summaries, providing guidance for implementing changes that support timely completion and help achieve the 7 day target.
Methods: We reviewed discharge summaries from January to December 2023 for patients discharged from Wards 3 and 4. The time from discharge to summary completion was recorded and compared against the 7-day target. Summaries were selected based on numerical randomisation, with 11 cases reviewed from Ward 3 and 13 from Ward 4. After data collection, we invited stakeholders to MDTs, where we identified nine key barriers, mapped the current process, clarified development regarding influence and interest, and prioritised two specific changes while exploring potential solutions.
Results: The review of discharge summaries from Wards 3 and 4 revealed delays in completion. In Ward 3, none of the 11 reviewed cases had their discharge summaries completed within the 7-day target. In Ward 4, 23% of the 13 reviewed cases met this target. These delays can negatively impact patient care by slowing communication with GPs and community teams. Nine key barriers were identified, and two were prioritised: lack of uninterrupted time and delays in the allocation of a doctor to complete the discharge summary.
Conclusion: This audit identified nine key barriers, including a lack of protected time, unclear doctor allocation, and frequent interruptions due to ward acuity. To address these challenges, we propose implementing a dedicated 4-hour weekly slot for junior doctors to complete summaries, assigning a responsible doctor at the time of discharge, and providing a quiet workspace away from the acute ward but onsite to ensure they remain contactable in an emergency. These changes aim to simplify the process, reduce delays, and support both patient care and staff well-being, helping to achieve the new target of 14 days, extended from the previous target of 7 days.

Diagnosis Concordance in Liaison Psychiatry Patients Transferred From a tertiary Center to Inpatient Psychiatric Care

Dr Tabea Winkler and Dr Nadine Cossette

Royal Infirmary of Edinburgh, Edinburgh, United Kingdom

doi: 10.1192/bjo.2025.10697

Aims: A subset of patients assessed by the Liaison Psychiatry service at the Royal Infirmary of Edinburgh are transferred for inpatient psychiatric care. The aim of this audit was to investigate diagnosis concordance, length of stay and nature of follow-up in this cohort. A comparison was made with a previous version of this audit from 2019.
Methods: A review of the relevant cohort took place using internally recorded data from the liaison psychiatry service and inpatient discharge letters from Trak (an electronic notes system). The chosen time period spanned 01/01/24–28/06/24 (n=68). Patients were excluded if no clear working diagnosis was available, they were admitted to an inpatient facility not using Trak or if they were transferred from and subsequently returned to IP care (n=54). Diagnosis concordance was split into complete agreement/match to disorder/match to group of disorder/match with +/- 1 additional diagnosis/no match.
Results: Demographic overview: 82% of patients had been discharged from IP care by the end of the audited time period. 55% of transferred patients were male; 45% female. Patients were most commonly aged between 31–35.

Length of stay: Length of stay ranged from 1–260 days, with a mean of 65.82 and a median of 36 days.

Diagnosis concordance: 33% had complete agreement, 8% match to disorder, 26% match to group of disorders, 20% had a match +/- another diagnosis and 13% had no match. Therefore, 87% of patients had a match of some kind. The most common diagnosis group was a mood disorder, followed by neurocognitive disorders and primary psychotic disorders.

Follow up: 44% had mixed follow up (>1 discipline), 24% CMHT, 7% IHTT, 9% RRT, 7% CPN, 7% specialist and 2% solely primary care.
Conclusion: In a majority of patients there was an element of diagnosis concordance. Liaison psychiatry diagnoses can partly be a snapshot based on a shorter stay, and inpatient admission may allow further details to come to light influencing diagnosis (i.e. first presentation psychosis to schizophrenia). Notably, in comparison to the 2019 median audit IP length of stay had increased by 11 days. Hypotheses explaining this include a changing patient cohort overall or increased bed pressures leading to a different subsection of patients being admitted to IP care. The most common disorder group (mood disorder) is in line with a high percentage of patients presenting to the RIE secondary to intentional overdose with suicidal intent.

Audit to Assess the Availability of Electrocardiogram (ECG) Machines on the Inpatient Units at Leeds and York Partnership Foundation Trust (LYPFT)

Dr Sabah Yasin and Dr Abhijit Chakrabarti

Leeds and York Partnership NHS Foundation Trust, Leeds, United Kingdom

doi: 10.1192/bjo.2025.10698

Aims: Establish the scale of the problem by collecting data on how frequently electrocardiogram (ECG) machines are not available, and the time doctors are spending searching for them.

Develop strategies for better monitoring and maintenance of available machines.
Methods: Initial data was collected from resident doctors within Leeds and York Partnership Foundation Trust (LYPFT) regarding incidents where ECG machines were not available over a period of 3 months beginning 01/08/2024 and ending 01/11/2024.

Data collection was facilitated by sending emails to resident doctors three times over the course of data collection. A reminder message was also sent out to the Resident Doctors WhatsApp group. Reports were received via email.

The data was collated and recorded on an Excel spreadsheet by SY.

Following data collection, statistical analysis was done on data received. This was via qualitative analysis such as calculation of the mean, median, mode; and through qualitative analysis via thematic analysis.

Due to the concerns surrounding early reports received and the implications for patient safety, concerns were escalated in the Trust senior leadership meetings and more ECG machines were sourced during the audit period.

Results were discussed at the Physical Health Team monthly meeting, to consider potential for improvements.
Results: A total of 28 reports were received over the three-month period, with the majority in August prior to escalating to senior

leadership. Doctors spent a total of 490 minutes searching for a machine, with the mode and median being 10 minutes, and the longest being 120 minutes. 4 incidents reported of ECGs not being done. 89% of ECGs were required for routine monitoring, with 11% being due to chest pain. 46% of incidents were due to a missing machine, and 54% were due to a faulty machine. Faults were due to a paper fault, broken leads, missing clips, no charging cables, or the machine itself not working.

Conclusion: There are clearly significant issues with the availability of ECG machines across the inpatient facilities within the trust, leading to potentially significant delays both for routine and urgent ECGs. Issues highlighted within the trust meetings suggested that faulty machines were often not reported or fixed. To address this, it has been agreed to develop instructional flowcharts to streamline the escalation process and to implement this within the trust over the coming months.

Audit of Antipsychotic Monitoring in an Old Age Community Mental Health Team in Accordance With NICE Guidelines

Dr Serife Dilara Yozgatli and Dr Felix Clay

CPFT, Cambridge, United Kingdom

doi: 10.1192/bjo.2025.10699

Aims: Antipsychotic monitoring is crucial for identifying and managing side effects, improving treatment compliance, and reducing risks associated with long-term use. NICE guidelines recommend routine monitoring to enhance quality of life and prevent disengagement due to adverse effects. This audit assesses compliance with these guidelines within an Old Age Community Mental Health Team (CMHT). This was also discussed in MDT, as well as with patients and carers to have a better understanding of patient experience and how we can enhance antipsychotic monitoring.

Methods: We have registered our audit with Clinical Effectiveness Team at Cambridgeshire and Peterborough NHS Trust. We screened 101 patients under Ely Neighbourhood Team. We included patients with Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Delusional Disorder currently on antipsychotic medication. Of the 18 patients identified with these diagnoses, 17 were on antipsychotics. We have screened their notes in the last 12 months for Body Mass Index (BMI), ECG, Complete Blood Count (CBC), Electrolytes (U&E),Blood Lipids, HbA1c, Pulse and Blood Pressure, Liver Function Tests (LFT), Emergence of Extrapyramidal Side Effects (EPSE) or Movement Disorders.

Results: 17 patients were included in the audit. Patients were between ages 66 and 84. Of them 5 were males and 12 females. Of the 17 patients 6 (35%) of them had Schizophrenia, 3 (18%) of them had Paranoid Schizophrenia, 3 (18%) of them had Delusional Disorder and 5 (29%) of them had Bipolar Disorder. Within the last 12 months, all patients on antipsychotics were offered monitoring; 1 patient declined. 94% had blood work monitoring. 100% had pulse and BP recorded. 29% (5 patients) did not have an ECG, despite being on medications requiring ECG monitoring. 11 patients (65%) were not asked about EPSE/movement disorders. Of the 6 patients asked about EPSE, 66% (4) were asked in outpatient reviews, and 33% (2) were asked as inpatients in psychiatric units.

Conclusion: Despite good compliance with most aspects of antipsychotic monitoring, ECG and movement disorder evaluations require improvement in elderly CMHT cohorts. We recommend psychiatrists to work collaboratively with GPs to enhance antipsychotic monitoring.

Clinical Audit : Supporting Post Detox Abstinence: Discussion of Relapse Prevention Medications by Community Addiction Services Prior to Referral for Inpatient Detoxification

Dr Farheen Zahra[1], Dr John Barker[1] and Dr Paul Briley[1,2]

[1]Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, United Kingdom and [2]University of Nottingham, Nottingham, United Kingdom

doi: 10.1192/bjo.2025.10700

Aims: Without a plan to support ongoing abstinence, detoxification ("detox") could increase, rather than reduce, risks to a patient. Before referring for inpatient detox from alcohol or opioids, community teams are expected to discuss relapse prevention medications (RPMs) with patients, as part of their wider support plan.

This clinical audit examined whether RPMs were mentioned in referrals by community teams to our inpatient detox unit.

Methods: We examined referrals for patients admitted to The Level Nottingham inpatient detox unit between 1 January and 31 August 2024. Of a total of 215 patients that completed opioid or alcohol detox, a random sample of 50 were selected, stratified according to referring team. Referral forms and running notes were used to assess compliance with the following criteria:

1. Referring teams mention RPMs (whether to be considered or not considered).
2. Referring teams provide blood test investigations.

There was no previous literature or audit to specify a standard, so, given the importance of the issues under consideration, this was set as 100% for each criterion. We also extracted: whether patients were planned to go to residential rehabilitation after detox, and, where relevant, which RPMs were mentioned and time from blood test results to referral and to admission.

Results: 68% of referrals were for alcohol, and 24% for opioid, detoxification (2% were for alcohol and opioid, and 6% for other substances).

40% of referrals for alcohol, and 77% of referrals for opioid, detoxification did not mention RPMs.

29% of referrals for alcohol, and 31% of referrals for opioid, detoxification did not mention RPMs and were not planned to go to residential rehabilitation (considered as some of these settings do not accept patients on RPMs, focusing solely on psychosocial support).

48% of referrals for any detoxification did not have blood test results available. Where blood test results were available, median time from test results was 22 days to referral and 85 days to admission.

Conclusion: During the study period, an estimated one-third of referrals for alcohol or opioid detoxification did not mention RPMs (and were not going to residential rehabilitation post inpatient stay).

Approximately half of admissions did not have blood test results available.

The above is likely to delay the prescription of RPMs, and potentially increase the risk of relapse post-detoxification.