

The medical device engineering team to complete maintenance and repair as needed.

4. Resuscitation equipment on each ward being checked weekly and replaced as needed (monthly before).

A re-audit was performed one year post intervention on four acute adult inpatient wards in the mental health hospital using similar parameters.

Results.

1. In general, 90.0% of the standards are met (out of 160 pieces of equipment, 144 are in stock and functional), similar to that of previous year (90.0%).
2. Decrease in overall available and functional physical health equipment: 76.6% (49/64) compared to 83.8% last year.
3. Increase in overall in overall available and functional resuscitation equipment: 99.2% (95/96) compared to 94.2% last year.

Conclusion. There is a significant decrease in percentage of overall available and functional physical health equipment; while that of resuscitation equipment has significantly improved when checked and corrected weekly using the trust Resuscitation Check Form.

Action plan:

1. All unavailable/ inadequate equipment to be reordered or sent for maintenance immediately.
2. Discussion in the upcoming trust Physical Health Nurses Forum and Medical Devices Standards Group on audit recommendations below:
 - . Allocation of named permanent staff member to check presence and functionality of medical equipment regularly.
 - a. Creating a checklist similar to the Resuscitation Check Form for physical health equipment.
3. Discussion in the trust Resus Standards Group on 'My Kit Check' (MKC), a centrally monitored electronic checking platform with alerts automatically sent for incomplete checks or expired resuscitation items (e.g., AED batteries, anaphylaxis kit) that are not replaced. A funding request has been submitted for this.

Audit on Smoking Cessation in a Community Secondary Mental Health Service

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Aims. Smoking is the single largest cause of preventable death. Smoking prevalence is higher in people with mental disorders and impacts on physical health, mental health and bioavailability of psychotropic medications. Evidence-based interventions exist to support smoking cessation (SC)/reduction in people with mental disorders, although evidence suggests less provision compared to the general population. We aim to determine the unmet SC needs and associated causes in a community secondary mental health service, in order to advise appropriate service response. This audit will inform relevant work of the RCPsych Public Mental Health Implementation Centre as a case example.

Methods. From the caseload of 364 patients, a sample of 91 case records was randomly selected for recording of smoking and provision of treatment. A survey of 31 smokers and 12 ex-smokers identified patient attitude and barriers in SC. Information on

availability and nature of other SC provision in the community was gathered from staff and relevant services.

Results. A sample of case records found 44% (n = 40) of patients were smokers compared to 13.5% in the general UK population. 31 patients were offered SC advice of whom 2 were recorded as wanting to quit. Nicotine Replacement Therapy (NRT) was offered to 13 patients and 5 were referred to SC services (SCS). Aside from smoking status, limited information on smoking was recorded.

The survey revealed that 20/31 smokers wanted to reduce or quit smoking, of whom 10 used NRT. Six were referred to SCS which helped 3 reduce. Four ex-smokers used SCS, which helped 3 to quit. Most frequently reported barriers in SC were habit, social isolation, availability of tobacco, and stress. Frequently reported enhancers in SC were NRT, allocated support with follow-up, social interventions and family support.

Regarding current service provision, we identified that local GP's did not prescribe NRT. Targeted SCS exist exclusively for inpatients and the only community SCS available offered 12 SC sessions without targeting needs of people with mental disorder.

Conclusion. Despite high smoking prevalence in our caseload, there is an implementation gap in providing and recording SC advice and treatment, both in our service as in local primary care and community services. Provision of evidence-based interventions and coordination with GP's and SCS could prove useful in narrowing this gap. Results from this local project could be explored on a larger scale to address the implementation gap in SC in this population at high risk of smoking associated harm.

An Audit Cycle Highlighting the Rate of Chlamydia Screening in a Forensic Child and Adolescent Mental Health Unit in Birmingham

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Aims. Chlamydia, a sexually transmitted bacterial infection caused by *Chlamydia Trachomatis* can result in long-term complications for affected individuals. The National chlamydia screening programme recommends screening at-risk young persons, however for the vulnerable patients at the Forensic Child and Adolescent Mental Health Service (FCAMHS), there has been no audit to determine the completion rate. This audit aim to (1) Determine the demographics of young persons on admission (2) To determine the rate of chlamydia screening as well as the percentage of patients who qualified for a Chlamydia screening (3) To determine the rate of documentation for completed tests.

Methods. This was a retrospective study. The medical electronic records of patients who met the inclusion criteria was searched. All the three mixed-sex adolescent forensic wards (2 medium secure units and one low secure unit) at FCAMHS Ardenleigh, Birmingham were sampled.

All patients that were on admission aged above 15 years of age were recruited.

A total sample size of 19 was obtained for the initial audit and 12 for the re-audit.

Data collection

Data were collected by the author for the initial-audit and re-audit by searching the clinical progress notes, the investigation

results and the physical health rethink forms. An excel software was used for analysis.

Results. Demographics

There were 11 males (57.9%) and 8 females (42.1%) in the initial audit

In the re-audit, there were 7 males (58.3) and 5 females (41.7). Some of the patients were still on admission at the time of the re-audit, hence the percentages were calculated differently. The mean age and average length of admission was also calculated.

Chlamydia screening

In the initial audit, the percentage of patients tested for Chlamydia was 11.5%, even though 36.8% of patients met the criteria for Chlamydia screening. In the re-audit, 25.0% were tested, and 41.7% met the criteria for Chlamydia screening.

Physical health (Rethink) forms

The physical health form was completed for majority of patients 73.7% in the initial audit although, this was not compatible with screening rates. Before the re-audit was concluded, the physical health forms were no longer in use.

Conclusion. The audit highlighted an overall improvement in the rate of screening following recommendations from initial audit. The inclusion of Chlamydia screening in admission processes could be useful in improving sexual health.

An Audit of the DNACPR Policy at Malta's Mount Carmel Hospital

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Aims. A consideration for patient dignity in end-of-life care dictates that good clinical judgment should be exercised in advance resuscitation decisions. The COVID-19 pandemic, and its inherent risks to caregivers, only adds to this importance. Our aim was to audit the standards for the DNACPR policy at Mount Carmel Hospital (MCH), which is Malta's major inpatient psychiatric hospital, against those at Saint Vincent De Paule Residence (SVPR), which is a long-term care facility where DNACPR decisions are taken by geriatricians as opposed to psychiatrists.

Methods. Resuscitation status designation and rates of form completion were measured in the five chronic psychiatric inpatient wards at MCH. This 98-patient population was compared against an age-matched cohort from SVPR to evaluate differences in decision-making.

Medical comorbidities and frailty scores (measured using the Clinical Frailty Scale) were compared between the two groups. As far as age-groups would allow, as many patients with a psychiatric comorbidity as possible were included from SVPR (36).

Z-score testing for two population proportions was used to evaluate the differences in resuscitation status designation. The Independent Sample T-Test was used to compare means in medical comorbidity and frailty. A p-value of <0.05 was used to assume statistical significance.

Results. Rates of resuscitation form completion were 73.47% and 94.90% in MCH and SVPR, respectively. In those patients with completed documentation, 9.72% of patients were designated as "Not for CPR" in MCH, compared to 61.29% in SVPR.

Between these two age-matched cohorts, the mean frailty score was slightly greater in SVPR, which was not statistically significant (5.83 vs 5.48, $p = 0.1456$). The mean number of medical comorbidities was significantly greater in the SVPR cohort (3.50 vs 2.47, $p = 0.0002$).

Conclusion. This striking difference in DNACPR designation suggests that geriatricians have a higher threshold for determining whether a patient would benefit from CPR compared to psychiatrists. Furthermore, rates of resuscitation form completion at MCH were disappointing. The greater likelihood for chronic psychiatric inpatients to be designated "For CPR" may be due to the perception that this entails a higher level care. In reality, in older, frailer patients, CPR may only prolong suffering, while a "Not for CPR" decision does not necessarily imply an omission of care.

In Malta, we've tailored resuscitation training to the inpatient psychiatry setting, which includes stations on decision-making and COVID-19.

Improving the Use of the Mental Health Risk Assessment (MHRA)

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Aims. The MHRA is a comprehensive form on our electronic patient records system. It includes 11 sections assessing different risk categories, with tick boxes to evidence input from various members of the MDT. Anecdotal experience suggested that these forms were sometimes incomplete and often lacked input from MDT members other than nursing staff. We aimed to increase the completion rate and multidisciplinary team (MDT) involvement, particularly doctor involvement, in the electronic MHRA documentation on an acute inpatient psychiatric assessment ward at the Royal Edinburgh Hospital.

Methods.

- Baseline survey (November cohort of 12 patients): data collection on number of sections completed (total number = 11) and whether the 'psychiatrist' box was ticked, indicating medical input.
- Intervention: doctors on the ward reviewed all inpatient MHRAs, added additional assessments if appropriate, and ticked 'psychiatrist' involvement in the MHRA.
- Repeat survey (February cohort of 11 patients): data collection as before and review of findings.

Results. In our baseline survey (November 2021), 75% (9/12) of patients had all sections of the MHRA completed. 33% (4/12) had the 'psychiatrist' box ticked. In our repeat survey (February 2022), 91% (10/11) of patients had all sections of the MHRA completed. 100% (11/11) had the 'psychiatrist' box ticked.

Conclusion. Accurate assessment and management of risk is an important factor in the safety of patients and staff on acute psychiatric wards. Our baseline data showed that risk assessments had limited medical input and at times had sections which were not filled in at all. Review of the MHRA by medical staff improved this, and in some cases found and added relevant information which had been missed. As a person dependent intervention, this may not be a sustainable change. As a first step to introduce a sustainable system change, a visual prompt has been introduced, in the form of a blue triangle icon in the duty room whiteboard to highlight whether each patient has a complete and up to date MHRA. Further interventions could include integrating a review of the MHRA in weekly ward rounds. This audit also raised the issue of some relevant information having been missed from risk assessments and showed that further audit of the quality of risk assessments is indicated.