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.

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.

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

Aims. This audit assesses the adherence to and effectiveness of rapid tranquilization protocols in a tertiary care psychiatric facility in Pakistan, particularly focusing on the use of intramuscular (IM) haloperidol and promethazine. The evaluation also includes an analysis of how these practices align with the prescribed guidelines for managing psychiatric emergencies.
Methods. A comprehensive retrospective analysis of patient records from January to December 2023 was conducted. The focus was on assessing the sequence of interventions (de-escalation techniques, oral medication, IM administration), medication choices, adherence to protocol steps, and documentation of patient monitoring post-administration. Descriptive and inferential statistical methods were applied to analyze the data.
Results. Among 482 patient records:

The primary diagnoses included schizophrenia (44%), bipolar disorder (29%), and severe depression with psychotic features (27%). IM haloperidol and promethazine were predominantly used, with 68% of cases bypassing oral medication or de-escalation attempts. Only 60% of cases showed adherence to the recommended protocol steps, including assessment for medical causes and optimization of regular prescriptions. In 12% of cases, a second injection was necessary, with the interval between injections undocumented in 15% of these cases. Vital monitoring post-administration was not recorded in 30% of cases. Medication unavailability was an issue in 8% of aggressive cases. Protocol deviations included the omission of recommended pretreatments, such as ECG for haloperidol and the lack of alternative options like buccal midazolam or inhaled loxapine.
Conclusion. The audit reveals significant deviations from established guidelines in the rapid tranquilization process. The frequent omission of non-invasive interventions and the lack of consistent monitoring and documentation practices highlight areas needing immediate improvement. Training in de-escalation techniques, adherence to step-wise intervention protocols, and ensuring the availability of a range of medications are crucial. This study underscores the importance of aligning psychiatric emergency practices with established guidelines to ensure patient safety and effective treatment outcomes.

Identifying Perimenopausal Symptoms in Women Diagnosed With Depression: A Focused Audit at a Tertiary Care Hospital

Dr Naima Gul*

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

doi: 10.1192/bjo.2024.572

Aims. This audit aimed to assess the recognition and management of perimenopausal symptoms in women diagnosed with depression at the Psychiatry Outpatient Department (OPD) of Benazir Bhutto Hospital, Pakistan. It focused on identifying gaps in screening for perimenopausal symptoms among these patients.
Methods. Conducted over a year, this retrospective audit included 250 women aged 45–55 years, previously diagnosed with depression. Post-diagnosis screening for perimenopausal symptoms was performed using the Menopause-Specific Quality of Life Questionnaire (MENQOL) and the Greene Climacteric Scale. Data on initial diagnostic criteria, treatment modalities, and patient outcomes were reviewed. Follow-up interviews provided insights into ongoing symptom management and treatment satisfaction.
Results. The retrospective screening revealed that 78% of these women had significant perimenopausal symptoms per the Greene Climacteric Scale, which were initially overlooked. MENQOL results showed 65% experiencing a substantial impact on quality of life due to menopausal symptoms. Treatment primarily consisted of antidepressants (used by 82% of patients), while 8% received psychological counseling, and 10% were advised on lifestyle adjustments and non-hormonal therapies. Only 45% of the patients reported satisfactory symptom management, indicating a potential discrepancy between the treatments for depression and the underlying perimenopausal condition.
Conclusion. The audit at Benazir Bhutto Hospital demonstrates a high incidence of undiagnosed perimenopausal symptoms in women treated for depression, suggesting a critical need for improved screening protocols. The results indicate that integrating perimenopausal symptom assessment into the initial diagnostic process for depression could lead to more effective, individualized treatment strategies. This approach may enhance the overall treatment satisfaction and quality of life for perimenopausal women, underscoring the importance of holistic patient care in psychiatric settings.

Monitoring Initiation and Administration of Covert Medication(s) for Service Users in Amber Ward of Millbrook Mental Health Unit, Nottinghamshire Healthcare NHS Foundation Trust: A Re-Audit of Compliance With Maudsley Prescribing Guidelines in Psychiatry

Dr Silvester Hammed*, Dr Adam Kinch and Dr Anto Rajamani

Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.573

Aims.
1. To evaluate standards of practice regarding initiation and administration of covert medication(s), with comparison to the previous audit completed in January 2021.
2. To highlight improvements and weaknesses requiring further recommendations for effective future practice.

Methods. This clinical audit assessed the current practice in Amber Ward (Old Age Ward for Dementia patients) against the same standards of practise used in the previous audit.

The Audit Checklist included 10 standards from Maudsley prescribing guidelines for Covert Medication Pathway.

A retrospective review of the paper and electronic records of 21 service users initiated on a covert medication plan between January 2021 and June 2022 was carried out.

A descriptive statistic on the data and presented results in tables comparing frequencies and percentages with the data from previous audit was then performed.
Results.
1. An increase in percentage of documented evidence of covert medication plan being discussed with a relative with Lasting

https://doi.org/10.1192/bjo.2024.571 Published online by Cambridge University Press