Although 100% of patient had their height, weight and physical observations recorded, a significant proportion did not have these plotted on centile charts as recommended.

A minority of patients had a full biopsychosocial assessment, with a major deficit in risk assessment for substance misuse.

Seclusion Reviews: Audit of Medical Documentation in a Psychiatric Intensive Care Unit

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Aims. Seclusion is a restrictive intervention used when a patient presents with risks that cannot be safely managed in their current environment. The Mental Health Act 1983 Code of Practice (MHA CoP) provides clear recommendations for both frequency and content of medical seclusion reviews, with compliance previously audited within Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Following the initial findings however, change was not implemented. A new audit has therefore been commenced to reassess baseline practice and identify areas requiring improvement.
Methods. The MHA CoP audit tool outlines the following timeframes for assessment: initial medical review within 1 hour, 4-hourly medical reviews until first internal multidisciplinary review, twice daily medical seclusion reviews with at least 1 by the Responsible Clinician. Documentation should evaluate: physical and mental health, medication adverse effects, observation level, prescribed medication, risk to others and self, need for ongoing seclusion. Data were collected retrospectively for all episodes of seclusion occurring in a CWP Psychiatric Intensive Care Unit during August 2022.
Results. 5 seclusion episodes related to 4 patients, ranging from 1 night to 15 days in duration. Regarding medical review frequency, 20% were seen face-to-face within 1 hour of seclusion commencing and 75% were seen 4-hourly until their internal multidisciplinary review. Mental health was more consistently commented on than physical health (97% vs 61% respectively), whilst medication was reviewed in 69% of assessments. Rationale for continuing seclusion was provided in 72%, referring to risk to others in 54%. Adverse medication effects and observation level were the least documented parameters (2%), followed by risk to self (7%).
Conclusion. Assessment time was often not explicitly stated and was substituted with time of documentation, meaning reviews may have occurred earlier than accounted for. The on-call doctor does cover multiple sites overnight, potentially contributing to delays in attending unforeseen time-sensitive tasks. Trust policy dictates constant visual observation must be maintained throughout seclusion and this is therefore not routinely subject to review or adjustment. Overall interpretation of the qualitative information was fairly subjective in a low number of seclusion episodes, however there was a notable lack of recording adverse medication effects and risk to self. Findings will be presented at junior doctor induction whilst a quick reference sheet is designed prior to reaudit. CWP's seclusion policy specifies medical review frequency, but does not outline expected content of documentation. There is scope to extend local policy and align with the MHA CoP.

Secondary Service Communications to GPs-a Regional Audit

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Aims. The purpose of the audit was to assess the standard of communication to GPs from secondary mental health services and to ascertain whether the information included in letters to GPs was in accordance with the recommendations of RCPsych and PRSB. The audit cycle was completed by re auditing to identify how the recommendations from the first audit has improved the quality of communication to GPs.
Methods. The audit was conducted on three psychiatric units, in three sites across Betsi Cadwaladr University Health Board and clinic letters were studied to identify whether the information was as per recommendations from: RCPsych and PRSB.

The first audit used 121 letters in total from 3 sites, with the data being collected using audit proforma over a 2 week period from 04/04/22.

The re audit looked at 69 letters with data collection using audit proforma over one week period from 19/12/22.
Results. Majority of letters sent to GP were lacking key information like details of Care coordinators ,medical comorbidities ,non psychiatric diagnosis, and actions for GP with this data missing in 91.7%, 61.22 %,79.59% and 71.43% respectively. Fill rates for other information like patients' details was 100% , psychiatric diagnosis was 83.47%, psychiatric medications , follow-up plan were 80.17%.

The results of the re-audit most letters contained Psychiatric Diagnosis (97.1%, previous 83.5%), Psychiatric Medication (91.4%)previous 80.17%), and Follow Up Plan(98.6%, previous 80.2%). Many letters did not include information regarding Medical Comorbidity (28.6% vs 31.4%), Non-Psychiatric Medication (65.7% vs 34.7%), Details of Care Co-ordinator (54.3% vs 8.3%) and Action for GP (27.1%, vs 44.6%).
Conclusion. The recommendations from first audit were to create local guidelines and templates with recommended headings for clinical letters, provide formal teaching for junior doctors and to re audit to see if the implemented changes has led to an improvement.

The re-audit showed improvement since the introduction of the template in majority of headings in GP letters with decline in fill rate for 2 headings and these changes varied among three sites.

Barriers identified affecting the overall outcome of the re audit were :template not being used, lack of training to juniors, and psychiatrist workload.

In conclusion , we aim to re-distribute the template and increase awareness with informal teaching sessions, provide

information on template during induction for doctors and organize training sessions on three sites.

Increased Violent Incidents During COVID-19 on Male Acute Psychiatric Ward

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Aims. This is an audit evaluating the impact of inpatient COVID-19 restrictions on the frequency of recorded violent incidents on a male acute general psychiatric ward. The aim of this study is to compare the frequency of violent and disruptive behaviours between pre-COVID-19, COVID-19 and post-COVID-19 periods on the ward.

Methods. Inpatient adverse incidents on the ward are logged into an electronic system as 'IR1' (Incident Reporting) through Ulysses by healthcare professionals. Data on logged incidents between April 2019 and March 2022 were obtained by contacting the Ulysses technical team. The reported incidents were classed into 'disruptive behaviour', 'violence to patient' and 'violence to staff'.

We chose to focus on the IR1s submitted between three twelve monthly time periods: Pre-COVID-19 (April 2019–March 2020), COVID-19 (April 2020–March 2021) and Post-COVID-19 (April 2021–March 2022). We opted for these cut off periods to be in line with the local trust guidelines with respect to COVID-19 restrictions.

Results. Out of 155 incidents which occurred during pre-COVID-19 period, 38 incidents were disruptive behaviours, 24 were violence to patients and 93 were violence to staff. Of the 249 incidents during COVID-19 period, 66 incidents were disruptive behaviours, 46 were violence to patients and 137 were violence to staff. Of the 216 incidents during post COVID-19 period, 67 cases were disruptive behaviours, 53 were violence to patients and 96 were violence to staff.

There was 74% increase in disruptive behaviour between pre-COVID-19 and COVID-19 phase but no increase between COVID-19 and post-COVID-19 phase.

There was a 92% increase in violence to patients between pre-COVID-19 and COVID-19 phase and a 15% increase between COVID-19 and post-COVID-19 phase.

There was a 47% increase in violence to staff between pre-COVID-19 and COVID-19 phase, but a 30% reduction between COVID-19 and post COVID-19 phase.

Violence to staff makes up the highest proportion of violent incidents recorded, followed by disruptive behaviours and violence to patients. This trend was seen in all three time periods.

Conclusion. Our study showed that violent incidents in a male acute psychiatric ward increased during COVID-19 period when compared to pre-COVID-19 period. This could be explained by increased ward restrictions and difficulties in communication related to PPE use. Further studies would need to be conducted looking at trend in other services within the Trust. Our findings will be of importance in monitoring risks in similar circumstances in the future.

An Audit Exploring Ethnic Inequalities in Accessing Perinatal Mental Health Services in Southwark

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Aims. Women from Black and minority ethnic backgrounds have been shown to experience an increased burden of common postnatal mental health conditions and higher rates of involuntary admissions. However, evidence demonstrates disparities in these women accessing perinatal mental health support. Reasons behind barriers to access must be defined and addressed. Our aim was to explore ethnic inequalities in accessing Perinatal Mental Health Services in Southwark (SWK PMHS). We hypothesised that SWK PMHS would meet Royal college of Psychiatrists (RCPsych) gold standards in providing equitable access to care.

Methods. The Trust's local clinical database was used to extract our cohort of women aged 15–44 years with a birth episode in contact with SWK PMHS between September and December 2021. Individual data were collected via local clinical notes system to establish basic measures (demographics and ethnicity) and detailed information (referral outcome, interventions, safeguarding etc). Ethnicity data were compared to King's College Hospital birth records for 2021 and local census data via Office of National Statistics.

Results. 105 patients were analysed in total. Overall, there was poor recording of ethnicity and 6.6% of referrals had no ethnicity documented at all. At the point of referral, there was no clear inequity based on ethnicity, with data appearing reflective of local census and maternity records. However, there were concerning inequities in treatment received by women in minority ethnic groups. Out of four hospital admissions in total, three (75%) of the women were from a Black ethnic group and all were detained. There were fewer referrals for psychology intervention for women in minority ethnic groups compared to women in the White ethnic group, with particularly low numbers of referrals for women in Asian and Mixed ethnic groups (2/35 women). 83% of all antipsychotics prescribed (5 out of 6) were to women from the Black ethnic group with the remainder being women in the White ethnic group. There were 31 safeguarding alerts, with almost half (48%) from women in the Black ethnic group.

Conclusion. There were concerning variations in interventions and type of care received by women from minority ethnic groups. Women from Black and minority ethnic groups were underrepresented in accessing psychology intervention though conversely overrepresented for antipsychotic treatment, safeguarding alerts and involuntary admissions.

This suggests that contrary to our hypothesis, SWK PMHS is not meeting RCPsych Gold Standards. Our audit findings reflect literature that there are apparent barriers to women from ethnic minority groups accessing certain specialist mental health services.