

CLINICAL
REFLECTION

Bed management in psychiatry: ensuring that the patient perspective is not forgotten

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SUMMARY

Bed management and the transfer of patients is an area of clinical care that is frequently overlooked. Often, the lack of discussion leads to the patient perspective being ignored and to transfers to new hospitals without appropriate handovers, both to the detriment of patient outcomes. This article reflects on the real-world consequences of the bed management systems used within the UK's National Health Service (NHS), using the example of a patient in psychiatric services.

KEYWORDS

Clinical governance; education and training; in-patient treatment; service users; stigma and discrimination.

Bed management has become an inescapable facet of modern medicine. The necessity to move patients between wards and hospitals depending on requirement has long been a crucial part of keeping a hospital running efficiently and may be needed to ensure that the patient receives the best care possible. However, increasingly patient transfer is more related to difficulties in finding a bed than a desire for optimal patient outcomes. In our desire to appropriately manage hospital capacity the patient perspective may be forgotten.

It is important to remember that the frequent moving of patients between hospitals is stressful for both patients and their relatives, may lead to poor patient and carer experience and, even when handled well, may prove detrimental for patient outcomes. Inter-hospital transfer may be associated with discontinuity of care, in particular gaps in communication, which are difficult to overcome once the transfer has been completed. In psychiatry, patient transfer often occurs to allow patients to receive specialist care that cannot be delivered elsewhere, improving the prognosis for the patient. However, if this is not communicated well to patients or clinical staff, from our experience the benefits may no longer be seen. For patients transferred multiple times, this leads to a loss of trust in services,

making them less receptive to treatment that was there to help them. Best patient care should include treating patients holistically, as individuals with personal needs. This should include access to personal support networks such as family visits, being in a familiar environment and consistency in care.

Discussion

In the long-term, patients who have perceived their in-patient mental healthcare negatively are more likely to require readmission under a legal sanction (Wykes 2017). Additionally, the disorientation of transfer can exacerbate confusion associated with a number of psychiatric disorders. Studies have shown that defined protocols before, during and after transfer ensure a more fluid patient experience (Kulshrestha 2016). Furthermore, they ensure that each clinician is aware of their role in the process (Bosk 2011). Unfortunately, there is no overarching prescriptive guidance in England's National Health Service (NHS) which dictates comprehensively the steps that must be taken in patient transfer, with the variation that exists between local policies leading to breakdowns of communication. When the pressure for beds becomes overwhelming, corners may be cut. Therefore, we believe that it would be ideal to develop checklists on a national scale and ensure that these are followed to offer an excellent patient experience.

The transfer process is also often the source of unique challenges for clinical staff delivering care, as patients may be transferred to new hospitals without an appropriate handover. Both the transferring and receiving facility should be ensuring continuity of care as a priority (Joose 2012), but the reality is that many patients are transferred to new locations without adequate communication regarding their clinical condition, treatment being given, reasons for transfer, mode of transfer and timeline of transfer between clinicians (Kulshrestha 2016). This leads to delays in care, as every time a patient is transferred the new team must start from scratch, with very little information provided

regarding the individual's current state. Psychologists and those delivering talking therapies are perhaps the worst affected, as these require the development of strong relationships with patients.

From our personal experiences, the best way to engage patients in the transfer process is to make no assumptions about what they have been told, involving them in every step of the journey. Often simply verbally confirming with the patient that they understand where they are going and why they are going there, as well as giving them the opportunity to ask questions, can make a huge difference. Although for the most severely unwell patients this can be difficult, it must be attempted and documented. The responsibility falls on every clinician in the team, not just a few members, to ensure that they have updated the patient with the relevant information regarding their care up to this point.

Throughout our careers, we have of course been made aware of the importance and pervasiveness of bed management systems. However, every day new problems present themselves, leading to unique challenges in delivering some of the key tenets of good-quality care. Here, we would like to share the case of an in-patient who presented to us at a psychiatric intensive care unit (PICU) and reflect on the wider implications of this case. Witnessed verbal and written consent were obtained from the patient and details have been anonymised. No further ethical approval was required for this clinical reflection.

Case reflection

He was a young man, not much older than us, who had presented to mental health services for the first time in August of 2020. He had presented with psychotic symptoms, in particular paranoia and hallucinations, following an altercation with police. After investigation it was concluded that he was suffering from a drug-induced psychosis and he was detained under section 2 of the Mental Health Act 1983. The patient had little memory of his early in-patient experience; however, he could recollect the first time he was moved between hospitals. He reported that he was not told where he was going or why he was being moved and can still not name the hospital he was moved to. He was subsequently moved again to another new location, where he spent the majority of his recovery. Following 2–3 weeks in this new location, he reported that his symptoms had subsided and he felt back to normal. However, for no clearly documented reason, he would be moved twice more, both times to intensive care units and both progressively further away from home.

Although it might be comforting to assume that this story is atypical, we were assured by clinical staff that this was not the case. Several times in this patient's journey the system failed to deliver on many of the key components of patient-centred care. The final hospital that he was admitted to was more than 60 miles away from where he lived, despite the NHS aiming to deliver care near to your place of living.

Moreover, despite his symptoms resolving he was not allowed to contribute to the decisions regarding his own care. He remained in the PICU for over a week despite showing little evidence of severe mental illness, and it is clear that the decision to move him into an environment such as a PICU, with some of the most unwell patients, only worsened his mental health. Indeed, he admitted to us that the whole experience had encouraged him to take some time away from the UK and return to his family home in Romania. It is only more saddening that this negative perception was developed further with each transfer that occurred. As English was his second language, the language barrier was a large problem and made it even harder for him to communicate his wishes. In this case an interpreter was not provided, as the receiving hospital was not made aware of the matter. Studies have shown that barriers to effective and equitable healthcare can result from linguistic differences between patients and clinicians (Meuter 2015) and therefore this must be flagged in advance to the clinical team.

The understandable frustration at his many transfers meant that by the time he reached the hospital where we met him, he was often resistant towards staff. Unfortunately, owing to his limited English language skills this was frequently misconstrued as being a component of his mental illness, further fuelling the discontent he felt towards the care he was receiving. Only on discussion with the ward consultant during ward rounds did he manage to convey his message, with the invaluable input of his family members over the telephone. It was clear that he never should have been transferred to a PICU in the first place, and in an unprecedented move he was discharged directly from the PICU into the community, as stepping down to a bed in the local area would have further delayed discharge. The input from his family members during ward rounds provided new insights into his care that were being missed because of the language barrier and also highlighted the difficulties he experienced at the time adapting to the new PICU environment, which he often found restrictive. The first guiding principle of the NHS constitution states that 'The NHS provides a comprehensive service, available to all [...] irrespective of gender, race, disability,

age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status' (Department of Health and Social Care 2012). Although there was no overt discrimination during his time under psychiatric services, it seems clear that this young man's background had an impact on the quality of the care he received.

Conclusions

This experience has shown us how we must strive to provide patient-focused care during our careers. We believe, with this case as an exemplar, that we have found a system that often fails to deliver care near the patient's home, presents challenges to clinicians, has a negative impact on patient autonomy and disproportionately affects those from minority backgrounds. Rather than ignoring the plight that patients face, our efforts must be focused on providing more favourable outcomes, with long-term planning to help tackle obstacles that present themselves.

Author contributions

T.K. was involved in the conception and design of the work, the collection of sources and drafting the article. T.F. was involved in the design of the work, source collection and analysis, and drafting the article. K.V. was involved in the conception of the work and the drafting and redrafting of the article. All three authors gave final approval of the

version to be published and agree to be held accountable for all aspects of the work.

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Declaration of interest

None.

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