counting and less emphasis on definitions. (f)Calorie counts and exercise trackers need 'more fun and interactive elements.

Based on these recommendations a revised CALMPOD- ID programme, co-produced with service users, is now being introduced in the service.

Heard, Valued, Empowered: Utilising a Quality Improvement Framework to Improve Trainee Experience

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Aims. Feedback from doctors in training (DiT) through the Scottish Training Survey has highlighted poor trainee experience within Psychiatry at St. John's Hospital, Livingston. Research suggests that a healthy, happy and engaged workforce experiences lower levels of burnout and provides higher quality patient care. Our aim was to improve the experience of DiT working within the department and thereby improve patient care.

Methods. We utilised the Wellbeing, Conditions and Rota Evaluation (WeCaRE) framework. This is a user-friendly quality improvement (QI) framework designed to improve trainee experience. As part of WeCaRE, questionnaires and 'what matters to you' conversations were undertaken with ten DiT (foundation doctors, GP trainees, and core psychiatry trainees). From the issues raised, trainees were empowered to co-create change ideas and use Plan-Do-Study-Act (PDSA) cycles to address the issues. Finally, the questionnaire was repeated to complete the loop.

This approach created an open, listening environment with clear communication channels from trainees to consultants and management. This allowed us to identify themes for improvement. These included induction, education opportunities, clinical supervision and escalation policies.

In collaboration with trainees, three improvement teams were formed, each of which addressed an issue through a PDSA cycle. These were:

1. Unclear referral pathway to Psychiatry resulting in inefficiency. The team co-created a flowchart identifying how to appropriately refer to Psychiatry, which has reduced the number of inappropriate bleeps.
2. Unclear escalation policies and consultant cover. The trainees worked with the multidisciplinary team to generate a clear escalation pathway.
3. Significant variation in content and documentation of clerking – the data collected helped drive change through the utilisation of an electronic clerking checklist.

Other issues were raised and quickly addressed without requiring a PDSA cycle. Such issues included provision of on-call rooms, parking spaces, improvements to induction, starting a Balint Group for trainees, and changing the mode of administration of Pabrinex.

Results. During the five-month period those who experienced joy in work several times a week or more increased from 0%-86%. Those who always felt a valued member of the team increased from 29%- 86%. Those with overall job satisfaction increased from 0%-75%

Conclusion. DiT experience comprises more than rota compliance. It includes well-being, psychological support, professional development, teamship and more. This project has demonstrated considerable improvement in trainee experience through utilising the WeCaRE framework. This highlights the power of listening to, valuing and empowering trainees, whilst utilising data as a vehicle to drive change.

Antipsychotic Monitoring Within the Home Treatment Team in the Southern Trust, a Quality Improvement Project

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Aims. The Royal College of Psychiatrists has a specialist group called the Home Treatment Accreditation Scheme (HTAS) that has published a set of best practice recommendations for Home Treatment Crisis Response (HTCR) teams across the UK. As of yet, the HTCR team in the Southern Trust is not accredited. We decided to focus our project on antipsychotic monitoring. SMART aim: All patients (100%) within the HTCR team commenced on antipsychotics are receiving an appropriate level of blood and physical monitoring as recommended by guidelines and these are being documented correctly within 10 days of discharge.

Methods.

PLAN

HTAS standards were reviewed alongside NICE guidelines on antipsychotic monitoring and a pro forma created. We collected baseline data on patients commenced on treatment dose antipsychotics in the HTCR team and assessed completion of bloods/ECGs/physical parameters and documentation.

DO

Our intervention for PSDA cycle 1 was to educate members of the multi- disciplinary team (MDT) via a presentation after the baseline data were analysed. We looked at correct documentation and how to fix common mistakes identified. We asked staff for their input on how to improve outcomes. Posters were printed off for guidance. We collected data after this intervention using the same pro forma.

STUDY

We analysed the results from PSDA cycle 1, comparing them to baseline results.

ACT

Our next step in PDSA cycle 2 would be to focus on continuing to improve poorer results such as prolactin levels and ECGs, with input from the MDT.

Results. Baseline data showed between a 14% and 59% completion rate for various baseline bloods, 68–72% completion rate for heart rate (HR)/blood pressure (BP)/weight and a 36% completion rate for ECGs.

Following PDSA cycle 1, this improved to between a 55–100% completion rate for baseline bloods, a 91% completion rate for HR/BP/weight and a 64% completion rate for ECGs.

Baseline documentation of these parameters was correctly recorded between 9–68% of the time. This overall improved after PSDA cycle 1 to 18–73%.

Conclusion. Our intervention from PDSA cycle 1 improved completion of bloods, physical parameters and ECGs in the HTCR team. Documentation also improved in all domains.

Our next step in PDSA cycle 2 would be to focus on continuing to improve poorer results, looking at altering practicalities that may have affected those areas.

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