Methods: An eleven-question survey was devised which included nine 5-point Likert scale questions and two free text questions. In November 2024 the survey was sent to current resident doctors to gather feedback about the original induction. There were eight respondents, and based on this feedback a new induction was set up. The existing presentation was replaced with seminar-style discussion and a duty doctor simulation session, led by current psychiatry trainees. This focused on site-specific scenarios designed to familiarize new trainees with common challenges.

In December 2024 five new resident doctors received this new trainee-led induction and following this they completed the survey. Again, based on this feedback the induction process was adjusted and in February 2025 five new resident doctors completed the updated induction and provided feedback via the survey.

Results: The feedback from doctors who had received the original induction was poor, and there was marked improvement in responses for both the December 2024 and February 2025 induction.

Of those who received the original induction, only 14% agreed that the induction had prepared them well for their first on-call shift at SMHC. This improved to 100% and 80% with the implementation of the new induction. There were also marked improvements in the number of respondents that agreed that induction helped them understand the post's roles and responsibilities, as well as their understanding of the electronic handover document. Improvements were also evident in the resident doctors feeling more confident in their ability to contact senior psychiatry colleagues and other acute specialities.

Conclusion: The new induction format has significantly improved the induction experience at SMHC, and resident doctors now feel more prepared for on-call shifts. We hope that this will eventually improve trainee morale, overall satisfaction with the training post and also improve clinical care.

This new version of induction will continue to be delivered, and feedback will be collected to ensure ongoing improvement. We await the results of the Scottish training survey and GMC national training survey to see whether our data is reflected in their results.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Simulated Resuscitation in a Psychiatric Setting (SRiPS)

Dr Abigail Runicles, Dr Leopold Rudolph, Dr Boris Warszawski and Dr Rebecca Howard

South London and Maudsley NHS Trust, London, United Kingdom

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Aims: Resuscitation events can be highly stressful, particularly for those expected to lead them. As a psychiatric doctor on-call, you are often the most senior member of the resuscitation team. However, the available equipment and expertise differ from the medical settings trainees may be accustomed to. This project aimed to create a safe and supportive environment for on-call doctors to practice leading emergency resuscitation scenarios using the available equipment in a psychiatric setting. The goal was to better equip doctors to provide optimal patient care in real emergencies.

Methods: Doctors on the on-call rota across three Oxleas sites were invited to participate in a simulated resuscitation event. Before the session, a questionnaire was distributed to assess their baseline knowledge and confidence regarding resuscitation.

The session was led by an Advanced Life Support (ALS) trainer, a resuscitation officer, and a core trainee. Trainees engaged in three on-call scenarios, including a ligature emergency. Each scenario was followed by a structured debrief, and the sessions were recorded for review.

After the event, participants completed a follow-up questionnaire to evaluate changes in their confidence and knowledge. In total, 11 doctors at various training stages attended the sessions at Green Parks House and Oxleas House.

Results: 27% of the cohort had no prior experience with Advanced Life Support (ALS). Before the session, only 9% of doctors strongly agreed with the statement: "I know what is expected of me in a cardiac arrest scenario." After the session, this increased to 82%.

Following the training, 91% of doctors became familiar with the contents of the emergency medical bag. Before the session, only 36% of participants somewhat agreed that they felt confident leading a cardiac arrest, with none strongly agreeing. After the session, 82% of participants reported increased confidence, including 18% who strongly agreed.

Additionally, 100% of participants found the session beneficial and stated they would recommend it to a colleague.

Conclusion: Overall, the session provided a valuable introduction to resuscitation in a psychiatric setting. Nearly all participants reported improved confidence, increased knowledge of their role in a cardiac arrest scenario, and greater awareness of the contents of the red emergency bag and blue drug box.

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Improving Communication of Discharge Medications to General Practitioners from Inpatient Psychiatric Wards: A Quality Improvement Project

Dr Dylan Thiarya, Mr Mizanoor Rahman and Dr Risha Ruparelia

North London NHS Foundation Trust, London, United Kingdom

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Aims: Upon discharge from an inpatient psychiatric unit, effective communication regarding discharge medications with general practitioners (GPs) is vital for continuity of care. Delaying the transfer of this information may compromise patient safety. According to their guidance, The Royal College of Psychiatrists expect discharge summaries to be sent within 7 days.

The aim of this quality improvement project (QIP) is to improve the time taken for GPs to receive discharge medication information to 7 days, achieving a rate of 100% over 9 months.

Methods: Baseline data was collected for patients discharged in May and June 2024 from two acute psychiatric wards at Edgware Community Hospital. Outcome measures included completion of a discharge summary and the time taken for it to be sent to the GP.

For the first PDSA cycle, a discharge notification form containing only vital information for GPs, and therefore a more succinct method of communication, was created. This form consisted of patient demographics and discharge medication, and was implemented for doctors to complete within a 24-hour period. Post-intervention, in addition to previous outcome measures, completion of a discharge notification and the time taken for it to be sent to the GP was also reviewed.

The second PDSA cycle intervention involved meeting with senior administrative colleagues to address ward clerk cover, and educating new doctors on the discharge notification template.