

This issue has been dealt with in different ways across North Wales and indeed the whole of Wales

Following a review of services in Wrexham during 2017, it was identified that there was an opportunity to pilot a new model which would allocate a designated Consultant to the local Primary Care Mental Health Team (PCMHT)

The Consultant would work entirely within Part 1 of the Mental Health Measure and would offer specialist opinions to Tier 1 Services

Result. PCMHT team members are maintaining open cases for a significant amount of time rather than the 8–10 sessions that was originally predicted during the implementation of the Mental Health Measures

In order to sustain the service, the minimum number of direct clinical patient contact sessions to be offered by the psychiatrist was up to 4 a week.

During the review period, total number of clinics offered were 51 and a total of 139 patients were offered appointments

Consultants in secondary care covering the same area received exactly 100 less referrals in the first 6 months of the pilot

Main source of referrals to the Tier 1 Consultant came from G.P.'s and the local PCMHT itself

Conclusion. Pilot demonstrated that bringing specialist consultant psychiatrist dedicated to the PCMHT improved the care offered to patients referred by G.P.'s

Scope of PCMHT needs to extend in order to absorb mild to moderate mental illness and thus avoid patients going into secondary care

This model should be supported, and further resources should be inputted into PCMHT

We should move from a categorical diagnostic referral system to a needs-based intervention where only the most complex cases requiring lengthy interventions shall progress to secondary care

Risk should not be classed as criteria to move patients into secondary care and PCMHT should be able to absorb moderately risky cases

Is pregnancy status being assessed within women's secure services?

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Aims. To establish rates of pregnancy testing on admission of women within a blended secure service.

Background. Women with psychiatric illness are known to be at increased risk of pregnancy, often due to engagement in risky sexual behaviours such as having a higher numbers of sexual partners and engaging in sexual activity whilst under the influence of drugs or alcohol. Awareness of pregnancy at the point of admission to psychiatric hospital would inform ongoing care plans to manage the pregnancy in the safest, least restrictive environment and inform future prescribing decisions, to minimise the risk of teratogenicity associated with some psychotropic medications. Ardenleigh in Birmingham is a blended female secure unit. No pregnancy screening guidelines for this population currently exist. This audit sought to establish current rates of pregnancy testing at the point of admission with a view to developing future guidelines.

Method. A retrospective case note audit of electronic records of all patients admitted to Ardenleigh blended women's service as

of 1st September 2019 (n = 26). The expected standard for pregnancy testing within one month of admission was set as 100%.

Result. Key results include:

The majority of patients (67%) were aged under 35 years (range 20–56). The most common ethnicities were Caucasian (42%) and African-Caribbean (38%). Almost half (46%) had a primary diagnosis of paranoid schizophrenia.

Two women were known to be pregnant at the point of admission. Only 54% of women with an unknown pregnancy status were screened for pregnancy within one month of admission. Rates of screening were particularly poor in women aged under 25 years (43%) and between 36 and 45 (0%).

Women not screened for pregnancy were typically admitted from other hospital settings, including AWA services (27%) or other medium secure units (55%). 2 women admitted from prison were not tested (29%)

Of those tested, the majority were checked using urine hCG (92%).

None of the women tested were found to be pregnant.

Conclusion. Overall pregnancy testing on admission to the unit was poor, with only 54% of service users screened. Less than 100% compliance could result in serious consequences for both the woman and unborn baby if a pregnancy is not discovered. Updating the admission checklist for Ardenleigh to include pregnancy testing may prove beneficial. It is recommended that a re-audit is completed 6 months following checklist introduction.

Urine drug screening in women's forensic mental health services: is current practice meeting guidelines?

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Aims. To investigate adherence to Trust guidelines for urine drug screening amongst female forensic psychiatric inpatients.

Background. The use of illicit substances is an important risk factor which needs to be considered in the management and treatment of forensic psychiatric patients. Research has demonstrated that a high proportion of women admitted within secure services in the UK have a history of substance use. Substance misuse amongst this population can lead to an increased risk of violence, re-offending and mental health relapse; which can pose a significant threat to the safety of other patients, staff and the public. It is therefore important that regular drug screening is carried out to minimise such risks. Ardenleigh is a blended female secure unit in Birmingham. The service has established specific substance use guidelines, outlining the need for each patient to have a personalised drug screen care plan in place. Here we present the findings of an audit completed in 2019.

Method. A six month retrospective electronic case note audit for female inpatients admitted to Ardenleigh as of 1st September 2019 (n = 27). We compared drug screen care plans and frequency of urine drug screens over 6 months with the recommendations of the current service-specific Trust guidelines. Care plans should include: information regarding random drug screening; frequency of random drug screening; triggers for increased risk of substance misuse; and consequences for a positive test result to be contained within inpatient care plans.

Result. Patient aged between 20 and 56 years old (median age 31). Fewer than half of inpatients (41%) had a documented random

drug screen completed within the review period. In terms of care-planning, only 52% of patients had random drug screening mentioned in their care plan. 22% of patient care plans reported the actions/consequences for a positive test result. Not a single care plan mentioned how frequently patients should be being tested or potential triggers for increased risk of drug misuse amongst inpatients.

Conclusion. Current practice and recording of drug screening amongst female forensic psychiatric patients is poor compared to expected standards. The lack of consistency in drug screening raises concerns regarding whether potential substance misuse amongst inpatients may be going undetected, and therefore impacting the recovery of patients. Improvements to drug screening practice should be considered in order to ensure optimal recovery and safety to patients and others.

Clinical Audit cycle of Mental Health Act (MHA) documentation for patients on section 3 staying 90 days and over in adult wards at Roseberry park hospital

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Aims. To complete the audit cycle on compliance of MHA documentation (including MCA1 form at admission and 3 months, T2 form, SOAD request and T3 form authorization) on patients on section 3 staying 90 days and over in adult wards at Roseberry park hospital

Method. In the initial audit, we collected data from all inpatients on section 3 staying 90 days and over, in Adult acute and rehab wards on Roseberry park hospital between the time period 28/10/19–04/11/19. Using a designated audit data collection tool, information was gathered from each patient's electronic record pertaining to the standards. The same method was used in re-audit where data were collected from all inpatients on section 3 staying 90 days and over in Adult acute wards on Roseberry park hospital between the time period 04/11/20–11/11/20. To note, the rehab ward at Roseberry park hospital was closed in Feb 2020. The data were analysed by the project lead.

Result. In the initial audit, 16 patients records were identified as meeting criteria, out of these 7 (44%) patients were on acute wards and 9 (56%) at rehab ward. Where as in re-audit 5 patients records were identified as meeting criteria and all were on acute wards. Days in Hospital - Ranged from 120 days to 664 days, average being 295 days and median of 186 days in the initial audit compared to 121 days to 290 days, average being 170 days and median of 150 days in the reaudit. Percentage of patients records with documented capacity assessment at admission and 3 months were same at 80% and 60% respectively in both audits. T2 form was completed in all consenting patients in both audits. SOAD request sent was recorded in only 1 (25%) patient in the reaudit, which was lower than the initial audit, where in SOAD request was sent in 7 (78%) patients but recorded in 5 (56%) of them. For patients lacking capacity, T3 form was documented only in 4 (45%) patients but T3 form authorisation was discussed with patient and evidenced in case notes in only 1(11%) case in the initial audit, where as in reaudit T3 form was not documented or discussed for any patient.

Conclusion. There needs to be improvement in MHA documentation for detained patients.

Metabolic side effects of clozapine in patients at south ceredigion community mental health team

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Aims. The aim of the audit was to identify patients at risk of developing Metabolic Syndrome who are on Clozapine in the community. Anyone who has three of following attributes has Metabolic Syndrome. A large waist size (greater than 40 inches in men or 35 inches in women) ,high blood pressure (130/85 mm Hg or higher) ,high triglycerides — a form of fat in the blood (150 mg/dL or higher) ,high blood sugar (a fasting level of 100 mg/dL or higher). Patients receiving should be regularly monitored under clinical review particularly in relation to side effects of the drug and maintain minimum standards of review both physically and clinical investigations once a year .

Background. To measure the screening of central obesity, Blood Pressure, serum glucose levels and lipid profile in last one year.

Method. Data were collected from Blood results and electronic entries of patients who are on Clozapine in South Ceredigion Community Mental Team. There were 31 patients of which 20 were male and 11 were female patients. The age range was 31–66 years and average was 46 years.

Result. 52% of the patients had obesity, 34 % with Hypertension, 50 % Dyslipidaemia and 43 % had Increased glucose tolerance. 80 % were only on clozapine, 3% were on combined Amisulpride, 10% on combined on Aripiprazole, 3 % on combined Quetiapine.

Conclusion. Treatment of causes like making changing lifestyle changes, weigh reduction using health diet and to include regular physical activity. Reduce Abdominal Obesity and in possible provide nutritional intervention.

Suicide: can we identify and manage those at risk more effectively?

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Aims. This study aimed to conduct longitudinal analysis of suicide reviews for mental health service users in Ayrshire to improve local practice and outcomes. Traditional risk factors – middle-age, male and alcohol misuse – were hypothesised to convey greater risk of completing suicide.

Background. Suicide is an important public health issue in Scotland, with potentially devastating impacts. Practice and policy may lag behind emerging evidence. Mental health problems are associated with an increased suicide risk, and care provided to those who take their own lives is reviewed to identify recommendations and learning points to improve practice and outcomes. However, these reviews and their conclusions are often considered individually, when studying them collectively over time it is necessary to characterise common themes and highlight factors that could be addressed to reduce suicide. Moreover, national averages can obscure local patterns.

Method. Access to reviews of suicides for mental health service users in Ayrshire was granted by the Adverse Event Review Group. Relevant data were extracted for the 35 General Adult service users completing suicide between 2013 and 2015, including details of the act, demographics and clinical factors, and analysed for trends.