

cycles of the audit (Data were collected in the 1st cycle between 06-07-2021 and 22-07-2021, and 2nd cycle between 16-10-2022 and 07-11-2022). Samples were selected randomly among patients who were inpatient or discharged recently. The data were collected from the first, middle, and last ward reviews. If the patient was inpatient at the time of the data collection, data were collected from their first review, the last/most recent ward review, and one of the reviews in between. Patients who did not meet this criterion were excluded. Based on 1st cycle results, strategies were recommended to improve record keeping. After 15 months, 2nd cycle results were used to evaluate their effectiveness.

Results. The results demonstrate significant areas of improvements in record keeping: a majority of questions did not meet the standard of 80% completion considered “satisfactory” in previous audits. In the 2nd cycle, 9 questions had a “satisfactory” completion rates. These were mandatory or automated questions and ones essential to immediate patient care. 7 questions had “average” completion rates above 45%. All (17) other questions and subquestions had “low” completion rates. Analysis of variations between cycles shows that question on “Responsible clinician” increased from 23.3% to 99.5% because it was automated. 4 other questions or sub-questions have seen a substantial increase in completion rate between the 1st and 2nd cycle. But our strategies’ effectiveness during the period of the audit has proven limited and difficult to trace.

Conclusion. It can be concluded that more efforts should be dedicated to improving medical record in the psychiatry wards of Essex Partnership University NHS Foundation Trust. The most effective strategy to secure high ward review documentation rates remains to make questions mandatory or auto-complete when possible. More research is necessary to demonstrate the effectiveness of other strategies such as the education of junior doctors in induction and awareness posters in wards.

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 on Antipsychotics: A Clinical Audit

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Aims. Patients with serious mental illness are more likely to suffer from serious physical health conditions, including: obesity, diabetes, heart failure and stroke. This, combined with the side effects of antipsychotic medication including weight gain and cardiac changes, means that patients with psychosis under the Early Intervention Services (EIS) taking antipsychotics require regular physical health monitoring, as per NICE guidelines. This includes: yearly BMI, blood pressure, ECG, blood tests (FBC, U+E, lipids, HbA1c, prolactin, LFT), alcohol status and smoking status. Our audit aims to assess the compliance of physical health checks for patients on antipsychotic medication under the EIS first episode psychosis team.

Methods. Patients on our caseload (for >6 months) between 01/2022 and 01/2023 (n=36) were included in this audit, and relevant data were collected using electronic records (i.e. carenotes and affinity). Data were recorded and stored electronically, and analysed using Excel and GraphPad. Patient information was

discussed with their lead practitioner to ensure data collected was accurate. Our audit standard was set at 100%.

Results. In terms of BMI, 91.67% (n=33) of patients had a recorded BMI, with 19.44% (n=7) of our patients being overweight and 19.44% (n=7) being classified as obese. Of the patients classified as overweight or obese (n=14), 85.71% (n=12) had received advice about their diet or exercise. Blood pressure measurements were available for 86.11% (n=31), and 13.89% (n=5) of these patients were found to have hypertension. Information relating to patients’ alcohol, smoking and recreational drug use was recorded in 97.22% (n=35) of our patients.

Qrisk data were not collected in 22.73% (n=5) of patients who were eligible for measurement (n=22). Furthermore, ECG tests were not recorded in 72.22% of patients (n=26). Compliance with blood tests was less than the desired standard, with 75% (n=27) of patients having an up to date FBC, U+E, lipids and HbA1c measurement.

Conclusion. Specific areas of physical health monitoring are carried out to a high standard in the EIS service, but there are areas which warrant improvement, particularly Qrisk and ECG monitoring. The EIS team is to re-audit these outcomes in 3 months’ time, after presentation of results to the team and physical health check clinics are employed.

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Clinical Audit of the Quality of Care Delivered by Community Mental Health Services for Older People to People Living With Dementia and Their Carers

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Aims. This clinical audit aimed to assess how well the local Community Mental health services for Older people (MHSOP) was implementing the latest NICE and Tees, Esk and Wear Valleys (TEWV) guidelines in dementia service delivery, and to identify what impact (if any), the COVID-19 pandemic lockdown had on their service delivery. In the UK, there are over 800,000 people living with Dementia; providing sustainable individualised care for them has significant cost implications for health and social care services. In 2018, NICE published evidence-based guidelines on delivery of dementia care by professional services within a person-centred and supportive framework. These guidelines together with the TEWV guidelines on Person-centred Dementia care pathway published in 2019, set the standards for this audit.

Methods. The first cycle was performed between 7th Nov 2020 and 15th Jan 2021; we included patients who had received an initial and diagnostic assessment from the team by 12/2020.

Second cycle was done from 7th Nov 2021 and 31st March 2022; inclusion criteria were patients who had initial and diagnostic assessments by Jan 2022.

In each cycle, data from 20 patient records were collected using a tool designed from NICE guidelines and Trust policy on Dementia care standards.

Results. In the first audit patients’ consents for assessment and information sharing purposes was recorded in 80% of cases; this fell to 65% in the re-audit.

In the first audit at diagnostic assessments, 47% of patients were given relevant information regarding their prognosis and