revert to the previous one. Adjustments to systems were made as per respondents' wishes. Guidance posters were displayed in each hospital between October 2025 and January 2026 to aid using the systems, and the doctors were surveyed once again (cycle 3) between 28/01/2026 and 04/02/2026 using the same questions.

Results: Please note "easy" will be used where respondents rated the system easy or very easy. There were a total of 10 respondents in cycle 1: 70% found the now-previous system easy to access, only 50% found it easy to edit and 40% found they had missed tasks. Only 10% were opposed to trialling a new system. In cycle 2, there were a total of 22 respondents: 73% found the new system easy to access, 81% found it easy to edit and only 18% had missed tasks. 73% wished to keep the new system. In cycle 3, preliminary results show 10 respondents thus far: 100% found the new system easy to access and edit, only 10% had missed tasks and 100% wished to keep the new system. The system is now part of Standard Operating Procedure in North Glasgow.

Conclusion: A new digital handover system replaced previous systems for each North Glasgow mental health hospital. The new system improved ease of access and editing as well as reducing the frequency of missed tasks for resident doctors. Displaying guidance posters further improved each of these categories and all doctors wished to keep the new system.

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A Labour of Labs: Improving Confidence in Postpartum Physiology

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Aims: Clinicians working in perinatal psychiatric settings frequently encounter blood results that fall outside standard reference ranges due to the physiological changes of the "fourth trimester". While information regarding accepted blood test levels throughout pregnancy is readily available, there is a lack of comprehensive, concise guidance for interpreting postpartum blood parameters and the time they require to return to baseline. This can lead to diagnostic uncertainty, unnecessary repeat investigations, and inappropriate specialist referrals. This Quality Improvement Project (QIP) was developed to address this gap in clinical confidence and reduce the burden of unnecessary medical interventions in the postnatal period. The project aimed to develop a comprehensive, evidence-based reference tool for postpartum blood parameter recovery timeframes and to evaluate its impact on clinician confidence and decision-making.

Methods: A reference guidance document was developed through review of published literature and clinical guidelines. This document summarized postpartum trends and accepted reference ranges for common investigations, including haematological, biochemical, and inflammatory markers (e.g., FBC, LFTs, U&Es, and thyroid function). To evaluate the impactof this intervention, an anonymous electronic survey was distributed to clinicians to assess their confidence levels before and after providing access to the guide. Improvement was judged based on clinicians' self-reported confidence using a Likert scale, and qualitative analysis was performed on free-text feedback provided in the survey.

Results: The survey was sent to 53 clinicians, with 25 responses received at the time of writing. Preliminary survey data demonstrated a marked increase in clinician confidence following the introduction of the reference guide. Participants reported greater clarity in distinguishing normal physiological postpartum shifts from true pathology. Early qualitative feedback suggests a reduced perceived need for specialist referrals and repeat blood tests, supporting the tool's utility in streamlining clinical care. Data collection is ongoing.

Conclusion: This QIP highlights a need for accessible, postnatal-specific guidance for doctors working in psychiatry. The resulting reference tool is a low-cost, sustainable intervention that improves clinician confidence and supports appropriate resource allocation. This guidance is considered for inclusion in local induction materials for doctors on psychiatric perinatal wards, with next steps including dissemination to wards nationally and potential for broader application in primary care.

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Improving Discharge Summaries on Vincent Square Eating Disorders Unit

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Aims: Discharge summaries (aka electronic discharge notifications, eDNFs) are a vital part of care, ensuring clear and timely communication between services and allowing for an accurate record of care to be maintained. If eDNFs are not completed in a timely fashion, or not completed at all, service users struggle to access follow-up care, repeat prescriptions and referrals to other services. In mid 2024, on Vincent Square Eating Disorders Unit (VSEDS), eDNFs were not being completed in a timely manner – many were not completed at all. From May 2024 to August 2024, of 15 patients discharged:

- 5 had an eDNF completed at time of discharge (33.3%).
- 3 had an eDNF completed late (20%).
- 7 did not have an eDNF completed at all (46.7%).

Our aim: 70% of patients discharged from VSEDS will have an eDNF completed within 24 hours

Methods: This project ran from mid 2024 to early 2025. We implemented 4 PDSA cycles, which included:

PDSA 1: weekly scheduled meetings between ward doctors and pharmacists.

PDSA 2: discharge medications prescribed and email sent to pharmacy at time that decision to discharge is made.

PDSA 3: attempted implementation of protected time for ward doctors to complete eDNFs (unsuccessful).

PDSA4: On Wednesday mornings pharmacy notified of all potential discharges; all discharge medications prescribed at this time.

Our QI project included input from a number of Experts by Experience, service users who have had previous experience of discharge from VSEDS. They emphasized the importance of a timely, clear and concise eDNF and spoke about the impact on their ongoing care and wellbeing. Some of their feedback is represented in our poster.

Results: From November 2024 to February 2025:

- 14 patients were discharged from the ward.
- All of these patients had a discharge summary completed within 72 hours of discharge.
- 12 of these patients (85.7%) had a discharge summary completed within 24 hours of discharge.

Conclusion: Our first PDSA cycle was unsuccessful – we found that in practice this simply added another meeting without making a difference to efficiency. PDSA cycle 2 appears to have the most impact by allowing pharmacy to process TTAs without having to wait for ward doctors to write a lengthy discharge notification first. We were ultimately unable to implement PDSA 3 successfully. In PDSA 4, we attempted to systematise PDSA 2 by setting a once weekly notification process for pharmacy regarding upcoming discharges.

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Improving the Quality of SHO Seclusion Review Documentation: A Quality Improvement Project

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Aims: The aim of this quality improvement project was for initial seclusion reviews completed by resident doctors to achieve 80% compliance when standardised against all domains featured in the Mental Health Units (Use of Force) Act 2018 between the dates of September 2025 and January 2026.

Methods: A quality improvement project was undertaken between September 2025 and January 2026. A driver diagram was developed at project initiation to identify primary drivers, which included improving clinicians' understanding of documentation requirements, increasing access to relevant criteria and resources and enhancing multidisciplinary knowledge regarding patient seclusions. Secondary drivers included targeted education for new and current doctors, improving accessibility and usability of the seclusion review template and policy and strengthening multidisciplinary team communication. A fishbone diagram was created, highlighting contributing factors related to people (time pressures, burnout, unfamiliarity with the process), process (time-consuming steps, inadequate handovers, limited out-of-hours support) and environment (reviews occurring overnight, limited software support). Based on these diagrams, a total of 4 PDSA cycles were performed, implementing 4 change ideas: (1) increasing accessibility to the seclusion proforma in handover, (2) circulating the proforma via email, (3) incorporating teaching into the academic programme, and (4) providing core trainee teaching in small groups. Regular audits were undertaken at two weekly intervals, and data was analysed using a Statistical Process Control chart.

Results: Despite the interventions, there was minimal change in the overall compliance rate. Of the reviews that met all required criteria, compliance increased from 75% to 83%. This is likely attributable to the small number of seclusion reviews occurring within each two-week period, as well as the random variation introduced by different on-call doctors. These factors produced substantial fluctuations in the results, depending on the doctors' level of training and the workload of their shifts. At the level of individual domains, documentation of risk assessment to self and others alongside subjective and objective assessments of physical health increased, indicating a positive change.

Conclusion: This quality improvement project demonstrates that achieving the target of 80% compliance with the seclusion review requirements set out in the Mental Health Units (Use of Force) Act 2018 is unlikely to be sustained through educational or individual-level interventions alone. More directive system-level approaches may be required for sustained compliance, such as mandatory completion of all domains prior to submission of a seclusion review and efforts to reduce the overall use of seclusion to allow adequate time for high-quality, reflective documentation. Improving compliance with seclusion reviews is central to patient safety and safeguarding the rights of service users.

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Making Clinic Letters Make Sense: A Patient-Focused QI Project

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Aims: Clinic letters are a key method of communication between secondary mental health services, primary care, and patients. However, traditional psychiatry clinic letters are often lengthy, clinician-centred, and difficult for readers to quickly identify key information and actions. This sits at odds with national priorities emphasising patient-centred care, shared decision-making, and improved collaboration across healthcare interfaces.

Informal feedback within our service suggested that existing clinic letters lacked clarity and accessibility for both general practitioners (GPs) and patients.

This quality improvement project aimed to design and implement a structured, patient-addressed clinic letter template and to evaluate its impact on satisfaction with letter length, layout, ease of understanding, and content among GPs and patients.

Methods: A structured clinic letter template was developed through multidisciplinary discussion, informed by best-practice guidance