use in low doses is increasing, possibly due to its sedative qualities, tolerability, low risk of extrapyramidal symptoms and to limit the unnecessary use of benzodiazepines. However, previous research highlights the risk of metabolic consequences even in low doses. Our aim is to establish the prescribing patterns and off-label use of quetiapine within a complete comminity mental health team population (CMHT).

Method. The GR1 CMHT provides care to a population of 25,000 people in a mixed urban and rural area. Multi-disciplinary case notes for all registered patients were reviewed for a one-year period. A database was created to include sociodemographic details, diagnosis, and medication. The proportion of patients prescribed quetiapine was identified and the dosage divided into multiple increments. The team's consultant reviewed and verified all ICD-10 diagnoses. Quetiapine dose by diagnosis was examined using descriptive statistics.

Result. Of 246 registered patients, 62 (25% of CMHT caseload) were prescribed Quetiapine. Quetiapine was prescribed across a range of disorders including psychotic 17 (27%), mood 18 (29%), anxiety 14 (22 %), personality disorders 11 (18%) and others 2 (3%). Doses spanned between 25 mg – 800 mg daily. 19 patients (31%) were prescribed less than 25 mg, 20 patients (32%) between 25 mg and 100 mg and 23 patients (37%) above 100 mg. In psychotic and mood disorders, dosage varied widely between the low and high range. Furthermore, of the psychotic disorders, 11 (65%) were prescribed a second antipsychotic medication. For diagnoses in which the prescribing indication was clearly off-label, the dosages were predominantly low (100 mg or less).

Conclusion. Quetiapine was commonly prescribed in our patient population. Its frequent off-label use in low doses suggests that its prescription was for its additional qualities. Our findings highlight the importance of assessing the risk-benefit profile for every patient given the potential side effects, involving patients in the consultation of its off-label use and appropriate monitoring.

Audit of compliance with WHO surgical safety checklist (modified for electroconvulsive therapy including NPSA advice)

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doi: 10.1192/bjo.2021.213

Aims. This audit aims to evaluate the compliance with the WHO surgical safety checklist during the electroconvulsive therapy treatment in ECT clinic at Greater Manchester Mental Health Bolton Directorate. The audit is based on WHO surgical safety checklist modified for ECT including National Patient Safety Agency advice. The goal is to improve the compliance and in turn improve clinical outcomes.

Background. The WHO surgical safety checklist (modified for Electroconvulsive therapy including NPSA advice) is devised to promote patient safety, improve teamwork, reduce errors/adverse events and improve overall quality of care. An audit was completed regarding the compliance with the safety checklist at the Bolton ECT clinic and to assess how this could be improved.

Method. Following approval from the clinical audit department, GMMH NHS Foundation Trust, 20 checklists from randomly selected patient ECT files were included in this audit. We looked at whether the checklists were completed, signed and dated. Our current WHO surgical safety checklist is as per the Electroconvulsive therapy accreditation service standards.

Result. A total of 20 WHO surgical safety checklists were reviewed. 95% of the checklists (19/20) were completed by the duty Psychiatrist. 1 form was not completed. 25% (5/20) were not signed rendering them invalid. A total of 75% checklists were complete and valid. Checklists were present in all the case notes.

Conclusion. Compliance with the WHO surgical safety checklist during the electroconvulsive therapy treatment can be challenging due to various reasons ranging from time pressure to difficult clinical situation. This audit has highlighted that the overall compliance with the set standards (100% completion) was not achieved. A repeat audit will be important to further improve the compliance and overall clinical outcome.

An audit addressing the quality of prescribing sodium valproate in early intervention service

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doi: 10.1192/bjo.2021.214

Aims. This Audit aims to review prescribing practice concerning Valproate in early intervention services.

Method. The audit was undertaken across four EI hubs in Birmingham. Audit standards were derived from POMH-UK (Prescribing Observatory for Mental Health) QIP. Drug cards of the entire EIS caseload in November 2020 were reviewed to identify patients on any preparation of Valproate. A total of 31 patients were identified. Electronic notes of all the patients on Valproate were reviewed to compare prescribing practices against national standards.

Result. A total of 31 patients were prescribed sodium Valproate. All these patients had target symptoms documented in their notes. Reason for starting Valproate was mostly documented as agitation and aggression rather than elation in the mood. In was unclear if patients had full physical health checked before starting Valprotae as in majority (94%) valproate was commenced as an inpatient. Not all cases had detailed inpatient discharge notes making it difficult to fully understand the rationale for starting Valproate.

55% of the patients were on an off-license valproate preparation. Where used off-license majority (93%)of these patients had no documentation of the rationale behind off-license use. Similarly, in most cases (93%)there was no evidence of off-license use being discussed with the patients. Most patients had received adequate monitoring in the community (74%) although there was limited documentation of screening for common side effects. Prescribers were noted to be using Semi-sodium Valproate and Sodium Valproate interchangeably despite these not being bioequivalent.

Conclusion. We recommend that

1. Periodic treatment reviews should document the assessment of response and screening for side effects.
2. Where used clinician should clearly discuss and document the off-license use with patients. 500 mg Semi-sodium valproate (Depakote) is approximately equivalent to 433 mg Sodium Valproate (Epilim). If switching from Semi-sodium Valproate to Sodium Valproate, a slightly higher (approximately 10%) dose of Sodium Valproate should be used.
3. Unless clear evidence of affective illness is identified, the ongoing need for Valproate should be regularly reviewed by the clinicians.