introduced from this QIP. We have shared our learning within the wider trust and plan to spread and scale our changes across a wider area.

Assessing Clinical Coding Compliance in a Mental Health Inpatient Unit: An Audit and Intervention Study

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Aims. Clinical coding (CC) is the translation of medical terminology into a coded format that is recognised both nationally and internationally. NHS trusts must record the clinical care given to inpatients and the resources used for inpatients while they are in hospital care. CC ensures accurate patient records, communication and data exchange between providers and can aid in epidemiological research, healthcare planning and quality as well as cost control. An audit was carried out in a mental health inpatient unit to assess whether CC was completed as per the local and national CC guidelines, followed by an intervention to improve compliance.

Methods. 2 inpatient wards were identified, 1 male and 1 female, and 10 patients from each ward were selected at random on the 15th of December 2023. Their notes were assessed to determine whether: the CC has been updated during their current admission, CC has been updated if new diagnosis, CC had been completed on last discharge, physical health conditions were included in the CC and the number of physical health diagnosis changes and their documentation. Intervention was carried out and a re-audit completed on the 31st of January 2024.

Results. Out of 20 patients: 5 (25%) had a completed CC during their admission and 4 had a diagnosis change but only 1 (25%) CC was updated. 9 had a physical health diagnosis but only 3 (33%) were included on CC. 16 (89%) had a completed CC on last discharge and 2 were admitted for the first time.

Doctors on the wards were informed about CC, how to access the form on the system and the importance of updating CC. This was communicated in teaching sessions and doctor communication groups.

The re-audit showed some improvement. Out of 20 patients: 10 (50%) had a completed CC during their admission, 4 had a diagnosis change and 3 (75%) CC were updated. 7 had a physical health condition and only 2 (29%) were included on CC. 12 (75%) had a completed CC on last discharge and 4 were admitted for the first time.

Conclusion. The audit showed a lack of awareness of CC and its importance. The intervention helped to improve compliance of CC in current inpatients. Further intervention and improvement is required for physical health CC and can be attempted with posters in the doctor's rooms and regular reminding during group sessions.

Are Patients Aware of Clozapine Side Effects?

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Aims. Patients should have a comprehensive understanding of the side effects, and monitoring requirements of the medications prescribed to them. Making the patient aware of serious side effects is important for patient safety and informed consent. Patients should know when and how to seek help for side effects. Health literacy also increases patient autonomy and shared decision making.

As an inpatient, a psychiatric patient's medications are closely monitored, and there is frequent contact with healthcare professionals who can identify any health needs. Within our trust, there is a side effect checklist to be completed by community staff each time a community patient has clozapine monitoring. However, in our clinical practice, we have observed that some patients have needed prompts regarding need for re-titration if dose missed for 48 hours.

We aimed to assess medication safety information awareness in a small sample of patients open to forensic community team who are prescribed clozapine.

Methods. A 26-point questionnaire was used to assess the participant's depth of knowledge of clozapine. A combination of 3 open and 22 closed questions were used. Patients were scored for their answers to the closed questions, using a predetermined marking scheme, being awarded 1 point per appropriate answer. We set the standard as maximum score of 22.

All participants (n = 7) were male and had been prescribed clozapine for at least one year.

Results. All participants were able to accurately state why they were prescribed clozapine. The mean score was 16. Zero participants scored 22. Lowest score was 14. One participant omitted two questions (Do you know what to do if you take more clozapine tablets than you are supposed to? Do you know what to do if you forget to take clozapine?). He stated that he was very careful regarding his medication and therefore, will not forget or miss any doses.

71% of patients were unsure what they should do if they were to accidentally take more tablets than prescribed.

Five out of seven participants were able to cite at least one side effect of clozapine without prompting.

Two patients were not able to spontaneously recall the monthly blood test requirement.

Conclusion. There was a range of knowledge deficits about clozapine in our sample. After including reminders of safety information about clozapine at quarterly care coordination reviews, we plan to re-assess in a year's time.

Clinical Supervisors' and (Junior) Doctors' Experiences of Breastfeeding Risk Assessment, and Where We Go From Here

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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