For sustainability, further service level interventions have been implemented, including bookmarking the AEC calculator on staff computers (medichec.com) and adding a prompt to the team's initial assessment template to check AEC. These measures aim to continue improving patient outcomes.

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Assessing Documentation of Analgesic Prescribing in a Medium Secure Forensic Psychiatric Setting

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Aims: This service evaluation sought to assess the consistency of documentation in 5 key areas of analgesic prescribing in a medium secure forensic unit in South Wales.
Methods: Five key areas which are important to document when prescribing analgesia were defined as follows: 1) Indication, 2) Prescription Review, 3) Risk, 4) Discontinuation Guidance and 5) Patient Counselling on Analgesic Choice. Data was collated on these 5 key areas for opioid and pregabalin prescriptions between 1 November 2023 and 1 April 2024. Using Hospital Electronic Prescribing and Medicines Administration (HEPMA), it was possible to establish prescription data. Information on each prescription was then collated from: clinical team meeting (CTM) notes, nursing notes, GP contact records and tribunal reports for each patient.
Results: There were 18 analgesic prescriptions which fitted project criteria. 11% prescriptions were for morphine, 17% for co-codamol, 39% for codeine and 33% for pregabalin. Documentation across the 5 key areas was deficient, with 0% patients with documentation in all 5 key areas, 14% patients with documentation in 4 areas, 36% patients with documentation in 3 areas and 50% patients with documentation in <2 areas. Indications were better recorded in CTM notes than on HEPMA. On HEPMA, only 50% prescriptions had an indication, and of those only 6% had a specific indication with the remainder noted as "pain" (33%) or "pain team advice" (11%). In comparison, 90% prescriptions from CTM notes had an indication; the most common indication being leg pain (40%). In terms of prescription reviews, only 56% prescriptions were reviewed. No patients had any documented consideration of the risk of prescribing analgesia based on their substance misuse history despite 93% patients included having a recorded substance misuse history. 57% patients were prescribed the drug they have a recorded history of addiction to. Only 36% prescriptions documented the physical health risks of prescribing analgesia. Similarly, there was no documented guidance for any patient on circumstances to discontinue analgesia. In regard to patient counselling, only 50% patients were counselled on the choice of analgesia.
Conclusion: Multiple sources of information made it time consuming to get a holistic view of each prescription. Some of the key areas such as discontinuation guidance and substance misuse risk were not documented at all, with other areas having sporadic documentation depending on the prescriber. To improve future practice, changing HEPMA to have mandatory fields to record 5 key areas when prescribing analgesia would ensure consistency of documentation.

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Healthcare Contacts Prior to Suicide by Those in Contact With Mental Health Services

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Aims: People under mental health (MH) services' care are at increased risk of suicide. We aimed to identify opportunities for suicide prevention and underpinning data enhancement in people with recent contact with MH services.
Methods: A population-based study of all who died by suicide in the year following an MH services contact in Wales, 2001–2015 (cases), paired with similar patients, with the same mental health diagnoses, who did not die by suicide (controls). We linked the National Confidential Inquiry into Suicide and Safety in Mental Health and the Suicide Information Database – Cymru with primary and secondary healthcare records. We present odds ratios and 95% confidence intervals (OR [95% CI]) of conditional logistic regression.
Results: We matched 1,031 cases with 5,155 controls. In the year before their death, 98.3% of cases were in contact with healthcare services, and 28.5% presented with self-harm.

A high proportion (98.3%) of cases were in contact with primary and secondary healthcare services in the year before their death. Compared with controls, cases were more likely to attend emergency departments (OR 2.4 [2.1–2.7]) and have emergency hospital admissions (OR 1.5 [1.4–1.7]); but less likely to have primary care contacts (OR 0.7 [0.6–0.9]), out-patient attendances (OR 0.2 [0.2–0.3]) and missed/cancelled out-patient appointments (OR 0.9 [0.8–1.0]).

A high proportion of cases presented to primary and secondary healthcare services with accidents, injury and poisoning, and especially self-harm – more so than controls (for self-harm, 28.5% of cases compared with 8.5% of controls; OR 3.6 [2.8–4.5]). This was particularly true for female patients admitted to hospital with injury and poisoning (OR 3.3 [2.5–4.5] in females compared with 2.6 [2.1–3.1] in males).
Conclusion: We may be missing existing opportunities to intervene across all settings, particularly when people present to emergency departments and hospitals, especially with self-harm. Intent underlying injury and poisoning events may be undisclosed, or recorded as undetermined or without specifying intent when they may in fact be self-harm, particularly in females. Efforts should be made to appropriately identify those who are self-harming, including by direct and non-judgmental questioning on presentation underpinned by staff training and awareness. Prevention efforts should focus on strengthening non-urgent and routine contacts (primary