Seclusion Pathway Review Audit

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Aims.

- Ensure compliance with seclusion trust policy and guidelines by the mental health team (goal of 100 percent).
- Confirm that proper documentation of commencement, periodic reviews, and termination is always maintained (goal: 100 percent).

Methods. Retrospective collection of data from one adult male Psychiatric Intensive Care unit and one adult female mental health ward.

Our sample consisted of patients who were secluded between the time period of September 2021 and June 2022. 33 seclusion episodes met this inclusion criteria. Data were collected from OpenRio progress notes and OpenRio seclusion section.

We developed a tool for monitoring of seclusion reviews included different data about patients demographics and other variables in seclusion reviews.

Results. We found out the following:

- In regard to patients demographics, the predominant age groups are between 20 and 40 years old, although there is also an increase in the number of people between 50 and 70 years old and the predominant ethnicity was white British.
- The rationale for seclusion start and continuity was documented in 100% of the cases in our sample of 33 episodes.
- The initial medical review was completed in the first hour was completed in 81.82% (27) , In 18.18% (6) of cases, it was not completed within the hour window.

In 4 cases, the doctor was not contacted in time to meet the one-hour limit.

In 2 episodes, the reasons for being late were not documented.

- 2 hourly nursing review completed in 93.94% (31).

There were 6.06 % (2 episodes) were the 2 hourly reviews were not completed. No specific reason found in the documentation for the missed episodes.

- The 4 hourly medical review (before MDT / consultant reviews) were completed within time in 24 episodes.

There were 9 episodes when the reviews were not completed within the time window of 4 hourly.

In 5 of the episodes the patient was sleeping, so the nursing team didn't contact the doctor.

There was 4 episodes with no documentation for the reason of the delay. However, the review was completed within extra 1-2 hours duration of time.

- The 8 hour MDT reviews with consultant were completed in 26 episodes (78.79%).

There was 7 episodes were it was not completed within the 8 hours window.

The primary reason was that the seclusion episode started on a weekend afternoon or early evening after normal working day and the consultant review was conducted on next day.

- Two medical reviews daily – at least one by responsible clinician (following initial MDT review) completed : In 3 of the episodes (9.09%), one of the two reviews was missed without specific reason or documentation.
- Rational to continue/ end seclusion documented at each review completed:

In 32 of the episodes the Rational to continue or end seclusion was documented.

There is one episode where seclusion was ended without documentation from the nursing team or doctors.

- Physical health observations record :100% compliance with physical health observations record.

Conclusion. Recommendations:

- Increase awareness of the importance of completing the initial reviews on time by conducting teaching sessions in the local academic program and informal teaching sessions with nursing staff.
- Adding the seclusion review guidelines to the junior doctors handbook and discuss the guidelines during induction meetings.
- Allocate different flyers and posters with information about seclusion reviews in the nursing stations and doctors office.
- Completing the re-audit cycle after that to gauge the scope of change.

Metabolic Syndrome Monitoring in Patients on Depot Antipsychotics

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Aims. We conducted this audit in patients attending the Community Mental Health Team (CMHT) at St Davnet's hospital in Monaghan, County Monaghan, Ireland. The British Association for Psychopharmacology (BAP) guidelines were used for this audit to assess our service compliance with standard guidelines and to consider implementing measures to enhance the service's compliance with guidelines and maintain improvement. Metabolic syndrome (MetS) is common in patients who are prescribed depot antipsychotics. Worldwide the prevalence of MetS in Schizophrenia patients is between 30 and 40%, and MetS increases the risk of CVD and mortality. Research showed that patients with severe mental illness die 10–30 years earlier due to physical illness.

Methods. The audit cycle was from the 15th of February to the 15th of June 2022. Demographic and therapeutic variables were collected from participants within the CMHT. The action plan which included psychoeducation for nursing staff regarding guidelines for monitoring and documentation was implemented following completion of the initial audit, and then re-audited.

Results. During initial audit the sample size was 48 patients; 77% were females and 23% were males. The mean age was 54.3 years, ranging from 24 to 90 years. 39.6% of patients had MetS monitoring charts in their files, and 29.2% had completed documentation of their MetS charts. Blood pressure, lipids, and glucose were documented in 31.3%, while BMI/girth was documented in 29.2%. Paliperidone was the most common used antipsychotic

(43.8%), followed by Flupentixol (31.3%), and Aripiprazole (14.6%). In re-audit the sample size was 46 patients; 76% were females and 24% were males. The mean age was 53.7 years, with the same age range as in the audit sample. MetS monitoring charts were 100% completed in all files. Glucose documentation was 95.7%, blood pressure was documented in 91.3%, BMI/girth, and lipids were documented in 87% of files. Paliperidone, Flupenthixol, and Aripiprazole were the commonly prescribed antipsychotics.

Conclusion. The implementation of the action plan resulted in recognizable improvement in MetS monitoring and documentation. To maintain this level of improvement it is essential for the CMHT to continue educating the nursing staff and other team members about the importance of MetS monitoring and documentation. Defining documentation roles and responsibilities among team members will facilitate monitoring. Identification of files that require MetS monitoring can be improved by placing colour code stickers. A MetS Clinic can be considered as a long-term plan.

Completing the Cycle: Re-Audit of Rotherham Specific Inpatient Physical Health Management and Documentation Following a 2021 Trust-Wide Audit

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Aims. Rotherham Doncaster and South Humber (RDaSH) NHS Trust completed a Trust-wide audit in August 2021 to look at aspects of physical health management in their inpatient units. Good results were achieved in relation to new admissions having completed initial medical examination within 24 hours and consideration being given as to whether the patient had the capacity to make the decision to agree or refuse such an examination. However, inadequate results were achieved in relation to anything more than an examination of appearance, pulse or blood pressure being conducted with a chaperone, and the patient being given the opportunity to state their preferences in relation to the sex of the chaperone. This audit completed the audit cycle by re-auditing the above criteria in Rotherham inpatient units in order to assess ongoing progress against targets following recommendations.

Methods. A dip sample of five patients per ward (two Acute Adult, one Rehabilitation, one PICU and two Older Adult wards) was used. Patients who were admitted between 1st July and 30th September 2022 were picked randomly and their electronic records were studied.

Results. Nearly 90% of patients received a physical examination by a doctor within 24 hours of admission. But, whilst these patients undertook an examination that was more than just general observation, blood pressure or pulse, in only 14% of these was it documented that they had a chaperone present. In addition, not a single person was offered the choice to choose the gender of their chaperone.

Just one third of patients had their capacity to agree or decline examination documented. Perhaps unsurprisingly, the Older Adult wards performed better against this criteria.

Conclusion. Rotherham inpatient wards continue to perform well in terms of conducting timely initial physical health examinations. However, we identified there is a clear lack of documentation around documenting whether someone has capacity to consent to their physical examination or not and what gender someone would prefer to chaperone them. Unfortunately, this is a continuing issue.

We have identified an opportunity at the RDaSH Junior Doctor's induction, where the clerking is explained, to intervene and educate around what the Trust expects as standard.

We plan to implement this change and re-audit the above criteria again to see if we can make an improvement.

Consent on Information Sharing

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Aims. This clinical audit is aimed at assessing the knowledge, attitude and practices of team members towards compliance regarding information sharing and consenting service users and to create awareness about existing Trust policies and national guidelines, importance of gaining consent for Information Sharing. Consent to share information should be recorded on the appropriate clinical record keeping system and/or paper. Service users also have the right to request that information is not shared – and staff must record these decisions in the clinical record. Team members work with other agencies and at times need to share patient information. Hence, there should be discussion about who information is going to be shared with, and why. A recorded consent is useful in instances when patient data may need to be shared in court.

Methods. The 1st cycle of the audit was conducted from 15th of December 2022 to 4th of January 2023. Clients that met the inclusion criteria were checked to see if the form was filled in by the relevant practitioner/ ever filled in. This was done for both the Community Mental Health Team (CMHT) and Memory assessment Services (MAS). A survey with 7 questions was sent out to team members to assess their knowledge of the Trust policy as well as national guidelines on consent on information sharing.

Results. A total of 238 service user records were assessed. 119 each under CMHT and MAS. Combined results of 37% of the 238 services users had consent documented while 63% did not have consent documented. 27% of services users under MAS had consent obtained and documented. 56% of service users under CMHT had consent obtained. 100% of team members that responded to the survey knew to discuss personal and confidential information sharing with patients. 91% of staff knew that the discussion on consent and information sharing should be documented. 23.5% of staff were not aware of trainings on information sharing and 35.3% of staff were unaware of where to document the consent.

Conclusion. Although rare, unrecorded discussion/consent on Information sharing can cause serious implications. This audit highlights the need to create awareness about the importance of recording Information Sharing consent. Possible reasons for results include team members not being aware of where to document in client records, Trust has not properly educated staff on

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