the potential to improve our practice of prescribing benzodiazepine and Z-drugs, it was decided to evaluate current use.
Method. The NICE guidelines were consulted, and we retrospectively reviewed the use of these agents from mid-January to the end of May 2020. Demographic variables included age, gender, and county. Patients were stratified into three groups, the benzodiazepine group, the Z-drugs group, and the combined benzodiazepine and Z-drugs group. In each group therapeutic variables were recorded including the medication type, dose, frequency, prescriber, and duration of treatment. Other variables included psychiatric diagnoses, length of inpatient admission, status on admission, and recommendations on discharge
Result. There were 101admissions during that period, and 74 of them were prescribed these agents (n = 74; 73.3%). Fifty one (n = 51; 68.9%) received benzodiazepines only, twenty-three (n = 23; 31.1%) were prescribed Z-drugs, and twelve (n = 12; 16.2%) received both benzodiazepines and Z-drugs. Forty two patients (n = 42; 56.8%) were commenced on hypnotics in the APU, 23 patients (n = 23; 31.1%) already received hypnotics from the CMHTs, and the rest were prescribed by both. Thirty two patients (n = 32; 43.2%) were discharged on hypnotics. Patients admitted involuntarily and female patients had longer admissions (mean of 16.62 ± 3.26 days and 16.16 ± 2.89 days respectively). Schizophrenia and BPAD were the commonest diagnoses.
Conclusion. It appears that large amounts of these agents are used in the Acute Hospital Setting which is not overly surprising given the severity of illness and clinical indications however improved awareness could still lead to more appropriate and hopefully reduced use. We therefore recommend:

A formal audit including appropriate interventions i.e., educate staff and patients, highlight guidelines, and review subsequent practice.

Train staff in safer prescribing practices including prn rather than regular use if appropriate.

Regularly review discharge prescriptions indicating recommended duration of use.

Root causes of deaths by suicide amongst patients under the care of a mental health trust: a thematic analysis

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Aims. This study explores common themes emerging from root causes of Serious Incident (SI) reports of mental health service users who died by suicide under the care of a mental health trust.
Background. Suicide is a global health problem. It is estimated every year about 800,000 people die by suicide worldwide. Previously, the United Kingdom (UK) reported a significant reduction. However, the latest report in 2018 indicated a marked increase. Furthermore, 28% of people who died by suicide in the UK were under the care of mental health service 12 months prior to their death. The causes of suicide are not usually straightforward, but sometimes could be preventable. Thus exploring the root causes is a step in the right direction to preventing this global problem.
Method. Thematic analysis was carried to identify themes emerging from the Root Causes (RCs) within the Serious Incident (SI) reports of patients who died by suicide while under the care of the Trust between January 1st, 2017 and July 31st, 2018. Over the 18 month period, there were 71 deaths, of which 36 were ruled as suicide by the coroner. A further 16 were considered by the review team as possible suicide and were therefore included to increase the scope of learning. This review is therefore based on 48 cases.
Result. Three main themes emerged from this study. They are patient, professional and organisational factors. Majority of the death were patient related factors, particularly exacerbation of patient's mental health condition. Furthermore, the most frequently occurring professional and organisational factor were issues around patient risk assessment and management and inadequate psychiatric bed respectively.
Conclusion. The findings of this study have helped gained an understanding of the perceived causes of death of patient who died by suicide. It is hoped that this will in turn influence the manner in which, decisions, policies and resource allocation are carried out to further prevent and reduce the incidence of suicide, particularly amongst mental health patients.

Pharmacological treatment of post-traumatic stress disorder- an audit of Cardiff Health access practice using a pharmacological prescribing algorithm

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Background. Post-Traumatic Stress Disorder (PTSD) is a mental health disorder characterised by symptoms of re-experiencing, avoidance and hyperarousal that may develop after exposure to a traumatising event. The prevalence of PTSD within the refugee population is ten times higher than in the general population. This audit was carried out in Cardiff Health Access Practice (CHAP) which is the main provider of primary health care for refugees and asylum seekers who are sent to Cardiff. The main objective of this audit was to evaluate current PTSD prescribing practice for patients presenting to Cardiff Health Access Practice (CHAP) against a pharmacological prescribing algorithm which has been developed for the Cardiff and Vale Traumatic Stress Service based on NICE and International Society for Traumatic Stress Studies guidelines
Method. A retrospective audit of patients with PTSD seen in the last 12 months at CHAP. Data were collected from patient notes and information on age, sex, trauma, comorbidities and medication dose was collated and analysed using SPSS statistics.
Result. 130 patients with PTSD were identified and their medications assessed for the audit. The mean age of these patients was 33 years and there was a 1.5:1 male to female ratio. Of the 130 patients only 10 were initiated on a first line medication, 117 were started on a fourth line medication. No patients were prescribed either the second- or third-line medications.
Conclusion. The low rates of compliance with the All Wales Pharmacological PTSD pharmacological prescribing algorithm are disappointing although not unexpected as it has yet to be fully introduced to the service. Following discussion of the results and teaching about the algorithm with clinicians in Cardiff Health Access Practice rates of evidence-based prescribing should improve. This audit focuses on a patient group (refugee and asylum seekers) which has been identified as a priority group by the Welsh Government. Through further implementation of this algorithm there should be improved evidence-based prescribing and continuity of care for refugees

Audit of therapeutic drug monitoring of 'clozapine plasma levels'

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Aims. To re audit the monitoring of Plasma Clozapine levels in Rehabilitation setting in CNTW Trust as per Trust Guidelines PGN on "Safe prescribing of Clozapine".
Objectives:
To determine if

1. The reason for a clozapine plasma level request is recorded.
2. Results are recorded correctly.
3. Appropriate action is taken and recorded when results are significant.

Background. Clozapine plasma level monitoring is useful when assessing adherence, adjusting the dose, monitoring the effects of changes in smoking habit, investigating clozapine side effects and when toxicity is suspected.

An initial audit was carried out within the Trust in 2015 and the following recommendations were made:

Check and record clozapine plasma level
At baseline (a level should be taken once the patient has been on the target dose for at least a week)
Annually.
When clinically relevant to optimise therapy.
An entry must be made in the patient's progress notes recording the reason of requesting the test.
On receipt of results, the paper copy must be scanned & an entry made in progress notes.
The clinician should comment on the significance of the results and propose an action plan.
We re-audited compliance with the guidance in Rehabilitation (inpatients and community) by reviewing patient notes for a 2 year period of 2017–2018.

Method. The audit work involved a review of 31 case records of patients prescribed Clozapine whose last plasma level was taken between 2017–2018. Patient's details were identified from a randomly generated list by the Trust pharmacy.
Result. <50% compliance was seen with baseline, annual monitoring, reason for recording and proposed action plan by clinician.

>50% compliance was seen with scanned results and levels checked when clinically relevant.

No significant improvement from the previous audit except improvement in compliance with documentation of levels.
Conclusion. Dissemination of Clozapine Key cards within teams.

Assessing the delivery of smoking cessation interventions in adult inpatients

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Aims. To assess level of compliance with national and local guidance with regards to the recording of service users smoking status and offering of interventions.
Background. Across the general population, prevalence of smoking is decreasing but in those with severe mental illness, the prevalence hasn't significantly changed. LYPFT are working towards becoming a smoke-free trust. The Trust Guidance expects that Trusts should ask 100% of service users if they smoke (which should be recorded on their physical health CQUIN) and of those that do, should be offered nicotine replacement therapy and cessation advice. Public Health England is working towards all hospital trusts across the UK being Smoke-free.
Method. All service users on each of the 4 adult inpatient wards at the Becklin Centre, Leeds, were included in the audit. A total of 78 service users were included in the audit.

We reviewed the digital records for every service user, specifically looking at the physical health CQUIN. We recorded if smoking status had been documented and what interventions (if any) had been recorded as given. Possible interventions included offering brief advice and offering Nicotine replacement therapy. We then reviewed medication charts to see if any nicotine replacement therapy had been prescribed.
Result. The audit found that approximately half of all service users in our audit smoked cigarettes and that the vast majority of these had their smoking status documented in their digital medical records.

Three quarters of those that smoked were offered brief cessation advice and half of them were offered Nicotine Replacement Therapy. Only a third of service users that smoked had NRT prescribed on their medication chart. This represented 65% of those recorded as being offered NRT.
Conclusion. There are numerous possible reasons for the above outcomes. These include a lack of knowledge and confidence in delivering smoking cessation interventions, conversations having taken place but not recorded and confusion regarding the appropriate staff member to deliver the intervention. In addition, whilst only medical professionals typically prescribe NRT, the physical health CQUIN is recorded by nurses. Therefore, this may reflect a lack of communication between staff groups.

Our trust will become smoke free in the near future. To facilitate this, we hope to reduce the discrepancy between the number of service users who smoke and the number prescribed NRT.

Trends in referrals to liaison psychiatry teams from UK emergency departments for patients over 65

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