prove useful to monitor the progress of these measures, and the scope of a future audit could also be widened to include the timeliness in which the FIRM is completed for new patients.

Reviewing Interventions to Ensure Management of Cholesterol Levels in Psychiatry Inpatients

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Aims. Studies have been done to suggest an increased risk of mortality in patients with mental illness, from cardiovascular diseases. This may be a result of factors ranging from lifestyle choices in the patient group, access to health-care facilities, side-effects of antipsychotic use etc. As a suitable predictor of cardiovascular risk, this audit reviews and attempts to improve the management of cholesterol levels in this patient group based on local trust guidelines.
Methods. 116 and 120 patients from general adult psychiatry wards were included in two cycles of the audit respectively. Blood results, discharge letters were obtained from the Clinical portal database; drug prescriptions from the 'Hospital Electronic Prescribing and Medicines Administration (HEPMA)' database. As per local trust guidelines, it was verified if 'ASSIGN' (indicator of cardiovascular risk developed in Scotland) scores were calculated and a statin was prescribed accordingly, lifestyle modification advice provided or blood results communicated to GP in the discharge letter. An email with a flyer was distributed among doctors with trust guidelines, as intervention after the first cycle of the audit, and the results were presented in internal teaching. This was followed by a reaudit in a few months.
Results. In the first cycle, 85 out of 116 patients had a lipid profile done on admission out of which 29 had abnormal levels without a prescription of statin. 6 patients had their abnormal lipid results mentioned in their discharge letter in the absence of an ASSIGN score calculation or lifestyle modification advice. In the second cycle, it was noted that only 35 patients out of 120 had a lipid profile done on admission and a total of 12 patients had abnormal lipid results without a statin prescription. Only 1 patient had their ASSIGN score calculated and 7 patients had their abnormal lipid results documented to the GP.
Conclusion. Unfortunately, considering both cycles of the audit, only a minority of patients had been managed in accordance with trust guidelines and no significant improvement was noted in the results of the reaudit. The importance of efficient management of cholesterol can be highlighted in a relevant forum and any barriers to change in practice may be explored. QRISK3, an alternative to ASSIGN may be suggested, which includes factors like severe mental illness and atypical antipsychotic use.

A Review of the Quality of Cardiometabolic Risk Monitoring Amongst Psychiatric Inpatients, and of Interventions to Reduce Their Long-Term Risk of Cardiovascular Disease

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Aims. In Britain, individuals with severe mental illness die on average 15–20 years earlier than the general population. Their higher rates of cardiovascular disease contribute significantly to this. This audit reviewed how well cardiometabolic risk factors are screened for during inpatient admissions, and how frequently appropriate interventions are implemented for identified risk factors. It then assessed ways of improving current monitoring and interventions. We prioritised enhanced collaboration between patients and healthcare professionals, combined with formalising and systematising the physical health screening process.
Methods. Bed coordination provided identification details of all patients admitted to an all-male acute psychiatric ward from 01/05/2019–31/08/2019. Each patient's record was reviewed to ascertain whether risk factors outlined in Lester UK Adaptation: Positive Cardiometabolic Health Resource were screened for. If a risk factor in this resource's "red zone" was identified, the patient's documentation was reviewed to see whether corrective action was attempted. Raw numbers and percentages of patients receiving any given physical health check were reviewed. For abnormal results, how many patients had appropriate action taken was then also checked.
Results. 63 patients were admitted, 50 of whom had a Rethink template completed. All physical health data (except blood results) were collected using the Rethink template.

41 patients smoked tobacco: seven accepted cessation support, 19 declined cessation support, and 15 were not offered support. 9 patients had no smoking status documented.

26 patients self-reported healthy lifestyles versus 24 who did not. Of these 24, 17 had no lifestyle intervention documented.

31 patients had a BMI > 25, of whom two were offered support, and 28 had no documented support.

12 patients were hypertensive, of whom three were offered further support, and eight had no further action documented.

44 patients were normoglycaemic, fifteen had no blood glucose test, and four had pre-diabetes/diabetes of whom one was offered further support.

32 patients had dyslipidaemia: one received further support, four were already on appropriate pharmacotherapy, and 27 had no further intervention documented. 25 had no bloods taken.
Conclusion. Most patients had identifiable cardiometabolic risk factors: smoking, BMI > 25, poor lifestyle, dyslipidaemia, hypertension, hyperglycaemia (in decreasing order). Where risk factors were identified, intervention to address these risk factors and identification of barriers to supporting patients were lacking. COVID-19 may have changed the nature of admissions and health priorities. Structural changes were implemented, including changes to admission physical health assessments, introduction of well-man clinics, and improved communication between inpatient and community settings on discharge. A re-audit is pending.

A Gap in Psychiatry On-Call Training: Post-Ligature Assessment

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Aims. 1. To assess documented practice on post-ligature assessment following a teaching session and simulated induction session introducing a post-ligature assessment tool. 2. To

implement the post-ligature assessment tool, for assessing patients who have tied a ligature, into trust guidance. 3. To support the incorporation of simulated induction teaching on post-ligature assessment into the standard induction timetable delivered to all new trainees in the trust, in order to complete the audit cycle.
Methods.
Audit Cycle 1 - Patient data collection November 2020 - January 2021

Action - Locality teaching presenting findings of audit and post-ligature assessment tool developed as part of audit. Concurrent trial of incorporation of post-ligature assessment tool into trust-wide simulation teaching for new trainees.

Audit Cycle 2 - Patient data collection August - October 2021
Results.
Audit Cycle 1:
15 incidents
2 involving anchor point/drop
Medic informed in 4 incidents
0 documented in ABCDE format
0 NEWS monitoring
3 follow-up plans documented
3 complications reported
Audit Cycle 2:
10 incidents
0 involving anchor point/drop
Medic informed in 4 incidents
0 documented in ABCDE format
NEWS monitored in 6 incidents
4 follow-up plans documented
3 complications reported

Overall, slight improvement in documentation of NEWS monitoring and follow-up.
Conclusion. Documentation continues to be highly variable. This may be because the teaching done was not trust-wide, simulation session involved only on new doctors in August, some incidents involved locum doctors, and small reach of assessment tool.

We aim to introduce the post-ligature assessment tool as part of trust practice through liaison with the resus teaching team, as well as incorporating it permanently into trust-wide simulation induction teaching.

Audit Cycle on Medical Reviews of Seclusion in Medium and Low Secure Learning Disability Units

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Aims. Seclusion is defined as "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others". Patients in seclusion require reviews at the frequency set out in the Mersey Care NHS Foundation Trust policy, "The use of seclusion and long-term segregation" (SD28). This is based on the requirements set out in the Chapter 26 of the Mental Health Act 1983 Code of Practice (2015).This audit will look at whether medical reviews for secluded patients in the secure learning disability wards meet with the expectations set out in the Trust Policy. In doing so, the audit will establish whether medical reviews of seclusion meet and uphold the guiding principles of the Mental Health Act Code of Practice as highlighted in Chapter 26.110.
Methods. Retrospective audit that collected data from inpatients on secure learning disability wards in Mersey Care. After reviewing data, we actioned plans which involved educating colleagues working in secure services. This was re audited after three months. One month of seclusion reviews was audited in each cycle, which equated to 39 reviews in the first cycle and 100 reviews in the second.
Results. The re-audit data showed an improvement in most parameters.

Re-audit showed that 66% (34%) of the seclusion reviews had an initial medical review within the first hour. The on call consultant was informed in 60% (50%) of the situations and 4 hourly reviews took place in 66% (50%) of scenarios. All MDT reviews took place within 24 hours, Responsible Clinician was present in 100% (67%) of reviews.

34% (33%) of MDT reviews had only 2 MDT members.

There was 100% compliance with reviewing physical health in both audits. 100% (90%) of the reviews commented on mental health, 72% (20%) commented on medications used, 51% (39%) of reviews commented on level of observations and 89% (48%) included risk assessment. 95% (92%) of reviews assessed need for continuing seclusion. 84% (59%) of reviews commented on reducing restriction in seclusion.
Conclusion. This audit cycle has focused on the quality of medical reviews and not just the frequency. The improvement in practice will strengthen the safeguard provided by these reviews.

An Audit on Driving Advice After Hospitalization in a Mental Health Unit

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Aims. To ensure driving status is confirmed on admission (Target 100%) and to confirm driving advice is given to all patients deemed unfit to drive (Target 100%) and to ensure adequate documentation is made in online clinical notes with regards to discussions about driving
Methods. The first cycle of data involved collecting retrospective data from two acute adult psychiatric units and one old age mental health ward. The first cycle of data consisted of inpatients admitted over a two month period in 2020 (36). Data were collected from OpenRio progress notes, OpenRio ward round notes and patient discharge summaries. Following the implementation of interventions the second cycle of data were collected over a 2 month period in 2021. 51 patients met the inclusion criteria for this.
Results. Following our interventions, 47% (24) of patients had their driving status confirmed on/during admission compared to 42% (15) in the first cycle. 15 current drivers were identified in the second cycle.

Of the confirmed drivers, there was a 6% improvement of patients informed they were unfit to drive. A 22% increase in patients given DVLA driving advice was also noted. DVLA notifications increased by 18% following the interventions.