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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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: