

Completion of consent form by the patient or carer.

Documentation of ongoing valid consent.

Right to withdraw consent.

The aspect of ECT administration process reviewed was the documentation of pulse, blood pressure and pulse oximetry readings.

The aspects of the monitoring process reviewed were:

Assessing and recording clinical response at baseline and between sessions.

The use of validated rating scales in assessing response.

Assessing and documenting cognitive side effects.

Results: Although the consent forms were completed by 100% of the patients or carers and ongoing valid consent was checked for all the patients before each ECT treatment, none of the patients were informed about the right to withdraw consent. The vital signs including the pulse, blood pressure and pulse oximetry readings were robustly documented before, during and after the administration of ECT. Unfortunately, no validated rating scale was used for assessing the symptomatic improvement during the course of ECT treatment, and the evaluation of improvement was solely based on the clinical judgement of the psychiatrist. With this reliance on clinical judgement, the clinical status of all the patients was assessed at baseline but the clinical response between each treatment session was assessed for only 45% of the patients. Regrettably, there was a lack of documentation regarding assessment and review of the cognitive side effects and no standardised cognitive assessment tool was used for this purpose.

Conclusion: This audit highlights several areas for improvement, including the failure to inform patients about the right to withdraw consent, irregular clinical evaluations, and the neglected use of standardised assessment tools for monitoring clinical response and cognitive side effects. We suggest updating the consent forms to include the right to withdraw consent. Culturally validated assessment tools should be designed for more structured and objective monitoring of clinical response and side effects. Finally, a re-audit should be scheduled in one year's time to assess improvement.

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.

High Dose Antipsychotic Therapy (HDAT) and Physical Health Monitoring for Patients Under the Liverpool Homeless Outreach Service

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Aims: To assess the antipsychotic burden and adherence to the Trust policy on HDAT and physical health monitoring for patients under the Liverpool Homeless Service.

Methods: Patient records were assessed for a three-month period between July to September 2024 to look at the antipsychotic burden for patients under the Liverpool Homeless Service. Sources of information included patient electronic records, and General Practitioner summaries. A two-stage process was then carried out depending on the HDAT calculations. For patients found to be HDAT, records were checked to measure the adherence to the protocol. Trust Protocol would require bloods and ECG to be done, followed by repeat tests at 3 and 6 months. For the rest of the patients on the caseload we assessed whether physical health monitoring had been done per policy. Trust policy on this was yearly Body Mass Index, full blood count, Liver function tests, Renal profile, HBA1C

level, lipid profile, serum prolactin. Compliance to these standards was set at 100%. A total of 40 patients were included in this audit

Results: We found that 2.5% of the patients in the service were receiving HDAT. HDAT protocols were not followed for these patients. With regards to physical health monitoring 62.5% of the patients had received the stipulated yearly bloods tests. 55% had Body Mass Index done. Reasons given for non-compliance to these checks included lack of engagement from service users, lack of timely reviews. 77.5% of patients assessed had ECG monitoring done, and this was on time in 60%.

Conclusion: Use of high-dose antipsychotics in the service was low, at 2.5%. There was low uptake of HDAT protocol in these patients. Physical health reviews were noted to be adherent to the policy in about half the caseload. To this end recommendations were made for a system to identify patients due for their physical health checks. Awareness was also to be raised in the team regarding HDAT.

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ADHD in Intellectual Disability Audit: Diagnosis, Medication and Monitoring

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Aims: Attention Deficit Hyperactivity Disorder (ADHD) is more prevalent in adults with an intellectual disability (ID). NHS Digital reported the prevalence of ADHD in the ID population to be 9% in 2023–2024, compared with 1.2% in those without ID. Understanding the prevalence of ADHD within our Mental Health of Learning Disabilities (MHL) team is crucial for tailoring our services accordingly and improving patient care. We decided to complete an audit across Kent and Medway to assess the degree of service demand arising from the diagnosis and treatment of ADHD in patients already open to the MHL service, and to assess our adherence to NICE guidance for medication monitoring for ADHD medications.

Methods: A cross-sectional study of all patients currently open to MHL was conducted. Total numbers across MHL were recorded, as well as the split between the East and West Kent caseloads. All case notes, clinic letters and GP records were reviewed to identify whether a diagnosis of ADHD (or possible ADHD) was present. Once identified, a deep dive of patient records took place to check medication history and GP monitoring. Information was collated about the type of medication prescribed and length of prescription and whether monitoring had been carried out over the past 6 months in accordance with NICE guidance.

Results: We found that 15% (N=97) of all MHL patients (N=629) had a confirmed diagnosis of ADHD, with 65.5% male and 34.5% female. The mean age of these patients was 24.6. Of those with confirmed diagnoses of ADHD, 43% (N=42) were prescribed medication. The most commonly prescribed medication was methylphenidate (62%), followed by atomoxetine (14%) and lisdexamfetamine (9.5%). Most patients had been on ADHD medication for less than 1 year (31%), with only 7% of patients being prescribed ADHD medication for over 10 years. With regards to medication monitoring, for those prescribed ADHD medication,