Mersey Care NHS Foundation Trust, Liverpool, United Kingdom
*Presenting author.

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Aims. Patients with serious mental disorders like psychosis may pose a significant risk to themselves and others when they drive. The DVLA has set out guidance for driving for patients with psychiatric disorders, substance use disorders, and for those taking psychotropic medications. It's good medical practice to identify risks associated with driving, discuss, advise appropriately, and document the same in the clinical notes.

To assess the compliance of the mental health professionals at Rathbone Rehabilitation Centre (RRC) with DVLA guidelines regarding patients about driving restrictions, documenting this appropriately and to increase awareness of the DVLA guidelines.
Methods. Data of all the discharged patients from RRC over a 12-month period was collected following a standardised process and assessed for 6 parameters.

A total of 51 discharges were identified and audited against the DVLA guidelines.
Results. 51 (100%) patients had a mental health diagnosis documented on patient electronic records (Rio).

9 (18%) of patients had their driving status documented. 42 (82%) did not.

Of the 9 patients whose driving status was recorded, 6 did not drive and are thus labelled not applicable for subsequent criteria. The type of vehicle driven was not documented in any of the cases and therefore was 0%.

Of the 3 patients who drive, 2 (67%) had been informed that their condition may affect their ability to drive.

67% had documented evidence of receiving advice on driving restrictions.

67% had documented evidence that the practitioner has informed the patient that they have a legal duty to inform the DVLA about their condition.
Conclusion. An action plan was designed to improve compliance with DVLA guidelines for practitioners managing inpatients.

- On admission all patients should be asked for their driving status and the result documented on Rio. This could be done on the clerking admissions proforma on Rio.
- For all patients that do drive, the types of vehicles they drive should be documented–this can also be included in the clerking admissions proforma on Rio.
- At their first ward review/discharge meeting and whenever relevant, patients should be informed whether their condition affects their ability to drive and if so, what the restrictions are. They should be informed of the legal requirements regarding informing the DVLA and documented.
- To consider driving status when assessing risk.

Antipsychotic Prescribing for In-Patients With Dementia at University Hospital Llandough to Look for Good Prescribing Practice in Line With NICE Guidelines

Dr Rakesh Puli* and Dr Arpita Chakrabarti

Cardiff and Vale University Health Board, Cardiff, United Kingdom
*Presenting author.

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Aims. NICE guidelines stipulate that alternative causative factors for Behavioural and Psychiatric Symptoms of Dementia (BPSD) must be considered before starting antipsychotic treatment. The symptoms of BPSD include agitation, aggression, wandering, hoarding, sexual disinhibition, shouting, repeated questioning, sleep disturbance, depression, anxiety and psychosis. Those who do develop non-cognitive symptoms or behaviours should at first be assessed to exclude alternative causes, such as physical health issues (pain/infection), side effects of medication, environmental factors, psychosocial factors, individual biography (e.g. religious beliefs) etc. Then, non-pharmacological approaches should always be used as the first line in treating behavioural problems before antipsychotics (e.g. haloperidol or risperidone) are started at a low dose and titrated up. Once these have been started, the patient should be reviewed at 6 weeks. The rationale for conducting this audit is to try and understand if the antipsychotic prescribing in the ward is in line with the NICE guidelines.
Methods. A retrospective study to compare the treatment of all the patients admitted for dementia in the Old age psychiatry wards located in University Hospital Llandough from November 2022–April 2023 with the NICE guidelines.
Results. Out of the 39 patients who met the criteria, the results indicate a predominant prevalence of Alzheimer's (46%), followed by mixed dementia (23%) and vascular dementia (21%), among the diagnosed cases. In 67% of instances, healthcare professionals have considered alternative causative factors for the observed symptoms beyond the identified dementia subtypes. In 62% of cases, patients received treatment for alternative causes, while non-pharmacological approaches were attempted in 51%. The utilization rates among patients indicate a predominant prescription of risperidone at 77%, followed by quetiapine at 31%, olanzapine at 10%, and aripiprazole at 5%. 95% of patients were commenced treatment at the lowest dose, while information for 3% (1 patient) was not available. 62% were monitored according to guidelines and 56% were reviewed every 6 weeks.
Conclusion. There is room for improvement in terms of considering other causes of behavioural symptoms, utilizing non-pharmacological approaches, and adherence to monitoring and review intervals outlined in the guidelines. These findings underscore the importance of continuous evaluation and refinement of clinical practices to enhance the overall management of BPSD in dementia patients.

Audit of Risk Assessment Tool in Adolescent Eating Disorders

Dr Mallika Punukollu* and Dr Camilla Mulligan

NHS, Glasgow, United Kingdom
*Presenting author.

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Aims.

Aim:
To develop better prioritisation and assessment of high-risk patients.

Standard:
RCPsych Junior MARSIPAN guidelines advise that reasonable aims for a first presentation to primary care involve physical examination and referral to the appropriate CAMHS or paediatric