Black Country Mental Healthcare Foundation Trust, Sandwell, United Kingdom

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Aims: Individuals with psychiatric disorders face a significantly higher risk of cardiovascular disease and other medical conditions, leading to increased morbidity and premature mortality compared with the general population. This disparity may also be partly due to diagnostic overshadowing. Effective communication between clinical settings is essential for patient safety and continuity of care whilst delays or inaccuracies in information sharing can have serious consequences.

This study aimed to evaluate the quality and timeliness of communication between an acute inpatient psychiatric unit, Hallam Street Hospital (HSH), Sandwell, Black Country Healthcare NHS Foundation Trust, and an emergency department, Midlands Metropolitan University Hospital (MMUH), West Midlands, to identify gaps and improve transitions of care.

Methods: A retrospective study was conducted between November 2024 and January 2025 reviewing inpatients transferred from HSH to MMUH. Patient records from the corresponding electronic systems were analysed (Rio (HSH) and Unity (MMUH)) to determine whether:

A handover document containing relevant clinical information was provided upon transfer to MMUH.

A discharge summary including a management plan was available upon patient's discharge to HSH.

Results: Twelve patients were referred from HSH to MMUH during the study period with three (25%) requiring re-attendance. A limitation of this study was its small sample size due to the recent transition of the handover system.

Ten patients (83%) were accompanied by staff, while one (8%) attended alone, one (8%) accompanied by family.

Four patients (33%) were sent to MMUH with a handover document. Only one (8%) had been scanned onto Rio. None were available for viewing on Unity.

Nine patients (75%) returned to HSH with discharge summaries, however only five (42%) had been uploaded onto Rio.

The discharge summaries generally contained adequate details on the patient's hospital course and management plan, aligned with NICE guidelines.

Conclusion: The audit highlighted a lack of a standardised protocol for written handover during patient transfers. While discharge summaries were electronically sent to GPs, a dedicated copy for HSH records was not consistently generated. Clinicians relied heavily on verbal handovers provided by accompanying staff or the patients themselves, increasing the risk of miscommunication and errors.

To enhance patient safety and continuity of care, we propose developing a standardised transition-of-care protocol, ensuring systematic documentation, and conducting a re-audit to assess improvements in practice.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Audit on Drug Screening Practice on Inpatient Psychiatric Wards

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Aims: The relationship between mental illness and substance misuse is well established. Early identification through drug testing can inform more holistic management plans. This audit aims to check the compliance of the current practice on acute psychiatric wards with the Trust policy for drug screening, it also aims to draw conclusions, and recommend changes to increase the compliance and benefits from implementing the policy.

Methods: Data was collected retrospectively from two adult acute psychiatric wards, including a sample of 20 male and 20 female patients admitted in 2024.

The parameters assessed were:

The presence of any documentation regarding drug testing on admission.

If the drug test was offered, accepted or refused, and if the results were documented.

If the positive results were acted on, such as referrals to substance misuse services.

Results: Any documentation related to drug screening was present in 23 out of 40 patient records (57.5%).

This indicates that nearly half of the patients admitted lacked proper documentation of whether a drug test was indicated, considered, offered, or completed.

21 out of 40 patients (52.5%) were offered a drug test.

In 4 cases, drug screening was recommended as part of the plan but was not offered or followed through. Reasons for this were not recorded.

Among the 21 tests offered, 15 patients (71.4%) completed the test. 8 (53.3%) were positive and 7 (46.7%) were negative.

6 patients (28.6%) refused UDS, but the reasons for refusal were not documented.

5 out of 8 patients with positive drug test results were referred to the substance misuse service.

Conclusion: This audit highlights inconsistencies in drug testing practices on inpatient wards, particularly regarding documentation, offering of tests, and follow-up on the results.

Recommended changes are as follows:

Drug screening should be offered to all inpatient groups, results should be acted on appropriately.

Improving documentation: The inpatient teams to ensure documenting if drug testing has been or should be offered, if it was accepted or refused, its results, and if positive, the follow-up plans.

By implementing those changes, drug testing can become a more effective tool for identifying and managing substance misuse, ultimately improving patient outcomes.

Findings and recommendations for change are being circulated in the Trust, and a re-audit following the implementation of recommendations will be undertaken after 3 months to evaluate the effectiveness of changes and ensure continuous improvement.

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Comprehensive Evaluation of Referral Practices From General Practitioners to Balbriggan CMHT, Dublin: Audit Cycle Overview

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Aims: The aim of this audit was to evaluate and enhance referral practices from general practitioners (GPs) to the Balbriggan Community Mental Health Team (CMHT), Dublin. Appropriate referrals are crucial for effective mental health care. The initial audit, conducted in mid-2024, sought to identify barriers to successful referrals, particularly regarding psychotherapy initiation and medication management. Following these findings, guidelines were developed and disseminated to GPs to improve the referral process. A follow-up audit was then conducted to assess the impact of these interventions on referral practices and identify any remaining challenges.
Methods: An audit cycle was conducted, comprising a retrospective initial audit followed by a prospective follow-up audit. The initial audit reviewed 110 referrals from 1 May to 1 August 2024, while the follow-up audit analysed 77 referrals from 1 September to 30 November 2024. Following the initial audit, local guidelines were created and shared with GPs on 19 August 2024, focusing on appropriate referral procedures, psychotherapy initiation, and medication management. Data collection focused on referral acceptance rates, reasons for rejection, and the initiation of psychotherapy and psychotropic medication. The effectiveness of the guidelines was also evaluated.
Results: The results of the audits showed significant improvements in referral practices. In the initial audit, 110 referrals were reviewed, resulting in 60 accepted (54.5%) and 50 rejected (45.5%). Key barriers included 16% of patients not receiving psychotherapy and 11% receiving suboptimal medication dosages. Additionally, 9% of referrals were declined due to non-initiation of psychotropic medications, indicating GPs' hesitancy to refer patients without prior treatment.

In contrast, the follow-up audit, which reviewed 77 referrals, showed a marked increase in acceptance rates, with 71 accepted (92.2%) and only 6 rejected (7.8%). However, 14% of patients still did not receive psychotherapy, suggesting persistent hesitancy among GPs. Notably, the percentage of rejected referrals for ADHD/ASD assessments increased from 21% to 33%, indicating that misalignment between GP expectations and CMHT services remains a challenge.
Conclusion: This audit demonstrates the importance of effective communication and collaboration between GPs and the CMHT in enhancing referral practices. The implementation of guidelines led to improved referral acceptance rates. However, challenges still exist regarding psychotherapy initiation and specific service offerings, particularly for ADHD/ASD assessments. Ongoing monitoring and education for GPs are essential to sustain these improvements and ensure optimal patient access to mental health care.

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Evaluating Care in Patients with Delirium and Dementia in a Busy District General Hospital: An Audit

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Aims: Delirium is defined as the acute confusional state common in the elderly patient population of hospitals. Alongside existing diagnosed and undiagnosed dementia, it is a common cause of cognitive impairment in the elderly. This project aimed to evaluate the care patients with delirium and dementia received by analysing interventions made by both the referring party and the liaison team as per the local and national guidelines.
Methods: The retrospective audit included 39 referrals made to the psychiatric liaison service (PLS) for delirium and/or dementia over three months in patients aged 65 and older. The data was collected from electronic health records to assess parameters such as diagnostic tools used (e.g., '4AT Rapid Clinical Test for Delirium', 'PINCH ME' a mnemonic for delirium risk factors including Pain, Infection, Nutrition, Constipation, Hydration, Medication, Environment), cognitive testing, medication reviews, and team actions.
Results: This study found ongoing positive practices and areas for improvement in diagnosing and managing delirium and dementia in older adults. Among the 39 patients, 43.6% had a pre-existing diagnosis of dementia, and 28.2% were admitted with acute confusion. While diagnostic blood work, medication reviews, and collateral histories were frequently performed by the referring team, only 51.3% of patients were referred to the Delirium and Dementia (DAD) team. The use of the 'PINCH ME' mnemonic was limited, with just 28.2% of cases incorporating it.

After referral, most patients had a history taken, a mental state examination (MSE) conducted, and collateral information gathered by PLS; however, only 10.2% of cases included the use of the mnemonic. Antipsychotics were prescribed in 30.7% of cases. At the point of discharge, 82.1% of cases had follow-up arranged by PLS, with 35% of patients referred to memory clinics for continued care.
Conclusion: This audit reveals areas for improvements in the assessment and management of delirium and dementia in hospitalized older adults. Recommendations have been made based on this data to help improve use of 4AT, PINCHME mnemonic and referral process.

Educational initiatives and increased collaboration with the Delirium and Dementia team have been introduced to improve early recognition, standardize care, and align practices with current guidelines. Further study will be conducted to explore its effect as part of a quality improvement project.

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Medical Treatment Under Community Compulsory Treatment Orders – Are Medications Prescribed Lawfully?

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doi: 10.1192/bjo.2025.10601

Aims: The Mental Welfare Commission (MWC) has provided information outlining good practice for consent to treatment in relation to The Mental Health (Care and Treatment) (Scotland) Act 2003. Patients prescribed psychotropic medications beyond two

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