Aims. To improve the quality of care received by service users of Electroconvulsive Therapy (ECT) treatment in Lincolnshire Partnership Foundation Trust (LPFT) by measuring the compliance of the local ECT clinic in Lincolnshire in accordance with National Institute of clinical excellence guidance and ECT accreditation services standards.

Methods. Pre-audit work up includes consultations with ECT clinic lead and stake holders to ensure ethical and governance standard are met. This audit is conducted with the permission of trust quality and safety team.

Sample population is identified from ECT clinic registry, Lincoln. A total of 10 patients who received ECT treatment between January 2023 and August 2023 are included regardless whether the necessary information is available on the clinical system or not, to minimise selection bias. Retrospective data collection by using Rio electronic case records. Descriptive analysis of data using Microsoft Excel and evaluation of results is based on 3 key domains such as indication, consent process and monitoring.

Results. A total of 10 service users, comprising 30% males and 70% females, underwent treatment in both inpatient (80%) and outpatient (20%) settings, primarily for severe depressive illness. In 70% of cases, a pre-ECT assessment was documented to evaluate potential risks and benefits. The consent procedure was completed by a psychiatrist in 70% of instances. However, ongoing consent was not consistently reviewed at each ECT treatment.

Baseline monitoring using the Clinical Global Impression and Comprehensive Psychopathological Rating Scale was conducted in 20% of cases, with no follow-up assessments performed after each treatment. The Montgomery–Åsberg Depression Rating Scale was employed at baseline for 40% of patients, yet there was no evidence of weekly monitoring. While the Montreal Cognitive Assessment was administered to all patients at baseline, it was not conducted after every four treatments.

Post-ECT follow-up data revealed that less than a quarter of patients underwent clinician reviews. Validated rating scales were utilized in no more than a fifth of patients at both one week and two months after treatment.

Conclusion. The findings suggest the need for improved documentation of the entire consent process and in regularly assessing the ongoing validity of consent. Moreover, there is a need for stronger monitoring at baseline, during, and after ECT treatment. It is recommended to revise the local ECT record pathway by December 2023, with a follow-up re-audit scheduled for March 2024 to evaluate the effectiveness of the implemented changes.

Driving Status in Patients Admitted to Acute Psychiatric Ward and DVLA Advice

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Aims. DVLA guidance is very clear about patients not driving during or shortly after episodes of acute mental illness. There is an obligation for patients to inform the DVLA if they are unwell. The obligation for doctors to inform the DVLA if the patient chooses not to, and continues to drive when they should not, is also well known.

This audit aims:

1. To identify the number of patients whose driving status was recorded following their admission to an acute psychiatric ward.
2. To identify the number of patients discharged with correct DVLA compliant advice.
3. To identify the number of patients whose notes reflected correct driving status information on discharge.

Methods. Patient ward notes and discharge summary documents relating to their admission on to the PICU ward were examined retrospectively for recorded evidence of patient's driving status and any documented DVLA advice given. Patients admitted from November 2022 and April 2023 were reviewed. 68 patients were identified and systematic sampling techniques identified a sample of 30 patients.

Keyword search included "Driving", "License", "Car", "Driving license", "DVLA".

Results. 30 patients were reviewed in total.

40% of sample patients had no driving status recorded on their notes.

Of the 60% of sample patients who were confirmed to be driving/held license, nearly half (47%) had no recorded advice documented regarding the DVLA or driving after an acute MH illness on discharge.

A third (33%) of sample patients were recorded as having been given generic advice regarding driving only.

Only 20% of sample patients recorded to be driving, were documented as having been given correct advice as per DVLA guidance on discharge.

Conclusion. This audit demonstrated that driving status is currently poorly recorded in patients admitted to PICU and documentation of correct DVLA-compliant driving advice being given on discharge to relevant patients is also poor. Patients may not be receiving important information that they need.

Providing correct and accurate advice to patients regarding the DVLA rules and psychiatric illness should be part of a safe and robust discharge plan, and forms part of the clinical teams obligations to the patient. Identifying patients as drivers and improved documentation of driving status and evidencing appropriate advice being given is key.

A number of interventions were implemented and a re-audit will be undertaken in Spring 2024. If successful at improving rates of DVLA compliant advice being given, it would be hoped these interventions could be shared across the trust.

Monitoring of Blood Clozapine Levels After a Change in Smoking Status for Patients Treated With Clozapine: A Clinical Audit From Hull Community Mental Health Team

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Aims. According to The Medicines and Healthcare products Regulatory Agency (MHRA) Drug safety update in August 2020 regarding clozapine, monitoring blood clozapine levels for toxicity is now advised in certain clinical situations such as when a patient stops smoking or changes to e-cigarette.