Aims. To achieve 100% of digital handover records being completed by doctors at end of shifts in Holywell Hospital, Northern Ireland.
Methods. Transition to completion of digital handover record began in 2019. This was initially audited during 2020-2021 with slowly worsening results. After this, audit data were no longer recorded.

Since becoming trainee representative in February 2022, I investigated, along with my colleagues, reasons as to why this was not being completed nor being achieved. Reasons established included unaware of necessity, chronic culture of not being completed, a lack of access to shared drive and outside locums covering shifts as well as a higher percentage of doctors who were on shorter 4 month rotations. Literature review around junior doctor handovers in other sites was also completed and analysed.

A Plan Do Study Act (PDSA) cycle was subsequently established taking these factors into account from August 2022 to January 2023 with a focus on information sharing, training at specific junior doctor changeover points, liaising with administration to ensure adequate access to handover and regular audit and feedback amongst junior doctors.
Results. From a new baseline of 5.36% of digital handovers being completed in February 2022 there has initially been a gradual increase noted at April 2022 to (35.00%) remaining relatively static into August 2022 (25.81%). Some of this related to doctors not having requisite access to shared folder.

However, percentage completed increased substantially after August 2022 with better administrative support and from September 2022 (70.00%) to December 2022 (88.71%) and into January 2023 (91.94%) handovers were completed.
Conclusion. Through a combination of better information sharing amongst junior doctors, signposting to digital handover, improvement of early access to requisite folder and specific teaching regarding handover at induction at all changeovers, stressing importance of completion from clinical governance perspective, there has been a genuine sea-change amongst junior medical staff that has included taking better ownership of the process and shared responsibility for it being completed.

This record-keeping improvement has been stark and maintained for a prolonged period, particularly from September 2022 and is now averaging over 90% being completed. There remains some issues regarding access if shift being covered by an outside locum doctor and this would be next targeted area with the goal of achieving 100% record of digital handover occurring.

NHS Ayrshire and Arran Sustainability and Well-being Committee - Assessing and Improving Trainee Well-being

Dr Sam Fraser*, Dr Megan Barrett, Dr Sophie Clark and Dr Racheal Pulley

NHS Ayrshire and Arran, Irvine, United Kingdom
*Corresponding author.

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Aims. To promote the Royal College's core principles of sustainable psychiatry, Junior Doctors at Ayrshire Central Hospital formed the Sustainability and Well-being Committee. The principle aim through 2022, following the COVID-19 pandemic, was to maximise junior well-being - knowing a sustainable workforce is one that feels supported and fulfilled by work and working conditions.

Methods. Through meetings with junior doctors, qualitative information on factors impacting well-being in the work place was gathered, and three targets for improvement were identified.

The following domains and interventions were implemented:

1. Improve working environment: The doctor's office was sized for 2 staff maximum - despite staffing levels consistently in excess of 20 junior doctors. Additionally, there was no natural light. We obtained a new significantly larger office space, with natural light.
2. Comfort break area – Doctors identified that having an area with comfort seating to take breaks and socialise away from patients and visitors would be beneficial. We obtained a seating area and a coffee machine, maintained by the junior doctors.
3. Access technology – Absence of desktops and IT issues with older laptops was impairing productivity and morale. We obtained 4 new desktop computers, and personal laptops for core trainees.

A digital questionnaire was used to collect quantitative data retrospectively, from doctors currently working in the department, or who had done so in the last 6 months.

Likert scales were used to assess pre and post-intervention levels of well-being, and ranking intervention impact on this. Doctors also identified future areas of intervention going forward into 2023.
Results. A total of 16 responses were obtained, and 100% of these agreed that feeling supported and good working conditions was important to maintaining wellness and productivity. Pre-intervention average wellness was rated 5.2 (with 1 being extremely poor, and 10 being extremely good), this increased to 8.1 post-intervention. Improved working environment had the most significant impact on well-being.

Respondents identified environmental sustainability as target for improvement in 2023, potentially through improved recycling, reducing meat consumption and car sharing. Further well-being interventions e.g., walks, promotion of Balint group and social events were also suggested.
Conclusion. Interventions from the trainee-led Sustainability and Well-being Committee through 2022 improved working environment and subjective well-being. This demonstrates that junior staff can successfully initiate and lead projects to promote and improve sustainability in psychiatry. Results indicate that junior staff are willing to actively participate in interventions to improve well-being, and environmental sustainability in 2023.

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.

Development of a Multi-Disciplinary Team Memory Clinic Checklist: A Quality Improvement Project

Dr Shona Ginty*, Dr Jiann Lin Loo, Dr Salvador Olivio Tereza and Professor/Dr Sarmishtha Bhattacharyya

Betsi Cadwaladr University Health Board (BCUHB), Wrexham, United Kingdom
*Corresponding author.

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Aims. Although "to err is human", human error in medical practice can be costly for both patients and the healthcare organisation. Different preventive methods have been developed and one of the approaches is the use of checklist. The conceptualisation of this quality improvement project (QIP) came about after a near-miss prescribing error occurred in the memory clinic. Therefore, the Memory Clinic Multi-disciplinary Team (MDT) Checklist has been created to make the documentation process of diagnosis,

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

Dr Heidi Grant*

Queen Elizabeth Hospital Kings Lynn, Kings Lynn, United Kingdom
*Corresponding author.

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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?

Dr Harriet Greenstone*, Dr Juliet Prentice and Dr Luciana Matone

Oxford Health NHS Foundation Trust, Melksham, United Kingdom
*Corresponding author.

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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