NICE guidance recommends verbal and written safety netting advice is given. Advice was given in 16% (n = 5) of incidents. NICE recommends a responsible adult remains with the patient for 24 hours, this was documented in 77% (n = 22) of incidents. NICE recommends ongoing doctor concerns necessitate patient transfer to A&E. Concerns/lack of concerns were documented in 6.6% (n = 2) of incidents.

Conclusion. This audit has demonstrated inconsistencies between doctor's documentation of self-inflicted head injuries in an inpatient CAMHS setting. The reviews do not meet the standards outlined by NICE. There is a good emphasis on gross neurology but less awareness of the need to document more subtle pathology and ongoing monitoring requirements.

Psychiatric Induction Programme in Fife

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Aims. To improve the Psychiatry induction for DiTs in Fife.

Methods. The purpose of induction is to provide Doctors in Training (DiT) with a smooth, supported transition between roles. Delivered well, it will promote confidence and also provide a thorough grounding in the key requirements of the role and clarity regarding sources of help.

A recent report, commissioned by the GMC, identified the key areas which should be covered in induction. The findings demonstrated a clear link between inadequate inductions to the impact on doctors' well-being and patient safety issues.

A questionnaire was issued to DiTs completing Psychiatry inductions in August and December 2021. Questions focused on the following key areas highlighted in the GMC report:

- Gaining access to workplace settings and systems
- Physical orientation of workplace
- Team inductions
- Daytime role and out of hours working and rotas.
- Familiarisation with common cases/procedures that doctors may deal with in this speciality: risk management, use of the MHA

Results. Questionnaire Results: Key Issues highlighted

August 2021

- FY2 to ST6 inducted together: differing experience levels
- Differences in site inductions (psychiatry is spread across 3 hospitals in Fife)
- Issues obtaining swipe cards/keys
- IT access for emails and various computer systems delayed
- Computer systems training not done

December 2021

- Lack of psychiatry experience of FY2s
- Continued IT access issues initially

Conclusion. In September 2021, a working group was established comprising DiT representatives and those responsible for induction. The August 2021 results were disseminated and key improvements were identified in areas covered by the clinical induction:

- An improved induction check list universal for all sites.
- Induction documents for each role detailing responsibilities and useful information.
- Integration of IT training.

The December results highlighted improvements in many areas but continued a theme of concerns for FY2s starting in Psychiatry. The transition to this speciality is a significant adjustment as it operates differently to most specialities, requiring different skills and knowledge.

Plans have been made to provide simulation events which would give DiTs practical experience in a safe environment of various topics e.g., risk management in psychiatry. Additionally, there are plans to revise induction for speciality trainees.

Audit Against DVLA Guidance for New Psychiatric Patient Referrals at the Early Intervention for Psychosis Team (EIP)

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Aims. To assess the compliance of the clinicians in EIP team with DVLA guidelines. *Objectives*: To assess if there was documented evidence of: 1)Patient's diagnosis, 2)Patients' driving status, 3) Type of vehicle driven, 4)Informing the patient that their condition may affect their ability to drive, 5)Advice regarding driving restrictions where applicable, 6)Informing the patient that they have a legal duty to inform the DVLA about their condition

Methods. We selected two-thirds of the patients(n = 40) enrolled in the EIP service in the last year by consecutive sampling. We collected the data retrospectively from the clinical documentation and analysed it using excel sheets.

Results. The mean age of the study sample was 34 years. 95%(n = 38) had a documented diagnosis, 67.5%(n = 27) had a documented driving status. The documentation of driving status was completed by doctors in 52%(n = 14), nurses in 26%(n = 7) and by both in 22% (n = 6). The type of vehicle driven was documented for only 33%(5) of the drivers. Among the drivers identified 33% (n = 5) had been informed that their condition might affect their driving, 67%(n = 10) had received information on driving restrictions and 47%(n = 7) had received information that they have a legal duty to inform the DVLA.

Discussion:. One of the reasons for the low compliance may be because another team might have documented the information at the time of referral. It is possible that the professional involved did elicit the information but didn't document the same. Healthcare professionals(HCP) have to identify, discuss and document driving-related information as advised by the DVLA. In cases where the patients' don't follow the advice, the HCP must notify the DVLA.

Conclusion. Assessment of driving history and the risks associated are critical. Awareness should be raised among the clinicians (through training and team meetings). This practice should be made an integral part of the structured initial assessments. Patients can be offered information leaflets. If successfully implemented, it will prevent unsafe driving and minimise the risk of harm for the patient and other road users.

Changes in Crisis Resolution Home Treatment Team Referral Numbers and Patient Caseload During COVID-19 Pandemic in First Lockdown

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