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

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.

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.