

A Clinical Audit on the Monitoring and Management of Antipsychotic-Induced Hyper Prolactinaemia

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Aims. Antipsychotic medications are one of the major iatrogenic causes of hyperprolactinaemia with the attendant short- and long-term effects and risks associated with it.

- The audit sought to answer the question: Are we monitoring and managing hyper prolactinemia caused by anti psychotic medications appropriately?

Methods.

- A literature search for relevant data and standards with regards to monitoring and management of hyperprolactinaemia was conducted.
- The audit was based on the standards derived from South West Yorkshire NHS Partnership Foundation Trust's (SWYPFT) standards, NICE guidelines, and the Maudsley Prescribing Guidelines in Psychiatry (14th edition), focusing on the Trust's standards.
- The total population under consideration included every patient under the care of the North Kirklees, Community mental health team (CMHT), Old age psychiatry services (OPS) that was using antipsychotic medication in the time period between 16 June 2022 and 15th July 2023.

Results.

- Total patients 61
- Female 30
- Male 31
- Age: 65 and above
- Already on antipsychotic: 49
- Started on antipsychotic: 12
- Two or more antipsychotic: 2
- Switch from one antipsychotic to other: 4
- Prolactin monitoring not required: 27 because were already using olanzapine, quetiapine and aripiprazole

Monitoring required: 34

- Initiation: 12
- Prolactin level done 2/12
- Prolactin level not done 10/12
- LAI (long acting antipsychotic) 11
 - Prolactin level done 7/11
 - Prolactin level not done 4/12
 - Not done: 75% were with Care coordinator
 - 25% Wellbeing team
- On oral antipsychotic that require prolactin level monitoring: 11
- Prolactin level done 5/11
- Prolactin level not done 6/11

Conclusion. Patients who were on antipsychotics in community required prolactin monitoring. In more than 50% of patients prolactin were not monitored regularly because of communication gap between Psychiatrist and GPs as no clear instructions were mentioned from Psychiatrist to GPs, patients and care coordinators.

A small number of patients in whom prolactin was raised were highlighted to their respective medics and managed accordingly.

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.

Audit of Resuscitation Equipment in a Mental Health Setting – Resulting in Trust-Wide Action

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Aims. The aim of this audit was to review the availability of recommended resuscitation equipment in Prospect Park Hospital (PPH), a psychiatric hospital based in Berkshire.

The objective was to improve patient safety standards and address staff concerns by ensuring that recommended resuscitation equipment was accessible and fit for purpose.

Our hypothesis was that the current standard of resuscitation equipment at PPH was unsatisfactory.

Background

This review followed concerns by doctors who struggled to obtain the necessary equipment required for emergency situations, particularly during their out of hours shifts.

This project was significant as within the previous year there had been two incident reports and extensive anecdotal evidence of equipment failure/absence.

Whilst each ward had been tasked with completing a weekly checklist issued by the Resuscitation team, these had not been audited to ensure that standards were being met.

Methods. Data was collected from ten locations at Prospect Park Hospital from 9th May to 15th May 2023.

Information was obtained by two doctors visiting the specified wards, reviewing the resuscitation bag equipment based on the standardised checklist.

The standards used were from local trust policy and Resuscitation Council UK policy.

Results. 7/10 locations did not meet the standards for resuscitation equipment, including missing or expired equipment such as adrenaline, suction devices and oxygen masks.

4/10 wards had not completed the weekly emergency drug checklist within the stipulated time frame.

70% of staff completed checklists were incorrect.

Conclusion. Our hypothesis was proven to be correct, in that the current standard of resuscitation equipment at PPH was unsatisfactory.

We worked closely with the Resuscitation lead to recommend improvements, including an updated, more detailed checklist, a standardised procedure for ward managers and regular future audits.

Due to the significance of the findings, this has since been re-audited and is in the process of being rolled out Trust-wide, including all inpatient and community settings.

As a result of this audit, the Resuscitation team have been granted additional staffing to action these changes and increased their remit to monitoring equipment in addition to training.

These findings demonstrate that it is vital that the recommended resuscitation equipment is available and suitably maintained, particularly in a community hospital setting with limited resources where it can be life-saving.

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Prolactin Monitoring for Inpatients on Antipsychotic Drugs: A Clinical Audit

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