The most frequently used outcome measure was the RCADS but the SDQ was also used.

Conclusion. There is work to be done to ensure the use of outcome measures becomes routine, and also to standardise both the type and frequency of use. The Trust is aiming to increase their use by utilising SystmOne's capabilities to interface with service user mobile devices to send out outcome measures to patients. There is also a plan to inform staff within the service about the expected use of outcome measures. This audit will be repeated in 2024 to see if the Trust are moving closer to delivering their promise.

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An Audit on Telephone Referrals to Beechcroft, a Step 5 Regional Child and Adolescent Mental Health Inpatient Unit

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Aims. To audit telephone referrals to Beechcroft inpatient unit.

Beechcroft inpatient unit is a step 5 regional child and adolescent mental health inpatient unit in Belfast. It receives a large volume of referrals from across all five health and social care trusts in Northern Ireland. The process of referral to Beechcroft can vary between trusts and clinicians; the majority of admissions are emergency. The demand for beds has risen by 30% since 2019. Emergency admissions are commonly telephone referrals whilst others submit written referrals. The referrals process is managed by the ward sisters, as there is no bed manager post. Referrals are discussed with a consultant psychiatrist.

Referrals received often lack key clinical information, which makes decisions around appropriateness of admission or prioritising multiple referrals difficult. Furthermore, as the admitting doctor relies on this information, missing clinical information could result in patient safety issues.

Methods. 24 telephone referrals were recorded between August to December 2023. 5 referrals were excluded for either no request for a bed (3) or telephone update following previous written referral (2). 19 telephone referrals were analysed across 7 different criteria as below, based on necessary information.

Criteria 1 Patient identifiable information
Criteria 2 Source of referral/referrer details
Criteria 3 Current location of patient
Criteria 4 Legal status
Criteria 5 Presenting symptoms
Criteria 6 Working diagnosis
Criteria 7 Risks warranting admission

Results.	Yes	No	%Yes
Criteria 1	19	0	100
Criteria 2	19	0	100
Criteria 3	13	6	68
Criteria 4	14	5	74
Criteria 5	18	1	95
Criteria 6	2	17	11
Criteria 7	15	4	79
Total	**100**	**33**	**75.2**

Patient identifiable information and source was documented in all referrals. Only 10% of referrals included a working diagnosis. Location of patient, legal status and risks warranting admission were documented between 68 and 78%.

Conclusion. Crucial information such as working diagnosis was missing in 90%. Risks or legal status missing in up to a quarter of referrals. This has an impact on timely access, bed flow and potentially patient safety.

A need for improvement in receiving and documenting telephone referrals has been identified. To aid improvement in patient safety and flow, a bed manager for in hours has now been appointed. A standardised proforma for recording data will be developed by inpatient staff in collaboration with community staff to include the above criteria. A re-audit will be carried out following these service improvements.

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Monitoring of Sodium Valproate Annual Risk Assessments Within Psychiatric Services

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Aims. To determine the number of patients within a service on sodium valproate for a psychiatric condition who have updated Annual Risk Acknowledgement forms in place.

Methods. It was firstly identified that within the NICE guidelines, it is recommended that all patients who are on sodium valproate should have an annual signed risk acknowledgement form in place. Following this, a list of patients was compiled who were currently prescribed this with the local area. Each patient was then checked to see if the valproate was prescribed by psychiatry or by neurology. This was then further divided into general adult and learning disability patients.

From this, a list of patients under the care of general adult psychiatry was compiled. The notes for these patients were obtained.

Data collection was then carried out. Each set of notes was reviewed by two individuals for the following:

1. To identify if an annual risk assessment form was carried out.
2. To check if this was within expiry date.
3. To identify patient diagnosis.
4. To identify the dose of sodium valproate.
5. To confirm if these patients were females of childbearing age.

Results. From the initial audit cycle, it was identified that 28 female patients who fell within the inclusion criteria were on valproate, and of these, 6 had forms in place. Of the 6 with forms in place, 50% had expired so needed to be replaced. 17 had no form in place, and for 4 patients it could not be certain if forms were present or not due to unavailability of records. Only 3 patients therefore had the correct form in place which were within expiry date. If we discount those with no data available, only 12% of patients had the correct annual risk acknowledgement form present and within expiry date.

Following the initial audit, two interventions were carried out:

1. The data from the above audit was presented at a consultant meeting, highlighting the importance of ensuring these forms are kept up to date.

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2. It was decided that pharmacy would take a leading role in ensuring the annual risk assessment forms are updated.

Following 6 months, this patient cohort was re-audited, with further results obtained.

These results showed a reduction in patients prescribed sodium valproate from 28 to 19. 37% of all patients prescribed sodium valproate had forms, but of these, only 30% were up to date. Therefore, only 11% of patients had correct annual risk acknowledgement forms in place which were up to date.

These results showed an improvement in those who had at one time had a form in place, but roughly similar compliance with availability of up to date forms.

Conclusion. Overall it appears that there is a real lack of consistency in ensuring the annual risk assessment forms are in place. A very low percentage of patients have the correct form in place within expiry date, despite interventions which have taken place as part of this audit. Further efforts should therefore be made by teams to ensure that these forms are in place and up to date for all women of childbearing age on valproate.

On a positive note, it may be possible to surmise that the reduction in number of patients on sodium valproate may be linked to raised awareness of the risks to women of childbearing age.

Additionally, a significant number of patients had been sent forms in the post, but had not returned them. Some of these same patients had, in the time that they should have had updated risk forms put in place, been admitted to an inpatient psychiatric hospital. It is therefore important to consider in future if these forms should be updated whilst the patients are admitted to hospital, to increase the number of patients with these forms up to date and therefore improve safety for this cohort of patients. Given that many of these patients have a diagnosis of Bipolar Affective Disorder, they may find it more challenging to return the forms whilst in the community, particularly if unwell; the ICD–11 criteria does note that patients with this condition may suffer from "distractibility, impulsive behaviour and rapid changes in mood state." Further research could therefore be carried out to determine if utilising inpatient admissions to discuss risks of their medications would be a beneficial way to improve compliance with Annual Risk Assessment Forms.

Lastly, we know that there has been discussion around implementation of such monitoring for men as well as for women. Should this be implemented within the NICE guidelines, further audits should be carried out to determine our compliance with this.

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Assessing the Compliance of Glucose Monitoring for Patients Prescribed Antipsychotics With Intellectual Disabilities

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Aims. To assess the compliance of glucose monitoring for patients prescribed antipsychotics in the local outpatient Learning Disability Team.

Methods. A review was conducted of all outpatients seen in a 6 week period during September and October 2023. Each patient was reviewed to check their diagnosis or diagnoses, the antipsychotic medication they are currently on and if they have had the required tests done. These tests were considered, as per the NICE guidelines, to be a plasma glucose test or HbA1c test. It was checked to confirm if these tests had been carried out within the past 12 months, as per NICE.

Results.

- 46/79 patients seen in a 6 week period at the outpatient clinic were found to be currently prescribed an antipsychotic.
- 30 of those prescribed an antipsychotic were on risperidone (65%).
- Of those prescribed any antipsychotic, 18 out of 46 had not had their glucose or HbA1c checked within the past 12 months (39%).
- This therefore demonstrates 61% of patients on an antipsychotic had appropriate glucose monitoring within the time period audited.

Conclusion. Monitoring glucose levels for patients on antipsychotic medication is very important for patients with an Intellectual Disability. Patients in this cohort are known to be more likely to have diabetes and obesity than the general population. In addition, there are higher levels of inactivity and multimorbidity. It is also important to note that over-prescribing of psychotropic medication to individuals with learning disabilities, particularly antipsychotic medications such as risperidone and olanzapine, may be contributing to levels of obesity and diabetes within this population.

NICE guidelines state that for patients prescribed an antipsychotic, plasma glucose or HbA1c should be checked 3 months after commencement of treatment, and then every 12 months whilst on treatment. For olanzapine and clozapine, levels should be checked after 1 month of commencing treatment. Symptoms of hyperglycaemia should also be asked about (such as polydipsia, polyuria and increased appetite).

The results from this audit demonstrate there is definitely room for improvement in our monitoring of glucose levels for these patients. From discussing this with colleagues, it appears that a multidisciplinary approach is needed to promote this change.

Going forward, therefore, interventions should include asking the nursing staff within the outpatient team to monitor for increased appetite, polydipsia and polyuria amongst patients, especially if they are on an antipsychotic. Additionally, for any patients seen in OPC who are prescribed an antipsychotic, it should be routinely checked when they last had a glucose or HBA1c test. If this was not within the past 12 months, this should be carried out by the GP or another appropriate member of the team.

Overall, the physical health of our patients with Intellectual Disabilities is paramount. Given the nature of their Intellectual Disability and depending on the severity, it may be very challenging for them to identify any new symptoms of diabetes themselves or to report these to carers. Therefore, when prescribing antipsychotic medication, it is vital to monitor the effects of this to ensure optimal patient care utilising a multidisciplinary team approach.

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