Although 100% of patient had their height, weight and physical observations recorded, a significant proportion did not have these plotted on centile charts as recommended.

A minority of patients had a full biopsychosocial assessment, with a major deficit in risk assessment for substance misuse.

Seclusion Reviews: Audit of Medical Documentation in a Psychiatric Intensive Care Unit

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Aims. Seclusion is a restrictive intervention used when a patient presents with risks that cannot be safely managed in their current environment. The Mental Health Act 1983 Code of Practice (MHA CoP) provides clear recommendations for both frequency and content of medical seclusion reviews, with compliance previously audited within Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Following the initial findings however, change was not implemented. A new audit has therefore been commenced to reassess baseline practice and identify areas requiring improvement.
Methods. The MHA CoP audit tool outlines the following timeframes for assessment: initial medical review within 1 hour, 4-hourly medical reviews until first internal multidisciplinary review, twice daily medical seclusion reviews with at least 1 by the Responsible Clinician. Documentation should evaluate: physical and mental health, medication adverse effects, observation level, prescribed medication, risk to others and self, need for ongoing seclusion. Data were collected retrospectively for all episodes of seclusion occurring in a CWP Psychiatric Intensive Care Unit during August 2022.
Results. 5 seclusion episodes related to 4 patients, ranging from 1 night to 15 days in duration. Regarding medical review frequency, 20% were seen face-to-face within 1 hour of seclusion commencing and 75% were seen 4-hourly until their internal multidisciplinary review. Mental health was more consistently commented on than physical health (97% vs 61% respectively), whilst medication was reviewed in 69% of assessments. Rationale for continuing seclusion was provided in 72%, referring to risk to others in 54%. Adverse medication effects and observation level were the least documented parameters (2%), followed by risk to self (7%).
Conclusion. Assessment time was often not explicitly stated and was substituted with time of documentation, meaning reviews may have occurred earlier than accounted for. The on-call doctor does cover multiple sites overnight, potentially contributing to delays in attending unforeseen time-sensitive tasks. Trust policy dictates constant visual observation must be maintained throughout seclusion and this is therefore not routinely subject to review or adjustment. Overall interpretation of the qualitative information was fairly subjective in a low number of seclusion episodes, however there was a notable lack of recording adverse medication effects and risk to self. Findings will be presented at junior doctor induction whilst a quick reference sheet is designed prior to reaudit. CWP's seclusion policy specifies medical review frequency, but does not outline expected content of documentation. There is scope to extend local policy and align with the MHA CoP.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Secondary Service Communications to GPs-a Regional Audit

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Aims. The purpose of the audit was to assess the standard of communication to GPs from secondary mental health services and to ascertain whether the information included in letters to GPs was in accordance with the recommendations of RCPsych and PRSB. The audit cycle was completed by re auditing to identify how the recommendations from the first audit has improved the quality of communication to GPs.
Methods. The audit was conducted on three psychiatric units, in three sites across Betsi Cadwaladr University Health Board and clinic letters were studied to identify whether the information was as per recommendations from: RCPsych and PRSB.

The first audit used 121 letters in total from 3 sites, with the data being collected using audit proforma over a 2 week period from 04/04/22.

The re audit looked at 69 letters with data collection using audit proforma over one week period from 19/12/22.
Results. Majority of letters sent to GP were lacking key information like details of Care coordinators ,medical comorbidities ,non psychiatric diagnosis, and actions for GP with this data missing in 91.7%, 61.22 %,79.59% and 71.43% respectively. Fill rates for other information like patients' details was 100% , psychiatric diagnosis was 83.47%, psychiatric medications , follow-up plan were 80.17%.

The results of the re-audit most letters contained Psychiatric Diagnosis (97.1%, previous 83.5%), Psychiatric Medication (91.4%)previous 80.17%), and Follow Up Plan(98.6%, previous 80.2%). Many letters did not include information regarding Medical Comorbidity (28.6% vs 31.4%), Non-Psychiatric Medication (65.7% vs 34.7%), Details of Care Co-ordinator (54.3% vs 8.3%) and Action for GP (27.1%, vs 44.6%).
Conclusion. The recommendations from first audit were to create local guidelines and templates with recommended headings for clinical letters, provide formal teaching for junior doctors and to re audit to see if the implemented changes has led to an improvement.

The re-audit showed improvement since the introduction of the template in majority of headings in GP letters with decline in fill rate for 2 headings and these changes varied among three sites.

Barriers identified affecting the overall outcome of the re audit were :template not being used, lack of training to juniors, and psychiatrist workload.

In conclusion , we aim to re-distribute the template and increase awareness with informal teaching sessions, provide