

To discuss the outcomes with the Carer Champions on each unit, to review what form their support currently takes, and consider how this could link in with the requirements of Standard 5.2.

To re-audit in 1 year.

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Prescribing and Monitoring of Psychotropic Medications in a CAMHS Inpatient Service

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Aims. To ensure that there is a clear rationale for commencing service users on psychotropic medications.

To ensure that the prescription of psychotropic medications is evidence-based and that they are in line with the Trusts and NICE guidelines.

Ensure that psychotropic medications are regularly reviewed by the managing team.

To ensure that information about medications is adequately shared with patients and carers.

To ensure that service users are well-monitored for side effects.

Methods. A 2-week retrospective audit on Phoenix ward.

Clinical information from all the current service users on psychotropic medication was reviewed.

The clinical information was collated from all 8 service users' medication cards, ward round documents, MDT reviews, and electronic notes (PARIS), and these were analyzed by the inpatient specialty registrar.

Results.

1. We attained a 100% mark in some areas of our prescribing such as indicating the rationale, the maximum dose for medication, and also prescribing within BNF limits.
2. We however could not evidence proper information sharing with patients (only 40% documented).
3. We could not evidence sufficient information sharing with carers (only 20% documented).
4. PRN medication was mostly prescribed as a range rather than a clear dose, which gave rise to subjective dispensing bias.
5. Side effect monitoring was documented for 85% of patients, meanwhile, the standard for this is 100%.

Conclusion. Clinicians are to ensure that medication information is always shared with service users, and their carers, and this is documented.

Clinicians are to also ensure that PRN medications are prescribed as a single dose rather than as a dose range.

Ward staff are to ensure that they are monitoring side effects and documenting these clearly on electronic notes and ward round documents.

The MDT is to ensure that all regular and PRN medications are reviewed regularly during ward rounds.

Present this audit, share relevant findings with the clinical team, and monitor the implementation of the action plans by doing a reaudit in 6 months.

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A Complete Audit Cycle of the Recording of the Baby's and Their Siblings' Age, Date of Births and Due Dates of Pregnant Mothers During the Initial Assessment Process for Patients Presenting to a Community Perinatal Mental Health Services

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Aims.

- To find out the proportion of patients for whom the dates of births of their children, age and their due date were recorded during their initial assessment as a means of reducing risks through safeguarding.
- According to the Royal College of Psychiatrists: Standards for Community Perinatal Mental Health Services 5th Edition (2020), Under Section 5 – Rights, Infant Welfare and Safeguarding: during the initial assessment, the baby's age and date of birth and mother's due date should be recorded as part of the infants' physical and emotional care needs assessment.

Methods.

- All new patients discussed during multidisciplinary team meetings within a 2 month period from 01/08/2023 to 30/09/2023 were identified
- Their clinical records were audited.
- This information was cross-checked with the information provided on their referral letters.
- Patients attending preconception counselling were excluded.
- The initial results were presented in one of the multidisciplinary team meetings.
- The recording of the children's ages, date of birth or due dates of their mothers was re-audited two months later.

Results.

Audit

- A total of 70 new patients were discussed within the initial two months period.
- 25 out of the 70 (36%) did not attend their appointments and two patients (3%) cancelled their appointment.
- 1 patient who attended for preconception counselling was excluded.
- Of the remaining 42 patients that were assessed, 6 (14%) were primigravida while 36 (86%) patients were multiparous patients.
- 15 out of the 42 (36%) had their children's age, dates of birth and due date recorded while 27 out of the 42 (64%) lacked this record.

Re-audit

- A total of 65 patients were identified during the re-audit period
- 18 out of the 65 patients (28%) did not attend their appointment and one patient cancelled her appointment.
- One patient that attended for preconception counselling was excluded from the re-audit process.
- Of the remaining 45 patients that were assessed, 2 (4%) were primigravida and the remaining 43 (96%) were multiparous women.
- The age, dates of birth and the due date were recorded for 26 (58%) out of 45 patients while 19 out of the 45 patients (42%) did not have this record.