patients prescribed Clozapine, frequency of blood testing was checked. For patients prescribed Sodium Valproate, completion of annual risk acknowledgement forms was checked.

Results. The following audit standards were met with 100% compliance: "For patients on regular psychotropic medication, there should be clear indications for this on the drug chart." "All patients on combined antipsychotic therapy or High Dose Antipsychotic Therapy should have a care plan in place." "For patients detained under the MHA, appropriate Consent to Treatment forms should be present and up to date." "All patients should have a documented annual health check within the last 12 months." "All patients prescribed psychotropics should have psychotropic blood monitoring within last 12 months."

The compliance for the standard "For patients detained under the MHA, appropriate capacity assessment documented on MHA 58 Assessment of Capacity for Treatment form should be present and uploaded to Carenotes" was 71%.

The compliance for the standard "All female patients of childbearing age prescribed Valproate should have an annual Risk Acknowledgment form completed" was 0%.

Conclusion. There was a good standard of documentation of medication and indications on drug charts. Consent to Treatment forms were up to date for all patients. Semi-sodium Valproate and antipsychotic medication used out of license was within Trust guidance. Sodium Valproate was used off license in three patients. Monthly FBC blood monitoring occurred for patients on Clozapine, with the most recent Clozapine level within the last 12 months. Physical health checks and investigations were carried out annually for all patients. However, it was difficult to locate all results. Areas for improvement included: All investigation reports should be uploaded in the same folders with easily identifiable file names for ease of access. All patients on Valproate should have a completed annual risk acknowledgement form. The audit recommendation was to put in place care plans for all patients prescribed Valproate therapy, including review dates for risk acknowledgement forms.

Risk Factors Related to Driving: A Review of Clinical Practice Evaluating and Addressing Fitness to Drive Among Psychiatric Inpatients

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Aims. Mental illness is linked with a higher risk of dangerous driving; e.g. patients with neurotic disorders have 50% more accidents than controls and 10% of drivers involved in accidents have reported feeling suicidal. The Driver and Vehicle Licensing Agency (DVLA) have provided guidance related to fitness to drive for those with mental illness. In this context we intended to study the risk factors associated with psychiatric inpatients related to driving and whether concerns have been documented in clinical reviews.

Methods. Case notes of 100 randomly selected psychiatric inpatients in one calendar month were evaluated including: their driving status; concerns regarding driving based on their clinical status (Diagnosis, Medications, Side effects); any clinical advice given and communication with DVLA in the previous one year, were ascertained from electronic records. Missing values were not included in calculation.

Results. The sample consisted of 51 female and 49 male patients (mean age 39.7±13.5 and 39.1±12.7 respectively), with the majority 69% from Caucasian ethnicity; 64% were informal. There was no difference noted in driving status based on ethnicity or legal status on admission.

On admission 33% of patients reported that they were not driving, 12% were driving, 2% refused to answer and in more than half (53%) driving status was not documented. Considering some of the risk factors for driving, persistent alcohol use was noted in 39.8%, drug use in 34.4%, personality disorder 37%, attention deficit hyperactivity disorder or autistic spectrum disorder in 4%, being on medications with side effects that may impair driving 80.8%, having side effects that impair driving 10%, and suicidality 54.5%. Only in a minority of cases were fitness to drive related issues discussed in their last review (3%), in progress notes (1%), or in discharge notes (2%). There was no documentation related to communication with the DVLA for any patients.

Conclusion. The results suggest there is a need to record the driving status of psychiatric inpatients and to discuss driving related concerns when considering mental state, medications and side effects. Information related to driving should be given to patients, and DVLA should be notified as appropriate. This might help in improving safety related to driving by psychiatric patients.

Physical Health Monitoring of Community Patients Under the Care of Adult Eating Disorder Service at Surrey and Borders Partnership NHS Foundation Trust

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Aims.

1. To determine if the physical health monitoring of patients in the Eating disorder service is done in line with the recommendations of the National Institute of Clinical Excellence (NICE) guidelines and relevant MEED Guidance on Recognition and Management.
2. To determine if the current local AEDS (Adult eating disorder services) guideline for physical health monitoring of Community patients, including blood tests and ECG is adequate for community patient cohort.

Methods.

1. For every attendance of patients to the Outpatient Physical health monitoring Clinic (PHMC), it is expected that the physical health monitoring to be offered would include:
   - Weight
   - Height (if first attendance)

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