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 follwing 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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doi: 10.1192/bjo.2021.251

**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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doi: 10.1192/bjo.2021.252

**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 IMPS 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