Medications – 68% full, 19% partial, 13% blank.

Leave – 77% full, 0% partial, 23% blank.

Conclusion: Ensuring consistent improvement in quality for MDT documentation is a challenge, complicated by limited meeting time, and rotations of trainees new to psychiatry.

We have tried different interventions, including strategies to improve access to information, and producing training material.

Our next intervention is to create a training pack for new doctors in the department, which includes the interactive video. We will then re-audit.

Re-Audit of Physical Health Equipment Available at the Mount Old Age Psychiatric Hospital

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Aims: The purpose of this audit was to re-audit (second cycle) the availability of physical health equipment on the psychiatric wards at the Mount psychiatric hospital. This was a second cycle of a previous audit performed in November 2023 to assess whether the previous recommendations had been successful in improving compliance with the 2022 CQC physical health recommended equipment list and equipment required to meet NICE guidelines for antipsychotic medication monitoring.

Methods: A stock check was performed of the physical health equipment available on the 4 old age psychiatric wards. This was against the items recommended in the 2020 CQC physical health guidance and key equipment required for basic investigations for monitoring of psychiatric medications, e.g. ECG and blood samples. The same criteria were used in the first cycle of this audit (completed by a different author), due to similarities in audit reference material, so this is a re-audit of the same checklist items.

Data was collected from all 4 old-age wards at the Mount on two separate occasions. Data from wards 1–3 were collected on 10/01/2025 and data from ward 4 were collected on 20/01/2025. This difference in date of data collection was due to staffing constraints.

Results: Overall, there was a lack of equipment across all four wards, with the percentage of recommended equipment that was not available ranging from 17.5–35%. There were 4 items that were missing across all 4 wards: Alcometer, Snellen chart, BMI chart, Tuning fork.

In addition to items that were lacking, as seen in item 2, there were several items that were either not working or expired. This includes several blood bottles and urinalysis sticks that are essential for basic monitoring. In terms of items that were not working, the only available otoscope and ophthalmoscope in the hospital was not functioning.

The variability in ECG machine function on all 4 wards means that QT interval monitoring cannot be performed reliably.

Conclusion: Overall, the results of the audit have shown that none of the wards at the Mount have all the necessary equipment required for adequate physical health care for psychiatric inpatients. This means that we are unable to provide adequate physical health care to psychiatric inpatients. Additionally, when compared with the results of the previous cycle of this audit there have not been significant improvements. Therefore, more clear-cut improvements are going to be required.

An Audit of Patients Who Did Not Attend Appointments in the East Lancashire Memory Assessment Service

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Aims: It is estimated that the rate of non-attendance at outpatient appointments in the NHS is 7.6%. As such, reducing the number of patients who "Did Not Attend" (DNA) is of paramount importance for improving capacity within the current NHS funding envelope.

The East Lancashire Memory Assessment Service (MAS) leads on cognitive assessment for patients from a geographically large catchment area which includes Hyndburn, Rossendale, Blackburn with Darwen, Burnley, Pendle and the Ribble Valley. Patients undergo a multi-disciplinary assessment, which typically includes a triage, initial assessment and diagnostic appointment. Medication monitoring is offered as required.

This audit aimed to establish how many patients DNA their MAS appointments and to understand the reasons for this.

Methods: We audited the records of the last 70 patients who had been discharged from the MAS as of 11 November 2024.

The Electronic Patient Record (EPR) was searched to identify key demographic characteristics and to establish whether any appointments were recorded as having an outcome of DNA. For any appointments that were not attended, we established what type of appointment had not been attended and whether any reminders had been sent.

Excel was used for data collection and analysis. Audit approval was granted by LSCFT.

Results: A total of 4 instances of patients not attending appointments were recorded in the EPR. These DNA were attributed to three patients. One who DNA an initial assessment, one who DNA a diagnostic appointment and one who DNA both an initial and a diagnostic appointment. In total, 99 appointments were offered to the patients in the audit sample, giving a DNA rate of 4%.

When there was a recorded reason for non-attendance, transport issues and an acute hospital admission were cited. Two patients sadly died whist awaiting already rescheduled initial assessments (these were not classed as DNA). Of the patients audited, there were no DNA for medication monitoring appointments.

Telephone reminders were offered to the majority of patients, 48 hours prior to their appointment, which may have reduced the total number of DNA. These reminders frequently led to appointments being re-arranged to more convenient times, helping to reduce the DNA rate.

Conclusion: Comprehensive telephone reminders ensure that the rate of DNA in the East Lancashire MAS is kept to a minimum and

allows appointments to be rescheduled if necessary. This audit has demonstrated that non-attendance at MAS appointments happens due to varied factors that are often outside of NHS control.

Assessment and Management of Substance Misuse Among Patients With Psychosis at a Mental Health Inpatient Unit in CNTW NHS Foundation Trust: An Audit

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Aims: The audit aims to check compliance with regards to assessment and management of substance misuse among patients admitted with psychosis in male wards, St George's Park hospital. The following National Institute of Clinical Excellence (NICE) guideline was considered for the audit: Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings – CG 120 (published on March 23, 2011).

Methods: All patients with diagnosis of psychosis and any comorbid substance use history admitted as inpatients in the wards from a period of July 1 to July 31 2024 were considered for the audit. Only patients who were on the wards for a minimum duration of 7 days were included.

A total of 37 patients were found as suitable. Patient progress notes and discharge letters were reviewed to check compliance with standards.

Results: Our results showed areas of both good compliance and poor compliance with regards to the standard. We found that 88.8% of patients were assessed for comorbid substance use during the first week of admission by the treatment team. In 62.06% of patients, there was evidence of involvement for specialist drug and alcohol services on admission and in the management of withdrawal symptoms. For 87.5% of patients, it was evident that policies were followed with regards to search procedures, visiting arrangements, planning and reviewing leaves, regular drug and alcohol testing and other security measures. However, only 42.8% compliance was noted regarding involvement with specialist substance use services on discharge.

Conclusion: The audit has demonstrated that wards showed good compliance to NICE guidelines around assessment of substance use and in following policies regarding measures to check for substance use in ward settings. However lower compliance was evident with regards to involvement of specialist substance misuse services during both admission and discharge. Following the outcome of audit and presentation in local team meetings, it was decided to initiate a service evaluation to look at barriers regarding involvement of specialist drug and alcohol services along with an educational programme for professionals especially nursing staff regarding the need of screening and referral for people with comorbid substance use in psychosis. A re-audit is planned after a period of 6 months.

Initial Audit Investigating Physical Health Screening and Management of Neuropsychiatric Manifestations in Parkinson's Disease (PD), Parkinson's Disease Dementia (PDD) and Dementia With Lewy Bodies (DLB) on the Mental Health Services for Older Persons (MHSOP) Wards

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Aims: To improve the overall quality of healthcare for mental health inpatients with a diagnosis of PD, PDD or DLB (with neuropsychiatric manifestations such as depression, agitation, psychosis or cognitive deficits), by improving: (a) physical healthcare screening and (b) the collaborative approach between inpatient mental health teams and PD specialists.

Methods: Our audit included 24 patients admitted to five MHSOP wards in Leicestershire, between 13/12/2020 and 27/10/2022. A list was obtained from the e-prescribing team, of patients on specific psychotropic or parkinsonian medications that were identified in advance by the audit team. An online audit tool was created which consisted of 17 questions relating to patient care. Three resident doctors conducted the retrospective data collection after being briefed by the audit lead, to ensure consistency in the data collection process.

Results: Antipsychotics were considered in 11/11 (100%) patients who had psychotic symptoms. 20/24 (83%) patients experiencing neuropsychiatric issues had bloods taken to rule out acute physical health causes. In 21/24 (88%) cases, an electrocardiogram was conducted prior to commencing an antipsychotic or cholinesterase inhibitor. Cholinesterase inhibitors were considered in 13/17 (76%) of patients with dementia.

Optimising dopaminergic therapy for those with PD was poor, with 8/18 (44%) patients having an intervention involving dopaminergic medications. For 5/24 (21%) patients, advice was sought from PD specialists (2 with geriatricians, 2 with neurologists and 1 with a PD specialist nurse). Of these, 3 (13%) were assessed in person by the PD specialist. In 8/24 (33%) cases, follow-up with a PD specialist was considered by the ward. There was poor compliance in screening for autonomic dysfunction in the context of PD (e.g. constipation, urinary dysfunction and orthostatic hypotension).

Conclusion: As stated in the DIAMOND-Lewy toolkit, "many patients with PDD or DLB do not receive the best possible management". Furthermore, the pathway for obtaining PD specialist input is unclear, although the collaboration between inpatient mental health teams and PD specialists is potentially vital for holistic care.