Further interventions such as frequent reminders and mentioning the importance of the form on induction could be made. A third cycle to assess compliance among the new junior doctors rotating onto the unit could be completed to assess the effectiveness of these interventions.

Assessing the Number of Patients Receiving 1:1 Sessions and Their Frequency per Week

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Aims. The aim of the audit was to assess whether patients on the ward were receiving 1:1 sessions with their named nurse and to assess the frequency of these sessions per week after many patients stated that they were not receiving such sessions. The role of the named nurse is to engage therapeutically with the patient and thus ensure the well-being, safety and satisfaction of the patient while communicating and enforcing the treatment plan. The named nurse answers the patient's questions and helps the patient with tasks such as preparing documentation. The named nurse also acts as an advocate of the patient and communicates the needs and requests of the patient to the team. The recommended frequency of 1:1 sessions is twice a week.
Methods. The electronic records of the patients admitted to a mental health ward were examined to assess whether they were having their documented 1:1 sessions with their named nurse on the 15th of October 2022. This was recorded on an excel sheet anonymously as "complete" and "not complete." The frequency of these sessions per week was also recorded on the same excel sheet. The audit was repeated on the 15th of January 2023 and the same parameters examined. Improvement was facilitated via speaking to nursing staff, explaining the importance of 1:1 sessions and reminding them of physical health forms in the morning meetings.
Results. The results showed that 4 patients had 1:1 sessions out of 20 admitted patients. 2 out of the 4 patients who had 1:1 sessions had them at least twice a week while the others had them once a week. The repeat audit 3 months later showed 12 out of 20 patients had 1:1 sessions and 5 of those patients had them at least twice a week.
Conclusion. The audit showed some improvement. It is likely that the task can be forgotten on a busy ward and reminding staff regularly is imperative. Further improvement can be managed by using posters in the nursing station to remind staff.

To Profile Patients Who Need Long Term Care Placement Following Admission to Acute Old Age Psychiatry Wards

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Aims. The Institute of Mental Health is the only tertiary Psychiatric Hospital in Singapore. It has two 29 bedded inpatient wards which provides acute care for the elderly with severe mental health problem. Over the past year there has been a trend of an increasing number of elderly patients who stay for a prolonged period of time as they require long term care placement and this increased length of stay leads to increasing healthcare costs, a reduction in availability of acute beds which in turn leads to elderly patients needing to be lodged in general adult wards. In 2022 the average length of stay for the elderly wards was 46 days as compared to the target of 21 days set by the hospital. Prolonged inpatient stays can lead to physical decompensation including reduced muscle strength, pulmonary capacity and osteoporosis.
Methods. We conducted a retrospective audit on 30 patients who were admitted between July and December 2022, requiring long term care placements. Our hypotheses were that patients with a diagnosis of dementia, who were frail and with caregiver burnout were more likely to require long term care placement. We subsequently designed a data collection form to collect the latter data and analysed them.
Results. Out of the 30 patients, 27 (90%) had a diagnosis of dementia, 25 (83.3%) were classified as frail (6 or more on the clinical frailty scale) and 23 (76.6%) had caregiver burnout, 12 (40%) family unable to look after patients in spite of community support and 3 (10%) had no next of kin.
Conclusion. Patients with dementia and frailty are more likely to require long term care placements. In the inpatient unit, we find that caregivers of these patients are burnt out because of their behaviour problems. We are embarking on an enriched model of care to reduce severe behavioural and psychological symptoms of dementia thereby reducing the need for restraints and its associated complications, and empowering caregivers to manage their behaviour problems.

This audit also stressed the importance of addressing issues upstream. Referrals to community facilities like day care which provide exercise and rehabilitation for the elderly will help delay the consequences arising from frailty. We are also partnering primary care to assist with early identification of dementia and providing early interventions to prevent caregiver burnout.

Clinical Re-Audit of the Interface Between Community and Inpatient Management of Service Users

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Aims.

- The working interface between inpatient and community mental health teams can ensure a smooth and safe transition for service users following admission to the hospital.
- It is the first opportunity to reassess this aspect of service after the pandemic as the original audit was done before the lockdown.

- To follow up on amber results and to identify if the data captured from the previous audit has improved.
- This clinical audit project also reviewed how often community mental health teams and service users met during a patient's inpatient stay.

Methods.

- The audit was conducted at West Park Hospital, Darlington. Information was collated from a consecutive group of female inpatients that were discharged from Elm Ward between 01/02/2021 and 23/03/2021. The audit data collection was performed between 01/05/2021 and 31/05/2021.
- Data were collected retrospectively and was obtained from the inpatient medical records system (PARIS), and input into a designated audit tool.
- Medical records were reviewed for the duration of each inpatient episode, and the criteria and standards above were applied.

Results.

- The data demonstrate that in the vast majority of cases, the ward invited the community team to the relevant meetings during the patient admission (96%) which indicates the improvement in compliance with virtual meetings
- In 100% of cases, there were contacts between the community team through MS Teams or directly through phone or face to face (the number of contacts depends on the length of admission, shown in the figure below)
- The percentage of patients that were offered a written copy of the care plan was observed to have increased when this is compared to the original Audit
- The percentage of patients whose GP doctor was informed also increased to 20%, however, that is still at red remarks

Conclusion.

- An amber compliance rating was assigned to this clinical audit report. High compliance was achieved for evidence of the reason for admission, anticipated risks, and capacity communicated to the ward by the care coordinator/crisis team.
- There is evidence of inviting the care coordinator/crisis team staff to the initial formulation meeting and review/MDT meetings. However, some elements of the Admission, Transfer, and Discharge policy required improvements, particularly in relation to information about expected length of stay communicated to the ward by care coordinators/crisis team staff
- It should be clear who should be responsible to inform the patient's GP within 24 hours of admission
- Still, compliance with offering patients a written copy of the care plan (care document/ intervention plan), is low.

An Audit of Planned Follow-Up Following Discharge From Four Black Country CRHT's

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Aims. It is well established in the evidence base that mortality and suicide risk increases following discharge from an inpatient admission, leading to the national implementation of '72 hour follow-up'. However, there is little data examining outcomes following discharge from an admission to a Crisis Resolution & Home Treatment Team. Following a number of noted Serious Untoward Incidents at a trust level, we sought to examine the standard of follow up post discharge from all four Black Country CRHT's (Dudley, Walsall, Sandwell and Wolverhampton) in order to improve policy and thus patient outcomes.
Methods. The caseloads for all four CRHT's for the period of 1st-31st December 2021 were obtained. The clinical notes system RIO was searched and scrutinised for each patient to determine when the patient's next planned follow-up following discharge from that particular spell in CRHT took place. This was compared to the audits standard: all patients discharged from CRHT should receive some form of planned follow-up in the 3 month period post discharge.
Results. All of the patients discharged from Wolverhampton CRHT received 72 hour follow-up as conducted by members of their own team, however despite this 12% of the total caseload were either lost to long term follow-up or went into crisis before planned follow-up could take place. With regard to Dudley and Sandwell, only 51% and 47% of patients respectively were routinely followed-up within 3 months. A total of 30 patients across all 4 CRHT's went into crisis before planned follow-up took place. One patient ended their life 4 months following discharge from the CRHT; no planned follow-up took place. All of Walsall CRHT's patients were followed up on discharge unless they were discharged directly back to their GP.
Conclusion. Timely, regular and robust follow-up embedded in the community mental health team is paramount to the provision of safe psychiatric care. This audit has also uncovered the need for follow-up for patients discharged from CRHT to their GP, as this cohort of patients is sizeable. However we argue that a one off '72 hour/7 day follow-up' is insufficient when reducing morbidity and mortality, and robust long term care plans and regular follow-up should instead be a feature of longer term community mental health care.

How Satisfied Are Local General Practitioners, Who Are Part of the Brompton and South Kensington Primary Care Networks, With Communications About Patients Referred to the Mental Health Triage and Assessment Team?

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Aims. The Triage and Assessment Team (T&AT) at South Kensington and Chelsea Mental Health Centre have conducted a research project to assess our written communication with General Practitioners (GPs) in primary care. We are responsible for screening and assessing new patients referred by GPs to the South Kensington and Chelsea Mental Health Centre community mental health team (CMHT) department.The aim is to ensure all patients referred from primary care, receive care from the most

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