

Aims. Medicine reconciliation in community teams is guided by trust guidance, which emphasises that for all new patients accepted into a community team, staff should be aware of all current medication (both psychotropic medication and those prescribed for physical health needs). This information needs to be considered at each review to inform safe prescribing. Upon this background, concordance between electronic mental health records and general practice shared records of medications and allergy status for patients residing at a community forensic supported accommodation was audited in order to identify areas for improvement in practice.

Methods. Data were collected from mental health electronic records (Rio) and general practice records (Health Information Exchange). All patients residing full-time at a community forensic supported accommodation in Cumbria Northumberland Tyne and Wear NHS Foundation Trust during January 2022 were included. Concordance between the records in medication and allergy status was assessed. Initial assessment was performed by one reviewer and 100% of included records were then cross checked by a second reviewer. Data collection was intended to pick up any mismatch in the records. Standards were set at 100% concordance.

Results. Eight patients were included. For allergy status, in two patients' (25%) records showed allergies which were present in electronic mental health records were not present in general practice records. The reasons as to lack of documentation of allergy status in general practice records were unclear. Cross check of the discharge summaries to primary care from the wards where allergies were originally identified indicates that allergies were clearly documented.

For medication, discrepancies between records were found in two patients (25%). In these patients, medications present on general practice records were not present on mental health records. These were both physical health medications (vitamin D supplements) which were being prescribed regularly by primary care and had been omitted during transcription onto electronic mental health records.

Conclusion.

- 1) Currently, standard practice is for updates of medication on mental health records to take place every four months as part of quarterly care coordination reviews. Electronic mental health records should not be relied upon solely to check patients' medication: while they provide a snapshot, cross checking with primary care records and pharmacy remains a must. This is current practice and ensures patient safety.
- 2) Primary care to be made aware of the omissions and requested to update their records as per the discharge summaries.
- 3) Continue regular re-audits every four months

Buckinghamshire Early Intervention Service' (BEIS) Compliance With the National Institute for Health and Care Excellence (NICE) Antipsychotic Monitoring Guidelines: Practical Challenges, Including Those Posed by the Pandemic, in an Outpatient Setting

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Aims. Antipsychotic use is associated with cardiovascular and metabolic side-effects, which may contribute to increase mortality and morbidity in this patient group. This highlights the importance of physical health monitoring. We aimed to assess our compliance with the more stringent NICE guidelines, updated in September 2021.

Methods. Half of BEIS team's caseload was audited (n = 67) during October 2021 for compliance with NICE's monitoring guidelines for patients initiated on antipsychotic medication. These included initial and, if indicated, repeat monitoring of body mass index (BMI), pulse, blood pressure (BP), blood results, electrocardiogram, and adverse effects. Patients who were not on antipsychotics were excluded. 61% of patients were initiated on antipsychotics as inpatients, and 39% were outpatients. These patients have been started on antipsychotics within the last three years. Data were collected via electronic record systems. 80% compliance was set as the standard, in line with National Clinical Audit of Psychosis standards.

Results. In the first three months of antipsychotic initiation (61% as inpatients, 39% in the community) six out of nine parameters met standards (ranging from 2% to 100%), with BMI measurement (weekly), pulse and BP measurements and one month repeat haemoglobin A1C (HbA1c) failing. When only accounting for patients who were started on antipsychotics in outpatient settings (BEIS or crisis team), compliance was only met on two parameters.

Three months post initiation, when patients were mainly monitored in the community, only three of the nine parameters met compliance (lipids, HbA1c, and side-effects).

Conclusion. Adherence to the NICE standards for physical health monitoring in the community poses significant challenges. Possible barriers include reduced patient contact during the pandemic, lack of awareness of monitoring requirements, poor documentation (particularly of declined screening) and a lack of time and resources. There is also a possibility of unnecessarily stringent and impractical guidelines which are difficult to achieve in outpatient settings – such as weekly BMI. We plan to implement interventions including providing a checklist for medical and nursing staff and encouraging patients to monitor their own blood pressure and weight at home. We will reaudit the same parameters in 6 months' time.

Availability and Functionality of Physical Health and Resuscitation Equipment in an Inpatient Setting: A Closed Loop Audit Cycle

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Aims. To ensure physical health and resuscitation equipment on all wards in a mental health hospital fulfil relevant standards. A closed-loop audit of this was performed on four acute adult inpatient wards after implementing interventions.

Methods. Data were collected from treatment rooms on each ward, with standards based on Physical Health in Mental Health; Final Report of a Scoping Group (Royal College of Psychiatrists) and Mental Health Inpatient Care Equipment and Drug Lists (Resuscitation Council UK) – parallel to the trust approved standards.

Percentage of availability and functionality against audit standards were tabulated and interventions were carried out, including:

1. Awareness presentations at trust clinical governance meetings.
2. Each ward to have own complete sets of physical health and resuscitation equipment.
3. Policy for wards to register their physical health equipment and service details on the trust maintenance services database.