



The intervention was a teaching session which was held with the ward staff to help improve staff confidence with identifying status epilepticus, medications, as well as timely management of seizures on the wards.

A second cycle of data collection and questionnaires was completed.

Results: The results showed that intravenous medications (lorazepam) are not regularly supplied at Woodland View. This was due to lack of IV training amongst the nursing staff.

All wards (100%) were adequately stocked with a supply of rectal diazepam which was the correct dose and in date. Buccal midazolam was only available in two (33%) of the six wards audited. The emergency packs had two preparation options of either midazolam or diazepam which were both in date with the correct dosing.

Following the intervention of staff education, ward staff self-reported that they felt more comfortable with identifying a seizure and locating medications in a timely fashion. There was a 50% self-reported improvement in staff's ability to identify the medications required for seizure management and a 19.5% self-reported improvement in staff's confidence of locating medications.

Conclusion: This audit demonstrated that first-line benzodiazepines for the treatment of status epilepticus are available on all wards in at least one preparation. It highlighted the need for staff education about these preparations and their location on the wards. Staff self-reported an improvement in their confidence and knowledge of status epilepticus following the intervention.

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 and Re-audit on Inpatient Prescription Writing in Psychiatry Ward of Allied Hospital 2 Faisalabad

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Aims: Writing a prescription is an essential task in wards for optimal management of patients. Errors in prescription writing can lead to discrepancy in patient's care. The aim of this audit is to identify errors in prescription writing in wards, communicate them to the staff for improving standard and quality of care, making sure the provision of adequate medication to the patient.

Methods: The study, conducted in early 2023 at a tertiary care hospital in Faisalabad, assessed prescription writing quality through a baseline audit, a faculty-led workshop intervention, and a re-audit after three months. Two team members evaluated randomly selected prescription cards using an audit tool. Results, discussed in a departmental meeting, revealed unsatisfactory standards. In response, mandatory teaching sessions addressed issues like inconsistent expectations, time management, and resident education gaps. Residents were trained on proper prescription documentation and its clinical importance. A follow-up audit showed improvements, highlighting the effectiveness of targeted educational interventions.

Results: Prescription charts of patients admitted in psychiatry ward were analysed, which included 156 charts and added up to a total of

624 drug prescriptions in the initial audit which showed severe discrepancies in writing of important parameters. A re-audit was done several months later in which inpatient charts of patients admitted in psychiatry ward were checked, including 200 charts with total 650 prescriptions which indicated positive response from staff resulting in much improvement in writing adequate prescriptions according to defined parameters.

Conclusion: This audit suggests the importance of improving prescription writing as 1st audit indicated many errors in prescription writing including missing medicine dosage, frequency or strengths and starting/ending dates of medicines. However in re-audit many improvements were noted in prescription writing in all the highlighted areas. Prescribing errors can be effectively prevented by better education and training of prescribing staff, appropriate task and role definitions, proper supervision and teamwork. After writing a prescription, success of the treatment should be reviewed and proper arrangements must be in place for future review and monitoring.

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Clinical Audit and Re-audit on Valproate Monitoring of Inpatients at DHQ Hospital, Faisalabad

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Aims: The aim of this audit was to ascertain the number of patients prescribed valproate who underwent pre-prescription evaluation and ongoing treatment monitoring was in alignment with NICE guidelines.

Methods: The study, conducted in early 2024 at a tertiary care hospital in Faisalabad, involved 18 bipolar affective disorder patients (12 male, 6 female) prescribed valproate. A baseline audit was followed by an intervention – a faculty-led presentation on monitoring guidelines – and a re-audit three months later. Data from patient files (1–30 April) was reviewed using an audit tool to assess compliance with NICE standards. Initial findings revealed unsatisfactory monitoring. Results were discussed in a departmental meeting, leading to targeted training for residents. The re-audit showed significant improvement in monitoring practices, demonstrating the effectiveness of the intervention.

Results: The initial audit revealed that only 3 out of 18 patients (16%) had baseline weight measurements, and 6 (33%) had full blood count and liver function tests during treatment. A re-audit conducted months later reviewed 25 patient charts, showing marked improvement: 20 patients (80%) had baseline weight checked, and 18 (72%) underwent recommended blood tests during treatment. These findings indicate a positive staff response and significant progress in adhering to monitoring guidelines for patients on valproate.

Conclusion: This audit underscores the critical need for comprehensive monitoring in patients prescribed valproate. The drug is associated with increased risks of insulin resistance, obesity, Type II diabetes, and cardiovascular complications.

Valproate also impacts haematopoietic homeostasis, inhibiting erythroid differentiation and activating the myelo-monocytic pathway, leading to thrombocytopenia manifesting as prolonged bleeding, platelet abnormalities, or petechial bleeding. Hepatotoxicity ranges from mild ALT elevation to severe liver injury, including jaundice, hepatic dysfunction, coma, or death. Rigorous monitoring of these parameters is vital for mitigating risks, enhancing patient safety, and improving quality of care through effective primary prevention strategies.

In conclusion, this audit highlights the critical importance of adhering to NICE guidelines for valproate monitoring to ensure patient safety and minimize potential adverse effects. The significant improvement observed in the re-audit demonstrates the effectiveness of targeted educational interventions, underscoring the need for ongoing staff training and regular audits to maintain compliance and enhance patient care.

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Audit of the ECT Service in Department of Psychiatry and Behavioural Sciences DHQ Hospital Faisalabad Against the National Institute of Clinical Excellence (NICE) Guidelines

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Aims: The aim of the audit was to ensure that the referral practices and assessment methods of patients who received ECT were carried out and documented as per the NICE guidelines.

Methods: Study was carried out at Allied Hospital 2, Faisalabad Medical University, Faisalabad. Data was collected from May 2023 to October 2023. Study includes all the inpatients referred for ECT during a 6-month period from May 2023 to October 2023. The data was collected by examination of the patient's notes to establish the adherence to all 9 standards required by NICE guidance.

Results: Total number of patients was 47 (24 females and 23 males) the results show that ECT guidelines were followed and 100% compliance was achieved in all standards except one. Assessment of cognitive functions, 44 patients (86.3%) were assessed for their cognitive functions before the course of treatment but only 29 patients (56.9%) were assessed after the course.

Conclusion: The adherence to referral and consent standards was excellent; however, greater attention is needed in the implementation and documentation of cognitive assessments before, during, and after treatment. This is particularly important due to the high incidence of cognitive dysfunction observed following ECT administration.

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Prescribing Trends of Promazine in Secondary Care

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Aims: The aim of this audit was to analyse the prescribing trends of promazine in secondary care within a psychiatry department, to evaluate adherence to current guidelines and best practices for promazine prescribing in secondary care and identify potential areas for improvement in prescribing practices to enhance patient care and safety.

Promazine is a phenothiazine-type, first generation (typical) antipsychotic with relatively weak antipsychotic activity making it less effective in treating psychotic disorders but with pronounced sedative effects. It is licensed for short term adjunctive management of psychomotor agitation, and for agitation and restlessness in the elderly. Promazine is highly sedative, has anticholinergic activity, hypotensive effect and can prolong QTc (Corrected QT Interval) at therapeutic doses. Promazine is not endorsed in any recent guidelines for management of agitation e.g. NICE (National Institute for Health and Care Excellence) or BAP (British Association for Psychopharmacology). The BNF (British National Formulary) marks it as a drug considered to be “less suitable for prescribing”.

Despite this, prescribing data suggests it is still being used widely in some areas, particularly in Bury and the North West.

Methods: A retrospective review of clinic letters from January 2024 was conducted within the psychiatry outpatient department at Irwell Unit, Fairfield General Hospital. Patients prescribed promazine were identified, and data was collected on diagnosis, indication, duration of use, dose, physical health monitoring, and treatment reviews.

Results: Fifty-three patients were prescribed promazine. Of these, 73.6% had no documented indication for its use, and only 3.8% had a documented treatment duration. No patients were on promazine for four weeks or less, the recommended treatment duration. There was no record of review of promazine in a significant proportion (81.1%) of the patients identified. 22.6% had not received any annual physical health checks. Additionally, 41.5% of patients were prescribed promazine alongside another antipsychotic.

Conclusion: The audit highlights that promazine is widely being used in the outpatient department at Irwell Unit, Fairfield General Hospital. Its use is not currently in line with local or national guidelines. The findings support the need for improved prescribing protocols, clearer documentation, and regular medication reviews. Action points include increasing awareness through education, ensuring appropriate physical health monitoring, and reviewing all identified patients at their next clinic appointment. A re-audit is planned in six months to assess the impact of these interventions.

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Improving the Management of Diabetes in a Secure Forensic Psychiatric Setting in the UK

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Aims: To measure the quality of care given to diabetic patients while admitted to a secure forensic setting. Across psychiatric services, individuals with a serious mental illness have higher rates of diabetes compared with the general population. Patients in forensic inpatient