I compared these data with results from a previous audit in January 2022 which had highlighted failings in meeting the standards recommended by Royal College of Psychiatrists. The initial audit led to the creation of an Admission checklist to improve practice. The results from August 2022 demonstrated the impact of the checklist.

Results. On 7th August 2022, there were 18 inpatients in Ward 4. Duration of admission varied from 1 day to 1,259 days.

The 3 routine investigations of Physical Examination, ECG and Bloods were completed within 24 hours of admission much more reliably than the initial audit.

Bloods were completed in 100% of cases compared to 52.9% in January 2022. Physical Examination was completed in 94.4% compared to 76.4% in January 2022. ECG was also completed in 94.4% compared to 58.8% in previous audit.

Conclusion. There was a marked improvement in completion of examination, investigations and recording of the results since creation of a checklist. This could be due to increased awareness of the requirements aided by the visible prompt of the checklist on the ward.

Staff are recognizing that mental health cannot be viewed in isolation from physical health which improves the quality of care patients receive during admission. Any health needs can be identified early allowing time for referral if required.

Reducing Restrictive Practice on a Medium Secure High Dependency Forensic Inpatient Unit

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Aims. Restrictive practice can include physical and chemical restraint and should be utilised as a last resort. It has been found to negatively impact patients causing psychological distress, re-traumatisation, and a sense of helplessness. Restrictive practice also negatively impacts staff, causing emotional distress, moral conflict and the risk of physical harm. Since 2018, there has been a drive to reduce restrictive practice in inpatient mental health wards across England by the National Collaborating Centre for Mental Health, which has been further developed by NHS England in 2021 within the Mental Health Safety Improvement Programme (MH-SIP). This study aims to reduce restrictive practice on a 10-bedded Medium Secure High Dependency Male Forensic Mental Health Unit over a 6-month period, incorporating staff and patient feedback and utilise QI methodology.

Methods. Number of total seclusion hours, seclusion episodes and secluded patients per day were measured at baseline utilising the Rio clinical system and continuously tracked during the study period. Interventions were discussed by a multi-disciplinary team including nurses, pharmacists, health care assistants, occupational therapists, psychologists, and doctors. Patients were invited to give feedback on restrictive practice during ward rounds. Potential interventions were then implemented utilising PDSA methodology with iterative changes tested and analysed. Staff and patients were also invited to complete surveys and semi-structured interviews to give further comments during the study.

Results. Baseline data of monthly activity showed 3,758 total seclusion hours, 10 seclusion episodes and 5.3 seclusions per day. Iterative interventions included; (i) MDT discussions to support positive risk taking (ii) Improved collaborative care planning with patients (iii) Incident calendars for patients (iv) excel spreadsheet indicating progress towards leave / referral to stepdown ward and (v) improving transparency on impact of incidents on progress. Month 6 activity showed 174 total seclusion hours (95% reduction), 1 seclusion episode (90% reduction), and 1 average seclusion per day (82% reduction). A survey completed at the end of the study period showed all patients either strongly agreed or agreed that they understood the process for termination of seclusion, with 100% either responding between “neutral" to "strongly agree” that this had improved.

Conclusion. It was hypothesised that a more collaborative approach with positive risk taking could lead to the reduction of restrictive practice. The interventions enacted have significantly reduced the use of restrictive practice. Further study is recommended into these interventions to review if similar results can be replicated in other inpatient wards.

An Audit of Information Provided to Paramedics / A&E Staff on Transfer to the Colchester General Hospital

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Aims. Following feedback from paramedics and staff, escorting patients to the A&E, concerns were raised when some information was missed during the verbal handover from patient/escorting staff to the ambulance/A&E staff. At times the purpose of the transfer was not clear. Essex Partnership University NHS Foundation Trust (EPUT) “Discharge and Transfer Clinical Guidelines” (CG24) provides clear guidelines to staff when a person is transferred while in the care of the Trust to another service such as another acute trust or, discharged from EPUT services completely. However, there are no current guidelines available for transferring patients for clinical reasons: in case of emergency or acute medical condition, for specialist treatment or investigation. The standard was used: the “Ambulance handover to emergency care standard V1.0” created by Professional Record Standards Body (PRSB). 100% of patients should have a support letter from doctors with relevant information shared with paramedics or the A&E department on transfer to a general hospital. The scope of the audit was Peter Bruff Mental Health Assessment Unit and Ardleigh Acute Inpatient Ward.

Methods. The data were collected retrospectively from notes available on the electronic health record database (Paris). The audit tool focused on quantitative and qualitative data collection on patient transfer.

Inclusion criteria: all patients admitted to the Peter Bruff MH Assessment Unit (male and female) and the Ardleigh Ward (female) over the period from 1 September to 15 September 2022. All data were anonymised. Results were tabulated and presented in statistical form back to the clinical teams.

Results. There were identified 18 male and 33 female patients on the Peter Bruff MH Assessment Unit. 2 patients were sent to the A&E via ambulance and 4 patients attended the A&E with staff escort. A support letter was available on one occasion. Compliance 17%.

Within the analysed period there were 15 female patients identified on the Ardleigh ward. 5 patients attended the A&E. A support letter was available on two occasions. Compliance 40%.

Conclusion. All transfers should be managed in a sensitive way ensuring all communication is clear, to promote robust information sharing between inpatient wards and A&E.

A template of the care summary and handover letter was created, which provided a standard structure of headings that is meaningful to clinicians and patients.

Case Study

Acute Psychotic Episode Due to Milk-Alkaline Syndrome

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Aims/ Background. : Milk-alkali syndrome is a medical condition, which could present with psychiatric manifestations. It is caused by hypercalcemia resulting from the ingestion of large amounts of calcium and absorbable alkali. The core symptoms include hypercalcemia, metabolic alkalosis, and renal failure. Diagnosing this syndrome requires a high index of suspicion. The aim of this paper is to describe the case of Mrs. C who had psychotic symptoms because of Milk-Alkaline syndrome

Methods/ Case Report. Mrs. C was a 75-year-old white British female with a previous history of anorexia nervosa who has been clinically stable for more than 15 years. She was discharged by the community mental health services about 11 years ago but has been on a repeated dose of Gaviscon for about 8 years.

She presented to the accident and emergency (A and E) unit with a history of confusion, unsteadiness, paranoid beliefs, low mood, and reduced rate of speech. No history of infection or other physical health concerns. Routine blood showed increased calcium 3.41(2.2-2.60) and a reduced potassium level 2.9 (3.5-5.3). CT head scan did not show any acute changes.

She was stabilized and transferred to the ward for further management.

While on the ward, she had a diagnosis of Milk-Alkaline syndrome with psychiatric manifestation. Gaviscon was discontinued because the medics felt this was responsible for the electrolyte imbalance. She was also referred to the mental health liaison team (MHLT).

Following the mental health liaison team review, Mrs. C's psychiatric presentation was suspected to have been probably related to her medical condition. After a few weeks on the ward, her electrolyte became normalized; adjusted Ca 2.72 (2.2-2.6), serum ca 2.74(2.2-2.6). She had a follow-up review by the mental health team that showed her psychosis had also resolved. No medication was prescribed for her presentation. She was subsequently discharged from MHLT and referred to the GP for follow-up.

Results/ Discussion. previous case-report have shown a suspected link between Milk alkaline syndrome and acute psychosis, although the reasons for this have not been understood. The current case further emphasized this link. What is not evident however is if there were other physical health issues that might have also contributed to the patient's initial presentation.

Conclusion. Diagnosis of Milk-Alkaline Syndrome requires a high index of suspicion, missing this could lead to inappropriate use of medication. As a psychiatrist, this case has shown the importance of adequate investigation before making a definitive diagnosis, especially in a psychiatric liaison setting.

Acute Psychosis in Hashimoto's Thyroiditis

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Aims. Hashimoto thyroiditis was discovered by Hakaru Hashimoto in 1912 but became more recognized in the 1950s. It is an autoimmune disorder with an incidence rate of about 0.8/1000/year in men and 3.5/1000/year in women. The inheritance pattern of Hashimoto thyroiditis is not fully understood and diagnosing this condition could be challenging. Among many presentations, its effects on mental health can lead to a greater burden on a patient. There has been an increased report of acute psychiatric symptoms in this condition. Literature has described a wide spectrum of psychiatric manifestations occurring prior to, during, and after this illness. The aim of this report is to describe a woman with diagnosed psychosis secondary to Hashimoto's thyroiditis.

Methods. Ms S is a 22-year-old female who was admitted in January 2021 to the emergency department of Hospital B with a history of sudden behavioural changes: agitation, responding to unseen stimuli, and bizarre behaviour.

Her previous record reveals that she had a similar presentation in November 2019, managed with antipsychotics. The diagnosis at the time was unclear however; meningoencephalitis was suspected and later for NDMA encephalitis. After 4 months of admission to Hospital A, her behavioural changes remained unresolved but she was discharged to a care home with 2:1 support. She remained in the care home until further deterioration, which warranted a further admission to Hospital B.

Following a psychiatric review in Hospital B, she was initially diagnosed with an Acute psychotic episode with query cause and managed with IM Aripiprazole.

Due to physical health concerns and the unclear nature of her diagnosis, she was transferred to the acute medical ward and further investigation was requested.

Her result showed significantly elevated Thyroid Peroxidase Antibodies of 845 IU/ml (normal up to 24 IU/ml), lumbar puncture and NMDA antibody test were both normal, TSH level was raised to 6.73. Following further discussion with the medical team, a diagnosis of Psychosis secondary to Hashimoto's thyroiditis was made.

She was co-managed by the psychiatrist, endocrinologist and others.

Ms S became settled but due to residual psychosis, she was transferred to an inpatient psychiatric ward where her psychosis resolved, and was discharged back to the community mental health services.