

whilst also improving general practitioner's satisfaction with waiting times for patient's referred to the Gloucester Recovery Team.

Method. We planned to introduce an email address for GPs to use to seek medication and diagnostic advice for patients known to and not known to the Recovery Team. We initially introduced this for the 'Team 2' catchment area consisting of five practices within Gloucester. These were then read and replied to by the Team 2 consultant, Dr Ikram, as appropriate. A further survey was then sent out. These results provided both quantitative ordinal data through a likert scale, which was then transformed into binomial data, such as those scoring 'extremely confident' 'very confident' 'somewhat confident' vs 'not so confident' and 'not confident at all' which is then compared using relative risk.

Result. Our response rate for our initial survey was 8 general practitioners, and for our follow-up survey 1 general practitioner and 2 nurse prescribers. Confidence in continuing psychotropic medications increased from 7 out of the 8 (78%) stating somewhat confident to extremely confident to 3 out of the 3 (100%) after the introduction of the email; a relative change of 1.14 (95% confidence interval 0.87-1.48 $p = 0.318$). Confidence in initiating psychotropic medications increased from 4 out of the 8 (50%) stating somewhat confident to extremely confident to 2 out of the 3 (66%) after the introduction of the email; a relative change of 1.33 (95% confidence interval 0.46-3.84 $p = 0.594$).

Conclusion. Analysing the qualitative data showed the email address was used for a variety of requests and advice including: 1) A capacity assessment, 2) Initiating medications for depression and anxiety, 3) Medications during pregnancy, 4) Medication for those with Intellectual Disability, 5) Switching medication, 6) Medications for poor sleep and 7) Mood stabilising medication.

This change appeared to be well received, however the response rate was very low which makes full analysis difficult. We also included nurse practitioners working in primary mental health in our second survey, whereas the initial survey was only sent to GPs. This initiative was also only started for 5 of the GP practices within Gloucester, and there may be a different knowledge base/confidence amongst the other practices.

An audit into the monitoring of off-label antipsychotics in primary care

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Aims. To ascertain whether patients prescribed second generation antipsychotics for off-label indications are being monitored and screened adequately for physical health side-effects.

Background. The prevalence of off-label antipsychotic use has increased significantly over recent decades. Common off-licence uses include dementia, post-traumatic stress disorder, adjunctive treatment for unipolar depression and personality disorders. Recent studies have demonstrated that up to 65% of antipsychotic prescriptions are now off-label. Since the metabolic side-effects of second-generation antipsychotics are well-established, guidelines have emphasised the need for active, routine physical health screening of all individuals taking these drugs. However, there have been few studies or reviews which have specifically

investigated screening rates of individuals receiving antipsychotic medications for off-licence indications.

Method. An audit of patients taking second-generation antipsychotics for off-label indications, under the caseload of Neighbourhoods 1, 3 and 4 of Lewisham Assessment & Liaison team, was conducted. After isolating individual patients fulfilling inclusion criteria, patient investigation documents were requested from relevant GP practices. 40 patients were isolated in total, and data were successfully collected in 60% ($n = 24$). Data were collected via a proforma. This consisted of patient information, indications for antipsychotic use, and each variable to be monitored. The audit standard used was the recommendations of the 12th Maudsley guidelines. Data were then entered into SPSS and analysed.

Result. The most common reasons for off-label antipsychotic prescribing were Emotionally Unstable Personality disorder (42%, $n = 10$) and depression (29%, $n = 7$). Findings demonstrated that 54% ($n = 13$) of patients audited had 'basic' blood screening (FBC, U&E, LFTs), however glucose (38%, $n = 9$), Prolactin (13%, $n = 3$), and Creatine Kinase (0%, $n = 0$), and monitoring was less frequent. 0% ($n = 0$) were completely monitored as per audit standard.

Conclusion. Primary care monitoring of off-label antipsychotics is unsatisfactory, with no patients having a complete set of investigations. Reasons for this are unclear at this stage, however based on initial discussion with GP surgeries, may be due to lack of education regarding screening investigations, patients lost between primary and secondary care services, and a lack of clarity regarding responsibility and designated roles. This audit will be expanded to also include patients from Neighbourhood 2 of the Lewisham Assessment & Liaison team. A more detailed investigation will be conducted into the barriers to physical health screening, such that a targeted intervention can be implanted.

Nile Ward PICU violence reduction quality improvement project

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Aims. To reduce incidents of inpatient violence and aggression at Nile Ward Psychiatric Intensive Care Unit (PICU), St Charles Hospital by at least 30% between December 2019 and December 2020. Reducing inpatient violence is a major quality improvement (QI) priority for CNWL NHS Foundation Trust.

Method. As a Psychiatric Intensive Care Unit, Nile Ward looks after male patients suffering from severe mental illness (SMI). This usually includes patients presenting with high levels of violent and aggressive behaviour. Prior to this QI project, there were high levels of patient assaults towards staff and other patients. This required a lot of medication use, including rapid tranquilisation, restraint and the use of seclusion. This QI project was started to allow the Nile MDT to explore ways to reduce serious incidents on the ward in the least restrictive manner.

We implemented a number of change ideas within this project. Our change ideas included: 1. A new risk management tool: 'Ragging', a daily risk assessment tool, was created to assess patients' risk of violence and aggression to allow signposting of appropriate interventions to safely manage risk. 2. A brand new Staff Photo board: New photos of all permanent and bank staff displayed in the ward with no hierarchy of positions. 3. A new Patient Feedback board: Patient experience, comments and

feedback displayed in common areas of the ward which are regularly updated. 4. Mutual Expectations between Staff and Patients: A set of expectations created in co-production with patients displayed in the communal areas of the ward to be followed by both staff and patients. 5. Gardening sessions : One of our newer change ideas during the COVID-19 pandemic was to provide a safe, socially distanced space for patients to be involved in growing and caring for the Nile Ward garden with our activities co-ordinator. 6. Optimisation of Physical Exercise : Focus on physical activity through garden fitness sessions and 1-1 fitness sessions in the gym. This was another change idea commenced during the COVID-19 pandemic. These sessions occur throughout the day with our fitness instructor and enable our patients to focus on their physical health & fitness. 7. Improved Ward Environment : Gym equipment were upgraded and the appearance of the ward gymnasium was enhanced using quality art created in co-production with patients.

Result. There was a 43% reduction in the number of violent incidents in the ward following QI interventions. The details of the results will be depicted in pictorial form in the poster.

Conclusion. Our patients are able to recover in a safe environment with a reduced level of violence and aggression resulting in patients receiving less rapid tranquilisation and restrictive interventions. We have had fewer assaults on staff which has made our staff feel safer to work in a busy PICU. Staff feel more confident in their role through the use of the new risk assessment tool. Patients and staff alike have given positive feedback to the changes implemented in this QI project, with violence being successfully reduced by 43%. We hope that our QI project can be used as an example to show how QI methodology can enable Violence Reduction within mental health services.

Improving cardiometabolic health assessments and interventions at St Charles Hospital, London

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Aims. St Charles is one of the largest inpatient mental health units in London with 8 wards and covers the boroughs of Kensington & Chelsea and Westminster. This project aimed was set up so that 95% of patients in St Charles Mental Health Centre would have a complete cardiometabolic health assessment by December 2020. This would include Weight, Smoking, Alcohol, Substance Use, Hypertension, Cholesterol and Diabetes assessments with necessary interventions recorded. The outcome of the intervention would improve overall physical health and life expectancy.

Method. People with serious mental illness experience significantly worse physical health and shorter life expectancy of up to 10 to 15 years than the general population. CNWL is making Physical Health of patients in Mental Health Services a priority. Performance in this area has been challenging across the Trust because of:

- Buy in from clinicians.
- Staff did not feel empowered to discuss interventions with patients.
- High sickness and absence as a result of COVID was found to directly correlate with reduced physical health monitoring/recording.
- Lack of training in completing the SystemOne physical health template

The following cardiometabolic risk monitoring interventions were recorded on SystemOne (electronic documentation platform) and performance reviewed using Tableau : Weight, Smoking, Alcohol, Substance Use, Hypertension, Cholesterol and Diabetes assessments with necessary interventions recorded.

Result. Prior to the commencement of this project, the wards in St Charles Mental Health Centre completed physical health assessments on roughly 8% of the patients in February 2020. The QI project was implemented in June 2020. By September 2020, physical health recording across 8 wards across St Charles had increased to 89% following successful implementation of the interventions.

Conclusion. The following interventions resulted in a significant improvement in physical health cardiometabolic risk monitoring at a busy inpatient mental health setting:

- Monthly physical health meetings to enable shared learning with ward doctors, nurses and healthcare assistants.
- Ongoing one-to-one and group support to train staff with completing and recording physical health assessments.
- Tableau Physical Health Report regularly reviewed with MDT during ward round meetings.
- Physical health leads given supernumerary days to run physical health clinics on the wards.
- Fortnightly Physical health monitoring meetings with the Director of Nursing and Head of Governance.

Manualising the induction of higher trainees in psychiatry for North Wales: The CiSGC Guide (“Croeso i Seiciatreg Gogledd Cymru”)

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Aims. There is a significant period of adjustment for new higher trainees in psychiatry given the presence of inter-trust differences in the National Health Services (NHS). It may take some time for a trainee to become familiar with the new administrative system and workflow of the new environment, which may be even longer for an international medical graduate (IMG). Although there is an existing induction system, having a written structured manual will assist the trainees to get through this process more easily. Hence, this Quality Improvement Project (QIP) outlined the creation of an induction manual that serves as a starter pack to facilitate the settling-in process of new North Wales higher trainees in psychiatry, i.e. the “Croeso i Seiciatreg Gogledd Cymru” (CiSGC) guide (means Welcome to North Wales Psychiatry in Welsh).

Method. The induction manual was initially drafted by the authors based on the available printed policies and information online. Further input and from different stakeholders were obtained to triangulate and enrich the manual. Specific links and further references were included in the manual for the reference of prospective manual users. Authors' contact details were included for any further clarification, suggestions or input.

Result. The manual consisted of four sections: A) General Process before, during and after Reporting Duty, B) Trainees' Duty, 3) Speciality-specific Guidance, and 4) Health Board-related Information. The General Process section covered the visa-related information, post-acceptance paperwork process, access to email