composite set of documentation, and a signed copy should be made available to the service user/parents.
Method. First Cycle commenced 15th October 2019. 166 files were selected from CAMHS team. Data were collected from clinical records from time of admission into CAMHS service to the time of audit. The audit report was prepared on the 6th December 2019, and intervention discussed at the multidisciplinary team meeting and wider DNCC CAMHS academic meeting. Second Cycle 23rd March 2020. 30 files randomly selected and audited. Data were collected by Dr Uchechukwu Egbuta, Mr Cillian Howley, Dr Anitha Selvarajoo, under supervision of Dr Muhammad Iqbal and Dr Diana Meskauskaite.

Method of data input/analysis is IBM SPSS.
Result. For each ICP, the following were looked at: Files with ICP, Identifiable key worker, Formulation, Goals, Action plan, Copy of ICP to young person/parents, Next Review Date, Projected discharge date.

Overall compliance shows 62% in first cycle, and 68% in second cycle after intervention.

There was a 6% quality improvement of ICPs in terms of overall compliance in applying the various components of ICP.
Conclusion. Each service user should have an individual care plan. Each individual care plan should be measured regularly. To develop a therapeutic individual care plan, a formulation of the case from history taking is essential looking at the bio-psychosocial model and should be service user focused. Care plans are part of clinical governance, therefore continuous re-audit every three months was recommended. The follow-up audit will be carried out by the multidisciplinary team members.

A physicians' compliance in identifying patients' as drivers and providing advice on the Driver & Vehicle Licencing Agency (DVLA) guidelines

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doi: 10.1192/bjo.2021.246

Aims. The DVLA has strict guidelines regarding how long a driver should stay off driving when they have certain mental health illnesses or severity of symptoms. It is difficult to give such advice if we are unaware of the patients' that drive; especially when they do not volunteer this information for various reasons.

This audit was aimed at identifying people who have been admitted to the Ward 3 at the Mount Hospital and if they were asked about driving. The audit also looked at whether there were discussions around the driving requirements and DVLA guidelines in terms of their mental health diagnosis. The expected outcome of this project was to improve information gathering when clerking in a new patient and to ensure that elderly patients' who drive are made aware of the DVLA guidelines.
Method. This audit retrospectively examined the care of 50 patients on Ward 3 at the Mount Hospital, a mixed acute psychiatric ward for older people, between 1st April 2020 and 11th November 2020. All patients' aged 65 years and over who were on admission within that period were audited. Data collection took place between 17th November and 17th December 2020; this involved reviewing patient records throughout their inpatient stay including paper notes and electronic records (on Care Director). Results were compiled using a pre-determined data collection tool and analysed using Microsoft Excel. The audit used the standards within the DVLA Guidance- Psychiatric Disorders: Assessing fitness to drive.
Result. Only 1 (2%) patient had sufficiently documented evidence around driving and the impact of psychotropic medication on driving. DVLA information was given verbally in 3 (9%) patients and only 2 patients had this information passed on to their General Practitioner (GP). Only 3 (6%) patients were made aware of the DVLA guidelines and 2 (4%) patients made aware of their obligation to inform the DVLA
Conclusion. Generally, the compliance of psychiatrists in identifying all patients' who drive is poor and seems even worse with elderly patients'. There was little documented evidence that patients were asked about their driving status on or during their admission, were given verbal or written information, had discussions around the impact of medication on driving or informed about their obligation to notify the DVLA. This study provides opportunity to improve practice by educating the medical workforce and raising awareness within the wider team. There also needs to be greater involvement and communication with GPs when completing discharge summaries.

To assess implementation of trust policy (smoke free policy) on an acute mixed mental health ward setting

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doi: 10.1192/bjo.2021.247

Aims. To assess implementation of Trust Policy (Smoke Free Policy) on the acute adult mental health unit To evaluate barriers to implementation of local standards and NICE guidelines To evaluate if Q-Risk score is being calculated and noted.
Background. There are about 34,000 people residents in mental health facilities in England and Wales on any one day (Commission for Healthcare Audit and Inspection 2005) and many of them smoke.

Smoke free policy implemented in the GMMH since 1st of July 2018.

Smoking is single largest preventable cause of ill health & premature mortality in England.

Smoking prevalence is significantly higher among people admitted to hospital due to the mental illness i.e. 70%

According to WHO SHS (second hand smoking), is a human carcinogen to which there is no safe level.
Method. An audit tool questionnaire was used to collect the data on the Acute Mixed mental health ward setting i.e. Bronte Ward, Laureate House, Wythenshawe Hospital

Identified method: interview with each patient, PARIS documentation review and Patient's Kardex review.

Sample size: 23 and on re-audit 12.

Method of data input: Microsoft Excel

Data were analyzed by calculating percentage
Result. The majority of the patients that took part in the Audit were smokers (91%), a high percentage overall. This indicate how important it is for a plan to be in place regarding smoking on the ward since there is a smoke free policy now in the GMMH. Our results showed that not everyone was asked regarding their smoking status (87%).

An important figure that came out from the results was that only 50% of the patients asked about their smoking status were told that there is a smoke free policy.

For a smoke free policy ward only 33% of the smokers that took part in the audit were provided with brief advice regarding

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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doi: 10.1192/bjo.2021.248

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 clincal and educational supervision

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doi: 10.1192/bjo.2021.249

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[1].

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 WPBAs 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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doi: 10.1192/bjo.2021.250

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