Conclusion: Figures from the data analyses were found to be below the standards set out by the NSCHT and the Royal College of Psychiatrists. This would suggest potential communication lapses between clinicians and ward staff.

Key Recommendations:

- Emphasising the importance of physical health assessments and filling the General Condition examination form as a **fundamental component** in the resident doctor's induction handbook and induction meetings.
- Adding the procedure of filling out the General Condition Examination form on *Lorenzo* to the induction smartphone application (EOLAS).

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Managing Memory - Optimising Anti-Dementia Medication Prescribing in an Inpatient Setting

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Aims: Sub-optimal prescribing of anti-dementia medications may compromise the cognition of patients with dementia. The aim of this audit was to assess the prescribing of anti-dementia medications, including Donepezil, Rivastigmine and Memantine, for patients diagnosed with dementia against local and national guidelines in relation to three domains: appropriate indication for dementia subtype, optimal dosage titration and recommended physical health monitoring. The target was to achieve a minimum of 90% adherence to guidelines for each domain.

Methods: This retrospective clinical audit was based at the Forget Me Not Unit, a specialist dementia intensive care unit in Worthing. The first audit cycle collected data from twenty patients discharged between February and May 2025. Data obtained from electronic medical records included dementia subtype and severity, pre-admission and inpatient-initiated anti-dementia medications, titration regimes, pulse checks and renal function profiles. Results were compared against Trust and Maudsley prescribing guidelines which served as standards. An action plan was subsequently implemented which included raising staff awareness of the audit, disseminating its results and placing visible audit reminders on ward lists. A second cycle was commenced in November 2025 to February 2026 which examined the data of twenty discharged patients following implementation of the action plan.

Results: In the first cycle, thirteen out of twenty patients were prescribed pre-admission anti-dementia medications (65%) whilst seven out of twenty patients were candidates for an inpatient-initiated anti-dementia medication given their dementia subtype (35%). Six of these patients were offered an anti-dementia prescription of which five were clearly indicated (83%). All prescriptions were titrated according to guidelines but recommended physical health monitoring was only completed for five patients (83%). Similar results were demonstrated in the second cycle. Eleven patients were prescribed an anti-dementia medication prior to their admission (55%), six patients were candidates for an anti-dementiamedication (30%) but only four patients were prescribed an indicated drug during their admission (67%). However, all inpatient-initiated anti-dementia medications were titrated and monitored according to standards.

Conclusion: Anti-dementia medications are licensed treatments for dementia but may be underutilised as evidenced by this audit. Although the target was achieved by the second cycle in two out of three domains, the indication of anti-dementia prescriptions was not fully adhered to against guidelines. Further audit cycles and tailored action plans could raise the standards of anti-dementia prescriptions and thereby improve patient safety and care.

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Improving Prescribing Documentation in a Community Learning Disability Team: A Clinical Audit and SOP (Standard Operating Procedure) Development

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Aims: Background

In April 2025, city-wide changes to General Practitioner (GP) prescribing increased prescribing activity within the Community Learning Disability Team (CLDT). This audit evaluated the quality and consistency of prescribing documentation to determine whether current practice met local standards and to identify areas requiring improvement.

Aims

1. Assess adherence to documentation standards for prescriptions recorded in the electronic health record (Care Director), clinic register, and clinical notes.
2. Describe prescribing patterns across the team.
3. Develop a Standard Operating Procedure (SOP) to address gaps identified through the audit.

Methods: Records of 297 service users receiving prescriptions between 01/04/2024 and 31/05/2025 were reviewed. Outcomes included whether prescriptions were uploaded to Care Director (scan or photograph), whether entries were completed in the clinic register, whether prescribing was documented elsewhere (case notes or letters), and the site of prescription issue. Prescribing patterns were summarised.

Results: A total of 319 prescriptions were issued to 147 patients. Of these, 65% (208/319) were uploaded to Care Director–half scanned and half photographed. Only 19% (58/300; clozapine excluded) were entered into the clinic register. Prescribing was documented elsewhere in 98% (314/319). Documentation occurred frequently but was inconsistent in format, location, and completeness.

Conclusion: Conclusions

The audit identified frequent but inconsistent documentation. The SOP provides a structured framework to improve accuracy, consistency, and audit-ability, with re-audit recommended at 6–12 months.

Actions

Based on the identified gaps, a SOP was developed. Key components included a scanfirst requirement, defined legibility standards, mandatory casenote entry confirming medication and dose, creation of a centralised electronic tracking register, quarterly monitoring, and data protection guidance.

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