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).