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 intro-
duced in the service.

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

Dr Elizabeth Andargachew*, Dr Ben Pearson-Stuttrand and Dr Louise Mowatt
St Johns Hospital, Livingston, United Kingdom
*Presenting author.

doi: 10.1192/bjo.2022.269

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 sug-
gests 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 experi-
ence. 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 improve-
ment. 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 appropri-
ately 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 requir-
ing 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 administra-
tion 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 compli-
ance. 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

Dr Cedar Andress*, Dr Paul Coulter and Dr Leah Watson
Southern Trust, Northern Ireland, United Kingdom
*Presenting author.
doi: 10.1192/bjo.2022.270

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 recom-
manded 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 antipsy-
chotics 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 base-
line 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 PSDA 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% comple-
tion rate for various baseline bloods, 68-72% completion rate
for heart rate (HR)/blood pressure (BP)/weight and a 36% com-
pletion rate for ECGs.

Following PSDA 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 PSDA cycle 1 improved com-
pletion of bloods, physical parameters and ECGs in the HTCR
team. Documentation also improved in all domains.

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