

months) undergone an ACE-III examination, split equally between the geographic East and West of the region (as covered by different consultant psychiatrists).

Independent reviewers reviewed each ACE-III against the 2017 scoring guide. Any ambiguous cases were decided by consensus. Certain aspects of the ACE-III cannot be objectively verified retrospectively and require contemporaneous observation, therefore these questions were excluded from the analysis.

Results: 45 of the 50 patients had a valid ACE-III available for review. Only 44% (20/45) assessments had no identifiable marking errors.

As hypothesised, the highest failure rates occurred in the visuospatial domains, with incorrect marking in the “copying a cube” in 20% (9/45) and “clock drawing” in 18% (8/45).

Moderate failure rates were observed within the language section with “sentence writing”, being inaccurately marked in 9% (4/45) and the visuospatial task of the “infinity diagram”, with issues in 7% (3/45).

Several of the attention, memory and fluency-specific tasks saw a mistake in at least one patient.

The mistakes were generally evenly spread across patients with no single ACE-III examination accounting for a disproportionate number of errors.

Conclusion: Uniformity in application and marking of the ACE-III requires revision with the team in order to achieve consistency. Even marginal inaccuracies in scoring could result in an under- or over-estimation of cognitive ability and influence clinicians’ interpretation and subsequent diagnosis.

In the teaching session, the team reflected on the results and their experiences, and collectively decided on further improvement measures:

- 1) in-house simulation ACE-III completion with a volunteer administrator, the team lead as patient, and remaining team observing,
- 2) to include a bi-annual team re-training with the ACE-III training video as a refresher, and
- 3) for re-evaluation in approximately six months’ time to monitor improvement.

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Improving Physical Health Monitoring on a Working-Age General Adult Inpatient Ward: A Quality Improvement Project

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Aims: Individuals with severe mental illness (SMI) face a significantly reduced life expectancy, primarily due to preventable physical health conditions. This project aimed to enhance the timeliness and comprehensiveness of physical health checks for inpatients in an acute psychiatric ward. An initial audit cycle identified gaps, prompting targeted interventions, with subsequent re-audit assessing their impact.

Methods: The first audit cycle (March 2023) reviewed adherence to physical health assessments, including physical examinations,

observations, height and weight measurements, ECGs, blood tests, and cardiometabolic checklist completion. Interventions implemented included daily reviews in the Multi-Disciplinary Team (MDT), integration into daily job lists, and master list documentation. These measures reduced delays in completing assessments.

The second cycle (November 2023) involved 35 inpatients over four months. Interventions included the introduction of a whiteboard for task tracking, post-MDT reviews, staff reminders, and induction sessions emphasising physical health monitoring. Colour coding was introduced to enhance task visibility and efficiency. Specific patient needs, such as those with heart failure and left bundle branch block (LBBB) or end-stage renal disease (ESRD) requiring dialysis, were incorporated into tailored care plans.

Results: The second cycle demonstrated that, overall, there were visible improvements in clinical practice. The whiteboard intervention significantly improved the timeliness and completion rates of physical health checks. Key findings included:

Physical examinations: Success rates increased from 93% to 100%.

BMI measurements: Reduced delays and increased completions.

Physical observations: Maintained at 100% completion.

Challenges included gender-based refusals for ECGs and reluctance from patients with eating disorders to undergo BMI measurements. These findings highlight the importance of personalised approaches to monitoring and addressing barriers to compliance.

Conclusion: Implementing a whiteboard for tracking physical health checks demonstrated substantial improvements in timeliness and completion rates through simple, cost-effective interventions. Despite challenges, this project underscores the potential of structured systems to enhance physical healthcare for patients with SMI. Scaling and expanding these strategies hospital-wide may contribute to addressing health disparities and improving outcomes for this vulnerable population.

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Impact of Dose Titration Using the Seizure Quality Rating (SQR) Scale on Electroconvulsive Therapy (ECT) Outcomes: A Quality Improvement Project

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Aims: This Quality Improvement Project (QIP) aimed to assess the impact of incorporating the Seizure Quality Rating (SQR) scale into ECT dose titration practices. The objective was to optimize treatment by improving seizure quality assessment and reducing cognitive side effects associated with higher electric doses, ultimately enhancing patient outcomes.

Methods: The QIP was conducted at the ECT clinic of Surrey & Borders Partnership NHS Foundation Trust. The SQR scale evaluated seizure quality using parameters such as EEG and visual seizure duration, mid-ictal amplitude, interhemispheric coherence, postictal suppression, and peak heart rate. Patients were categorized into two groups:

Pre-SQR (Standard Group): Treated between May 1, 2023, and October 30, 2023, with dose titration based on seizure duration.

SQR (Post-Intervention Group): Treated between December 1, 2023, and May 31, 2024, with dose titration guided by the SQR scale.

Inclusion criteria were depressive disorders (e.g. recurrent depression, bipolar depression), excluding primary psychotic disorders. Outcomes measured included the number and dose of treatments, Clinician's Global Improvement (CGI) scores, and subjective memory reports (patient-rated).

Results: The SQR group ($n=7$) received lower mean electric doses (622 mC) compared with the pre-SQR group ($n=11$; 705 mC) while maintaining comparable therapeutic outcomes. Both groups required a similar number of treatments (mean: 12 sessions). CGI improvement scores (CGI-I) and subjective memory ratings post-ECT showed no significant difference between the groups. These results suggest that the SQR scale may support safer dosing without compromising clinical efficacy.

Conclusion: The integration of the SQR scale into ECT practice demonstrated a promising trend toward optimizing treatment by reducing electric doses while maintaining clinical effectiveness. This structured approach offers the potential to minimize cognitive side effects, particularly in vulnerable populations such as the elderly. These findings underline the broader implications of incorporating data-driven tools like the SQR scale into routine ECT protocols across various trusts to enhance precision, safety, and patient outcomes on a wider scale. Future recommendations include gathering patient feedback to assess the cognitive and mood benefits of lower doses, conducting further research with larger cohorts to validate the findings, and embedding the SQR scale into standard ECT guidelines to promote consistency and improve treatment outcomes.

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From 'Memory Assessment Please' to Masterpieces: Refining the Referral Process

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Aims: Inappropriate or incomplete referrals for memory assessment were a recurrent issue within our Old Age Psychiatry community multidisciplinary team (MDT) triage meetings. These referrals often lacked essential information, such as duration of cognitive concerns, patient consent, results of confusion screen blood tests, clarity on the presence of delirium versus long-standing cognitive concerns, ECG and imaging findings, or results of a cognitive screen. Some referrals were minimal, providing only the phrase "memory assessment please", leading to inefficient use of resources, delays in assessment, and unnecessary correspondence with referring teams. Since memory assessments involve detailed 60-minute home visits by experienced nurses, followed by consultant evaluation, optimizing referral quality was imperative to reduce inappropriate referrals and improve service efficiency.

Methods: A retrospective analysis of referrals from wards and clinics to our weekly MDT triage meeting was conducted over a two-month period (July 1–August 31, 2024). Referrals were assessed for the presence of key information required for triage, including patient consent, confusion screen blood results, cognitive screen findings, imaging results, and clarity on the nature of the cognitive concern.

Following this analysis, we collaborated with clinicians from Old Age Psychiatry, Liaison Psychiatry, Geriatrics, and administrative staff to design a standardized one-page referral form. The form, adapted from an existing referral template in use elsewhere in Scotland, was tailored to include all critical elements necessary for triage decisions.

Results: Implementing the new referral form led to a marked improvement in the completeness and quality of referral information. Key details, such as cognitive screen results and delirium assessments, were routinely included. This reduced the need to search clinical notes during MDT meetings, saving significant time for the 30–40 mental health professionals present. Additionally, there was a substantial reduction in follow-up emails and phone calls to clarify referrals. The streamlined process improved triage efficiency, decreased inappropriate referrals, and shortened waiting times for patients requiring assessment.

Conclusion: Introducing a standardized referral form significantly improved the quality and efficiency of referrals for memory assessments. By ensuring all essential information was provided upfront, we optimized resource use, minimized delays, and enhanced communication between teams. The referral form remains a living document, with ongoing review to ensure its continued relevance and effectiveness.

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Trust-Wide Quality Improvement Project on Improving the Competence and Confidence of First On-call Doctors in Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)

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Aims: This project emerged in response to surveys conducted in 2022–23, which revealed first on-call doctors at NHCFT, perceived they were required to operate beyond their competency levels. Recognising this could negatively affect both patient safety, and training experience of resident doctors, we sought to improve their confidence and competence through structured support, education, and resource development.

The project's aim was to ensure that no first on-call doctor would feel that they were working beyond their competency.

Methods: Cycle-1: The project began with anonymous baseline surveys using Hewson Confidence Tool, grade-specific focus groups which revealed a lack of knowledge in both clinical and practical aspects, increased stress due to untriaged workloads, and feelings of insufficient support from senior staff which contributed to widespread sense of being overwhelmed and impacted confidence and competence. Primary intervention included targeted on-call teaching sessions focussing on areas such as the role of on-call resident doctors, management of common tasks, seclusion reviews, legal frameworks, and escalation pathways.

Cycle-2: Observing the positive impact on doctors' self-reported competency and confidence levels in the first PDSA cycle, Cycle 2 began with stakeholder engagement through listening events with first on-call doctors. We held discussions with key leaders, Director of Medical Education, Associate Director of Nursing, Deputy