patients were discharged to a psychiatric admission and 38% discharged to their usual place of residence.

Discussion: There are clear gaps to collaborating with patients to create safety plans, with minimal evidence they are being provided in writing. This could be impacted by the nature of the workload of the Liaison Psychiatry department, and the unpredictability of awaiting availability of mental health beds. Patients awaiting psychiatric beds may have been too unwell to engage with safety planning. There should be consideration for how to keep this document live and accessible by patients, their regular clinicians and those who may encounter the patient at a time of crisis (GP, mental health teams, liaison teams, emergency department staff and emergency workers).

Conclusion: Prolonged inpatient admission due to either mental health or physical health reasons provides a good opportunity to engage patients with safety planning, an opportunity which is not being utilised within this Liaison Psychiatry department. Within this department there needs to be further uptake of engagement in safety planning.

DNACPR Documentation Audit on Old Age Psychiatry Wards in Aneurin Bevan University Health Board (ABUHB) in South Wales

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Aims: DNACPR All-Wales policy for adults was launched in 2015 by the deputy minister for Health. It was revised in 2017, 2020, 2022 and 2024. DNACPR decisions should be clearly recorded and communicated between health professionals.

This audit aims at assessing the quality of DNACPR on older adult psychiatric wards in ABUHB to identify any deficits and to improve the quality of documentation in the future.

Methods: Inpatients' notes from all four old age psychiatry wards in ABUHB were examined; patients with DNACPR were identified. To gather data, we created an audit tool based on all-Wales policy.

Results: 24 DNACPR decision forms were identified.

"Decision date" was missed in 2 forms.

DNACPR decision was not clearly "signed with date and time" in 1 form.

In 10 forms, decision was not "documented in clinical notes" because the decision was made by another team and their notes were not available to examine.

"Discussion with patient" only took place in 9 forms while "discussion with IMCA/attorney or family/carers" took place in 20 forms.

"Patient demographic details" were recorded in all forms but with some errors; one patient's name was incorrectly spelt and one patient had missing details.

For "reason of decision", 1 was "not in the best interest, natural anticipated and accepted death and patient refused CPR", 1 was "patient refused CPR" and 1 had no stated reason. The remaining 21 forms stated "not in the best interest".

For "signatures in section 5 and section 6" where section 5 is for "the health care professional completing the form" while section 6 is for "the senior responsible clinician". The signatures were appropriate in 17 forms. 7 forms were not countersigned in section 6; 5 of these are signed in section 5 by a consultant while 1 is signed by a junior doctor and 1 is signed by a registered nurse.

Different versions of the DNACPR form were being used in some instances.

Conclusion: Identified deficits represent deficient forms which could lead to inappropriate CPR attempts. This could lead to physical and emotional distress and possible litigation.

To avoid this, our audit concludes that DNACPR forms must be completed thoroughly and that a unified version of DNACPR form is to be used. It is also good practice to document the DNACPR discussion in the clinical notes of the patients.

As secondary outcomes, we recommended to add DNACPR status and treatment escalation plan status to our ward round proforma.

Appraising Quality of GP Discharge Letters Completed by the Liaison Team for Patients Reviewed by South of Tees Liaison Team

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Aims: Discharge letters from liaison services to General Practitioners (GPs) are critical for ensuring continuity of care. These letters should contain essential clinical information that aids GPs in managing patients post-discharge. The purpose of this audit is to assess the quality and completeness of discharge letters from South of Tees liaison services and ensure they meet the necessary standards for effective communication.

Methods: Obtain a list of all patients discharged from South Liaison team during the period of 1 September to 30 September.

Randomized selection of 35 GP letters.

Establish availability of discharge letter on the electronic systems.

Appraise discharge letters for patients discharged using audit tool.

Results: Discharge letters on CITO: Only 40% of the letters were available on electronic system. RED.

Lack of GP credentials on the letter: 44% had a clear address and name of the GP practice. RED.

Date of referral to and date of discharge from PSL services: 18% of the letters had a clear mention regarding date of referral while none of the letters mention date of discharge. RED.

Reason for referral: 62% of the available letters had a clear reason for referral. AMBER.

Background history: 44% of the letters noted background history, with majority of them only mentioning psychiatric history. RED.

Summary of clinical assessment: 19% had a section for summary of clinical assessment which is useful to the user, especially the GP, to have an overview regarding psychiatry liaison service involvement. RED.

Risk assessment: 75% of the letters had an easy to identify risk assessment with majority not covering all 3 main groups of risks