Poster Presentations
(Listed alphabetically by main author’s surname indicated by bold italics)

Thursday, 13 March 2014

1 Prescription of Antipsychotics for Patients with Dementia
Dr Sharada Abilash, Specialty Doctor Old Age Psychiatry, Dr Luay Kafienah, Staff Grade Old Age Psychiatry, Dr Soha Gouda, ST6 Old Age Psychiatry

Background
There have been increasing concerns over the past years about the inappropriate use of antipsychotic medications for people who suffer from behavioural and psychological symptoms of dementia (BPSD). Antipsychotics have only a limited positive effect in treating BPSD, and for elderly patients with dementia, they are associated with increased risk for all cause mortality and cerebrovascular events.

Aims/Objectives
• To determine current practices of antipsychotic prescribing for dementia patients with behavioural and psychological symptoms of dementia at Bloxwich Hospital are with national guidelines.
• To make recommendations to improve prescribing.

Standards
Current guidelines of NICE, The Royal College of Psychiatrists and the Maudsley prescribing guidelines in psychiatry.
Method: The project was registered with the audit department. A set of auditing standards were drawn up and a corresponding auditing tool was created for collection of data from patient records both in inpatients and community patients. The same tool was used for both the audit and reaudit. The adit was done in February 2013 and reaudit in December 2013.

Results
Results of the audit found that the rate of antipsychotic prescribing was greatest within inpatients compared with community-based patients. Overall, the practice of antipsychotic prescribing fell short of the 100% target for each auditing standard and in general, patient prescriptions managed in hospital adhered more closely to current guidelines. Higher rates of antipsychotic prescribing within inpatients may be justified by an increased severity of BPSD in this population. However, evidence for severe BPSD was seldom documented in patient records. It was inconclusive whether inappropriate antipsychotic prescribing at Bloxwich Hospital was attributable to reduced awareness of the guidelines or poor documentation. One recommendation, therefore, was to devise antipsychotic prescribing forms, which ensure that all aspects of the prescription are considered and documented.

In the reaudit there was a clear improvement in the documentation of the reason for antipsychotic prescription, dose titration, and duration of treatment, patient monitoring, and prescription review.
Conclusion: There was overall improvement in the reaudit. It was a good learning experience to complete the full audit cycle.

2 including older person’s mental health
Dr O. Adeyemo, Diane Morris, Laurie Wrench, Corrina Knight, Working Group (North Staffordshire Combined Healthcare NHS Trust).

The audit aimed to improve the identification of and care planning for service users at risk of self-harm and / or suicide. All detentions under the Mental Health Act between 1 January 2012 and 30 April 2012 were identified by the Mental Health Law Team (n=181) and their paperwork reviewed to determine if suicide, self-harm or a level of self-neglect amounting to self-harm were mentioned in the Approved Mental Health Professional’s report (n=40). Ten service users were subsequently excluded, leaving a total of n=30. A tool based on the National Patient Safety Agency’s Preventing Suicide toolkit was designed and data collected from service users’ notes. Separate tools were also developed to obtain information from Ward Managers about suicide prevention on individual wards and to capture information regarding North Staffordshire Combined Healthcare NHS Trust’s (NSCHT’s) organisational approach to harm prevention and risk management.
The results of the initial audit showed varying compliance with the standards. Where a joint care review had taken place, a list of those present was available in 100% of cases. However, performance against some standards showed room for improvement, including valid care plan present (73%), service users at risk of self harm or suicide allocated to CPA (87%), and discharge plan indicated whether problems with engagement were anticipated (77%). There were also some standards which required particular attention, such as care plan included reference to heightened risk within the first three months post-discharge (59%), evidence regarding consent to contact family or carers (43%) and medication review including potential for harm through side-effects or self-harm (65.5%).

In response to these results an action plan was developed and the audit was repeated in February 2013 on a sample of 26 records. The results showed significant improvements. All service users now had a valid care plan present and all those at risk of self-harm or suicide were allocated to CPA. Evidence regarding consent to contact family and carers was present in 74% of cases and medication review including potential for harm through side-effects or self harm had taken place in 84% of cases, though these results indicate that there are still potential improvements to be made.

3 An Information and Support Group for Patients with Dementia with Lewy Bodies and their Care-givers.
Dr Folasade Aina, Old Age Psychiatry Specialty Trainee, Campus for Ageing & Vitality, Newcastle; Alison Killen, Research Assistant, Campus for Ageing & Vitality, Newcastle University; Dr John-Paul Taylor, Senior Lecturer and Honorary Consultant in Old Age Psychiatry, Newcastle University.

Introduction
Dementia with Lewy Bodies (DLB) is a common form of dementia. Functional disability tends to be of greater severity compared with Alzheimer’s dementia at a similar level of cognitive impairment. DLB is associated with greater patient and carer burden, with more informal care utilised, more pharmacological therapy and higher dependency related to instrumental activities of daily living. Caring for people with DLB has also been associated with significantly more carer stress than other forms of dementia. Whilst many dementia-specific carer support groups exist, none focus on the many distressing features common to DLB, a gap which this novel group based at a hospital in North East England aimed to address.

Aims
1. To provide patients and their caregivers with three sessions of psycho-education specific to DLB.
2. To enable a supportive forum for discussion of experiences.
3. To explore positive ways of coping with the diagnosis and dealing with future uncertainties.
4. To signpost caregivers towards long term generic carer support within their local community.

Methods
Participants included patient and care-giver attendees at a specialist DLB clinic. Sessions were delivered by a specialty trainee and a trainee health psychologist. Areas covered included:
1. The cause, core features and treatment used for DLB.
2. Ways of managing the impact of behavioural changes, communication problems, neuropsychiatric symptoms and agitation using pharmacological and psychological approaches.
3. Developing practical skills e.g. cognitive stimulation for retaining and enhancing memory, cognitive behavioural therapy (CBT) techniques for coping with uncertainty, relaxation and introduction of a gratitude diary to promote a positive mindset.

Results
Two groups facilitated so far have involved 15 patients, spouses and adult children. One ethnic minority couple have attended. Feedback cards have been overwhelmingly positive and members have exchanged contact details for future support. Further evaluation will compare Relative Stress Scale scores at baseline with those at 8 weeks post session.

Conclusions
Positive responses from both care-givers and patients reinforce the need for interventions to help deal with the psychosocial challenges faced by patients with DLB and their care-givers. This type of dementia is often unknown within the community and may be poorly understood by those offering community care. Providing a brief but specific condition related intervention prior to signposting towards longer term local support may better equip families to manage expectations and develop coping strategies.
4
Audit of Delirium in admissions to an Old Age Psychiatric Ward
Dr Itunuayo Ayeni & Dr Gianetta Rands, Camden and Islington NHS Foundation Trust

Aim
Delirium or acute confusional state (ACS) is a fluctuating cognitive disorder that is commonly seen in the elderly population. It is thought to affect up to 30% of elderly patients presenting to an acute setting and is caused by a wide range of illnesses. The aim of this audit was to assess the prevalence of delirium in patients admitted informally or under section, to an acute elderly psychiatric ward.

Method
This was a retrospective case note analysis of forty-six patients admitted or transferred to an acute elderly psychiatric ward between the months of January 2013 to September 2013. All data were obtained from medical records on the electronic database RIO.

Results
Of the total admissions, 35% (16/46) had evidence of delirium and 54% (25/46) were under section 2 of the mental health act. Of the section 2 admissions, 44% (11/25) had evidence of delirium. Urinary tract infections were the most common cause of delirium. Of patients with delirium, 69% (11/16) were admitted on a section 2 and 31% (5/16) informally. Patients with delirium were equally likely to be admitted from home and from an acute hospital. They are also more likely to have a previous diagnosis of dementia.

There were significant differences in clinical outcome observed between patients with delirium and those without. Patients with delirium spent on average 14.4-days on section 2, compared with 22-days. They were more likely to have their section rescinded and be discharged by the end of the audit, spending on average 19-days less in hospital when compared with patients without delirium.

Conclusions/ Comments
This audit demonstrates the complexity and the overlap of mental and physical illnesses. It shows that delirium is a common presentation within an acute elderly psychiatric ward. A significantly high proportion of elderly patients are being admitted using the mental health act. The audit therefore raises questions about the use of the mental capacity act in managing acute confusional states. There is a clear need to educate medical and allied health professionals about the presentation of delirium in the elderly population. With the current economic climate and shortage of elderly psychiatric beds, disentangling ‘physical’ and ‘mental’ illness will be crucial in avoiding unnecessary or prolonged admissions to psychiatric wards.

5
Delusions of Home - Clinical and Legal Considerations in Old Age Mental Health
Dr Karyn Ayre, ST Academic Trainee, South London and Maudsley NHS Foundation Trust
Dr Dominic Ffytche, Consultant Psychiatrist in Old Age Mental Health, South London and Maudsley NHS Foundation Trust

Introduction
We describe the clinical and legal options considered in the management of a 78 year old lady with a fixed delusion of owning her own home. In all other respects she was able to function independently, however discharge was impossible when she refused to consider living in alternatively arranged accommodation. This has serious impact on the provision of care for the patient and on their risk assessment, as well as posing a dilemma for the clinicians involved.

Aims
Highly specific delusions such as these raise interesting questions regarding clinical management options and mental capacity. Whilst fully capacitous in all other areas of life, the patient was non-compliant with anti-psychotics, lacked the ability to understand the risks attached to returning to their imagined property, and could not understand the reality of eventually becoming homeless in inner city London, after inevitable disappointment regarding the property. Should the patient be forcibly medicated under the Mental Health Act, in the hope the delusions would recede and alternative housing be accepted? Or should we accept this manifestation of psychosis, and use Guardianship to mandate alternative living arrangements? This poster summaries our clinical management, case outcome and the options for clinicians in
managing fixed delusions as well as a review of the legal pathways available to allow suitable housing for such patients to be arranged in this unique situation.

Results
There is little evidence that anti-psychotics improve fixed, long-held delusions and our patient developed severe extra-pyramidal side-effects to a test dose of depot. In addition, she had been trialled on oral anti-psychotics during a previous admission to another service, which ameliorated her delusions but not to the extent she could be re-housed. Her non-compliance with medication might have eventually mandated a Community Treatment Order however these are inappropriate in enforcing housing arrangements, as they relate only to clinical management. Applying for local authority Guardianship in this case was thought to be the most appropriate step if she would not accept the alternative accommodation arranged.

Conclusions
Fixed delusions must be considered within the context of the patient’s overall function. Clinical assessment and knowledge of the legal frameworks for ensuring the patient does take up appropriate accommodation to prevent homelessness is crucial.

6 Trends in referred patient profiles in a memory clinic over twenty years.
Dr Bushra Azam, South West Yorkshire Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, Mr Tim J. Whitfield, North Essex Partnership University NHS Foundation Trust, Mr Darren Radford, North Essex Partnership University NHS Foundation Trust, Dr Santhosh G. Dontham North Essex Partnership University NHS Foundation Trust, Dr Thomas Dannhauser, North Essex Partnership University NHS Foundation Trust & Mental Health Sciences Unit, University College London, Dr Tim Stevens, North Essex Partnership University NHS Foundation Trust, and Dr Zuzana Walker, North Essex Partnership University NHS Foundation Trust & Mental Health Sciences Unit, University College London

Aim
The increasing numbers of people with dementia in the UK, as well as the associated costs have lead to an effort to improve dementia services for the benefit of patients, caregivers and the taxpayer. These efforts have frequently emphasised the importance of early diagnosis in dementia care.
We sought to test the hypotheses that the mean cognitive score of new referrals to a secondary care service increased while mean age decreased over a period of twenty years. The result of this study would help services to plan for a changing pattern of referrals.

Methods
This was a retrospective database study using data gathered from semi-structured routine assessments taking place in West Essex Memory Clinic, established in 1993. The clinic is a highly specialized service offering a comprehensive cognitive and clinical assessment.
All statistical tests were carried out using SPSS for Windows version 19 (IBM, 2010). We calculated sample demographic means for the variables age, CAMCOG-R, Mini Mental State Examination (MMSE; Folstein et al., 1975) and years of education.
We also calculated sample frequencies for gender and diagnosis at baseline.
Full ethical approval was obtained for this study.

Results
The data of 1,476 patients were analysed. We observed trends of increasing number of new referrals. Our results show that, over time, the average cognitive score of newly referred patients increased. Over time the average age of newly referred patients decreased, but this was not significant after controlling for cognitive scores and education. It is not possible to be certain about the causes of the rise in the initial cognitive scores. However, greater awareness of dementia amongst the public and increased emphasis on early identification of cognitive impairment amongst medical professionals are likely to have influenced this rise. These finding could also be a reflection of the efforts of governmental and charitable organisations along with increased coverage of dementia related items in the media to encourage the diagnosis of cognitive problems at an early stage.
There are many implications of the trend for persons being referred at increasingly early stages of cognitive impairment. Memory services need to be developed with the less cognitively impaired patient in mind. Diagnosing patients at an early stage may raise ethical questions. There may be limited or no treatment options in early cognitive impairment. Limited resources may dictate that patients with milder cognitive impairment are discharged from services rather than followed.
up.

7
A complete Audit Cycle of GPs Satisfaction with the Community Mental Health Team (CMHT) Service for Older People
Dr Andrew Byrne, Consultant psychiatrist, St. Georges Park, Morpeth, Northumberland, Dr Jamal Hilal, Speciality doctor in old age psychiatry, St. Georges Park, Morpeth, Northumberland, Dr Priya Bandi, ST4 Old age Psychiatry, Bensham Hospital, Gateshead, Dr Sian Arkell, Speciality doctor in old age psychiatry, St. Georges Park, Morpeth, Northumberland

Background
A good quality effective mental health service for older people in the community is essential. With the advent of GP commissioning, a high quality and efficient mental health service for older people linked with good relations with primary care colleagues is more important than ever. This is evidenced and backed up by key national publications.
1. The National Service Framework (NSF) for mental health
2. The Healthcare Commission
3. The Royal College of Psychiatrists
4. The National Dementia Strategy
5. GMC guidance
The above indicators describe the standards of assessment, management and communication expected of clinicians caring for older people with mental health problems.

Aim
This audit aims to provide GP feedback on how well psychiatrists in a psychiatric sector (Central Northumberland and Blyth Valley) are meeting these standards.

Methods
A survey questionnaire using Likert Scale was designed. It included: The speed of response to routine/urgent referrals, the quality of the diagnostic assessments, The assessment and management process re: memory /risk, The quality & clarity of medical letters/ documents and finally The general service provided. The survey questionnaire was rolled out in 2012 and again in 2013.

Results
The first audit attracted 11 responses while the second round had 20 respondents. Most GPs were quite happy with all aspects of the service.

The average responses in 2012 ranged between 53% and 65% (mode 62%), with urgent responses being the poorest.

In 2013 all aspects were rated higher ranging between 51% and 70% (mode 68%) with urgent responses scoring 64% average and attracting more excellent and very good markings. However routine responses scored less than last year.

Discussion and implications
Following analysis of the first audit, specific amendments were made to job plans, deploying more medical time and availability to urgent responses was enhanced.
The documentation has been standardized to suit the primary care needs.

In response to the re-audit; medical time with the CMHT appears to be supportive in reducing waiting times further. The current situation that we have no waiting list and the response to urgent assessments is predominantly within 24 hours, however in some cases it would be within 48 hours.

8
Use of Covert Medication in an Inpatient Psychiatric Unit for Older Adults.
Dr Emma Barrow, CT3, The Barberry, BSMHFT, Dr Lakshmi Murali, Associate Specialist, Edward Street Hospital, BCPFT, Dr Faroq Khan, Consultant Psychiatrist, Juniper Centre, BSMHFT, Dr Lisa Blissitt, Consultant Psychiatrist, Edward Street Hospital, BCPFT

Aims
The covert administration of medications is sometimes necessary for patients who lack capacity to consent but require medication for mental or physical illness. A background literature search identified sources such as the Royal College
position statement on covert medicines; Mental Capacity Act 2005; UKCC position statement on covert medicines and Mental Welfare Commission for Scotland 2006, as well as Black Country Partnership Foundation Trust’s ‘Consent to Treatment Policy’. From these a set of ‘National Standards’ was developed, against which a set of audit criteria was established. An expected target of meeting these standards in 100% of cases was set.

Methods
The initial audit was conducted in 2011 and identified 12 inpatients (from 53 total) that were administered their medicines covertly. Patient notes and medication cards were then audited using a tool of nine questions derived from the set standards. These questions mostly required yes/no responses and covered factors such as ‘capacity to consent’, ‘MDT decision to use covert method’, ‘family awareness’ and ‘regular review’. The audit tool was piloted before use and during the re-audit in 2013 the same audit tool was applied to a smaller sample of 7 inpatients.

Results
In the initial audit ⅔ of the patients were male and the rest were female, all had a diagnosis of advanced dementia, some with behavioural symptoms. Lack of capacity was clearly documented in all cases, as was the MDT decision. However in other areas such as having an up to date care plan or keeping family members informed, the documentation did not meet the expected standard. In the initial audit there was failure to achieve 100% in 6 out of the 9 audit criteria. Therefore the initial audit recommendations included a revised care plan specifically for covert administration that included space for clear documentation of the set standards. The results of the re-audit in 2013 demonstrated favourable success with the implementation of this new care plan. In the re-audit the majority of patients were female but were diagnostically similar to the initial audit. The sample size was smaller but in all cases an up to date and completed care plan was present, satisfying the set standards in all but two cases - where documentation of discussion with the family was made elsewhere but still included as being present. Therefore, in the re-audit, the set standards of 100% were achieved in all 9 criteria.

9
Family therapy and dementia: what can we learn from the literature?
Professor Susan Mary Benbow, Professor of Mental Health and Ageing, Staffordshire University, Director of Older Mind Matters Ltd and systemic psychotherapist & Victoria Sharman, Director of V2Recovery Ltd and family psychotherapist.

Aims
The NICE/ SCIE Dementia guideline includes the use of family therapy in a case example and notes that: “Joint interventions with the person with dementia and family carers, such as family therapy, recognise the fact that the diagnosis does not impact on just one person but on a whole family system …” Despite this family therapy is not widely available in the United Kingdom to families living with a dementia. We carried out a literature review to explore what can be learned from the existing literature on family therapy and dementia.

Method
We searched Medline and PsychInfo for (family therapy or couples therapy or marital therapy) and dementia from the year 1992 onwards for English language papers. This identified 22 papers to which we added a further eight from the reference lists and our own collections, giving a total of 30 papers included in the review.

Results
Of the 30 papers identified, 5 were classified as theoretical; 10 as expository; and the remaining 15 as research (2 descriptive; 9 quantitative and 4 qualitative). We summarise learning points from the papers classified as research in the review.

Conclusions
Much of the literature, which purports to focus on family therapy/ counselling and dementia, in fact focuses on the main carer, uses some techniques drawn from family therapy, or includes family therapy as part of a complex intervention package. Those papers, which employ therapy/ counselling, often only give a brief broad indication of the model or approach utilised. Future research would benefit from clarity regarding the therapeutic model employed.

The few studies identified, which attempted systematically to evaluate the impact of therapy, differed in the outcome investigated. Evaluation of therapy is complex but treatments aimed at benefiting families should logically be evaluated from a variety of perspectives, including that of the person living with dementia and the referring agent (if one is involved).
There are four potential roles for family therapy in practice with families living with dementia: as an agent of change; as a preliminary to the acceptance of treatment; as an adjunct to other treatments; and as a source of useful techniques applicable in other contexts. To make family therapy more widely available in practice would necessitate dealing with a number of challenges related to the context, the family and the therapy itself.

10
Idiosyncratic or essential? Rolling out Primary Care Memory Clinics
Professor Susan Mary Benbow, Visiting Professor of Mental Health & Ageing, Staffordshire University & Consultant Psychiatrist, Gnosall Primary Care Memory Clinic, Professor Tony Elliot, Consultant Psychiatrist, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Professor Dave Jolley, Consultant Psychiatrist, Gnosall Primary Care Memory Clinic & Honorary Reader in Old Age Psychiatry, Personal Social Service Research Unit, Manchester University

Aims
We describe how a Primary Care Memory Clinic (PCMC) model, developed in one Health Centre, is being rolled out to 41 practices covering 280,000 patients and highlight the challenges involved.

Method
A PCMC has been running for over 7 years in Gnosall Health Centre. We describe key features of the model, the plan for rolling it out across the local health economy, and outline the challenges involved.

Results
Key features of the roll-out include: the three tier model; the clinic pathway; the role of the eldercare facilitator (ECF) and other team members. The Pilot Go Live Date is 6th January 2014, following recruitment of ECFs. The contract value is £500,000, and duration of the pilot phase 12 months (including evaluation). The provider will deliver an enhanced multi-disciplinary shared care dementia service, based in the community: the Prime Contractor is South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Sub Contractor (The Provider) is GP First Ltd. Registered patients of Stafford & Surround CCG and Cannock Chase CCG of any age who are diagnosed with dementia and their carers will be service users.

Discussion
Challenges include serving differing populations; some areas may be deprived. Individuals involved may not have the same commitment, priorities, personal attributes, working relationships, as those who initiated PCMCs. GPs may question the benefit to the GP Practice, and who is clinically responsible for the patient? It will be necessary to integrate services involved in the dementia pathway eg mental health services; complex and challenging behaviour; social care. The PCMC needs to be compatible with NICE Guidance. Information Technology and data sharing will be necessary. Where will letters be stored? How will duplicate work be avoided, eg will the Trust have to enter data onto their system as well as the GP system? Who will count the activity?

PCMCs bring together secondary and primary care expertise, allow specialists to access the knowledge, skills and information available in primary care, and are less daunting for patient and family who are seen in their own familiar Health Centre. The model has been evaluated positively in one Health Centre where it improved quality and decreased costs, but rolling it out will need careful assessment to ensure that the model can be applied more widely and is not solely the consequence of bringing together a group of enthusiasts. Key players in success will be community based ECFs and practice staff.

11
Sexuality and dementia: a survey
Professor Susan Mary Benbow & Mr Derek Beeston, Staffordshire University, Stafford

Aims
Sexuality in later life is a neglected topic, and the intimate relationships of people with dementia are even more neglected. There is evidence suggesting that sexuality and intimacy are important in the quality of life of people with dementia and of their family and carers. Since little is known about how sexuality is affected by dementia, we have designed a survey to ask families living with dementia to tell us about any impact on sexuality and intimate relationships. The question we aimed to address is: are people with dementia and their family carers aware of changes in sexuality and if so what changes do they perceive (descriptive/ qualitative data)?
Method
An online questionnaire has been drafted using Qualtrics, an online package which facilitates the design of and analysis of questionnaires. The questionnaire starts with information and consent procedures, and then consists of two parts. Part 1 asks for basic demographic information followed by open questions about sexual changes in relation to dementia. Part 2 consists of the ASKAS (Aging Sexuality Knowledge and Attitudes Scale) attitudes sub-scale (a 26 item questionnaire which investigates attitudes towards sexuality in later life) with the consent of Charles B White, who developed it. A link to the questionnaire and information about it has been circulated to third sector organisations in the locality in contact with people with dementia and their families.

Results
Qualtrics collates the responses received and generates reports. Open answers to questions in Part 1 are being analysed thematically using NVIVO (a computerised software package) and part 2 will generate an attitudes score which can be compared with previous research. Initial results suggest that Part 1 of the questionnaire is more acceptable to families: that an online questionnaire may not be applicable to this population (two organisations have preferred to print out the questionnaire for circulation to families in contact with them) and that loss of a sexual relationship is an area of concern to carers and people living with dementia.

Discussion
This study is in its early stages and has raised a number of issues, not only about sexuality and dementia, but also about how to appropriately investigate and discuss these issues with families.

12 Mental Health Promotion in Black and Minority Ethnic elders- a review of practice.
Dr Sarmishtha Bhattacharyya, Consultant, Old Age Psychiatry, Betsi Cadwaladr University Health Board, Wrexham Maelor Hospital, Wrexham, UK and Professor Susan Mary Benbow Visiting Professor of Mental Health & Ageing, Staffordshire University, UK

Background
Office for National Statistics (ONS) figures suggest that people from BME backgrounds currently make up approximately 12 per cent of the UK population. UK population is growing in size and ageing and this trend is likely to continue into the future. There were about 9.8 million people aged 65 or over UK in 2007, but by 2032 this number is projected to rise to 16.1 million. Population ageing brings a new set of challenges in terms of health, cost and dealing with diversity. One challenge is the growth in numbers of older adults from Black and Minority Ethnic (BME) groups, which will result in increasing numbers of older BME adults with dementia, depression and other mental disorders. Older BME individuals are concentrated in large urban areas with high levels of unemployment and deprivation: have lower pensionable incomes than the majority of their peers: and are more likely to be living in low-income households and overcrowded accommodation. BME elders are also likely to suffer poorer health and from a range of debilitating conditions. Physical and mental health are closely interrelated and physical health problems can affect mental wellbeing and vice versa. Suicide prevention is also an increasing concern in this population and concern has been raised regarding the application of generic suicide prevention models to BME elders. Generic research on mental health promotion in elderly age groups may not be applicable to BME populations and their social disadvantages are likely to compound the difficulties of improving mental and physical health.

Aims
To review available research on mental health promotion relevant to BME elders.

Methods
A systematic literature search of Pubmed, Medline and Google Scholar was carried out using the terms ‘BME, migrant, minority ethnic, dementia, depression, suicide, mental health promotion’. Abstracts were screened to identify relevant papers and reports, which were read by both authors to identify models of mental health promotion amongst BME elders.

Results
The results are in preparation.

Conclusion
Person-centred care benefits all and an emphasis on delivering holistic person-centred mental health services for all would meet the needs of BME elders across the UK. This is equally applicable to mental health promotion amongst BME elders.

13
The Challenge of Dementia! Is Knowledge the Answer?
Dr F. Black, Dr M S Krishnan, Lustrum Vale, Tees, Esk and Wear Valley Trust, Stockton On Tees.

Background
It is estimated that 800,000 people are living with dementia in the UK, with 670,000 in England alone. This number is anticipated to double in the next 30 years. The National Dementia Strategy (2009), was set up to increase standards in dementia care, with Dementia Challenge (2012) aiming to deliver major improvements by 2015.

Method
A custom designed questionnaire was used to assess the public’s perception and understanding of dementia, during Dementia Awareness Week, 20-24th May 2013 in a North East town. The questionnaires were given out at local libraries, The George Hardwick Foundation, and by volunteers on the high street. These were simple multiple choice answers based around dementia awareness, including knowing someone with the illness, perceptions by others, symptoms and signs, treatment, prevalence and the participants age in comparison as to how worried they were at developing the illness themselves.

Results
Detailed results will be discussed in the poster
190 questionnaires were completed, 93% of participants had heard of the term dementia, with 87% recognising the term Alzheimer’s, however less than half had heard of vascular dementia. When considering who was likely to be affected with the illness, 30% felt it was part of growing old.
Results related to social aspects of living with dementia, 9% felt that people should be looked after in care homes once diagnosed. 69% believed that people with dementia are vulnerable, being laughed, teased and vulnerable to others. 93% felt sorry for those with the diagnosis. 94% thought it was common for displays of aggression were common in the disease, with 74% displaying depressive symptoms. 94% believed there was no cure for the disease but 80% felt that there was medication that could help delay the disease process. The 61-80year group were most concerned about developing dementia themselves.

Conclusion
When compared to other studies, our findings were comparable to those from Northern Ireland (2010), and with the Dementia awareness study by Alzheimer’s Society (2009), where it was highlighted that there was a shocking lack of awareness.

Acknowledgement – Dr V Thomas, My clinical Supervisor

14
Safety of Transfers from General to Psychiatric Care- A Service Evaluation
Dr Jenny Bryden, CT2, Royal Cornhill Hospital, Aberdeen), Dr John Callender (Consultant Psychiatrist and Associate Medical Director, Royal Cornhill Hospital, Aberdeen), Ms Elodie Schrijver (Economist, Quality, Governance and Risk. NHS Grampian).

Aims
Junior doctors had been concerned that patients were being transferred from general (Aberdeen Royal Infirmary- ARI) to psychiatric (Royal Cornhill Hospital- RCH) care with insufficient information for continuity of care or while physically unstable. It was decided to audit all patient transfers between ARI and RCH to identify if these concerns were valid.

Background
Old age psychiatry services care for patients who are often frail, complex and require good multi-disciplinary input. Unfortunately, patients with any psychiatric diagnosis often receive poorer quality physical care and communication between specialities can be lacking.
Methods
All wards in RCH were contacted weekly over two months to identify patient transfers. Transfer letters were compared to the standard set in Scottish national guidelines for immediate discharge letters and an audit proforma was completed, documenting the patient’s age, physical and psychiatric diagnoses, reasons for transfer, problems in the process of transfer and re-admissions to ARI. Simple descriptive statistics were calculated and narrative accounts of patient journeys were transcribed for the report. The final report was emailed to doctors involved care of the patients to check for accuracy.

Results
Half of the patients who transferred between general and psychiatric care were over 65 and had a primary diagnosis of dementia. Overall, 35% of patients were transferred without any documentation. All of these transfers involved people with dementia, meaning that 70% of these transfers were unaccompanied by any medical documentation. In 40% of transfers, patient safety was endangered. Again, all of these incidents involved patients over 65. Problems included incorrect information on medication (omitting new antibiotics, anti-thrombosis medication and also analgesia). Abnormal investigations were missed (including significant anaemia, high inflammatory markers, and high sodium.) Significant medical problems ongoing on arrival back in psychiatric care included dehydration, two cases of urinary retention, a patient who was unable to swallow his analgesia or other medication, ongoing chest pain and acute respiratory distress.

Conclusions
There are significant problems in transfers from general to psychiatric care, especially involving the care of adults with dementia. These problems have directly affected patient safety. This has been taken to the ARI/RCH liaison meeting and will be re-audited next year.

15
Venous thromboembolism risk assessment audit - two old age psychiatry wards at an inpatient unit
Dr Matthew John Burton MBBS and Dr Rajesh Balasubramanian MBBS, DPM, MRCPsych

Background
A 2005 All-Party Health Committee report identified venous thromboembolism as a major preventable source of death in hospital inpatients. In response to this NICE produced clinical guidelines (CG92) to outline the role of venous thromboembolism risk assessment. The NICE guidelines do not distinguish between different groups of inpatients.. In South Essex Partnership Trust a VTE Risk Assessment has been introduced in the four old age psychiatry wards, and two old age psychiatry continuing care wards from 10th September 2012.

Aims: To assess the implementation of the venous thromboembolism risk assessment in two wards on the same clinical site. One ward covered patients with organic illness and the other with functional illness. The same two clinical teams looked after patients on both wards.

Method
A Snapshot audit was conducted of all inpatients including patients on leave on 15th February 2013 who were admitted after the risk assessment was implemented. A standard audit tool was used to assess how the risk assessment had been completed.

Results: 39 patients were included - 20 on the Organic ward and 19 on the Functional ward. One team looked after 21 patients the other team 18 of split between the two wards. 56% of the risk assessment were partially completed or completed. 85% on the organic ward were completed and 26% on the functional ward were completed or partially completed. When completed they were generally completed in a timely manner and in their entirety. No patients were assessed as needing VTE prophylaxis.

Conclusion
There was marked variation between the two wards despite being managed by the same medical staff and the same on call staff. This could be put down to the variability of availability of the documentation on the different wards and the importance placed on physical health matters given in a dementia setting versus a functional disease setting. Where completed the forms were generally completed well. Ongoing education and development is needed to ensure compliance improving compliance and high standard completion.

Discussion
Are VTE Risk assessments a useful and necessary adjunct in Old Age Psychiatry? Whilst NICE guidelines do not distinguish
between mental health inpatients and other inpatients. Evidence recently published suggested a roughly equivalent incidence between old age wards and medical inpatients. Further work is needed on the role of risk assessment and VTE prophylaxis. Further audit is needed at a trust wide level to ensure that the risk assessment are being carried out appropriately.

16
Venous Thromboembolism (VTE) Risk Assessment. A potential silent killer in Old Age Psychiatry.
Dr Abid Choudry, CT3 and Dr Shigore Job, Dudley and Walsall Mental Health Trust

Introduction
It is estimated that 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year\(^1\). Treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service.

Unfortunately the risks of thrombosis are increased in frail older people due to age, co-morbid medical problems, reduced mobility, and previous history of VTE as well as antipsychotic use.

NICE guidelines in 2010 recommended that every inpatient should be assessed for venous thromboembolism within 24 hours\(^2\).

With this is mind an audit looking into venous thromboembolism risk assessment was completed in a 30 bedded old age unit.

Aims
The aim was to study inpatients admitted to the old age psychiatric unit and see if NICE and Department Of Health guidelines are being followed in relation to VTE (Venous thromboembolism) risk assessment and prophylaxis\(^1,3\).

In addition to this the aim was to get an opportunistic snapshot of VTE risk factors that old age patients may present with when admitted to hospital.

Methods
A literature review was initially performed around the topic of interest. Following this the audit proforma was designed. Standards were based on the NICE and Department Of Health guidelines\(^1,2\). A prospective opportunistic sample of all the inpatients in the old age psychiatric unit during a 2 week period was audited.

Results
All 30 inpatients were audited over a 2 week period. 13% of patients developed a deep vein thrombosis during the admission period audited. No patients had a VTE risk assessment completed on admission. Every patient had at least one risk factor for developing DVT (deep vein thromboembolism) due to being over 65 years old.

93% had at least 2 risk factors and 63% had at least 3 risk factors. Despite this no patients were treated prophylactically with graded compression stockings or Enoxaparin.

Conclusions
Following completion of this audit it was evident that VTE risk assessment and prophylaxis was not something that was being considered for patients admitted to the old age psychiatric inpatient unit. However due to the risk factors involved and the proportion of patients developing DVT’s during their admission it is something vitally important. As a consequence of presenting the audit locally to doctors and across the trust in the audit meeting a service change was recommended with a VTE risk assessment planned to be introduced across the trust.

17
Evaluation of a community based Guided Self Help Cognitive Behavioural Therapy group for patients aged over 65 with mild to moderate depression and/or anxiety symptoms
Dr Robert Clafferty, Consultant Psychiatrist NHS Lothian Royal Edinburgh Hospital, Edinburgh, NHS Lothian, Ms June Dickson, Community Development Officer, Action on Depression, Edinburgh,

Background
Although guided self help cognitive behavioural therapy (GSH-CBT) is recommended in national expert guidelines as an
evidence based intervention for the treatment of mild to moderate depression\(^1\), there is limited evidence for its use in people over 65\(^2\) or advice on practical issues of how it can be best delivered within a standard clinical setting\(^3\).

**Aims**

a) To examine the effectiveness of a GSH-CBT intervention for patients over 65 with mild to moderate depression / anxiety symptoms from a standard clinical sample.

b) To explore the feasibility of a collaborative service provision between health and voluntary sector.

**Methods**

Patients identified from an existing sector consultant psychiatrist outpatient clinic service who had been referred by their GP for assessment over a 12 month period (up until July 2013).

Inclusion criteria: age >65 with mild to moderate depression determined on clinical interview by consultant psychiatrist based on standard ICD-10 diagnostic criteria, able to attend a clinic setting for treatment and no psychotropic drug changes occurring within one month of group start date.

Exclusion criteria: any significant cognitive impairment or current severe depression symptoms (e.g. suicidal ideation or psychotic symptoms).

**Outcome measures**

Baseline Hospital Anxiety and Depression Scale\(^5\) (HADS) depression and anxiety scores compared with final HADS score on completion of group.

**Results**

Of the 20 patients (F:M =18:2) identified as eligible to participate, 12 patients accepted an invitation to join the group, 1 dropped out after 1 session (citing personal choice). 11 patients (55%) (F:M=9:2) completed 3 or more sessions and were included in the final analysis. Average age 77 (range 66-86)

Individual attendance ranged from 3 – 6 sessions and attendance over the course of the group was 87% (range 50 – 100%). 10 of 11 patients completed baseline and endpoint HADS questionnaires. Average baseline anxiety score 9.2 declined to endpoint 7.6 (1.6 reduction). Average baseline depression score 5 declined to endpoint 4.5 (0.5 reduction).

Assuming a significant marker to be a change of >1 on HADS subsets this suggested significant improvement for anxiety scores and a positive trend for depression scores between start and end of intervention.

**Conclusions**

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

18

**A complex activity intervention to reduce the risk of dementia in mild cognitive impairment – ThinkingFit.**

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**Background**

Dementia affects 35 million people worldwide and at present there is no cure. Many cases of dementia may be preventative because regular participation in physical, mental and social leisure activities during middle age is associated with up to 47% dementia risk reduction in later life. However, the majority of middle-aged adults are not active enough. High-risk groups can be identified and adults diagnosed with mild cognitive impairment (MCI) are at particularly high risk, as 39% will convert over 3 years. MCI is therefore a clear target for activity interventions aimed at reducing dementia risk. An active lifestyle during middle age reduces dementia risk but it remains to be determined if increased activities reduces dementia risk when MCI is already evident. Before this can be investigated conclusively, complex activity programs are required that (1) combine multiple health promoting activities, (2) engage people with MCI, and (3) result in sufficient adherence rates.

**Methods**

We designed the ThinkingFit program to engage people with MCI in a complex intervention comprised of three activity components: physical activity, group-based cognitive stimulation (GCST) and individual cognitive stimulation (ICST). Engagement and adherence were promoted by applying specific psychological techniques to enhance behavioural
flexibility in an early pre-phase, and then during the course of the intervention. To pilot the intervention, participants served as their own controls during a 6- to 12-week run-in period, which was followed by 12 weeks of activity intervention.

Results
Out of 212 MCI patients screened, 163 were eligible, 70 consented and 67 completed the intervention (mean age 74 years). Activity adherence rates were high: physical activity=71%; GCST=83%; ICST=67%. Significant treatment effects were evident on physical health (decreased BMI and systolic blood pressure), fitness (decreased resting and recovery heart rate), and cognition (improved working memory).

Conclusions
We found satisfactory recruitment, retention and engagement rates, coupled with significant treatment effects in elderly MCI patients. It appears feasible to conduct randomized controlled trials of the dementia prevention potential of complex activity interventions such as ThinkingFit.

19 Clinical Effectiveness of a Specialist Mental Health Liaison Team for Older people
Dr Sarah Wilson, Dr Sujata Das, Nottinghamshire Healthcare NHS Trust

Background
Mental health problems are common in older people in general hospitals with poor outcomes including increased mortality, loss of independent function and higher rates of institutionalisation. Mental health liaison services for older people have been shown to improve outcomes. Aim of the study was to evaluate the effectiveness of liaison team by looking at outcome measures of response time, length of stay and institutionalisation rate.

Method
Referrals to team from Sep 2011 to Jan 2012 were included in initial study. Following an expansion in workforce, referrals from Sep 2012 to Jan 2013 were included in repeat audit. Referral data and data on Patient Administration System were analysed.

Results
342 referrals were included in initial audit and 443 in following year. Majority of referred patients (58% initially, 61%repeat) were female with spread of ages from 43 to 106 years over two periods. Main diagnoses in audits were comparable, more than 40% had dementia, more than 20% had delirium and more than 8% had depression, while around 7% did not have mental illness. In initial audit 68% of routine referrals were assessed within 2 working days, increasing to 82% for re-audit. 48% of urgent referrals were seen the same day between 2011-2012, while 50% were seen the same day in 2012-13. In initial audit 28% of patients referred to team were discharged within 2 weeks of admission and 56% within 4 weeks, this increased to 42% and 66% respectively in second study. Only 12% of patients in this sample were discharged into long-term care initially, reducing to 7% a year later, while the proportion transferred to temporary residential care reduced from 13% to 9%. Number of patients returning home increased from 56% to 61%.

Conclusion
Psychiatric Liaison Accreditation Network, RCPsych standards for timescale for assessment of routine and urgent referrals were met by team most of the time (>50%). Team is still smaller than that recommended by RCPsych; suggesting that team is on target to meet the accreditation standards once workforce expands further to meet the recommendations. Rate of institutionalisation was lower than anticipated but length of hospital admission remained protracted in number of cases. 37% had hospital stay of over 4 weeks initially, although this did drop to 22%. Number of reasons were identified including periods of rehabilitation, delayed discharges due to problems with discharge destinations and prolonged physical ill health. Diagnoses reflect those expected in an old-age liaison service.

20 ECGs in The Management of Dementia, a Clinical Audit
Dr Pravati Mishra CT2, Dr Sarita Dasari ST6, Old age psychiatry, Prof. Stephen Curran, Consultant old age Psychiatrist

Introduction
It is estimated that approximately 700,000 people suffer from dementia. Numbers are likely to double in next 30yrs.
Wakefield memory service receives about 1200 referrals a year. This service was set up ten years ago. It facilitates access to assessment, diagnosis, treatment and support for people with dementia.

NICE and SCIE(Social Care Institute for Excellence) have jointly published recommendations about identification, treatment and care of patients with dementia. There is a potential for cardiac side effects from these medications. Atrial Fibrillation is a frequent finding in elderly and is a known risk factor for cerebrovascular accidents.

It is recommended that a recent ECG should be available for reference at diagnostic appointments. In clinical practice these medications are contraindicated in patients with specific conduction abnormalities and bradycardia.

Cardiac effects of AChI’s in the literature
Rowland et al(2007)
Pooled RCT evidence shows no significant side effects between drug and pulse.
Hernandez et.al said there is increased risk of bradycardia in patients taking choline esterase inhibitors.
For all patients referred to Memory Clinic an ECG is requested from general practitioner.

Aims
To measure the extent to which Wakefield memory service is meeting standards with regards to ECG.
To establish the relationship between ECG findings and prescribing anti dementia medication.

Standards
A comprehensive memory assessment should include routine ECG.(NICE 2011)
A copy of ECG recording should be available at diagnostic appointment.
ECG should be readable.

Method
Data collection
Retrospective audit of notes.
Referral log used to identify 50 consecutive referrals to memory service.
Sequential case notes were retrieved.
Patients with Mild cognitive impairment or Vascular dementia excluded.

Results
72% of patients attending had an ECG done prior to appointment.
Well below gold standard of 100%.
Treatment prescribed without ECG.
100% of treatment decisions made in presence of ECG were documented.
One person had Sinus Bradycardia with Right bundle branch block.
Two people had atrial fibrillation.
No repeat ECGs though 9 abnormal ECGs found.
1 cardiology referral done .

Recommendation
To repeat the audit in 1 year.
Locally agreed guidelines between physicians and psychiatrists on what cardiac abnormalities should contraindicate prescribing.
Training clinicians to read ECG’s.

References
NICE

PET or SPECT brain imaging procedures for dementia? Consumer views
Claire Bamford, Newcastle University, Chris Davison, Newcastle University and Northumberland, Tyne and Wearside
Background
Current guidelines recommend perfusion single photon emission computed tomography (SPECT) or 18F fluorodeoxyglucose positron emission tomography (PET) to facilitate differential diagnosis of dementia. Currently there is a lack of data regarding acceptability of SPECT or PET.

Aim
To explore patient and carer views and experiences of SPECT and PET scans and identify which approach is more acceptable.

Methods
68 people aged over 60 with mild or moderate dementia who met the criteria for probable AD or probable DLB were recruited prospectively from clinical services in north east England. Thirty age and sex matched controls were also recruited. All participants completed SPECT and PET scanning on separate occasions within a 3 month period.

Participant views on the experience of SPECT and PET were explored through:
- Questionnaires completed immediately after each scan
- A prioritising task to evaluate which characteristics of scans are most important
- A preference questionnaire administered after both scans (controls and carers only)

The prioritising task was included to explore the relative importance attached to different aspects of scans and to help interpret the significance of any differences on the questionnaires. The preference questionnaire explored whether one scan was preferred and if so, the strength of preference.

Results
Few significant differences were found in participant views of the two types of scan. For patients and carers, the significant differences between PET and SPECT centred around whether their relative was in the room during the scan (carers are excluded from PET – CT scans due to radiation risks) Controls found the PET scan less comfortable than the SPECT scan. Overall most controls and carers (69.8%) did not have a preference for either type of scan and of those who expressed a preference, neither scan was consistently preferred. Most participants valued accuracy more than other attributes of the scan (ranked as important by 89.5% of respondents).

Discussion
This study is the first to our knowledge to compare consumer views of PET-CT and SPECT brain imaging for diagnosis of dementia. Our findings suggest that the two types of scans were equally acceptable to the majority of people with dementia, their family members and healthy controls. The majority of people with dementia, their family members and healthy controls prioritised diagnostic accuracy over other characteristics of scans.

22
The development of a multidisciplinary Lewy Body disorder memory clinic
Dr Christopher Davison, Northumberland Tyne and Wear Foundation Mental Health Trust, Dr John Paul Taylor, Northumberland Tyne and Wear Foundation Mental Health Trust

Background
A specialist Lewy Body Disorder memory clinic was set up in Newcastle in September 2010 offering detailed diagnostic assessments of patients with possible Lewy Body Dementias including detailed neuropsychiatric testing, functional assessments and physical examination as well as providing specialist, on-going and holistic management of their cognitive and neuropsychiatric symptoms.

The clinic has been subject to a service review which reviewed all referrals and attendances between August 2011 and August 2012 and included a survey of patients, relatives and carers attending the clinic.

Aim
A review of the Newcastle Lewy Body Disorder clinic has been undertaken to evaluate the current service provision and direct future improvements to the service with proposals outlined.

Methods
A service evaluation of the Newcastle Lewy Body Disorder clinic between August 2011 and August 2012 was completed. Time to definitive diagnosis and benefits of management, as assessed using the Clinician Global assessment of Change (CGIC) were examined. Demographic data and changes to rating and assessment scales were also assessed and service users and carers were questioned using a predesigned preference questionnaire based on survey methodology to review
the service.

Results
Clients were referred from a variety of sources including psychiatric, medical and primary care services. Average age of referrals was 79 years old. Diagnoses were able to be given on average at the 2nd appointment. Patients received referrals to specialist medical services to optimize treatment and more than half were treated within the clinic. Follow up of CGIC scores shows objective treatment benefits. Results of the surveys found the clinic to be excellently received by patients and carers with subjective benefits to care received, prompt diagnosis and provision of appropriate treatment. It also provided suggestions and support for incorporating other disciplines and a support group to further improve the clinic for the future.

Discussion
The clinic has proved successful in providing prompt accurate diagnosis and optimal treatment of Lewy Body Dementias. In response to the success of the clinic it has accepted referrals from a larger area of the North East. The service review and questionnaires have led to the provision of specialist Lewy Body patient and carer support groups running alongside the memory clinic. There are plans to attempt to further develop the clinic to incorporate multi-disciplinary and multi-speciality involvement to improve care and outcomes for patients.

23
A cost effective and sustainable approach to address staff training needs in care homes- a new vision
Dr Dulith Kasun De Silva, MBBS MRCPsych, ST6 in Old Age psychiatry; West London Mental Health Trust, UK

Dementia is an increasingly recognized clinical, social and financial challenge that requires far greater attention. There is a greater focus on dementia care today than ever before. A large number of patients with dementia ultimately end up in care home settings. The Prime Minister’s Dementia Challenge (March 2012) sets out plans to go further and faster in improving dementia care, focusing on raising diagnosis rates and improving the skills and awareness needed to support people with dementia and their carers.

People with dementia have specialist needs. They may experience problems communicating and may struggle to express their preferences and needs. They may also display behavioural and psychological symptoms of dementia, which need to be understood if they are to be responded to appropriately. The key element to overcome the above challenges would be to provide quality training in dementia for staff.

We have piloted a new approach involving a senior psychiatric trainee and a psychologist/psychology trainee to provide a well structured training program in number of care homes in west of London borough of Ealing. Overall feedback we received from the attendees were very positive and encouraging for us to propose similar model that would be cost effective and sustainable addition to the various options of care home training currently available.

We also believe that such training could be incorporated as a core element in old age psychiatry training curriculum as it provides the opportunity for the higher trainee to develop their teaching and leadership skills while contributing to national dementia challenge.

24
An analysis of outpatient letters sent following initial assessment in a Somerset Older Adult Psychiatric service
Mr Viren Ahluwalia Medical Student University of Bristol, Miss Jenni Lane Medical Student University of Bristol & Dr Stephen De Souza ST5 Old Age Psychiatry Somerset Partnership Foundation Trust

Introduction
Good communication between Old Age Psychiatrist in secondary care and general practitioners is vital. The outpatient letter is a formal record of the consultation, allows for communication of the care plan to primary care, and allows for an update on the patient’s progress. Department of Health guidance suggests that these letters should also be sent to the patient or their carer, to ensure they have an understanding of the consultation. However there was concern that the letters designed for primary care may not be appropriate for patients.

Aims
The study looked at the quality of a sample outpatient letters from a community of practice in the West of Somerset. The study also aimed to examine the readability of the letters that were being sent to primary care, which could also be sent to the patient or their carer.
Methods
A sample of 30 letters sent following initial assessments by an older adult mental health service were analysed. A review of literature identified a number of key needs which general practitioners would expect following a specialist opinion from secondary care. The letters were analysed for these key features.

In order to objectively assess the letters for readability each letter was assessed for Flesch-Kincaid Reading Grade Level and Flesch Reading Ease.

Results
Four key needs were identified from a review of the literature, these were diagnosis, treatment, follow up and prognosis. Of these a diagnosis or provisional diagnosis was made in 96% of cases. Treatment was mentioned in 93% of cases, follow up in 90% of the sample. However prognosis was not mentioned through out.

A Flesch Reading Ease scores above 60 and a Flesch-Kincaid Reading Grade of 10 are commonly considered average. 19 letters had a score less than 60 and 13 letters had a grade scores of more than 10, both of these implying that the letters were more difficult than average to read.

Conclusion
While a number of the key needs were present, prognosis was not reported in any letter sampled. In general most letters were beyond the reading level of the average patient. Ways of improving readability will be discussed.

25 Nutritional status in patients with Alzheimer Disease
Dr Olufunmi Deinde, Brain Science Research Unit, Surrey and Borders Partnership NHS Foundation Trust, Dr Ramin Niforoooshan, Brain Science Research Unit, Surrey and Borders Partnership NHS Foundation Trust, David Broadbent, Dietetics Department, East Sussex, Naji Tabet, Institute of Postgraduate Medicine, Brighton & Sussex Medical School and Cognitive Treatment

Aims
Dementia is a multifactorial degenerative disorder characterized by deterioration in cognitive ability and the capacity for independent living. Various studies have sought to investigate the link between nutrition and cognitive impairment. We aim to evaluate the nutritional status of patients with Alzheimer Disease (AD) compare with their healthy carers (partners).

Methods
Patients taking part in the study were 65 years of age or older and were recruited through the memory clinic service in East Sussex, United Kingdom. All patients included were diagnosed with mild AD. Patients recruited lived in the community with their partners (carers) who were willing and able to help with completing a 4-day diet intake record. Controls were partners of recruited patients who had no diagnosis of dementia.

All participants taking part in the study consumed a varied diet and did not have any acute illness as to interfere with their routine dietary intake. Furthermore, participants did not have any disorders that might have interfered with food intake and absorption. In total 26 patients and 26 controls were recruited to the study.

Results
The demographic characteristics of the AD and control groups did not differ significantly in age, gender or Body Mass Index. Forty two nutritional variables were measured. Wilcoxon Rank Sum Test of each variable did not show any statistical significant differences between the two groups.

We also analysed the data as paired – matching each control/AD. We did not find any statistical significant differences between each control/AD pair.

This is a surprising data as most of the nutritional studies on AD showed decreased food intake and eating behaviour disturbances among those patients. In This study we compared AD’s nutritional intake with their healthy partners and it may suggest that having a healthy partner is a protective factor against decreasing food intake in AD at early stage.

26 Staff opinion on access to the liaison psychiatry service and quality of the service provided at an acute general hospital
Dr Olufunmi Deinde, St. Peter’s Hospital, Chertsey, Surrey

Aims
To evaluate staff opinion about their experience of the liaison psychiatry service at Frimley Park Hospital. To identify common themes of unmet need in mental health service provision and in identifying gaps, to work with the liaison team in positive service development.

Methods
A qualitative survey was deemed the most appropriate method of gathering opinion. An online survey making website was used to create the survey. This was circulated via email to all doctors and nursing staff as they are the individuals most likely to be involved with liaison psychiatry referrals. Data collection was carried out over a 6 week period from March 29\textsuperscript{th} to May 10\textsuperscript{th} 2013.

Results
There were in total 32 respondents to the survey. Of the 32 respondents, the majority (44\%) rate their experience with the liaison psychiatry team as positive whilst 22\% rate their experience as negative. The majority of respondents (90\%) knew how to access the liaison psychiatry service. The majority of respondents (63\%) were either satisfied or very satisfied with the quality of assessments and service provided by the older adults team compared with 47\% for the working age team. Of the respondents, 59\% were either satisfied or very satisfied with the time it took for their patient to be seen by the older adults team compared with the 44\% for the working age team. Of the respondents, 66\% either agreed or strongly agreed that the level of communication from the liaison psychiatry team was satisfactory in regards to the older adults team compared to the 50\% for the working age team.

Conclusion
Whilst some areas of good practice were noticed, significant proportions of staff felt dissatisfied with some aspect of the service offered for example, not knowing who to refer, the time taken for patients to be seen, quality of assessments, communication from the team, access out of hours and the need for more education and training. The survey reveals staff are more dissatisfied with the working age team than the older adult team regarding the time taken to see patients, communication and quality of assessments. Key recommendations include the development of clearer guidance showing staff how to access the service out of hours and in emergencies and for the team to develop better, clearer methods of communicating their assessments.

27
Amyloid imaging in dementia with Lewy bodies
Dr Paul Donaghy, Institute for Ageing and Health, Newcastle University, Professor Alan Thomas, Institute for Ageing and Health, Newcastle University, Professor John O’Brien, Department of Psychiatry, University of Cambridge

Background
Lewy body (LB) disorders, including Parkinson disease (PD), Parkinson disease dementia (PDD), and dementia with Lewy bodies (DLB), are the second most common type of neurodegenerative dementia. The pathological hallmarks of LB disorders are Lewy bodies and Lewy neurites. Amyloid-beta (Aβ) deposition is a characteristic pathological feature of Alzheimer’s disease (AD). Significant Aβ deposition is also seen in some subjects with DLB and PDD. Ligands that allow PET imaging of brain Aβ deposition in vivo have recently been developed. These make it possible to compare Aβ deposition across different diseases, and to examine if Aβ deposition is associated with a different clinical presentation.

Aims
We reviewed all studies that reported results of amyloid imaging in Lewy Body (LB) disorders. We hypothesised that (i) Aβ deposition would be greater in LB dementias (DLB and PDD) than controls or PD, but less than AD, and (ii) that Aβ deposition may be associated with a more ‘AD-like’ clinical profile.

Methods
A MEDLINE search was carried out in January 2013. The search terms used were: [“Amyloid”] + [“Positron Emission Tomography” OR “PET”] + [“Lewy” OR “Parkinson”].
82 results were found, of which 16 contained original amyloid imaging data.

Results
LB disorders were associated with lower cortical Aβ binding than AD. Compared with controls, DLB and PDD had increased Aβ deposition, though, unlike AD, a large proportion of PDD and DLB
patients had normal amyloid scans (PDD 65%; DLB 43%; AD 22%).
PD without dementia was not associated with increased Aβ binding.
Reports of correlation between Aβ deposition and symptom profile, severity or progression were inconsistent. Some results suggest a synergistic interaction between Aβ and α-synuclein.

Conclusions
Cortical Aβ may be a factor in some cases of dementia in LB disease. Interpretation of the evidence is hampered by small sample sizes and differing methodologies across studies. Longitudinal studies are needed to clarify the association of Aβ with symptom profile, severity, progression and treatment response in LB disorders.

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28
Prodromal dementia with Lewy bodies
Dr Paul Donaghy, Institute for Ageing and Health, Newcastle University, Professor John O’Brien, Department of Psychiatry, University of Cambridge, Professor Ian McKeith, Institute for Ageing and Health, Newcastle University, Professor Alan Thomas, Institute for Ageing and Health, Newcastle University

Background
The clinical condition of dementia is now recognised as a diagnosis that can only be applied too late in the disease process to be useful for therapeutic approaches centring on disease modification. As a result, in recent years increasing attention has been given to mild cognitive impairment (MCI) and the diagnosis of prodromal dementia. Though diagnostic criteria have been proposed for mild cognitive impairment in Parkinson’s disease and Alzheimer’s disease, no criteria have yet been proposed for the prodromal diagnosis of dementia with Lewy bodies (DLB).

Aims
To review the evidence for the clinical presentation of prodromal DLB.

Methods
A MEDLINE search was carried out in September 2013. The search algorithm used was: [“MCI” OR “Mild cognitive impairment” OR “prodrom”*” OR “RBD” OR “REM sleep behaviour disorder”] + [“Lewy”]. 483 English-language results were found. Of these, 30 studies could be identified that provided evidence of the prodromal presentation of subsequently confirmed DLB.

Results
Longitudinal studies have reported that 5-22% of MCI subjects who progress to dementia receive a diagnosis of DLB. Long term studies with post-mortem follow up suggest that prodromal DLB can present as any MCI subtype, though visuospatial and executive domains may be most commonly affected. Prodromal DLB may also present with non-cognitive symptoms. Sleep disturbance, autonomic symptoms, hyposmia, hallucinations and motor symptoms appear to be more common in prodromal DLB than prodromal Alzheimer’s disease. REM sleep behaviour disorder (RBD) may present decades before the development of DLB.
There has been little research into the use of biomarkers in prodromal DLB. In RBD cohorts, poor olfaction and colour vision; autonomic and motor dysfunction; reduced striatal dopaminergic innervation on SPECT; substantia nigra hyper-echogenicity and increased hippocampal perfusion have been associated with an increased risk of developing DLB. Multiple biomarker profiles are likely to be more informative than single biomarkers in the identification of prodromal DLB. These profiles are likely to change over time as the disease progresses.

Conclusions
The evidence available suggests that prodromal DLB can be differentiated from other dementia prodomes by the presence of i) characteristic clinical features of DLB, ii) other prodromal clinical features and iii) the use of multiple staged biomarkers.

Financial Support
This work was supported by the National institute for Health Research (NIHR) Newcastle Biomedical Research Unit based at Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University. The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

29
**Grief in dementia – more than just a Promethean experience**
By Andrew Dooley, Oxford University, Oxford, Medical Student Prize Winner

Bereavement, the death of a loved one, is a painful and stressful experience. Yet despite its substantial prevalence, most people come to terms with their loss without the need for professional support. Both bereavement and dementia are more likely amongst the elderly, yet the experience of grief in dementia has not been widely studied. In Greek mythology, Prometheus was punished by being bound to a rock, where an eagle would feed on him every day. This shocking and painful experience is similar to that felt by some with dementia following bereavement. They are unable to retain the information of their loss, and so every time they are made aware of it, it is the first they know about it. The result is acute pain for them and those who care for them. This raises the ethical issue as to whether those with dementia should be made aware of their loss. There are interventions that can help such patients retain this information, but this is not the only challenge of bereavement in dementia. Grief in dementia has not been widely studied, and there is little data as to how bereavement in dementia differs from bereavement in other elderly people. The death of a supportive family member can result in long established dementia being “unmasked” following bereavement. In elderly people following bereavement, there are similarities in the presentations of grief, depression (which can present as pseudodementia) and dementia. Bereavement in dementia is difficult for patient, family and professionals, and causes significant distress, as well as diagnostic and management challenges.

30
**Elderly psychiatric inpatient team have a chance to reduce the use of Benzodiazepine and Hypnotics**
Dr Louise Drury, FY1 & Dr Ramin Nilforooshan, Consultant, Surrey and Borders Partnership NHS Foundation Trust

Aims
Benzodiazepine and hypnotics are commonly prescribed for elderly by General Practitioners (GPs) in community and by specialist including Psychiatrist in hospitals. Long term use of these medications is likely to induce physical and psychological health problems in that group.

Methods
All admissions to three psychiatric units between January to June 2013 were audited. Patients who were admitted on Benzodiazepine or hypnotics were identified and percentage of them who were discharge on none of the above calculated. We also looked at inpatients for whom Benzodiazepine or Hypnotics were prescribed and what percentage of them was discharged on one of them at the point of discharge.

Results
In total there were 191 admissions. Seventy Three patients (38.2%) were admitted on a benzodiazepine or other hypnotic of those, 44 patients (61.1%) were discharged on one (38.9% reduction). During admission 145 (75.9%) patients were treated with a benzodiazepine or other hypnotic and only sixty patients (38.4%) were discharged on a benzodiazepine or other hypnotic (37.5% reduction). Twenty five (49%) of those admitted on a benzodiazepine were discharged on one (51% reduction) and 16 (51.6%) of those admitted on a hypnotics were discharged on one (48.4% reduction).

Inpatient units can play a very important role on weaning patients off Benzodiazepine and hypnotics. Psychiatric team must communicate clearly with detailed plan for patients whom been discharged on one of those medications.

31
**The use of point of care simulation training to improve emergency medicine staff awareness of dementia.**
Ruth Edwards, Clinical Simulation Fellow (Dementia), Mr Peter Thomas (Emergency Medicine Consultant), Milton Keynes NHS Foundation Trust

Aim
The aim of this project is to use point of care simulation training to improve staff awareness of dementia within the Emergency Department.

Method
A needs assessment survey demonstrated that dementia awareness within the trust was poor. As a result a programme
of point of care simulation teaching has been introduced, and piloted within the emergency department.

We have designed a number of scenarios that reflect the varying complexity of care required for patients with dementia.

The following scenarios included;

- Recognising patients with memory impairment to enable appropriate referral back to patients own GP for consideration of memory assessment.
- Managing behaviour that challenges within the Emergency Department.
- Recognising families in crisis who care for relatives with dementia.

The simulated scenarios have been designed using real actors to play the role of the patient with dementia and their family/carer. Real clinical events have been used to design the scenarios. The doctor attending is provided with a verbal brief of the patients’ history and reason for admission to A&E.

The scenarios are facilitated and then the learner is debriefed using a tool for structured feedback.

**Results**

Initial analysis of feedback from participants demonstrates the usefulness of simulation to provide an interactive learning environment and highlights the difficulties associated with taking a history from patients with memory problems. Awareness of the appropriate investigations and referral pathway for patients with suspected dementia is enhanced.

**Conclusion**

Our initial pilot demonstrates the usefulness of point of care simulation in raising awareness of patients with dementia by emergency medical staff

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**An audit of nursing documentation on a ‘Complex Needs’ old age psychiatry ward – are nursing staff writing weekly reports about their patients’ progress? What type of information is included?**

Dr Egan, CT3, Dr Adeyemo, Consultant in Old Age Psychiatry

**Aims**

‘Complex Needs’ is a fifteen bed inpatient ward for psychiatric patients over 65 years old who, due to challenges with their behaviour, have been identified by referring teams as needing a specialist environment for their care. These patients can have a range of diagnoses including dementia, psychosis, mood and anxiety disorder. Frequently these patients have challenges in communicating their needs which can lead to them using alternative mechanisms to communicate which can impact on quality of life for both themselves and the people with whom they live (for example aggression).

In this type of environment nursing documentation is essential to assess patients’ progress. It is this information which helps to inform MDT decisions about diagnosis, treatment plans, efficacy of interventions and discharge planning. Each patient is allocated a ‘named nurse’ who is tasked to produce a weekly review for their patients.

Our audit standard for cycle 1 was that 100% of patients should have a weekly review written in the clinical notes. Cycle 1 also collected qualitative information about content.

The MDT then worked together to devise a ‘support tool’ which would give clearer guidance to nurses about the type of information that would be helpful to include.

Cycle 2 contained the same standards as cycle 1 but additionally used the ‘support tool’ as a secondary standard to see if the content of the reviews had changed.

**Methods**

Audit proforma devised.

Cycle 1: notes reviewed for 7 inpatients between 1/3/13 and 30/4/13.

‘Support Tool’ devised with input from all MDT members.

Cycle 2: notes reviewed for 11 inpatients between 1/10/13 and 1/11/13.
Results
Cycle 1: 68% of total inpatient weeks had an accompanying written review, 85% of which were documented in the clinical notes.
Cycle 2: 74% had a review, 100% documented in clinical notes.
Content of reviews:
- 100% mood and behaviour
- 96% sleep and diet
- 80% medication issues
- 44% discharge planning

Conclusions
On searching the literature, there appears to be a lack of guidelines about the purpose or content of psychiatric nursing documentation.
Our support tool increased the frequency of reviews and changed their content, but there remain questions about whether nurses need more training in this area.

33 Audit of alcohol related cognitive impairment screening and detection on an inpatient detoxification ward (Edward Myers Unit)
Dr Egan, CT3, Dr Gunawardene FY2, Dr Watts, Consultant Substance Misuse

Aims
There is a spectrum of cognitive impairment found in alcohol dependence from subtle frontal lobe impairment, to the specific deficits of the amnestic syndrome and the global changes of dementia. Alcohol related dementia accounts for 10% of all cases of dementia whilst Wernickes-Korsakov’s syndrome affects 1 per 1000 population worldwide. The cognitive consequences of excess alcohol consumption are well recognised but there are limited guidelines about what type of cognitive screening (if any) is recommended in alcohol dependence.

The Edward Myers Unit is a 15 bed inpatient unit which offers inpatient detoxification for patients with alcohol dependence. The aim of this audit was to answer the following:
- Are patients being appropriately screened for the presence of cognitive impairment?
- If detected, are cognitive deficits followed up with either appropriate investigations or referral?
- Is this information being shared with general practitioners?

Methods
The notes of all patients discharged in June and July 2013 who were admitted for an alcohol detoxification and had a primary diagnosis of alcohol dependence syndrome were audited against a proforma.

Results
A total of 44 patients identified. Current local standards for cognitive screening questions and neurological examination on admission were not being met in all. Overall 22 of 44 patients were identified on admission as having either cognitive or neurological deficits.

Of these 22, the following follow-up occurred during the course of their admission:
- 9% repetition cognitive screening questions
- 50% repetition neurological examination
- 9% MMSE and ACE-R
- 18% additional blood investigations
- 5% CT head
- 9% liaison with other teams
- 5% neuropsychiatry referral
- 32% had details of above findings or follow up communicated to their GP on discharge

No patients had memory impairment coded on their formal discharge paperwork

Conclusions
We are detecting cognitive or neurological deficits in 50% of admissions for alcohol detoxification, but the follow up of these findings during admission appears sporadic and is not sufficiently communicated with the general practitioners. As a result of this audit we are designing a cognitive impairment pathway that will improve admission cognitive screening and enable this to be followed up in a standardised manner. We are implementing this pathway and our re-audit will examine its efficacy in improving detection, follow up and communication in this important area.

34
The use of SPECT scan, CT-scan and Psychometric testing in the investigation of dementia – A regional current practice review
Uchenna Ezenwilo, F1 Old Age Psychiatry, Rakesh Pulpa Specialty Doctor in Old Age Psychiatry

Background
There are no established referral criteria for functional scans and psychometric testing in Memory Clinic at the Derbyshire Healthcare NHS Foundation Trust.

Aim
To review current consultant practice in the investigation of dementia with focus on the use of SPECT scan, CT-scan and Psychometric testing, with the view of setting a local referral guideline.

Method
All referrals for SPECT (single photon emission computerised tomography) scan made from Memory Clinic by six consultants at the Derbyshire Healthcare NHS Foundation Trust from January to June 2013 were identified. The scan results were analysed to see if the SPECT scan confirmed the provisional clinical diagnosis or not. The clinical notes were also reviewed to see if CT-scans were performed prior to SPECT scan and if psychometric testing was used before and after SPECT scan.

Results
After analysing the SPECT scan of 71 patients, SPECT scan confirmed the provisional clinical diagnosis in 50 patients (70%). In 13 patients (18%) SPECT scan did not confirm clinical diagnosis and the results from 8 patients were inconclusive. CT-scans were done in 45 patients (63%) prior to SPECT scan and it showed no abnormality in 62% of these patients. Psychometric testing after SPECT scan was done in 17% of patients and a definite diagnosis after psychometric testing was made in 35% of these patients.

Conclusion
SPECT scans and CT-scans are useful in the investigation of dementia. However, psychometric testing is also helpful when there is diagnostic uncertainty and could be used more often.

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Differences in demographic characteristics and symptoms between patients with subjective cognitive impairment and mild cognitive impairment
Andres Saez-Fonseca, University of Roehampton, Rhiannon Ducksbury, North Essex Partnership University NHS Foundation Trust, Joanne Rodda, North East London NHS Foundation Trust, London, Chitra Nagaraj, Mersey Care NHS Trust, Timothy Stevens, North Essex Partnership University NHS Foundation Trust, Kallur Suresh, North Essex Partnership University NHS Foundation Trust, Zuzana Walker, North Essex Partnership University NHS Foundation Trust & Mental Health Sciences Unit, University College London

Introduction
This retrospective observational study compared baseline social, psychiatric and demographic information of patients presenting with subjective cognitive impairment (SCI) and amnestic mild cognitive impairment (aMCI) in a National Health Service (NHS) cognitive disorders diagnostic clinic in North Essex, UK, between 2001 and 2007 (inclusive). There is evidence to suggest that SCI may represent a prodromal stage of Alzheimer’s disease (AD). Comparing this group with those who present with aMCI (a high risk state for AD) may highlight factors that precede cognitive decline or if there is something unique about this group that seeks medical attention without objective cognitive deficits.

Hypothesis
We hypothesised that SCI patients at baseline will have: a younger age, more years spent in education, higher premorbid IQ, higher scores on scales of depression/anxiety and higher levels of physical illness than those with aMCI.
Results
The results showed that those presenting with SCI (n=80, 37 male, 43 female) were younger, had more years of education (but not higher pre-morbid IQ) and were prescribed more medication. However this group had fewer physical medical conditions than the aMCI group (n=131, 59 male; 72 female) and there was no difference between groups for anxiety and/or depression at baseline.

Conclusions
The profile of our patients with SCI is not entirely consistent with our hypothesis. One explanation for the findings is that, rather than there being an ‘SCI profile’, having more education motivates people to seek help from medical professionals earlier as they depend more on cognitive performance for their occupation. This might also explain why they seek help at a younger age. Possible motivators for help seeking behaviour includes a distinct fear of AD after having a family member or spouse suffer the disease, social comparisons and causal attributions or personal concern, perceived GP attitude, availability of alternative sources of reassurance and an opportunity to seek help.

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Factors that predict cognitive decline in patients with subjective cognitive impairment
Andres Saez-Fonseca, University of Roehampton, Rhiannon Ducksbury, North Essex Partnership University NHS Foundation Trust, Joanne Rodda, North East London NHS Foundation Trust, London, Chitira Nagaraj, Mersey Care NHS Trust, Timothy Stevens, North Essex Partnership University NHS Foundation Trust, Kallur Suresh, North Essex Partnership University NHS Foundation Trust, Zuzana Walker, North Essex Partnership University NHS Foundation Trust & Mental Health Sciences Unit, University College London

Introduction
Current evidence supports the concept of a clinically ‘silent’ phase of Alzheimer’s disease (AD) where pathological, metabolic and functional changes are present in asymptomatic individuals. Subjective cognitive impairment (SCI) may represent the earliest point on the continuum of clinical Alzheimer’s symptomatology. A better understanding of the baseline characteristics this group of patients present with may enhance our knowledge of the underlying disease processes, facilitate early diagnosis, follow-up and treatment.

Aim
The aim of this study was to investigate which factors at baseline predict cognitive decline measured by a diagnosis of amnestic mild cognitive impairment (aMCI) or dementia at follow-up.

Method
We recruited all patients with SCI presenting to a tertiary cognitive disorders diagnostic clinic in Essex between 2001 and 2007 and examined their records. Using a retrospective cohort design we compared baseline scores and demographic characteristics of patients with SCI that declined cognitively on subsequent follow up appointments and those that did not.

Results
Significant differences were evident in age of onset, age first presenting at the memory clinic, number of medications and physical illnesses. There were differences in test scores of the Trail Making B test, CAMCOG-R (attention subscale). Using those variables of interest we performed a survival analysis to ascertain the differences in the rate of conversion over time between the groups with the factors associated with decline and the groups without. Using this method we demonstrated important cut off points for analysing test scores in light of predicting later decline significant in age of onset, age at first assessment, trail making B score and NART score.

Conclusions
These cut-offs are indicative of important differences in executive function, simple attention and cognitive reserve between those individuals suffering from SCI who are likely to decline and those who are likely to remain stable. Attentional deficits may be of particular importance in these individuals. Knowing which factors and test results predict conversion to aMCI or dementia is useful in clinical practice for early detection, to make decisions about frequency of follow up in SCI, to answer questions regarding prognosis from patients and to make treatment decisions.
An audit looking at the recording of the driving status and advice given to patients, regarding driving, who attend the memory service in the Northern Trust in Northern Ireland.

Dr Catherine Forgie, CT3 Psychiatry, Dr Ronan Kehoe, SpR Old Age Psychiatry

Aims
Patients suffering from dementia may lose the ability to drive safely, putting themselves and others at risk. Therefore the DVA and the GMC have issued clear guidance regarding driving with dementia. As health care professionals it is our responsibility to respect this guidance and to endeavour to ensure that each patient is asked about driving status at clinic and the appropriate action taken thereafter. This main aim of this audit was to assess our current compliance with these guidelines and to implement appropriate changes to improve our practice and the ongoing care of patients with dementia.

Methods
The data was collected retrospectively, looking at the charts of patients who attended the memory clinic and had a diagnosis of dementia. This included 6 clinics in total and 24 patients. Information was collected regarding when the driving status had been recorded and whether patients had been informed of their role to inform the DVLNI. If patients have failed to follow advice and inform the DVLNI it should have been clearly documented in their notes. The responsible clinician may then have informed the DVLNI of the patient’s diagnosis and if this took place, the patient should have been informed and written to, following the action taken. Results were summarised and represented in a data collection table and bar charts were used for comparison.

Results
Reflecting on the documentation of driving status, it was only recorded in 54% of cases at initial appointment. Focusing on subsequent appointments, 54% of patients were asked about driving at their next appointment. It is important to note that 27% of cases were never asked about their driving status. In half of the cases reviewed, there was documented evidence that the patient or relative had been asked to inform the DVLNI of their diagnosis. There were 2 patients who continued to drive despite advice not to. For one of these patients, the DVLNI was informed and the patient had been informed and written to regarding this decision.

Future
As a result of the audit, we presented our findings at the local journal club and to the old age faculty teams within our Trust. The audit presentations were an opportunity to present the most updated information and regulations on driving and dementia. Additionally, our new Trust wide memory service is in its development stage and the results have fed into the design of the new proforma. We are currently in the process of designing leaflets and posters that can be given to patients and displayed visually at the local memory clinics.

Psychiatry of Old Age - Audit of Physical Health Monitoring

Dr Stephen Foster, CT2 Psychiatry, Dr R McNally, Consultant in Old Age Psychiatry, Mental Health Outpatient Clinic, Ards Hospital, Newtownards, NI (SE Trust)

Aims/Objectives
Here we present an audit examining physical health monitoring in patients over the age of 65yrs with a diagnosis of schizophrenia or schizoaffective disorder. The need for accurate monitoring of physical health for those on anti-psychotic medication is increasingly recognised. This is all the more important in the elderly population who are more likely to suffer from medical co-morbidities than the general adult population.

Method
We identified all patients within our caseload with a diagnosis of schizophrenia or schizoaffective disorder. Our proforma for collecting information on physical health monitoring was based on the National Audit of Schizophrenia audit forms. We obtained information on physical health parameters including BMI, blood pressure and glucose levels from clinical notes and health records held by GP practices.

Results
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A review of the workload of providing a Psychiatry of Old Age Liaison service to a Supra Regional Centre.
Dr Anne Gallagher, Department of Old Age Psychiatry, University Hospital Galway, Dr Mary Davoren, Prison Inreach and Court Liaison Service, Central Mental Hospital, Dundrum, Dublin, Dr Karena Meehan, Department of Old Age Psychiatry, University Hospital Galway.

Aims
Older people occupy two-thirds of UK General Hospital beds, with similar figures in Ireland. Psychiatric disorder is common amongst elderly patients in medical and surgical wards, with depression, delirium and dementia being the conditions most frequently encountered. Galway University Hospitals, comprising of University Hospital Galway (UHG) and Merlin Park University Hospital (MPUH) provide a comprehensive range of emergency and elective services across two sites and serves a large catchment area in the west of Ireland, as well as being a designated supra regional centre for cancer and cardiac services serving a catchment area in the region of one million people along the West from Donegal to Tipperary North. This audit examined the workload of providing a Psychiatry of Old Age liaison service to Galway University Hospitals.

Methods
A retrospective chart review of all liaison referrals, to the Psychiatry of Old Age Service Galway West, from the 1st of January 2010 to the 1st of September 2010 was conducted. Information pertaining to source of referral, diagnosis, and treatments instigated was collected.

Results
Of the 100 charts reviewed, 51% were male patients. The majority (78%) of those patients seen were from the “older old” i.e. over 75 years, group. The majority of consult requests came from the General Medical teams (59%) with the remaining requests from Medicine for the Elderly Teams (19%), Surgical Teams (12%) and Orthopaedic Teams (8%). Diagnoses included depression (20%), delirium (15%) and dementia (12%), of note patients may have had more than one diagnosis. 58% of those patients seen by the team on a consult basis resided outside the catchment area of the Galway West Psychiatry of Old Age Team.

Conclusion
Over half of the consults seen by the Psychiatry of Old Age Team in Galway University Hospitals were from outside the catchment area of the team. The Liaison aspect the Psychiatry of Old Age service is provided in the main by the medical members of the team with input from other team members when required. Given that resources are allocated to teams on the basis of psychiatric catchment areas that can be vastly different to the catchment area of the General Hospital to which the Psychiatry of Old Age team is providing a liaison service, this finding has important implications for planning and resources, most especially in the light of recent closures of services in smaller regional hospitals, junior doctor shortages and the ageing population.

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A Non-Systematic Review of the Literature on the Role that Film Plays in the Public Understanding of Later Life Psychiatry
Ahmed Hankir, National Institute of Health Research Academic Clinical Fellow in Later Life Psychiatry, Manchester University, Manchester, England. (with permission from Professor Sir Simon Wessely)

There has been a burgeoning interest in the portrayal of mental health issues in popular culture, particularly in film and the media. Examples of this include a monthly blog that the College supports entitled, ‘Minds on Film’. According to the College website Minds on Film, “…explores psychiatric conditions and mental health issues as portrayed in a selection of readily available films…”
The medical film festival Medfest is another initiative that the College supports. Medfest has been touring universities throughout the UK every year since its inauguration in 2011. The festival in 2012 was entitled “‘HealthScreen’: Understanding Illness through Film’ and its aim was, ‘…to stimulate debate of the social, political and ethical implications of portrayals of health and illness on our screens’.

There are numerous films that have a later life psychiatry theme. Actress Meryl Streep garnered an Oscar for her stellar performance in the 2012 motion picture The Iron Lady directed by Phyllida Lloyd. Streep masterfully portrayed the
insidious and indeed cruel effects that dementia had on Margaret Thatcher’s functioning. Thatcher, it seems, also has had an effect on patients who suffer from dementia.

Professor Sir Simon Wessely (in his first ever paper) and colleagues conducted a retrospective study on elderly patients with organic dementia. Their results indicated that the recall of Mrs Thatcher is possible at cognitive levels that up until the point of the study precluded memory for the Prime Minister. Moreover, their results also revealed that Thatcher was easier to recall than the Queen.

Almost 20 years later Professor Wessely published a film review of *The Iron Lady* in the *Lancet* in which he describes how he feels it tells us little about dementia that we did not know and has nothing to say about how Thatcher achieved dominance in politics. Professor Wessely argues that there have been better dramatic tellings of Mrs Thatcher’s early years, and better portrayals of the ravages of dementia such as the 2011 BBC drama *The Exile* and the film of John Bayley’s memoir of his wife, *Iris Murdoch*.

This poster will present a series of papers that qualitatively analyse and discuss the portrayal of Later Life Psychiatry issues in film. We aim to explore if such portrayals are indeed accurate and the role they play in influencing public understanding and attitudes with a particular focus on Wessely’s papers.

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An Audit on the Prescribing of Citalopram and Escitalopram in the Elderly

Ahmed Hankir, National Institute of Health Research Academic Clinical Fellow in Later Life Psychiatry, Manchester University, Manchester, England.

Vivek Tharaken, ST6 Trainee in Later Life Psychiatry, Manchester Royal Infirmary, Manchester, England.

**Background**

The Medicines and Healthcare products Regulatory Agency (MHRA) guidelines were introduced in December 2011 recommending that the maximum dosage of Citalopram (C) and Escitalopram (Es) be reduced to 20 mg and 10 mg respectively in the elderly (>65yrs) due to recent data that revealed associated dose-dependent QT interval prolongation. QT interval prolongation has been reported to be associated with increased total risk of cardiovascular morbidity and mortality including sudden cardiac death.

In view of the above, we conducted an audit in order to establish if a Later Life Psychiatry service provider team in Manchester Royal Infirmary was adhering to the aforementioned MHRA guidelines.

**Methods**

We performed a word search for C and Es on AMIGOs which is Manchester Mental Health and Social Care Trust’s electronic database for patient records. We identified 48 patients out of a caseload of 242 (19.8 %) who met the inclusion criteria for the audit (patients > 65 yrs on citalopram/escitalopram). We then manually went through each letter and collected data relevant to the MHRA guidelines and subjected it to analysis.

**Results**

20/48 (41.7 %) were initiated on C/Es after December 2011 of which 20/20 (100 %) were on a dosage within the recommended range.

28/48 (58.3 %) were started on C/Es prior to December 2011, 13/28 were on dosages that were within range and 15/28 (53.6 %) were not. 9/15 (60 %) of these patients had their dosage reduced, 3/15 (15 %) were switched to an alternative anti-depressant and 3/15 (15 %) remained on a dosage above the recommended guidelines. Of these 3 patients, only 1 had documentation that there was a discussion about the associated risks. 3 out of these 3 (100%) had an ECG prior to or during treatment however 0/3 had 6 monthly ECGs.

4/48 (8.3 %) of our total sample were also on drugs that can pro-long QT interval, of which 1/4 (25 %) had an ECG.

**Discussion**

This audit has enabled us to identify 6 patients (12.5 % of our caseload) for whom we are not adhering to the MHRA prescribing guidelines for C/Es. We will arrange to review these patients immediately with a view to taking the relevant action to ensure that the guidelines are being adhered to for 100 % of our patients.

We will disseminate the findings of our audit in local and national meetings to educate and/or remind Old Age mental health service providers of the potentially serious adverse effects of prescribing dosages of citalopram/escitalopram above the MHRA guidelines.
Antipsychotics for behavioural and psychiatric symptoms of dementia: A re-audit in a specialist inpatient service
Professor Camilla Haw, Dr Martine Stoffels, Dr Debasiah Das Purkayastha & Dr Sudad Sofi
St Andrew’s, Northampton, UK

Background
The use of antipsychotics for the management of behavioural and psychiatric symptoms of dementia (BPSD) is controversial. These drugs are associated with increased mortality from cerebrovascular events, as well as with falls and cognitive impairment. In 2009 a UK target was set to reduce their use in dementia patients by two-thirds over a three year period.

Aims
To re-audit rates of antipsychotic prescribing to dementia patients in a specialist inpatient service and to see if prescribing standards had improved compared to an earlier audit carried out in 2007. The re-audit was carried out in 2012.

Method
Cross-sectional survey of inpatients with BPSD on four wards for older adults and one ward for patients with Huntington’s disease in a large charitable psychiatric hospital. Prescribing standards were derived from the NICE dementia guideline and Royal College of Psychiatrists prescribing update.

Results
Of 37 patients with BPSD 28 (76%) were prescribed antipsychotics for this (in 2007 the figure was 56%) and median total percentage dose of antipsychotic had increased (38% vs 27%). BPSD was severe in 68% and the most commonly prescribed antipsychotics were second generation drugs (olanzapine, 39%; quetiapine, 25%; risperidone, 21%). The main symptoms targeted were aggression followed by agitation, psychosis and sexual disinhibition. Almost all (89% vs 79% in 2009) patients were being prescribed an antipsychotic when transferred to our service. In 2012 as compared with 2007, greater use of other pharmacological strategies e.g. memantine and acetylcholinesterase inhibitors had been made (100% vs 18%), and a higher proportion of relatives had been involved in the decision to prescribe the antipsychotic (100% vs 60%), starting dose was lower as was speed of titration (100% vs 50%), and withdrawal of the antipsychotic had been attempted in a slightly greater proportion of patients (54% vs 47%) but there was greater use of antipsychotic polypharmacy (11% vs 4%) and for no patient was the off-label use of the antipsychotic documented in the case notes.

Conclusions
The increased use of antipsychotics in this specialist inpatient service that is a tertiary referral centre is likely to reflect the increasingly disturbed population of dementia patients admitted to our service, since a greater proportion are now detained and already receiving an antipsychotic at the time of their admission. The audit standards showed a modest improvement in many areas compared to the earlier audit but there was still room for improvement, particularly in case note documentation. Further audits of prescribing quality are planned.

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End of Life care in Dementia
Dr Helen Henfrey, FY1, Tees, Esk and Wear NHS Foundation Trust, Harrogate and District NHS Foundation Trust

Background
End-of-life care for patients with terminal dementia is a topic of priority within the trust and is especially relevant to mental health services for older adults. When asked what constitutes a ‘good death’ most people would like to be without pain and to be treated as an individual with respect [1]. The Liverpool Care Pathway for the Dying Patient (LCP) provides clear standards for end-of-life care, allowing unambiguous audit comparison to be made. The LCP prioritises patient comfort and dignity and diminishes the importance of unnecessary investigation and treatment [2]. Whilst the LCP has been criticised and phased out in some clinical units it still represents a set of core standards based on successful models of palliative care.

Standards
1. Recognition of the terminal stage and documentation in the notes
2. DNAR decision discussed and documented in notes
3. Discontinuation of non-essential medications
4. Unnecessary investigations avoided in terminal phase
5. Unnecessary monitoring of vital signs to be stopped
6. Use of medications to relieve distressing symptoms
7. GP informed of patient’s death

Methods
Setting
Sixteen-bed adult inpatient psychiatric unit

Target sample
Any patient with terminal dementia who died within the last 18 months.

Data collection
Medical notes, PARIS records, Drug charts and EWS charts were retrospectively examined

Results
In the last 18 months six patients died on Rowan ward, one of which was unrelated to terminal dementia (sudden cardiac death) therefore five patients were used to calculate the data. 100% compliance was seen for standards 1-6, however only 80% accordance was seen with standard 7.

Discussion
The results of the audit suggest that good quality of care is being provided to patients with terminal dementia in terms of recognition and treatment of the terminal phase of life in accordance to the standards of the LCP. The only shortcoming identified was relating to communication with GP where no evidence of a letter could be found.

Recommendations
• A reminder should be given to medical staff to complete GP the letter.
• It is imperative in the future to ensure that the standards detailed above are met even if the LCP is no longer in use. Many criticisms of the LCP refer to its prescriptive nature. Despite this the standards above can be utilised to provide bespoke patient centred care, therefore overcoming the commonly cited problems.
• This topic can be re-audited in 18 months from now.

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Are we meeting the needs of Younger People with Dementia?
Dr Anitha Howard, Consultant Psychiatrist and Emma Prendergast, Manager, Gateshead Younger People with Dementia Service, Woodside, Dunston Hill Hospital, Gateshead.

Background
The Royal College of Psychiatrists and the Alzheimer’s Society outlined recommendations for the management of Younger People with Dementia. Recommendations include collaboration with neurology, neuropsychology, medical genetics and substance misuse services in addition to social services and occupational therapy. Gateshead has a dedicated service for the management of patients with a diagnosis of dementia made under the age of 65 including medication review and monitoring, outreach support, day hospital, community groups and carers support.

Aim
To determine whether the Gateshead Younger People with Dementia Service (GYPDS) are meeting recommendations made by the Royal College of Psychiatrists and the Alzheimer’s Society (Services for younger people with Alzheimer’s disease and other dementias and Younger people with dementia- a guide to service development.)

Method
The notes of patients under the care of the GYPDS over the period September 2012 to September 2013 were reviewed and what services provided were recorded. Data concerning demographics, original source of referral, diagnosis, marital status, employment status of the patient and partner were recorded. The notes were reviewed to determine whether patients had involvement with Neurology, Medical genetics, Occupational therapists (OT), Social Services and substance misuse services if appropriate.

Results
A total of 50 patients were identified of which 47 were appropriate for the service. All patients had a Consultant Psychiatrist involved in diagnosis and, management but only 32% had been assessed by a neurologist. 82% had extensive neuropsychology testing completed prior to diagnosis but only 4% had psychological therapy as part of their management. 26% had an OT assessment and 10% had social services input at the time of diagnosis with 76% receiving advice regarding benefits, pensions and employment being provided by nurses. 32% of patients and 66% of partners were in employment at the time of diagnosis. 22% received carers support, 76% received outreach support, 32% required day hospital care and 64% requiring medication monitoring and review and 24% attended community groups. 22% had co-morbid substance misuse but none received any input from the local drug and alcohol services with support being provided by GYPDS.

Conclusion
While the GYPDS do meet the recommendations in regards to providing support to younger people with dementia more work needs to be done to establish collaboration between our service and neurology, Occupational therapy, social services, the voluntary sector and substance misuse services.

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Vascular Dementia and Normal Pressure Hydrocephalus
Dr Brett Metelkerkamp and Dr Michelle Hutchinson, Kent and Medway NHS and Social Care Partnership Trust

A comparison of patients with normal pressure hydrocephalus and subcortical arteriosclerotic encephalopathy found that the patients with normal pressure hydrocephalus had a later age and more frequent gait disturbance at the onset, shorter duration of the illness, rare signs of vascular disturbances and more frequent severe mental deterioration. Psychiatric disturbance, commonly depression, is more prominent in subcortical arteriosclerotic encephalopathy. However there was no clinical indicator to define the two conditions and imaging alone may not always be sufficient to differentiate between the two conditions.

Cerebrospinal fluid is representative of the metabolic processes happening within the brain. A study of 62 patients with normal pressure hydrocephalus and subcortical arteriosclerotic encephalopathy compared cerebrospinal fluid concentrations of molecules reflecting these processes. Subcortical arteriosclerotic encephalopathy is characterised by degeneration in the white matter caused by atherosclerosis, leading to microangiopathy with demyelination and small vessel associated lacunae. Normal pressure hydrocephalus is characterised by oedema, gliosis, and neuronal degeneration. The most striking finding was that the cerebrospinal fluid sulfatide concentration, representing the process of demyelination, was markedly increased in patients with subcortical arteriosclerotic encephalopathy compared with patients with normal pressure hydrocephalus. Therefore the raised levels in the Cerebrospinal fluid would reflect the current understanding of the different pathological processes underlying subcortical arteriosclerotic encephalopathy and normal pressure hydrocephalus. The high sensitivity (74%) and specificity (94%) of which this can discriminate normal pressure hydrocephalus from subcortical arteriosclerotic encephalopathy make it a useful diagnostic tool. However the invasive procedure required to obtain samples, a lumbar puncture, may limit its use.

Although the studies on donepezil and memantine described yield promising results for the treatment of vascular dementia, the research is in relative infancy and has yet to provide strong evidence for pharmacological treatment. If studies incorporated tests of subcortical function and differentiated between small and large vessel disease, then it would be expected from current results to find an improvement in at least cognitive tests in subjects with small vessel disease.

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Emerging trends in referrals received for memory assessment in a tertiary psychiatry clinic
Dr Martins Ischhienrhien, Specialty doctor, Pennine care NHS Foundation Trust, Dr Ayodeji Awe, ST5, Mersey Care NHS Trust, Dr Damian Ezeh, Specialty doctor Cheshire and Wirral NHS Trust

Aims
This is a retrospective study of the emerging trend of referral to memory clinic over a period of 1 year. The memory assessment and treatment service at Oldham provides specialist service for those with mild to moderate memory impairment

Methodology
All the referrals received from the General Practitioners to the memory clinic at the psychiatry out -patient department between April 2012 to March 2013 period were reviewed and relevant data extracted including the source of referrals,
age range, waiting time between referral and the assessment. Cumulative yearly data from April 2006 to March 2012 were extracted and compared with the result of our study. Results were analysed using SPSS.

Result
There is a progressive increase in the numbers of referrals to memory clinic. The total numbers from April 2012 to March 2013 were 770 referrals. This is more than twice the referral received in 2006 (267 referrals). The yearly referrals were 2007 (324 ), 2008(347 ), 2009(441), 2010 (558 ), 2011(623 ) and 2012 (770 ). The main source of referrals in the one year period was from General practitioners (657 referrals) and others (113 referrals). In 2006 the memory service had a waiting time target of ten working days to two weeks. But in 2013 our study shows that only 198 out 770(26%) could be assessed within two weeks. The time between the referral and the assessment shows that between 0 to 14 days (198 referrals assessed) and more than 14 days (554 referrals assessed).The study shows that the ages between 70 to 90 years constitute the highest number of referrals. The age distribution includes, less than 60 years (18 ), 61-70 years (108 ), 71-80(260 ), 81-90years (304 ) and above 90 (65 ). As a result of this gradual and significant increase in the number of memory assessment, there is a need for more memory assessors to be trained so as to this bridge this gap.

47 Early Diagnosis of Dementia: A Review of Initial Assessments in Patients with Suspected Cognitive Impairment
Dr Monika Mastalerz, CT2 in Psychiatry, 5 Boroughs Partnership NHS Foundation Trust; Dr Syed Javaid, ST5 in Old age Psychiatry, 5 Boroughs Partnership NHS Foundation Trust; Dr Ashley Baldwin, Consultant in Old age Psychiatry, 5 Boroughs Partnership NHS Foundation Trust.

Aims
To appraise the initial assessments performed at Knowsley cognitive function clinic on new referrals with suspected cognitive impairment. The authors analysed the assessments against the National Institute of Health and Clinical Excellence (NICE) guidelines and the current guidance by The Royal College of Psychiatrists.

Background
The government’s dementia strategy recognises the importance of a thorough, holistic initial assessment in achieving the goal of early diagnosis and eventually improving the quality of life in patients with dementia. Knowsley cognitive function clinic is an established local facility. We receive referrals from different sources including General Practitioners and geriatricians.

Methods
A retrospective case-note study was conducted in November 2012. Out of 59 new referrals received between January and December 2010, 48 received an initial assessment. 11 patients died before or refused an assessment. A questionnaire was developed to capture the required information anonymously. The data was analysed using Microsoft Excel.

Results
The sample comprised of 35% males and 65% females. 85% were referred by their GPs.
The initial assessment took place within 7 days of referral in 23 (48%) cases. Full psychiatric history was documented in 100% of the cases included cognitive and risk assessments. 21% assessments did not mention the working diagnosis. 38 (79%) mentioned discussion about the diagnosis and management with the carers. Only 16 (33%) mentioned patients’ capacity to consent. 38 (79%) detailed investigations like blood tests and brain imaging.

Only 10 (21%) assessments included Health of the Nation Outcome Scales (HoNOS) score.

Conclusions
While the study showed generally a reasonable standard of clinical assessments, issues were identified around documenting working diagnosis, discussion with the carers and patients’ capacity to consent. Based on the results, we have recommended changes to staff education and training including additional training in using HoNOS. We recommend a re-audit in 2 years following the implementation of these suggestions.

48 Advance care planning and palliative medicine in advanced dementia: a literature review
Dr Ketan Dipak Jethwa, Academic Clinical Fellow in General Psychiatry, CT1, University of Warwick, Dr Oluwademilade Onalaja, Consultant Old Age Psychiatrist, Coventry & Warwickshire Partnership NHS Trust
Dementia is a progressive brain disease affecting over 800,000 people in UK. This number is set to rise with an aging population and improvements in healthcare. Dementia represents a significant burden on patients and carers because it involves memory loss, speech impairment, behavioural disturbance and functional decline. Towards the end-of-life the majority of patients are admitted to general hospitals with acute medical problems from which they may not recover. Increasing age and male gender are associated with increased mortality. Dementia patients have complex needs and are often unable to express their wishes. It is known that patients with advancing dementia experience significant comorbidities such as pressure sores, malnutrition and dehydration. They may have no advance care plan and this can pose difficult management decisions for their families and attending physicians with regards to palliation and end-of-life care. A search of MEDLINE, EMBASE and PsycINFO was performed to identify key themes in advance care planning (ACP) and palliative care (PC) in dementia. 64 articles were found, 12 of which were review articles. Review of the articles identified key three areas: 1) barriers to ACP, 2) raising awareness and fostering communication between professionals and patients and 3) disease-specific interventions. These areas are discussed in more detail and key issues are highlighted to help guide future primary research, systematic reviews and service development in the UK. The findings of this review are broadly applicable to practice in the UK, in principle, however generalisability is limited. This is because the majority of studies were conducted in the USA or Continental Europe. Given differences in practice and health service organisation direct application is limited. Relatively small sample sizes, differing methodologies and inconsistent outcome measurement also need to be borne in mind. More studies are needed in the UK, with larger sample sizes and standardised methodologies to allow generalisability and comparison between studies. The UK-specific organisational and legal aspects also need to be addressed to ensure ACP can be facilitated.

49 Exploratory qualitative survey on Memantine
Dr Devdutta Joardar, Consultant in Old Age Psychiatry, Norfolk and Suffolk NHS Foundation Trust, UK, Dr Anne Gnanamithran, FY1, QEH, King’s Lynn.

Aims
Alzheimer’s disease (AD) is the most common neurodegenerative disorder, yet current treatment with medications is far from adequate. The mainstay group of medication used are acetylcholinesterase inhibitors (AChEIs). The second class of drugs is uncompetitive N-methyl-D-aspartate receptor antagonist, Memantine. In 2011, NICE (National Institute for Health and Clinical Excellence) issued guidelines stating that memantine can be used as a treatment option for moderately severe to severe Alzheimer’s disease and for those patients with moderate disease who cannot take AChEIs. Since its licensing, memantine is being prescribed more widely. Memantine has been demonstrated to be safe and effective in the symptomatic treatment of Alzheimer’s disease (AD). This report below, aims to explore professionals and caregivers’ views on memantine.

Methods
A short survey comprising of 5 open-ended questions on positive and negative aspects of memantine on patients and caregivers’ views on memantine was sent to all the members of Old Age Psychiatry department of King’s Lynn, Norfolk, including doctors, clinical psychologists, social worker, community and dementia nurses and healthcare assistants.

Results
The summary of responses received shows that team members felt that with memantine there were improvements in mood, agitation and reduction in challenging behaviour, better results when combined with AChEI. Negative comments shows, increased agitation at higher dose, inability to tolerate higher dose with side effects of unsteadiness, falls. Caregivers comments suggest, reduction in aggression, hallucinations and confusion, improved mood but unsteadiness was reported as side effect.

Discussion
This was only an exploratory qualitative survey study, therefore we cannot comment on significance of results nor generalise to the population. Results reinforce positive effects of Memantine on BPSD. There is some concern regarding intolerance at higher doses. This perhaps reinforces the need to increase doses slowly with nursing support. Currently NICE guidelines do not support combined therapy is more beneficial. There is emerging research on combined therapy. DOMINO study found that there were no significant benefits of the combination of donepezil and memantine over donepezil alone. Only few studies with such rigorous parameters have been done. Results from this qualitative survey suggest the need for more robust placebo-controlled randomised trials on the efficacy of memantine and combination treatment on short and long term outcomes for Alzheimer’s disease.
Prevalence rates of people living in the UK with dementia stand at around 820,000 (Alzheimer’s research 2010). With the population living longer this figure is set to increase and is predicted to rise to around 1.4 million in just 30 years. It has been highlighted that people who have been diagnosed with Mild Cognitive Impairment are at an increased risk of developing dementia. This current study examines the transition rates of people diagnosed with Mild Cognitive Impairment to dementia. In addition the study also looks at factors which may increase the rate of progression to dementia, such as diabetes. One hundred and eighteen people accessing the memory service in Southport were monitored over a two year period. These people were followed up with an MMSE to monitor any cognitive decline; activities of daily living were also assessed. The results from the study highlighted that 79% of people diagnosed with Mild Cognitive Impairment either stayed at that diagnosis or improved. For those individuals who did go on to develop dementia, Alzheimer’s disease was most common (17%). On average for those who converted to dementia it was within the first 12 months of being diagnosed with Mild Cognitive Impairment. Finally, our research has highlighted that diabetes may also be a variable in the onset of dementia. The findings revealed that 13% of those who went on to develop dementia also had a diagnosis of Type II diabetes. Type II diabetes was also associated with an increase in the speed of conversion (Diabetes 6 months; no diabetes 13 months). In conclusion, this research examines the transition rates from Mild Cognitive Impairment to dementia in a routine memory clinic population. In addition it also measures the impact of Type II diabetes on the onset of dementia suggesting that it may be a factor in hastening the transition from Mild Cognitive Impairment to dementia.

An Audit looking at the signage of diagnostic reports (Laboratory, Radiology and Other Reports) in the acute dementia assessment ward, Tardree, Holywell Hospital.

Dr Ronan Kehoe, SpR, Dr Kevin McCarthy, F2, Dr Sarah McCann, Consultant

Introduction
In August 2013 there was correspondence with urgent instruction from the Medical Director to all consultants relating to “an unacceptably high level of unsigned/unactioned reports filed in case notes”. This was as a result of unacceptable SAls including a radiologist’s recommendation for a patient to have a CT chest following a CXR that went unactioned; the patient subsequently was diagnosed with lung cancer months later which could have been discovered and treated more promptly. Among the guidance issued by the Trust were recommendations that “all reports are signed off legibly by doctors with the date and time clearly marked” and that “unsigned reports should not be filed in medical charts”.

Aim
This audit set out to examine all inpatient medical records on the dementia assessment ward, Tardree, to determine the level of compliance with Trust guidance relating to signing of diagnostic reports.

Method
We contacted the Trust Audit Department and used the same audit tool in place for the general hospital. We performed data collection on all in patient charts on a random day in November 2013. The tool required the total number of reports in each chart and to document if they were signed, signed legibly, dated and timed.

Results
There were a total of 406 reports filed in the relevant section of the patients’ notes of which: 93.3% were signed; 90.6% signed legibly; 54.4% signed with a date; and, 24.8% signed with a time. The type of report that performed worst were ECGs, which were only signed with a date in 40% of cases and signed with a time in 10% of cases.

Discussion
There is obvious room for improvement in all areas of this guidance in that standards were not met in any individual area: It could be argued that staff, both medical and clerical, are not aware of the guidance regarding signing and filing of reports in that in nearly 50% are signed without a date and nearly 75% are signed without a time would suggest of this on the part of medical staff; the fact that they are filed when lacking the recommended details (including 6.7% without even
a signature) suggests clerical staff are not aware of the guidance or perhaps do not feel they can return/refuse to file reports that fall short of the recommendations.

Improving staff awareness through education would be the first starting point. This could be done in a number of ways such as: email guidance to all staff medical and clerical, presenting audit findings at faculty meeting to increase awareness of standards and highlighting particular shortcomings such as signing with a date and time.

We are also advocating a potential design modification that could improve outcome, and hopefully reduce morbidity/mortality: All investigative reports, when printed out, could include a section with a prompt for signature, GMC number (to aid identification for illegible signatures), date and time.

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Cross sectional analysis of all current admissions to the Acute Dementia Assessment ward, Tardree, captured in September 2013.
Dr Ronan Kehoe, SpR, Dr Sarah McCann, Consultant

Aims
Our Trust currently employs eight old age psychiatrists working within a sector-based model. In response to our New Ways of Working (NWW) we are attempting to look at the delivery of our service using a functional-based approach. With the redistribution of service comes a reduction in the amount of acute assessment beds for people with dementia. Unsuccessful attempts have been made to look at the healthy reduction of these beds. As a result we decided to perform a cross sectional analysis of all patients in our ward in the month of September as a basis for important and necessary information to aid a future reduction and feed into the imminent move to the functional design of care.

Methods
Along with colleagues we constructed a table (contents below) of contributable factors before, during and post admission that creates pressure on the demand for this in patient service:

In addition to demographic details and diagnosis we collected information on the status of admission (formal or informal), time of admission, destination of the patient before admission, whether they were known to a community psychiatry team or specialised behaviour science presently or in the past, if they had a previous admission, reason for admission and if a suitable community alternative could have been pursued, length of stay, length of time medically fit before suitable discharge destination is found.

We collected this information on all the current in patients using their current and previous medical/ MDT charts including correspondence and in the presence of senior medical staff responsible for the care of each individual patient.

Results
The majority of admissions were male (60%) and ages ranged from 63-90 years with an average of 79 years. Greater than half were admitted formally under the Mental Health Order. Almost half of the patients were treated for a comorbid psychiatric diagnosis in addition to a dementia.

Positively the re-admission rate was very low concluding that most patients had an adequate and thorough initial assessment and most patients on admission were known to the Community Mental Health and Older People’s Team. Unfortunately only a third of the admissions were during normal working day hours and decision about care and placement were possibly being made by professionals with no prior knowledge of the patients. There were very few patients who had prior or current involvement from Behavioural Science Team as a strategy to support carers and attempt to prevent admission.

The average time of a patient being declared fit for leave until a community placement is found is almost three weeks.
The average time of a patient being declared fit for transfer to the hospital challenging behaviour ward as assessment is complete is in excess of five weeks

Future:
These results have subsequently been fed back to our NWW group. Positive change is evident form an early stage:

Regarding admissions: the results have helped in the design of an operational policy for the unit including admission criteria that has been constructed by the researching and visits to other similar units in different sites. We have also expanded our BST and formed a new Dementia Support Team that are working with patients and carers to prevent admission.

Regarding discharge: we have appointed a hospital social worker and the efficiency with family meetings and discharge arrangements has greatly improved. We have taken this workload from the community staff and thereby increasing time with their other patients and carers.
Identification of physical health problems in elderly psychiatric inpatients
Dr Marlene Kelbrick, Specialty Registrar, General Adult Psychiatry, Leicestershire Partnership NHS Trust, Dr Marco Picchioni, Senior Lecturer and Honorary Consultant Forensic Psychiatrist, St Andrew’s Academic Centre Department of Forensic and Neurodevelopmental Science, Institute of Psychiatry, King’s College, London, UK; Northampton, UK

Background
Elderly psychiatric patients are at increased risk of a range of physical health problems associated with significant morbidity and mortality. Older people find it harder to access good quality physical and mental health care. The presence of physical and mental health problems simultaneously, impacts significantly on physical and mental health treatments and their outcomes.

Aims
To identify and describe the prevalence and extent of physical health problems in patients admitted to a typical acute elderly psychiatric inpatient unit over a period of six months, and to establish current clinical practice in that unit with regard to physical health screening.

Method
Retrospective data extraction from electronic records of patients admitted to an acute elderly psychiatric inpatient unit over a six-month period between February and July 2013.

Results
Physical health problems were common, with just under a quarter (24%) patients having five or more concurrent physical health problems. Hypertension and cardiovascular disease were the most frequent findings (53% and 35% respectively). The majority of patients (86%) were prescribed psychotropic medicines. Most patients had had a history taken and were physically examined and had blood screening performed at the time of admission, although laboratory investigations were variable and inconsistent in their comprehensiveness.

Clinical implications
Our evaluation emphasizes the need for increased awareness of the risk of physical health problems in elderly psychiatric patients admitted to secondary psychiatric care, the importance of multifaceted comprehensive physical health screening at admission, and the need to develop action plans to assertively address physical health abnormalities when identified.

An evaluation of staff training on dementia, delirium, depression and dignity in Heartlands Hospital
Miss Nabila Khan, BSc Hons, PgDip (RAID Heartlands), Miss Pernille Woods, MSci Hons (RAID Heartlands), Professor George Tadros, MB BCh, DPM, MRC Psych, MD (RAID Heartlands).

The Rapid Assessment, Interface and Discharge (RAID) model is an innovative 24-hour psychiatric liaison service (HSJ winner, 2010), which delivers a comprehensive range of mental health specialties within one team in a general hospital, so that all patients over the age of sixteen can be assessed and treated, signposted or referred appropriately.

The 4D’s training is a two day training course accredited by Staffordshire University. The aim of the training is to teach general hospital staff about dementia, delirium, depression and dignity in older adult patients. The training incorporates lecture style teaching, open discussions, workshops and case studies in order to engage the staff effectively. The RAID liaison psychiatry team based at Heartlands hospital have utilised this training to teach staff at Heartlands hospital about these vital aspects of an older adults care. Attendees at the training include senior nurses, general staff nurses, healthcare assistants, physiotherapists, managers and occupational therapists.

The RAID liaison psychiatry team have been based within the Heartlands hospital since March 2012 and deliver this training on a yearly basis. The staff members taking part in the training are given questionnaires prior to the training, testing their knowledge on what they know about the topics of dementia, delirium, depression and dignity. The participants in the teaching are asked about how they would normally manage various everyday challenging situations at present. After the two day training is complete the staff are given the questionnaires again, and asked to think about how they would now manage similar situations after receiving the training. The participants are also given evaluation questionnaires after the training, asking for feedback on how they felt about the training and how they expect it will help with the management of their older adult patients.
The data from the questionnaires is analysed to determine the effectiveness of the teaching programme on staff attitudes, and potential improvements in patient care. The staff feedback will provide the necessary information required to continually improve the training. Results for training in the past have shown a significant improvement in staff knowledge and attitudes. The next set of training is due to take place in January 2014. The data will be analysed and submitted on acceptance.

55 Screening older adult patients at the front doors of the hospital: more savings, better quality

Miss Nabila Khan, BSc Hons, PgDip (RAID Heartlands), Miss Pernille Woods, MSci Hons (RAID Heartlands), Professor Paul Kingston (University of Chester), Mr Rafik Salama (University of Chester), Dr Naseen Mustafa (University of Chester), Mrs Karin Graber (RAID City), Professor George Tadros, MB BCh, DPM, MRC Psych, MD (RAID Heartlands).

The Rapid Assessment, Interface and Discharge (RAID) model is an innovative 24-hour psychiatric liaison service (HSJ winner, 2010), which delivers a comprehensive range of mental health specialties for adult patients in a general hospital, providing assessment, treatment, signposting and onward referral.

It was found that on average referrals from the acute hospital made to RAID for older adult patients were being delayed by about 14 days. Following training and raising awareness amongst the acute hospital staff it was found that this was reduced to 12 days. A study was undertaken where older adult patients were screened at the hospital front door in the medical assessment unit (MAU). The aim was to find out how this affected the older adult patients’ journey and length of stay in the hospital. The study aimed to screen all patients aged 65 and over who were admitted to the MAU, between November 2011 and August 2012, using four standardised screening tools. The screening tools were MMSE (Mini-Mental State Examination), the Clock-Drawing Test, the CAM (Confusion Assessment Method), and the GDS (Geriatric Depression Scale).

Retrospective data showed that of 1000 patients assessed by RAID 104 were given a diagnosis in the patient case notes when admitted to a ward. Data from the screening study showed that of 761 patients, 421 were given a diagnosis whilst in the MAU and a further 79 were given a diagnosis later when admitted to a ward. Prior to screening 10.4% of patients were given a diagnosis where as with screening 73.4% of patients left the hospital with a mental health diagnosis. This results in significant improvements in the patients care and quality of life. Also leads to significant savings and leads to reduced readmissions.

Screening patients at the hospital front door significantly reduced length of stay. An independent evaluation by the London school of Economics found that patients being assessed by RAID reduced length of stay by 4 days. Patients who were screened by RAID in the MAU study were found to have length of stay reduced by 7 days. Those patients screened by RAID and then followed up on the ward had a reduction in length of stay of 8 days.

Patients referred to and seen by RAID are 35% more likely to stay in the community in comparison to those not referred by RAID. RAID screening in the MAU leads to an extra 4 days saving in comparison to normal RAID. The reductions in length of stay and discharge back in the community lead to significant savings financially.

56 A case study illustrating the barriers to diagnosing bipolar disorder in the elderly

Ms Ella-Grace Kirton, Faculty of Medicine and Health Sciences, University of Nottingham

A 75 year old lady was referred to the community mental health team by her GP. She presented with anhedonia, low mood, feelings of guilt and suicidal ideation. She was being treated for depression with venlafaxine 75mg BD. She had had multiple episodes of low mood over a number of years with one admission to an acute psychiatric unit for severe depression. She had also had episodes of being ‘very well’ during which she appeared to have had symptoms of elevated mood. Despite this a diagnosis of bipolar depression had not yet been considered. There were barriers that were specific to this lady’s case but there are also barriers to diagnosing bipolar disorder that are common to all elderly service users. These include the higher prevalence of unipolar depression compared with bipolar disorder in the elderly as well as in the population as a whole. Diagnosis is also complicated by differences in the presentation of elderly patients with both unipolar and bipolar depression. For example the elderly patient with bipolar disorder is less likely to experience increased activity or language-thought disorder during the manic phase and are more likely to experience mania with more hostility, irritability and mixed features. Furthermore, the differential for mania differs in the elderly person to that in the younger person and includes dementia, acute confusional state and unipolar depression with psychomotor agitation. There is also a lack of recent, large scale studies into the epidemiology, aetiology and clinical features of bipolar disorder in the elderly. More research is required in this field in order to best identify and treat elderly patients with
bipolar disorder.

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Survey of Psychotropic Prescribing in Dementia
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Introduction
Dementia is a national priority; by 2025 one million people in the UK will have the condition. There are significant fiscal implications, with dementia currently costing the UK over £17 billion per year. The use of antipsychotic medication in the management of behavioural and psychological symptoms of dementia has steadily increased in profile over recent years, attracting strong media attention. The hazards of antipsychotic use, combined with calls from the Scottish Dementia Strategy for a commitment to reduce inappropriate prescriptions, served as an impetus for this project.

Aims
To illustrate psychotropic medication use in people with Dementia across NHS Dumfries and Galloway. Incorporation of elements of audit referring to local/national standards for use of pharmacological agents in dementia. To feedback to individual practices information on their medication usage, including practice comparisons.

Methods
This is a cross sectional survey encompassing elements of audit. There was a fixed sampling period of several months. Initially, a comprehensive information letter was sent via email to every practice in Dumfries and Galloway (n=34). There was subsequent communication confirming receipt of the letter plus discussion of any questions/concerns then patient medication summaries containing no identifiable patient information were requested. A unique GP number was supplied on each record allowing means of identification if concerns arose. Data was stored securely in a locked office or password protected network drive (for electronic format). Prescription characteristics, including current and previous antipsychotic use, hazardous interactions and anticholinesterase usage were entered into a spreadsheet.

Results
Preliminary results (244 patients) at this initial stage are revealing important trends. With regards current antipsychotic use, 8.6% of the population were prescribed quetiapine and 9% of the population had received quetiapine previously. 28% of patients were prescribed an anticholinesterase, with 19.3% receiving donepezil. Additionally, potentially hazardous situations were identified, including antipsychotic/SSRI combinations, plus instances of prescriptions exceeding recommended dosage for citalopram in this population.

Conclusions
The survey is ongoing; however at this initial stage it is evident there is a predominance of quetiapine prescription, however not to excessive levels. We are continuing to process data regarding a variety of important characteristics of psychotropic use in dementia. We are confident this data will allow identification of opportunities to improve patient care by reducing inappropriate/hazardous antipsychotic use in addition to improving cost efficiency. We would endeavour to standardise prescribing practices in Dumfries and Galloway through use of a protocol in keeping with the current evidence base.

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A Joint Radiology and Old Age Psychiatry Multidisciplinary Meeting: Innovative Practice to Improve Dementia diagnosis in Complex Cases
Dr Helen Linnington, Dr Kavita Garneti, Dr Rachel Walker and Dr Jerry Seymour

Aims
To give a description of an innovative practice of collaborative working between the Consultant Old Age Psychiatrists from Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) in Rotherham and the Radiology Department of Rotherham District General Hospital.

Methods
Rotherham memory clinic serves a population of 46000 and sees 700 new patient referrals for a diagnosis of dementia every year.
All patients referred to the memory service in Rotherham undergo a clinical assessment, including patient and informant history and cognitive and behavioural assessments. As part of the diagnostic process Computed Tomography (CT) scanning of the brain is used. The CT data is reconstructed to produce measurements of the radial widths of the temporal horns (rwh) as standard. Access to DaTSCAN SPECT and $^{99m}$Tc-HMPAO SPECT is also utilised relatively easily.

To improve the diagnostic process the Consultant, training grade and staff grade Psychiatrists and one of the Consultant Radiologists began to meet 3 monthly to discuss the clinical presentation and to review the radiological images of the patients who presented a diagnostic dilemma. Case review with the radiological images presented simultaneously on a large screen occurred at the radiology department at Rotherham District General. All patients who have $^{99m}$Tc-HMPAO SPECT or DaT scanning, plus any others who the psychiatrists or radiologist wished to review were discussed.

Results
It was found that the collaborative discussion between the two specialities reduced delay to diagnosis, avoidance of unnecessary investigations and improved diagnostic accuracy. An additional benefit was that the meetings were a valuable learning experience for both the psychiatrists and the radiologist. They also provided a great training opportunity for junior doctors and lead to increased confidence of interpretation of the radiology results for the psychiatrists.

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Attitudes to ageing in Older Carers
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Aims
This project aims to investigate attitudes to ageing in older carers and non-carers.

Background
The population is rapidly ageing. There is improved access to healthcare with increased longevity. However, there are large numbers of older people who have significant disability and require additional support to remain living in the community. Informal carers are unpaid people who provide care, and they play an important role in supporting older people to stay at home. These informal carers are usually spouses and other family members, who are also growing older.

Carers are at increased risk of adverse mental health effects, such as depressed mood [1], anxiety [2], and high levels of burden [3, 4] with some studies suggesting that older carers are at the highest risk of these adverse effects [5]. There have been many studies investigating factors that may influence the mental health of carers. However, there is little literature investigating how attitudes towards ageing may influence the mental health of older carers.

Attitudes to ageing are the internalised attitudes that people hold towards themselves, the ageing process and older people. These may originate from the negative stereotypes of older people, such as that they are useless, boring, or dependent. Attitudes to ageing have been found to be associated with worse physical [6] and mental health effects [7].

Carers have their own perceptions of getting older, and as a carer whose role is looking after someone who is demonstrating these negative aspects of ageing, these factors may lead to carers having more negative attitudes to ageing. This is important, because negative attitudes can lead to adverse mental effects in a group of already vulnerable people.

This project hypothesises that carers will have more negative attitudes to ageing compared to non-carers.

Methods
A cross sectional study comparing attitudes to ageing, using the World Health Organisation developed Attitude to Ageing Questionnaire (AAQ) was administered to carers and non-carers.
Results
Ninety three older carers and fifty three older non-carers completed the AAQ. Consistent with the hypotheses, non-carers had significantly higher scores in the subscales of Psychological Growth and Physical Change. Overall, non-carers also had higher total scores of the AAQ.

Conclusions
This study is one of the first to compare attitudes to ageing in carers and non-carers. Results suggest that providing care may significantly impact on carers’ attitudes to ageing, which in turn may be linked to adverse health effects, in an already vulnerable group.

References

Driving the quality of care in dementia in acute hospital: The Impact of Liaison Psychiatry on psychotropic prescribing in dementia
Dr Ksenia Marjanovic-Deverill, Consultant Liaison/Old Age Psychiatrist Ealing Hospital, Dr Audrey Ng, Consultant Liaison/Old Age Psychiatrist, West Middlesex University Hospital

There have been significant national and local initiatives to reduce use of antipsychotics in dementia and to align prescribing practices nationwide.

Liaison psychiatry services in Ealing Hospital and West Middlesex Hospital were set up in 2012 and have antipsychotic medication review in dementia as one of the commissioning requirements.

The aim of this study was to evaluate the impact of dedicated Liaison Psychiatry Service on psychotropic prescribing practices on Care of Elderly Wards over time, in 2 acute hospitals in North West London.

Methodology
Data were collected from acute trust pharmacy electronic recording system on the total spend for all antipsychotics, antidepressants, acetylcholinesterase inhibitors and hypnotics/anxiolytics, prescribed by all Geriatricians within two, three-months long sample periods (pre and post Liaison Psychiatry Service set up).

Results
Cost reduction in psychotropic prescribing by 64% at EHT and 47% at WMUH following an introduction of dedicated Liaison Psychiatry Service.

Results by drug class
- Antipsychotic cost reduction by 78.5% at EHT and 44.5% at WMUH, taking into account reduction in price of Quetiapine as it became generically available. The actual quantity of Quetiapine in milligrams issues by the Pharmacies was reduced by 40,500mg at WMUH and 6,350mg at EHT.
- Acetylcholinesterase inhibitors cost reduction by 78.6% at EHT and 58% at WMUH. The reduction in spend is likely
due to proactive review and rationalisation of medication by the old age psychiatrists in the liaison teams in line with NICE guidance. Cost reduction was also demonstrated without Donepezil included in analysis, as it became generically available.

- Hypnotics/anxiolytics cost reduction by 67.2% at EHT and 72% at WMUH, although the overall cost was small.
- Antidepressant cost increase by 135% at EHT and 3.5% at WMUH, suggesting earlier detection and treatment, especially in EHT where the number of ward referrals pre- and post Liaison Psychiatry service increased from 9.3 to 40 per month (WLMHT Liaison Psychiatry Service database).

Results suggest that interventions from Liaison Psychiatry Service may be associated with a downward trend in psychotropic drug use in dementia. The above outcomes have been achieved by delivering non pharmacological and pharmacological interventions, education for acute hospital staff and contribution to the clinical governance structures such as Delirium Policy and Rapid Tranquilisation policy. This audit looked at reduction in cost, but lower antipsychotic use is also associated with a lower rate of clinical incidents, better outcomes and reduced length of stay.

We would like to thank Ms Claire Stanniland and Ms Seema Shah, Specialist Pharmacists at West London Mental Health Trust for their contribution to this study.

61 New patient assessments in old age psychiatry: A risky business?
Dr Svetlana Hemsley, Dr Aneeba Anwar, Dr Rebecca McKnight, Sarah Jones and Dr Lola Martos, South Locality Older Adults Community Mental Health Team, Abingdon Mental Health Centre, Oxfordshire Health NHS Foundation Trust.

Aims
In recent years the role of non-medical community mental health team (CMHT) clinicians has widened to include new patient assessments. It is unclear if all professionals have the skills and confidence to do this to a high quality. The aims of this service improvement project were to establish the proportion of new patient assessments undertaken by non-medical clinicians’ in a large older adult community mental health care team, evaluate the quality of current new assessments and explore the unmet training needs of the multidisciplinary assessors.

Method
This study consisted of three components.
Retrospective evaluation of professionals undertaking new patient assessments from electronic notes.
A complete audit cycle in South Oxfordshire Older Adults CMHT in 2012-2013, to determine if existing practice meets agreed standards as to what information should be elicited and recorded during a routine new patient assessment.
A cross-sectional survey of the unmet training needs of non-medical clinician’s undertaking new patient assessments across an Older Adults Service in Oxfordshire.

Results
The majority of new patient assessments were carried out by non-medical clinicians: 72.4% versus 27.6%
The audit cycle showed that demographic profile of the sample remained static 2012-2013: 44% male with an average age of 79.5yrs. The professionals conducting assessments were community psychiatric nurses (64%), occupational therapists (16%) and psychiatrists (20%).
In 2012 the proportion of assessments clearly marked ‘new assessment’ and properly structured with subheadings was 45%; this increased to 75% (p<0.05) in 2013. In 2012 the recording of risk assessments was poor. By 2013, the proportion of risk assessments had doubled from 35% to 66.7% and they were more comprehensive.
A cross-sectional questionnaire survey of the unmet training needs of non-medical staff was completed by 72% staff, representing primarily CPNs (50%), social workers (17%) and occupational therapists (17%).
75% of the respondents felt at least partially ‘confident’ to assess a new patient, with 22% reporting ‘no confidence’. 75% reported feeling ‘stressed or unsupported’ whilst doing the assessment. In all, 83% of respondents said they would like the opportunity to attend training, with 86% keen for training in assessment, diagnosis and management of mental disorder. The most popular methods of delivering training were seminars (83%) and 1-day short courses (78%).

62 The effect of standardised documentation on antipsychotic prescribing in young onset dementia: a complete audit cycle
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Background
Over 800,000 people in the UK suffer from dementia. Many patients, in addition to cognitive decline, suffer from behavioural and psychological symptoms. These symptoms have often been treated with antipsychotic drugs, which, while effective in some patients, carry the risk of premature death. In 2009 the department of health reported that antipsychotic’s were implicated in approximately 1,800 deaths each year in England.

NICE guidance on the management of dementia has 10 individual recommendations regarding prescribing and monitoring antipsychotic medication for behavioural symptoms in dementia (2006; update 2010). Central to this guidance, and supported by the March 2009 Medicines and Healthcare Products Regulatory Agency (MHRA) drug safety update, is the use of antipsychotics only in very specific circumstances and with close monitoring.

Aim
To assess the effectiveness of a standardised documentation protocol on our department’s adherence with NICE guidance on the use of antipsychotics in dementia.

Setting
Coventry Young Onset Dementia Service – a tertiary referral centre based in the West Midlands.

Method
A baseline audit was performed in 2008. Due to poor adherence with NICE guidance, a standardised documentation protocol was then implemented as a guide for documenting initiation, target symptoms, side effect, risks and review of medication. A re-audit to measure effectiveness was conducted in 2013. Standards for the audits were taken from NICE and MHRA drug safety update, including aspects of initiation of treatment and monitoring. Both audits were retrospective reviews of case notes using a standardised proforma.

Results
In 2008 a total of 16 patients were prescribed an antipsychotic out of a possible 100. Documentation was poor, with a 7% adherence with some aspects of guidance.

In 2013 four patients out of a possible 74 were prescribed an antipsychotic (a reduction from 16% to 5.4%). Documentation was clear and in place in 100% of cases.

Conclusion
The implementation of a standardised documentation protocol has resulted in more accurate documentation, with 100% adherence to NICE guidance. We also noted a decrease in the number of patients prescribed antipsychotics – this may be a result of increased awareness, improved documentation, changing prescription habits over time, or a combination of all three. This approach may be useful in other departments as an aid to improving adherence to published guidelines.