colleagues. After discussing the findings with our stakeholders, we developed a new discharge summary template with the subheadings of ‘Reason for Liaison Psychiatry Involvement’, ‘Summary’, ‘Diagnosis (if applicable)’, ‘Risk Formulation’, and ‘Treatment or Plan of Action’.

We held a team meeting and distributed a guidance document with scoring criteria for each subheading for our clinical colleagues to practise for two weeks. Subsequently, 75 discharge summaries were randomly selected and independently scored across seven weeks by an internal team member and an external QI data analyst to improve inter-rater reliability. 98 discharge summaries written six weeks before the new letter template was introduced were retrospectively scored for baseline measurement.

Results. At baseline, the discharge summary scores ranged between 6 and 20 (out of a maximum of 20), depending on the individual completing them. The mean score was 12.3.

The implementation of the new discharge summary template improved the mean score to 19.0, irrespective of the author. The mean score was consistent across seven weeks.

Most of our colleagues did not face significant challenges in learning a new style of writing and for some, a standardised template reduced administrative time. The same GPs reviewed the new set of anonymised discharge summaries and were satisfied with the new summary format.

Conclusion. Formulating a standardised discharge summary template which adhered to professional guidelines was pivotal in improving the quality of GP discharge summaries. GP involvement throughout the project convinced stakeholders and colleagues to commit to a new writing template and tremendously helped achieve our project aim.

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.

Eating Disorders Intensive Treatment (EDIT) Subteam: Shoring Up MDT Working to Turn the Tide for Patients at Risk of Hospitalisation

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doi: 10.1192/bjo.2024.444

Aims. Presentations of severe Eating Disorders (ED) to the Tertiary Eating Disorders Specialist Service (TESS) in Lanarkshire have increased in recent years. Our criteria has also expanded to include severe Avoidant-Restrictive Food Intake Disorder (ARFID), increasing demand for a multidisciplinary team (MDT) approach for patients at high physical risk with less typical ED presentations. Medical Emergencies in Eating Disorders (MEED) recommends MDT working and development of pathways to support these patients.

The “EDIT subteam” was thus developed in March 2023, comprising: TESS psychiatrist, TESS GP, dietician, assistant practitioner, and TESS psychologist.

For TESS patients at high physical risk, high risk of hospitalisation, and who would benefit from a trial of “stepping up” treatment, we aimed to employ coordinated MDT intervention to 1. optimise community treatment, 2. regularly review risk and 3. reduce need for hospital admission.

Methods. Each patient was discussed at a weekly MDT meeting attended by EDIT subteam, where risk assessment and management plan was agreed.

6-month review was conducted using meeting minutes, staff survey and group discussion, with consideration given to: number of patients prevented from requiring hospital, number of patients admitted to hospital and consideration if different levels of intervention could have prevented this, staff satisfaction and review of the MDT complement.

Results. 22 patients – 17 female, 5 male – were included on EDIT for the first 6 months. At point of step-down from EDIT, 13 had ongoing TESS community input, 5 were admitted to hospital, 3 were discharged from TESS and 1 transferred to Community Mental Health Team.

Most EDIT patients received input from multiple domains of the MDT. Given baseline low admission rates and complexity of patient presentation, we were unable to determine how many hospital admissions were prevented, but consensus was that overall, a higher level of care was provided. It was not felt that different levels of intervention could have prevented any of the 5 admissions. Staff feedback was positive: EDIT improved communication, provided job role diversification, contained and shared risk, improved awareness of care plans and resulted in better-considered onward referrals.

Areas for improvement included a lack of Occupational Therapy and nursing, and concern about EDIT patients skipping waiting lists.

Conclusion. The EDIT subteam provides an avenue for high risk patients to be regularly discussed in an MDT setting – although impossible to empirically quantify if admissions were reduced, consensus within TESS was that the introduction of EDIT has improved community treatment for this group of patients.

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VTE Prophylaxis Quality Improvement of Service Users Data in Older Adult Mental Health Inpatient Wards in St Charles Hospital, CNWL NHS Trust

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doi: 10.1192/bjo.2024.445

Aims. To reach the target of 100% for VTE (venous thromboembolism) prophylaxis data submitted for all St Charles Older Adult inpatients.

Methods. It was found at the start of the QI project, the service was at 63% (August 2023). I reviewed this data and discussed it with the ward managers of the older adult inpatient wards and implemented two PDSA cycles. I went through the ward list of service users and noted on the database who had an outstanding VTE prophylaxis check. From this, I then created a section for the nursing handovers to include whether each service user had their VTE prophylaxis forms filled in and whether VTE prophylaxis was appropriately prescribed. The wards have a weekly MDT meeting where this could be discussed and all staff could be reminded to document the VTE data on the trust data system. I rechecked the data two months later to see if the data had improved. Following this, I created a VTE poster to be distributed via email to ward staff and hung up in the ward doctors’ offices to

https://doi.org/10.1192/bjo.2024.444 Published online by Cambridge University Press