Aims. With recruitment and retention of NHS doctors an increasingly topical issue, the facilitation of a supported Return To Work (RTW) following a period of leave is particularly important. That the support provided takes a holistic approach to the wellbeing of the individual and their family unit is necessary if it is to be of the greatest success, especially with regards to new parents. The World Health Organization recommends breastfeeding until 2 years of age but in the UK just 0.5% of parents are breastfeeding at 1 year and, perhaps more significantly, 90% of breastfeeding parents stop before they would like to. Under the 2010 Equality Act, breastfeeding is a protected characteristic and legally, upon RTW, a breastfeeding parent must have a Breast-Feeding Risk Assessment (BFRA). The Health and Safety Executive have set out factors to be considered when completing BFRAs which enable the identification, mitigation or removal of risks that threaten breastfeeding, often via impacting the physical and mental health of the parent and child.

Our aim was to explore the experiences of both JDs and clinical supervisors in accessing and completing BFRAs in order to identify whether further work was required on this subject.

Methods. A survey was sent to psychiatry JDs across the West Midlands inviting those who had RTW whilst breastfeeding to share their experiences. Another survey was sent to leads and supervisors across the region, exploring their confidence with BFRAs and their recommendations.

Results. 20 JDs responded. 16% received a BFRA with 5% being undertaken prior to RTW (best practise). For most of those who received one, it was a positive experience and 81% of those who did not receive one reported that they would have liked to but were either unaware that they existed or that they apply to children over 1 year.

36 consultants responded. 31% were aware of BFRAs with 9% feeling confident in completing one and none having had any training to do so. There was a strong sense that BFRAs should have a multi-disciplinary approach which contrasted with what occurred in reality.

Conclusion. Identifying a lack of knowledge, as well as doctors' need and desires regarding BFRAs, has resulted in a multifactorial approach to raising awareness of their existence, content and potential impact. Sessions for JDs and supervisors have been organised regionally and locally and there has been engagement with each trust in order to create a more uniform breastfeeding policy.

Reducing the Use of Physical Restraints in Patients With Dementia Who Are Admitted to Acute Old Age Psychiatry Wards With Agitation

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Aims. The Institute of Mental Health is the only tertiary Psychiatric Hospital in Singapore. It has two 29 bedded inpatient wards which provide acute care for the elderly with severe mental health conditions including dementia. Restraints are one of the methods employed in managing agitation in patients with dementia. The physical consequences of restraints are reduced mobility resulting in decreased muscle tone and mass, bone demineralisation, orthostatic hypotension, and atelectasis. This results in patients who are more prone to falls, aspiration pneumonia, deep vein thrombosis/pulmonary embolism and ulcers. The psychological consequences include aggravating agitation, feelings of humiliation, negative emotions like anger and despair. Hence, we embarked on a program to reduce the use of physical restraints in the management of agitation in patients with dementia.

Methods. Baseline restraint hours were collected from 7am to 9pm for all dementia patients who were restrained for agitation for a period of 5 months. Patients on Geri chair with seatbelt used primarily for fall prevention were not included. The Pittsburgh Agitation Scale was used to measure agitation.

The nursing staff were trained on the Enriched model for targeting behaviour and on the VIPS (Valuing people, Individualised care, Personal perspectives, Social environment) framework for person centred care. Restraint hours were collected post intervention as well as benzodiazepine usage data over both periods to monitor any changes in the usage.

Results. The baseline data (preintervention) over a 5-month period determined that patients with dementia who were agitated were being restrained on an average for 3.33 hrs per day from the period of January to May 2021. Following the training of nursing staff on the enriched model of care and the use of VIPS framework for person centered care the restraint hours reduced to 1.48hr per day over 5 months from January to May 2022. Benzodiazepines usage went down from 0.34mg at baseline to 0.17mg per dementia patient per day post intervention.

Conclusion. Nonpharmacological interventions (enriched model and VIPS framework for person centered care) using a multidisciplinary team approach is effective in the management of agitation resulting from dementia and should be used as a first line in the management of such conditions.

Implementation of a Formal Medical Handover in an Acute Mental Health Unit

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Aims. To implement a robust and reliable medical handover process in the Bluestone Unit, Craigavon Area Hospital, Southern Health and Social Care Trust. Following discussion with Junior Medical Staff, Doctors did not feel confident that they were always aware of outstanding physical investigations or any acutely unwell patients on the inpatient wards. This could lead to patient safety issues which we aimed to address using the PDSA model for effective change management.

Methods. A) Twice daily face to face handover was introduced at 09:00 and 16:45 in the Junior Doctor's office, easily accessible to staff. A standardised handover template was already in existence. The outgoing Doctor On-Call overnight would complete this to handover any outstanding tasks. The Doctor carrying the On-Call bleep during the day would then use this template to lead a formal, face to face handover with a team of Junior Doctors covering each of the inpatient wards. This helped to

clarify which wards were covered and ensure timely, effective allocation of tasks.

B) A formal, face to face "weekend handover" was introduced at 15:30 in the Conference Room every Friday afternoon.

A survey was sent to twelve Junior Doctors to gather formal feedback both before and after these interventions.

Results. Following these two interventions:

1. 91.67% feel there is now a structured and comprehensive daily handover. 91.67% felt this was not the case before.
2. 63.64% feel there is now always a successfully completed morning handover. 0% felt this was the case before.
3. 83.33% feel there is now always a successfully completed weekend handover. 41.67% felt this was not the case before.
4. 75% feel they are always aware of sick patients when On-Call. 25% felt they were not at all aware before and 66.67% felt they were only occasionally aware before.
5. 91.67% feel they are always aware of outstanding bloods to chase. 8.33% felt always confident before.
6. 83.33% feel they are always aware of outstanding investigations to chase. 16.67% felt always confident before.
7. 90.9% feel they know which wards are covered and uncovered when carrying On-Call bleep. 9.09% felt they knew before.

Conclusion. The implementation of a formal handover process has significantly improved Doctors' awareness of outstanding tasks and ward cover, which is likely to benefit patient safety moving forward. Further action is necessary to improve communication between medical and nursing colleagues regarding physical investigations performed and appropriate, timely follow up.

Healing and Hope for Forced Migrants in Norwich: The SHIFA Clinic for Asylum Seekers and Refugees

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Aims. The poster will discuss our Quality Improvement project around improving access to mental health assessments for asylum seekers and refugees and why this model of care proved to be useful in reducing barriers to accessing specialist mental health services for these patients.

The clinic was launched as part of the Advancing Mental Health Equality (AMHE) Collaborative, which is a 3-year programme run by the National Collaborating Centre for Mental Health at the Royal College of Psychiatrists, and Norfolk and Suffolk NHS Foundation Trust (NSFT) was one of the organisations that signed up to this initiative.

Methods. The clinic was named SHIFA, which stands for (Supporting Holistic and Integrated Forced Migrants Assessments). SHIFA means 'Healing' in Arabic, Turkish, Urdu, Kurdish and Pashtu (languages spoken by many patients accessing this clinic) and the name was selected in collaboration with staff and service users.

What are the objectives of the SHIFA clinic?

- To offer a trauma-informed approach to the assessment of forced migrants. This is an essential objective of the SHIFA clinic as the trauma-informed approaches are guided by trust, rapport and offering person-centred care.
- Reduce barriers to mental health care for people seeking asylum, refugees and people forced to migrate.
- Work collaboratively across the systems to bridge the gap among different services to improve the person-centred and continuity of care and avoid the re-traumatising effect of re-telling their stories.
- Co-production and putting the voice of our service users and carers at the heart of everything we do.
- Share learning and embed inclusive practice within the mental health services in NSFT and other organisations.

Results. We will provide data on patients seen in the clinic, the diagnosis and treatment. We will also give examples of the feedback we received from professionals and service users and why this model successfully provided collaborative and joint working opportunities with various services working with these patients.

Conclusion. The QI project represented in this clinic has provided a local solution to meeting the needs of forced migrants in our community, reducing mental health inequalities. It ran without funding initially and was successful in receiving funding due to the clear difference it made in providing good quality care for these patients.

Similar projects can be easily implemented in various mental health trusts.

Improving Quality of Care for Patients With Attention-Deficit/Hyperactivity Disorder in an Early Intervention for Psychosis Service

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Aims. Attention-deficit/hyperactivity disorder (ADHD) is frequently associated with other psychiatric conditions, including psychotic disorders. There is evidence for shared genetic susceptibility to both conditions (Hamshere ML, Stergiakouli E, Langley K, et al. Shared polygenic contribution between childhood attention-deficit hyperactivity disorder and adult schizophrenia. Br J Psychiatry. 2013;203(2):107–111) and first-degree relatives of people with ADHD have twice the risk of having schizophrenia compared with healthy controls (Larsson H, Rydén E, Boman M, et al. Risk of bipolar disorder and schizophrenia in relatives of people with attention-deficit hyperactivity disorder. Br J Psychiatry. 2013;203(2):103–106)

There are treatment challenges, and monitoring of physical health has differences with the Early Intervention Psychosis standards following antipsychotic monitoring.

Combined outcomes (symptomatic and functional recovery) may be worse unless addressing ADHD in addition to psychosis, and addressing substance use is important.

Primary objective/aim:

To create an integrated pathway through a clinical practice guideline for patients with ADHD in early intervention for psychosis service.

Secondary objectives/aims:

Identify the prevalence of ADHD in EIP service.

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