**Conclusion.** The scale of impact identified affirms that exploration of the lockdown's contribution to presentation should be routine, particularly for identified at-risk patient groups. Areas frequently highlighted by patients can be used to fully explore the impact of lockdown on presentation during assessment. Patient information for self-referral needs to be regularly updated given frequent changes in service provision. Staff also need to be kept up to date on changing service structure at handover meetings.

## Improving the Identification, Assessment and Management of Osteoporosis and Fragility Fracture Risk on a Later Life Psychiatry Ward: A Complete Audit Cycle

Dr Morwenna Senior*, Dr Thomas Hewson, Ms Francesca Brownless and Dr Ross Dunne

Greater Manchester Mental Health NHS Foundation Trust, Manchester, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.340

**Aims.** Osteoporosis is common amongst elderly patient populations and is associated with significant morbidity and mortality. We aimed to assess whether national clinical guidelines regarding the identification, assessment and management of osteoporosis and fragility fracture risk were being adhered to on a female later life psychiatry ward. We then aimed to improve the detection and treatment of osteoporosis amongst this patient cohort and subsequently conducted a re-audit of adherence to relevant clinical guidelines.
**Methods.** In July 2021, the electronic health records of the 20 most recently discharged patients from a female later life psychiatry ward were reviewed. The proportion of patients who appropriately received FRAX screening, DEXA scanning and pharmacological management of osteoporosis and fragility fracture risk was recorded. The results were compared to standards identified in national clinical guidelines from the National Institute for Health and Care Excellence (NICE) and the National Osteoporosis Guideline Group (NOGG). In addition, the proportion of patients who had FRAX scores communicated to their general practitioners on discharge was recorded. Recommendations were made based on audit findings, and several changes to ward processes were implemented including incorporating fracture risk scoring in a structured ward round template and displaying information posters about osteoporosis in clinical areas. A re-audit was completed in February 2022 using the same methodology as baseline to re-assess adherence to the audit standards.
**Results.** All included patients were female and aged >65 years, and therefore eligible for consideration of fragility fracture risk according to NICE guidelines. 88% (15/17 patients) of those without pre-existing osteoporosis had FRAX scores calculated during their admission on re-audit compared to 50% (8/16 patients) at baseline. 73% (11/15 patients) had FRAX scores communicated to their GP on discharge at completion of the audit cycle compared to 25% (2/8 patients) at baseline. At completion of the audit cycle 10% (1/10 patients) with intermediate fragility fracture risk received measurement of bone mineral density during admission while 30% (3/10) had this recommended to their GP on discharge. None of the high-risk patients (n = 4) were started on bisphosphonate therapy.
**Conclusion.** On completion of the audit cycle, we found excellent compliance with national guidelines regarding the identification of osteoporosis and fragility fracture risk, which demonstrates the feasibility of considering this aspect of physical health in the setting of a later-life psychiatry ward. Areas for improvement include the assessment and management of patients identified as having intermediate or high risk of osteoporosis and fragility fractures.

## Simple Interventions Can Greatly Improve Clinical Documentation: A Quality Improvement Project of Record Keeping on the Legal Aspect of Dementia at Memory Service

Dr Shabinabegam Abdul Majid Sheth* and Dr Claudia Wald

Central and North West London NHS Foundation Trust, London, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.341

**Aims.** 1. To ensure there is documented evidence of discussion about legal aspect of dementia with patients and relatives. 2. To Improve documentation of Financial management by 100% at the end of 3 months. 3.To Improve documentation of LPA and other related legal areas by 70% at the end of 3 months
**Methods.** In Kensington and Chelsea and Westminster Memory services, we are seeing patients with cognitive impairment which can be due to dementia. So, it is really important to discuss and help a person and/or relative with making decision about client's health, welfare or finances. Though each team member discusses about what they did for the same, we identified that it was not reflected in the documentation.

After finalising data collection form, we then performed a retrospective collection of number of documented assessment/discharge report/progress notes within an identified 3-month time period from March to May 2021. Our intervention was Email and MDT remainders, developing patient information video, and structured format to document about legal aspect of dementia like, financial management, Lasting power of Attorney, Court of protection, Advance will, etc. We run PDSA cycles and collected a data at the end of each month to see whether change ideas are helping to improve documentation and whether any modification will require with the plan.
**Results.** Out of 67 patients record which were reviewed as a baseline data, 39% of them has diagnosis of dementia or Mild Cognitive impairment. Discussion about LPA was recorded in only 16% of the documents. There is no mention of how a person is managing their finances in 30.7 percent of documents. After implementing change ideas, 29 patients who were seen during the month of December were reviewed using the same data collection form. Documentation of discussion about financial management was improved to 93.1%. Documentation of Discussion about how to set up LPA, if a person doesn't have one has been approved from 10.4% to 55.2%. The cycles will continue for month of January and February and data will be assessed and compared at the end February 2022.
**Conclusion.** Basis on the data available till date, a general improvement in the record keeping of notes was seen. Simple intervention like email reminders, reminder in MDT, structured format for documentation and patient information in visual format can improve the documentation of work. More detailed conclusion will be drawn at the end of 3 months.

## Do Patients on Section 42 Understand Their Section and What Is Involved?

Dr Chung Mun Alice Lin[1] and Dr Neeti Sud[2]*

[1]National Institute of Health Research Newcastle Biomedical Research Centre and the Translational and Clinical Research Institute,

Newcastle University, Newcastle upon Tyne, United Kingdom and [2]Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle upon Tyne, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.342

**Aims.** Mental health disorders, mostly notably paranoid schizophrenia and personality disorders are commonly seen in patients with a forensic background. Section 37/41, within the Mental Health Act 1983, detains patients who are mentally unwell in hospital for treatment, instead of a prison sentence, with the addition of a community restriction order for public safety. Once stable, patients are discharged by the Ministry of Justice (MoJ) on Section 42, otherwise known as a conditional discharge. This means they can live freely in the community but under a set of conditions they must follow in order to obtain absolute discharge. A leaflet on Section 42 was created after a gap in patient knowledge was identified during consultations. Furthermore, a literature review did not retrieve any relevant results on this topic. The aim of this leaflet was to improve both patient and staff knowledge.
**Methods.** A patient leaflet was created using information from relevant legislation, MoJ official documents, trust resources, the charity MIND UK as well as staff knowledge. A checklist consisting of 12 questions was created to test the patients' knowledge, with space for additional comments. Care was taken to ensure every question on the checklist had a corresponding answer in the leaflet. Six suitable patients were identified and supported to read the leaflet and a structured interview using the checklist was conducted pre- and post-leaflet. In addition, feedback was sought from staff members of multiple backgrounds. A resource questionnaire was also given to participants to collate feedback. The pre- and post-test answers were compared and given a mark out of 12. A mark was given for answers that were sensible and correct, even if parts were missing for questions that encompassed multiple facts.
**Results.** All patients were previously on Section 37/41 and now on Section 42. All showed a substantial improvement in knowledge base, with 4/6 patients scoring full marks afterwards. Patient feedback obtained was overall very positive, with many describing it as "useful", "informative" and "helpful". Staff feedback was also collated and found to be positive too, with comments including "very informative", "easy to read" and "clear and precise".
**Conclusion.** Our leaflet was well received by both patients and staff. It improved their knowledge base as well as confidence in understanding the medico-legal jargon used in day-to-day practice in the forensic setting. Feedback was overall positive, and the additional patient feedback was encouraging, with many of them wishing for sooner access to similar resources.

## Implementation of STOMP (Stopping Over-Medication of People With Learning Disability, Autism or Both With Psychotropic Medications) PLEDGE: A Quality Improvement Project at Bradford District Care Foundation Trust CAMHS Learning Disability Team

Dr Mahira Syed* and Dr Sarojit Ganguly

Bradford District Care NHS Foundation Trust, Bradford, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.343

**Aims.** The project's aim coincides with NHS England STOMP Pledge signed by BDCFT. To maintain up to date records of children and adolescents with learning disabilities eligible for STOMP reviews, implement planned supervised dose reduction, consider alternatives to psychotropics and maintain an up-to-date record of physical health monitoring for patients on antipsychotic medications according to local Trust guidelines.
**Methods.** The sample consisted of the caseload registered with the CAMHS learning disability Team at BDCFT in December 2021. Each case was reviewed retrospectively through electronic records. Data were collected on a data collection tool designed in Microsoft Excel.

Baseline data about Diagnosis and Psychotropic medications prescribed were recorded. The Antipsychotic prescribing practice was audited against local Trust guidelines as part of the project.

The project was registered and approved by the Trust Audit Team.
**Results.** The study included 106 cases registered in December 2021.
42 patients (40%) were prescribed psychotropic medication only
10 patients (9%) were prescribed psychotropic medication plus ADHD medication
14 patients (13%) were prescribed ADHD medication only
40 patients (38%) were not prescribed any medication
66 (62%) patients from the sample were prescribed medication.

Medications were divided into, Psychotropics and ADHD medication groups. Each group was assessed against a prescription time standard of either less or more than 12 months.

Antipsychotics were the most frequently prescribed psychotropic medications; 60% of those prescribed psychotropics were on Antipsychotics. A smaller number (31%) on an Anxiolytic, and an even small number (12%) on an Antidepressant. Anticonvulsants were prescribed to 6 in our sample, but all by another service provider (Paediatrics). 20 patients (38%) were on more than one psychotropic medication.

The length of the time was divided into less and more than a year on medication. 20% of patients were on psychotropics for less than 12 months and about 80% for more than 12 months.

As there are local BDCFT guidelines for monitoring patients on Antipsychotics, a summary of compliance against standards was included as an audit in the project.

All 66 patients on medications were deemed eligible for STOMP reviews, and 64 out of them had behavioural support plan in place.
**Conclusion.** 66 patients who had eligibility for STOMP:
1. 35%: Undergoing reduction plan.
2. 35%: Reduction was not deemed suitable.
3. 30%: No review or reduction plan in place

Recommendations are made in the report to achieve full compliance with STOMP objectives and a re-audit in a year to monitor progress.

## Quality Improvement Project to Improve GP Referrals to a Rural Psychiatric Team

Mr George Tresilian[1]*, Ms Hamnah Nasser[1], Dr Su Hyun Park[2], Dr Dehneez Asad[2], Dr Raja Akbar Khan[3], Ms Helen Moran[3] and Dr Vishnu Gopal[3]

[1]University of Sheffield, Sheffield, United Kingdom; [2]Nottingham Healthcare NHS Foundation Trust, Nottingham, United Kingdom and [3]Derbyshire Healthcare NHS Foundation Trust, Derby, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.344