

health clinic, with specific staffing allocation, to ensure a more thorough and efficient way to address physical health.

Diabetes and liaison psychiatry: the characteristics of patients with diabetes referred to a liaison psychiatry service in London

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Aims. To determine the characteristics of adult patients referred to a Liaison Psychiatry service in a general teaching hospital in London, UK with 950 inpatient adult beds.

Method. All referrals for adult inpatient psychiatric consultation made during a period of 9 months were reviewed; those that involved a patient with a diagnosis of diabetes were analysed. Descriptive statistics were used; data were collected on demographic characteristics and physical and mental health parameters, including type of diabetes, number of years since diabetes diagnosis, glycaemic control, presence of diabetes-related complications, reason for Psychiatry consultation request, psychiatric diagnosis, psychotropic medication, frequency of admissions to general hospital, psychiatric risk issues and outcome of psychiatric consultation.

Result. Pilot results indicate that 30 diabetic patients were referred for a psychiatric consultation in 9 months. Of those, 9 had type 1 diabetes, 17 had type 2 diabetes and 1 had pre-diabetes 3 were unknown. 13 were male and 17 were female; the median age was 46 (range 18 to 68); the ethnicities were 6 White, 15 Black, 1 Asian and 8 other.

Diabetes-related complications were present in 77% (retinopathy 10%, kidney disease 27%, neuropathy 13%, diabetic foot 16%). 6% had comorbid cardiovascular disease. 10% were on dialysis and 3% had had amputations.

The main reason for referral for psychiatric consultation was low mood and self harm; other reasons were recurrent DKA, anxiety and self neglect. Psychiatric risk issues included 20% risk of self-harm/suicide; 13% risk of violence; 10 risk of self-neglect. The outcomes of liaison psychiatry consultation were: 30% received an assessment that led to recommendations to the general medical team and did not require further psychiatric input; 27% received continued psychiatric follow-up during the admission. With regards to treatment, 36% had psychiatric treatment (including medication) reviewed; 47% received general treatment recommendations, including recommendations for new laboratory or radiological investigations or change in level of nursing care. 20% required transfer to an inpatient psychiatric unit, with 33% discharged to care of community mental health.

Conclusion. Our findings indicate the scope of practice for a Liaison Psychiatry service with regards to adult hospital inpatients with diabetes. Our data suggest that patients with type 2 diabetes are the majority of inpatients with diabetes that require psychiatric consultations, and that the majority of those are patients already known to psychiatric services due to long-term severe mental disorders, particularly schizophrenia, schizoaffective disorder or bipolar disorder. Most of those patients have medical comorbidities and severe diabetes-related complications. Patients with type 1 diabetes, despite making up a smaller proportion of referrals for psychiatric consultations, also tend to have recurrent hospital admissions and features of self-neglect.

Implementation of physical examination pro forma – a complete audit cycle

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Aims. Aim of this audit is to achieve and maintain 100% compliance in physical examination on admission.

Background. Conducting physical examination on admission is a mandatory requirement and is monitored by the Mental Health Commission during yearly inspections. A report published by Inspectorate of the Mental Health Commission recently in 2019 identifies a gap in physical health monitoring. We conducted a complete audit cycle in an inner city hospital psychiatric ward to monitor compliance with physical examination on admission.

Method. We based the audit on Judgment Support Framework (JSF) version 5 standards. A retrospective review of all of the patient's medical records was carried out. 13 medical records were reviewed in the first cycle. The results of the first cycle were presented to the Multi Disciplinary Team (MDT) members, including the Non-Consultant Hospital Doctors (NCHD). Physical health policy was reviewed, in consultation with the committee and Clinical Director, a Physical Examination pro-forma (colour coded) was developed and implemented. It was based on the National Guidelines and the JSF ver.5. All members of the MDT and NCHDs were briefed on the pro forma introduced. A repeat audit cycle was conducted of all patients admitted after first audit cycle. Data were collected using a simple audit tool indicating if physical examination was conducted or refused.

Result. A total of 22 medical records were audited. 13 medical records in the first cycle indicted only 3 patients had physical examination on admission. However, prior to admission a total of six patients had physical exam in the Emergency Department (ED). Upon implementation of the pro forma, 9 medical records of all patients admitted post-first cycle were audited. A total of 7 patients had physical examination on admission to the ward. Two patients refused physical examination and this was clearly documented. One patient had physical examination completed in ED. All newly admitted patients had physical examination completed or the reason why it wasn't completed documented clearly.

Conclusion. Physical examination pro forma was successfully implemented, raising current compliance to a 100%, with a significant improvement from 23% compliance in the first cycle. Existing pro forma is helpful as a reminder to NCHDs. Colour coding of pro forma improves accessibility and distinguishability during the process of admission and auditing. Physical examination pro forma will be audited every 6 monthly.

Audit on monitoring physical health of patients on mood stabilisers following NICE guidelines

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Aims. The aim is to find out if the physical health monitoring is adhered to in accordance with NICE guidelines in individuals with Intellectual disability who are on mood stabilisers and known to LD services.

Method. We sought to explore if the physical health monitoring for prescribing mood stabilisers in a sample of people with ID was consistent with good practice guidelines.

We collected the data by reviewing the clinical records of individuals with LD who were under the care of mental health services in the CLDT- Wrexham and prescribed a mood stabiliser drug. We also contacted the patient's carers who came to outpatients and by calling the GP surgery and enquiring about the details. We also assessed the Welsh clinical portal in order to assess the blood tests.

Data were collected by trainee doctors in Psychiatry. This was a retrospective audit, looking at data from Learning Disability psychiatry caseload. We identified about 16 patients on mood stabilisers.

Result. Physical health monitoring for prescribing mood stabilisers was almost consistent with good practice guidelines. This has shown that the majority of the monitoring has complied. There are few lacunae, such as Thyroid function not being monitored every 6 months for patients on Lithium, Serum Carbamazepine levels not being monitored as per guidelines with 1 patient not having blood done at all whilst on Carbamazepine. Moreover, the details are not readily available for the Consultant/ team when needed, thus making it very tedious for them to search/ contact the GP, etc.

Conclusion. Medications such as mood stabilisers can increase the risk further if the patient's physical health is not monitored regularly. This can lead to compromised quality of life for the patient and in some cases increased morbidity. Hence we have come up with a proforma that can be attached to patient case notes. This will serve as a record for us and prompt for physical monitoring. We will keep a database online with reminders set. This is to ensure a continuity of care for the patients.

High dose antipsychotic therapy (HDAT) in the Greater Manchester mental health adult psychiatric inpatient setting

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Aims. To identify the number of adult inpatients prescribed HDAT across GMMH.

To establish whether guidelines for the prescribing and monitoring of HDAT are adhered to.

To consider the initiation of HDAT, evaluating whether prescriptions of HDAT are intentionally made by consultant psychiatrists and the MDT, or by rotational junior doctors.

Background. High Dose Antipsychotic Therapy (HDAT) is defined by the Royal College of Psychiatrists as either: a total daily dose of a single antipsychotic which exceeds the upper limit stated in the BNF or A total daily dose of two or more antipsychotics which exceeds the BNF maximum as calculated by percentage.

The decision to prescribe HDAT should be made by a consultant psychiatrist and discussed with the patient and wider MDT. Clear documentation of this discussion, including the clinical indication, should be recorded within the case notes.

The use of HDAT comes with greater risk of physical health complications and requires regular monitoring of ECG, BMI and blood biochemistry. For patients detained under the Mental Health Act, consent and appropriate consultation with a SOAD should be sought for HDAT where the patient lacks capacity.

This audit investigates prescription of HDAT in the acute adult inpatient population within Greater Manchester Mental Health NHS Foundation Trust (GMMH).

Method. Six junior doctors were recruited to collect data across the 5 sites covering general adult inpatients within GMMH. Data were collected week beginning 21st January 2020. Data were collected from all 20 general adult inpatient wards within the trust. Medication cards for each patient on the electronic bed-state at 9am on the day of the audit were checked for HDAT prescription. Subsequently, data were collected from electronic notes of patients identified as being on HDAT. Data were collated and submitted to the audit lead for analysis.

Result. 31 patients were identified as being on HDAT, of those, 21 instances of HDAT were commenced during the patients MDT, although in only 2 of these cases was it noted that the medication prescribed would result in initiating HDAT. Of the remaining cases, 8 were prescribed by junior doctors and 2 were unclear. 15 out of 31 patients had an ECG within a month prior to commencing HDAT, of 24 patients on HDAT for longer than 3 months, only 5 had a repeat ECG within this time.

Conclusion. Guidelines are not closely adhered to, there is clear and necessary scope for improvement.

High dose antipsychotic therapy (HDAT) prescribing practice within the south trafford community mental health team

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Aims. High Dose Antipsychotic Therapy (HDAT) is defined by the Royal College of Psychiatrists as either: "A total daily dose of a single antipsychotic which exceeds the upper limit stated in the BNF" or "A total daily dose of two or more antipsychotics which exceeds the BNF maximum as calculated by percentage."

The use of HDAT is associated with significant risks to physical health and as such requires regular monitoring of various physiological parameters such as ECG, bloods and an assessment of cardiometabolic risk.

Following previous audits of HDAT prescribing practice in the inpatient setting within Greater Manchester Mental Health (GMMH) NHS FT, an audit of HDAT prescription in a general adult CMHT was conducted in Summer 2020, with the following aims:

To identify patients in the South Trafford CMHT who are prescribed HDAT.

To assess the prescription of HDAT against local guidance on the use of unlicensed medications.

To highlight good practice and areas for improvement in the prescription of HDAT.

Method. All patients under the South Trafford CMHT in Summer 2020 were identified. Current prescriptions for antipsychotic medication were ascertained through review of electronic patient records. Those noted to be on HDAT were assessed against audit criteria