The Acute Admission Ward as 'Patient'

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I suspect that caring not only for patients but also for staff is the lot of most senior registrars. Patients need understanding and 'formulating', while staff need support and supervision. A less obvious role for the senior registrar is that of caring for the organization of which staff and patients form a part. True, this is often done by the consultant. But frequently the unique position of the senior registrar, closely in touch with the day-to-day life of the ward and yet sufficiently detached, makes him the ideal person for this role.

Let me elaborate. Any organization, for example an acute admission unit, has a structure. This will include the inevitable meetings, communication arrangements, staff work roles, and much else. All of these combine to form the fabric of ward life. While often appearing monolithic, these structural arrangements are not necessarily so, and from time to time may need to be reviewed in the light of changing needs of the unit.

With such notions in mind, formulated from experience in my first senior registrar attachment, I moved to my second appointment 18 months ago on an acute admission ward. As 'new boy' I naturally became the focus of hopes for change, and staff were forthcoming about their needs, of which two in particular stood out: firstly desire for more supervision, and secondly a wish for better communication between disciplines.

These complaints must be universal. What I want to describe is my experience of understanding them and trying to deal with them. What makes supervision and communication so important on the acute psychiatric ward? After all they are activities with little visible therapeutic benefit. To understand their importance better we must remind ourselves of two things.

Firstly, the working conditions on acute admission wards which are characterized by high levels of anxiety. Among the many features that contribute to this are: high patient turnover, patients who fail to improve despite care, the acting out of unpredictable and self-destructive impulses, the pressures of 'specialling' at-risk patients, the long shifts that nurses in particular have to work with little time off the wards, the ambivalent feelings of relatives ranging from idealization to anger, and, of course, pressures arising from ward routine and the fear of what seniors may think.

Secondly, the increased emphasis in the past decade on a multidisciplinary approach. This quiet revolution, questioning the traditional hierarchical medical model, has resulted in a reappraisal of roles not only for doctors, nurses and other disciplines, but also for the patient. The outcome for nurses in particular has been an expansion of their traditional role as carer and provider. They increasingly see themselves as therapists. It is the shift in role, taking greater responsibility for individual patients, that may heighten anxiety in an already pressurized work setting.

In these working conditions, demands for support and guidance are justified and must be taken seriously if morale and therapeutic safety and effectiveness are to be maintained. Patients will not be getting the best from staff who are anxious and unsupported.

Closely related is the need for a good communication system. Keeping everyone informed is the obvious pay-off, but there are hidden benefits as well. Sharing certain types of information, the suspicion of a patient's suicidal intent for example, may relieve anxieties previously contained within an individual staff member or sub-group. Good communication facilitates informed and rapid decision-making, which may again keep anxiety levels among staff at workable proportions. Thus, communication, anxiety and supervision are all inextricably linked. Let me now elaborate on two fundamental issues: supervision and communication.

Supervision

The developing role of the nurse as individual therapist, and her closer relationships with particular patients, mean greater responsibility, and this inevitably results in an increase in anxiety. This anxiety, experienced particularly by new therapists, can be alleviated in two main ways. It can be shared and made acceptable. In this way it will be contained and better understood, rather than being split off or allowed to undermine the therapist's self-confidence. Secondly, new skills and strategies can be learnt which develop a therapist's ability to feel therapeutically useful. Group supervision can be a way of achieving both these goals. It was with this in mind that a weekly multidisciplinary supervision meeting was started on the Unit. Membership includes nurses, psychologists, doctors, social workers and occupational therapists. Each has responsibility as primary therapist of one or more patients. Therapists and patients are matched either at the ward round or at the primary therapist

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meeting, when therapeutic aims are reviewed. Patients' sessions are usually held on a regular basis at a particular time and place. Grief work, supportive psychotherapy, counselling and focal psychotherapy would be typical of the sort of work done.

From the beginning it was recognized that supervision would be a shared task for the group. Everyone contributes according to his or her experience. This is made easier by the wide range of experience levels represented. As senior registrar I have a different role however, particularly as boundary keeper; for example, ensuring the group does not stray from its task and providing the degree of organization needed to maintain the scheme. In addition, my interventions are often aimed at making it easier for the group to use its own resources and experience.

Broadly speaking, the aim of supervision is to give therapists the opportunity to discuss their work with patients. Attention is paid not only to strategies of therapy and the responses of the patient but also to therapist's feelings and behaviour. We spend a short time reviewing cases recently discussed, and then focus on one therapist's work with a particular patient. After a short presentation, emerging themes or difficulties can be explored through general discussion, sharing of experience and role play. The psychodynamics are also examined in order to understand the particular therapist-patient relationship.

The importance of the meeting is to absorb anxiety about increasingly closer relationships with patients, to increase identification of staff with the Unit's task of making patients better, and so increase work satisfaction; and to provide firm boundaries within which therapists can develop these new roles, feeling that they are supported and know the extent and potential of the roles they are developing.

An edited transcript of part of a primary therapists' meeting follows to illustrate the work of the supervision group. The therapist, a nurse, was seeing a patient who had been causing much anxiety. He had attempted suicide on a number of occasions over a short space of time. The therapist had spent an anxious weekend on duty seeing much of the patient, who was then discussed in the Monday ward round. The therapist brought up what she felt was an important aspect of his problems, but her comments were ignored. Later the doctors were scolded by the nurses for never bringing coffee into the ward round.

Doctor A	So what was your irritation saying; it came out as anger at the doctors' never organizing the coffee.
Nurse B	I think we do a lot of the ground work, being with that patient over the weekend. No one took a bit of notice. If someone had only said 'what a load of old rubbish', at least I would have known they had heard what I had said.
Social Worker C	Perhaps it is to do with the structure of the ward round, we zip through.
Psychologist D	People would have said something if she had talked about an enormous bedsore.
Social Worker E	We are always under pressure to get through the ward round.
Psychologist D	Odd that a comment which had been thought out was ignored.
Social Worker G	There has been a lot of anxiety about the management of this chap.
Doctor A	You did carry the can for him over the weekend. A lot of responsibility and anxiety. Perhaps we did not recognize that when we ignored your comment.
Nurse F	Your comment was also ignored in the handover.
Nurse B	And it is being discussed now, which makes me feel better . . . I have been recognized . . . It has been recognized that I have spent time with him, and during that time I feel I have got to know him. (Later in the session)
Psychologist D	Nursing officers are not really involved, they are out there somewhere. One wonders what would happen if the patient killed himself, and what the support system would be like up there.
Social Worker G	We seem to be focusing it all on the nursing officer, but he stands for a lot of people.
Doctor A	We seem to be using nursing officers as a scapegoat. It started off being angry about the way doctors did not respond to what the nurse was saying on the ward round, and now it has moved on to the nursing officer. It is important to see that feelings can get deflected in this way. How do you feel about the session today?
Nurse B	My anxieties are recognized, which makes me feel I am not wrong or I am not being weak, but I am also talking for other nurses.
Social Worker E	As an outsider I feel the anxiety, but how is it expressed? The impression on the ward often is of people cutting off . . . you take it as just not wanting to communicate. One should perhaps stop and say 'you must be having a very hard time'; instead of just going away.
Nurse B	I remember the first session here after a traumatic experience on the ward, somebody severely injuring himself. It was really good to have someone you could talk to about it. We gave the students support, but did not get anything for our own needs. That particular night it happened, none of us wanted to go off duty, we hung around, it was important to talk about it in the group.

This sort of detailed supervision is not possible in a busy ward round, but denied the opportunity of such supervision

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it can be seen that feelings experienced by this therapist could easily have passed unnoticed. As a result she might have continued to feel unsupported and unacknowledged in her work, adversely affecting the therapy. The way feelings became focused on lazy doctors who don't help with the coffee was also an object lesson. For such feelings, originating from the therapist's work, anxiety can easily become established as staff battles which in turn may affect the functioning of the whole unit.

Communication

An acute admission ward is often hectic. The ward one left last night may be very different the next morning. There is so much to do, and it is under this sort of pressure that good ward communication is most needed, particularly between the disciplines. This is important for the efficient transfer of information and ease of decision-making. But also, as mentioned previously, it serves to prevent the build up of unnecessary high anxiety within one particular group or individual.

On our Unit, communication between disciplines, for example between doctors and nurses, was good; but it lacked system. Nurses would find themselves briefing different doctors individually and patients were not systematically discussed on a daily basis. As the business of keeping everyone informed would drag on through the morning, it was an inefficient use of time. The lack of system also brought little cohesion to the Unit, and at worst prolonged anxieties because of the delay and unpredictableness in communication. It was interesting to compare the nurses' intra-disciplinary communications system—a well-established, highly systematic handover occurring between each shift.

To meet these limitations, a daily 15-minute meeting at 8.45 was instituted. The responsible ward nurse runs the meeting, and all doctors attend, other disciplines participating less regularly. Each patient is mentioned. Incidents, ward atmosphere, admissions and discharges, and plans for the day are highlighted. Any urgent decisions are taken.

The aim of the meeting is to focus communication into a predictable regular forum. Repetition is reduced, since everyone is informed at the same time. Secondary aims include minimizing anxiety that results from poor communications; recognition that the sharing of information may have a supportive function when staff are under particular stress; emphasis of the nurses' role since this is an important meeting managed by them; and finally, fostering team spirit.

Some problems encountered

The primary therapist group is large, often containing ten people. Although learning takes place by observing others, there is insufficient time to share around to everyone. Staff in training, for example student nurses and medical students, are not included, partly for reasons of size, partly to ensure the group has constant membership and develops a high level of trust. Usually trainees receive supervision elsewhere. Another constant problem is the nursing shift system, and the demands of ward work also diminishes nurses' attendance. Clarifying the precise areas of responsibility between primary therapists and the junior doctors has been a problem. Encouraging nurse therapists to participate fully in decision-making about their patients is sometimes related to the under-valuing of their role both by themselves and by others.

Problems with the daily morning meeting have chiefly concerned the efficient use of the short time available, resisting the tendency to expand according to Parkinson's law into any space available. It has been an education for me, having been brought up on three-hour ward rounds, to see just how much can be communicated and decided in a space of just 15 minutes.

Parliamentary News

The Bill in the Lords: Committee Stage

The Mental Health (Amendment) Bill was further debated in the Lords by a Committee of the Whole House on 19 and 25 January and on 1 February 1982.

The Government speakers were Lord Elton, of the DHSS, Lord Belstead, of the Home Office, Lord Cullen of Ashbourne and Lord Sandys.

Medical Peers who took part were Lord Hunter of Newington, Lord Richardson and Lord Winstanley, the last, however, speaking more as a politician than as representing a medical point of view.

Peers who proposed and spoke to amendments included Lords Wallace of Coslany, Wells-Pestell, Elystan-Morgan and Lady Jeger from the Labour benches; Lords Winstanley and Hooson and Lady Robson of Kiddington from the Liberal side, often associated with Lord Kilmarnock. Lady Faithfull was an assiduous speaker and proposer of amend-

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