Although non-compliant, there were clear improvements in documenting indicated use (2018: 61.65%, 2021: 80.8%), and providing prescriptions of <4 weeks in duration (2018: 58.2%, 2021: 79.2%)

Key areas of concern were as follows: poor documentation of indication, duration of treatment and plans for review/discontinuation (compliance ranged from 31.5% - 81.2% in these areas). There was poor documentation of what verbal advice was given (0–16.9%), and lack of clearly documented tapering/discontinuation plans for those on long-term prescriptions (16.1%). The provision of written advice reduced from previous audit (2018: 10.7%, 2021: 5.8%). As 41/51 encounters were via telephone or video due to COVID-19 pandemic, this may have impacted on results.

Conclusion. Despite improvement in some areas, there remains scope for ongoing improvement in other areas. To improve these, we plan to produce and distribute an educational email to all prescribers, including the following: information on this audit and its findings, prescribing guidelines, relevant e-links to patient information leaflets as well as the audit proforma used for this audit, to encourage prescribers to undertake self-directed practice. A poster will be distributed, highlighting prescribing guidelines and standards, to be printed and displayed in clinical areas as reminder of prescribing responsibilities and the importance of documentation. Prescribers will be encouraged to participate in a small quiz to test learning. Efficacy of these measures will be assessed with a re-audit in one years' time.

Driving Risk Assessment and Advice Provision for Inpatients Based on Features of Illness, Treatment and Driver and Vehicle Licensing Agency (DVLA) Guidelines

Dr Oghenefejiro Ofovwe* and Dr Nduka Nzekwue

Kent and Medway NHS and Social Care Partnership Trust, Kent, United Kingdom
*Presenting author.

Aims. The aim of the project was to improve the routine incorporation of driving advice based on Driver and Vehicle Licensing Agency (DVLA) guidance into discharge planning by responsible inpatient teams. This would optimize patient safety, demonstrate good clinical practice (trust and professional body values) and minimize/prevent the emergence of accidents/unfair loss of licenses/unfair attribution of driving accidents caused by people who have been under recent or ongoing inpatient care.

Methods. The following questions: "Do you have a valid license", "Do you own/have access to a vehicle", "Do you currently drive" were developed as a standard template for gathering patients' driving information.

These questions were embedded within:
1. Barriers to ward discharge discussions
2. Trust-wide communications via screensaver and circular

Answers to these questions were to be clearly documented on patient's records to serve as prompts for the responsible discharging team to take up providing the appropriate advice.

After a specified period, the electronic discharge notification (EDN) database was searched for patients with relevant diagnosis who were discharged from all the general adult/older adult acute inpatient wards within a specified period. The patients' records were then checked for documentation of relevant driving information evidenced by documentation of answers to the screening questions as well as recorded evidence of DVLA discussion/advice held since date of diagnosis or admission.

The standards audited against were all patients:
1. should have their driving licence status recorded during their admission
2. should have their access to a vehicle recorded during their admission
3. with a relevant mental health diagnosis should have a record of advice regarding driving given in bespoke and DVLA informed manner during ward discharge planning by the responsible discharging team
4. should have documentation of the outcome of the driving advice given by the responsible team in their records

Results. 28 patients with relevant DVLA notifiable mental health conditions were audited. 11% (n = 3) had driving licence status recorded. 14% (n = 4) had access to a vehicle recorded. 7% (n = 2) had driving advice given. Only one patient had outcome of driving advice recorded. No best practice was identified.

Conclusion. Documentation of driving information, DVLA signposting advice and outcome for patients with relevant mental health diagnosis is a crucial part of patient risk assessment and management as these patients are not free from posing a driving risk on discharge. The trust is implementing actions to improve the routine incorporation of driving advice based on DVLA guidance into discharge planning.

Medical Assessment and Management of Self-Inflicted Head Injury in an Inpatient Child and Adolescent Mental Health Services (CAMHS) Setting

Dr Georgie Patrick*, Dr John Smallwood and Dr Cara Webb

Fairfield General Hospital, Manchester, United Kingdom
*Presenting author.

Aims. To ascertain whether current medical assessment and management of self-inflicted head injuries in an inpatient CAMHS setting conforms with current NICE guidance.

Methods. Incidents of self-inflicted head injury were identified on the incident logging system Ulysses. Incidents were matched to entries on Paris, the online clinical notes system. Data were collected from Paris on whether the incident was reviewed by a doctor, time until doctor review and which components of the NICE guidance were completed during the review. The data were collated into an Excel spreadsheet and analysed.

Inclusion criteria were CAMHS inpatients at 1 Greater Manchester hospital during November 2021 who had an incident of 'head banging' recorded on Ulysses. Exclusion criteria were patients on ward A as the ward was found to have its own care plans for managing head banging rather than escalating to doctors.

Results. There were 52 incidents of head banging logged. 56% (n = 29) of incidents received a doctor review and 32% (n = 17) did not. For 10% (n = 5) of incidents a doctor review was declined and for 2% (n = 1) a review was conducted for another indication. The mean time taken until review was 4.3 hours with a range of 1 to 16 hours.

NICE guidance lists 9 components of the history that should be covered. 1 component met the 100% target and 1 component was documented in > 50% of incidents. The remaining 7 components were documented in < 50% of incidents.

NICE guidance lists 16 components of physical examination that should be completed. No components of the physical examination met the 100% target. 5 components were documented in > 50% of incidents. The remaining 11 components were documented in <50% of incidents.