

Conclusion. Compliance with completing the GASS weekly improved following staff education, identifying the main factor affecting compliance as staff not offering the GASS to patients. Patients generally engaged well with side-effect monitoring, as most completed the GASS when offered. Further staff education may produce even greater compliance with guidelines, and involving pharmacy staff to review GASS scores and inform medication choices may lead to use of the GASS resulting in more tolerable and effective treatment plans.

Improving risk assessments for CAMHS admissions at Great Ormond Street Hospital

Lisanne Stock* and Sacha Evans

Great Ormond Street Hospital

*Corresponding author.

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Aims. During the COVID-19 pandemic, admissions to the Mildred Creek Unit (MCU), an Inpatient CAMHS Ward at Great Ormond Street Hospital (GOSH) changed.

The MCU is a 7–10 bed unit for children aged 7–15 years based on therapeutic milieu principles. The ward accepts patients via a planned national referral pathway, however, during the COVID-19 pandemic, patients were admitted as emergencies and consequently risk assessments were missed. Risk assessment is important in all admissions and as the MCU is not a locked unit, early risk assessment is particularly important.

We aimed to review whether risk assessment occurred within one working day of admission, as suggested by the ward risk assessment policy, and if this was not the case, our aim was to ensure that all risk assessments took place within this period via our audit interventions.

Method. We collated data looking at the time between admission to GOSH and the date at which first risk assessments took place. We then put in place three interventions.

- 1) Posters prompting doctors who were providing on-call liaison input to perform a risk assessment within one working day of admission.
- 2) New junior doctors were provided with written and verbal information to emphasise the importance of early risk assessment.
- 3) Guidelines also highlight that assessment of risk may need to be on-going. We therefore added a prompt section in the weekly ward round proforma with the aim of reducing the interval between risk assessments during admission.

The first audit cycle was conducted on the 3/8/2020 and the second on the 28/11/21 to allow for a comparative number of inpatients between the first and second audit cycle.

Result. We found these interventions significantly reduced delays in risk assessments. Prior to the audit's first cycle the average delay between admission to GOSH/MCU and a risk assessment was 2 weeks. After the interventions there were no patients whose risk assessment was delayed outside the next working day parameters.

Conclusion. This full cycle audit demonstrates the impact that prompts to clinical practice can make on patient care. It is important to recognise the need for flexible risk assessment with regular review, especially at times of clinical change. We hope that this continued trend for early risk assessment leads to improved clinical care and timely discussion of risk for all new CAMHS inpatients at GOSH.

Audit of physical health monitoring in a forensic psychiatric community caseload

Neeti Sud* and Michael Lacey

Cumbria, Northumberland, Tyne And Wear NHS Foundation Trust

*Corresponding author.

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Aims. Adherence to Cumbria Northumberland Tyne and Wear NHS Foundation (CNTW) Trust physical health monitoring guidelines for a caseload of community forensic psychiatry patients residing at Westbridge supported accommodation was audited to identify areas for improvement in practice. It was also our aim to highlight the delay in obtaining non-urgent investigations due to the need to minimize COVID infection transmission risks.

Method. Data were collected from mental health and acute trust electronic records (Rio and ICE) of all patients taking antipsychotic medications currently care coordinated by the Westbridge Forensic Community Mental Health Team (FCMHT) between January 2020 and January 2021 (8 patients). Analysis of compliance with standards set by Trust guidelines was made.

Result. In the chosen audit period, compliance with physical health monitoring standards was below target of 100% (80% compliance for bloods, 50% for ECG). Reasons for non-compliance were unexpected restrictions in service availability (e.g. temporary closure of walk-in ECG clinic) and one omission of sending a pro-lactin levels request.

Conclusion. The need for practice adaptation and advance planning by team in anticipation of potential delays was identified. Request for routine bloods and ECGs will now be made two months before the annual due dates to compensate for delays in the new process with plan to continue re-audit yearly.

An audit cycle of physical health monitoring and record keeping of long term in-patients at male and female psychiatric rehabilitation wards using QI approach

Hina Tahseen* and Peter Bramall

Delfryn Lodge, Cygnet Health Care

*Corresponding author.

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Aims. To complete an audit cycle to evaluate and improve physical health monitoring practice for in-patients by incorporating small QI based projects between baseline audit and re-audit.

Background. People with mental health illness are at increased risk of physical illness, morbidity and mortality compared with general population, mainly due to adverse effects of psychotropic medications, polypharmacy, poor lifestyle choices and socio-economic difficulties. It is important to recognise the need for active health promotion, including formal health checks for psychiatric in-patients.

Method. Standards were obtained from NICE Guidelines, RCPsych Report on Physical Health in Mental Health and Cygnet Health Care's Physical health policy.

An Audit tool with simple checklist was generated from key areas of Cygnet's physical health policy. Physical Health Files of 24 patients from Female Rehabilitation Ward and 28 patients from Male Rehabilitation Ward were audited in the initial audit cycle.

Checklist included physical health examination within 24 hours of admission, Annual Health Improvement Profile (HIP),

Monthly physical health reviews (including observations and weights), High Dose Antipsychotics Monitoring, Bloods and ECG records. After the initial baseline audit in Apr., 2019, some of the Quality Improvement (QI) approaches (4 PDSA cycles, driver diagrams, model for improvement) were used before conducting the re-audit in Oct., 2019.

Result. The baseline audit in Apr., 2019 showed 98% compliance with physical assessment within 24 hours of admission, however, there was a significant gap in the monthly physical health reviews (62%), Annual HIP (30%), High-dose antipsychotic monitoring (10%) and ECG/Bloods for antipsychotic monitoring (64%) as per guidelines. 10 Female and 12 male patients had regularly refused obs, weight checks and physical health monitoring.

The re-audit showed an overall improvement of 92% in compliance, with increased High-dose antipsychotic monitoring (100%), Monthly physical health clinics (88%), Annual HIP (75%), Annual antipsychotic monitoring/bloods/ECG(95%).

Conclusion. Interventions, using QI approaches, between baseline and re-audit, included MDT discussion around strategies to improve patients' engagement with monthly physical health clinics with Specialty doctor, adding to care plan points, timescales and reminders in doctors' diaries for next bloods and ECGs due, MDT and patients' health education and a designated support staff for physical obs and maintaining physical health files. This helped in providing a framework to test recommended changes and evolve design based on repeated data collection between cycles.

The QI Interventions helped in implementation of a more holistic approach towards assessments due to which, the re-audit demonstrated a sustained improvement in compliance with all aspects of physical health monitoring.

Re-audit of use of seclusion in a tier 4 adolescent psychiatric intensive care unit

Yuki Takao*, Francesca Davis, Ivan Saeger, Sophia Ulhaq and Rafik Refaat

East London Foundation Trust

*Corresponding author.

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Aims. To re-audit seclusion practices within a Tier 4 Adolescent PICU provision in London, originally audited in 2018. To ensure restrictive practices are only used in exceptional circumstances for short term risk management. To evaluate whether practice has improved following introduction of incidence reduction strategies and identify any further areas of development.

Background. This Tier 4 Adolescent PICU provides treatment of up to 16 high risk and unwell adolescents with severe and enduring mental health illnesses. Seclusion should be a short term risk management strategy with subsequent review of the care plan and treatment. It should be used for the shortest time possible. Following the audit in 2018, three strategies were implemented to reduce restrictive practice: (1) daily nursing safety huddles, (2) weekly Incidence Reduction meetings, and (3) ongoing QI project on restrictive practice.

Method. Data were collected from all patients requiring seclusion between January and December 2019 (n = 18), which included 46 incidents. Data were collected from RiO computer records, extracting details of patient demographics, reasons and context of seclusion, risk reduction steps prior, length of seclusion, monitoring, and modifications to care plans.

Result. Average length of stay in seclusion was 20h, reduced from 30h previously. Over half of patients requiring seclusion had symptoms of psychosis, consistent with the original audit. Majority of incidents involved assault to staff (80.4%) as indication for

seclusion, compared to 50% previously. In 58.7% of cases, verbal de-escalation was followed by further risk reduction with oral medication. Overall, rapid tranquillisation was required in 45.7% of incidents. Restraint was used in 84.8% of incidents, always in combination with at least one other management strategy.

Just under half of seclusions were monitored and documented in line with Trust guidelines, however, there was significant improvement in documentation of consultant reviews within 24h from under 70% to over 90%. Care plan modification rates improved from 63% to over 95%.

Conclusion. Majority of seclusion incidents were due to violent acts by young people presenting with psychotic features/disorder. This reflects the complex nature of psychosis and the substantial need for research to reduce restrictive practice in such cases.

Ongoing review of data relating to seclusion will continue to inform and improve practice. This re-audit demonstrates improvement in various areas after implementation of strategies to reduce restrictive practice – importantly, average time in seclusion, documentation of 24 hour consultant reviews and focus on non-pharmacological risk reduction approaches in care plan modifications.

Audit of antipsychotic prescribing and monitoring for the management of behavioural and psychological symptoms of dementia

Catrin Thomas^{1*}, Sharmi Bhattacharyya² and Elizabeth Bond³

¹ST4 Old Age Psychiatry, Betsi Cadwaladr University Health Board;

²Consultant Old Age Psychiatrist and Clinical Lead, Betsi Cadwaladr University Health Board, Visiting Professor, University of Chester and ³Head of Pharmacy, Mental Health and Learning Disabilities Division, Betsi Cadwaladr University Health Board

*Corresponding author.

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Aims. To assess the use of a piloted shorter version of the local Checklist for Antipsychotic Initiation and Review (CAIR) form by an Older Persons Community Mental Health Team (OPCMHT), and to assess whether the National Institute for Health and Care Excellence (NICE) guideline on use of antipsychotics for the management of behavioural and psychological symptoms of dementia (BPSD) is being adhered to.

Method. Retrospective audit analysing notes of all patients currently open to the OPCMHT that are prescribed an antipsychotic medication for the management of BPSD. Patients with a diagnosis of any subtype of dementia and prescribed any antipsychotic were included. Data collected from paper notes using an audit proforma.

Result. The total number of patients was 11. The most common diagnosis was Alzheimer's disease (45%), followed by mixed type dementia (36%), vascular dementia (9%) and Lewy Body dementia (9%). The majority of the patients reside in their own home (64%) whilst the remaining 36% reside in a residential home for the elderly and mentally infirm. The CAIR form was present in 73% of the patient's notes, however only 37% had the new, piloted, shorter version of the CAIR form. Of the CAIR forms present, only 63% were fully completed. There was documented evidence that 100% of patients had an assessment of underlying causes of their challenging behaviour; that non-pharmacological interventions were tried first; and that target symptoms were identified. There was evidence of a discussion with the patient or carer about the risks and benefits of antipsychotic use for all patients, however the details of the discussion was often vague. All patients had a review of the antipsychotic medication within the last three months.

Conclusion. There was evidence that pre-prescribing assessments are being undertaken for all patients. There needs to be clearer