

increased to 58%. For some patients, the reason for not receiving a non-pharmacological intervention was due to urgency of treatment or being on a waiting list for occupational therapy, but for most the reason was not explicitly documented.

For 63%, there was evidence of a discussion of the risks of treatment with the patient, carer or family member. 63% had initial baseline blood tests and 54% had a baseline ECG. Of the patients who did not have initial monitoring, a suitable reason was given for just over 60%. Only 33% of patients who had antipsychotic treatment for over 12 weeks had a trial of discontinuation or dose reduction. Less than 22% of patients had physical health monitoring at one year of treatment.

Conclusion. There were shortfalls in several areas including the offer of non-pharmacological interventions, regular review of the ongoing need for antipsychotics, and physical health monitoring.

Introduction of a checklist before antipsychotics are prescribed is recommended, to include discussion of risks and benefits, non-pharmacological interventions, and initial monitoring. Also recommended is a system to identify when monitoring and review of antipsychotics are due.

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An Audit on the Uptake of Psychosocial Interventions in a Nationally Accredited Memory Service

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Aims. The impaired functioning of patients with dementia has economic, social and quality of life implications for individuals, carers and wider society. We audited the provision & uptake of psychosocial interventions to promote the cognition, independence and well-being of Later life Adults under Macclesfield Memory services, supported by Service and Involvement, Recovery and Wellness Centre at Jocelyn Solly Resource Centre, United Kingdom. Compliance with National guidance on psychosocial care for patients with dementia was assessed: 1. NICE guideline [NG97] "Dementia: assessment, management and support for people living with dementia and their carers." 2. "Memory Services National Accreditation Programme Standards for Memory Services"

Methods. Electronic patient records were retrospectively reviewed. Clerical staff identified all patients with dementia reviewed at Jocelyn Solly Resource Centre from 1/4/22 – 31/07/22 (n=140) and data of referrals to, and engagement with, the Recovery College collected.

Results. 23/140 patients (16.4%) were referred to the Involvement, Recovery and Wellness Centre by a single referrer; 12 booked onto workshops, 4 declined, 1 was unable to attend due to lack of transport & 6 were not successfully contacted. 11.4% (n=16) of clinic letters documented referral and nil stated referral rationale. n=1 patient attended tai-chi and booked workshops included: Cognitive Stimulation Therapy (CST) (n=8), Living well with dementia (n=1), Living well with a long term condition (n=1), Anxiety Management (n=1). Compliance was 100% for: trained staff delivering workshops, patients and carers having access to psychosocial interventions for challenging behaviour and assessment and interventions for the emotional,

psychological and social needs of carers. 99.3% of patients (n=139) were offered pharmacological intervention (or the exception documented). There was no access to individual/maintenance CST, art or creative therapies nor input from psychology or occupational therapy due to vacancies. No patients <65 were signposted to work, education or volunteering.

Conclusion. Though the Recovery college adequately trains and supervises staff and documents patient outcomes, there is capacity to improve the quantity of referrers, referrals & attendances to maximize existing resource utilisation. Implementing strategies to reduce access barriers and hiring a psychologist & occupational therapist would improve service quality. Documenting patient-defined goals and using multiple outcome measures would better enable staff to review progress and could heighten patients' motivation to engage with services.

Recommendations to improve compliance include: amending clinic letter proformas to include patient-defined goals, psychological and social interventions; educating team members about services offered and referring to the Recovery college and implementing multidisciplinary review of recovery college referrals.

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Physical Health Monitoring in Patients Established on Clozapine

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Aims. We set out to compare the physical health monitoring of patients established on Clozapine within our local mental health team (LMHT) to national and trust guidance. We also compared data collected in this audit with results from a similar audit conducted in 2018 to identify if improvements had been made to services. We then sought to present the findings to our LMHT to shape the formation of a newly set up pharmacy technician led Clozapine clinic.

Methods. National Institute for Health and Clinical Excellence (NICE) and Nottinghamshire Healthcare Trust (NHT) guidelines were reviewed to set criteria for the audit. Where NICE and NHT guidance stipulated similar recommendations, NICE guidance was used to set criteria. Criteria was found to be met if it had been collected within the last 12 months. Data were collected by a single clinician over the period of one month on review of electronic medical records.

Results. 30 patients were identified as established on Clozapine within our LMHT. 27 (90%) patients had a licensed diagnosis for Clozapine prescription. Smoking status was recorded in 26 (83.3%) patients and caffeine intake in 21 (70%) patients. Full blood count, liver function tests, urea and electrolytes all met the criteria at the 100% target however one patient was found to have Hba1c and lipid measurement outstanding. Weight was documented for 29 patients (96.7%) however waist circumference was documented in five (16.6%). This was the lowest scoring criteria. Pulse and blood pressure was recorded in 27 (90%) patients. Electrocardiograms were less consistently recorded as completed, with 22 (73.3%) recorded. Physical health monitoring was recorded for 27 (90%) patients, whilst 10 (33.3%) had a GASS-clozapine form completed. Percentages for all criteria

that were measured in 2018 were found to be higher in the 2022 cycle.

Conclusion. Findings show that physical health monitoring for the patients prescribed Clozapine in our LMHT does not consistently meet guidance. Development of a 'Clozapine clinic' was already planned. Results from this audit were shared within the LMHT and recommendations were made as follows; i) a measuring tape to be placed in each room ii) data such as weight, blood pressure and heart rate to be entered in a way that it can be plotted over time iii) pharmacy technician to work with a healthcare assistant to ensure all criteria can be met in the designated yearly Clozapine clinic

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The Utilisation Rate of Clozapine for Treatment Resistant Schizophrenia Within Trustwide Adult Inpatient Services Over One Year

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Aims. The audit was undertaken to explore if inpatients with treatment resistant schizophrenia (TRS), or whose condition has not adequately responded to two antipsychotics of an optimal duration and dose, were offered clozapine as per NICE guidelines (CG178 1.5.7.2).

Methods. Data were collected retrospectively and anonymously from all electronic notes via the UK-CRIS analysis platform.

The inclusion criteria required patients, aged 18–64 years, to have a schizophrenia (ICD10 F20) diagnosis and to have been admitted to one of ten Trust inpatient wards between 01/01/2020 and 01/01/2021.

Patients were required to fulfil the criteria of treatment resistance, as having an inadequate response to two or more antipsychotic drugs, one of which was an atypical agent.

Patients who had previously tried or were currently on clozapine were excluded. Those with non-schizophrenia psychotic disorders were also excluded. 347,645 records were electronically screened according to the criteria, and 209 records were reviewed.

Results. 43 patients from the 209 patients reviewed were found to be eligible for clozapine. 28 (65%) were offered clozapine during their admission and 9 of these patients had started the titration process (21% of those eligible).

Of the 19 patients who declined clozapine when offered, 14 had refused the drug with the most common reason of not accepting the required blood monitoring (n=10).

Of the 15 eligible patients who were not offered clozapine, the clinical team had documented a consideration to offer clozapine in 6 patients (14%) but had rejected its, predominantly due to concerns of non-compliance.

For 3 patients (7%) the clinical team considered for but did not offer clozapine. There was no documentation regarding clozapine for 6 patients (14%).

Conclusion. This audit identified that most patients with TRS were offered clozapine during their admission. However, a proportion of patients were not offered the gold standard treatment for TRS and this may lead to poorer outcomes.

It demonstrated that a minority of eligible patients ultimately start the drug. There are barriers for eligible patients to accept clozapine, for instance around the regular blood monitoring required.

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Re-Audit of Prescribing Responsibility for Antipsychotic Depots for Shared Care Patients (PRAD-SCP)

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Aims. To re-audit whether community teams are requesting GPs to take over the prescribing of antipsychotic depots for patients who have been stabilised on treatment, in line with Shared Care Pathway protocols by Greater Manchester Medicines Management Group (GMMMGM).

Methods. The sample size was 199 patients open to Rochdale, Heywood and Middleton community mental health team antipsychotic depot clinics. Information was gathered from depot cards, care records and clinical entries on Paris and imputed on an Excel spreadsheet. This was a prospective audit and data collection took place between 01/11/22 and 30/12/22 by the auditors. Microsoft Excel was used to carry out simple percentage analysis by the authors and presented using charts.

Results. Transfer of prescribing responsibility for first generation antipsychotic had the highest compliance rate with 98% prescribed by GP on shared care protocol for stable patients followed by Paliperidone and Risperidone at 94%. Aripiprazole was the least compliant with 91% prescribed by GP for stable patients as against 100% target.

Overall compliance rate for all depot antipsychotics was 96% compared with 83% from original audit in 2020. In comparing the different community teams, one team was compliant by 99% overall in transferring prescribing responsibility to the GP for stable patients and 100% compliant with 1st generation antipsychotics, paliperidone and risperidone.

The data showed that CMHT prescribed higher proportion of 2nd generation antipsychotics when compared to original audit.

Conclusion. This re-audit has demonstrated that overall, there was significant improvement in compliance with GMMMGM shared care guidelines by Rochdale community teams from 83% in 2020 to 96% in 2022. However, this does not meet the standard of 100% target for depot antipsychotics as per GMMMGM guidelines. In other to ensure that target standards are met a 100%, secondary care prescribers should ensure appropriate transfer of prescribing responsibilities via the shared care protocol to the GP for stable patients are done and also shared with the new team particularly during the transition phase for patients transferred from one team to another who are stable on their current medication.

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