy. To determine whether further risk assessment tool documentation on monthly basis was carried out as indicated by trust policy. To determine whether key recommendation from falls risk assessment tool were met.

Methods
Retrospective audit registered with the audit department, it did not require Caldicott approval. All Patients admitted to Inpatient organic wards between period of 01/01/14 -31/03/2014 were identified. Electronic notes for falls risk assessment tool were manually checked. Further evaluation was done from scrutinising progress notes if evidence for recommendation set were met. Once all the possible patients were identified using the means described above then data collection tool was used to collect relevant information pertaining to the standards in this audit. Following data collection the information was inputted onto an Excel spreadsheet.

Results
20 patients were admitted to the ward in the designated time period. 19 patients were included( 1 patient was excluded due to short stay) All the patients admitted were >65 yrs of age. 10 patients were female (53%) and 9 patients were male (47%). Initial risk assessment documentation was done in 90% patients

Further Risk assessment
review on monthly basis as carried out in 32% patients as per trust policy. Recommendation were carried out:Combination of Physiotherapy & OT assessment in 74 % patients & Pharmacy review in 26% patients

Conclusion
Despite the small numbers of patients included in the audit there are areas that can improve patient safety and awareness of the need for regular review of falls risk assessment tool.

This is Me: personalised care of the elderly in an acute hospital setting

Dr Mary Renton, Heart of England Foundation Trust, Birmingham and Solihull Mental Health Foundation Trust, Prof. George Tadros, Heart of England Foundation Trust, Birmingham and Solihull Mental Health Foundation Trust, University of Warwick, University of Chester

Aim
Audit investigation of personalised care of the elderly in an acute hospital. Background: In the UK there are >800,000 dementia sufferers, occupying up to ¼ of acute hospital beds. Rapid assessment interface and discharge (RAID) provides liaison psychiatric services at Heartlands Hospital, Birmingham. Many RAID referrals are for challenging behaviour in dementia. Data shows dissatisfaction with the quality of dementia care in hospitals in 77% of carers. The Royal College of Nurses dementia guideline recommends person-centered care using ‘This is Me’, a personalised care proforma. Supporting discharge one week earlier for patients with dementia could save £80million/year. Personalised care can reduce behaviour disturbance, antipsychotic use and delayed discharge.

Methods
A case-note review assessed personalised information documentation for patients ≥75 on three wards: Vascular & Thoracic (V&T), Trauma & Orthopaedic (T&O) and Elderly care. An anonymous staff questionnaire recorded views on the provision of dementia care.
Results
Case-notes reviewed n=46 (Elderly n=22, T&O n=19, V&T n=5), with documented confusion/dementia in 13/46 (28.3%). There were 0/46 (0%) ‘This is Me’ forms and no available ward copies. There was 1/46 (2.2%) personalised care proforma, completed prior to admission. In remaining notes, an equivalent documentation was not recorded, 0/45 (0%). Partial aspects of personal information were recorded in: Surgical inpatient pathway 2/24 (8.3%) and Inpatient transfer sheet 7/45 (15.6%). Staff questionnaire n=56 (Elderly n=17, T&O n=31, V&T n=8) showed 78.6% are feel confident with dementia care and 44.6% have specific training. 51.8% report a system to alert staff to a dementia diagnosis and 66.1% are aware of RAID support. 46.4% of staff are not confident managing challenging behaviour and 60.7% feel inadequately trained. 25.0% of staff are aware of local training strategies. 19.6% are aware of their Senior Clinical Lead for dementia and 7.1% reported a designated ward champion. 55.4% have not heard of ‘This is Me’. 94.6% would like training in personalised dementia care.

Conclusions
We found limited evidence of personalised care provision. This is in keeping with the National Audit of Dementia that showed

62 Clinical case reviews – Significance of Dopamine Transporter visualization using (DaT-SPECT) brain imaging to assist the diagnosis of Lewy Body Dementia
Dr Mohammad Saidi, Sheffield Health and Social Care, Dr Velusamy Sivakumar, Sheffield Health and Social Care

Background
Dementia with Lewy Bodies (DLB) accounts for around 4% of all recorded dementia. There is good evidence that this condition is under-diagnosed. It is often misdiagnosed as Alzheimer's disease (AD). Based on post-mortem studies, DLB may represent as much as 10% of all dementia. The consensus clinical criteria have 80 – 90% specificity but the sensitivity is quite low to the extent that in some studies it is even below 30%. In the UK, NICE guidelines recommend the use of DaTSCAN to establish the diagnosis of DLB.

Objective
1. To review clinical utility of SPECT with dopaminergic presynaptic ligand to differentiate between AD and LBD by use of Iodine-123-radio labelled. 2. To present 2 clinical summaries where DaTSCAN has been employed as a diagnostic tool with some surprising outcomes.

Methodology
This reviews the usefulness of DaTSCAN in clinical practice. Two case reports demonstrate how it helped to differentiate the diagnosis. One of them presented with visual hallucinations in the background of recurrent infective exacerbation of Chronic Obstructive Pulmonary Disease. Initially, the hallucinations were thought to be related to sub-acute delirium. The second patient presented with visual hallucinations and persecutory delusion for a year for which there was a consideration of antipsychotic treatment in the primary care. There was subsequent development of gradual cognitive decline and unilateral resting hand tremor. These two cases demonstrate the clinical relevance of DaTSCAN in the differential diagnosis and plan the appropriate management.

Conclusion
We have reviewed the recent literature to support our conclusions with regard to these two cases. We highlight the importance of accurate diagnosis in the clinical setting and the helpful aspects of DaTSCAN as a diagnostic investigation for patients who initially presented with varied psychopathology. DaTSCAN aided the early confirmation of the diagnosis. Both the patients tolerated the IV ligand lofultane with no adverse effects.
Osteoporosis: assessing the risk of fragility fracture in men over the age of 75 and women over the age 65 using NICE short clinical guidelines

Dr Tania Saour, Lakeside Hospital/West London Mental Health Trust

Aims and hypothesis
To determine if NICE guidelines were being followed on Meridian Ward, Hammersmith & Fulham Mental Health Unit for assessing the risk of osteoporosis in both men aged over 75 and women aged over 65. Guidelines include checking Vitamin D levels, Bone profile and by carrying out a DEXA scan.

Background
Osteoporosis results in an increase in bone fragility and this in increases the risk of fractures. Fractures can result in reduced mobility in the elderly. Women aged over 65 and men aged over 75 are at increased risk of osteoporosis. This seems to be due to reduced levels of oestrogen in women following the menopause and reduced testosterone in men causing reduced bone mineral density. Studies have shown higher rates of annual bone loss among antidepressant users and about 4% to 5% lower bone mineral density. This increases the likely hood of fractures. There is a well-established link between the use of antipsychotics, falls and fractures due to increased prolactin levels. Methods Males over the age of 75 and females over the age of 65 were selected to take part. I used both RIO computer system and cross checked with the pathology laboratory to see whether the selected patients have had a vitamin D and bone profile check since their admission. Using both RIO computer systems and speaking to the DEXA scanning department at St Marys I was able to identify whether these patients had a DEXA scan since the date of admission, and if not whether they have had a DEXA scan requested.

Results
In this audit 11 patients out of 16 reached the criteria to take part. Included are 9 female patients 2 male patients The results showed that targets were not being met in majority of cases. We found Vitamin D levels as low as 32.5. This patient went on to have a DEXA scan which confirmed osteoporosis of the hip and spine. He was successfully treated. Conclusion Investigating and preventing osteoporosis is very important in reducing long term disability and maintaining mobility in the elderly. Patients may be on a large number of psychiatric medications which could increase their risk of osteoporosis further. I devised a poster which was then placed on the wards and in several of the doctors offices. This informed nurses and doctors that patients will require a vitamin D, and bone profile check, along with a DEXA scan.

Lithium initiation and monitoring in Poole

Dr Abhishek Shastri, Dorset HealthCare University NHS Foundation Trust, Dr Sunil Sinha, Dorset HealthCare University NHS Foundation Trust

Aims and hypothesis
To measure current practice of Lithium prescribing and monitoring of Lithium therapy. Lithium is known to have a narrow therapeutic/toxicity ratio and initiation of lithium requires specialist input. Furthermore, lithium is associated with side effects effecting renal function and can lead to lithium toxicity if not monitored effectively. This audit studies whether standards are met for initiation and subsequent maintenance of lithium therapy.

Background
The Prescribing Observatory for Mental Health (POMH-UK) have suggested guidelines for management of lithium therapy (Topic 7d). These include completion of the following tests before initiation of treatment: Urea and electrolytes including creatinine; thyroid function tests and weight or body mass index or waist circumference. Furthermore, during maintenance treatment: serum lithium levels must be measured every 3 months; other blood tests every 6 months and weight during the last year must be recorded. Other guidelines include an electrocardiogram (ECG); documentation of evidence of clinical assessment for side effects; that service user is informed about side effects, risk factors and signs and symptoms of lithium toxicity; national patient safety lithium initiation pack is given.

Methods
To review all patients in Poole Community Mental Health Team (CMHT) – Older Peoples Mental Health Services who were either commenced on Lithium or those who are on maintenance treatment. This involved collecting data in July 2013 using electronic clinical records system. No new initiation was done and 7 service users were on maintenance therapy. Following this, recommendations were made which included discussion at weekly multi-disciplinary meeting and identification of lead nurse from within the CMHT who will help the clinician in lithium monitoring. A further cycle of data collection in August 2014 included 2 new initiation and 9 service users on maintenance treatment. Results: In
the first cycle of data collection, the 4 blood tests domains showed 100% compliance and 70-85% compliance was seen in ECG, weight monitoring and clinical assessment documentation. Re-audit showed 100% compliance being observed in 8 out of the 10 domains mentioned above and 80-91% compliance was achieved in weight monitoring and clinical documentation for toxicity assessment.

Conclusions
The audit shows improvement in management of lithium prescribing and maintenance which shall benefit service users. Furthermore, it has aided in improving clinical care and good medical practice by helping reduce side effects or toxicity of lithium. Future plans include setting up of lithium clinic alongside annual psychoses physical health checks.

65 Evaluation of a New Specialist Home Treatment Team for Older Adults in The Belfast Health and Social Care Trust
Dr Chris Southwell, Belfast Health and Social Care Trust, Dr Caroline Donnelly, Belfast Health and Social Care Trust, Dr Elaine Boyd, Belfast Health and Social Care Trust

Aims
The aim of our project was to evaluate the home treatment team service for older adults in the Belfast Trust. Information was gathered to look at the number and type of referrals to the service over a period of 18 months and to assess the impact of the service on admissions to the acute functional inpatient unit. A breakdown of care delivered to patients was also derived from the information.

Background
The Belfast Home-treatment team was established in 2005 and was the first of its kind in Northern Ireland. The Team covers the Greater Belfast Area with a population of 333,000 including an estimated 55,000 aged over 65. In April 2013 the Home Treatment Team for Older People was established consisting of a 0.7 FTE Consultant Old Age Psychiatrist, Band 7 nurse and a 0.5 FTE Senior Trainee in Psychiatry of Old Age. At present the team do not deal exclusively with older adults and other members of the Home treatment team are involved in managing the older adult caseload.

Methods
A retrospective case-note survey of all referrals to the psychiatry of old age home treatment team over a period of 18 months (April 2013 to Oct 2014) was carried out. Information on source of referral, demography, diagnosis, comorbidities and length of stay with Home treatment was gathered. A review of current literature on specialist home treatment services for older adults was also carried out.

Results
During the 18 month period (April 2013 – October 2014) the service received approximately 215 referrals. Patients were referred from a variety of sources and primarily with affective disorders. On reviewing the admission numbers to the acute functional old age ward we can see an approximate reduction of 50% in admissions with an associated reduction in bed days of those admitted to the inpatient unit. Conclusion: Since setting up the service in April 2013 there has been a steady increase in referral rates and an associated reduction in admissions to the inpatient unit. Our service also helps to address the growing concerns regarding age discrimination in health services. The benefits of having a specialist service within an established service is that it gives members of the team an opportunity to increase their knowledge and experience in dealing with older adults with mental illness, which they previously may not have had.

66 The use of the Addenbrooke's Cognitive Examination in a community memory clinic
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Aim
To Assess the usefulness of the ACE-R (Addenbrooke's Cognitive Examination – revised) in a community memory clinic. The Addenbrooke’s Cognitive Examination (ACE; Mathuranath et al., 2000) was developed to provide a brief test sensitive to the early stages of dementia and, at a later stage, its revised version was validated with different diagnoses (Mioshi et al., 2006). Mioshi et al. (2006) found that a cut-off score of 82 is 100 times more likely to come from a patient with dementia than one without. There is a lack of studies in the literature with larger samples reporting the use of the ACE-R in a community memory clinic. Two-hundred and six consecutive patients attending a community memory clinic based in Cynon Valley Hospital, South Wales between 2010 and 2012 were examined retrospectively for three parameters: clinical diagnosis, ACE-R results, and radiological brain scan findings. VaD, or suspect FTD. We have tested the ACE-R diagnostic accuracy against the clinical diagnostic standard criteria by calculating the diagnostic odds ratio.
(OR), 95% confidence interval, sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), and likelihood ratio (LR+). All p-values were calculated using the two-tailed Fisher Exact test.

Results
The most common diagnoses were AD (37%), vascular dementia (22%), and mixed dementia (14%) with an average duration of cognitive impairment from onset of reported symptoms of 28 months (SD = 15.1). With a cut-off score for diagnosing dementia of 82, the overall accuracy of the ACE-R was 61%, sensitivity of 80%, specificity of 71%, PPV of 56%, and NPV of 51%. These results differ from the original work of Mathuranath et al. (2000). The authors reported that at a cut-off score of 83, they had an optimal sensitivity (82%) and specificity (96%), and maintained a reasonably high PPV and NPV at different prevalence rates of dementia. However, the original paper was administered to a smaller, younger group of patients whereas this study reflects clinical practice in that there was no selection of patients by disease category, no application of exclusion criteria, and the fact that all patients had at least a complaint of impaired cognition (usually of memory) hence their referral.

Conclusion
The authors confirm that the ACE-R is a useful test to use in a community memory clinic as it is practical and simple to use. Conflict of interest None.

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Do patients with Young onset Alzheimer’s disease deteriorate faster than those with Late onset Alzheimer’s disease?
A review of the literature
Dr Karen Stanley, North Essex Partnership NHS Foundation Trust, Dr Zuzana Walker, University College London

Background
Young onset Alzheimer’s disease (YOAD; onset before 65 years of age) is thought to have a more rapid course and increased rate of progression compared to late onset Alzheimer’s disease (LOAD). This assumption appears partly due to important clinical, structural, neuropathological and neurochemical differences suggesting YOAD is a separate entity to LOAD. The aim in this review was to systematically identify and examine appropriate studies comparing rate of cognitive decline between patients with YOAD and patients with LOAD.

Method
A computer-based literature search was initially undertaken, followed by citation tracking and search of related articles. Primary research studies specifically focussed on the rate of cognitive decline between people with YOAD and LOAD were included. Studies were described, critically analysed, presented and discussed in the review.

Results
Four studies were included, of which 3 were longitudinal and 1 was a case control study. Three of the included studies found a faster rate of decline in patients with YOAD, and 1 found no difference in rate of decline between the two groups.

Conclusions
The findings of the review are mixed and conflicting, and limited by the heterogeneity of the included studies. There is a need for future research to design systematic studies that include sufficient sample sizes and follow up periods, and control for possible confounding factors such as education level, baseline cognitive impairment, and vascular risk factors. This will help to validate the findings so far and improve our understanding of the rate of cognitive decline in people with YOAD and LOAD.
A Completed Audit Cycle into use of Standardised Early Warning Scores in Acute Old Age Psychiatry Wards
Dr Lucy Stirland, NHS Lothian, Dr Chris O'Shea, NHS Fife, Dr Alex McLean, NHS Lothian, Dr Sara Broom, NHS Lothian

Introduction
Patients in acute Old Age Psychiatry wards often have medical co-morbidities and are at risk of physical deterioration. The Standardised Early Warning Score (SEWS) system is a tool for monitoring changes in observation parameters and aids detection of clinical deterioration. It is promoted by the Scottish Patient Safety Programme. We drew on results of a 2010-2011 audit in the same department which led to the SEWS system being introduced across the Royal Edinburgh Hospital’s Old Age services. We are now presenting the completed audit cycle following our intervention.

Aims
We aimed to examine the following before and after intervention: i) Compliance with the SEWS policy, both on admission and when patients became medically unwell; ii) Communication of this information with junior doctors and documentation of these discussions. The standard in all areas was 100% compliance.

Methods
We carried out a cross-sectional study of current inpatients’ notes on two wards using a standardised assessment tool in October 2013. Notes were examined on set criteria relating to the aims. Following the first round of audit, we designed and implemented interactive educational workshops for nursing staff as our primary intervention. 76 staff attended. Additionally the old TPR observation charts were removed from all wards. We re-audited in October 2014, on the same wards as examined in the first round. Results 44 patients’ notes were studied in the first round, and 50 in the second. In the first round, despite 82% of patients having a partial set of observations, none had a full set of observations documented on a SEWS chart within 4 hours of admission. This rose to 43% in the second round. In the first round, there were 121 incidents where nurses suspected a patient had become medically unwell and 90 incidents in the second. Of these, 31% had a full set of observations taken in the first round, rising to 42% in the re-audit. In the first round, 17% of patients had observations recorded on a SEWS chart with a score correctly calculated, and this rose to 39% following our intervention. In the second round 96% of patients’ notes contained SEWS charts.

Conclusions
Following the completion of this audit cycle the appropriate use of SEWS charts has improved but their use is still below national standards. We have discussed this with nursing management and aim to further the project with additional interventions.

Service Evaluation of Single Point of Referral System for Older Adult Patients with Mental Health Needs in Dudley
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Aim
To evaluate Single Point of Referral (SPOR) system operating for Older Adults with mental health needs in Dudley.

Background
Single Point of Referral (SPOR) for Older Adults with mental health needs was introduced in Dudley in November 2013 to enable patients to have access to the appropriate services quickly and effectively. The Single Point of Referral System for Older Adults with mental health needs in Dudley operates from 9 am to 5 pm during weekdays. All the out of hours referrals are dealt by the Crisis Resolution Team. During weekdays, SPOR have a duty system (nurse led) wherein the person who is on duty deals with urgent referrals. Telephone advices and signposting to appropriate services are also part of their responsibility. All the routine referrals for Community Mental Health Teams are discussed in the multi disciplinary team meetings and allocated to the relevant professionals. Prior to the introduction of SPOR all the referrals were sent to the respective area Consultant for allocation and discussion in the multi disciplinary team.

Method
Retrospective analysis of records of both routine and urgent referrals to the service between the months of May to July 2014 was carried out. This data was compared with the figures during May –July 2013 when SPOR was not introduced. The variables analysed included the time taken to allocate cases and waiting period before patients gets seen. We also looked at the team members who carried out the initial assessment to see if there was any change in trend with the introduction of SPOR.
## Results

Prior to the introduction of SPOR, all the referrals were allocated within 3 days and the medics carried out the initial assessment for all the patients referred to the service. With the introduction of SPOR, only 69% of the cases were allocated within 3 days and only 83% of the initial assessments were carried out by medics. Around 70-80% of the patients were seen within 4 weeks irrespective of the type of service.

## Conclusion

Analysis of the above data does not demonstrate a significant difference between the two services, with regards to the time frame of seeing patients. It also appears that with the new system, more time is taken to allocate routine referrals. Our study highlights the need for more comprehensive analysis of the service provision with the SPOR system in order to identify areas where it needs optimising.

### Venous Thromboembolism (VTE) audit in specialist care units

**Dr Amanda Thompsell**, South London and Maudsley NHS Foundation Trust

**Aims and Hypothesis**

On the hypothesis that people in specialist care would as a group be at particularly high risk of VTE, the audit was aimed at considering the adequacy of practice in assessing and reducing the risk of VTE in patients within three specialist care units for older adults, applying standards outlined by NICE.

**Background**

NICE and the Department of Health guidelines recommend that every patient admitted to hospital be assessed for VTE and managed appropriately. This appears to be a significant risk. A previous multi-centre trial of incidence of VTE in psychiatric units reported a 6% incidence. An association between VTE and antipsychotics has also been observed.

**Method**

There are various tools for assessing whether VTE prophylaxes should be recommended but none take account of antipsychotic or benzodiazepine use as risk factors or consideration of the risk of gastric bleeds for those on antidepressants, all factors that were likely to be frequently encountered with this cohort. Accordingly, we amended and designed our own one page screening tool to take these factors into account. We piloted the tool and amended it in light of the pilot. We then assessed all the patients in the units using this tool.

**Results**

A total of 57 patients was sampled. Of the 57 people in the specialist care units only 12 (24%) had ever been assessed for VTE (all from one unit) and there was no standardised assessment form. The majority of patients had multiple risk factors. Fewer patients had multiple bleeding risk factors and 42% had none. The majority of patients were not prescribed anti-embolism treatment, 19 were prescribed stockings and 1 anti-coagulants but the compliance with using stockings was poor.

**Conclusion**

It became apparent that the assessment could not just be about the number of risk factors but that there needed to be a clinical assessment within the Multi Disciplinary Team of the individual’s risk and the potential for compliance with the treatment options.

Now all patients have had a VTE assessment on admission (the screening tool is scanned onto the notes) and we have developed information leaflet about VTE for relatives and patients and information leaflet for staff on how to put on stockings. Discussion of VTE risk and treatment options are had at each CPA. The feedback from relatives/patients of having this discussion (even if no prophylaxis is given) has been positive.
71 Deviating from NICE guidelines: the use of maintenance ECT in the treatment of longstanding, refractory depression. 
Dr Jessica Two, Worcestershire Health and Care Trust, Dr Tara Walker, Worcestershire Health and Care Trust

Background
Maintenance Electroconvulsive Therapy (ECT) is, at present, not recommended by NICE in the treatment of depressive illness as the ‘longer-term benefits and risks of ECT have not been clearly established’. The Royal College of Psychiatrists acknowledges this but suggests it ‘may be permissible in some circumstances’. We present a case in which maintenance ECT was used effectively in a 79 year old lady, for the treatment of longstanding, refractory depression. Treatment Mrs C is 79 year old lady who was admitted to Kidderminster Older Adult Psychiatric Ward in May 2013 with symptoms of a severe depressive illness. She was first diagnosed with severe depression in 1963 and subsequently experienced eleven relapses, six of which were of a severity to require admission to an inpatient psychiatric ward. Despite treatment with various combinations of SSRIs, TCAs, antipsychotics and Lithium it was impossible to find a medication regime that affected sustained remission of her depressive illness. Historically ECT had proven to be the only treatment to produce a dramatic improvement in Mrs C’s mood. A course was therefore administered during this admission and she responded quickly. However the benefit of acute ECT was not sustained over time and she again relapsed. In the hopes that it would break the recurrent pattern of depressive relapses we hesitantly suggested the possibility of maintenance ECT and Mrs C agreed. Outcome At present Mrs C’s has had fourteen sessions of ECT, administered on a monthly basis and remains euthymic in mood. Her Mini Mental State Examination (MMSE) score remains unchanged at 28/30. Sessions are prescribed on a six monthly basis and she is reviewed on a fortnightly basis by both the medical and community mental health team. All ECTAS conditions are being met. Mrs C., who has now remained well for a sustained period of time, reports feeling better than she has in many years, with vastly increased mood, energy and quality of life. At present she is unhindered by side effects and describes herself, cautiously, as depression free.

Conclusion
There remains little evidence to support the use of maintenance ECT in recurrent depressive disorder. Despite the potential long term risks remaining largely unidentified, we strongly believe that sustained remission of Mrs C’s depressive symptoms would not have been possible without the use of maintenance ECT and to withhold maintenance treatment for this reason would have been detrimental to our patient.

72 Re Audit of Patient Driving Status within North Worcestershire Older Adult Community Mental Health Team
Dr Tara Walker, Worcestershire Health and Care NHS Trust, Dr Dhan Marrie

Background
It is estimated 57% of people over the age of 65 hold a driving licence. It is well documented that your skills as a driver as you become older reduce. If someone has a mental illness this can have an additional impact on their ability to drive. The DVLA provides guidelines regarding driving recommendations in several psychiatric diagnoses’ including acute psychosis, mania, schizophrenia, mild cognitive impairment and dementia. As a Community Mental Health Team (CMHT) for older adults in North Worcestershire it is imperative patients driving status is known if they no longer meet the criteria steps should be taken such as referring for a formal driving assessment, or to inform the DVLA when necessary.

Aim
The aim of the audit was to evaluate if the driving status of patients was known and if appropriate subsequent action was taken.

Methods
Patient information was taken from a database on the shared drive and all patients that were new referrals between 1st September 2013 and 30th November 2013 were analysed. A data collection sheet was then completed which addressed issues including, demographics, diagnosis, if driving had been discussed within the initial assessment, which member of staff discussed driving and what actions were taken. The re-audit followed the same method, except covered a different time period, March-May 2014.

Results
In the initial audit only 50% of all patients undergoing a new assessment had their driving status documented in correspondence. Only 50% of those found to be driving were fit to drive according to DVLA guidance and only 50% of those who were not had appropriate action taken. As a result of these results, strategies to improve compliance were implemented including education of the team regarding driving safety and including driving status in the risk assessment
Conclusion
The initial audit highlighted a gap in patient safety where patients were not being screened for driving, which is a key issue in relation to dementia. Simple measures such as staff education, and formally identifying driving status in documentation encouraged awareness of driving safety, which was suggested by improved results from the re-audit.

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Physical Observations in a Psychiatric Ward for Patients with Dementia: An Audit Cycle
Dr Lauren Waterman, Sussex Partnership NHS Trust

Aims
To audit the frequency of physical observations performed on patients in a psychiatric dementia unit in Hove; the types of observations getting missed; and the clarity with which observations are recorded. • To implement quality improvement interventions.

Background
Patients on old-age psychiatry wards commonly have co-morbid physical health problems. Working on the dementia unit, I found that patients were often transferred from general hospitals, still physically unwell, under the assumption that we could care adequately for their physical needs. However, I noted that physical observations were frequently not performed on patients as requested by doctors, and identified patient safety incidents where physical illness was missed due to inadequate monitoring of vital signs.

Methods
I reviewed physical observation charts and calculated the fraction of times that: observations of vital signs were performed after they had been requested; each individual vital sign was recorded; charted values were illegible; time was recorded; and abnormal observations were acted upon. I excluded documented cases where patient had refused observation. Consequently, I implemented several quality improvement interventions. These included replacing existing charts with Modified Early Warning Score (‘MEWS’) charts; education to nursing staff about the importance of measuring respiratory rate in detecting physical illness; and interventions to improve communication within the multidisciplinary team, such as implementing a whiteboard handover system. I re-audited 3 months later using identical methods.

Results
Observations were performed 32% of the times they had been requested by doctors; this value increased to 85% on re-audit. Of the times observations were actually performed, often only blood pressure was recorded, with only 5% including a value for respiratory rate; on re-audit, 95% included respiratory rate. The time of observations being taken was recorded only in 52%; this improved to 98% on re-audit.

Conclusions
There was significant improvement in the regularity of physical observation. The MEWS chart seemed to contribute to this, possibly due to including guidelines of when to respond to abnormal observations, and an area for doctors to indicate the frequency that observations are required. Training of staff in how to use the chart seemingly stimulated enthusiasm for trying something new. Education on the MEWS chart appeared to improve understanding about the importance of physical observations, particularly respiratory rate. On re-audit, recorded values were more legible. Written instructions from doctors via the MEWS chart and whiteboard were also beneficial, as within a busy dementia unit a verbal handover is often ineffective.
An audit of standards in place to assess patients’ mental and physical wellbeing on admission to an acute older adult in-patient ward - A surrogate marker of Safeguarding

Dr Katrina Watson, South West Yorkshire NHS Foundation Trust, Dr Subha Thiyagesh, South West Yorkshire NHS Foundation Trust

Aim and hypothesis

To ascertain what standards are in place to monitor safeguarding issues on the ward. We hypothesised that documentation of thorough physical and mental health assessment and completion of incident reports would be surrogate markers of successful recording of safeguarding practice. Background: The fundamental link between physical and mental health is important but can sometimes be overlooked. It is known that vulnerability of patients is affected by their surroundings, dependence on others and through risk from others. Poor mental health can predispose people to issues of self-neglect, vulnerability and resultant poor physical health, especially in older people. This service improvement project investigates standards in place to protect patients’ global wellbeing following admission. The results will act as a surrogate marker for safeguarding so that necessary changes can be made, which will be re-audited.

Methods: This is a retrospective analysis, looking at qualitative and quantitative data. A proforma was drawn up with the indicators that would be looked for in each patient’s electronic notes. The first fifty admissions (27 females) from January 2014 were included, spanning a 7 month period.

Results

A physical examination was performed by a doctor within 24 hours of admission in 76% of cases. Blood tests were taken within the first 7 days of admission in 94% of patients, and 88% had an ECG within the first 7 days. Twenty-three patients were formally detained under the Mental Health Act (MHA); the other 27 were admitted on an informal basis. Deprivation of Liberty Safeguarding (DOLS) was only documented as having been considered in one case. Capacity was discussed and documented in 72% of cases; half of these patients lacked capacity to consent to admission and just under half lacked capacity to consent to treatment. Forty-six of the 50 patients had documentation of assessment of risk to themselves and 41 patients had documentation of their risk to others. Twenty patients had incident reports within the first 4 weeks of admission; five related to harm to self and nine related to harm to others.

Conclusions

Physical health is generally investigated and documented appropriately in a timely fashion. Documentation of risk could be more comprehensive, but most patients did have a risk assessment on admission. Where incidents occurred, these patients were generally already identified as being of potential risk to themselves or others. Plans for further improvement and setting standards to improve safeguarding practice will be discussed.

Risk assessment and documentation of service user leaves on an acute elderly inpatient mental health ward: A Quality Improvement Project

Dr Christian Wilson, South West Yorkshire Mental Health Trust, Dr Sonya Dhand, South West Yorkshire Mental Health Trust, Dr Katrina Watson, South West Yorkshire Mental Health Trust, Dr Subha Thiyagesh, South West Yorkshire Mental Health Trust

Aim

This project aimed to examine the existing clinical practice of the service user leave process and documentation of risk assessment and a subsequent introduction of a proforma to standardise this process.

Hypothesis

We hypothesised that by introducing a structured leave proforma for the in-patient service users following an educational workshop for the ward staff, there would be not only improved documentation but also an improvement in quality of patient care. Background: It is recognised that service users going on leave from a psychiatric ward have an increased risk of a serious untoward incidents (SUI). There does not appear to be any current local or national guidelines regarding documentation and risk assessment for older adult service users considering leave. This quality improvement project was undertaken to address this clinical need.

Method

A retrospective quantitative research method was used to collect baseline data over a 3 month period. This was followed by an educational intervention, with presentation of results and subsequent creation of a ward leave proforma. An interim re-audit was then completed to assess the impact. The audit proforma was completed using data from the electronic patient records and the episodes of leave absences were verified using the ward fire register.
Results
Data was collected from 319 episodes of leave from 29 service users. Mental health Act (MHA) status was documented in all cases. Leave was documented in 83% of sectioned and 73% of informal leave episodes, with the service users being reviewed formally by staff (28%) and a mental state assessment documented (15%) in the notes. There was documentation of formal risk assessment in about 4% of leave episodes. An interim re-audit collected data following agreement to use a brief leave proforma. The data was collected over a 7-week period covering 78 episodes of leave. About 67% of patients were sectioned. Documentation of MHA status, assessment of mental state and risk assessment was fully completed in 38% of these leaves.

Conclusions
The results show that a significant improvement in documentation of assessment can occur following an audit and a simple intervention through educational workshop and leave proforma. The next steps would be to work with the local trust to create robust in-patient leave guidelines across the acute pathway and further educational sessions and focus groups to consistently maintain high completion rate.
Biographies

David Anderson
David Anderson is Consultant Old Age Psychiatrist, Associate Medical Director with Mersey Care NHS Trust in Liverpool, Honorary Senior Lecturer in Old Age Psychiatry at the University of Liverpool & Honorary Consultant Psychiatrist with the Royal Liverpool & Broadgreen University Hospitals NHS Trust.

His special interest is liaison psychiatry for older people and the interface between physical medicine & psychiatry. He chaired the Royal College of Psychiatrists working group producing the first national guidelines on the development of liaison psychiatry services for older people (Who Cares Wins) & has influenced national policy development in this area.

Rishikesh Behere
Dr Rishikesh V Behere, Assistant Professor at the Department of Psychiatry, Kasturba Medical College, Manipal University, India. He is associated with the Neuropsychiatry clinic at the University Hospital which provides clinical services for patients with Dementia, in liaison with the Department of Neurology. He has been working on developing a brief bedside scale for assessment of cognitive functions; The Indian Instrument for Cognitive Examination (IICE), which would be culturally sensitive, comprehensively assess all domains of cognitive functioning and have normative data for our population especially for illiterates. His research interests includes understanding social cognition deficits especially Facial Emotion Recognition Deficits in Schizophrenia and its relation to various aspects of psychopathology, socio occupational functioning and their neurobiological correlates.

Claire Hilton
is an old age psychiatrist in North West London and is editor of the Old Age Faculty Newsletter. She has a MD in cross-cultural psychiatry and a PhD in history.

Debbie Browne
is an ST6 in old age psychiatry and is the faculty Higher Trainee Representative. She is currently working in NHS Forth Valley.

Ann Boyle
Ann is a Consultant psychiatrist at Leicestershire Partnership NHS Trust and Associate Postgraduate Dean Health Education East Midlands. She is also the RCPsych Foundation Programme Advisor.

Tom Brown
Tom Brown is a recently retired Consultant Liaison Psychiatrist from Glasgow. He is Past Chair of RCPsych Scotland aergraduates" chairs its Teaching and Recruitment group. He has a longstanding interest in undergraduate teaching and training and has published on these topics, including (with John Eagles) the RCPsych Press book "Teaching Psychiatry to Undergraduates". He is currently the RCPsych Associate Registrar for Recruitment and chairs the college’s Promoting Recruitment in Psychiatry group.

Wendy Burn
Wendy became a Consultant Old Age Psychiatrist in Leeds in 1990 and currently works in a fulltime community post. She is a Clinical Lead for Dementia for the Yorkshire and the Humber Strategic Clinical Network. She has held many roles in Education including College Tutor, Training Programme Director, Director of Postgraduate Medical Education, Chair of Specialty Training committee and Associate Medical Director for Doctors in Training. She set up the Yorkshire School of Psychiatry and was the first Head of School. On behalf of the College she has been an examiner, a Senior Organiser of clinical examinations, a Deputy Convenor, Regional Co-ordinator for CPD and the Deputy Lead for National Recruitment. She became College Dean in 2011. She enjoys feedback and discussion on clinical or educational matters and can be contacted by email, Facebook or twitter.
Professor Alistair Burns is Professor of Old Age Psychiatry and Vice Dean for the Faculty of Medical and Human Sciences at The University of Manchester. He is an Honorary Consultant Old Age Psychiatrist in the Manchester Mental Health and Social Care Trust (MMHSCT) and is the National Clinical Director for Dementia, NHS England.

He graduated in medicine from Glasgow University in 1980 and trained in psychiatry at the Maudsley Hospital and Institute of Psychiatry in London. He became the Foundation Chair of Old Age Psychiatry in The University of Manchester in 1992, where he has been Head of the Division of Psychiatry and a Vice Dean in the Faculty of Medical and Human Sciences, with responsibility for liaison within the NHS. He set up the Memory Clinic in MMHSCT and helped establish the old age liaison psychiatry service in UHSMT. He is a Past President of the International Psychogeriatric Association.

He is Editor of the *International Journal of Geriatric Psychiatry* and is on the Editorial Boards of the *British Journal of Psychiatry* and *International Psychogeriatrics*. His research and clinical interests are in mental health problems of older people, particularly dementia and Alzheimer's disease. He has published over 300 papers and 25 books.

Jane Casey
Jane is a general adult and old age psychiatrist and her main clinical role is as the Lead Clinician in the Auckland Hospital psychogeriatric inpatient unit. Her special interests include treatment-resistant mood disorders, personality disorders and suicide in older age, areas in which she has also published. Jane has knowledge in lateral topics such as spirituality and capacity assessment in the older person and has established respect in her expert opinion status in legal settings. Although she would describe herself as a pure-blooded clinician, she is an Honorary Clinical Lecturer at Auckland University and for the last several years she has had an active role in the College and holds the position of the Bi-National Chair of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists.

Robert Clafferty
Dr Robert Clafferty is a Consultant Psychiatrist at the Royal Edinburgh Hospital (NHS Lothian) and Honorary Clinical Senior Lecturer (Edinburgh University). He is the past recipient of the Royal College of Psychiatrists McHarg Essay prize, Morris Markowe public education prize and the Felix Post prize for topics related to psychiatry of old age.

Claire Hilton
Claire is a consultant old age psychiatrist in north-west London. She recently submitted her PhD on the development of old age psychiatry services in England, c.1940-1989 and hopes it will contribute to informing policy debate. More historical research is planned, on the *Sans Everything* and Ely Hospital scandals of institutional care in the 1960s. Other psychiatric interests relate to religion and culture and she has spoken about older people’s mental health at mosques and synagogues. She edits *Old Age Psychiatrist*, the Faculty newsletter.

John Holmes
Dr John Holmes is a Senior Lecturer in Liaison Psychiatry of Old Age at the University of Leeds, and established one
of the first dedicated Liaison Psychiatry Service for Older People at Leeds General Infirmary in 1999. John trained in general medicine, old age psychiatry and liaison psychiatry, and was previously a Community-Based Consultant in Old Age Psychiatry in Leeds. He has clinical and research interests in novel approaches to mental health service delivery for older adults, and in the management of mental health problems in the general hospital setting. More recently he has focussed on medical education. He is the Head of Performance Assessment for the Leeds MBChB course and convenes the Year 4 Multi-speciality OSCE.

Alasdair MacLullich
Professor of Geriatric Medicine, University of Edinburgh, Scotland

Alasdair MacLullich trained in medicine and psychology at the University of Edinburgh. He was Clinical Lecturer in Geriatric Medicine, then MRC Clinician Scientist Fellow before becoming Professor of Geriatric Medicine at the University of Edinburgh in 2009.

Alasdair’s main research interests are the pathophysiology and neuropsychology of delirium. He is particularly interested in the role of stress responses in delirium (eg. cortisol levels after hip fracture), and the development of research and clinical tools for delirium assessment (eg. www.the4AT.com).

Alasdair’s clinical work is in acute geriatric medicine and acute orthogeriatrics. He is active in delirium education and clinical improvement work, and is currently working on a national clinical implementation project on delirium detection and management with the Scottish Government. Alasdair co-founded the European Delirium Association and is its current President.

Dr Anthony J. McElveen
MRCPsych, MRCGP, DRCOG, MBChB, BSc (Hons)
Member of Medical and Dental Defence Union Scotland

Career Statement
The daily pursuit of excellence as a professional, dynamic and compassionate Old Age Psychiatrist.

Professional Qualifications & Prizes
- Member of the Royal College of Psychiatrists
- Approved Medical Practitioner under Section 22 of Mental Health (Care and Treatment)(Scotland) Act 2003
- Member of the Royal College of General Practitioners
- DRCOG 2008
- MBChB with commendation, University of Glasgow 2005
- BSc First Class Honours, Prosthetics & Orthotics, Strathclyde University 1999
- Limbless Association Prize for Clinical Excellence 1999

Additional Experience
West of Scotland Psychiatry Higher Trainee’s Committee Chairperson Aug 2014 to present
BMA West of Scotland GP Trainee Representative 2009-2010
Support worker for people with learning difficulties 1999-2003
Volunteer Helper for the Handicapped Children’s Pilgrimage Trust (HCPT)

Baroness Murphy of Aldgate (Elaine) MD, PhD, FRCPsych:

Elaine Murphy has been a politically independent crossbench life peer since 2004. She was until last year Secretary to the All Party Parliamentary Group on Mental Health. She worked as a doctor and academic in the National Health Service for 25 years and was Foundation Professor of Psychiatry of Old Age at the United Medical and Dental Schools of Guy’s and St Thomas’ Hospitals (now part of King’s College) from 1983 to 1996. She was also a general manager in the NHS, including three years as a District General Manager in London. She was the Chief Medical Officer’s Personal Advisor in psychiatry of old age and UK Advisor in Mental Health to the WHO for 10 years. Her role as Vice Chairman of the Mental Health Act Commission led to taking part in several public enquiries. She is a Vice President of the Alzheimer’s Society.

After retirement, she chaired NHS Trusts and Authorities in East London and then the NE London Strategic Health Authority. Her final role was Chair of Council at St George’s, University of London. In her spare time she...
undertakes social history research, and was from 2003-2007 an Honorary Senior Research Fellow at the Wellcome Trust Centre for the History of Medicine at University College London. She and her husband, a scientist, now live mostly in Norfolk but also spend time in Italy.

Dr Ramin Nilforooshan is working as a consultant psychiatrist for older adults in Surrey and Borders Partnership NHS Foundation Trust. He is the Medical Lead for R&D in that Trust and Speciality Lead for DeNDRoN in Kent, Surrey and Sussex. His special interest is biomarkers in Dementia.

David Owens-
Professor of Clinical Psychiatry at the University of Edinburgh, and honorary consultant psychiatrist, the Royal Edinburgh Hospital. I am a faculty member of the British Association for Psychopharmacology's schizophrenia certificate course and Psychiatric Commissioner on the Commission on Human Medicines and Chair of its Expert Advisory Group on CNS drugs (neurology, psychiatry and pain). I am author of the only single-author text on neurological side-effects associated with antipsychotic drugs use, now in its second edition. My longstanding interests are in the biological basis of psychotic illness, especially schizophrenia and psychopharmacology, in particular antipsychotics.”

Tony Rao-
Dr Rao is a consultant old age psychiatrist at South London & Maudsley NHS Foundation Trust. After completing an MSc in the Clinical Public Health aspects of Addiction, he was co-author of Our Invisible Addicts in 2011. He has been a specialist advisor to the All Party Parliamentary Group on Alcohol Misuse, Institute of Alcohol Studies and Alcohol Concern. Dr Rao received a clinical governance award from his Trust for service development for Dual Diagnosis. He currently leads the Trust Dual Diagnosis in Older People strategy, as well as the Substance Misuse in Older People Working Group at the College.

Tom Russ-
Tom is Clinical Lecturer in Old Age Psychiatry at the University of Edinburgh and is interested in dementia prevention, specifically socio-environmental risk factors we can infer from geographical variation in dementia rates.

Ms Marie Claire Shankland BA Hons, MSc, C Psychol.
I am a Chartered Consultant Clinical Psychologist, I hold an undergraduate (BA Hons) degree from University of Manchester in Psychology and an MSc in Clinical Psychology from the University of Leicester. My speciality is Older People's care and I worked from 1993-2008 in Sheffield as lead psychologist for Older People’s Mental and Physical Health Services. I am currently working at NHS Education Scotland, as part of a team of clinical psychologists and health psychologists, developing models of training for staff in providing psychological interventions for people with physical health problems. From 2008-2011 I was the Director of Primary Care Psychological Therapies Service for Sheffield. In 2012/13 I was the Older People’s Adviser to the Department Of Health (England) Improving Access to Psychological Therapies Programme. My areas of interest are, improving general psychological skills with the healthcare workforce, psychotherapy with older people, working with carers of people with dementia, psychotherapy outcome research and improving access to psychological therapies.

Anna Sobel-
ST6 working in Neuropsychiatry at The National Hospital for Neurology and Neurosurgery due to get CCT in Old Age Psychiatry in November 2015. She has a special interest in liaison psychiatry, in particular neuropsychiatric illness, and has held Liaison posts across 5 different London hospitals. She has spent a year working at the Cognitive Disorders Clinic which runs in parallel with the Dementia Research Centre, part of the Department of Neurodegenerative Disease at the UCL Institute of Neurology. She is currently involved in research into functional memory disorders.

Dr Christine Taylor-
I am a specialist registrar (ST5) in Old Age Psychiatry in the East Midlands HEEM currently working in Ilkeston, Derbyshire. I started out my career in Psychiatry in 2000 and have previously worked as an Associate Specialist in West Bromwich for a number of years during which time I developed a special interest in dementia in ex-
footballers. I returned to higher training in August 2013. My other special interest areas include Parkinson’s disease, palliative care in dementia and promoting fairer access to services for older people.

Amanda Thompsell
Dr Thompsell was initially a consultant with the Care Homes Support Team working with care homes with nursing before moving to old age liaison. More recently she has worked in specialist care. She has worked with NICE on developing quality standards for medicines management in care homes and leads on the Improving care workstream for London Dementia Strategic Clinical leadership group. She participates in Namaste care research and implementation. She has been involved in developing quality standards on telehealthcare as part of her work with the Good Governance Institute and has written and presented on telehealthcare issues in dementia.

Jonathan Waite
Dr Waite has been working with older people for more than thirty years, he is currently a part-time Consultant in Liaison Psychiatry of the Elderly in Nottingham. He has an interest mental health law, he is a medical visitor for the Court of Protection. He is an author of Dementia Care (OUP 2008) and has contributed to several books on medical law and clinical practice, such as Management for Psychiatrists (4th edition). Recent work for the Royal College of Psychiatrists has included contributing to college guidance Prevention and Management of Violence (Highly Commended in the BMA Medical Book Awards 2014) and Management of Older People in Emergency Settings (The Silver Book”; with BGS & College of Emergency Medicine).
He has responsibility for ECT in Nottingham and is editor of the 3rd edition of The ECT Handbook (also Highly Commended in the BMA Medical Book Awards 2014).
His licence to practice has just been renewed until 2020.

James Warner
James Warner is a Consultant old age psychiatrist at CNWL Foundation Trust and Reader in Psychiatry at Imperial College London. James’ academic interests include teaching, evidence based psychiatry and research into dementia. He has contributed to over 50 peer reviewed research papers and several books and book chapters. James is Chair of the Old Age Faculty at the Royal College of Psychiatrists and National Professional Advisor at the CQC.