challenges the practice of lighting the funeral pyre only by the sons. She reminisces telling her mother that once she dies she will get all her jewellery and displays guilt around this, leading to significantly low mood and bargaining as well. Once they are in the process of finishing all the rituals she comes to terms with her mother's death and reconciles with her father, showing acceptance.

The cultural milieu plays a strong role in various responses to bereavement. The family follows various Hindu rituals for 13 days, which helped them stick to each other's side and reach the stage of acceptance following the death of a daughter, a sister, a wife and a mother.

Conclusion. This movie beautifully exemplifies how grief is a universal concept even in various socio-cultural backgrounds. It is a good study for anyone interested in understanding grief through a cultural medium. It demonstrates the importance of support network in tiding over significant life events.

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Disseminating Lessons Learned From Serious Incidents (SI): Multidisciplinary Ward Based Simulation and Bite-Sized-Teaching

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Aims. Improve staff confidence in responding to and managing ward based medical emergencies

Methods. The deputy borough lead nurse, a clinical nurse manager and a core trainee met to discuss how to build confidence across all staff in responding to ward-based medical emergencies following a number of recent SI.

Initially, weekly ward-based simulations were conducted. Scenarios were SI focused and included choking, drug overdose, head injury and hanging. Whilst it was clear there was an appetite for learning and upskilling, unannounced simulations did not appear to foster a relaxed, productive learning environment conducive to building confidence.

Following four weeks of simulation, the approach was altered. Instead of unannounced simulations, sessions were broken down into three parts. Firstly, each session began with a brainstorm of 'key roles for any medical emergency' (call for help, vital signs, scribe…), this was followed by a skills session on key topics. Areas for learning were identified following an MDT discussion and staff feedback focus group. These were; 1. Grab bag orientation, 2. Oxygen delivery, 3. SBAR handover, 4. Operating the suction machine, 5. A-E assessment. Finally, all sessions ended with practicing CPR on first aid training manikins. Sessions ran once or twice a week, depending on availability, rotating through the seven inpatient wards. Each session lasted approximately 20 minutes and two sessions were run back-to-back in order to ensure where possible every staff member working that shift was able to attend. These sessions have been running since mid-September. To date we have run a total of twelve sessions conducted both in and out-of-hours. After each session participants were asked to fill out feedback.

A 'flash card' aid providing quick action prompts applicable to all medical emergencies was drafted and reviewed by the trust's resuscitation lead for inclusion in ward emergency grab bags.

In addition to ward based teaching, grab-bag orientation sessions were run during doctor's induction.

Results. Ward based learning:

Sessions were attended by nurses, social therapists, occupational therapists and doctors of all grades. Approximately sixty people have attended the bite-sized teaching to date. All participants across all sessions found the teaching useful and relevant.

Junior doctor induction:

All attendees at the inductions strongly agreed the session was useful. 100% agreed that the session helped to increase their confidence around responding to medical emergencies with 78% strongly agreeing. All participants strongly agreed the session improved confidence in utilising the emergency grab bag.

Conclusion. People with severe mental illness are at greater risk of poor physical health and have higher premature mortality than the general population. Responding to medical emergencies in the psychiatric inpatient setting is a source of anxiety for most staff. Currently, nursing staff in psychiatric settings are required to have ILS training, many feel this annual course is insufficient. The majority of the emergency response team have BLS or no physical health training at all. Lone doctors, unfamiliar with available emergency equipment and psychiatric settings lack confidence to act optimally.

There is a great appetite for regular emergency physical health training. Our weekly sessions were well received, useful and relevant.

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Examination of Medical Students' Expectations of Psychiatry Prior to Placement: A Qualitative Study

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Aims. There is limited literature regarding medical students' expectations of psychiatry placements, although studies focussing on nursing students reveal fear and anticipation of aggression and violence to be prominent factors. Anecdotally, authors have been aware of medical students having reported impressions of psychiatric wards which were at odds with the reality. This study aims to explore what medical students specifically imagine and expect from psychiatric wards and psychiatric intensive care units prior to their placement. Psychiatric intensive care, arguably the most intense experience students will have in psychiatry, was used as a specific focus to highlight the full extent of their preconceptions.

Methods. Students undertaking their psychiatry attachment between July and December 2021 were invited to complete a semi-structured questionnaire, deemed to be more preferable to interviews as it was thought that anonymity would encourage more students to participate, provide open and honest responses, thereby exposing the full scope of presumptions. Question content was designed by 2 psychiatrists, with modifications after consultation with 2 student advisors. Questions explored student emotions regarding their visits to psychiatric wards and psychiatric intensive care, as well as expectations of the ward atmosphere, layout, activities, where patients would be, what they would be doing and how they would be managed. 37 responses were received.

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Analysis followed the well-recognised six stages of thematic analysis. Two authors read and coded all text independently, before discussing any discrepancies and then defining and refining themes with involvement from all authors, in a process of several reviews.

Results. Five themes emerged from the data: 1) Mixed feelings about the placement (with anxiety being prominent), 2) Mixed views about patient behaviour with many assumed to be violent, 3) Caring and holistic-minded staff, 4) A restrictive and locked environment, 5) Assumed similarities to acute general hospital care. Some of the expectations of students were markedly different to the realities of psychiatric inpatient and intensive settings, with students reporting ideas of patients in locked rooms, physically restrained, sedated and attached to ventilators.

Conclusion. This study offers a unique insight into what medical students expect from their psychiatry placement, a key issue of which all educators and clinicians who supervise students should be aware. Results can inform better student preparation and placement supervision, leading to more meaningful learning and improved well-being.

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Introducing the Emotional Logic Method as a Self-Care Approach for Staff Well-being

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Aims. The Emotional Logic method teaches that although unpleasant, all emotions have an inbuilt useful purpose. Through recognising our emotional responses to situations, this solution-focused approach helps us discover the hidden losses behind our emotions, empowering us to move forwards. Activating our inner Emotional Logic can help to build emotional resilience, improve self-awareness, strengthen relationships and reduce burn out.

Methods. The Emotional Logic method was introduced to staff across the Learning Disability Psychiatry Division during a two hour webinar. The session was advertised via email circular to all staff with an emphasis on using the method for self-care. It was attended by thirty-two, clinical and non-clinical staff from across the multi-disciplinary team. Interactive polls were used during the session as well as feedback forms at the end.

Results. In Emotional Logic, a safe place is a physical place, relationship or mindset that we can visit when we are doubting our resources to cope, here we can let our emotions settle and make a plan. An interactive poll during the session showed that 98% of staff could identify a safe place. This was reduced to only 52% when asked if they could identify an accessible safe place at work.

The session overall was rated as 4.57 (on a scale of 1 (poor)-5(excellent) 90% said they felt Emotional Logic was relevant to them personally, with the remaining 10% answering "maybe." Qualitative feedback included: "I thoroughly enjoyed all aspects of the session which would benefit me personally and on a professional level" "Helped me to manage my thoughts/control my thoughts" "Its always hard to take a look at yourself and your behaviors or reactions to things that impact you on a daily basis and I think that a lot of people would find it a real benefit." 86% said they would be interested in further learning.

Conclusion. In order to care for other people, we need to first look after ourselves. The striking statistic that 48% of staff do not have an accessible safe place at work highlighted the importance of providing staff with the tools to help improve their own well-being. The session was an introductory session, which will be built on through offering follow up workshops and formal courses. The aim of these will be to improve self-care whilst also providing a language to use with colleagues and patients to help everybody move forwards.

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A Mixed-Methods SWOT Analysis of a Medical Student Balint Group Programme

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Aims. Balint groups explore the clinician-patient relationship, with benefits for empathy, resilience, and interpersonal skills. Their use with medical students is increasing, but more research is needed to understand how their benefit, feasibility and accessibility can be optimised. We aimed to explore this over a one-year pilot of a medical student Balint group programme.

Methods. An explanatory sequential mixed methods design was used. Eight medical student Balint groups ran for six weeks during 2022–2023, with 90 students participating. Students completed quantitative and qualitative feedback at the end of each cohort. Themes were identified using qualitative content analysis. Balint group leaders kept reflective session notes and used these alongside student feedback to undertake a strengths, weaknesses, opportunities and threats analysis of the programme.

Results. Students reported a neutral to slightly positive experience of the groups. Strengths were coded as containment, learning, and community identity. Students identified weaknesses due to pace, facilitation, and anxiety. Threats to the future success of the Balint group programme were related to engagement and the group being perceived as inauspicious and intimidating. Potential opportunities to develop the Balint group programme included widening participation and sharpening focus. The strengths, weaknesses, opportunities, and threats identified by the group leaders were in line with those of the students, but also acknowledged the broad range of ethico-legal material discussed by students, timetabling and organisational challenges. A range of opportunities were identified for how the Balint group programme could optimally enrich the clinical curriculum.

Conclusion. Integrating successful Balint groups into the medical school curriculum is challenging on individual and organisational levels. However, students perceive value in these groups, and they provide a unique space to combine learning and emotional support with personal, professional and community development. Ongoing consideration is needed to optimally and sustainably

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