Audit of Melatonin Use Across Child and Adolescent Mental Health Services (CAMHS) in Lincolnshire

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doi: 10.1192/bjo.2025.10535

Aims: To establish baseline data on melatonin use.

To compare the patterns of use with national guidelines.

To make recommendations to the teams.

Methods: A retrospective audit of patient records under the CAMHS services in Lincolnshire was undertaken to identify patients on melatonin as of June 2024. Data was collected from medical records between June and July 2024. Patients under 19 years and prescribed melatonin were included. Patients previously on melatonin but discontinued by June 2024 were excluded.

This audit was inspired by the POMH melatonin audit.

Results: 54 patients were identified, 23 males and 31 females. About half of the patients had been on melatonin for over one year (n=25).

Autism/autistic spectrum disorder was the most common diagnosis/comorbidity – 36 patients, 29 patients had an anxiety disorder, 21 patients had diagnosed/comorbid hyperkinetic disorders, 12 patients had mood disorders while 14 patients did not have a diagnosed neurodevelopmental disorder.

In 84.6% of prescriptions, evidence-based non-pharmacological measures were tried first.

The target symptom(s) for melatonin treatment was clear in 55.6% of cases. Sleep latency was the most common target, followed by reducing night-time awakening.

Licensed melatonin preparation was used in 46.3% of prescriptions. The preparation was however not clearly documented in most of the cases. (Licensed use covers insomnia with autism spectrum disorder (Slenyto), insomnia with Smith–Magenis syndrome (Slenyto), insomnia associated with behavioural disorders in children and adolescents (Adaflex)).

86.7% of prescriptions were reviewed for efficacy within 3 months while tolerability (side effects) was reviewed in 46.7%.

The need for continuing melatonin treatment was reviewed annually in 80.8% of cases while tolerability was reviewed in 30.8%.

Conclusion: The audit revealed high rates of prescription in certain areas of the county, it also showed that documentation of indication and target symptoms was not always available, similarly review of tolerability (side effects) was not always available.

The findings were presented to the CAMHS consultants. The high rates were thought to be related to shift in practice over time, perhaps due to consultants shortage.

Documentation of efficacy was more often done than review of tolerability. One reason for this could be that melatonin was being monitored by the community paediatrics team or the GP.

The need for clear documentation can therefore not be overemphasized.

The audit did not consider those who were able to stop melatonin. This could be useful to support patients.

Re-Audit of Safe Deprescribing on Inpatient Psychiatric Wards After Implementation of an Electronic Prescribing Management and Administration (EPMA) System in an NHS Trust

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doi: 10.1192/bjo.2025.10536

Aims: The audit aimed to evaluate the effectiveness of transitioning from paper-based patient prescription charts (Kardex) to an electronic prescribing and medication administration system (EPMA) in improving compliance with safe deprescribing practices on inpatient psychiatric wards. Specific objectives included assessing adherence to Trust guidelines, reducing incidents of incorrect medication deprescription, and enhancing clarity regarding medication changes.

Methods: This audit was performed in May 2024 on all psychiatric inpatient wards utilising the EPMA system. This system had been in use for over a year in the Trust following a phasing out of the paper Kardex. During this period, the EPMA records of inpatients were evaluated. The findings were compared with that from a previous audit, which examined Kardex records in March 2022. The comparative analysis centred on deprescribing practices, examining whether medications were properly discontinued, entries were completely filled, and justifications for deprescribing were noted. The audit complied with Trust protocols and ethical governance requirements.

Results: The transition from the Kardex system to EPMA resulted in significant improvements in safe deprescribing practices. There was 100% compliance in details on the system corresponding to most of the standards measured in the previous audit, including name crossed, row crossed fully, ID, code (reason) and stop date. The sole exception to this was observed when utilising the 'other' option in EPMA's dropdown menu, where adherence to providing a stated reason was 94.5%, a metric not evaluated in the initial audit as this was not facilitated by the paper Kardex. In this audit, all the standards were met and the medications were considered safely deprescribed. This stands in contrast to the previous audit where less than 33.88% of deprescribed medications met the standards.

Conclusion: The EPMA system demonstrated substantial progress in promoting safe deprescribing practices aligned with Trust guidelines. The notable improvement in compliance clearly demonstrates the significant influence of technology on clinical practice and patient safety in relation to medication prescription and administration in this case.

Audit of NICE QS101 Learning Disability: Behaviour That Challenges

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