

# 'Own Space' Ward Rounds: a model for debate

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## Introduction

This article presents one London acute psychiatric in-patient ward's attempts to change practice to better meet the needs of patients and to function more effectively and efficiently. The initiative was awarded the Oxleas Innovative Practice Award 2000. We would be interested to engage in a debate with other acute ward services and share ideas about how to organise the major clinical decision-making event of the week: the ward round.

The ward round is arguably one of the most traditional methods of clinical decision making and care planning for psychiatric in-patients. It evokes strong feelings in many services. Attitudes to it vary from dislike to fear among patients, to frustration and concern among the professionals involved.

Norman Ward is the catchment area ward for the people of the Penge and Anerley area of PCG 1 locality in the London Borough of Bromley. Until May of 2000 we worked in one of the most impoverished acute ward settings in London. The old ward was in an ancient building, on three floors; with numerous access and exit points, several blind areas and this environment was the subject of major criticisms from the Mental Health Act Commission on every visit. The old fashioned dormitory setting, with only curtains separating beds made for a lack of privacy. The absence of an office in which to interview patients made effective patient care a major challenge! In May 2000, we moved to Green Parks House, a modern building where each patient has a single room. The ward has a number of interview rooms, dining and sitting areas. This has allowed us to change practice in a number of ways. One of the major changes we sought to make was a more effective, efficient and 'Own Space' style ward round.

## Ward rounds: Why did we change?

Until May, our ward rounds followed the traditional pattern. The multi-disciplinary team met in the clinical conference room. Patients and carers, in addition to external agencies involved in the care planning, met at timetabled half hourly slots during a 4-5 hour period each week. During 1998-1999, we seemed to be achieving reasonable outcomes for our patients, with a reduction from 80% to 12% of patients relapsing and 'revolving' back into the ward within a 3 month period, the ward round was a source of concern to almost everyone involved. The process of change was the establishment of a multi-disciplinary brainstorming group, including recent in-patients and their carers. The conclusion of the group was that we should change, and pilot a new style format for the following reasons:

- **Patient request:**, they found themselves 'paralysed' and 'mute' in front of a large gathering of professionals. They wanted a system in which they could spend more time with their primary nurses, and have more opportunity to think about what they wanted to present to the MDT ward round, and achieve from it each week.
- **Carer request:** they felt that their opinions were not sought, or not really heard. They found it intimidating to say what they thought in front of a large gathering of professionals. They wanted to meet with the consultant in a more private way

- **Users and carers:** were concerned about the time pressure professionals were under and the inability to take the time needed to agree decisions, rather than fit it all into the time available. With up to 20 patients to be seen and have care plans developed per ward round, time was pressurised.
- **Primary nurses:** felt that their opinions were often not represented or listened to.
- **Senior nurses** wanted a more efficient means of communicating the decisions of the ward round and the planning of effective discharges.
- **Ward Clerk** was run ragged trying to get hold of laboratory results, appointments etc. on the day.
- **Junior doctors:** observed that too many functions were taking place at the same time and there too much paperwork to complete.
- **Consultant:** intensely disliked the format, felt that too many functions were taking being squeezed into one meeting. Making mental state assessments in the most unrelaxing way possible felt like a courtroom and jury, rather than a friendly engaging opportunity. The multiple tasks of chairing, time-keeping, recording, reviewing, negotiating, facilitating and decision-making for up to 20 patients was a recipe for burnout!
- **Violence and tension levels** on the ward seemed to increase both before and during ward round days. Although the slots were timetabled, patients were stressed and anxious. Decisions, were attributed to the 'consultant' and there was a need to shift the perception that responsibility for decisions was shared among the entire senior multi-disciplinary team.

#### **Ward rounds, all things to all men: too many functions**

The evidence base on conducting effective interviews concludes that 'a maximum of 5 interviews per day is possible in situations where complex information is being assimilated, multiple decisions are being made and communicated and major change processes being implemented'. The NHS's implementation of this particular piece of the evidence base is seldom applied! We analysed the numerous functions that the ward rounds were trying to achieve

1. Assessment of the patient's mental state
2. Assessment of the carer views and plans
3. Summary of the assessments and care plans of the different disciplines; nurses, medics, OTs, psychology, pharmacy, social workers etc. -a
4. Meeting of the most senior professionals team (ward manager, consultant, OT, Psychology, social work) to agree the clinical decision plans for the patient for the week
5. Resolution of multi-disciplinary and user and carer disagreements about plans and priorities
6. Agreement of the timescales of assessment, admission & discharges
7. Training of junior doctors, nursing staff and pharmacists etc.
8. Induction for new staff
9. Completion of reams of paperwork by, especially junior doctors and nurses & consultants to include S 17 forms, drug charts, notes, ward round book, weekly diary, referral forms, discharge forms, discharge prescription forms to name but a few!!

Our conclusion was that we were trying to do too many complex tasks in one forum and a new style of ward round emerged after discussion.

## What is the new 'Own space' developmental format?

The Millennium style ward round is a **3-stage process**, each of which is crucial:

**Stage 1: Intensive Pre-ward round preparation:** The principle is that the bulk of the necessary information should be gathered before the ward round in a manner that makes it easier for service users and carers to express their views. The ward round time can therefore be spent in decision-making informed by accurate information, NOT information gathering

### **Stage 2: Ward Round Day: This has 3 parts:**

1. **'Own Space' Meetings** assessment by consultant and non-ward based MDT staff. The patient chooses if they want to be seen in their own rooms, or in an interview area. The consultant, junior doctor and primary nurse meet with the patient and the consultant is able to undertake a mental state assessment and hear the patient's plans. Other non-ward based staff, social worker, and psychologist also meet with the patient in the area chosen by the patient.
2. **Clinical-Decision making Business;** meeting involving senior staff.
3. **Feedback and handover** to the next shift, primary nurses etc.

**Stage 3 Follow-up and Communication:** Typed list of all agreed responsibilities and tasks faxed to all relevant members of MDT and agencies

### **Stage 1: Pre-ward round work: crucial:**

The crucial idea is that most of the work is done before the ward round. All information necessary to decision making is gathered before the day, or before the business meeting

### **Primary nurses with the Ward manager**

- Sit with the client and do their Life Event Chart Autobiography (Appendix A)
- Complete, with their patients the 'blue form' in which patients meet with their primary nurse, agree the progress made, the problems which need to be addressed and together identify the care plans they would like to take forward (Appendix B)
- Talk to carers or family to gain objective evidence of What has happened and what should take place (Appendix C)
- If admitted under the Mental health Act, agree the level of S 17 leave they would like to achieve
- Prepare weight, sleep, fluid etc charts
- Talk with the CMHT keyworker to share progress and plans

### **CMHT Keyworkers:**

- Contact community agencies to agree start dates of day care etc.
- Contact CMHT to find out who has been allocated as key worker, CPN, social workers and exact dates and times of appointments

### **Junior doctors**

- Spend 1--2 hours per patient completing the case-note summary of all previous episodes of illness, treatments, medication history etc.
- Undertake up to date detailed mental state assessments
- Interview, with primary nurses, the carers
- Undertake and find out results of blood and radiology assessments
- Undertake any agreed standardised formal assessment (Appendix F).

### **OTs**

- Complete their report and superb home assessment of daily living skills to present.
- Work with service users to agree the weekly timetable of activities to put on their personal notice-boards.
- Prepare reports on their objective observations of the patients in group and community activities

### **Social workers**

- Have time to interview the clients and undertake a social needs assessment
- Make practical arrangements to expedite discharge back to the community e.g. residential and supported accommodation, debt counselling, carer package and support.

### **Ward Managers & Ward**

- Contact provider e.g. housing to find out exact
- Dates, Dates, Times of assessment and placement
- Contact ECR department to speed up placements
- Contact specialist providers' e.g. SLAM to speed up assessments, both OPAs and In-patients

### **Psychologist:**

- Can undertake assessment and therapies
- Can review management programmes with patients

### **Pharmacists:**

- Can undertake, where appropriate medication history reviews to inform decision making around effective medication
- Review charts to ensure that there is no polypharmacy
- Undertake some education about medication with clients 'if requested

### **Mental Health Act Administrator**

- Can prepare the summary folder of meant health issues e.g. which patients have an approaching Mental Health Review Tribunals, which consent to treatments are due, which sections are coming up for discharge or renewal

## **Stage 2: On the day: The whole team is geared to maximum efficiency and effectiveness**

### **Ward Clerk:**

- Sets out drug charts
- Puts all notes on the trolley
- Tells all patients to stay in their rooms for 1 hour
- Acts the dragon: Tells all visitors that this is an important hour and to make them scarce unless they have vital business!!

### **The 9.30-11.00 'Own space' individual assessment and discussion:**

- The consultant has the opportunity to see the client's alone in their room or with the junior doctor and primary nurses to assess mental state
- The meeting is, with the patients' consent done in their bedroom, so that
- The patient feels less threatened and
- The consultant has the chance to see the patient in the context of his or her own space, which, like a community home visit provides excellent information about mental state etc.
- The relatives can be present if the user wishes, and talk about their wishes and concerns
- The social worker can make their assessment in the patients' client
- The psychologist can visit patients in their room and consult and assess
- The OT can also revise the Care Plan.

### **Clinical-Decision making Business meeting involving senior staff. From 11.30-1.00**

The business meeting is attended by the full MDT including the ward manager. Charge nurse or shift co-ordinator, consultant psychiatrist, Junior doctor, OT, psychologist, CMHT representative, social worker and ward clerk

- The senior multi-disciplinary team meet with the notes, the medication charts S 17 forms, ward rounds book that contains blood request and radiology request forms etc.
- Each client is discussed and the care plans which the client has prepared with the primary nurse, OT social worker and junior doctor is agreed or modified
- The ward clerk types up the actions to be undertaken in preparation for immediate taking of the list of task to each agency/ professional

### **Handover and communications**

**Feedback and handover** to the next shift, primary nurses and others who were not at the ward round as soon as possible is vital. The ward clerk faxes, or phones all those charged with actions to implement the care plans. Each nursing shift works to the agreed care plans. Each primary nurse and the junior doctor uses the next session with the user and carer to work through their care plan agenda as agreed.

## What are the advantages?

Our next step is to do a formal evaluation, but early feedback suggests that:

- *Users feel more relaxed and "it's easier to talk in private"*
- *No longer are heard the dreaded words :*
  - 'I've not been here for 3 days and I know nothing about the patients!!!' or*
  - 'Nobody listens to my opinion'*
  - 'Can we please have objective information not rumours and disinformation!!!'*
  - 'I need coffee and donuts to survive ward. rounds!!!'*
  - 'This patient has been here for months longer than she should be!'*
  - 'He's a bed blocker! No he isn't, he's a delayed discharge!'*
- *Primary nurses feel involved, listened to, and have a clear action plans to pursue*
- *Consultant psychiatrists are likely to have lower blood pressure and live longer (to haunt their wards!!)*
- *Junior doctors feel that the process is more efficient; there is time for separate supervision*
- *Relatives feel more relaxed.*