

and ensuring these steps are clinically documented). Recommendations for improvement included: (1) adding a full AUDIT screening for those scoring at least 5 in the extended AUDIT-C; (2) upskilling staff in brief intervention advice; (3) developing a regional alcohol services directory for signposting; and (4) providing psychoeducation materials on safe alcohol use. After implementation of recommendations, the audit will be repeated.

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Women and Their Pattern of Use of Novel Psychoactive Substances

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Aims: This study aims to explore the patterns of psychoactive substance use among women attending the Club Drugs Clinic. It also explores associations with demographic factors and mental health comorbidities to identify additional therapeutic needs beyond current clinical treatments. The findings will help contribute to improving service provision for this population.

Methods: This is a quantitative study of 27 female patients who attended the Club Drugs Clinic across three boroughs between May 2021 and June 2024. Data collected includes demographic information, primary, secondary, and tertiary use of Novel Psychoactive Substances (NPS), age of onset of substance misuse, age of onset of treatment, associated mental health comorbidities, and harmful alcohol use.

Results: The majority of female patients attending the Club Drugs Clinic are of White British origin, with 20% identifying as Asian, Brazilian, or African Caribbean.

The average age of onset of psychoactive substance use is 25 years, while most patients begin treatment between 25–35 years old.

The most commonly used primary substances are ketamine, methamphetamine, and GHB/GBL, with fewer patients using nitrous oxide and benzodiazepines.

60% of women are polysubstance users, with methamphetamine + GHB being the most common combination (37%).

All primary methamphetamine users struggle with dependence, with 37% identifying as transgender and 71% engaging in sex work. 37% of those who are dependent on methamphetamines had history of psychosis and been treated with antipsychotics.

66% of Ketamine users present with severe anxiety (GAD-7 score >15), and 56% experience ketamine bladder symptoms, requiring referral to Urology.

44% of women at the clinic have a diagnosis of PTSD, linked to trauma such as domestic violence, sexual abuse/assault, sex trafficking, and war-related trauma. These patients received therapy from the team psychologist or are referred to trauma-focused therapy within secondary mental health services.

Conclusion: This study identified ketamine and methamphetamine as the most commonly used primary psychoactive substances among female patients attending the Club Drugs Clinic. Methamphetamine dependence poses a significant risk for psychosis, while ketamine dependence increases the likelihood of developing ketamine-related bladder dysfunction, highlighting the importance of screening for cystitis symptoms. Additionally, the majority of patients reported a history of trauma and used substances as a coping mechanism. These findings emphasize the need for integrated care approaches, including close collaboration with trauma services, to enhance

treatment outcomes and improve overall service provision for this vulnerable population.

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Delays in the Autism Spectrum Disorder Diagnostic Pathway: An Audit of Wait Times for Initial Assessment and Post-Diagnosis Support in Greater Preston

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Aims: Timely initiation of assessment for Autism Spectrum Disorder (ASD) is crucial as delays can significantly impact development of children and family well-being. This audit aimed to assess the adherence to National Institute for Health and Care Excellence (NICE) guideline recommendations of timely initiation of ASD assessment and follow-up care in the Greater Preston Area.

Methods: A retrospective observational study was conducted, using electronic patient records of patients referred to the ASD diagnostic pathway and listed for further investigation in 2022 in the Greater Preston area. Data on wait times between referral and first appointment and times between diagnosis and follow-up appointment were collected and analysed. Patients eligible for this study were under 18 years of age, living in the Preston area and had been referred to the ASD diagnostic pathway and listed for further investigation in 2022. 37 school-age and 48 preschool-age children were included in this study.

Results: It was found that 18.9% of school-age and 16.7% of preschool-age children were seen within the 13-week window between referral and first appointment recommended by NICE guidelines. This study also showed that 18.9% of school-age children and 20.8% of preschool-age children received a follow-up appointment within the 6-week guideline.

Conclusion: This study found significant delays in accessing the ASD diagnostic pathway and follow-up care which indicates the Greater Preston area is not in adherence with NICE guidelines. Changes are necessary to address these gaps and ensure timely support for children affected by ASD.

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The Monitoring of Physical Health Observations After the Administration of Rapid Tranquillisation

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Aims: Rapid tranquillisation is a restrictive practice used to manage acute behavioural disturbance, where medication is given in the form of an IM injection. The first-line medication used is lorazepam. There is an increased risk of the emergence of serious side effects (sedation, loss of consciousness and respiratory depression/arrest) from giving lorazepam via the IM route. MPFT SOP states that

physical observations must be checked at a specified frequency and duration and recorded on the restrictive interventions monitoring form found on the RIO IT system. The monitoring at Norbury House (PICU) in Stafford (MPFT) is often incomplete. This audit evaluates the current adherence to the SOP by reviewing the monitoring of physical observations after the administration of rapid tranquillisation, identifying some of the reasons for incomplete monitoring and areas of practice that require improvement. This audit aims to demonstrate the importance of physical health monitoring and focus on improving patient safety by ensuring stricter adherence to monitoring protocols.

Methods: Data was collected between 8 September and 8 November 2024. To assess the current compliance with the SOP, data will be collected from the EPMA and RIO IT systems to check that the physical observations have been recorded at the correct frequency and duration as per SOP. To identify some of the reasons for incomplete monitoring, a Microsoft form questionnaire will be sent to staff members at Norbury to complete anonymously. The collected data will be used to identify areas of practice that require improvement.

Results: From twenty-one cases, there was one case where monitoring was completed, five cases where no monitoring or documentation was recorded, eleven cases where monitoring and documentation were recorded but not completed and four cases where monitoring and documentation were partially completed. Based on the eleven questionnaire responses, three responses outlined the SOP correctly, four were unsure, and the remaining four were incorrect. Barriers to completing monitoring included patient agitation, time restrictions, forgetting to document, no computer access and low staffing levels. Suggestions for support included education, appropriate delegation of tasks, EPMA alerts, adequate staffing levels and frequent re-auditing.

Conclusion: There is evidence that the current adherence to monitoring protocols is below the set standard. The data collected demonstrates that monitoring is often incomplete. The questionnaire responses highlighted the gaps in knowledge of the SOP and the existing barriers to completing the monitoring. Measures that could be taken may include staff education, alerts and frequent re-auditing.

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Audit of Rapid Tranquillisation Prescribing and Monitoring Practices at Rohallion Medium and Low Secure Forensic Psychiatry Unit, Murray Royal Hospital, NHS Tayside

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Aims: To assess whether current prescribing and monitoring practices for oral 'as required' medications and Rapid Tranquillisation align with local and national guidelines.

To identify areas of non-compliance and enhance awareness of best practice guidance.

Methods: The audit included all patients at Rohallion Clinic, Perth, who had 'as required' medications prescribed for sedation, anxiety,

agitation, or behavioural disturbance at the time of data collection. Female, child, and adolescent patients were not included, as these populations are not present in Rohallion Clinic.

Data collection: Data were collected using an audit proforma during the period between 05/03/2024 and 04/09/2024 of 47 inpatients. Patients' online drug charts and EMIS (electronic notes) were reviewed using MS Excel.

Standard:

1. 100% of patients should have a documented plan for oral and intramuscular 'as required' medication in the notes, including if more than 1 medicine is required.

2. 100% of patients should be offered oral medication, if practicable, before administration of intramuscular medication.

3. 100% of patients should have side-effects monitored within 1 hour of rapid tranquillisation. If not possible, this should be documented on the observations chart and in the notes.

Criteria:

1. Multidisciplinary teams should develop and document an individualised pharmacological strategy for using calm, relax, tranquillise or sedate patients who are at risk of violence and aggression.

2. Oral medicines should be offered first, if practicable, before intramuscular medication.

3. After rapid tranquillisation, monitor side-effects, observations, level of hydration and level of consciousness at least every hour until there are no further concerns regarding physical health.

Results: NHS Tayside's guideline on the pharmacological management of acute behavioural disturbance was updated in Oct 2024.

Total 81% (38) patients had 'as required' medicines prescribed on the drug chart.

Lorazepam was prescribed most frequently. This is in line with NHS Tayside guidelines which consider lorazepam the first strategy for management of acute behavioral disturbance.

63% (24) of patients (who were on 'as required' medications) had a documented plan.

Standard 1 is not met.

The reasons for administering intramuscular as-required medications, along with documentation of side effect monitoring and observations, including any reasons for omissions, were recorded in electronic notes 25.42% of the time.

Therefore, standard 2 and standard 3 are not met.

Conclusion: One area identified as compliant with current NHS Tayside guidance is the frequency of medication administration, with most medicines prescribed every 4 hours.

Our data shows that lorazepam, promethazine, and haloperidol are the most commonly used medications, with fewer newer medications being prescribed.

Standards 1, 2, and 3 are not met.

Action plan:

Collaborate with the clinical team and pharmacist to improve the accuracy and completeness of documentation related to medication administration, including consent, administration records, and observed effects.

Add additional headers to online assessment templates to support more comprehensive documentation.

Re-audit once the action plan is implemented to assess any changes.

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