

Aims. High Dose Antipsychotic Therapy (HDAT) prescriptions and combinations of antipsychotic agents are not currently recommended as standard practice by the RCPsych. College guidance (RCPsych, CR 190) advises that there is “little convincing evidence that off-label prescription of doses of antipsychotic medication above the licensed dosage range has any therapeutic advantage in any clinical setting” and that “any prescription of high-dose antipsychotic medication should be seen as an explicit, time-limited individual trial with a distinct treatment target”. Despite this, both national and local data demonstrate that HDAT has continued to be used regularly across psychiatric inpatient settings, often out of hours and often secondary to the use of PRN Antipsychotics, without a clear treatment plan or rationale. My aim was to create a simple, accessible, online tool that would allow prescribers to quickly and efficiently calculate the BNF percentage of any antipsychotic prescription and that this will enable safer prescribing.

Methods. With the support of a web-developer, I developed an online tool quickly and easily calculate antipsychotic BNF percentages. The tool can be found here: www.hdat.co.uk

Results. The HDAT Helper has been well received at local presentations and I have recently gained the support of senior management at Southern Health NHS Foundation Trust to develop an education programme on HDAT and the HDAT Helper to expand use of the tool across Southern Health.

Conclusion. The current expert guidance, clinical research and my own audit work demonstrates that there are ongoing issues with the prescription of high dose antipsychotics and that at times this occurs inadvertently when different agents are combined.

I believe that the HDAT Helper can make prescribing of antipsychotic agents clearer and more efficient and as a result significantly improve patient safety.

Antipsychotic Cardiometabolic Monitoring: Systemic Gaps and Hidden Groups

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Aims. To determine whether there are any gaps in cardiometabolic monitoring within primary or secondary care for people prescribed antipsychotic medication. A well-established system of cardiometabolic monitoring and checks has been implemented for patients with psychosis and bipolar in secondary care. It was unclear whether patients without these diagnoses were receiving the same level of monitoring.

Methods. Data were collected retrospectively from case notes of service users under CMHRS Reigate. We included all patients from three GP practices (100 patients) and identified all who were prescribed antipsychotics and their diagnoses. The GP practices were contacted to determine whether a system was in place to flag physical health monitoring requirements for service users on antipsychotics regardless of diagnosis. The results were used to calculate the potential number of patients across the entire trust who were at risk of not receiving cardiometabolic monitoring.

Results. 24/100 patients were prescribed antipsychotics without a diagnosis of psychosis or bipolar. 11/24 had a diagnosis of Emotionally Unstable Personality Disorder. Quetiapine was the commonest antipsychotic. None received routine cardiometabolic monitoring.

The total caseload for all 11 adult community teams in the Trust is 2434. If prescribing and monitoring practices are similar 584 individuals may be affected.

2/3 GP practices responded. Both confirmed that they would only conduct cardiometabolic monitoring when taking over prescribing/on discharge from secondary care if specifically requested to do so.

Conclusion. This service improvement project has identified a significant group of patients who aren't automatically offered cardiometabolic monitoring in secondary care.

Private correspondence from Professor David Taylor confirms that these patients would also benefit from monitoring when prescribed doses that are more likely to cause adverse effects (Quetiapine > 150mg/Olanzapine >5 mg Risperidone >2mg)

Secondary services need to identify these patients and include them in routine cardiometabolic monitoring.

Secondary services need to work closely with primary care to ensure that responsibility for checks is agreed and handed over when necessary.

Do We Know if You Drive? a Quality Improvement Project Improving Compliance With DVLA Guidelines

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Aims. Background: The Driving & Vehicle Licensing Agency (DVLA) states: “Doctors and other healthcare professionals should: advise individuals on the impact of their medical condition for safe driving ability and also advise the individual on their legal requirement to notify DVLA of any relevant condition”. Within mental health, the guidance states that depression or anxiety associated with “Significant memory or concentration problems, agitation, behavioural disturbance or suicidal thoughts” must be reported to the DVLA. Aims: Identify whether information was collected on driving status of patients presenting with depression/anxiety and self harm. Identify whether accurate advice was provided and documented. Implement changes that would improve compliance with guidance.

Methods. We reviewed notes to collect baseline data for 3 weeks prior to commencing interventions, then weekly for 2 months from November 2021. Cases were defined as: those presenting to Liaison Psychiatry (LP) with an act of self-harm either on antidepressants or with a confirmed diagnosis of depression/anxiety on their record. Each week, the notes of 10 cases were reviewed for evidence of documentation of driving status and advice regarding DVLA guidelines.

Weekly Interventions.

Week 1: Email communication to team highlighting the guidance, responsibilities and where to document.

Week 2: Driving status discussed in handover daily to increase awareness and identify/address concerns.

Week 3: Repeat email to team.

Week 4: DVLA guidance posters placed in LP office.

Week 12: Teaching session by Occupational therapist from regional driving assessment centre.