Triangle of Care Standards Incorporation and Audit Implementation to Optimise Carer Involvement and Support Services Across Psychiatric Rehabilitation and Acute Wards at Cygnet Churchill Hospital London

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Aims: UK National Institute for Health and Care Excellence Guidelines recognise the importance of effective family and carer involvement in ensuring good patient care and outcomes.

We aim to embed infrastructural changes supporting carer involvement through Cygnet's Model of Acute and Rehabilitation Care (CMARC), embed rolling audit processes ensuring maintenance of standard adherence across wards and optimise carer support services at Churchill Hospital.

Methods: Triangle of Care (TOC) is an alliance between patient, carer and therapeutic staff. The Carers Trust's TOC partnership (CTTOCP) accreditation was identified as a basis of the initial audit criteria.

Stakeholders were identified and on boarded which included: Cygnet Healthcare Senior Steering Group (CHSSG); Hospital Senior Management Team (SMT); Lambeth Carer's Hub (local community services) and Carer's Advocacy Service (CAS). Carer information packs and feedback forms were created by CHSSG and personalised by the Hospital Carer Lead Team (HCLT) for each ward (multidisciplinary clinical and administrative staff) with LCS/CAS sited.

Interventions implemented across 3 audit cycles included 3 areas: formalising communication across stakeholders (shared calendars; audit and carer communications in SMT/Heads Of Department Meetings and Clinical Governance Reports); increasing HCLT personnel (recruitment; Carer Awareness Training and intra hospital promotion); administrative changes (introduction of Carer Communication forms (CCF) clarifying consent status and Carer communication log tables created to improve consistency in record-keeping in ward rounds) and carer engagement initiatives (monthly inter-disciplinary topic-based carer events delivered by HCLT tailored to carer feedback).

Significant changes in results were achieved after the introduction and subsequent iteration of the infographic Carer Involvement Protocol, which aligns with CMARC and Audit criteria in achievable SMART steps. This was disseminated at Stakeholder and HCLT meetings.

Results: An audit was carried out in April 2024 with compliance to standards being 87% for rehabilitation and 68% acute wards. Limited carer communication was in place with ad hoc feedback provided. Triangle of care Accreditation was achieved in May 2024. Audit Cycles 2 and 3 in September 2024 and November 2024 both resulted in 100% adherence.

Carer engagement has significantly improved with an increase in attendance overall since conception of monthly events by 28%.

Conclusion: There has been significant improvement in the infrastructure of carer services at Churchill Hospital which has relied upon the inter-disciplinary, multi-tiered teamwork and resulted in positive feedback from carers and patient outcomes.

Expert-by-experience led carer events are being introduced in February 2025 with aims to further develop community links and achieve TOC 2 star accreditation.

Re-Audit of Adherence to Antipsychotic Prescribing Guidelines in a Psychiatric Unit for Older Adult Females: Evaluating Improvements and Compliance Post-Interventions

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Aims: The aim of this audit was to assess adherence to antipsychotic prescribing guidelines in one of the Older Adults Female wards at Kent and Medway NHS and Social Care Partnership Trust (KMPT). Specifically, the audit focused on the documentation of key parameters for patients prescribed antipsychotics, including metabolic and cardiovascular risks, baseline assessments, and monitoring, in accordance with NICE guidelines. A re-audit was conducted in June–July 2024 to evaluate improvements following initial interventions. The original audit was published in BJPsych and presented at RCPsych 2024.

Methods: The initial audit in 2023 identified areas for improvement in documentation and monitoring of antipsychotic prescribing. Key parameters were assessed based on NICE guidelines. An action plan was developed and implemented, including refinements to the existing ward round process and the introduction of a physical health monitoring poster for junior doctors. A re-audit was conducted in 2024, analysing compliance with these parameters for two months of patient records. Compliance rates from 2023 and 2024 were compared to evaluate the effectiveness of the implemented changes.

Results: The re-audit showed significant improvements in several areas. In 2024, compliance for documenting patient age, diagnoses, and MHA status remained at 100%. The documentation of antipsychotic indication improved from 80% in 2023 to 100%. Consent to treatment and the MCA tab improved from 66.66% and 53.33% to 100%. Baseline ECG compliance rose from 86.66% to 100% and repeat ECGs within the recommended time frame increased from 53.33% to 79.17%. Blood tests showed significant improvements: fasting glucose/HbA1c (73.33% to 88%), lipid profile (73.33% to 92%), and liver function (73.33% to 100%). Repeat blood tests, such as fasting glucose, HbA1c, and lipid profile, also showed notable increases. Monitoring for side effects improved to 100%, compared with 46.66% in 2023. GP follow-up recommendations for physical health monitoring were fully documented in 2024, compared with 50% in 2023.

Conclusion: The re-audit demonstrated significant improvements in adherence to antipsychotic prescribing guidelines in one of the Older Adults Female wards at KMPT, particularly in areas related to baseline assessments, monitoring, and follow-up care, all in line with NICE guidelines. The changes made in response to the original audit, including refinements to the existing ward round process and the introduction of a physical health monitoring poster, while accommodating the rotation of junior doctors, were effective in

enhancing documentation and compliance. Continued monitoring and future audits will be essential to sustain these improvements and further refine practice and documentation.

Quality of Care of Young People Presenting With Self-Harm at the Norfolk and Norwich University Hospital Emergency Department

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Aims: To determine the quality of care received by young people (16–25 years) presenting with self-harm at the Norfolk and Norwich University Hospital Emergency department using NICE guidelines QS34.
Methods: Retrospective data collection from electronic patient records.

These patients referred via the emergency department of the Norfolk and Norwich University Hospital were assessed as a one off.

271 patients presented with self-harm behaviour to the Accident and Emergency of the Norfolk and Norwich University Hospital in July and August 2024. They were all referred for assessment to the Mental Health Liaison Service. 85 of these patients were of ages 16–25. All the 85 were audited.
Results: 84.7% of patients had a record of risk assessment to reflect if there were any immediate concerns about their safety while 11.8% did not have a record of risk assessment. 3% left before assessment.

81.2% had mental state examination done, 15.3% did not have a mental state examination. 3% left before assessment.

78.8% had an initial assessment of safeguarding concerns, 17.6% did not, and 3% left before the assessment.

82.3% had a collaboratively developed care plan, 11.8% did not and 5% of them either left before the assessment or did not engage with care planning.

80% had initial assessment of social circumstances, 12% did not and 5% either did not engage or left before the assessment.

More than 80% compliance was achieved within the areas of assessment except for safeguarding concerns which was only 78.8%.
Conclusion: Positively, the trust has a template which is aligned with NICE standards. If followed, the guidelines will be adhered to. Assessments that did not meet the guidelines did not use the template. Other NHS trusts should ensure their Electronic patient records have the same and provide regular training to staff.

It is useful to familiarize new/locum staff about the importance of the different aspects of assessment and to follow the guide of the template provided on EPR.

The content of these assessments varied, some had comprehensive assessment while others were less detailed. This should be investigated in the future to determine the definition of an adequate assessment across board.

Audit of Missed Seizure Rate and Management at the Northamptonshire Healthcare (NHS) Foundation Trust ECT Clinic

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Aims: Missed seizures (MS) are non-therapeutic, making their frequency a key measure of an ECT clinic's efficacy. In our initial audit at the NHFT ECT clinic (October 2021–March 2023), an MS rate of 12.6%, a restimulation rate of 67.5%, and poor adherence to the stimulus dosing protocol were identified. To address this, staff training, discussions, and dose chart displays were introduced. A follow-up audit was then conducted to assess the impact of these interventions.
Methods: The audit was conducted retrospectively over 13 months (June 2023–July 2024). Data were collected on total treatments, patient demographics, and stimulus doses. According to the NHFT ECT protocol, MS is defined as stimulation that fails to produce motor convulsions or EEG activity. The protocol recommends that during the seizure-threshold (ST) determination phase, dosing should be titrated as per the stimulus dosing protocol, while in the treatment phase (TP), restimulation should involve a 10% dose increase. The MS rate was calculated as the ratio of MS to total stimulations, and the restimulation rate as the ratio of total restimulations to MS.
Results: The clinic administered 210 bilateral ECT treatments to 22 patients – predominantly middle-aged (40–60 years), 59.1% male, and 77% White/British. The MS rate decreased to 11.6%, and the restimulation rate increased to 81.5%. Of the 27 MS, 19 occurred in the ST determination phase, with 17 restimulated, while 8 were in the TP, with 5 restimulated. Compared with the initial audit, the ST phase saw MS decrease from 81% to 70%, with correct dosing improving from 36% to 88%. After establishing the ST, full compliance with the dosing protocol was achieved – contrasting with the earlier audit, where 84% either received the same or a slightly higher dose. In TP, the current audit achieved full compliance with the recommended 10% dose increase for all restimulations, whereas previously, 2/3 doses were suboptimally increased. Additionally, documentation of the protocol showed marked improvement.
Conclusion: Appropriate management of MS is vital, as they are linked to treatment failure and increased post-ECT side effects. Our interventions have improved protocol adherence, yet further progress is needed. The Bridgend ECT clinic has maintained an MS rate of ≤5% over six years. To achieve similar outcomes, we recommend that the NHFT ECT clinic restimulate rather than proceed with 'doubtful' seizures, as they often lead to MS. Additionally, restimulating at the same dose as the previous MS in subsequent sessions should be avoided, as it is ineffective.