Review of Activity Within Unscheduled Care at Royal Cornhill Post-Pandemic

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Aims. We sought to review the changes in assessments within the Unscheduled Care Team (UCT) at Royal Cornhill in Aberdeen since the pandemic. Previous UCT data highlighted an increase in monthly assessments from October 2018 to October 2020 by 18% 240(204). We hoped to identify areas for intervention and reform within the UCT and the wider service.
Methods. An excel spreadsheet was distributed to clinicians on-call from 1st–31st October 2021 and 1st-31st October 2022. Data analysed included time of referral, the role of the clinician, source of referral (Enhanced Access, Acute medical admissions/A&E, Other Hospital Wards, Community Mental Health Teams (CMHT), Police, GP, GMEDS (out-of-hours GPs), and Other Sources), method of assessment, time taken to complete assessments, time taken to discuss assessments and assessment outcomes. The spreadsheet also had space for clinicians to provide additional qualitative data. Following the 2021 data collection, a PowerPoint presentation was given to members of staff with the initial findings from 2021. The UCT added additional practitioners to the twilight period 1700-2100 due to the noted increased demand during this period. They also spoke to CMHTs about Enhanced Access and to the Police directly, as they were the two most frequent referrers. Following the 2022 data collection, the 2021 and 2022 datasets were compared.
Results. The overall number of assessments increased by 10% from 2021 to 2022 - 405(367). Additionally, total assessment time increased by 15% - 299(261) hours. In terms of assessment outcomes, the largest changes were seen in outpatient follow-up with CMHTs, with a 65% increase 238(144); UCT discharge, with a 43% decrease 64(112) and non-specified outcomes, with a 52% decrease 14(24). The largest changes in referral rates were from GMEDs 48(30) 60% increase, CMHTs 4(16) 75% decrease, GP 50(34) 47% increase. Enhanced access 96(95) and police referrals 78(77) remained the most stable, increasing by 1%.
Conclusion. There has been an evident increase in workload for the UCT since the pandemic, which could be managed with additional staffing for the team. The targeted interventions, both for Enhanced access and Police, have limited the increase of their referral rate. Similar targeted interventions and review of referral criteria may mitigate increased demand from other sources. Increasing outpatient CMHT follow-up after assessment may suggest that routine outpatient work may not be back to pre-pandemic levels; further study would be required to confirm this.

Documentation of Capacity Assessments for Psychiatric Inpatients

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Aims. How frequently and to what quality are mental capacity assessments being recorded on inpatient acute ward? Capacity is the ability to consent to a particular decision and is defined in law by the Mental Capacity Act (MCA). Capacity to make decisions is an area of particular importance in mental health care, as many mental illnesses can lead to people losing the capacity to make some decisions. Capacity assessment is a two-stage process. If a patient passes Stage 1, then they have capacity. If they fail Stage 1 then the assessment progresses to Stage 2. The person being assessed must then be competent at every step of Stage 2 to then be deemed to have capacity. Documentation of capacity assessments should demonstrate this two-stage assessment.
Methods. The sample included all people who were inpatients during the data collection window of 05 to 09 Sep 2022.

For each person, their MHA status was recorded as this determined whether capacity to consent to admission was relevant. For each patient, their EPR was checked for any Mental Capacity Assessment proformas which were examined and recorded as being for admission, treatment, or something else. The cumulative case notes were then searched for any mention of 'capacity' and any additional capacity assessments were examined and added to the tool. All capacity assessments were reviewed against the defined standards.
Results. Sample and demographics - 22 male inpatients. 21 patients subject to the MHA and 1 was an informal patient. The CTT rule applied to 7 patients.
Treatment - 17 of 22 had capacity assessment for treatment at admission. All of these were recorded using the proforma and all were in line with best practice guidance. 7 had the CTT rule applied to at the time of the audit. None of the records for these people included documentation of a repeated mental capacity assessment.
Something Else - 9 capacity assessments recorded for 'something else'. Five were recorded on proforma and in line with best practice guidance. 4 capacity assessments were as case notes and didn't meet best practice criteria.
Conclusion. Capacity assessment for treatment is being conducted and recorded well at the time of admission, but not at the point that CTT rules apply from.

Most capacity assessments were recorded on the EPR proforma and all of these met best practice guidance. 4 capacity assessments were recorded in case notes and none of these met best practice guidance.

Inpatient Ward Review Documentation Audit

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Aims. Good medical records are essential to the continuity of patient care. The aims of this audit were to evaluate the quality of ward review documentation in 7 Psychiatry wards in Essex Partnership University NHS Foundation Trust, to identify areas of improvement, to recommend strategies to improve record keeping, and to measure their effectiveness by comparing records in the 1st and 2nd cycles of audit.
Methods. A sample of 10 patients from each of the 7 wards was selected, for a total of 70 patients, in each of the 1st and 2nd

cycles of the audit (Data were collected in the 1st cycle between 06-07-2021 and 22-07-2021, and 2nd cycle between 16-10-2022 and 07-11-2022). Samples were selected randomly among patients who were inpatient or discharged recently. The data were collected from the first, middle, and last ward reviews. If the patient was inpatient at the time of the data collection, data were collected from their first review, the last/most recent ward review, and one of the reviews in between. Patients who did not meet this criterion were excluded. Based on 1st cycle results, strategies were recommended to improve record keeping. After 15 months, 2nd cycle results were used to evaluate their effectiveness.

Results. The results demonstrate significant areas of improvements in record keeping: a majority of questions did not meet the standard of 80% completion considered "satisfactory" in previous audits. In the 2nd cycle, 9 questions had a "satisfactory" completion rates. These were mandatory or automated questions and ones essential to immediate patient care. 7 questions had "average" completion rates above 45%. All (17) other questions and subquestions had "low" completion rates. Analysis of variations between cycles shows that question on "Responsible clinician" increased from 23.3% to 99.5% because it was automated. 4 other questions or sub-questions have seen a substantial increase in completion rate between the 1st and 2nd cycle. But our strategies' effectiveness during the period of the audit has proven limited and difficult to trace.

Conclusion. It can be concluded that more efforts should be dedicated to improving medical record in the psychiatry wards of Essex Partnership University NHS Foundation Trust. The most effective strategy to secure high ward review documentation rates remains to make questions mandatory or auto-complete when possible. More research is necessary to demonstrate the effectiveness of other strategies such as the education of junior doctors in induction and awareness posters in wards.

Physical Health Monitoring in Patients on Antipsychotics: A Clinical Audit

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Aims. Patients with serious mental illness are more likely to suffer from serious physical health conditions, including: obesity, diabetes, heart failure and stroke. This, combined with the side effects of antipsychotic medication including weight gain and cardiac changes, means that patients with psychosis under the Early Intervention Services (EIS) taking antipsychotics require regular physical health monitoring, as per NICE guidelines. This includes: yearly BMI, blood pressure, ECG, blood tests (FBC, U+E, lipids, HbA1c, prolactin, LFT), alcohol status and smoking status. Our audit aims to assess the compliance of physical health checks for patients on antipsychotic medication under the EIS first episode psychosis team.

Methods. Patients on our caseload (for >6 months) between 01/2022 and 01/2023 (n=36) were included in this audit, and relevant data were collected using electronic records (i.e. carenotes and affinity). Data were recorded and stored electronically, and analysed using Excel and GraphPad. Patient information was discussed with their lead practitioner to ensure data collected was accurate. Our audit standard was set at 100%.

Results. In terms of BMI, 91.67% (n=33) of patients had a recorded BMI, with 19.44% (n=7) of our patients being overweight and 19.44% (n=7) being classified as obese. Of the patients classified as overweight or obese (n=14), 85.71% (n=12) had received advice about their diet or exercise. Blood pressure measurements were available for 86.11% (n=31), and 13.89% (n=5) of these patients were found to have hypertension. Information relating to patients' alcohol, smoking and recreational drug use was recorded in 97.22% (n=35) of our patients.

Qrisk data were not collected in 22.73% (n=5) of patients who were eligible for measurement (n=22). Furthermore, ECG tests were not recorded in 72.22% of patients (n=26). Compliance with blood tests was less than the desired standard, with 75% (n=27) of patients having an up to date FBC, U+E, lipids and HbA1c measurement.

Conclusion. Specific areas of physical health monitoring are carried out to a high standard in the EIS service, but there are areas which warrant improvement, particularly Qrisk and ECG monitoring. The EIS team is to re-audit these outcomes in 3 months' time, after presentation of results to the team and physical health check clinics are employed.

Clinical Audit of the Quality of Care Delivered by Community Mental Health Services for Older People to People Living With Dementia and Their Carers

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Aims. This clinical audit aimed to assess how well the local Community Mental health services for Older people (MHSOP) was implementing the latest NICE and Tees, Esk and Wear Valleys (TEWV) guidelines in dementia service delivery, and to identify what impact (if any), the COVID-19 pandemic lockdown had on their service delivery. In the UK, there are over 800,000 people living with Dementia; providing sustainable individualised care for them has significant cost implications for health and social care services. In 2018, NICE published evidence-based guidelines on delivery of dementia care by professional services within a person-centred and supportive framework. These guidelines together with the TEWV guidelines on Person-centred Dementia care pathway published in 2019, set the standards for this audit.

Methods. The first cycle was performed between 7th Nov 2020 and 15th Jan 2021; we included patients who had received an initial and diagnostic assessment from the team by 12/2020.

Second cycle was done from 7th Nov 2021 and 31st March 2022; inclusion criteria were patients who had initial and diagnostic assessments by Jan 2022.

In each cycle, data from 20 patient records were collected using a tool designed from NICE guidelines and Trust policy on Dementia care standards.

Results. In the first audit patients' consents for assessment and information sharing purposes was recorded in 80% of cases; this fell to 65% in the re-audit.

In the first audit at diagnostic assessments, 47% of patients were given relevant information regarding their prognosis and

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