

(9 patients). Physical health data required were determined by local policy and the Maudsley guidelines.

Parents were invited to attend the clinic with their child through telephone calls. Height, weight, blood pressure and pulse were measured in the appointment. A blood test form was provided for parents to take to local outpatient phlebotomy services. A GP letter was sent with the results of the physical health check with a request to conduct an ECG and notify us of any abnormal results. Feedback forms were collected from parents to share their experience of attending the physical health clinic.

Five patients were identified as having difficulty attending the CAMHS clinic due to refusal/challenging behaviour. For three patients, school visits were organised to conduct a physical health check.

Result. The results from the second round of the audit indicate an overall improvement in the adherence to monitoring guidelines for antipsychotic and stimulant medication. This was particularly evident for the patients on antipsychotic medication. Feedback collected from parents regarding the service provided was also positive.

Conclusion. The physical health clinic identified challenges preventing 100% compliance in all patients. This included difficulties with parents bringing their child to CAMHS due to challenging behaviour. In a few of the patients, it was possible to solve this issue by conducting a school visit.

It was also observed that there were multiple instances where challenging behaviour lead to inability to conduct certain tests including blood pressure, blood tests and ECG. Additional strategies should be considered to improve compliance.

A notable issue that also arose from the development of the physical health clinic was that it was unclear how to obtain an ECG at CAMHS.

Continuation of the clinic as well as extension to include patients within other teams at Tower Hamlets CAMHS would be recommended.

Reducing admission time to Broadmoor High Secure Hospital – a case review

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Aims. Prolonged waiting times for admission to psychiatric hospital settings are a common and widespread issue. Delayed admissions may result in poorer outcomes due to prolonged mental suffering and delays in initiating treatment. Long waiting times also have a negative impact at a service level, impeding patient flow.

National guidance has been recently updated, recommending that patient transfers to secure services take no longer than 28 days from referral. These transfers are frequently affected by delays in admission, possibly resulting in increased risk to patients, staff and the public.

The aim of this project was to audit all referrals to Broadmoor High Secure Hospital in England within a one year period with special focus taken on calculating the time taken from referral to admission. We aimed to assess if there were any rate limiting steps which could be targeted to reduce time from referral to admission.

Method. We collected data and conducted a retrospective cohort review for all admissions from September 2019–September 2020.

Where available, information was obtained for each step of the referrals process. Individual patient records were reviewed where required.

Exclusion criteria: data withdrawn, transfers from other high secure services (HSS), incomplete data, “MOJ instruction” or urgent admission bypassing the process.

Result. 18 cases were excluded as per exclusion criteria. 46 patients were included in the study. 16 referrals originated from medium secure psychiatric hospitals, and 30 from prison.

The average time from referral to admission was 44.3 days. Admission of patients from MSUs was quicker, taking an average of 40.3 days when compared to prison referrals, which took 45.9 days.

The breakdown of timings for each step in the referrals process was calculated to determine if a rate limiting step could be identified. On average it took 2.1 working days to allocate a case to a clinician, 7.6 days for an assessment, 9.2 days to complete a report and 3.5 days to submit this to the admissions panel. The mean time from referral to the date of the panel hearing was 22.5 working days, and admission took a further 21.8 days on average.

Conclusion. The current average time to admission exceeds the new 28 day recommendation. This could both be due to the COVID-19 pandemic, and miscommunication about time targets. We will review the process and aim to reduce the time from referral to admission in line with new guidance.

Elderly offenders at Wathwood Hospital: perspectives and practicalities

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Aims. The following project explores where Wathwood Hospital stands in provision of services to its elderly patients.

Background. The only dedicated forensic medium secure unit for elderly offenders in England is the St. Andrews medium secure unit in Northampton with only 17 beds. Due to the limited beds, other units must accommodate elderly patients, which raises the question whether these units can provide the appropriate services for this very vulnerable population.

Method. Inclusion Criteria:

Male

>55 years of age

Admitted from 2012 onwards (from when database was maintained)

Data were gathered using patient electronic records including index offence, mental disorder, physical health comorbidities and discharge destinations. Patient identifiable data were anonymized to protect their identities.

A staff survey was also conducted to find their perspective on managing elderly patients and whether Wathwood Hospital had the appropriate resources for elderly offenders in their area of work.

Result. A total of 220 referrals were searched with only 9 patients >55 years. Index offenses, mental disorder diagnoses, physical comorbidities including cognitive assessments in the form of memory tests and brain imaging were also collated for identified patients from electronic patient records.

Index offences included violence against person, arson, homicide, robbery, threatening behaviour and dangerous driving and

affray. Diagnoses included learning disability, delusional disorder, paranoid schizophrenia, bipolar affective disorder, alcohol dependence, personality disorder and depressive disorder.

Patients had multiple comorbidities such as diabetes, COPD, hypertension, coronary artery disease and musculoskeletal problems. Out of the nine admitted patients, only six had an ACE with an average score of 70.83. Five patients had brain imaging, with two normal results and the others showing some degree of atrophy and ischemic changes.

Discharge destinations included medium secure units, low secure unit and prison. One patient unfortunately died during admission and four are still inpatients.

A staff survey conducted showed their perspective on the challenges in managing elderly patients and whether Wathwood Hospital had the appropriate resources for them to work with elderly offenders in their area of work. All results will be explained through tables and graphs.

Conclusion. It's evident that there are challenges in managing elderly patients in units not specifically designed to manage them. This is also due to the lack of geriatric training and resources available to allied health care professionals to carry out their respective work. It's therefore crucial we formulate more inclusive strategies to address these challenges.

The use of antipsychotic polypharmacy at Ravenswood House Medium Secure Unit: the extent of use and reporting of outcomes

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Aims. To evaluate the use of antipsychotic polypharmacy in Ravenswood House Medium Secure Hospital. We also aimed to review the reporting of the outcomes of their use.

Background. The use of antipsychotic polypharmacy (APP) continues to be practised within forensic psychiatric inpatient settings yet there is a lack of robust evidence for the benefits of doing so. The practice is also associated with the use of higher total antipsychotic doses beyond the recommended BNF maximum. Such prescribing is associated with an increased side effect burden. Doctors have a duty to justify the ongoing use of antipsychotic polypharmacy and to avoid potentially ineffective and/or harmful use.

Method. A cross-sectional review of the medication cards for 51 in-patients at Ravenswood House Hospital was completed. Demographic data and data pertaining to diagnoses and medication was also gathered from the electronic patient records.

Result. 23 patients (45%) in Ravenswood House Hospital were prescribed antipsychotic polypharmacy. 87% of those prescribed antipsychotic polypharmacy had a primary diagnosis of either schizophrenia or schizoaffective disorder. 19 patients (37%) had two regular antipsychotics prescribed. 74% of these prescriptions were above the recommended BNF maximum. 62% were also prescribed a regular benzodiazepine. The vast majority of indications documented for APP were chronic behavioural disturbance and treatment resistant schizophrenia. The majority of these patients were on a T3. There was a significant under reporting of the rationale of prescribing APP. It could be surmised that at least 11 combinations were in part to mitigate side effects, but only 3 had this documented. There was also a lack of documentation

or use of rating scales regarding the clinical outcomes and side effects of APP.

Conclusion. Prescription of antipsychotic polypharmacy is an important issue in secure forensic hospital settings. The lack of clear documentation of clinical effectiveness and side effect burden remains a concern. Wider study is required to establish the benefits of such prescribing to justify its ongoing use.

Capacity and consent to treatment – how well did we do?

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Aims. An audit on capacity assessment and consent to treatment on inpatient visits to Atherleigh Park Hospital was performed using the Mental Health Act Code of Practice as a framework. Six standards were evaluated:

- 1) documentation of capacity assessment in patient care records
- 2) documentation of patients who display a lack of capacity
- 3) completion of a Section 58 and/or 62 for detained patients
- 4) documentation of medicines on T2/T3 form and if they match with the patient's prescription chart
- 5) evidence of medication concordance and monitoring of adverse side effects
- 6) patient education on medicines prescribed for them

Method. Inclusion criteria included patients who were detained under Sections 2, 3 and informal admissions, who were admitted for 72 hours or more, between October and December 2019. This gave a total sample size of 75. Data were collected by looking at patients' care records and if applicable, their Section paperwork to identify any documentations related to the standards evaluated as above. Data collected were transcribed to a web link, downloaded and analysed.

Result. In standard 1), it was found that 77% of the capacity assessment and consent to treatment forms were recorded in patient care records. Of these, 100% of were completed by a medic and 99% of all sections in the form were completed. However, only 57% of patients were re-assessed when their capacity and consent changed during admission. In standards 2), 3) and 4), documentation of patients who lacked capacity, completion of a Section 58 or 62 form and charting of medications on the T2/T3 forms were fully compliant. In standards 5) and 6), 76% of medication concordance were documented in patients' records. Only 39% of adverse effects from medications were documented but monitoring compliance was 100%. Medication counselling was done infrequently, with 47% of patients given a leaflet and 28% educated on their side effects.

Conclusion. Action plans were identified. Firstly, to link the capacity assessment form with patient electronic ward round notes to ensure clinicians complete it at the end of a review. In order to monitor adverse effects from medications, physical examination, blood tests and ECG are to be done following a new prescription, and to be repeated if indicated. Information leaflets on common psychiatric medications are to be made readily available for patients. The findings from this service evaluation and the actions plans were shared with doctors. A re-audit is vital to re-evaluate the hospital's compliance.