leadership. Doctors spent a total of 490 minutes searching for a machine, with the mode and median being 10 minutes, and the longest being 120 minutes. 4 incidents reported of ECGs not being done. 89% of ECGs were required for routine monitoring, with 11% being due to chest pain. 46% of incidents were due to a missing machine, and 54% were due to a faulty machine. Faults were due to a paper fault, broken leads, missing clips, no charging cables, or the machine itself not working.

Conclusion: There are clearly significant issues with the availability of ECG machines across the inpatient facilities within the trust, leading to potentially significant delays both for routine and urgent ECGs. Issues highlighted within the trust meetings suggested that faulty machines were often not reported or fixed. To address this, it has been agreed to develop instructional flowcharts to streamline the escalation process and to implement this within the trust over the coming months.

Audit of Antipsychotic Monitoring in an Old Age Community Mental Health Team in Accordance With NICE Guidelines

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Aims: Antipsychotic monitoring is crucial for identifying and managing side effects, improving treatment compliance, and reducing risks associated with long-term use. NICE guidelines recommend routine monitoring to enhance quality of life and prevent disengagement due to adverse effects. This audit assesses compliance with these guidelines within an Old Age Community Mental Health Team (CMHT). This was also discussed in MDT, as well as with patients and carers to have a better understanding of patient experience and how we can enhance antipsychotic monitoring.

Methods: We have registered our audit with Clinical Effectiveness Team at Cambridgeshire and Peterborough NHS Trust. We screened 101 patients under Ely Neighbourhood Team. We included patients with Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Delusional Disorder currently on antipsychotic medication. Of the 18 patients identified with these diagnoses, 17 were on antipsychotics. We have screened their notes in the last 12 months for Body Mass Index (BMI), ECG, Complete Blood Count (CBC), Electrolytes (U&E),Blood Lipids, HbA1c, Pulse and Blood Pressure, Liver Function Tests (LFT), Emergence of Extrapyramidal Side Effects (EPSE) or Movement Disorders.

Results: 17 patients were included in the audit. Patients were between ages 66 and 84. Of them 5 were males and 12 females. Of the 17 patients 6 (35%) of them had Schizophrenia, 3 (18%) of them had Paranoid Schizophrenia, 3 (18%) of them had Delusional Disorder and 5 (29%) of them had Bipolar Disorder. Within the last 12 months, all patients on antipsychotics were offered monitoring; 1 patient declined. 94% had blood work monitoring. 100% had pulse and BP recorded. 29% (5 patients) did not have an ECG, despite being on medications requiring ECG monitoring. 11 patients (65%) were not asked about EPSE/movement disorders. Of the 6 patients asked about EPSE, 66% (4) were asked in outpatient reviews, and 33% (2) were asked as inpatients in psychiatric units.

Conclusion: Despite good compliance with most aspects of antipsychotic monitoring, ECG and movement disorder evaluations require improvement in elderly CMHT cohorts. We recommend psychiatrists to work collaboratively with GPs to enhance antipsychotic monitoring.

Clinical Audit : Supporting Post Detox Abstinence: Discussion of Relapse Prevention Medications by Community Addiction Services Prior to Referral for Inpatient Detoxification

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Aims: Without a plan to support ongoing abstinence, detoxification ("detox") could increase, rather than reduce, risks to a patient. Before referring for inpatient detox from alcohol or opioids, community teams are expected to discuss relapse prevention medications (RPMs) with patients, as part of their wider support plan.

This clinical audit examined whether RPMs were mentioned in referrals by community teams to our inpatient detox unit.

Methods: We examined referrals for patients admitted to The Level Nottingham inpatient detox unit between 1 January and 31 August 2024. Of a total of 215 patients that completed opioid or alcohol detox, a random sample of 50 were selected, stratified according to referring team. Referral forms and running notes were used to assess compliance with the following criteria:

1. Referring teams mention RPMs (whether to be considered or not considered).
2. Referring teams provide blood test investigations.

There was no previous literature or audit to specify a standard, so, given the importance of the issues under consideration, this was set as 100% for each criterion. We also extracted: whether patients were planned to go to residential rehabilitation after detox, and, where relevant, which RPMs were mentioned and time from blood test results to referral and to admission.

Results: 68% of referrals were for alcohol, and 24% for opioid, detoxification (2% were for alcohol and opioid, and 6% for other substances).

40% of referrals for alcohol, and 77% of referrals for opioid, detoxification did not mention RPMs.

29% of referrals for alcohol, and 31% of referrals for opioid, detoxification did not mention RPMs and were not planned to go to residential rehabilitation (considered as some of these settings do not accept patients on RPMs, focusing solely on psychosocial support).

48% of referrals for any detoxification did not have blood test results available. Where blood test results were available, median time from test results was 22 days to referral and 85 days to admission.

Conclusion: During the study period, an estimated one-third of referrals for alcohol or opioid detoxification did not mention RPMs (and were not going to residential rehabilitation post inpatient stay).

Approximately half of admissions did not have blood test results available.

The above is likely to delay the prescription of RPMs, and potentially increase the risk of relapse post-detoxification.