3. Implement changes targeting highlighted challenges.
    1. Present at ward QI meetings.
    2. Create & discuss Infographic for staff.
    3. Highlight role/importance of forms and usefulness to clinicians.
4. Re-audit after 2 months.

Results. Initial results found a completion rate of 7% across both wards reviewed (n = 41). Within this, 1 form was actually valid. One of the wards had no completed forms. The post-intervention group had fewer patients involved (n = 35), but an increased number of completed forms. Completion rate had risen from 7% to 26% (3–9 patients). Within this, the valid forms had increased from 1 to 4.
Conclusion. There was a clear impact on completion rate after initial interventions. The sub-optimal increase in completion highlighted the ongoing need for further input to improve completion rates.

This was a small, local audit of patients in an acute inpatient psychiatric ward. There was a recognised limitation on the number of patients in the study and acuity of some patient's illness, preventing completion.

Assessment of Compliance With NICE Guidelines on Safety Planning Following Self-Harm in Elderly Patients in a Mental Health Trust

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Aims. Our aim was to evaluate the extent to which the risk assessment protocol post self-harm incidents for patients aged over 65 at the Black Country Healthcare Trust is aligned with the recommendations set forth in the NICE Guideline (NG225). We specifically sought to determine whether safety plans are incorporated as recommended by the NICE Guideline (NG225), and in the absence of a distinct safety plan, whether essential components of such a plan are integrated within the risk assessment framework utilised following episodes of self-harm.
Methods. A retrospective audit was conducted utilizing data from the trust on self-harm incidents over a six-month duration. Of the 1,408 recorded incidents, 68 involved individuals aged 65 years or older. A sample of 30 incidents was randomly selected from this cohort to constitute the target sample for this study. Each case was anonymized with a unique identifier and subjected to a comprehensive review employing a bespoke data collection instrument, expressly developed for this audit. The review process was facilitated by the trust's digital record system (RIO). Data collated for analysis encompassed a range of variables, including demographic details, diagnostic classifications, geographical location, care setting, self-harm methodologies, the severity of the self-harm events, the origin of data, and compliance with the stipulated criteria of the NICE Guidance (NG225).
Results. Comprehensive safety plans were present in a minority of cases, specifically 6.7% (2 out of 30 patients). The documentation of individual components of the safety plan, analysed separately, yielded the following results:

1. Documentation of self-harm mechanisms was achieved in 70% of cases (21/30).
2. Identification of precipitants or triggers was noted in 56.7% of cases (17/30).
3. The formulation of coping strategies was documented in 20% of the sample (6/30).
4. The enumeration of essential contacts was completed in 33.3% of cases (10/30).
5. The identification of family members pertinent to the patient's support network was noted in 33.3% of cases (10/30).
6. The inclusion of contact details for these identified individuals was present in 30% of cases (9/30).
7. Guidelines to ensure a safe environment were applicable and recorded in 38.9% of the relevant cases (7/18).

Conclusion. The majority of patients did not have a safety plan post self-harm incidents. Notwithstanding the absence of a comprehensive safety plan, critical elements prescribed by NICE Guidance (NG225) were insufficiently addressed within the risk assessment and subsequent management planning post self-harm.

Full Cycle Audit on Health Appointment Attendance: Comparative Analysis of Initial Audit and Reaudit Findings in a Psychiatric Care Setting

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Aims. The full cycle audit aimed to evaluate and enhance attendance rates at health appointments in a psychiatric care setting. The initial audit (Phase 1) identified baseline attendance rates and underlying factors contributing to missed appointments. The reaudit (Phase 2) was conducted to assess the effectiveness of implemented interventions from Phase 1 and to identify areas for continued improvement.
Methods. Both phases employed a retrospective evaluation methodology. Phase 1 reviewed records of 23 patients over two years, totaling 89 appointments. Phase 2, conducted as a follow-up, involved 19 patients with 39 appointments over a six-month period. Data collected included the number of attended and missed appointments, and reasons for non-attendance. Interventions after Phase 1 focused on addressing identified issues such as patient transfers, leave protocols, and transportation challenges.
Results. Phase 1 recorded an attendance rate of 68.5%, with the missed appointment rate at 25.8%. Common reasons for non-attendance included patient decline and unclear reasons. Phase 2 showed a slight improvement in attendance rates (71.8%) but also an increased missed appointment rate (28.2%). Notable reasons for missed appointments in Phase 2 included patients on leave, ward cancellations, and transportation issues. The comparison revealed an improvement in attendance rates post-interventions, though challenges persisted, particularly in patient leaves and transportation.

The chi-square statistic is 2.2893 and the p-value is 0.3183. This indicates that there is no statistically significant difference between the attendance rates in Phase 1 and Phase 2. This suggests that the changes implemented between the two phases did not result in a statistically significant difference in attendance rates.

Conclusion. The full cycle audit demonstrated marginal improvements in appointment attendance rates following targeted interventions. While Phase 2 showed a higher attendance rate, it also highlighted ongoing challenges, particularly in managing patient leaves and transportation. These findings underscore the need for continuous monitoring and adaptable strategies to further enhance attendance rates. Recommendations include improved communication during patient transfers, proactive leave management, addressing transportation issues, and ongoing evaluation to sustain improvements in health appointment attendance in psychiatric settings.

Do Not Attempt Resuscitation (DNAR) Orders in an Older-Age Psychiatric Hospital

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Aims. We aim to see whether DNAR discussions are being undertaken at an appropriate time for our patients, as well as seeing whether these are recorded formally and regularly reviewed, as per local protocol. We also aim to see whether the immediate medical/nursing teams are aware of the local guidelines, as well as which of their patients have a DNAR in situ, and how to find this out. As an old-aged psychiatric unit, this is very important.
Methods. We used 2 methods of data collection. One was questionnaires that we gave out to medics, nurses, and HCAs on our wards. We collected quantitative data from them on whether they knew where DNAR forms were and which of their patients had DNAR forms. We then also collected quantitative data from our online notes, looking into which patients had DNARs, whether these were recorded online and in a physical copy, whether it was discussed on clerking, and whether it was regularly reviewed and documented in MDTs. We used data from 51 inpatients over 3 wards.
Results. Over 30% of patients have a DNAR in situ across the 3 wards. The dementia-focussed wards have a higher number of DNARs in place. All patients with a DNAR had a purple form completed and kept on the ward. 75% of staff knew where these were. Only 20% of those with DNARs had these documented online as per local guidelines; only 45% of staff knew where to find this information online. Only 8% of patients had their DNAR status discussed on admission, and 10% in their first MDT. Only 60% staff knew which patients had a DNAR in situ.
Conclusion. There is evidence that purple forms are completed appropriately and stored well. The main issue is the online record-keeping; staff either don't know how to or that they can document this online. This is reiterated as many did not know where the information was online. This demonstrates a lack of knowledge and education.

DNAR conversations are not occurring in the first place; the status is not being regularly reviewed, leading to issues where these conversations are rushed during acute events. It is important to think about these things earlier to ensure everyone, patient, family and staff, understands the process and rationale.

Lack of staff knowledge on which patients have DNARs in situ could be a great issue if an acute event were to occur, and compromises patient safety.

Clozapine Monitoring in Older Adults: An Audit Evaluating Compliance With Clozapine Guidelines in Community Settings

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Aims. To review compliance with current blood monitoring guidelines of Older Adult Community Mental Health (OACMHT) patients who are on clozapine within the community teams of Herefordshire and Worcestershire Health and Care NHS Trust. This is for full blood count, prolactin, glycated haemoglobin (HbA1C), liver function, renal function, lipid profile, glucose, and clozapine assay.
Methods. Our trust guidelines state the following blood parameters should be monitored every 6 months:

1. Full Blood Count (FBC)
2. Glucose (fasting if possible)
3. Prolactin
4. Urea & electrolytes (U&E)
5. Lipid profile (fasting if possible)
6. Liver Function Tests (LFT)
7. HbA1c (annually)
8. Clozapine plasma assay (annually)

We reached out to the medical secretaries of the following OACMHTs: Wyre Forest, Malvern Evesham & Pershore, Worcester & Droitwich, Redditch & Bromsgrove to collate a list of patients on clozapine. We then retrospectively looked at blood test results in the past 1 year from 31.12.22 to 31.12.23 and assessed compliance of the 8 haematological parameters.
Results. In total, 7 patients were identified across the 4 OACMHTs caseloads who were on clozapine. In the past 1 year, we would expect 2 episodes of monitoring for FBC, Glucose, U&E, Prolactin, Lipid profile, and LFT, as well as 1 episode of HbA1C and clozapine drug levels.

Compliance for FBC monitoring for 2 episodes was achieved for 100% (n = 7) of the patients. Compliance for 2 episodes of glucose and prolactin monitoring were 0%. Compliance for 2 episodes of renal profile monitoring was 57% (n = 4), but 86% (n = 6) of the patients had at least 1 episode of renal profile monitoring. Compliance for 2 episodes of Lipid profile monitoring was 0%, however 43% (n = 3) of the patients had at least 1 test. In terms of LFTs, 71% (n = 5) of the patients achieved the expected 2 episodes of monitoring, and 100% of them at least 1 episode of monitoring. For HbA1C monitoring, 100% of the patients had the expected 1 episode of monitoring annually. For clozapine plasma levels, 43% (n = 3) of the patients achieved their expected annual episode of monitoring.

An interesting observation of note was that a number of blood parameter investigations were performed by GPs/hospitals as part of another investigation, not exclusively for the sole purpose of clozapine monitoring. For example, 50% of the U&Es, 33% of