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.