The legislation recommends that prior to making a decision to detain on Section 136, the constable must, if practicable, consult mental health services for information to guide decision making.

The 136 suite is the preferred POS except for patients requiring urgent medical treatment in which case the Emergency Department (ED) is preferred. If the 136 suite is unavailable, then alternatives like the ED may be used.

This audit examines the use of the Birmingham City Hospital Emergency Department as a POS following Section 136 detention, the adherence to the aforementioned legislation and the outcomes of the assessments.

Methods. The audit was approved by the clinical governance team and a list of all Birmingham City Hospital patients detained under Section 136 for a three-month period (January–March 2022) was retrospectively obtained. Clinical records were examined, and the relevant data was extracted from the clinical notes.

Information including the reason for use of the ED as a POS, police contact with mental health services prior to detaining, time taken prior to assessment, reasons for mental health act assessment (MHAA) delays, and outcomes were collected and collated using Microsoft Excel.

Results. The ED at City Hospital was used a place of safety for 80 patients in this period. In 52.5% of cases the ED was used as a place of safety due to lack of space at the POS. Contact with mental health services prior to detention was documented in only 29% of cases. The average time for a MHAA to take place in the period under review was 11.5 hours. Only 20% of these cases ended up detained under the mental health act.

Conclusion. The results show poor adherence in the use of Section 136 to the recommendations of the legislation. Improvements are needed on time taken for assessments and use of ED as a place of safety due to unavailability of beds at the s136 suite. The police should be re-educated on the importance of contacting mental health services prior to detaining patients on Section 136. The audit result was presented at a clinical governance meeting and repeat audits are planned across all the emergency departments in Birmingham.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Clinical Audit of Standard for Electronic Recording of Dementia Diagnostic Assessments in Stockton Mental Health Services for Older People

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Aims. This clinical audit aimed to assess if the recording of patients seen for their diagnostic appointments in memory clinic measures up to the minimum standards required in the delivery of dementia services. This standard mandated primarily that a minimum body of key information must be promptly recorded by clinicians, in patient electronic records within 24 hours, as stipulated by Trust and NICE guidelines.

Methods. The first cycle was conducted from 16 October 2022 to 10 February 2023. In this cycle random sampling was used to select 25 patients on the caseloads of the mental health services for older people. Before the start of the second phase all diagnosing clinicians within the team were informed about the project and the expected improvements against which compliance would be audited. The second phase was conducted between 10 February 2023 to 31 March 2023 and another 25 patients on the caseloads were obtained via random sampling for the second cycle. Inclusion criteria for both phases were patients who had received a diagnostic assessment in these periods.

Results. In the first set of records, the minimum body of information was recorded in 90–100% of cases according to the team's recommended standards namely diagnostic information, prognostic information, treatment plans, post-diagnostic contact plans and documentations being made within 24hrs of consultation. In the Set 2 the minimum body of information was recorded in 95–100% records studied. That is, diagnosis, treatment, medication treatment plans (prescription plans), and post-diagnostic contact plans were covered in the diagnostic sessions. In particular, case note documentations were made within 24 hours in all but one of the records applicable.

Conclusion. Given that a diagnosis of dementia can be life-changing, not discussing prognostic information would not prepare patients and carers adequately with information on how to live well with dementia following their diagnosis. This could potentially lead to poor adjustment to the condition and anxiety for some. At a trust-wide level, this means there is still room for improvement for the trust as regards dementia care ideals recommended by NICE.

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Clinical Audit of Psychiatrist Reviews of Patients on Depot Antipsychotic Medication Under a General Adult Community Mental Health Service in North Norfolk

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Aims. In outpatient settings, depot administrations are done to a large extent by Community mental health nurses and other trained clinical personnel who are not psychiatrists. As a result of this, there is a possibility that patients who are having depot medications are not reviewed by a psychiatrist for a long duration of time which can be more than a year. The aim of this audit is to find out if patients currently taking depot medication under a General Adult Community Mental Health Service in North Norfolk are being reviewed by a psychiatrist according to the standard guidelines. The Maudsley prescribing guidelines states that all patients receiving long-term treatment with antipsychotics medication should be seen by their responsible psychiatrist at least once a year (ideally more frequently) to review their treatment and progress.

Methods. List of patients currently on depot medication were taken from the spreadsheet on the Unit's Shared drive. All 47 patients currently receiving depot medication on this list were reviewed. The review period was from Ist January 2023 to

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31st December 2023. Psychiatrist Review included Reviews/ Appointments by Consultant Psychiatrists, Specialty registrars, Trainee doctors and GPST doctors in psychiatry posting.

Results. It was recorded that 28 patients on depot medication have been reviewed within the last one year which is approximately 60% of the patients currently on depot medication. 19 patients who are currently on depot medication have not been reviewed by a psychiatrist in the last one year, which is approximately 40% of the patients on depot medication. Out of the 19 patients who have not been reviewed in the last one year by a psychiatrist, only 8 of them were offered an appointment.

Conclusion. We can conclude only 60% of patients currently on depot medication were seen by a psychiatrist for a medication review in the last one year. This fell below the expected target of having 100% of these patients meeting with the standard that states all patients receiving long-term treatment with antipsychotic medication should be seen by their responsible psychiatrist at least once a year. A significant proportion of patients might have been deprived of an adequate assessment of their progress and response to treatment and the review of the side effects of these depot medications. These findings have been discussed with the Community Team Manager who has agreed to facilitate that these patients are reviewed promptly.

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Child and Adolescent Mental Health Service (CAMHS) Black Country Healthcare Foundation Trust (BCHFT) Trust-Wide Audit on Adherence to NICE Guidelines in Prescribing Medications for Children With Autism Spectrum Disorder (ASD)

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Aims. This comprehensive study seeks to evaluate the adherence of (CAMHS) service, Black Country Healthcare National Health Service (NHS) Foundation Trust to National Institute for Health and Care Excellence (NICE) guidelines in prescribing medications for children diagnosed with Autism Spectrum Disorder (ASD). Our primary objectives include identifying variations in prescribing practices across different localities within the trust and identifying specific areas that may benefit from improvement.

Methods. A meticulous retrospective analysis was conducted on 142 randomly selected cases involving children diagnosed with ASD and prescribed psychotropic or sleep medications. A comprehensive analysis of patient records, encompassing progress notes and clinic letters, facilitated the gathering of extensive data. The evaluation centred around benchmarking adherence to NICE guidelines. Throughout the process, strict adherence to ethical standards was maintained.

Results. Within the cohort of 142 children diagnosed with ASD, 44% underwent alternative interventions before medication initiation. Notable variations were observed across localities, with 87% receiving psychological therapy as an alternative intervention. Documentation of consent for commencing medication was present in 62% of cases. Specialists consistently initiated psychotropic medications at the minimum effective dose, and 70% of cases had a follow-up within 3–4 weeks. Sleep medications were prescribed to 77% of the cohort, with 55.5% of those undergoing alternative interventions before prescription.

Conclusion. The study's findings underscore significant variations in adherence to NICE guidelines, emphasizing the critical importance of exploring alternative treatment modalities before resorting to medication. Furthermore, collaboration with supporting agencies is highlighted as a crucial aspect of comprehensive care. The documentation of consent forms for all patients is deemed imperative, and adherence to specified intervals for reviewing medication side effects, as outlined in the guidelines, is considered crucial for optimal and safe patient care.

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Lithium Prescribing on an Older Adult Inpatient Ward and Trialling Improvements to Communication on Discharge

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Aims. Lithium is the recommended first-line pharmacological treatment for bipolar disorder and as an augmentation of the treatment for depression. Both NICE and local guidelines stipulate the need for patient counselling regarding side effects, interactions and toxicity, alongside strict monitoring requirements for initiation and maintenance.

We aimed to assess compliance with these guidelines for patients prescribed lithium on a functional older adult inpatient ward in Hertfordshire Partnership NHS Foundation Trust (HPFT). Additionally, following feedback from the local crisis and community colleagues, concerns were emphasised around inconsistent communication on discharge. We therefore also aimed to evaluate the introduction of a small-scale intervention to the method of discharge communication.

Methods. A retrospective analysis of electronic patient records was undertaken for the 43 patients within HPFT prescribed lithium during their inpatient stay on a functional older adult ward over a five-year period (2019–2023).

Lithium monitoring on drug initiation was assessed for compliance with the standards set by NICE guidelines for the management of bipolar disorder. For all patients prescribed lithium, we also noted demographics, diagnosis, rate of side effects and toxicity, discontinuation, and documentation of discharge communication to the community. A standardised template for communication with community and crisis colleagues was introduced, and its impact was assessed.

Results. 58% (n = 25) of patients were initiated on lithium, with 80% (n = 20) of them having documentation of counselling. Baseline blood tests were consistently recorded for all newly prescribed lithium patients (n = 25), and regular serum monitoring was present in all patients. Common side effects included tremors (26%; n = 11) and polyuria (7%; n = 3), while in 63% of patients (n = 27), no side effects were noted. Toxicity occurred in four cases, leading to discontinuation in 50% of them.

Prior to concerns being highlighted around handovers to community colleagues, there was specific documentation of a

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