

Conclusion. HACP practice mostly improved from October 2019 to July 2020. This may have been due to increased awareness of HACP Standards, following the presentation of initial data to inpatient teams.

A much larger influence, however, was likely to be the COVID-19 pandemic and associated efforts to improve HACP practice throughout the Health Board.

Evaluation of staff knowledge; attitudes and experience of breastfeeding on a mother and baby unit

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Aims. To evaluate the knowledge and experience of breastfeeding of staff working on a Mother and Baby Unit (MBU).

To assess the level of breastfeeding education of Staff on the MBU.

To identify any area of concern around breastfeeding on the MBU.

Method. A fourteen question questionnaire was designed with assistance of the medical team, midwife, and health visitor on the unit. The questionnaire was comprised of questions requiring "yes/no" and free text responses alongside Likert scales. The questionnaire focused on staff experience on breastfeeding, education levels and whether they felt Mothers were sufficiently supported. This questionnaire was distributed to all staff groups within the team to ascertain the level of expertise. 29 questionnaires were returned from a staff team of 31.

Result. Staff on this unit is made up of Multi-disciplinary professionals. Most respondents were Nursery Nurses (15%). 79% of staff had a lived experience of breastfeeding. Only 5 out of 29 respondents have had any breastfeeding training which was mainly in-house training, and these were the Health Visitor; Midwife and Nursery nurses. Of the respondents, 21% felt mothers who choose breastfeeding as their preferred mode of infant feeding were not adequately supported on the MBU. Seven percent were unsure and 72% felt women were adequately supported. 54% of staff were not aware of breastfeeding initiatives. 63% were able to list contraindications including names of psychotropic medications as well as personal choice and past medical history. The median rating in relation to confidence in skills on Likert scale of 1-10 was 5.

Conclusion. 23 out of 29 professionals felt that Training would increase their confidence and skills in breast feeding support for women admitted to the unit. There is clear indication from the Staff Members that mothers on the MBU who choose breastfeeding as their preferred mode of infant feeding require further support. There is lack of confidence in staff's breastfeeding support in the MBU. An evaluation of patient's own experience of breastfeeding support they receive from staff is being undertaken alongside this, but data will be analysed later.

Clozapine initiation in the Belfast Health and Social Care Trust (BHSCT)

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Aims. The aim of this project is to improve the quality of documentation and recording of the assessment and monitoring of patients commencing clozapine in BHSCT.

Background. Clozapine is an effective treatment for patients with schizophrenia who have not responded to at least two other anti-psychotics. Due to clozapine's significant side effect profile patients must be carefully assessed prior to treatment initiation with close monitoring of their physical observations and reported side effects during initiation.

The BHSCT Clozapine Pathway currently uses a Clozapine Assessment Integrated Care Pathway (ICP) common to inpatient and outpatient clozapine titrations and a Clozapine Titration ICP which varies slightly between inpatient and outpatient titrations.

Method. The Clozapine ICPs of patients commenced on clozapine in BHSCT in a 9 month period commencing January 2019 were reviewed. Handwritten clinical records were used to collect data on rates of completion of all aspects of the pathway.

These results were used to identify areas of the pathway that were being poorly completed and the "Method for Improvement Model" used to trial changes to the pathway using Plan-Do-Study-Act (PDSA) cycles.

Result. 20 patients in BHSCT were commenced on clozapine in the 9 month period. 1 Clozapine Initiation Pathway could not be located; therefore data were collected on 19 patients. 2 patients were initiated in the community and 17 patients initiated as inpatients.

The results showed that sections of the Clozapine Assessment ICP were poorly completed; for example only 27% of the "Patient Baseline Preparation Checklist" were complete, with 60% partially complete and 13% completely blank.

In the inpatient clozapine titration ICP the physical observations record was complete in only 20% of patients and the side effects monitoring record complete in only 13% of patients. Conversely the physical observations and side effects monitoring records were complete in 100% (n = 2) of patients.

Conclusion. BHSCT Clozapine Pathways were being poorly completed, with outpatient pathways being completed better than inpatient pathways. Analysis of the data shows that repetition of information in various parts of the pathway leads to gaps in documentation.

Parts of the pathway that were poorly completed have been redesigned and the impact of these changes assessed using the PDSA cycle method. It is hoped that this along with education of staff will lead to an improvement in the assessment and monitoring of patients being commenced on clozapine.

On-call handover ‘– if it isn't documented then it didn't happen’

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Aims. 1. To standardise the doctor handovers for on-call duties
2. To ensure there is documented evidence of handover taking place at the end of each shift

Background. Since the introduction of the European working time directive the amount of hours that doctors are allowed to work has been reduced, resulting in increased handovers between teams. The National Patient Safety Committee and General Medical Council have recognised that this means we need to ensure handovers are as safe and robust as possible to ensure that patient safety is not compromised. A recent serious investigation report carried out at Chase Farm Hospital, London identified a lack of formalised handover between doctors as a contributing factor leading to patient harm. One of the recommendations of

the report was for a Quality Improvement Project to be carried out in order to formalise handover.

The handover procedure at Chase Farm Hospital for core trainee doctors 'on-call' prior to this QIP was not standardised and consisted of an informal, verbal handover. Frustrations had been raised by doctors and other staff members that this current method of handover was unreliable and unsafe.

Method. We sent out a questionnaire about handover to all doctors on the on-call rota to help establish what intervention would be appropriate.

We then performed a retrospective collection of documented handovers within a two month time period.

Our intervention was to introduce an email handover procedure.

Following a two month trial of this intervention, we resent the questionnaire and performed a second retrospective collection of handover documentation.

Result. Prior to this QIP we found that 0% of on call handovers were being formally documented. After the introduction of our handover email 88% of handovers were being formally documented using the handover email.

Satisfaction with the handover procedure went from 0% being very satisfied and only 33% being satisfied to 50% being satisfied and 50% being very satisfied.

Conclusion. A standardised and documented handover procedure is crucial for patient safety and to allow doctors to communicate jobs effectively with each other.

A secure email for handover is a successful way of formalising the handover process.

Limitations include:

Access to the handover email for new staff or locum staff.

Ensuring that doctors who aren't on the on-call rota know how to use it to handover their ward jobs.

Rehabilitation during a pandemic: psychiatrists as first responders?

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Aims. The South London and Maudsley High Support Rehabilitation Team supports a cohort of 120 long-term rehabilitation patients in the densely populated London borough of Southwark.

COVID-19 has a high transmission rate and is more lethal amongst the elderly, ethnic minorities and those with comorbidities.

For these reasons, COVID-19 poses a particular challenge to our patients. Most have significant comorbidities, live communally, engage infrequently with primary care and take high-risk medications like clozapine. Many are from black and minority ethnic backgrounds.

During the Spring coronavirus wave, we found that unwell patients or their carers would contact our service for advice ahead of 111, primary care or emergency services.

In response we designed a standard operating procedure to guide our response to possible cases. This aimed to ensure our advice and management for patients drew upon the latest emerging evidence.

We audited our work and the burden of disease within our service until November 2020.

Method. At a team level, we introduced same-day remote assessments structured around a standard operating procedure incorporating the latest primary care and national guidelines.

At a trust level, treatment guidelines were amended permitting consultant discretion when deciding whether an urgent blood count was required for those unwell on clozapine, and routine blood count monitoring was extended to 3 months for eligible patients

Result. By November 2020 we had only one confirmed case of COVID-19 on our caseload. This patient required ITU and recovered. Seven patients were judged 'suspected' to have suffered COVID-19 and eight were possible cases. One supported living accommodation had a possible outbreak.

Conclusion. We are surprised to have had just one confirmed case of COVID-19, despite the vulnerability of our cohort. The attentiveness of our patients and their carers to government guidelines will have contributed to this figure. They have shown remarkable resilience.

This pandemic has prompted trust-wide changes to clozapine monitoring and perhaps a permanently less intensive monitoring regime for some patients.

That our patients contacted our team ahead of 111, primary care or emergency services may reflect the close trust they place in us to support them through difficulty. It is fitting for a service aiming to provide holistic care that our scope should have expanded in this way during the pandemic. Community rehabilitation services are well placed to act as first responders.

Establishing safety huddles on a general adult acute psychiatric ward: staff's views and relation with restrictive practice

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Aims. To establish Safety Huddles (SH) on an acute general adult psychiatric ward, exploring links to restrictive practice. Additionally, to obtain multidisciplinary staff feedback on SH's impact on their workload/wellbeing and on patient care, and to identify barriers in implementation.

Background: A SH is a multidisciplinary daily briefing focused on patients most at risk, held at a fixed time and place, lasting max 5-10 minutes. Effective SH involve agreed actions, are informed by multidisciplinary staff feedback of data and provide the opportunity to appreciate and celebrate success in reducing harm. SH are a valuable team building activity, promoting situational awareness and helping with prioritising daily tasks.

Method. SH were introduced on September 2020. Templates were developed to prompt staff how to facilitate. Staff were encouraged to identify key goals and reflect on issues in the last and next 24 hours. Each participant was allocated a role, e.g. record keeping or dissemination of information. In December 2020, records of incidence of restrictive practice (numbers of restraints, seclusions and rapid tranquilisations) were obtained for the periods June-August 2020 and September-November 2020. Additionally, staff feedback was obtained through a short anonymous Survey Monkey questionnaire. It explored whether SH had an effect on patient care and staff's workload/wellbeing, and possible barriers to implementation.

Result. Comparing the two 3-month periods before and after SH implementation, restraint episodes were reduced from 47 to 21, seclusion episodes from 19 to 2, and rapid tranquillisation episodes from 10 to 3. Nine staff members responded to the feedback questionnaire. All believed SH had a positive impact on patient care, or had the potential to do so. Staff reported SH gave them