

help educate staff on the importance of VTE prophylaxis. The statistics were rechecked two months later for further improvement.

Results. At the start of the QI, it was found that the service was underperforming in reaching its target of 100% of the VTE prophylaxis data entry for all service users in older adult inpatient wards. After implementing the first PDSA cycle, the data increased to 84% compliance (October 2023 data). After implementing the second PDSA cycle, the data increased to 100% compliance (December 2023 data). The data showed both implementations had a significant impact on the data input and the target being reached. The new strategy has now been firmly placed into the team working pattern as a routine measurement and continues to be actively utilised.

Conclusion. In an older adult inpatient ward setting with service users who have co-morbidities, reduced mobility and risk of dehydration from self neglect, it is vital they are assessed appropriately for VTE risk factors and prescribed the appropriate prophylaxis. Once this was highlighted to the ward staff and an easy system of the PDSAs were implemented, the team are now able to actively input the data and provide optimal care for the service users.

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Improving Women's Sexual and Reproductive Health in Acute Inpatient Psychiatric Services – A Quality Improvement Project

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Aims. Women with severe mental illness are at higher risk of sexually transmitted infections (STIs), unplanned pregnancies and poor engagement with cervical and breast screening. Despite current national guidance, these issues are poorly addressed during psychiatric admissions.

We aimed to improve the provision of women's sexual and reproductive healthcare on psychiatric wards using a quality improvement framework.

Methods. Female psychiatric inpatients aged over 18 were included. A baseline audit was performed in October 2022 on a female psychiatric ward, followed by six PDSA cycles from August 2022–January 2024 (n = 108).

We introduced women's health assessments (WHAs), offering counselling on: (1) contraception, (2) cervical and breast screening, and (3) STI screening. We arranged treatment and follow-up.

Changes were made at each PDSA cycle: ensuring provision of emergency contraception and STI swabs; establishing a protocol for referring to the sexual health clinic; creating dedicated clinic time to offer counselling; developing a poster and educational leaflet; and creating a proforma to record outcomes. The interventions were then extended to a neighbouring ward.

We reviewed electronic notes and recorded the percentage of patients offered counselling at baseline and after each cycle, later also recording the percentage of patients accepting interventions.

Results. At baseline, 12.5% of inpatients had been offered at least one of: contraceptive counselling, cervical and breast screening or STI screening. This improved to 87.7% offered a leaflet and 63.1% offered counselling by the final cycle. Of these patients, 48.8% accepted at least one intervention. On the neighbouring ward, offers of counselling increased from 28.6% to 63.6%.

Introduction of dedicated clinic time increased offers of interventions the most, to 94.1% (cycle 3). Compliance was lowest in cycle 4 (54.2% offered any intervention) which coincided with junior doctor changeover. Provision of an educational leaflet did not increase acceptance of interventions (cycle 5).

Introduction of WHAs led to detection and treatment of STIs in seven patients. Absent contraception was identified and started for a patient taking sodium valproate. Five patients were administered emergency contraception and two commenced long-term contraceptives. A case of female genital mutilation was identified, and a case of cervical neoplasia (CIN 3) was detected.

Conclusion. Provision of WHAs improved women's healthcare in inpatient psychiatric settings, with clinician contact being the most valuable resource in achieving this. There were several barriers, importantly clinician availability and awareness during junior doctor changeover. We will establish our interventions trust-wide, protocolising WHAs in the junior doctors' handbook, and collect patient feedback.

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Developing and Delivering a Regional Teaching Programme in Liaison Psychiatry: A Quality Improvement Project

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Aims. Several sites across the North London Mental Health Partnership (NLMHP) do not have a liaison-specific rolling teaching programme. Best practice standards set by the RCPsych Psychiatric Liaison Accreditation Network (PLAN) are therefore not being met.

The aims of this quality improvement project (QIP) were to: (1) ascertain the perceived need for liaison-specific teaching across NLMHP sites; (2) develop and deliver a teaching programme; and (3) assess attendance, clinician satisfaction and confidence before and after teaching sessions.

Methods. A pre-programme questionnaire on Microsoft Forms was sent to team members across NLMHP sites to assess whether respondents were receiving liaison-specific teaching, the perceived utility of the programme, and suggestions for development.

A cross-site monthly teaching programme was developed. Sessions were presented by liaison clinicians from a list of liaison-specific topics via Microsoft Teams.

A post-session questionnaire was sent to establish session satisfaction, confidence pre- and post-session, and further comments. Mean satisfaction scores were calculated. Percentage change in confidence score was calculated for each session and overall.

Themes were identified from the qualitative data and suggestions implemented.

Results. Of the 11 professionals who responded to the pre-programme questionnaire, 50% were not receiving any liaison-specific teaching. Respondents agreed the programme would be helpful in improving their knowledge and clinical practice (mean score = 4.9/5).

Attendance for the sessions ranged from 15–27 professionals (mean = 22). A range of 2–10 professionals completed each post-programme questionnaire (mean = 6.3; total responses = 25). Mean satisfaction for each session ranged from 4.3–5/5 (overall mean = 4.7/5). Percentage increase in confidence scores ranged from 4.6–48% (mean = 24%).

Feedback-driven changes made to improve the programme included: making session recordings available; sending reminder emails; creating an online platform and making session feedback available to presenters.

Respondents considered the sessions interesting and informative, that topics provoked good discussion, and that the 'bite-sized' training allowed attendance without interfering with clinical work.

Conclusion. This QIP highlighted the need for a liaison-specific teaching programme across NLMHP. Participants agreed that this would improve their knowledge and practice. The programme was reasonably well-attended across sites. Respondents reported improved confidence and felt the sessions were relevant to their clinical practice.

Limitations included the low and variable questionnaire response rate and limited data on the new programme's utility.

The next stages of the project include wider delivery, involvement of patients and carers, and of specialists in related psychiatric and medical fields.

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A Quality Improvement Project to Investigate How Addenbrooke's Cognitive Examination-III (ACE-III) Training Improves the Accuracy of ACE-III Scoring in an Older Adult Community Mental Health Team

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Aims. Aims – An Audit in the Older Adult Community Mental Health Team identified that there were inaccuracies in the Addenbrooke's Cognitive Examination-III (ACE-III) scoring used to help diagnose dementia. The aim of this Quality Improvement Project was to determine if ACE-III training delivered by a neuropsychologist would improve the accuracy and reliability of ACE-III scores used by the team to help diagnose dementia.

Methods. ACE-III surveys completed over a 6 month period were analysed to determine if they followed the ACE-III scoring guidelines provided by the ACE-III Administration and Scoring Guide (2012). ACE-III surveys were completed by different members of the multidisciplinary team. Following identification of inaccuracies and inconsistencies in scoring we delivered ACE-III training via a neuropsychologist to determine if this would improve ACE-III scoring (as per the ACE-III Administration and Scoring Guide) in the following 6 month period after the training was received.

Results. Following ACE-III training delivered by a neuropsychologist in how to complete the ACE-III survey, surveys were analysed using the Administration and Scoring Guide (2012). ACE-III scores were more accurate in the 6 months following the ACE-III training delivered by a neuropsychologist to the team.

Conclusion. ACE-III training improved the accuracy of ACE-III scores in the multidisciplinary CMHT. This finding would advocate for ACE-III training to become part of our roles within Older Adult Psychiatry in order to improve service delivery to the patient.

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Improving Clinical Communication With the Doctor On-Call: A QI Project

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Aims. Clear, accurate and efficient clinical communication between wards and on-call doctors is vital for good patient care. Issues were raised locally regarding the quality and content of these calls, and a QI project devised to assess the issue and implement meaningful change.

Methods. An initial QI Audit was undertaken, using Likert scale questionnaires to rank areas of concern. These were sent to all the doctors currently manning the on-call rota, and doctors who had previously covered these on-calls. Responses were used to gauge the key concerns, and a blank space and multiple choice question on possible contributors to the issues were included.

A communication prompt was designed that tackled the key issues highlighted by the audit. A clear flow-chart ensured that safe and sensible steps were taken to maximise the efficiency of a necessary call. A summary of the SBAR communication tool was also included to encourage structured handover. These prompts were cheap and easily affixed to ward telephones and were laminated and wipe-clean. Implementation was agreed with and supported by the senior nursing team.

A post-QI questionnaire was then sent out one month after the intervention, getting feedback from the junior doctors covering on-call shifts in that time.

Results. Questionnaire Likert scales measured either Frequency (1-Very Rarely – 5-Very Frequently) or Quality (1-Poor – 5-Excellent), and a mean of the scores was taken for each question.

The initial audit (n = 14) included all the doctors currently on the on-call rota (n = 7). Key issues raised were Average Call Quality (2.2/5), how frequently recent NEWS scores were available (2.3/5), and how frequently key clinical information was on hand during the call (1.9/5). Many trainees were made to feel uncomfortable or like they were being difficult for requesting more information (3.2/5). And calls were often noted to not be relevant (3.9/5) or were confusing/unclear (3.9/5).

A second questionnaire was completed 1 month post-intervention by the doctors working the on-call rota in that time (n = 6). 100% reported some improvement, 33.3% reported significant improvement. Improvements included average call quality (4/5), frequency of recent NEWS (3.7/5), and availability of Key clinical information (3.5/5).