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Aims: Serious concerns have been raised by a HM Coroner in England regarding poor medical recording and communication following Mental Health Act Assessments (MHAA). We aimed to undertake a 'deep-dive' audit of documentation and inter-professional communication to assess compliance with GMC Good Medical Practice (GMP) and Mental Health Act Code of Practice 2015 (MHACP) following a MHAA in the Doncaster locality of Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH).
Methods: Audit standards were set using the GMC GMP guidance and the MHACP. GMC GMP states 'You must make sure that formal records of your work (including patient records) are clear, accurate, contemporaneous and legible' and makes clear each doctor is responsible for recording their own independent medical opinion for any significant clinical intervention.

All patients detained on section 136 in September 2024 in the Doncaster locality were selected. The electronic records system (SystmOne) was scrutinised for (1) length of time taken for the assessment to be documented on SystmOne by any of the assessing team, (2) the number of doctors documenting the assessment, (3) whether any doctor communicated with the GP.

An email was sent to each patient's GP regarding any communication they received from a doctor relating to the MHAA in case communication was not included on the internal Trust system.

Data was also collected on the outcome of the assessment, number of doctors involved, their roles and whether they were employed by the Trust.
Results: Of the 23 MHAAs, 18 took place in the Doncaster S136 suite and 5 in A&E. Nineteen assessments did not result in detention, 3 resulted in an informal admission, and 1 in detention.

Documentation on SystmOne took over 1 day for 61% (14/23) of MHAAs, all completed by an Allied Mental Health Professional (AMHP). In 26% (6/23) documentation occurred within 4 hours, all by an assessing doctor. In 4% (1/23) it was completed within 12 hours by an AMHP.

A total of 9% (2/23) had no AMHP report or documentation. In 70% (16/23) neither doctor documented, while in 30% (7/23) one doctor documented.

In only 22% (5/23) of MHAAs a letter was sent to the GP by an assessing doctor.
Conclusion: The documentation and communication following a MHAA was not in keeping with GMC GMP guidance and the MHACP in the vast majority of cases assessed. This poses a significant patient safety concern.

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.

Evaluating Rosewood Mother & Baby Unit's Compliance With Vitamin D Monitoring and Prescribing for Mothers

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Aims: To audit the current practices of vitamin D screening and replacement in patients admitted to Rosewood Mother & Baby unit in Kent.
Methods: Retrospective audit was conducted to evaluate current practices in screening and treating vitamin D deficiency among patients admitted to mother and baby unit. Relevant standards were set and data collected for patients admitted Jan 2023–Dec 2023. Results presented to stakeholders and improvement plan implemented by circulating trust vitamin D guidelines and discussion with unit dietician. Re-audit was carried out reviewing details of patients admitted from Jan 2024 to Dec 2024.
Results: Audit 2023: Out of 60 patients admitted, 95% patients (57) were screened for vitamin D status. 65% of screened patients were either insufficient or deficient (12 insufficient and 27 deficient). Patients received vitamin D replacement as per KMPT guidelines. Aftercare instructions to GP communicated for 93% and 100% patients with vitamin D insufficiency and deficiency respectively. Regarding infant feeding mode 50% were breastfed, 35% on formula milk and 11.6% received mixed feeding. One patient was pregnant and data of one patient not recorded.

Re-audit 2024: Of 56 patients admitted in 2024, 2 patients were not screened. Among 54 patients, 21 and 9 were insufficient and deficient respectively. Out of these 30 patients, 24 were given appropriate supplementation in line with current KMPT clinical guidelines. Aftercare instructions to GP communicated for 17 patients. There was a drop in GP communication and this has been noted for improvement. Four infants were breastfed, 29 on formula milk and 16 received mixed feeding. Three patients were pregnant and for 2 patients the data not recorded.

It is important to highlight that lactating mothers can be deficient in vitamin D. Therefore, this was especially analysed in both audit reports. In both audits, 57 out of 116 patients either breastfed or mix fed the babies. Among these 57 patients, 8 were deficient while 28 were insufficient. This indicates significant (63%) number of patient in both were deficient/insufficient. As vitamin D is implicated in mood and immune system regulation it could play a vital role in the mental state of post-partum patients.
Conclusion: This audit/re-audit highlighted need for routine vitamin D screening in patients admitted to psychiatric units especially breastfeeding mothers. It is also important to note that vitamin D could play a vital role in mood and immune system regulation.

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Initiating and Maintaining ADHD Medications in Islington CAMHS 2023

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Aims: To evaluate and improve the adherence to NICE guidelines in recording physical health parameters during the initiation and maintenance of ADHD medications.
Methods: Retrospective data was collected from electronic medical records (RIO) of patients who were initiated and maintained on ADHD medication, referred to Islington CAMHS in 2023. Collected data was stored and analysed using Microsoft Excel. Inclusion criteria:

1. All the patients with ADHD referred to Islington CAMHS in 2023 for initiation of medication were sampled.

Exclusion criteria:

1. Patients not started on medication.
2. Patients who had previously been on medication.
3. Patients who had medication initiated by paediatrician.
4. Patients who had medication initiated by private psychiatrist.

Results: A total of 74 patients were identified, 55 males and 19 females.

Pre-medication Physical Health Assessment: The physical health parameters before initiating medication were recorded in 100% of cases, with 96% adhering to the standards outlined by NICE. This indicates a strong adherence to pre-medication assessment protocols.

Medikinet XL was the most prescribed medication for both initiation and maintenance.

Side Effects and Medication Management: Side effects were reported by 22% of patients, with reduced appetite being the most common. Medication was stopped in 4% of cases due to side effects, and 11% required a change in medication. This highlights the importance of ongoing monitoring and the need for flexibility in treatment plans to address side effects promptly.

Standard Monitoring Compliance: The monitoring of physical health parameters during medication maintenance also met the standards in 100% of cases, underscoring a consistent approach to ongoing patient care.

Comorbidities: The audit identified patients with psychiatric comorbidities, such as Autism Spectrum Condition (47%), Tourette's (3%), Anxiety (3%), and Dyslexia (1%).

Conclusion: The audit highlighted the importance of maintaining high standards in ADHD medication management and suggested areas for further improvement, such as the documentation of rating scales to objectively monitor medication effectiveness. Based on the audit results, an ADHD clinic proforma was developed to incorporate all required data points, ensuring comprehensive documentation during clinic appointments.

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Audit Cycle of Record Keeping by Doctors in Older Adult Inpatient Settings

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Aims: To assess compliance with record keeping policies.Medical records play a vital role in supporting patient care. However, effective record keeping in clinical practice, particularly in mental health, poses significant challenges. The General Medical Council's (GMC) good medical practice, states that doctors must ensure their records are clear, accurate, and legible. Regulation 28 of the Coroners and Justice Act 2009 empowers coroners to address concerns that could lead to future deaths. Davies Arnold Cooper (DAC) Beacroft's 2022 report identified record keeping as a key issue in mental health.

Methods: Patients across three older adult inpatient wards were identified using convenience sampling method. Five hundred and thirty-three entries made by doctors for the audit and 424 entries made by doctors for the re-audit were identified using patient identifier. Data compilation was done using Excel spreadsheet and analysed using descriptive statistics. Outpatient entries and ECT entries made by doctors were excluded, ensuring a focused assessment of inpatient records. The results were presented using bar charts, pie charts and tables.

Results: The results were compared with the trust's Record Management Policy and the previous audit conducted in January 2023. The re-audit found an improvement in the percentage of validated entries across all three wards compared with the previous audit. One of the wards showed the highest improvement, with a 35% increase in validated entries. However, the overall validation rate was still below the 80% requirement standard set. The timescales for validation across the three wards also showed some improvement, with the majority of validated entries meeting the 12-hour standard, although a small percentage remained unvalidated for longer periods. In addition, doctors were more likely to sign off their entries during normal work hours than out of hours

Conclusion: The findings suggest that while there has been improvement in the timeliness and completeness of clinical entries validation, more work is needed to ensure full compliance with the trust's policies and the GMC's good medical practice. Recommendations include regular reminders to doctors on promptly signing off clinical entries, incorporating record-keeping guidelines into local inductions, and a review of the trust's guidelines on note validation for inpatient entries. This audit cycle led to a broader quality improvement project and trustwide policy change on validation of clinical entries. It highlights the importance of maintaining accurate and timely clinical entries.

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Prescribing for Substance Misuse: Alcohol Detoxification in Adult Mental Health Inpatient Services. The National Prescribing Observatory for Mental Health (POMH-UK) Quality Improvement Programme: 14c

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Aims: To help specialist mental health Trusts/healthcare organisations improve their prescribing practice. To assess the Trusts' alcohol detoxification practices, benchmark against the national average performance and to compare results to the previous audit of 2016. This was the second re-audit in the cycle.

Methods: The audit included any person (Male and Female) admitted to an acute adult or psychiatric intensive care ward, or a specialist inpatient drug or alcohol unit, who underwent alcohol detoxification (assisted alcohol withdrawal) whilst an inpatient. Patients identified via RiO, EPMA, Pharmacy Databases and Ward/Team caseloads. The final sample consisted of 80 patients, 20 patients from each of the 4 boroughs (Warrington, Halton, Knowsley, Wigan).

Data was collected in May 2021 via clinical audit days over Microsoft Teams, checked for quality twice by the audit leads and inputted by the Medicines Management Team in June 2021.