ePoster Presentations

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Audit

Audit to assess discussion of sexual dysfunction for new patients entering a community mental health recovery service

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doi: 10.1192/bjo.2021.210

Aims. Sexual dysfunction should be enquired about as a symptom of mental health disorders and as side effects of commonly used psychotropic drugs. We audited against NICE guidelines the record of sexual dysfunction discussion at initial assessment and follow-up by the community mental health recovery service (CMHRS).

Background. Research reports that sexual dysfunction occurs more often in individuals with serious mental illnesses including depression and schizophrenia. Sexual dysfunction is also a reported side effect of antidepressant and antipsychotic medications. NICE guidelines recommend assessment of biological symptoms of mental health disorders and discussion of potential side effects of treatments being considered prior to initiation and at follow-up.

Method. Our sample consisted of 71 patients, all new patient assessments from referrals made to CMHRS between January 1st and March 31st 2019.

We reviewed all initial assessment and follow-up electronic notes and any correspondence generated from these meetings.

Result. Our results showed that no record was made of sexual dysfunction as present or absent by health care professionals (HCPs) completing initial assessment or follow-up.

We surveyed the HCPs from the team and observed a high level of confidence in discussing sexual dysfunction and high self report of this discussion being conducted.

Conclusion. Our audit results show no records of the discussion of sexual dysfunction, we held to the principal that in absence of record the discussion did not take place. Our survey results suggested that HCPs were confident they do assess for sexual dysfunction. We wondered, therefore, if HCPs would be less likely to make record in the event that symptoms are denied, recognizing that the list of potential symptoms and side effects is extensive and documentation of all negative results would be time consuming.

Our audit results may show then, that sexual dysfunction is not present in any of the sample; however this would contrast to research findings of higher than average rates of sexual dysfunction in groups with serious mental illness and those using antidepressants or antipsychotics.

We propose further assessment is needed for the disparity between our and recognised rates of sexual dysfunction.

We propose the standard that recording 'absence of biological symptoms' of mental health disorders or recorded supply of medicine information leaflets are adequate record. We also made suggestions for training and recording to assist HCPs initial assessment.

Psychiatric staff training in managing medical emergencies: re-audit

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doi: 10.1192/bjo.2021.211

Aims. In the UK, people with severe mental illness at a greater risk of poor physical health and have higher premature mortality than the general population, highlighting the importance of responding to physical health problems among patients suffering from psychiatric conditions. However, training for staff on inpatient psychiatric units to meet patients' physical health needs is sometimes overlooked and has not always been effective.

According to NICE Clinical Guideline 25 (2005) and NPSA Rapid Response Report (2008/RRR010), staff on any psychiatric inpatient setting must be capable of monitoring, measurement, and interpretation of vital signs. They must have both adequate information and skills to identify signs indicating worsening of patients' health and respond effectively to severely ill patients.

Hence, we aim to re-audit the results of a similar audit carried out in 2016 to review the level of medical emergency training (in terms of life support training) of clinical staff across the inpatient psychiatric wards at our local hospital - Stepping Hill Hospital- in Stockport.

Our hypothesis is that there will be a gap in meeting the required standards for training.

Method. A questionnaire including 6 questions (role of the staff member, level of their life support training, when was their training last updated, whether they know the location of the crash trolley, whether they know the local hospital emergency number and whether they should resuscitate the patient if their training is out of date) was given to staff on acute inpatient psychiatric units in Stepping Hill Hospital.

Result. The sample included 49 staff members from all the 3 wards included in the audit. The level of training of nursing staff on the 3 wards was meeting standards except for nursing staff who were new to the wards or coming back to work from prolonged leaves. There was also a gap identified in the level of training of other staff members on the ward as well as on the remaining standards measured by the audit.

Conclusion. A gap was identified in meeting the required standards of training on the inpatient psychiatric units. Reasons identified for this gap are mainly due to the fact that new or bank staff are asked to cover the wards without providing them with appropriate training and without orientating them about the location of different equipments and policies on the ward.

Quetiapine: off-label prescribing in a community mental health team

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doi: 10.1192/bjo.2021.212

Aims. Quetiapine is an atypical anti-psychotic medication licensed for the treatment of schizophrenia, bipolar disorder and adjunctive use in major depressive disorder. It's off-label

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.