

- BMI
 - HR (Pulse rate)
 - Sitting/Standing BP and
 - Temperature
2. Relevant Blood tests and recent ECGs on a schedule based on patient's BMI or as needed based on clinical indication.

24 patients were identified from April 2021 to December 2022. 7 patients were deemed inappropriate due to scant documentation. Of the remaining 17, 9 patients were randomly selected. 9 patients' documentation were looked at all contacts with AEDS. The monitoring was audited at 3 single point of contact over the course of their first clinic appointment after April 2021, the middle and latest/last monitoring.

Results.

1. At the first clinic after April 2021 the compliance was 100% for all parameters except for the monitoring of BMI and Temperature which was 88.9%.
2. At the mid-point there was 100% compliance with BMI, weight, blood pressure and pulse monitoring, there was a drop in temperature monitoring to 77.8%.
3. In the last clinic monitoring for pulse and temperature dropped to 88.9% and 77.8% respectively, all other parameters showed 100% compliance.
4. The frequency of monitoring ECG and blood tests in the subsequent clinics gradually dropped from 100% to 66.7% and 88.9%.

Conclusion. Reasons for decreased monitoring in Bloods and ECG.

1. Documentation was missing.
2. Investigations were delayed from the patient's side.
3. Due to COVID-19 there was difficulty accessing the primary care appointments for investigations.
4. The temperature equipment was not working properly.

Recommendations.

1. Keeping a fixed format for documenting PHMC. New format for documentation introduced.
2. Document all the parameters checked in the patients' electronic records on the same day.
3. PHMC clinical team to upskill on ECG via training.
4. Introduce weekly ECG alongside phlebotomy clinics.
5. SUSS test to be done for all RED (High risk) patients and should be clearly documented in the notes.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

A Clinical Audit on Adult ADHD From Community Mental Health Teams: Experience From the East of North Wales

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Aims. The Royal College of Psychiatrists (RCPsych) has formulated "Attention Deficit-Hyperactive Disorder (ADHD) in Adults: Good Practice Guidelines" to provide evidence-based

guidance for clinicians, acknowledging there is an increasing burden on the services with the assessment and management of adult ADHD in the United Kingdom. As there is no trust-wide policy in North Wales and some practitioners perceive that it is challenging to perform an extensive assessment for ADHD in the adult secondary mental health services, there is a need to study the pre-referral workup and diagnostic approach for patients referred to the adult mental health services. This clinical audit is aimed at understanding the guideline adherence level of the assessment and management of adult ADHD by both primary and secondary mental health services in Betsi Cadwaladr University Health Board.

Methods. Convenient sampling was performed on 50 patients from three community mental health teams (CMHT) from East of North Wales for patients with a confirmed diagnosis of adult ADHD. The source of information included referrals from the primary care (including general practitioners and primary mental health service) and medical records from the secondary mental health care. Relevant clinical information was collected and coded as "present", "absent", or "unclear". The data were compared to the standard derived from "ADHD in adults: Good practice guidelines".

Results. Only 34% of the referrals documented the use of Adult ADHD Self-Report Scale, 18% documented the use of Autism Spectrum Quotient (AQ-10), and none documented the use of Weiss Functional Impairment Rating Scale (W-FIRS).

Only 46% of patients was diagnosed using a standardised instrument after more than one session of diagnostic assessment. The percentage of documentation of baseline blood pressure, pulse rate, weight, and height were 58%, 70%, 50%, and 44% respectively.

Most documentations fell below 50%, including comorbid and family history of physical health conditions, history of neurodevelopmental issues, and corroborative history. All teams performed well with the documentation of functional impairment, comorbid anxiety disorder, depressive disorder, and substance use disorder, i.e., >90% of patients.

Conclusion. This audit reflects the need for quality improvement in documentation in both primary and secondary care settings although the solution should not add to the existing burden of practitioners. Convenient sampling from East of North Wales limits the generalisability of findings. Also, the absence of data may be contributed by logistic issues around paper-based medical records, i.e., illegible handwriting and inability to locate the documentation.

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Physical Health Assessment and Monitoring for Adults Receiving Pharmacological Treatment for ADHD in an Adult CMHT: Clinical Audit

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Aims. ADHD diagnoses have skyrocketed in the recent times resulting in a lot of the patients being on stimulant medications. NICE guidelines recommends a baseline review of physical health which should include height, weight, baseline pulse and blood pressure and a cardiovascular assessment before starting these medications. It also recommends 6 monthly monitoring of weight, blood pressure and pulse. We aimed to assess the current

practice of baseline and 6 monthly physical health monitoring against the standards set by NICE guidelines.

Methods. 33 random case notes were identified from the adult CMHT who had a diagnosis of ADHD and were receiving stimulant medications. An audit pro-forma was designed to collect data on baseline blood pressure, pulse, weight, cardiovascular assessment before commencing treatment and 6 monthly monitoring of Blood pressure, Pulse and weight. The data were collected over a period of 3 months between October 2022 and December 2022. The results were presented in the local CMHT meeting and a new proforma was designed for baseline and follow-up physical health assessment which will be incorporated in the case notes. A re-audit is planned in March 2023.

Results. There were 16 females and 17 males in the identified cases. 19 patients were on different Methylphenidate formulations, 8 patients were on Lisdexamfetamine and 6 were on Atomoxetine. 19 patients (57%) had documentation of baseline blood pressure, 13 patients (39%) had documentation of baseline pulse, 17 patients (51%) had documentation baseline weight and 2 patients (6%) had documented baseline cardiovascular assessment in the case notes. 10 out of 33 patients had 6 month follow-up visits and monitoring data were collected from them. None of the patients (0%) had documentation of blood pressure, pulse or weight in the case notes.

Conclusion. The adherence to NICE guidelines was low in physical health monitoring as hypothesized by the team. A new proforma for baseline and 6 monthly physical health monitoring is developed by the audit team which is aimed to increase awareness about the physical health monitoring amongst the clinicians. The need for improving this practice is crucial due to increasing number of patients on these medications and the risk of serious side effects.

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Anaesthetic to ECT Time Interval (AETI): Is the Time Interval Between Administration of Propofol to the Time of Delivery of Stimulus in Electroconvulsive Therapy (ECT) Being Documented and Within the Limits Set by a New Departmental guideline

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Aims. To establish if new departmental guidelines regarding Anaesthetic to ECT Time Interval (AETI) documentation were being followed. The guideline states that the average time from end of Propofol administration to the time of stimulus delivery should be at least 120 seconds. AETI should be recorded at all ECT sessions including the initial titration sessions when the seizure threshold is being established. The aim of the guidance is to reduce the impact of the Propofol use on seizure threshold and quality. By improving seizure quality, the stimulus dose required to elicit an adequate seizure can be kept to a minimum which is associated with a lower risk of cognitive side effects during ECT. **Methods.** Review of electronic RiO notes and ECT prescription documentation for patients who received ECT treatment using Propofol as the induction agent at Hopewood Park ECT Department over a 4 week period in August 2022. Analysis of data collected and presentation to department.

Results. 6 patients met inclusion criteria, age range 35-78. The indication for ECT was severe depressive illness (4) or catatonia (2). In total there were 30 ECT treatment sessions included, of those, 23 (76%) had AETI times documented. There was no clear correlation between sessions for patients who did not have an AETI time recorded and those who did. Two were documented as unsuccessful seizures and needed further dose titration. The others happened to be the first treatment dose of ECT given following titration session. The treatments where AETI time was recorded were all equal to or more than 120s (mean AETI was 151.7s). Therefore, 100% of the AETI times that were recorded did meet this standard.

Conclusion. 76% of patient treatments had AETI recorded and of those recorded 100% met the standard of being >120s. To improve documentation, a prompt box is to be added to the ECT documentation sheet. The AETI guidelines are to be uploaded to the Trust Intranet Page and displayed in the ECT department. The guideline is planned to be rolled out across the other two ECT departments in the Trust in the coming months. Further work is planned to gather data pre- and post- Trust wide roll out to observe any trends in dose escalation or other clinical factors.

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Assessing Whether Physical Health Forms Are Completed for Every New Admission on a Mental Health Ward

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Aims. The audit assessed whether physical health forms, which are separate from admission clerking notes, were being completed for new admissions on the ward. A physical exam has to be carried out for every new admission and the findings recorded on the form within 24 hours of the admission. After the first audit cycle, recommendations were to be made and interventions carried out. A re-audit was completed to assess the compliance.

Methods. The records of all patients admitted onto a ward at a mental health unit on the 1st of October 2022 were reviewed to determine whether the admitting doctors had completed the physical health form or not. This was recorded on an excel sheet as complete, recorded on clerking but form not complete, or patient was not seen. After data extraction, junior doctors were reminded about the form personally and a poster was made informing junior doctors about the form which was placed in the junior doctor's room. A re-audit was carried out four months later.

Results. The audit showed that the forms for 75% of patients were not completed by the duty doctor on admission. Out of the forms that were not completed, one patient was not clerked in on time and one patient did not want to see the doctor and refused examination. Therefore, 65% of patients were examined and examination recorded on admission clerking, but the form was not completed. On the second cycle, 35% of the forms were not completed with one patient refusing examination, thus, 30% of the forms were not completed despite examination being carried out.

Conclusion. The recommendations and interventions proved to be successful as the compliance in completed forms increased.