feelings of mistrust, uncertainty and a limited sense of safety toward services.

Attachment theory takes into account the individual, their experiences, their social world and the significant people in their lives. The principles required for the developing child to develop a secure attachment from a stable base are similar to those required for people experiencing mental illness to facilitate recovery and develop resilience to help manage and reduce episodes of relapse.

Systems that work well, frequently exhibit values underlying models of care that include continuity, consistency, respect, safety, autonomy, human rights, freedom, supportive, trusting relationships and collaboration. The opposite of that seen in what presents as autocratic and risk-averse approaches of many mental health services.

The principles required to enable a child to develop into a psychologically well-adjusted adult are similar to those required when a person is at their most vulnerable. Episodes of mental illness can be a time for reflection and growth, with the right care and therapeutic intervention, illness can also be a time to learn and develop skills for greater resilience in future.

Conclusion. This paper outlines the implications and cultural changes that are required so that the principles of attachment theory can serve as a theoretical framework across mental health services to provide a stable base for people using the services and staff providing the care.

Moving From Peripheral Project to Integrated Governance: Developing System Sustainability in Excellence Reporting

Dr Jessica Scott*, Dr Jennifer Ledger and Dr Helen Smith

Devon Partnership NHS Trust, Exeter, United Kingdom
*Presenting author.

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Aims. There has been increasing recognition that healthy cultures within NHS organisations are key to delivering high-quality, safe care (King's Fund). A focus towards developing systems which recognise and learn from excellence has been shown to improve services' safety and contribute to staff's morale (Kelly *et al.* 2016). In 2019 Secure Services at Devon Partnership NHS Trust (DPT) developed an Excellence reporting system. Once successfully piloted, the intention was to extend to other departments before expanding to the entire Trust. Our aims initially were SMART: for 13 reports per week in Secure services and 8 in Perinatal (a smaller team). As we expanded the aim became qualitative: for a system to be embedded so staff could as readily and instinctively report Excellence as they could an error.

Methods. We developed our Theory of Change using Deming's theory of profound knowledge, ran a series of PDSAs, and introduced an Excellence system. We engaged early adopters, sent hand-written cards and shared data widely.

Learning included understanding setting up the system, and the importance of a team rather than an individual holding the system. We took this forward to bring the system to Perinatal. We continued to run PDSAs, then ran monthly trust-wide meetings providing space to learn from other directorates.

Results. Staff were initially excited, reports submitted, feedback good, then a plateau and slump.

Something was stopping the system perpetuating. When staff received timely thanks, and others heard about it, staff would go on to promote excellence. However, this was not possible without sufficient admin resources.

In early 2021 we changed tact and approached the top: we presented data to Directors who recognised the value and agreed to support. We then set about publicising the system, and demonstrating at trust-wide meetings.

By July 2021 we saw 10 reports per week in the Specialist Directorate.

By early 2022 reports were being inputted from staff across all directorates and our monthly meetings began to focus on sharing the learning.

Conclusion. We recognised the system's potential impact on safety and staff morale but struggled to sustain the system and support dwindled when staff were stretched.

After approaching leaders, then allocated resources, it allowed for more success. However, it is not *yet* fully embedded in our Trust's culture.

A lot of our work happened during COVID-19 and despite challenges there has been a new-found flexibility to innovate, greater ease to negotiate, and instigate change.

Understanding the Psychological Impact of Lockdown: Combining Quantitative and Qualitative Analysis of Emergency Presentations

Dr Tom Scurr*

Derriford Hospital, Plymouth, United Kingdom
*Presenting author.

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Aims. The pandemic of the COVID-19 variant caused a near-global lockdown, and the psychological impact of the direct effects of the virus, along with the resulting lockdown periods cannot be overestimated. Referrals made to the Liaison Psychiatry service at Derriford hospital during the 2020 lockdown were audited to better understand effects on patients' mental health and resulting emergency presentations to services. These data were then used to identify areas for improvement, in order to tailor services to better support the population during recovery from the current lockdown, and for planning for future similar events.

Methods. Referrals to the Derriford Liaison Psychiatry service between the 1st and 12th of May 202 were audited, totalling 106 referrals and a subsequent 87 assessments. Quantitative data on patient demographics, presentation, and outcomes was extracted from assessments along with qualitative data on patients' subjective experiences from the initial lockdown period for thematic analysis. Routine data were used for comparator time periods from 2019, and during the second 2021 lockdown.

Results. Despite a lower number of presentations to ED during the first lockdown, the data demonstrate a higher acuity in presentations with more referrals for admission under section. The lockdown is shown to have particularly affected those with pre-existing psychiatric and physical comorbidity, along with specific patient groups. Thematic analysis confirms this, showing the diverse factors contributing to emergency presentations and demonstrating the increased stress of life in the home under lockdown. Comparisons between the qualitative and quantitative data confirm that patient experiences directly match both the routinely collected data and prior research. The project also revealed a reliance on private and third sector organisations for signposting on from assessments, and highlighted frequent changes to services during lockdown as a source of confusion for both patients and staff.

Conclusion. The scale of impact identified affirms that exploration of the lockdown's contribution to presentation should be routine, particularly for identified at-risk patient groups. Areas frequently highlighted by patients can be used to fully explore the impact of lockdown on presentation during assessment. Patient information for self-referral needs to be regularly updated given frequent changes in service provision. Staff also need to be kept up to date on changing service structure at handover meetings.

Improving the Identification, Assessment and Management of Osteoporosis and Fragility Fracture Risk on a Later Life Psychiatry Ward: A Complete Audit Cycle

Dr Morwenna Senior*, Dr Thomas Hewson, Ms Francesca Brownless and Dr Ross Dunne

Greater Manchester Mental Health NHS Foundation Trust, Manchester, United Kingdom
*Presenting author.

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Aims. Osteoporosis is common amongst elderly patient populations and is associated with significant morbidity and mortality. We aimed to assess whether national clinical guidelines regarding the identification, assessment and management of osteoporosis and fragility fracture risk were being adhered to on a female later life psychiatry ward. We then aimed to improve the detection and treatment of osteoporosis amongst this patient cohort and subsequently conducted a re-audit of adherence to relevant clinical guidelines.
Methods. In July 2021, the electronic health records of the 20 most recently discharged patients from a female later life psychiatry ward were reviewed. The proportion of patients who appropriately received FRAX screening, DEXA scanning and pharmacological management of osteoporosis and fragility fracture risk was recorded. The results were compared to standards identified in national clinical guidelines from the National Institute for Health and Care Excellence (NICE) and the National Osteoporosis Guideline Group (NOGG). In addition, the proportion of patients who had FRAX scores communicated to their general practitioners on discharge was recorded. Recommendations were made based on audit findings, and several changes to ward processes were implemented including incorporating fracture risk scoring in a structured ward round template and displaying information posters about osteoporosis in clinical areas. A re-audit was completed in February 2022 using the same methodology as baseline to re-assess adherence to the audit standards.
Results. All included patients were female and aged >65 years, and therefore eligible for consideration of fragility fracture risk according to NICE guidelines. 88% (15/17 patients) of those without pre-existing osteoporosis had FRAX scores calculated during their admission on re-audit compared to 50% (8/16 patients) at baseline. 73% (11/15 patients) had FRAX scores communicated to their GP on discharge at completion of the audit cycle compared to 25% (2/8 patients) at baseline. At completion of the audit cycle 10% (1/10 patients) with intermediate fragility fracture risk received measurement of bone mineral density during admission while 30% (3/10) had this recommended to their GP on discharge. None of the high-risk patients (n = 4) were started on bisphosphonate therapy.
Conclusion. On completion of the audit cycle, we found excellent compliance with national guidelines regarding the identification of osteoporosis and fragility fracture risk, which demonstrates the feasibility of considering this aspect of physical health in the setting of a later-life psychiatry ward. Areas for improvement include the assessment and management of patients identified as having intermediate or high risk of osteoporosis and fragility fractures.

Simple Interventions Can Greatly Improve Clinical Documentation: A Quality Improvement Project of Record Keeping on the Legal Aspect of Dementia at Memory Service

Dr Shabinabegam Abdul Majid Sheth* and Dr Claudia Wald

Central and North West London NHS Foundation Trust, London, United Kingdom
*Presenting author.

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Aims. 1. To ensure there is documented evidence of discussion about legal aspect of dementia with patients and relatives. 2. To Improve documentation of Financial management by 100% at the end of 3 months. 3.To Improve documentation of LPA and other related legal areas by 70% at the end of 3 months
Methods. In Kensington and Chelsea and Westminster Memory services, we are seeing patients with cognitive impairment which can be due to dementia. So, it is really important to discuss and help a person and/or relative with making decision about client's health, welfare or finances. Though each team member discusses about what they did for the same, we identified that it was not reflected in the documentation.

After finalising data collection form, we then performed a retrospective collection of number of documented assessment/discharge report/progress notes within an identified 3-month time period from March to May 2021. Our intervention was Email and MDT remainders, developing patient information video, and structured format to document about legal aspect of dementia like, financial management, Lasting power of Attorney, Court of protection, Advance will, etc. We run PDSA cycles and collected a data at the end of each month to see whether change ideas are helping to improve documentation and whether any modification will require with the plan.
Results. Out of 67 patients record which were reviewed as a baseline data, 39% of them has diagnosis of dementia or Mild Cognitive impairment. Discussion about LPA was recorded in only 16% of the documents. There is no mention of how a person is managing their finances in 30.7 percent of documents. After implementing change ideas, 29 patients who were seen during the month of December were reviewed using the same data collection form. Documentation of discussion about financial management was improved to 93.1%. Documentation of Discussion about how to set up LPA, if a person doesn't have one has been approved from 10.4% to 55.2%. The cycles will continue for month of January and February and data will be assessed and compared at the end February 2022.
Conclusion. Basis on the data available till date, a general improvement in the record keeping of notes was seen. Simple intervention like email reminders, reminder in MDT, structured format for documentation and patient information in visual format can improve the documentation of work. More detailed conclusion will be drawn at the end of 3 months.

Do Patients on Section 42 Understand Their Section and What Is Involved?

Dr Chung Mun Alice Lin[1] and Dr Neeti Sud[2]*

[1]National Institute of Health Research Newcastle Biomedical Research Centre and the Translational and Clinical Research Institute,