2. The importance of completing all aspects of monitoring and documenting these each time was highlighted.
3. If monitoring could not be completed, the reason must be documented, to avoid further "unknowns".
4. An agreed plan to schedule monitoring appointments following virtual reviews.
5. Annual re-audit using the same data template, with the aim of improving each year.

Prescribing Practice of Citalopram and Escitalopram in Older Adults Following the 2014 MHRA Guidance of Associated QTc Prolongation: A Clinical Audit

Dr Shreyan Kar[1]* and Dr Aparna Prasanna[2]

[1]The Royal Wolverhampton NHS Trust, Wolverhampton, United Kingdom and [2]Black Country Healthcare NHS Foundation Trust, Wolverhampton, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2024.588

Aims. Citalopram and escitalopram are commonly used serotonin-specific reuptake inhibitors (SSRIs) for the treatment of depression and anxiety. These medications are known to cause corrected QT interval (QTc) prolongation, with risks of further arrhythmias. In 2014, the Medicines Healthcare Regulatory Agency (MHRA) published guidance outlining this risk and advised decreased maximum daily doses of citalopram 20mg and escitalopram 10mg in the elderly population. The aim of this audit was to explore the prescribing patterns of citalopram and escitalopram in a community sample of older adults with psychiatric disorders, against MHRA guidance.
Methods. Older adults (aged >65 years) in the community mental health services in Wolverhampton, who were prescribed citalopram or escitalopram, were identified through a search of clinic letters in June 2023. We checked the medications, doses, history of QTc prolongation, concurrent medications that may prolong QTc, electrocardiogram (ECG) reviews, and any discussion about the risk. The data was collected by accessing the electronic patient record and related health records. In total 17 patients were included, with no exclusions.
Results. Most of the patients (94.1%, n = 16) were on citalopram and only one patient was on escitalopram. The most common dose of citalopram was 20 mg (62.5%, 10/16), with one patient having a higher than the recommended dose (30 mg). Escitalopram was within the recommended dose. There was no history of QTc prolongation in any patient. Concurrent medications that could prolong QTc were identified in 35.3% (n = 6) of the patient population; all of these were antipsychotics. A small proportion (11.8%, n = 2) of the patients had documentation stating about QTc prolongation and arrhythmia risks for citalopram or escitalopram. A review of ECG when initiating or adjusting treatment was noted in only one patient.
Conclusion. Most of the older adults had citalopram and escitalopram within recommended limits. A considerable proportion of patients had concurrent medications with an additional risk of prolonging QTc and subsequent arrhythmia. It is essential to consider ECG in all elderly patients before starting medications with a risk of QTc prolongation. There is a need to discuss the cardiac risk associated with citalopram and escitalopram with the patients and improve documentation. It may be better to provide written information to the patients and caregivers regarding this.

Improving Health System Engagement in Patients With Substance Use Disorders: Audit of Care Plans in the National Drug Treatment Centre

Dr Mary Keenan[1]* and Dr Siobhan Rooney[2]

[1]Central Mental Hospital, Dublin, Ireland and [2]National Drug Treatment Centre, Dublin, Ireland
*Presenting author.

doi: 10.1192/bjo.2024.589

Aims. The National Drug Treatment Centre in Dublin is the longest established treatment service for drug users in Ireland. Led by Addiction Psychiatry teams, it provides specialist multidisciplinary input for patients with complex medical and psychiatric needs secondary to substance use. Many patients attending the centre engage poorly with other healthcare services in the community. The aim of this audit was to improve physical healthcare engagement in a caseload of 60 patients, through improving GP registration rates and possession of medical cards (providing access to free public health services).
Methods. The comparison standard for the audit was the Irish Health Service Executive (HSE) Clinical Guidelines for Opiate Substitution Therapy: 2016. These stipulate that all drug users entering treatment and rehabilitation should have a care plan based on assessed need. Specific domains covered include: Drug and Alcohol use, Physical Health, Psychological Health and Social Functioning.

During the initial audit cycle, electronic care plans in a caseload of 60 patients were reviewed for information on their GP and medical card status.

Intervention: Following the initial cycle, results were presented and discussed at a multidisciplinary team meeting. A combined MDT effort was made to discuss medical card and GP status with patients during each interaction. Patients were referred to social work for support in application/renewal of medical cards and GP registration where required.
Results. Results following re-audit:

The percentage of patients with GP registration clearly displayed on their care plan increased from 66% to 93%.

The percentage of patients with an up to date medical card increased from 12% to 45%.

The percentage of patients whose medical card status was unknown reduced from 72% to 44%.

The percentage of patients with their medical card number displayed on their care plan increased from 25% to 55%.
Conclusion. There was a significant improvement in the number of patients with GP and medical card information documented clearly on their electronic care plan. This has assisted National Drug Treatment Centre staff in supporting patients' physical health needs more effectively, through close liaison with primary care providers and onwards referral to other services where required. It was noted that further efforts were required to build upon these results and reach 100% compliance. Recommendations and an action plan were developed to ensure ongoing improvement in standards.