attainment that hinders international medical graduates' (IMGs) outcomes.

Methods. The pilot phase started on August 2020. During this phase 3 trusts in the West Midlands were approached to share in the scheme. A fourth trust already had their own local buddy scheme. Only 1 trust shared in the process at the beginning and a second one joined later. The scheme was coordinated by the local Post Graduate Medical Education Departments in the respective trusts. All CT1s newly joining the training program were paired with a more experienced core trainee (CT2) who had their respective job the previous year. Next phase started in August 2021. During this phase all 3 trusts shared in the scheme from the beginning. A training session on the expectation from CT2s was conducted for them. A higher trainee was allocated to coordinate the process for each trust. CT2s were advised to meet their buddies at least once a month in the first 3 months.

Results. A total of 24 CT1s shared in the pilot phase. All of them found the training either good or very good. 57% of CT1s found the scheme helpful in easing the transition into training and made them more confident in fulfilling their role. Most of them communicated with their buddies 1–2 times in the pilot phase. In the second phase around 40 CT1s shared in the scheme. Around 80% of CT1s found the scheme helpful and recommended that it continues. There was more contact between buddies at this stage.

Conclusion. All trainees found it easy to approach their buddy and would consider becoming a buddy next year. The most discussed topics were portfolio, work-place based assessments, expectations of the day job and on-call duties, followed by exams and end of year assessments (ARCP).

Quality Improvement Project: Monitoring of Intellectual Disability Patients on Anti-Psychotic Medications in Outpatients Clinic, Northern Health & Social Care Trust, Northern Ireland

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doi: 10.1192/bjo.2022.293

Aims. Working as part of a newly-established Community Intellectual Disability Team since April 2020, we set a goal of achieving a target of monitoring 90% of patients who attend outpatient's clinic and who are on antipsychotic medications. This includes both physical observations and blood results, inline with NICE Guidelines. On initial analysis, we were essentially starting from a baseline of zero as patients were often deemed too difficult in primary care for monitoring and this simply wasn't happening as a result.

Methods. Retrospective Analysis of patients who attended Outpatients Clinic between February and August 2021. n = 242. Duplicates and Nursing Home Patients were deemed as exclusion criteria.

Analysis via Paris and Electronic Care Record as to which patients were on Antipsychotic medication. n = 73

Analysis of data regarding physical checks and blood records from September 2020–2021 to capture data in line with NICE guidelines.

Liaising with clinical staff to establish any reasons for exclusions, such as a lack of consent. Follow-up of same.

2x PDSA cycles established. One to capture results, and a second involving acquiring new ECG machine and establishing baseline testing, training and analysis of patients.

Results. 91% of patients met target criteria of having antipsychotic bloods monitored. Aim 90%.

97% of patients met target of having physical observations monitored. Aim 90%.

Starting from a baseline of zero, we began to capture ECG monitoring of patients from October 2021 and are currently achieving 42% of patients monitored between October 2021 and January 2022 and aim to achieve over 90% by September 2022.

Conclusion. Working as part of a highly-motivated new community team, we have shown that it is clearly possible to achieve a high level of monitoring of patients with mild to profound intellectual disability who are on antipsychotic medications, in line with NICE guidelines.

This has established a new baseline that is a clear and valid evidenced improvement compared to previous standards.

Future monitoring and PDSA cycles will continue to crystalize this data and establish a high standard of care in the community for this patient cohort improving living standards and avoiding and delaying onset of physical health concerns secondary to the cardio-metabolic effects of antipsychotic medications.

Missing Person Protocol: Rapid Risk Assessment Re-Audit 2021

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doi: 10.1192/bjo.2022.294

Aims. The Rapid Risk Assessment (RRA) has been a part of the Missing Person's Protocol since 2017 following a ward level intervention to try and provide as much information in as succinct a way as possible to the Police when a patient goes missing from the ward. This tool allows for rapid evaluation of a person's risk level on admission to hospital allowing consistent decisions to be made around risk to self and others, including physical risk and states why the risk level has been so set. In line with the National Framework for Missing Persons, a Return to Ward Interview is undertaken when a patient returns to the ward. The document is reviewed on a weekly basis at MDTs. The aim is to re-audit the extent to which the RRA within all wards at Royal Cornhill Hospital has been completed within the patients' notes.

Methods.

- All General Adult (GAP), Older Adult (OAP) and Learning Disability Wards were audited for the level of completion of the RRA proforma.
- 10 sets of notes were audited in each ward (where possible).
- Data were gathered on a proforma for consistency looking at each area of the RRA: Patient Details, Brief Admission Details, Risk Level, Police Contact.

Results. 58 sets of patient notes were checked. 100% of notes contained the RRA proforma.

The average completion of all sections was 87.5%.

There has been a 21% improvement in completion of the RRA since the first audit in 2017. There was variability across the wards, but there has been a 14.5% improvement in completion of sections compared to the previous audit.

The Patient Details section of the RRA was the most fully completed area, The Brief Admission Details section was poorly completed and it is important to be able to give this information to the Police when they are contacted about a missing person.

Conclusion. Across the wards, the data were less well completed by General Adult Psychiatry and best within Learning Disabilities. This

https://doi.org/10.1192/bjo.2022.294 Published online by Cambridge University Press

is perhaps because of the higher turnover of patients but it would be interesting to consider the reasons for the disparity in data.

Improvement seems to have been driven by the teaching around the RRA and weekly review of the RRA at MDT

None of the wards audited had completed the Return to Ward Questionnaire. The ward staff made comment that the questions within this document are asked but more informally.

Alcohol Screening on Admission to an Acute Mental Health Ward

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doi: 10.1192/bjo.2022.295

Aims. Alcohol misuse is estimated to cost the NHS £3.5 billion/year. Only 6% of people suffering from alcohol dependence in England, receive treatment per year, highlighting that alcohol misuse is under-identified. During the COVID-19 pandemic, people have significantly changed their drinking habits, evidenced by government tax receipt data, suggesting alcohol sales increased by 3% to 5% in the UK compared to 2019. Problems associated with harmful alcohol consumption were intensified by the crisis, even though the long-term impacts of COVID-19 on alcohol consumption are uncertain. There was a notable increase of patients with dual diagnosis of mental illness and alcohol misuse on our ward, which is a general adult inpatient psychiatric ward. As such, the aim was to assess and improve alcohol screening on admission to an acute mental health ward.
Methods. Through a System One review, we assessed whether alcohol consumption is documented on admission (within 72 hours) in units, and a validated screening tool is used (AUDIT-C), which was expected in all patients. Their notes were initially retrospectively analysed and subsequently reviewed approximately six weeks following the implementation of interventions.

Interventions included presenting the findings of the primary survey to our colleagues during a multidisciplinary team meeting on the ward and a trust-wide audit meeting attended by both junior and senior doctors. Additional interventions included posters outlining the importance of alcohol screening in the interview rooms of the acute wards (including a QR code link to our presentation and findings).
Results. Out of the 17 patients on the ward, 47% (8/17) were not appropriately screened for alcohol misuse during their first 72 hours of admission. 47% (8/17) had no documented alcohol history on admission clerking. Only 12% (2/17) had partially quantifiable alcohol intake, both drinking above the recommended weekly amount. None of the 'Current Drinker' patients had AUDIT-C screening. Improvement was noted following the interventions during the secondary survey.
Conclusion. Although alcohol screening in acute psychiatric admissions is often vague or incomplete, simple reminders and education can improve screening. If the alcohol history cannot be obtained from the patient on admission, which is often the case, the clinician should clearly document review of notes for historical alcohol use, to avoid potential complications, such as alcohol withdrawal, delirium tremens or seizures.

This project raises further questions on how effective brief interventions for excessive alcohol consumption in acutely unwell/psychotic patients are, encouraging a further area of research.

Outcomes of a Quality Improvement Project to Reduce Unnecessary Blood Tests in Beechcroft Regional Child & Adolescent Mental Health Unit, Belfast Trust

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doi: 10.1192/bjo.2022.296

Aims. An estimated 25% of blood tests are unnecessary with an annual cost to the trust of approx. £26.5 million. Aside from the huge financial impact, patients are undergoing unnecessary invasive procedures with detrimental impact on lab flow processes and inappropriate use of Doctor and Nursing Staff time. Some young people have multiple admissions to Beechcroft in a short space of time or bloods checked in A + E prior to transfer are missed and replicated. Longstanding use of blood template terms "Admission bloods" or "Eating Disorder Bloods" has added to the problem. Initial scoping exercise found one young person had 40 blood tests during their admission. AIM STATEMENT: Reduce baseline blood testing of Glucose, Lipids and TFTs by 10% by June 2021
Methods. QI project commenced December 2019 using the IHI Model for Improvement Methodology was promoted by the project team through conversations with staff, unit meetings, email and posters.

Outcome Measure: Total glucose, lipid and TFT blood tests recorded fortnightly for the unit over 18 months
Process Measures: Training as part of new nursing staff induction, reminders in daily nursing handover, number of staff attending Biochemistry liaison meetings
Balance Measures: Reduced blood test costs, reduced unnecessary staff workload
Change Ideas
6 PDSA cycles were implemented

- Separate Bloods Diary for each ward – January 2020
- Blood diary brought into weekly care planning meetings – July 2020
- Education Posters displayed in ward clinical rooms – September 2020
- MDT meeting with Clinical Biochemistry – April 2021
- Junior Doctor to update bloods diary post weekly care-planning – May 2021
- Bloods diary brought to daily nursing handover & dissemination of new monitoring guidelines – June 2021

Results. Glucose tests reduced by 68% with new median of 2.2 instead of 7. Lipids and TFTs median of 10 remains unchanged.
Conclusion. COVID-19 has disrupted monitoring. Fundamental changes made within our service by stopping blood glucose monitoring and using BMs instead has led to significant improvements. We will continue to monitor results following 2 recent change ideas. We hope to include patient feedback moving forward.

Improving Oncall Handover Through Digitalisation / a QI Project at Newham Centre for Mental Health

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https://doi.org/10.1192/bjo.2022.294 Published online by Cambridge University Press