the columns

correspondence

Real-life prescribing

We agree with the recent audit of Meagher & Moran (*Psychiatric Bulletin*, July 2003, **27**, 266–270), in which they reported that real-life prescribing differs from evidence-based guidelines. Our audit of Cambridge's rehabilitation service (a tertiary referral centre) was carried out over 1 week in June 2003. Two-hundred and seventeen patients were receiving antipsychotic medication through our pharmacy: 171 received oral medication alone, 29 long-acting intramuscular medication and 17 combined oral and intramuscular medication. Similar to Meagher & Moran, we found antipsychotic polypharmacy in 56 patients (26%), but 26 of these were receiving clozapine plus adjunctive, e.g. sulpiride. Polypharmacy was evident in the in-patients, with 52% of our 58 in-patients receiving more than one antipsychotic in comparison to 16% of the 159 out-patients, implying that polypharmacy might be a transient phenomenon. No one was prescribed thioridazine or droperidol.

We found, using a percentage of the British National Formulary (BNF, 2003) maximum recommended limit, a practical method of calculating the total daily dose as two-thirds of our patients were prescribed atypical monotherapy. Sixteen of our patients (7.4%) received antipsychotics above BNF maximum limits, while Meagher & Moran found 4.9% received more than 1000 mg chlorpromazine equivalents (CPZEs). Yorston & Pinney (2002) state that there are a number of problems with the use of CPZEs and also report that there is no simple linear relationship between CPZEs and percentage of BNF maximum limits for high doses. This may account for some of the differences found. Another explanation may be the number of patients with treatment-resistant schizophrenia.

BRITISH NATIONAL FORMULARY (2003) *British National Formulary*. London: British Medical Association and The Royal Pharmaceutical Society of Great Britain.

YORSTON, G. & PINNEY, A. (2000) Chlorpromazine equivalents and percentage of British National Formulary maximum recommended dose in-patients receiving high-dose antipsychotics. *Psychiatric Bulletin*, **24**, 130–132.

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Prescribing errors in psychiatry

We read with interest the paper by Paton & Gill-Banham (*Psychiatric Bulletin*, June 2003, **27**, 208–210). They say there are no systematic studies of prescribing errors in psychiatry. We have recently published an analysis of prescribing errors detected by pharmacists working in a 400-bed specialist psychiatric hospital (Haw & Stubbs, 2003). A panel of three assessors (two consultant psychiatrists and the head pharmacist) screened and classified errors according to the definition and classification of Dean *et al* (2000). Error severity was rated on a four-point scale.

During the one-month study period, 311 errors were detected that met the study definition. Fifty-six per cent were rated as clinically insignificant, with only 9% rated as having the potential to cause the patient harm, and none as potentially life-threatening. A greater proportion of the more serious errors had been made by non-consultant psychiatrists. Prescription writing errors (e.g. transcription errors) (88%) were more common than decision-making ones (e.g. prescribing a drug to which the patient has a known allergy) (12%). The error rate for non-psychotropics was twice that for psychotropics, perhaps reflecting psychiatrists' greater familiarity with the latter.

Our findings are broadly similar to those of Paton & Gill-Banham (2003), but we found most errors to be of the prescription writing (clerical) type. We agree that clinical pharmacists have a role to play in detecting errors. However, we found that in 42% of cases, the drug involved had already been administered. Most errors would probably have been detected at the source by electronic prescribing with computerised physician decision support.

DEAN, B., BARBER, N. & SCHACHTER, M. (2000) What is a prescribing error? *Quality in Health Care*, **9**, 232–237.

HAW, C. & STUBBS, J. (2003) Prescribing errors detected by pharmacists at a psychiatric hospital. *Pharmacy in Practice*, **13**, 64–66.

PATON, C. & GILL-BANHAM, S. (2003) Prescribing errors in psychiatry. *Psychiatric Bulletin*, **27**, 208–210.

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Pre-registration house officer training in psychiatry

I was interested to read your article regarding pre-registration house officer training in psychiatry (Herzberg *et al*, May 2003, **27**, 192–194). I am also interested and glad to hear of your findings regarding trainees' improved confidence and target skills as well as high rates of satisfaction.

In 1981, in Sheffield, I was involved in one of the first pre-registration house officer posts in psychiatry in this country. This pre-registration house officer training was reviewed by O'Dwyer (1999).

From my experience of doing the psychiatry 4-month post as the first in a rotation of psychiatry, medicine and surgery, I personally felt this was of great benefit – particularly in relation to communication skills and gaining a wider view of illness within the context of a person's life and family relationships. It also helped raise my awareness of the importance of appropriate settings and privacy when interviewing patients and discussing issues that are distressing. This was a help as well as a hindrance when I was subsequently to be a surgical and medical house officer, where one has to clerk in large numbers of patients within busy wards or Accident and Emergency departments with only curtains drawn and little privacy, e.g. prior to major surgery such as mastectomy.

The pre-registration house officer post helped me to gain further insight into and develop communication skills, to consider wider issues and to have a wider perspective when interviewing physically ill patients on medical and surgical wards. Therefore, this should be considered alongside the 'target skills in psychiatry' when planning pre-registration training.

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