admitted voluntarily, some required higher levels of containment and intensive risk management.
Conclusion: This study demonstrates that private psychiatric hospitals in Bangladesh manage patients with substantial clinical complexity, risk, and prior treatment exposure, challenging assumptions that private-sector psychiatry predominantly addresses low-acuity or elective care. The observed service and clinical profile shows important parallels with private services in high-income countries. These findings support the inclusion of private-sector data in global mental health research and highlight private hospitals as important components of mental health systems where public capacity is limited.

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Clozapine Prescribing in General Hospitals: A Second-Cycle Service Evaluation Following Quality Improvement Interventions

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doi: 10.1192/bjo.2026.11598

Aims: Clozapine is an effective medication for adults with treatment-resistant schizophrenia. However, its safe prescribing and monitoring can be challenging during General Hospital admissions. An initial service evaluation conducted in 2023–2024 identified inaccurate documentation of clozapine in community records, delayed referrals to Liaison Psychiatry and inconsistent monitoring of clozapine-related risk factors. In response, quality improvement interventions were implemented, including local education, a Trust-wide clozapine policy for General Hospitals and a clozapine admission checklist. This second-cycle service evaluation aimed to assess whether these interventions improved the safety and consistency of clozapine prescribing and monitoring.
Methods: A retrospective review was conducted of patients prescribed clozapine in the community who were admitted to two General Hospitals in England between March 2024 and February 2025. There were 66 admissions involving 53 patients. Electronic records from community services, General Hospitals and Mental Health services were reviewed. Data collected included the accuracy of clozapine documentation on community records, whether referrals to Liaison Psychiatry were made and the timeliness of referral and review. Liaison Psychiatry documentation was reviewed to determine whether key clozapine-related factors were considered, including full blood count monitoring, medication concordance, smoking status, bowel function, physical health concerns, medication interactions, signs of clozapine toxicity and advice regarding plasma level monitoring.
Results: Clozapine prescriptions were correctly documented in community records in 26% (17/66) of admissions, compared with 16% in the first cycle. On admission, 79% (52/66) of patients were referred to Liaison Psychiatry, with a reduction in mean time to referral from 41.07 hours to 32 hours. Of those referred, 87% (54/62) were reviewed within 24 hours, compared with 68% in the first cycle.

Within Liaison Psychiatry reviews, documentation rates were highest for medication concordance and physical health concerns (both 88%) and full blood count monitoring (78%). Documentation was lower for medication interactions (59%), bowel movements (50%), signs of clozapine toxicity (33%) and smoking status (19%). Advice regarding plasma level monitoring was documented in 40% of cases.
Conclusion: This second-cycle service evaluation demonstrates improvements in referral rates to Liaison Psychiatry, timeliness of review and the quality of Liaison Psychiatry documentation following targeted quality improvement measures. However, challenges remain in the consistent documentation of clozapine prescriptions in community records and routine assessment of smoking status and signs of toxicity. Further quality improvement initiatives and repeat evaluation cycles are recommended to support safe and consistent clozapine management in General Hospitals.

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Re-Auditing of Quality Improvement Project in Psychiatric Liaison Service for Evaluation of the Ageless Service Model

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doi: 10.1192/bjo.2026.11597

Aims: This re-audit aimed to evaluate the Ageless Psychiatric Liaison Service (PLS) by: (1) assessing older adult (OA) and working age adult (WAA) referrals in terms of source, triage, assessments, and outcomes; (2) evaluating psychiatric admissions, including reasons for admission, senior medic involvement, observation levels, medical clearance, and bed management; and (3) appraising alternatives to admission, such as referrals to Crisis House and Home Treatment Teams (HTT).
Methods: A retrospective review was conducted over three months (April–June 2025) using electronic psychiatric (SystmOne) and hospital (EPIC) records. A random sample of 50 patients (25 OA, 25 WAA) was selected, with two young-onset dementia cases included in the OA group. Data were extracted systematically using a structured Excel sheet capturing referral details, clinical assessments, management, and outcomes.
Results: WAA presentations predominantly involved acute psychiatric crises, including self-harm and suicidal ideation, with short hospital stays (mostly 1–2 days) and low observation requirements. Referrals were primarily crisis-driven, with 88% medically optimized for discharge at the time of referral, and were largely managed through a nurse-led model by Band 6 and 7 nurses. Most WAA patients were discharged to community services, including HTT, CMHRS or GP with only a small proportion requiring acute hospital admission.

In contrast, OAA presentations were more complex, involving cognitive, behavioural, and medical comorbidities, resulting in longer and more variable hospital stays and needing one-to-one nursing in nearly half of cases. Management was multidisciplinary, involving old age specialists, Band 7 nurses, and PLS medics in 92% of cases. Half of OAA patients were referred to CMHT-OP for ongoing management, while 20% awaited psychiatric admission due to limited bed availability. Delays in transfer to psychiatric beds ranged from 23 hours to 21 days, reflecting a scarcity of psychiatric beds.
Conclusion: The re-audit highlighted effective nurse-led crisis management for WAA, whereas OAA patients presented with