Criteria included in patients with a diagnosis of ASD, taking antipsychotic medication, with records of clinical interventions and investigations. We conducted a search to electronic and paper files. Electronic records were available at MYPATH system as well as ward files with physical observations and health Action plans. Data were collected on spreadsheets and later analysed.
Results. A total of 17 patients were identified, we excluded 2 service users that were not taking antipsychotic medication, and 1 of these did not have a diagnosis of ASD. We collected data from 15 participants. All patients have Blood pressure, Body Mass Index and measure of HbA1C (100%), 86.6% had records of lipid profile, but only 60% have a waist circumference.

We analysed individually the risks factors for metabolic syndrome on the 15 selected patients; 79 % of the patients had excess central adiposity (large WC). 20% among males were diabetic type 2 and smokers. About 40 percent (40%) of sampled individuals were obese.
Conclusion. The findings of our study supports the notion that screening for metabolic side-effects needs to be prioritised for individuals. Clinicians need to be aware of the risk of metabolic syndrome. Periodical screening is required across all health services treating people with ASD, especially those taking regular medication. General measures of control such as losing weight, exercising regularly. Eating a healthy, balanced diet to keep blood pressure, cholesterol and blood sugar levels under control. Also, stopping smoking.

Lithium Monitoring in the Community; Mapping, Finding, Improving

Dr Micheline Tremblay MD, MSc, FRCPsych[1]*, Kate Megan Jones BSc[1], Damilola Adeyemi MPharm[1] and Sarah Robinson BSc, MSc, FRCPath[2]

[1]Cheshire and Wirral Partnership NHS Foundation Trust, Chester, United Kingdom and [2]Royal Stoke University Hospital, Stoke-on-Trent, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.480

Aims. Lithium is a well-recognised treatment in Affective Disorders. Careful monitoring is required due to its narrow therapeutic index. Adherence to monitoring standards has been generally poor with high levels of incidents reported to the National Patient Safety Agency leading to financial settlements and inclusion in patient safety alert potentially selected on inspection by the Care Quality Commission. This audit aimed at mapping the provision of lithium monitoring for patients stable on Lithium in Vale Royal to facilitate implementation of quality improvements in ongoing transformation of community services. There are twelve general practices in Primary Care (PC) for this area, one specialist mental health Trust Cheshire and Wirral Partnership NHS Trust (CWP) and one Hospital Trust MidCheshire Hospital Trust (MCHT).
Methods.
1. Systems inventory

No lithium central register was identified.

All lithium requests were processed by North Midlands and Cheshire Pathology services (NMCPS).

In specialist care lithium was managed by one Consultant Psychiatrist.

In primary care nine practices provided information, all supported by a software overseen by administrative staff working collaboratively with doctors.

b. Data collection.

Anonymised Lithium results for adult patients stable between November 2021–2022 were collected from NMCPS.

Plasma levels and frequency were compared to generally accepted standards of 0.4-1 mmol/L every 6 months for stable patients.
Results. Ninety patients were identified, eighty in PC and ten with CWP, median age 58, females (53%)/males (47%) gender ratio.

Frequency was mostly 3 monthly for 74% of patients in PC and 80% for CWP.

Levels below 0.4 mmol/L were found in 22.5% of levels measured in PC and 27% for CWP, and over 1 mmol/L in 5% in PC and 0% CWP.
Conclusion. This audit revealed that lithium monitoring for stable patients was primarily managed in PC.

Lithium level was measured more frequently than recommended which could be due to automated cues. Levels were often maintained at the lower end of the range. Those findings could be medically related.

Both computer and clinician led systems allowed for meeting, if not exceeding, targets.

Electronic systems are likely cost savings over a specialist clinic but could generate potentially unnecessary automatic checks, still require data reviews and medical oversight. This could be addressed by system amendments and an audit programme.

The absence of formally recognised central register could be remediated by shared agreement and managed by NMCPS.

Systemic approach to lithium monitoring can be collaboratively extrapolated to other localities, medications, or targets .

Naloxone Audit

Dr Paster Venan*

Essex Specialist Treatment and Recovery Services, Colchester, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.481

Aims. The aim of this audit was to look into the services' fidelity of Naloxone provision and training across the Essex wide area compared with local guidelines as well as national guidelines (UK guidelines on clinical management of drug misuse and dependence, 2017)
Methods. The electronic records database for substance misuse services (THESEUS) was used for extracting the data. A total of 1991 patient records were analysed out of these 885 patient records were excluded, as these patients had never injected heroin. The remaining 1106 patient records were treated as the QUALIFYING POPULATION. A time frame period of 3 years (2019 to 2021) was further applied to the qualifying population, which resulted in 700 patient records being analysed for Naloxone data.
Results. Naloxone provision was recorded under two different headings in the electronic database. The first heading, Naloxone episode – indicated the discussion held by the professional with the patient regarding the use of Naloxone. The second heading, Naloxone event – indicated the actual event of Naloxone being provided to the patient by a professional. There was a lack of clarity on both episode and events data capture regarding previously injected status.

Another important finding was that in the NON-QUALIFYING POPULATION i.e., patients who have

never injected heroin in the past were provided with Naloxone for 367 patients, although this is a good practice it comes at the expense of missing out on providing Naloxone to patients who would definitely need it (OUALIFYING POPULATION)
Conclusion.

1. The robustness of the data collection done by the professionals was commendable, but this was let down by the ambiguity and obscurity of the data recorded on two different headings (episode and events)
2. There was evidence of Naloxone being provided to the patients who have not injected heroin
3. There was accurate documentation on the type of Naloxone being issued (Injectable vs Nasal)
4. There was sparse documentation on the Naloxone training provision within the electronic system.

An Audit Reviewing the Completion and Quality of the Admission, Then Six Monthly ALL-Physical Health Assessments (A Six Monthly Health Check) on a Low Secure, Inpatient Forensic Psychiatric Ward in Sussex Partnership NHS Foundation Trust

Dr Elizabeth Vogel[1]*, Dr Shumaila Asmat[2], Dr Benjamin Jones[2] and Dr Moustafa Saoud[2]

[1]University Hospitals Sussex NHS Foundation Trust, Chichester, United Kingdom and [2]Sussex Partnership NHS Foundation Trust, Chichester, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.482

Aims. Background: It has long been known that having a Severe Mental Health Condition is a risk factor for cardiovascular disease. In order to facilitate early intervention, NHS has implemented annual physical health reviews. Within Sussex Partnership Foundation Trust (SPFT), compliance with this is outlined within local guidance and an assessment on admission and thereafter six-monthly is mandatory and called ALL-Physical Health Assessment. Historically, completion of this has been poor and therefore, this audit has been done to review the quality of completion and whether ALL is UpToDate and implement changes to improve the care. The Categorisation of completion into green, amber, and red as errors are linked to potential harm to patient's care. The review of actions taken from areas highlighted as abnormal results.
Methods. This study was done within the setting of Pine Ward, a 17-bed male, inpatient, low-secure forensic psychiatric ward.

Data were collected in November 2022 by reviewing ALL-Physical Health Assessments (six-monthly physical health check) on Carenotes(an electronic record system) and evaluating the quality of completion by categorising it as green(no errors), amber(minor errors, potential for risk to patient care), and red (major error/ missing documentation, which can lead to serious harm). ALL has fourteen categories. Smoking, Diabetes, Cholesterol/HDL ratio, Blood pressure, Pulse, Body Mass Index, Diet, Exercise, Alcohol, Substance misuse, National screening programme, Sexual functioning, Oral health and QRISK. This was compared with the results from February 2022 ALL assessments.
Results. Of the 17 patients, 15(88%) had an ALL done in the last 6 months. When splitting completion of the ALL, 89.9% of completions were green, 4.6% amber and 5.5% red.

In February, overall 76.4% of patients had ALL done and 67.2% of completions were green, 15.5% amber and 17.2% were red.

Improvement was seen in QRISK, Alcohol, diet, and exercise status, as they were 100% documented in November whilst it was 70%, 58%, 82%, and 70% respectively in February. The diabetic and smoking status is now 82% and 88% whilst it was 58% and 76% in February.
Conclusion. This audit has highlighted that certain areas of the ALL that are not completed up to the standard expected. The importance of the assessment needs to be raised to trainees to allow for the best patient care. There is potential for harm to patients if the assessment is completed inaccurately or incorrectly.

Side-Effect Monitoring for Patients on Depot Antipsychotic Medication Within a Community Treatment Team

Dr Harry Waterman[1,2]*, Dr Hanna Zaborowska[2] and Miss Julie Taylor[2]

[1]Northumbria Lead Employer Trust (LET), Newcastle, United Kingdom and [2]Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle, United Kingdom
*Corresponding author.

doi: 10.1192/bjo.2023.483

Aims. To determine whether the community treatment team (CTT) were meeting the following three trust standards for patients receiving antipsychotic depot medication: 1. 100% of patients should have side effects monitored using a validated scoring system in the form of the Glasgow Antipsychotic Side-effect Scale (GASS) once yearly. 2. 100% of patients should have had a GASS completed ever. 3. 100% of patients with a completed GASS should have this document available in full. Additionally adherence to these measures was compared to the previous year's audit to assess for change following interventions and change in documentation.
Methods. A list of 146 patients receiving antipsychotic depot medication within the CTT was produced and subsequently set up in a Microsoft excel spreadsheet. Exclusion criteria were then applied as follows: any patient no longer under the CTT, any patient no longer on depot antipsychotics and any patient admitted in hospital at the time of audit (to allow for comparison to previous year where this was applied.) Following this 127 patients remained for whom I accessed their online notes and searched for evidence of completed GASS, when this was completed and if the full completed form was available. Once these data were gathered percentage of completion was calculated for each of the three standards outlined above both overall and subsequently broken down by depot administration group. These results were then compared to the results of the previous year's audit.
Results. None of the three standards outlined above were met, however notable improvement was noted when compared to the previous year and are listed below:

1. In this audit 66% of patients had received a GASS in the previous year compared to 53% previously.
2. In this audit 97% of patients had a completed GASS ever compared to 95% previously.

https://doi.org/10.1192/bjo.2023.481 Published online by Cambridge University Press