Methods: Searches on EMIS were conducted from a list of registered patients currently on atypical antipsychotics to assess whether weight, glucose/HbA1c, blood lipids and BP had been checked in the previous year, in accordance with BNF recommendations for monitoring. Standards set were:

- **100% of patients will have three or more of the four CVD risk factors monitored within the past year.**
- **80% of patients in the practice monitored for each measure within the past year.**
- **A statistically significant increase in overall rates of monitoring from 2024 to 2025 using Fisher's Exact Test.**

Results: For standard 1, there was an increase from 48% to 60% of patients who met this standard from 2024 to 2025. For standard 2, none of the four measures met the criteria in either year, however three measures had increased from 2024. Standard 3 was met as the overall monitoring rate had increased from 58% in 2024 to 65% in 2025, which was a statistically significant increase using Fisher's Exact test with a p value of 0.04.

Conclusion: NICE guidelines state that patients taking antipsychotics should have annual monitoring of cardiovascular risk factors due to their potential side effects. Although results show that neither of the first two standards were met in both cycles, standard 3 was met, showing a statistically significant improvement in rates of monitoring. This suggested that recommendations made from the 2024 cycle had a positive effect on rates of cardiovascular monitoring of patients on antipsychotics but that further improvements could be made. Further recommendations were made, including implementing manual monitoring reminders for patients not under the SMI checks and long-term solutions for phlebotomy access. Another re-audit will be conducted to assess the impact of these recommendations.

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An Audit to Determine Whether Managing Non-Cognitive Symptoms of Dementia with Antipsychotics in the Crisis Function Team Is Conducted in Line with the NICE Guidelines

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Aims:

- To ensure the Southwest Crisis Function Team (in HPFT) manages non-cognitive symptoms of dementia as per NICE guidelines, and provides appropriate non-pharmacological and pharmacological management options.
- If not possible, identify reasons and challenges, and suggest methods for improvement, which could be implemented and re-audited.

Methods:

1. All referrals received by CFT in a 12-month period were obtained through the SPIKE database.
2. 48-hour referrals and wrong referrals were excluded.
3. Only service users with a diagnosis of dementia AND were presenting with agitation, aggression, distress or psychosis were included. This information was obtained through PARIS.
4. Service users' case notes were reviewed to ascertain whether they or their carers:
   - Had a structural assessment and had been offered psychosocial and environmental interventions as initial and ongoing management to reduce distress for service users.
   - Had been offered antipsychotics and:
   - If they were at the time at risk of harming themselves or others, or were experiencing agitation, hallucinations or delusions that are causing them severe distress.
   - If they had discussions about risks and benefits of antipsychotics.
   - Had been started on the lowest effective dose possible and were recommended to be reassessed by the prescriber.

Results:

1. In 2023, a total of 247 new Service Users (SU) were referred to CFT. After excluding 48-hour follow up referrals and inappropriate referrals, A total of 55 referrals were for SUs who were diagnosed with dementia and were presenting with agitation, aggression, distress, or psychosis. 12 out of the 55 referrals were for 6 SUs who were referred twice at different times during the year.
2. 100% (55/55) of the included referrals received a structural assessment to 1- explore possible reasons for their distress, and 2- check for and address clinical or environmental causes. 100% (55/55) were also offered psychosocial and environmental interventions as initial and ongoing management to reduce distress for SUs.
3. In 12/55 referrals, SUs were already on antipsychotics. In 7/55 referrals, SUs could not be managed without a new prescription of antipsychotics.
4. In these 7 referrals (12.7% of total eligible SUs), SUs received new prescriptions of antipsychotics as a pharmacological intervention and in all 7 referrals, the SUs were at risk of harming self or others**or**were experiencing agitation, hallucinations or delusions that are causing them severe distress.
5. 100% of the 7 referrals showed that SUs were started on the lowest effective dose of the prescribed antipsychotic.
6. However, out of the 7 referrals that received new prescriptions of antipsychotics, none of them (0%) had documentation on PARIS about discussions of risk and benefits of antipsychotics.
7. Finally, when looking at all the referrals where antipsychotics were used (19 referrals in total), there was clear documentation on PARIS about reassessment or a recommendation for reassessment of antipsychotic after 6 weeks in 4/19 referrals (21%).

Conclusion:

- 100% of referred SUs received a comprehensive, structural assessment.
- The team offered psychosocial and environmental interventions to all SUs who were eligible.
- The team offered antipsychotics only when necessary, in a small percentage of cases(12.7%), and followed NICE guidelines for initial doses and service user eligibility.
- However, no documentation in any of the service user's case notes mentioned discussions about risk and benefits of antipsychotics and only 21% had recommendations for reassessment of the antipsychotics within 6 weeks.

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Retrospective Audit on Liaison Psychiatry Referrals

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Aims: This audit compares the old and new referral forms to determine whether the redesigned version captures the required data more effectively, whether certain fields are unnecessary, and whether further improvements are needed. It also explores whether the older form encouraged more information or whether both forms still fall short in key areas.
Methods: Data were obtained from stored copies of liaison psychiatry referrals submitted to University hospital of Limerick. A total of 100 referrals were reviewed. Two samples were created:

Baseline audit included 50 referrals randomly selected from January to April 2024 (using the old referral form)

Re Audit 50 included referrals randomly selected from January to April 2025 (using the redesigned referral form)

Data were collected and analysed. Each referral was reviewed against the predefined checklist of required data items derived from the 2025 redesigned referral form.

A structured Excel spreadsheet was used to record the presence or absence of each criterion for all referrals. Analysis was performed to compare completion rates between the old and new forms, assess compliance with the working standard, and identify areas requiring further refinement.
Results: Overall, the redesigned referral form demonstrated significant improvement in the completeness and consistency of information provided across nearly all domains.

The new referral form showed compliance for patient identifiers and referrer details. In contrast, the old form showed inconsistent completion rates for key administrative data, particularly GP details, referring doctor, referrer contact number, and email.

Medical status, suspected psychiatric symptoms, duration, and pattern of symptoms were better captured in the new form compared to the old form.

Cognitive screening items such as alertness, AMT4 score, and counting months backwards were rarely recorded in the old referrals but were captured with much higher consistency in 2025.

The reason for admission was well documented in both forms, though more consistently in the new version.

Documentation of previous psychiatric diagnoses, current psychiatric medications, and attempts to treat prior to referral improved markedly with the new form. These elements were commonly missing or incompletely described in the old referrals.

Risk documentation was among the most significant improvements
Conclusion: The redesigned 2025 referral form clearly improved the completeness of information submitted to liaison psychiatry, as demonstrated by the higher documentation rates across nearly all criteria. However, despite these improvements, several challenges remain that impact the practical usability and clinical value of the referral information received. This audit will inform a new service and quality development project.

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Evaluation of Suicide Risk Assessment Documentation Standards in Psychiatric Outpatient Clinics

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Aims: To evaluate the quality of suicide risk assessment documentation in outpatient consultations against NICE NG225 and Local Trust standards, and to assess whether a focused feedback intervention improved documentation quality.
Methods: A retrospective baseline audit reviewed the first 50 consecutive outpatient consultations from 1 December 2025. Findings were summarised and fed back to clinicians. A re-audit examined 50 subsequent consultations from 23 January using the same structured assessment criteria. Core criteria included documentation of suicidal ideation, plan, intent,access to means, history of self-harm, risk formulation, and safety planning. Additional criteria assessed shared decision-making and communication with the General Practitioner.
Results: Substantial improvement followed the feedback intervention. Documentation of consent and confidentiality increased markedly (from 4% to 76%), reflecting greater attention to patient involvement and transparency. Recording of history of self-harm, a key predictor of future risk, improved significantly (from 28% to 76%). Protective factors, often under-recorded locally, increased from 52% to 78%, strengthening overall risk formulation. General risk formulation itself showed a notable improvement (62% to 82%), showing a clearer integration of dynamic and historical factors.

Among patients expressing suicidal ideation (baseline 28%, re-audit 50%), documentation of suicidal plan and intent improved from 0% at baseline to 84% post-intervention–representing one of the most clinically meaningful changes observed. Despite improvement in several domains, access-to-means exploration remained low (6% to 14%), identifying an important area requiring further attention. Documentation of shared decision-making showed some decline (98% to 84%), suggesting that emphasis on risk-specific domains may have inadvertently reduced focus on collaborative discussions.
Conclusion: Targeted feedback led to clear and meaningful improvements in several domains central to high quality suicide risk assessment, particularly self-harm history, protective factors, overall risk formulation, and documentation of plan and intent among patients with suicidal ideation. Persistent gaps in assessing access to means highlight a priority area for additional intervention. Future work would focus on embedding structured reminders within clinical templates, reinforcing collaborative practice, and conducting further re-audits to sustain improvement.

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Evaluation of Admission Clerking Practices for Psychiatric Inpatients on Ward F, Neath Port Talbot Hospital

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Aims:

1. To evaluate the completeness and quality of admission clerking documentation for psychiatric inpatients on Ward F, Neath Port Talbot Hospital.
2. To identify areas for improvement to ensure compliance with national psychiatry standards.

Methods: A retrospective audit was conducted on 13 December 2024, reviewing admission clerking proformas for all 23 inpatients on Ward F. Documentation was assessed across key domains including patient identification, presenting complaint, psychiatric and medical history, forensic and substance misuse history, risk assessment, mental state and physical examinations, medication