be operated. Patients were being secluded in general areas in these locations, leading to increased risk for staff and patients alike. Recommendations have been made to the Trust in various clinical network meetings that these clinical areas should either have a dedicated suite made available, which is compliant with the recommendations, or that the Trust is to create a new Standard Operating Procedure (SOP) detailing how a patient needing seclusion in these areas is to be managed until an appropriate seclusion suite is identified for them.

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An Extended, Trust-Wide Audit Assessing the Handover Process Between Mental Health Inpatient Services and Emergency Departments

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Aims: A primary audit revealed widespread non-compliance with NICE Quality Standard (QS174) in patient handovers between the emergency department and a psychiatry inpatient unit. This second audit evaluated whether the issue was specific to one ward and/or emergency department or if it was prevalent across the trust.

Methods: 9 wards across 3 locations within the same trust were sampled. For each ward, online case notes from 5 patients transferred to the emergency department between April and September 2024 were reviewed, identified by selecting the most recent admissions and working backward until 5 cases were obtained. Cases were assessed for (a) handover documentation, (b) discharge summary availability, (c) required actions for the psychiatry ward, and (d) nature and implementation time of these actions. Results were analysed using Microsoft Excel.

Results: 45 patient case notes were reviewed. 62% (n=28) did not have a handover documented which followed the NICE definition of Situation Background Assessment Recommendation (SBAR) and 28% (n=8) had no discharge summary. 5 patients had no discharge summary and no documented handover. 56% (n=25) of patients returned with actions for the ward, and 20% (n=5) of these had actions delayed, which included medication changes (antibiotics). All but one ward identified potential issues with handovers, both between physical and mental health trusts and within the mental health trust itself.

Conclusion: The results of this extended audit show improvement from previous findings but still highlight significant concerns. It is possible that the number of cases reviewed were too small to detect the extent of the issue within wards. Nevertheless, the audit highlights ongoing communication issues between physical and mental health services, requiring further investigation. It also identifies the need for improvement in internal communication, as some patients with discharge summaries still experienced delayed actions.

The identification of problems across multiple sites also suggest audits of other mental health trusts would be worthwhile to establish if this is a national problem.

Quality improvement work is being undertaken to better understand and address the specific challenges faced by wards and emergency services that are affecting handovers of care across different locations within the trust. This will allow us to improve patient safety across the trust.

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Venous Thromboembolism (VTE) Risk Assessments in Psychiatric Inpatients Audit

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Aims: The aim of this audit was to assess the compliance of Coventry and Warwickshire Partnership NHS Trust (CWPT) with the National Institute for Health and Care Excellence (NICE) venous thromboembolism (VTE) in over-16s guidelines. NICE guidelines recommend that all acute psychiatric patients should be assessed to identify their risk of VTE and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. In addition, NICE guidelines also recommend that all patients admitted to an acute psychiatric ward should be reassessed for risk of VTE and bleeding at the point of consultant review.

Methods: All patients admitted to inpatient wards in CWPT are required to have a digital physical health document, which contains a section on VTE risk assessment, completed by the duty doctor. The digital physical health document for all inpatients (n=244) across 16 wards in CWPT were retrospectively reviewed in October 2024. A standardised tool was created to collect data using an adaptation of the NICE VTE guidelines. This tool ensured parallel data was collected for each patient, including whether patients had a VTE risk assessment completed on admission to hospital, whether VTE risk assessments were dated and signed, at what point in time VTE risk assessments were completed following admission, and whether patients had a VTE risk assessment completed at the point of consultant review.

Results: 63% (n=153) of patients had a VTE risk assessment completed and documented on admission to hospital, including being signed and dated. 63% (n=154) of patients had a VTE risk assessment completed within 24 hours of admission. 99% (n=242) of patients did not have a VTE risk assessment completed at the point of consultant review. 5% (n=13) of patients had a VTE risk assessment completed without being signed and/or dated. 7% (n=16) of patients had documentation of communication of assessment with a registered mental health nurse.

Conclusion: CWPT's compliance with NICE recommendations for VTE risk assessment was deemed below standard. Recommendations have been made to introduce a VTE risk assessment section into every new doctor's induction, to ensure

they are aware of the importance of completing them and how to complete them appropriately. In addition, if possible, making the VTE risk assessment a required field to submit the physical health aspect of the clerking proforma would aid in increasing compliance rates. A re-audit in 6–12 months is also recommended.

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Audit of Renal Function Monitoring and Indications in Patients Prescribed Memantine at Ribchester Centre: A Review of Compliance With Pre-Prescription Guidelines

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Aims: To assess whether renal function tests are appropriately reviewed prior to the prescription of memantine, in accordance with NICE clinical guidelines, ensuring the safety and effectiveness of medication.

To assess if memantine is prescribed according to the indications listed in NICE guidelines.

Methods: This retrospective audit reviewed patients with a diagnosis of dementia, seen at old age psychiatry outpatient clinic Bury from 1 August to 31 October 2024.

The review focused on patients starting memantine during this period, assessing whether renal function was evaluated prior to initiation, the indication for memantine use, and whether it was prescribed as monotherapy or adjunctive therapy.

The targeted population included patients over 18 years, with a sample size of 395 (August: 118, September: 151, October: 126). Data were collected by reviewers from 1 to 15 November, using letters on Paris and online care records, and recorded in an Excel sheet.

Results: Of the 12 patients recommended for memantine, only three had a diagnostic indication explicitly documented in their letters, in alignment with NICE guidelines.

In two cases, memantine was prescribed as an adjunct therapy alongside acetylcholinesterase inhibitors – donepezil in one instance and rivastigmine in the other.

For one patient, memantine was utilized specifically for the management of severe Alzheimer's disease.

All patients had their estimated glomerular filtration rate (eGFR) and renal function test (RFT) documented in the GM records.

For seven patients, these details were not included in their correspondence but present on GM record.

For the remaining five patients the letters either explicitly mentioned the eGFR or referenced the eGFR.

Conclusion: Guideline adherence: Only 3 out of 12 memantine prescriptions had diagnostic indications documented per NICE guidelines, indicating incomplete compliance.

Prescribing practices: Memantine was used appropriately as adjunct therapy in two cases and for severe Alzheimer's in one case.

Renal function monitoring: While all patients had eGFR and renal function tests documented in GM records, these details were not clearly recorded in correspondence for 7 patients, highlighting communication gaps.

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A Clinical Audit on Pre-Treatment Assessment Protocol Adherence to Clozapine Therapy

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Aims: This study meticulously evaluated adherence to the pre-clozapine initiation protocols outlined in The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition. The study, conducted at different psychiatry units of the Punjab Institute of Mental Health Lahore, Pakistan, aims to evaluate the comprehensiveness of baseline evaluations and uncover significant deficiencies in monitoring vital physical health markers (like ECG) crucial for patient safety and treatment effectiveness.

1. In this study the clinical practices of pre-clozapine are critically assessed based on standard guidelines
2. It delineates the systemic, clinical, and administrative impediments affecting adherence to pre-clozapine workup protocols.
3. The completeness, accuracy, and consistency of documentation are ensured during the study.

Methods: This retrospective analysis examined case notes from 42 patients to evaluate compliance with pre-clozapine workup protocols at the Punjab Institute of Mental Health, Lahore. The data was examined in accordance with The Maudsley Prescribing Guidelines in Psychiatry, 13th Edition, to evaluate clinical practices, identify hurdles to adherence, and assess trends in the completion of assessments and the accuracy of documentation.

Results: The baseline assessments included a full blood count, liver function test, urea and electrolytes analysis, and plasma glucose measurement, all of which were conducted in 100% of cases. However, electrocardiography (ECG) was performed in only 76% of patients before clozapine initiation. Blood lipid profiling was completed in 33% of cases, while erythrocyte sedimentation rate (ESR) and plasma troponin assessments were conducted in only 19% and 14% of cases, respectively. Notably, C-reactive protein (CRP), beta-natriuretic peptide, and general physical examinations were entirely absent from the records, highlighting significant gaps in baseline cardiovascular and haematological risk assessments.

Conclusion: This audit identified significant gaps in pre-clozapine workups at the Punjab Institute of Mental Health, Lahore, including protocol deficiencies, inadequate staff/doctors training, sampling errors, and inconsistencies in prescriber practices. Communication breakdowns among participants and administrative constraints, such as funding and staffing limitations. To address these challenges, the implementation of standardized protocols, enhanced staff/doctor training, improved participants' communication/documentation, adequate resource allocation, and quality assurance measures. Strengthening these areas is critical to ensuring a comprehensive and safe clozapine initiation therapy.

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