(43.8%), followed by Flupentixol (31.3%), and Aripiprazole (14.6%). In re-audit the sample size was 46 patients; 76% were females and 24% were males. The mean age was 53.7 years, with the same age range as in the audit sample. MetS monitoring charts were 100% completed in all files. Glucose documentation was 95.7%, blood pressure was documented in 91.3%, BMI/girth, and lipids were documented in 87% of files. Paliperidone, Flupenthixol, and Aripiprazole were the commonly prescribed antipsychotics.

Conclusion. The implementation of the action plan resulted in recognizable improvement in MetS monitoring and documentation. To maintain this level of improvement it is essential for the CMHT to continue educating the nursing staff and other team members about the importance of MetS monitoring and documentation. Defining documentation roles and responsibilities among team members will facilitate monitoring. Identification of files that require MetS monitoring can be improved by placing colour code stickers. A MetS Clinic can be considered as a long-term plan.

Completing the Cycle: Re-Audit of Rotherham Specific Inpatient Physical Health Management and Documentation Following a 2021 Trust-Wide Audit

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Aims. Rotherham Doncaster and South Humber (RDaSH) NHS Trust completed a Trust-wide audit in August 2021 to look at aspects of physical health management in their inpatient units. Good results were achieved in relation to new admissions having completed initial medical examination within 24 hours and consideration being given as to whether the patient had the capacity to make the decision to agree or refuse such an examination. However, inadequate results were achieved in relation to anything more than an examination of appearance, pulse or blood pressure being conducted with a chaperone, and the patient being given the opportunity to state their preferences in relation to the sex of the chaperone. This audit completed the audit cycle by re-auditing the above criteria in Rotherham inpatient units in order to assess ongoing progress against targets following recommendations.

Methods. A dip sample of five patients per ward (two Acute Adult, one Rehabilitation, one PICU and two Older Adult wards) was used. Patients who were admitted between 1st July and 30th September 2022 were picked randomly and their electronic records were studied.

Results. Nearly 90% of patients received a physical examination by a doctor within 24 hours of admission. But, whilst these patients undertook an examination that was more than just general observation, blood pressure or pulse, in only 14% of these was it documented that they had a chaperone present. In addition, not a single person was offered the choice to choose the gender of their chaperone.

Just one third of patients had their capacity to agree or decline examination documented. Perhaps unsurprisingly, the Older Adult wards performed better against this criteria.

Conclusion. Rotherham inpatient wards continue to perform well in terms of conducting timely initial physical health examinations. However, we identified there is a clear lack of documentation around documenting whether someone has capacity to consent to their physical examination or not and what gender someone would prefer to chaperone them. Unfortunately, this is a continuing issue.

We have identified an opportunity at the RDaSH Junior Doctor's induction, where the clerking is explained, to intervene and educate around what the Trust expects as standard.

We plan to implement this change and re-audit the above criteria again to see if we can make an improvement.

Consent on Information Sharing

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Aims. This clinical audit is aimed at assessing the knowledge, attitude and practices of team members towards compliance regarding information sharing and consenting service users and to create awareness about existing Trust policies and national guidelines, importance of gaining consent for Information Sharing. Consent to share information should be recorded on the appropriate clinical record keeping system and/or paper. Service users also have the right to request that information is not shared – and staff must record these decisions in the clinical record. Team members work with other agencies and at times need to share patient information. Hence, there should be discussion about who information is going to be shared with, and why. A recorded consent is useful in instances when patient data may need to be shared in court.

Methods. The 1st cycle of the audit was conducted from 15th of December 2022 to 4th of January 2023. Clients that met the inclusion criteria were checked to see if the form was filled in by the relevant practitioner/ ever filled in. This was done for both the Community Mental Health Team (CMHT) and Memory assessment Services (MAS). A survey with 7 questions was sent out to team members to assess their knowledge of the Trust policy as well as national guidelines on consent on information sharing.

Results. A total of 238 service user records were assessed. 119 each under CMHT and MAS. Combined results of 37% of the 238 services users had consent documented while 63% did not have consent documented. 27% of services users under MAS had consent obtained and documented. 56% of service users under CMHT had consent obtained. 100% of team members that responded to the survey knew to discuss personal and confidential information sharing with patients. 91% of staff knew that the discussion on consent and information sharing should be documented. 23.5% of staff were not aware of trainings on information sharing and 35.3% of staff were unaware of where to document the consent.

Conclusion. Although rare, unrecorded discussion/consent on Information sharing can cause serious implications. This audit highlights the need to create awareness about the importance of recording Information Sharing consent. Possible reasons for results include team members not being aware of where to document in client records, Trust has not properly educated staff on

Information sharing and the way to record it in electronic health records and the Concept of implied consent.

Re-Audit of Blood Monitoring of Lithium in Outpatients of Working Age Under Dudley Mental Health Services

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Aims. Lithium remains the first line mood stabilising therapy recommended by NICE for Bipolar Disorder and an important treatment option for augmentation of the treatment of Depression. Lithium has a strict monitoring requirement due to long term impact on Renal, Thyroid function and risk of toxicity due to a narrow therapeutic range. This Re-Audit aimed to assess improvement in Lithium Blood monitoring in working age adults in Dudley following an initial 2021 audit.
Methods. We used the standards set by NICE CG185- Bipolar Disorder Assessment and Management. We agreed a standard of 3 monthly monitoring of lithium levels due to the number of indications for 3 monthly monitoring to ensure safest practice. We also agreed to standards for 6 monthly monitoring of Urea and Electrolytes (U&Es) and Thyroid Function Tests (TFTs). An additional standard was agreed that at every outpatient review Lithium blood results should be reviewed and documented. A sample of 40 patients was gathered from the 8 outpatient sector teams. We used Rio notes system for demographic, diagnosis and clinical information and blood results systems EMIS and ICE for blood results over a period of November 2021- November 2022.
Results. There was a noted minor improvement to compliance with 3 monthly monitoring, overall increasing from 10% to 17.5%, but this result is still poor. The number of patients who had 4 or more Lithium blood tests over the 12 month period was more of a positive increase, to 32.5% from 17.5% in the previous audit cycle. There was also an improvement in the mean number of lithium blood tests per patient from 2.67 to 3.3. For U&Es 90% of patients were monitored 6 monthly while for TFTs 85% of patients were monitored 6 monthly. There was a slight reduction in documentation of blood results at clinic review, reducing to 62.5% from 67.5% in the initial audit.
Conclusion. While the progress is positive, the results are still far below where the trust would like to be. We considered whether frequency of outpatient review, poor awareness of 3 monthly monitoring standards and a lack of formal system to remind or ensure patients are monitored appropriately. It was agreed that measures to ensure compliance such as a lithium blood monitoring clinic may be useful to improve compliance with monitoring.

Aetiological Investigation of Epilepsy in Adults With a Learning Disability – a Community Audit

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Aims. To demonstrate adherence to national standards for the aetiological investigation of epilepsy in Bromley Community Learning Disability Team (CLDT), Oxleas NHS Foundation Trust. The National Institute for Health and Care Excellence (NICE) and International League Against Epilepsy (ILAE) advise strenuous attempts to identify the aetiology of epilepsy as it often carries significant treatment implications. The ILAE divides aetiology into six categories selected because of their potential therapeutic consequences (structural; genetic; infectious; metabolic; immune; unknown).
Methods. Audit standards were derived from NICE and ILAE. The key standard was that 100% of patients should have sufficient aetiological investigation of their epilepsy, including a dysmorphism assessment, neuroimaging, and genomics, as appropriate. The population was defined as all patients open to the Epilepsy Service of Bromley CLDT in December 2021. Data were collected using a secure electronic database between December 2021 and January 2022.
Results. 76 patients (52 male, 24 female) were audited, mean age 38 years (range 18-79 years). Learning disability severity included borderline (n=3), mild (n=28), moderate (n=24), severe (n=17) and profound (n=4). Identified aetiologies included structural (42%; n=32), genetic (13%; n=10), and infectious (5%; n=4), with one patient having both genetic and infectious aetiology. Aetiology was unknown in the remaining 41% (n=31) of patients, of which 58% (n=18) had outstanding investigations. In 72% (n=13), there was no apparent reason for investigations to be outstanding. Genomics was the commonest outstanding investigation (70%, n=14), followed by neuroimaging (20%, n=4) and dysmorphism assessment (10%, n=2). In addition, 40% (n=12) of patients were newly eligible for whole genome sequencing – a recent development within 12 months and thus excluded from outstanding investigations.
Conclusion. This audit demonstrates adherence to national standards is below 100%. Where appropriate, patients with outstanding investigations should be approached. Dissemination of findings and an action plan are required before re-audit.

Stopping Over-Medication of People With a Learning Disability, Autism or Both (STOMP) – a Community Audit

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Aims. The stopping over-medication of people with a learning disability, autism or both (STOMP) campaign was launched by NHS England in 2016 as part of the Transforming Care programme. It aims to reduce the inappropriate prescribing of psychotropic medication to manage challenging behaviour in the absence of a licenced indication. The current audit aimed to demonstrate adherence to national standards for STOMP within the community learning disability teams (CLDTs) of Oxleas NHS Foundation Trust. Additionally, a secondary aim was to