one-month period via the Emergency Department at St. James's Hospital.

Background. Homelessness has now reached a crisis point in Ireland. In July 2019, there were 10,275 people documented as homeless nationwide, with the number of homeless families increasing by 178% since June 2015. The majority of individuals registered as homeless are located in Dublin. St. James's Hospital (SJH) provides psychiatric care to a population of 136,704 people across Dublin South-City within areas of significant deprivation according to the most recent social deprivation index.

Method. All Emergency Department psychiatry referrals over a one-month period were recorded. Month of study was randomly generated. Data were collected from electronic records. Socio-demographic information was analysed. Data were anonymised and recorded using Microsoft Excel. Current homelessness statistics were accessed from the Department of Housing, Planning, and Local Government and compared to the data collected.

Result. During the month of the Study (March 2019), 4315 adults accessed emergency homeless accommodation in Dublin. Of the 109 psychiatry referrals received through the Emergency Department at SJH during this time, over a quarter (28%) of those referred reported themselves to be homeless or living in temporary accommodation. An additional 5% were documented as living in residential or sheltered care at time of assessment. All of the referred homeless patients were unemployed (n = 30). 50% of homeless patients were referred to psychiatry following expressed thoughts or acts of self-harm. Illicit drug abuse was associated with 73% of referrals. Alcohol abuse was associated with 47%. Of those who were referred, under a quarter (23%) were assessed as having a major mental illness, and in the majority of these cases, illicit drug and alcohol abuse were compounding factors in exacerbating symptomatology. Of those referred, 66% had previously been reviewed by psychiatry during prior ED presentations and 60% of homeless presenters reported that they had previously been, or were currently linked in with community mental health teams.

Conclusion. Frequently, vulnerable patients most in need of social and psychiatric care, such as homeless people with addiction issues, are eclipsed from accessing supports. The high proportion of patients reporting to be homeless is cause for concern and suggests the need for tailored and integrated multidisciplinary assessments and interventions at an Emergency Department level.

Alcohol hand sanitisers on mental health wards safety risk educational and QI poster

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Aims. To provide awareness of safety concerns around use of alcohol hand sanitiser on a mental health ward, and to consider ways of improving how learning for a serious adverse incident in one trust can better be communicated to other trusts

Background. DD a male patient with history of paranoid schizophrenia alongside historic illicit drug use and current alcohol dependency admitted detained to Bluestone hospital following bizarre behaviour at a wake. Had been non-compliant with medication. Transferred to PICU due to going AWOL and returning under influence of alcohol.

2nd April overnight staff noted him to become over-sedated, presenting with slurred speech and appeared under influence of alcohol – transferred to A + E due to deteriorating GCS – was intubated, and transferred to ICU. Blood alcohol level was 373. Several empty bottles of hand sanitiser from dispensers on ward found in his room and he later disclosed he had accessed further alcohol hand sanitiser in sluice while washing clothes

SAI learning outcomes from one healthcare trust in Northern Ireland not currently routinely shared with other trusts

Method. Literature review carried out to search for reports of similar incidents – 1 previous review article suggesting one death and 11 other major complications from consumption of alcohol hand sanitiser over 5 year period 2005-2009.

Quality improvement steps implemented to address this risk

Ward policy was reviewed to ensure patients no longer had unsupervised access to wash clothes

Liaised with Infection Control to assess the need for alcohol hand sanitiser to be available to patients given the ward is effectively a community setting

Intoxication policy reviewed and education sessions on this provided to all medical and nursing staff

Regional regular PICU staff update seminar launched for purpose of bringing PICU staff from across Northern Ireland together to share learning from SAIs and cases

Result. Infection control agreed alcohol hand sanitiser dispensers could be removed from wards and kept only in locked nursing office with use of visitors.

Learning from this case shared with other trusts locally at newly launched regional PICU update seminar

No further incidents to date

Conclusion. Patient access to alcohol hand sanitisers found to be a significant safety risk in PICU setting

Following implementation of quality improvement steps no further incidents of patients swallowing alcohol hand sanitiser

Improved awareness of risk of alcohol intoxication on ward with nursing staff escalating concerns to on-call doctor more frequently

Improving safety-planning in patients admitted with self-harm

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Aims. Self-harm is a common presentation to acute hospitals, associated with increased risk of completed suicide. Safety plans are increasingly recommended to help patients recognise and prevent escalation of self-harm behaviours.

This project aimed to improve quality and documentation of safety planning for patients admitted at an acute general hospital due to self-harm, who were assessed by Liaison Psychiatry. We aimed to increase the number of patients given written safety plans on discharge by 50%.

Method. The PDSA cycle model of quality improvement was used. A retrospective audit of clinical records was conducted over 3 months to establish baseline documentation of safety planning (n = 51). A template for a self-harm crisis plan, used in other areas of the Trust, was adopted, to be adapted to each patient. A leaflet for sources of crisis support and patient feedback form were developed and distributed to clinicians in the team. Data collection was repeated one month later (n = 48). The second set of interventions involved a training session for clinicians on

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.