AEC score assessment, 27% (n=3) of these medications scored 1, 64% (n=7) scored 2, and 9% (n=1) scored 3.

For the above patients whose AEC scores indicated a review, 0 patients went on to receive a documented medication review and follow-up AEC score.

Conclusion: Increasing awareness and understanding of the anticholinergic effect on cognition can help provide better patient care. This can be achieved by sending a poster about the importance of reviewing medication for higher AEC scores to the pharmacy team and the ward doctors. Likewise, implementing the AEC score in the ward-round template and recording any changes to the medication on RIO and eMeds. By utilising the AEC score to guide medication reviews and deprescribing regimes, the cognitive burden of anticholinergic medications may be significantly reduced and ultimately promote improved outcomes.

Compliance With DVLA Guidelines Within an Early Intervention in Psychosis Service

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doi: 10.1192/bjo.2025.10631

Aims: Early Intervention in Psychosis (EIP) services provide specialised support for individuals experiencing their first episode of psychosis. Psychosis can impair cognitive and motor skills, which may affect an individual's ability to drive safely. If a patient's fitness to drive may be impaired by their condition or treatment, both DVLA and the GMC advises doctors to (i) alert patients to this issue, (ii) inform patients of their legal obligation to notify the DVLA, and (iii) document advice regarding fitness to drive in the patient's medical records. This audit aimed to assess the EIP teams' compliance with these guidelines.

Methods: A retrospective audit of 52 patients referred most recently to the EIP services. Online patient case notes were reviewed for information on (i) driving status, (ii) licence status, (iii) information provided on driving, including the need to inform DVLA.

Results: 59% (n=31) patients had driving status recorded by the EIP team, 81% (n=42) had licence status recorded. 10% (n=5) had no information about their driving or licence status. 27% (n=14) of patients received general advice about driving by the EIP team.

31% (n=16) of patients held a current driving licence, 69% (n=11) of these received advice about driving, 56% (n=9) were advised to inform the DVLA.

Conclusion: The majority of patients with a current driving licence received driving advice. However, a significant proportion did not, posing risks to both patients and the public. The EIP team should aim for 100% compliance with the DVLA/GMC guidance.

Requesting information about driving status is already included in the EIP clerking proforma. To improve adherence to completing this documentation, the audit findings will be presented to the multi-disciplinary team to raise awareness and reinforce the importance of this section. In addition, a poster with proforma screenshots will be distributed to support colleagues in locating it this section. A re-audit in six months will assess progress and determine if further interventions are needed.

Suicide Prevention Audit in Accordance With the NCISH Toolkit – A PAN Trust Audit Across the Four Localities of the Black Country

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doi: 10.1192/bjo.2025.10632

Aims: The primary aim of the re-audit was to identify specific areas where key components of the NCISH guidelines were not consistently applied in the care of patients who died by suicide. By addressing these gaps, the Trust seeks to ensure that NCISH-recommended standards are embedded into practice across all patient care pathways. Our objectives were to assess the level of compliance with NCISH standards across all localities where patients died by suicide, evaluate whether the care provided aligns with National Standards and extract key lessons from the cases audited to drive improvements in care delivery and patient safety.

Methods: This was a PAN Trust re-audit. A retrospective collection of data was done, and a sample was provided by the trust's Serious Incident & Inquest Manager. The criteria were any patient known to the trust who completed suicide between April 2022 and March 2023, in line with NCISH guidelines. This collection saw 33 cases, however only 32 cases were audited, as one was withdrawn. This was an increase from the previous 2 years. The cases were split between team members for data collection, and for each case the RiO patient notes and incident reports were used to fill out the audit tool on Microsoft Excel. Data was analysed by the quality improvement team.

Results: The audit revealed that no patients died as psychiatric inpatients, but six suicides occurred within three months of discharge. Most were males in their 60s, single, unemployed, and living alone, with depressive illness as the primary diagnosis. Common methods included hanging and self-poisoning, with most suicides occurring at home. Many patients received treatment, though risk assessments and follow-up practices were inconsistent, with structured tools used in only three cases. Lessons learnt emphasize the need for timely, structured post-discharge care, better crisis intervention, enhanced staff training, improved communication between services, and increased access to dual-diagnosis and mental health resources.

Conclusion: Post-Review Changes:

Risk assessments now use formal tools, with improved documentation and training on difficult conversations. Collaboration between GPs and mental health services has improved.

Recommendations:

Strengthen post-discharge follow-ups within three months. Provide suicide prevention training for GPs and staff. Increase home monitoring for high-risk patients, especially in Dudley. Launch male-focused mental health campaigns addressing stigma. Enhance inter-