reasons for not reporting harassment, and views on the role of the Trust and supervisors in addressing PIVSH. Qualitative data were analysed using thematic analysis and externally validated.

Results. 42 responses were received across staff groups. 95.2% respondents had experienced PIVSH in the last year. 26.2% had formally reported an incident of PIVSH, with only 30.8% stating the report had been actioned by a senior. 'Less severe' harassment types were the most common, and the type staff were least confident to address. Five themes were identified in thematic analysis:

1. **Nature of PIVSH:** Unwanted, covert, influenced by victim demographics, the situation, and motivation of the perpetrator
2. **Response to PIVSH:** Victim's emotional and practical response, and of the wider MDT
3. **Impact on trainee:** Personal (desensitisation, feeling unsupported) and professional (time off, moved teams, avoidance of wards)
4. **Barriers to action:** Practical barriers to reporting (lack of time, complexity) and organisational culture ('patient unwell' justification, trivialisation, lack of trust in management)
5. **Areas of improvement identified:** Written policy on PIVSH clearly communicated to staff and patients; wider cultural changes of zero tolerance to PIVSH; open discussion and reporting, backed up by education and training; formalised support post-PIVSH event

Conclusion. There is a negative impact of PIVSH on staff at sLaM and it is not properly recognised. **The NHS is its staff** and we cannot afford to neglect their well-being. Action as a result of this survey will include:

1. Creation of a training package with Maudsley Simulation
2. Development of informational posters for clinical spaces
3. Write up-to-date trust policy on PIVSH

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Could a Virtual Clinic Improve the Quality of Physical Health Monitoring for Safe Antipsychotic Prescribing in an Older Adult Community Mental Health Team (CMHT)? Encouraging Preliminary Results From a CMHT in Wales

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Aims. Antipsychotics are linked to increased cardiometabolic risk. The National Institute for Health and Care Excellence (NICE) and the Royal College of Psychiatrists have developed guidance on PHM to mitigate this risk. Both risks and guidance are age-blind, and very relevant to Older Adults due to age-related increase in cardiovascular risk. The COVID-19 pandemic boosted digital healthcare, which remains relevant due to rocketing demand and stretched services. This is a Quality Improvement Project aiming to improve physical health monitoring (PHM) for safe antipsychotic prescribing in an Older Adult Community Mental Health Team in South Wales. Baseline data, a virtual clinic model and preliminary results of the first Plan-Do-Study-Act cycle are presented.

Methods. An audit was conducted (06/2021–12/2021), with continuous prospective data collection thereafter. A scoping exercise was conducted to establish available resources. A local protocol/operational framework was developed. Education interventions (03/2022-on-going), a junior-doctor-led virtual PHM clinic and a phlebotomy/electrocardiogram (ECG) pathway (10/2022-on-going) were designed and implemented.

Results. Baseline (06/2021-09/2022): completed lifestyle advice=0%, physical observations=3%, blood tests=3%, ECG=3% of eligible patients. No patient (0%) had the full PHM as per guidance. Mean overall compliance with guidance/patient=9%. Pareto chart: no clear pathway and lack of prescriber awareness were the main reasons (>95%) for poor performance.

Scoping exercise: No Health-Board/Trust-wide approach for Older Adults and PHM is problematic in all localities. General Practitioners assertive regarding no responsibility/funding to deliver PHM for at least the first 12 months or until antipsychotic dose and mental state are stable. Geriatric teams, district nurses, general adult teams stretched and unable to support. Care home staff lack training and resources. Phlebotomy and ECG departments of local hospitals could support but no pathway.

First PDSA cycle (preliminary):

Change idea 1: staff education: clear shift (04/2022 onwards). Proportion of trained staff reached 100% in December 2022, and remains 100% in January 2023.

Change idea 2: virtual PHM clinic (10/2022 to 01/2023) – mean overall compliance with guidance/patient = 69% (vs. 9% baseline). Proportion of patients with complete PHM as per guidance reached 50% in January 2023. 75% patient response rate.

Change idea 3: phlebotomy/ECG pathway (10/2022 to 01/2023) – proportion of patients with bloods and ECG done reached 67% in January 2023.

Conclusion. Preliminary data suggest an encouraging trend for significant continuous improvement which, from a clinical perspective, is already significant. However, more data are required to draw safe conclusions regarding the clinical and cost effectiveness of this model of a virtual PHM clinic.

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Reducing the Use of Rapid Tranquilisation in Over 65s in a General Hospital

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Aims. A previous audit of use of rapid tranquillisation in older adults conducted in 2019 identified high rates of use of sedation, and poor adherence to local guidelines. Following this audit, a number of quality improvement (QI) initiatives were undertaken in order to try to improve practice, including multiple teaching sessions to a variety of staff. This re-audit was conducted to study whether initiatives had been effective in line with the Plan Do Study Act cycle of Quality Improvement.

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Methods. Using the same audit tool developed in 2019, six wards (2 geriatric, 3 medical and 1 surgical) were audited. Patients over 65 given oral or intramuscular sedating medications had their drug charts and notes reviewed. Data were collected on type of sedation, route prescribed, whether it was prescribed regularly or PRN, whether an indication was documented, underlying diagnosis and what monitoring took place post sedation.
Results. 297 drug charts were reviewed, and 13 patients were prescribed rapid tranquilisation (RT). The maximum daily dose was included in 63% of prescriptions similar to that of the first audit (58%). The most common route of administration was intramuscular, unlike the previous audit which was oral/intramuscular.

50% of prescriptions documented an indication, of which 25% were illegible. Whilst in the first audit the figure was 33%.

Of all the patients prescribed RT, 77% had a diagnosis of delirium, 77% had a diagnosis of dementia and about 53.8% had both. In both audits 100% of patients had a diagnosis of dementia or delirium. Most prescriptions were for lorazepam (75%). There was no evidence of observations being taken in line with post RT monitoring in the trust policy in both audits
Conclusion. Further work needs to be done to improve practice. Interventions to date have not been effective. Further plans for QI work include updating the RT policy to be more specific and useful for the acute trust, to fit in with a recently introduced electronic records system (ERS) and to include a clear section on older adults with signposting to the delirium and dementia policies. As well as adding prompts and protocols to the ERS to support safe prescribing and dispensing of RT. Teaching will be repeated and a poster has been developed and promoted on all the wards. The project group are planning to join the trust's 'medication safety huddle' regularly to include pharmacists in teaching and work. The audit will be repeated in three months time.

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Improving Allergy Status Documentation on Electronic Patient Records- a Trust-Wide In-Patient Quality Improvement Project

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Aims. NICE guideline CG183 states that "both the drug and the description of the reaction must be documented on all forms of prescription and in a patient's medical records". Black Country Partnership NHS Foundation Trust (BCPNFT) documents allergy status on both paper drug charts and the Electronic Patient Record""Ri"" (EPR). Incomplete Allergy Status on EPR poses a significant patient safety risk, particularly in an era of hybrid working and out of hours input from remotely based clinicians. The standard for this audit is that 100% of drug charts and Rio notes should have allergy status documented. The BCPNFT is a collection of psychiatric services across four towns- Dudley, Walsall, West Bromwich and Wolverhampton. The aim was to ensure consistent practice and standards across all sites. Following the initial data collection, discussion of findings and Action Plan (AP), and to ensure consistent standards, it was agreed to expand the project to include all General Adult in-patient units.
Methods. A data collection tool was designed collaboratively with the QI Department, to capture demographics, diagnosis, admission duration, legal status and allergy status both written and digital. This tool applied for all 96 older adult in-patients across the four localities within the trust on 03.10.22. The only exclusion criteria was admission within 24 hours of the data collection date.
Results. Data Collection: 100% of Paper Drug Charts had allergy status documented, only 70% have type or severity of allergic reaction documented. Despite 76% of in-patients admission of 4 weeks or longer, only 62% of patients had their allergy status documented on EPR, this varied from 30-100% across individual wards. EPR allergy status documented: Wolverhampton 93% West Bromwich 100% Dudley 33% Walsall 39%
Conclusion. The results from all four localities were presented at the respective locality post graduate teaching, the EPR configuration team meeting and the QI Group meeting to gain Multi-Disciplinary Team feedback for both low documentation rates and high variability across sites. Based on this feedback, the AP comprised of incorporating an Allergy Status prompt into the electronic clerking document, visual prompts of stickers and posters across all wards. Also, liaising with Pharmacy to request they also update the allergy status on EPR; and Ward Matrons who have added an Allergy Status alert onto their bed state view. Data will then recollected post AP interventions, across all older and working age adult inpatient wards- a sample size of around 300 patients. The second data collection is currently being undertaken.

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Our Care Improvement System

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Aims. Our Care Improvement System is an integrated quality and performance system designed to develop co-ordinated approach to managing performance at all levels of the organisation, ensuring everything we do is aligned to achieving our goals set out in our Trust strategy. The aim of this programme is to help the team move away from typical firefighting routines, towards a more structured routine of problem solving, applying quality improvement tools and methodology.
Methods. Five members of multidisciplinary team (MDT) in a Lewisham Community Mental Health Team were chosen as the core working team. They underwent four-month training programme which was one day per month plus weekly team coaching sessions from the Trust's Quality Improvement lead. One targeted measure was identified. This was to focus on improving patient discharges for more manageable caseloads, and ultimately provide a better staff and patient experience. A3 methodology was adopted to provide a structured framework for thinking through the problem. This included: problem statement, current situation, aims statement, root cause analysis, change ideas, actions,

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