

whilst also improving general practitioner's satisfaction with waiting times for patient's referred to the Gloucester Recovery Team.

Method. We planned to introduce an email address for GPs to use to seek medication and diagnostic advice for patients known to and not known to the Recovery Team. We initially introduced this for the 'Team 2' catchment area consisting of five practices within Gloucester. These were then read and replied to by the Team 2 consultant, Dr Ikram, as appropriate. A further survey was then sent out. These results provided both quantitative ordinal data through a likert scale, which was then transformed into binomial data, such as those scoring 'extremely confident' 'very confident' 'somewhat confident' vs 'not so confident' and 'not confident at all' which is then compared using relative risk.

Result. Our response rate for our initial survey was 8 general practitioners, and for our follow-up survey 1 general practitioner and 2 nurse prescribers. Confidence in continuing psychotropic medications increased from 7 out of the 8 (78%) stating somewhat confident to extremely confident to 3 out of the 3 (100%) after the introduction of the email; a relative change of 1.14 (95% confidence interval 0.87-1.48 $p = 0.318$). Confidence in initiating psychotropic medications increased from 4 out of the 8 (50%) stating somewhat confident to extremely confident to 2 out of the 3 (66%) after the introduction of the email; a relative change of 1.33 (95% confidence interval 0.46-3.84 $p = 0.594$).

Conclusion. Analysing the qualitative data showed the email address was used for a variety of requests and advice including: 1) A capacity assessment, 2) Initiating medications for depression and anxiety, 3) Medications during pregnancy, 4) Medication for those with Intellectual Disability, 5) Switching medication, 6) Medications for poor sleep and 7) Mood stabilising medication.

This change appeared to be well received, however the response rate was very low which makes full analysis difficult. We also included nurse practitioners working in primary mental health in our second survey, whereas the initial survey was only sent to GPs. This initiative was also only started for 5 of the GP practices within Gloucester, and there may be a different knowledge base/confidence amongst the other practices.

An audit into the monitoring of off-label antipsychotics in primary care

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Aims. To ascertain whether patients prescribed second generation antipsychotics for off-label indications are being monitored and screened adequately for physical health side-effects.

Background. The prevalence of off-label antipsychotic use has increased significantly over recent decades. Common off-licence uses include dementia, post-traumatic stress disorder, adjunctive treatment for unipolar depression and personality disorders. Recent studies have demonstrated that up to 65% of antipsychotic prescriptions are now off-label. Since the metabolic side-effects of second-generation antipsychotics are well-established, guidelines have emphasised the need for active, routine physical health screening of all individuals taking these drugs. However, there have been few studies or reviews which have specifically

investigated screening rates of individuals receiving antipsychotic medications for off-licence indications.

Method. An audit of patients taking second-generation antipsychotics for off-label indications, under the caseload of Neighbourhoods 1, 3 and 4 of Lewisham Assessment & Liaison team, was conducted. After isolating individual patients fulfilling inclusion criteria, patient investigation documents were requested from relevant GP practices. 40 patients were isolated in total, and data were successfully collected in 60% ($n = 24$). Data were collected via a proforma. This consisted of patient information, indications for antipsychotic use, and each variable to be monitored. The audit standard used was the recommendations of the 12th Maudsley guidelines. Data were then entered into SPSS and analysed.

Result. The most common reasons for off-label antipsychotic prescribing were Emotionally Unstable Personality disorder (42%, $n = 10$) and depression (29%, $n = 7$). Findings demonstrated that 54% ($n = 13$) of patients audited had 'basic' blood screening (FBC, U&E, LFTs), however glucose (38%, $n = 9$), Prolactin (13%, $n = 3$), and Creatine Kinase (0%, $n = 0$), and monitoring was less frequent. 0% ($n = 0$) were completely monitored as per audit standard.

Conclusion. Primary care monitoring of off-label antipsychotics is unsatisfactory, with no patients having a complete set of investigations. Reasons for this are unclear at this stage, however based on initial discussion with GP surgeries, may be due to lack of education regarding screening investigations, patients lost between primary and secondary care services, and a lack of clarity regarding responsibility and designated roles. This audit will be expanded to also include patients from Neighbourhood 2 of the Lewisham Assessment & Liaison team. A more detailed investigation will be conducted into the barriers to physical health screening, such that a targeted intervention can be implanted.

Nile Ward PICU violence reduction quality improvement project

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Aims. To reduce incidents of inpatient violence and aggression at Nile Ward Psychiatric Intensive Care Unit (PICU), St Charles Hospital by at least 30% between December 2019 and December 2020. Reducing inpatient violence is a major quality improvement (QI) priority for CNWL NHS Foundation Trust.

Method. As a Psychiatric Intensive Care Unit, Nile Ward looks after male patients suffering from severe mental illness (SMI). This usually includes patients presenting with high levels of violent and aggressive behaviour. Prior to this QI project, there were high levels of patient assaults towards staff and other patients. This required a lot of medication use, including rapid tranquilisation, restraint and the use of seclusion. This QI project was started to allow the Nile MDT to explore ways to reduce serious incidents on the ward in the least restrictive manner.

We implemented a number of change ideas within this project. Our change ideas included: 1. A new risk management tool: 'Ragging', a daily risk assessment tool, was created to assess patients' risk of violence and aggression to allow signposting of appropriate interventions to safely manage risk. 2. A brand new Staff Photo board: New photos of all permanent and bank staff displayed in the ward with no hierarchy of positions. 3. A new Patient Feedback board: Patient experience, comments and