

smoking cessation which shows that there might be a need of a more precise implementation regarding support to receive brief intervention for smoking cessation, NRT and specialist advice.

The results also showed that the QRisk is not calculated, a useful marker of cardiovascular risk.

**Conclusion.** Give leaflets regarding smoking cessation on admission, offer support and advice to all the patients being on the ward. And re-audit in due course to see the effect of this intervention.

### Constipation and clozapine: a QI project in Leicestershire Partnership NHS Trust, (LPT)

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**Aims.** Constipation in patients on Clozapine is the biggest cause of mortality. We have no set protocol in LPT for how to manage and monitor Constipation in Clozapine initiation in the inpatient setting. Internationally protocols, (such as the Porirua protocol) exist but have not been widely used locally.

We wanted to assess local compliance with monitoring constipation in patients admitted to hospital and started on Clozapine. We also wanted to assess whether patients are prescribed PRN or regular laxatives, before considering implementing a local protocol.

**Method.** In LPT we use the ZTAS system for prescribing Clozapine. They provided us with a list of patient IDs who had recently started on Clozapine.

We captured data on patients started on Clozapine.

1. What date was this started?
2. What date was either PRN or regular laxatives started?
3. Was a bowel chart recorded?
4. Any evidence of constipation or significant bowel issues relating to Clozapine?

**Result.** We initially analysed 30 patients, (20 of whom were initiated on Clozapine as inpatients, and 10 as outpatients). A bowel chart was started in only 1 inpatient. Laxatives were started in 50% (15, only 3 of whom were outpatients). 14 were regular and 1 was a PRN prescription. 12 inpatients had constipation, and 1 outpatient suffered with constipation. 2 patients suffered with diarrhoea but there were no other significant issues with bowel problems.

**Conclusion.** From our initial data we can see that there are many inconsistencies in practice.

Existing patients on Clozapine attend a local clinic, (Clozapine clinic) where ongoing monitoring of constipation, (and other parameters, e.g. ECGs etc are completed).

We have written a new protocol which we will share, that the trust has implemented, that identifies when PRN and regular laxatives should be prescribed. We have also expanded the protocol to agree for initiation of Olanzapine bowel charts and PRN laxatives should be used.

### Audit on availability, quality and frequency of clinical and educational supervision

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**Aims.** GMC defines clinical supervisor as a trainer who is responsible for overseeing a specified trainee's clinical work throughout a placement in a clinical or medical environment and is appropriately trained to do so<sup>1</sup>.

This AUDIT aimed to review the frequency, content and quality of clinical supervision for psychiatric trainees within Somerset NHS Foundation Trust. Both Severn deanery and Somerset NHS Foundation Trust both recommend psychiatry trainees have one hour of supervision per week, involving exploration of trainee clinical and educational needs.

**Method.** All trainees working in Somerset NHS Foundation Trust psychiatry from February 2020 were invited to participate. A survey was designed to quantify the frequency of supervision amongst this cohort. Survey online software, SurveyMonkey, was chosen for the accessibility and user friendly modality and disseminated via email to all junior doctors (n = 27). Survey responses were collected in the last month of the placement (July–August 2020).

Questions on accomplishing workplace based assessments (WPBA), managing e-portfolio requirements were asked, with Likert scale responses available. Quality of supervision was explored via white space answers.

Surveys were reviewed by the AUDIT authors and descriptive data collected.

**Result.** 63% trainees responded (17 out of 27). Educational objectives were discussed at the beginning of the placement. Over half the respondents stated that time was not set aside to look at e-portfolio.

Workplace based assessments (WBPAs), and Case based discussions (CBDs) were more frequently achieved than observed assessments of clinical encounters (ACEs/Mini-ACEs) (assessment of clinical encounter).

30% core psychiatry trainees respondents (4 out of 7) discussed their audits/QI projects with their supervisors most/always. 42% (3 out of 7) had a discussion sometimes.

2 GP and foundation trainees stated they were unable to obtain community mental health experience. The response rate to this question was disappointing and we think it may be secondary to the pressures of the pandemic.

100% respondents described educational supervisors as supportive and approachable.

**Conclusion.** Whilst all respondents found their supervisors approachable and supportive, completion of formal WBPAs and portfolio reviews was suboptimal.

Following regional presentation of results, the pertinence of these findings for all trainees was highlighted. A supervision template has been created and extension of this initial audit to a regional quality improvement project is underway.

Specific recommendations included brief and regular supervisor check-ins with trainees regarding projects and psychotherapy competencies and a mid-placement review of portfolio.

### Are medications with anti-cholinergic properties prescribed and reviewed appropriately on a male older person's organic ward?

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**Aims.** Patients admitted to Roker ward (male organic psychiatric ward) should have a decreased anticholinergic burden of

medication on discharge compared to admission. This will be demonstrated by a reduced score on the Anticholinergic Cognitive Burden (ACB) scale on discharge compared to admission. Target: 80%.

Where new medicines with anticholinergic burden are prescribed during admission, there should be evidence that the anticholinergic properties of these medications have been considered prior to prescribing (via documentation in care co-ordination reviews or progress notes). Target: 100%

**Method.** Electronic records were searched for all discharges from Roker ward between 1/1/2019 – 31/12/2019. For each record the following information was recorded: demographics; primary diagnosis; total ACB score on admission; and total ACB score on discharge. For all new medications started with an ACB score of over zero, records were searched to establish whether there was evidence that the anticholinergic properties of these medications had been considered.

**Result.** 47 patients were identified who were discharged over the time period in question. 30 patients had no difference in ACB score between admission and discharge; 10 patients had a reduction in ACB score and 5 patients had an increase. A total of 9 new medications with ACB scores over zero had been started during all admissions; there were no occasions where there was documented evidence to show that the anticholinergic burden of these medications had been considered.

**Conclusion.** 27% of patients had a reduction in their total ACB score during admission; the target was 80%.

The reasons for starting medications with an ACB score of greater than 1 were documented in 0% of cases; the target was 100%.

As both targets were missed by a significant margin, it was recognised that there were significant areas for improvement. The following plan was therefore implemented:

1. Following discussion with the ward consultant and ward pharmacist, regular prescriber meetings have been set up which involve senior nursing staff, medical staff and pharmacy – anticholinergic burden is calculated for each patient as part of these meetings
2. A re-audit is recommended after 6 months.

## Assessing the quality of risk assessment conducted for new psychiatry inpatients

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**Aims.** An audit was conducted to assess if thorough risk assessments had been documented in electronic clinical record notes (ECR) clerking for new patients in two acute mental health wards. Risk assessment is a vital part of admission clerking and when done well it can prevent early incidents and aid the ward nursing team greatly. During induction, junior doctors are advised to document assessed risks when clerking a new patient. A screening of the risks on admission could help determine the levels of observations required to minimise the identified risks whilst the patient awaits their first ward review.

**Method.** The NHS numbers for the 30 current inpatients across male and female acute psychiatric wards were gathered at the time of the audit (February – March 2020). Admission clerking was analysed for a clear statement of patient risk to self, others or property. Within these categories quantitative results were obtained on how often the risk of self-harm, self-neglect,

absconding, vulnerability or aggression was documented. The term ‘risk’ was used for each patient on their ECR notes to search for risk assessments in all entries other than admission clerking.

**Result.** 12 out of the 30 patients had a junior doctor risk assessment documented in their clerking (40%). 14 patients had no mention of risk assessment on admission (47%) and their first formal risk assessment was documented only in their senior ward review. Of the 12 assessments completed in clerking; all assessed self harm/suicide risk and violent risk to others, 1 mentioned risk of absconding, 8 mentioned risk of illicit substance use and 8 mentioned vulnerability. It was unclear if the risks documented were based on current or historic presentation. Junior doctors were anonymously surveyed following this audit and reported they did not feel confident in how to document a risk assessment or whether to document negative findings.

**Conclusion.** Clear documentation of risk assessment being performed was lacking in over half of junior doctor admission clerkings. When risks were assessed it was mainly violence/self harm risk documented not vulnerability and physical health risks. Based on these findings we have designed more comprehensive teaching on risk assessments and a template for how to complete a risk assessment. We feel the use of a template will ensure all elements of risk are clearly considered even if they are not present currently. This is being reaudited to assess if the changes have impacted the quality of risk assessment conducted.

## Audit of the impact of the integrated psychological medicine service (IPMS) on service utilisation

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**Aims.** An audit to assess the impact of an Integrated Psychological Medicine Service (IPMS) on healthcare utilization pre & post intervention. We hypothesized that an IPMS approach would reduce healthcare utilization.

**Background.** The IPMS focusses on integrating biopsychosocial assessments into physical healthcare pathways. It has developed in stages as opportunities presented in different specialities leading to a heterogeneous non-standardised service. The key aim is involvement of mental health practitioners, psychologists & psychiatrists in complex patients with comorbidity or functional presentations in combination with the specialty MDT. This audit is the first attempt to gather data across all involved specialities and complete a randomised deep dive into cases.

**Method.** Referrals into IPMS from July 2019 to June 2020 pulled 129 referrals, of which a 10% randomised sample of 13 patients was selected to analyse. 5 patients had one year of data either side of the duration of the IPMS intervention (excluding 8 patients with incomplete data sets).

We analysed; the duration & nature of the IPMS intervention, the number, duration & speciality of inpatient admissions & short stays, outpatient attendances, non-attendances & patient cancellations. Psychosocial information was also gathered. One non-randomised patient was analysed as a comparative case illustration.

**Result.** Randomised patients; patient 78's utilisation remained static, patient 71 post-referral engaged with health psychology & reduced healthcare utilisation. Patient 7 increased healthcare utilisation post-referral secondary to health complications. Patient 54