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

factor in line with RefHelp guidance for urgency, and what the end outcome of the referral was.

Results. During the 3 month period, there were 92 urgent referrals. Of these, only 12% were deemed urgent upon triage. Almost all accepted referrals related to concerns around potential psychotic illness (82%). Although only 12% of referrals were accepted as urgent, 35% had factors which, in accordance with RefHelp guidance, would be cause for considering an urgent referral.

There were a variety of disposals including "soon" appointments, redirection to other services such as Thrive or offering advice to the referring clinician. The most common outcome was the offer of a "soon" appointment, closely followed by redirection to the Thrive team.

Conclusion. The majority of urgent referrals were not deemed urgent at triage. There was a clear discrepancy between referrals containing urgency factors according to RefHelp and those offered urgent appointments. This would suggest that the available guidance is not sufficiently clear.

Many referrals were redirected to other services, including Thrive. This redirection may reflect a lack of awareness and a further project may examine Thrive referrals to establish if the number initially sent to psychiatry outpatients is significant.

Additionally, several referrals were triaged as "soon" and seen in 6–8 weeks, as opposed to waiting for a routine appointment. Though RefHelp advises highlighting routine referrals which may be a priority, this pathway was not being used and there is no direct route for "soon" referrals.

Next steps may include liaison with primary care teams to establish views and concerns, updating RefHelp guidance and adding a further referral pathway to address the apparent gap for "soon" referrals.

Quality Improvement Project to Reduce the Anticholinergic Burden in a Rehabilitation Unit

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Aims. We conducted a quality improvement project in a female rehabilitation unit, with an aim to reduce the total anticholinergic burden.

Methods. Most patients were reluctant to change the medications that they have been taking for long time. Hospital staff were also concerned about the potential risk of destabilising the mental health of patients who are currently stable.

As a first step, we used ACB (Anticholinergic Burden) calculator to calculate ACB score

We agreed on a realistic safe target. We decided not to include patients who are on clozapine. Information related to anticholinergic burden was shared with nursing team and staff members. This was discussed in MDT meetings to answer any questions.

Team collaboratively created an information leaflet, including an easy read version. Group sessions and 1:1 sessions were arranged with patients to discuss the potential side effects.

Medication changes were carried out following a consultation with patients.

Results. ACB score of all 15 patients were over 3. One patient is over the age of 65. Five patients scored more than 10 on total ACB score. Two patients were on clozapine.

Promethazine, procyclidine, hyoscine hydrobromide, oxybutynin and clozapine were causing most of the anticholinergic burden.

We decided not to change medications of two patients who were on clozapine. For the remaining patients procyclidine and promethazine were reviewed and stopped following a consultation. All 12 patients' ACB score is now less than 10. There has been a reduction of 3–6 points.

Conclusion. This project has helped in reducing the ACB burden successfully. Promethazine with an ACB score of 3 was stopped for all patients. Some patients received promazine instead of promethazine. Procyclidine has been stopped for several patients and for some patients it has been changed from regular to PRN (to take when required). Consideration has been given to reduce the dose of typical antipsychotic medication instead of using procyclidine to treat extrapyramidal side effects.

Providing information and then reviewing the prescription of promethazine and procyclidine has resulted in significant reduction in the total ACB score.

Impact of Raising Staff Awareness on Recording Patient Consent to Receive Text Message Reminders of Appointments and Increasing the Frequency of Reminders on Did Not Attend (DNA) Rates in Community Mental Health (CMH): A Quality Improvement Project

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Aims. Patients not attending appointments without letting the service know prior (referred to as did not attend – DNA) is a significant problem in community mental health (CMH). However, there are limited studies conducted in the United Kingdom on this issue. Patients forgetting appointments was a reoccurring reason for DNAs in the literature. To address this, we aimed to assess the impact of raising staff awareness on recording patient consent to receive text message reminders of appointments and increasing the frequency of reminders on DNA rates in Arndale House (a CMH service covering Dartford, Gravesend and Swanley as part of the Kent and Medway NHS and Social Care Partnership Trust – KMPT).

Methods. DNA rates at Arndale House from August to October 2023 were assessed to determine a baseline before implementing interventions. Following this, two interventions were put in place; the first occurred on 18/10/23, consisting of an online teaching session for the staff at Arndale on documenting patients' consent to receive text message reminders for their appointments. Posters with instructions on this were posted on the trust intranet and set up within the building. The second intervention occurred on 20/11/23 and included sending out text message reminders more frequently, from three and one day prior to appointments

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