Aims.
- To find out discrepancies around community treatment order section paperwork and renewal hearings.
- Explore if CTO is helpful in delaying relapse of mental illness.

Methods. All inpatients from general adult male and female wards in the North East Essex area in the last 3–5 years who were detained under section 3 of the Mental Health Act and were discharged on a Community treatment order were included. All included patients were followed up for a period of two years and data was reviewed to know if the standard guidelines regarding the CTO paperwork completion and renewal hearings were followed.

Data about episodes of further recalls to hospital, further revocation or discharges on CTO during that two year period for these patients is included.

Information about the timely filling of the CTO forms and uploading on the system upon readmission is explored wherever applicable.

Finally, the time duration between discharges and each readmission is explored.

Results. Total no. of patients: 13, Male: 10, Female: 3

Out of the 13 patients,

One had 4 readmissions in the consequent two year period (Days since last discharge – 158, 80, 14, 365 days), duration of each admission: (39, 9, 71, 53) days.

Two had 2 readmissions (on days 623 and 80: On day 65 and 9), Duration of each stay (6 and 90 days; 80 and 164 days).

Four patients had 1 readmission (on days 683, 133, 30, 723) and duration of stay is (14, 33, 1510 and 1460 days).

Six patients never had any admission.

As for the tribunal hearing, one patient's tribunal hearing was missed, one of them did not attend, one had his CTO rescinded and one was admitted soon after. Rest of the patients had their regular timely hearings and were regularly reviewed in the community.

Out of 13, only 3 patients had appealed against the CTO, had tribunal hearing.

Out of 13 patients, only one patient had his CTO lapsed and he had two readmissions during the 2 years follow up.

Delay in admission following recall was due to section 135 being issued.

CTO3 paperwork was missing in two cases.

A second CTO3 or recall notice was issued in 4 cases, in 1 case, reason was not documented, in 2 cases, patient agreed for informal stay but later did not comply with care plan. In one case, reason was not documented.

Conclusion. CTO paperwork are missed in rare cases and could be avoided by reminders from Mental Health Act Office.

CTO renewal hearings take place regularly as per mental health act guidelines, though in rare cases, meeting is missed. This could be avoided by having patients discharged on CTO to be booked for timely reviews beforehand.

The audit is too small and is inconclusive to indicate if CTOs prevent readmissions and relapses and hence future study with more sample size is called for.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Venous Thromboembolism (VTE) Risk Assessment in an Older Adult Mental Health Inpatient Ward

Dr Oluwatobi Ajewole[1,2]* and Dr Margaret Ogbeide-Ihama[1]

[1]Oxleas NHS Foundation Trust, London, United Kingdom and [2]King's College, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.526

Aims. This audit aimed to investigate how VTE risk assessments on one of our older adult inpatient units meet to the recommended standard by:
1. Assessing the compliance of admissions to the trust VTE policy, which is based on the corresponding National Institute for Health and Care Excellence (NICE) guideline.
2. Determining if VTE assessments were performed using appropriate clinical tools, as recommended in the policy, and correctly recorded in patient notes.

Methods. All admissions to the ward (n = 77) within the one year from 01.06.2021 to 31.05.2022 were retrospectively reviewed for VTE assessments based on the abovementioned standards. Data was extracted from progress notes and ward round entries for completion of the VTE assessment during admission, documentation of the assessment tool, documentation of the VTE prophylaxis prescription if indicated, and reassessment of risks during admission.

Results. This audit showed that only 3% of patients had a VTE assessment documented within the first 24 hours of admission. Overall, over a 10th of all patients never had an assessment, and of those who did, no one had the assessment tool used documented or uploaded on their clinical records. Also, of those who had a VTE assessment done, 5% were assessed to be at risk, and of these, only half had VTE prophylaxis prescribed.

Conclusion. This audit showed the ward is essentially not meeting the standard for VTE risk assessment, with recommendations to incorporate VTE assessment as part of the clerking proforma and the medication charts, similar to the usual practice on physical health wards.

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A Survey on the Electronic Discharge Summary Process in an Acute Inpatient Ward

Dr Ruth Akani*

South West Yorkshire Partnership NHS Foundation Trust, Halifax, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.527

Aims. The study aimed to assess staff understanding of the discharge process in an Elmdale ward, Halifax and improve the promptness of discharge reports to other primary care professionals.

Methods. Initially, the discharge process was reviewed in March 2023 to establish a baseline, focusing on completion time and personnel involved in the process. An online survey was conducted using Survey Monkey with 20 responses from the staff, including nurses, pharmacists, and doctors, to gather insights into their comprehension of the discharge process.

Electronic data for EPMA (electronic prescribing and medication administration) discharge form from SystmOne was analyzed to determine the percentage of completed discharge summaries and identify any incomplete or absent summaries among patients discharged from Elmdale ward (an acute inpatient ward) between March 1st and March 31st, 2023.

https://doi.org/10.1192/bjo.2024.527 Published online by Cambridge University Press

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.

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Dementia and Driving

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

NHFT, Northampton, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.528

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.

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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.

doi: 10.1192/bjo.2024.529

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.

https://doi.org/10.1192/bjo.2024.527 Published online by Cambridge University Press