

Disability service to have an MDT coordinated approach by July 2022. This followed concerns about disjointed care and long waits for therapeutic support when being referred between different MDT branches within the service having a negative impact on patient care.

Methods. An MDT project team was formed and weekly meetings were arranged. A driver diagram was created. Our primary outcome measure was determined: percentage of referred patients per week that had MDT coordinated assessments, with data being collected manually from electronic progress notes and MDT meeting minutes. Number of referrals per week was recorded as a process measure. Baseline data were added to the Life QI web platform upon collection, allowing generation of run charts for outcome and process measures. The time-frame over which referrals were recorded was changed from weekly to fortnightly, to help differentiate graphically between zero values resulting from the absence of MDT coordination and those resulting from no referrals being received on a given week. Attempts were made to obtain service user input via easy-read questionnaires and subsequent discussion in a service user participation group. A weekly Positive Behavioural Support meeting was set up and a Positive Behavioural Support database was established, and the combination of these changes simplified data collection and gave a focus to MDT working and collaboration for these service users. Data were recorded from 28/06/2021 to 03/07/2022 initially and subsequently extended to 06/11/2022 as part of a further PDSA cycle.

Results. A shift in proportion of service users referred with behaviour that challenges who had MDT involvement at the point of allocation was observed, to above the mean value of 0.5, commencing 07/02/2022, this shift was sustained until the project's endpoint. In terms of our process measure, the median number of new behaviour that challenges referrals per fortnightly period to psychiatry and psychology was one. This ranged from 0-4 referrals per fortnightly period, but no sustained change in this value was observed over the course of the project.

Conclusion. Implementing a new behaviour that challenges database and weekly meeting to focus on MDT coordinated working in those newly referred with behaviour that challenges has been successful in leading to a measurable and sustained improvement in the proportion of those service users receiving timely MDT coordinated care.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Audit of Seclusion Practice in an Inpatient Adult Intellectual Disability (ID) Psychiatry Unit

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Aims. To investigate if current practice regarding the use of seclusion in an adult ID assessment and treatment unit was in keeping with the newly developed NHS Highland Seclusion Policy.

Methods. Case notes were reviewed for all patients who had had a period of seclusion between 20 September and October 2022.

Data were collected regarding the following:

- Administration of seclusion (date; time started; medication used prior; reason for administration & duration);

- 15 min interval monitoring (record of patient's mental & physical state including presentation, behaviour, conscious levels, respirations & appearance)
- Review at 2 and 4 hours (including plans on how to end seclusion)
- Documented Datix submitted and Monitoring of improvements.

Results. Thematic analysis showed that the most common reason for the use of seclusion was due to increasing agitation and aggression.

Data collection showed that the following information was missing from case records:

- Use of anxiolytic before seclusion;
- Under the 15 minute interval recording - respiration rate & appearance was missed most of the times;
- Review at 2 hours: Plans to end seclusion was often missed; Review at 4 hours: on most occasions the duty consultant was not informed. They could give valuable insight and plans on stopping seclusion if it has prolonged more than 4 hours.
- Datix was not sent every time seclusion commenced and this is needed as it would further provide to better identify and manage patients needing it.

Conclusion. Seclusion places people at risk. It is vital to ensure that there is robust monitoring of the patient's mental and physical state to reduce the risks associated with seclusion and, in particular, when medication which may lead to respiratory depression has been used. Seclusion should be used for the shortest time possible - explicit consideration of when and how to end seclusion provides an opportunity to limit the length of this highly restrictive intervention and minimise the impact on the person.

The results of the audit were shared with the staff team via the Seclusion Policy Short Life Working Group and will allow subsequent drafts of the service protocol to reflect good clinical practice. Results were also shared via the internal teaching programme and at the Clinical Governance forum. An additional session will also be provided during the induction plan for new trainees. Finally, a reaudit will be done to assess changes in seclusion practice.

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An Evaluation of Core Trainees' Views on Clinical Rotations in the West Yorkshire Psychiatry Training Scheme

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Aims. Gathering honest feedback on experiences of clinical rotations is vital to allow improvement of training. However, our current local systems lack anonymity, which may lead to reduced confidence in providing honest views. Aim: To provide trainees with a method of giving honest and protected feedback to improve future training posts.

Methods. A Survey Monkey feedback form which was sent to core trainees across West Yorkshire in July 2022. This allowed feedback

for up to 6 rotations, meaning those finishing CT3 could retrospectively review all their placements. The data were analysed by the project leads, grouped into themes, and anonymised.

Results. We received responses for a total of 57 posts from 23 core trainees (total trainees July 2022 = 71), some of whom responded for multiple posts. Types of posts reviewed included: General Adult (40.4%), Older Adult (24.6%), Child and Adolescent Mental Health (8.8%), Forensics (7%), Learning Disability (5.3%) and Psychotherapy/Liaison (3.5%). 10.5% of responses did not specify the speciality. Overall, respondents strongly recommended 51.8% (n=29) and recommended 12.5% (n=7) of posts to other trainees. Respondents strongly did not recommend 5.3% (n=3) and did not recommend 1.8% (n=1) of posts to other trainees. Positive themes included having a range of experiences and a supportive team. Trainees valued having a range of cases with appropriate autonomy. They liked having a job that was busy enough to gain the required experience but not too busy to impede training and learning opportunities. An accessible and supportive supervisor who provided regular supervision with completion of work based placed assessments was also important. Negative themes included lack of regular supervision and heavy workload, which impacted a trainee's ability to attend teaching and participate in other aspects of professional development. Feedback for inpatient posts suggested that physical health obligations sometimes limited training opportunities.

Conclusion. Our results have shown that training needs are varied between trainees. It is therefore important that trainees have honest discussions with their supervisors about their needs and areas for development. Overall, trainees would recommend the majority (64.3%) of posts reviewed, however areas for improvement were highlighted. These may include extra training opportunities and increased physical health support. The main limitation of our evaluation was the low survey uptake (32.4%) in comparison to total trainee numbers. We hope that sharing our findings with both trainers and trainees will improve future responses.

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Improving Education Around High-Risk Psychotropic Medication in Supported Living Facilities

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Aims. Of the medication-related incidents that have been reported in supported living placements, many involved high-risk psychotropic medications such as Clozapine, Lithium and Sodium Valproate. An evaluation of these incidents found problems with administration and inadequate monitoring. Consequently, a virtual education programme was commissioned to educate support staff in living placements in South West Hertfordshire which showed strong positive evidence that the training session improved learning and management surrounding psychotropic medication. This education programme has now been expanded to supported living facilities in the North of the trust to further ameliorate safe medication management and care provision within these placements.

The aim of this teaching programme is to provide an educational platform to improve the knowledge and risks associated with Clozapine, Lithium and Sodium Valproate in an effort to reduce medication-related incidents within the placements.

Methods. Virtual training was developed and delivered for support staff across supported living facilities in the Northern directory of the trust. This teaching was collaboratively designed and delivered by a multidisciplinary team including pharmacists, doctors and nurses. The virtual nature of the session lent increased accessibility to staff members from various regions.

Results. 28 staff members from 6 support living facilities covering a resident population of over 65,000 people attended the 3-hour virtual education programme. Quantitative studies run on the pilot lecture in the high-risk psychotropic learning programme found strong evidence that this training leads to increased understanding of the administration, management and risk profiling of the aforementioned high-risk medication.

Conclusion. Education surrounding high-risk medication will reduce long-term incidences of medication-related adverse events. The expansion of this learning programme to the entirety of the Hertfordshire trust is a step further in improving patient care within local mental health services.

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“The Only Way Is Up; Lets Do It!” - a Quality Improvement Project for Physical Health Improvement for Patients Diagnosed With Schizophrenia at a CMHT in Glasgow Using Smart Interventions

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Aims. Cardiovascular death is the leading cause of early mortality in patients with schizophrenia. We audited physical health monitoring (via Lester tool) of all patients diagnosed with schizophrenia over the past year. There were 163 patients, 60% were up-to-date on blood tests, but only 28% had an up-to-date ECG. We found poor documentation of lifestyle risk factors (smoking/alcohol/weight) and recording of interventions that were offered to modify these. We felt it was important to try a pro-active model of engagement and intervention in order to improve outcomes and empower patients in collaboration with GPs.

Methods. A subset of the cohort (35 patients) were invited along for an all-inclusive check up with a doctor at the psychiatry clinic (blood tests, discussion and advice regarding lifestyle risk factors and on-site ECG utilising the new Kardia 6L) lasting 30 minutes. Information was collated and then distributed via a letter to the GP, the consultant psychiatrist and the patient.

Results. Of the 35 patients invited to attend the physical health check-up, 18 (51%) attended. All patients then underwent physical health monitoring and discussion of how to improve their risk factors. The Kardia6L allowed for QTc monitoring to occur quickly and easily in the outpatient setting and was liked and accepted by patients. We found that most patients were overweight (88%) and were undertaking less than 30 minutes of exercise a day (50%). Half of the patients required active medical