Senior Leadership to discuss methods for improving the training experience.

Audit of the Management of High Clozapine Levels Within Solihull Community Mental Health Teams (CMHTs)

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Aims. To review the practice of management of clozapine plasma levels in Solihull CMHTs between April and September 2023. Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) clozapine guidelines were issued in January 2023 and further ratified in December 2023. The standard set out in the January 2023 guideline was that service users with elevated clozapine levels >600mcg/L should be assessed for signs of toxicity and consideration given to a dose reduction. Those with levels above 1000mcg/L should be reviewed urgently.
Methods. Clozapine blood clinic diaries were reviewed in order to obtain a list of 48 service users who had attended for clozapine blood tests between April and September 2023. Blood results were reviewed for clozapine level results. For those service users whose clozapine level had been over 600mcg/L, clinical notes were reviewed to determine whether they had been screened for clozapine toxicity.
Results. Of the 48 service users prescribed clozapine, 24 had clozapine levels over 600mcg/L and 11 had levels over 1000mcg/L. Of the service users with clozapine levels over 600mcg/L, 16 (67%) were screened for toxicity. Of those with clozapine levels over 1000mcg/L, 9 (82%) were screened for toxicity.
Conclusion. Between April and September 2023, Solihull CMHTs demonstrated an understanding of the need for actioning elevated plasma levels as a priority, however, this could be further improved. The risks of adverse effects and toxicity with clozapine increase with raised plasma levels, particularly with levels over 1000mcg/L. Therefore, it is important that raised plasma levels are actioned accordingly. Locally, we have implemented a flow chart which summarises the updated clozapine guidelines, to assist clinicians in interpreting and acting on high clozapine levels and to prompt clinicians to review service users for signs of toxicity. We hope to incorporate this visual aid into the updated BSMHFT guidelines.

Clinical Audit of Rapid Tranquilisation in Mental Health Services for Older People (MHSOP)

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Aims. Rapid Tranquilisation (RT) is the parenteral (intramuscular) administration of medication to calm or sedate an agitated, violent or aggressive patient in a timely and safe manner. This audit specifically looks at the clinical practice in the use of rapid tranquilisation in inpatient MHSOP against trust policy. The aim of this audit is to assess the effectiveness of RT and if other methods of de-escalation are being utilized first to provide better care for patients and utilize the least restrictive management options possible.
Methods. The audit was registered, and care was taken to uphold ethics, access patient information appropriately, and to ensure that data collected was both relevant and ensured confidentiality. All incidents of RT were identified across both wards of Auckland Park Hospital from the period of August to October 2023. DATIX numbers were identified to show incidents of RT from the specified period, these numbers were used to identify patient ID with liaison with relevant staff members. Patient ID was used to review the incident, specifically to investigate de-escalation techniques documented and effectiveness of RT. Only parenteral RT incidents were included to assess if appropriate measures were taken beforehand.
Results. A total of six Incident reports were identified over the three-month period. In all cases the choice and dose of the medication was within the current recommendations. 33% of incidents utilised promethazine 25mg while the other 66% utilised lorazepam either 1mg or 500mcg. All patients had baseline observations recorded on NEWS chart prior to the incident, however only 33% of incidents involved full recordings of observations at appropriate intervals on the NEWS chart. The reason for this in all cases was due to patient refusing observations which was documented. There were no documented side effects but 33% of incidents involved a raised NEWS score post RT. In all cases the NEWS score resolved spontaneously within the post RT monitoring period. In 100% of incidents de-escalation techniques were utilised and documented and evidence of post RT debrief with the patient was shown. 66% of incidents involved a medication review post RT as per recommendations.
Conclusion. Guidelines are being followed with good effect regarding RT in MHSOP. It is important to always undertake nonpharmacological de-escalation methods prior to considering RT which is reflected in the low numbers of RT during this period. Recommendations are made to follow local guidance as well as to exhaust nonpharmacological de-escalation methods to reduce the need for RT.

The Use of the Emergency Department as a Place of Safety Following Section 136 Detention

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Aims. Section 136 of the Mental Health Act 1983 allows for a person who appears to a constable to be suffering from a mental disorder and needing immediate care to be removed to a place of safety (POS) for their protection or the protection of others.

The legislation recommends that prior to making a decision to detain on Section 136, the constable must, if practicable, consult mental health services for information to guide decision making.

The 136 suite is the preferred POS except for patients requiring urgent medical treatment in which case the Emergency Department (ED) is preferred. If the 136 suite is unavailable, then alternatives like the ED may be used.

This audit examines the use of the Birmingham City Hospital Emergency Department as a POS following Section 136 detention, the adherence to the aforementioned legislation and the outcomes of the assessments.

Methods. The audit was approved by the clinical governance team and a list of all Birmingham City Hospital patients detained under Section 136 for a three-month period (January–March 2022) was retrospectively obtained. Clinical records were examined, and the relevant data was extracted from the clinical notes.

Information including the reason for use of the ED as a POS, police contact with mental health services prior to detaining, time taken prior to assessment, reasons for mental health act assessment (MHAA) delays, and outcomes were collected and collated using Microsoft Excel.

Results. The ED at City Hospital was used a place of safety for 80 patients in this period. In 52.5% of cases the ED was used as a place of safety due to lack of space at the POS. Contact with mental health services prior to detention was documented in only 29% of cases. The average time for a MHAA to take place in the period under review was 11.5 hours. Only 20% of these cases ended up detained under the mental health act.

Conclusion. The results show poor adherence in the use of Section 136 to the recommendations of the legislation. Improvements are needed on time taken for assessments and use of ED as a place of safety due to unavailability of beds at the s136 suite. The police should be re-educated on the importance of contacting mental health services prior to detaining patients on Section 136. The audit result was presented at a clinical governance meeting and repeat audits are planned across all the emergency departments in Birmingham.

Clinical Audit of Standard for Electronic Recording of Dementia Diagnostic Assessments in Stockton Mental Health Services for Older People

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Aims. This clinical audit aimed to assess if the recording of patients seen for their diagnostic appointments in memory clinic measures up to the minimum standards required in the delivery of dementia services. This standard mandated primarily that a minimum body of key information must be promptly recorded by clinicians, in patient electronic records within 24 hours, as stipulated by Trust and NICE guidelines.

Methods. The first cycle was conducted from 16 October 2022 to 10 February 2023. In this cycle random sampling was used to select 25 patients on the caseloads of the mental health services for older people. Before the start of the second phase all diagnosing clinicians within the team were informed about the project and the expected improvements against which compliance would be audited. The second phase was conducted between 10 February 2023 to 31 March 2023 and another 25 patients on the caseloads were obtained via random sampling for the second cycle. Inclusion criteria for both phases were patients who had received a diagnostic assessment in these periods.

Results. In the first set of records, the minimum body of information was recorded in 90–100% of cases according to the team's recommended standards namely diagnostic information, prognostic information, treatment plans, post-diagnostic contact plans and documentations being made within 24hrs of consultation. In the Set 2 the minimum body of information was recorded in 95–100% records studied. That is, diagnosis, treatment, medication treatment plans (prescription plans), and post-diagnostic contact plans were covered in the diagnostic sessions. In particular, case note documentations were made within 24 hours in all but one of the records applicable.

Conclusion. Given that a diagnosis of dementia can be life-changing, not discussing prognostic information would not prepare patients and carers adequately with information on how to live well with dementia following their diagnosis. This could potentially lead to poor adjustment to the condition and anxiety for some. At a trust-wide level, this means there is still room for improvement for the trust as regards dementia care ideals recommended by NICE.

Clinical Audit of Psychiatrist Reviews of Patients on Depot Antipsychotic Medication Under a General Adult Community Mental Health Service in North Norfolk

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Aims. In outpatient settings, depot administrations are done to a large extent by Community mental health nurses and other trained clinical personnel who are not psychiatrists. As a result of this, there is a possibility that patients who are having depot medications are not reviewed by a psychiatrist for a long duration of time which can be more than a year. The aim of this audit is to find out if patients currently taking depot medication under a General Adult Community Mental Health Service in North Norfolk are being reviewed by a psychiatrist according to the standard guidelines. The Maudsley prescribing guidelines states that all patients receiving long-term treatment with antipsychotics medication should be seen by their responsible psychiatrist at least once a year (ideally more frequently) to review their treatment and progress.

Methods. List of patients currently on depot medication were taken from the spreadsheet on the Unit's Shared drive. All 47 patients currently receiving depot medication on this list were reviewed. The review period was from Ist January 2023 to

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