trust protocols and incident reports, included increasing confidence with: identifying physical signs and symptoms of fractures and head injuries; initial assessments, management, ongoing review, and escalation process following a fall; the role of team working, handover and communication with family and colleagues; documentation and reporting systems after falls incidence, and increased awareness of the tools available to assist on the intranet.

Each delivery is co-facilitated by simulation faculty and ward staff. The course features four simulated patients, portrayed by actors. The scenarios are designed to each include different risk factors, mechanisms and consequences of falls. Each scenario is followed by a reflective modified diamond debrief.

Results: Pre and post-course questionnaires currently show increased confidence with regard to all the learning objectives. A thematic analysis of free text comments will also be presented, alongside reflections from the facilitators.

Conclusion: Simulation using live actors is an under-utilised medium for training in situations where physical and mental health presentations co-occur, and can be instrumental in embedding new policies or learning from serious incidents.

Addressing the Complexities of Physical Health Monitoring in ADHD and Autism in Oxfordshire: Implications for Overall Well-Being and Psychiatric Treatment

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doi: 10.1192/bjo.2025.10317

Aims: Individuals with ADHD and autism may face increased risks of cardiovascular issues or metabolic disorders influenced by both their neurodevelopmental traits and prescribed treatments. Ensuring consistent monitoring can help manage these risks and support better long-term outcomes. This paper explores the challenges of physical health monitoring in ADHD and autism and presents a quality improvement project aimed at enhancing monitoring practices in clinical care.

Methods: Challenges in physical health monitoring for individuals with ADHD and autism include variability in practice, limited access to medical equipment, space constraints in clinical settings, and the need for clearer guidelines. To address these issues, we conducted an assessment within the ADHD and autism service in Oxfordshire to identify essential materials for comprehensive monitoring of ADHD medications, antipsychotics, and antidepressants, alongside overall physical well-being.

Results: Key materials identified included blood pressure monitors, ECG machines, height and weight measurement tools, blood glucose and cholesterol testing kits, liver and kidney function tests, electrolyte testing kits, drug screening tests, and nutritional assessment tools. The assessment identified several challenges in physical health monitoring within ADHD autism service. Out of 12 assessed items, 58.33% had the necessary materials available, though essential equipment was not always present, and time constraints made integration difficult. Among those, 85.7% had functioning equipment, while 14.3% had non-functional equipment.

Conclusion: In ADHD and autism services, where psychopharmacology plays a central role in treatment, the importance of physical health monitoring becomes even more critical due to the side effects of medications such as stimulants, antipsychotics, and antidepressants. Inconsistencies in equipment availability, maintenance, and staff training were noted, leading to potential risks to patient safety, reduced efficiency, and increased costs. Recommendations include improved maintenance, acquisition of additional equipment, and enhanced staff training to ensure effective monitoring across services.

Breaking the Silence: Exploring Barriers to Raising Concerns in Psychiatry

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doi: 10.1192/bjo.2025.10318

Aims: Raising concerns is an important duty for those working in medicine, which can have a broad impact on factors including safety, training, and wellbeing. This project aims to explore resident doctors' experiences of raising concerns in psychiatry, including establishing awareness of available processes, and identifying barriers to utilising these. This work has been conducted as part of a wider Quality Improvement Project, aiming to improve resident doctor awareness and engagement with the process of raising concerns by overcoming identified barriers.

Methods: Resident doctors of various grades working in psychiatry within a six month period were invited to attend focus groups to gather information about their perspectives of raising concerns. Thematic analysis of focus group discussion was conducted. Quantitative data was obtained from an online survey which was sent to all resident doctors working in the trust for anonymous completion.

Results: 19 resident doctors attended focus groups. Thematic analysis of this content demonstrated five key themes with additional subthemes:

Repercussions (impact on career + feedback, wellbeing, reputation).

Futility.

Uncertainty (culture, acceptability, process).

Division (hierarchy, staff groups).

Variability (receptiveness, response, supervisor relationship).

25 resident doctors responded to the survey: 52% felt unfamiliar with the process for raising concerns; 5 respondents had raised a concern within the trust; 9 had experienced concerns that they had wanted to raise but could not.

Most concerns related to training (56%), supervision from seniors (31%), patient safety (25%), bullying/harassment (19%), and resident doctor wellbeing (13%). 16% of respondents felt that a barrier to raising a concern was related to race, sexuality, gender, or any other protected characteristic. 57% felt they were not taken seriously when they had raised a concern. 71% felt they had not received adequate feedback after raising a concern.

Conclusion: Resident doctors are experiencing a range of concerns, but many find that barriers prevent them from raising these. These barriers generally relate to uncertainty regarding the process, futility

of raising concerns based on previous experiences, and fear of repercussions. This data suggests that there are issues resident doctors are experiencing that are going unreported, relating to their own training experiences as well as patient safety concerns. Focus group data has allowed us to have a better understanding of the barriers resident doctors face when raising concerns. Subsequently, we are working alongside resident doctors and key stakeholders using Quality Improvement methodology to trial the implementation of several change ideas to streamline the process of raising concerns.

Improving Carer Recognition and Understanding of Constipation for People with Intellectual Disability: Quality Assurance of an Online Learning Resource

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doi: 10.1192/bjo.2025.10319

Aims: People with Intellectual Disability (PwID) have a reduced life expectancy in comparison to the general population, and constipation has been identified as a contributing factor to mortality by the Learning Disability Mortality Review. As part of a broader Quality Improvement project seeking out ways to reduce the rate of constipation for PwID it was recognised that robust and long-term education of carers was lacking.

An online learning resource was created 'Constipation in PwID for Social Carers' to support those caring for PwID to recognise and appropriately signpost constipation-related issues.

The learning resource was created by healthcare professionals, and it was therefore deemed necessary to undertake Quality Assurance of the module to ensure it was appropriate in both content and tone for support workers working in the social care sector. The final module was developed therefore with the input of those it was aiming to teach.

Methods: Focus groups and feedback forms collected information regarding carer's role, experience working with PwID, understanding and relevance of learning outcomes, overall quality, and suggested improvements of the learning resource. This was undertaken in focus groups, or on a one-to-one basis. Feedback forms were completed by 12 individual participants. Focus groups involved 20 participants total including community nurses, supported living managers, support workers, social workers, and occupational therapists.

Results: Overall, the quality of the draft learning resource was rated 'excellent' and the general feedback was that it was appropriately pitched for carers. Aspects of the draft that helped with understanding content involved the use of scenario based interactive questions and visual aids. The information which was considered most useful included the Bristol Stool Chart, red light signs of constipation, and statistics on the prevalence of constipation in PwID.

Suggested improvements for language were consistent terminology for PwID, and avoiding medical jargon to keep advice applicable in different settings. Participants asked for clear communication of the responsibility of support workers to escalate information to supported living management, GP, and NHS 111.

Conclusion: Undertaking a robust Quality Assurance exercise for this online learning resource has ensured that language and terminology is appropriate for the target audience. Participants requested a clear message about how to escalate concerns. The next step will be to publish the resource online and evaluate its effectiveness in improving knowledge of constipation for carers of PwID.

Enhancing RCPsych Addiction Competencies: A Pilot Programme Integrating Training and Taster Days for North London Foundation Trust's Core Trainees

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doi: 10.1192/bjo.2025.10320

Aims: There are new requirements for addictions competencies as part of the 2022 core trainee curriculum. The Silver Guide, section 5.1.2 includes a requirement for two work based placed assessments (WBPA) in addictions to be completed during core training. This has posed challenges nationally, especially in England due to the way addiction services are commissioned and tendered. Whilst most training schemes have opted for CBD groups, our region of London wanted to provide practical and experiential learning with taster days at both NHS and 3rd sector services. Trainees were an integral part of the stakeholder group to ensure co-production.

Methods: Between Nov 23 and March 24, a pilot training lecture day and 4 taster days were held. Trainees registered on a first-come-first-served basis. The taster days gave trainees an opportunity to assess at least one patient under supervision in an addictions environment and have a case-based discussion (CBD) with an addictions consultant. The teaching day included presentations across addiction topics requested by the trainees. Feedback, both quantitative and qualitative was collated after both events.

Results: 100% of trainees felt more confident in assessing patients with substance use problems and 88% felt more confident in management after attendance. 100% of trainees also felt that the programme gave them useful knowledge in their future practice beyond what could be offered by other sources. 100% of trainees also felt the topics were relevant and would recommend the course to others. Trainees described the taster days as providing "intensive, immersive and enriching experience", and that 1 trainee each day "was the right level". It was also described as "a really great learning opportunity" that they "would do again".

Conclusion: Both the training day and taster days had overwhelmingly positive feedback. This has led to a permanent implementation of a rotating programme between the 3rd sector and NHS addiction services in the region. Particularly with the new curriculum requirements, these appear to fill a gap in trainee learning. This programme is the first of its kind in the country, as other trusts have opted to run CBD groups. The aim will be to expand this into an annual programme for all core trainees in the trust, continually improve on the structure and possibly expand attendance to higher grades. This year, many doctors of varying grades, including other consultants have expressed interest in attending. Widening addiction training will only improve patient care nationally.