

assess the success of these interventions in improving best medical practice.

**Results.** Of the 23 service users, 20 patients had their VTE risk assessment completed on admission and there was a delay of over a month with the remaining 3 patients. Of significance is that of all initial VTEs, 6 out of 23 contained inaccurate details, such as omission of comorbidities or a subjective assessment of mobility, indicating the need to use a standardized tool which allows for comparison across time. The mean admission duration for all 23 inpatients, as of February 2022 was calculated to be 16.2 months, with a range of 2 and 59 months. 15 patients did not have their VTE risk assessment repeated during admission, and of these 2 did have a change in their risk profile, indicating non-adherence with NICE guidelines.

**Conclusion.** This study has identified significant areas for improvement, specifically the need for clear timing for repeated VTE assessments, consistent sources of patient's medical history and documentation of mobility status. The project has highlighted the need for a more robust VTE assessment protocol which is currently being developed, to improve patient mortality and outcomes.

### Pre-Menstrual Dysphoric Disorder (PMDD) in Young People: What We Know About It, the Role of CBT as a Treatment Option, and the Development of High-Quality Psychoeducation Material for Clinical Use

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**Aims.** We aim to explain more about PMDD in young people and explore the evidence looking at the role of CBT as an intervention. We aim to develop high-quality psychoeducation material with the involvement of young people, to be able to offer clinically relevant information and empower young people with PMDD.

**Methods.** A literature search was conducted in 2019 and updated in February 2022 using the Cochrane Library, Psych-info, MEDLINE, Cinahl, EMBASE and Google Scholar, to look at the evidence available for CBT in young people with PMDD or PMS. The search included PMS as well as PMDD due to the heterogeneity in definitions used in studies.

Focus groups with young people are underway to develop high quality written psychoeducation material about PMDD.

**Results.** There were no specific studies looking at CBT as an intervention in young women under the age of 18 with PMS or PMDD. There was one intervention study with a treatment arm of psychoeducation in 62 young people under 18 with PMS versus a no treatment group (Taghizadeh 2013), with improvement in symptoms after 3 months from baseline reported.

There were more studies available in women over the age of 18. The search identified 3 meta- analyses in 2009 and 2012 (Busse 2009, Lusty, 2009; Kleinstauber 2012) and a more recent systematic review (Landolt 2020). Kleinsteiber et al included 22 RCTs, with a median age of 39, and broadly showed CBT to have a small to medium positive effect size, although any conclusions were limited due to the small numbers involved in the individual trials and methodological flaws. Landolt 2020 looked at CBT or elements of CBT as an intervention arm over the last 30 years or so in woman of all ages. Variations of CBT including virtual, group, couple and psychoeducation alone were included, and all were reported to have favourable outcomes.

**Conclusion.** There is a huge gap in research looking at PMDD in the adolescent population. Translating research from adults is not ideal. Increasing awareness and developing psychoeducation is a step in the right direction.

### An Evaluation of Admissions to an Old Age Psychiatry Ward: A Quality Improvement Project

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**Aims.** It has been well publicised the pressures on inpatient bed capacity within mental health services in recent years. The RCPsych have stated in their publication 'Exploring mental health inpatient capacity' that bed occupancy has risen above their recommended 85% occupancy target in most areas. Waiting lists for beds have also grown. The aim of this project was to identify whether there could have been any extra community resources in place that could have prevented admissions to hospital within an older adult CMHT. This in turn reducing the demand on inpatient beds.

**Methods.** Inclusion criteria: All patients from the older adult CMHT admitted to either an organic or functional mental health inpatient bed between the 1st September and 31st December 2021.

All patients who met the inclusion criteria were discussed as part of a panel consisting of members of the MDT who were involved in the patients' ongoing care. The panel discussed each patient and individually scored each admission on a scale of 1-5 (where 1 was deemed to be very avoidable and 5 completely unavoidable). Where an admission did not score a 5 we considered whether anything could have been in place to have prevented the admission.

**Results.** Our search identified 21 patients who had been admitted to the respective old age psychiatry ward during our period of interest. The predominant diagnosis of these patients was vascular dementia (n=5), followed by Alzheimer's disease (n=3). Following our consensus panel discussion, we identified that the most common reason for admission to hospital was for management of behavioural and psychological symptoms of dementia (n=10), followed by increasing patient vulnerability (n=4) in the community. Carer stress was a theme in 2 admissions. Following panel discussion regarding potential avoidability of admission, we identified that 14 out of the total of 21 admissions scored a 5, 1 scored 4, 1 scored 3, and 5 scored 2.

**Conclusion.** Behavioural and psychological symptoms of dementia continues to remain a significant clinical challenge and was the most common reason for admission in our patient cohort. The majority of admissions to hospital in our cohort were deemed unavoidable as a result. However, we identified that carer stress was a significant theme in 2 out of our 21 admissions, suggesting potential scope to implement services which may reduce carer stress and ultimately, prevent hospital admission.

### The HDAT Helper - Developing an Online Tool to Improve the Safety and Accuracy of Antipsychotic Prescribing

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**Aims.** High Dose Antipsychotic Therapy (HDAT) prescriptions and combinations of antipsychotic agents are not currently recommended as standard practice by the RCPsych. College guidance (RCPsych, CR 190) advises that there is “little convincing evidence that off-label prescription of doses of antipsychotic medication above the licensed dosage range has any therapeutic advantage in any clinical setting” and that “any prescription of high-dose antipsychotic medication should be seen as an explicit, time-limited individual trial with a distinct treatment target”. Despite this, both national and local data demonstrate that HDAT has continued to be used regularly across psychiatric inpatient settings, often out of hours and often secondary to the use of PRN Antipsychotics, without a clear treatment plan or rationale. My aim was to create a simple, accessible, online tool that would allow prescribers to quickly and efficiently calculate the BNF percentage of any antipsychotic prescription and that this will enable safer prescribing.

**Methods.** With the support of a web-developer, I developed an online tool quickly and easily calculate antipsychotic BNF percentages. The tool can be found here: [www.hdat.co.uk](http://www.hdat.co.uk)

**Results.** The HDAT Helper has been well received at local presentations and I have recently gained the support of senior management at Southern Health NHS Foundation Trust to develop an education programme on HDAT and the HDAT Helper to expand use of the tool across Southern Health.

**Conclusion.** The current expert guidance, clinical research and my own audit work demonstrates that there are ongoing issues with the prescription of high dose antipsychotics and that at times this occurs inadvertently when different agents are combined.

I believe that the HDAT Helper can make prescribing of antipsychotic agents clearer and more efficient and as a result significantly improve patient safety.

### Antipsychotic Cardiometabolic Monitoring: Systemic Gaps and Hidden Groups

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**Aims.** To determine whether there are any gaps in cardiometabolic monitoring within primary or secondary care for people prescribed antipsychotic medication. A well-established system of cardiometabolic monitoring and checks has been implemented for patients with psychosis and bipolar in secondary care. It was unclear whether patients without these diagnoses were receiving the same level of monitoring.

**Methods.** Data were collected retrospectively from case notes of service users under CMHRS Reigate. We included all patients from three GP practices (100 patients) and identified all who were prescribed antipsychotics and their diagnoses. The GP practices were contacted to determine whether a system was in place to flag physical health monitoring requirements for service users on antipsychotics regardless of diagnosis. The results were used to calculate the potential number of patients across the entire trust who were at risk of not receiving cardiometabolic monitoring.

**Results.** 24/100 patients were prescribed antipsychotics without a diagnosis of psychosis or bipolar. 11/24 had a diagnosis of Emotionally Unstable Personality Disorder. Quetiapine was the commonest antipsychotic. None received routine cardiometabolic monitoring.

The total caseload for all 11 adult community teams in the Trust is 2434. If prescribing and monitoring practices are similar 584 individuals may be affected.

2/3 GP practices responded. Both confirmed that they would only conduct cardiometabolic monitoring when taking over prescribing/on discharge from secondary care if specifically requested to do so.

**Conclusion.** This service improvement project has identified a significant group of patients who aren't automatically offered cardiometabolic monitoring in secondary care.

Private correspondence from Professor David Taylor confirms that these patients would also benefit from monitoring when prescribed doses that are more likely to cause adverse effects (Quetiapine > 150mg/Olanzapine >5 mg Risperidone >2mg)

Secondary services need to identify these patients and include them in routine cardiometabolic monitoring.

Secondary services need to work closely with primary care to ensure that responsibility for checks is agreed and handed over when necessary.

### Do We Know if You Drive? a Quality Improvement Project Improving Compliance With DVLA Guidelines

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**Aims.** Background: The Driving & Vehicle Licensing Agency (DVLA) states: “Doctors and other healthcare professionals should: advise individuals on the impact of their medical condition for safe driving ability and also advise the individual on their legal requirement to notify DVLA of any relevant condition”. Within mental health, the guidance states that depression or anxiety associated with “Significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts” must be reported to the DVLA. Aims: Identify whether information was collected on driving status of patients presenting with depression/anxiety and self harm. Identify whether accurate advice was provided and documented. Implement changes that would improve compliance with guidance.

**Methods.** We reviewed notes to collect baseline data for 3 weeks prior to commencing interventions, then weekly for 2 months from November 2021. Cases were defined as: those presenting to Liaison Psychiatry (LP) with an act of self-harm either on antidepressants or with a confirmed diagnosis of depression/anxiety on their record. Each week, the notes of 10 cases were reviewed for evidence of documentation of driving status and advice regarding DVLA guidelines.

#### Weekly Interventions.

Week 1: Email communication to team highlighting the guidance, responsibilities and where to document.

Week 2: Driving status discussed in handover daily to increase awareness and identify/address concerns.

Week 3: Repeat email to team.

Week 4: DVLA guidance posters placed in LP office.

Week 12: Teaching session by Occupational therapist from regional driving assessment centre.