improvement in admission clerking completion rates, although quantitative variability in documentation quality remained. During the second PDSA cycle, the extended 72-hour target was retained and combined with the standardized clerking template. Over the final twelve weeks of data collection, this combined approach resulted in a sustained improvement in both timeliness and completeness, achieving a 100% admission clerking completion rate.

Conclusion: Clearly defined timeframes combined with standardized documentation tools can significantly improve the quality, timeliness, and sustainability of admission clerking in inpatient psychiatric settings. Plans are underway to scale this intervention across the wider trust and continue data collection to evaluate long-term impact and sustainability.

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Improving T3 Medication Authorisation Compliance on an Old Age Psychiatry Ward: A Quality Improvement Project

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Aims: Unlawful medication administration under the Mental Health Act (MHA) poses significant patient safety and legal risks in Old Age Psychiatry. Cognitive impairment, fluctuating capacity and behaviour disturbances increase the likelihood of patients requiring rapid tranquillisation. In August 2025, four incidents occurred, where either the route or frequency were administered outside the parameters of medication authorisation forms (T3 particularly).

This Quality Improvement Project aimed to eliminate T3 medication errors by improving Registered Nurses' (RN) knowledge and confidence in compliance with MHA medication authorisation forms. We hypothesised that a combined intervention of a visual prompt and targeted teaching would improve compliance and reduce errors to zero.

Methods: We included all RNs on a 16-bed Old Age Psychiatry ward (n=10). Baseline data included incident reports and questionnaires identifying inconsistent knowledge and varied confidence of medication form processes among RNs.

Two interventions were implemented: (1) a visual whiteboard placed above the drug trolley identifying patients with active T3 medication forms to prompt checks at administration times; (2) a targeted teaching session using real ward-based incidents to reinforce legalrequirements for T3 authorisation. Monthly audits monitored medication authorisation errors, and questionnaires were repeated following the teaching session.

Results: Following implementation, off-T3 medication incidents reduced from four in August 2025 to zero in September 2025, and remained at zero for four consecutive months. Staff reported that the visual prompt aided adherence to MHA T3 medication forms. Mean knowledge questionnaire scores increased from 58% at baseline to 71% after the teaching session. Mean self-reported confidence in interpreting T3 forms increased from 3.7 to 4.3 on a 5-point Likert scale.

Conclusion: Low-cost, scalable interventions integrating visual aids and focussed education eliminated unlawful T3 medication errors to zero and significantly improved staff knowledge and confidence, ensuring sustainable T3 compliance. This Quality Improvement approach supports safer practice and is transferrable to other inpatient psychiatric services.

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Post-Fall Care in Older Adult Psychiatric Inpatient Settings: Identifying Variations and Implementing Standardised Medical Review Practices

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Aims: This quality improvement project aimed to strengthen the timeliness, consistency and quality of post-fall medical assessments and documentation across older adult inpatient wards. National standards, including NICE Quality Standard 86 and Royal College of Physicians' recommendations, emphasise prompt review and comprehensive assessment following inpatient falls. Local incident reviews, however, indicated delays in medical examination, inconsistent documentation, and variation in practice. The project aimed to evaluate current practice, identify gaps, and inform the development of an improved post-fall medical review template, as well as contribute to the revision of the Trust's Falls Policy.

Methods: A retrospective review of 30 inpatient fall incidents was conducted across six older adult mental health wards at the Julian Hospital and Carlton Court Hospital over a three-month period. Data were extracted from incident reports and clinical records, focusing on:

- Whether a post-fall medical review was completed.
- Time from fall to medical assessment.
- Completeness and quality of documentation.
- Differences between witnessed and unwitnessed falls.
- Variation by time of day.

Performance was compared against NICE QS86 (statements 4, 5, 6), Trust Falls Policy C86, and national audit benchmarks.

Results: Medical reviews were not consistently completed, with approximately 40% of falls lacking documented medical assessments. Among documented reviews, median time toassessment was 8.7 hours, within the 12-hour standard but indicating avoidable delay, especially for unwitnessed falls and out-of-hours incidents. Documentation quality varied significantly, with omissions in neurological examination, pain assessment, medication review, and rationale for monitoring. Reviews conducted during evening/night shifts tended to be shorter and less comprehensive. Unwitnessed falls showed higher rates of missing neurological observations and inconsistent application of Trust guidance. Overall, substantial variation existed across wards.

Conclusion: The current post-fall medical assessment practice showed significant gaps in both timeliness and documentation quality, creating potential risks for undetected injuries. This highlighted the need for a more structured and standardised approach across older adult psychiatric wards.

Based on the findings of this QI project, a new, user-informed post–fall medical review template was developed to support clearer, more comprehensive documentation. Alongside this, a wider rewrite of the Trust's Slips, Trips and Falls Policy (C86) is underway. This ongoing work aims to make the policy more detailed, practical, and