assessment criteria and in 5% of service users for the medical review criteria for the CRHTT assessments done by the south Cambridgeshire CRHTT team for the period between August 2021 and July 2022.
Conclusion. This audit suggests that the south Cambridgeshire CRHTT is currently not meeting the standards laid down by HTAS and there is room for improvement in the physical health assessment and medical review process. The recommendations were made and additional audits may be necessary to ensure that all service users receive HTAS-compliant care.

An Audit of PPI Cover in Those Taking SSRIs Within an Older Adult Community Mental Health Team

Dr Michael Cooper[1]*, Dr Clare Langan[2] and Dr Christopher Haxton[2]

[1]NHS Lanarkshire, Glasgow, United Kingdom and [2]NHS Greater Glasgow and Clyde, Glasgow, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.411

Aims. Serotonin in platelets has a major role in promoting vasoconstriction and platelet aggregation. Selective serotonin reuptake inhibitors (SSRIs), which are widely used clinically, inhibit the serotonin transporter responsible for serotonin uptake into platelets. This serotonin depletion reduces clot formation, thus increasing bleeding risk. This risk is particularly elevated in older adults who are also more likely to have co-morbid physical health conditions. The Maudsley Guidelines recommend that if SSRIs cannot be avoided in those assessed as high bleeding risk, then gastro-protective proton pump inhibitors (PPIs) should be prescribed. The aim of this full cycle audit was to evaluate all patients in an older adult community health team (OACMHT) to assess how many were prescribed an SSRI and whether PPI cover had been considered in those deemed to be at higher risk of a GI bleed due to either age or concomitant medication use.
Methods. All patients open to the OACMHT prescribed an SSRI were identified. Their electronic notes were checked to see if they were either prescribed medications or had comorbidities which increased bleeding risk. Electronic notes were reviewed to assess if bleeding risk had been considered at the time of prescribing SSRI, in addition to whether a PPI had been prescribed.

This was repeated 6 months later following the results being presented to prescribers within the OACMHT.
Results. Patient age ranged from 60 – 101 years. 23% of patients were prescribed SSRI medication. There was an improvement in the proportion of patients on SSRIs prescribed PPIs in the second cycle compared to the first cycle of this audit (64.7% vs 56.5%). We also found that the majority of patients prescribed an SSRI and medications known to increase bleeding risk were prescribed a PPI in both audit cycles. We found only 1 patient in our cohort had bleeding risk explicitly documented in electronic notes.
Conclusion. SSRI use is common within the OACMHT. The majority of patients were prescribed a PPI alongside their SSRI. This improved in the second cycle of this audit. A significant number of those prescribed a PPI had their PPI prescription commenced prior to an SSRI being prescribed which may have artificially inflated our results.

However, a significant proportion of patients prescribed SSRIs were not prescribed PPI cover which is not in line with current Maudsley guidelines. Therefore there is still work to be done in minimising bleeding risk in patients taking an SSRI within the OACMHT.

Clozapine Serum Level Timing Audit: Medium Secure Rowan View

Charles Daniels*

Rowan View, Merseycare, Liverpool, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.412

Aims. To assess the degree of compliance for clozapine serum level timing post clozapine dose using synnovis (previously viapath) and maudsley 14th edition guidelines in a medium secure hospital.
Methods. Electronic prescribing systems were reviewed on each ward to identify clozapine established patients. Viapaths electronic database was reviewed from 01 May 2021 (18 months) and recorded timings were compared to guidelines in Maudsley, 14th edition and synnovis. 12 hours was used as the guideline post dose in OD (once daily), BD (twice daily)/TDS (three times daily) regimes following the night time or evening dose.
Results. 4 different types of clozapine prescribing regimes were identified – OD, BD am/nocte or evening, BD pm/night or evening and TDS. 45 patients in total.

OD 12 - most recent bloods 8/12 patients were >15 hours. Total samples in 18 months >12 hours 63.6% (38/55). Total samples in 18 months >15 hours 56.3% (31/55). In the OD group 26 samples are from 2 patients both of whom have samples taken later than 14 hours.

BD 26 - BD mane evening/nocte - 2/5 most recent samples were >15 hours. Total samples in 18 months >12 hours 51.6% (32/62). Total samples in 18 months >15 hours 12.9%(9/62). Need to consider – evening dose time 18:00 compared to 22:00 adding more time.

BD pm evening/night 5 - 2/5 patients > 15 hours. 4/5 patients not at 13-14 hours. Total samples in 18 months >12 hours 75% (9/12). Total samples in 18 months >15 hours 25% (3/12)

TDS 2 - 0 patient > 15 hours, 1 patient at 14 hours. Total samples at 18 months >12 hours - 41.7% (5/12). Total samples at 18 months >15 hours - 16.7% (2/12).
Conclusion. Higher than expected clozapine serum level timing inaccuracy was demonstrated, markedly in bespoke regimes - OD (56.3%) or BD pm evening/night regimes (25%) compared to traditional regimes (TDS 16.7 %, BD am nocte/evening 12.9%). Contributing factors are a knowledge gap amongst services, Maudsley guidelines don't consider bespoke timings when advising trough levels. Findings suggest bespoke regimes need greater consideration when assessing clozapine serum levels.

Action from this initial audit involves informing teams regarding recent samples which are >15 hours post dose. Service education highlighting safety concerns of potential underestimation of clozapine serum level. Guideline change with support from pharmacy. Re audit in 12 months.