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 bedstate 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) prescibing 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