- 25% were prescribed a trial dose of non-benzodiazepine hypnotic medication (n=2).
- 25% % were prescribed regular non-benzodiazepine hypnotic medication with no trial dose (n=3).
- 50% were prescribed alternative sedative medication for insomnia (n=4).

Conclusion. Commonly, patients were not provided with sleep hygiene advice. The patients who were prescribed non-benzodiazepine hypnotic medication were often not prescribed a trial dose. Half of the patients were prescribed an alternative to a non-benzodiazepine hypnotic medication.

- Interventions will include:

Creation of a sleep hygiene information leaflet to provide to inpatients, medical and nursing staff.

- Presentation of data to medical and nursing staff.
- Ensuring guidelines are available to all medical and nursing staff in the ward environment.
- The audit will be repeated in six months after the interventions.

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Assessing Recording of Allergy Status on Rio Amongst Patients in Sandwell CAMHS

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Aims. To assess recording of allergy status for patients under the care of Sandwell CAMHS

Methods. This audit was performed at Sandwell CAMHS. The project was discussed and logged with the Trust's audit department.

Medical records of all patients (516 patients) seen between January and March 2022 by the medics in Sandwell CAMHS were examined for documentation of allergy status

For all patients the alert bar on Rio was examined to determine whether or not their allergy status was recorded.

A data collection tool was devised to collect information in accordance with the standard i.e, the drug allergy recorded or not and when recorded;

- it is present
- no known allergy

where present;

- substance name
- reaction
- severity
- date recorded
- Evidence and Certainty

Results. For the Recording of Allergy Status on Rio, the audit revealed:

A. 60 out of the 516 patients had their allergy status recorded.
   Out of these 60 patients;
   18 had possible allergy
   42 had no known allergies
B. 456 had no recordings of allergy status
C. Those with possible Allergies;

The substance name was documented for all in Rio for those who had allergies indicated

12 of the 18 possible allergies had the allergic reaction documented

13 of the 18 possible allergies had the severity documented

3 of the 18 possible allergies had the date recorded

1 of the 18 possible allergies had evidence and certainty recorded

Conclusion. The audit revealed a poor recording of the allergy status

The following recommendations have been made:

Present audit at the Specialist mental health quality improvement group.

Clinicians should be made aware of the expected Nice Guidelines for documentation of allergy status.

Clinicians to update allergy status of patients every 6-12 months.

Develop an action plan and governance documentation with the specialist mental health quality improvement group.

The results of this audit have been shared with the Rio lead for them to consider making relevant changes in Rio i.e. The systems should include prompts for annual updates of allergy status.

A clear trust policy of documentation on how allergy status/ adverse effects will be should be recorded Rio.

If possible, it should be included in the junior doctors' handbook and the eLearning.

To carry out a re- audit in 6 months to 1 year

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Evaluating and Optimising the Self-Administration of Medication (SAM) in an Inpatient Psychiatric Rehabilitation Setting

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Aims. To analyse the process of self-administration of medication (SAM) in an inpatient psychiatric rehabilitation setting in order to improve the MDT awareness and engagement with the process. The project also aims to improve the level of completion of the relevant SAM documentation in the department.

Methods. The medication prescriptions and self-administration charts (where present) for the patients on the ward were reviewed to identify errors or omissions in completion of the documentation.

Thereafter a number of interventions were completed. This included informal education sessions and follow-up written correspondence to the relevant staff (via email and the ward handover book). The potential for SAM was additionally prompted at the weekly MDT meeting in order to identify additional suitable patients for the process.

Results. Three out of 18 inpatients were initially engaged to some degree with SAM at the start of the project. For the relevant patients involved, completion of attendance documentation and adherence to written instructions from 70% to 90%. Improvements in other aspects of the documentation were also observed. Following the prompted MDT discussions a further five patients were identified to commence SAM, who may

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