did not attend & increased healthcare utilisation post-referral. Patient 106 had increased healthcare utilisation post-referral from a new health condition. The randomised sample identified limitations of using healthcare utilisation as an outcome measure when contrasted to the non-randomised case (which significantly reduced healthcare utilisation post-referral).
Conclusion. Correlation only can be inferred from the data due to sample size, limitations & confounding factors e.g. psycho-social life events, acquired illness. Alternative outcome measurements documented (e.g PHQ9/GAD7) were not reliably recorded across pathways.

The results evidenced that single cases can demonstrate highly desirable effects of a biopsychosocial approach but they can also skew data sets if results are pooled due to the small sample size & heterogeneous interventions. With some patients an increase in healthcare utilisation was appropriate for an improved clinical outcome. This audit identified that utilising healthcare utilisation as an outcome measure is a crude tool with significant limitations & the need to agree tailored outcome measures based on the type of intervention to assess the impact of IPMS.

Reasonable adjustments for autistic adults

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Aims. To embed the use of reasonable adjustments for adults with autism within in mental health services.
Objectives. The objectives of the project are as follows:

To identify how many service users with a diagnosis of autism are under care of local mental health services
Is there evidence that reasonable adjustments were considered for these service users
If identified as needing reasonable adjusments is there evidence of such adjustments being made

Method. We looked at service users with an established diagnosis of autism under care of Leeds and York NHS foundation trust to ascertain if reasonable adjustments have been considered. The audit is based on guidelines provided by Think Autism-department of health statutory guidance 2014. This is based on autism act 2009.

Data were collected for 30 cases in mainstream mental health services undr care of various teams including inpatient and community.
Result. It was identified that in only 2/30 cases reasonable adjustments were considered and agreed upon. Only 1/30 service users had a disability status updated on electronic patient records. None of the service users had a hospital passport or reasonable adjustment care plan completed.None of the records had "good evidence" of reasonable adjustments.

These findings point to a wider issue for the trust as well as natioanlly as it indicates that autism is not being adequately taken into account for patients accessing our services. Due to the lack of reasonable adjustments adults with autism are potentially at increased risk to disengage leading to deterioration in their mental state and increase in risks.
Conclusion. These findings point to a wider issue for the trust as it indicates that autism is not being adequately taken into account for patients accessing our services. Due to the lack of reasonable adjustments adults with autism are potentially at increased risk to disengage leading to deterioration in their mental state and increase in risks.

We recommend training in autism for all healthcare professionals in the trust to improve their understanding of autism, including making reasonable adjustments.

We also recommend review trust procedure about recording diagnoses and disability status on electronic patient records. We recommend that the reasonable adjustments section on care director is more prominent and easily accessible.

We recommend that an 'autism flag' is prominent on patient records to alert staff to the presence of autism

Dementia screening: an audit of screening for reversible causes of dementia

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Aims. This audit aimed to assess to what extent patients being referred for assessment of memory problems were receiving appropriate screening for reversible causes. We considered the blood tests recommended by the National Institute for Clinical Excellence (NICE).
Background. Research into 'reversible dementias' identified numerous common underlying causes. As a result of this NICE complied comprehensive guidance on investigations which should be performed in the initial stages of assessing patients with memory problems, ideally at a primary care level. These investigations are also crucial at the point of secondary care assessment in order to make a confident diagnosis.
Method. Details of patients referred by their GP to the Older Adult CMHT with memory problems over a one month period were collected. We then used the local laboratory database to note whether each of the eight recommended blood tests had been performed in the preceding 6 months. We measured this against an agreed standard of 95%.

After the first cycle of data collection we prepared business-card sized 'aide memoirs' for GPs that could serve as a quick reminder. These were sent out to all GPs in the area along with a letter outlining the audit findings.
Result. Overall 31 patients were included in the first cycle. 15 patients had all 8 dementia blood screens (48%), 13 (42%) had some of the recommended tests and 3 patients had no screening tests at all (10%). On average patients had 76.6% of the recommended bloods completed. The most commonly completed tests were Full Blood Count (FBC) and Urea & Electrolytes (U&Es), with blood Glucose being the most frequently omitted.

In cycle 2, 20 patients were included. Of these patients, 10 had the full complement of screening bloods (50%); 8 had some tests completed (40%) and 2 patients had no screening tests complete (10%). On average 76% of tests were completed. There was an improvement in the rate of completion of both Glucose and Liver Function Tests from cycle1.
Conclusion. This audit demonstrated that current practice does not meet the national standard in general. Our intervention produced a modest improvement in the proportion of patients who received a full complement of dementia screening tests, as well as increasing the rate of patients receiving a blood glucose as part of their screening. It would likely be beneficial to consider further intervention and a 3rd audit cycle in due course.

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