pack. By increasing this knowledge, we aimed to improve RFC satisfaction surrounding the admission process. Previously published evidence has shown that increasing the perception of involvement of RFCs in a patient's admission promotes greater satisfaction within this group. Adequate information provision is regarded as an important part of promoting perceived involvement; conversely, a lack of information provision and communication has been associated with dissatisfaction with hospital admissions among RFCs.
**Methods.** Using a survey directed towards members (n=9) of the ward MDT, we identified several topics relating to hospital admission that were regarded as high priority for inclusion in an information pack. MDT members were also asked about their perception of RFC satisfaction in the admission process. RFCs (n=8) were asked how well-informed they felt about these topics with a separate survey, and their level of satisfaction with the admission process. An information pack was created based on the results of these surveys and distributed to RFCs. The RFC survey was then repeated to assess improvements in RFC knowledge and satisfaction.
**Results.** Perceived RFC satisfaction among staff members prior to the publication of the information pack was lower than actual RFC satisfaction. RFC satisfaction with and knowledge about the admission process increased following the distribution of the care pack.
**Conclusion.** Admission information packs can be used on inpatient old age wards to improve patient family, friend and carer knowledge and satisfaction.



## Lifestyle Factors and the Physical Health of Patients on Depot Antipsychotics in the Haywards Heath Catchment Area, Linwood ATS (Phase1, 2022)

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**Aims/Context.** Patients with severe mental illness have reduced life expectancy, representing one of the most significant health disparities. Although the cause is multifactorial, cardiovascular disease & other comorbid chronic conditions play an essential role. Individuals with mental illness often face considerable barriers to accomplishing their health and well-being goals. As a result, there is a growing interest nationally and internationally and research evidence for the role of lifestyle interventions in managing mental health conditions. NICE guidelines now reflect this, recognizing the impact of physical health comorbidity and recommending monitoring of metabolic status and cardiovascular risk (using the Q-RISK3 tool) in the management of schizophrenia & bipolar. *AIMS:* -Phase 1: to identify & analyse lifestyle parameters contributing to patient'' health & leading to excessive disease burden and the QRISK3 calculations for patients in the Haywards Health catchment area on depot antipsychotics. -Phase 2: make recommendations focused on lifestyle factors interventions in addition to standard care-Phase 3: to re-assess following the recommendations from phase 2.
**Methods.** *Phase 1 Steps*:

- Identifying all patients on depot antipsychotics living in the defined catchment area.
- Data Collection from the electronic clinical record: diagnoses, gender, physical activity, alcohol intake, smoking, lipids, employment, BMI, blood pressure, QRISK3.
- Analyse results.
- Make Phase 1 Recommendations

*Phase 2*: Implement phase 1 recommendations
*Phase 3*: Use the electronic records to conduct a second analysis assessing the offer of intervention to patients, reassessing the lifestyle parameters and QRISK3 calculation
**Results.** *Phase 1* Results: All patients identified (6) had a detailed overview of the lifestyle parameters assessed. None of the patients had the QRISK®3 calculation in phase 1.
**Conclusion.** A series of recommendations were made at the end of *Phase 1* in view of initial results.

- Disseminate results locally, including in primary care
- Ascertain up-to-date information regarding physical health and lifestyle parameters in the OPC reviews; include in the letters to GP updates on the category of lifestyle parameters included in this project.
- Discussion with patients on the impact of lifestyle factors in the OPC reviews
- Signpost patients to resources they can use to support implementing positive lifestyle choices
- QRISK®3 measurement
- 1:1 psychoeducational session focusing on improving lifestyle choices.
- Engage patients to engage in co-producing psychoeducational sessions aimed at improving lifestyle choices.

*Phase 2:* implement phase 1 recommendations (October 2022-September 2023)
*Phase 3:* re-assess in October 2023



## Unspoken: Verbal Sexual Harassment by Patients in Psychiatry

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**Aims.** Patient-initiated verbal sexual harassment (PIVSH) is common in the healthcare workplace, however institutes often neglect to address it. Objectives: (1) Define extent of PIVSH among staff at South London and the Maudsley Trust (sLaM), (2) Characterise the impact of PIVSH on staff, (3) Understand barriers to reporting PIVSH, (4) Inform policy and training to support staff.
**Methods.** A questionnaire from Scruggs et al. (2020) was adapted with types of PIVSH on a standardised scale of severity from 'most' to 'least' harassing. The anonymous, retrospective, online survey was disseminated to sLaM staff via Trust-wide communications, staff networks and Whatsapp groups. Descriptive statistics were used to analyse quantitative data (PIVSH frequency, confidence to respond to PIVSH, reporting practices). Respondents used free text to describe the impact of PIVSH,

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.