

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

Dr Hanna Tu<sup>1,2\*</sup> and Dr Jonathan Campion<sup>1,3</sup>

<sup>1</sup>South London and Maudsley NHS Foundation Trust, London, United Kingdom; <sup>2</sup>KU Leuven, Leuven, Belgium and <sup>3</sup>RCPsych Public Mental Health Implementation Centre, London, United Kingdom

\*Presenting author.

doi: 10.1192/bjo.2022.497

**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

Dr Theresa Ugalahi<sup>1\*</sup>, Dr Hamid Hassan<sup>2</sup> and Dr John O'Brien<sup>2</sup>

<sup>1</sup>Leeds Community Healthcare NHS Trust, Leeds, United Kingdom and <sup>2</sup>Birmingham and Solihull Mental Health Foundation Trust, Birmingham, United Kingdom

\*Presenting author.

doi: 10.1192/bjo.2022.498

**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