1902 CHILDREN AND ADOLESCENT MENTAL HEALTH (CAMH) SERVICES IN THE EMERGENCY DEPARTMENT: UK-WIDE ONLINE SURVEY

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10.1136/bmjpo-2022-RCPCH.41

Objectives Children and young people (CYP) and their carers often have few alternatives than to come to the Emergency Department (ED) when in crisis. This survey aimed to examine the availability of services for this group of patients in UK Emergency departments in 2021, and to assess progress since the previous survey in 2018.

Methods An online survey was distributed via email and WhatsApp groups by the Royal College of Emergency Medicine (RCEM) to all UK ED Clinical and Mental Health leads (covering 240 EDs). Participants were given one month (October 2021) to complete the survey. The survey asked about services for children and adolescents presenting to the ED with mental health problems. Questions in 2021 survey were adapted from the 2018 survey and included multiple choice and free text responses.

Results The response rate was 23% (56 of 240 EDs) responses compared to 39% (93 EDs) in the 2018 report. 54% of respondents reported that CAMH ED services were generally poor or awful, which was unchanged from 2018 (53%). However, there was a mixed picture as 23% rated their CAMH service as good or excellent compared to 9% in 2018. Overall, 23% reported an improvement, 37% unchanged and 40% worsened service quality over the last 3 years. 62% of responders reported the availability of a local specialist CAMH phone service. 20% of respondents reported availability of specialist CAMH services with 24/7 coverage (up from 8% in 2018) but 64% of respondents reported no service after 5pm. Half of participants indicated wait times of 12–24 hours for CAMH assessment for a CYP presenting to the ED between the hours of 3pm and 7pm. 65% reported deviation from 2013 NICE guidelines which recommend admitting CYP who are awaiting a psychosocial assessment by specialist services. 70% reported that their paediatric ED's lacked specific areas to assess or observe CYP in crisis. Two thirds of respondents reported waiting times of over 24 hours for a tier 4 bed, with free text comments indicating that some patients have waited 5 days.

Conclusions This survey shows slight improvements in hours of coverage for CYP in crisis, and introduction of a 24/7 CYP crisis phone line in many areas. Unfortunately, there are large numbers of patients who cannot be seen by a specialist after 5pm. There are still unacceptably long waits for assessment in many departments and shockingly long waits for mental health beds for CYP. Since 2015 more funding has been assigned to CAMH services and in many cases the rate limiting step to improving services has been the difficulty recruiting specialists. The pandemic has exacerbated the demand for CYP mental health services and more needs to be done to meet the needs of this group.

1904 A RETROSPECTIVE AUDIT OF THE MANAGEMENT OF PATIENTS ON A GENERAL PAEDIATRIC WARD WITH ANOREXIA NERVOSA AGAINST MARSIPAN GUIDELINES

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10.1136/bmjpo-2022-RCPCH.42

Objectives The Junior MARSIPAN guidelines were created to improve the medical care of paediatric patients with severe anorexia nervosa. This audit aims to evaluate the care provided by a general paediatric ward compared to the recommendations outlined in the MARSIPAN guidelines and the completion of risk assessments.

Methods Retrospective analysis of patient notes was conducted on the most recent admission to the general paediatric ward of 10 patients with anorexia nervosa within the last 24 months. The documentation of their care was audited against a pre-made proforma based on the MARSIPAN guidelines and the MARSIPAN risk assessment. Medical notes and a nursing care pathway document were reviewed. The initial blood tests, refeeding blood and nursing care was also assessed. The inclusion criteria for this audit was any patient under the age of 18-years-old admitted in the last 24 months to the general paediatric ward. Any patients currently admitted or without a complete set of admission and inpatient medical notes were excluded.

Results 10 patients were included and a total of 434 bed days were assessed. Our results show variability in compliance with the MARSIPAN guidelines, in terms of the initial admission and the care received. On admission, 70% of the patients were reviewed by a consultant, 30% had a full MARSIPAN risk assessment and 40% had a percentage median BMI calculated. Important investigations were inconsistently completed, such as an ECG with a recorded QTc length (70%), sitting and standing blood pressure (20%), dehydration assessment (30%), and SUSS stand-squat and sit-up test (20%). Common initial blood tests such as Full Blood Count, Bone Profile and Liver Function Tests were completed for all patients, however many of the other important investigations were incomplete; for example Folate and B12 (40%), amylase (20%) and creatinine kinase (0%). 80% of the patients received daily biochemical blood tests to screen for refeeding syndrome in their first week in hospital; 100% of the refeeding blood tests included U&Es, magnesium, and phosphate levels. During their stay, 80% of patients had input from a dietitian and 100% had input from either CAMHS or a specialist eating disorder service. 20% of patients had daily consultant reviews and 30% of patients had a MARSIPAN risk assessment done during their admission, with only 10% having regular risk assessments. All patients received thiamine and vitamin supplementation. Nursing care was adherent to guidelines with 4-hourly vitals, enforced bed-rest, and supervised mealtimes for 100% of patients. 70% of patients had 4-hourly blood glucose measurements.

Conclusions The medical care documentation assessed in this audit was not compliant with MARSIPAN guidelines but nursing care was. The findings in this audit, along with national audits, suggest sub-optimal care for inpatient admissions with

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