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207 THE IMPACT OF ESTABLISHING A COMPREHENSIVE STOP SMOKING SERVICE AT A PRIMARY HEALTHCARE SETTING IN THE QUIT ATTEMPTS: A QUALITY IMPROVEMENT PROJECT

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10.1136/bmjoq-2025-QSHU.207

Introduction In 2005, Oman joined the WHO Framework Convention on Tobacco Control (WHO FCTC) to minimize tobacco consumption (WHO, 2020). Countries ratifying the FCTC are mandated to offer tobacco cessation service at its best practice, which includes tobacco cessation medications, counselling, and a toll-free Quitline (WHO, 2013). Current epidemiological data revealed that Oman lacks a national tobacco cessation program that meets the WHO FCTC minimal standards. The trend of tobacco use is on the rise (8.0%) and is attributable to 8.7% of deaths in Oman (Salma and Paul, 2023). This study aims to analyse the impact of establishing a tobacco cessation service at North Al-Khuwair Health Center (NKHC) at its best practice approach in the quit attempt of tobacco users.

Methods A quality improvement initiative was carried out at NKHC using the plan-do-study-act (PDSA) cycle to establish a tobacco cessation service at its best practice. The study population was tobacco users of all age groups who attended NKHC from July 2024 to March 2025. Brief advice was provided as general practice at each clinical encounter. Tobacco users who expressed their readiness to quit were evaluated at a stop smoking clinic and were given free tobacco cessation support (behavioural and nicotine replacement therapy). All patients were followed up with a blended approach (in person and by phone) for a total of three months. The outcome of interest was a quit attempt. Descriptive analysis (n,%) was carried out using SPSS version 27.

Results Prior to July 2024, the tobacco cessation service was not operational at NKHC. A total of 30 tobacco users visited the stop smoking clinic from July 2024 to March 2025. More than half (n=17, 56.7%) were over the age of 40. Almost one in five (n=5, 16.7%) of tobacco users were under the age of 18. Most tobacco users were males (n=29, 96.7%), married (n=23, 76.7%), employed (n=23, 76.7%), and used compostable tobacco products (n=24, 80.0%). Over one third (n=12, 40.0%) used tobacco products at home, and a similar portion smoked with either friends (n=15, 30.0%) or family members (n=1, 3.3%). Nearly two thirds (n=19, 63.3%) of tobacco users were exposed to second-hand smoke. Over two thirds (n=21, 70.0%), while mental health accounted for 13.3% of tobacco users. Nearly half of tobacco users had a previous quit attempt, with the majority (n=11, 79.0%) attempting to quit using cold turkey methods. All tobacco users (n=30, 100.0%) who attended the clinic were asked and advised to quit tobacco products by healthcare professionals. The majority were ready to quit (n=24, 80.0%) and a similar portion attempted to quit.

Activating tobacco cessation services at their best practice can increase uptake of cessation services, increase readiness to quit, and subsequently increase quit attempts. More research is required to examine the impact of implementing tobacco cessation at its best practice in increasing quit rates.

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208 IMPROVING MEDICINES USE AND SAFETY FOR OLDER PEOPLE LIVING IN UK CARE HOMES

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10.1136/bmjoq-2025-QSHU.208

Background Older people living in care homes (long-term care facilities) have multiple health conditions and as a result are prescribed several medicines. While medicines can be beneficial, taking multiple medicines (polypharmacy) can have negative outcomes such as adverse drug reactions and hospitalisation. Reducing problematic polypharmacy has the potential to reduce adverse events and improve quality of life. In the UK, structured medication reviews (SMRs) are conducted to comprehensively evaluate a patient's medicines and care home residents are high priority. However, there is limited research on the best approach to conducting SMRs, including communication when medicines are stopped for care home residents. We previously co-designed patient-centred resources with stakeholders to support older people living at home to help prepare them for SMRs. These resources have been widely implemented in UK primary care. This project aimed to adapt the resources for older people living in care homes.

Methods This research was underpinned by the ADAPT principles for modifying interventions to new contexts (Moore et al, 2021) and the experience-based co-design (EBCD) approach to intervention development (Bowen et al, 2013; Tsianakas et al, 2021). The first stage of data collection comprised 'think aloud' interviews with different stakeholder groups. During interviews, the original intervention materials were shown to care home residents, their relatives, care home staff and primary healthcare professionals, and their thoughts towards the fit of the materials in the care home context were explored. Data were analysed using the person-based approach to intervention development (Yardley et al, 2015). Following interviews, four co-design workshops were conducted with a mixture of care home residents' relatives, care home staff and primary healthcare professionals. During the workshops, ideas generated from the interviews were discussed alongside potential implementation challenges for care homes. Following each workshop, adaptations were made to the intervention materials for discussion at subsequent workshops.

Finally, intervention materials were shared with residents during individual consultations and final adaptations made.

Results Twenty 'think aloud' interviews were conducted with 4 residents, 4 residents' relatives, 5 care home staff and 7 healthcare professionals (HCP). Across the four workshops, 19 participants took part (7 HCPs, 3 care home staff and 9 relatives). Four residents participated in individual consultations. Stakeholders discussed the benefits of the provision of a written record which can coordinate input from residents, relatives and care home staff which can be used to guide the SMR discussion. The importance of explaining the SMR process carefully and considerately to families and care staff was perceived as crucial by participants alongside emphasising the potential benefits of reducing medications for residents and avoiding the use of jargon. Staff training to develop familiarity with the adapted documents and an understanding of the benefits of deprescribing are likely to make implementation easier and more sustainable.

Five resources were produced

1. An easy-read SMR invite letter for residents explaining the process and its purpose with space to make written notes in preparation for the SMR.
2. A relative SMR invite letter explaining the process and purpose of the review alongside suggestions for how they might contribute to the review.
3. An easy-read 'Safely Stopping Medicines' document to inform residents about medication to be stopped following a SMR. The document includes the rationale for stopping a medicine and advice on what side effects to look out for which may be associated with medication changes.
4. A 'Safely Stopping Medicines' document for care home staff and relatives which explains which medicine(s) have been stopped and why. It also includes advice on identifying side effects which are potentially associated with medication changes.
5. A care home staff education poster, to familiarise staff with the purpose of SMRs and their role in SMRs.

Conclusion The previously developed SMR materials required significant adaptation to the care home context. The adapted materials aim to improve the quality and safety of SMRs by taking a resident-centred approach and involving all stakeholders.

209 IMPROVING QUALITY OF IMAGING REQUESTS AND REPORTS IN A PRIMARY CARE SETTING

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10.1136/bmjoq-2025-QSHU.209

Introduction We recognise that the quality of primary care imaging requests and reports can be variable, and a discussion amongst clinicians highlighted room for improvement. We therefore conducted a primary care quality improvement project in a rural practice in the United Kingdom. The practice has a list size of 16,500 patients across two sites, with a team of General Practitioners and ancillary clinical staff.

The project was discussed with the clinical team to assess feasibility and usefulness. There was consensus that this would be an effective quality improvement activity.

Methods We devised a checklist of 5 criteria to look at the standard of imaging requests and reports. These were based on the Royal College of Radiologists Standards for Interpretation and Reporting of Imaging Investigations.[1] We analysed randomly selected imaging requests and reports following a checklist: 1. Clinical question in the request 2. Clinical question answered by report 3. Differential diagnosis in report 4. Advice about management in report 5. Action taken on management advice.

Results Initial analysis indicated a clinical question was included in 52% of requests, and clinical question answered 98% of the time. A differential diagnosis was given in the report 95% of the time, and action recommended in 20%. Recommendations were acted on by the clinicians in 95% of cases.

These findings were discussed at a clinical meeting, and examples of good practice were considered. Feedback and suggestions for improvement were invited. There was consensus to improve the quality of imaging requests. Following this, findings and points for improvement were circulated to the whole practice team. Specific areas highlighted for improvement were including a clinical question in the request and ensuring that 100% of reports were acted upon.

Three weeks after the initial data collection, we analysed another random selection of 47 requests and reports using the same criteria. A clinical question was included in requests 68% of the time after intervention, compared to 52% previously. Recommendations were acted on 95% of the time at baseline and 100% thereafter. There was little change in clinical question answered (98% vs 87%), differential diagnosis given (95% and 89%), or action recommended by the report (20% vs 21%).

Limitations A limitation of the project was that we had little input from the radiology department, and we were not able to involve patients or carers.

How were patients involved

Patients were not involved in this project, though going forward we feel this would be useful.

What this study adds

A simple intervention using clinician education and involvement can improve the quality of imaging requests. This has implications for improving patient care, as better quality requests are likely to result in more useful reporting.[2]

No conflicts of interest to declare.

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210 RESIDENTIAL RADON EXPOSURE AND LUNG CANCER – A FEASIBILITY STUDY IN THE INTERIOR HEALTH AUTHORITY REGION OF BRITISH COLUMBIA, CANADA

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10.1136/bmjoq-2025-QSHU.210

Introduction Lung cancer is the second most commonly diagnosed cancer in Canada and is the leading cause of death in both men and women. The most common causative agent is