The intervention was a teaching session which was held with the ward staff to help improve staff confidence with identifying status epilepticus, medications, as well as timely management of seizures on the wards.

A second cycle of data collection and questionnaires was completed.

Results: The results showed that intravenous medications (lorazepam) are not regularly supplied at Woodland View. This was due to lack of IV training amongst the nursing staff.

All wards (100%) were adequately stocked with a supply of rectal diazepam which was the correct dose and in date. Buccal midazolam was only available in two (33%) of the six wards audited. The emergency packs had two preparation options of either midazolam or diazepam which were both in date with the correct dosing.

Following the intervention of staff education, ward staff self-reported that they felt more comfortable with identifying a seizure and locating medications in a timely fashion. There was a 50% self-reported improvement in staff's ability to identify the medications required for seizure management and a 19.5% self-reported improvement in staff's confidence of locating medications.

Conclusion: This audit demonstrated that first-line benzodiazepines for the treatment of status epilepticus are available on all wards in at least one preparation. It highlighted the need for staff education about these preparations and their location on the wards. Staff self-reported an improvement in their confidence and knowledge of status epilepticus following the intervention.

Audit and Re-audit on Inpatient Prescription Writing in Psychiatry Ward of Allied Hospital 2 Faisalabad

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Aims: Writing a prescription is an essential task in wards for optimal management of patients. Errors in prescription writing can lead to discrepancy in patient's care. The aim of this audit is to identify errors in prescription writing in wards, communicate them to the staff for improving standard and quality of care, making sure the provision of adequate medication to the patient.

Methods: The study, conducted in early 2023 at a tertiary care hospital in Faisalabad, assessed prescription writing quality through a baseline audit, a faculty-led workshop intervention, and a re-audit after three months. Two team members evaluated randomly selected prescription cards using an audit tool. Results, discussed in a departmental meeting, revealed unsatisfactory standards. In response, mandatory teaching sessions addressed issues like inconsistent expectations, time management, and resident education gaps. Residents were trained on proper prescription documentation and its clinical importance. A follow-up audit showed improvements, highlighting the effectiveness of targeted educational interventions.

Results: Prescription charts of patients admitted in psychiatry ward were analysed, which included 156 charts and added up to a total of 624 drug prescriptions in the initial audit which showed severe discrepancies in writing of important parameters. A re-audit was done several months later in which inpatient charts of patients admitted in psychiatry ward were checked, including 200 charts with total 650 prescriptions which indicated positive response from staff resulting in much improvement in writing adequate prescriptions according to defined parameters.

Conclusion: This audit suggests the importance of improving prescription writing as 1st audit indicated many errors in prescription writing including missing medicine dosage, frequency or strengths and starting/ending dates of medicines. However in re-audit many improvements were noted in prescription writing in all the highlighted areas. Prescribing errors can be effectively prevented by better education and training of prescribing staff, appropriate task and role definitions, proper supervision and teamwork. After writing a prescription, success of the treatment should be reviewed and proper arrangements must be in place for future review and monitoring.

Clinical Audit and Re-audit on Valproate Monitoring of Inpatients at DHQ Hospital, Faisalabad

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Aims: The aim of this audit was to ascertain the number of patients prescribed valproate who underwent pre-prescription evaluation and ongoing treatment monitoring was in alignment with NICE guidelines.

Methods: The study, conducted in early 2024 at a tertiary care hospital in Faisalabad, involved 18 bipolar affective disorder patients (12 male, 6 female) prescribed valproate. A baseline audit was followed by an intervention – a faculty-led presentation on monitoring guidelines – and a re-audit three months later. Data from patient files (1–30 April) was reviewed using an audit tool to assess compliance with NICE standards. Initial findings revealed unsatisfactory monitoring. Results were discussed in a departmental meeting, leading to targeted training for residents. The re-audit showed significant improvement in monitoring practices, demonstrating the effectiveness of the intervention.

Results: The initial audit revealed that only 3 out of 18 patients (16%) had baseline weight measurements, and 6 (33%) had full blood count and liver function tests during treatment. A re-audit conducted months later reviewed 25 patient charts, showing marked improvement: 20 patients (80%) had baseline weight checked, and 18 (72%) underwent recommended blood tests during treatment. These findings indicate a positive staff response and significant progress in adhering to monitoring guidelines for patients on valproate.

Conclusion: This audit underscores the critical need for comprehensive monitoring in patients prescribed valproate. The drug is associated with increased risks of insulin resistance, obesity, Type II diabetes, and cardiovascular complications.