Prescribing on psychiatric acute wards at four hospitals

Guidelines for prescribing psychotropic medication are available from a variety of sources; however, the case mix complexity on acute psychiatric wards might be expected to present challenges to adherence to these standards. Dr Hodgson and colleagues set out to audit prescribing on acute psychiatric wards at four hospitals covering similar catchment populations to ascertain practice.

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Guidance on psychotropic prescribing exists in many forms, of which the manufacturer's summary of product characteristics (SmPC) is the most important. However, psychiatrists' real world prescribing patterns are frequently divergent.[1] Other guidelines that impact on prescribing include those of the National Institute for Health and Clinical Excellence (NICE), who have published treatment guidelines for schizophrenia and other disorders, and recommend the use of atypical antipsychotics as first-line drugs in the management of schizophrenia.[2] Psychiatrists have been made aware of the dangers of prescribing high doses of antipsychotics and have been advised against polypharmacy.[3]

Psychiatric acute ward prescribing is likely to reflect accurately psychiatrists' prescribing behaviour for the most acutely ill and potentially difficult to manage patients. However, other non-patient factors influence prescribing decisions. Bowers *et al.*[3] noted variation in prescribing patterns between countries, relating partly to the relative availability of drugs.

Harrington *et al.*[4,5] reported the results of the Royal College of Psychiatrists' Research Unit's audit of acute ward prescribing for 3132 inpatients in 49 mental health services. Antipsychotic medication at a total dose above the *BNF* recommended daily limit was prescribed for 20 per cent of patients. For only a small minority of cases (5.5 per cent of those prescribed a high dose) was this due to the prescription of a single type of antipsychotic drug at a high dose. For the remainder, high-dose prescribing was a result of prescribing a combination of two or more antipsychotics drugs. If only regular antipsychotic drugs prescriptions were considered then 10 per cent of the total sample were prescribed a high dose. Just less than half (48 per cent) were prescribed more than one antipsychotic drug on the census day. Services varied greatly in the proportion of patients who were prescribed high doses (0-50 per cent) and in the proportion on polypharmacy (12-71 per cent).

Paton and Lelliott[6] noted the lack of routine data collection regarding acute ward prescribing and explored the use of such data as a quality indicator. They noted that such data provide a 'benchmark' against which other services can compare themselves and that each incidence of high-dose prescribing or polypharmacy should probably be audited to ascertain whether it is justifiable. Additionally, there should be a review of prescribing practice and relevant service-level factors in services that are consistent outliers.[5]

Given these recommendations and the publicity they received, we conceived a survey to establish a current baseline for prescribing on acute wards. We were also interested in whether the perception by many that prescribing varies widely between Trusts was reliable.

Method

On an agreed census day in 2005, prescribing data were collected prospectively from the acute wards at four hospitals in the West Midlands. These hospitals have relatively similar catchment demography and service provision. They are all teaching hospitals. All prescription charts were examined including those of patients on leave. Data collection was completed on separate days at the four hospitals. The data were recorded by experienced specialist registrars in psychiatry following piloting of the data collection form. We used the Maudsley Prescribing Guidelines[7] as the standard for monitoring and the manufacturer's SmPC as the standard for off-licence prescribing. The data were analysed using SPSSv11.5.

Results

The catchment populations are similar and this is reflected in the demography of admitted patients (see Table 1). The only significant exception is the higher rate of comorbid physical illness in hospital four.

There was significant variation in the mean number of psychotropics prescribed and mean as-required dose (see Table 1). This is reflected in the number of individual drugs prescribed at the four hospitals. The range of drugs pre-