in reducing trans-generational trauma. This requires appropriate skills and training in staff.

**Methods.** Service users were identified retrospectively over a 24-month period and categorised into C-PTSD traits (trait) and non-C-PTSD traits (non-trait). Comparisons of routine outcome measures (ROMs) identified higher distress in the C-PTSD group and reduced satisfaction. Staff survey highlighted areas of anxiety and low confidence in working with service users with C-PTSD traits.

Actions were divided into three streams – Admission, Transitions and Communication. Staff training needs were identified and training given. Admission processes were reviewed with a focus group including past service users and changes based on DBT principles were implemented. A leaflet was developed to aid communication with service users considering MBU admission via Outreach and Community Perinatal teams.

**Results.** Surveys were the primary source of data before and after changes. As of September 2023 the majority of training had been rolled out but numbers completing the training survey were too small to draw conclusions. Anecdotal feedback was predominantly positive and the survey will be repeated at the same time as other data in March 2024.

Ward process changes started in late August 2023 and routine outcome measure data will be compared at 6 months (March 2024). Again anecdotal feedback is positive.

The leaflet was rolled out for use by community teams and service users in November 2023 and feedback via survey will be collected in March 2024.

**Conclusion.** Evaluation of routine outcome measures showed poorer outcomes and experiences for patients with traits of Complex-PTSD. Staff survey highlighted lack of confidence in managing the same. Consultation with a range of staff and past service users led to changes in admission practices, communication prior to admission via a leaflet, and staff training. Anecdotal feedback since implementation has been positive but we hope to see this confirmed in the Routine Outcome Measures and surveys 6 months after the changes were implemented.



## Promoting Post-Restraint Patient Debriefing in an Acute Psychiatric Inpatient setting

Dr Harry Jackson[1]*^, Dr Munzir Quraishy[2]^, Dr Maya Mendoza[1] and Dr Alex Berry[3,1]

[1]Camden and Islington NHS Foundation Trust, London, United Kingdom; [2]Barnet, Enfield and Haringey Mental Health NHS Trust, London, United Kingdom and [3]National Hospital for Neurology and Neurosurgery, London, United Kingdom

*Presenting author.

^Joint first authors.

doi: 10.1192/bjo.2024.385

**Aims.** Controlled physical restraint is a commonly used, but controversial practice in inpatient psychiatric settings, at times bringing psychiatric practice into potential conflict with accepted medical ethical standards for preserving autonomy and bodily-integrity. However, physical restraint can produce high levels of patient distress, re-traumatise those who have experienced physical or sexual abuse, and may lead to inadvertent bodily injury, and even death on rare occasions. There is an international consensus to attempt to reduce restrictive practices, including physical restraint, as demonstrated in the World Health Organization's Quality Rights Initiative. Post-restraint patient debriefing can promote recovery, prevent future restraint, and promote a more ethical and humanising care environment.

We aimed to audit the frequency of restraint events, and post-restraint debriefs offered to patients in a single, London-based, male acute psychiatric ward.

**Methods.** In the pre-intervention sample, data was extracted from the records of patients admitted over a six-month period (n = 75), to identify the number of patients who had undergone restraint and the number who had been debriefed. The search terms "restrain", "PMVA", "response team" and "debrief" were used. After each restraint event, the notes for the following two weeks were reviewed to see if a debrief was delivered.

The intervention consisted of a single description and dissemination of the results in a ward business meeting, with instruction that all staff members within the ward multidisciplinary team can help provide debrief if appropriate to do so. Where a patient was known to have been restrained, debriefs were offered during subsequent ward round reviews as appropriate.

In the post-intervention sample, we collected data from patients admitted over a 10-month period (n = 89).

We used Chi-Squared testing to compare categorical variables pre- and post-intervention.

**Results.** Pre-intervention, 15 patients underwent restraint and of these, 8 patients (53.33%) were debriefed. Post-intervention, 21 patients underwent restraint and of these, 10 patients (47.62%) were debriefed. There was no statistical difference in the proportion of patients offered a psychological debrief ($p = 0.735$).

**Conclusion.** Following a single intervention there was not a sustained difference in the proportion of post-restraint debriefs offered. It is likely more sustained interventions would bring about more substantive practice change. Incorporating the need for post-restraint debriefs in daily ward safety-huddles, or in structured "ward round proformas", may increase the proportion of patients offered post-restraint debriefing. It is possible that the note review strategy did not capture all debriefs delivered.

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.

## The Appropriateness and End Outcomes of Urgent Referrals to Outpatient General Adult Psychiatry

Dr Zoe Johnston*, Dr Douglas Murdie and Dr Kenneth Murphy

NHS Lothian, Edinburgh, United Kingdom

*Presenting author.

doi: 10.1192/bjo.2024.386

**Aims.** The urgent referral system to outpatient psychiatry in NHS Lothian is intended for patients who require to be seen within 5 days. However, many of the referrals are not deemed this urgent upon triage. This project aims to illustrate the extent of this issue and highlight potential reasons, in order to improve the pathway for patients referred on to secondary care services.

**Methods.** Over a 3 month period from August 2023 to November 2023, all urgent referrals received by an Edinburgh sector general adult psychiatry outpatient's department were reviewed. Data was collected on broad presenting complaint, whether or not the referral was deemed urgent upon triage, whether it contained a