100% of doctors felt the new process met medico-legal requirements.
Conclusion: Transitioning from an informal Handover system to a structured MS Teams platform led to substantial improvements in documentation quality, patient confidentiality, and Resident Doctor satisfaction. The standardised approach reduced the risk of errors, improved information transfer, and aligned with national best practice guidelines. Further refinements, including optimising accessibility and ensuring sustained engagement, will be explored in future cycles of this project.

Improving Women's Sexual and Reproductive Health in a Psychiatric Inpatient Setting Quality Improvement Project: Development and Implementation of a Women's Physical Health Clinic in a Psychiatric Hospital in North London

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Aims: Following a pre-clinical survey of psychiatric female inpatients, it was highlighted that they found it challenging to access obstetric, gynaecological and sexual health investigations and management. It was also found that mental healthcare professionals in the same psychiatric unit had limited knowledge and awareness of women's physical health issues. The aim of this QI project were to develop and establish a monthly women's physical health clinic (WPHC) on an inpatient psychiatric hospital site, offering assessment, investigation and treatment by obstetricians and gynaecologists.
Methods: We have established a monthly WPHC occurring, since January 2024, on every 3rd Thursday of the month 1–5 pm at a psychiatric hospital in North London. It was run voluntarily by two local obstetrics and gynaecology (OBGYN) specialist registrars with a special interest in mental health. Specialised clinical equipment was sourced through central procurement. We developed a detailed referral pathway. This involved creating a referral form which would be emailed to all female wards and later screened. Patients accepted into the clinic were booked for roughly 45-minute slots based on priority. The OBGYN involvement included specialist investigations, treatments and liaison with patients' GPs. In order to raise awareness of the WPHC with psychiatric inpatient staff and patients, we designed posters and information leaflets, sent weekly email reminders to the clinical team about the clinic referral procedures and raising awareness through trust induction, academic teaching, and the Resident doctors' WhatsApp group.
Results: Referrals increased from 8 before May 2024 to 28 after implementing targeted interventions totalling 36 overall. While numbers increase initially, fluctuations occurred in subsequent months due to leave, strikes and staff shortages. Patient qualitative feedback obtained via surveys included requests for more frequent clinics (unmet need was even greater than anticipated), positive experience of a smooth service and complaints related to clinic delays linked to multiple factors. Staff feedback included satisfaction with the simplicity of the referral form, swift replies. Virtual clinics were suggested as a way of improving the access further, especially for advice regarding acutely unwell patients.
Conclusion: Our QI project data has demonstrated the importance of providing women with physical health care in a female psychiatric inpatient setting. The large increase in referrals following introduction of the WPHC highlights the unmet medical need for female psychiatric inpatients accessing obstetric, gynaecological and sexual health services. Our next steps will include securing funding for more regular, biweekly clinics, as the unmet need identified is greater than expected.

Improving Rates of Capacity Assessment in an Acute Psychiatric Ward in London

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Aims: Capacity is a decision and time dependent construct and assessing capacity regularly is a core tenet of ethical practice, particularly in a psychiatric setting. However, on our ward we found that these assessments were not formally recorded for all patients. We felt it was pertinent to assess the proportion of patients for whom capacity assessments for consent to treatment and to admission were documented, and to trial interventions to improve these rates.
Methods: We collected retrospective data from electronic medical records of 40 patients admitted on an acute men's psychiatric ward between 1/10/2023 and 2/2/2024. For each patient we identified whether their capacity to consent to admission or treatment was recorded on their clerking, or on any subsequent ward-round documentation. Further to this we recorded whether each patient had a capacity assessment recorded on the dedicated Rio capacity form. We then implemented changes including the circulation of a standardised proforma for ward-rounds and clerkings, which included a capacity assessment. After 6 months we re-recorded these metrics for 29 patients admitted between 15/8/2024 and 24/10/2024 and compared the results of each metric using a chi-square test.
Results: We found that there was an increase in the proportion of patients receiving an assessment of their capacity to consent to treatment between cycle 1 and 2. However, this did not reach statistical significance ($p=0.66$). Similarly, in comparing rates of assessment for capacity to consent to admission on initial clerkings, there was an increase which was not statistically significant ($p=0.94$). For ward-round documentation, we found an improvement in rates of capacity assessment for treatment which was not statistically significant ($p=0.68$), and a decrease in rates of capacity assessment for admission which was not significant (0.94). However, there was a statistically significant increase in the proportion of patients who had a formal capacity assessment documented using Rio forms ($p<0.05$).
Conclusion: We did not find any statistically significant increase in the recording of capacity assessment on doctor's notes, either on initial clerkings or in ward-round documentation following our intervention. However, we did see a significant improvement in the