Inpatient experiences of ward rounds in acute psychiatric settings

WARD rounds occur regularly on most medical wards and in psychiatric settings they play a pivotal role in the weekly review of a patient’s care in hospital, evaluating treatment and planning for discharge. It is the point at which professionals and patients can discuss future care in the community, according to the principles of the care programme approach, to provide a ‘sound framework for service delivery’ (Social Services Inspectorate, 1999).

Surprisingly, there has been little research into the structure of the ward round or its clinical outcomes (Birtwistle et al, 2000). Although various quantitative and qualitative studies of general patient satisfaction suggest that patients perceive psychiatric ward rounds as intimidating and distressing (Lovell, 1995; Ballard and McDowell, 1990) and tend to rate them as one of the least useful aspects of inpatient care (Sharma et al, 1992).

The Journal Open Mind (Wolf, 1997) has, however, outlined a code of conduct for ward rounds, with the suggestion of standardising the code across NHS psychiatric services. The issues covered include a patient’s right not to attend, having set appointment times, asking questions in a respectful and sensitive manner, thinking about seating arrangements and keeping the number of professionals present to a minimum.

Further, a recent Department of Health document emphasises the need for ‘clarity about the aims, timing and organisation of regular clinical activities such as ward reviews... agreed in consultation with service users’ (DoH, 2002). National concerns about adult acute inpatient care, such as ‘poor coordination and communication across the system of care’ (DoH, 2002) together with the need to treat service users as ‘equal partners, at every level’ (DoH, 2001) highlight the need for more research into the functioning of psychiatric ward rounds.

Studies of general medical ward rounds have been carried out (Birtwistle et al, 2000) finding little evidence of reported patient distress, with the majority seemingly reassured by the number of physicians present (Seo et al, 2000). Further, in Bains and Vassilas’ (1999) study of carers of people with dementia, carers perceived the ward round as useful and helpful, and would attend again. No studies have focused solely on inpatient perceptions of psychiatric ward rounds.

There is, therefore, some uncertainty about how psychiatric inpatients perceive ward rounds, with general surveys of satisfaction indicating negative views, contrary to evidence found in non-psychiatric settings. This may, however, be a methodological issue. Qualitative methods are recommended for studies of this type (Goodwin et al, 1999; Greenwood et al, 1999), or a combination of qualitative and quantitative methods (Birtwistle et al, 2000; Lovell, 1995), because measuring the complex concept of patient satisfaction in any meaningful way is difficult and tends to be insensitive to potentially negative views about services (Greenwood et al, 1999; Lovell, 1995). Alternatively, it may be that the format of psychiatric ward rounds differs to that of non-psychiatric ward rounds, in ways that lead to greater levels of dissatisfaction among its participants.

The aim of this study was to explore patients’ perspectives of ward rounds using qualitative methods. All interviews were carried out by a trainee clinical psychologist on placement (the first author) as she was thought to be well placed to help address this issue, being largely independent of the daily functioning of the ward, and perhaps less open to bias. It is important for qualitative researchers to consider how participants view the interviewer – for example as someone involved in their care, as an advocate or as a researcher – as this may influence the outcome of the research (what participants are willing to say) and the process of data interpretation (what researchers are willing to report) (Salmon, 1996).

Ethical approval for this research was granted by South West London and St George’s NHS Trust Ethics Committee.

Method

A semi-structured interview was developed in conjunction with previous findings and informal discussion with ward staff. It comprised targeted questions to gather information and establish rapport, and five open questions exploring participants’ experiences of ward rounds (Box 1). The ward admitted patients from four community mental health trusts and outreach/rehabilitation teams. Patients were attached to one of five consultant psychiatrists, each of whom led their own ward rounds. Patients in the care of two of the five consultants were interviewed. This was to ensure that enough participants were recruited, and the consultants were chosen in order to minimise the effect of variations in style because they conducted ward rounds in a similar way.

Eight patients agreed to participate. Each interview took place within one week of their last ward round. All participants were white and British. Five women and three men were interviewed, ranging in age from 18 years to 70 years (mean = 43.5 years, standard deviation = 19.12). Their length of stay in hospital ranged from one to 24 weeks (mean = 8.5, SD=8.36) and the number of previous admissions ranged from one to nine (mean = 3, SD=2.64). Five of the patients had a diagnosis of schizophrenia; two had depression; and one had a variety of diagnoses still under discussion by the psychiatric team.

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ABSTRACT


This study explores inpatients’ experiences of ward rounds. Eight patients on an acute admissions ward were interviewed using a semi-structured interview. Data was analysed using content analysis. The findings showed satisfaction with the ward-round process, but participants identified limitations it was concluded that some interesting themes were explored in future studies.

AUTHORS

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participants were divided into four sub-categories: sequences of the ward rounds; and issues to do with the ward round; feelings about the outcome and consequences of the ward round. Two participants said that they would not change any aspect of the ward round.

Thirteen statements indicated negative perceptions of the ward round, including ‘I hate going in.’ Eight responses referred to feeling intimidated by, or fearful of, the ward round, for example: ‘It feels more like an interrogation than a formal meeting.’ However, to balance this view, it was interesting that four responses explicitly indicated that they were not intimidated. For example: ‘I didn’t feel intimidated or anything like that.’

Four statements were concerned with the effect that the outcome of the ward round can have on patient feelings. For example: ‘When I have progress I feel all right, when I don’t I feel disappointed.’

Three statements referred to the way in which the feelings expressed could have consequences for the patient in the ward round. For example: ‘If you’re shy, it could help you to overcome your shyness,’ and ‘If one was of a nervous disposition, it could be difficult to express themselves.’ Four responses referred to the way in which people coped with the ward round. For example: ‘You know I coped with it. I became familiar,’ and ‘I tend to ignore the people outside – those I don’t know.’

External processes

Nine statements commented on the way decisions were made. Seven of these indicated that some decision-making or discussion had occurred before the patient entered the ward round. Patients seemed quite separate from any decision-making process. For example: ‘Prior to you coming in, they’ve already made an assessment about how they’re going to conduct the ward round.’

Eleven statements were concerned with the way decisions were conveyed to the patient. Ten of these indicated that the consultant or the medical team were the only people to communicate with the patient during the ward round. For example: ‘I’ve never been to a ward round where anyone, or very few, other than the consultant or charge nurse actually speak.’ One participant expressed the wish to change this focus on the medical team as the main communicators in the ward round, saying: ‘If they’re all making a decision on my treatment, I’d expect that they’d all come and talk to me.’

Nine statements referred to the number of people present. Six patients expressed dissatisfaction. For example: ‘There were just too many people, I just wanted to talk to one person.’ Three participants generated ideas to change this aspect of the ward round, including not having as many people present. One participant said: ‘When a patient comes in, they should have a smaller group. They should have a larger group when the patient feels better in themselves.’

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Each interview lasted approximately half an hour. Four participants did not want their interview audiotaped, so responses were recorded in writing as it was felt to be important to include their views in the study. The interviews were transcribed and responses to open questions were analysed using content analysis (Day, 1993, Weber, 1990) with emergent themes being identified once the data was collected. Examination of the data indicated certain themes recurring throughout. Categories were identified and made explicit, before phrases were assigned to particular categories. These were refined through cross-referencing and collapsing some categories into one, or constructing new ones, until a list of relevant, exclusive categories was established.

An independent researcher was asked to assign data to one of the emergent categories in the same way. If the independent researcher’s categories agreed with this research, the categories were likely to be reliable. Using Cohen’s Kappa (Fleiss, 1981), the content analysis was shown to be reliable (Cohen’s Kappa = 0.75).

Results

Analysis of the data revealed two major categories referring to internal and external processes. Internal processes, which related to the participants’ feelings, included: satisfaction with the ward round; negative feelings about the ward round; feelings about the outcome and consequences of the ward rounds; and issues to do with coping with the ward round.

The external processes, which were not related to the participants, were divided into four sub-categories: decision-making; communication; the number of people present; and practical arrangements.

Internal processes

Eleven statements indicated feelings of satisfaction with ward rounds. Six were of a general nature, for example: ‘The whole thing was very good in general.’ Three were more specific, referring to feeling relaxed, challenged by or interested in the process. Two participants said that they would not change any aspect of the ward round.

Thirteen statements indicated negative perceptions of ward rounds, including ‘I hate going in.’ Eight responses referred to feeling intimidated by, or fearful of, the ward round, for example: ‘It feels more like an interrogation than a formal meeting.’ However, to balance this view, it was interesting that four responses explicitly indicated that they were not intimidated. For example: ‘I didn’t feel intimidated or anything like that.’

Four statements were concerned with the effect that the outcome of the ward round can have on patient feelings. For example: ‘When I have progress I feel all right, when I don’t I feel disappointed.’

Three statements referred to the way in which the feelings expressed could have consequences for the patient in the ward round. For example: ‘If you’re shy, it could help you to overcome your shyness,’ and ‘If one was of a nervous disposition, it could be difficult to express themselves.’ Four responses referred to the way in which people coped with the ward round. For example: ‘You know I coped with it. I became familiar,’ and ‘I tend to ignore the people outside – those I don’t know.’

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Ten statements referred to practicalities. Although one
participant said that they would not change anything about the arrangement of the ward round, five participants were concerned with the layout of the room. For example: ‘Everyone was sitting there in high chairs’ and ‘they had to get everyone in the same room, so they all sat around, perched.’

One participant referred to having appointment times: ‘you don’t have a set time... if you go and see a doctor or a nurse you always have a set time... I think it’s very unprofessional... they just assume you’ll be sitting round.’

Recollections about staff present
Participants expressed a much greater understanding of the role of the psychiatrist, senior house officer and social worker in the ward round than any other professional group, including: nurses, community psychiatric nurse, clinical psychologist and the team as a whole. Only two participants indicated an awareness of the function of having a team approach.

A number of participants reported that the professionals present were unknown to them and in general participants did not believe they had been formally introduced. However, this did not correspond with the first author’s experience of the ward rounds in question (weekly attendance for six months) where patients were always observed as having been introduced to people unknown to them. However, in the context of their presenting acute mental health problems and the perception that the ward round feels too intimidating to cope with, it is unsurprising that a patient’s memory of what happened may be skewed. This raises questions about managing patient care and how best to help challenge what seems like a rather passive acceptance of care arrangements.

Discussion
It is encouraging that there were several indications that participants were satisfied with the ward round, some identifying useful aspects such as confidence-building. However, the theme of fear and intimidation was alluded to on several occasions, indicating that aspects of the external environment may be less than optimal for some.

The external factors mentioned by the participants can be viewed in terms of power differentials within the ward-round process. Many referred to decisions being made prior to attendance, and being informed of these in the meeting. None of the responses indicated that the participant felt part of the decision-making process.

In contrast to studies of general medical ward rounds (Birtwistle et al, 2000), the high number of professionals reported to be present in this study was not perceived as reassuring but was commonly felt to be excessive. This also had an impact on the layout of the room, with the most effective arrangement for the team being to have the chairs in a circle, but one participant said this felt like an interrogation.

This raises questions about the necessity of including all professionals directly in every patient’s ward review, despite how useful this might be in improving communication between professionals, as it seems to shift the power balance away from the patient and may contribute to feelings of intimidation.

The suggestion made only to increase the number of health care professionals present as the patient becomes less distressed and more accustomed to the ward environment may be worth considering. Ward rounds may have become too institutionalised in terms of how they attempt to meet the needs of the patient. It seems there is a good case for tailoring the meeting according to the individual needs of a patient at any point in time.

The notion that patients’ levels of distress upon entering the ward may affect their perceptions of ward rounds is important when analysing the results of this study. It may be a limitation in terms of obtaining reliable data, and has been used as a criticism of patient satisfaction surveys in the past (Crawford and Kessel, 1999). However, the results are designed to show inpatient perceptions of ward rounds as they occurred and are still useful in understanding patients’ reactions to them, regardless of the impact of mental illness. Levels of distress may have contributed to the discrepancy between participants’ recollections of whether they were introduced to unknown faces, and the first author’s own recollection that in fact all patients were introduced to new faces. Some recognition of poor recollection at this time of treatment may be advisable when providing patients with information. This seems to be reflected by the poor awareness some had regarding the role of each professional present in the ward round.

Although it may be impossible to make the ward round an ideal experience for everybody, asking patients their views is becoming an important part in the development of services (Crawford and Kessel, 1999; Goodwin et al, 1999). This study highlights important negative aspects of ward rounds, including feelings of intimidation, limited patient involvement in decision-making and difficult practical arrangements, that should be explored further in future studies. Some of these issues were identified in the Open Mind publication (Wolf, 1997), so this small study certainly provides evidence to support the recommended changes.

Limitations
This was a very small study, providing a snapshot of patient views at one point in time on one ward. Differences in length of stay, consultants, age, cultural and ethnic background, and diagnosis may all affect patients’ perceptions, so further studies should incorporate more participants, and compare responses according to these factors, or select a sample that is more representative of the population as a whole.

The limited time frame available and the ethnic mix on the ward at the time of this study meant it was not possible to recruit participants who were not white. This would be an important area to explore in future studies. However, despite these limitations, this small-scale, exploratory study highlights important areas for future research, and shows the usefulness of qualitative methods.