original papers

cardiac arrest (Pilowsky *et al*, 1992). Current best practice in rapid tranquillisation suggests that a patient's vital signs should be monitored every 5–10 min for 1 h and then every 30 min until the patient is ambulatory (Taylor *et al*, 2005). The Code of Practice of the Mental Health Act 1983 (Department of Health, 1999) requires that the approved social worker consider the most humane, least threatening and safest means of transferring the detained patient.

This study has a number of limitations that will affect the interpretation of the results. The sample, although large (n=82), was not complete and we may not therefore be able to generalise the results. A telephone survey to the senior nurse or clinical services manager may not be the best means of ascertaining this information. As revealed in the response rates, contemporaneous pressure of work might have influenced the respondent's ability to give each question full consideration.

Despite these limitations, this survey has a number of important implications. Patients presenting to the emergency department with primary psychiatric problems are circumventing the customary avenues of primary and secondary psychiatric care. Many have significant mental disorder and are at risk of suicide, self-harm, violence and absconding into the community without appropriate treatment. Such patients require safe and comfortable transport if being admitted to a psychiatric unit, often some kilometres distant. Senior emergency department staff should have a clear understanding of the issues around the safe transfer of these patients. The significant discrepancies in practice revealed by our survey, coupled with likely local geographical and service variations, suggest that all emergency departments should have a policy governing the transfer of patients to acute psychiatric units. Liaison psychiatry departments would be ideally placed to facilitate and monitor the development of such policies.

There are a number of studies that would be helpful in this area. Further research should be aimed at monitoring the development of such policies and the factors that specifically influence variations in practice. The regular audit of practice against such policies is also an important piece of collaborative work for liaison psychiatry and emergency departments alike.

Declaration of interest

None.

References

DEPARTMENT OF HEALTH (1999) *Mental Health Act 1983 Code of Practice*. London: Department of Health.

DEPARTMENT OF HEALTH (2004) *Improving the Management of Patients with Mental Ill Health in Emergency Care Settings*. London: Department of Health.

PILOWSKY, L. S., RING, H., SHINE, P. J., *et al* (1992) Rapid tranquillisation. A survey of emergency prescribing in a general psychiatric hospital. *British Journal of Psychiatry*, **160**, 831–835.

ROYAL COLLEGE OF PSYCHIATRISTS (2004) *Psychiatric Services to Accident and Emergency Departments* (Council Report CR118). London: Royal College of Psychiatrists.

TAYLOR, D., PATON, C. & KERWIN, R. (2005) *The Maudsley 2005–2006 Prescribing Guidelines* (8th edn). London: Taylor & Francis.

TINTINALLI, J. E., PEACOCK, F. W. & WRIGHT, M. A. (1994) Emergency medical evaluation of psychiatric patients. *Annals of Emergency Medicine*, **23**, 859–862.

YATES, K., PAXTON, R., GRIFFITHS, H., *et al* (2000) Changes in psychiatric admissions in rural northern England. *Journal of Mental Health*, **9**, 105–111.

Charles Antwi Senior House Officer, Learning Disability Psychiatry, Exeter, ***Adrian Flynn** Specialist Registrar in Addictions, Cornwall Drug and Alcohol Service, Redruth, email: adeflynn@yahoo.com, **Paul Chrichard** Mental Health Liaison Nurse, **Amanda Haddock** Mental Health Liaison Nurse, **Claire Johnson** Mental Health Liaison Nurse, **Jo Hammond** Mental Health Liaison Nurse, **Peter Aitken** Consultant Liaison Psychiatrist, Director of Research and Development, Wonford House Hospital, Exeter

Psychiatric Bulletin (2006), **30**, 449–451

POLASH SHAJAHAN AND TIMOTHY AGNEW

Availability of patient records and psychiatric admission rate

AIMS AND METHOD

Trainee psychiatrists often perform emergency mental health assessments. Traditionally, it has been considered that having access to past psychiatric records will reduce the likelihood of a patient being admitted. We examined whether the availability of records had an influence on admission by recording all contacts to the duty junior psychiatrist in two district general hospitals over a 6-month period.

RESULTS

For those with chronic or enduring mental illnesses there is a 27% increase in the likelihood of admission if past records are available. For all other patients the increase is 10%.

CLINICAL IMPLICATIONS

Contrary to our expectations, the availability of records increases the likelihood of admission to mental health admission units.

Maintaining patient records is an essential component of good clinical care (General Medical Council, 2001). The Scottish Executive considers avoiding admission and providing healthcare within community settings to be an important part of improving unscheduled care (Scottish Executive, 2004). Mental health clinicians assume that the availability of clinical records reduces admission to acute psychiatry units. This is thought to be because decisions involving greater risk will be easier when clinicians are armed with more information. Second, previous records

https://doi.org/10.1192/pb.30.12.449 Published online by Cambridge University Press

original papers

can reassure the assessing clinicians that the patient is not markedly different to usual. Third, records may show alternatives to admission, such as imminent community or out-patient contacts. Previous records are not always immediately available to on-call clinicians for emergency assessments. We aimed to establish whether availability of records reduces the rate of admissions to acute psychiatry units by trainee psychiatrists.

We also considered that the lack of availability of case records may encourage receiving doctors to rely on opinions of other professionals who know the patient. We hypothesised that if these views were biased a doctor might be persuaded that admission was inappropriate. Patients potentially disadvantaged by this might include those whose secondary problems were aggression and alcohol or substance misuse disorders.

Method

The 'duty doctor logbook' was introduced into two hospitals within Lanarkshire in February 2003. The junior on-call psychiatrist was instructed to note details of all calls, excluding those from the acute in-patient psychiatric wards. The logbook was handed over to the next on-call doctor. An example of the details recorded is given in Fig. 1.

Referrer

Referrers were grouped into: accident and emergency department, general practitioners, medical wards, liaison psychiatry nurses, community psychiatric nurses (including other community mental health team staff), other wards within the hospital, the day care facility within the hospital, other hospital transfers (usually the result of lack of beds), and others which did not fit into any of the above.

Problem

To allow flexibility and aid completion of the logbook, the junior psychiatrist was allowed to record medical problems pragmatically (e.g. 'relapse of schizophrenia' or 'hearing voices') rather than using operational diagnoses. The first recorded problem was taken for analysis. Problems were grouped as follows.

- Alcohol problem – any mention of alcohol in the problem column, ranging from a past history of alcohol problems or intoxication at the time of presentation
- Substance misuse problem – any mention of substance misuse in the problem column, ranging from a past history of substance misuse problems or intoxication at the time of presentation
- Psychosis – any mention of the following or their variants: psychosis, schizophrenia, delusions, hallucinations or bizarre behaviour
- Bipolar – mention of bipolar disorder, manic–depression, hypomania, mania, flight of ideas, pressured speech or elated mood
- Anxiety/depression – terms such as anxiety, depression, low mood or agitation
- Self-harm/overdose/suicidal – those who had either threatened to harm themselves, thought about doing so or had self-harm as part of their referred problem
- Aggression – those presenting in an aggressive way as perceived by the referrer
- Confused – those who were described as confused or disorientated
- Other – the problem did not fit into any of the above.

Severe or enduring illness was then defined as any problem relating to possible psychosis or bipolar disorder, for example, 'hearing voices', 'known patient with schizophrenia', or 'manic episode'. All other patients included those with all other problems, for example, 'low mood', 'anxious', 'or self-poisoning'.

To examine whether secondary problems such as aggression, or alcohol or substance misuse influenced the likelihood of admission we examined all those presenting with any other primary problem whose notes were unavailable.

Outcome

This was dichotomised into those who were admitted to an acute psychiatric ward and those who were not.

Availability of records

The availability of records at the time of assessment was recorded in the logbook.

Date	**Patient's name and address**	**Referred by**	**Problem**	**Outcome**
5th Feb 2003	Jo Smith 4 West Street Hamilton	Dr Stewart GP	Hearing voices Suicidal	Admitted–Wd 1
Time 9.15 am			Can't cope	
Your ID Dr Bloggs	**d.o.b.** 4/11/87			**Any records available?** Y (N)

Fig. 1 Example of details recorded in the duty doctor logbook.

https://doi.org/10.1192/pb.30.12.449 Published online by Cambridge University Press

original papers

Table 1. Admission in relation to the availability of records in patients with severe/enduring illness and all other patients

	Admitted	Not admitted	Outcome unknown
		n (%)	
Patients with severe/enduring illness			
Records available, *n*=88	77 (87)	11 (13)	0 (0)
Records unavailable, *n*=64	38 (60)	26 (40)	0 (0)
No indication of availability, *n*=39	32 (82)	7 (18)	0 (0)
All other patients			
Records available, *n*=257	100 (39)	154 (60)	3 (1)
Records unavailable, *n*=321	93 (29)	228 (71)	0 (0)
No indication of availability, *n*=188	39 (21)	141 (75)	8 (4)

Results

There were 982 contacts recorded in the logbooks during the 6 months of the study. The availability of records was noted for 746 contacts (76%). Records were available for 349 of 746 (47%), of whom 166 (48%) were admitted to the psychiatric wards. Records were unavailable for 397 patients (53%); 139 of these were admitted (35%; $\chi^2=12.1$, $P=0.001$). If there was no indication of record availability the admission rate was 72 of 236 (30%). Table 1 illustrates the breakdown for patients with severe/enduring illness versus those with other disorders; 77 out of 88 of those patients with severe/enduring mental disorder (87%) were admitted when notes were available compared with 38 of 64 (60%) when the records were unavailable ($\chi^2=15.9$, $P<0.001$).

For all patients who did not have records available, 63 had secondary problems of aggression, alcohol or substance misuse; 26 out of these 63 were admitted (41%). There were 271 people with no other secondary problems recorded and 83 out of these were admitted (30%; Fisher's exact test, $P=0.16$ (one-sided)).

Discussion

Contrary to our expectations, availability of case note records was associated with increased admission rates. Although enduring illness increases the likelihood of admission, availability of records has a similar effect: one is more likely to encounter markers of relapse or risk, hence increasing the probability of admission.

Comorbid secondary problems of aggression, alcohol or substance misuse did not reduce the likelihood of admission. Although the numbers were small, these comorbid problems increased the likelihood of admission (41 *v.* 30%). We suggest that adding to the complexity of presentation with such problems results in more difficulty in avoiding admission. Admission may allow initiation of the management of multiple complex problems. This finding is worthy of further investigation.

One reason for a pessimistic view of psychiatric admission is the nature of some National Health Service psychiatric wards (Quirk & Lelliot, 2001). Our view is that admission to a properly staffed ward should be considered a useful option for facilitating prompt and intensive treatment of mental disorder. Clinicians should strive to access as much information as possible before making decisions. One potential solution, which we are developing locally, is to have an online version of case record correspondence. This is available to emergency clinical staff in hospitals, community and specialist team bases and partly solves the dilemma of where to store case records.

Declaration of interest

None.

Acknowledgements

We thank all the junior doctors who helped maintain the on-call logbooks and Drs Anthony Pelosi and Mark Taylor for their helpful comments during the preparation of this paper.

References

GENERAL MEDICAL COUNCIL (2001) *Good Medical Practice*. London: General Medical Council. http://www.gmc-uk.org/guidance/library/GMP.pdf

QUIRK, A. & LELLIOT, P. (2001) What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. *Social Science and Medicine*, **53**, 1565–1574.

SCOTTISH EXECUTIVE (2004) *Working Together to Improve Unscheduled Care in NHS Scotland*. Edinburgh: Scottish Executive.

***Polash Shajahan** Consultant Psychiatrist, NHS Lanarkshire, Airbles Road Centre, 49 Airbles Road, Motherwell ML1 2TP, email: polash.shajahan1@lanpct.scot.nhs.uk, **Timothy Agnew** Senior House Officer in Psychiatry, NHS Lanarkshire, Airbles Road Centre, Motherwell

https://doi.org/10.1192/pb.30.12.449 Published online by Cambridge University Press