A review of documents assessing capacity and treatment needs to safeguard adults with incapacity

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Aims. To audit the completion of Adults with Incapacity (AWI) documents (Assessment of Capacity, Section 47 Certificate of Incapacity and Treatment Plan) to ensure they met the legal standards required. We hypothesised that the forms were not all completed comprehensively, particularly with regards to the Treatment Plans.
Method. In addition to being legal documents, AWI documents provide an important framework to guide clinicians when giving treatment and balancing patient safety with patient autonomy. Correctly completed documents help provide vulnerable patients with ethical and lawful treatment that allows them to be treated with respect and dignity.

An audit was conducted across two Old Age Psychiatry wards at Ayrshire Central Hospital during October 2020. We assessed all AWI documents available on the wards (n = 20) using criteria based on the standards set by the Mental Welfare Commission for Scotland to ensure legal competence.
Result. 95% of the forms were signed and dated, and the nature of the incapacity was given in 100% of the documents. On the other hand, 35% of the forms gave no indication of the presence or absence of a guardian. Only one of those identified as having a guardian was consulted with regards to the treatment plan. Another member of staff was consulted on the Treatment Plan in 45% of cases. 30% of the Treatment Plans were not precisely worded enough to be considered justifiable for treatment. In the Certificate of Incapacity, two out-of-date certificates were found, and staff were notified immediately. 45% of certificates were considered over-generalised with regards to the description under medical treatment.
Conclusion. Overall, the forms were mostly signed and dated, with the nature of incapacity given. The two areas that appeared to be the most problematic were the issue of identifying and discussing plans with a guardian, and the specification of treatment covered by both the Certificate of Incapacity and the Treatment Plan.

Discussion with members of the healthcare team found some confusion over how to complete the forms and many cited a lack of formal training as the main reason for their uncertainty. In addition, accessing clear information online or on the wards on how to complete the forms was challenging. We intend to improve the completion of these documents by implementing teaching and a guidance poster, based on the areas that we identified as being problematic, and completing the audit cycle.

An audit of ECG monitoring in patients admitted to the general adult wards at clock view hospital

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Aims. To identify whether patients admitted to the general adult inpatient wards at Clock View Hospital, an inpatient unit in Mersey Care NHS Foundation Trust, have an ECG performed following admission and whether, if this done, the ECG report is properly documented in the patient's electronic record, and whether those patients with an abnormal ECG have any further investigations requested.
Background. An important risk factor for development of cardiac disease is use of psychotropic medications. Antipsychotics can increase the QTc interval.

NICE guidelines recommend that, before starting antipsychotic medication, an ECG should be offered if physical examination identifies cardiovascular risk factors, there is personal history of cardiac disease or if the individual is being admitted to hospital. The Royal College of Physicians states all patients should be assessed for cardiovascular disease, including having a routine ECG. Mersey Care's physical health policy recommends all new admissions to inpatient wards have an ECG performed within 24 hours of admission as part of their admission physical examination and investigation.
Method. A sample of 60 patients discharged from the general adult wards at Clock View Hospital between 16th of July 2019 and 30th of September 2019 was obtained. An audit tool was designed and each patient's electronic record scrutinised to determine whether an ECG was performed within 24 hours of admission; in those patients who didn't, whether the reason why was recorded; and whether those patients who had an abnormal ECG were referred for further investigation. The quality of documentation of ECG reports was also analysed.
Result. Age range of patients was 19–66 years. Only 31 patients had an ECG performed within 24 hours of admission. Of the remaining 29, there was documentation of why an ECG was not performed in only 16 cases. Thirteen patients had an abnormal ECG, but only three were referred for further investigation. Of the ECG reports that were analysed, only a minority met the required standard for "good", with there being no documentation of the ECG report in one third of cases.
Conclusion. There is significant room for improvement in performance of ECG monitoring and documentation of the ECG report. The importance of the ECG as part of the admission process needs to be highlighted in the induction of junior doctors. Training nursing staff on the wards to perform ECGs would reduce the likelihood of unnecessary delay to a patient having an ECG done following admission.

An audit of high-dose and combination antipsychotic prescribing across the general adult inpatient wards in Mersey Care NHS Foundation Trust

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Aims. To review the number of prescriptions of regular high-dose antipsychotics and combination antipsychotic therapy across the eight general adult inpatient wards in Mersey Care NHS Foundation Trust and examine whether these prescriptions followed Trust recommendations for high-dose antipsychotic therapy (HDAT).
Background. The two main rationales behind prescribing HDAT are pharmacokinetics differ in individuals and so insufficient