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Aims. Many antipsychotics are known to adversely affect prolactin levels causing hyperprolactinemia. National Institute for Health and Care Excellence (NICE) guidelines have suggested monitoring of prolactin levels. It specifies that prolactin should be checked 6 months after starting treatment, then every 12 months; and to ask about symptoms of raised prolactin which include low libido, sexual dysfunction, menstrual abnormalities, gynaecomastia, and galactorrhoea. This also mentions that it is not required for aripiprazole, clozapine, quetiapine, or olanzapine (less than 20 mg daily). We intended to audit the monitoring of prolactin in a sample of inpatients who are on antipsychotic drugs and to check whether action was taken in the event of a high prolactin level.
Methods. All the adult inpatients of a general psychiatric hospital on a specific date (34, 16 (47.1%) female and 18 (52.9%) male patients), who were on antipsychotics were considered for the audit. We checked the antipsychotic drugs, prolactin assessment within one year and level, action taken if there was hyperprolactinemia. The data was collected from electronic patient records and medication charts.
Results. The mean age of the sample was 39.1 ± 14.2 years (range 18–63). Most inpatients (91.2%, 31/34) were on antipsychotics and 25.8% (8/31) were on two antipsychotic drugs. Prolactin was measured in 80.6% (25/31) patients in the last year, with 48% (12/25) having hyperprolactinemia; and amongst these action was taken in 5 (41.7%). Hyperprolactinemia was present in 58.3% of female and 38.5% of male patients. Specifically, out of 31 patients, 14 (45.2%) were on antipsychotic drugs that need monitoring, and 9 (74.3%) of them had taken it for at least one year. Out of these 9 patients, prolactin was measured in 8 (88.9%) patients in the last year, it was elevated in 5 (55.6%), action was taken in 3 (60%) and action was not clear in 2 (40%) patients.
Conclusion. Almost half of the patients on antipsychotic drugs had hyperprolactinemia, highlighting the need to monitor prolactin levels. Along with this, symptoms of hyperprolactinemia should be consistently checked in routine clinical evaluations. Clinician and patient education regarding hyperprolactinemia and its symptoms might improve its monitoring.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Food for Thought: Evaluating Dietary Documentation in Psychiatric Settings

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Aims. This study aims to evaluate dietary history documentation by junior doctors in a psychiatric hospital setting in Scotland. With emerging evidence in nutrition psychiatry highlighting diet's impact on mental health, especially ultra-processed foods, this aspect often receives insufficient attention in clinical assessments. The audit benchmarks current documentation against UK Public Health nutritional guidelines and UK Parenteral & Enteral Nutrition Guidelines on Malnutrition, assessing adequacy and consistency across psychiatric diagnoses.
Methods. This audit conducted a systematic review of medical records in psychiatric wards, focusing on patients newly admitted over six months. The data collection examined admission sheets by junior doctors, covering patient identifiers, admission time, diagnosis, doctor's grade, and comprehensive details on dietary habits, eating behaviours, BMI, and substance use. The review incorporated a dietitian's input to align dietary assessments with UK Public Health Nutritional expectations and the prevention of Malnutrition Guidelines. The goal was to assess the regularity, quantity, variety, and documented changes in patients' dietary behaviours, screening for potential nutrient deficits, impacts of psychotropic medications, and eating disorder psychopathology.
Results. The results showed significant deficiency in the detail and consistency of dietary history documentation across all wards, regardless of the doctors' grade or the patients' psychiatric diagnoses. Most entries were inadequately documented or entirely missing. A particular discrepancy was noted in documenting dietary habits in patients with low BMI or those on metabolic altering antipsychotics, which should necessitate health behavior change dietary interventions. Furthermore, even in severe psychiatric conditions, there was a gap in dietary documentation indicating a widespread oversight in recognising the potential relevance of nutrition in the overall health and treatment planning of psychiatric patients, regardless of the severity or type of their condition.
Conclusion. The audit reveals a gap in psychiatric patient care concerning detailed dietary relevance history documentation. While Scotland's wards routinely use the Malnutrition Universal Screening Tool (MUST) for identifying malnutrition, this tool often overlooks key dietary elements like variety, quantity, and regularity, which are vital for linking diet content to mental health. This oversight is significant given the burgeoning field of nutritional psychiatry. Our findings suggest the necessity for systemic changes to improve dietary history documentation in psychiatric settings. This includes a more structured and systematic approach, integrating insights into the harmful effects of ultra-processed foods on mental health, to provide holistic care.

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Audit of Non-Pharmacological and Rapid Tranquilisation Practices in Managing Distress Among Older Adults: A Comparative Study in Inverness Hospitals

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Aims. This audit evaluates the adherence of nursing and medical staff to local protocols for managing distress in older adults (aged >65 years) using non-pharmacological approaches and rapid tranquilisation (RT) in a psychiatric hospital's dementia ward, an acute medical unit, and a geriatric ward in a general hospital.

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