ASD, and 41 were suspected as having ASD. In total, 39% of service users had, or were suspected of having, ASD. The prevalence was higher in female service users than males with a total of 48% of female service users having, or being suspecting of having ASD, compared with 22% of males. Comparative data demonstrated that autistic/suspected autistic young people presenting to the service were more likely than their neurotypical counterparts to be: over 13 years old, have a longer symptom duration before presentation, have an Educational Health Care Plan, report friendship difficulties, have a family history of neurodiversity, report sensory difficulties, and have sleep difficulties. RCADS scores found that the ASD group were more likely than the neurotypical group to have clinical levels of anxiety (58.3% vs 15.3%) and depression (80.6% vs 58.3%).

Conclusion. Our audit suggests that there is a higher prevalence of young people with ASD/ASD traits presenting to a paediatric fatigue service than found in the general population. Reasons for this may relate to undiagnosed ASD presenting as severe fatigue due to the energy draining nature of camouflaging, as well as sensory overload, known as autistic burnout. Do we need to develop a specialist treatment pathway which is better adapted to these young people's needs? We are planning a follow up study and focus groups to explore this complexity further.

Psychiatric Emergency Bleep Documentation Enhancement Audit

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Aims. West Lothian Psychiatry operates in a district general hospital, fostering a close working relationship between medical and psychiatric practitioners including the Psychiatric 2222 call (akin to medical emergency/cardiac arrest response). No other team like this has been identified in Scotland. Whilst there is a range of scenarios where this is used, there is no 'gold standard' for defining a psychiatric emergency or how to document these. Preliminary data gathered between August and November 2022 revealed concerns regarding call appropriateness, medical staff proficiency in de-escalation and restraint on medical wards, inadequate handovers, and poor documentation. This prompted a collaborative quality improvement project, undertaken by psychiatric and medical team leaders. Part of this initiative was an audit to improve the documentation of psychiatric emergencies to achieve a 90% compliance rate using a new checklist.

Methods. Cycle 1 of the audit (December 2022 to April 2023) identified patients through the 2222 calls to switchboard (n = 54). TrakCare notes were reviewed to assess call rationale and outcomes, focusing on documentation by the attending psychiatric team. A documentation checklist within the electronic records system was designed and introduced in July 2023, for completion by the junior doctor. Cycle 2 (November 2023 to January 2024, n = 47) aimed to assess improvements by comparing results with the previous cycle.

Results. There was a significant improvement in documentation rates with the checklist (44% to 90%). Indirect enhancements were observed in ward nursing documentation (65% to 83%) and medical ward doctor documentation (39% to 57%). Appropriateness of emergency calls increased from 65% to 74%, with attending doctors' participation in emergencies longer than 10 minutes rising to 68% from 47%. The initial audit revealed a lack of awareness among senior medical staff regarding overnight psychiatric emergency calls, especially in cases of repeated calls for the same individual. The improved documentation played a pivotal role in addressing this issue, facilitating effective information sharing and changes in patient management plans, reducing further emergency calls.

Conclusion. The documentation checklist significantly improved junior doctor documentation, positively impacting patient care and communication among staff. This successful intervention serves as a promising model that can be replicated in other documentation domains. Moreover, this project has set the stage for broader initiatives within a larger Quality Improvement framework. The ongoing efforts are directed towards establishing a shared model for the psychiatric emergency bleep, optimising staffing resources for restraint procedures and improving staff de-escalation skills.

An Audit of the Prescribing and Monitoring of Antipsychotic Medication in an Older Adult Inpatient Psychiatric Ward Using NICE Guidance [CG178] Psychosis and Schizophrenia in Adults: Prevention and Management

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Aims. The National Institute for Health and Care Excellence (NICE) offers guidance for prescribing and monitoring of antipsychotic medications. In this audit we sought to investigate if our unit was compliant with this guidance.

Methods. The audit was carried out on a 28 bedded older adult inpatient psychiatric unit. The notes of all patients admitted to this ward on 27/11/2023 were reviewed. Any patient on an antipsychotic was included in the audit. Four standards reflecting the prescribing and monitoring of antipsychotics were identified. These were:

1.3.5.1 The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees.
1.3.6.1 Before starting antipsychotic medication, undertake and record the baseline investigations.
1.3.6.2 Before starting antipsychotic medication, offer the person with psychosis or schizophrenia an electrocardiogram (ECG).
1.3.6.3 Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial.
1.3.6.4 Monitor and record the following (response to treatment – side effects – adherence – physical health) regularly and systematically throughout treatment.

These five areas of guidance were broken down into 22 domains which are outlined in results below.

Results. Of 28 patients admitted to the ward, 22 were on antipsychotic medication.

1.3.5.1: Medication benefits were discussed and documented in 9/19 cases (47%), with 3 patients refusing to engage in this discussion. Side effects were discussed and documented in 5/21 cases (23%).

1.3.6.1: Patients underwent a range of investigations. In some cases, the patient hadn't been on the medication for long enough to require additional tests. Some patients were excluded as they refused testing. Glycosylated Haemoglobin (100%), Weight (100%), Pulse and Blood Pressure (100%), Blood Lipid Profile (86%), Prolactin Levels (77%), Assessment of nutritional status, diet (77%), baseline fasting blood glucose (38%), Level of Physical Activity (31%), Assessment of any movement disorder (22%), Waist Circumference (0%).

1.3.6.2: An ECG was offered in 94% of cases.

1.3.6.3: The rationale of continuing, changing or stopping the medication was recorded in 86% cases and no patients had antipsychotic doses above BNF maximum.

1.3.6.4: Overall physical health monitoring, weekly weights and, pulse and BP at 12 weeks (100%). Adherence and response to treatment were both 95%. Measurement of glycaemic control (57%), movement disorders (14%) and side effects (13%).

Conclusion. While there are areas of good practice, there are a number of significant omissions. Remedies to these deficits will be proposed.

An Audit of the Consistency and Quality of Letters From Choice Appointments in CAMHS South Edinburgh

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Aims. Hypothesis: Choice letters generated by Child & Adolescent Mental Health Services (CAMHS) South Edinburgh are not consistent in quality and content.

Aims:

1. To assess the consistency and quality of letters generated by clinicians following Choice appointments in CAMHS South.
2. To observe the range of resources shared in Choice letters.

Methods. Patients were identified retrospectively from the team Choice diary.

Choice or Complex Choice appointments attended between 13th October–27th November 2023 at CAMHS South were included. See Soon appointments and appointments that were not attended or cancelled were excluded.

Standards to which all letters should adhere were devised from the CAPA (Choice & Partnership Approach) Book and the CAMHS South Choice Handbook.

Standards: current concerns, background information, patient goals, clinician impression, choices discussed, choices made, self-help agreed, services required, maximum two sides of A4, copy to patient, copy to referrer, sent within two weeks.

Letters were accessed via electronic records and analysed with a proforma.

A maximum of three letters per clinician was included.

A log of resources and frequency shared was kept.

Results. 57 appointments were attended, with 50 letters generated by 22 clinicians.

Adherence to standards in 50 available letters:

Current concerns 92%
Background information 96%
Patient goals 40%
Clinician impression 62%
Choices discussed 22%
Choices made 100%
Self-help agreed 52%
Services required 100%
Maximum two sides of A4 50%
Copy to patient 88%
Copy to referrer 100%
Sent within two weeks 72%

94 different resources were shared in the letters, with minimum 0 resources and maximum 19 resources per letter.

Conclusion. There were areas of good quality and consistency in Choice letters, including documentation of current concerns, background information, and highlighting of required services. These are areas likely to feature in most assessments regardless of clinician background.

There were areas that require improvement, including documentation of goals, clinician impression, self-help agreed, and keeping to a maximum of two sides of A4. These areas are perhaps more obscure for different types of clinician.

A wide range of resources were shared in Choice letters with a considerable amount of variability in number of resources. This suggests differing levels of individualisation of resources to the patient.

Since this audit, CAMHS South have implemented additional Choice training, electronic canned text for letters, and collation of Choice guidance. There is a plan to re-audit following these interventions.

Audit on Antidepressant Prescribing; Documentation of Indication; and Compliance With EIPN Standards in Medication Review, at Hailsham Early Intervention in Psychosis Service

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Aims.

- To improve documentation of antidepressant prescribing in our service, aiming to improve frequency of review, and guide measurement of outcomes.
- Identify patients requiring medical review.

The standards that we audited against are that, for patients under The Early Intervention in Psychosis Service (EIPS), a diagnosis should be recorded alongside each antidepressant prescription and, according to EIPN guidelines, psychotropic medications should be reviewed every 6 months.

Population data from the UK indicates that lack of recording of a diagnosis is associated with increased duration of treatment, and reduced frequency of mental health reviews.

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