tests done, 83 (52%) had an HbA1c level done, 89 (56%) had a random serum total cholesterol level and random lipid profile done. 86 (54%) of the 160 inpatients had an ECG done on admission. Of the 69 female inpatients, only 15 (22%) had a urine pregnancy test done. Only 31 (19%) of the 160 inpatients had a urine drug screen done.

Conclusion: This audit highlighted that current practice indicates need for improvement. There needs to be increased awareness of which blood tests are required following admission. This could be achieved during the junior doctor Trust induction. There is also a need to make nursing staff aware of the need for female inpatients of reproductive age to be offered a urine pregnancy test. There should be a daily review of any patients who decline any physical health investigations on admission, with attempts made to complete these as promptly as possible.

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An Audit of Sexual Health Screening Practices on the General Adult Female Inpatient Wards in Mersey Care NHS Foundation Trust

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Aims: Women with mental illness face increased sexual and reproductive health risks, including trauma, sexually transmitted infections (STIs), reproductive-associated diseases, and contraceptive challenges. In 2024, Mersey Care NHS Foundation Trust ratified its clinical policy for physical health care. The authors assessed compliance with annual physical health checks (APHCs), sexual health assessments, and their communication in discharge summaries. The aims of this audit were to identify gaps and develop improvement strategies for the Trust's general adult female inpatient wards.

Methods: A retrospective audit design was used with convenience sampling based on the data collection day. Compliance was benchmarked against NICE guidelines and the Trust's Clinical Policy SD29 (target 100%). Data were extracted from electronic patient records for APHCs, sexual and reproductive health screenings, and evidence of actionable findings in discharge summaries. If no valid APHC was available, the most recent assessment was searched for. Topics were "covered" if decision-making processes were documented.

Results: Sixty-two female patients from four general adult inpatient wards were identified. Mean age was 42 years (19–70 years). Mean admission length was 50.82 days (1–339 days). Mental health diagnoses included schizoaffective, psychotic, anxiety, depressive, neurodevelopmental, and personality disorders. 60% of inpatients were detained under Section 2 of the Mental Health Act 1983, 19% under Section 3, and 21% were voluntary.

Regarding APHCs:

94% valid (none fully complete).

Four patients without a valid form; two had documented reasons and one offered follow-up.

All national cancer screening programmes were covered in 55% of age-eligible patients (6% declined).

55% covered sexual health history (3% declined).

22% covered menstrual history.

12% covered obstetrics and gynaecology history (3% declined).

Regarding inpatient screening:

90% lacked documented contraceptive discussions beyond oral contraception on admission.

Pregnancy tests: 48% on admission, 15% during admission, 13% documented reason for non-completion; 25% non-completion in over 45s likely due to undocumented menopausal status.

STI screening considered in 13% of cases.

Sexual health counselling offered to 11%. Four out of seven inpatients accepted.

One patient had a positive STI screen in a previous admission.

Conclusion: Despite high APHC completion rates, gaps in sexual health screening and in documentation were identified. Key improvements include better integration of sexual health within assessments, increased review of reproductive health needs, and more consistent STI screening. The authors suggest exploring staff awareness, regional staff teaching, updating policy guidance, and increasing policy distribution. Future audits should evaluate intervention effectiveness, ensuring comprehensive care for this vulnerable patient population.

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Audit of the Handover in Resident Doctors' First On-call Rota

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Aims: Handover is 'the accurate reliable communication of task-relevant information across shift changes or between teams thereby ensuring continuity of safe and effective working'. Handover is of critical importance; this ensures high quality care of our patients. Therefore this audit **Aims:**

To explore the compliance rates for completing handover in the junior doctor on-call rota in Blackburn Area.

To explore the current practice of whether handover is completed in person, whether it is documented or whether these are done together.

To use this audit to implement changes to improve the current handover practice.

Methods: A form was printed and put in the on-call room, doctors coming into handover were requested to tick if they received handover face to face, written, both, or none, on that particular shift.

If a doctor forgot to fill the form, they were followed up by email.

The data was collected over a three-week period covering 57 shifts changeover.

Data analysis was qualitative and quantitative.

Results: 57 shifts changeover, over 21 days.

(14%) 8 shifts changeover with no handover done at all.

(28%) 16 shifts changeover only with complete handover (in person and written).

(23%) 13 shifts changeover with only in person handover with no documentation.

(35%) 20 shifts changeover with only written handover with no in person handover completed.

Conclusion: This audit was able to look into the purpose it was designed for. It identified an area of improvements to work on, to achieve good practice and to maintain patient's safety. One of the findings of this audit, is that on some occasions, doctors have indicated they have received a written handover, however it was not

found in the assigned handover teams channel, therefore, it is possible that the handover was sent in another way, i.e. in private chat in teams or emails etc. This audit has concluded the importance of keeping handover in one assigned place, so records can be easily accessible to other team members when needed.

Recommendations were made by meeting the locality college tutor, discussion was carried around notifying all doctors in training about the importance of handover in induction meetings and reminder emails. A poster was also designed and put in doctors' on-call room.

This audit is to be repeated for monitoring purposes. with a recommendation of having senior doctors involvement in monitoring.

There have been some limitations in doing this audit, for instance, the handover for twilight shifts could have been only partial when completed and this audit did not go into details whether full handover was received from all wards or not. This audit also did not look into the quality of the handover itself – whether details are clear and information needed is provided.

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An Audit on Antidepressant Prescribing Practices for Children and Adolescents With Depression in Tonteg Hospital, Tonteg

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Aims: To measure the extent to which management of depression in children and adolescents compares with standard guidelines.

To enhance the quality of care and improve management practices for depression in children and adolescents.

Methods: Source of data: Electronic patient records.

Audit time frames:

Initial audit: 01/01/2017–31/01/2024.

Re-audit: 01/06/2024–31/01/2025.

Retrospective data.

Inclusion Criteria: Children and adolescents from the Taf Ely area within the Rhondda Cynon Taf Council, Wales diagnosed with depression and started on antidepressants between January 2017 and January 2025 in Tonteg Hospital were studied.

Exclusion Criteria: Patients prescribed antidepressant medication without a diagnosis of Depression.

Results: Demographics: In both the initial audit and the re-audit, females outnumbered males. The age range was 13–18 years.

Findings: In the initial audit, 82.6% (38/46) of the patients had other diagnosis (e.g., anxiety, eating disorders, PTSD). This was 54.5% (6/11) in the re-audit. There were no comorbid cases of bipolar disorder and psychosis.

Psychological therapy was provided to 63% (29/46) of patients before initiating antidepressants in the initial audit, improving to 82% (9/11) in the re-audit.

100% of the patients were prescribed a single antidepressant medication in the initial audit and re-audit. Fluoxetine and sertraline were the only prescribed antidepressants. No other psychotropic medication was prescribed.

Conclusion: The findings are not different with regards to the prevalence of depression in males compared with females. There is a higher prevalence of depression in females in both audit and re-audit.

In the re-audit, there is an 82% compliance with the latest NICE guidelines for the treatment of depression in children and adolescents. This is an improvement from the initial audit which showed a 63% compliance.

Following the initial audit, it was recommended that psychotherapy must be considered before starting any child with a diagnosis of depression on an antidepressant medication. Also, this information must be included in letters sent to the GP. These recommendations were effectively implemented, contributing to improved compliance in the re-audit.

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Enhancing Patient Safety: Audit of Medicines Reconciliation of Psychiatry Inpatients in NHS Lanarkshire 2023–24

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Aims: Medication errors at the interface of care (admission, transfer and discharge) are a leading cause of patient morbidity and mortality. For this reason, the Scottish Patient Safety Programme and National Institute for Health and Care Excellence (NICE) have highlighted the need for accurate medicines reconciliation, and set a 95% standard that all medicines should be reconciled within 24 hours of the patient's admission. This audit intended to assess quality of completion of Medicines Reconciliation forms and identify any potential barriers to completion. The objectives of this audit were to assess current adherence to local Medicines Reconciliation guidelines across General Adult Psychiatry Wards 19 and 20 in University Hospital Hairmyres (UHH) and identify any potential factors which may be contributing to Medicines Reconciliation forms not being completed appropriately.

Methods: An audit of Medicines Reconciliation form completion for admissions to Wards 19 and 20 in UHH was carried out retrospectively for all (24 no.) patients admitted from 10/11/2023–12/12/2023 using electronic case notes. Other systems, including the software for online prescribing and TrakCare were also used. Each section of the proforma was assessed and information recorded in an Excel spreadsheet as well as information about whether this was completed in the first 24 hours of admission. Following this, a summary document with the latest guidelines and the link to an e-learning module were distributed amongst the Resident Doctors, and raised at the monthly Resident Doctor's meeting. The form completion was then re-audited for patients admitted from 11/3/24–11/4/24 (34 no.).

Results: In the first cycle of the audit, only 70% of patients had their form completed within 24 hours of admission, which then improved to 100% in the second cycle. Another section with poor compliance in the first cycle was the section confirming that 2 sources of information had been used (66% completed), which also increased to 100% in the re-audit. In terms of the other parameters assessed, there were improvements in all 12 areas.

Conclusion: The audit was straightforward to carry out and yielded valuable insights to improving inpatient psychiatry care. However,