Improving Clozapine Prescribing at a London District General Hospital: A Quality Improvement Project

Dr Jack Benson[1]*, Dr Tara Amin[1], Dr Diana Shroff[2] and Dr Kirsty Allen[3]

[1]Barnet, Enfield and Haringey Mental Health NHS Trust, London, United Kingdom; [2]Royal Free Hospital NHS Trust, London, United Kingdom and [3]North Middlesex University Hospital NHS Trust, London, United Kingdom
*Presenting author.

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Aims. The liaison psychiatry team at North Middlesex Hospital (NMH) noticed that many patients on clozapine were missing doses in hospital, risking the need for re-titration and deterioration in mental state. Although clozapine is a widely used medication in psychiatry, non-psychiatric clinicians may not be aware of the importance of compliance. In addition, clozapine is often not widely available in acute medical hospitals and ascertaining the correct dosage can be difficult as it is not prescribed by the GP. Furthermore, clozapine can cause a variety of side effects that our medical colleagues may not be familiar with.

The aim of this project was to improve clozapine prescribing at NMH and improve communication with the liaison psychiatry team.

Methods. We reviewed the notes of 97 admissions in which patients were dispensed clozapine from the hospital pharmacy during the period April 2020 to December 2023 to determine what proportion had missed a dose of clozapine, and the clinical implications of this. We also reviewed the reasons for the missed doses to gather information on what could be done to improve patient safety.

From July 2022 we began implementing changes. This included the creation of a hospital guideline, putting in place an automatic email that would be sent to the liaison team when clozapine was prescribed, placing an alert on the online prescribing system to emphasise the importance of not omitting doses, and providing teaching to clinicians.

Results. We compared omissions of clozapine doses and referrals to the liaison team before and after changes were implemented. The percentage of patients inappropriately missing at least one dose fell from 67.4% to 31.1%. The proportion of patients who were referred to the liaison team rose from 40.8% to 89.2%.

We identified several recurring causes of missed doses. These included doctors not being aware of clozapine prescriptions or dosages, poor awareness that clozapine is a critical medicine and long stays in accident and emergency. There were also incidents where clozapine was stopped by the medical team without obtaining advice from psychiatric colleagues.

Conclusion. We were able to reduce the proportion of patients missing doses by improving awareness of clozapine compliance within the hospital. We were also able to improve communication between medical and psychiatric teams.

The clozapine guideline and prescribing alerts will continue to be utilised within the hospital. We plan to continue to provide regular teaching to rotational junior doctors and to pursue a similar project for lithium prescribing.

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.

Implementing a Primary Care Referral Pathway for Further Investigations and Management of Fatty Liver Disease (FLD) in the Absence of Fibrosis Identified in Patients Who Have Undergone a Fibroscan Within the Belfast Addictions Service

Dr Zuhayr Booley*

Addictions Service, Belfast, United Kingdom
*Presenting author.

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Aims. Alcohol misuse presents a major health concern in Northern Ireland with a 50% rise in alcohol-specific deaths in the past 10 years[1]. Excessive alcohol use may lead to fat deposition within the liver and risks progressive liver disease secondary to fibrosis and/or inflammation. The aim is to extend upon an existent Hepatology referral pathway for patients with alcohol misuse and liver fibrosis on Fibroscan; to include onward referral to primary care for investigations of patients shown to have FLD in absence of fibrosis and facilitate early identification and intervention of associated metabolic syndromes. There was previously no referral mechanism for screening for metabolic syndromes such as diabetes, hypertension and hypercholesterolemia for these patients.

Methods. Case records were reviewed for all patients offered a Fibroscan through the Belfast Addictions service. Patients identified with evidence of steatosis on Fibroscan without fibrosis/cirrhosis i.e. liver stiffness score < 8Kpa and controlled attenuation score (CAP) > 248, would trigger an onward referral to primary care for further investigation and management. A letter was sent notifying the patients' registered GP of the Fibroscan result and NICE recommendations for follow up liver function testing, HbA1c, lipid profile and Q-risk scoring for consideration of lipid lowering medication. A review of patients' electronic care record (ECR) 2 months following the dispatch of letters was conducted to identify those patients who received further investigations.

Results. 286 Fibroscans were conducted in the Belfast Addictions Service in 2023. Alcohol misuse was the indication for 92% of these scans with 32% identified as having evidence of fatty liver disease without fibrosis. This prompted onward referral for primary care follow up and letters were sent out to GPs from November 2023. Review of ECR 2 months post-intervention revealed of the 7 letters sent out in November, 57% (4) had follow up bloods and 75% (3) of those were shown to be deranged. Data collection is ongoing and will be complete by date of congress.

Conclusion. 32% of the patients who had a Fibroscan in the Belfast Addictions service in 2023 had evidence of fatty liver disease without cirrhosis. Initial data shows a positive change in clinical practice and patient care, and builds upon the existing hepatology referral pathway.

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Developing a Pathway for Referrals of Patients With Dementia Within a Mental Health Liaison Team

Dr Alex Burns* and Dr Nadia Imran

South West Yorkshire Partnership NHS Foundation Trust, Barnsley, United Kingdom
*Presenting author.

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Aims. Assessment and management of the mental health needs of patients with dementia has been identified as a key role for a mental health liaison team (MHLT). The existing practice for referrals of patients with dementia made to Barnsley Hospital's MHLT was for them to be redirected to the memory team for assessment, who have limited scope for in-reach work into hospital, rather than being assessed by MHLT who are based on the hospital site.

This project aimed to clarify the pathway for dementia referrals presenting with psychiatric issues at Barnsley Hospital and determine which patients should be seen by either MHLT or the memory team. It also aimed for MHLT to increase the number of dementia referrals assessed compared with existing practice and increase the proportion of face-to-face reviews for these patients.

Methods. 2 periods of data collection took place within MHLT, where the outcome of referrals made from Barnsley Hospital for patients with diagnosed or suspected dementia requiring assessment was recorded. The first period recorded existing practice and the second period recorded practice following the implementation of a new pathway for referrals.

The new referral pathway was created in collaboration between MHLT, memory team and Barnsley Hospital's dementia nursing staff. MHLT would review cases of suspected dementia not currently open to memory team whilst referrals made for patients open to memory team would be referred to memory team initially, with the option of MHLT input subsequently being requested.

Results. First data collection period 3–28 April 2023:

4 referrals in total.

2 were assessed by MHLT, 1 seen face-to-face, 1 by telephone. 2 were redirected to memory team.

Second data collection period 17 July–17 September 2023 following implementation of the pathway:

10 referrals in total.

7 were assessed by MHLT, 7 seen face-to-face. 3 were redirected to memory team.

Conclusion. The implementation of the pathway led to improved outcomes, with absolute increases of 20% in the proportion of referrals assessed by MHLT and of 45% in the proportion of patients assessed face-to-face. Undertaking the project also helped to identify that there was a training need for MHLT practitioners regarding dementia assessment and management. The next aim is for MHLT to assess 100% of dementia referrals following dementia training being delivered to the MHLT practitioners, and to continue regular MDT meetings to monitor the efficacy of the pathway and maintain collaboration between MHLT and the memory team.

Physical Health Monitoring in Waverley Community Mental Health Recovery Service (CMHRS)

Dr Steve Calvosa*

Surrey and Borders Partnership Foundation Trust, Guildford, United Kingdom

*Presenting author.

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Aims. To audit the recording of physical health parameters for the clients of Waverley Community Mental Health Recovery Service (CMHRS).

To ensure Trust and NICE guidelines are met for monitoring of:

1) Psychiatric drug prescribing.
2) Psychiatric disease monitoring.
3) Past medical history and biophysical parameters relevant to prescribing decisions.

To develop a clinical review process for the clients to ensure that physical health parameters are monitored longitudinally.

Methods. A random sample of 100 patients from Waverley CMHRS was analysed. The data was collected between November 2022 and January 2023. The process involved establishing the cohort, dividing the caseload for review, and applying an audit questionnaire. The questionnaire was applied to both SystmOne Electronic Patient Records and GP Shared Care Records to assess compliance with physical health monitoring in both secondary and primary care. All data collected were compiled onto an Excel Spreadsheet. The level of compliance for monitoring of each parameter was calculated and audited against Trust and NICE guidance.

Results.

For secondary care:

1. Compliance with physical health monitoring requirements is consistently low.
2. Higher levels of compliance (>50%) for height, weight, Audit C (Alcohol), Smoking status.
3. Lowest compliance levels observed for: blood tests, ECG request, substance misuse status, sleep, medication side effects.
4. Evidence of a comprehensive physical health review was found in 1% of patients.

For primary care:

1. 95% of patients from our sample consented to giving access to their Shared Care Record.
2. Compliance with physical health monitoring requirements in primary care was higher.
3. Compliance was particularly high (> 87%) for: height, weight and BMI, BP, evidence of alcohol monitoring, evidence of smoking monitoring.
4. Smoking monitoring is the parameter with the highest level of compliance (95%).
5. Parameters are monitored more regularly.

Conclusion. The audit identified gaps in the documentation and assessment of physical health parameters within Waverley CMHRS. Compliance with monitoring requirements was significantly lower in secondary care, highlighting the need for intervention. Conversely, primary care demonstrated higher adherence to monitoring guidelines. The results show deficiencies in physical health monitoring that need to be addressed to ensure comprehensive psychiatric care.

The project was crucial in optimizing physical health monitoring within Waverley CMHRS. Recommendations include targeted training, improved communication between primary and secondary care, and the designation of physical health coordinators. An action plan was developed with assigned responsibilities and a timeline for implementation. A re-audit will follow to assess the impact of implemented changes.

Mental Health Policies in Low and Lower Middle-Income Countries (LLMICs): A Narrative Synthesis

Mr Usman Arshad[1,2], Prof Imran Chaudhry[1,2]*, Prof Nasim Chaudhry[1,2], Prof Rachel Jenkin[3] and Prof Nusrat Husain[2,4]