3. To identify any possible areas of difficulty in ensuring full compliance with said guidelines and suggest possible solutions.

Methods. A retrospective design was used, in which the electronic and hardcopy patient records of service users at both sites, covering a specified time-frame (2nd Dec 2021- 2nd Dec 2022) were screened. Data collected from eligible users included demographic information, names of anti-psychotics used and results of each individual's screening profile measured against the respective Trust's guidelines.
Results. The demographic profiles of eligible service users at both sites were largely similar.

17 out of 18 services users from GMH and 23 out of 50 service users from the Fens Unit were found eligible for the audit.

The majority of eligible service users at both sites (88-100%) were compliant with measurement of relevant laboratory markers, as per Trust guidelines.

However, at both sites, there were notable omissions in monitoring of certain physical parameters, especially waist circumference (100% omission in both sites) and ECG monitoring (60% omission in prison,14% in GMH), which is important given the significant comorbidity of cardiovascular risk factors amongst service users at both sites.
Conclusion. We noted disproportionate compliance in the monitoring of different physical health parameters. While laboratory tests were on the whole, satisfactorily monitored, there were gaps in other clinical measurements like waist circumference and ECG recordings. We postulate several reasons for this discrepancy, including:

- A possible lack of awareness about the importance of measuring parameters like waist circumference, which also indicates a lack of familiarity with Trust guidelines.
- A lack of time/inconvenience in ensuring adequate recording of clinical parameters
- Inadequate reminders to conduct relevant physical health checks.

We suggest possible solutions to ensure 100% compliance: for example, creating a teaching session for staff and service users on pertinent topics, like metabolic syndrome or creating electronic aids to remind staff when physical measurements are due.

This audit also engendered further questions on appropriateness of anti-psychotic prescription and importance of educating service users about physical complications of anti-psychotic use. These could be the focus of future audits.

Improving Physical Health Monitoring for Patients Diagnosed With Emotionally Unstable Personality Disorder

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Aims. The aim of this work was to apply the well established standards for patients suffering from diagnoses classed as Severe Mental Illness (SMI) to patients with a diagnosis of emotionally unstable personality disorder (EUPD) in our EUPD psychotherapy service. This patient population is also known to suffer lower life expectancy and greater physical comorbidities than the general population, and indeed than patients with other personality disorders, and this represents part of the holistic care we hope to offer in our service. In order to bring this in line, we were aiming for an annual medical review including: height, weight, blood pressure, blood tests including lipids, up to date information about alcohol and substance misuse.
Methods. One month before a patient's 6-week and 12-month review we liaised with their general practitioner (GP) for the above information. We then followed up as needed. In the first cycle of this work (January through July 2022) we found that we were able to establish contact with patients' GPs and there was qualitative evidence from patient testimonials about improved relationships with their GPs. However, the information that we were receiving was not complete - 0% had all the information that was requested.

Following discussion in the team, a proforma was developed to make it as clear as possible to the GP which information we were seeking. We more proactively engaged GPs and patients' other physical care teams, including neurology teams. Where patients had home monitoring equipment like a blood pressure cuff or scales, we also collected information from these. Compliance was reviewed again at the end of the next six-month cycle (August 2022-January 2023).
Results. Between the first cycle, from January 2022 through July 2022 and the second cycle from August 2022 through January 2023, we improved compliance toward the target of having all these data points documented for all patients from 0 to 57%. This included 100% compliance for blood pressure and pulse measures and 86% compliance for documented weight.

We also note improved relationship between patients and GPs and other healthcare professionals including a patient testimonial "Having not had the support of Waterview dedicated staff and the group I probably would not attend any of the hospital appointments."
Conclusion. Introducing the proforma significantly improved compliance with physical health monitoring targets from 0 to 57%. Further work within the team and with GPs including education on the diagnosis may improve this further.

A Re-Audit of Teesside On-Call Email System

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Aims. An on-call email system was put in place to facilitate communication between wards and the on-call doctor, allowing prioritisation of duties according to green, amber and red tasks. Information regarding the patient, nature of request and clinical background are expected in the request form. The doctor is expected to respond to the email within 45 minutes. We completed a re-audit to compare if expected standards were reached in practice and attempt to find any areas of practice that could be improved.
Methods. We collected information on request forms, presence of adequate information and response time by reviewing the Teesside on-call email inbox. One day was randomly chosen from each week for a 24 month period and all emails were

reviewed from chosen days. This amounted to (N=680) emails. The compliance was measured against local trust criteria with expected standard of 100%. We assessed four parameters of completion of request forms, providing adequate information including clinical information, patient identification and location, and response within 45 minutes by the doctor.

Results. The compliance in all four standards was subpar, with notable decrease in compliance from previous results. Compliance was less than 70% across all standards, where previously three standards were above this mark. There was a notable increase in requests with inappropriate tasks defined as non-urgent tasks as per trust guidelines.

Conclusion. Better communication can be ensured with use of SBAR (Situation, Background, Assessment, Recommendation) in the request forms. Mutual sharing of information between doctors, nursing staff and administration with regard to appropriate written communication could constitute the base for structural change and improvement within the workplace. New staff members and doctors should be inducted with regards to the process of on-call email communication. Regular re-auditing and sharing of results is essential to the monitoring of change in compliance.

Adherence to the Best Practice Guideline for Admission to Adult Mental Health Wards for Under 18's at NHS Grampian

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Aims. The aim is to improve quality of care and patient safety based on adherence to updated standards guiding the admission to non specialist wards of individuals under the age of 18.The objective is to assess adherence to the updated standards at NHS Grampian.

Methods.

- An audit was registered with the quality and improvement and assessment department (Project ID 5584)
- A list of patients admitted to Royal Cornhill hospital. NHS Grampian between 01 January 2020 and 31 December 2021 was obtained from the health intelligence department, NHS Grampian
- The 2021-2022 period yielded 19 patients. In patients with multiple admissions only the initial admission was considered.
- CCUBE electronic notes system was used to access all patient records for the admission period.
- The MH case records, nursing notes and MHA documentation in CCUBE was assessed to obtain information relevant to the 8 categories of the Scottish government guidance.
- MHLDS procedures for dealing with admissions to and discharges form Royal Cornhill hospital version 3 (May 2021) was used to ascertain current admission standards at NHS Grampian.

Results. Environment and facilities

- The ward has safeguards in place to monitor media use and prevent exposure to inappropriate material

Staffing and training

- Staff trained to work with YP are available on each shift
- Staff have training in managing LD in YP
- Staff induction- includes policy on whistle blowing, covers key aspects of caring for YP on ward

Assessment, admission, transfer and discharge

- Written care plan including evidence a social care needs assessment has taken place.
- YP involved in choosing and developing a program of activities with staff- Documented in 1 Case only

Care and treatment

- Staff wear name badges or picture board of staff so YP know who they are (uncertain about this)
- Care plan shows evidence of social care needs assessment having taken place
- YP are involved in developing a program of activities with staff Information and advocacy
- Parent/ carer information pack
- Parents and YP receive information about how complaints may be made
- Formal admissions- Parents and YP are given verbal and written explanation about MHA- verbal explanation documented in 2 cases
- YP are informed how to seek independent advice and supported to use advocacy services- Documented in 5 cases only

Consent and confidentiality

- Staff inform YP both verbally and in writing of their right to refuse or agree treatment and the limits of this.
- Staff should inform informal YP with capacity that their consent to treatment can be withdrawn at any time
- YP and carers receive verbal and written information of their rights to confidentiality and the limits of this

Other safeguards

- After restraint staff should spend time with the YP reflecting on why it was necessary and their views are included in the post incident analysis

Conclusion. Unlikely that a ward would meet all of the extensive guidance therefore each standard classified as

- Type 1-3
- Type 1- failure to meet would result in significant threat to patient safety
- Type 2-standards ward expected to meet
- Type 3-excellent
- There is no clarity on how many of the categories in each standard should be met to designate type 1-2

Clinical Audit on the Measurement of Antipsychotic Side Effects Using Rating Scales (GASS, LUNSERS, and SESCAM) in Community Settings

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