Black Country Mental Healthcare Foundation Trust, Sandwell, United Kingdom

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Aims: Individuals with psychiatric disorders face a significantly higher risk of cardiovascular disease and other medical conditions, leading to increased morbidity and premature mortality compared with the general population. This disparity may also be partly due to diagnostic overshadowing. Effective communication between clinical settings is essential for patient safety and continuity of care whilst delays or inaccuracies in information sharing can have serious consequences.

This study aimed to evaluate the quality and timeliness of communication between an acute inpatient psychiatric unit, Hallam Street Hospital (HSH), Sandwell, Black Country Healthcare NHS Foundation Trust, and an emergency department, Midlands Metropolitan University Hospital (MMUH), West Midlands, to identify gaps and improve transitions of care.

Methods: A retrospective study was conducted between November 2024 and January 2025 reviewing inpatients transferred from HSH to MMUH. Patient records from the corresponding electronic systems were analysed (Rio (HSH) and Unity (MMUH)) to determine whether:

A handover document containing relevant clinical information was provided upon transfer to MMUH.

A discharge summary including a management plan was available upon patient's discharge to HSH.

Results: Twelve patients were referred from HSH to MMUH during the study period with three (25%) requiring re-attendance. A limitation of this study was its small sample size due to the recent transition of the handover system.

Ten patients (83%) were accompanied by staff, while one (8%) attended alone, one (8%) accompanied by family.

Four patients (33%) were sent to MMUH with a handover document. Only one (8%) had been scanned onto Rio. None were available for viewing on Unity.

Nine patients (75%) returned to HSH with discharge summaries, however only five (42%) had been uploaded onto Rio.

The discharge summaries generally contained adequate details on the patient's hospital course and management plan, aligned with NICE guidelines.

Conclusion: The audit highlighted a lack of a standardised protocol for written handover during patient transfers. While discharge summaries were electronically sent to GPs, a dedicated copy for HSH records was not consistently generated. Clinicians relied heavily on verbal handovers provided by accompanying staff or the patients themselves, increasing the risk of miscommunication and errors.

To enhance patient safety and continuity of care, we propose developing a standardised transition-of-care protocol, ensuring systematic documentation, and conducting a re-audit to assess improvements in practice.

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 Drug Screening Practice on Inpatient Psychiatric Wards

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Aims: The relationship between mental illness and substance misuse is well established. Early identification through drug testing can inform more holistic management plans. This audit aims to check the compliance of the current practice on acute psychiatric wards with the Trust policy for drug screening, it also aims to draw conclusions, and recommend changes to increase the compliance and benefits from implementing the policy.

Methods: Data was collected retrospectively from two adult acute psychiatric wards, including a sample of 20 male and 20 female patients admitted in 2024.

The parameters assessed were:

The presence of any documentation regarding drug testing on admission.

If the drug test was offered, accepted or refused, and if the results were documented.

If the positive results were acted on, such as referrals to substance misuse services.

Results: Any documentation related to drug screening was present in 23 out of 40 patient records (57.5%).

This indicates that nearly half of the patients admitted lacked proper documentation of whether a drug test was indicated, considered, offered, or completed.

21 out of 40 patients (52.5%) were offered a drug test.

In 4 cases, drug screening was recommended as part of the plan but was not offered or followed through. Reasons for this were not recorded.

Among the 21 tests offered, 15 patients (71.4%) completed the test. 8 (53.3%) were positive and 7 (46.7%) were negative.

6 patients (28.6%) refused UDS, but the reasons for refusal were not documented.

5 out of 8 patients with positive drug test results were referred to the substance misuse service.

Conclusion: This audit highlights inconsistencies in drug testing practices on inpatient wards, particularly regarding documentation, offering of tests, and follow-up on the results.

Recommended changes are as follows:

Drug screening should be offered to all inpatient groups, results should be acted on appropriately.

Improving documentation: The inpatient teams to ensure documenting if drug testing has been or should be offered, if it was accepted or refused, its results, and if positive, the follow-up plans.

By implementing those changes, drug testing can become a more effective tool for identifying and managing substance misuse, ultimately improving patient outcomes.

Findings and recommendations for change are being circulated in the Trust, and a re-audit following the implementation of recommendations will be undertaken after 3 months to evaluate the effectiveness of changes and ensure continuous improvement.

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Comprehensive Evaluation of Referral Practices From General Practitioners to Balbriggan CMHT, Dublin: Audit Cycle Overview

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