system. The backdrop of the QI programme was the essential role of rehabilitation psychiatry in aiding the recovery and reintegration of individuals with mental health challenges, and sub-optimal audit results about patient's attendance and positive step-down discharges at an in-patient psychiatric unit.
Objectives: The QI programme aimed to implement and explore Co-production, a transformative approach involving patients and healthcare professionals as equal partners.

- To promote co-production in psychiatric in-patient service
- To improve patient experience in the CPA meetings
- To reduce anxiety associated with the CPA meetings and discharge planning
- To assess staff's limitations and barriers in promoting co-production.

Methods: The QI programme was divided into phases, including diagnostic, problem-solving, and evaluation. It employed diagnostic tools such as the fishbone cause and effect diagram and the 5-Why Technique for root cause analysis. The project's aim was aligned with the Model of Improvement, guided by the three fundamental questions. Change ideas were developed using driver's diagram and were then evaluated through PDSA cycles. Quantitative analysis utilized paired t-tests to assess the significance of changes, and qualitative analysis focused on patient perspectives gathered through the co-produced CPA questionnaire. Emerging themes from the questionnaire responses were integrated into the project's trajectory through narrative synthesis. Predictions were formulated to measure project success: 50% patient attendance in the next CPA meetings, 70% positive step-down discharges, and improved Hamilton Anxiety Rating Scale (HAM-A) scores.
Results: The iterative Plan-Do-Study-Act (PDSA) cycles demonstrated the evolving impact of interventions on patient engagement and discharge outcomes. Implementation of patient information leaflets, staff training, and a CPA agenda template led to increased attendance and positive step-down discharges. Analysis of HAM-A scores revealed a substantial decline in anxiety levels for almost all participants, suggesting the effectiveness of the interventions. Discharge outcomes were influenced by patient engagement and tailored interventions. Patient responses revealed themes such as challenges during transitions to community care, empowerment from shared decision-making, and diverse experiences in communication with healthcare professionals.
Conclusions: The CPA agenda template improved patient experiences by enhancing communication and patient-centeredness.

Disclosure of Interest: None Declared

EPV0872

REVIEW OF MEDICATION INCIDENTS IN MENTAL HEALTH SERVICE

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Introduction: In this review, medication incidents accross different mental health care facilities was reviewed and nuances, challenges, and advancements in the administration and management of psychiatric medications was noted. Through gaining a better understanding of the complexities surrounding these incidents, valuable information can be gathered that will enhance patient safety, improving healthcare practices, and fostering a deeper understanding of the critical intersection between mental health care and medication management.
Objectives: To identify the most frequent types of medication errors or patterns of medication errors in a mental health service accross different settings including inpatient, outpatient, liaison and long term residential unit
Methods: This is a multicentre project as it covers medication incidents in mental health care in a regianal area in Ireland. It includes an acute psychiatric Unit, the General Hospital and patients admitted in medical and surgical wards and as well long term residential care. Using the National Incident Management System we collected National Incident Report Forms (NIRF) relating mental health care provided and medication prescribed within a region in Ireland. From these we selected the ones were medication hazard was noted. Data collection happened between July 2020 and July 2021. A statuystical analysis was then performed to identify any patterns to medication errors.
Results: A total of 22 incidents were included. On review of these, it was noted, among other findings, that here was a significant increase in the frequency of medication errors during the month of December. It was also noted errors ranged from medication being given to the wrong patient, medication being given twice and medication being missed.
Conclusions: Minimising medication errors requires a comprehensive, multidisciplinary approach that involves healthcare providers, patients, and healthcare systems. Healthcare organizations should foster a culture of safety where medication errors are seen as preventable and where providers are encouraged to report errors without fear of retaliation.

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EPV0873

Compassion and the quality of life of the inpatient healthcare team

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Introduction: Nurse-patient relationships and interactions during inpatient care evoke feelings of empathy and compassion. Compassion can lead to satisfaction, but also to exhaustion. Compassion fatigue is a commonly used concept that signifies the exhaustion of healthcare personnel due to the specific activities and repeated exposure to the suffering of others. This manifests through physical and emotional over-tiredness, anxiety, anger and irritability, low vitality, social isolation, diminished sense of enjoyment of one's career, cognitive disorders, and sleep disturbances.
Objectives: To assess the level of compassion of the healthcare staff employed in a Romanian general hospital.