clinically informative, ensuring staff have clearer guidance when managing both witnessed and unwitnessed falls.

Next steps include staff engagement, implementation of the revised tools, and a re-audit after three months to measure improvement in timeliness, consistency, and quality of post-fall medical care.

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.

Optimising Referrals: A Closed Loop Quality Improvement on Blood Test Compliance in Memory Clinic Referrals

Dr Naduni Jayasinghe, Dr Thomas Rose, Dr Claire Weaver and Dr Malarvizhi Sandilyan

Prospect Park Hospital, Reading, United Kingdom

doi: 10.1192/bjo.2026.11401

Aims: Dementia commonly affects older adults, with over 944,000 affected and one in eleven adults aged over 65 in the UK diagnosed. Due to the increasing number of referrals to memory clinics (MC), the recognition and management of reversible causes of cognitive impairment in primary care is essential. During the first cycle, missing information and blood tests were found to delay patient care and reduce efficiency. The National Institute for Health and Care Excellence (NICE) recommends the following: full blood count (FBC), urea and electrolytes (U&Es), liver function tests (LFTs), thyroid function tests (TFTs), glycated haemoglobin (Hbs-352c), serum calcium (Ca), erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), and serum vitamin B12 and folate (B12/folate). The second cycle assessed whether a specialised proforma and education leaflets for primary care clinicians increased the availability of blood tests within two months of referral.

Methods: Patient information was extracted from referrals received over two twelve-week time periods, one and a half years apart. Cycle one was conducted between 10/10/2023 and 20/11/2023, and cycle two between 07/08/2025 and 28/10/2025. Data on referrals and blood tests, completed within two months of referral, were obtained from RiO and ICE West and analysed in Excel, with data anonymised. Patients with an existing dementia diagnosis or those referred directly by secondary care were excluded. After the first cycle, focus groups were held with the multi-disciplinary MC team, followed by the distribution of an information update letter and updated proforma to all primary care clinicians.

Results: A total of 101 referrals were included. In Cycle one, only 11.9% of patient referrals had all recommended blood tests completed within two months prior to referral. 27.1% hadnone of the recommended tests. In Cycle two, 85.7% of referrals used the distributed proforma. The proportion of patients with all recommended blood tests completed increased to 23.8%. Of the referrals utilising the proforma, 80% included all relevant blood tests two months prior to the referral receival.

Conclusion: Overall, 85.7% of referrals used the MC proforma. Using the proforma improved referral quality by prompting inclusion of relevant information and blood tests, enhancing service efficiency. Notably, around 75% of referrals lacked vital blood tests, affecting the efficiency of MC services. Focus group discussions highlighted that MC staff should now refer referrals lacking up-to-date bloods back to primary care and that wider distribution of the proforma with clear blood test requirements may further increase compliance, suggesting a further audit cycle could be beneficial in future.

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.

Improving QRISK Assessment in Patients Admitted with Severe Mental Illness

Dr Upeshala Jayawardena[1] and Dr Vasudevan Krishnan[2]

[1]University Hospitals of North Midlands NHS Trust, Stoke-on-Trent, United Kingdom and [2]St Georges Hospital, Stafford, United Kingdom

doi: 10.1192/bjo.2026.11402

Aims: Severe mental illness (SMI) is associated with significant cardiovascular disease due to a combination of lifestyle factors, metabolic effects of antipsychotic medications and reduced access to preventive healthcare. This quality improvement project (QIP) wasconducted to enhance cardiovascular risk assessment in patients with SMI by improving the efficiency and consistency of QRISK score documentation.

Methods: This study was conducted over two cycles involving patients admitted with SMI to a general psychiatric unit. Cycle 1 covered a five-month period (December 2024–May 2025), and Cycle 2 a four-month period (July 2025–October 2025). Cardiovascular risk was assessed using QRISK®3 (2018) tool, with eligible patients aged 25–84 years included. Thirty patients were analysed in Cycle 1 and 27 in Cycle 2. Data were retrospectively collected from patient's electronic records and physical health parameters. Following baseline assessment, a standardised algorithm was implemented to improve consistency of QRISK calculation. Cycle 2 reassessed outcomes to evaluate the impact of this intervention.

Results: In Cycle 1, 30 patients with severe mental illness (SMI) were included, of whom 70% were male. In contrast, Cycle 2 comprised 27 patients, with females accounting for 59% of admissions. The age range was 26–75 years in Cycle 1 and 32–63 years in Cycle 2. Schizophrenia was the most common diagnosis in both cycles (36% in Cycle 1 and 33% in Cycle 2), followed by bipolar affective disorder (20% and 18%, respectively). Aripiprazole was the most frequently prescribed antipsychotic in both cycles (37% in Cycle 1 and 25% in Cycle 2).

During Cycle 1, QRISK scores were not documented for 15 patients (50%). Following implementation of the clinical algorithm, this improved in Cycle 2, with only 5 patients (18.5%) lacking a recorded QRISK score. In Cycle 1, a total of 8 patients were identified as having QRISK scores >10%, of whom 2 had not been documented. In Cycle 2, 6 patients had QRISK scores >10%, with no patients missed, following intervention.

Conclusion: This QIP highlighted the importance of routine QRISK assessment in patients admitted with SMI, who are at increased risk of cardiovascular disease. Implementation of a structured clinical algorithm significantly reduced missed QRISK calculations, improving identification of high-risk individuals. Continued staff education and strengthened collaboration between mental health and primary care services may further enhance follow-up and long-term cardiovascular risk management in this population.

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.

https://doi.org/10.1192/bjo.2026.11402 Published online by Cambridge University Press