Conclusion: GP trainees and foundation doctors are better able to engage with the Balint group when barriers to attendance are actively addressed. However, not all resident doctors feel comfortable with the Balint group format, and hence it may not reduce the risk of burnout for these individuals; in such cases, attendance should not be mandated.

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Procyclidine Use with Long-Acting Injectable Antipsychotics

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Aims: Our aim was to review if procyclidine is being prescribed as per BNF guidelines at DGS CMHT. As per BNF guidelines, procyclidine is recommended to be initiated at 2.5 mg of procyclidine three times per day increasing by 2.5 mg daily until symptoms are relieved. The effective maintenance dose is usually 10–30 mg procyclidine per day. After a period of 3–4 months of therapy, procyclidine should be withdrawn and the patient should be observed to see whether the neuroleptic-induced extrapyramidal symptoms recur.
Methods: A retrospective clinical audit was conducted on 36 patients receiving long-acting injectable antipsychotics at the Dartford, Gravesham, and Swanley Community Mental Health Team (DGS CMHT) between September 15, 2023, and January 7, 2024. Data was collected on patient demographics, diagnosis, antipsychotic medication, procyclidine use, Glasgow Antipsychotic Side-effect Scale (GASS) scores, and procyclidine review.
Results: The majority of patients were male (27 out of 36 [75%]) and in the 55–64 age range (16 out of 36 [44%]). The primary diagnoses were schizophrenia (25 out of 36 [69%]) and bipolar disorder (9 out of 36 [25%]). 14 out of 36 patients (39%) were currently taking regular procyclidine, with doses ranging from 5 mg once daily to 10 mg three times daily, while 6 were taking procyclidine as PRN. Regular procyclidine reviews were undertaken in 13 patients (92.9%), with review intervals ranging from monthly to 6-monthly. The common outcomes of reviews included dose adjustments, side effect monitoring, and discontinued use due to adverse effects or lack of efficacy. Out of those on regular procyclidine, 9 patients (64%) showed an improvement in their GASS scores. Among those on regular procyclidine, the starting dose was not available for 6 patients because the starting time pre-dates electronic records. From those included in our electronic records, the data indicates that the starting dose of procyclidine varied, with some patients being started on 5 mg as per need and later changed to regular, while others being started on 5 mg once a day, but none was started as per the trust recommended dosage of 2.5 mg three times a day. While there is no specific mention of a plan to review within 3–4 months for response to start of, or change in dosage of procyclidine, the data suggests, however, that regular reviews were being conducted to monitor the effectiveness and side effects of procyclidine. However, 4 patients, when they were first started on procyclidine, were asked to be reviewed by the GP.
Conclusion: The clinical audit demonstrates that procyclidine was being used to manage extrapyramidal side effects in patients receiving long-acting injectable antipsychotics at the DGS CMHT. The starting doses and review intervals for procyclidine varied, but regular monitoring of GASS scores and patient outcomes was occurring. The data suggests that procyclidine was generally effective in improving GASS scores and managing extrapyramidal symptoms, with 64% of patients showing improvement. It was worth noting that none of the patients in the record were started on the recommended starting dose of 2.5 mg TDS. Increasing awareness of trust protocol regarding prescribing of procyclidine is recommended to ensure evidence-based practice. This was presented in the local audit conference with team of doctors and pharmacists and changes implemented.

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A Safer Prescription: Quality Improvement in Medication Practices on West Ward

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Aims: To reduce medication errors on West Ward, a busy adult mental health ward, by addressing multiple domains of medication safety identified in a baseline audit. The project aimed to improve prescribing practices, medication administration, and related processes through targeted interventions and continuous monitoring.
Methods: A baseline audit of medication practices on West Ward revealed significant errors across various domains, including temperature recording, medication stock management, MHRA actions and alerts, record keeping, incomplete processes, prescribing technicalities, clinical issues, administration errors, controlled drug management, emergency drug and equipment availability, medicine ordering, and medicine information.

A quality improvement (QI) project was implemented over six months, incorporating three Plan-Do-Study-Act (PDSA) cycles. Interventions included:

Training: Targeted training for doctors and nurses on best practices in medication safety, focusing on identified error hotspots.

Documentation Improvement: Introduction of standardised templates and improved documentation processes to enhance clarity and completeness.

Induction Changes: Revision of the induction process for new staff to emphasise medication safety protocols and ward-specific procedures.

Controlled Drug Review: A comprehensive review and strengthening of controlled drug management procedures, including prescribing, storage, and administration.

MHRA Record Keeping Review: Implementation of a robust system for recording and acting upon MHRA alerts and drug safety information.

Data was collected throughout the project using regular audits of medication practices, mirroring the baseline audit. Error rates were tracked across all targeted domains for each PDSA cycle to assess the impact of the interventions. Sustained improvement was evaluated through follow-up audits after the project's completion.
Results: The QI project demonstrated a significant reduction in medication errors on West Ward. Overall, a 51% reduction in the total number of medication errors was achieved over the six-month period. Each PDSA cycle contributed to this improvement, with error rates progressively decreasing. Specific areas showing marked improvement included prescribing technicalities, administration

errors, and controlled drug management. Follow-up audits conducted after the project's conclusion indicated that the reduced error rates were sustained over time, demonstrating the effectiveness of the interventions.

Conclusion: This QI project successfully reduced medication errors on West Ward through a multifaceted approach targeting multiple domains of medication safety. The combination of training, documentation improvements, process changes, and focused reviews. This project demonstrates that targeted QI initiatives can lead to significant and lasting improvements in medication safety within a busy mental health setting, ultimately benefiting patient care and safety. Further work will focus on exploring the factors contributing to sustained improvement and disseminating these findings to other wards and healthcare settings across the organisation.

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Quality Improvement Project: Introducing Pharmacy Input Into Consultant Psychiatry Outpatient Clinics

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Aims: This Quality Improvement (QI) Project aimed to enhance the overall level of care received/experienced by patients within the Havering Older Adult Mental Health Team (HOAMHT) through combining the clinical expertise of a Consultant Psychiatrist with the pharmacological acumen of a Specialist Mental Health Pharmacist, within a joint mental health outpatient clinic. Key areas tackled included: medication adherence, faster optimization of psychotropic medications, management of polypharmacy, de-prescription of drugs of dependence, physical health monitoring, and expediting patient discharge from HOAMHT back to the GP.

Methods: Our QI project utilised Plan/Do/Study/Act (PDSA) cycles. The first PDSA cycle took place in 2023/2024 over 6 months. The second PDSA cycle took place in 2024/2025 over 6 months. The 1st PDSA Cycle used patient satisfaction outcome scoring, which was randomly collected from 15 patients that had been reviewed within the joint clinics. The results from the 1st PDSA cycle led to a second PDSA Cycle being undertaken, in which the establishment of a ten minute pharmacist's corner feature was implemented within the joint clinic, and further patient satisfaction data was collected. Based on this data, in 2025/26 a third PDSA cycle will take place over 6 months, where there will be joint clinics consisting of junior doctors and pharmacists. This will serve to develop and refine teaching opportunities for the specialist clinical pharmacists. Then, the 4th PDSA cycle will look to expand and include other community mental health teams within our Trust, in order to see if improvements are possible to be achieved at scale.

Results: PDSA Cycle 1: There was a 38% improvement in patient satisfaction scoring for joint clinics vs stand-alone consultant/junior doctor clinics.

PDSA Cycle 2: Patient satisfaction scores increased further with the introduction of stratification, where the pharmacist was given protected time within the clinic to tackle medication-related queries, which patients found invaluable.

Conclusion: In England, there is just one Consultant Psychiatrist for every 12,600 people. Hence, the demands on clinical services for treatment have become unsustainable. Consequently, a novel and agile approach is required when organising community mental health services, so that all available clinical knowledge and expertise is exploited and geared towards maintaining a high quality of clinical care for patients, despite the resource limitations that are present. This QI project serves to demonstrate the value of effective collaboration between professionals in the pursuit of clinical excellence.

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Enhancing and Improving Resident Doctor Handover Practices at Black Country NHS Foundation Trust

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Aims: Effective handovers are essential for patient safety and continuity of care. Poor communication during shift transitions is a major contributor to medical errors and adverse events. Guidelines from the Royal College of Psychiatrists (RCPsych), British Medical Association (BMA), and National Institute for Health and Care Excellence (NICE) emphasise the need for structured, distraction-free handovers with clear documentation of key clinical information.

A review of handover practices at Hallam Street Hospital, Sandwell revealed reliance on informal unregulated communication channels, primarily WhatsApp, raising concerns about confidentiality, documentation consistency, and patient safety.

This Quality Improvement Project (QIP) aimed to evaluate existing handover practices to implement a more secure and structured system.

Methods: A baseline survey was completed by 21 out of 35 Resident doctors (Core Trainee Year 3 and below) participating in on-call and daily handover processes. The survey assessed satisfaction, confidentiality concerns, and patient safety risks associated with the existing WhatsApp-based handover system. Findings concluded:

62% were dissatisfied with the current WhatsApp-based handover process.

66.67% felt patient safety was compromised.

61.91% lacked confidence in receiving and reading handovers by the intended recipient.

Using the Plan-Do-Study-Act (PDSA) model, the intervention involved transitioning to a structured Microsoft Teams (MS Teams) handover platform, which was already successfully implemented at Bushey Fields Hospital, Dudley.

A standardised template was produced, including key information such as patient demographics, clinical status, outstanding tasks, and risk factors. Training sessions, user guides, and drop-in support were provided to facilitate the transition.

Results: Post-intervention data was collected via a follow-up survey after the implementation of MS Teams Handover channel. The results demonstrated a significant improvement in handover quality:

100% of respondents were either satisfied or very satisfied with the new system.

Confidence in patient confidentiality increased, with 100% of respondents being either very or extremely confident.

Concerns regarding patient safety decreased from 66.67% to 20%.

Confidence in handovers being received and read improved significantly.