SQR (Post-Intervention Group): Treated between December 1, 2023, and May 31, 2024, with dose titration guided by the SQR scale.

Inclusion criteria were depressive disorders (e.g. recurrent depression, bipolar depression), excluding primary psychotic disorders. Outcomes measured included the number and dose of treatments, Clinician's Global Improvement (CGI) scores, and subjective memory reports (patient-rated).

Results: The SQR group (n=7) received lower mean electric doses (622 mC) compared with the pre-SQR group (n=11; 705 mC) while maintaining comparable therapeutic outcomes. Both groups required a similar number of treatments (mean: 12 sessions). CGI improvement scores (CGI-I) and subjective memory ratings post-ECT showed no significant difference between the groups. These results suggest that the SQR scale may support safer dosing without compromising clinical efficacy.

Conclusion: The integration of the SQR scale into ECT practice demonstrated a promising trend toward optimizing treatment by reducing electric doses while maintaining clinical effectiveness. This structured approach offers the potential to minimize cognitive side effects, particularly in vulnerable populations such as the elderly. These findings underline the broader implications of incorporating data-driven tools like the SQR scale into routine ECT protocols across various trusts to enhance precision, safety, and patient outcomes on a wider scale. Future recommendations include gathering patient feedback to assess the cognitive and mood benefits of lower doses, conducting further research with larger cohorts to validate the findings, and embedding the SQR scale into standard ECT guidelines to promote consistency and improve treatment outcomes.

From 'Memory Assessment Please' to Masterpieces: Refining the Referral Process

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Aims: Inappropriate or incomplete referrals for memory assessment were a recurrent issue within our Old Age Psychiatry community multidisciplinary team (MDT) triage meetings. These referrals often lacked essential information, such as duration of cognitive concerns, patient consent, results of confusion screen blood tests, clarity on the presence of delirium versus long-standing cognitive concerns, ECG and imaging findings, or results of a cognitive screen. Some referrals were minimal, providing only the phrase "memory assessment please", leading to inefficient use of resources, delays in assessment, and unnecessary correspondence with referring teams. Since memory assessments involve detailed 60-minute home visits by experienced nurses, followed by consultant evaluation, optimizing referral quality was imperative to reduce inappropriate referrals and improve service efficiency.

Methods: A retrospective analysis of referrals from wards and clinics to our weekly MDT triage meeting was conducted over a two-month period (July 1–August 31, 2024). Referrals were assessed for the presence of key information required for triage, including patient consent, confusion screen blood results, cognitive screen findings, imaging results, and clarity on the nature of the cognitive concern. Following this analysis, we collaborated with clinicians from Old Age Psychiatry, Liaison Psychiatry, Geriatrics, and administrative staff to design a standardized one-page referral form. The form, adapted from an existing referral template in use elsewhere in Scotland, was tailored to include all critical elements necessary for triage decisions.

Results: Implementing the new referral form led to a marked improvement in the completeness and quality of referral information. Key details, such as cognitive screen results and delirium assessments, were routinely included. This reduced the need to search clinical notes during MDT meetings, saving significant time for the 30–40 mental health professionals present. Additionally, there was a substantial reduction in follow-up emails and phone calls to clarify referrals. The streamlined process improved triage efficiency, decreased inappropriate referrals, and shortened waiting times for patients requiring assessment.

Conclusion: Introducing a standardized referral form significantly improved the quality and efficiency of referrals for memory assessments. By ensuring all essential information was provided upfront, we optimized resource use, minimized delays, and enhanced communication between teams. The referral form remains a living document, with ongoing review to ensure its continued relevance and effectiveness.

Trust-Wide Quality Improvement Project on Improving the Competence and Confidence of First On-call Doctors in Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)

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Aims: This project emerged in response to surveys conducted in 2022–23, which revealed first on-call doctors at NHCFT, perceived they were required to operate beyond their competency levels. Recognising this could negatively affect both patient safety, and training experience of resident doctors, we sought to improve their confidence and competence through structured support, education, and resource development.

The project's aim was to ensure that no first on-call doctor would feel that they were working beyond their competency.

Methods: Cycle-1: The project began with anonymous baseline surveys using Hewson Confidence Tool, grade-specific focus groups which revealed a lack of knowledge in both clinical and practical aspects, increased stress due to untriaged workloads, and feelings of insufficient support from senior staff which contributed to widespread sense of being overwhelmed and impacted confidence and competence. Primary intervention included targeted on-call teaching sessions focussing on areas such as the role of on-call resident doctors, management of common tasks, seclusion reviews, legal frameworks, and escalation pathways.

Cycle-2: Observing the positive impact on doctors' self-reported competency and confidence levels in the first PDSA cycle, Cycle 2 began with stakeholder engagement through listening events with first on-call doctors. We held discussions with key leaders, Director of Medical Education, Associate Director of Nursing, Deputy

Associate Director of Physical Healthcare, ECG Trainer, Physical Healthcare Nurse, and Ward managers.

Subsequently, we designed and delivered a bespoke 'First On-Call Workshop for Resident Doctors', held as two 90-minute sessions in September 2024. The workshops used interactive tools, case-based scenarios, and audio-visual aids on psychiatric medication side effects, managing psychiatric emergencies, risk assessment, escalation pathways, legal procedures e.g., Section 5(2), demonstration videos for ECG and catheterization, along with site orientation videos.

Results: Cycle-1: Results displayed a 7% increase in confidence and competence.

Cycle-2: Outcome measures displayed positive qualitative feedback and an increase in confidence in quantitative feedback by 17% in handling common on-call tasks and clinical scenarios.

For sustainability, online resources and tools, i.e., workshop materials, videos, and podcasts, were made accessible and included in Resident Doctors' Survival Guide. Senior medics are now equipped with resources to facilitate these workshops, ensuring the project's longevity.

Conclusion: This project contributed to enhancing the competence and confidence of first on-call doctors, thereby improving patient safety, and fostering a supportive learning environment within NHCFT. This initiative has underscored the importance of structured educational interventions and collaborative support systems in promoting both trainee and patient well-being.

Bridging the Physical Health Gap in Mental Health Settings: A Ward-Based Multidisciplinary Educational Intervention

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Aims: Adults with severe mental illness face a significantly higher risk of morbidity and premature death from preventable physical health conditions, with life expectancy reduced by 10–20 years compared with the general population. Early identification and management of physical health issues in mental health settings are crucial to reducing these disparities. We designed a Quality Improvement Project (QIP) focused on enhancing physical health outcomes through a ward-based multidisciplinary educational intervention on an acute male psychiatric unit in London.

Methods: We conducted an initial questionnaire to determine the MDT's general knowledge level around physical health. We also surveyed the MDT on which teaching topics would be most relevant and interesting. The first audit cycle evaluated the MDT's knowledge in physical health and baseline confidence on specific physical health topics. Our intervention involved a six-week, ward-based short course on physical health for mental health professionals taught by the ward's resident doctors. A re-audit measured post-intervention improvements in topic specific confidence and knowledge.

Results: Fourteen members of the MDT completed the initial knowledge questionnaire, which, along with our survey, helped identify common gaps in knowledge and guided the selection of teaching topics for our intervention. The selected topics were: (1) Identifying and Escalating Abnormal Vital Signs, (2) Managing an Acutely Unwell Patient, (3) Commonly Used Psychiatric Drugs and Side Effects, (4) Clozapine, (5) ECGs, and (6) Medical Emergencies in the Psychiatric Setting. Before and after each teaching session MDT attendees were asked to complete a questionnaire assessing their knowledge and confidence on the given topic. On average, each session was attended by six MDT members. Baseline confidence in individual topics varied but improved following the intervention. Post-session knowledge scores were higher compared with pre-session assessments, demonstrating the effectiveness of the teaching sessions.

Conclusion: Ward-based interventions are effective in bridging gaps in physical health knowledge and improving confidence among MDT members. As learning is a continuous process, single teaching sessions may not be sufficient. On our ward, our QIP has led to the continuation of MDT teaching sessions by resident doctors. To further expand the impact of our QIP, we plan to extend MDT teaching to other wards within our Trust. To support this, course materials and summary infographics have been made available online, ensuring accessibility for our MDT and other wards looking to implement similar initiatives.

This work was carried out under the supervision of Dr Sarah Parry (Psychiatry Registrar) and Dr Jonathan Beckett (Psychiatry Consultant).

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.

Tools for Stools – Recognising and Managing Constipation on an Older Adult Inpatient Ward: A Quality Improvement Project

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Aims: Constipation is a common problem in psychiatric patients and can have serious consequences. Patients taking antipsychotics with anticholinergic properties are at higher risk of constipation. The risk is further increased in older adults due to reduced mobility and polypharmacy. To treat constipation, patients should have their bowel movements monitored and preventative laxatives considered. We faced similar challenges and this project was undertaken following a Serious Untoward Incident due to constipation related complications,

This quality improvement project aimed to increase detection, recording and management of constipation on an 18 bedded older adult inpatient ward. Thus, preventing complications like delirium, faecal impaction and bowel obstruction.

Methods: For this QI project, we used the Model for Improvement (MFI) framework, which involves defining the aim, measuring progress, and identifying changes that lead to improvement, along with the Plan-Do-Study-Act (PDSA) cycle. Bowel monitoring was initiated using the Bristol stool charts, with staff training and awareness sessions. Data collection was conducted for all 18 patients. In the second half of 2023, charts were integrated into MDT discussions, and further staff training was provided. In 2024, the bowel charts and Norgine risk assessment tool were used, a patient