To ensure that 100% of male patients on valproate in the practice are informed about family planning risks associated with valproate use and have documented advice recorded in patient electronic record system (EMIS) within 2 months.

Methods: The cohort consisted of 22 male patients on valproate, identified using the EMIS system. These patients were targeted for the intervention to ensure compliance with the MHRA guidance on family planning risks.

The first intervention involved sending an Accurx text message to all 22 patients. outlining the potential risks associated with valproate use around conception, need for effective contraception for both partners, and encouraged patients to contact the practice if they were planning to start a family.

After 1.5 months, a follow-up intervention was conducted. All 22 patients were contacted by phone to verify whether they had received the text, assess their awareness of the MHRA guidance, and provide family planning advice if they were previously unaware. Phone calls were made on two separate occasions, spaced two weeks apart, to maximise the likelihood of reaching patients.

Results: Of the 22 patients, 18 were successfully contacted. Amongst these, 8 confirmed receiving the original text message, while 10 didn't. During the phone calls, it was noted that 5 patients were already aware of the MHRA alert, 13 were unaware but were informed of the guidance during the call.

Patients were also given an opportunity to ask any further questions or express concerns. For those who required additional information, the option of a consultation with the practice pharmacist was offered. Despite repeated attempts, 4 patients could not be reached.

Conclusion: This QIP revealed significant gaps in patient awareness of valproate family planning risks and the challenges of engaging patients with automated messaging. Key reflections include: Challenges with Automated Texting; Improved Communication with Phone Calls; Limited Patient Engagement.

This QIP successfully raised awareness of an MHRA alert regarding valproate use among male patients in a GP practice. While the initial response to automated texts was poor, follow-up phone calls ensured that most patients were informed. The project underscored the importance of a multi-modal, sustained approach to patient education for sensitive topics like family planning.

Recommendations

Routine Medication Reviews.

Pharmacist-Led Discussions.

Enhanced Communication Strategies.

Practice-Wide Alerts.

Improving Staff Knowledge and Confidence in Lithium Counselling to Enhance Patient Safety and Standardise Practice Across Community Mental Health Teams

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Aims: The 2019–20 Community Pharmacy Quality Scheme audit concluded 34% of audited patients were unfamiliar with lithium toxicity symptoms, where 29% were unaware of how to prevent it, highlighting the gap in effective patient education. Our preliminary research revealed that 50% of medical professionals lacked confidence in providing lithium counselling with 41% being either unaware or unsure of how to counsel a patient if they had missed a dose. Therefore, we aim to tackle staff knowledge and improve abilities in lithium counselling to enhance patient safety and understanding, ultimately leading to fewer incidences of toxicity and harm.

Methods: An initial survey was conducted to assess healthcare professionals' confidence in lithium counselling prior to the teaching sessions, identifying specific gaps in knowledge among staff. The Quality Improvement Project was implemented through two Plan-Do-Study-Act (PDSA) cycles:

PDSA Cycle 1 (19 attendees): A lecture-based teaching session using an online presentation was delivered, covering key information regarding lithium counselling. An improvement in knowledge was assessed using pre- and post-session quizzes, created using the information in the "Lithium Policy KMPT Handbook".

PDSA Cycle 2 (6 attendees): An interactive OSCE-based teaching session was delivered to reinforce and apply the content from PDSA 1 via two clinical-based scenarios including discussion and feedback.

All teaching material was distributed to staff members, and the session was recorded for future training opportunities, accounting for standardised teaching methods.

Results: The baseline average score was 50%. Following the PDSA 1 session, this increased to 79%, demonstrating a statistically significant improvement ($t = \times 5.14$, $p<0.001$). Following the PDSA 2 session, there was a slight decrease to 77%.

Key areas of knowledge that showed notable improvement after PDSA 1 included:

1 – Missed Dose Advice: χ^2 (1, N=37 =0.000154, p=0.05.

2 – Lithium use in pregnancy: χ^2 (1, N=37)=0.00056, p=0.05.

3 – Initiating lithium monitoring: χ^2 (1, N=37)=0.004238, p=0.05.

Direct comparison between post PDSA 1 and 2 is limited due to the lack of participant continuity.

Conclusion: After PDSA 1, a clear improvement in staff scores was observed. Despite showing a slight decrease in knowledge after PDSA 2, both teaching methods proved effective in improving lithium counselling knowledge from baseline.

We hypothesise that attending both sessions would lead to the greatest improvement; however, scheduling constraints prevented consistent attendance. Attempting to account for this, sessions were planned online. Upon reflection, recording and disseminating all teaching resources were vital in ensuring standardised training.

Management of Psychosis in Perinatal Period in Local Psychiatric Inpatient Unit, Current Pathways and Proposal to Improve Standards of Care

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Aims: To enhance the quality of care for patients experiencing psychotic episodes during the perinatal period (antenatal and postnatal) by improving service pathways and management.

Methods: This was a retrospective study, in which existing care pathways for patients presenting with psychosis in perinatal period

were reviewed, gaps identified and then solutions to improve standards were proposed. Out of 41 patients admitted to the local inpatient unit with psychosis in perinatal period between January 2022 and October 2024, 11 patients were selected as they met the criteria of diagnosis of perinatal psychosis. Data was collected and reviewed from electronic records and patients' notes.

Data was assessed, whether the key elements for patients presenting with psychosis were documented in admission history, the management plans and the extent of involvement of perinatal team throughout different stages of their care.

Results: It was found that 90% of patients (10/11) were clerked on admission. In 63% patients (7/11) reasons of admission were documented, and 54.5% (6/11) having documentation about parity.

81.8% (9 of 11) had perinatal team involvement during admission, 45.45% (5 of 11) had discharge follow up with perinatal team, while 27.27 % (3 of 11) were discharged to other teams. Only 9% (1/11) were asked about perinatal family history, 81% (9/11) were not asked about perinatal family history while 1 patient had missing clerking documentation.

Conclusion: There were notable gaps picked up in clerking history especially perinatal family history, gestational age and parity, which are critical points in history taking in patients presenting with psychosis in perinatal period. While there is consistent involvement of perinatal team during admission, there seems to be lack of consistency in post-discharge engagement.

The data suggested more standardised clerking, and discharge planning process to ensure all element of care are covered. By implementing the proposed, we anticipate a positive impact on patient outcome, more cohesive multidisciplinary care and improved patient follow up leading to better quality care.

Improving Trainee Engagement in Trainee Council Meetings at Birmingham and Solihull Mental Health Foundation Trust

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Aims: Trainee Council Meetings (TCMs) offer a dedicated time and place for trainees working in the Trust to highlight issues and raise concerns relating to their rotations.

Trainee engagement in these meetings has historically been variable. This project was developed with the aim of improving trainee engagement with TCMs. It is part of a larger 'Raising Concerns' Quality Improvement Project within the Trust.

Increase attendance at Trainee Council Meetings (TCMs) by Foundation, GP and Core Psychiatry Trainees.

Improve structure and organisation of Trainee Council Meetings.

Improve trainee access to records of meeting minutes.

Methods: Retrospective TCM attendance data was collected in Summer 2023. The only data available were numbers of attendees, not trainee grade. The following issues were identified:

TCMs sometimes took place in person and sometimes took place online (via Microsoft Teams). Attendance tended to be poorer for in-person meetings than those online.

There was no clear leadership structure within the Trainee Council.

There was lack of clarity over which representatives were responsible for planning and facilitating TCMs. This led to an unfair and unequal distribution of TCM workload.

The following change ideas were implemented from the respective dates:

July 2023 – It was agreed that TCMs would always take place online.

August 2023 – Development of two leadership roles within the Trainee Council: 'Trainee Representative and Induction Co-ordinators' and 'SHO Inclusion Co-ordinators'. Planning and facilitation of TCMs was agreed as a responsibility to be shared amongst these representatives.

Development of a Meeting Proforma (see Appendix), clarifying actions to be taken by council leads before, during and after TCMs.

Attendance data were collected prospectively between September 2023 and March 2024. Data included numbers of trainees attending and trainee grade.

Results: Trainee attendances before change ideas:

December 2022 – 20

March 2023 – 9

June 2023 – 22

Trainee attendances after change ideas:

September 2023 – 38

November 2024 – 34

March 2024 – 36

Conclusion: Attendance data show that there has been an improvement in numbers of trainees attending Trainee Council Meetings following implementation of change ideas.

Attendance of trainees by grade was unknown prior to June 2023. The majority of attendees between September 2023 and March 2024 were Core Psychiatry trainees. Attendance by Foundation and GP trainees is low.

Promoting Wellbeing and Resilience Amongst Resident Doctors

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Aims: To develop and promote wellbeing amongst Resident doctors and embed this into the Core Trainee Committee (CTC).

Methods: This Quality improvement project was part of a response to Trainees' wellbeing developed after noting the dissatisfaction of trainees with wellbeing in the 2024 GMC National training survey. It reported that over a fifth (21%) of trainees measured to be at high risk of burnout and over half (52%) described their work as emotionally exhausting to a very high or high degree.

Dr Sungum (wellbeing lead), devised the pathway using an internally generated traffic light system of the wellbeing department in the Trust and Deanery. Following this, some Core trainees trained as wellbeing activists to support their peers and created and distributed a wellbeing pathway and poster to that effect. We organised activities to improve wellbeing including monthly trainee socials and wellbeing lunch drop-ins. We created a Survey about wellbeing distributed amongst all Psychiatry trainees in the health board.

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