

making and mental capacity". NICE guideline NH108 (2018) recommendations 1.4 Assessment of mental capacity were used as a standard for this audit. 100% of all admitted patients should have MCA completed during the admission clerking.

Methods. The data were examined retrospectively from the MCA on admission, available on the electronic health record database (Paris). The audit tool focuses on quantitative data collection on Mental capacity documentation.

A random sample was selected of 15 patients admitted in May, June, September, and October 2022 to the Peter Bruff MH Assessment Unit (male and female). Total 60 patients.

All data were anonymised. Results were tabulated and presented in statistical form back to the clinical teams.

Results. All patients who were admitted to the assessment unit were subjected to capacity assessment, consenting to informal admission and acceptance of treatment.

MCA was completed and patients had capacity both on clerking and during the ward review in 85% of cases, (n=61). MCA was completed and 3 % of all patients were found to lack capacity on clerking (n=2). MCA was completed, and patients had the capacity on admission, however, they had no capacity during the review in 5% of cases (n=3). MCA was not completed, or the information was unavailable, for 7% of the cohort (n=4).

Capacity to consent is specific to a decision and can vary over time; a patient is therefore competent or not with respect to a specific decision and for a given moment in time.

We found that after the clerking assessment, when patients were reviewed by the unit doctor and the consultant, whether on the day of admission or shortly after (in a matter of hours), on several occasions some patients were lacking the capacity to consent to the admission.

Conclusion. The missing link to be identified between the MCA capacity assessment that was carried out by the clerking doctor, compared to the MCA that was conducted by the unit doctor and consultant. This could be a restrictive environment on the unit or less attention paid to the quality of capacity assessment and further training is needed for professionals.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Audit

A Review of Unmet Needs – Making a Case for a High Dependency Rehabilitation Service

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Aims. The Kent and Medway Partnership Trust (KMPT) Rehabilitation service strategy 2020-2025 in line with NICE guidance for Complex Psychosis 2020, sets out to deliver a complete mental health rehabilitation pathway with local provision of high dependency rehabilitation units (HDRU), open rehabilitation units and community rehabilitation provision across the county. There is a lack of HDRU provision in Kent and Medway in its rehabilitation

pathway. All HDRU provision is by external providers, often out of area, dislocating people from family support and local resources essential for their recovery and integration. Kent has a relatively high number of out of area (OAT) placements based on national benchmark data (GIRFT). The proposal to develop a HDRU locally led to a review of local population needs for HDRU. The review with the existing OAT data provided information on the number of HDRU beds required in Kent and Medway.

Methods. We identified 564 patients who had had 5 or more Mental Health Act assessments, in cluster 16 and 17, more than 3 admissions to psychiatric inpatient units and with CTO recalls. Two senior clinicians reviewed these patients against the HDRU eligibility criteria. Demographics, diagnosis and comorbidities were also recorded.

Results. 119/564 patients met the threshold for HDRU assessment. Using our conversion rate from referral to admission in our open rehab, it means about 20% (24) of this cohort would require treatment in a HDRU. Demographics, diagnosis and comorbidities were reviewed which gave important information about service provision requirements. This was compared with NICE guidance recommendations of 1 high dependency unit per 600,000 - 1,000,000. Therefore, based on this, we would be expected to have between 23 and 38 patients requiring HDRU treatment.

Conclusion. A high level of unmet need for HDRU exists in Kent and there is a need for further recognition of the relevance within the rehabilitation pathway. Lack of local provision of HDRUs means the use of longer, expensive and variable quality out of area or private placements. These can be not only detrimental for patients due to a loss of connection to an area and social network but a drain on resources. These results support the case for x2 12 bedded HDRUs. The lack of provision of HDRU impacts on the wider system and patient's timely access to appropriate treatment pathways.

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Application of Section 17 Leave on Old Age Psychiatric Ward Audit

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Aims. Most patients on the old age psychiatry ward have dementia so they would need extra care from the ward team regarding their rights for a better quality of life. Therefore, the purpose is to ensure that inpatients under MHA on the ward are not deprived from their liberty to time off the hospital grounds in accordance with the leave granted by the responsible clinician. Additionally, to ensure that the appropriate steps are followed before the patient leave the ward, to ensure safety for the patient and accompanied staff if escorted.

Methods.

1. Data were collected with approval of the ward consultant and the ward manager from RIO records.
2. Data included checking the forms for S17 on RIO, and answering the audit questions after checking the records for each patient.
3. Patients included admissions within the last 6 months on the ward under the MHA weather section 2 or 3 which included 28 patients.
4. Checked data were: