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**Aims.** Patients with serious mental disorders like psychosis may pose a significant risk to themselves and others when they drive. The DVLA has set out guidance for driving for patients with psychiatric disorders, substance use disorders, and for those taking psychotropic medications. It's good medical practice to identify risks associated with driving, discuss, advise appropriately, and document the same in the clinical notes.

To assess the compliance of the mental health professionals at Rathbone Rehabilitation Centre (RRC) with DVLA guidelines regarding patients about driving restrictions, documenting this appropriately and to increase awareness of the DVLA guidelines.

**Methods.** Data of all the discharged patients from RRC over a 12-month period was collected following a standardised process and assessed for 6 parameters.

A total of 51 discharges were identified and audited against the DVLA guidelines.

**Results.** 51 (100%) patients had a mental health diagnosis documented on patient electronic records (Rio).

9 (18%) of patients had their driving status documented. 42 (82%) did not.

Of the 9 patients whose driving status was recorded, 6 did not drive and are thus labelled not applicable for subsequent criteria. The type of vehicle driven was not documented in any of the cases and therefore was 0%.

Of the 3 patients who drive, 2 (67%) had been informed that their condition may affect their ability to drive.

67% had documented evidence of receiving advice on driving restrictions.

67% had documented evidence that the practitioner has informed the patient that they have a legal duty to inform the DVLA about their condition.

**Conclusion.** An action plan was designed to improve compliance with DVLA guidelines for practitioners managing inpatients.

- On admission all patients should be asked for their driving status and the result documented on Rio. This could be done on the clerking admissions proforma on Rio.
- For all patients that do drive, the types of vehicles they drive should be documented—this can also be included in the clerking admissions proforma on Rio.
- At their first ward review/discharge meeting and whenever relevant, patients should be informed whether their condition affects their ability to drive and if so, what the restrictions are. They should be informed of the legal requirements regarding informing the DVLA and documented.
- To consider driving status when assessing risk.

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.

## Antipsychotic Prescribing for In-Patients With Dementia at University Hospital Llandough to Look for Good Prescribing Practice in Line With NICE Guidelines

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**Aims.** NICE guidelines stipulate that alternative causative factors for Behavioural and Psychiatric Symptoms of Dementia (BPSD) must be considered before starting antipsychotic treatment. The symptoms of BPSD include agitation, aggression, wandering, hoarding, sexual disinhibition, shouting, repeated questioning, sleep disturbance, depression, anxiety and psychosis. Those who do develop non-cognitive symptoms or behaviours should at first be assessed to exclude alternative causes, such as physical health issues (pain/infection), side effects of medication, environmental factors, psychosocial factors, individual biography (e.g. religious beliefs) etc. Then, non-pharmacological approaches should always be used as the first line in treating behavioural problems before antipsychotics (e.g. haloperidol or risperidone) are started at a low dose and titrated up. Once these have been started, the patient should be reviewed at 6 weeks. The rationale for conducting this audit is to try and understand if the antipsychotic prescribing in the ward is in line with the NICE guidelines.

**Methods.** A retrospective study to compare the treatment of all the patients admitted for dementia in the Old age psychiatry wards located in University Hospital Llandough from November 2022–April 2023 with the NICE guidelines.

**Results.** Out of the 39 patients who met the criteria, the results indicate a predominant prevalence of Alzheimer's (46%), followed by mixed dementia (23%) and vascular dementia (21%), among the diagnosed cases. In 67% of instances, healthcare professionals have considered alternative causative factors for the observed symptoms beyond the identified dementia subtypes. In 62% of cases, patients received treatment for alternative causes, while non-pharmacological approaches were attempted in 51%. The utilization rates among patients indicate a predominant prescription of risperidone at 77%, followed by quetiapine at 31%, olanzapine at 10%, and aripiprazole at 5%. 95% of patients were commenced treatment at the lowest dose, while information for 3% (1 patient) was not available. 62% were monitored according to guidelines and 56% were reviewed every 6 weeks.

**Conclusion.** There is room for improvement in terms of considering other causes of behavioural symptoms, utilizing non-pharmacological approaches, and adherence to monitoring and review intervals outlined in the guidelines. These findings underscore the importance of continuous evaluation and refinement of clinical practices to enhance the overall management of BPSD in dementia patients.

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## Audit of Risk Assessment Tool in Adolescent Eating Disorders

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**Aims.**

**Aim:**

To develop better prioritisation and assessment of high-risk patients.

**Standard:**

RCPsych Junior MARSIPAN guidelines advise that reasonable aims for a first presentation to primary care involve physical examination and referral to the appropriate CAMHS or paediatric

service depending on the level of risk. The framework set out within the guidelines can be used to highlight areas useful to assess and grade concern.

NICE guidelines also state that in primary care, when assessing for an eating disorder or deciding whether to refer people for assessment, the following should be considered: BMI or body weight for their age, rapid weight loss, restrictive eating practices, mental health problems, physical signs of malnutrition, poor circulation and behaviours such as excessive exercise, unexplained electrolyte imbalance or hypoglycaemia.

Indicator and target: Proportion of GP referrals which contain information to allow risk assessment and prioritisation of referrals within CAMHS.

#### Methods.

Eating disorder referrals were reviewed over a three month period. Using EMIS, SCI store referrals were reviewed to check the source of referral and information included.

Referrals were checked against the following criteria: weight, degree of weight loss, fluid intake, calorie intake, heart rate, blood pressure, mental health screening, compensatory behaviours and blood analysis.

#### Results.

First cycle Results: from period from May–July 2021, comprising 8 referrals. The percentage of referrals which included information on the following were: weight 25%; weight loss 50%; calorie intake 37.5%; fluid intake 12.5%; heart rate 0%, blood pressure 12%, mental health 62%, compensatory behaviours 12.5%, bloods analysis 25%.

Action plan: Pro forma was developed to increase awareness of the information that is useful to CAMHS to prioritise and assess risk as per standards expected from NICE and Junior MARSIPAN guidelines.

This was circulated to East Renfrewshire GP practices in August 2021.

Second cycle Results: Referrals were reviewed in the period after the pro forma was circulated from Sept–Dec 2021. This comprised of 4 referrals. Upon review results showed that the percentage of referrals which included information on the following were: weight 100%; weight loss 50%; calorie intake 25%; fluid intake 25%; heart rate 25%, blood pressure 50%, mental health 100%, compensatory behaviours 75%, bloods analysis 50%.

**Conclusion.** The audit showed, that following the pro forma being circulated, there was an improvement in proportion of referrals which contained appropriate information (26% compared with 55% cumulative percentage of information included).

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## Improving Patients' Experiences of Ward Round in Psychiatry Wards

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**Aims.** The aim of the audit is to improve the patients' experience in the ward round, to ensure all the patients feel included in their

ward rounds, to find out if their physical health gets as much attention as their mental health and to establish they receive appropriate feedback of their treatment progress while being inpatient.

By carrying out the audit, our target was to ensure patients are prepared, that service users and carers are involved, clear goals are set, patient confidence is increased, there is direct patient interaction, and the ward round is a positive experience for both the patient and the care team.

**Methods.** This audit included 34 patients from our acute adult psychiatry mixed unit and perinatal psychiatry unit, who have had at least two ward rounds in the inpatient setting, have the capacity to consent to treatment and have insight to their mental health issues.

Data collection was done by a face to face patient interview with a questionnaire by the junior doctors in the wards. The questionnaire was discussed with the head of patient experience team and clinical audit & improvement facilitator team prior to starting the audit. Confidentiality was maintained and at no point were the patients requested to reveal their identity.

**Results.** Among the patients admitted during the period of October 2022 to November 2022, 40 patients were chosen randomly. Among them, data was collected from 34 patients according to the inclusion criteria.

Based on the patients' feedback and experience, 52.9% service users thought the ward round time tables ran by schedule, whereas 11.8% service users thought they did not run by schedule at all.

20.6% service users reported that they were not informed in advance, if there were any change in the ward round time schedule; whereas 41.2% service users were informed of the changed time schedule.

50% service users reported that they received appropriate support prior to the ward round should they need this, on the other hand 8.8% said they did not require any support, therefore refrained from answering the question.

Majority of the service users 94.1% reported that they were happy with the ward round physical environment, the sitting arrangement and the ambience and 88.23% service users reported being reviewed by the consultant at least once a week. None of the service users were found, who was not reviewed by the consultant at least once weekly during their stay in the inpatient wards.

47.1% service user reported that they did not feel confident and comfortable in front of all the professionals present in the ward round.

20.6% service users complained that their physical health was not getting as much attention as their mental health in the psychiatric wards and they were not referred for their physical health needs accordingly.

23.5% of service users had little to moderate understanding on what was being discussed in the ward round meeting, whereas 76.5% understood completely what was being advised in the ward round.

8.8% of the service users did not feel involved in their ward round at all and majority of the service users, 52.9% got regular feedback on the treatment progression and a chance to talk with their named nurse after the ward round.

**Conclusion.** Ward rounds are the formal meetings where service users come to the professionals with their queries and are informed about their progression on treatment. These meetings should be comfortable and palatable for both sides of the table. Further arrangements are required to improve the settings and make it more service user friendly to get the best outcome from ward rounds.

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