To discuss the outcomes with the Carer Champions on each unit, to review what form their support currently takes, and consider how this could link in with the requirements of Standard 5.2.

To re-audit in 1 year.

Prescribing and Monitoring of Pychotropic Medications in a CAMHS Inpatient Service

Dr Olorunleke Erunkulu[1]*, Dr Shermin Imran[2] and Dr Wasim Ashraf[2]

[1]Manchester Foundation NHS Trust, Manchester, United Kingdom and [2]Greater Manchester Mental Health Trust, Manchester, United Kingdom

*Presenting author.

doi: 10.1192/bjo.2024.563

Aims. To ensure that there is a clear rationale for commencing service users on psychotropic medications.

To ensure that the prescription of psychotropic medications is evidence-based and that they are in line with the Trusts and NICE guidelines.

Ensure that psychotropic medications are regularly reviewed by the managing team.

To ensure that information about medications is adequately shared with patients and carers.

To ensure that service users are well-monitored for side effects.

Methods. A 2-week retrospective audit on Phoenix ward.

Clinical information from all the current service users on psychotropic medication was reviewed.

The clinical information was collated from all 8 service users' medication cards, ward round documents, MDT reviews, and electronic notes (PARIS), and these were analyzed by the inpatient specialty registrar.

Results.

1. We attained a 100% mark in some areas of our prescribing such as indicating the rationale, the maximum dose for medication, and also prescribing within BNF limits.
2. We however could not evidence proper information sharing with patients (only 40% documented).
3. We could not evidence sufficient information sharing with carers (only 20% documented).
4. PRN medication was mostly prescribed as a range rather than a clear dose, which gave rise to subjective dispensing bias.
5. Side effect monitoring was documented for 85% of patients, meanwhile, the standard for this is 100%.

Conclusion. Clinicians are to ensure that medication information is always shared with service users, and their carers, and this is documented.

Clinicians are to also ensure that PRN medications are prescribed as a single dose rather than as a dose range.

Ward staff are to ensure that they are monitoring side effects and documenting these clearly on electronic notes and ward round documents.

The MDT is to ensure that all regular and PRN medications are reviewed regularly during ward rounds.

Present this audit, share relevant findings with the clinical team, and monitor the implementation of the action plans by doing a reaudit in 6 months.

A Complete Audit Cycle of the Recording of the Baby's and Their Siblings' Age, Date of Births and Due Dates of Pregnant Mothers During the Initial Assessment Process for Patients Presenting to a Community Perinatal Mental Health Services

Dr Chinenyenwa Eze* and Dr Emma Brotchie

Community Perinatal Mental Health Services, Heredfordshire and Worcestershire Health and Care NHS Trust, Worcester, United Kingdom

*Presenting author.

doi: 10.1192/bjo.2024.564

Aims.

- To find out the proportion of patients for whom the dates of births of their children, age and their due date were recorded during their initial assessment as a means of reducing risks through safeguarding.
- According to the Royal College of Psychiatrists: Standards for Community Perinatal Mental Health Services 5th Edition (2020), Under Section 5 – Rights, Infant Welfare and Safeguarding: during the initial assessment, the baby's age and date of birth and mother's due date should be recorded as part of the infants' physical and emotional care needs assessment.

Methods.

- All new patients discussed during multidisciplinary team meetings within a 2 month period from 01/08/2023 to 30/09/2023 were identified
- Their clinical records were audited.
- This information was cross-checked with the information provided on their referral letters.
- Patients attending preconception counselling were excluded.
- The initial results were presented in one of the multidisciplinary team meetings.
- The recording of the children's ages, date of birth or due dates of their mothers was re-audited two months later.

Results.

Audit

- A total of 70 new patients were discussed within the initial two months period.
- 25 out of the 70 (36%) did not attend their appointments and two patients (3%) cancelled their appointment.
- 1 patient who attended for preconception counselling was excluded.
- Of the remaining 42 patients that were assessed, 6 (14%) were primigravida while 36 (86%) patients were multiparous patients.
- 15 out of the 42 (36%) had their children's age, dates of birth and due date recorded while 27 out of the 42 (64%) lacked this record.

Re-audit

- A total of 65 patients were identified during the re-audit period
- 18 out of the 65 patients (28%) did not attend their appointment and one patient cancelled her appointment.
- One patient that attended for preconception counselling was excluded from the re-audit process.
- Of the remaining 45 patients that were assessed, 2 (4%) were primigravida and the remaining 43 (96%) were multiparous women.
- The age, dates of birth and the due date were recorded for 26 (58%) out of 45 patients while 19 out of the 45 patients (42%) did not have this record.

Conclusion.
- The children's ages were commonly recorded compared with their date of birth.
- Gestational ages of the pregnant mothers were commonly recorded compared with their due dates.
- Date of birth is needed for a quick check on a child for safeguarding reasons and this is useful during the admission of mothers onto a mother and baby unit.
- The re-audit showed a significant improvement in the documentation of this information in the patients' records.

Improving the Assessment and Management of Sleep Problems in a Specialist NHS Gambling Treatment Service

Dr Harry Fagan[1,2*], Dr Holly Austin[3,2], Dr Mat King[1], Professor Samuel Chamberlain[1,2] and Dr Konstantinos Ioannidis[1,2]

[1]Southern Gambling Service, Southern Health NHS Foundation Trust, Southampton, United Kingdom; [2]Clinical and Experimental Sciences (CNS and Psychiatry), Faculty of Medicine, University of Southampton, Southampton, United Kingdom and [3]Dorset HealthCare University NHS Foundation Trust, Poole, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.565

Aims. Sleep disorders, such as insomnia, are common in the general population and in patients with psychiatric conditions including the behavioural addiction Gambling Disorder (GD). The NHS Southern Gambling Service (SGS) is a tertiary centre providing evidence-based assessment and treatment for people affected by GD across the South-East of England. We aimed to assess the prevalence of sleep problems in help-seeking adults with gambling difficulties, including the association with gambling severity and other measures of psychopathology, and determine if 1) sleep is appropriately assessed and 2) whether sleep disorders are appropriately diagnosed and managed, in line with NICE guidelines, in this particular cohort.

Methods. All patients referred from September 2022–October 2023 who completed an initial clinician assessment were included. Gathered data included age, gender, pre-existing physical health conditions, and scores from the following questionnaires: Gambling Symptoms Assessment Scale (GSAS), Pathological Gambling Yale-Brown Obsessive Compulsive Scale (PG-YBOCS), Brief Pittsburgh Sleep Quality Index (B-PSQI), Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder 7 (GAD-7). Data analysis was performed under ethical approval (23/HRA/0279). Relationships between gambling severity and sleep quality, and depressive/anxiety symptoms were explored (using Pearson correlation coefficient). In patients with a B-PSQI score > 5 (suggestive of underlying sleep disorder), we determined whether sleep problems were appropriately assessed and managed.

Results. 83 patients completed an initial clinician assessment (81% male, average age 38 years). Baseline B-PSQI scores were weekly positively correlated with gambling severity on the GSAS (r = 0.18) and the PG-YBOCS (r = 0.10) and anxiety symptoms severity on the GAD-7 (r = 0.26). Baseline B-PSQI scores were moderately positively correlated with depressive symptom severity on the PHQ-9 (r = 0.39) and higher B-PSQI scores were noted in patients reporting suicidality.

54/83 (65%) patients had a baseline B-PSQI score > 5, of these, seven (13%) had a clearly documented management plan for insomnia in line with NICE guidelines.

Conclusion. Most patients referred to SGS had baseline B-PSQI scores suggestive of current sleep problems. B-PSQI scores were positively correlated with gambling severity and severity of anxiety and depression. Findings highlight that sleep problems are common in people presenting to the NHS gambling service, but also that there is scope to improve and extend signposting for affected individuals to receive sleep-specific support. The audit findings have been presented to the SGS team; resources for the assessment and management of sleep problems have been shared and a re-audit is planned for Summer 2024.

Additional authors: Dr. Jodi Pitt, Esther Gladstone, Dr. Peter Hellyer.

Benzodiazepine Prescribing Within a Community Mental Health Team Setting

Dr Azra Farooq*

Pennine Care NHS Foundation Trust, Manchester, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.566

Aims. Current guidelines provide for short-term relief of symptoms using benzodiazepines, but patients, including those with complex emotional disorders often seek these medicines for longer. The current audit aims to review clinical practice in respect of benzodiazepine prescribing against national and local guidelines.

Methods. Retrospective analysis of all benzodiazepines prescriptions during the study period (March–December 2021 and January–December 2023). Data was assessed against National Institute for Health and Care Excellence, British National Formulary and local Trust guidelines using a proforma and spreadsheet. The study authors separately reviewed prescribing for separate years of the study.

Results. In the 2021 subsample, (9/15) 60% of patients received a benzodiazepine for less than one month. All of these patients had a psychotic disorder diagnosis. 6/15 (40%) received a benzodiazepine for more than 4 weeks, with an average duration of 5 months. Of these, only one patient had a diagnosis of a Personality Disorder. 7 patients in total (46%) were offered psychological interventions. Patients receiving benzodiazepines for more than 4 weeks were offered a tailored management plan to address their use.

In the 2023 re-audit, 10/51 (20%) patients received a benzodiazepine for greater than one month. The common indications were agitation, anxiety and crisis management. The commonest diagnoses were Personality Disorder, Post-Traumatic Stress Disorder and Schizoaffective Disorder. 4/10 (40%) patients with a Personality Disorder were prescribed a benzodiazepine for more than 4 weeks. The average duration of benzodiazepine prescribing was 11 weeks.

Conclusion. Although benzodiazepines continued to be commonly used for a range of conditions, the proportion of patients not compliant with the one month, recommended duration for prescribing was reduced by half. There was a general reduction in the overall duration of prescribing but patients with a