team. However, this alone was not sufficient to reduce the stress derived from trying to meet clinical demands with inadequate staffing levels.

Interventions improving job satisfaction, like this project, could play an important role in fighting workforce erosion if combined with long-term commitment to a sustainable workforce on an institutional level.

Assessing Confidence in Antidepressant Prescribing Amongst the Foundation Year Cohort

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Aims: The aim of this quality improvement project was to assess, and improve the confidence in antidepressant prescribing and management of common side effects amongst the Foundation Year (FY) trainees.

Methods: PDSA cycles involving a questionnaire sent out to 25 FY doctors in psychiatric jobs.

Results: A survey was sent out to the FY cohort currently doing a psychiatry job placement to assess their baseline confidence in antidepressant prescribing, which highlighted a lack of confidence. With regards to management of depression and anxiety, 25% felt unconfident, 50% felt neutral, and 25% felt somewhat confident. With regards to prescribing antidepressants, 75% felt neutral, and 25% felt somewhat confident. When it came to managing side effects of antidepressants, 25% felt very unconfident, 50% felt somewhat unconfident, and 25% felt somewhat confident.

A flowchart detailing indications for antidepressant prescribing and basic principles on swapping and titrating doses was distributed to help improve confidence. The group was reassessed with the same questionnaire to accurately identify any improvement.

When re-assessed, there was still a lack of confidence with regards to the management of side effects, with 63% feeling somewhat unconfident, 13% feeling neutral, and 25% feeling somewhat confident.

A presentation was prepared and delivered at the weekly teaching, which detailed the use of common antidepressants, their side effects, and the management of complications including serotonin syndrome.

The cohort was again re-assessed, showing an overall improvement in confidence in all aspects, with 80% feeling somewhat confident in management of depression and anxiety, and 100% feeling somewhat confident in prescribing antidepressants and management of side effects.

Conclusion: Positive outcomes included an overall improvement in confidence in prescribing antidepressants. Additionally, some participants found that the gaps in their knowledge were greatly reduced through these two cycles of information sharing.

Potential improvements to the study include using a larger cohort sampling outside of the FYs in psychiatry rotations to get a broader idea of the general FY cohort confidence. Furthermore, some participants still feel they have gaps in their knowledge, which could be addressed through more teaching sessions tackling individual cases in the future.

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.

Re-Audit of Preadmission Handover Meeting on a Medium Secure Rehabilitation Ward

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Aims: Patients are admitted to our medium secure rehabilitation ward from high secure hospitals or other medium secure wards from within and outside our trust. We have a waiting list. There is extensive documentation and updates shared prior to any transfer over months. For patients within our trust, we share the same electronic records system. The legal status of most patients requires mandatory information sharing prior to any transfer for example via Ministry of Justice applications.

We examined our process of preadmission handover meetings for all five admissions in 2023–2024. We identified a lack of structured approach to preparing for the preadmission meeting. We concluded that a structured checklist may help. At the time of the re-audit in January 2025, we had two vacant beds and therefore two planned admissions from our waiting list were imminent in the coming weeks.

Methods: We used the following broad national, forensic and trust standards. NICE NG53: "1.2.7 During admission planning, record a full history or update that covers the person's cognitive, physical and mental health needs, includes details of their current medication, identifies the services involved in their care." Trust Policy: "Lead professional should make contact with service that covers the area the service user is to move to/from and arrange a formal hand over." QNFMHS: "When patients are transferred between services there is a handover which ensures that the new team have an up to date care plan and risk assessment."

We re-audited our service using a preadmission checklist based on last year's audit to review what information has already been handed over and what needs to be specifically requested prior to admission. We then compared the preadmission meeting minutes of the last five admissions of 2023–2024 with the first two admissions of 2025 to reflect on our learning.

Results: There was no difference in terms of overall information sought by our team both pre- and post-audit. Updates were needed regarding physical and mental health and third party safeguarding information in the meeting.

Conclusion: Going through the preadmission list in preparation for the formal transfer meeting in a structured manner ensured any

information gaps were identified prior to the preadmission meeting and timely requests made. There were reflections on the relational aspect of the information sharing process.

Management of Clozapine Induced Hypersalivation on Slow Stream Rehabilitation Ward

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Aims: Sialorrhoea (hypersalivation), a common side effect of clozapine can impact the quality of life of patients. At present, no drugs are licensed to manage clozapine-induced hypersalivation, but there are various practical and pharmacological management options included in literature. These include chewing sugarless gums during the day. At night, covering the pillow with a towel, elevating the head and sleeping on the side may reduce aspiration risk. With regard to pharmacological treatment, the first step should be to review the clozapine dose and reduce it if possible. The second step is to consider adding anticholinergic, antihistaminergic and adrenergic drugs and substitute benzamides such as amisulpride. There is also consideration of injecting botulism toxin to salivary glands.

Methods: We retrospectively audited the case notes of all six patients on clozapine in our male inpatient slow-stream rehabilitation service to assess if we have actively attempted to manage clozapine-induced hypersalivation side effects. We searched keywords 'hypersalivation', 'drooling', 'pillow', 'saliva' to identify case note entries and collected data on strategies used to manage hypersalivation. We reviewed past and current prescriptions and doses.

Results: Age ranges of our patients varied from 26 to 65. All six patients reported hypersalivation as a side effect. All patients had clozapine within therapeutic range with no option to reduce further. One patient preferred not to be on any medication to manage this side effect. All other patients had tried hyoscine hydrobromide tablets first. The tablet has a half-life of 4 hours. One patient was due a dose review of hyoscine due to ongoing hypersalivation. Three patients had been asked to suck or chew the tablets. Prior to this they had been swallowing the tablets. Two patients had tried the hyoscine patch (which lasts approximately 72 hours) but had found it not helpful. One patient had tried trihexyphenidyl tablets but then requested to change back to hyoscine. One patient had tried atropine drops following a trial of hyoscine tablets and patch. He then tried amisulpride with no impact and subsequently found trihexyphenidyl beneficial. All patients were monitored for worsened constipation with addition of anticholinergics.

Conclusion: The audit identified the need to proactively and systematically manage hypersalivation. It was also noted that practical interventions like raising the pillow, chewing gum during day were not routinely tried. We plan to re-audit the service in a year's time to see if there is any improvement in use of management strategies and also measure hypersalivation using Nocturnal Hypersalivation Rating Scale and the Drooling Severity and Frequency Scale.

Effectiveness of Zonal Observation in Reducing Restrictive Practices on a Male Psychiatric Intensive Care Unit (PICU) Over a One-Year Period

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Aims: We aimed to reduce the use of seclusion, 1:1 and 2:1 observations in our PICU, without compromising safety, by introducing zonal observation levels which is considered less intrusive, allowing greater privacy for the patient and better engagement.

Hypothesis: We expect a reduction in number of enhanced observations with no change in levels of aggression with a further reduction in the second survey as staff become more confident in using zonal observations.

Background: PICUs often rely on enhanced observations, such as 1:1 or 2:1, to reduce violence and aggression. However, these practices have limited evidence of effectiveness and are frequently perceived negatively by staff and patients. At Willow Suite, a 12-bed male PICU, zonal observations were introduced in January 2024 as a less restrictive alternative. This approach involved designating staff to specific zones for proactive engagement with patients while maintaining safety and improving patient experience.

Methods: Data were collected from clinical records and incident reporting systems for three periods: pre-implementation (November–December 2023), immediate post-implementation (January–February 2024), and 10 months after implementation (November–December 2024). Key metrics included incidents of violence, seclusion episodes, and the duration of enhanced observations.

Results: The duration of enhanced observations reduced significantly, from a total of 51 days to 22 days in the first 2 months and maintained the same 10 months later. The average length of enhanced observations decreased by 58% immediately post-implementation, from 8.5 days per incident to 3.6, and further reduced to 3.1 days after 10 months. Seclusion episodes initially increased from 6 to 11 as staff were adapting to the new system, but the average length of seclusion dropped from 3.2 to 2.2 days with 55% of seclusions lasting a day or less. After 10 months, seclusion incidents had reduced further to 10 with average length of 2.5 days.

The length of all restrictions combined reduced from 70 days (average length 5.8 days) to 17 (average 2.7) in the first 2 months and to 11 (average 2.9) 10 months later.

There was no increase in incidents of violence and aggression in the initial 2 months and a reduction 10 months later.

Conclusion: The results suggest that zonal observations successfully maintained safety while reducing restrictive practices in our PICU