VTE Assessment for Psychiatric Inpatients–Quality Improvement Project on Acute Male Ward

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Aims: There is an observed poor compliance with assessing venous thromboembolism (VTE) risk when patients are admitted to an acute male ward in Lambeth Hospital. NICE guidelines state that psychiatric patients should have this reviewed at least by first consultant review.

Psychiatric patients have unique risk factors for VTE – antipsychotic use, poor hydration/nutrition and possible use of physical restraint. It is therefore important to assess and treat risk as advised to minimise VTE occurrence. Through improving engagement with risk assessment tool, and documenting if patients are at risk, this will help identify patients who require prophylactic treatment.

Methods: Use electronic patient records (ePJS) to access ward patients' medical records, every 2 weeks. For each patient carry out the following 1. Establish admission date. 2. Search 'VTE' 'vtrap' 'dvt' on notes. 3. Access VTRAP tool under assessment. Document if completedvs not completed. Change implemented through including VTE assessment in ward round proforma and creation of posters reminding resident (clerking) doctors to assess VTE risks.

Results: 18 bed male ward, with average length of stay 32. Baseline data showed 12% completion rate of VTE risk assessment prior to change implemented.

Following change (2 changes implicated of poster + VTE included in ward round proforma), every data collection was over 66%, with all but one being over 80%.

Conclusion: Causes for low compliance for VTE assessment of psychiatry inpatients include lack of knowledge of medical staff that this is a guideline/expectation when admitting patients and lack of knowledge of increased risk in psychiatric patients, and hence need for VTE risk assessment. Through education and engagement, this change has been effective in improving compliance of VTE screening. Improving assessment and education will hopefully in turn improve adherence to VTE prophylaxis and encouragement in improving dynamic risk factors (dehydration/immobility) by the whole MDT.

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.

Improving VTE Risk Assessments in Psychiatric Hospitals

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Aims: Psychiatric inpatients face elevated risk of venous thromboembolisms due tosedation, antipsychotic use and reduced mobility. Following a serious incident involving a patient death from VTE complications, we aimed to increase VTE risk assessment completion within 14 hours of admission (KPI standard) from 74.7% to over 90% at St Charles Hospital and CNWL NHS Foundation Trust by November 2025.

Methods: We conducted three PDSA cycles between November 2024 and November 2025, analysing 975 admissions across 8 psychiatric inpatient wards. Baseline compliance was 74.7% with 7.4% of patients never assessed.

Root cause analysis using fishbone diagrams identified gaps in staff awareness, competing clinical priorities and absence of electronic system prompts.

Cycle 1: We targeted education through training sessions reaching 80% of staff, resident doctor forums and targeting resident doctor inductions.

Cycle 2: We corrected the Tableau dashboard (data analytics platform) and started weekly automated emails for underperforming wards. With the aim of increasing data visibility.

Cycle 3: Implemented a mandatory soft-stop prompt in the SystmOne electronic patient record–which is triggered after prescribing. This was deployed as a regional trust-wide quality improvement intervention which affected all the inpatient beds at the CNWL trust (excluding CAMHS).

Results: Education and awareness failed. Compliance fell 2.2 percentage points to 72.5%.

The data analytics dashboard visibility achieved partial improvement, raising compliance by 5.1 percentage points to 77.6%.

The semi-mandatory electronic prompt delivered the greatest impact, improving compliance by 9.6 percentage points to 87.2%.

Median time to assessment fell by 42%, from 1.30 hours to 0.76 hours.

The mean time fell from 58.1 to 9.1 hours; this indicates that there are far fewer extreme outliers who never receive VTE assessments.

Out-of-time assessments fell from 17.9% to 7.8%.

Overall compliance (comparing baseline to post cycle 3) rose from 74.7% to 87.2%.

The trust-wide implementation ensured consistent standards and an improvement in KPI across all inpatient wards.

Conclusion: The system level change delivered better results than targeting human factors. Making VTE assessment semi-mandatory through an electronic prompt embedded into the clinical workflow and proved to be the best intervention. In addition the placement in the clinical workflow was designed to avoid prompt fatigue on the electronic systems and to ensure emergency prescribing was not interrupted.

This approach may benefit other mental health trusts seeking to improve VTE compliance. Further specific guidance on implementation can be provided for SystmOne orientated trusts.

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Safe Transitions: Optimising Medical Handover in Broadmoor, a High-Secure Forensic Hospital

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Aims: We aimed to improve the safety, reliability and confidentiality of the medical handover process at Broadmoor, a high-secure forensic hospital. The existing system relied on a mass email sent at the end of on-call shift containing clinical updates, seclusion information and outstanding tasks. We identified key risks: outdated patient lists, missed seclusion reviews, task not reaching the on-call doctor, poor structure and routine sharing of patient full names