Methods. 1. For every attendance of patients to the day-care Clinic it is expected that the physical health monitoring to be offered would include:

- Weight
- Height (if first attendance)
- BMI
- HR (Pulse rate)
- Sitting/Standing BP
- Temperature

2. Relevant blood tests and ECGs on a schedule based on patient's BMI or as needed based on clinical indication.

23 patients were identified as having been seen in AEDS day-care centre between April 2021 till the point of discharge. 9 were deemed inappropriate due to incomplete information. Of the remaining 14, 9 patients were randomly selected, their documentation were looked from admission to day-care to the point of discharge. The monitoring was audited at 3 points of contact over the course of their first clinic appointment, the middle and point of discharge.

Results.

1. Comparing data from previous audit, the average admission in day-care decreased from 5.5 to 3.5 months.
2. There was overall improvement in the ECG and blood test monitoring.
3. At the admission and the last assessment there was 100% monitoring of BMI, weight, blood pressure and pulse.
4. There was a drop in temperature monitoring by 11.1% in the first and last assessment due to faulty equipment.
5. The ECG and bloods percentage dropped by 11.1% at all the monitoring points.
6. At the midpoint there was no documentation of BMI, Blood Pressure, and pulse for 1 patient.

Conclusion.

1. Investigations were delayed from the patient's side.
2. Due to COVID there was difficulty in accessing the primary care appointments for investigations.
3. The temperature equipment was not working properly.

Recommendations:

1. Keeping a fixed format for documenting day-care visits on the SystmOne software. A Sample format made available for documentation.
2. Document all the parameters checked in the patients' electronic records on the same day.
3. Day-care clinical team to upskill on ECG via training.
4. Team Resources to be allocated to have in-house ECG in day-care.
5. SUSS test to be done for all RED (High risk) patients as clinically indicated and clearly document in the notes, e.g. SUSS: done/not done and reason with date SUSS conducted on.

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.

Health Notes Audit

Dr Charlotte Golding* and Dr Neeti Sud

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle upon Tyne, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.570

Aims. To assess whether patients admitted to the forensic secure rehabilitation ward are transferred with their physical health notes.

Most patients admitted to secure rehabilitation do not have an open GP record due to last registration with primary care having been many years previous as a result of a lengthy prison/hospital stay. Additionally, patients may be referred from an out of area prison or hospital. A comprehensive psychiatric history paperwork is obtained at referral. This audit was to assess how many patients currently on the rehabilitation ward arrived with complete physical health notes. We defined a complete set of physical health notes to mean:

1. Records from medical consultations linked to physical health during time in prison or psychiatric hospital.
2. Any physical health history prior to current incarceration/admission episode from primary and secondary care.
3. Complete prescription of physical health related medications including allergies, doses, regime, and indication.

Methods. Retrospective review of patient electronic records sent by discharging institution when the patient was transferred to the rehabilitation ward.

Data collected: List of documentation of patient's physical health records around transfer time. Identification of the contents of the records provided by the transferring ward.

We then compared the information available to our criteria for complete physical health notes.

Participants: All current residents of the male secure rehabilitation ward (n = 12) were included.

Results. 7 out of the 12 patients included were transferred to the secure ward with notes that fulfilled the criteria as set by audit team.

Two patients were transferred with only the prescription of current medications. There was however, a brief physical health summary in care coordination notes sent earlier.

One patient was transferred with the prescription and a brief list of their past medical history.

The remaining 2 patients were transferred without any formal physical health documentation prior to transfer, however, they were transferred from an adjacent ward and therefore, all records were already on the electronic records. There was no formal verbal or written physical health handover.

Conclusion. It is important for our ward to ensure we have comprehensive and complete physical health summary for each patient on admission.

A proforma will be used at preadmission meetings from February 2024 to request specific information from discharging wards. We will re-audit in February 2025 to assess improvement in records requested and obtained.

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 Adherence to Rapid Tranquilization Protocols in Psychiatric Emergencies: An Audit of a Tertiary Care Facility in Pakistan

Dr Naima Gul* and Professor Asad Nizami

Institute of Psychiatry, Rawalpindi Medical University, Rawalpindi, Pakistan
*Presenting author.

doi: 10.1192/bjo.2024.571

https://doi.org/10.1192/bjo.2024.570 Published online by Cambridge University Press