We collected the data by contacting the residential homes, carers, Collecting details from case notes, from the Staff nurse who made the protocol for their patients

A questionnaire based on the standards mentioned above was developed and files and prn protocols were marked against these standards.

Result. The standards from the medical file were 100 % achieved. Thus indicating the importance of the psychotropic prn medication and documentation of the same.

However, the protocol that needs to be with the patient/carers had some lacuna/deficits. Overall only in 53% of the case, standards were achieved. This needs to be highlighted to the team.

The Audit gave an insight into what needs to be improved.

THE FOLLOWING AREAS NEEDED IMPROVEMENT

1. There should be a prn protocol/ similar instruction to the staff about the use of prn medication(written by appropriately trained professional)
2. Prn protocol should be accessible to direct care staff
3. There should be a description of when to use the prn medication
4. There should be a description of what non-pharmacological de-escalation methods ought to be tried before using prn/ is there a detailed behaviour support plan available
5. Protocol should describe what the medication is expected to do
6. Protocol should describe the minimum time between doses if the first dose has not worked
7. Protocol should state the maximum dose in 24 hour period
8. Use of prn should be recorded

Conclusion. I hope this audit will help in improving the patient care with the right psychotropic prn medication, with correct doses and further details as mentioned in the standards of the protocol.

We also hope to ensure that in our area, prn psychotropic medication used for agitation and behavioural disturbance is used safely, appropriately and consistently by staff teams. This would be in accordance with the guidelines.

Audit of the quality and content of discharge summaries from mental health inpatient units across Betsi Cadwaladr University Health Board

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Aims. Our aim was to carry out an audit of summaries sent from inpatient psychiatric units across North Wales (namely Heddfan in Wrexham, Ablett in Rhyl, and Hergest in Bangor), against recommendations from 'Standards for Inpatient Mental Health Services' (RCPsych 2014) and PRSB Mental Health Discharge guidelines (2018).

Method. Ablett summaries are typed onto and electronically sent through the Welsh Clinical Portal (WCP) directly to the GP. Hergest and Heddfan both have their own templates which are then sent to the GP and filed in the case notes. Data were collected from both sources. The first audit cycle used 25 discharges selected at random from the male and female open wards in each site (n = 75 summaries). Data were collected over 3 months time using the audit proforma.

Result. All mandatory headings are automatically inputted into the WCP summary used in Ablett therefore documentation was 100% for information such as patient name, DOB, and GP Details. Documentation of allergies was poor across 3 sites, particularly in Hergest, in which there was no mention of allergy status in 96% of summaries. Only 13% of Ablett summaries and 0% of Hergest summaries reach the GP on the day of discharge, however, 100% of summaries from Heddfan do, possibly due to their method of 'discharge notification'. The date and location of discharge were documented in 84% of Heddfan summaries, 100% of Hergest summaries, and 100% of Ablett summaries. This implies that this heading is already incorporated into the templates for the 2 sites which scored 100%. In the Ablett, medication was documented in 88%, but we found that in 49% of discharge summaries, the medication was the only field filled in! In these cases, the GP may not even know why the patient had been admitted. This is clearly unacceptable. Risk history is poorly documented across the sites, with 0% in Hergest and Heddfan, and 12% in Ablett. 0% of summaries across the Health Board mentioned crisis contacts. 0% of summaries in Heddfan and Ablett contained details of the patient's care coordinator.

Conclusion. Our audit has identified a lack of psychiatry-relevant headings in the discharge summaries, particularly for those working in Ablett.

Psychotropic prescribing practices in adults with intellectual disability and autism spectrum disorder in Richmond Neurodevelpmental Services

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Aims. Our aim was to evaluate psychotropic prescribing practices in adults with intellectual disability (ID) and autism spectrum disorder (ASD) across the Richmond Neurodevelopmental Service (NDS).

Stopping over-medication of people with a learning disability, autism or both with psychotropics (STOMP) aims to reduce the potential harm of inappropriate use of psychotropic medications. We aimed to evaluate our prescribing practices in keeping with STOMP and the NICE guidelines.

Method. We collected information from our clinical records on patients that met the inclusion criteria (≥18 years + diagnosis of ID and autism) from October-November 2019. We gathered the following: age, sex, severity of ID, psychiatric diagnoses, psychotropic medication, presence of challenging behaviours, involvement of positive behaviour support (PBS) and documentation of a PBS plan.

Result. 32 patients met our criteria (3:1 Male-Female ratio with an age range of 20-74 (Median 33 years old)). All 32 patients showed evidence of challenging behaviours. In the cohort, mild ID represented 18.8% (n = 6), moderate ID 40.6% (n = 13) and severe ID 40.6% (n = 13).

17 patients (53%) had a PBS plan in place. For those without a PBS plan (47%, n = 15), a referral to behavioural analysis had been considered/requested in 67% (n = 10).

31 patients were on psychotropic medication and 84% (n = 26) had an indication documented in the notes although every patient had had a medication review in the last 6 months. 67.7% (n = 21) of the prescriptions were for challenging behaviours.

The average number of medications prescribed was 2 (median 2, mean 2.41) but this was reduced to 1 (median 1, mean 1.76) when additional psychiatric diagnoses and epilepsy were excluded.

Conclusion. Prescriptions are regularly reviewed in keeping with STOMP guidance but there is more scope for utilising behaviour analysis input as well as the need to improve documentation of the rationale for psychotropic medications.

Sodium valproate prescribing safety in women of childbearing potential

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Aims. The purpose of this audit was to identify all women being prescribed Sodium Valproate under the Bassetlaw Local Mental Health Team (LMHT) caseload to see how well latest prescribing guidelines are being met, and help set up a system allowing efficient monitoring of Sodium Valproate prescribing in the future.
Background. Despite early concerns regarding potential teratogenicity, Sodium Valproate became a widely used anticonvulsant and mood stabiliser and is licensed for use in Epilepsy, Migraine prophylaxis and Bipolar affective disorder. Research evidence now shows its use in pregnancy increases risk of neurodevelopmental disorders to 40%, and serious birth defects to 10%. Despite research finding these risks prescribing practice did not significantly change. To better reflect these findings in clinical practice in 2018 the Pharmacovigilance Risk Assessment Committee recommended Sodium Valproate should not be used in pregnancy unless they have a form of epilepsy unresponsive to other anti-epileptic drugs, and all with childbearing potential should be enrolled in a pregnancy prevention programme (PPP). This was endorsed by UK Medicines and Healthcare Devices Regulatory Agency in April 2018 with launch of the PPP.

Standards:

Must be offered counselling about risks of valproate to unborn child and importance of effective contraception.

Annual specialist Review by a specialist now mandatory

Risk acknowledgement form must be updated at least annually.
Method. The electronic RiO records for all female patients on the Bassetlaw LMHT caseload in the year 2019 were checked to identify those prescribed Valproate. For those prescribed Valproate, evidence of annual risk acknowledgement form, date of last appointment, underlying diagnosis and contraceptive method was checked. This data was stored together on an excel file and used to create a patient list to help allow future monitoring.
Result. From 594 female patients identified, 27 (4.5%) were prescribed Sodium Valproate. Of these, 14 (52%) had PPP documentation uploaded, 24 (89%) had been reviewed within the last 12 months, and 13 (48%) had no documentation of contraceptive method.
Conclusion. This audit helped highlight there is likely a large population of patients not yet on the Pregnancy Prevention Programme. Creating a monitoring system in excel for female patients being prescribed Valproate can help improve adherence to latest guidelines, with a colour coding system to highlight those needing risk acknowledgement forms/appointments within the next three or six months. Educating patients and other healthcare professionals about risks will also help improve prescribing practice and avoid use in pregnancy.

VTE prophylaxis admission assessment full cycle audit and QI project

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Aims. The aim of the project was to assess completion rates for the VTE prophylaxis assessment for patients admitted to Dova Unit, Dane Garth. Another aim of the project was to identify areas for improvement and changes which could increase compliance rates.
Method. In the first cycle of the audit 20 randomly selected patients admitted to Dova Unit, Dane Garth between June and December 2020 were identified and included in the project. Data were then collected from the online patient record system Rio and analysed using an excel spreadsheet.

In the second cycle of the audit 10 randomly selected patients admitted to Dova Unit, Dane Garth between January and February 2021 were identified and included in the project. Data were then collected from the online patient record system Rio, analysed using an excel spreadsheet and compared with the results obtained in the first cycle of the project.
Result. In the first cycle of the audit the overall compliance was found to be 35%. VTE Risk assessment was completed for 50% of patients included in the study. 'Active VTE on admission' section of the VTE prophylaxis admission assessment was completed for 30% of patients included in the study. 'Active VTE at 72 hours' section was completed for 20% of the patients in the study and the 'risk assessment for VTE' form was completed for 40% of patients included in the study.

In the second cycle of the audit the overall compliance was found to be 50%. VTE Risk assessment was completed for 60% of patients included in the study. 'Active VTE on admission' section of the VTE prophylaxis admission assessment was completed for 40% of patients included in the study. 'Active VTE at 72 hours' was completed for 40% of the patients included in the study and 'risk assessment for VTE' form was completed for 60% of patients included in the study.
Conclusion. There was an overall improvement in the completion rates for the VTE prophylaxis admission assessment as a result of conducting the project. Working with the junior doctors and other healthcare professionals responsible for completing the VTE prophylaxis admission assessment, we aim to improve our completion rates of vital information even further.

An audit of Individual Care Plan (ICP) in Dublin North City and County (DNCC) child and adolescent mental health service (CAMHS)

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Aims. The objectives/aims of the Audit include:

1. To standardize and implement ICP for service users attending DNCC CAMHS team in accordance with the established policy.
2. To achieve greater involvement of service users/parents in ICP.
3. To standardize and improve treatment of care involving all members of one team.

Background. Every patient should have a care plan. Each care plan has a set of needs and goals. These are agreed between the service user and key worker and are assessed and measured frequently. Consultation with each service user/parents, as far as practicable is important. Specification of treatment and care required in accordance with best practice should be recorded. Identification of the necessary resources should be recorded and discussed with service user and key worker. Records kept in one