The next steps will be run as a quality improvement project addressing MDT and service-user barriers to assertive medication management:
- Trial methods to improve adherence (depot prescribing, psychoeducation, peer support)
- Encourage efficient up-titration and frequent MDT review of AP efficacy (empowering service-users self-management, care-coordinator opportunistic mental state assessments to trigger dose increase, medical review frequency)
- Identify and refer service-users suitable for clozapine

Lithium Counselling in Women of Childbearing Age

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Aims. Lithium is a commonly prescribed mood stabiliser given to women of childbearing age. There are risks of teratogenicity in first trimester of pregnancy, most notably cardiac abnormalities. It is not clear whether this is highlighted to patients. Our aim was to evaluate whether women were being counselled according to NICE and BNF guidelines.
Methods. We analysed records for 25 female inpatients who were commenced on lithium in Goodmayes Hospital from August to September 2021 to see if lithium counselling was done and documented on Rio. This was corroborated with e-prescribing records on ePMA.
Results. Data were collected from 26 patients; 1 was post-menopausal (excluded), final sample size n = 25. 16% were given a lithium leaflet, 92% had trialled alternative antipsychotics, 8% were asked if planning pregnancy, 4% had the risks of lithium in pregnancy explained and 12% were offered contraception.
Conclusion. Lithium counselling needs to improve. We should give patients information via lithium leaflets and explain the risks when they improve in mental state. We should arrange contraception referrals if desired and signpost perinatal psychiatry team if planning a pregnancy.

Making Sense of the Urgent GP Referrals; Audit Into How Many Are Actually Urgent?

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Aims. The trust policy dictates that all urgent GP referrals should be contacted within 48 hours by the duty team. The duty team carries out a telephone screening assessment and offers the patients who are deemed to be urgent, a face-to-face assessment. Those who are not assessed to be urgent are signposted to the right service.
Methods. All the urgent GP referrals of the month of July 2021 were followed up retrospectively and the outcome was recorded to assess the influx and outcome of urgent referrals from primary care. The urgent referrals from all other routes such as Psychiatric Liaison, and Social Services, Police etc were not included in the data.
Results. A total of 124 urgent referrals were received in the month of July 2021. Only 13 out the 124 were deemed urgent following the telephone assessment and they were offered a face-to-face assessment. Fifty three patients were referred to primary care mental health team, 24 were referred to the secondary community mental health, 20 were referred to the older adults team and 10 were discharged back to the GP following. Out of the 13 who were assessed by the duty team, 6 patients were referred to primary care mental health team and 6 were referred to the secondary community mental health team. The urgent referrals came from 20 GP surgeries that cover a wide area of the rural and urban communities and the surgeries with most urgent referrals were highlighted
Conclusion. Trying to work on improving the quality of urgent referrals, the team tried to analyse the results, which proved to be complicated. The efforts to standardise the referral process has depended mainly on the degree of awareness of the GPs about the way the mental health service operates considering there is a percentage of locum GPs who might not be fully aware of how mental health service works.

The recommendation of the audit is to arrange visits to the GP surgeries to work on raising awareness among GPs about the referral system to the Mental Health team. It is also recommended that the GPs should be able to complete a brief risk assessment to justify why the referred patient needs to be reviewed urgently instead of on routine basis.

Looking at Current Practices Regarding Implementation of Covert Administration of Medication Policy

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Aims. The aims of the audit was to find out current practices regarding implementation of covert administration policy guidance. The Covert Medication Administration policy was introduced during the past two years, but due to ongoing pandemic, awareness of it was low. Guidelines for when making a decision to administer medication covertly were clear in the policy. Covert medication administration is a very restrictive practice, albeit clearly in a patient's best interests. Instances were found when medication for physical health was administered covertly and there isn't authority to do so under the Mental Health Act as noted in Care Quality Commissioning inspections.
Methods. The sample selection was obtained by Incident Reporting forms for covert medication prescription from which 10 patients were identified from a four month retrospective sample of geriatric psychiatric inpatient admissions at the Juniper Centre at Moseley Hall Hospital, Birmingham from April to August 2021.

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Results. Covert medications administered were used to treat physical and mental health conditions. The physical health medication given was not for side-effects of mental health medication. Of the 22 medications and 10 patients there were no instances where the covert medication checklist had been completed. 9 of 22 medications (41%) (across 7 patients (70%)) had neither a best interest meeting nor a separate discussion held with the patient's family, friend, carer or advocate documented on the electronic record. Of the 22 medications, 7 medications (32%) belonging to 3 different patients had documentation of pharmacist involvement in the decision of covert medication administration whereas 15 medications belonging to 8 different patients did not.
Conclusion. Our findings conclude inadequate following of the standards protocol of the covert medication administration policy. Despite 77% of medications being prescribed with a completed multi-disciplinary covert care plan and 95% of medications having had completed Incident Reporting forms, the rest of the standards were notably missed.

Prescribing and Monitoring of High Dose Antipsychotic Therapy (HDAT) in the Acute Inpatient Setting

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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 calculated by percentage. HDAT is defined as 'off-label' prescribing and the prescribing clinician should clearly document rationale for its prescription and clear discussion with the patient regarding the risks and benefits. If the patient is deemed to lack capacity, this should be clearly documented, and appropriate legal processes followed as defined by the Mental Health Act 1983. The use of HDAT comes with greater risk of physical health complications and requires regular monitoring of electrocardiogram (ECG), body mass index (BMI) and blood biochemistry. Aims: To re-audit the number of inpatients prescribed HDAT across three acute general adult inpatient wards, and to establish whether guidelines for the prescribing and monitoring of HDAT are adhered to.
Methods. Initial audit was completed in January 2020. Education sessions were provided to rotational junior doctors in the six months following initial audit. For re-audit, medication cards for each patient on the electronic bed-state at 9pm on 27/11/2021 were checked for HDAT prescription. Data were collected from electronic notes of patients identified as being on HDAT.
Results. Initial audit in 2020 demonstrated that 3 of 49 inpatients (6%) were prescribed HDAT, with no evidence of documentation of rationale, and variable monitoring of physical health indicators. Re-audit in 2021 demonstrated that 11 of 47 inpatients (23%) were identified as being on HDAT. Of those, seven instances of HDAT were commenced during review by the multidisciplinary team or the consultant, with only two of these cases noting that the medication prescribed would result in initiating HDAT. Of the remaining cases, the prescriber was unclear. Eight had an ECG within a month prior to commencing HDAT. Only three patients had a repeat ECG within 7 days of initiation. Three patients were noted to gain at least 5 kg in weight following implementation of HDAT.
Conclusion. Education of junior doctors following initial audit had limited impact, likely due to high turnover of doctors. Implementations currently in development include: 1) Departmental teaching session for doctors of all grades, 2) Introduction of stickers on medication charts for patients prescribed HDAT to highlight monitoring recommendations, 3) Development of ward round template to include review of HDAT.

How Are We Prescribing? a Re-Audit of Prescribing Practices for People With Personality Disorder Presented at the Local Personality Disorder Forums

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Aims. NICE recommends that drug treatments shouldn't be used specifically for the treatment of individual symptoms or behaviours associated with Borderline Personality Disorder but may be considered for the overall treatment of comorbid conditions. National audits have been completed by Prescribing Observatory for Mental Health UK (POMH-UK) in 2012 and 2014, with a local Trust audit in 2017. Subsequently, 'Guidance for Prescribing in Personality Disorder' was published and circulated across the Trust in Dec 2020.This audit aims to establish whether there has been a change in the prescribing trends in the Trust since the last audit in 2017.
Methods. Electronic records of patients identified and presented at Personality Disorder forums throughout the Trust between June-December 2021 were reviewed.

Two audit standards and four treatment targets derived from the POMH-UK audit were used.
Results. 24 electronic patient records were reviewed.

79% patients had a documented crisis plan, fewer than the 87% in 2017.

The proportion on antipsychotics with documented clinical reasons for prescribing was 69%, compared to 43% in 2017.

For those on antipsychotics in the absence of a comorbid psychotic illness, 91% were on them for >4 weeks, compared to 86% in 2017.

Z-hypnotics were prescribed for >4weeks in 37.5%, significantly more than the 13% in 2017. Benzodiazepines were prescribed for >4 weeks in 38% of patients, with 28% recorded in 2017.

100% of patients eligible for medication reviews had had them, an improvement from 90%in 2017.
Conclusion. Compared to the previous audit, fewer patients had crisis plan documentation, but more patients had a clinical indication for antipsychotics recorded.

Rates of prescribing Z-hypnotics, benzodiazepines and antipsychotics for >4 weeks seems to have risen, demonstrating a lower compliance with the treatment targets.

The proportion of patients having medication reviews has improved, however, the quality of these reviews remains similar to the 2017 audit.

The findings will be presented within the Trust with the re-emphasis on guidelines.

Prescribing in people with personality disorders can be revisited in 2 years.

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