Virtual RAMPPS - an Online Simulated Teaching Method of the RAMPPS Model

Dr Chinwe Okeke, Dr Ramy Teama, Dr Louise Connor and Dr Daniel Whitney

TEWV NHS Foundation trust, Middlesbrough, United Kingdom

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Aims: Virtual RAMPPS - An Online Simulated Teaching Method of the RAMPPS Model

Methods: We delivered two separate half day courses, each including three scenarios to groups of Foundation Trainees, GP Trainees, Core Trainees and Trust Grade Doctors.Sessions were delivered on MS Teams and participants could answer next steps in their assessment/ management anonymously using Slido.

Physical health emergencies covered included: Ligature Strangulation

Clozapine Induced Bowel Obstruction

Wernicke's Encephalopathy

Neuroleptic Malignant Syndrome

Opioid Overdose

Venous Thrombo-Embolism

There was opportunity for debrief and discussion at the end of each clinical scenario, where personal and systemic factors affecting management of the cases were addressed along with questions from participants.

Results: The study results were derived from qualitative feedback obtained from participants, which was analyzed to identify distinct themes regarding the simulation training. The findings were categorized into two primary domains: **Personal Factors** and **Systemic Factors**.

Under Personal Factors, the analysis highlighted the importance of early recognition, familiarity with guidelines, and case-specific confidence, which directly influenced the management of specific clinical scenarios such as cardiac problems, hypo- and hyper-glycaemia, wound management, and overdoses.

Systemic Factors focused on operational elements, including resources, staffing, team knowledge, and the availability of senior psychiatric colleagues and nursing teams.

The results also mapped the complex logistical challenges faced by staff, such as the practicalities of transferring patients to acute hospitals, remote management, access to patient background information, and the specific limitations of medical provisions available on-site.

Conclusion: Positive feedback demonstrates Virtual RAMPPS is a valuable learning tool, helps with personal factors like knowledge and skills, but also develops participants ability to deal with systemic factors. We intend to expand the course to include additional cases. Consideration will be made into expanding the audience to include physical healthcare practitioners and wider MDT.

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.

Review of Mental Capacity Assessments and Best Interest Documentation on the East Suffolk Older People's Ward at the Norfolk and Suffolk Foundation Trust

Dr Oluwaseun Olaluwoye[1] and Dr Shamim Ruhi[2]

[1]Norfolk and Suffolk NHS foundation Trust, Norwich, United Kingdom and [2]Norfolk and Suffolk NHS foundation Trust, Ipswich, United Kingdom

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Aims: The Mental Capacity Act (MCA) 2005 requires healthcare professionals to assess a patient's capacity to make decisions about their treatment and care. When a patient lacks capacity, a best interest assessment (BIA) must be completed to guide safe and lawful decision-making. Ensuring timely and accurate completion of these forms is essential for safeguarding patient rights and maintaining compliance with legal and Trust-wide standards.

The aim of the audit is to evaluate the completeness and timeliness of Mental Capacity Assessments (MCA) and Best Interest Assessments (BIA) completed for all new admissions to older people's Ward between 1 January and 30 June 2025, in alignment with the MCA 2005 and local Trust policy.

Methods: A retrospective review of the Trust's patient information system was conducted to identify all admissions to older people's Ward during the study period. Transfers from other mental health wards were excluded, and readmissions were counted once. For each admission, the following were recorded: admission status (informal, MHA sections, or DoLS), whether an MCA was completed within 24 hours, capacity outcome, and whether a required BIA was completed within 24 hours. Copies of completed MCA and BIA forms were reviewed for completeness and quality of documented rationale. Data were recorded and analysed using Microsoft Excel.

Results: Thirtytwo patients were admitted during the study period. Most admissions were under section 2 of the Mental Health Act (75%), with additional admissions under section 3 (6%), DoLS (3%), and informal status (16%). MCA forms were completed within 24 hours for 84% of admissions, while 16% were not completed in the required timeframe. One patient (3%) required a BIA; however, this was not completed within 24 hours. All completed MCA forms demonstrated full completion of required sections with clear rationales documented.

Conclusion: The majority of patients admitted to older people's Ward received timely and welldocumented capacity assessments; however, delays remain in a minority of cases, including the timely completion of BIAs. These findings highlight the need for improved consistency in meeting the 24hour documentation requirement and suggest potential areas for staff training, workflow improvement, and strengthened oversight to ensure full compliance with the Mental Capacity Act 2005.

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