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Although non-compliant, there were clear improvements in documenting indicated use (2018: 61.65%, 2021: 80.8%), and providing prescriptions of <4 weeks in duration (2018: 58.2%, 2021: 79.2%)

Key areas of concern were as follows: poor documentation of indication, duration of treatment and plans for review/discontinuation (compliance ranged from 31.5% - 81.2% in these areas). There was poor documentation of what verbal advice was given (0–16.9%), and lack of clearly documented tapering/discontinuation plans for those on long-term prescriptions (16.1%). The provision of written advice reduced from previous audit (2018: 10.7%, 2021: 5.8%). As 41/51 encounters were via telephone or video due to COVID-19 pandemic, this may have impacted on results.

Conclusion. Despite improvement in some areas, there remains scope for ongoing improvement in other areas. To improve these, we plan to produce and distribute an educational email to all prescribers, including the following: information on this audit and its findings, prescribing guidelines, relevant e-links to patient information leaflets as well as the audit proforma used for this audit, to encourage prescribers to undertake self-directed practice. A poster will be distributed, highlighting prescribing guidelines and standards, to be printed and displayed in clinical areas as reminder of prescribing responsibilities and the importance of documentation. Prescribers will be encouraged to participate in a small quiz to test learning. Efficacy of these measures will be assessed with a re-audit in one years' time.

Driving Risk Assessment and Advice Provision for Inpatients Based on Features of Illness, Treatment and Driver and Vehicle Licensing Agency (DVLA) Guidelines

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Aims. The aim of the project was to improve the routine incorporation of driving advice based on Driver and Vehicle Licensing Agency (DVLA) guidance into discharge planning by responsible inpatient teams. This would optimize patient safety, demonstrate good clinical practice (trust and professional body values) and minimize/prevent the emergence of accidents/unfair loss of licenses/unfair attribution of driving accidents caused by people who have been under recent or ongoing inpatient care.

Methods. The following questions: "Do you have a valid license", "Do you own/have access to a vehicle", "Do you currently drive" were developed as a standard template for gathering patients' driving information.

These questions were embedded within:

1. Barriers to ward discharge discussions
2. Trust-wide communications via screensaver and circular

Answers to these questions were to be clearly documented on patient's records to serve as prompts for the responsible discharging team to take up providing the appropriate advice.

After a specified period, the electronic discharge notification (EDN) database was searched for patients with relevant diagnosis who were discharged from all the general adult/older adult acute inpatient wards within a specified period. The patients' records were then checked for documentation of relevant driving information evidenced by documentation of answers to the screening questions as well as recorded evidence of DVLA discussion/advice held since date of diagnosis or admission.

The standards audited against were all patients:

1. should have their driving licence status recorded during their admission
2. should have their access to a vehicle recorded during their admission
3. with a relevant mental health diagnosis should have a record of advice regarding driving given in bespoke and DVLA informed manner during ward discharge planning by the responsible discharging team
4. should have documentation of the outcome of the driving advice given by the responsible team in their records

Results. 28 patients with relevant DVLA notifiable mental health conditions were audited. 11% (n = 3) had driving licence status recorded. 14% (n = 4) had access to a vehicle recorded. 7% (n = 2) had driving advice given. Only one patient had outcome of driving advice recorded. No best practice was identified.

Conclusion. Documentation of driving information, DVLA signposting advice and outcome for patients with relevant mental health diagnosis is a crucial part of patient risk assessment and management as these patients are not free from posing a driving risk on discharge. The trust is implementing actions to improve the routine incorporation of driving advice based on DVLA guidance into discharge planning.

Medical Assessment and Management of Self-Inflicted Head Injury in an Inpatient Child and Adolescent Mental Health Services (CAMHS) Setting

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Aims. To ascertain whether current medical assessment and management of self-inflicted head injuries in an inpatient CAMHS setting conforms with current NICE guidance.

Methods. Incidents of self-inflicted head injury were identified on the incident logging system Ulysses. Incidents were matched to entries on Paris, the online clinical notes system. Data were collected from Paris on whether the incident was reviewed by a doctor, time until doctor review and which components of the NICE guidance were completed during the review. The data were collated into an Excel spreadsheet and analysed.

Inclusion criteria were CAMHS inpatients at 1 Greater Manchester hospital during November 2021 who had an incident of 'head banging' recorded on Ulysses. Exclusion criteria were patients on ward A as the ward was found to have its own care plans for managing head banging rather than escalating to doctors.

Results. There were 52 incidents of head banging logged. 56% (n = 29) of incidents received a doctor review and 32% (n = 17) did not. For 10% (n = 5) of incidents a doctor review was declined and for 2% (n = 1) a review was conducted for another indication. The mean time taken until review was 4.3 hours with a range of 1 to 16 hours.

NICE guidance lists 9 components of the history that should be covered. 1 component met the 100% target and 1 component was documented in > 50% of incidents. The remaining 7 components were documented in < 50% of incidents.

NICE guidance lists 16 components of physical examination that should be completed. No components of the physical examination met the 100% target. 5 components were documented in > 50% of incidents. The remaining 11 components were documented in <50% of incidents.

NICE guidance recommends verbal and written safety netting advice is given. Advice was given in 16% (n = 5) of incidents. NICE recommends a responsible adult remains with the patient for 24 hours, this was documented in 77% (n = 22) of incidents. NICE recommends ongoing doctor concerns necessitate patient transfer to A&E. Concerns/lack of concerns were documented in 6.6% (n = 2) of incidents.
Conclusion. This audit has demonstrated inconsistencies between doctor's documentation of self-inflicted head injuries in an inpatient CAMHS setting. The reviews do not meet the standards outlined by NICE. There is a good emphasis on gross neurology but less awareness of the need to document more subtle pathology and ongoing monitoring requirements.

Psychiatric Induction Programme in Fife

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Aims. To improve the Psychiatry induction for DiTs in Fife.
Methods. The purpose of induction is to provide Doctors in Training (DiT) with a smooth, supported transition between roles. Delivered well, it will promote confidence and also provide a thorough grounding in the key requirements of the role and clarity regarding sources of help.

A recent report, commissioned by the GMC, identified the key areas which should be covered in induction. The findings demonstrated a clear link between inadequate inductions to the impact on doctors' well-being and patient safety issues.

A questionnaire was issued to DiTs completing Psychiatry inductions in August and December 2021. Questions focused on the following key areas highlighted in the GMC report:

- Gaining access to workplace settings and systems
- Physical orientation of workplace
- Team inductions
- Daytime role and out of hours working and rotas.
- Familiarisation with common cases/procedures that doctors may deal with in this speciality: risk management, use of the MHA

Results. Questionnaire Results: Key Issues highlighted

August 2021

- FY2 to ST6 inducted together: differing experience levels
- Differences in site inductions (psychiatry is spread across 3 hospitals in Fife)
- Issues obtaining swipe cards/keys
- IT access for emails and various computer systems delayed
- Computer systems training not done

December 2021

- Lack of psychiatry experience of FY2s
- Continued IT access issues initially

Conclusion. In September 2021, a working group was established comprising DiT representatives and those responsible for induction. The August 2021 results were disseminated and key improvements were identified in areas covered by the clinical induction:

- An improved induction check list universal for all sites.
- Induction documents for each role detailing responsibilities and useful information.
- Integration of IT training.

The December results highlighted improvements in many areas but continued a theme of concerns for FY2s starting in Psychiatry. The transition to this speciality is a significant adjustment as it operates differently to most specialities, requiring different skills and knowledge.

Plans have been made to provide simulation events which would give DiTs practical experience in a safe environment of various topics e.g., risk management in psychiatry. Additionally, there are plans to revise induction for speciality trainees.

Audit Against DVLA Guidance for New Psychiatric Patient Referrals at the Early Intervention for Psychosis Team (EIP)

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Aims. To assess the compliance of the clinicians in EIP team with DVLA guidelines. *Objectives*: To assess if there was documented evidence of: 1)Patient's diagnosis, 2)Patients' driving status, 3) Type of vehicle driven, 4)Informing the patient that their condition may affect their ability to drive, 5)Advice regarding driving restrictions where applicable, 6)Informing the patient that they have a legal duty to inform the DVLA about their condition
Methods. We selected two-thirds of the patients(n = 40) enrolled in the EIP service in the last year by consecutive sampling. We collected the data retrospectively from the clinical documentation and analysed it using excel sheets.
Results. The mean age of the study sample was 34 years. 95%(n = 38) had a documented diagnosis, 67.5%(n = 27) had a documented driving status. The documentation of driving status was completed by doctors in 52%(n = 14), nurses in 26%(n = 7) and by both in 22% (n = 6). The type of vehicle driven was documented for only 33%(5) of the drivers. Among the drivers identified 33% (n = 5) had been informed that their condition might affect their driving, 67%(n = 10) had received information on driving restrictions and 47%(n = 7) had received information that they have a legal duty to inform the DVLA.
Discussion:. One of the reasons for the low compliance may be because another team might have documented the information at the time of referral. It is possible that the professional involved did elicit the information but didn't document the same. Healthcare professionals(HCP) have to identify, discuss and document driving-related information as advised by the DVLA. In cases where the patients' don't follow the advice, the HCP must notify the DVLA.
Conclusion. Assessment of driving history and the risks associated are critical. Awareness should be raised among the clinicians (through training and team meetings). This practice should be made an integral part of the structured initial assessments. Patients can be offered information leaflets. If successfully implemented, it will prevent unsafe driving and minimise the risk of harm for the patient and other road users.

Changes in Crisis Resolution Home Treatment Team Referral Numbers and Patient Caseload During COVID-19 Pandemic in First Lockdown

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