1. All the patients with ADHD referred to Islington CAMHS in 2023 for initiation of medication were sampled.

Exclusion criteria:

1. Patients not started on medication.
2. Patients who had previously been on medication.
3. Patients who had medication initiated by paediatrician.
4. Patients who had medication initiated by private psychiatrist.

Results: A total of 74 patients were identified, 55 males and 19 females.

Pre-medication Physical Health Assessment: The physical health parameters before initiating medication were recorded in 100% of cases, with 96% adhering to the standards outlined by NICE. This indicates a strong adherence to pre-medication assessment protocols.

Medikinet XL was the most prescribed medication for both initiation and maintenance.

Side Effects and Medication Management: Side effects were reported by 22% of patients, with reduced appetite being the most common. Medication was stopped in 4% of cases due to side effects, and 11% required a change in medication. This highlights the importance of ongoing monitoring and the need for flexibility in treatment plans to address side effects promptly.

Standard Monitoring Compliance: The monitoring of physical health parameters during medication maintenance also met the standards in 100% of cases, underscoring a consistent approach to ongoing patient care.

Comorbidities: The audit identified patients with psychiatric comorbidities, such as Autism Spectrum Condition (47%), Tourette's (3%), Anxiety (3%), and Dyslexia (1%).

Conclusion: The audit highlighted the importance of maintaining high standards in ADHD medication management and suggested areas for further improvement, such as the documentation of rating scales to objectively monitor medication effectiveness. Based on the audit results, an ADHD clinic proforma was developed to incorporate all required data points, ensuring comprehensive documentation during clinic appointments.

Audit Cycle of Record Keeping by Doctors in Older Adult Inpatient Settings

Dr E Betty Anthony[1], Dr Damola Akinmoladun[2], Dr Dumogo Anochie[3] and Dr Oluyemi Akinmolayan[1]

[1]Cumbria Northumberland Tyne and Wear NHS Foundation Trust, Newcastle, United Kingdom; [2]South Tees NHS Foundation Trust, Middlesbrough, United Kingdom and [3]Northamptonshire Healthcare NHS Foundation Trust, Northamptonshire, United Kingdom

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Aims: To assess compliance with record keeping policies.Medical records play a vital role in supporting patient care. However, effective record keeping in clinical practice, particularly in mental health, poses significant challenges. The General Medical Council's (GMC) good medical practice, states that doctors must ensure their records are clear, accurate, and legible. Regulation 28 of the Coroners and Justice Act 2009 empowers coroners to address concerns that could lead to future deaths. Davies Arnold Cooper (DAC) Beacroft's 2022 report identified record keeping as a key issue in mental health.

Methods: Patients across three older adult inpatient wards were identified using convenience sampling method. Five hundred and thirty-three entries made by doctors for the audit and 424 entries made by doctors for the re-audit were identified using patient identifier. Data compilation was done using Excel spreadsheet and analysed using descriptive statistics. Outpatient entries and ECT entries made by doctors were excluded, ensuring a focused assessment of inpatient records. The results were presented using bar charts, pie charts and tables.

Results: The results were compared with the trust's Record Management Policy and the previous audit conducted in January 2023. The re-audit found an improvement in the percentage of validated entries across all three wards compared with the previous audit. One of the wards showed the highest improvement, with a 35% increase in validated entries. However, the overall validation rate was still below the 80% requirement standard set. The timescales for validation across the three wards also showed some improvement, with the majority of validated entries meeting the 12-hour standard, although a small percentage remained unvalidated for longer periods. In addition, doctors were more likely to sign off their entries during normal work hours than out of hours

Conclusion: The findings suggest that while there has been improvement in the timeliness and completeness of clinical entries validation, more work is needed to ensure full compliance with the trust's policies and the GMC's good medical practice. Recommendations include regular reminders to doctors on promptly signing off clinical entries, incorporating record-keeping guidelines into local inductions, and a review of the trust's guidelines on note validation for inpatient entries. This audit cycle led to a broader quality improvement project and trustwide policy change on validation of clinical entries. It highlights the importance of maintaining accurate and timely clinical entries.

Prescribing for Substance Misuse: Alcohol Detoxification in Adult Mental Health Inpatient Services. The National Prescribing Observatory for Mental Health (POMH-UK) Quality Improvement Programme: 14c

Dr Fareeba Anwar[1], Dr Haroon Siddiq[1] and Dr Roisin Nuttall[1,2]

[1]Merseycare.nhs.uk, Warrington, United Kingdom and [2]Cheshire and Wirral NHS Trust, Chester, United Kingdom

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Aims: To help specialist mental health Trusts/healthcare organisations improve their prescribing practice. To assess the Trusts' alcohol detoxification practices, benchmark against the national average performance and to compare results to the previous audit of 2016. This was the second re-audit in the cycle.

Methods: The audit included any person (Male and Female) admitted to an acute adult or psychiatric intensive care ward, or a specialist inpatient drug or alcohol unit, who underwent alcohol detoxification (assisted alcohol withdrawal) whilst an inpatient. Patients identified via RiO, EPMA, Pharmacy Databases and Ward/Team caseloads. The final sample consisted of 80 patients, 20 patients from each of the 4 boroughs (Warrington, Halton, Knowsley, Wigan).

Data was collected in May 2021 via clinical audit days over Microsoft Teams, checked for quality twice by the audit leads and inputted by the Medicines Management Team in June 2021.