

Conclusion. Results suggest that the aim is on the way to being met. Our next change idea is to obtain formal feedback from staff and patients on this process.

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Implementing a Digital Handover System to Improve Safety and Efficacy of Handover Across Acute Psychiatric Inpatient Sites

Dr Aaron Harris*

Oxleas NHS Foundation Trust, London, United Kingdom

*Presenting author.

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Aims. To implement a digital handover system within Oxleas inpatient sites to improve the visibility of tasks both completed and pending, to reduce the number of tasks missed and to provide a clear audit trail relating to tasks handed over.

Methods. Junior doctors providing on-call cover to acute sites across all 3 boroughs served by Oxleas were invited to complete a questionnaire relating to the efficacy of handover. With this data & information gathered through discussions with the trust's informatics team, a digital handover system, based in Microsoft Teams, was developed. This was piloted and refined through 6 PDSA cycles from September 2022 – August 2023 before being implemented across all Oxleas acute sites from August 2023. Further questionnaires were completed 1 month & 6 months after its roll out to assess the impact of the change.

Results. Doctors were asked to complete a questionnaire at 3 time points: pre-intervention (T0, 20 respondents), 1-month post-intervention (T1, 13 respondents), and 6-months post-intervention (T2, 12 respondents).

- At T0, 92.3% of respondents reported tasks created by the on-call team had been missed due to staff not being aware, this reduced to 11.1% at T1, and 28.6% at T2.
- At T0, 23.1% of respondents agree/strongly agree that it is easy to view tasks that have been done on their ward out-of-hours.
- By comparison, at T1 69.2% reported the digital handover system has made it easier to view what had been done on a ward out-of-hours, rising to 83.3% at T2.
- At T1, 76.9% reported the digital handover system has made it easier to view tasks when on-call, rising to 83.3% at T2.
- At T0, 30% agree/strongly agree that the outgoing on-call doctor leaves a written record of tasks completed and outstanding. This rose to 69.3% at T1, and 41.7% at T2.

Conclusion. There is strong evidence that effective handover is a key aspect of clinical care, and failure of this is a preventable cause of patient harm. The initial questionnaire highlighted issues with the efficacy and safety of the handover process within acute sites at Oxleas, which the digital system sought to address. After implementation of the digital system, the findings demonstrated improvements in the handover process, with visibility increasing for tasks both completed & in progress, and fewer reports of tasks being missed by the ward-based doctors, which was maintained over the 6-month follow up period.

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Improving Bone Health Care and Monitoring of Intellectual Disability Patients on a Low Secure Female Unit

Dr Serena Hinze^{1*}, Dr Rosie England², Dr Ambreen Rashid¹ and Ms Nicole Freeman¹

¹Coventry and Warwickshire Partnership NHS Trust, Coventry, United Kingdom and ²Black Country Healthcare NHS Foundation Trust, Walsall, United Kingdom

*Presenting author.

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Aims.

- To ensure all patients on a low secure female inpatient unit have bone health risk factors assessed, identified and interventions initiated within 3 months of admission.
- The above to be achieved through creation of a Bone Health proforma, integration of a Bone Health checklist into the Intellectual Disability (ID) Annual Health Check and delivery of bone health education for patients and staff.

Background

Intellectual Disability has been shown to be associated with poor bone health, osteoporosis and increased fracture risk. The current NICE guidelines and risk tools (QFRACTURE), do not adequately reflect the true risk within this patient group who present with additional risks of epilepsy, antiepileptic medication and greater likelihood of low vitamin D. Bone health has not routinely been monitored in this population hitherto. This quality improvement project sought to develop a process whereby potential risk factors for poor bone health were identified and managed effectively.

Methods. The project was undertaken between February 2022 – October 2023 on a female low secure unit. All 8 patients on the unit were included. A baseline screening of risk factors was conducted to assess current practice and explore the clinical need for the project. Most patients were found to have multiple risk factors which had not previously been highlighted, indicating the need for formalised monitoring. Based on questionnaire feedback, a Bone Health Care Plan, a risk factor checklist which was integrated with patients' ID Annual Health check and Educational workshops were developed. Primary and secondary drivers were identified at the outset and plan, do, study, act cycles were used to refine change ideas. The changes were evaluated using quantitative and qualitative measures.

Results. Every inpatient has a completed Bone Health Care Plan. Twenty-five percent of patients were identified as having a particularly high risk and have had referrals accepted for Dual-energy X-ray absorptiometry (DEXA) scans. All patients are using a new easy-read ID Annual Health Check form with Bone Health checklist incorporated. All staff and patients were given the opportunity to attend a series of four bone health workshops, 43% of patients attended at least one session. Positive written and verbal feedback was received from both patients and staff.

Conclusion. 100% of service users have had their risk factors for bone health assessed and any necessary interventions applied. There is now an embedded process for reviewing the bone health of these patients annually where previously there was no regular monitoring.

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