

Personality Disorder continued to receive benzodiazepines for longer than recommended.

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### Evaluation of the Clinical Significance of Assessing Previous Gambling Problems Before Initiating Antipsychotic Treatment: An Audit

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**Aims.** This audit aims to address the critical link between antipsychotics and impulsive behaviors, particularly pathological gambling, by emphasizing the importance of assessing patients' gambling history before initiating antipsychotic treatment. The focus is on patients under the care of the Bolton Early Intervention in Psychosis (EIT) service, with the aim of meeting the standard set by NICE guidelines, ensuring that 100% of patients started on antipsychotics are asked about their previous gambling history.

**Methods.** Data was collected from prescription and shared care protocol lists for patients prescribed antipsychotics in the last six months. The PARIS progress notes and clinical correspondence were then searched to determine if patients had been asked about gambling.

**Results.** The audit revealed a significant gap in the practice, with minimal adherence to NICE guidelines regarding assessing gambling history before prescribing antipsychotics. Out of 35 patients, only one was asked about gambling history.

**Conclusion.** The recommendations for improvement include incorporating a gambling prompt into the medical review proforma, educating the team about the importance of this assessment, and adding the Problem Gambling Severity Index to the initial review by EIT.

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### Clinical Audit of Dementia Diagnosis and Management – According to Disease Severity

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**Aims.** The NICE guidelines NG97 (1.5) currently recommend to consider memantine in addition to acetylcholinesterase inhibitors in the management of moderate to severe Alzheimer's dementia, if tolerated, as opposed to the monotherapeutic management with either class of drug. This management practice was adopted by the trust and updated on Trust guidelines.

I noted that most of the patients on follow up in memory clinic, had a generic diagnosis of dementia subtypes, without a

mention of the degree of severity of the illness and as such, on monotherapy.

**Aim**

This audit serves to establish the practice in recent years, if patients diagnosed with dementia, were diagnosed, and managed according to the severity of their condition.

If not, for necessary changes to be implemented in practice and a re-audit carried out.

**Methods.** The audit was conducted in February 2023 as a retrospective study. We analysed records of 60 patients seen for a diagnostic appointment in Middlesbrough Memory Service between January 2020 and December 2020.

All referrals made to the memory clinic within 2020 were retrieved from trust electronic records and 5 patients were selected at random from each month using the google random number generator, and analysed on Excel.

**Results.** The most common dementia diagnosis was mixed dementia (Alzheimer's + vascular disease) with 40% of diagnoses, followed by Alzheimer's disease at 39%, while Lewy body dementia was least diagnosed at 8%.

**Assessment:** Only 46 records completed the dementia diagnostic pathway (initial assessment, ACE III, CT scan alongside pre-referral blood screen), the other 14 patients were unable to complete this pathway due to functional decline.

**Severity of illness:** Of the patients evaluated, only 7% had the severity of disease in their diagnosis, which were all Moderate severity. 93% had generic diagnosis.

**Pharmacological Treatment:** 46 out of 60 patients evaluated, were on medication.

And all were on monotherapy, irrespective of disease severity, with majority being on anticholinesterase inhibitors (Donepezil) being the first and most popular choice.

**Conclusion.** Severity of disease condition were not identified or documented.

The use of combination therapy is yet to be considered at the diagnostic stage. This should be implemented before discharging a patient with moderate to severe disease. Although, local best practice is to offer this as early as moderate disease is identified.

Combination therapy is yet to be adopted in the organic pathway.

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### A Re-Audit of Physical Health Monitoring of Day-Care Patients in the Adult Eating Disorder Service at Surrey and Borders Partnership NHS Foundation Trust

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**Aims.** To determine if the physical health monitoring of day-care patients in the Adult Eating disorder service (AEDS) is done in line with the recommendations of NICE guidelines and relevant Medical Emergencies in Eating Disorders (MEED) Guidance on Recognition and Management.

**Methods.** 1. For every attendance of patients to the day-care Clinic it is expected that the physical health monitoring to be offered would include:

- Weight
- Height (if first attendance)
- BMI
- HR (Pulse rate)
- Sitting/Standing BP
- Temperature

2. Relevant blood tests and ECGs on a schedule based on patient's BMI or as needed based on clinical indication.

23 patients were identified as having been seen in AEDS day-care centre between April 2021 till the point of discharge. 9 were deemed inappropriate due to incomplete information. Of the remaining 14, 9 patients were randomly selected, their documentation were looked from admission to day-care to the point of discharge. The monitoring was audited at 3 points of contact over the course of their first clinic appointment, the middle and point of discharge.

#### Results.

1. Comparing data from previous audit, the average admission in day-care decreased from 5.5 to 3.5 months.
2. There was overall improvement in the ECG and blood test monitoring.
3. At the admission and the last assessment there was 100% monitoring of BMI, weight, blood pressure and pulse.
4. There was a drop in temperature monitoring by 11.1% in the first and last assessment due to faulty equipment.
5. The ECG and bloods percentage dropped by 11.1% at all the monitoring points.
6. At the midpoint there was no documentation of BMI, Blood Pressure, and pulse for 1 patient.

#### Conclusion.

1. Investigations were delayed from the patient's side.
2. Due to COVID there was difficulty in accessing the primary care appointments for investigations.
3. The temperature equipment was not working properly.

#### Recommendations:

1. Keeping a fixed format for documenting day-care visits on the SystemOne software. A Sample format made available for documentation.
2. Document all the parameters checked in the patients' electronic records on the same day.
3. Day-care clinical team to upskill on ECG via training.
4. Team Resources to be allocated to have in-house ECG in day-care.
5. SUSS test to be done for all RED (High risk) patients as clinically indicated and clearly document in the notes, e.g. SUSS: done/not done and reason with date SUSS conducted on.

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### Health Notes Audit

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**Aims.** To assess whether patients admitted to the forensic secure rehabilitation ward are transferred with their physical health notes.

Most patients admitted to secure rehabilitation do not have an open GP record due to last registration with primary care having been many years previous as a result of a lengthy prison/hospital stay. Additionally, patients may be referred from an out of area prison or hospital. A comprehensive psychiatric history paperwork is obtained at referral. This audit was to assess how many patients currently on the rehabilitation ward arrived with complete physical health notes. We defined a complete set of physical health notes to mean:

1. Records from medical consultations linked to physical health during time in prison or psychiatric hospital.
2. Any physical health history prior to current incarceration/admission episode from primary and secondary care.
3. Complete prescription of physical health related medications including allergies, doses, regime, and indication.

**Methods.** Retrospective review of patient electronic records sent by discharging institution when the patient was transferred to the rehabilitation ward.

Data collected: List of documentation of patient's physical health records around transfer time. Identification of the contents of the records provided by the transferring ward.

We then compared the information available to our criteria for complete physical health notes.

Participants: All current residents of the male secure rehabilitation ward (n = 12) were included.

**Results.** 7 out of the 12 patients included were transferred to the secure ward with notes that fulfilled the criteria as set by audit team.

Two patients were transferred with only the prescription of current medications. There was however, a brief physical health summary in care coordination notes sent earlier.

One patient was transferred with the prescription and a brief list of their past medical history.

The remaining 2 patients were transferred without any formal physical health documentation prior to transfer, however, they were transferred from an adjacent ward and therefore, all records were already on the electronic records. There was no formal verbal or written physical health handover.

**Conclusion.** It is important for our ward to ensure we have comprehensive and complete physical health summary for each patient on admission.

A proforma will be used at preadmission meetings from February 2024 to request specific information from discharging wards. We will re-audit in February 2025 to assess improvement in records requested and obtained.

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### Evaluating Adherence to Rapid Tranquilization Protocols in Psychiatric Emergencies: An Audit of a Tertiary Care Facility in Pakistan

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