

Methods. Data were collected retrospectively from psychiatric inpatient wards in Lanarkshire for patients on Clozapine therapy. The review focused on electronic medical records to evaluate the regularity of bowel habit screening. Additionally, we examined the Hospital Electronic Prescribing and Medicines Administration (HEPMA) system to gather information on laxative prescriptions.

Results. The audit revealed that bowel habit monitoring, which should be a standard practice at each clinical encounter, was found to be inconsistent. Regular assessments were documented for only 40% of patients. Monitoring was most thorough in rehabilitation wards, where patients on Clozapine had their gastrointestinal function assessed routinely through screening questionnaires. Furthermore, 80% of the surveyed patient population was documented as having been prescribed laxatives.

Conclusion. The documentation of bowel movements for inpatients on Clozapine was suboptimal, leading to the potential oversight of critical side effects. The audit highlights a discrepancy in adherence to national and Lanarkshire's local guidelines for the monitoring of inpatients treated with Clozapine. To rectify this, we recommend the implementation of a standardized screening protocol to assess constipation risk systematically. Proactive monitoring should be incorporated into regular clinical evaluations for patients on Clozapine, ensuring that this assessment occurs at every clinical interaction. This approach is crucial not only for patient safety but also for enhancing treatment efficacy and patient quality of life. Moreover, these measures will likely lead to improved documentation and compliance with established guidelines, thereby reducing the incidence of preventable complications associated with Clozapine-induced constipation.

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Improving Staff Awareness of Sensory Aid Needs and Dementia Status on an Old Age Ward

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doi: 10.1192/bjo.2024.343

Aims. The aim of our quality improvement project was to explore and improve care for patients who use sensory aids, with or without dementia, on an old age ward at King's College Hospital. We sought to do this by increasing the staff awareness of each patient's sensory needs and dementia status.

Guidelines state that sensory aids (glasses and hearing aids) are important in orientating patients with delirium and dementia, yet these devices frequently go missing during admission or are not being used appropriately. This could affect communication and therefore overall care, both physical and mental. It is widely understood that delirium and dementia are associated with increased morbidity and mortality. In this project we aimed to explore issues around sensory aid use and to identify and implement impactful changes.

Methods. 2 Plan, Do, Study, Act cycles were conducted between October 2022 to February 2023. A driver diagram was created following staff interviews on the ward. The first cycle focused on increasing awareness of a form in electronic patient records (EPR) and the need for documenting each patient's sensory aid possessions and dementia status. This was done through bite-size teaching sessions to the team and monitoring of completion of

this form. The second cycle included utilising a new laminated bedside checklist that is manually filled in and was aimed to serve as a visual cue of the patient's sensory impairment/dementia status. A survey was used at baseline and then repeated over the course of both cycles to evaluate awareness of staff (named nurse) of each patient's sensory impairment/dementia status on the ward.

Results. Baseline survey showed that staff were unsure of the sensory aid needs (glasses, hearing aids, dentures) of 25% of patients and 46.7% when it came to dementia status. EPR form completion increased by 14% between 14/12/22 and 25/01/23, however this was not statistically significant. 18% of bedside checklists were filled after 4 weeks. Overall, there was a statistically significant decrease in staff not knowing the sensory impairment status (by 32%) as well as dementia status (by 40%).

Conclusion. Whilst uptake of the forms and bedside checklist was slow, the project did show an improvement in awareness of staff and our hypothesis is that this leads to better use of sensory aids. The next step would be to assess whether this leads to better care through further PDSA cycles.

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Early Intervention in Psychosis in Southwark – Bringing Antipsychotic Prescribing Closer to the Gold Standard

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doi: 10.1192/bjo.2024.344

Aims. This quality improvement project was conducted in an Early Intervention in Psychosis CMHT (Community Mental Health Team). We aimed to compare prescribing practices to the RCPsych gold standard for treatment of first episode psychosis. Following an initial audit, intervention was completed aiming to improve adherence to these guidelines and thereby the proportion of patients achieving remission.

Methods. An initial audit of the whole CMHT caseload (with exclusions for patients currently admitted to hospital, under the care of a home treatment team or awaiting assessment) was conducted in June 2021. This was completed from information contained in the electronic patient care record. This recorded for each patient details of whether an antipsychotic was recommended, if one was being taken, the dose, if remission was achieved and the number of previously trialled medications. Following this initial audit interventions were completed through designing a one-page flowchart to empower members of the wider multi-disciplinary team (in particular care coordinators) around prompting appropriate medication changes, with an accompanying education session. Following these interventions, a re-audit was completed in March 2023 and the two samples compared through descriptive statistics. In the first audit 269 patients were included (27 exclusions), and in the second 255 (49 exclusions).

Results. The initial pre-intervention audit found that of patients taking medications, 33% (N = 172) hadn't achieved remission. In the follow up audit the proportion of patients taking medication without having achieved remission remained similar at 37%