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.