

otherwise have remained on traditional nurse-led medication administration.

**Conclusion.** Engagement with SAM was initially variable and therefore was improved by targeted discussions and more MDT involvement. Documentation was identified as a potential pitfall and completion improved due to the interventions above. During the project a number of medication errors were incidentally highlighted and were reported via the DATIX tool. This demonstrates the importance of risk awareness associated with the SAM process in order to improve patient safety. There should be an MDT approach when considering patients for SAM process as this can affect discharge decisions. SAM could also be considered outwith the inpatient rehabilitation setting (e.g in General Adult Psychiatry wards). SAM is important in order to promote patient autonomy and independence in a safe manner. In the future it would be useful to explore patient attitudes towards medication self-administration in order to identify barriers to concordance.

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 the Impact of COVID-19 on the Transition From CAMHS to AMHS in ABUHB – a Retrospective Study

Miss Elise Maylor<sup>1\*</sup>, Dr Kavitha Pasunuru<sup>2</sup> and Dr Andrew Todd<sup>2</sup>

<sup>1</sup>Cardiff University, Cardiff, United Kingdom and <sup>2</sup>Aneurin Bevan University Health Board, Newport, United Kingdom

\*Corresponding author.

doi: 10.1192/bjo.2023.446

**Aims.** To evaluate the transitions of Aneurin Bevan University Health Board (ABUHB) Child and Adolescent Mental Health Service (CAMHS) patients to Adult Mental Health Services (AMHS) during the COVID-19 pandemic, against regional Health Board policy standards.

**Methods.** Following a review of the current ABUHB transitions policy and a focused review of the literature, relevant standards were elicited. Retrospective data of transition cases between April 2020 and March 2021 were collected using a standardised data-capture tool from CAMHS records using the EPEX system; cases were anonymised. A questionnaire was constructed and distributed by email to ABUHB CAMHS clinicians to gain further qualitative data.

**Results.** A total of 34 patients were identified as CAMHS transition cases. 3 were identified as having a transitions co-ordinator, 6 had no record of AMHS having been informed with only 1 case documenting liaison with AMHS at the 6 month mark. 20 cases showed evidence of good patient support before and after transition, and 25 showed young person involvement in decision making. 28/34 cases showed evidence of good coordination of MDTs (multi-disciplinary teams).

There were 16 responses to the staff survey. 93% of respondents were aware of the transition policy, and 68.8% of clinicians strongly agreed/agreed with “I involve young people in their decision making process”. 25% of respondents strongly disagree/disagree when asked whether they work in collaboration with the AMHS. For “I believe my patients are ready to transition at the age of 18” 37.5% remained neutral.

**Conclusion.** Several of the standards outlined in the ABUHB transition policy are not being met. These include: naming a

transition coordinator, informing AMHS 6 months prior to the patient turning 18, and involving the young person in the decision of transfer of care. COVID-19 has evidently impacted the transition process, but more audits must be conducted in order to compare these data to pre-pandemic times.

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.

## Medication Initiation in Children Newly Diagnosed With ADHD, Measured Against NICE Guideline NG87

Dr Emma McWilliams\* and Dr Eleni Markopoulou

Manchester University NHS Foundation Trust, Manchester, United Kingdom

\*Corresponding author.

doi: 10.1192/bjo.2023.447

**Aims.** ADHD is a common neurodevelopmental disorder, which is usually diagnosed in childhood. The aim of this audit is to assess practitioners' compliance with NICE guideline NG87 in relation to the initial assessment and medication choice in children with ADHD (age 5 and over), prior to the commencement of ADHD medication.

**Methods.** The sample was children aged 5 years and over who have been diagnosed with ADHD and referred for medication initiation, in a Manchester CAMHS community team between May and October 2022. The audit tool used to collect the data included each of the standards and measured each individual patient's compliance. Information was collected from electronic patient records and paper notes.

**Results.** Sample size was 32 patients.

Standard One stated that 100% of patients, before starting medication, should have a full assessment, including: a review to confirm they meet the criteria for ADHD and need treatment, mental health and social circumstances including coexisting psychiatric/neurodevelopmental conditions, educational/employment circumstances, risk assessment for substance misuse and care needs. Overall compliance was 9%.

Standard 2 stated that all patients should have a physical health review including medical history, medication, height, weight and physical observations and, a cardiovascular assessment. Overall compliance was 0%.

Standard 3 stated that 100% of patients who met specified criteria should be referred for a cardiology assessment prior to starting medication. Overall compliance was 28%.

Standard 4 stated that 100% of patients who met criteria for referral to cardiology or had a co-existing condition treated with a medicine that may pose cardiac risk should have an ECG completed. Overall compliance was 75%.

Standard 5 stated that 100% of patients who have a blood pressure consistently above the 95th centile for age and height should be referred to paediatric hypertension specialist. Overall compliance was 9%.

Standard 6 stated that 100% of patients should be offered methylphenidate as first line treatment for ADHD or an alternative if they cannot tolerate stimulants. Overall compliance was 100%.

**Conclusion.** Three major areas of improvement were identified. Cardiovascular risk assessments are not fully compliant due to lack of cardiac examination which could affect rates of cardiology referral as referral criteria include a murmur on examination.

Although 100% of patient had their height, weight and physical observations recorded, a significant proportion did not have these plotted on centile charts as recommended.

A minority of patients had a full biopsychosocial assessment, with a major deficit in risk assessment for substance misuse.

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.

## Seclusion Reviews: Audit of Medical Documentation in a Psychiatric Intensive Care Unit

Dr Laura Middleton\*

Health Education England North West School of Psychiatry, Liverpool, United Kingdom

\*Corresponding author.

doi: 10.1192/bjo.2023.448

**Aims.** Seclusion is a restrictive intervention used when a patient presents with risks that cannot be safely managed in their current environment. The Mental Health Act 1983 Code of Practice (MHA CoP) provides clear recommendations for both frequency and content of medical seclusion reviews, with compliance previously audited within Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Following the initial findings however, change was not implemented. A new audit has therefore been commenced to reassess baseline practice and identify areas requiring improvement.

**Methods.** The MHA CoP audit tool outlines the following timeframes for assessment: initial medical review within 1 hour, 4-hourly medical reviews until first internal multidisciplinary review, twice daily medical seclusion reviews with at least 1 by the Responsible Clinician. Documentation should evaluate: physical and mental health, medication adverse effects, observation level, prescribed medication, risk to others and self, need for ongoing seclusion. Data were collected retrospectively for all episodes of seclusion occurring in a CWP Psychiatric Intensive Care Unit during August 2022.

**Results.** 5 seclusion episodes related to 4 patients, ranging from 1 night to 15 days in duration. Regarding medical review frequency, 20% were seen face-to-face within 1 hour of seclusion commencing and 75% were seen 4-hourly until their internal multidisciplinary review. Mental health was more consistently commented on than physical health (97% vs 61% respectively), whilst medication was reviewed in 69% of assessments. Rationale for continuing seclusion was provided in 72%, referring to risk to others in 54%. Adverse medication effects and observation level were the least documented parameters (2%), followed by risk to self (7%).

**Conclusion.** Assessment time was often not explicitly stated and was substituted with time of documentation, meaning reviews may have occurred earlier than accounted for. The on-call doctor does cover multiple sites overnight, potentially contributing to delays in attending unforeseen time-sensitive tasks. Trust policy dictates constant visual observation must be maintained throughout seclusion and this is therefore not routinely subject to review or adjustment. Overall interpretation of the qualitative information was fairly subjective in a low number of seclusion episodes, however there was a notable lack of recording adverse medication effects and risk to self. Findings will be presented at junior doctor induction whilst a quick reference sheet is designed prior to re-audit. CWP's seclusion policy specifies medical review frequency, but does not outline expected content of documentation. There is scope to extend local policy and align with the MHA CoP.

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.

## Secondary Service Communications to GPs-a Regional Audit

Dr Tajnin Mitu<sup>1\*</sup>, Dr Vinila Zachariah<sup>1</sup>, Dr Jason Ray<sup>2</sup>, Dr Alberto Salmoiraghi<sup>3</sup>, Dr Ramandeep Singh<sup>1</sup>, Dr Laura Williams<sup>2</sup>, Dr Vikram Bhanu<sup>1</sup>, Dr Asmaa Elsayed<sup>1</sup>, Dr Opeyemi Ikuewumi<sup>2</sup>, Dr Wamiqur Rehman Gejdhar<sup>1</sup>, Dr Amin Rezk<sup>4</sup>, Dr Mohammad Khan<sup>1</sup>, Dr Christopher Rowley<sup>4</sup> and Dr Lopez Okhiai<sup>1</sup>

<sup>1</sup>Betsi Cadwaldr University Health Board, Wrexham, United Kingdom; <sup>2</sup>Betsi Cadwaldr University Health Board, Rhyl, United Kingdom; <sup>3</sup>Betsi Cadwaldr University Health Board, Wrexham, United Kingdom and <sup>4</sup>Betsi Cadwaldr University Health Board, Bangor, United Kingdom

\*Corresponding author.

doi: 10.1192/bjo.2023.449

**Aims.** The purpose of the audit was to assess the standard of communication to GPs from secondary mental health services and to ascertain whether the information included in letters to GPs was in accordance with the recommendations of RCPsych and PRSB. The audit cycle was completed by re-auditing to identify how the recommendations from the first audit had improved the quality of communication to GPs.

**Methods.** The audit was conducted on three psychiatric units, in three sites across Betsi Cadwaldr University Health Board and clinic letters were studied to identify whether the information was as per recommendations from: RCPsych and PRSB.

The first audit used 121 letters in total from 3 sites, with the data being collected using audit proforma over a 2 week period from 04/04/22.

The re-audit looked at 69 letters with data collection using audit proforma over one week period from 19/12/22.

**Results.** Majority of letters sent to GP were lacking key information like details of Care coordinators, medical comorbidities, non-psychiatric diagnosis, and actions for GP with this data missing in 91.7%, 61.22%, 79.59% and 71.43% respectively. Fill rates for other information like patients' details was 100%, psychiatric diagnosis was 83.47%, psychiatric medications, follow-up plan were 80.17%.

The results of the re-audit most letters contained Psychiatric Diagnosis (97.1%, previous 83.5%), Psychiatric Medication (91.4% previous 80.17%), and Follow Up Plan (98.6%, previous 80.2%). Many letters did not include information regarding Medical Comorbidity (28.6% vs 31.4%), Non-Psychiatric Medication (65.7% vs 34.7%), Details of Care Co-ordinator (54.3% vs 8.3%) and Action for GP (27.1%, vs 44.6%).

**Conclusion.** The recommendations from first audit were to create local guidelines and templates with recommended headings for clinical letters, provide formal teaching for junior doctors and to re-audit to see if the implemented changes had led to an improvement.

The re-audit showed improvement since the introduction of the template in majority of headings in GP letters with decline in fill rate for 2 headings and these changes varied among three sites.

Barriers identified affecting the overall outcome of the re-audit were: template not being used, lack of training to juniors, and psychiatrist workload.

In conclusion, we aim to re-distribute the template and increase awareness with informal teaching sessions, provide