which include risk of self-harm/suicide, risk to others and risk from others. AMBER.

Diagnosis: 66% of the letters had a clearly defined diagnosis or clinical impression which were at times (43%) not concise. AMBER.

Medication: Only 12% of the letters had a list of medications and any changes to medication by psychiatry liaison services clearly documented. RED.

Actions for GP: Only 29% of the letters had an identifiable list of actions for the GP to undertake. RED.

Conclusion: The audit highlighted that lack of a local service specific guidance and a lack of a standardized GP format led to marked variability, lack of consistency and missing of vital information from GP discharge letters; furthermore it became apparent that some letters were not uploaded to the electronic system.

Adherence to Trust Section 17 Leave Policy at High Dependency Unit and an Open Rehab Unit

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Aims: Following initial audit on trust policy for section 17 leave in 2023, this second cycle aimed to reassess staff adherence with the trust section 17 leave policy as well as monitor the change in practice. The first cycle of audit was presented at the clinical forum, and all the professionals agreed about documentation of reflections on leave and urine drug screen (UDS) in electronic notes.

Methods: Data was collected retrospectively from electronic case notes/patient portal in July 2024, for all detained patients on both units. Fifteen patients were included in this audit. Section 17 leave was a Multidisciplinary team (MDT) decision.

Results: For all patients, a clear discussion regarding appropriateness of leave including current presentation and risk were documented. A clear physical description and photographs were completed for all the patients. The patients involved in the audit had utilized a total of 197 leaves in a one-month period. This included 33 escorted, 155 unescorted, 9 accompanied leaves. For accompanied leave, the accompanying person, and the purpose of the leave was recorded. For all leaves, restrictions and contingency plan were clearly documented on the leave prescription.

At the end of any leave period, staff reflection on the leave period were documented in 7.6% as compared with 20.14% in the first cycle of the audit. Staff scored 100% in recording patient feeling after the leave on patient portal. Out of 155 unescorted leaves, 92 leaves had search restriction. 100% searches were conducted which was an improvement from 95% in first cycle. UDS required as per leave prescription for 62 of unescorted leaves were completed and documented in 53.20%, which was an improvement from 17.20% in the first cycle.

Conclusion: The audit results show effective completion of risk assessment, physical description and making leave decisions as an MDT. There had been slight increase in the post leave search and UDS in comparison to the first cycle of audit (2023). However, staff reflection on electronic notes and UDS compliance still needs improvement.

Recommendations include increased training of staff in documentation, regular audits, and encouraging post leave evaluations to enhance the safety of section 17 leave process.

Re-Audit of the Assessment and Prevention of Risk of Fragility/Osteoporotic Fractures by Community Physicians in at Risk Old-Age Female Patients Admitted to Central Norfolk Older Adult Inpatient Unit at the Norfolk and Suffolk NHS Foundation Trust

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Aims: Osteoporotic fractures are a major cause of mortality and morbidity in older adults, often leading to long-term disability and reduced quality of life. The National Institute for Health and Care Excellence (NICE) guidelines (2012) recommend that women aged ≥65 years and men aged ≥75 years be assessed for fracture risk using tools such as FRAX and QFracture. These assessments help identify high-risk individuals, enabling timely interventions like lifestyle changes, bone density scans (DEXA), and pharmacological treatments, including calcium and bisphosphonates, to prevent fractures. This audit aims to assess compliance with these NICE guidelines by General Practitioners (GPs) in a hospital setting and determine whether high-risk patients received appropriate management.

Methods: Retrospective audit was conducted using electronic patient records. The sample included 20 patients admitted to the ward in the month of December 2024. The audit focused on determining whether fracture risk assessments were performed using FRAX or QFracture for service users (women) aged 65 years and older. Additionally, the audit examined whether high-risk patients received appropriate management, including bone density scans (DEXA), lifestyle changes, and pharmacological treatments. Secondary risk factors such as chronic kidney disease, diabetes, and smoking were also evaluated for their impact on fracture risk.

Results: 0% had documented FRAX/QFracture assessments or evidence of a DEXA scan.

Over 90% of the audited patients were classified as having intermediate or high risk for major osteoporotic or hip fractures within 10 years.

Despite the high fracture risk, only 19% of patients were actively treated with bone-protecting medications, and none had documented assessments for fragility fracture risk prior to admission.

60% of the patients had secondary risk factors, such as chronic kidney disease, diabetes mellitus, rheumatoid arthritis, glucocorticoid use, smoking, or low BMI, which further increased their fracture risk.

Approximately 70% had a history of falls, and 57% had a history of previous fractures. However, none had undergone orthopaedic surgeries.

Internal barriers to initiating bone-protecting medications, largely due to the mental health-focused nature of the care

team, were noted, with responsibility for prescribing remaining with GPs.

Conclusion: The audit revealed significant gaps in the implementation of NICE guidelines, with none of the patients receiving documented fracture risk assessments or appropriate interventions. Despite a high prevalence of secondary risk factors and fall histories, the management of fracture risk was insufficient. Addressing internal barriers and improving follow-up care is critical to ensuring better adherence to guidelines and preventing fragility fractures in high-risk patients.

Audit of the Ward Environment in an Inpatient Autism Unit

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doi: 10.1192/bjo.2025.10667

Aims: Creating an optimal ward environment for autistic inpatients is essential for their well-being and therapeutic progress. This audit aimed to assess the inpatient ward environment of two autism rehabilitation wards – Spring Center (a locked rehabilitation ward) and Spring Wing (an open rehabilitation ward) – against the Gold Standard Environmental Standards for Learning Disability (LD) and Autism Spectrum Disorder (ASD) inpatient hospitals, as well as the Quality Network for Learning Disability (QNLD) standards.

Methods: A structured questionnaire was developed based on gold-standard guidance for autism inpatient wards. The audit was conducted by a Staff Grade Doctor and a Specialist Occupational Therapist (OT), who inspected both wards, interviewed staff and patients, and evaluated adherence to 22 key environmental standards. The OT's input was crucial in assessing the sensory needs of autistic individuals.

Results: Out of the 22 assessed parameters, both wards failed to meet 7 critical requirements, including:

Lack of consultation with autistic individuals regarding the design and assessment of sensory spaces.

Absence of active patient and family feedback regarding the ward environment.

Insufficient autism and sensory sensitivity training for all staff, including non-clinical members.

Lack of soft furnishings and carpets to reduce background noise.

No structured process to identify and minimize strong odours in patient areas.

Limited bedding options catering to individual sensory preferences.

No use of unscented cleaning and personal-care products.

The remaining 15 parameters were met in both wards. The findings were shared with the ward manager, hospital manager, and medical team, with plans to present them in a clinical governance meeting to develop a business case for environmental improvements.

Conclusion: The audit identified several areas requiring immediate attention to enhance the sensory environment and overall ward quality for autistic inpatients. It also highlighted the importance of specialized spaces and therapy rooms tailored to sensory needs. A re-audit is planned in six months to assess the implementation of recommendations and ensure continued improvements in the ward environment. An autism ward environment should be designed to be calm, low-sensory, and predictable, with features like soft lighting, quiet spaces, minimal noise, clear visual cues, and a consistent routine to minimize sensory overload and create a therapeutic space for autistic individuals who can be easily distressed by overstimulation in a typical hospital ward; this often includes designated quiet areas, muted colours, and staff trained in autism-specific communication strategies.

Audit on Venous Thromboembolism (VTE) Assessment in Adult Inpatient Wards on Admission

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Aims: Aim of this audit was to assess if VTE (Venous thromboembolism) assessments on admission to adult inpatient wards (two working age and one old age ward) at the Inpatient Psychiatry unit are carried out as per the local Trust's Policy.

Methods: I made a questionnaire comprising 6 questions, based on the local Trust's VTE assessment policy.

Data was reviewed for a total of 70 patients but collected for 54 patients between 17/04/2024 and 07/05/2024 admitted on all three wards at the Acute Inpatient Psychiatric Unit.

16 patients were excluded due to them being transfer patients from other units and not new admissions.

Data was collected from patients' electronic records which included VTE assessment risk forms, progress notes, initial psychiatric assessment forms on admission, physical examination forms and Multidisciplinary team reviews.

Data entry and analysis was done using Microsoft Word and Excel.

Results: Based upon the Trust's policy, the following practices/guidelines were checked for compliance against the expected standard:

1. Was the VTE assessment carried out on admission? Standard – 100%. Compliance – 68%.

2. Was the VTE assessment questionnaire completed correctly as per Trust's Policy on patient's electronic record system? Standard – 100%. Compliance – 66.6%.

3. Were the VTE related Examination findings documented in the Physical Examination section/form on the Electronic Record System? Standard – 100%. Compliance – 63.4%.

4. Was VTE risk re-assessed on consultant review? Standard – 100%. Compliance – 1.8%.

5. Were the patients assessed to be 'at risk' of developing VTE, re-assessed within 24 hours of admission or later if the patient's condition changed? Standard – 100%. Compliance – 33.3%.

6. Were all patients assessed to be at risk of VTE offered thromboprophylaxis that is consistent with NICE and Trust guidelines unless contraindicated? Standard – 100%. Compliance – 100%.

Conclusion: Results showed that the current practice standards are below the expected standard in all areas except prescribing the correct prophylactic medication if indicated. Based on these results, the following recommendations were made:

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