Trainees' Forum

Psychiatric Ward Rounds in Practice

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Interest in all aspects of NHS management has increased recently, and senior registrar training schemes are becoming widespread.

The notions of management at ward level and interdisciplinary meetings are enshrined in the Griffiths Report, and the draft Code of Practice[1] which advocates "mutual trust and respect" but does not proceed to suggest how such admirable sentiments may be engendered. At the opposite extreme, a recent editorial[2] points out the logistical problems of communication in a "typical" seven person team, and bluntly proposes that "consensus management by equals be eased towards the cliff edge".

Currently, the various management functions are divided between professional disciplines, and these gather together, more or less frequently, to discuss clinical issues at meetings, usually designated 'ward rounds'. In psychiatry, the ward is rarely circumnavigated, but the term persists. This shift, from the bedside to the sideroom, may explain some of the many differences between 'medical' and psychiatric rounds; it is the latter which will be considered in this paper.

Faced with the task of conducting such meetings myself, and having been exposed to what I felt to be widely differing styles of organisation, I was unable to find any helpful guidelines in the psychiatric literature and decided to review my own experience in this neglected area. The subsequent discussion is not intended to be exhaustive or definitive but to stimulate debate.

The following description is based on my own training in two different teaching centres, working for 15 consultants, 10 in general psychiatry and five in subspecialities.

The findings

Of the consultant firms 12 (80%) had one ward round per week, the average length being 2.5 hours; three (20%) also had a medical meeting or teaching round. The number of new and follow up cases discussed varied from 30 or more to as few as four, discussed on a rotational basis. All teams also had morning 'handovers', of differing degrees of formality, for junior doctors and members of the nursing team. Six (40%) firms had regular staff meetings, other than ward rounds, for education, policy making, 'group psychotherapy', or simply lunch; 12 (80%) had a ward community meeting.

All ward rounds were held either in ward sitting rooms or in dormitories. Conditions can be described as comfortable, or conducive to efficient working, in only nine (60%) cases. Three (20%) ward rounds had a formal break at approximately the mid point, a further six (40%) being interrupted by the arrival of coffee, with business continuing. Smoking was uniformly banned.

On average four professional groups were represented (range 3–7), the total number of trained staff being eight (range 6–15); 14 (93%) meetings were conducted by the most senior doctor present. Patients were routinely seen during, or immediately following, the round in six (40%) instances, otherwise rarely. Of five firms using problem lists, three displayed them using visual aids. A key worker system was prominent on one specialist unit but the nursing process, or a derivative of it, was in use on every ward.

Comments

I was, therefore, a participant observer, with all the problems contingent on such a methodology. However, as one of my principal reasons for embarking on this analysis was my virtual failure to restructure any of the various ward rounds deliberately, it could be argued that my mere presence was unlikely to have had any consistent influence. All data were collected retrospectively, which may have led to the inclusion of some misremembered information, but had the advantage that all meetings were carried out with both myself and others blind to the fact that we were later to be described. Postings lasted for a minimum of six months, meaning at least 65 hours spent in ward rounds per firm.

The selection of my placements was not (I have been assured) the result of a random process but experience was spread between teaching, district general and psychiatric hospitals. Consultants ranged in experience from their first year in post to within a year of retirement and in orientation from eclectic/biological to eclectic/psychodynamic.[3]

A descriptive model Informal discussion with colleagues, of different professional groups, has led me to draw up a simple two-dimensional, descriptive model of the way in which ward rounds are run. The majority of post ward round comment, almost universally critical, can be fitted onto the following axes:

Axis 1: 'Duration': ranging from impractically brief to interminably long. Problems may arise at either end of the spectrum: from frustration at being unable to deal with matters in sufficient depth, to thirst, failing concentration, fatigue and, in the terminal stages, sleep. (I have

https://doi.org/10.1192/pb.12.2.55 Published online by Cambridge University Press

encountered the last phenomenon only once, the culprit being the consultant.)

Axis 2: 'Decisiveness': from non-goal-oriented and *laissez-faire*, to despotic and quixotic. At the former extreme, levels of frustration and anxiety are raised whilst no management plan is decided upon, whilst at the latter, the majority of staff feel excluded and intimidated, decisions being resented, subverted, or even ignored.

From discussion of my own mode of running ward meetings, I generally fall in the 'despotic brief' quadrant.

Where an 'ideal' or optimal ward round would fit onto such a matrix must depend on the defined purpose of the meeting, which leads onto the question. . . .

Why psychiatric ward rounds? Perhaps all would agree that the ultimate purpose of a ward round is the better management of patients, and I would suggest from my experience that the following are the most commonly used methods of trying to achieve this:

(1) the gathering together of information from different disciplines
(2) decision making and subsequent review
(3) clinical supervision of junior doctors
(4) didactic teaching and clinical examination practice for junior doctors
(5) a staff support and social function, where therapeutic success or failure can be shared and anxieties ventilated
(6) an opportunity for staff to meet the patients.

Clearly, items 1 and 2 require regular meetings of informed representatives from each discipline. These two constitute the highest common factors of the meetings I have attended, the ward round usually being the only time during the week when they are possible.

Numbers 3 and 4 are generally of limited relevance to the majority of those present at ward rounds. Other professional groups carry out these same functions in the company of their peers, but this is relatively unusual for psychiatrists. Whilst, in my experience, multi-disciplinary education in clinical and theoretical matters is valuable when it occurs, it is my thesis that a meeting with identified primary goals of information gathering and decision making is an unsuitable place for, necessarily esoteric, medical matters.

Working with the mentally ill is an onerous task, generating powerful emotions amongst staff at every level. All aspects of ward organisation should ideally make allowance for this. The question is, does the ward round provide a particularly appropriate opportunity for dealing with these issues directly? Because of the principal aims of the meeting and prevailing staffing levels, it is common for only the senior members of staff to attend. The relatively formal nature of proceedings, and the perceived expectation to 'perform' efficiently, particularly amongst new staff, all militate against any sharing of feelings about the work being done. For trainees, clinical tutors will give careful consideration to this aspect of their supervision. For trained staff a regular, informal meeting where open discussion is welcome has been of demonstrable benefit to the wards on which I have worked.

The ward round is an awkward place both to assess patients' mental states and to discuss their management with them. Little information is likely to be gleaned in front of an audience of between six and 15 relative strangers that cannot be more sensitively explored elsewhere. It is even less likely that they will register correctly any information passed on to them. Some feedback of the ward round discussion is usually welcomed, if not actively sought by patients, but this is most appropriately given by their key worker, or ward doctor.

Towards an ideal ward round? If the above lines of argument are accepted, then the functions of the multi-disciplinary ward round can be reduced to two: the collection and sharing of mutually useful information about the patients on the ward and the co-ordinated planning of their subsequent management. With the purposes of the meeting defined, how can they optimally be achieved?

I would tentatively propose the following: outside the meeting members of staff, with sufficient experience to discriminate the genuinely urgent from the merely important, should be available to deal with patients, telephone calls and visitors. 'Drug keys' and bleeps should preferably be left with colleagues on a reciprocal basis.

The room should be spacious, well ventilated and comfortable, with a large table and all relevant information to hand. Around this no more than eight participating staff are seated punctually. The attendance of community based workers involved in the patients' care would also be encouraged.

The meeting should occur in the afternoon, but never on a Friday. This permits ample time for completion of the day's other business, which tends to be most pressing in the morning. The meeting should be time-tabled, by whoever is in the chair, to finish promptly after 1.5 hours. In my opinion no minimum time should be set. Parkinson's Law[4] should not be allowed to prevent a business meeting from being concluded when, through diligence or good fortune, there is too little work 'to fill the time available'.

Prepared 'overheads' or flipcharts of problem lists should be available for each patient: these to include any action to be taken, who is responsible for ensuring that this occurs, and when any progress will be reported back to a subsequent ward round. Under the guidance of the chair, discussion should be limited to 15 minutes for each new case and 10 minutes per follow up. Each discipline represented should be invited to make a contribution.

Recently admitted and acutely disturbed patients may need to be discussed every week but for the majority, after a management plan has been agreed, detailed discussion in a ward round is usually only necessary on a two or three weekly basis. On each such occasion the problem list will be updated, all aspects of treatment reconsidered and a further review date set. Careful notes should be kept of the rationale behind decisions reached and of any changes made to treatment. Coffee should be available at the end

of the meeting for those without pressing engagements elsewhere.

The commonly pursued subsidiary aims of the ward round are in themselves valuable but can prove unhelpful distractions from the main agenda. They may, in my experience, profitably be structured into a 'doctors' meeting' and a 'staff meeting'. Both of these can be used to increase staff involvement in the running of the ward, as well as being educational and recreational. With the forthcoming introduction of a clinical component to Part 1 of the Membership examination a doctors' meeting could provide an ideal forum for practice in the detailed presentation of cases, as well as other aspects of clinical supervision. I am not suggesting that a doctors' meeting should supplant day to day counsel, but rather add to it.

This proposed format for ward meetings has several potential disadvantages. It replaces one tried, tested and flexible meeting, part of the oral tradition of psychiatric method, with up to three meetings, modestly different in style and content, needing considerable preparation. There is the danger that the 'means' of the meeting will come to dominate the 'ends' and that the introduction of such different practices will be resisted. Effective change is said usually to come from the top.[5] The consultants I have worked with who run meetings significantly different from the 'average', 2.5 hour, multiple agenda, meeting described above were all of the opinion that rapid regression towards the 'average' would follow withdrawal of their determination and energy.

I would contend that the benefits of such a style outweigh both the risks and extra effort involved. The limiting of numbers of staff, coupled with preplanning and chairing, encourages participation and effective use of time. The consequent brevity allows sustained attention. Optimally, all staff should leave the meeting with established, shared goals and defined areas of accountability. The ward round would thus be central to the co-ordinated planning of patient management, and therefore an essential focus for all members of the team. Finally, setting clear aims for the meeting itself and the use of problem lists would enable clinical audit to be introduced with little additional work.

I calculate that, during the course of a 35 year career in psychiatry, more than 1.5 of these will be spent in ward rounds. From another perspective, casting half an eye towards clinical budgeting, a ward round costs over £200 per week for manpower alone. To run ward rounds effectively (and enjoyably?) must therefore be in the interests of all.

ACKNOWLEDGEMENT

I am grateful to all the consultants for the training I have received.

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[1]Mental Health Act 1983: Section 118—*Draft Code of Practice*. (1985). London: DHSS.

[2]Editorial (1986) *British Journal of Clinical and Social Psychiatry*, **4**, No. 1.

[3]WILKINSON, G. & WILLIAMS, P. (1986) Development of a scale to measure treatment attitudes in psychiatry. *British Journal of Psychiatry*, **148**, 581–586.

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[5]PEMBERTON, M. (1982) *A Guide to Effective Meetings*. London: The Industrial Society.

Mental Health Foundation Essay Prize

A prize to the value of £500 will be awarded for an essay during the 1987/88 Session of the Section of Psychiatry of the Royal Society of Medicine. Candidates in the United Kingdom and the Republic of Ireland in training at any grade from senior house officer to senior registrar or equivalent are eligible and need not be members of The Royal Society of Medicine.

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