responsibility on public bodies such as Royal Colleges to address discrimination in training and assessment. Understanding DA in undergraduate medical education can help understand DA in the postgraduate setting. Consequently, this systematic review aims to detect the processes that enable and impede DA in UK undergraduate medical education.

Method. Seven online databases including PubMed, Scopus, PyschInfo, and ERIC were searched. A formal grey literature search was also conducted. Inclusion criteria comprised studies dated from January 1995 to present and included UK undergraduate medical students. We present the preliminary findings from 13 papers, analysed to create a conceptual framework for a further mixed methods analysis. The studies were critically appraised for methodological quality.

Result. Five key themes emerged from the preliminary analysis of 13 papers. BAME students experienced:

Being 'divergent': Not feeling part of the current organisational learning milieu

Lack of social capital: Difficulty in being absorbed into existing 'networks' of relationships in a manner that is 'approachable' and not 'intimidating'

Continuum of discrimination: 'Indirect' impact of subtle communication processes in the learning environment undermining individual 'belief' in own performance

Institutional discriminatory factors: Culture, rules, norms, and behavioural routines of educators that lead to differential outcomes for learners

Lack of external support: Relative lack of interventions tackling DA.

Conclusion. The key finding of this review is that British BAME undergraduate medical students experience discriminatory behaviours early in medical schools that impact on personal, educational, and professional outcomes. These factors may need to be borne in mind by postgraduate training organisations such as the Royal College of Psychiatrists as they commence the challenging task of addressing DA.

Improving the safety of rapid tranquilisation in older people

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Aims. To identify intramuscular rapid tranquilisation (IMRT) events in all >65 years inpatients in Sussex Partnership NHS Foundation Trust (SPFT) and to establish whether accompanying documentation meets SPFT guidelines. This is a re-audit, initial data were collected in 2016. Multimodal intervention has been implemented since initial data collection. In psychiatric inpatients IMRT should be administered as a last resort to calm acutely disturbed patients after verbal de-escalation and an offer of oral medication has failed. IMRT can cause physical health complications and impact therapeutic relationships. Quality improvements made since initial data collection were: an IMRT treatment algorithm for >65s, a teaching package for staff, IMRT prescription area on medicine cards and post IMRT physical monitoring forms – in line with updates to trust IMRT policy.

Method. Retrospective case note audit cycle of 119 patients. Electronic and paper records were reviewed for inpatients >65 years on 1/9/2019. Records were examined for instances of IMRT– the following features were noted: diagnosis; verbal de-escalation; oral medication offered prior to IMRT; IMRT prescription location; and post-IMRT monitoring. Descriptive statistics were performed. This audit was approved by the trust audit committee.

Result. There were 34 RT events in 17 patients, reduced from 83 RT events in 20 patients in 2016. De-escalation was attempted in 62% versus 34% in 2016, oral medication offered first in 71% versus 59% in 2016. Physical monitoring was fully completed in 50% of instances in 2019, an improvement from 23% in 2016.

Conclusion. Education, a new treatment algorithm, medicine card changes, and IMRT physical monitoring forms have improved adherence to trust standards. There was a 49% reduction in IMRT events in 2019 versus 2016. De-escalation is being performed more frequently, and oral sedation offered in more cases. The physical monitoring of patients has improved.

The psychiatry virtual-on-call experience: Can it improve confidence of foundation and GP trainees with out-of-hours work in psychiatry?

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Aims. Out-of-hours ('on-call') work can be perceived by junior doctors to be a daunting experience, associated with feeling unprepared and less supported. Simulated on-call programmes have been used to great effect in medicine and surgery to improve junior doctors' skills in task prioritisation, interpersonal communication and confidence on-call. However, few psychiatry-specific programmes exist.

We aimed to: i) Develop a psychiatry specific virtual-on-call programme, ii) Investigate if the virtual-on-call programme improved confidence amongst junior trainees in key areas of psychiatry practice.

Method. The Psychiatry Virtual-On-Call programme commenced in December 2020. It involves attending an introductory on-call lecture, followed later in the rotation by a 2-hour simulated on-call shift. All trainees are expected to attend during their attachment and the simulated shifts are ongoing. During the shift, trainees are 'bleeped' with different psychiatry specific tasks. They work through the tasks, using local intranet policies and telephone advice from the on-call psychiatry registrar. Due to COVID-19 the sessions were delivered virtually. Participants completed a questionnaire evaluating confidence in ten domains, rated on a Likert scale from 0–10. Questionnaires were completed at four time-points during the programme; pre- and post-introductory lecture and pre- and post-simulated shift. Scores were compared using Mann-Whitney U tests. Significance was defined as $P < 0.05$ with Bonferroni correction applied for multiple testing.

Result. Twenty-nine trainees attended the introductory lecture, 25 and 21 trainees completed the pre- and post-lecture questionnaire respectively. A non-significant improvement in confidence was reported in three domains: seclusions reviews, prescribing, detention under the mental health act.