available for part-time training particularly at the SHO/Registrar level. Indeed, I have reluctantly come to the conclusion that the problems facing trainee psychiatrists who have young children are more formidable than they were a generation ago, as I trained on a part-time basis.

I deplore the potential loss to psychiatry of motivated recruits whose time spent in child rearing provides an experience which is far from irrelevant to any branch of psychiatry. I hope, in collaboration with the Dean, to arrange a meeting where the implications of part-time training and other related issues can be discussed and measures taken to provide a remedy.

ANN GATH
Registrar

Computerised audit systems

DEAR SIRS

I read with interest of the computerised audit system currently under development by Professor Marks (*Psychiatric Bulletin*, August 1989, **14**, 495) and would like to echo his comments that such systems make the process of audit easier. SafetyNet is now being established in several hospitals across the UK and provides a sophisticated but simple solution to monitoring/charting clinical progress (employing recognised 5 point scales) and staff interventions. Since the system was first outlined in the *Psychiatric Bulletin* (**13**, 677–679) it has been enhanced and now incorporates a module called ResearchBase (also written using Ashton Tate's Dbase IV).

ResearchBase (which is also available independently of SafetyNet) allows any user (without computer expertise) to add in rating scales and questionnaires for time-series data collection. The system handles non-branching and branching scales, all data types (data are automatically validated) and will be useful to anyone wishing to repeatedly administer schedules as part of a research project, or who wishes to speedily develop a custom built audit or case register system that collects the data and descriptions they have selected. The system can handle virtually unlimited patient numbers, and up to 99 separate scales each with up to 999 questions.

Once data are on the system they can be very simply transferred to SPSS PC+ (SPSS UK) for analysis. ResearchBase comes with complete ICD-9 codes and descriptors (around 5,000) and medication codes and descriptors (proper drug names drawn from the BNF). Both SafetyNet and ResearchBase run on standalone IBM compatible machines (AT 286 or 386 computers with hard disks running MSDos) and do not require Dbase IV. Anyone interested in SafetyNet or ResearchBase can write to me at 309 Gray's Inn Road, for more information.

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Discharge summaries

DEAR SIRS

We were interested to read of the brief computerised discharge summary reported by Wattis & Protheroe (*Psychiatric Bulletin*, June 1990, **14**, 330), in particular that 93% of GP's questioned preferred a short summary with the opportunity to request more detail.

For the last 12 months our psychogeriatric department has kept detailed case summaries based on Institute of Psychiatry guidelines and including DSM-IIIR diagnoses. One copy is filed in the case notes, a second on the ward to provide instant access should patients be re-admitted and case notes not immediately available, and, a third in the department for internal audit and reference. The GP is sent a prose style letter on one side of A4 with a note explaining that a more detailed account of the patient's illness, history and progress is available on request.

Since this has been the policy we have discharged 90 patients to 72 GPs (about 50% of those in the catchment area) and, as yet, nobody has asked for the detailed summary.

Studies of GPs' requirements of discharge letters suggest the brief style is most popular (Craddock & Craddock, 1989; Kerr, 1990) and although a proportion always claim to want more detailed information our experience is that this is not requested even when the offer is clearly made.

A standard computerised format will become essential for audit but there is a danger that using too brief a summary will result in oversimplified audit results that may not accurately reflect our workload and clinical dilemmas and we feel the more detailed summaries will provide a more useful database for this purpose. As Craddock & Craddock (1989) demonstrated, the requirements of GPs and psychiatrists differ.

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Stinking wards

DEAR SIRS

It is ironic that the letter from Dr Azuonye (*Psychiatric Bulletin*, July 1990, **14**, 431) should appear in the same issue as an interview with Dr Alex Baker, in which he describes the formation of the Hospital Advisory Service, latterly becoming the Health Advisory Service.

This organisation monitors services for the elderly and the mentally ill in England and Wales, paying attention to the environment in which people are living as well as the professional services devoted to their care. Among many other matters to be considered is the presence of homely and comfortable hospital accommodation. The presence of large areas of vinyl flooring is more in keeping with an emphasis on reduction in domestic tasks than achieving an acceptable domestic environment.

One cannot ignore the facts of clinical reality, and while every effort should be made to reduce incontinence by an effective range of practices, aided by a suitably trained adviser, accidents will happen. It may well be that deep-pile carpeting is not the floor covering of choice, but there are many carpet-like fabrics which are amenable to cleaning, particularly if there are sufficient staff to achieve this rapidly.

The answer to Dr Azuonye's problem must be prevention of incontinence, insofar as this is possible, and the use of easy-clean, synthetic simulated wool carpets for comfort and appearance.

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DEAR SIRS

Dr Azuonye recommends in his letter (*Psychiatric Bulletin*, July 1990, **14**, 431) that psychogeriatric wards must have lino floor coverings to avoid unpleasant smells. He is quite wrong.

The Scottish Hospital Advisory Service has been conducting a crusade for carpeted wards for the best part of two decades, a crusade which has been increasingly successful. We can direct Dr Azuonye to psychogeriatric and geriatric wards where carpets have been down for several years and there are no offensive odours. To achieve this requires three things.

Firstly, the carpets should be appropriate for the task: there are several satisfactory brands. Secondly, a speedily available system of carpet cleaning and the domestic staff to use it must be at hand. Thirdly, a modern system of incontinence management has to be in use.

Given these three facilities, there is no more need to floor a psychogeriatric ward with lino than there is to do the same for a dwelling house containing an incontinent child.

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DEAR SIRS

I was interested but shocked to read I. O. Azuonye's letter 'Stinking wards' (*Psychiatric Bulletin*, July 1990, **14**, 431).

Lino is, of course, appropriate in the kitchen, bathroom and toilet of any hospital ward. However I feel it is sterile, unhomely and unnecessary to have it in any living area such as the lounge or bedroom. Instead with a carefully planned, individualised and well staffed nursing plan I have found urine and faecal incontinence is acceptably managed on many carpeted wards for elderly mentally ill people.

I think it should be established that continuing care areas for all long-term residents be suitably carpeted.

May I finally add that I have never been fortunate enough to have worked anywhere in the NHS where there are "deep-pile carpets" – not even in the nurses' home or doctors' mess.

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Consent and the mentally handicapped

DEAR SIRS

Dr Race raises an extremely interesting point regarding the difficulties of obtaining consent to treatment for a 29-year-old woman with mental handicap and manic depressive psychosis, whose parents objected to treatment with lithium carbonate on the grounds that it was a "toxic drug" (*Psychiatric Bulletin*, July 1990, **14**, 429). I see two possible ways of resolving this issue. The first follows on from the judgement of the Law Lords in the case of F v Berkshire Health Authority (Dyer, 1989) and the second is through the provisions of the Mental Health Act 1983.

As Bicknell (1989) points out, adults with mental handicap cannot give valid consent for treatment and no-one else, including parents, can give it on their behalf. The judgement by the Law Lords in July 1989