other mood stabilizers; pre-initiation monitoring was poor for both carbamazepine and valproate. There was general improvement in the standards compared with the 2018 audit.

The guidelines for monitoring mood stabilizers apart from lithium needs to be made popular especially pre-initiation monitoring for valproate and carbamazepine.

An Audit on the Prescribing of Antipsychotics Among People With Recorded Emotionally Unstable Personality Disorder (EUPD) Within a Community Mental Health Service in Stroud, Gloucestershire

Dr Amir Palermo* and Dr Claire Dibben

Gloucestershire Health and Care NHS Foundation Trust, Stroud, United Kingdom
*Corresponding author.

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Aims. (1)To quantify the prevalence and duration of the prescribing of antipsychotics among people with a record of EUPD, particularly those without a mental health comorbidity that licenses an antipsychotic prescription; (2)To determine whether gender, age, and mental health comorbidities affect the likelihood of being prescribed antipsychotics; (3)To determine whether off-license use of antipsychotics among those with EUPD have ever been reviewed, with the aim of having these prescriptions stopped or reduced.
Methods. Study design: Retrospective cohort study.

Setting: Data sourced from Stroud Recovery's electronic patient record of 287 people. Cohort entry was defined as the date of referral to Stroud Recovery. End of follow-up was the date of audit (20/11/2022).

Primary outcome measures: Prevalence and duration of antipsychotic prescription among people with a record of EUPD within the Stroud Recovery caseload.
Results. Of the 287 people registered with Stroud Recovery, 37 (13%) had a recorded diagnosis of EUPD. 30 (81%) were ever prescribed antipsychotics. Only 6 of these 30 people (20%) have a mental health comorbidity that licenses an antipsychotic prescription (3 with bipolar affective disorder; 2 with severe depression requiring antipsychotic augmentation; 1 with schizoaffective disorder).

The rest belonged to a subgroup of 24 people (80%) with recorded EUPD who were prescribed antipsychotics but with no history of co-morbid illness that licenses their use. This subgroup was predominantly female (75%) and aged 20–29 years (46%). Quetiapine was used in this subgroup the most, followed by olanzapine and aripiprazole. 12 (50%) have had more than one antipsychotic prescribed. None were prescribed for less than 1 week (defined by NICE as short-term use). In fact, the mean duration of antipsychotic prescription in this subgroup was 36.79 months. Only 10 (42%) had these prescriptions reviewed with the aim of having them stopped or reduced. None were offered a routine physical review.
Conclusion. According to NICE guidelines, antipsychotics are not recommended in the treatment of EUPD, not recommended in the treatment of medium to long-term impulsivity and other symptoms of EUPD, and antipsychotics should be reviewed for people with the aim of reducing and stopping unnecessary drug treatment. Contrary to NICE guidelines, in this community mental health service, antipsychotics are frequently prescribed for extended periods to people with recorded EUPD but with no history of a co-morbid illness that licenses their use. An urgent review of clinical practice is warranted, including the effectiveness of such prescribing and the need to monitor for adverse effects, including metabolic complications.

Physical Health Monitoring in the Memory Service

Dr Cara Pattiata* and Dr Tolulope Olusoga

Tees, Esk and Wear Valley NHS Foundation Trust, Harrogate, United Kingdom
*Corresponding author.

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Aims. Local guidelines state that pulse rate, weight, ECG if indicated, and bloods (U&E, LFT) are monitored in patients prescribed an acetylcholinesterase inhibitor or memantine. This can affect management as the above parameters can affect medication selection and titration. Aberrant measurements can indicate drug related adverse events. Compliance to standards will optimise patient safety. This audit aims to assess compliance to these guidelines in one Memory Service in the Trust.
Methods. This is a single-centre, baseline, retrospective audit performed on 19/10/2022.

An internal database was used to identify all patients seen for a diagnostic assessment between September 2021 and October 2022. Patients who were prescribed an acetylcholinesterase inhibitor or memantine were eligible for selection. These were randomised to identify 30 cases.

Information was gathered through electronic patient notes, clinician diagnostic letters, referral forms, and pathology specimen result reporting software.
Results. Compliance were as follows:

- Pulse rate recorded: 97%
- Weight recorded: 0%
- ECG requested when indicated: 20%
- Blood samples taken and the results recorded: 100%

Pulse rate is part of the assessment proforma and blood sampling is a requirement prior to referral. This suggests that having guidelines incorporated to local protocols enhances compliance.

Weight was not routinely monitored: the rationale behind this being part of the guidelines is that rivastigmine can cause weight loss as per the BNF due to loss of appetite. However, on speaking to the Memory Team, this was not routinely done in the service as staff appear to rely on reports of appetite loss.

ECG was not routinely done when patients fall under the criteria for indications. Clinicians appear to judge the requesting on ECGs pragmatically based on their clinical judgment rather than guidelines alone.

Blood pressure is not a requirement in the guidelines for monitoring so cannot be audited. However, this is essential for decision making of treatment commencement, titration, switching, or titration.

Findings suggest that local guidelines may need to be reviewed.
Conclusion. This audit suggests some general learning points as well as service-specific ones.

The incorporation of guidelines into routine practice such as proformas or the pathway itself contributes to good compliance. This may be due to these standards being auditable as well as acting as prompts for staff members or even requirements for patients to proceed in the pathway.

This was also a reminder that clinical judgment may differ from guidelines; this may not necessarily be an indicator of poor practice but may result from pragmatic decision making for individual patients.

The findings were presented at a consultant meeting, the result of which was that the guidelines will be reviewed with likely inclusion of blood pressure monitoring. This is an illustration of the role of audits and quality improvement in improving standards of care.

Mental Health Triage Form Use in Emergency Department Clerking – Audit at Royal Cornwall Hospital

Dr Alisha Pradhan[1]*, Dr William Lee[2], Dr Nathan Batley[2], Ms Suzanne Burton[2] and Ms Zoe Wyatt[2]

[1]Royal Cornwall Hospital, Truro, United Kingdom and [2]Cornwall Partnership NHS Foundation Trust, Truro, United Kingdom
*Corresponding author.

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Aims. The aim of this audit is to assess use of the Mental Health Triage Form (MHTF) at the Royal Cornwall Hospital Emergency Department (ED), during June 2021 and to determine whether MHTF use increases rates of psychiatric-specific information being documented by ED staff. Patient attendances to Accident and Emergency (A&E) departments in the UK during 2020-21 decreased by 30.3% in comparison to 2019-20. However, attendances to A&E at the Royal Cornwall Hospital (RCH) in June 2021 increased by 51.2% compared to June 2020. Psychiatric patients accounted for 2% of attendances to A&E at RCH in June 2021. The Royal College of Emergency Medicine (RCEM) have recommended use of a mental health proforma document in line with recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) document 'Treat as One'. Based on these guidelines, the Psychiatric Liaison department at RCH have a produced a local Mental Health Triage Form (MHTF) to be used in A&E when assessing and clerking psychiatric patients.
Methods. This was a retrospective audit of clinical records of 125 mental health cases attending the Accident & Emergency Department (A&E) at Royal Cornwall Hospital during June 2021, which were referred to Psychiatric Liaison.

NHS numbers were identified for each referral made during the study period. Each referral's A&E clerking documents were reviewed on an online patient records system. Information was recorded on whether each question in the Mental Health Triage Form had been answered with or without use of the form.
Results. The Mental Health Triage Form (MHTF) was used in 44 out of 125 patients (35%). 15 patients (12%) had missing Accident & Emergency Department documentation on online records. Where the MHTF was used, there was an 25% average increase in information recorded. Over half of the questions on the MHTF were answered more when the form was used versus when it was not used.

Questions relating to the patients 'Triage Code', which are used to determine the level of observation, urgency of referral, and appropriate place of assessment, had the highest rates of improvement using the form.
Conclusion. Overall use of the Mental Health Triage Form during June 2021 reduced to 35% in comparison to 46% use during June 2020. This implied that patients attending the Accident & Emergency Department at the Royal Cornwall Hospital with psychiatric presentations were not being assessed fully. This may be due to various reasons such as staff unfamiliarity with the triage form and increasing pressure on Emergency Department services.

Audit on the Adherence to Guidelines for the Management of Alcohol Withdrawal Syndrome in a General Hospital

Dr Manjula Simiyon, Mr Rob Connah, Dr Rhian Proffitt*, Mrs Sharon Downes, Mrs Jennifer Jarvis and Dr Catherine Baker

Betsi Cadwaladr University Health Board, Wrexham, United Kingdom
*Corresponding author.

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Aims. Problematic drinking of alcohol is a common problem in the United Kingdom. As alcohol is a central nervous system (CNS) suppressant, when a chronic user abruptly stops drinking alcohol, the alcohol-mediated CNS inhibition is withdrawn and the glutamate-mediated CNS excitation is left unchecked leading to a total excitation of the CNS. This results in alcohol withdrawal syndrome (AWS). The aim of this audit was to assess the compliance to the health board's policy for management of AWS available in the intranet as NU16 which was developed based on the NICE guidelines, across the wards in the General hospital. We aimed to assess compliance concerning four aspects:

1. Initial clinical and laboratory assessment
2. Prescribing for alcohol detoxification (benzodiazepines and vitamins)
3. Scoring of and adherence to CIWA-Ar
4. Specialist advice during the admission

Methods. We requested for the case records of patients admitted to the Wrexham Maelor Hospital during May 2022 with problematic alcohol consumption. We have received 56 case notes from the medical records department among which, 50 fulfilled the inclusion criteria. A case report form was prepared based on the NU16 and anonymized data were collected.
Results. Average age of the participants was 56 years ranging from 21 to 95.There were 29 males and 21 females. Mean days in the hospital was 3.25(+0.88). Only 4% of the records had complete documentation of drinking history, 84% had documentation of physical examination, and 20% had the documentation of signs of Wernicke's encephalopathy. CIWA-Ar was applied in 44% with correct scoring only in 24%. Compliance to laboratory investigations varied from 16% for gamma glutamyl transferase (GGT) to 84% for full blood count. Benzodiazepines were prescribed for 38%, oral thiamine was prescribed for 58%, 42% had two pairs of intravenous pabrinex three times a day and 6% had received 1 pair once a day. Benzodiazepine regimen was completed in 75% and alcohol liaison opinion was obtained only in 16%
Conclusion. We could find that there were omissions in multiple areas of adherence to the guidelines in all the four domains. Alcohol