Results. The data showed that 76.9% of discharges were completed within 24 hours, with weekend discharge completion at 4 and only 25% after 5 pm. Half of the discharge summaries were closed by nurses, 46% by doctors, and one by the ward clerk.

The median time taken to complete the discharge process was 25.83 hours, slightly exceeding the 24-hour target. Survey results indicated that 60% of staff were aware of the 24-hour timeline, but there were gaps in communication between staff members. Additionally, only 40% of staff had received formal EPMA discharge summary training, with nursing staff being the majority.

Eighty percent of survey respondents expressed challenges with the discharge summary process, particularly regarding communication with the pharmacy team and closing the discharge summary. Weekend discharge data revealed gaps in responsibilities when the ward clerk was unavailable to send letters.

Overall, the findings suggest a need for improved communication and training to enhance the efficiency and effectiveness of the discharge process, ensuring timely and accurate transmission of discharge reports to primary care physicians and other professionals.

Conclusion. More than half of the staff understood the discharge process however communication between staff in regard to the discharge process impacted on the timeliness of the summaries completed.

Dementia and Driving

Dr Mohammed Al-Dabbagh*, Dr Faquiha Muhammad and Dr Dolapo Odegbaro

NHFT, Northampton, United Kingdom
*Presenting author.

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Aims. This audit focuses on assessing the compliance of health professionals with the UK law by informing the drivers with dementia about their legal requirement to report their condition to the DVLA and their insurance companies. The aim of this audit is to ensure public safety by adhering to the General Medical Council (GMC) guidance; "Confidentiality: patients' fitness to drive and reporting concerns to the DVLA or DVA", as well as the Driving with Dementia or Mild Cognitive Impairment Consensus Guidelines for Clinicians; endorsed by RCPsych and Alzheimer's Society. This will help ensure public safety and prevent potential accidents or incidents caused by impaired driving.

Methods. The audit reviewed retrospective data of 40 patients selected randomly (17 males, 23 females and mean age 78 years old), referred to the memory clinic at Watermill Resource Centre in Berrywood Hospital, Northampton. The inclusion criteria was patients referred between 1st January and 31st December 2022 that were diagnosed with dementia. We set a compliance target of 100%.

Results. The results showed that out of the 40 patients diagnosed with dementia, 23 had a recorded risk assessment. 11 patients were driving at the time of assessment. 7 patients were referred to occupational therapy for a driving assessment. The compliance in informing patients about reporting to the DVLA and their insurance companies was low. 8 out of 11 (73%) patients were informed about reporting to the DVLA, and 5 out of 11 (45%) were informed about contacting their insurance company. Additionally, only 4 out of 11 (36%) patients were informed about the consequences of not reporting to the DVLA and their insurer. There was also a lack of systematic documentation regarding driving risk assessment. There was no record of medics contacting the DVLA.

Conclusion. Overall, the audit revealed a need for improvement in compliance and documentation. It is recommended that health professionals strictly adhere to their responsibilities in risk assessment and informing drivers with dementia about their legal requirements regarding informing DVLA and insurance companies. Clear documentation should be made using a standard template available.

Audit of Psychotropic Polypharmacy Amongst Inpatients in East Suffolk

Dr Shamim Ruhi[1], Dr Anne Alase[2]*, Dr Motolani Aregbesola[1], Dr Quratulain Khan[1] and Dr Fariha Rizvi[1]

[1]Norfolk and Suffolk NHS Foundation Trust, Ipswich, United Kingdom and [2]Leeds and York Partnership NHS Foundation Trust, Ipswich, United Kingdom
*Presenting author.

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Aims. The use of psychotropics and polypharmacy among patients with learning disability have been widely discussed. Mental illness increases morbidity and mortality and the addition of polypharmacy potentiates these risks.

It is important to determine the proportion of inpatients with psychotropic polypharmacy, highlight associated socio-demographic and clinical factors, and follow up plans for such patients at the point of discharge.

Methods. A retrospective collection of data was completed using electronic records of patients 18 years and above who were discharged from inpatient psychiatric wards located in East Suffolk between 1st July and 31st December 2021.

Data available in discharge medication letters, discharge summaries and inpatient clinical notes were also used in the study.

Results. Amongst 256 inpatient episodes included within the audit, polypharmacy was found in 52% cases.

Of which 80% of patients were above 65 yrs and 56.3% of them were male.

Out of the included episodes, 74% were on combination and 26% were on augmentation therapy.

About 40% had a single diagnosis of schizophrenia/schizophrenia-like delusional disorders, while around 25% had a mood disorder.

9% of episodes had a singular diagnosis of personality disorder and 8.4% of episodes had >1 psychiatric diagnosis.

Conclusion. Despite the increased side effect burden and risks in the presence of physical health co-morbidities, polypharmacy remained prevalent in this group of inpatients.

More than a quarter of patients were on sedative augmentation without any clear plan or recommendation for deprescribing after discharge.

In order to improve clinical practice, more frequent medication reviews should be recommended when there is high prevalence of psychotropic polypharmacy.