1. Too old to follow the rules? An audit of treatment of severe depression in the inpatient setting

Dr Yasmin Al-Asady, FY1, Nottinghamshire Healthcare Trust, Dr Nisha Mokashi, SpR, Nottinghamshire Healthcare Trust

Aims
To determine whether patients are being treated as per the Maudsley guidelines for severe depression

Method
We conducted a baseline service assessment of the treatment of severe depression on a functional old age psychiatry ward. Information was gathered from current and previous psychiatric notes of an opportunistic sample of inpatients being treated for a severe depressive episode on the census day.

Results
Of the twenty patients on the ward, eleven were being treated for a severe depressive disorder. Six of these patients were previously known to psychiatric services, presenting with a recurrence of symptoms. The remaining five patients presented with a first episode of depression, all of whom also displayed psychotic symptoms.

Of the first presenters, contrary to recommendations, an SSRI only featured as the first line drug of choice in two cases. Of the remaining three patients however, two had been unsuccessfully treated in the community with an SSRI immediately prior to admission.

Treatment pathways for the six patients treated for recurrent depression were more variable, accounting for each patient’s individual treatment history, response to treatment and occurrence of treatment side-effects.

ECT was required in two cases in accordance with guidelines as both a lifesaving treatment in severe depression, as well as an adjunctive therapy in a case of treatment-resistant depression.

Conclusion:
This snapshot of practice reveals that guidelines are largely adhered to, with some variations attributable to the specific needs of the patient demographic. Significantly, little emphasis is placed on the potential benefit of psychological therapies.

Suggestions:
Whilst deviation from clinical guidelines is acceptable as per each individual clinical situation, it is the way in which these decisions are made and documented that seems to have a lasting effect. This audit has highlighted the importance of the communication of management decisions both to the patient and within the MDT supplemented by clear, accurate documentation.

2. Dementia and the arts: a qualitative analysis of the impact of dementia on the identity of artists

Professor Susan Mary Benbow and Rev Rob Merchant, Centre for Ageing and Mental Health, Staffordshire University, Stafford, UK.

Background and aims
What do we know of how a dementia affects the artistic endeavour of established artists who develop a dementia, and what it means to them and to their families? In considering this we have used Sabat’s theory of three selves: Self 1 involves the expression of personal identity whether by language or by action such as gesture; Self 2 is the self of physical and mental attributes; Self 3 consists of a number of socially constructed selves which change depending on social context and which emerge in relationship with others. In terms of an artist at the level of Self 2 they may have artistic attributes and beliefs about themselves, and at level 3 they may
have a number of socially constructed selves, including artist as businessperson, artist as teacher, artist as esteemed creator. Sabat argues that Self 3 is vulnerable to the way that other people respond to a person’s diagnosis of dementia: this may lead them to respond to ‘the person with dementia’ rather than their other selves.

We describe a preliminary qualitative analysis of the effect of a dementia on the selves of four artists.

**Method and results**
We interviewed family members of two painters who developed a dementia about the changes in their artistic activities and the effects on them as the dementia developed. The interviews were audiotaped, transcribed verbatim, and thematically analysed using a computer software package (NVivo). In addition we have taken two interviews from the public domain with well known figures, one a writer and the second a musician, and submitted them to analysis using NVivo.

**Discussion**
The thematic analysis raises a number of questions about the impact of dementia on the selves of an artist. If selves are socially constructed then it may be possible to support and maintain them in the context of a dementia, at least in the early stages. Our findings have implications for how artists are supported during the process of diagnosis and as their illness progresses.

3. **People living with a dementia: what can old age psychiatry services learn from their experiences?**

*Professor Susan Mary Benbow* & Professor Paul Kingston; Centre for Ageing & Mental Health, Staffordshire University, Stafford, UK.

**Aims**
To assist people living with dementia (PWD) to produce narratives of their journeys, and to identify key themes and learning.

**Method**
We recruited carers and PWD who prepared a written, audio taped or videotaped narrative. All narratives were transcribed verbatim, and returned to participants. Completed narratives were analysed thematically using NVIVO. A short summary of the analysis was circulated to participants, inviting further comments/feedback. The analysis was reviewed in response to feedback.

**Results**
We recruited 21 carers and 20 PWD. All chose to make audiotapes in conversation with one of the team, apart from two carers who wrote their own narratives. Six couples were included: five couples elected to be interviewed jointly and one separately. A number of important themes were identified.

**Conclusions**
1. Service providers need to reflect on support for people during the process of getting a diagnosis.
2. All services should investigate ways to build in feedback loops in order to get regular routine feedback from the people using their services.
3. PWD and carers need someone who acts as a point of contact from diagnosis onwards, and provider organisations need to review how they provide continuity for people using services.
4. PWD and their carers need continuing opportunities to enjoy life: services need to recognise and support people in finding new things they can enjoy because their life has changed, and in helping them to carry on doing things that are important to them.
5. Families, friends and the public continue to need to learn more about dementia.
6. Producing a narrative can be a valuable experience for both PWD and carers and could be adopted in routine practice. It allows people to talk and to make sense of their journey with dementia.

**Acknowledgement:** This work was funded by the BMA Dawkins Strutt Grant 2009.
4. A critical analysis of adult safeguarding practices in NHS mental health services

**Miss Tina Fanneran**, Centre for Ageing and Mental Health, Staffordshire

This poster presentation will feature a PhD research project designed to explore adult safeguarding practices in NHS mental health services. It will briefly review existing literature relevant to this area, highlighting the immediate need for empirical research. This will be followed by an overview of the proposed methods of data collection and analysis for the study. Finally, the concluding section of the poster will provide an outline of the expected uses and benefits of the findings of this study.

Safeguarding is the U.K's response to abuse and neglect, which involves a national effort to implement policies, procedures, and practices within our national services to ensure that vulnerable adults are adequately protected. Since its inception, many services appear to have embraced the concept of safeguarding, with evidence highlighting improvements to practice in services for children, older adults and adults with learning disabilities. However, despite the vulnerability of some mental health service users, as highlighted within the ‘No Secrets’ guidance 2000, mental health services appear to be resistant to change and ‘reluctant to tackle the problem of abuse’ (Williams & Keating, 2000, p32). As the number of reported cases of adult abuse in mental health continues to rise, it is clear that a critical examination of adult safeguarding practice in mental health services is paramount.

The prevailing body of literature that examines adult protection work or safeguarding adults practice focuses predominantly on learning disabilities services. Consequently, explanations offered for the neglect to adult protection work in mental health, tend to be based on commentary unsupported by empirical data. Indeed few studies have been identified that empirically explore adult protection work or safeguarding adults practice in a mental health setting. A study carried out by Brown & Keating (1998) identified resistance of mental health staff to adult protection work, revealing that participants viewed the application of generic adult protection policies and procedures as inappropriate within a mental health setting. In addition a number of barriers to adult protection work perceived to be specific to mental health settings were identified. A more recent study carried out by Rees & Manthorpe (2010) found that in general the development of adult protection practice, policy and legislation in a small number of residential adult mental health and learning disability units, was perceived to have had a positive impact. However, the data gathered revealed a disruption to the provision of services in addition to the increased levels of stress reported by residents, staff and managers as a result of the newly implemented policies.

These studies highlight the challenges faced by mental health staff when attempting to integrate adult protection practice and policies within already established structures and suggest a 'translational gap' between policies and procedures and their practical application (Tansella & Thornicroft, 2009). It is therefore suggested that in-depth exploration of the implementation, development and use of current adult safeguarding practices in mental health services is required. This will provide an advanced understanding of keeping adults safe in mental health care and help to bridge the gap between adult safeguarding policy and practice in mental health services.

5. Survey of Achievement of Liaison Psychiatry Competencies in Older Adult Psychiatry trainees

**Dr Anna Fryer**, Manchester Mental Health and Social Care Trust, North West Deanery

**Background**

Over the last decade Older Adult Psychiatrists have been developing liaison services that are age specific to the hospital population. The NHS confederation report “Healthy minds, healthy bodies” argues a compelling case for the development of liaison services within General hospitals, to improve the quality of care in the general hospital setting, increase productivity and deliver savings (Healthy minds, healthy bodies, Issue 179, April 2009, The NHS Confederation).
Aims
This survey was of a sample of UK Older Adult ST4-6 trainees, to gain information about the provision of training opportunities in liaison psychiatry within 4 deaneries areas within England, and the achievement of relevant competencies.

Methods
The population surveyed were ST4-6 trainees in Older Adult Psychiatry of 4 Deaneries. The survey was sent as a link within an email to the training programme director, or identified lead, of the deaneries involved in the survey. It was requested that it was sent to Older Adult trainees within the locality with a covering email.

There were 8 questions which comprised of Likert scale responses reflecting the subjective competence the trainee felt on the areas identified in the Intended Learning Outcomes that were specific for liaison posts, within the competency based curriculum. There were further data collected on deanery, training year and comments on the availability of training opportunities in liaison psychiatry for older adult trainees.

Results
Most Older Adult Psychiatry trainees reported achieving sufficient competencies in General Hospital Liaison, and reported having access to most relevant training opportunities. However, relatively few trainees reported that they had achieved competencies in the use of psychotherapeutic skills in assisting staff in the general hospital in the management of complex situations, and few felt they had a lot of experience in the use of Mental Health Act and Mental Capacity Act.

Discussion
Whilst most trainees are receiving sufficient exposure to liaison psychiatry to achieve relevant liaison competencies, they appear to report difficulty in gaining competency in the use of psychotherapeutic skills in the general hospital in complex cases. Few felt they had a lot of experience in the use of the MHA and MCA in the general hospital, where there is potential overlap between the two Acts. This is a relatively small survey and was limited to only 4 deaneries, however the response rate of over 47% was good. If the results are generalisable to other Deaneries, steps should be introduced to ensure old age trainees have adequate exposure to patients with complex problems whose problems may fall under the auspices of the MHA or the MCA. This may involve using special interest sessions for brief attachments in liaison psychiatry, either in specific age related services or age non-specific services.

6. Amyotrophic lateral sclerosis presenting as fronto temporal dementia with constant uncontrollable laughter.
Dr Catherine Gordon, Dr Emma Bronjewski, Nottinghamshire NHS Community Trust

Case history
A 68 year old lady presented to our service with a years history of personality change; social disinhibition, wandering, increased obsessionallity, only eating sweet foods, and constant uncontrollable laughter in the last few weeks. Her language skills had declined and on examination she had global cognitive loss with poor function on frontal lobe testing. She scored 19/30 on a Mini-mental state examination being disorientated in time, with poor concentration, poor recall, nominal aphasia but intact visou-spacial skills. She also could only name four animals in a minute and had poor abstract thought. She had no prior history and no family history. A clinical diagnosis of frontal type dementia was made.

Results
A CT brain confirmed frontal atrophy with prominent sulcal spaces in the superior frontal gyrus, but with otherwise normal brain volume. A PET scan also showed reduced metabolic activity in the medial aspects of the frontal lobe and also in the temporal lobes supporting a diagnosis of fronto-temporal dementia.

She was referred to a neurologist as she had weight loss, possibly due to dysphagia and constant laughing which was socially quite incapacitating and causing distress.
She was found to have upper limb hyper-reflexia, wasting and fasciculation of the intrinsic muscles of her hands, trapezius and triceps. EMG studies confirmed fasciculation, occasional fibrillation and high frequency discharge and a diagnosis of motor neuron disease confirmed-amyotrophic lateral sclerosis (ALS) subtype.
Conclusion
ALS is a disorder characterized by loss of upper and lower motor neurons. Most cases present with twitching, cramps, or stiffness of muscles or problems walking or running. Slurred/nasal speech or problems chewing or swallowing can also be presenting symptoms.
Only 5% of patients with ALS present with a dementia, usually cognitive symptoms of a frontal-temporal lobe dementia. 25% of ALS patients present with a bulbar palsy and may have problems with swallowing and tongue mobility.
A pseudo bulbar affect is found in between 15-45% which is degeneration of the bulbar neurons which can cause emotional lability. This has been described in other dementias such as Alzheimers, Parkinsons, multiple sclerosis and ALS.
Patients presenting with a pseudobulbar affect may have ALS. In addition, patients presenting with frontal lobe dementia may have ALS- signs of lower motor neurone involvement may be seen in their hands. This lady is interesting as she presented with a dementia and a severe pseudo bulbar affect.

Judith Harrison 1,2,3, Helen Nicholas4, Richard Brown5, and Harry Boothby3
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Aims
The pathogenesis of Alzheimer’s Disease (AD) remains unclear. Personality traits have been identified as a risk factor; an association between AD and fully-expressed syndromes of personality disorder has yet to be examined. This study uses a case-control design and informant-based assessments of personality.

Methods
217 cases (160 females and 57 males) with probable late onset AD were recruited from the community and nursing homes in South London and Guildford. 76 controls (44 females and 32 males) were recruited from the same area; most were unaffected siblings of cases. Premorbid personality was assessed using the Standardised Assessment of Personality (SAP) by informants.

Results
Rates of personality disorder were significantly higher amongst AD cases. 11% of cases had a personality disorder compared to 2% of siblings (p=0.003; CI 0.032-0.15). AD was strongly associated with Cluster A disorders (Paranoid, Schizoid and Schizotypal); 8% of cases and 2% of controls had Cluster A disorders (p=0.03; CI 0.062-0.119). Cluster C personality disorders (Narcissistic, Obsessive-Compulsive, Anxious and Dependant) were also significantly associated with AD, although to a lesser extent: 4% of cases and 0% of controls (p=0.003, CI 0.016-0.074). The prevalence of all subtypes of personality disorder was higher in the AD group apart from Borderline and Narcissistic PD (see Table 2). However, only Paranoid PD was significantly more common among AD than controls; 2% and 0% respectively (p=0.045; CI 0.0004-0.0406). Linear regression analysis showed that any personality disorder was a predictor of developing AD (P=0.048). There was a significantly higher rate of personality disorder in females than males; 8.4% and 5.6% respectively (p=0.049).

Conclusions
Personality disorders, particularly Clusters A and C, are a significant risk factor for AD. Those with personality disorders and AD may be more likely to have Behavioural and Psychological Symptoms of Dementia (BPSD); pre-existing personality disorder should be distinguished from personality change associated with dementia. When new preventative interventions emerge, assessment for personality disorders, alongside other factors, may allow early identification of groups at risk.
8. A prospective three month survey looking at the medical demand placed on psychiatry trainees in a large, secondary psychiatric service in NI.

Dr Ronan Kehoe, Holywell Hospital, Antrim

Holywell Hospital is a secondary psychiatric service based in Antrim, Northern Ireland. It currently has approximately two hundred in patients. Over the last few years there have been marked changes, leading to the implementation of a new rota with establishment of a new way of working in order to be compliant with European Working Time Directive. After 5pm there is no on-site medical cover yet there are a significant number of patients with medical co-morbidities including more than one old age psychiatry unit. The majority of the nursing staff are also not general nursing trained. However there still does remain an expectation on the covering off-site psychiatry SHO to assume responsibility for both the psychiatric and medical care of all patients.

The aim of the study was to evaluate, over a three month period, the demand on the psychiatry SHO for the hospital of the medical workload. I designed a list of “medical jobs” and pinned them on a board in the doctors’ room. After an induction and explanation of the study at one of the weekly, local teaching sessions, I encouraged the medical staff to complete the desired tables when such jobs were required. The job list consisted of: IV fluids, Pabrinex, antibiotics, CNS observations, A&E advice and referral, medical advice and referral and “other” which included cannulation, ECGs and medical emergencies.

The results clearly highlight the demand on the psychiatry SHO for a medical workload of jobs that perhaps wouldn’t be accepted on other local sites in NI and are perhaps not being conducted by the most appropriate person.

The study has highlighted the need for review of the jobs and specifications of the psychiatry SHO. It has presented to the management the possibility of increasing the training and skills of nursing staff, better liaison with other community services e.g. Rapid Response team who would otherwise be responsible for such jobs and it has helped encourage the appeal for dedicated medical care from physician staff.

9. Dementia in India - It’s high time to address the need

Dr Farooq Ahmed Khan, Specialist Registrar in Old Age Psychiatry, Shelton Hospital, Shrewsbury, Hon Lecturer, Centre for Ageing and Mental Health, Staffordshire University, Stafford, UK

Aims
To find out the prevalence and awareness of dementia and dementia care in India.

Methods
The review of literature was carried out with the studies specifically focusing on the prevalence of dementia in India, awareness of the dementia, management and care of dementia patients and the carer burden faced by the families looking after the dementia patients.

Results
The situation in India with regards to dementia prevalence has not been researched thoroughly though there have been indications of prevalence according to the 10/66 Dementia study which was conducted in seven low and middle income countries in eleven sites which included both rural and urban India. The population trend projects to a rise from 5.63% of older adults in 1961 to 6.58% in 1991 reaching 7.5 per cent in 2001. Men between the age group of 75 – 79 years and women of same age group account to 5.7% and 15.7% of dementia sufferers respectively. This figure rises to 11% and 29.4% when the age group of 80 years and above is considered. The educational background, social status, urban / rural living, understanding of assessment process and validation of the assessment tools used are to be taken into account when diagnosing somebody with dementia. Though large families and many generations living together in the same house provides supportive care to the elderly it also affects the carer with burden and affects the economy due to lack of income generation by that member of family in addition to the psychosocial stress faced. India is currently spending INR 0.15 to 160 billion per year for care of people with dementia. It is predicted that the current number of people with dementia would double by 2030 (3.69 million to 7.61 million) and the immediate consequence
would be that the cost of care would also double. The growing elderly population in India is a combination of number of factors like improvement of healthcare access, conquering some of the communicable / infectious diseases, awareness of medical conditions and betterment of lifestyle and this has lead to people living longer but this brings on the question of increasing number of dementia patients that has been projected to rise more than ever.

10. Elderly patient discharge destination after acute hospital admission: The RAID experience

*Nabila Khan*, Nageen Mustafa, Rafik Salama, Professor George Tadros

**Background**

Birmingham and Solihull Mental Health Trust launched the Rapid Assessment Interface and Discharge (RAID) service at Birmingham City Hospital in December 2009. The service provides a comprehensive range of mental health services for all adults in acute hospital. National figures suggest that 30% of elderly patients admitted to acute hospitals from their own homes are discharged to care homes.

**Aim**

To measure the effect of RAID on discharging elderly patients in acute hospital back to their own homes.

**Method**

This study compared discharge destinations of two groups of older adult patients in acute hospital, with mental health diagnosis, against a control historical group. The two experimental groups were: RAID group which included all elderly patients with mental health diagnosis seen by RAID and RAID-influence group which included all elderly inpatients with mental health diagnosis managed by the acute hospital staff with support from RAID but never seen by RAID. The experimental groups covered the period between Dec 2009 and July 2010 while the control group was between Dec 2008 and July 2009.

**Results**

In the control group only 34% of patients were discharged back to their own homes. While, in the RAID influence group 44% of patients went back to their own homes. This is compared with 67% of patients seen by RAID going back to their own homes.

The London school of Economics (LSE) used national data reported by the Personal Social Services Research Unit to illustrate the possible savings. The average cost of local authority-funded residential care for elderly people was £446 a week at 2006/2007 prices, compares with an average cost of £129 a week for home care (PSSRU 2012). The saving would be even larger in the case of an avoided discharge to nursing home care. Data suggests that the RAID service prevented about 175 discharges to institutional care amongst elderly people in 2009/2010, implying aggregate savings of around £60,000 for each week of such avoided care.

**Conclusion**

RAID service has been significantly effective in increasing the number of elderly patients discharged from acute hospital back to their own homes rather than to residential care. The total savings to social care cost are significant. The service has widened patients discharge choices.

11. Management of Vitamin B12 Deficiency in Acute In-Patients in Old Age Psychiatry

*Dr. Alee Maletnlema-Grossmann*, CT1 In Psychiatry, Dr. Subha N. Thiyagesh, Consultant In Old Age Psychiatry, Honorary Senior Clinical Lecturer, Academic Clinical Psychiatry; Sheffield Health and Social Care NHS FT, Older Adult Directorate, Wheata clinic, Sheffield

**Background**

Vitamin B12 deficiency is more commonly found in older people; with prevalence rates of 5% in the 65-74y olds and 10% in the over-75y age group. Commonest cause is relative failure to absorb vitamin B12, probably due to the natural decline in acid production by the stomach with age. Autoimmune illnesses such as pernicious anaemia or
coeliac disease can also cause this deficiency. Vitamin B12 deficiency can cause symptoms such as memory loss, anxiety, panic attacks and depression. The major complication is the involvement of the nervous system causing sub-acute combined degeneration of the spine; presenting with weakness of legs, arms, trunk, tingling and numbness that worsens progressively. Vision changes and confusion may also be present. These symptoms can become irreversible if the deficiency is detected late. There is no current national guideline for management of Vitamin B12 deficiency. Different hospitals treat according to their individual experience/agreed local guidelines.

**Aim**
To improve the clinical practice of management of Vitamin B12 deficiency in elderly patients admitted to psychiatric wards. To facilitate a local guideline that can be used across the service.

**Method**
A total of 104 cases admitted to a psychiatric ward from September 2009 to September 2011 were analysed in a retrospective audit. All information was gathered from electronic notes (INSIGHT system). The standard guideline was used according to Clinical Knowledge Summaries (CKS) NHS evidence.

**Results**
Out of the 104 cases reviewed, 55.5% had vitamin B12 and 74% had folate levels checked on admission. 9 cases found with vitamin B12 deficiency, 8.62% in the 66-75y old (younger age) group and 6.89% in the over-75y (older age group). A third of the patients with deficiencies had an identified cause and were all treated. Further analysis includes data on the untreated patients and the outcomes.

**Conclusions**
The prevalence of deficiency was higher in the younger age and lower in the older group, compared to reported prevalence rates. The results indicate a need for a standardised local protocol to aid in the detection and management of vitamin deficiency. Early detection and treatment can prevent further morbidity in this vulnerable group and thus improve quality of care given to patients.

12.
**Breaking barriers building trust - Personal Communication Aid (PC Aid)**
*Drs Nisha Mokashi*, SpR Old Age Psychiatry, Queens Medical Centre, Nottingham, Nottinghamshire Healthcare NHS Trust

**Background**
Older people whose first language is not English can have considerable difficulty in making their needs known to staff and in being able to communicate a history of their mental health symptoms. Equally, medical staff who need to make risk assessments and treatment plans for these patients can find it difficult to make an accurate assessment of a patient’s mental state.

In addition to this, language is an important way of building relationships and mutual trust. This is essential is being able to communicate in a therapeutic sense and helps the patient to feel as if their needs are being understood and respected.

**Aims**
1) Facilitate the process of assessment for medical staff and nursing staff
2) To improve the quality of care of the older person whose primary language is not English whilst inpatients on a Functional ward
3) To build relationships and engage in a therapeutic way with Functional patients

**Method**
We are carrying out a pilot project to incorporate the PC Aid into the daily running on the Functional inpatient ward at Queens Medical Centre, Nottingham. The PC Aid is a booklet that will be used to ask basic questions about daily care, assess mental state and risk and can be updated regularly with the patient and family/interpreter. As the patient’s admission progresses...
the PC Aid will be updated and used to communicate with the patient in their primary language. In addition to this, we are using the iPad with Translate applications to assist in communication.

We will carry out a qualitative survey of the patients, family and nursing and medical staff after 6 weeks to assess the impact of the PC Aid and the iPad and use this feedback to improve and extend the scope of the project.

**Results**
We envisage we will improve the quality as well as the quantity of communication with a patient whose primary language is not English and enable us to have a more therapeutic and respectful way of treating inpatients in mental health services for older people.

13. **Audit of the assessment of driving and follow up practice in patients referred to Wrexham Older Persons Mental Health Team (OMPHT) with memory problems**
*Dr Priya Nathwani*, FY2, Dr Ashok Krishnamoorthy, Consultant Old Age Psychiatry

**Introduction**
Driving in patients with dementia can be a difficult topic for health professionals to address but it has significant public health and medico-legal implications. This audit was designed to explore current practice in the assessment of driving status, risk and follow up in patients referred to an older person’s mental health team with memory problems. Our standards proposed all patients with memory problems should have their driving status and risk whilst driving discussed and documented at their initial assessment. Additionally, all patients with a diagnosis of dementia should be informed by the health professional in writing to notify the DVLA of their change in health status.

**Methods**
A retrospective analysis of all new patient referrals to Wrexham OMPHT between January and August 2011 was undertaken. Seventy three cases were identified as patients with memory problems or requesting a memory assessment. Patient notes were reviewed and data collected on demographics of the patient, diagnosis, documentation of driving status, concerns about driving and any action taken, and documentation regarding notification to the DVLA.

**Results**
Sixty three patients aged between 66 and 95 were included in the analyses. Driving status was discussed and documented in 64% (N=40) of cases. 25% (N=16) of patients were known to be driving, 51% (N=32) were non drivers and in 24% (N=15) driving status was unrecorded. Two out of the 16 patients still driving did not have any information about their driving risk documented. Concern was raised about three of the patients still driving, and the action taken following this varied. Of the patients still driving and given a diagnosis of dementia, only 25% (N=1) were advised in writing to inform the DVLA.

**Conclusion**
Our audit has shown that driving status and risk whilst driving is not always discussed at an initial assessment when a patient has been referred with memory problems. The use of a proforma which includes a section on driving appears to be a useful reminder to discuss driving with patients. Health professionals appear to be unsure of the protocols to follow if a concern about a patient’s driving is raised or following a diagnosis of dementia. This audit has further educated health professionals within Wrexham mental health services about the importance of prompt communication regarding driving, and the procedures to follow as recommended by the DVLA and GMC.

14. **Auditing The Reconciliation of Medicines in Shelton Psychiatric Hospital**
*Dr E Nazir*, Consultant Psychiatrist, Services for Older People, Shelton Hospital, Shrewsbury, Shropshire, Lecturer in the Faculty of Health, Staffordshire University; Dr Y Al-Shammary, FY1 Shelton Hospital

**Aims**
It is well known that a high risk of prescribing errors which can have potentially devastating
consequences exists at the point of transfer between care settings. This problem is particularly important in elderly psychiatric patients as they potentially have multiple comorbidities, have been prescribed many medications and may not be compliant with all of these. The aim of the study was to evaluate how thoroughly the medications patients being admitted to Shelton hospital were being reconciled, and whether discrepancies were being addressed appropriately.

Methods
The audit took place on three elderly wards from 14/10/2011 – 21/10/2011 in Shelton psychiatric hospital. The audit included patients already on the ward, patients admitted in this period and patients on leave.

Drug cards in Shelton hospital feature a section on the front cover which requires either the admitting or the team doctor to specify whether any discrepancies in a patient’s pre-admission and hospital medications have been reconciled. An audit tool was designed to assess how well this was being completed. The criteria for passing the audit, i.e. successful reconciliation were; a primary source was used e.g. the patients’ own drugs, a verification source was used e.g. GP prescription or discharge summary, any discrepancy between the two sources was reconciled e.g. by asking the patient, their family or contacting their GP.

Results
35 patients’ drug cards were audited in the specified period, resulting in 21 passes and 14 fail. The most common reason for failing the audit was that no attempt was made at reconciling medications (8/14), followed by not cross-checking a primary source with a verification source (5/14).

Conclusions
Whilst ensuring that patients admitted to hospital continue to take their regular medications is important, it is particularly difficult in the elderly mentally ill. At Shelton hospital, we have tailored patients’ drug cards and the admission process towards minimising prescribing the disruption to patients’ medications. Despite this, however, our audit reveals we have achieved only partial success. Improvements could be made by placing greater emphasis on medicines reconciliation in ward rounds, and by ensuring covering doctors/locums attempt to complete the reconciliation.

15. Evaluating the Efficacy and Tolerability of Single Versus Dual Cholinesterase Inhibitors: A Retrospective Cohort Study
Dr E Nazir, Consultant Psychiatrist, Services for Older People, Shelton Hospital, Shrewsbury, Shropshire, Lecturer in the Faculty of Health, Staffordshire University; Dr S Kshemendran, Associate Specialist, Services for Older People, Shelton Hospital; Dr E Al-Shammary, FY1; Dr Y Al-Shammary, FY1, Shelton Hospital; Prof Tony Elliott, Clinical Director, Services for Older People, Shelton Hospital

Aims
The aims of this study were to evaluate whether changing from the use of a single (Donepezil, Galantamine) to a dual (Rivastigmine) cholinesterase inhibitor resulted in improvement in cognition in dementia. Furthermore, attempts were made to identify the side effect profile and how well tolerated each class of drug was.

Methods
This was a retrospective cohort study. Patients included in the study must have attended memory clinic in Shropshire from 2007 to 2011 and had alternated from a single to dual cholinesterase inhibitors for the treatment of dementia. Mini-mental state examination (MMSE) scores taken at regular intervals were used to identify disease progression and response to treatment. In addition, side effects were noted, as were the reasons for changing treatments.

Results
A cohort of 18 patients eligible for the study was identified (11 Female, 7 Male). 3 patients could not be included as their MMSE score was not recorded on changing medication. 1 patient could not be included as their Rivastigmine patch was stopped after 3 weeks. All but two patients had been diagnosed with Alzheimer’s dementia. The most common initial treatment was Aricept 5mg. Patients starting treatments with cholinesterase inhibitors had varying cognitive
capabilities (initial MMSE scores range 29-13).
The study found no significant benefit in changing from a single cholinesterase inhibitor to a dual inhibitor. The mean 3-4 month follow up MMSE score was 0.75 points lower than the score on changing treatments. Only 2 patients gained more than 1 MMSE point on 3-4 month follow up after changing to a dual inhibitor. Most patients did not show any improvement in their MSSE scores following switching from a single to a dual cholinesterase inhibitor. The most common reason for changing medications was nausea.

**Conclusion**
The study found that changing from a single to a dual cholinesterase inhibitor does not result in an improvement in MMSE scores in the majority of cases. Further evidence is required, however, to reveal whether changing medications may slow disease progression. In addition, whilst the study did not reveal any improvement in cognition following treatment with Rivastigmine, it also did not look at other previously stated benefits such as improvement of behavioral symptoms.

16.

**Physical Examination of Elderly Mental Health Service Users: A Re-Audit**

**Dr E Nazir**, Consultant Psychiatrist, Services for Older People, Shelton Hospital, Shrewsbury, Shropshire, Lecturer in the Faculty of Health, Staffordshire University; **Dr S Kshemendran**, Associate Specialist, Services for Older People, Shelton Hospital, **Dr Y Al-Shammary**, FY1 Shelton Hospital), **Dr S.Lyle**, Consultant Psychiatrist, Shelton Hospital

**Aims**
The level of comorbidities in mental health patients is high, and in elderly mental health patients it may well be higher still. Physical examination of these patients on admission is necessary to provide a baseline for monitoring their physical health and to identify potential physical causes for their mental health problems. Previous studies have found that physical examination is generally performed poorly on mental health service users. The aim of the audit was to assess how well doctors were performing physical assessments of patients admitted to the four elderly wards of Shelton psychiatric hospital, Shropshire.

**Methods**
Physical assessments of newly admitted patients are carried out by junior doctors using a standardised pro-forma. The audit took place from 22/11/2011 – 29/11/2011. The case notes of 37 patients on 4 elderly wards incorporating a mixture of organic and functional psychiatric illnesses were audited. Whether patients had had a physical assessment within 24 hours of admission was identified. In addition, quality was assessed using a 30 point scoring system which broke the physical examinations down into general examination, cardiovascular, respiratory, abdominal, neurological, continence and locomotor components.

**Results**
3 out of 37 patients did not have a physical examination with 24 hours of admission to Shelton hospital. It had been recorded in the notes that all 3 of these patients had refused examination. The quality of the physical assessments (as assessed using our 30 point scoring system) varied, with a range of 10/30 – 21/30. No physical assessment was recorded as being ‘complete’. The mean score was 15.7/30. There was little inter-ward variation in performance (mean score of worst performing ward 14.4 versus mean score of best performing ward 16.3). Of the various aspects of physical examination, abdominal (19/37 complete) and locomotor (36/37 complete) were the best performed, while neurological and continence recording were very rarely attempted fully.

**Conclusions**
Our findings concurred with previous studies that revealed physical examination of mentally ill patients is not being completed satisfactorily. Neurological examination and recording of continence status was particularly poor. We suggested that the physical assessment form used in Shelton hospital could be altered in order to make examination simpler. In addition, greater emphasis on physical assessment could be made during ward rounds. Finally, a re-audit should be performed in 6 months to evaluate whether these measures have affected performance.

1. Adeyemo O, Hodgson R, Physical Examination Performed by Psychiatrists, 2004
17. Pilot Study Evaluating the Usefulness and Practical Application of the FRAX Assessment Tool For Osteoporotic Fractures in an Inpatient Setting

Dr E Nazir, Consultant Psychiatrist, Lecturer in the Faculty of Health, Staffordshire University; Dr S Razaq, Foundation Doctor, Dr Y Al-Shammary, Foundation Doctor, Cathy Riley, Chief Pharmacist, Denise Walker, Modern Matron South Staffordshire and Shropshire Health Care NHS Foundation Trust

Aims
A six month pilot study was commenced in April 2011 on an elderly organic psychiatric ward at Shelton Hospital, Shropshire, using the FRAX assessment tool to evaluate the risk of having osteoporotic fractures for older adults (>65 years old). A patient centred management plan was formulated for primary and secondary prevention of osteoporotic fractures.

Methods
The WHO FRAX (fracture risk assessment) tool is an online questionnaire designed to assess osteoporotic fracture risk. This was used on inpatients on Chestnut Ward, Shelton Hospital. An audit tool was developed incorporating the FRAX assessment which included features such as patient number, date of birth, history of falls, history of osteoporosis, and previous treatment for osteoporosis.

Following the completion the FRAX tool a 10 year probability of a major osteoporotic fracture is given. This value can be used to group patients into low, intermediate and high risk groups. Low risk patients were given lifestyle advice. Intermediate risk patients had letters written to their GP recommending Bone Mineral Density measurement. High risk patients were treated (Calcium and Vitamin D supplementation plus Bisphosphonates) according to NICE guidance.

Results
46 patients were admitted to Chestnut ward in Shelton hospital from 01/04/2011 to 30/09/2011. Of these, 41 were included in the final study. Patients excluded from the study were either too old (FRAX assessment tool is only applicable to patients from 40 to 90 years of age) or did not have their height and weight measured whilst in hospital. Patients’ ages ranged from 90 – 68. 22 women and 19 men were included in the study.

BMI ranged from 15.2 - 37.7, with an average BMI of 25.1. Of the 41 patients, 12 had a previous history of fractures and 4 had a parental history of fractures. 5 patients were current smokers, 9 patients drank 3 or more units of alcohol per day and 6 patients were receiving treatment with glucocorticoids. 8 patients had pre-existing osteoporosis. These patients were aged 71 – 87 and none had suffered osteoporotic fractures prior to admission.

Using the FRAX assessment tool, 21 patients were deemed to be at low risk of osteoporotic fractures in the next 10 years. These patients were offered lifestyle advice where possible and a letter was sent to their GP. 14 patients were identified as being at intermediate risk of osteoporotic fractures. For these patients a letter was sent to their GP asking them to measure Bone Mineral Density in order to more accurately determine fracture risk. The remaining 6 patients were at high risk of fractures according to the FRAX tool. 4 of these patients already had a diagnosis of osteoporosis. All of the high risk patients were female. They were treated with Alendronic Acid and Calcium and Vitamin D supplements.

Conclusion
This pilot study highlights the importance of using the FRAX tool to identify patients at high risk of having osteoporotic fractures over a period of 10 years in order for them to be treated with bisphosphonates. This will help to improve the outcome of people with a history of osteoporosis and previous fractures.

18. Immigrant Religion Indigenous Culture: South Asian Experiences of Dementia in the UK

Miss Jemma Regan MSc
This poster presents details of an ongoing PhD research project, funded by a scholarship from the Centre of Ageing and Mental Health, Staffordshire University.

In the U.K. Black and Ethnic Minority (BME) communities are most at risk for developing vascular dementia and experience a higher rate of young onset dementia (under 65 years), as
compared with the majority ethnic population (RCP, 2009, p12). Despite this, BME dementia patients access health services and receive diagnoses later in their disease progression and are less likely to access anti-dementia medication or partake in research trials and care (Mukadam et al, 2011). Current clinical assessments may be ‘culturally biased’ (DoH Standard 7, 2001).

The Western tradition to seek clinical intervention in the case of physical or mental illness highlights the discrepancy between indigenous U.K. culture and immigrant religious practices and rituals. A prominent theme emerging from existing research, not yet directly addressed, is the impact of spirituality and religiosity on dementia; in terms of perceiving the illness, accepting the illness, coping with the illness and accessing services (Milne and Chryssanthopoulou, 2005). This offers one explanation for why barriers exist for BME dementia patients accessing services.

Further study is needed to elucidate the role that religion and culture play in the help-seeking pathway for dementia, and to improve equity of access to healthcare services.

**Aims of the investigation**
- Identify and analyse how religiosity and culture influences the experiences of care and coping for South Asian individuals with dementia, in the UK.
- Discover and evaluate the potential deficits in and benefits of existing dementia care provided for South Asian groups.

**Objectives of the project**
Research and critically evaluate the views and experiences of religiosity on dementia from the perspectives of:
- The South Asian dementia patient
- The dementia carer
- The N.H.S. healthcare professional
- The dementia organisation worker
- The religious leader

**Method**
The study is based on a qualitative design incorporating semi-structured interviews, to be analysed using Grounded Theory, across three phases:
- Phase 1 (PILOT): T1
- Phase 2: T1 + 3 months
- Phase 3: T1 + 6 months

**Predicted Outcomes and Benefits**
Increasing knowledge of the effect of immigrant religious beliefs and practices on dementia experiences will improve care provision and develop ‘culturally competent practice’ (LaFontaine et al, 2007).

19. **Patient Safety Non Negotiable: Audit of standards in generic medical record keeping**

*Dr Neelam Shah,* Specialty Doctor; Dr Simon Wright Clinical Director/Consultant Psychiatrist, Jerry Seymour, Consultant Psychiatrist, Dr Kavita Garneti, Consultant Psychiatrist Mental Health Unit for Elderly, Woodlands, Rotherham, Rotherham Doncaster and South Humber Mental Health Foundation Trust

**Background**
With the increasingly litigious nature of medical practice, accurate record keeping is critical. The records are essential for effective communication and good medical care. Yet they are often accorded low priority. Various independent inquiries have criticised the quality of medical records. Structuring the record can bring direct benefits to the patients by improving patient outcomes and doctor’s performance.

**Aims**
1. To assess the degree of compliance of current medical record keeping with the standards developed by the Royal College of Physicians.
2. The findings of the audit would allow the trust to evaluate its performance with respect to medical record keeping.
Method
Based upon the literature search the standards and the audit tool for generic medical record keeping were adapted. The medical records of last 30 patients, who were discharged in 2011, were retrieved and of these 13 were randomly selected for the audit. The case notes were reviewed, the data were collected and analysed.

Results
There was high level of compliance (77 to 100%) with published standard in relation to 1) standardised protocol for organisation of medical notes, 2) the notes viewable in chronological order from admission to discharge, 3) clerking proforma, 4) standardised discharge summary, 5) every entry signed- (86%), and 6) dating of entries (83%). There was shortfall of the standard in the following: 1) Patients’ name on every page (12 to 42%), 2) Unique identification number (3 to 24%), 3) Every entry timed (22%), 4) clinician’s name printed on every entry (39%), 5) number of entries altered or deleted (2) and 6) counter signed (9%), 7) Number of entries indicating presence of lead clinician (35%), 8) Number of gaps of more than 4 days in between the entries (26%), 9) Number of gaps of more than 4 days where explanation given (38%), 10) change in the consultant responsible for patients’ care, change dated (0 to 100%) and timed (0 to 100%) and 11) advanced decision to refuse the treatment, consent and Cardio Pulmonary Resuscitation decision were not recorded in these case notes studied for the audit, although the trust has got structured proformas for these items.

Conclusion
This audit identifies key areas of strengths and weaknesses in the generic medical record keeping standards, although there is room for considerable improvement. We recommend regular assessment of the standard of record keeping and reaudit. If the services are introducing electronic notes, then having mandatory fields to be completed to the college standards would be one way to improve quality of record keeping.

20. Evaluation of Community Mental Health Team following start of the Dementia care team
Dr Praveen Singh, ST5, East London NHS Foundation Trust

Background
Dementia Care Team (DCT) has been set up in Hackney. This is linked to the new Memory services. Hence there has been a functional and dementia split within the mental health care for older people services. We thought that it would be a good time to do a service evaluation on the remaining “functional” side of the CMHT.

Aim
1. Service evaluation arm-To see the total number, source and nature of referrals to the CMHT and the outcome of these referrals.
2. Audit arm-To monitor the response of the team to meet the standards as envisaged in the 2005 DOH document “Securing better health for older adults”.

Standards
The standards for the audit part were drawn up based on the DOH document mentioned above. This included being a responsive service and screening referrals within 7 days, assessing patients within 14 days, corresponding with referrers within 7 days of assessment, doing multidisciplinary and comprehensive (health and social care) assessments.

Method
Log book of the referral and outcome, referral letters, Patient notes, Correspondence to and from General Practitioners (GP)
All referrals from 1.11.2010 to 1.11.2011 were included in the service evaluation.
**Results**

**Audit**

Carers present in 77 % assessment  
Screening within 7 days of referral -86.8%  
Seen within 14 days of referral-77.8%  
GP correspondence in 7 days-69%  
Multidisciplinary assessment- 90%. All assessments involved a doctor  
Care Plan/ Statement of need-41%

**Service evaluation**

**Total referrals**-189  
Seen for assessment by the CMHT-135 (comparison from previous years - 2004-208, 2005-166)  
Not seen for assessment by CMHT – 54 (19 referred to Dementia services)  
Male: Female-39:61  
Home-73%  
Diagnosis  
Cognitive problems-46%, “Functional” -42% and No mental illness-12%  
Outcome of all referrals (seen or not)  
Discharged-45%  
Care-coordinated-21%  
Dementia care team and Memory clinic-10%  
Intermediate care team (akin to the Home treatment team)-5%

**Conclusions**

1. Although there has been a functional/dementia split about half the patients seen by the CMHT are patients with Dementia  
2. Most patients get a good service and are seen within 2 weeks of referral and these visits were multidisciplinary and always involved a doctor and where possible a carer was present.  
3. Very few new referrals were admitted showing that the Intermediate care team was reducing hospitalisation.  
4. We need to communicate quicker with the GP’s and complete social care assessments.

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21.  
**Audit of Electroconvulsive Therapy (ECT) practice in East Lancashire**  
*Varinder Bir Singh*, ST5 Old Age Psychiatry, Kavitha Venkatesan, Trust Doctor and Albert Swana, Consultant Psychiatrist, Lancashire Care Foundation Trust

**Introduction**

There has been no standardised ECT administration service in the UK for a long time although the treatment has been in use since 1939. National Institute of Clinical Excellence (NICE) published the standards in 2003. Following this, in December 2003 first edition of The ECT Accreditation Service (ECTAS) standards for ECT administration were published. These standards were derived from literature review and consultation with all stakeholders. In East Lancashire, the ECT is administered on the premises of Royal Blackburn Hospital. The service is accredited with ECTAS, however no baseline audit was yet conducted in this department. We devised the audit to examine our service against the desired standards.

**Aims and objectives**

To investigate whether the East Lancashire ECT service is meeting the recommendations stipulated by the ECTAS.

**Methodology**

Patients who received a course of ECT treatment within a 6 month period (Dec 2010 to May 2011) were identified (n=12). However, the data was available for only 10 of these patients as the notes for 2 patients could not be located. Sample strength was therefore 83.34%. An audit-tool was devised to collect data corresponding to the standards. Anonymous data for these patients was collected from the ECT treatment -forms and cross checked with electronic notes for any missing information.
Conclusion
Mostly elderly female patients were given ECT treatment in this time-period. The department was found to be doing well in assessing and preparing the patients for ECT treatment. However, it was identified that improvement in documentation in the aspects of medical history (80%), all-systems physical examination (80%), ASA grade (90%) and drug allergies (90%) was needed. Recording the MMSE score before the start of treatment (70%) was poor and no reasons for omitting this were documented.

The department was following most recommendations for obtaining consent and information sharing but recording and documenting capacity 24 hours before the ECT treatment by the prescribing team was found to be absent in all cases.

It was identified that a vast improvement is needed in monitoring/recording the clinical status and MMSE during the course of treatment and upon its completion. Only in 30% of cases presence or absence of non-cognitive side effects was noted; documentation in this area also needs improvement.

22.
Are NICE guidelines for the management of BPSD challenging to acute hospital staff?

An audit of the use of anti-psychotics in managing behavioural and psychological problems in patients with dementia in the acute hospital setting.

Huay Shan Yuen, University of Birmingham Medical School, Ishrat Ahmed, University of Birmingham Medical School, Dr Marie Stolbrink, RAID - Birmingham City Hospital Psychiatry Liaison Team, Professor George Tadros, RAID - Birmingham City Hospital Psychiatry Liaison Team

Background
Behavioural and psychological symptoms of dementia (BPSD) can cause significant problems in acute hospitals. NICE published management guidelines including non-pharmacological and pharmacological methods. The use of anti-psychotics is associated with an increased risk of cerebrovascular events and death in patients with dementia.

Aims
To audit the use of anti-psychotics in the management of BPSD according to NICE guidelines in acute hospital.

Methods
Patients with BPSD were identified from the Birmingham City Hospital Psychiatry Liaison (RAID) Team referral database. Inclusion criteria included seen between January-December 2011, age > 65 years, diagnosis of dementia, presentation with BPSD and treatment with anti-psychotic drugs. 124 patients were referred for BPSD, 32 patients treated with anti-psychotics. Hospital and pharmacy notes were obtained for 16 patients; a total of 17 admissions. The records were analysed to establish whether the patient was admitted on anti-psychotics; presenting symptoms; the duration, dose, who prescribed and stopped the anti-psychotic; whether prescription was urgent and whether NICE guidelines were followed.

Results
The most common reasons to prescribe anti-psychotics were agitation, aggression and wandering.

Ten cases (58%) were on anti-psychotics on admission, 7 initiated by CMHT and 3 by GPs, risperidone was most common antipsychotic (50%). In most cases (60%) anti-psychotics were discontinued in hospital by the liaison team. However, in 4 cases a second anti-psychotic was prescribed (3 urgently, 1 non-urgently), all by the ward doctor without psychiatry input and for one day or less. When a second anti-psychotic was prescribed urgently (3 cases), a low-stimulation environment, using the lowest effective dose and offer of discussion with family were not provided.

For those who were prescribed anti-psychotics during hospital admissions, the majority were prescribed in the first 6 days (85%), urgently (71%) and by the ward doctor (71%) rather than RAID. The majority (71%) were on anti-psychotics for less than 5 days, and only 1 patient was discharged on anti-psychotics (14%). The most commonly used antipsychotic for urgent cases was haloperidol (100%), followed by risperidone and olanzapine for non-urgent cases.
Assessment of cardiovascular risk factors was carried out well in all admissions, but particularly providing an appropriate environment, communication with patients’ families and exploring co-morbidities were carried out poorly.

**Conclusion**

NICE guidelines were poorly followed, particularly in urgent cases. The majority of anti-psychotics were prescribed by ward doctors but discontinued the liaison team. In non-urgent cases co-morbidities such as depression were never considered. More education of physicians and close cooperation between psychiatry and medicine is needed for the best patient care.

23. How are relationships negotiated by people with dementia? A comparison between young onset dementia and later onset dementia.

Edward Tolhurst, PhD Student

This qualitative study is exploring how support might be tailored to meet the variable requirements of people with dementia of different ages following diagnosis. Different life stages are likely to intersect with the experiences of people with dementia as they negotiate relationships with family members and professionals. This study will thus explore whether actual and perceived differences in age-based needs might impact upon the experiences of people with dementia and their families. To explore this research question, semi-structured interviews are being undertaken with a number of people with young onset dementia and a number of people with older onset dementia. A joint-interview format is being deployed with the partners of people with dementia also participating.

The majority of people with dementia are older adults. However, a significant number have young onset dementia. There is scant qualitative research which draws direct comparison between the subjective experiences of younger and older people with dementia.

The notion of status passage suggests that people move between different stages or statuses throughout their life. A status passage can be linked to age, such as movement from childhood to adulthood; however it may also refer to other life experiences. For example, a significant health condition could be considered a status passage. To some extent a health-related status passage may be integrated with that of age, as declining health is to some extent associated with ageing. However, dementia underscores the fact that ageing and illness do not have a straightforward correlation. When a health-related status passage confounds normative notions of age-based experience, as with young onset dementia, what impact does this have upon the person with dementia and their family?

A key aim set out in the UK’s Dementia Strategy is to provide diagnosis of the condition as soon as possible following onset; this is so that the person with dementia has optimum opportunity whilst they have capacity to make choices which will influence their future care. Recognition of the similarities and differences between those experiencing young onset dementia and those with older onset dementia can help to ensure that this strategic rhetoric is increasingly complemented by professional support and service delivery. This study will conclude in late 2013.

24. Venous thromboembolism awareness survey of Mental Health Services for Older People clinical staff in Tees, Esk and Wear Valleys NHS Foundation Trust

Dr Martin van Zyl, ST5, Old Age Psychiatry, Bowes Lyon Unit, Durham, Tees, Esk and Wear Valley NHS Foundation Trust; Dr Gillian Wieczorek, ST5, Old Age Psychiatry, Centre for the health of the elderly, Campus for Ageing and Vitality, Newcastle upon Tyne, Northumberland, Tyne and Wear NHS Foundation Trust; Prof Joe Reilly, Professor of Mental Health, Wolfson Research Institute, Stockton on Tees, Tees, Esk and Wear Valleys NHS Foundation Trust

**Aims**

Currently, failure to adequately screen and prevent venous thromboembolism (VTE) is estimated to cause between 25000 and 32000 potentially avoidable deaths annually in the UK. We aimed
to assess the awareness of VTE in clinical staff working in Mental Health Services for Older People, Tees, Esk and Wear Valleys NHS Trust.

Methods
The authors devised a questionnaire to assess awareness of VTE in regards to: 1) where in the body VTE developed, 2) the comprising aspects of VTE, 3) clinical symptoms, 4) risk factors, 5) prevention, and 6) treatment. We distributed the questionnaire to clinical staff working in Mental Health Services for Older People, including nursing staff, doctors and pharmacists working on inpatient units.

The survey was initially sent out in May 2011 to Nurse Managers in the Durham and Darlington localities and cascaded to inpatient nursing staff. A total of 49 nurses responded. A second wave of identical surveys in the same localities was distributed to all Consultant Old Age Psychiatrists via the Clinical Director, with 12 responses. Finally, a senior pharmacist distributed the survey to trust pharmacists, generating 11 responses.

Results
The study confirmed a need for improved awareness amongst all clinical staff including nurses, pharmacists and doctors. Clinical staff had significantly more limited knowledge of pulmonary embolism compared to deep vein thrombosis with weaknesses in, especially, presentation, risk factors and prevention. The need for an improved awareness of VTE was further highlighted by the fact that a significant proportion of staff had previous involvement in the treatment of VTE.

Recommendations
To improve awareness we will distribute a VTE E–learning tool to all clinical staff. Managing VTE will also be included in annual First Response Training compulsory to all clinical staff in the trust. To assess the impact of these recommendations, the survey will be repeated in 12 months.

25. Education Theory and Dementia Training for Health Care Professionals
Dr Roz Ward, ST6 in Old Age Psychiatry, Avon and Wiltshire Mental Health Partnership NHS Trust.

Dementia is out in the open, a challenge no longer ignored. The population living with dementia in the UK is predicted to increase by 154% over the next 45 years and with its associated disability, social and economic burdens, dementia is emerging as a national priority. The National Dementia Strategy was launched in February 2009. It recognised the poor level of both public and professional understanding of dementia and the “need for improved training as a priority that runs across all themes in the strategy.” Furthermore there is evidence that dementia care quality across health and social care settings is too often less than optimal. This suggests that health care professional dementia education to date has been inadequate and ineffective. As dementia specialists, many of us engaged in teaching, how should we respond?

In this paper I reflect on a successful personal dementia learning experience, brief Dementia Care Mapping training, and examine what insights educational theories provide for its efficacy as a learning method. I then consider how educational theories can be applied to facilitate health care professional learning about dementia in a variety of settings. Barriers to learning about dementia are examined, including the importance of taking into account the incentive and social dimensions of learning rather than a focus solely on the content dimension. Avoiding these barriers creates the potential for innovation and change in dementia training and avoids ineffective imposed dementia education.

26. Audit of fidelity of clinicians to the Mental Capacity Act in the process of capacity assessment and arriving at best interests decisions.
Dr Oluwatoyin Sorinmade, Consultant Older Adult Psychiatrist, Oxleas NHS Foundation Trust, UK, Dr Geraldine Strathdee, Consultant Psychiatrist, Oxleas NHS Foundation Trust, UK, Dr Catherine Wilson, CT3 in Psychiatry, South London and the Maudsley NHS Foundation Trust, London UK, Dr Belinda Kessel, Consultant Geriatrician, Princess Royal University Hospital, South London Healthcare NHS Trust, London, UK, Dr Obafemi Odesanya, Core Trainee in Psychiatry, Oxleas NHS Foundation Trust, UK
Aim
The purpose of this audit was to evaluate how closely healthcare professionals adhere to the principles of the Mental Capacity Act (MCA) in both determining mental capacity and arriving at best interests decisions in those individuals found to lack capacity to make a decision.

Methods
This was a retrospective audit of the electronic case notes of 68 patients, over the age of 18, that had been determined by a healthcare professional to lack the mental capacity to make a specific decision about consenting to treatment; deciding on place of abode or managing financial affairs within the last two years. The notes were examined by four doctors using an audit tool which addressed how the clinicians had documented their assessment of the patient’s mental capacity and on what grounds they lacked capacity. The tool also looked at whether clinicians were following the legal process for involving others in making best interests decisions for example a Lasting Power of Attorney or Court Appointed Deputy as well as the clarity of documentation.

Results
The audit demonstrated that there was no clear system of documenting capacity assessments and it was often hard to find information relating to this in case notes. Where comments were made in the case notes these were often minimal with very little information regarding the process of assessment of mental capacity and on what grounds the patient was deemed to lack capacity. Over half of the assessments related to the capacity to decide on place of abode. It was evident that in the majority of cases clinicians only partially followed the procedure prescribed by the MCA in determining best interests. In only 25% of cases did clinicians comment on trying to ascertain whether someone had a Lasting Power of Attorney and much fewer commented on a Court Appointed Deputy or IMCA where relevant (the latter only 6%).

Conclusions
Clinicians are either not clearly documenting or not rigorously following the process set out in the MCA for assessing capacity and making best interests decisions. The authors recommend that the process for assessing capacity and coming to a best interests decision should be taught more widely throughout the Health Service and that clinicians should be provided with an easy to follow flow chart explaining the process and ensure that they document these assessments clearly.

Poster Presentations
Friday 16 March
Main author/presenter indicated by bold/italics

1. "When do you pull the last straw?" A survey on discontinuation of choline esterase inhibitors
Dr Antony Prakash Antony, Dr Simon Thacker

Background
The latest (2011) guidance from the NICE recommends that choline esterase inhibitors (ChEI) are prescribed for people with mild-to-moderate Alzheimer’s disease. The drugs should only be continued while the patient’s MMSE score remains at or above 10 points (subject to few exclusions) and their global, functional and behavioural condition remains at a level where the drug is considered to be having a worthwhile effect. ‘Worthwhile effect’ is not clearly defined by NICE. How does the clinician decide upon what constitutes benefit especially once the illness has continued to worsen?

Methods
We surveyed some old age psychiatrists in the East Midlands and Yorkshire by email and the respondents were requested to complete a questionnaire electronically. 17 consultant old age psychiatrists responded to our questions on their practice of withdrawing ChEIs.

Results
One third of our respondents did not feel confident in judging the timing of stopping ChEIs.
There was unanimity against adherence to stopping the drugs on solely the basis of MMSE score whilst significant majorities (13/17 in each case, p<0.05 on tow-tailed binomial test) favoured being led by pragmatic indicators of progression such as care home placement or failure to recognise family members.

One third (6/17) were happy to prescribe ChEI if the patient lived in their own home and disregard of the MMSE score, global functioning and severity of illness. While one fourth of respondents would consider stopping ChEIs once the patient was placed in a care home, another one fourth of clinicians would wait until the patient had lost the ability to recognise close family.

Many of our respondents admitted that they sometimes initiate ChEI for patients with BPSD in severe dementia. One third of our respondents were reluctant to stop ChEI due to fear of relapse of BPSD. More than half of our respondents would continue to prescribe ChEI if the carer was reluctant to stop the drugs.

**Conclusion**
Clinicians vary in their practice on withdrawing ChEI and there is little agreement on what they consider as a ‘worthwhile effect’ of antidementia drugs. Antidementia drugs also serve the purpose of maintaining hope and clinicians cannot ignore the ‘hope’ factor while considering stopping the drugs. This was reflected on our survey results as majority (11/17) of our respondents were willing to stop ChEI if they had access to Memantine which the clinicians may view as an alternative route to prescribe hope. Meanwhile, the amount of hope needed to navigate this illness should not be underestimated

2. **Do we need more monitoring of Anti psychotics prescribing in patients with Dementia?; An Audit of Anti psychotics prescribing in patients with Dementia in NSCHT, Stoke on Trent.**

*Dr Ramesh Atikum*, Dr Adeyemo, Val Alcock, Laurie Wrench

**Aim**
To ensure best practice of the prescribing of Antipsychotic Medication for Dementia patients at North Staffordshire Combined Healthcare NHS Trust.

**Standards**
The clinical indications (target symptoms) for antipsychotic treatment should be clearly documented in the clinical records.
Before prescribing antipsychotic medication for behavioural and psychological symptoms in dementia, likely factors that may generate, aggravate or improve such behaviours should be considered.
The potential risks and benefits of antipsychotic medication should be considered, documented, should be discussed with the patient and/or carer(s), prior to initiation.
Medication should be regularly reviewed, and the outcome of the review should be documented in the clinical records.

**Method**
All patients recorded on the Dementia register/database who were newly prescribed an antipsychotic medication between 1 July and 30 September were identified. Where the register was not fully populated, a manual trawl of patient records to identify the above patient group was undertaken. The total number of patients identified was n=38.
Retrospective data was collected from patient notes and recorded onto a data collection form.
Data was analysed by the clinical audit department using SPSS and validated according to departmental guidelines

**Results**
Total Sample 38
21 (55%) Male
17 (45%) Female
100% of the Patients were White British Origin
95% of patients at least one clinical goals for Anti Psychotics were documented
5% of Patients had no documentation of clinical goals
62% of Patients, all the potential reasons for BPSD in Dementia were considered
82% of Patients had at least one of the non Pharmacological interventions were tried
79% of the patients there is a evidence that a risk / benefit analysis regarding antipsychotic 
medication was undertaken
82% of the patients either patient or family member were consulted prior to the initiation of the 
Anti Psychotic
59% of the patients had all the following considered:
Clinical indication for antipsychotic medication documented
All potential underlying causes of BPSD documented
At least one non-pharmacological intervention tried
Risk/benefit analysis taken in to account
Patient / carer(s) consulted regarding risks / benefits prior to antipsychotic initiation

Conclusion
Recommended to achieve 100% compliance and check list has been circulated to all the relevant 
teams, agreed to re evaluate in 4 months time.

3. Are we following the best practice in the care of Elderly people with Dementia?; An 
evaluation of Discharge planning in patients with Dementia on Anti-Psychotics, NSCHT, UK.
Dr Ramesh Atikum, MRCPsych. Dr Olubukola Adeyemo, MRCPsych, Laurie Wrench.

Aim
To ensure best practice in the prescribing of antipsychotic medication for dementia patients at 
North Staffordshire Combined Healthcare NHS Trust.

Method
Sample and Data Collection
All patients discharged with a diagnosis of Dementia and on an antipsychotic between 1st 
July and 30 September 2011 (inclusive) were indentified, through a discharge report from electronic 
record, for those discharged between the above dates with a diagnosis code of F00 to F03 
(n=51), A review of patient notes identified above was carried out to determine those 
discharged on an antipsychotic (n=14) Retrospective data was collected on the final sample from 
patient notes and recorded onto a data collection form. Data was analysed by the clinical audit 
department using SPSS and validated according to departmental guidelines.

Results
6/14 (43%), were Male
8/14 (57%) were Female

Side Effects Review after the Initiation of Anti Psychotics
50% Patients Mobility Reviewed
57% Patients Falls Reviewed
27% Patients Sedation Reviewed
78% Patients Blood Pressure Reviewed
21% Patients anti cholinergic Side effects were reviewed.
0% Patients all the above were considered.

Pre & Post Discharge Review Of Anti Psychotics
64% Patients had Predischarge Review on Anti Psychotics
64% Patients had a discharge Care Plan
55% patients care plan refers to Anti Psychotic use
77% Patients had Post Discharge date is set.
85% cases GP contacted post discharge
100% included the details of anti psychotics in GP letter
1 Patient had post discharge care review
1 Patient had review but data not recorded
1 patient did not have the review
In 10 Patients time had not elapsed to have the review

Conclusion
Results were presented in the care quality review meeting and discussed on strategies to 
improve our current standards of practice, in order to achieve 100% compliance with the
guidelines in the best interest of the patients. Results are presented to all the teams and the check lists were circulated to all the relevant team. Re evaluation will be carried out in another 4 months time.

4. **A survey of patient delays on the care pathway in our Old Age Psychiatry inpatient unit**

**Dr Paul Brown**, NHS Dumfries and Galloway; **Dr Ajay Macharouthu**, NHS Dumfries and Galloway

**Introduction**
The care pathway is the patient’s journey from admission, assessment and therapeutic interventions through to discharge. Delays in the care pathway and in particular, delayed discharges are a significant problem in the NHS with adverse financial and patient welfare ramifications. A delayed discharge is a hospital inpatient who has been judged clinically ready for discharge by the responsible clinician in consultation with all agencies involved in planning that patient’s discharge, and who continues to occupy the bed beyond the ready for discharge date (RDD). Such delays are costly to economically pressured services and obstruct available beds for patients who are psychiatrically unwell. Delayed discharges occur secondary to a plethora of factors capable of adversely impacting on patient care, including the potential psychological impact of affected patients, hindering further clinical recovery.

**Aims and objectives**
To evaluate the performance of our old age psychiatry inpatient unit in efficient utilisation of the patient care pathway, focusing on management of discharge planning and efficient discharge processes.
To elicit the reasons for inefficient patient care pathways focusing on delayed discharges thereby facilitating awareness and potentially targeting resources to resolve such issues.

To inform service development, particularly illuminating problems with a disintegrative social services model and close collaboration with the delayed discharge coordinator to rapidly resolve delays.

**Methods**
Fifty (n=50) patients were randomly selected from the admissions log (25 patients from the organic unit and 25 patients from the functional unit). The citrix system was then utilised for data capture. This system keeps daily electronic records regarding each patient. These daily records included the pertinent information required for this survey, including records from MDT meetings and documentation of discharge delays/explanations.

**Results**
Our preliminary results reveal clear and potentially rectifiable reasons for care pathway delays. Full results will be presented at the time of the conference.

**Conclusion**
Although our results and data processing are at a preliminary stage, clear trends are emerging including readily identifiable and correctable reasons for delays in the care pathway, including delays in social work allocation and in discharge planning processes. Importantly, a number of identified reasons for delays could be addressed and therefore there is excellent potential to increase efficiency, with tangible improvements in patient care and reduction in cost. We hope to help inform service development towards more efficient social service models and desire that our survey serves as an impetus for a robust prospective audit in delayed discharges.

5. **Undiagnosed Dementia and Inappropriate Use of Antipsychotics Within Long Term Care**

**Dr Craig Gordon**, NHS Dumfries and Galloway; **Dr Paul Brown**, NHS Dumfries and Galloway; **Ms Lynn Kirkwood**, NHS Dumfries and Galloway; **Ms Margaret Hollinger**, NHS Dumfries and Galloway; **Ms Judith Logan**, NHS Dumfries and Galloway; **Mr Ian MacQuarrie**, NHS Dumfries and Galloway; **Dr Ajay Macharouthu**, NHS Dumfries and Galloway; **Ms Linda Mckechnie**, NHS Dumfries and Galloway
Introduction
Dementia is a national priority. There are an estimated 683,597 people with dementia in the UK, representing approximately one person in every 88 (1.1%). Dementia is a significant cause of disability in later life, being third in the world health organisation’s global burden of disease report. By 2025 one million people in the UK will have dementia. Surprisingly, only 1.4% of research papers since 2002 have investigated dementia resulting in limited exploration of how dementia is recognised and managed in care homes. Previous studies have confirmed that 2/3 of residents within care homes suffer from dementia. Dementia has attracted a high media profile, particularly in relation to antipsychotic prescribing.

Aims and objectives
Our primary aim was to explore dementia diagnoses within care homes. The objectives included quantifying prevalence rates of undiagnosed dementia within residents of care homes throughout Dumfries and Galloway. Additionally we examined prevalence rates of diagnosed dementia in care homes in addition to prevalence of anticholinesterase prescription for dementia. Additionally we aimed to quantify rates of inappropriate antipsychotic prescribing in undiagnosed dementia.

Methods
All care homes within Dumfries and Galloway were invited to participate. Patient lists from each care home were compiled and every third patient randomly selected for potential participation and consenting. Post randomisation 299 patients were eligible for consideration of inclusion with 192 meeting inclusion criteria. An MMSE was performed on each participant along with a CAM scale and a FAST. Exclusion criteria included current antibiotic use, delirium and sensory difficulties. Care home staff were interviewed to obtain a cognitive history and the participant’s notes were scrutinised for a dementia diagnosis in addition to other pertinent clinical information.

Results
The completed results of this study will be submitted for analysis and available during the presentation. Statistical analysis of our preliminary results demonstrate compelling findings. These include 86% of patients recruited to date meeting the criteria for dementia and of those, a statistically significant 27% (p=0.016) had no previous history of dementia.

Conclusions
Our results are at a preliminary stage however important conclusions are emerging. Our results suggest a higher prevalence rate of dementia within care homes than previously thought with a significant proportion of undiagnosed cases. In addition, we identified undesirable levels of antipsychotic prescribing and demonstrate a concerning association of unrecognised dementia and high antipsychotic prescribing. Our final conclusions could influence service model development for timely diagnosis and management of dementia in care homes.

6. A completed audit cycle: Antipsychotic prescribing in dementia patients in care homes in Wolverhampton
Dr. MK Choyi, Dr. J. Viswanathan, Dr. S. Gilani, Dr. S. Bhattacharyya

Background
Prof. Sube Banerjee’s government commissioned report in 2009 and The NICE Guidelines 2006 (revised in March 2011) strongly recommended reducing the use of antipsychotics in people with dementia.

Aim
To analyze the current practice of antipsychotic prescribing in dementia in Wolverhampton against the gold standard of Nice guidelines.

Method
Retrospective analysis of care notes of patients with dementia, residing in care homes in Wolverhampton seen by all teams in a month. The initial audit was done for the month of April 2009 and included 135 patients and the re: audit for the month of September 2011 included 273 patients.
The main findings of the first and second audits respectively:
Patients were on antipsychotics: 49.5% and 41.8%
  - Quetiapine 35.3% and 10.1%,
  - Promazine: 27.4% and 33.3%,
  - Haloperidol 13.7% and 3%
  - Risperidone 3.9% and 21.2%
  - Combined 11.8% and 6.1%
Pre-start counseling documentation in 7.8% and 30.3%
The indications were:
  - Challenging behavior in 86.2% and 63.6%
  - Psychotic symptoms in 19.6% and 30.3%
Review of medication:
  - Less than 4wks: 1.9% and 15.1%
  - <3 months: 49% and 72.7%
  - >3 months: 43.1% and 9.9%
Indications to continue antipsychotics was recorded in 78.4% and 72.7%
The duration of antipsychotic use was less than 1 year in 50.9% and 48.4%

Recommendation following the first audit was to ensure compliance with the NICE guidelines with monthly peer group review of prescribing practice.

Key factor - Culture change
The existing guidelines were taken as the best practice protocol and an intensive awareness and educative initiative within each team under the guidance of the consultants was undertaken to bring about a change in the prescribing culture in the Trust.

Recommendations of the second audit
1. Monthly review of Antipsychotic prescribing practice by psychiatrists
2. To improve the quality of documentation when anti-psychotics are initiated or continued.
3. At least 3 monthly or earlier review of prescribed antipsychotics

7.
Delivery of individual Cognitive Stimulation Therapy by carers: reflection on the development of a CST carer’s training course within the Services for the Elderly.
Dr. Rinki Ray Dutta, ST5 Old Age Psychiatry, Leicestershire Partnership NHS Trust, Dr Karolina Kujawska-Debiec, CT1, Leicestershire Partnership NHS Trust; Sarah Platton, Senior Community Psychiatric Nurse, Memory Clinic, St. Mary’s Hospital, Kettering

Introduction
Cognitive Stimulation Therapy (CST) is a group programme to improve the cognition and quality of life in dementia. This is recommended by NICE and research suggests maintenance CST could sustain the cognitive benefits achieved during the initial programme.

CST groups have been running at the Kettering Resource Centre, for the last 2 years. However shortage of resources has resulted in the Trust not being able to deliver maintenance therapy.

Feedback from carers and patients indicated a need for a therapy which can be delivered at home. This would be particularly beneficial for those, unwilling to go out or attend groups. Moreover such a project may help the relationship between carers and patients.

Method
We developed a CST training course for carers. A formal consent was obtained from CST group attendees in February 2011 and carers were contacted by phone.

The course consisted of an introductory face to face session. A specially designed workbook was distributed with a feedback form. The carers were instructed to use the workbook as a guide and deliver sessions twice a week for 8 weeks after the initial CST group terminated. A second session was organised at the 9th week of this intervention to enable carers to share their experiences with peers and professionals.
A pre and post programme MMSE score was recorded. A QOL-AD (Quality of life in Alzheimer's disease) score was obtained from both carers and patients.

**Results**

MMSE scores showed a 2 to 3 point improvement in 5 cases. There was a drop out of 1 due to the service user being hospitalised.

The QOL-AD scores show a 1 to 2 point improvement in the 'life on the whole' and 'ability to do things for fun' domains for all 5 cases.

**Conclusion**

Overall the carers programme indicated a positive outcome and feedback from carers and service users suggested a favourable response like 'being able to do fun things at home'.

The carer’s workbook and information leaflet designed for this project is already in use within the Trust. The Memory Services Committee is considering implementation of this intervention as a part of each CST programme.

We plan to analyse the cognition and quality of life scores for future groups once the course is implemented. If the efficacy of this intervention is replicated in future we would expect this to become a popular and widely used intervention for people with dementia and their carers.

8. **Euthanasia and a 'good death': an inductive study of data from the Mass Observation Archive**

**Dr Peter Kevern**, Faculty of Health, Staffordshire University, Professor Susan Mary Benbow, Centre for Ageing and Mental Health, Staffordshire University and Professor Paul Kingston, Centre for Ageing and Mental Health, Staffordshire University

**Aim**

To analyse narrative data on current thoughts, emotions, convictions and deep assumptions concerning death and assisted dying.

**Method**

The Mass Observation Archive gathers the views of a panel of volunteers nationwide on a regular basis, through sets of questionnaires known as directives. Part of the directive for summer 2011 included a section on Ageing and Care; containing three questions which sought to elicit the volunteers’ opinions on death and assisted dying: What do you think would be a 'good death'; Do you think people have a right to kill themselves; and What are your thoughts about whether people should be able to choose euthanasia? A total of N=166 individuals responded to the directive, of which 6 replied by email. Data were gathered as free-text answers which were analysed [N=66 email replies] thematically in three independent ways: by one researcher through NVivo, and by the other two individuals through individual scrutiny.

**Results**

Analysis of the data is ongoing. One preliminary conclusion is that the discussion of a good death is based upon a very limited palette of themes when viewed historically and transculturally. In addition, the responses to the section on death and euthanasia were notably brief and sketchy, compared to sometimes lengthy expositions on care and caring. A peaceful, quick and painless death was widely regarded as an ideal, though this was in some tension with a desire to involve family members and to minimise their suffering. This in turn may help to explain why the main argument offered in favour of euthanasia was the primacy of personal choice; and the main concern expressed was fear of coercion. Religious reasons for opposing euthanasia were only rarely given, but among those in favour of legalising euthanasia the assumption was frequently made that opposition was religiously-driven. The sample of respondents appears to be predominantly white, retired and educated; their representativeness of the population as a whole is therefore in question.

**Conclusions**

Among white, retired and educated respondents, discussion of the characteristics of a 'good death’ and the role of euthanasia in securing such an outcome draws on an unexpectedly narrow
range of themes, and an uncharacteristically short set of responses. This raises the question of whether a richer range of tools would enable some people to contemplate and plan for their own and others’ death – it may also suggest that reflection on the end of the life course is fraught with ambivalence and angst.

9. Use of Community Treatment Order (CTO) in Older Adults

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Aim
The aim of this review is to critically analyse the use of Community Treatment Order (CTO) in older adults.

Method
A review of literature was performed using the standard search mechanisms including the National Health Service (NHS) library, Staffordshire University library research database exploring the use of CTO in older adults with mental health challenges. The terms used in the search were: CTO use in older adults, CTO use in dementia population, old age psychiatrists and use of CTO. The results obtained by the search were then analyzed to explore the number of CTOs used in the United Kingdom (UK), its use and perceptions among the psychiatrists and the need to further explore the attitudes and perceptions of old age psychiatrists in using CTO.

Results
One of the most significant and controversial changes to mental health law in the last 20 years was probably the introduction of Supervised Community Treatment (SCT) through the 2007 amendments to Mental Health Act 1983. It is also an element, which has proved contentious to both service user and professional groups, both having voiced strong views about its use (Crawford 2000; Mental Health Alliance, 2006). Mullen et al (2006) described six dilemmas that face clinicians considering the use of CTOs: uncertain efficacy, uncertain balance of advantages, impact on therapeutic relationships, resource constraints, the dilemma of discharge (i.e. does success indicate that discharge is appropriate: ‘the more successful, the more unnecessary the CTO appears to be’) and administrative burden. Taylor (2010) reports that a Cochrane review (Kisely 2003) examining the efficacy of CTOs pooled data from the only two relevant trials and estimated that 85 people would need to receive a CTO in order to avoid one psychiatric admission, and that 238 people would need to receive a CTO in order to avoid one arrest. There is little available evidence on use of CTOs in over 65s from accessing CQC, which despite providing adequate data on mental health detentions provides no age specific data. At any given time, about 16,000 patients are detained in hospital under the Mental Health Act, and more than 4,000 people are subject to CTOs. Therefore a hypothesis could be developed that CTOs were likely to be used much less in over 65s and need arises to survey perceptions and attitudes of old age psychiatrists on use of CTOs in older patients.

10. Is there a link between dental pain and behavioural and psychological symptoms of dementia (BPSD) in older nursing home patients?

Dr Anna Tsaroucha, Research Associate, Staffordshire University; Prof. Paul Kingston, Professor and Director, Centre for Ageing and Mental Health, Staffordshire University, Stafford; Dr. John Morris, Consultant in Dental Public Health, Staffordshire PCTs; Dr. Farooq Khan, Specialist Registrar, Black Country NHS Partnership Trust, Hon Lecturer, Centre for Ageing and Mental Health, Staffordshire University, Stafford; Dr. John Morris, Consultant in Dental Public Health, Staffordshire PCTs; Dr. Farooq Khan, Specialist Registrar, Black Country NHS Partnership Trust, Hon Lecturer, Centre for Ageing and Mental Health, Staffordshire University, Stafford; Prof George Tadros MD MRCPsych., Consultant Old age Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust, Professor in Old age Psychiatry, Centre for Ageing and Mental Health, Staffordshire University, Stafford

Aim
This study aimed to investigate the potential link between treatable dental problems (that cause
pain) and BPSD in nursing home patients.

Method
A single group pre-test/post-test design was employed to investigate the possible involvement of dental pain in nursing home residents with dementia who present with BPSD. According to this design, a group of older nursing home patients with BPSD were measured in terms of cognitive and behavioural status using the Mini Mental State Examination (MMSE) and Cohen Mansfield inventory (CMAI), then subjected to dental screening and as the researchers did not find any dental health issues on screening there was no treatment necessary, and measured again to identify if their behavioural status has improved as a result of the treatment.

Results
A total of 65 patients (28 males and 37 females) between 58 and 99 years of age exhibiting BPSD were recruited in the study. 25% (n=16) patients were on pain relief medication, 9% (n=6) patients were on antipsychotics and 14% (n=9) patients were both on pain relief and antipsychotic medication. A total of 89% (n=58) had no capacity to consent for the inclusion into the study and the mean MMSE score was 5.03. CMAI was used to assess the agitated behaviours of BPSD and were divided into four categories of agitation. The sub-classification of the CMAI revealed following scores: physically aggressive behaviours (mean=27.7, maximum 60), physically nonaggressive behaviours (mean=27.04, maximum 54), verbally aggressive behaviours (mean=10.2, maximum 22) and verbally nonaggressive behaviours (mean=9.2, maximum 21). The dental examination by a qualified dentist revealed no dental problems that required treatment in any of the patients of the three nursing homes. Hence, there was not a need for a follow up behavioural assessment. The results suggested that the behavioural and psychological symptoms on dementia are not caused by dental problems or dental pain. The data also suggests that a large number of care home patient (89%) will not have mental capacity to make an informed choice of giving consent for any type of research, the MMSE scores indicate that a majority of patients with dementia will be classified under severe spectrum of the disorder and physically and verbally aggressive behaviour poses a risk in identification and management of dementia patients. The sample size was 65 patients and the authors don’t support the generalization of results to the whole older adult population.

11. Pros and cons of using Single Photon Emission Computed Tomography (SPECT) or Computed Tomography (CT) scan in diagnosing dementia

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Aim
To demonstrate the pros and cons of using either SPCET or CT scans in the differential diagnosis of dementia.

Method
All the notes of patients referred to CT / SPECT head scans during 2009 and 2010 belonging to Services For Older People (SFOP) were analyzed in this retrospective study design. The notes were hand search for demographic details, reasons for referral to SFOP, reasons for requesting the specific scan, timings of the scans, findings on the scans, diagnosis before and after the scans and the changes to the management of the patients after the scan. The findings of CT / SPECT scans were compared with each other to demonstrate the use of specific scans in possibilities of specified dementia conditions.

Results
Out of 46 patient’s notes scrutinized 76% were females and 65% were over the age of 70 years. The general physicians referred 87% of these patients to SFOP mainly for memory problems, after the first assessment 67% were referred for scanning for cognitive impairment followed by 13% for psychosis (delusions and hallucinations). Only over 40% of patients received some form of diagnosis after the first assessment and about 60% did not receive any diagnosis probably the reason being that the Community Psychiatric Nurses (CPN) performed 59% of the first assessments followed by middle grade doctors (24%) and consultants (17%). About 56.5% of
patients scored 26 or more on Mini Mental State Examination (MMSE) and none of the patients scored less than 10. Compared to CT scans (1 case), SPECT scanning showed a clear diagnostic indication of vascular, Alzheimer’s and fronto-temporal dementia (6 cases). In 26% cases SPECT showed involvement of different lobes and regions of the brain including temporal, frontal, parietal, occipital and cerebellar lobes and internal capsule and basal ganglia. Predominant vascular changes were picked up more accurately by the CT scan (5 cases) compared to (2 cases) SPECT scans. It can be concluded that choosing the specific type of scanning requires an initial consideration of diagnosis by the referrer so that particular type of scanning is requested. This will eventually work well if provisional diagnosis is made early so that appropriate scanning could be offered and would also be economical.

12. The use of supportive observations within an inpatient psychiatric unit for older people and dilemma of using the Mental Health Act or the Mental Capacity Act

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Aims
To find out the conflicts that arises as a result of implementing observation policies on older adult wards and using mental health and mental capacity act.

Methods
This is a review of articles, which is based on the studies performed specifically in the areas of inpatient mental health units focusing on the conflicts between the observation policies and the use of mental health or mental capacity act.

Results
In England and Wales the interface between the Mental Capacity Act (MCA) and Mental Health Act (MHA) is frequently encountered in mental health practice. In services involving older adults many service users will have cognitive impairment and assessments regarding their mental capacity to make decisions are frequently required. Service users with these illnesses are admitted to psychiatric wards and occasionally nursed under ‘close observations’ in order to maintain their safety and that of others. The concepts of ‘complete and effective control’ which may be exercised by ward staff in these circumstances, and the resulting ‘loss of autonomy under supervision and control’ must be understood in consideration of whether a ‘deprivation of liberty’ ensues, particularly when they does not have mental capacity to make decisions about the observations. The MCA (2005) states that mental capacity is assumed to be present unless demonstrated otherwise. The observation policy must clearly delineate the different forms of nursing observations possible – e.g ‘close’, ‘constant’, ‘intermediate’, ‘general’ etc to avoid confusion amongst staff members implementing the observation plan. Nursing staff working in both psychiatric and acute hospitals need training in concepts of MCA, MHA and Deprivation of Liberty Safeguards (DoLS). The observation policy in hospitals must be unambiguous and must take into consideration all levels of observation. The policy must clearly incorporate the grading of the observations from ‘close’ through to ‘intermediate’ and ‘general’ to avoid confusion among staff implementing observation policy. Staff working in both mental health and acute hospitals need to be trained in the basic concepts of MCA, DoLS and MHA so that they are equipped to understand the medicolegal context in which they are working, particularly when ambiguous or difficult cases and scenarios are encountered.

13. Physician Assisted Suicide (PAS) and Euthanasia in Indian context: sooner or later the need to ponder!

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Aim
To find out the legal issues around Physician Assisted Suicide (PAS) and awareness among health professionals in India.

Methods
Extensive review of literature was carried out to find out the current status of PAS in India. The focus of our review was mainly around the legal aspects, Indian Penal Code, awareness among healthcare professionals about the PAS especially so in psychiatrists.

Results
PAS is a controversial subject, which has recently captured the interest of media, public, politicians and medical profession. Though, active euthanasia and PAS are illegal in most parts of the world with exception of Switzerland and The Netherlands, there is pressure from some politicians and patient support groups to legalize this practice in and around Europe that could possibly affect many parts of the world. The legal status of PAS and Euthanasia in India lies in the Indian Penal Code (IPC), which deals with the issues of Euthanasia both active and passive, and also PAS. Euthanasia as in Penal Code, 1860 held, active euthanasia is an offence under Section 302 (punishment for murder) or at least under Section 304 (punishment for culpable homicide not amounting to murder) IPC - Euthanasia and physician-assisted death difference lies in who administers lethal dose; in euthanasia, this is done by doctor or by third person whereas in physician assisted death, this is done by patient himself. Various religions and their aspects on suicide, PAS and Euthanasia are discussed. People argue that hospitals do not pay attention to patient's wishes specially when they are suffering from terminally ill, crippling and non-responding medical conditions. This is bound to change with the new laws, which might be implemented if the PAS is legalized. This issue is becoming relevant to psychiatrists as they need to deal with mental capacity issues all the time. People argue that hospitals do not pay attention to patient's wishes specially when they are suffering from terminally ill, crippling and non-responding medical conditions.

14. Use of covert medication in an inpatient psychiatric unit for older adults
Dr Emma Barrow, CT2 Old age Psychiatry, Edward Street Hospital, West Bromwich; Dr Lakshmi Murali, SAS Old age Psychiatry, Edward Street Hospital, West Bromwich; Dr Farooq Khan, Specialist Registrar, Old age Psychiatry, Edward Street Hospital, West Bromwich; Dr Lisa Blissitt, Consultant Old age Psychiatrist, Edward Street Hospital, West Bromwich

Aim
To find the frequency of use of covert medications on the inpatient older adult wards and monitor the adherence to the guidelines.

Methods
Of 53 inpatients, 12(23%) were receiving their medications covertly. Those 12 case notes and medication charts were examined using a study tool of 9 distinct criteria, addressing factors such as capacity to consent, MDT awareness of the covert method, family awareness and regular review of the decision to use covert methods.

Results
The Covert Administration of Medications is sometimes necessary for patients who lack capacity to consent, but require medication for their mental or physical illness. The National standards were collated from Rights, risks and limits to freedom, Guidance for practitioners considering restraint in residential care, Mental Welfare Commission for Scotland, Mental Welfare Commission for Scotland. Of the 12 patients included in the audit, 3(25%) were male and 9(75%) female, with a mean age of 79 years. All had a diagnosis of advanced dementia, with 3(25%) having disruptive behavioural and psychological symptoms of dementia (BPSD) and 1(8%) having ongoing physical illness. Lack of capacity to consent was clearly documented in all cases except 1 patient receiving medications for both physical and mental health. Members of the MDT were in agreement to use covert methods in all 12 cases and this was evidenced by regular review in 9(75%) of the 12 cases. Areas where documentation failed to meet the standards set were in keeping an up to date care plan in the patients notes which was absent in 7(58%) of cases and only 7 (58%) family members were informed about the decision. Of the 9 distinct criteria audited, there was failure to meet 100% expectations in 6 of these. This
highlights the failure to meet standards when administering medications using covert methods. In line with local Trust policy our recommendations would be to introduce a standardised Care Plan, which covers each of the 9 criteria and would be linked to the patient’s medication chart to ensure the policy is adhered to. It was also felt that medication charts should clearly display which medications are to be given covertly. In view of these recommendations it is also necessary to get perceptions and attitude of staff members who are involved in administering covert medications to patients.

15.
Audit addressing factors to reduce the time from assessment in the West Lothian Memory Clinic to diagnosis and commencement of treatment

Dr Caroline Kruszewski, Specialist Trainee 3, South East Scotland Deanery; Dr Anna Beaglehole, Consultant Psychiatrist in Old Age Psychiatry, St John's Hospital Livingston NHS Lothian

Background
In line with government guidelines, the West Lothian Memory Treatment Clinic aims to reduce the time from GP referral to assessment and commencement of cholinesterase inhibitors. Referral to neuropsychology was a factor identified as adding considerable time to the assessment process. The aim of this audit was to address factors resulting in a delay in initiating treatment with a cholinesterase inhibitor and identifying changes to streamline the assessment process.

Standard
The 18 Weeks Standard set up by the Scottish Government stipulates 18 weeks will become the maximum wait from referral to treatment for non-urgent patients.

Methods
Case notes were reviewed retrospectively. Subjects were patients assessed in the West Lothian Memory Clinic who were referred for further neuropsychiatric testing between October 2009 and April 2010. Information was collected on; date of referral, reason for referral, diagnosis after neuropsychiatric assessment, suitability for cholinesterase inhibitor, time to assessment by neuropsychiatry and starting a cholinesterase inhibitor. Data collection was repeated from October 2010 to June 2011 after implementation of an electronic referral system.

Results of first round
23 referrals were made for neuropsychiatric assessment from October 2009 to April 2010, average age 74 years. Of these referrals, 8 subjects (35%) were found to have Alzheimer’s dementia or mixed dementia and were suitable for treatment with a cholinesterase inhibitor. The average duration between GP referral to starting a cholinesterase inhibitor was 262 days (37 weeks).

Intervention
Typing and sending of referrals and feedback of information from psychology contributed to the delay in the assessment process. An electronic referral template was created which was used to refer patients to psychology via e-mail. The key results of neuropsychiatric assessment were e-mailed back to the responsible consultant.

Results of second round
23 referrals were made between October 2010 and June 2011, average age 73. Of these referrals, 9 subjects (39%) were found to have Alzheimer’s dementia or mixed dementia and were suitable for treatment with a cholinesterase inhibitor. The average duration between GP referral and starting a cholinesterase inhibitor was 153 days (22 weeks).

Conclusion
The introduction of electronic referrals and communication of results has decreased the time to starting treatment with a cholinesterase inhibitor in a group of patients associated with greatest delay, namely patients referred for neuropsychiatric testing.

16.
Improving quality on a dementia assessment unit: An audit of benzodiazepine prescribing leading to an improvement in clinical practice
**Aims**

Benzodiazepine prescribing is associated with fractures, falls, cognitive dysfunction and dependency. Whilst there can be a role for judicious, short-term prescribing of benzodiazepines, people with dementia may be particularly vulnerable to the risks posed by benzodiazepines. Benzodiazepine prescribing for people with dementia is being seen increasingly as an outcome measure which serves as a proxy for quality of care.

The aims of this audit were threefold:

1. To conduct a baseline audit to assess adherence to NICE guidance and trust policy regarding benzodiazepine prescribing on a dementia assessment unit
2. To introduce measures designed to improve the quality of care on a dementia assessment unit
3. To conduct a re-audit after six months to quantify any changes in benzodiazepine prescribing practice

**Methods**

This retrospective audit was conducted by an FY1 doctor on a dementia assessment unit during May 2011. Following a multidisciplinary discussion, an action plan was devised and re-audit undertaken six months later. 20 patients’ medical notes were initially audited and 14 during the re-audit, over a mean period of 26 days and 27 days respectively.

Measures introduced in the six months to re-audit included increased staff training in Dementia Care Mapping, development of ward-based psychology input, introduction of non-pharmacological measures to reduce anxiety and agitation such as animal-assisted therapy and aromatherapy and more frequent multi-disciplinary medication reviews.

**Results**

PRN benzodiazepine prescribing was initially ubiquitous (100% of patients) but reduced to 64% at re-audit. Improvements were made in recording of vital observations following IM benzodiazepine administration (50% vs 0%). Documentation of weekly prescription review improved (33% vs 0%) and documented querying of unused prescriptions improved (20% vs 0%).

Despite improvements, a similar proportion of patients had unused PRN benzodiazepines prescriptions (33% vs 30%). There was no improvement in documented discussion with patients or families when new prescriptions of benzodiazepines were initiated, or in documentation of the reason for administering PRN benzodiazepines by nursing staff (13% vs 20%).

A dramatic reduction of benzodiazepine prescribing occurred over a six month period. Further work is now underway to specifically ensure unused prescriptions are discontinued earlier and to improve documentation of initial benzodiazepine prescribing and discussions with family members. A re-audit is proposed after a further six months.

**17. Malnutrition Universal Screening Tool: Complete Clinical Audit Cycle**

**Dr Shweta Mittal**, CT2 Psychiatry; **Dr Keith Wildgoose**, Consultant Old Age Psychiatrist

NICE Clinical Guideline 32 – nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition.

Screening for malnutrition and the risk of malnutrition should be carried out by healthcare professionals with appropriate skills and training.

Nutrition support should be considered in people who are malnourished, defined by − BMI of less than 18.5 kg/m2

Unintentional weight loss greater than 10% within the last 3–6 months.

**Aim**

To ensure compliance to local protocols based on NICE guidelines in St.Catherine’s hospital, Doncaster.

To monitor if all patients are being weighed weekly and any reason documented if not being
weighed.
To monitor if MUST score is recorded for all patients weekly.
To monitor if all patients on risk of malnutrition are offered fortified diet and referred to dietitian if weight loss continues.

**Methods**
Malnutrition Universal Screening Tool (MUST) hospital proforma based on The British Association for parenteral and Enteral Nutrition (BAPEN). Local protocol used in the wards based on Nice Guidelines CG32 and BAPEN was studied. Data was collected retrospectively on a single day for all the inpatients in Old Age Mental Health wards in the audit and then for the reaudit after 1 year.
Data entered into a proforma and simple statistics were done on 24 and 20 inpatients during audit and reaudit respectively.

**Results**
During the audit - All the patients in old age wards had their BMI recorded but only 50% had their weight loss scored. MUST score was calculated for 87.5% of patients. 83.3% of patients were weighed weekly. 45.8% of patients were found to be at risk of malnutrition out of which 45.4% were on fortified diet. Only 66% of high risk patients were referred to dietitian.
During the reaudit – 90% of patients in old age wards had their BMI and weight loss recorded. MUST score was calculated for 80% of patients. 90% of patients were weighed weekly. 25% of patients were found to be at risk of malnutrition out of which 60% were on fortified diet. The significant improvement in number of high risk patients being referred to dietitian was evident in reaudit with 80% patients being referred.

**Recommendations**
All patients should be weighed weekly and reason documented if not being weighed. All patients should have their weight loss and MUST score calculated and recorded weekly.
All patients on risk of malnutrition should be offered fortified diet and should be referred to dietician if weight loss continues.
As there is still significant scope for further improvements, another reaudit will be done next year after the implementation of recommendations.

18. **Are we following guidelines while prescribing cholinesterase inhibitors in dementia?**

*Dr Arunima Ghosh-Nodiyal*, Consultant Psychiatrist, Bowes Lyon Unit, Durham, Dr Eman Arebi, CT1 Psychiatry, Bowes Lyon Unit, Durham

**Aims**
To look at the current practise of cholinesterase inhibitors prescribing in the old age services and to compare it to the expected standards; with a view to making recommendations to improving practise.

**Methods**
Patient’s referred from the Diagnostic Clinic of Consultants to the memory clinic for follow up were included. Medical notes were reviewed. Every 10th patient in one memory nurse’s caseload from Aug 2010- Aug 2011 was looked at. Only patients prescribed cholinesterase inhibitors were included. Audit tool was designed. This included demographic data and questions to check if the recommended guidelines were being followed. NICE Guidelines for Dementia was the standard used to compare current practise.

**Results**
There were 26 patients on cholinesterase inhibitors. 14 were females and 12 were males. 9 patients were between the age of 65-74 years. 12 were between 75-84 years, while 5 were over the age of 85 years. 10 were single, while 16 were married. 24 patients lived in their own home and 2 lived with family members. None were in residential homes. 100% patients had a diagnosis documented. 16 patients had Alzheimer’s dementia as their diagnosis, 1 had vascular dementia and 9 had other diagnoses (which included mixed dementia and frontotemporal).None had Dementia of Lewy Bodies.
100% had a MMSE recorded and 2/26 had an additional ACE-R completed. 20 patients had a MMSE more than 20, 6 had MMSE between 10-20 while there were none below MMSE 10.11/26
were on psychotropic medications. 9 patients were on antidepressants, 1 was on an antipsychotic and 1 was on Benzodiazepines. 18/26 had a dementia screen of bloods, while 8 did not. 25/26 patients had neurostructural imaging. 20 had a CT scan, 3 had MRIs, 2 had SPECT scans and 1 had none. 24/26 were seen in less than 4 weeks, but 2 were seen after the 4 week period. There was no documentation of consent taken for treatment in 18/26 patients. 23/26 patients had discussion of diagnosis with family documented. 12/26 had discussion of side effects documented. Driving advice was given in only 16/26 patients. 10/26 were offered a cognitive stimulation programme. Recommendations are to undertake dementia screens for all patients, to take consent to treatment and consistently document discussion of side effects, discussion of diagnosis with family and driving advice. To offer cognitive stimulation programmes to all patients. Aim would be to re-audit in 2 years, to check for improvement in practice.

19. **An Audit Exploring the Procedure of Transfer of Elderly Mental Health Patients Between an Acute Older Adult Mental Health Unit (Woodbury Unit) and a District General Hospital (Whipps Cross University NHS Hospital). How Good is the Practice?**  
**Dr Ishaq Pala**, ST5 Old Age Psychiatry, North East London NHS Foundation Trust; **Dr Shakil Khawaja**, Consultant Psychiatrist, North East London NHS Foundation Trust.

**Aim**  
To look into the care pathway of the transfer of elderly mental health patients between an Acute Mental Health Unit (Woodbury Unit, North East London NHS Foundation Trust) and a district general hospital (Whipps Cross University Hospital) and was it appropriate.

**Method**  
A list was compiled of all patients between June and October 2009 who were either admitted initially to an older adult psychiatric inpatient ward but subsequently required transfer to the DGH for assessment of physical co-morbidity or admitted to DGH initially for assessment and treatment of medical problems and then were subsequently transferred on discharge to the Woodbury Unit for on-going treatment of a psychiatric condition. The electronic (RIO) and paper records of all these patients were audited by a member of the audit team. The audit instrument was a semi-structured questionnaire designed by the team incorporating 5 set standards.

**Results**  
38 cases were audited, 22 were in group A (transferred from the Woodbury Unit to WXUH for physical treatment and subsequently readmitted to the Woodbury Unit) and 16 were in group B (admitted initially to WXUH and on discharge transferred to the Woodbury Unit). Only 1 of the 5 standards was achieved in more than 50% of cases.

41% (9/22) of Group A patients were subsequently medically admitted to the DGH. 50% (11/22) of patients were found not to be medically fit enough for transfer back to the mental health unit by the psychiatric team (and their transfer was delayed) even though they had been medically cleared for transfer by physicians at the DGH. Nearly 60% (13/22) of patients were not assessed by or discussed with a psychiatrist before transfer back to the mental health unit. 61% (8/13) of these needed to be re-referred to the DGH. Discharge letter was given to only 50% of the patients.

88% (14/16) of Group B patients were admitted directly from the Accident and Emergency Department of WXUH to the Woodbury Unit. 50% (7/14) of these were actually planned psychiatric admissions but the patient's physical condition necessitated thorough medical assessment, investigation and treatment before the patient could be admitted to the psychiatric ward. Only 63% (10/16) patients were discussed with a psychiatrist before transfer to mental health unit.

20. **Audit to investigate the assessment of venous thromboembolism risk on psychiatric wards at the Rivington Unit, Bolton.**  
**Dr Fozia Rahman**

**Aims**
The aim of the audit was to evaluate whether inpatients on a psychiatric unit had been assessed for risk of venous thromboembolism (VTE). VTE is a serious cause of morbidity and mortality. The House of Commons health committee have reported an annual death rate of 25000 preventable deaths from hospital acquired VTE. In addition it has been suggested that numerous medications including antipsychotics and antidepressants can increase the risk of VTE.

**Method**
Audit standards were taken from the NICE guidelines on VTE prophylaxis and an audit tool was developed. During September 2011 the electronic notes of all patients discharged from the psychiatric wards in the Royal Bolton Hospital were audited against the standards from the NICE guidelines.
NICE guidelines state that all patients must be assessed for risk of VTE and bleeding on admission, 24 hours post admission and whenever the clinical situation changes. During their in-patient stay measures should be taken to reduce the risk of developing a VTE if necessary. It is also recommended that VTE prophylaxis advise is given to patients +/- relatives on discharge from hospital.

**Results**
Sixty-three patients were discharged from the psychiatric wards during September 2011. The results showed that 0% of the patients were assessed for risk of VTE, bleeding or mobility status. None of the 63 patients were offered VTE prophylaxis of any sort. None of patients were given information on VTE or the importance of seeking help should they encounter any problems post discharge from hospital.

21.
Using pharmacy dispensing records to categorize patients referred to a psychiatry liaison service in secondary care: an exploratory study

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**Background**
The use of antipsychotics in the elderly and the prescription of multiple antipsychotics has caused significant concern.[1] The Rapid Assessment, Interface and Discharge (RAID) psychiatry liaison team was initiated in City Hospital, Birmingham, in December 2009 and has achieved success in optimizing patient outcomes. This study sought to determine whether RAID was targeting these at risk groups, by looking at differences between patients seen by RAID and the wider population of patients taking antipsychotic medication. Specific objectives were to compare patients prescribed antipsychotic medication who were seen by RAID to those who were not for the following two variables:
- Prescription of more than one antipsychotic drug (polypharmacy)
- Patient age

**Methods**
Pharmacy dispensing records were used to provide data for drugs dispensed at City Hospital, Birmingham from 1/12/2009 to 1/12/2010. Drugs included for analysis were those listed in BNF Chapter 4: Psychotropics. A list of all the patients RAID had seen during the period of study was then matched to the dispensing data to separate the sample into ‘unseen’ (i.e. all patients not seen by RAID) and ‘seen’ (i.e. all patients seen by RAID). Patients were then grouped by polypharmacy and age. Data were compared using Pearson’s Chi square test for categorical data and Student t test for continuous data.

**Results**
During the study period, 1,013 dispensing events were found for 407 individual patients. The 407 patients consisted of 138 patients seen by RAID (34%) and 269 patients in the ‘unseen’ cohort (66%).
Twenty-eight patients were prescribed more than one antipsychotic during the study time
period. 13 of the 28 were seen by the RAID team (n.s) The mean age of patients in the unseen cohort was 66 years (s.d= 19.5) and 65 years (s.d= 19.2) in the seen by RAID cohort (n.s).

**Discussion**

Polypharmacy was lower in our study population compared to a previous UK study.[1] No difference was found between seen and unseen groups for the proportion of patients prescribed more than one antipsychotic or patient age. The results suggest elderly patients taking antipsychotic medication and those patients that are taking multiple antipsychotics are not being targeted by RAID. Pharmacy dispensing records have the potential to be used as a screening strategy for RAID referral to enhance targeting of patients by identified risk factors.

**References**


22. Audit of use of Citalopram in the elderly following MHRA communication of dose-dependent QT interval prolongation

**Dr Gurinder Singh**, CT2, Dr Qusai Bharmal, Speciality Doctor, Ms Sue Horton, Pharmacist, Dr Aparna Prasanna, Consultant Psychiatrist, Black Country Partnership NHS Foundation Trust

**Aim**

Prescribing advice from the MHRA on the association of Citalopram with dose dependent QT interval prolongation was issued in October 2011. In view of the patient safety issues which were raised, it was expected that current practice among clinicians would reflect the guidance issued. Aim of our audit was to ensure that local practice for use of Citalopram in elderly complies with MHRA recommendations in 100% of elderly patients prescribed Citalopram, under the care of Older Adult CMHT (South East Wolverhampton)

**Standards**

100% of patients on Citalopram
- Should be informed about risk of QT prolongation
- There should be documentation of consent by patient to proposed treatment plan

100% of patients on Citalopram > 20 mg
- Dose should be decreased to 20mg or less, if clinically stable mental health
- An ECG must be requested if dose continued at > 20mg
- GP should be informed re. change of dose

100% of patients on Citalopram and concurrent medications known to prolong QT interval
- Citalopram or concurrent medication should be discontinued, if clinically stable mental health.
- An ECG must be requested if both medications to be continued
- GP should be informed re. discontinuation of either medication

**Method**

Sample population consisted of all active patients under care of SE CMHT for older adults who were prescribed Citalopram. Sample population was identified by an electronic search of care notes. A deadline to review all of sample population was agreed (16/01/2012). Data was collected with respect to the set standards, using the audit tool designed for study.

**Results**

Out of a total of 33 identified patients, 25 patients (76%) were reviewed. Of the 25, 60% (n=15) were on Citalopram <20 mg and 40% (n=10) were on Citalopram >20 mg. In addition 36% (n=9) were prescribed concurrent medications known to prolong QTc Interval. There were 15 patients who were either receiving Citalopram > 20 mg or were on concurrent medications. Of these, in 67% patients (n=10) the dose of Citalopram was reduced or Citalopram or concurrent medication was discontinued. GP was informed about proposed treatment plan for all patients (n=25).

**Recommendations**

1. Trust wide audit to include all elderly patients on Citalopram to ensure compliance with MHRA guidance
2. Re-audit in 6 months.
23. From Admission to Discharge: Prescribing Pattern of Benzodiazepine in the acute psychiatric wards
Dr Manikoth-Talapan, Dr Kaur, Dr Tungaraza TE, Dr Viswanathan, Dr Bhattacharyya

Introduction
Reports of National Treatment Agency and National Addiction centre showed that the prescribing of benzodiazepine (BZD) as has increased substantially between 1991 and 2009. BZD may be beneficial for short-term use, however, a significant number of patients continue to use them for a long time despite lack of evidence.

Aim
To examine whether BZD are prescribed within the existing guidelines.

Methods
An audit was conducted at Penn hospital between August 2011 and October 2011. Case notes, treatment cards and discharge letters of eligible patients (Younger and older adults) were examined.

Audit Standards
100% compliance to Audit standards
- Comply with CSM and BNF guidance (not to prescribe for > 4 weeks)
- To document the indication.
- To document the reason if continued for >4 weeks.
- To have a clear plan to the GP when discharging patients on benzodiazepine

Results
Fifty patients, (equal males and females) were selected. 41 were from the younger adult wards. 44 (88%) received BZD during admission. The most common BZD prescribed were Lorazepam 31(62%) and diazepam 10(20%). The clinical indication was stated in 6 cases (13.6%)
- Among the 44 on BZD on admission, 10(20%) were already on BZD before admission. 34(68%) were started on the ward with 29 (85%) being started on the first day of admission. 38(76%) were given as PRN, 4 as both regular and PRN and only 2 received regular prescription. Of the 44 on BZD, 2 (5%) were on regular dose, 4(9%) on both regular and prn dose and 38(86%) took only on prn. 80% (35/44) of those prescribed BZD had out of hour admission. 13 patients were prescribed benzodiazepine as PRN but never received it (29.54%).
- Only 7 (16%) were discharged on BZD of which 5 (10%) were started on ward and 2 (5%) continued on previous BZD. Only 3 out of 7 (43%) had instructions regarding on-going use following discharge.
- 21/44 patients prescribed for < 4 weeks (47.72%) and 8/44 patients > 4 weeks (18.18%)

Conclusion
Our findings indicate that BZD was prescribed to patients mostly on a PRN basis on admission during out of hours. Moreover, there were no clinical indications documented either in their case notes or treatment cards in most cases. It is notable that though only a few of them were discharged on BZD, there were no clear advice given to the GP about further treatment plan in half the cases.

24. Physical Health Assessment in Dementia Screening
Dr Pravija Manikoth-Talapan, ST5 Trainee, Dr Dhariwal, Consultant Psychiatrist

Aim
To assess the current practice of physical health assessment as a part of dementia screening among patients referred to the CMHT at Little Bromwich centre (East Birmingham) and its adherence to NICE guidelines.
Subjects & Methods

Subjects: 22 cases were recruited for the initial audit, and 21 cases for the re-audit. A pre-designed questionnaire was used for data collection.

Study period:
Audit: January to March 2011
Re-audit- July to August 2011

Inclusion criteria: All patients referred to CMHT with memory problems during the above period.

Audit standards: (NICE UK)
1. A basic dementia screen to be performed at the time of presentation, including blood investigations if possible by primary care service.
2. ECG when clinically indicated.
3. Neuroimaging should be requested in suspected dementia, to exclude other cerebral pathologies.

Methods: After the initial audit, appropriate recommendations were made, based on relevant observations. Re-audit was carried out after two months, to reassess the practice.

Results

Initial Audit
Between January and March, of the 22 patients who were seen in the clinic, 8 patients (36.3%) had their blood tests done at our CMHT and 6 patients (26%) at their GP surgery. 12 patients (54.5%) had ECG and 10 patients (45.5%) had CT brain scan arranged at the CMHT.

Areas Of Concerns
5 patients (22.5%) had no investigations.

Recommendations
Staff to contact GP's and request results of blood investigations when patients referred without relevant investigations.
ECG to be done in clinically indicated cases like patients with significant cardiac history
CT/MRI head to be requested if the presentation is acute or there are other neurological symptoms.

Reaudit
On re-audit, 4 patients (19) had blood tests done at Little Bromwich Centre, and 13 patients (61%) at the primary care. 6 patients (28.5%) were referred for CT head by CMHT. 7 patients (33.3%) had ECG at our Centre and indications for requesting the tests were clearly stated in their notes.

Areas of Concerns After The Reaudit
3 patients (14.28%) did not have any blood investigations.
In 9 patients (42.8%) who did not have CT head, the reason for the decision was not documented.

Recommendations
1. Referral proforma for the primary care; this should include a check-list of the recommended investigations.
2. The reasons for arranging/not arranging imaging and ECG should be stated in the case notes.
3. Improve access to blood test results.

25.
Audit on Pulse monitoring with Acetylcholinesterase inhibitors

Dr Stamatia Tzigianni, ST4, Old Age Psychiatry; Dr Santosh Bangar, Specialty Doctor; Dr C A Biggins, Consultant Psychiatrist, Millside CUE, Meanwood, Leeds, Leeds Partnerships Foundation NHS Trust

Background
Treatment with acetylcholinesterase inhibitors (AChE-I) is indicated and widely prescribed in dementia. The second generation AChE inhibitors donepezil, rivastigmine and galantamine were introduced into clinical practice in 1997 and are generally well tolerated. However, there is a risk of significant and potential cardio-vascular side-effects, i.e. heart block and sinus bradycardia.
This is due to the vagotonic effect of AChE inhibitors on the heart. Therefore, it is good practice to monitor pulse during treatment in order to minimise cardio-vascular risks.

**Standards**
There is currently a lack of clinical guidance available. There is no consensus on monitoring the cardio-vascular risks. The standards used were obtained from a clinical protocol, published in APT, 2007, which suggests that pulse monitoring should be done during the course of treatment with an AChE inhibitor. According to these guidelines, the use of ECG before initiation of treatment is unlikely to be helpful and is not recommended.

**Method**
We randomly selected 100 notes from a database of 280 patients over 65 years of age on AChE-I. The sample was obtained from a community memory service over the last 5 years. We looked at pulse monitoring during the course of treatment.

**Results**
Out of the 100 patients, only 28 (28%) had their pulse monitored during the treatment. None of the patients included in the audit experienced any significant cardio-vascular side-effects that necessitated withdrawal from the treatment.

**Conclusion and Recommendations**
- Current guidelines from the National Institute for Health and Clinical Excellence do not include pre-treatment screening. There is, however, a need for robust guidance for clinical use.
- Pulse should be checked at baseline and at follow-up.
- We recommend monthly pulse checks during titration of the AChE inhibitor, and 6-monthly checks thereafter.
- If bradycardia (<50 bpm) occurs, the underlying cause should be investigated before initiation or during treatment. Those with mild bradycardia (50-60 bpm) should be monitored more closely.
- Re-audit the current practice in 6-12 months.

26. Pharmacological treatment of delirium of elderly patients on a shared care ward

Dr Stamatia Tzigianni, Millside CUE, Leeds Partnerships NHS Foundation Trust; Dr Richard McLelland, FY1 in Medicine, York District Hospital

**Background**
Delirium is a clinical syndrome described by disturbed consciousness, cognitive function or perception. It is sometimes called “acute confusional state”. It is characterized by an acute onset and a fluctuating course and is associated with poor outcomes. Delirium affects 30-40% of elderly hospitalised patients. It is associated with 10-26% mortality risk in inpatients and may lead to Dementia.

**Standards**
A diagnosis of Delirium can be reached by using the Confusion Assessment Method algorithm (CAM). According to NICE guidelines, if a person with Delirium is distressed or considered a risk to themselves, they should be given a short-term (usually for 1 week or less) trial of haloperidol or olanzapine. Antipsychotics should be used with caution or not at all for people with conditions such as Parkinson’s disease or Dementia with Lewy bodies.

**Method**
We audited all the inpatients on the care of the elderly wards (87 in total). We identified the patients with Delirium using CAM. We then looked at pharmacological interventions on patients with Delirium, duration of treatment with antipsychotics and presence of Dementia.

**Results**
- 25% of inpatients had Delirium. Of those, 32% received treatment with an antipsychotic.
- 3/7 patients were treated with Haloperidol, 1/7 patients with Olanzapine, 1/7 patients with quetiapine,
- 1/7 with Risperidone and 1/7 with a combination of Haloperidol and Olanzapine.
- 6% of patients had treatment with an antipsychotic for more than 7 days.
- 15 out of 87 elderly in-patients had Dementia (17%).
- 10 out of 22 pts with Delirium had Dementia (45%)
Conclusion and Recommendations

- Delirium is mostly managed by non-pharmacological interventions.
- First line Pharmacological Intervention should be Haloperidol or Olanzapine.
- Once initiated, the drug’s continuation should be reviewed at 7 days.
- The medication should be used at the lowest possible effective dose.
- Guidelines should be easily accessible.
- Documentation of medication review after 7 days of treatment.
- For pts with Dementia should relatives be involved in discussions about the use of the medication?
- Non-pharmacological approaches should be used in the first instance.
- For pts with Dementia an atypical antipsychotic is to be preferred over a typical one (olanzapine versus haloperidol).
- Future audits should be done retrospectively, following patient discharge.

27. Rising Substitute Prescription in Dementia?

Dr. Jayashree Viswanathan, Dr. Mohan Kumar Choyi

Antipsychotic medication prescription for challenging behaviour in Dementia has attracted attention due to the increased risks (Sube Banerjee, DOH 2009). NICE has issued guidance on appropriate prescription of antipsychotic drugs and timely review (NICE 2006, 2011). Whilst the focus of clinicians remained on measures to reduce the use of antipsychotic drugs in dementia, there has been a significant increase in the prescription of anti depressants and benzodiazepines. Could this be equated to substitute prescription?

Audits (2009 and 2011) on prescribing practice of medication in dementia patients residing in care homes in the city of Wolverhampton has revealed that there is a significant difference in the drugs we prescribe. The audit sample was all patients with a diagnosis of dementia and residing in a care home seen in clinics in one month period by the clinicians (103 in 2009 & 79 in 2011). Whilst a significant reduction was observed in antipsychotic drug use (49.5% to 41.8%), there was a marked increase in the prescription of antidepressants (13.6% to 45.5%) and benzodiazepines (9.7% to 30.3%).

Citalopram was the highest prescribed antidepressant and 4.3% were prescribed 30mgs per day. The results become more significant taking into account the recent MHRA alert (2010) on Citalopram and QTc prolongation especially at higher doses.

This audit has highlighted the need for clinicians to review their overall prescribing practice especially in the elderly population.

28. Audit for psychotropic medication prescribing in EMI nursing homes in Monmouthshire Wales

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Introduction

Various psychotropic drugs are commonly used in patients with dementia and BPSD, despite weak evidence of efficacy. There has been increasing concern over the excessive use of psychotropic medications. Studies showed 21% of residents in nursing homes received a recent prescription of antipsychotics in England and Wales, and 40% of prescriptions for residents in nursing homes may be inappropriate. Benzodiazepine use in nursing homes is another major concern across the world.

Aim

To ascertain whether psychotropic medication prescribing in EMI nursing homes is in keeping with NICE/SCIE guidelines.
To ascertain the level of awareness of staff at the nursing homes re monitoring BPSD and side effects of psychotropic medication.

Audit Standards

Standards on antipsychotics prescribing: 1) Non-pharmacological interventions should be offered
as first line in all cases; 2) Target symptoms should be identified, quantified and documented; 3) There should be documentation of severe distress or of immediate risk to themselves or others; 4) The risks should be discussed with the person and/or carers and clearly documented; 5) The dose should be low and then titrated upwards if needed; 6) This should be time limited and reviewed every 3 months.

Standards on antidementia drugs: 1) Only specialists should initiate treatment; 2) Patients who continue on treatment should be reviewed six monthly in all cases; 3) Treatment should be reviewed by the specialist team.

Standards on lithium prescribing: 1) Lithium level should be checked every 3 months in all patients; 2) U&Es, TFTs should be checked every 6 months in all patients; 3) All patients on lithium should have a lithium monitoring card.

Standards on benzodiazepines prescribing: 1) All prescribing should have a clear end date or be part of a gradually reducing regime; 2) Only one benzodiazepine should be prescribed at a time; 3) Dose should be below 30mg Diazepam equivalent; 4) If standards not met, there should be documentation giving clinical reason why.

**Methodology**

4 EMI nursing homes in Monmouthshire visited and all patients on psychotropic medication were included. Clinical notes in CMHT reviewed and primary care contacted. Nursing home care records were also reviewed and staff were interviewed.

**Results**

The interim results suggest that monitoring of psychotropic medication is patchy and clearer monitoring agreements between primary and secondary care would be beneficial. Better adherence to prescribing standards, and better training and increased awareness of staff at nursing homes should be achieved.

We will present the final analysis at the faculty meeting.