teaching session. Distributed poster and displayed in staff facing areas on HTNFT inpatient units.

November: Shared results of pre-intervention questionnaire. Re-shared tool. Post Intervention questionnaire – gathered feedback regarding tool implementation into practice.

Results: Pre-Intervention Questionnaire:

Delivered face to face.

31 doctors responded of mixed grades.

Around half had never completed a PHBR (coincided with beginning of rotation).

19.4% selected 'Not confident at all' with such task.

93.5% were unaware of any helpful tools.

100% answered yes to 'Would a tool such as an acronym help your approach?'.

Post-Intervention Questionnaire:

Delivered online.

9 doctors responded of mixed grades.

Most used the tool.

100% would recommend.

Comments: easy to use, relevant to clinical practice, clever acronym, improved confidence.

Conclusion: PHBRs remain a daunting yet apparent task for psychiatry RDs. The bedside tool 'BANGED' shows promise for improving approach, by offering guidance for key areas of focus.

Future practice – further cycles required, delivered in person – better response rate.

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.

Quality Improvement Project Investigating the Quality of Completed Section 5(2) Forms

Dr Ellen Cornish

Portsmouth Hospitals University NHS Trust, Portsmouth, United Kingdom

doi: 10.1192/bjo.2025.10355

Aims: This quality improvement project aims to investigate the quality of completed Section 5(2) forms in a large, acute NHS hospital in England. It seeks to establish a current data baseline and identify common errors. The statutory section 5(2) form can be confusing for those who are unfamiliar with it, especially the section requiring correct deletion of options to identify the completing doctor's status. Incorrectly completed Section 5(2) forms may later need rectification or can lead to the invalid detention of a patient, in which case the patient may be able to claim financial compensation.

Methods: The most recent twenty (n=20) Section 5(2) forms across adult and paediatric medicine from November to December 2024 were analysed against a created proforma containing twelve criteria needed to correctly complete the form and provide rationale for detention.

Results: On average Section 5(2) forms were 84% correctly completed with a total of 202/240 criteria met. Of the twenty forms surveyed, 100% were legally valid. Furthermore, 100% recorded diagnoses, symptoms, or behaviours suggestive of a mental health disorder and were legible, signed, and dated by the relevant parties. 70% identified risks to the patient or others if the patient were not detained and 55% contained correctly deleted phrases to reflect the status of Registered Medical Practitioner (RMP), Approved Clinician (AC) or Nominee. However, the majority (55%) contained medical abbreviations and only 40% indicated detention was necessary to allow a Mental Health Act Assessment (MHAA) to occur.

Conclusion: Overall Section 5(2) forms are completed well by doctors in this survey with all citing evidence of a mental health condition and the majority including an assessment of risk. Increased physician education and awareness of key information may increase the documentation of risks, the need for a MHAA and promote the avoidance of abbreviations which can cause errors. The ongoing work reviewing the new Mental Health Act could consider simplifying the pre-determined options, which may increase the correct completion of the RMP/AC/Nominee status section. Meanwhile, doctors may benefit from an aid with clear examples of the correctly deleted phrases being issued alongside the Section 5(2) forms. The surveyed hospital is currently revising Section 5(2) guidelines and preparing example templates for doctors to use. After allowing time for the implemented changes to take effect this project will aim to re-audit and measure impacts.

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.

A Quality Improvement Protocol for Assessing the Quality of Assessments for Children and Adolescents in Crisis

Dr Azim Daud, Dr Tauseef Mehdi, Ms Emily Perrin and Ms Mary Curtis-Weight

Berkshire Healthcare NHS Foundation Trust, Reading, United Kingdom

doi: 10.1192/bjo.2025.10356

Aims: Berkshire Healthcare NHS Foundation Trust utilises a Quality Management Improvement System (QMIS) which facilitates a culture of continuous improvement across the Trust. This system includes regular "Huddles" where all staff are encouraged to participate in identifying areas for improvement. Through a Huddle within the Berkshire Child and Adolescent Mental Health Service (CAMHS) Rapid Response Team, concerns were raised about the variable quality of assessments for children and adolescents in crisis. This project was designed to address this concern.

Methods: We designed a multifaceted approach to accurately map out the scale of the issue from multiple perspectives to help identify training needs and direct future interventions involving:

1. Designing a quality framework and rating system for reviewing assessments looking at domains agreed by the senior multidisciplinary team (psychiatry, management, psychology and nursing) and informed by existing assessment guidelines. Domains agreed:

Comprehensiveness.

Accuracy and clarity.

Formulation.

Sensitivity and cultural competence.

Document quality.

Rated from 1–5 (1 – poor, 2 – needs improvement, 3 – satisfactory, 4 – good and 5 – excellent).

2. A rating exercise using the framework is to be completed by all assessing clinicians split into two groups (for anonymity), facilitated by senior clinicians. A total of 36 assessments (18 per group) completed in the preceding three months are to be reviewed.

3. Finally, the systemic family therapist would arrange to observe all assessing clinicians in at least one initial assessment to identify and note any other areas for improvement or concern within the assessment itself.

Following the above, information will be collated and analysed to identify specific areas of need within the team's assessments.