

The percentage of referrals received for each criterion (e.g. the percentage with a risk assessment completed) was then derived from the data.

**Result.** There has been a marked improvement in a variety of areas. The percentage of referrals containing a risk assessment increased from 28% to 96%. This is likely due to the risk box now requiring an entry prior to being able to submit the referral form. Similarly the percentage containing past psychiatric history has risen from 38.8% to 90%. Previously 46.2% of referrals contained a working diagnosis which was not consistent with the clinical picture, but again this has improved, with 60% of initial diagnoses now matching the final outcome. There are however areas for improvement. Only 14% of referrals contained a specific clinical question, which is lower than the 20% achieved previously. This may be because the new referral form does not provide a specific free text box for this.

**Conclusion.** The intervention yielded a marked improvement in the quality of referrals received by the Liaison Psychiatry Department at Frimley Park Hospital, and it is the intention to continue to use the current process. Based on the new results we will look to make small adjustments, for example adding a free text box for a specific clinical question and emphasising the importance of this information.

### Transfer and transition referrals of patients with intellectual disability from children's services to adult community learning disability teams

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**Aims.** The audit aimed to assess if patients under the care of children's services in Wessex were transferred at the appropriate age and whether transition referrals to Community Learning Disability teams (CTLD) occurred timely. It also aimed to look at how many patients underwent transitions in a three month period, and if their transition support plan (TSP) was completed. A transition support plan should include chronological information on psychopharmacology, psychotherapy, and social support measures. Patients should be referred between the ages of 17–19 but require a justification after 18 years of age.

**Method.** The BI team was contacted to provide all IDs for patients referred within a three month period between the ages of 17–19. The BI team provided 42 patients with their ID. Patients discharged from services within a short time span were excluded for the following reason: inappropriate referral (9pts), discharged after 1st assessment (6pts), internal discussion (6pts), only referred to Autism team (4pts), moved out of area (1pts). From the initial 42 patients, 16 patients were analysed using the collection tool.

**Result.** 4/16 had a TSP, and only two had a complete TSP and transitioned in another trust and were inter-team referrals.

CAMHS services referred 1/16 patients.

Psychotropic medication was prescribed to 12/16 prior to or on time of referral, but only two patients had a complete psychotropic medication history.

8/16 patients' referral was commenced prior to their 18th birthday, and no information was provided for delay in transfer.

Health records did mention psychotherapy, but apart from 2/16 TSP records, no additional information was available on the modality.

**Conclusion.** Patients with Intellectual Disability face challenges when transferring from children to adult services. Insufficient referral information may have a detrimental impact on patients wellbeing and long-term care.

Access to a patient's chronological journey through the different children's services allows Adult CTLD health professionals to provide effective care. Historical psycho-social and pharmacological interventions provide a reference point for future interventions.

Concerns included: limited information on most TSP regarding psycho-social and psychotropic treatments, lack of access to CAMHS/CHYPS paperwork and ineffective inter-trust communication for transition patients.

This project highlighted the average number of transition cases in 3 months. It led to changes to the transition pathway, as awareness was raised in trust and CCG meetings to improve patient outcome. CTLD created the new role of transition facilitators to support children's services. They sit in meetings before patients transition referrals.

### Auditing improvements to physical health in the acute psychiatric inpatient setting

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**Aims.** Whilst patient psychiatric health is the primary focus in the acute psychiatric inpatient setting, there has been a recent focus on ensuring a greater integration with physical health to address the physical health outcome inequalities between patients with psychiatric conditions and those without. Despite the ward having a robust physical health clerking proforma, there were issues with its completion; at initial clerking patients often aren't able, or refuse, to consent to physical examination or investigations. This led to the trust's electronic physical health form, designed to collate these results, not always being completed. Our aim was to increase the rates of completion.

**Method.** Changes to ward handover sheets were made in an effort to increase rates of physical health form completion and improve 24 and 72 hour completion rates. Columns were added delineating which parts of the physical clerking were outstanding, ensuring the MDT were aware of which jobs needed actioning. Data for two months prior and post intervention were analysed.

**Result.** 266 admissions were analysed for the two months prior and post the intervention. Form completion rose from July (88%) to October (100%), with 24 and 72 hour completion rate increasing from 47% & 55% respectively, to 84% & 96%, during the same time period. Greater completion rates of physical health forms led to increased knowledge of patients' physical health issues. Having 96% of patients physical health issues within three days of admission (cf. 55%, July), led to a 'physical health huddle' being held during the MDT. This provided a platform to discuss relevant physical health treatment plans with the whole team. These findings were summarised under a new column on the handover sheet and updated biweekly during the MDT meeting. Placement on the handover sheet ensured daily visibility to all staff.

**Conclusion.** Simple structural changes can bring physical health to the fore in psychiatric care. Timely and more complete physical health data enabled biweekly reviews of physical health issues and allowed input across the MDT. Increased knowledge and awareness of physical health issues led to an increase in medical review requests. These are currently performed on an ad hoc basis, which can be quite disorganised and inefficient. The results above, of improved physical health outcomes based on a structured approach, have led to a recommendation of a biweekly physical

health clinic, with specific staffing allocation, to ensure a more thorough and efficient way to address physical health.

### Diabetes and liaison psychiatry: the characteristics of patients with diabetes referred to a liaison psychiatry service in London

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**Aims.** To determine the characteristics of adult patients referred to a Liaison Psychiatry service in a general teaching hospital in London, UK with 950 inpatient adult beds.

**Method.** All referrals for adult inpatient psychiatric consultation made during a period of 9 months were reviewed; those that involved a patient with a diagnosis of diabetes were analysed. Descriptive statistics were used; data were collected on demographic characteristics and physical and mental health parameters, including type of diabetes, number of years since diabetes diagnosis, glycaemic control, presence of diabetes-related complications, reason for Psychiatry consultation request, psychiatric diagnosis, psychotropic medication, frequency of admissions to general hospital, psychiatric risk issues and outcome of psychiatric consultation.

**Result.** Pilot results indicate that 30 diabetic patients were referred for a psychiatric consultation in 9 months. Of those, 9 had type 1 diabetes, 17 had type 2 diabetes and 1 had pre-diabetes 3 were unknown. 13 were male and 17 were female; the median age was 46 (range 18 to 68); the ethnicities were 6 White, 15 Black, 1 Asian and 8 other.

Diabetes-related complications were present in 77% (retinopathy 10%, kidney disease 27%, neuropathy 13%, diabetic foot 16%). 6% had comorbid cardiovascular disease. 10% were on dialysis and 3% had had amputations.

The main reason for referral for psychiatric consultation was low mood and self harm; other reasons were recurrent DKA, anxiety and self neglect. Psychiatric risk issues included 20% risk of self-harm/suicide; 13% risk of violence; 10 risk of self-neglect. The outcomes of liaison psychiatry consultation were: 30% received an assessment that led to recommendations to the general medical team and did not require further psychiatric input; 27% received continued psychiatric follow-up during the admission. With regards to treatment, 36% had psychiatric treatment (including medication) reviewed; 47% received general treatment recommendations, including recommendations for new laboratory or radiological investigations or change in level of nursing care. 20% required transfer to an inpatient psychiatric unit, with 33% discharged to care of community mental health.

**Conclusion.** Our findings indicate the scope of practice for a Liaison Psychiatry service with regards to adult hospital inpatients with diabetes. Our data suggest that patients with type 2 diabetes are the majority of inpatients with diabetes that require psychiatric consultations, and that the majority of those are patients already known to psychiatric services due to long-term severe mental disorders, particularly schizophrenia, schizoaffective disorder or bipolar disorder. Most of those patients have medical comorbidities and severe diabetes-related complications. Patients with type 1 diabetes, despite making up a smaller proportion of referrals for psychiatric consultations, also tend to have recurrent hospital admissions and features of self-neglect.

### Implementation of physical examination pro forma – a complete audit cycle

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**Aims.** Aim of this audit is to achieve and maintain 100% compliance in physical examination on admission.

**Background.** Conducting physical examination on admission is a mandatory requirement and is monitored by the Mental Health Commission during yearly inspections. A report published by Inspectorate of the Mental Health Commission recently in 2019 identifies a gap in physical health monitoring. We conducted a complete audit cycle in an inner city hospital psychiatric ward to monitor compliance with physical examination on admission.

**Method.** We based the audit on Judgment Support Framework (JSF) version 5 standards. A retrospective review of all of the patient's medical records was carried out. 13 medical records were reviewed in the first cycle. The results of the first cycle were presented to the Multi Disciplinary Team (MDT) members, including the Non-Consultant Hospital Doctors (NCHD). Physical health policy was reviewed, in consultation with the committee and Clinical Director, a Physical Examination pro-forma (colour coded) was developed and implemented. It was based on the National Guidelines and the JSF ver.5. All members of the MDT and NCHDs were briefed on the pro forma introduced. A repeat audit cycle was conducted of all patients admitted after first audit cycle. Data were collected using a simple audit tool indicating if physical examination was conducted or refused.

**Result.** A total of 22 medical records were audited. 13 medical records in the first cycle indicted only 3 patients had physical examination on admission. However, prior to admission a total of six patients had physical exam in the Emergency Department (ED). Upon implementation of the pro forma, 9 medical records of all patients admitted post-first cycle were audited. A total of 7 patients had physical examination on admission to the ward. Two patients refused physical examination and this was clearly documented. One patient had physical examination completed in ED. All newly admitted patients had physical examination completed or the reason why it wasn't completed documented clearly.

**Conclusion.** Physical examination pro forma was successfully implemented, raising current compliance to a 100%, with a significant improvement from 23% compliance in the first cycle. Existing pro forma is helpful as a reminder to NCHDs. Colour coding of pro forma improves accessibility and distinguishability during the process of admission and auditing. Physical examination pro forma will be audited every 6 monthly.

### Audit on monitoring physical health of patients on mood stabilisers following NICE guidelines

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**Aims.** The aim is to find out if the physical health monitoring is adhered to in accordance with NICE guidelines in individuals with Intellectual disability who are on mood stabilisers and known to LD services.