derived from the GMMH Unlicensed Medicines Policy, previous audits of HDAT use and the RCPsych consensus report on HDAT prescription.

Result. 11 of 252 patients (4%) were identified as being on HDAT, of which eight were due to polypharmacy and three to high dose of a single antipsychotic. For 1/11 patients target symptoms and a risk/benefit rationale were documented. The mean length of time on HDAT was 6 years. 7/11 patients had either tried or considered clozapine in the past. 8/11 patients had not had an ECG within the last year, 4/11 had not had yearly U&E. 8/11 had regular mental health reviews.

Conclusion. Compliance with the audit standards was found to be highly variable. This may reflect many factors, including the length of time since commencing HDAT and the complex shared care arrangements currently in place in Trafford. Thus, the following recommendations have been made:

To start a register of all patients prescribed HDAT.

To review local guidelines and documentation to ensure they are up to date and can be effectively implemented in routine clinical practice.

To ensure that the responsibility for conducting yearly physical health checks for patients prescribed HDAT is communicated to the relevant parties.

Patient factors associated with the use of psychotropic polypharmacy in patients under the care of a community mental health team in the West of Ireland

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Aims. Psychiatric polypharmacy refers to the prescription of two or more psychotropic medications to any one patient. This definition is purely quantitative and does not take into account whether such a prescription is detrimental, or unnecessary. In many cases, polypharmacy has been implemented in challenging illnesses, and some studies have shown that it can improve overall outcomes for certain patients. Evidence suggests that the prevalence of psychotropic polypharmacy is increasing, despite advances in psychosocial interventions. The aim of this study was to assess the current prevalence of polypharmacy among patients being treated by a community mental health team (CMHT), and the patient factors associated with its use.

Method. We performed a cross-sectional study of all patients registered with a CMHT in a mixed urban/rural area on a single date. Case records were examined to determine the most recently prescribed drug regimen for each patient. Clinical chart diagnoses were recorded and each one independently verified by the team consultant using ICD-10. A number other sociodemographic variables were recorded. Using Microsoft Excel, we analysed the medications prescribed as well as rates and levels of polypharmacy based on multiple different patient characteristics.

Result. Of the 245 patients, the mean age was 56.3 and 51.2% (n = 126) were female. Psychotropic polypharmacy was seen in 62% (n = 152) of patients. 33% (n = 82) of patients were on two psychotropic medications, and of this subset, a combination of one antipsychotic and one antidepressant was the most common drug regimen, seen in 16.7% (n = 41) of all patients. Polypharmacy was more prevalent in females, with 68% (n = 85) being on two or more psychotropics, in comparison to 58% of male patients. In relation to age, patients aged between 51 to 65 years had the highest prevalence of polypharmacy, at a rate of 71% (n = 49). Among all primary diagnoses, polypharmacy was most common in patients with affective disorders, with 80% (n = 40) of this patient cohort on two or more medications. Second to this was psychotic disorders, with polypharmacy seen in 65% (n = 62) of this group.

Conclusion. We found that psychotropic polypharmacy is highly prevalent in psychiatric patients being treated in a community setting. Certain demographics and patient factors, such as age, gender and psychiatric diagnosis influenced the rate of polypharmacy and certain drug combinations were more commonly prescribed than others.

Monitoring side-effects of antipsychotics using the glasgow antipsychotic side-effect scale

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Aims. Antipsychotic drugs frequently produce side-effects which represent common reasons for noncompliance. National guidelines, published by the National Institute of Care and Health Excellence, the Royal College of Psychiatrists, and the Maudsley Prescribing Guidelines in Psychiatry, stipulate that patients prescribed antipsychotic drugs should be reviewed for side-effects on a weekly basis. This completed audit cycle, conducted on a mixed acute general adult psychiatric ward, examined whether patients were being assessed for side-effects of antipsychotic drugs using a standardised, self-reporting scale – the Glasgow Antipsychotic Side-effect Scale (GASS) – as per national guidelines. As identification of side-effects is important in tailoring treatment to improve compliance, auditing monitoring practice was important in realising these outcomes.

Method. Retrospectively, 26 inpatients were identified over a two-month period who were prescribed antipsychotic drugs. Their notes were reviewed for documented weekly GASS scores for the duration of antipsychotic treatment. Initial data demonstrated 0% compliance with guidelines, as no patients completed a weekly GASS. The intervention to improve compliance was a training session for ward staff on implementing the GASS. Data were subsequently collected prospectively over three weeks for 15 patients.

Result. Seven patients completed the GASS weekly over three weeks, representing 47% compliance. Two patients (13%) completed two forms, three (20%) completed one form, and three (20%) completed no forms. There was a positive correlation between being offered the GASS and completing it – only one patient declined to complete it and was not offered it during the third week. Of the remaining 14 patients, if the GASS was offered there was 100% rate of completion. Staff did not offer the GASS to every patient each week, which accounted for most cases of non-completion. Some patients with pre-existing symptoms of physical illnesses included these on the GASS, which complicated interpretation. Future interventions could include further staff education, and involving a ward pharmacist to review results during medication reviews to optimise treatment compliance, as no medication changes resulted directly from patients completing the GASS.