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Audit of advice on driving following hospitalisation for an acute psychotic episode

AIMS AND METHOD

Psychiatrists are expected to follow guidelines in relation to patients' responsibilities regarding driving. In this study we reviewed advice on driving recorded for patients discharged from hospital following an acute psychotic episode. Guidelines on appropriate advice were then sent to all medical staff looking after in-patients.

RESULTS

The first cycle of the audit included 48 patients. No advice was recorded. The second cycle included 70 patients. Advice was recorded for 8 patients. Six of these patients received a standard discharge letter with a prompt for 'driving advice'.

CLINICAL IMPLICATIONS

In contrast to current guidelines, advice regarding driving is not routinely given to patients with an acute psychotic episode. A standard discharge letter with prompts on driving may improve adherence to guidelines.

The Driver and Vehicle Licensing Agency (DVLA; 2005) provides guidelines for doctors on what advice to give to their patients about driving. It is licence holders' legal responsibility to notify the DVLA if they have a medical condition that may affect their driving (Driver and Vehicle Licensing Agency, 2005). Doctors should follow the General Medical Council (GMC) guidelines to notify the DVLA when patients may be unfit to drive and refuse to inform the DVLA themselves (General Medical Council, 2006). Although there is no statutory obligation on doctors to do so, good practice dictates that if a patient fails to notify the DVLA despite attempts at persuasion by the doctor, that doctor should inform the patient that they intend to notify the DVLA without the patient's consent (Royal College of Psychiatrists, 2006). While the onus to notify the DVLA is with the patient, doctors have a responsibility to alert their patients to this, as well as inform them that failure to do so constitutes an offence and may have insurance implications. The importance of carrying out this procedure is highlighted by Taylor (1995), who suggests that medical conditions in drivers may account for 1–2% of road accidents.

Wise & Watson (2001) highlighted that a large percentage of psychiatrists failed to know or apply the existing DVLA regulations. The study was based on the clinicians' account of their knowledge. In this study we aim to test this in a more objective manner by analysing the medical case records of patients discharged from hospital following an acute psychotic episode. A similar study was carried out in 2001 (Rowe *et al*, 2001), but it also included advice recorded irrespective of diagnosis before and after an educational programme.

Method

In a first audit cycle we reviewed medical case records of patients discharged from three acute psychiatric wards in South Glasgow during the period between 1 September 2004 and 1 March 2005, diagnosed with schizophrenia, schizotypal and delusional disorders (ICD–10 (World Health Organization, 1992) codes F20–29). The inclusion criteria were the above diagnosis with an increase in severity of delusions, hallucinations or thought disorder within the previous 3 months. A person was excluded from study where comorbid persistent misuse of or dependency on alcohol and/or drugs was recorded. This is addressed in a separate chapter in the DVLA guidelines.

Each patient was managed by one of seven consultant-led teams. All entries by medical staff into case records were examined. Symptoms on admission and during hospitalisation were reviewed to ensure that there was evidence for diagnosis of an acute psychotic episode. Any advice regarding driving was noted. Following the results of the first round of the audit, a message was distributed to all medical staff looking after in-patients on psychiatric wards. It detailed the aims of the audit and summarised the DVLA advice on psychiatric disorders (Driving and Vehicle Licensing Agency, 2005). The audit cycle was immediately repeated, from 1 June to 1 December 2005, with a repeat message, unchanged from the original, exactly halfway through the second audit cycle. Review of case records following completion of the second audit cycle was performed as for the first cycle.

Results

Audit cycle 1 generated 55 patients with an ICD–10 F20–29 diagnosis. Seven patients were excluded owing to the absence of acute symptoms: one had taken an overdose, two were admitted because of low mood, one because of non-adherence to medication, one for a medication review and two for respite. In total 48 patients were included in the study. There was no advice regarding driving in any of those patients' case records.

Audit cycle 2 generated 76 patients with an ICD–10 F20–29 diagnosis. Six were excluded owing to absence of acute symptoms. They were admitted to the acute

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wards for a variety of reasons including: alcohol detoxification, social stressors, medication review, depressive episode and threatening self-harm. Seventy patients were included in the second audit cycle and advice was recorded for eight of them (11%).

Discussion

Recording advice on driving in the case notes grew from 0% in the first audit cycle to 11% in the second audit cycle. This compares with no improvement noted in the study by Rowe *et al* (2001). For all eight patients the advice given was in accordance with the DVLA guidelines. Two of the eight patients had this advice recorded as a ward round case record entry. Six patients (8% of total cycle 2 study population) had this advice documented in the form of a standard discharge letter which was implemented between the first and second audit cycle. All these patients were treated by the same consultant psychiatrist, who recorded advice for all of his patients included in the second audit cycle. The discharge letter he used included a front page checklist of four items, one of which was headed 'driving advice'. The doctor completing it detailed whether advice was relevant and what form it took. It appears that the improvement noted in the second round of the audit may have resulted not as a consequence of the message to the medical staff, but rather as a result of the coincidental implementation of a standard discharge letter in one of the teams. Nevertheless, the results are of interest and suggest that the introduction of a standard discharge letter with relevant prompts may ensure that patients are discharged with appropriate advice.

This study did not directly establish rates of car ownership among the audit population and we recognise that the implications may be greater in areas with more car owners. However, based on the postcode areas covered by the psychiatric teams, rates of car ownership were shown to range from 26 to 94% (Medical Research Council, 2004). We would predict that those rates are lower for people with mental health problems.

We are aware that doctors may discuss driving with their patients, but fail to document this in the case records. Although this may be informative for the patient, we do not believe this to be acceptable. The DVLA guidelines actually state that 'doctors are advised to document formally and clearly in the notes the advice that has been given' (Driving and Vehicle Licensing Agency, 2005). Patients ignoring medical advice to cease driving could face consequences with respect to their insurance cover.

Conclusion

Psychiatrists appear not to be aware of the recommendations and responsibilities regarding mental illness and driving. Informing psychiatrists of the DVLA guidelines may have resulted in improvement regarding advice on driving given to patients in this study. It is more likely, however, that a standard discharge letter with a specific prompt about driving advice is a more effective way to ensure that DVLA guidelines are followed. There is potential for further audit following the introduction of such discharge letter on a wider scale.

Declaration of interest

None.

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