investigation, and treatment more systematic and structured, which will in turn reduce the risk of errors associated with it. The checklist is separated into the subtype of Initial Assessment and Follow Up. This article is aimed to share the outcome of the QIP.

Methods. The QIP was carried using the Plan-Do-Study-Act (PDSA) model. Version 1 of the checklist was made based on the guidance from the National Institute of Clinical Excellence (NICE) guideline NG97, which was tried in the Memory Clinic MDT discussion of Older Person Mental Health Community Team of Wrexham Maelor Hospital (OPCMHT WMH), Betsi Cadwaladr University Health Board (BCUHB). Microsoft Forms survey was performed to capture the feedback from the junior doctors using the checklist. The following five properties were ranked using a five-point Likert scale (with one as the lowest and five as the highest): ease of use, time efficiency, environmentally friendly, capturing important information and space availability. The checklist was then updated based on the qualitative feedback and PDSA cycle was repeated until the feedback was rated more than 4/5 on average for all domains.

Results. Two PDSA cycles were needed to reach the version that was rated as more than 4/5 on average for all domains and the final version of the checklist was accepted as the completed version, i.e. the Version 3. There was a significant improvement in the ease of use, time efficiency, environmentally friendly and space availability. All versions of the Memory Clinic MDT checklists were good for capturing important information but not performing well for the other domains.

Conclusion. The Memory Clinic MDT Checklist are now fully in use in OPCMHT WMH BCUHB. Long term evaluation is still required to maximise the efficiency of the checklist. There is further plan of expanding the use of checklist in different memory clinic of BCUHB.

Audit and Quality Improvement of Physical Health of New Admissions to an Acute Inpatient Facility

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Aims. The poorer physical health of psychiatric versus non-psychiatric patients has been well-documented. Lifestyle and antipsychotic medications have an adverse effect on the cardiovascular system and are more likely to cause metabolic syndrome, obesity and diabetes. The purpose of this audit was to determine if Samphire ward is in 100% compliance with the Norfolk and Suffolk NHS Foundation Trust (NSFT) Physical Healthcare Policy (C84). The aim is to ensure minimum physical health investigations are requested within 24 hours of admission, including: 1) baseline blood tests, 2) physical examination, and 3) electrocardiogram (ECG). A re-audit was also completed, which aimed to determine if compliance improved following a quality improvement (QI) intervention.

Methods. A retrospective data collection (Lorenzo and WebICE) was compiled of all new patients admitted and transferred to Samphire ward from 01/06/21 to 03/10/21 (n=66). Data included baseline bloods, physical exam, and ECG documentation within 24 hours of admission. A QI intervention (A3 visual aid) was then placed on the ward. The policy was re-audited from 04/10/21 to 30/11/21, including all new patients admitted and transferred to Samphire ward (n=24).

Results. Initially, 34.5% of new admissions had a physical examination or a patient refusal to consent that was documented on the physical exam form (NSFT Physical Exam Form v2.0) on Lorenzo completed within 24 hours of admission; post-intervention, this increased to 47%. 53% of new admissions had an ECG or a documented refusal in the initial audit; this increased to 61%. 68% of patients had baseline blood tests taken or a documented refusal within 24 hours of admission but only 4.5% had the correct blood tests taken; this increased to 71% and 33%, respectively, following the QI intervention. All 3 components within the 24-hour time period were met 0% of the time during the baseline audit; this increased to 33% post-QI intervention.

Conclusion. Overall, there was still poor compliance noted for all 3 physical health components required upon admission and fell far below the minimum standard as set out in the NSFT Trust Physical Healthcare policy. Further analysis showed ward doctors adhered to the standard significantly more than duty doctors. Recommendations include teaching regarding the physical health standard at junior doctor induction training and encouraging accountability among junior medical staff. A re-audit is recommended that includes further elements of physical health, including venous thromboembolism (VTE), height/weight, and nursing elements.

Getting Better: How Well Are We Assessing and Managing Anxiety Disorders in Community Camhs?

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Aims. Anxiety disorders are a common presenting problem for young people under the care of Melksham Community CAMHS. Guidelines from NICE outline recommendations for best practice in assessment and treatment of these disorders. A local gap analysis in 2017 identified areas for improvement in assessment of anxiety disorders. Measures were implemented following this, including training for staff. A repeat audit was conducted in 2021 and results compared.

Methods. NICE guidelines were used to set audit standards, which were used for data collection in both 2017 and 2021. A proforma was developed. A pilot sample of five patients was used to test the proforma. A cut off of 80% compliance was used. Caseload screening by clinicians was used to identify all eligible patients, then a random sample of these was selected by the project leads. Case note review was then conducted. Patients with a diagnosis of autism were excluded from the sample. ROMS, SDQ, GAD-7 or general clinical observation was used as a measure of treatment response. In total in the 2021 sample, 22 patient records were audited.

Results. Treatment and follow up for anxiety disorders was good or excellent in 2017 and remained so in 2021. Areas for improvement lay in the assessment of anxiety disorder. In the 2017 audit, there was poor documentation of: mental health history (this had improved from unacceptable to good by 2021), past treatments (improved from unacceptable to requires improvement by 2021), family history (improved from unacceptable to good by 2021), domestic violence/CSA (improved from unacceptable to requires

improvement by 2021). Response to treatment was inconsistently documented in the 2017 audit. In 2021 there remained some inconsistencies in documentation. Improvements in recording response to treatment would assist with clearly evidencing compliance with the NICE standards.
Conclusion. Overall, treatment and follow up for anxiety disorders was good or excellent (and remained so in 2021). Areas for improvement lay in the assessment of anxiety disorder. Recommendations to promote ongoing improvement include: 1) Circulation of re-audit results to the team 2) Brief recap of guidelines on assessment of social anxiety disorder to the team 3) Written/ email reminder to consider and document the other areas that received less than 80% compliance 4) Continue use of ROMS. Effective assessment and management of anxiety disorder is an important area of clinical practice for all clinicians in the team; we would recommend this is re assessed in 2023 to ensure standards continue to improve.

A Quality Improvement Project to Increase Junior Doctors' Satisfaction With Handover Process Using Microsoft Teams (MS Teams) as a Platform

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Aims. To improve junior doctors' satisfaction with handover process to >70% over a period of 10 weeks.
Methods. Baseline level of overall satisfaction with current handover practice was measured through a survey using Likert scale. Using the same scale, the team also looked at:

1. Degree of confidence in tasks being completed
2. Degree of confidence in handover being confidential
3. Degree of confidence in handover being sufficient for medico-legal purposes

Part of the survey also asked junior doctors using free text comments on how handover is currently carried out between shifts. The results from the survey were analysed and suggestions were considered for improvement.

A new method of handover using MS Teams was trialled. During subsequent PDSA cycles change ideas were adopted to improve engagement with the new process and allow for safe handovers.

On a weekly basis, post-intervention level of overall satisfaction with the new handover process was measured using the same Likert scale. Other measurements measured weekly included:

1. Percentage of handovers completed using the agreed template
2. Percentage of handed over jobs being acknowledged to signify receipt of handover

Results. Pre-intervention, verbal handover was the most frequent way of handing over (85.7%) followed by Whatsapp/text messaging (64.3%) and paper (42.9%).

Baseline level of overall satisfaction of handover process is 21.4%. At the end of PDSA Cycle 1, this increased significantly to 78% and by week 10 (end of PDSA Cycle 2) it rose to 92%.

Pre-intervention, 35.7% of junior doctors reported feeling confident in the handed over tasks being completed. 28.5% were confident that the handover process is confidential and 14.3% that it is sufficient for medico-legal purposes.

Post-intervention, 100% of the handovers are completed using a standardised template and 100% of the tasks were being acknowledged by the appropriate team members.
Conclusion. Prior to this intervention the process of junior doctor handover was not uniform and led to near-misses. This created confusion hence opportunities for errors to occur which can compromise patients' care. Following the introduction of MS Teams as the handover platform, overall satisfaction from junior doctors on the handover process has increased significantly. Moreover, it provides a clear record of handovers taking place which ensures accountability, safety and continuity of patients' care.

Improving Cardiac Monitoring for Patients on Depot Antipsychotic Medication in a Mental Health Service for Homeless People

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Aims. Patients under the Joint Homelessness Team (JHT) in Westminster have poor health outcomes as they face the double-hit of serious mental health illness (SMI) and homelessness. Many patients are on depot antipsychotic medication to manage their SMI. Depot antipsychotics are associated with increased risk of arrythmias and guidance advises annual electrocardiogram (ECG) monitoring for all (Maudsley: Prescribing Guidelines in Psychiatry, Taylor). However, a proportion of JHT patients are not well engaged with services and do not have an annual ECG recorded on SystmOne. In this QI study, we aimed to improve the percentage of JHT patients on depot antipsychotic medication who have a recorded ECG within the year on SystmOne, from current level to 80% over a 4-month period.
Methods. 44 patients at JHT were identified as being on depot antipsychotic medication (1 patient was later excluded due to ongoing inpatient admission). PDSA cycles were used over a 4-month period from October 2022 to January 2023.

Intervention 1: Using available ECGs from GP or secondary care records to update SystmOne records.

Intervention 2: Email to GP requesting they invite patients for annual ECG.

Intervention 3: JHT inviting patients for targeted ECGs.
Results. At baseline only 48.8% of patients had an ECG recorded on SystmOne within the last year. Intervention 1 increased our recorded ECGs to 72.1%. Intervention 2 increased completed ECGs to 74%. Finally, intervention 3 increased completed ECGs to 83.7% by Mid-January 2023. Overall, results show an improvement of 34.9% or relative increase of 1.71 times the amount of recorded ECG over 4 months.
Conclusion. As a result of incorporating dedicated liaison and clinical time, we have improved uptake of annual ECG monitoring of patients on depot antipsychotic medication. We found there was a lot of existing physical health data in the GP and secondary care records that was not readily accessible to JHT. In the future, with the development of shared clinical data systems, both