The reason for ongoing seclusion was stated in all but one case. Termination reasons were reported in 91% of cases, with 78% showing required steps undertaken.

Conclusion: This audit identifies strengths in authorisation, reporting, and de-escalation, with areas for improvement in review timing, NEWS assessments, and MDT consistency. Recommendations, shared with stakeholders, are in progress, including staff training, policy updates, automated reminders, enhanced documentation, Non-touch NEWS and virtual MDT meetings, to be monitored in the re-audit.

Measurement and Documentation of Physical Health Parameters of Patients With a Diagnosis of an Eating Disorder at the Cove (Inpatient Unit), in Accordance With the MEED Guidelines

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doi: 10.1192/bjo.2025.10612

Aims: Over the recent years hospital admissions for eating disorders have been on the rise and RCPsych identified this is partly attributable to lack of guidance and training amongst healthcare professionals in recognition of the, often missed, alarming signs.

The Medical Emergencies in Eating Disorders guidelines (MEED) have been introduced to enable assessment and risk stratification of patients with an eating disorder based on a number of physical health parameters to aid emergency management. The complex interplay between physical and mental health of eating disorder patients highlights the importance of good documentation and assessment of clinical factors which would help in seeking appropriate specialist input.

The aim of the audit is to determine if young people admitted to The Cove with a diagnosis of eating disorder have clear documentation on their notes which include physical health parameters in accordance with MEED.

Methods: Data was collected retrospectively from electronic notes of service users with a diagnosis of eating disorder (n=20) admitted to a CAMHS unit over a 30-month period. This baseline audit addresses documentation of evidence of physical health parameters.

Results: The baseline audit focused on documentation of physical health parameters during the period of admission. A high assurance of 80% and above was recorded for: weight for height, heart rate, ECG and blood investigations at The Cove during this audit cycle. A limited assurance whereby the compliance was 70–75% was noted for monitoring of core temperature. There was some underperformance, such as, in documentation of SUSS test and/or hydration status.

Conclusion: The baseline audit achieved an overall compliance of 69%, providing not a high assurance in the monitoring and documentation of physical health parameters on the electronic notes. The compliance calculations were based on a small cohort of service users.

The MDT would need to consider implementing a template that would cover the parameters expected by the MEED guidelines. Following implementation of the tool a re-audit would be performed in due course.

Enabling Environments? A Spotlight on Community Mental Health Team Offices in Wales

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doi: 10.1192/bjo.2025.10613

Aims: A CMHT office should provide a comfortable, supportive, and therapeutic environment for staff and visitors. It should be accessible and welcoming, it should support the development and maintenance of good relationships, recognition of boundaries and make staff and service users feel physically and emotionally safe.

A CMHT office should enable people to communicate effectively, especially those with differing abilities, cultural differences and languages and it should encourage involvement.

Welsh Government commissioned NHS Wales' Joint Commissioning Committee and RCPsych Wales to audit all CMHTs in Wales against these principles.

Methods: A 109-point specification focused on the environment of care was developed. All points were classed as either 'desirable', or 'essential', based on legal or regulatory requirements, potential impact on staff safety, effectiveness, or the possible impact on service user safety, outcomes, inclusion or experience.

The specification was split into 10 areas: Build & Maintenance; Enabling Access; External Areas; Internal Areas; Experience, Privacy & Dignity; Equity; Supporting & Protecting Staff; Clinical Care; Health & Social Care Integration; and Community Links.

The specification was designed so the review team could allocate one of three indicative 'positions' in response to each question, corresponding to whether a particular aspect of the CMHT office was:

'Poor/substandard/not present',
'Adequate/reasonable/acceptable' or
'Good/effective/present'.

A single auditor was used for site visits to support comparative evidence gathering. All Health Boards agreed to participate, and all 45 CMHT offices in Wales were subject to a site visit. During these site visits the environment was assessed, documentation reviewed, and staff interviewed.

Results: Across the 109 point specification, there were stark findings.

Examples of 'more than two-thirds':

89% of CMHT office external areas were tidy.

89% of CMHT offices were less than 5 minutes walk from a bus stop.

Examples of 'less than a third':

24% of CMHT offices had the facility to dispense medications.

22% of CMHT offices parking areas were secure.

Examples of Inequalities in Care:

20% of CMHT offices provided no disabled parking for service user.

2% of CMHT offices had BSL proficient staff and/or access to VSL technology.

Conclusion: This audit highlights effective joint working between RCPsych Wales and NHS Wales' Joint Commissioning Committee. It further highlights that:

Strategic investment is necessary to enhance the CMHT environment in Wales,

Investment must seek to address inequalities in care that are experienced due to the design and state of environments.

Exploring Non-Attendance Rates in the Tri-Borough Perinatal Service: An Audit of Demographic and Socioeconomic Predictors

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doi: 10.1192/bjo.2025.10614

Aims: Non-attendance at initial assessment appointments in perinatal services can delay crucial care and negatively affect maternal and infant health outcomes. The Tri-Borough Perinatal Service, covering Ealing, Hounslow, and Hammersmith and Fulham, aims to maintain a non-attendance (DNA) rate of 15% or lower. This study assessed DNA rates for initial assessments and explored demographic and socioeconomic factors to identify potential predictors of non-attendance.

Methods: Retrospective data from 369 patients scheduled for initial assessments between August and October 2024 in the Tri-Borough Perinatal Service were analysed. After excluding duplicates and incorrectly labelled DNAs, 283 patient records remained. Demographic variables considered included age, ethnicity, self-referral status, need for a translator, disability status, and receipt of benefits. Socioeconomic deprivation was assessed using the Index of Multiple Deprivation (IMD) Rank, based on the English Indices of Deprivation 2019. Statistical analyses, including Chi-square test and binary logistic regression, were conducted to identify significant associations between these factors and DNA rates. A p-value of <0.05 was considered statistically significant.

Results: The overall DNA rate for initial assessments was 35.3% (n=100), which exceeds the gold standard. The average age of patients was 30 years. Most patients (94.7%) were referred by an external body (e.g. midwife, GP, health visitor), 16.6% required a translator, and 15.2% had a known disability. 101 patients (35%) were recorded as receiving benefits, although this was not recorded for 30 patients (10.6%). Ethnicity was not significantly related to DNA rates (p=0.062), with White British patients comprising 16.3% (n=46) of the sample, however 18% (n=51) of ethnicity data was missing due to not being recorded. DNA rates were significantly affected by appointment location (p=0.035), with the highest rates observed for physical centre appointments (40.0%), compared with home visits (20.7%) and remote appointments (25.9%). Socioeconomic deprivation, as measured by the IMD Rank, was a strong predictor of DNA rates ($p<0.001$), with higher deprivation correlating with higher non-attendance.

Conclusion: Socioeconomic deprivation and appointment location were found to be key factors influencing non-attendance, with higher DNA rates observed in more deprived areas and for physical centre appointments. These findings suggest that further improvement studies will be necessary to explore interventions such as alternative appointment formats and targeted support for patients from disadvantaged backgrounds, which may help reduce non-attendance and improve engagement with the service.

Audit of Seclusion Room Standards Across the Humber Teaching NHS Foundation Trust

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doi: 10.1192/bjo.2025.10615

Aims: To identify a set of appropriate standards against which to evaluate all seclusion rooms across Humber NHS Foundation Trust.

To identify thematic issues relating to seclusion rooms that need addressing.

To make evidence-based recommendations to improve the standard of seclusion rooms throughout the sites.

Methods: We arranged to attend each clinical area in person to assess the seclusion area against a defined checklist.

Considerations were made to the time and day of attendance as well as if any areas were in use. Should they be in use we determined we would assess the area at the time of seclusion review if it would not be at detriment to the patient.

If an area was used for long-term seclusion, review would be omitted.

Results: Of audited areas, none were 100% compliant.

Of the areas with dedicated seclusion rooms, none had an actual bed in the room, but all were equipped with mattresses.

Compliance is not at 100% for blind spots.

No clear bedding was available in a high number of rooms.

The lights and heating appear to pose some issues in several of the seclusion areas.

Four wards, Mill View Lodge, Mill View Court, Maister Lodge and Maister Court have no dedicated seclusion rooms. Despite this there have been incidents on three of those four wards, requiring a patient to be secluded before being transferred to an appropriate suite. From looking at the data for these areas, none are 100% compliant with the recommendations and as such mean that a safe and appropriate seclusion cannot be conducted.

Conclusion: Through this audit we highlighted that there are key concerns across all areas of the Trust in regard to the standardisation of the seclusions rooms.

Most of the identified issues were considered 'easy fixes' that had not yet been raised as an issue and arrangements with estates could be made to rectify them.

Unfortunately we identified three areas that did not have dedicated seclusion suites but did have seclusion policies that could