Result. Our audit standards had an overall audit compliancy of 73% with paired HoNOS better than PBQ. Mental health severity mitigated and maternal bonding improved to a significant degree. Depression was the principal presentation as were patients from deprived areas. Only 55% of babies had ASQ scores completed appropriately pre- admission.
Conclusion. As the newest MBU in the country, this an initial foray of perinatal outcomes. Gratifyingly, benefits of MBU admission for mother and baby is evidenced in this snapshot.

Compliance to completion of sodium valproate annual risk acknowledgement form among women of child-bearing age prescribed sodium valproate in the intellectual disability (ID) services of an NHS trust

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Aims. To determine the proportion of women of child-bearing age prescribed SV who have the SV ARF filled.
Background. In 2018, the Medicines and Healthcare products Regulatory Agency (MHRA) gave guidance regarding Sodium Valproate (SV) prescription. It acknowledged the significant risk of birth defects and developmental disorders in women of child-bearing age prescribed SV.

Consequently, the MHRA recommendation is that SV must not be used in females of child-bearing age unless: conditions of pregnancy prevention programme are met; other treatments are ineffective or not tolerated; and evidence of discussion of risks with patient or carer and annual review of the risks are documented. The evidences of the above criteria are expected to be documented in an Annual Risk Acknowledgement Form (ARF).
Method. Retrospective study involving systematic search of Trust database to identify women with ID, aged 16–50 years prescribed SV from 2018 to 2019.
Result. 18 of 28 patients had ARF filled, a 64% compliance.

The main indications for SV prescription were epilepsy; challenging behaviour; and mood stabilization.

The distribution showed neurology and psychiatrist led prescription initiation equally distributed at 50%.

The ARF compliance was higher in the neurology group (93%) compared to 36% in psychiatrist group.

A review across the 5 ID teams (A,B,C,D and E) of the trust shows variable compliance to ARF compliance (17%,81%,100%, 60%,0% respectively) with teams having higher proportion of neurology led SV prescription initiation also having higher proportion of ARF completion compliance (0%,55%,80%,80%,0% respectively).
Conclusion. Conclusion / Recommendation

ARF compliance is below standard at 64%.

Despite the SV prescription being equally distributed between neurology led and psychiatry led, patients whose prescription of SV is neurology led (prescription indication as epilepsy) had better ARF compliance outcome (93%) compared with patients whose prescription is psychiatry led (prescription indication as challenging behaviour or mood stabilization) with 36% ARF compliance.

Organizational difference with dedicated epilepsy nurse in the ID service means patients with epilepsy had reviews of medication and compliance to MHRA guidance in completing the ARF.

There is need to increase doctors' awareness to review ARF status during patients' appointment. Information Technology design to flag up out of date ARF may be helpful.

The review of ARF may also flag up consideration of other alternatives: behavioural, psychological, functional and environmental interventions as well as alternative medications like Risperidone for challenging behaviours and other mood stabilizing options. This will minimize SV prescription, which is the original goal of the MHRA guidance.

GASS-tly side effects: antipsychotic monitoring for inpatients across NHS Lanarkshire

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Aims. Best practice in the prescribing of antipsychotic therapy includes monitoring for medication side effects. National guideline SIGN 131 advises the use of a validated side effect scale, for example the Glasgow Antipsychotic Side-effect Scale (GASS). Local recommendation in NHS Lanarkshire advises that patients prescribed antipsychotic therapy should be offered GASS at each contact and after initiation or titration. We aimed to improve compliance with antipsychotic side effect monitoring for inpatients in general adult psychiatry across two hospital sites in NHS Lanarkshire.
Method. We conducted a full-cycle audit. In October 2020, we took a cross-sectional sample of inpatients in general adult psychiatry in University Hospital Hairmyres and University Hospital Wishaw who were prescribed antipsychotic therapy for a functional psychotic disorder. For these inpatients, if applicable, we identified whether GASS had been completed on admission (OA), whether GASS had been completed after initiation or titration of antipsychotic therapy (I/T), and whether GASS had been acknowledged and discussed at consultant-led multi-disciplinary team meeting (MDT). Thereafter, we implemented several targeted interventions in order to improve compliance. In January 2021, we completed the cycle by taking a new cross-sectional sample of inpatients fulfilling identical parameters.
Result. First cycle in October 2020 (n = 27) showed compliance OA of 4.2%, I/T of 9.5%, and MDT of 3.7%. Our interventions included a presentation at trust-wide clinical governance meeting; a presentation at one of the weekly departmental teaching sessions in psychiatry; an email summarising the audit to consultants in general adult psychiatry; meetings with senior charge nurses for each ward; and inclusion of GASS as part of routine admission paperwork. Re-audit in January 2021 (n = 23) showed compliance OA of 11.1%, I/T of 40.0%, and MDT of 21.7%.
Conclusion. Our full-cycle audit led to modest improvement in documented monitoring for antipsychotic side effects. There was relatively greater improvement in prescriber-led outcomes I/T and MDT, suggesting increased prescriber awareness. However, rather than reliance on individual prescribers to ensure compliance, consideration of GASS alongside monitoring of other physical health parameters would likely result in greater and more sustained improvement. In NHS Lanarkshire there is ongoing work to this end, ultimately with the intention to set up a defined antipsychotic physical health monitoring schedule, integrated across inpatient and community care.

Audit of section 2 and section 3 mental health act paperwork in Derby inpatient psychiatric units using an audit tool by Mason et al. (2012)

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Aims. Complete an audit of Section 2 and Section 3 Mental Health Act Paperwork in Derby Inpatient psychiatric units using an audit tool developed in a study by Mason et al. (2012).
Background. The 1983 Mental Health Act enables doctors approved on behalf of the Secretary of State under Section 12 to be able to make recommendations for the detention of individuals with a mental health problem where the degree and/or nature, and associated risk to that person's health or safety, or that of others, makes inpatient care necessary. For the detention and the associated deprivation of their liberty to be lawful, it is necessary that the clinical situation meets certain criteria as outlined in the Mental Health Act.
Method. Ward status was reviewed for each inpatient ward in Derby and the first five patients alphabetically, who were detained under sections 2 or 3 were selected. The Mental Health Act medical recommendation documents were reviewed according to the necessary criteria, using an assessment tool generated from a study by Mason et al. in 2012 'Compulsion under the Mental Health Act 1983: audit of the quality of medical recommendations'. A junior colleague was trained to analyse Mental Health Act paperwork using the audit tool. Medical recommendations were reviewed and rated as 'clear', 'implied' or 'none' for each criterion.
Result. Evidence of a mental health problem and the nature or degree of illness was well documented. Evidence regarding why informal admission was not appropriate was also reasonable but with room for improvement. Poor compliance was evident mostly in relation to the justification related to risk to health, safety or others, the lowest clearly documented percentage of these appear to be regarding health.
Conclusion. From analysing the documentation, often written justification incorporated general safety as a whole; however health and safety are identified by the mental health act as separate criterion requiring clear justification of each. In a number of occasions people failed to identify which of the three risk categories were relevant for the patient. Potential criticisms of this audit include the subjective nature of the interpretation of clearly explained and implied and that data analysis was completed by a non-section 12 approved doctor. Data were presented at the local weekly academic teaching to raise awareness of the results and a recommendation was made for the subject to be included in the junior doctor induction.

Are blood tests being performed for new inpatient admissions to a psychiatric hospital as recommended by RCPsych guidelines?

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Aims. Severe mental illness (SMI) has a significant impact on a person's physical health and mortality. There is a 10–25-year life expectancy reduction in patients with SMI. The majority of deaths are due to physical health conditions. The Royal College of Psychiatry (RCPsych) sets out a standard that new inpatient admissions to Mental Health Services should have routine blood tests performed within 24 hours of admission, unless they have had a recent blood test. The aim of this audit was to review whether blood tests were performed either in the 48 hours preceding admission or the 48 hours after admission to Leverndale Hospital.
Method. Clinical records were reviewed for new inpatient admissions to two general adult wards over a four-month period.
Result. 79 patients were admitted (M = 39, F = 40, Age: 18–62 years old). 70/79 (89%) had blood tests performed within the 48-hour timeframe. 5/79 (6%) had a blood test performed after 48 hours of their admission. 4/79 (5%) did not have a blood test. The blood tests performed varied. 51/75 (68%) patients had at least one abnormal blood test. The yield of abnormal blood results ranged from 2% for thyroid function tests to 35% for a full blood count.
Conclusion. This audit has established that the majority of patients had blood tests performed within the 48-hour timeframe. This could be improved by setting up an electronic reminder to prompt the clinician to perform a blood test at 24 hours as per RCPsych guidance if one had not yet been done. The blood tests performed varied. RCPsych guidance does not specify which blood tests should be done. A further scope for this audit could be to review the clinical significance of abnormal blood results to develop a standard set of blood tests for admission.

Venous thromboembolism (VTE) risk assessment completion in psychiatric inpatients

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Aims. To audit VTE risk assessment compliance across psychiatric inpatient wards at three different sites within Surrey and Borders Partnership NHS Foundation Trust (SABP), and to highlight the importance of completing VTE risk assessments for psychiatric inpatient safety and care as set out by NICE guidelines (2019).
Method. Numbers of VTE risk assessments completed (within 24 hours, and those completed any time during inpatient stay) and VTE risk assessments not completed were collected via SABP electronic mental health records. Percentage compliance for each ward and hospital involved in the study were calculated. Chi square statistical t tests were conducted using Excel to check for associations between type of ward (older adult and working age) and VTE risk assessment completion.

A total of 3004 patients were included in the study. Ages ranged from 18–82 years of age, and both males and females included in the study. A total of 2060 were working age (WA) patients (aged 18–64 years) and 944 were older adults (OA) (aged > 65 years).
Result. Across all three sites, more than 90% of all inpatients admitted between May 2018 and October 2020 did not have a formal VTE risk assessment completed. Across all sites, less than 1% of all inpatients had a completed VTE risk assessment done within 24 hours, as recommended by the NICE guidelines. Older Adult wards showed better compliance with VTE risk assessment completion with 38% of patients on one OA ward having had a completed VTE risk assessment, and 28% on another completed OA ward. Being admitted to an OA ward