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

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