Interventions focusing on behavioural change in the mental health unit did achieve behavioural change but failed to solve issues with handover between departments.

It is worth noting that there was significant delay in some transfers out of mental health being escalated, considering the reduced facilities in mental health wards versus acute wards.

Conclusion. Transfer handover between Psychiatry and Acute Wards is a multi-system issue and as such will require a multi-system approach to achieve meaningful change. New local guidance for handover between mental health and acute wards is being drafted in response to the findings of this audit.

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Audit on Monitoring of National Early Warning Scores 2 (NEWS2) in Old Age Patients

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doi: 10.1192/bjo.2024.586

Aims. NEWS 2 is integral to post-admission physical health monitoring, guiding baseline establishment and observation frequency decisions. MDT discussions, involving medics or nurses per guidelines, ensure tailored care. Trust Standard Operating Procedure (SOP) and Physical Health policy, provides detailed procedures for assessment, recording, and actions. Adhering to NEWS 2 and SOP 1.62a, aligned with Trust standards, facilitates prompt escalation in case of patient deterioration, reinforcing our commitment to superior healthcare.

AIM

- To evaluate if NEWS2 monitoring is done as per set Trust standards/guidelines.
- To identify areas of improvement in the use of this observational tool.
- To improve the services and care of patients.

Methods. We conducted a comprehensive review of each section of NEWS 2 charts for 39 patients admitted to Ward 6 and 7 at Harplands Hospital over a 3-week period. Patient stays varied from 21 to 67 days. No pregnancies were noted; all patients were aged between 59–96, with a near equal gender distribution. Utilizing SPSS, we conducted data analysis, comparing results against Trust-set standards.

Results. Of the 39 charts, 37 were completed at admission, with notable issues: 9 lacked demographics, 13 had date/time missing. Weekly NEWS was predominant, but challenges included 6 missing signatures, 9 illegible entries, and 12 incomplete sections (4 without connecting observations). GCS completion issues were identified in two charts if CPVS score was more than 3. Escalation patterns varied: scores 1–4 were often routed to a Registered Nurse before medics, while scores >4 were mainly escalated directly to medics. Most charts were uploaded to electronic records, yet the electronic versions were frequently left unfilled.

Conclusion. In conclusion, the implementation of NEWS charts at admission, consistent chart uploads to Lorenzo, and effective escalation practices underscore a commitment to patient monitoring. The detailed procedures, including demographics completion, trend identification, and weekly reviews, contribute to a comprehensive approach. The incorporation of printed patient information labels and targeted education sessions for ward teams further reinforces the emphasis on standardized and meticulous documentation practices, enhancing overall patient care and safety. Discussions with ward management will further support the ongoing success of these initiatives.

Above recommendation has been completed and Re-Audit in planned few months.

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Is ADHD Medication Monitoring Being Completed in CAMHS?

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doi: 10.1192/bjo.2024.587

Aims.

- To determine the demographics of the patients prescribed medications for ADHD under the CAMHS teams within Southern Trust (NI).
- To assess whether the physical health monitoring guidelines (as outlined by NICE – nice.org.uk/guidance/ng87) have been followed.
- If monitoring is not up to date, to determine why not.

Methods. We reviewed records from clinical notes and NIECR (Northern Ireland Electronic Care Record) to collect demographic details.

Following NICE guidelines, we used the clinical notes to determine which patients had physical health monitoring up to date, including heart rate (HR), blood pressure (BP), weight and height.

For any patient with monitoring not up to date, we reviewed the notes or contacted the practitioners to determine why this was the case.

Results. 96 patients were found to be prescribed ADHD medications. Full demographic details were obtained and collated for these patients, including age, sex, diagnosis, co-morbidities, and medication information (e.g. preparation, dose, polypharmacy).

Of the 96 patients, 1 was excluded as their monitoring was carried out by paediatrics.

71 out of the remaining 95 had their monitoring up to date, leaving 24 patients with monitoring not up to date. Of these 24:

- 8 were due to non-attendance
- 4 were due to equipment issues (e.g. faulty/unavailable)
- 3 only had partially completed monitoring (e.g. BP, weight, height but no HR recorded)
- 1 was only reviewed virtually
- 1 had documented completion of monitoring, but no figures documented
- 7 unknown – no reason given.

Conclusion. After 1 patient was excluded, 71/95 patients had monitoring up to date (~75%).

Of the remaining 24, some were due to systemic issues affecting all services, e.g. non-attendance or faulty equipment. However, some were due to issues more easily addressed.

This led to a discussion at a trust-wide patient safety meeting, with the following outcomes:

1. Staff were given a presentation on NICE guidelines for ADHD medication monitoring to ensure knowledge is up to date.

2. The importance of completing all aspects of monitoring and documenting these each time was highlighted.
3. If monitoring could not be completed, the reason must be documented, to avoid further "unknowns".
4. An agreed plan to schedule monitoring appointments following virtual reviews.
5. Annual re-audit using the same data template, with the aim of improving each year.

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Prescribing Practice of Citalopram and Escitalopram in Older Adults Following the 2014 MHRA Guidance of Associated QTc Prolongation: A Clinical Audit

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doi: 10.1192/bjo.2024.588

Aims. Citalopram and escitalopram are commonly used serotonin-specific reuptake inhibitors (SSRIs) for the treatment of depression and anxiety. These medications are known to cause corrected QT interval (QTc) prolongation, with risks of further arrhythmias. In 2014, the Medicines Healthcare Regulatory Agency (MHRA) published guidance outlining this risk and advised decreased maximum daily doses of citalopram 20mg and escitalopram 10mg in the elderly population. The aim of this audit was to explore the prescribing patterns of citalopram and escitalopram in a community sample of older adults with psychiatric disorders, against MHRA guidance.
Methods. Older adults (aged >65 years) in the community mental health services in Wolverhampton, who were prescribed citalopram or escitalopram, were identified through a search of clinic letters in June 2023. We checked the medications, doses, history of QTc prolongation, concurrent medications that may prolong QTc, electrocardiogram (ECG) reviews, and any discussion about the risk. The data was collected by accessing the electronic patient record and related health records. In total 17 patients were included, with no exclusions.
Results. Most of the patients (94.1%, n = 16) were on citalopram and only one patient was on escitalopram. The most common dose of citalopram was 20 mg (62.5%, 10/16), with one patient having a higher than the recommended dose (30 mg). Escitalopram was within the recommended dose. There was no history of QTc prolongation in any patient. Concurrent medications that could prolong QTc were identified in 35.3% (n = 6) of the patient population; all of these were antipsychotics. A small proportion (11.8%, n = 2) of the patients had documentation stating about QTc prolongation and arrhythmia risks for citalopram or escitalopram. A review of ECG when initiating or adjusting treatment was noted in only one patient.
Conclusion. Most of the older adults had citalopram and escitalopram within recommended limits. A considerable proportion of patients had concurrent medications with an additional risk of prolonging QTc and subsequent arrhythmia. It is essential to consider ECG in all elderly patients before starting medications with a risk of QTc prolongation. There is a need to discuss the cardiac risk associated with citalopram and escitalopram with the patients and improve documentation. It may be better to provide written information to the patients and caregivers regarding this.

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Improving Health System Engagement in Patients With Substance Use Disorders: Audit of Care Plans in the National Drug Treatment Centre

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doi: 10.1192/bjo.2024.589

Aims. The National Drug Treatment Centre in Dublin is the longest established treatment service for drug users in Ireland. Led by Addiction Psychiatry teams, it provides specialist multidisciplinary input for patients with complex medical and psychiatric needs secondary to substance use. Many patients attending the centre engage poorly with other healthcare services in the community. The aim of this audit was to improve physical healthcare engagement in a caseload of 60 patients, through improving GP registration rates and possession of medical cards (providing access to free public health services).
Methods. The comparison standard for the audit was the Irish Health Service Executive (HSE) Clinical Guidelines for Opiate Substitution Therapy: 2016. These stipulate that all drug users entering treatment and rehabilitation should have a care plan based on assessed need. Specific domains covered include: Drug and Alcohol use, Physical Health, Psychological Health and Social Functioning.

During the initial audit cycle, electronic care plans in a caseload of 60 patients were reviewed for information on their GP and medical card status.

Intervention: Following the initial cycle, results were presented and discussed at a multidisciplinary team meeting. A combined MDT effort was made to discuss medical card and GP status with patients during each interaction. Patients were referred to social work for support in application/renewal of medical cards and GP registration where required.
Results. Results following re-audit:

The percentage of patients with GP registration clearly displayed on their care plan increased from 66% to 93%.

The percentage of patients with an up to date medical card increased from 12% to 45%.

The percentage of patients whose medical card status was unknown reduced from 72% to 44%.

The percentage of patients with their medical card number displayed on their care plan increased from 25% to 55%.
Conclusion. There was a significant improvement in the number of patients with GP and medical card information documented clearly on their electronic care plan. This has assisted National Drug Treatment Centre staff in supporting patients' physical health needs more effectively, through close liaison with primary care providers and onwards referral to other services where required. It was noted that further efforts were required to build upon these results and reach 100% compliance. Recommendations and an action plan were developed to ensure ongoing improvement in standards.

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https://doi.org/10.1192/bjo.2024.587 Published online by Cambridge University Press