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Aims. Many antipsychotics are known to adversely affect prolactin levels causing hyperprolactinemia. National Institute for Health and Care Excellence (NICE) guidelines have suggested monitoring of prolactin levels. It specifies that prolactin should be checked 6 months after starting treatment, then every 12 months; and to ask about symptoms of raised prolactin which include low libido, sexual dysfunction, menstrual abnormalities, gynaecomastia, and galactorrhoea. This also mentions that it is not required for aripiprazole, clozapine, quetiapine, or olanzapine (less than 20 mg daily). We intended to audit the monitoring of prolactin in a sample of inpatients who are on antipsychotic drugs and to check whether action was taken in the event of a high prolactin level.
Methods. All the adult inpatients of a general psychiatric hospital on a specific date (34, 16 (47.1%) female and 18 (52.9%) male patients), who were on antipsychotics were considered for the audit. We checked the antipsychotic drugs, prolactin assessment within one year and level, action taken if there was hyperprolactinemia. The data was collected from electronic patient records and medication charts.
Results. The mean age of the sample was 39.1 ± 14.2 years (range 18–63). Most inpatients (91.2%, 31/34) were on antipsychotics and 25.8% (8/31) were on two antipsychotic drugs. Prolactin was measured in 80.6% (25/31) patients in the last year, with 48% (12/25) having hyperprolactinemia; and amongst these action was taken in 5 (41.7%). Hyperprolactinemia was present in 58.3% of female and 38.5% of male patients. Specifically, out of 31 patients, 14 (45.2%) were on antipsychotic drugs that need monitoring, and 9 (74.3%) of them had taken it for at least one year. Out of these 9 patients, prolactin was measured in 8 (88.9%) patients in the last year, it was elevated in 5 (55.6%), action was taken in 3 (60%) and action was not clear in 2 (40%) patients.
Conclusion. Almost half of the patients on antipsychotic drugs had hyperprolactinemia, highlighting the need to monitor prolactin levels. Along with this, symptoms of hyperprolactinemia should be consistently checked in routine clinical evaluations. Clinician and patient education regarding hyperprolactinemia and its symptoms might improve its monitoring.

Food for Thought: Evaluating Dietary Documentation in Psychiatric Settings

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Aims. This study aims to evaluate dietary history documentation by junior doctors in a psychiatric hospital setting in Scotland. With emerging evidence in nutrition psychiatry highlighting diet's impact on mental health, especially ultra-processed foods, this aspect often receives insufficient attention in clinical assessments. The audit benchmarks current documentation against UK Public Health nutritional guidelines and UK Parenteral & Enteral Nutrition Guidelines on Malnutrition, assessing adequacy and consistency across psychiatric diagnoses.
Methods. This audit conducted a systematic review of medical records in psychiatric wards, focusing on patients newly admitted over six months. The data collection examined admission sheets by junior doctors, covering patient identifiers, admission time, diagnosis, doctor's grade, and comprehensive details on dietary habits, eating behaviours, BMI, and substance use. The review incorporated a dietitian's input to align dietary assessments with UK Public Health Nutritional expectations and the prevention of Malnutrition Guidelines. The goal was to assess the regularity, quantity, variety, and documented changes in patients' dietary behaviours, screening for potential nutrient deficits, impacts of psychotropic medications, and eating disorder psychopathology.
Results. The results showed significant deficiency in the detail and consistency of dietary history documentation across all wards, regardless of the doctors' grade or the patients' psychiatric diagnoses. Most entries were inadequately documented or entirely missing. A particular discrepancy was noted in documenting dietary habits in patients with low BMI or those on metabolic altering antipsychotics, which should necessitate health behavior change dietary interventions. Furthermore, even in severe psychiatric conditions, there was a gap in dietary documentation indicating a widespread oversight in recognising the potential relevance of nutrition in the overall health and treatment planning of psychiatric patients, regardless of the severity or type of their condition.
Conclusion. The audit reveals a gap in psychiatric patient care concerning detailed dietary relevance history documentation. While Scotland's wards routinely use the Malnutrition Universal Screening Tool (MUST) for identifying malnutrition, this tool often overlooks key dietary elements like variety, quantity, and regularity, which are vital for linking diet content to mental health. This oversight is significant given the burgeoning field of nutritional psychiatry. Our findings suggest the necessity for systemic changes to improve dietary history documentation in psychiatric settings. This includes a more structured and systematic approach, integrating insights into the harmful effects of ultra-processed foods on mental health, to provide holistic care.

Audit of Non-Pharmacological and Rapid Tranquilisation Practices in Managing Distress Among Older Adults: A Comparative Study in Inverness Hospitals

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Aims. This audit evaluates the adherence of nursing and medical staff to local protocols for managing distress in older adults (aged >65 years) using non-pharmacological approaches and rapid tranquilisation (RT) in a psychiatric hospital's dementia ward, an acute medical unit, and a geriatric ward in a general hospital.

We hypothesize that operational differences between these wards significantly influence the management of older adult patients.
Methods. Conducted from September 17 to October 8, 2022, in hospitals in Inverness, Scotland, this study reviewed 322 case notes and drug charts from patients who underwent RT in three wards: the Old Age Psychiatric Ward, Acute Medical Unit (AMU), and Geriatric Ward. Focus groups and informal discussions with ward nurses and junior doctors were organized to understand their perspectives on handling distress in dementia patients, with an emphasis on de-escalation techniques.

Data focused on key parameters:

- Patient Diagnosis and Legal Status.
- Administration Details: including initiation time, de-escalation techniques, consultation with senior doctors, and details of drugs administered (route, drug, and dosage).

Results. Staff nurses in all wards prioritized non-pharmacological de-escalation techniques, such as recognizing early signs of agitation, employing distraction and calming tactics, and acknowledging the importance of personal space, even in the face of staffing challenges and high patient loads. These measures were consistently employed prior to considering RT, adhering to the local protocol. Physical restraint was employed only in scenarios where there was a risk to the patient or others, executed by personnel trained in managing violence and aggression.

Conversations with junior doctors, particularly in the AMU, revealed a limited understanding of the RT protocol, suggesting a need for enhanced training and awareness. Overall, the study indicates that while RT is regarded as a last resort after the failure of psychological and behavioral approaches, there is a clear necessity for further education and training to ensure the safe and effective administration of RT.
Conclusion. This audit demonstrates that despite the varying environments and pressures in the three wards, adherence to the local protocol for managing distress in older adults is largely effective, with a strong preference for non-pharmacological methods. The findings highlight the need for ongoing education and reinforcement of RT protocols, particularly among junior doctors, to ensure patient safety and adherence to best practices. The results suggest that with proper support and training, the use of RT can be a carefully controlled and beneficial tool in managing distress in older adult patients.

Use of Antipsychotics in Emotionally Unstable Personality Disorder

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Aims. Emotionally unstable personality disorder (EUPD) is characterized by affective instability, unstable interpersonal relationships, poor self-image and marked impulsivity. Patients may present with a variety of symptoms including impulsivity, suicidal behavior, affective instability and intense anger. This makes the treatment very patient specific.

Treatment guidelines support the use of Dialectical Behavior Therapy (DBT) as the first line treatment of EUPD. Currently, no medications are indicated for the treatment of EUPD which leads to off label use of medicines by clinicians.

More than 90% of individuals receive a variety of pharmacologic treatment with psychotropic medications, especially second-generation antipsychotic drugs for the treatment of cognitive perceptual symptoms and impulse control behavior. Additional psychotropics are usually added leading to psychotropic polypharmacy which should be avoided.

Aim of this study is to assess the frequency of prescription of antipsychotic medications in patients with a primary diagnosis of emotionally unstable personality disorder.
Methods. Protocol was registered with the Audit and Quality Improvement project team of the NHS trust and the audit registration certificate was obtained.

Case records of 42 patients with EUPD who attended psychiatric outpatient department from June to August 2023 were collected and screened. A retrospective study was carried out.

Inclusion criteria
Patients above 18 years of age, with a primary diagnosis of emotionally unstable personality disorder.

Exclusion criteria
Patients with comorbid diseases like Attention Deficit Hyperactivity Disorder, Bipolar Affective Disorder and Psychosis where use of antipsychotics is warranted.

All other personality disorders.

After screening 42 case records, 20 cases of EUPD which fulfilled the inclusion and exclusion criteria were found and analyzed. Descriptive statistics were used.
Results. Retrospective data of 20 patients with a primary diagnosis of EUPD were analyzed which included 18 females and 2 males. The mean age of the participants was 27.1.

70% (14) of the patients diagnosed with EUPD were treated with antipsychotics. 20% (4) patients received antidepressants. 10% (2) of the patients received only DBT.

Quetiapine was the most commonly used antipsychotic – 43% (6) followed by Olanzapine – 22% (3), Risperidone – 21% (3) and Zuclopenthixol long-acting injection – 14% (2).
Conclusion. Dialectical behavior therapy is the first line treatment of EUPD. National Institute for Health and Care Excellence (NICE) guidelines do not recommend the use of antipsychotics in the treatment of EUPD. Contrary to the guidelines, antipsychotics are prescribed long term for patients with EUPD who are without any comorbid conditions. This audit has found that 70% of patients with a primary diagnosis of EUPD are being prescribed antipsychotic medication. This needs to be kept in check so that polypharmacy can be avoided.

Prescribing for People With a Personality Disorder

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Aims. The primary aim was to identify areas where there may be a significant gap in following the NICE recommendations.

To compare how antipsychotic and benzodiazepine prescribing practice in Community mental health team, measures against