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doi: 10.1192/bjo.2023.417

Aims. To investigate compliance with British Society of Haematology (BSH) guidelines and NICE clinical summarieson diagnosis and treatment of folate and cobalamin deficiencies in CAMHS Transition service, Oldham.
Methods. The standards used were based on BSH guidelines and Nice clinical summaries, with targets for all 100%:

1. Haemoglobin concentration and mean corpuscular volume (MCV) checked at the same time as assay for serum cobalamin and folate.
2. Cobalamin and folate assays should be assessed concurrently due to the close relationship in metabolism.
3. Treatment of established cobalamin deficiency should follow the schedules in the BNF.
4. All patients with anaemia, neuropathy or glossitis, and suspected of having pernicious anaemia, should be tested for anti-IFAB regardless of cobalamin levels.
5. Patients found to have a low serum cobalamin level in the absence of anaemia and who do not have food malabsorption or other causes of deficiency, should be tested for IFAB to clarify whether they have an early/latent presentation of pernicious anaemia.
6. Treatment of folate disorders should follow the schedule in the BNF.
7. We reviewed all open cases to Transition service in Oldham. Their NHS number was checked through the pathology laboratory portal. In addition, notes on Paris electronic system and digital letters were checked to see if results were acknowledged. The initial audit period run from February 2021 to April 2021.The results were shared with the Multidisciplinary Team and an algorithm was created and shared in an attempt to improve the practice. The re-audit run from May 2022 to July 2022. A total of 80 patients were included in the audit and 25 patients in the re-audit. We entered and analysed our data using Microsoft excel.

Results. Compliance levels for the standards for the audit were as following: standard number 1, 2 and 5 were 100%, number 3 and 6 were 0%, and number 4 was not applicable.

Compliance levels for all the standards were 100% for the re-audit.
Conclusion. The results of the initial audit indicate that not all standards were met. However, results of the re-audit indicate all standards were met. It appears implemented changes may have affected the outcome of results. However, as the sample of patient was small might need to repeat this audit cycle in the future to see if the results remain the same.

The physical health protocols are relevant to psychiatric practice and the algorithm can be disseminated for further use.

An Audit to Assess the First Patient Follow-Up After Initiation of SSRIs in Primary Care

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doi: 10.1192/bjo.2023.418

Aims. NICE guidelines recommend that patients started on antidepressants aged 18–25 years are reviewed 1 week after initiating treatment to check response. All other patients should be reviewed within 2 weeks. The audit aimed to evaluate if these guidelines are being met in Primary Care now that most mental health appointments have changed from face to face to telephone consultations post COVID-19.
Methods. Notes of 60 patients that had been started on an SSRI across the period of January 2022 – December 2022 at a North West based Primary Care practice were analysed. Time from initial consultation to medication review with a general practitioner (GP) and/or contact with a Mental Health Practitioner (MHP) within the practice were recorded. Consultation notes from MHPs were analysed for reference to tolerability of medication to assess if the patient's new treatment was discussed as part of support appointments.
Results. Median time for initial follow-up of patients aged 18–25 years was 3 weeks demonstrating 8% compliance with NICE guidelines. Median time for initial follow-up for those >25 was 4 weeks, demonstrating 19% compliance with NICE guidelines. Of those that did not receive a follow-up with a GP within the suggested time frame, 20% met with a MHP for support with their condition and had side effects of new medication referenced in the notes. Within 4 weeks, 58% of patients had an appointment with a MHP where medication was mentioned. Median follow-up for anxiety disorders was 4.5 weeks compared to disorders of depression at 4 weeks. Patients new to the SSRI were followed up at a median of 3 weeks compared to 4 weeks for those that had completed a course previously.
Conclusion. Current follow-up of patients at the practice is not compliant with NICE guidelines. A practice meeting will be held to identify improvements to the patient follow-up process and look at the barriers patients face when arranging follow-up appointments. More than half of audited patients met with a MHP for support within 4 weeks of SSRI initiation. This highlights an opportunity to assess patients that are already meeting with practice staff when GPs have been unable to review them within the time frame. A pro-forma will be developed for MHP to utilise to specifically ask about medication. A repeat audit of both GP and MHP appointments will be completed in 6 months.

Audit of Prescribing Practices & Medication Monitoring on Learning Disability Female Low Secure Unit

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doi: 10.1192/bjo.2023.419

Aims. To ensure psychotropic medication is being prescribed and monitored as per Trust and national guidelines.
Methods. The audit included all patients admitted to the low secure female forensic unit at the time of data collection, giving a total of seven patients. Data were collected from medication charts, psychiatric report and clinical notes. The data collection tool looked at Mental Health Act (MHA) status, diagnoses, current psychotropic and physical health medication, documented indications, consent to treatment forms, completed capacity assessment forms, last medication review and recent physical health monitoring. For

patients prescribed Clozapine, frequency of blood testing was checked. For patients prescribed Sodium Valproate, completion of annual risk acknowledgement forms was checked.

Results. The following audit standards were met with 100% compliance: "For patients on regular psychotropic medication, there should be clear indications for this on the drug chart." "All patients on combined antipsychotic therapy or High Dose Antipsychotic Therapy should have a care plan in place." "For patients detained under the MHA, appropriate Consent to Treatment forms should be present and up to date." "All patients should have a documented annual health check within the last 12 months." "All patients prescribed psychotropics should have psychotropic blood monitoring within last 12 months."

The compliance for the standard "For patients detained under the MHA, appropriate capacity assessment documented on MHA 58 Assessment of Capacity for Treatment form should be present and uploaded to Carenotes" was 71%.

The compliance for the standard "All female patients of childbearing age prescribed Valproate should have an annual Risk Acknowledgment form completed" was 0%.

Conclusion. There was a good standard of documentation of medication and indications on drug charts. Consent to Treatment forms were up to date for all patients. Semi-sodium Valproate and antipsychotic medication used out of license was within Trust guidance. Sodium Valproate was used off license in three patients. Monthly FBC blood monitoring occurred for patients on Clozapine, with the most recent Clozapine level within the last 12 months. Physical health checks and investigations were carried out annually for all patients. However, it was difficult to locate all results. Areas for improvement included: All investigation reports should be uploaded in the same folders with easily identifiable file names for ease of access. All patients on Valproate should have a completed annual risk acknowledgement form. The audit recommendation was to put in place care plans for all patients prescribed Valproate therapy, including review dates for risk acknowledgement forms.

Risk Factors Related to Driving: A Review of Clinical Practice Evaluating and Addressing Fitness to Drive Among Psychiatric Inpatients

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doi: 10.1192/bjo.2023.420

Aims. Mental illness is linked with a higher risk of dangerous driving; e.g. patients with neurotic disorders have 50% more accidents than controls and 10% of drivers involved in accidents have reported feeling suicidal. The Driver and Vehicle Licensing Agency (DVLA) have provided guidance related to fitness to drive for those with mental illness. In this context we intended to study the risk factors associated with psychiatric inpatients related to driving and whether concerns have been documented in clinical reviews.

Methods. Case notes of 100 randomly selected psychiatric inpatients in one calendar month were evaluated including: their driving status; concerns regarding driving based on their clinical status (Diagnosis, Medications, Side effects); any clinical advice given and communication with DVLA in the previous one year, were ascertained from electronic records. Missing values were not included in calculation.

Results. The sample consisted of 51 female and 49 male patients (mean age 39.7±13.5 and 39.1±12.7 respectively), with the majority 69% from Caucasian ethnicity; 64% were informal. There was no difference noted in driving status based on ethnicity or legal status on admission.

On admission 33% of patients reported that they were not driving, 12% were driving, 2% refused to answer and in more than half (53%) driving status was not documented. Considering some of the risk factors for driving, persistent alcohol use was noted in 39.8%, drug use in 34.4%, personality disorder 37%, attention deficit hyperactivity disorder or autistic spectrum disorder in 4%, being on medications with side effects that may impair driving 80.8%, having side effects that impair driving 10%, and suicidality 54.5%. Only in a minority of cases were fitness to drive related issues discussed in their last review (3%), in progress notes (1%), or in discharge notes (2%). There was no documentation related to communication with the DVLA for any patients.

Conclusion. The results suggest there is a need to record the driving status of psychiatric inpatients and to discuss driving related concerns when considering mental state, medications and side effects. Information related to driving should be given to patients, and DVLA should be notified as appropriate. This might help in improving safety related to driving by psychiatric patients.

Physical Health Monitoring of Community Patients Under the Care of Adult Eating Disorder Service at Surrey and Borders Partnership NHS Foundation Trust

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doi: 10.1192/bjo.2023.421

Aims.

1. To determine if the physical health monitoring of patients in the Eating disorder service is done in line with the recommendations of the National Institute of Clinical Excellence (NICE) guidelines and relevant MEED Guidance on Recognition and Management.
2. To determine if the current local AEDS (Adult eating disorder services) guideline for physical health monitoring of Community patients, including blood tests and ECG is adequate for community patient cohort.

Methods.

1. For every attendance of patients to the Outpatient Physical health monitoring Clinic (PHMC), it is expected that the physical health monitoring to be offered would include:
   - Weight
   - Height (if first attendance)

https://doi.org/10.1192/bjo.2023.419 Published online by Cambridge University Press