

rejected for an assessment which was also statistically significant (27.3% vs 66.7%; chi-square=1.96, p-value \approx 0). Reasons for rejection have been recorded. More age groups (19, 20, 22 years old) were more widely represented in the new cohort of patients.

Conclusion. The introduction of an EDI champion and an EDI discussion, within the clinic intake meeting selection process, seems a valuable instrument to tailor intervention for disparity groups (e.g. ethnicity), assessing both quality and disparities at the same time aiming for a Culturally Competent Quality Improvement within the service. This findings can be easily applied to other departments and implemented more broadly.

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Induction Folder for New Doctors in Psychiatry in North Wales- a Quality Improvement Project to Make Life Easy for Junior Doctors

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Aims. The purpose of induction is to welcome our new employees and also ensure that they have the information and support to carry out their roles effectively. A robust induction not only benefits the doctor but also helps employers to ensure the delivery of high-quality patient care, increases retention, reduces absenteeism, and will promote the organization as a good employer. Doctors need to be supported in the workplace to provide safe, high-quality patient care. Induction as a minimum should introduce doctors to employer procedures and rules, arrangements for clinical governance (patient safety, clinical errors, clinical risk management, complaints, and litigation), orientation, and support. We have developed a new Induction folder containing all the necessary information for a beginner in Psychiatry in North Wales

Methods. We initially arranged for a preintervention questionnaire for the Junior doctors in Psychiatry in North Wales. That included Core trainees, Foundation year doctors, Senior house officers (LAS CT- SHO, JCF- non-training post), and GP trainees.

The QIP started in 2019 August with Audits followed by PDSA cycles. Over a period of 2 years, various doctors both from the present and from the last 3 years were contacted via email and google forms. We completed 3 PDSA cycles.

During these 2 years, we included certain topics that were missed, such as medication during an emergency, contact details from the deanery, etc. We have been following up on the Induction folder with the new doctors as and when there is new recruitment.

Results. The first PDSA showed promising results. Following the first PDSA, we amended a few changes in order to improve the response which resulted in an overwhelmingly positive response from the new doctors/ old doctors in Psychiatry. Following the third PDSA, we included details from the deanery contact and updated the contact details from our own trust.

Conclusion. 2 years of work on this project has yielded good results. However, the sustainability of changes is questionable. This indicates continuity in changes. We are hoping that the new trainee doctors, either junior or senior trainees can consider

working on this project and continue to amend changes on yearly basis.

The amended version of the folder can be completed at least 4 weeks prior to the major induction that happens every August.

We will consider sharing the Induction folder as handbooks/pdf versions to all the trainees and non-trainees in our trust. Apart from this, we will continue to keep the information at a high quality and standards. We will achieve this by ensuring feedback from the new doctors.

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Medical Emergency Drills: An Essential Component of Inpatient Psychiatric Care

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Aims. At Farmfield Hospital, medical emergency drills are conducted monthly, as well as at all other Elysium Healthcare sites. Managing medical emergencies is an expected component of inpatient care, though without regular practice of Immediate Life Support (ILS) skills they can degrade rapidly. We propose that medical emergency drills should be considered an essential component of inpatient care, and explore how we have used them to create targeted teaching and to build skills after significant events.

Methods. We reviewed all medical emergency drills at Farmfield Hospital over the previous 12 months, looking through standardised event reports and feedback on quality and timing of response. We explore and compare qualitative feedback from involved staff members, and detail methods by which medical emergency drills can be used to create targeted teaching and training where skill gaps are noted.

Results. Staff fed back that these drills are key to building their confidence in managing medical emergencies. Core reports include that without these drills, for some staff the only regular practice would be at annual ILS recertification, and reports that they would feel considerably less confident to manage medical emergencies without regular practice and feedback. We use a case study exploring human factors and leadership skills being highlighted in one emergency drill as needing improvement, and how through targeted training and reassessment through subsequent drills we improved this skill gap and enabled staff to become more confident leaders in emergency situations as measured by direct feedback and assessment in subsequent drills.

Conclusion. Medical emergency drills are not currently standard practice across psychiatric inpatient services, and this creates several challenges. While ILS recertification is annual, these are perishable skills, and without regular practice confidence falls rapidly. Moreover, specific skill gaps such as leadership or even technical competencies such as familiarity with specific emergency equipment may go unnoticed until needed in a live medical emergency call. Organising these drills does not require a significant time investment, and we have found the increase in quality of response and staff confidence in managing emergencies makes these drills an essential part of our standard practice. We propose a simple structure for drill design and assessment as part of an ongoing Quality Improvement architecture.

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Co-Production of a Digital Symptom Self-Management Resource for Patients With Functional Neurological Disorder

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Aims. Patients with Functional Neurological Disorder (FND) experience neurological symptoms which may impair motor control, sensory function, or awareness. Long waiting lists before treatment mean the risk of relapse during this period is high. A lack of knowledge around FND also results in a lower quality of life. Therefore, it is important patients with FND receive appropriate psychoeducation to empower them to understand and manage their symptoms. We aimed to strengthen our symptom self-management booklet for patients in a community neuro-psychiatry setting, using a co-production model and taking forward improvements into a digital audiovisual format.

Methods. We used co-production as part of a quality improvement project (QIP) at East Kent Neuropsychiatry Service to identify improvements to our existing symptom self-management booklet and apply these in the production of a digital resource. Initially, the symptom self-management booklet was distributed to 10 patients, awaiting further assessment and treatment, chosen by the multidisciplinary team following triage appointments. Two weeks later, 7 patients reviewed the booklet with 4 medical students by phone and qualitative and quantitative feedback was obtained from patients and carers. Quantitative feedback was collected using an adapted 20-point Ensuring Quality Information for Patients (EQIP) tool. Informed by this feedback, scripts were developed for the audiovisual resource. The scripts were further reviewed by a medical student, 2 multidisciplinary team members and 3 Trust Communications Department members.

Results. The first QIP cycle highlighted the importance of the symptom self-management booklet. Most patients had used the booklet. Patients found it a helpful source of information. Two patients noticed a considerable improvement in their quality of life, others did not due to the short length of booklet use. EQIP tool demonstrated an improved score of 80.51% compared to previous round of feedback (53.33%). Carers identified the booklet as reassuring. Additional links to external information was identified as an area for development.

Patient feedback informed the development of scripts for the audiovisual resource. Consultation with the Trust Communications Department identified three themes of improvement: accessibility to patients, increased clarity and concise language, and an appropriate visual format, therefore scripts were further refined.

Conclusion. Our QIP shows the value of a psychoeducation and symptom self-management tool for FND patients which was positively received by patients and carers. Collaborating with patients in the digitalisation of this information allows for a more

accessible resource which effectively addresses patient concerns and empowers symptom self-management.

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Quality Improvement Project to Co-Produce Effective Triangulated Communication Between Inpatient Psychiatric Team, Community Mental Health Teams, Patients and Carers to Help Patient Involvement and Positive Step Down Discharge Planning

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Aims. The aim of the QI project was to promote patient involvement, choice and recovery using effective communication and collaborative planning. To achieve this, we aimed to ensure that patient's voice remained central to the decision making process in meetings. Using 5-Why QI methodology, the MDT of Delfryn-House—a private 28-bedded rehabilitation unit, reviewed the communication interruptions between the internal and external CMHT (especially after the pandemic), which in turn was hampering patients' progress towards positive discharge. It was also noticed that patients' attendance was significantly dropped and they were not showing interest in their CPA/CTP meetings, as they were not seeing any benefits of them. The MDT planned the project to improve the communication for continuity of care and to have better involvement of patients, their families and external teams.

Methods. The Intervention project, based on QI model-of-improvement, established that effective communication was the main aim, to be achieved with new change ideas. The outcomes were both qualitatively and quantitatively measured e.g.using feedback questionnaires from CMHT and patients and carers, attendance and discussion of discharge goals for the admitted patients. Driver diagrams were used for change ideas e.g. Microsoft teams invites to all teams for the patient review and care plan review meetings, MDT adding the progress feedback to the patient review meeting proforma to be shared internally and externally prior to the meetings, informing the care coordinators prior to change in Mental health act status, same day email to CCOs about medication changes, incidents, safeguarding, and ensuring discharge goals are discussed at every meeting. Satisfaction surveys to the CMHTs and patients were conducted pre- and post-intervention. Qualitative data were collated, helping to generate quantitative statistical analysis of the satisfaction ratings. The attendance of meetings and positive discharge from the unit were also used to measure the outcomes.

Results. There was significant improvement in both commissioners and CMHT's satisfaction of improved communication from Delfryn House. There was increase in attendance (44% by patients, 20% by carers, 64%by CMHT and 40% by Commissioners). There was increase (45%) in patients reading and signing their care plans. A notable increase in positive step-down discharge plans were noted, however, as the QI project was run in a rehabilitation unit requiring longer admissions, there were not many actual discharges to show a noticeable difference.

Conclusion. The QI-project helped in establishing clearer pathways towards positive discharge and continuity of care, signifying the importance of effective communication between teams and