Aims. As part of a wider quality improvement project (QIP) aiming to improve trainees' experiences with 'Raising Concerns' in a large mental health trust, we sought to improve the trainee representative (rep) structure. This would give trainees more transparent processes and provide intermediaries by which to raise concerns. Based on change ideas generated from our driver diagram, roles were created to coordinate meetings and represent specific groups of trainees and on-call rotas.
Methods. Prior to August 2022, there were an undefined number of 'Senior House Officer' (SHO) reps who were recruited informally by the Post-Graduate Medical Education Team. The duties of these reps were not clearly detailed. As part of our first 'Plan, Do, Study, Act' (PDSA) cycle, we identified groups of trainees that needed additional representation (International Medical Graduates [IMGs], Less than Full Time trainees [LTFT]) and introduced a Wellbeing Rep to cover all training grades. Specifically for SHOs, we introduced three core roles (Rota/Placement, Inclusion, and Social) and individual roles for the six on-call rotas. Following the implementation of this rep structure, we gathered quantitative data, including whether trainees had utilised the reps and how effective they were in raising concerns, and qualitative feedback. We gathered data from both the reps and the whole cohort of trainees. We then started another PDSA cycle in August 2023.
Results. On a 1–5 scale (5 = very effective), the average response from trainees for how effective the trust reps were in supporting raising concerns was 3.8 (5 responders), with no trainees who responded feeling that any of the rep roles needed restructuring. However, the rep survey highlighted that the following roles needed restructuring: Rota/Placement rep, Social rep, and Rota reps. The Rota/Placement role was highlighted as being unnecessary due to the existence of individual rota reps, but there was a need for a 'lead' rep to coordinate rep meetings and induction. Unfortunately, a Social rep was not recruited, however it was identified that due to the importance of the role more than one trainee may be required to arrange social events.
Conclusion. Overall, the trainee response to the new rep structure has been neutral/effective, but we hope to obtain more responses in the next PDSA cycle. The rep feedback highlighted the need for coordinator roles to improve cohesion. The results have informed change ideas which we implemented in August 2023. The second PDSA cycle will be completed in July 2024.

QIP Improving Trainee Confidence in Male Sexual Dysfunction History-Taking in an Acute Inpatient Unit

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Aims. Trainees on the psychiatry on-call rota at a London acute inpatient unit reported a lack of confidence in asking male patients about sexual dysfunction during clerking. Research shows that history-taking barriers include embarrassment, time shortage and task prioritisation. Sexual dysfunction is prevalent amongst the general population, markedly so amongst people with mental health diagnoses.

In response, we designed a quality improvement project (QIP) to improve confidence by addressing the need for good history-taking and the technique for doing so.
Methods. To gauge trainee confidence, we produced and disseminated an online questionnaire with a mixture of qualitative and quantitative questions.

Based on the data collected, we contacted a local sexual health consultant and requested a teaching session on the importance of sexual history-taking, the impact of not doing so, barriers to history-taking and how to ask about sexual dysfunction.

A follow-up questionnaire was produced and disseminated.
Results. The results of the first questionnaire showed that 100% of respondents (n = 10) did not ask male patients questions about their sexual function, on admission. The main reasons for this were embarrassment for themselves (25%) and the patient (66.7%), lack of confidence on how to word these questions (50%), lack of time (58.3%) and feeling that these questions are not relevant (33.3%).

Following the teaching session, 71.4% of respondents said that they would ask male patients questions about symptoms of sexual dysfunction on admission. The majority of responses quoted that the teaching had increased their confidence, decreased their embarrassment in asking these questions, and helped them to understand the relevance of asking these questions. Two respondents queried the appropriateness of asking acutely unwell patients these questions on admission and if these questions could be asked during a patient's admission instead.

Limitations: Small sample size of results; slight drop in responses from first questionnaire to second questionnaire; questionnaire only asking questions about male patients, not female patients.
Conclusion. This QIP shows that a single, simple intervention can improve trainee confidence in the short term. This intervention can be applied across the UK. Online teaching can improve access to the expertise of local sexual health consultants. This QIP also provides a basis for further analysis: whether single interventions can improve trainee confidence in the long term, when is the best time to ask questions about sexual function and applying this intervention to female sexual function history-taking.

Complex PTSD Pathway for Kingfisher Mother and Baby Unit

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Aims. When Kingfisher Mother and Baby Unit (MBU) opened in 2019 personality disorder and severe self-harming behaviours were exclusion criteria for admission. Complex Post Traumatic Stress Disorder (C-PTSD) with its emotional dysregulation, interpersonal difficulties and common presence of self-harm was similarly categorised.

Currently, C-PTSD presentations are frequently admitted to the MBU, making up around 45.9% of admissions. There is increasing understanding of the importance of effective and trauma informed treatment in admission outcomes, particularly

in reducing trans-generational trauma. This requires appropriate skills and training in staff.

Methods. Service users were identified retrospectively over a 24-month period and categorised into C-PTSD traits (trait) and non-C-PTSD traits (non-trait). Comparisons of routine outcome measures (ROMs) identified higher distress in the C-PTSD group and reduced satisfaction. Staff survey highlighted areas of anxiety and low confidence in working with service users with C-PTSD traits.

Actions were divided into three streams – Admission, Transitions and Communication. Staff training needs were identified and training given. Admission processes were reviewed with a focus group including past service users and changes based on DBT principles were implemented. A leaflet was developed to aid communication with service users considering MBU admission via Outreach and Community Perinatal teams.

Results. Surveys were the primary source of data before and after changes. As of September 2023 the majority of training had been rolled out but numbers completing the training survey were too small to draw conclusions. Anecdotal feedback was predominantly positive and the survey will be repeated at the same time as other data in March 2024.

Ward process changes started in late August 2023 and routine outcome measure data will be compared at 6 months (March 2024). Again anecdotal feedback is positive.

The leaflet was rolled out for use by community teams and service users in November 2023 and feedback via survey will be collected in March 2024.

Conclusion. Evaluation of routine outcome measures showed poorer outcomes and experiences for patients with traits of Complex-PTSD. Staff survey highlighted lack of confidence in managing the same. Consultation with a range of staff and past service users led to changes in admission practices, communication prior to admission via a leaflet, and staff training. Anecdotal feedback since implementation has been positive but we hope to see this confirmed in the Routine Outcome Measures and surveys 6 months after the changes were implemented.

Promoting Post-Restraint Patient Debriefing in an Acute Psychiatric Inpatient setting

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Aims. Controlled physical restraint is a commonly used, but controversial practice in inpatient psychiatric settings, at times bringing psychiatric practice into potential conflict with accepted medical ethical standards for preserving autonomy and bodily-integrity. However, physical restraint can produce high levels of patient distress, re-traumatise those who have experienced physical or sexual abuse, and may lead to inadvertent bodily injury, and even death on rare occasions. There is an international consensus to attempt to reduce restrictive practices, including physical restraint, as demonstrated in the World Health Organization's Quality Rights Initiative. Post-restraint patient debriefing can promote recovery, prevent future restraint, and promote a more ethical and humanising care environment.

We aimed to audit the frequency of restraint events, and post-restraint debriefs offered to patients in a single, London-based, male acute psychiatric ward.

Methods. In the pre-intervention sample, data was extracted from the records of patients admitted over a six-month period (n = 75), to identify the number of patients who had undergone restraint and the number who had been debriefed. The search terms "restrain", "PMVA", "response team" and "debrief" were used. After each restraint event, the notes for the following two weeks were reviewed to see if a debrief was delivered.

The intervention consisted of a single description and dissemination of the results in a ward business meeting, with instruction that all staff members within the ward multidisciplinary team can help provide debrief if appropriate to do so. Where a patient was known to have been restrained, debriefs were offered during subsequent ward round reviews as appropriate.

In the post-intervention sample, we collected data from patients admitted over a 10-month period (n = 89).

We used Chi-Squared testing to compare categorical variables pre- and post-intervention.

Results. Pre-intervention, 15 patients underwent restraint and of these, 8 patients (53.33%) were debriefed. Post-intervention, 21 patients underwent restraint and of these, 10 patients (47.62%) were debriefed. There was no statistical difference in the proportion of patients offered a psychological debrief ($p = 0.735$).

Conclusion. Following a single intervention there was not a sustained difference in the proportion of post-restraint debriefs offered. It is likely more sustained interventions would bring about more substantive practice change. Incorporating the need for post-restraint debriefs in daily ward safety-huddles, or in structured "ward round proformas", may increase the proportion of patients offered post-restraint debriefing. It is possible that the note review strategy did not capture all debriefs delivered.

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.

The Appropriateness and End Outcomes of Urgent Referrals to Outpatient General Adult Psychiatry

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Aims. The urgent referral system to outpatient psychiatry in NHS Lothian is intended for patients who require to be seen within 5 days. However, many of the referrals are not deemed this urgent upon triage. This project aims to illustrate the extent of this issue and highlight potential reasons, in order to improve the pathway for patients referred on to secondary care services.

Methods. Over a 3 month period from August 2023 to November 2023, all urgent referrals received by an Edinburgh sector general adult psychiatry outpatient's department were reviewed. Data was collected on broad presenting complaint, whether or not the referral was deemed urgent upon triage, whether it contained a