Aims. Rampton Hospital is the High Secure Hospital of Nottinghamshire Healthcare NHS Foundation Trust's Forensic Service. It is one of three such hospitals in England, following Security Directions set out by the Department of Health. Patient management occurs through the implementation of strict policies and procedures. Policy requirements highlight the need for MDT post-incident discussion of restrictive interventions, and in particular, of Rapid Tranquilisation (RT). This primary audit aimed to ascertain current practice and if necessary, suggest interventions to ensure that patient-care remains safe, effective, and well-led.
Methods. To establish current practice with regards to the discussion of individual cases of RT in MDT settings, specifically in Ward Round, we commenced a retrospective data collection from electronic notes covering all directorates within the High Secure estate between May and June 2022.

From these notes, we tried to ascertain whether the following policy standards were being met:

- A de-brief with the patient should take place as soon after the incident as is practicable and reasonable, ideally within 72 hours.
- The MDT meeting post RT episode should explicitly discuss the episode, and consider medication and any triggers of periods of acutely disturbed behaviour.
- There were 81 data sets to explore.

Results. Not all data sets were viable. Out of those analysed, less than 10% were found to have met the aforementioned ideal policy standards of having had a reflective discussion within 72 hours with both the patient and as an MDT, exploring the episode itself and its antecedents.
Conclusion. There are several interesting factors to consider from the results obtained. We postulate that the frequency of episodes of RT makes meeting the policy standard problematic; pragmatically, there is a significant time barrier to exploring these incidents in detail and the various teams, operating in dynamic and high-risk environments, may find it difficult to coalesce in order to debrief appropriately.

Furthermore, the reflections may actually be happening, but the burden of documentation mean that these are not being recorded formally in a way that can be measured.

There are limitations to the searches of electronic notes and we did not have access to Incident Reports, often completed at the time of these episodes; further information may have been uncovered if they were available.

Despite this, there is room for interventions that inform staff of this need and to provoke improvements in current practice.

Seclusion on Psychiatric Intensive Care Unit – Is the Trust Medical Review Policy Being Followed?

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Aims. Seclusion is a restrictive intervention used in inpatient settings for the safe management of patients who present with severe behavioural disturbance which is likely to cause harm to others. Clinical notes were used to establish if the trust policy of medical reviews for patients in seclusion was being followed on the Psychiatric Intensive Care Unit (PICU).
Methods. Patients admitted to male PICU at Springfield Hospital, Southwest London, over a 4 month period (February 2022 to May 2022) were included in this audit. Patients who were secluded outside this time period or prior to admission to PICU were excluded from this audit.

The clinical notes computer system (Rio) was searched using the term "seclusion". The timing of initiation and termination of seclusion were noted as well as the timing and grade of medical professionals present for documented reviews.
Results. Over this period, 12 discrete episodes of seclusion were identified. The length of seclusion varied from 8 hours 45 minutes to over 5 days, with a mean length of almost 3 days (2 days, 20 hours, 25 minutes).

As the length of seclusion differed so did the required medical reviews in line with trust policy. This involves Senior House Officer (SHO) review at 30 minutes, Registrar review at 8 hours, Consultant review at 24 hours followed by 2 senior reviews (one Registrar and one Consultant) over each subsequent 24 hour period of continuous seclusion.

10 episodes of seclusion lasted over 24 hours in this audit. Of these 40% had the required medical reviews documented in the clinical notes appropriately for the full period of seclusion. 50% of cases had at least 1 missed or not documented Registrar review. There were 2 incidents of missed Consultant medical reviews for a 24 hour period of continuous seclusion.
Conclusion. From these results medical reviews were not being correctly carried out, or were not documented correctly, in the majority (60%) of cases of seclusion over 24 hours. This suggests missed opportunities for patient review to terminate seclusion at the earliest safe opportunity in line with national and trust guidance. These results have informed the update of trust guidelines on seclusion to bring it in line with national guidance with a view to improve patient care and will be re-audited.

Clinical Audit Reviewing Compliance With Respective Trust-Based Physical Health Monitoring Guidelines, Amongst Inpatients Prescribed Anti-Psychotic Medication in Two Distinct Secure Care Facilities: A Low Secure Unit and a Prison Personality Disorder Unit

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Aims.

1. To review the current level of compliance with CPFT (Cambridge & Peterborough Foundation Trust) guidelines by inpatients prescribed anti-psychotics at George Mackenzie House (GMH) low-secure unit and likewise, with NHFT (Northamptonshire Foundation Trust) guidelines by inmates prescribed anti-psychotics at HMP Whitemoor's Fens Unit.
2. To identify any differences or similarities in compliance rates between both sites.

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