3. In this audit 99% of patients with a completed GASS had the full document available compared to 98% previously.
4. Additionally significant variation between depot administration groups was identified ranging from 17% completion to 100% completion.

Conclusion. It is clear the standards of 100% completion of GASS yearly are not being met however there was notable improvement following previous intervention suggesting this was beneficial and further interventions have been put in place including, but not limited to, supply of a spreadsheet with up to date list of when patients are due a repeat GASS for future tracking to further improve adherence to standards.

Comparison of Management (Non-Pharmalogical Approaches and Rapid Tranquilisation) of Older Adults (≫65 Years) With Dementia Between the Dementia Ward, Acute Medical Unit and the Geriatric Ward in a Rural Health Board

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Aims. To investigate if current practices by nursing and medical staff in the dementia ward (New Craigs Psychiatric Hospital), acute medical unit and geriatric ward (Raigmore General Hospital) followed the local protocol for managing distress of non-pharmalogical approach and rapid tranquilisation (RT) in older adults (aged >65years). We believe the split between the general and psychiatric hospitals and the different time pressures experienced in these 3 wards will influence the management and RT of their older adult patients.
Methods. Data were collected from 17/09/2022 to 8/10/2022 from case notes and drug charts of older adult patients that received rapid tranquilisation from 3 wards:

1. Ruthven Ward, New Craigs Psychiatric Hospital
2. Acute Medical Unit (AMU), Raigmore Hospital
3. Ward 2C (Geriatrics), Raigmore Hospital

Focus groups and informal discussions were made with the ward nurses and junior doctors to understand their point of view on managing distressing behaviours in patients with dementia using de-escalation techniques.

A table was collated using Microsoft Excel. The parameters used were:

1. Patient Diagnosis and Legal status
2. Administration
- Date and time started
- If de-escalation techniques were used
- If discussed with a senior doctor
- 1st and/or 2nd line of drugs administered (route, drug and dosage)
- If Haloperidol given and if ECG was done

Results. Data collection showed the following:

1. Ruthven Ward- all 32 patients did not receive RT.
2. AMU- only 1 out of 280 patients received 4 subsequent RT in 5 hours including 3x haloperidol (total 3mg) and 2mg of Midazolam despite an ECG showing prolonged QT interval. The latter prescribed after consultation with a senior doctor.
3. Geriatric Ward – all 10 patients did not receive RT.

Conclusion. Focus groups and informal discussions with staff nurses from all three wards concluded that in spite of the stressful environment posed by issues of understaffing and high patient load, de-escalation techniques (recognition of early signs of agitation, distraction and calming techniques, recognising the importance of personal space) were prioritised before moving on to RT as per local protocol. Restraining was often used if patient was at risk to self or others by staff trained in violence and aggression management.

Informal discussions with junior doctors rotating in and out of AMU showed limited awareness of the RT protocol. In general, it was evident that RT was a last resort when psychological and behavioural approaches failed but that further education was required to administer RT safely.

Antipsychotic Prescribing for Behavioural and Psychological Symptoms of Dementia: An Audit of Prescribing Practices in the Harrogate Community Mental Health Team for Older Adults

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Aims. Behavioural and Psychological Symptoms of Dementia (BPSD) include a range of neuropsychiatric disturbances such as agitation, aggression, depression, and psychotic symptoms. These common symptoms can impact patients' functioning and quality of life. Antipsychotic medication can be prescribed to alleviate some symptoms, but this comes with significant risks including cerebrovascular events and increased mortality. We aimed to review antipsychotic prescribing of the Harrogate Older Adult Community Mental Health Team (CMHT); to measure compliance with NICE guidance and local policy and thus improve the prescribing and monitoring process.
Methods. Using electronic patient records, we identified all patients under the care of the CMHT with a diagnosis of dementia currently receiving antipsychotic treatment; a total of 55 patients. A random sample of 24 patients were reviewed; their records were hand searched for relevant information.

The standards measured were derived from the NICE Guideline (NG97) June 2018: 'Dementia: assessment, management and support for people living with dementia and their carers' as well as local trust guidance.
Results. All 24 patients were receiving antipsychotics for severe distress or aggression. 88% of patients had an assessment of sources of distress before treatment was started, but only 42% had a non-pharmacological intervention before antipsychotic treatment was started. Once antipsychotic treatment had started this

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.

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.

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.

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