psychiatry as a speciality to medical students. Larger sample sizes and additional data collection may be needed to detect more nuanced effects of these interventions: particularly in areas concerning self-stigma. Incorporating free-text responses in future evaluations could provide valuable qualitative insights into students' experiences.

Westminster CAMHS Happy Doc Spread Reducing Initial Assessment Time: Freeing Up Time for Treatment

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Aims:

Main outcome: To reduce the total time taken for Initial Assessments (IAs) in CAMHS by 10% by January 2025.

Process measure: To reduce time taken to complete the Initial Assessment Form and Care Plan letter.

Balance measures: To improve service user experience of the assessment process; to improve clinician experience of completing Initial Assessments (IAs).

Methods: PDSA 1: Developmental and medical history form collected ahead of Initial Assessment.

PDSA 2: Happy Doc Initial Assessment Proforma and automated Care Plan Letter.

PDSA 3: Dictation software.

PDSA 4: Locally developed wild card PDSA – parents offered a "Pre-assessment" session, initially trialled as a phone session (PDSA 4 i) and subsequently in person (PDSA 4 ii).

A parent QI Team member offered Expert by Experience advice on design and implementation. Parent views on the Care Plan Letter and Pre-assessment session are being collected by questionnaire. Qualitative and quantitative data has been collected from clinicians on each PDSA cycle.

Results: PDSA 1: Medical & Developmental History forms were not returned to the clinic ahead of assessment. To implement differently within PDSA 4.

PDSA 2: Process measure indicated 35% reduction in Time to complete IA Form and Care Plan Letter.

PDSA 3 and 4: No change to Total Initial Assessment Time yet. Possible early suggestion of reduced variation between assessments.

Parent feedback: Face to face Pre-assessment Clinic rated as positive and useful experience. Parents appreciate a space to share information without their children present.

Clinician feedback: "The assessment has felt so much quicker with the Pre-assessment session. Usually it feels unfinished after 2 appointments but I feel that I have enough information to conclude the assessment."

Conclusion: The significant reduction of time from PDSA 2 (35%) reflected by the Process Measure has not yet impacted significantly on the Total IA Time.

Subsequent introduction of dictation software (DragonMedical1) was difficult for clinicians, with low satisfaction and negative impact on time. With further use and individual adaptation, feedback improved. Implementation of a technology to aid workflow may require more time for learning before benefits become evident.

Parent engagement in telephone Pre-assessment Clinic (PDSA 4i) was poor. Following further iteration to in-person format (PDSA 4ii), engagement and feedback have improved.

The Pre-assessment Clinic has reduced assessment related tasks for clinicians who report this as a positive experience.

Positive staff stories about the Happy Doc Initial Assessment Proforma and Care Plan Letter led to the whole service deciding to adopt it.

Supporting Non-Psychiatric Trainees to Engage with Reflective Practice and Attend to Their Wellbeing Through Balint Group

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Aims: Doctors in training report high rates of burnout. The Balint group lends itself to addressing emotional stress and hence the associated risk of burnout. However, Balint group attendance among GP trainees and foundation doctors locally has been poor compared with psychiatric trainees. A Quality Improvement project was undertaken to explore and address barriers to attendance with the aim of improving GP trainees' and foundation doctors' engagement with the Balint group.

Methods: QI methodology was used throughout 2024. We implemented a quantitative, cross-sectional design using anonymous online surveys. We used purposive sampling by sending the surveys to GP trainees and foundation doctors on psychiatric placements within Kent and Medway NHS and Social Care Partnership Trust (KMPT). The survey was semi-structured, with closed and open-ended responses. The survey explored their understanding of the Balint group, how important they perceived it to be, and the barriers they experienced to attending.

Data gathered informed several 'change ideas' which were implemented through consecutive plan-do-study-act (PDSA) cycles. The timing of Balint groups was changed to ensure that less-than-full-time doctors had options to attend and that groups were less likely to conflict with clinical commitments. Improvements were made to the induction process to better socialise non-psychiatric trainees with the Balint group. A face-to-face format was trialled, replacing the previous virtual format.

Post-intervention surveys were administered, which included validated measures of burnout (Abbreviated Copenhagen Burnout Inventory).

Results: Resident doctors' understanding of the Balint group's function and process has improved. In parallel, attendance has increased in some Balint groups; for example, 75% attendance in June 2024 compared with 25% in March 2024. However, with frequent rotations of GP trainees and foundation doctors, each cohort having its own needs and preferences, we have found that improvements are not consistently sustained. Barriers still exist, such as conflicts with clinical commitments and the format feeling 'alien' and unhelpful to others. Changes to the degree of burnout through attending the Balint group are inconclusive and will be clarified with the results of a follow-up survey in March 2025.

Conclusion: GP trainees and foundation doctors are better able to engage with the Balint group when barriers to attendance are actively addressed. However, not all resident doctors feel comfortable with the Balint group format, and hence it may not reduce the risk of burnout for these individuals; in such cases, attendance should not be mandated.

Procyclidine Use with Long-Acting Injectable Antipsychotics

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Aims: Our aim was to review if procyclidine is being prescribed as per BNF guidelines at DGS CMHT. As per BNF guidelines, procyclidine is recommended to be initiated at 2.5 mg of procyclidine three times per day increasing by 2.5 mg daily until symptoms are relieved. The effective maintenance dose is usually 10–30 mg procyclidine per day. After a period of 3–4 months of therapy, procyclidine should be withdrawn and the patient should be observed to see whether the neuroleptic-induced extrapyramidal symptoms recur.
Methods: A retrospective clinical audit was conducted on 36 patients receiving long-acting injectable antipsychotics at the Dartford, Gravesham, and Swanley Community Mental Health Team (DGS CMHT) between September 15, 2023, and January 7, 2024. Data was collected on patient demographics, diagnosis, antipsychotic medication, procyclidine use, Glasgow Antipsychotic Side-effect Scale (GASS) scores, and procyclidine review.
Results: The majority of patients were male (27 out of 36 [75%]) and in the 55–64 age range (16 out of 36 [44%]). The primary diagnoses were schizophrenia (25 out of 36 [69%]) and bipolar disorder (9 out of 36 [25%]). 14 out of 36 patients (39%) were currently taking regular procyclidine, with doses ranging from 5 mg once daily to 10 mg three times daily, while 6 were taking procyclidine as PRN. Regular procyclidine reviews were undertaken in 13 patients (92.9%), with review intervals ranging from monthly to 6-monthly. The common outcomes of reviews included dose adjustments, side effect monitoring, and discontinued use due to adverse effects or lack of efficacy. Out of those on regular procyclidine, 9 patients (64%) showed an improvement in their GASS scores. Among those on regular procyclidine, the starting dose was not available for 6 patients because the starting time pre-dates electronic records. From those included in our electronic records, the data indicates that the starting dose of procyclidine varied, with some patients being started on 5 mg as per need and later changed to regular, while others being started on 5 mg once a day, but none was started as per the trust recommended dosage of 2.5 mg three times a day. While there is no specific mention of a plan to review within 3–4 months for response to start of, or change in dosage of procyclidine, the data suggests, however, that regular reviews were being conducted to monitor the effectiveness and side effects of procyclidine. However, 4 patients, when they were first started on procyclidine, were asked to be reviewed by the GP.
Conclusion: The clinical audit demonstrates that procyclidine was being used to manage extrapyramidal side effects in patients receiving long-acting injectable antipsychotics at the DGS CMHT. The starting doses and review intervals for procyclidine varied, but regular monitoring of GASS scores and patient outcomes was occurring. The data suggests that procyclidine was generally effective in improving GASS scores and managing extrapyramidal symptoms, with 64% of patients showing improvement. It was worth noting that none of the patients in the record were started on the recommended starting dose of 2.5 mg TDS. Increasing awareness of trust protocol regarding prescribing of procyclidine is recommended to ensure evidence-based practice. This was presented in the local audit conference with team of doctors and pharmacists and changes implemented.

A Safer Prescription: Quality Improvement in Medication Practices on West Ward

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Aims: To reduce medication errors on West Ward, a busy adult mental health ward, by addressing multiple domains of medication safety identified in a baseline audit. The project aimed to improve prescribing practices, medication administration, and related processes through targeted interventions and continuous monitoring.
Methods: A baseline audit of medication practices on West Ward revealed significant errors across various domains, including temperature recording, medication stock management, MHRA actions and alerts, record keeping, incomplete processes, prescribing technicalities, clinical issues, administration errors, controlled drug management, emergency drug and equipment availability, medicine ordering, and medicine information.

A quality improvement (QI) project was implemented over six months, incorporating three Plan-Do-Study-Act (PDSA) cycles. Interventions included:

Training: Targeted training for doctors and nurses on best practices in medication safety, focusing on identified error hotspots.

Documentation Improvement: Introduction of standardised templates and improved documentation processes to enhance clarity and completeness.

Induction Changes: Revision of the induction process for new staff to emphasise medication safety protocols and ward-specific procedures.

Controlled Drug Review: A comprehensive review and strengthening of controlled drug management procedures, including prescribing, storage, and administration.

MHRA Record Keeping Review: Implementation of a robust system for recording and acting upon MHRA alerts and drug safety information.

Data was collected throughout the project using regular audits of medication practices, mirroring the baseline audit. Error rates were tracked across all targeted domains for each PDSA cycle to assess the impact of the interventions. Sustained improvement was evaluated through follow-up audits after the project's completion.
Results: The QI project demonstrated a significant reduction in medication errors on West Ward. Overall, a 51% reduction in the total number of medication errors was achieved over the six-month period. Each PDSA cycle contributed to this improvement, with error rates progressively decreasing. Specific areas showing marked improvement included prescribing technicalities, administration