Methods. It was recorded for each patient whether they had an antidepressant prescribed, which medication, the documented indication, and their most recent medical review. Data was collected in a 'snapshot' cross section of all 89 patients on the caseload in December 2023.

Data was obtained from carenotes by reviewing clinic letters and clinical notes; and cross-referencing with GP records.

Results. 33 patients (37%) were prescribed an antidepressant. Of these, 25 (76%) had a recorded indication. The commonest indication was mixed anxiety and depression followed by depression. Sertraline was by far the commonest prescribed antidepressant (52%) followed by mirtazapine. 3 patients were prescribed combination antidepressants. 67 patients (84%) had had a medical review within 6 months.

Conclusion. Among patients with a first episode of psychosis, there is a significant comorbidity of depression and anxiety spectrum disorders.

Our standard was met for most patients but there were several exceptions, and we considered why 8 patients did not have a listed diagnosis. There can be a degree of diagnostic uncertainty in distinguishing anxiety and depressive disorders from negative symptoms, and the affective changes that are an established part of recovery from an acute psychotic episode. In these circumstances it may be appropriate to consider a trial of antidepressants in consultation with the patient. Some of these patients also have been on long-term therapy which preceded their referral to EIPS, leading to uncertainty of the indication and pre-morbid status.

We conclude the following recommendations:

1. Prompt a review of antidepressant use in those identified without a clear indication, discussing risks and benefits with the patient at next review.
2. Arrange medical reviews for those exceeding the 6-monthly window.
3. Record last review for patients under shared care.
4. Re-audit in 6 months to monitor improvement.

Keeping Up Standards: An Audit of Adherence to Admission Standards on Acute Mental Health Wards in NHS Lanarkshire

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Aims. We audited the adherence to part of the minimum admission standards for Mental Health, Learning Disabilities and Addictions Services (MHLDA) for 6 acute wards, across two sites (UHH and UHW) in NHS Lanarkshire. We focussed on the section of the standards that the admitting junior doctor/ANP is responsible for. This comprised:

- An admission assessment (including presenting complaint, history of current episode of illness, medication, mental state examination and risk assessment).
- Physical health assessment (examination, bloods, ECG, VTE assessment), medicine reconciliation and prescribing on HEPMA - within 12 hours.

Methods. Five individuals collected data across both sites and both cycles. For our first cycle, all admissions in March 2023 were retrospectively reviewed, a total of 94 admissions (UHH 47, UHW 47). Electronic notes/systems were reviewed (Morse, Clinical Portal, Hepma, Trakcare).

This first cycle demonstrated poor adherence to the minimum admissions standards. A proforma for admission statement was created, including prompts for the admission assessment and for the components of the physical health assessment, medicines reconciliation and prescribing. Presentations were made at postgraduate teaching and at ANP teaching. The majority of people were unaware of the existence of the admission standards or did not know where to find them. The admission standards document and the proforma were circulated via email and added to the shared R drive. A second cycle was completed, reviewing all admissions in July 2023, a total of 74 admissions (UHH 41, UHW 33). The proforma has now been included in the induction material for new doctors.

Results. Following interventions, there was improvement in completion of admission statement (90% vs 81%). There was improvement in the inclusion of all components, most notably MSE (91% vs 71%) and risk assessment (59% vs 18%). Where the proforma was used (57%), all aspects of admission statement were present (97–100%). When not used, there was variable inclusion of the different components (7–90%). There was improvement in the completion of all components of physical health assessment (except small decrease in medicine reconciliation). In every case of missing components with no documentation as to why, the proforma had not been used.

Conclusion. Development of a proforma for admission assessment has led to improved completion of admission assessment, physical health assessment, medicines reconciliation and prescribing within 12 hours. Qualitative feedback is being sought on the proforma from junior doctors, ANPs and senior medics to guide next steps and further improvements. Review of the admissions standards guidance is now due.

Antibiotic Prescribing in Acute Wound Management

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Aims. The primary aim is to ensure patients receive recommended acute wound care. Specific objectives include improving wound management, enhancing antimicrobial stewardship, and aligning practices with national guidelines.

Methods. A retrospective audit spanning May to October 2023 assessed prescriptions for in-patients receiving antibiotics for wound management. Detailed patient records were scrutinized to evaluate compliance with standards, including wound assessment documentation, antibiotic indication adherence, tetanus status recording, and wound swab collection.

Results. A total of 21 patients/encounters met the criteria for inclusion. Documentation deficiencies were prevalent, with only

61.9% of prescriptions featuring complete wound assessments. Additionally, antibiotic indications met NICE criteria in only 42.8% of cases, while tetanus status documentation was absent across all records. Despite 76% receiving first-line antibiotics, only 19% had wound swabs collected.

Conclusion. Self-harm rates in the United Kingdom, particularly among those with mental health disorders, are alarming. Hospitalizations are often required to address acute self-inflicted wounds, yet in-patient settings present unique challenges exacerbating self-harming tendencies.

This audit underscores the imperative of optimizing acute wound management in in-patient settings. By implementing evidence-based practices and addressing identified deficiencies, healthcare providers can enhance patient outcomes and ensure optimal care delivery.

Introduction of the DUNDRUM Triage Urgency Tool to a Medium Secure Unit in Bed Crisis

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Aims. At a time of increased pressures across the whole forensic estate, The Orchard Clinic Medium Secure Unit faced the additional challenge of having to close multiple acute admission beds.

This led to challenges in determining how to triage patients in the face of multiple external pressures, frustrations for clinicians managing severely ill patients in prison and human rights concerns for those unfit to stand trial but remanded to custody to await a bed.

The need for an objective tool to aid triage decisions became apparent. We therefore piloted the use of the DUNDRUM triage urgency manual, a structured professional judgement tool to aid triage decisions for forensic units.

The aims of introducing this tool were to ensure decisions are more consistent and reliable, ensure scientifically valid items are not forgotten, make decision making processes more transparent, demonstrate equality of access to services and reduce chance of serious error.

Methods. This audit reviewed all acute admissions to The Orchard Clinic between Aug 22–Aug 23. This covered a period 6 months prior to the introduction of the tool and 6 months after.

In order to determine if the use of the tool improved our triage making decisions the Dundrum score was retrospectively calculated for admissions and those on the waiting list during the first 6 month period of the audit. The same information was recorded for those following the introduction of the tool in the second 6-month period.

Results. Prior to introduction of the DUNDRUM, the team's triage decisions were not in line with validated tools, those with lower DUNDRUM scores were prioritised over those with higher scores. Following introduction of the tool our triage decisions improved. Common themes emerged when we analysed the reasons why our triage decisions were out of line with validated tools. These included patients in hospital settings taking precedence over those in prison, patients admitted without prior discussion at bed management meetings, legal urgency taking precedence over clinical and lack of available HDU space.

Conclusion. Prior to the introduction of the DUNDRUM triage urgency manual the audit demonstrates that the team's triage decisions were not in line with validated tools. This improved following training and use of the tool at bed management meetings. The Orchard Clinic has now formalised use of this tool within bed management meetings. We are currently in the process of re-auditing over a 12-month period.

Is Annual Monitoring of Prolactin for Patients on Long Term Antipsychotics Being Completed and Results Acted Upon in Rochdale Community Mental Health Team?

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Aims. National guidelines (NICE) recommend that prolactin should be monitored every 12 months for patients on antipsychotics, excluding patients on aripiprazole, clozapine, quetiapine or on doses of less than 20mg daily of olanzapine. The purpose of this audit was to investigate whether patients under our services who are prescribed antipsychotics implicated in causing hyperprolactinemia, were having regular annual prolactin measurements as per the guidelines and whether abnormal results were being actioned appropriately.

Methods. A total of 61 patients were surveyed, as a random selection from the Outpatient Consultant case load in Rochdale CMHT. This was a retrospective analysis looking at annual prolactin measurements over 5 years between 01/01/2017 and 31/12/2022. This included all patients who had been stabilised on an antipsychotic for more than 2 years, and excluded patients on antipsychotics that did not cause significant prolactin rise (and so do not require annual prolactin measurements as per NICE guidelines).

Results. Our results showed that the majority of patients were not having regular annual prolactin measurements, with only 3.3% of patients having prolactin measured annually 100% of the time. 23% of patients had no prolactin measurements at all while on antipsychotic treatment during the time period assessed. In cases were there was an elevated prolactin reading, only 15% of these readings had a documented action plan.

Conclusion. This audit has demonstrated that the overall compliance with the NICE standards for annual prolactin monitoring for people on antipsychotic medication is of a poor standard, and we highlight possible reasons why this may not be done and areas for improvement.