

Improving physical health assessment of old age inpatients on the Oaks Acute Admission Ward

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Aims. Old age psychiatry patients are subject to increased frailty, comorbid load and medication adverse events than equivalent older age populations without psychiatric illness. Timely physical health assessment and monitoring is therefore an essential part of treatment provision. The Oaks is a 20-bed old age acute admissions ward in Barnet, Enfield and Haringey Mental Health Trust. With this quality improvement project, we aimed to deliver high-quality assessment and treatment of physical health for our patients.

Method. Using NICE guidelines as a blueprint, we devised a list of parameters essential to the management of old age inpatients. This included blood tests (full blood count, urea and electrolytes, liver function, thyroid function, cholesterol, lipids, iron studies, vitamin D, glycated haemoglobin, prolactin), investigations (imaging, ECG, physical examination, cognitive testing) and assessments (body mass index [BMI], functional review, mobility, Rockwood Frailty Score). The implementation goal was to ensure all parameters were acted on within 24 hours of admission (or 48 hours for patients admitted on weekends).

We initially audited these parameters in patients admitted to the Oaks in October and November 2020 ($n = 24$). We subsequently collated all parameters into an online spreadsheet, which was distributed to ward medical staff. For each new admission, parameters could be marked as pending or complete. The spreadsheet was reviewed in daily ward handover. Following implementation, we collected data on the parameters for patients admitted in December 2020 and January 2021 ($n = 16$).

Result. Prior to implementation of the spreadsheet, 42.0% of all parameters had been actioned within 24 hours of admission. Following the implementation of the spreadsheet, 86.2% of parameters had been actioned within 24 hours (mean difference 44.2%, 95% CI 13.5% to 64%, $p = 0.006$).

In detail, there were significant increases in timely actioning of magnesium (increased by 61.7%, $p < 0.001$), cholesterol (61.7%, $p < 0.001$), glycated haemoglobin (65.8%, $p < 0.001$), vitamin D (65.8%, $p < 0.001$), prolactin (61.7% $p < 0.001$), lipids (61.7%, $p < 0.001$), thyroid function (51.7%, $p < 0.01$), iron studies (80.9%, $p < 0.001$), imaging (42.5%, $p = 0.01$), frailty scores (60.0%, $p < 0.01$), BMI measurement (55.9%, $p < 0.001$), and functional review (42.5%, $p = 0.01$).

Conclusion. Implementation of a monitoring spreadsheet with relevant parameters linked to daily ward handover resulted in widespread and significant improvement in the assessment of physical health among old age psychiatry inpatients.

Use of clonidine in the management of opiate withdrawal in community patients

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Aims. Clonidine has been used to alleviate symptoms of opiate withdrawal. No validated prescribing schedules exist for the use

of Clonidine in opiate detoxification in community patients. We have devised a Clonidine prescribing schedule for adult outpatients seeking opiate detoxification.

Background. Opiate cessation following prolonged use produces a central noradrenergic (NA) response in the locus coeruleus (LC), causing symptoms that can result in reinstatement of use. Pharmacotherapies for withdrawal are thought to work through decreased NA release in the LC by agonising pre-synaptic alpha-2 adrenoceptors. Clonidine has been used since the 1970s. However, it is off-license in the UK, and superseded by Lofexidine. Though both cause hypotension, this is less marked with Lofexidine, which may be anxiolytic and considered better tolerated. Lofexidine is no longer available in the UK. Specialists may need to resort to Clonidine for those seeking opiate detoxification.

Method. We performed a feasibility study with the primary outcome being tolerability of an outpatient clonidine schedule. Patients ($n = 7$) were aged between 18 and 65 years (mean 32). Six were prescribed buprenorphine as opiate substitution (OST), and one methadone.

Exclusion criteria were in keeping with BNF contraindications.

An ECG was obtained for each patient before treatment. A urine drug screen and Clinical Opiate Withdrawal Scale were taken to confirm opiate dependence and withdrawal. Patients self-monitored withdrawal using the Subjective Opiate Withdrawal Scale and daily blood pressure measurements. Standard adjuvants for withdrawal were prescribed.

A test dose of 100mcg Clonidine was given to assess for hypotension. If tolerant they received 100mcg QDS, reducing over eight days.

Patients were contacted by their recovery worker twice during the period.

Result. Five of the seven completed the course, two dropped out due to hypotension. No other adverse effects warranting discontinuation were encountered. Patients reported fatigue and light-headedness as their most troublesome side-effects. Of 3 patients who returned SOWS scores, 2 reported decline by 21/64 and 14/64 respectively. One reported an increase of 49/64 over 8 days. 3 of the 5 subjects who completed the course were not abstinent at completion, citing opiate withdrawal symptoms as causative.

Conclusion. There is scope for the safe use of clonidine in the community for motivated individuals. Adequate monitoring of heart rate and blood pressure is required. Starting doses at 100mcg QDS appear well tolerated. Prescribers may wish to reduce this over a longer period to encourage completion and improve tolerability. Further research is needed.

An audit: fitness to drive assessment in inpatients of general adult and old age psychiatry

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Aims. To determine if fitness to drive is assessed on admission and discharge, if applicable, and for this to be documented during clerking and on discharge notifications.

To determine if patients are being educated about the impact of their condition on the ability to safely drive.