Are We Executing Our Vision?

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doi: 10.1192/bjo.2023.383

Aims/Background. Safety plan and Goal setting are standard interventions offered by CAMHS Crisis Resolution and Home Treatment team. The Department of Health Best Practice Principles and NICE guidelines recommend collaborative production of risk management plans and recovery orientated input. We wanted to ensure compliance and understand patient's views on usefulness of these.Aims:- Did all patients complete safety plan and goal setting? Was this done collaboratively?Did these strategies help?Were documents easy to access?
Methods. There were two arms to the project.

1. Review of 40 electronic case notes out of 715 patients seen from Jan to April 2021. We looked at completion of safety plan, goal setting, goals achieved, HONOSCA scores, risk ratings and mood scores.
2. Between April and July 2022, willing patients were requested to complete anonymised electronic questionnaire through a QR code. The questionnaire asked if patients felt included when completing the safety plan and goal setting, whether these interventions helped recovery and if the documents were easy to access. A free text option for feedback was also given.

This proposal was approved by the Improvement and Knowledge Hub within the LPT NHS trust who confirmed that ethical approval was not required.

Results are reported in percentages.
Results. Case notes review (n=40):

- 99% had safety plans completed, done collaboratively.
- 90% had goal setting completed, done collaboratively
- Rationales documented within the notes for not completing.
- 85% reported Improved mood scores
- 90% reported improved risk ratings
- 65% achieved 2 or more of 3 goals set.
- 67.5% had HONOSCA at admission (average score 13.6) and discharge (average score10.5) – improvement documented.

Questionnaires: 18 questionnaires returned.

- 100% completed safety plan and goal setting
- 83% reported they felt included when doing safety plan and goal setting.
- 83% said goal setting was helpful in recovery.
- 94% said safety plan helped.
- 82% reported easy access to documents.

Conclusion. Results suggest compliance with guidelines and strategies are useful. There is consistency in relevant information from the case note review and questionnaire feedback. Case note review included objective and subjective perspectives. Questionnaires gathered patient perspective; in confidence/anonymously.
Recommendations:

1. Repeat survey ensuring case review and patient feedback for same period.
2. Use children and young people friendly version, offer paper version, advertise widely - to improve questionnaire response rate.
3. Complete HONOSCA on admission and discharge.
4. Research to explore usefulness of interventions in CYP

Satisfaction Survey of Patients and Carers for Telephone vs Face-to-Face Reviews - a Service Evaluation Project

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doi: 10.1192/bjo.2023.384

Aims. The COVID-19 pandemic necessitated major changes in clinical care, including remote patient contact. Havering Older Adults Mental Health Team and Memory Service (HOAMHT&MS) patients often fell within the vulnerable category for poorer outcomes with the SARS-CoV-2 virus, so remote contact was preferable during the pandemic. Telephone assessments were offered to replace face-to-face reviews for some patients. Feedback from patients and carers was collected to compare these modes of patient contact. Remote assessment has positive impacts including; improving access to care in remote areas/ when local services cannot meet demand and for disabled patients. Understanding the patient experience about remote assessments helps navigate decisions about future modes of consultation.
Methods. This evaluation was organised in HOAMHT&MS. A Rio* diary search was conducted for practitioners from 15/07/2020 to 15/10/2020. 75 questionnaires were sent from each clinic (OAMHT and Memory Service). We sent an equal number of questionnaires for telephone appointments and face-to-face reviews. Questionnaires were posted to patients with pre-paid envelopes to return responses.

*Rio is our Electronic Patient Record System
Results. We had a total return of 23 questionnaires from the Memory Service and 24 from the OAMHT clinic. Most questions were a likert scale from Poor (1) to Excellent (5). The overall satisfaction score out of 5 (average of all the responses):

OAMHT:
Patient/telephone: 3.7 (n=13)
Patient/face-to-face: 4.1 (n=7)
Memory Service:
Carer/telephone: 4.4 (n=8)
Carer/face-to-face: 4.2 (n=9)
Some of the open ended feedback:
OAMHT:

- **Carer/telephone:**
"The telephone was rushed and at the end of the meeting the person wanted to sign my husband off."

- **Patient/face-to-face:**
"Help was always there for me."
"The clinic deserves a medal."
Memory Service:

- **Carer/telephone:**
"Very helpful - I am now contacting them for further advice. They understand my stress and give me full support."

- **Patient/face-to-face:**
"Very happy with the care and attention from the consultant, doctor and nurses at the memory service."

Conclusion. OAMHT Responses:

- Face-to-face feedback more positive
- Patients experienced more distress - nature of illness (distress/crisis) compared to memory (usually gradual decline)

- Telephone appointments seem less satisfactory - less likely to meet the emotional need of patient/carer

Memory Service:

- Generally positive feedback from carers and patients in all areas - able to take a meaningful history over telephone

Optimising and Future-Proofing Dementia Care With Amnestic Mild Cognitive Impairment (aMCI) Clinics

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doi: 10.1192/bjo.2023.385

Aims. Amnestic Mild Cognitive Impairment (aMCI) is considered a pre-dementia (prodromal) phase of Alzheimer's disease (AD), with a higher probability in patients with positive biomarkers (temporo-parietal region, atrophy on CT/MRI imaging and hypometabolism on FDG-PET scan).We developed a pilot service development project in the North Sector of Gloucestershire Health and Care (GHC) Trust. Its' main aim was to ease some of the pressures on the Memory Assessment Service (MAS) nurses and the medical memory clinics. The main objectives were: 1. To develop and run an aMCI Clinic service for eight months between March and November 2022 at GHC with North Sector patients to reduce waiting times compared to the preceding years. 2. In patients with aMCI and a positive biomarker, continue annual cognitive testing with early identification of conversion to dementia, thereby starting anti-dementia medication, and continue through the post-diagnosis pathway. Future plans include creating a business case for the Care Commission Group to consider commissioning a countywide aMCI service.
Methods. Patients (n=23) with the diagnosis of aMCI and a positive biomarker were selected. Data included the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) to assess patients' daily functioning, clinical history and service satisfaction questionnaires. Different initial objective tests, including Addenbrookes Cognitive Examination (ACE-III), Repeatable Battery for the Assessment of Neuropsychological Status (R-BANS), Telephone Interview for Cognitive Status (TICS), and Rowland Universal Dementia Assessment Scale (RUDAS) were used. Data for waiting times from referral to first assessment were collected and statistically analysed using a repeated measures design across years 2020,2021,2022 (March-November) and a one-way repeated measure ANOVA was performed.
Results. Analysis of waiting time indicated a non-significant decrease in waiting times from referral to first assessment. A decrease in the waiting times from September 2022-November 2022 was noted, pointing towards a possible time lag effect. Within six to twelve months of repeat testing, 62% of patients remained with an aMCI diagnosis whereas 32% of patients progressed to dementia (Alzheimer's or Vascular). From the post-appointment patient feedback received (65%), all patients reported to be very satisfied (57%) or satisfied (9%).
Conclusion. It is prudent to assess the time lag effect on the results produced in subsequent months. A repeat review with a larger sample size to increase the sensitivity and specificity of the results obtained is recommended.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

High Lithium Levels: Dead, Alive or Doing Well? a Service Evaluation Looking at Outcomes Over Subsequent 2 Years

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doi: 10.1192/bjo.2023.386

Aims. Lithium is an effective mood stabiliser in the management of Bipolar affective Disorder. Timing and decision to restart lithium after an episode of toxicity can be challenging. National guidelines offer advice on management of acute toxicity but little information on restarting lithium. Abrupt withdrawal of lithium can provoke relapse. Clinical experience of the authors was that patients who had Lithium stopped following toxicity often relapsed, leading to poor mental health, frequent admissions to acute and psychiatric hospitals and sometimes death. Restarting of lithium in hospital or after discharge was often variable. The aim of the evaluation was to review the outcomes of patients admitted to the University Hospitals Birmingham NHS Foundation Trust (UHB) with a lithium level over 1.2 mmol/L.
Methods. Patients were selected if recorded lithium level was over 1.2mmol/L on admission to UHB. Case note review of electronic patient records was carried out to identify demographic factors of participants alongside medical and psychiatric outcomes over the following 2 years.
Results. 84 patients were identified as having lithium levels over 1.2mmol/L. 76% Female. Mean age 61 years (range 20-95 years). 77% of patients had been prescribed lithium for more than 6 years. Mean lithium level was 1.68 mmol/L (range 1.2-3.44 mmol/L). Around 2/3 of patients admitted with lithium above therapeutic range were referred to the liaison psychiatry team. 12% of the patients died during that admission. Just over 2/3 (69%) of those discharged from hospital had been restarted on lithium. When lithium was not restarted during the acute admission, only 13% were restarted in the community within the next 2 months. Two year mortality of patients admitted with elevated lithium levels was 31%. 10% of patients were admitted to a psychiatric hospital within 1 year. The mean number of admissions to the acute hospital (UHB) within one year was 1.6 (range 0-26).
Conclusion. Admission to hospital with high lithium levels appears to be associated with a number of negative outcomes. These data cannot attribute causality. Conditions predisposing to lithium toxicity such as frailty could contribute to negative outcomes. Given these high mortality figures for this group, discussions on restarting lithium following high levels may need to focus more on the priorities for the patient. Further studies looking at the outcomes of restarting and discontinuing lithium and comparing with those who have not experienced elevated levels would be helpful.