- BMI
- HR (Pulse rate)
- Sitting/Standing BP and
- Temperature

2. Relevant Blood tests and recent ECGs on a schedule based on patient's BMI or as needed based on clinical indication.

24 patients were identified from April 2021 to December 2022. 7 patients were deemed inappropriate due to scant documentation. Of the remaining 17, 9 patients were randomly selected. 9 patients' documentation were looked at all contacts with AEDS. The monitoring was audited at 3 single point of contact over the course of their first clinic appointment after April 2021, the middle and latest/last monitoring.

**Results.**

1. At the first clinic after April 2021 the compliance was 100% for all parameters except for the monitoring of BMI and Temperature which was 88.9%.
2. At the mid-point there was 100% compliance with BMI, weight, blood pressure and pulse monitoring, there was a drop in temperature monitoring to 77.8%.
3. In the last clinic monitoring for pulse and temperature dropped to 88.9% and 77.8% respectively, all other parameters showed 100% compliance.
4. The frequency of monitoring ECG and blood tests in the subsequent clinics gradually dropped from 100% to 66.7% and 88.9%.

**Conclusion. Reasons for decreased monitoring in Bloods and ECG.**

1. Documentation was missing.
2. Investigations were delayed from the patient's side.
3. Due to COVID-19 there was difficulty accessing the primary care appointments for investigations.
4. The temperature equipment was not working properly.

**Recommendations.**

1. Keeping a fixed format for documenting PHMC. New format for documentation introduced.
2. Document all the parameters checked in the patients' electronic records on the same day.
3. PHMC clinical team to upskill on ECG via training.
4. Introduce weekly ECG alongside phlebotomy clinics.
5. SUSS test to be done for all RED (High risk) patients and should be clearly documented in the notes.

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 Clinical Audit on Adult ADHD From Community Mental Health Teams: Experience From the East of North Wales

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**Aims.** The Royal College of Psychiatrists (RCPsych) has formulated "Attention Deficit-Hyperactive Disorder (ADHD) in Adults: Good Practice Guidelines" to provide evidence-based guidance for clinicians, acknowledging there is an increasing burden on the services with the assessment and management of adult ADHD in the United Kingdom. As there is no trust-wide policy in North Wales and some practitioners perceive that it is challenging to perform an extensive assessment for ADHD in the adult secondary mental health services, there is a need to study the pre-referral workup and diagnostic approach for patients referred to the adult mental health services. This clinical audit is aimed at understanding the guideline adherence level of the assessment and management of adult ADHD by both primary and secondary mental health services in Betsi Cadwaladr University Health Board.

**Methods.** Convenient sampling was performed on 50 patients from three community mental health teams (CMHT) from East of North Wales for patients with a confirmed diagnosis of adult ADHD. The source of information included referrals from the primary care (including general practitioners and primary mental health service) and medical records from the secondary mental health care. Relevant clinical information was collected and coded as "present", "absent", or "unclear". The data were compared to the standard derived from "ADHD in adults: Good practice guidelines".

**Results.** Only 34% of the referrals documented the use of Adult ADHD Self-Report Scale, 18% documented the use of Autism Spectrum Quotient (AQ-10), and none documented the use of Weiss Functional Impairment Rating Scale (W-FIRS).

Only 46% of patients was diagnosed using a standardised instrument after more than one session of diagnostic assessment. The percentage of documentation of baseline blood pressure, pulse rate, weight, and height were 58%, 70%, 50%, and 44% respectively.

Most documentations fell below 50%, including comorbid and family history of physical health conditions, history of neurodevelopmental issues, and corroborative history. All teams performed well with the documentation of functional impairment, comorbid anxiety disorder, depressive disorder, and substance use disorder, i.e., >90% of patients.

**Conclusion.** This audit reflects the need for quality improvement in documentation in both primary and secondary care settings although the solution should not add to the existing burden of practitioners. Convenient sampling from East of North Wales limits the generalisability of findings. Also, the absence of data may be contributed by logistic issues around paper-based medical records, i.e., illegible handwriting and inability to locate the documentation.

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.

## Physical Health Assessment and Monitoring for Adults Receiving Pharmacological Treatment for ADHD in an Adult CMHT:Clinical Audit

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**Aims.** ADHD diagnoses have skyrocketed in the recent times resulting in a lot of the patients being on stimulant medications. NICE guidelines recommends a baseline review of physical health which should include height, weight ,baseline pulse and blood pressure and a cardiovascular assessment before starting these medications. It also recommends 6 monthly monitoring of weight, blood pressure and pulse. We aimed to assess the current

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