the results may have been influenced by individual variability, given the involvement of multiple doctors in the clerking process for new admissions. The findings highlight the importance of regular training and reinforcement of local guidelines to enhance patient care. Nonetheless, there remains an opportunity for further work in this area, including regional audits and updates to local guidelines.

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 the Appropriateness of Monitoring Frequencies and Clinical Escalation From National Early Warning Scores 2 (NEWS2) in Old Age Psychiatry Patients

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Aims: Physical health monitoring and assessment in psychiatry is fundamental to holistic care provision, and NEWS2 provide an objective, standardised pathway that aids the timely detection of clinical deterioration. This subsequently facilitates appropriate clinical review and care escalation.

This audit based on an older adult functional psychiatric ward aimed to evaluate the adherence to NEWS2 protocols in the following domains:

Monitoring frequency.

Clinical responses to NEWS2.

Methods: A thorough review of NEWS2 documentation for 24 patients on Beech Ward at Rochford Hospital over the same time period of 3 weeks was completed. Of these patients, 12 were present for this same time period, and 3 of these patients were omitted due to frequent refusal of clinical observations. This review yielded 476 NEWS2 entries from 9 patients between ages 68–86, with a gender ratio of 4:5 male to female and admission durations from 44–355 days. The aggregate score for each NEWS2 entry was collated, and the appropriateness of monitoring frequency was assessed by directly comparing the documented monitoring frequency to the Royal College of Physicians' recommended monitoring frequency. To evaluate the appropriateness of clinical responses to the aggregate score, care escalation documentation for each NEWS2 entry alongside corresponding clinical documentation of patient reviews by nursing staff and doctors were assessed.

Results: This study yielded 476 NEWS2 entries – 42% demonstrated appropriate monitoring frequencies, with most adherence to 12-hourly routine monitoring due to NEWS 0 (81%). The remaining 58% of entries evidenced monitoring frequencies which deviate from standard recommendations, with all of these observations monitored at frequencies less than the recommended minimum. Recommended minimum 1-hourly observations were monitored up to 12-hourly, minimum 4-hourly observations were monitored up to 30-hourly, and minimum 12-hourly observations were monitored up to 48-hourly. Inappropriate clinical responses to patient escalation were secondary to incomplete documentation of care escalation, and lack of escalation to the medical team for clinical review in light of a score of 3 in a single parameter.

Conclusion: In conclusion, these findings highlight the need for better adherence to recommended monitoring frequencies to promote patient safety and care, as evidenced by the deviation in monitoring intervals. Clinical nursing responses to NEWS2 were appropriate, however, completeness of documentation is imperative to ensure care escalation is not overlooked. This has prompted discussions with the multidisciplinary team regarding adherence to NEWS2 documentation recommendations, and intradepartmental teaching sessions outlining clinical handover and indications for care escalation.

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Audit of Seclusion: Evaluating Performance Against National and Local Standards

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Aims: Seclusion, under the Mental Health Act (MHA 1983) Code of Practice, is the supervised confinement of a patient to manage severe risks. The Mental Health Law Governance Group commissioned a clinical audit to assess compliance with the Trust's Seclusion Policy and MHA Code of Practice, prioritised in the 2024–2025 Audit Programme.

Aim and objectives were to improve the management of patients undergoing seclusion at North Staffordshire Combined Healthcare NHS Trust (NSCHT), and to assess compliance with seclusion standards and identify actions for improvement where necessary.

Methods: All seclusions were identified by the Mental Health Law Team (n=46) from January 2023 to February 2024. Data were collected using a template based on standards and analysed with SPSS by the Clinical Audit Department.

Results: Seclusions mostly occurred within the first week of admission, mainly in patients with bipolar disorder or paranoid schizophrenia, with over half detained under Section 2 of the MHA. The majority were authorised by the Nurse in Charge, with incident forms completed in 83% and de-escalation attempted in 87%. NEWS (National Early Warning Score) was incomplete in 82% at seclusion initiation. The Site Manager was informed in all cases, but timings were unclear in 93.5%. The doctor was notified in all but one case (67% within 30 minutes).

100% had medical reviews, with 39% within one hour and 29% after 120 minutes. In 96% of cases, reviews were repeated before Multi-disciplinary Team (MDT) meetings, with half occurring every four hours. Nursing reviews occurred in all cases, with half conducted every two hours and two nurses involved in two-thirds of cases.

Internal and external MDTs took place in 63% and 72% of cases, respectively. Internal MDTs occurred in 17% of cases in the first 24 hours, and external MDTs in 46%. External MDTs were repeated every 24 hours in 83%. In 46% of cases, both internal and external MDTs were conducted, but 11% had neither. Night-time reviews were suspended in 14 cases, as 10 patients were asleep, leading to review deferral.

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.

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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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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.

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

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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: