An Audit of Clinicians Completing Independent Seclusion Reviews (Trust-Wide Audit Within Cumbria, Northumberland, Tyne and Wear, NHS Foundation Trust)

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Aims. The Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) seclusion policy states that if a patient has been nursed in seclusion for 8 consecutive hours (or 12 hours intermittently over a 48 hour period), then an independent seclusion review (ISR) is mandated. One member of this ISR team must include an Approved Clinician (AC). Our aim was to establish whether an AC (including non-medical) was present at ISRs. If the doctor was not an AC, we established whether a discussion with an AC was documented.

Methods. The method included reviewing all episodes of seclusion that took place in CNTW between the 01.10.2021 and the 31.12.2021 (i.e. Q4 for 2021). All electronic (RiO) seclusion records and progress notes were examined to determine who was present at each ISR occurring within each episode of seclusion.

Results. 260 episodes of seclusion occurred in Q4 2021 within CNTW. 96 episodes continued long enough to trigger an ISR.

Of the 96 episodes, a total of 221 ISRs were examined.

Of those senior clinicians present at ISR, 83% were medical members of staff, 11% were non-medical ACs and 6% were neither.

Of the medical clinicians present at ISR, 68% were not AC grade.

Of the different grades of non-AC doctors present at ISRs, 72% were "SHO grade".

The overall breakdown of non AC medical staff included 6% F2 Doctors, 16% Higher Trainees, 19% Speciality Doctors, 4% Associate Specialists, 5% were International Fellows and 1% Senior Trust Fellows.

29% of ISRs occurred outside of normal working hours.

71% occurred 9:00-17:00 Monday to Friday (excluding Bank Holidays).

0% of non-AC medical ISRs had a documented discussion with the AC.

Conclusion. Nearly a third of IRSs occurred outside of standard (contracted) working hours for doctors.

In addition, the majority of ISRs were completed by non AC doctors. The majority of these doctors were "SHO" level Doctors (including Core Trainees, GP Trainees and Foundation Trainees).

The audit was presented at the CNTW Seclusion Steering Group, with actions including a change to the seclusion policy. This now explicitly states that ISRs must be conducted by an AC "unless in the case of extreme circumstances, and in such cases the review should be discussed with an AC".

There are additional plans to develop consistent approaches for organising ISRs (to ensure the vast majority happen within normal working hours and with an AC present).

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.

A Re-Audit of ECG Monitoring in Patients Admitted to the General Adult Inpatient Wards at Clock View Hospital, Liverpool, Mersey Care NHS Foundation Trust

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Aims. The aim of this re-audit was to analyse current practice following a previous audit of ECG monitoring in patients admitted to the general adult wards at Clock View Hospital in 2020 and determine whether recommendations made from the original audit have improved performance.The objectives of this re-audit were: screen for recording of the admission ECG; ensure clear documentation of the ECG report; identify any reason why the ECG was not performed within 24 hours of admission and identify whether inpatients with an abnormal ECG on admission had any further investigation(s) done.

Methods. 92 inpatients discharged from the three general adult wards at Clock View Hospital between 1st of January 2022 and 31st of March 2022 was obtained. The same audit tool designed and used in the original audit in 2020 was used for this re-audit. Each inpatient's electronic record was reviewed to determine whether an ECG was performed within 24 hours of admission. In those patients who didn't have an ECG done, the reason why was recorded (if documented) and whether those patients who had an abnormal ECG were referred for further investigation. The quality of documentation of ECG reports was analysed.

Results. Of the 92 inpatients, 57 (62%) had an ECG within 24 hours of admission and 16 (17%) had one done more than 24 hours after admission. 19 (21%) inpatients never had an ECG done at any point during their admission. The reason for not performing an ECG was documented for 32 (91%) of affected inpatients. Of the 73 inpatients who had an ECG done, 16 (22%) had an abnormal ECG, but only nine had further investigation (56% vs 23% in the original audit).

Conclusion. The findings from this re-audit showed that completion of an ECG within 24 hours of admission to the general adult inpatient wards at Clock View Hospital has improved from 52% to 62%. There has been improvement in quality of documentation of ECG reports. There was no documentation of the ECG report in 13% of cases compared to 35% in the original audit. In almost all affected cases, the reason for not performing an ECG was documented. The authors recommend creating an alert on the electronic record system if an ECG is not performed within 24 hours of admission and asking the ECG reporting service to copy the ECG report to the ward clerk and / or Consultant PA to ensure the report is reviewed promptly.

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Compliance Audit on Diagnosis and Treatment of Folate and Cobalamin (Vitamin B12) Levels in CAMHS Transition Service at Oldham, a Full Cycle Audit

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Aims. To investigate compliance with British Society of Haematology (BSH) guidelines and NICE clinical summarieson diagnosis and treatment of folate and cobalamin deficiencies in CAMHS Transition service, Oldham.
Methods. The standards used were based on BSH guidelines and Nice clinical summaries, with targets for all 100%:

1. Haemoglobin concentration and mean corpuscular volume (MCV) checked at the same time as assay for serum cobalamin and folate.
2. Cobalamin and folate assays should be assessed concurrently due to the close relationship in metabolism.
3. Treatment of established cobalamin deficiency should follow the schedules in the BNF.
4. All patients with anaemia, neuropathy or glossitis, and suspected of having pernicious anaemia, should be tested for anti-IFAB regardless of cobalamin levels.
5. Patients found to have a low serum cobalamin level in the absence of anaemia and who do not have food malabsorption or other causes of deficiency, should be tested for IFAB to clarify whether they have an early/latent presentation of pernicious anaemia.
6. Treatment of folate disorders should follow the schedule in the BNF.
7. We reviewed all open cases to Transition service in Oldham. Their NHS number was checked through the pathology laboratory portal. In addition, notes on Paris electronic system and digital letters were checked to see if results were acknowledged. The initial audit period run from February 2021 to April 2021.The results were shared with the Multidisciplinary Team and an algorithm was created and shared in an attempt to improve the practice. The re-audit run from May 2022 to July 2022. A total of 80 patients were included in the audit and 25 patients in the re-audit. We entered and analysed our data using Microsoft excel.

Results. Compliance levels for the standards for the audit were as following: standard number 1, 2 and 5 were 100%, number 3 and 6 were 0%, and number 4 was not applicable.

Compliance levels for all the standards were 100% for the re-audit.
Conclusion. The results of the initial audit indicate that not all standards were met. However, results of the re-audit indicate all standards were met. It appears implemented changes may have affected the outcome of results. However, as the sample of patient was small might need to repeat this audit cycle in the future to see if the results remain the same.

The physical health protocols are relevant to psychiatric practice and the algorithm can be disseminated for further use.

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An Audit to Assess the First Patient Follow-Up After Initiation of SSRIs in Primary Care

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Aims. NICE guidelines recommend that patients started on antidepressants aged 18–25 years are reviewed 1 week after initiating treatment to check response. All other patients should be reviewed within 2 weeks. The audit aimed to evaluate if these guidelines are being met in Primary Care now that most mental health appointments have changed from face to face to telephone consultations post COVID-19.
Methods. Notes of 60 patients that had been started on an SSRI across the period of January 2022 – December 2022 at a North West based Primary Care practice were analysed. Time from initial consultation to medication review with a general practitioner (GP) and/or contact with a Mental Health Practitioner (MHP) within the practice were recorded. Consultation notes from MHPs were analysed for reference to tolerability of medication to assess if the patient's new treatment was discussed as part of support appointments.
Results. Median time for initial follow-up of patients aged 18–25 years was 3 weeks demonstrating 8% compliance with NICE guidelines. Median time for initial follow-up for those >25 was 4 weeks, demonstrating 19% compliance with NICE guidelines. Of those that did not receive a follow-up with a GP within the suggested time frame, 20% met with a MHP for support with their condition and had side effects of new medication referenced in the notes. Within 4 weeks, 58% of patients had an appointment with a MHP where medication was mentioned. Median follow-up for anxiety disorders was 4.5 weeks compared to disorders of depression at 4 weeks. Patients new to the SSRI were followed up at a median of 3 weeks compared to 4 weeks for those that had completed a course previously.
Conclusion. Current follow-up of patients at the practice is not compliant with NICE guidelines. A practice meeting will be held to identify improvements to the patient follow-up process and look at the barriers patients face when arranging follow-up appointments. More than half of audited patients met with a MHP for support within 4 weeks of SSRI initiation. This highlights an opportunity to assess patients that are already meeting with practice staff when GPs have been unable to review them within the time frame. A pro-forma will be developed for MHP to utilise to specifically ask about medication. A repeat audit of both GP and MHP appointments will be completed in 6 months.

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Audit of Prescribing Practices & Medication Monitoring on Learning Disability Female Low Secure Unit

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Aims. To ensure psychotropic medication is being prescribed and monitored as per Trust and national guidelines.
Methods. The audit included all patients admitted to the low secure female forensic unit at the time of data collection, giving a total of seven patients. Data were collected from medication charts, psychiatric report and clinical notes. The data collection tool looked at Mental Health Act (MHA) status, diagnoses, current psychotropic and physical health medication, documented indications, consent to treatment forms, completed capacity assessment forms, last medication review and recent physical health monitoring. For

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