

The project had been registered with the NHS Grampian Quality Improvement & Assurance Team prior to data collection beginning.

Results. All of the notes reviewed (100%) had the clinical indication for ECT clearly documented.

Three (50%) of the patients had received the RCPsych Patient Information Leaflet for ECT.

A clear risk/benefit assessment discussion was documented in three (50%) of the patients' notes.

Specific discussion of side effects including cognitive impairment and anaesthetic risk was documented in three (50%) of the patients' notes.

Conclusion. There is a clear need for improvement in the documentation of the consent process for ECT in NHS Grampian. While the indication for receiving ECT is being clearly recorded, documentation of the risk/benefit assessment, discussion of specific side effects, and involvement of family or advocacy is less consistent. The introduction of the NHS Grampian standardised consent form is being considered as an option to improve this documentation. The documentation of the consent process for ECT can be re-audited once this form has been introduced.

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

An Initial Audit of Delirium Detection and Management in an Intensive Care Setting

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Aims. In the intensive care unit (ICU), delirium occurs in up to 80% of patients on mechanical ventilation. Delirium is associated with an increased risk of morbidity and mortality, long-term cognitive decline, and risk of reintubation. This initial audit aims to identify areas of improvement in the early detection, prevention, and management of delirium in the ICU of the general hospital following trust guidelines.

Methods. In this baseline audit, data was collected about all inpatients on admission over a 7-week period (81 patients in total). The parameters audited were in accordance with trust guidance on the management of delirium and compliance to this was recorded. Parameters included: the correct use and documentation of screening tools, type and cause of delirium, pharmacological and non-pharmacological management, and other demographics such as sensory impairment and length of stay. Confused patients handed over verbally during ward rounds were also assessed again at the time, with documentation and parameters reviewed.

Results. Of the 81 inpatients in the ICU, 20 were observed with delirium during their stay. The documentation of delirium via the CAM-ICU screening tool was incorrect in 25% of patients with delirium (PWDs). Furthermore, behaviour (including sleep) was only monitored for 15% of PWDs and 0% had a complete "This is me" document (support tool for patient-centred care).

Sensory aids were not available for 50% of PWDs and 25% of this group had drug/alcohol dependence. A diagnosis of delirium was only formally documented in 40% of PWDs and of these, 15% had the type of delirium documented. Only 8 PWDs received

a specific management plan, with 6 PWDs receiving haloperidol or lorazepam for agitation. Non-pharmacological managements were not documented.

The average length of stay in the hospital was 20% longer in PWDs compared with non-delirium patients, with 10 deaths in the ICU; 50% of these being PWDs.

Conclusion. There is a lack of accurate documentation and a lack of medical optimisation for PWDs, which may lead to missed delirium diagnosis, greater risk of mortality and longer hospital stays. The results highlight a need for further education about delirium in the ICU, to increase awareness for better detection, prevention and promotion of appropriate delirium management and formal documentation as per trust guidelines. Furthermore, a need to consider alternative pharmacological management for delirium, specifically in the ICU where lorazepam and haloperidol may not be suitable in consideration of anaesthetic drug interactions and respiratory support requirements.

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Audit of the Completion Rate of BPD Admission Checklist for the Hospital Admitted Service Users With EUPD

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Aims. As admissions have the potential to contribute to iatrogenic harm, Mersey Care NHS Foundation Trust (MCFT) introduced an admission checklist to help the decision-making process around admitting people with Borderline Personality Disorder (BPD).

1. To conduct an audit to review if the admission checklist was being used after its introduction.
2. To provide data on the context of admission including the use of MHA.

Methods. Data from admissions for people with BPD to nine acute care wards in (MCFT) over a three-month period were collected and assessed for 21 parameters.

A total of 60 admissions were identified for 51 patients (9 patients had more than one admission).

Results. None of the recorded 60 admissions had a completed BPD checklist at the time of admission.

36 (60%) of the decisions to admit took place during the Normal Working Hours (NWH), 24 (40%) out of hours (OOH).

33 (55%) informal admissions, 27 (45%) on Section 2 of the MHA.

NWH admissions were associated with a higher number of informal admissions compared with OOH admissions (24 vs 9 respectively).

3 out of 27 OOH admissions requested by Crisis Resolution and Home Treatment (CRHT) resulted in informal admissions. The remaining OOH admissions were following a Mental Health Act Assessment (MHAA) by trainee psychiatrists.

At the point of admission, 9 (15%) patients were not open to secondary mental health team in MCFT prior to their referral for MHAA; 48 (80%) patients were under Community Mental Health Teams and/or the CRHT; 12 (20%) were open to the Personality