

Method. We sought to explore if the physical health monitoring for prescribing mood stabilisers in a sample of people with ID was consistent with good practice guidelines.

We collected the data by reviewing the clinical records of individuals with LD who were under the care of mental health services in the CLDT- Wrexham and prescribed a mood stabiliser drug. We also contacted the patient's carers who came to outpatients and by calling the GP surgery and enquiring about the details. We also assessed the Welsh clinical portal in order to assess the blood tests.

Data were collected by trainee doctors in Psychiatry. This was a retrospective audit, looking at data from Learning Disability psychiatry caseload. We identified about 16 patients on mood stabilisers.

Result. Physical health monitoring for prescribing mood stabilisers was almost consistent with good practice guidelines. This has shown that the majority of the monitoring has complied. There are few lacunae, such as Thyroid function not being monitored every 6 months for patients on Lithium, Serum Carbamazepine levels not being monitored as per guidelines with 1 patient not having blood done at all whilst on Carbamazepine. Moreover, the details are not readily available for the Consultant/ team when needed, thus making it very tedious for them to search/ contact the GP, etc.

Conclusion. Medications such as mood stabilisers can increase the risk further if the patient's physical health is not monitored regularly. This can lead to compromised quality of life for the patient and in some cases increased morbidity. Hence we have come up with a proforma that can be attached to patient case notes. This will serve as a record for us and prompt for physical monitoring. We will keep a database online with reminders set. This is to ensure a continuity of care for the patients.

High dose antipsychotic therapy (HDAT) in the Greater Manchester mental health adult psychiatric inpatient setting

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Aims. To identify the number of adult inpatients prescribed HDAT across GMMH.

To establish whether guidelines for the prescribing and monitoring of HDAT are adhered to.

To consider the initiation of HDAT, evaluating whether prescriptions of HDAT are intentionally made by consultant psychiatrists and the MDT, or by rotational junior doctors.

Background. High Dose Antipsychotic Therapy (HDAT) is defined by the Royal College of Psychiatrists as either: a total daily dose of a single antipsychotic which exceeds the upper limit stated in the BNF or A total daily dose of two or more antipsychotics which exceeds the BNF maximum as calculated by percentage.

The decision to prescribe HDAT should be made by a consultant psychiatrist and discussed with the patient and wider MDT. Clear documentation of this discussion, including the clinical indication, should be recorded within the case notes.

The use of HDAT comes with greater risk of physical health complications and requires regular monitoring of ECG, BMI and blood biochemistry. For patients detained under the Mental Health Act, consent and appropriate consultation with a SOAD should be sought for HDAT where the patient lacks capacity.

This audit investigates prescription of HDAT in the acute adult inpatient population within Greater Manchester Mental Health NHS Foundation Trust (GMMH).

Method. Six junior doctors were recruited to collect data across the 5 sites covering general adult inpatients within GMMH. Data were collected week beginning 21st January 2020. Data were collected from all 20 general adult inpatient wards within the trust. Medication cards for each patient on the electronic bed-state at 9am on the day of the audit were checked for HDAT prescription. Subsequently, data were collected from electronic notes of patients identified as being on HDAT. Data were collated and submitted to the audit lead for analysis.

Result. 31 patients were identified as being on HDAT, of those, 21 instances of HDAT were commenced during the patients MDT, although in only 2 of these cases was it noted that the medication prescribed would result in initiating HDAT. Of the remaining cases, 8 were prescribed by junior doctors and 2 were unclear. 15 out of 31 patients had an ECG within a month prior to commencing HDAT, of 24 patients on HDAT for longer than 3 months, only 5 had a repeat ECG within this time.

Conclusion. Guidelines are not closely adhered to, there is clear and necessary scope for improvement.

High dose antipsychotic therapy (HDAT) prescribing practice within the south trafford community mental health team

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Aims. High Dose Antipsychotic Therapy (HDAT) is defined by the Royal College of Psychiatrists as either: "A total daily dose of a single antipsychotic which exceeds the upper limit stated in the BNF" or "A total daily dose of two or more antipsychotics which exceeds the BNF maximum as calculated by percentage."

The use of HDAT is associated with significant risks to physical health and as such requires regular monitoring of various physiological parameters such as ECG, bloods and an assessment of cardiometabolic risk.

Following previous audits of HDAT prescribing practice in the inpatient setting within Greater Manchester Mental Health (GMMH) NHS FT, an audit of HDAT prescription in a general adult CMHT was conducted in Summer 2020, with the following aims:

To identify patients in the South Trafford CMHT who are prescribed HDAT.

To assess the prescription of HDAT against local guidance on the use of unlicensed medications.

To highlight good practice and areas for improvement in the prescription of HDAT.

Method. All patients under the South Trafford CMHT in Summer 2020 were identified. Current prescriptions for antipsychotic medication were ascertained through review of electronic patient records. Those noted to be on HDAT were assessed against audit criteria

derived from the GMMH Unlicensed Medicines Policy, previous audits of HDAT use and the RCPsych consensus report on HDAT prescription.

Result. 11 of 252 patients (4%) were identified as being on HDAT, of which eight were due to polypharmacy and three to high dose of a single antipsychotic. For 1/11 patients target symptoms and a risk/benefit rationale were documented. The mean length of time on HDAT was 6 years. 7/11 patients had either tried or considered clozapine in the past. 8/11 patients had not had an ECG within the last year, 4/11 had not had yearly U&E. 8/11 had regular mental health reviews.

Conclusion. Compliance with the audit standards was found to be highly variable. This may reflect many factors, including the length of time since commencing HDAT and the complex shared care arrangements currently in place in Trafford. Thus, the following recommendations have been made:

To start a register of all patients prescribed HDAT.

To review local guidelines and documentation to ensure they are up to date and can be effectively implemented in routine clinical practice.

To ensure that the responsibility for conducting yearly physical health checks for patients prescribed HDAT is communicated to the relevant parties.

Patient factors associated with the use of psychotropic polypharmacy in patients under the care of a community mental health team in the West of Ireland

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Aims. Psychiatric polypharmacy refers to the prescription of two or more psychotropic medications to any one patient. This definition is purely quantitative and does not take into account whether such a prescription is detrimental, or unnecessary. In many cases, polypharmacy has been implemented in challenging illnesses, and some studies have shown that it can improve overall outcomes for certain patients. Evidence suggests that the prevalence of psychotropic polypharmacy is increasing, despite advances in psychosocial interventions. The aim of this study was to assess the current prevalence of polypharmacy among patients being treated by a community mental health team (CMHT), and the patient factors associated with its use.

Method. We performed a cross-sectional study of all patients registered with a CMHT in a mixed urban/rural area on a single date. Case records were examined to determine the most recently prescribed drug regimen for each patient. Clinical chart diagnoses were recorded and each one independently verified by the team consultant using ICD-10. A number of other sociodemographic variables were recorded. Using Microsoft Excel, we analysed the medications prescribed as well as rates and levels of polypharmacy based on multiple different patient characteristics.

Result. Of the 245 patients, the mean age was 56.3 and 51.2% (n = 126) were female. Psychotropic polypharmacy was seen in 62% (n = 152) of patients. 33% (n = 82) of patients were on two psychotropic medications, and of this subset, a combination of one antipsychotic and one antidepressant was the most common drug regimen, seen in 16.7% (n = 41) of all patients.

Polypharmacy was more prevalent in females, with 68% (n = 85) being on two or more psychotropics, in comparison to 58% of male patients. In relation to age, patients aged between 51 to 65 years had the highest prevalence of polypharmacy, at a rate of 71% (n = 49). Among all primary diagnoses, polypharmacy was most common in patients with affective disorders, with 80% (n = 40) of this patient cohort on two or more medications. Second to this was psychotic disorders, with polypharmacy seen in 65% (n = 62) of this group.

Conclusion. We found that psychotropic polypharmacy is highly prevalent in psychiatric patients being treated in a community setting. Certain demographics and patient factors, such as age, gender and psychiatric diagnosis influenced the rate of polypharmacy and certain drug combinations were more commonly prescribed than others.

Monitoring side-effects of antipsychotics using the glasgow antipsychotic side-effect scale

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Aims. Antipsychotic drugs frequently produce side-effects which represent common reasons for noncompliance. National guidelines, published by the National Institute of Care and Health Excellence, the Royal College of Psychiatrists, and the Maudsley Prescribing Guidelines in Psychiatry, stipulate that patients prescribed antipsychotic drugs should be reviewed for side-effects on a weekly basis. This completed audit cycle, conducted on a mixed acute general adult psychiatric ward, examined whether patients were being assessed for side-effects of antipsychotic drugs using a standardised, self-reporting scale – the Glasgow Antipsychotic Side-effect Scale (GASS) – as per national guidelines. As identification of side-effects is important in tailoring treatment to improve compliance, auditing monitoring practice was important in realising these outcomes.

Method. Retrospectively, 26 inpatients were identified over a two-month period who were prescribed antipsychotic drugs. Their notes were reviewed for documented weekly GASS scores for the duration of antipsychotic treatment. Initial data demonstrated 0% compliance with guidelines, as no patients completed a weekly GASS. The intervention to improve compliance was a training session for ward staff on implementing the GASS. Data were subsequently collected prospectively over three weeks for 15 patients.

Result. Seven patients completed the GASS weekly over three weeks, representing 47% compliance. Two patients (13%) completed two forms, three (20%) completed one form, and three (20%) completed no forms. There was a positive correlation between being offered the GASS and completing it – only one patient declined to complete it and was not offered it during the third week. Of the remaining 14 patients, if the GASS was offered there was 100% rate of completion. Staff did not offer the GASS to every patient each week, which accounted for most cases of non-completion. Some patients with pre-existing symptoms of physical illnesses included these on the GASS, which complicated interpretation. Future interventions could include further staff education, and involving a ward pharmacist to review results during medication reviews to optimise treatment compliance, as no medication changes resulted directly from patients completing the GASS.