developing safety plans in collaboration with patients, and a poster highlighting the process to be undertaken when discharging a patient admitted with self-harm.

Result. Following initial interventions, 20% of patients had completed safety plans and 50% received advice, an increase of 20% and 40% respectively. The second PDSA cycle showed increase in numbers to 38% and 67% respectively.

Conclusion. Creating a crisis plan with a hospital-specific leaflet for the Liaison Psychiatry team increased the number of patients discharged with safety plans in place. 86% of patients who participated in safety-planning found the process helpful and felt likely to use the plan in future crises. This is an area of ongoing quality improvement which can be implemented in other hospitals to better equip patients with skills and support to reduce self-harm/suicide attempts.

A quality improvement project on the discharge summary completion process in an addictions service

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Aims. Discharge summaries are vital documents that communicate information from hospital to primary care providers. The documents contain description of the patient's diagnostic findings, hospital management, laboratory results, medications list and arrangements for post-discharge follow-up. Ineffective communications between healthcare providers in the form of delayed or poor quality discharge summary may adversely affect patient care and safety.

The setting of this project is Gwent Specialist Substance Misuse Service (GSSMS) which is the statutory specialist addictions service within Aneurin Bevan University Health Board (ABUHB). GSSMS has been arranging and managing inpatient alcohol detoxes for many years. One of the issues highlighted by an inpatient alcohol detox audit in 2017 was discharge summaries were not being completed for every patient who was admitted with a compliance rate of only 57.7%. A quality improvement project was initiated following the presentation of the audit on a Staff Education Day.

The aim of the project is to increase the discharge summary completion rate from 57.7% to 80% by June 2019.

Method. A discharge summary process map was developed to understand the possible causes of delay then Plan, Do, Study, Act (PDSA) methodology was utilised. The result of the original audit was taken as the baseline measurement and benchmarking activities and PDSA cycle were performed. Interventions included root cause analysis by way of brainstorming, education, communication and constructing a checklist.

Result. There has been significant improvement with the compliance rate following the PDSA cycle. It went up to 100% before tapering off to 85% by the end of the project.

Conclusion. Awareness building, continuous monitoring and engagement of teams alongside regular feedback were shown to be the important factors to achieve and sustain the improvement.

Microsoft teams virtual handover system

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Aims. Accurate and timely handover of clinical information is of great importance to continuity and safety of care. Psychiatry doctors typically cover a number of sites across a catchment when they are on-call. Consequently, handover between on-call teams and day teams in psychiatric hospitals is reliant on using the nursing staff as an intermediary to flag concerns or relying on the day teams proactively checking the notes on daily basis for outstanding tasks.

The key objective of this project was to use Microsoft teams to establish a handover system that is efficient, safe, reliable, easy to use and replicable.

Method. A microsoft teams group was created comprising of all the medical staff members working at inpatient units across three sites that are part of Birmingham and Solihull Mental Health Trust. These members were divided into two groups - the 'on-call team' and the 'day team'. Within the 'day team', every consultant was grouped with their junior doctors to form multiple subgroups.

A system was established wherein the two teams could communicate with each other by posting a message and tagging the appropriate team. A provision was made to create a channel for every ward to allow for easy segregation and monitoring of tasks.

Qualitative information about the use of the tool was monitored by monthly focus group meetings. A formal review of the messages was conducted after 8 weeks to assess the following parameters:

Number of messages posted
Number of messages acknowledged
Number of safety-related incidents

Result. Initial evaluation of the results suggests that the new handover system was perceived to be safe, accurate and efficient while being intuitive and hassle-free. This increased the quantity and enhanced the quality of communication between the 'on-call' and the 'day teams' and allowed for early completion of tasks while reducing the number of safety-related incidents.

Conclusion. The Microsoft teams proved to be a viable alternate tool to create a virtual handover process that is efficient, safe, reliable and user-friendly. It also has the potential to enhance the communication between inpatient and community teams.

A quality improvement (QI) project on improving trainee confidence in conducting remote psychiatric consultations at Pennine Care National Health Service (NHS) Foundation Trust in the United Kingdom (UK)

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Aims. When the coronavirus disease 2019 pandemic hit the UK, clinicians within Pennine Care NHS Foundation Trust (a five-borough mental health trust) were faced with the challenge of rapidly switching to a novel way of assessing patients remotely.

The idea for a QI project on trainees' experience with remote consultations was conceived in April 2020. We present our February 2021 results here.

We aimed to improve trainee confidence in conducting remote psychiatric assessments by at least 40%, to ensure effective and safe patient care during their 6 months placement.

Method. Our discovery process included surveying trainees in April 2020 to explore experiences with remote psychiatric consultations, a literature search of current UK guidance and a local audit. The audit reviewed documentation of consent to remote consultations, with reference to standards as per NHS England remote consultation guidance. Key change ideas included publication of an article, 'Remote consultations – top tips for clinical practitioners', video-simulated remote consultations and a session on remote consultations in the trainee induction.

In the first 'plan-do-study-act' (PDSA) cycle, we presented key findings from the article in a video presentation, which was sent trust-wide. We measured confidence in conducting remote assessments pre- and post-presentation via a feedback survey. Unfortunately, response rates were low and in the second PDSA cycle we targeted a smaller cohort of trainees at the August 2020 induction, although encountered similar difficulties. In the third PDSA cycle, we collected real-time data using an interactive app at the February 2021 trainee induction, and measured pre- and post- confidence following a presentation and a video-simulated remote consultation.

Result. 2/34 respondents had accessed previous remote psychiatric consultation training and 12/35 had some telepsychiatry experience. Pre-induction trainee confidence results revealed: extremely uncomfortable (16%), not confident (31%), neutral (47%), confident (6%) and very confident (0%) and post-induction confidence was 0%, 22%, 52%, 26% and 0%, respectively.

Conclusion. Our project started during the first peak of the pandemic, which may be a reason for initial limited response rates. Our results suggest that the remote psychiatric consultation trainee induction session has shown some improvement in trainee confidence; the 'confident' cohort improved from 6% to 26%.

Our next steps include collecting similar real-time data, mid-rotation and uploading video-simulated remote consultations to the Trust Intranet. We plan to complete the local audit cycle. We also plan to incorporate patient experience (from an ongoing systematic review) to inform a potential triage process post-pandemic, choosing between face-to-face versus remote consultations.

Reducing the use of oral psychotropic PRN medication in acute mental health inpatients

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Aims. Project aim:

To reduce the use of oral psychotropic PRN* medication on Ward 3 AMHIC (Acute Mental Health Inpatient Centre) by 20% by May 2020

(*PRN = Pro re nata/As required)

On Ward 3, we identified a number of unintended negative consequences of PRN medication to both patients and staff.

These included issues with over-use, dependence and side effects; as well as loss of staff ownership and challenging interactions with patients, (including escalation to aggression).

Following the success of our Child and Adolescent Mental Health Inpatient colleagues in this area, we decided to embark on a project to change practice within our ward.

Method. In order to quantify the problem, we first collected baseline data on current use of psychotropic PRN medication.

As a multidisciplinary project team, we then brainstormed potential contributory factors and displayed these visually as a driver diagram.

This divided our project into 3 main areas:

1) Safe prescribing
2) Safe administration,
3) Safety culture.

Project measures were also agreed as follows:

Outcome: Number of doses of oral psychotropic PRN medication administered per week

Balancing: Violent incidents; IM administrations of psychotropic medication

Process: Time taken to complete interventions; Patient and staff satisfaction. Change ideas were selected and implemented sequentially, using Plan-Do-Study- Act methodology.

These included:

1) Weekly review of PRN prescribing
2) Nursing administration sheet

Data were collected weekly and plotted on our run chart.

Result. By the end of May 2020, we had exceeded our initial goal, reducing the weekly median number of doses of oral psychotropic PRN medication administered by over 30%.

Our balancing measures remained stable and we gained useful insights and development ideas from a staff survey.

Further change ideas were planned for implementation over the months that followed, however, the impact of the COVID-19 pandemic meant that the project lost some momentum.

Conclusion. Despite running into some difficulty over recent months, the team remain motivated to maintain and build upon our previous success.

In the past few weeks, "Calm Cards", (a patient-centred intervention promoting use of individualised alternative coping strategies), have been introduced.

We hope that the outcomes of this intervention will be positive, both in terms of further reducing use of PRN medication and encouraging development of skills which can be utilised beyond the hospital environment.

We also intend to share our learning with colleagues and explore the possibility of introducing the project to other wards within the hospital.

Reducing levels of Violence in the Psychiatric Intensive Care Unit (PICU) - a multidisciplinary quality improvement project

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Aims. Our aim: To reduce the number of Level 1* violent incidents in Ward 4 by 30% by April 2020

*Level 1 is defined as "Behaviour involving force, which causes or is intended to cause physical harm to others; but excludes assault on objects, threats or verbal abuse"

Ward 4 is Belfast Health and Social Care Trust's only PICU, with a total of 6 beds. Our project took place on the background of a recent move to a new purpose-built inpatient unit, as well as a trust-wide initiative to address levels of violence across inpatient psychiatry services.

Method. We divided our project into 3 main areas:

Patient factors

Staff factors