Psychiatric Bulletin (2005), **29**, 171–173

original papers

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A survey of ward round practice

AIMS AND METHOD

A postal questionnaire was sent to consultant psychiatrists in the West Midlands to establish their current ward round practice. This questionnaire addressed ward round etiquette, practical issues and educational function. Consultants received only one mailing.

RESULTS

A total of 96 (out of 139) consultants replied (69% response rate). The majority of consultants saw patients on the ward round (97%) and all consultants introduced both themselves and team members to the patient; 72% explained the purpose of the ward round. A median of seven professionals attended the ward round with psychology (6.5%) and pharmacy services (0%) being underrepresented. When consultants added comments, the recurrent themes were that ward rounds were an effective use of professional time but were often daunting for patients.

CLINICAL IMPLICATIONS

Our results indicate some uniformity in the conduct of ward rounds. The lack of representation at ward rounds for certain professional groups may adversely affect the range of opinions and therapies for patients. Changes could be made to incorporate the views of users, which would make ward rounds more productive for users and professionals.

Ward rounds have a pivotal role in hospital-based care. Healthcare professionals are able to meet and develop an integrated plan of care. In medical and surgical practice (Manias & Street, 2000) the goals of the ward round include: enhancing the quality of care; improving communication; addressing patient concerns and problems; planning and evaluating treatment. Multiprofessional training and education is also enhanced. However, little is known about the origins of the ward round and variations in practice. In physical medicine the term ward round is descriptive, as many patients have limited mobility and may need physical examination. Therefore, it is more appropriate for the clinical team to visit the patient. Usually, this is not the case in psychiatry.

Despite service developments such as home treatment teams, acute psychiatric wards still have a central role in the management of severe psychiatric problems and no suitable alternatives can be identified for many in-patients (Beck *et al*, 1997). The management of these patients often requires a multiprofessional approach, although acute wards are poorly staffed from this perspective (Rix & Sheppard, 2003). Often the ward round is the only venue to crystallise this multiprofessional approach. Multiprofessional working is an important part of psychiatric practice and is evident not only in acute wards but is enshrined in good practice initiatives such as the care programme approach (CPA) (Easton & Oyebode, 1996). Patients often have reservations about large meetings (Foster *et al*, 1991), but addressing their concerns without compromising their care is a delicate balancing act.

In physical medicine attempts have been made to define ward round standards (Plume, 1985) but these guidelines are likely to be outdated. A Medline and EMBASE search did not find contemporary observations on psychiatric ward round practice. However, user groups have made recommendations (Highland Users Group, 1997). These include the use of appointment times, appropriate introductions and arranging seating so 'that the service user is part of the circle, not at the centre of it'.

Method

A postal questionnaire was sent to all identified substantive general adult consultant psychiatrists in the West Midlands. This questionnaire covered good practice guidelines by user groups and areas of professional interest. No personal identifying data were requested and the questionnaire was designed to be completed in less than 2 min if no additional comments were made. Consultants were mailed on one occasion only. Quantitative data were analysed using Statistical Package for the Social Sciences version 10.5 for Windows.

Results

Out of 139 consultants who were sent a questionnaire, 96 (69%) returned a completed form; 4 forms were only partially completed and were excluded from analysis (Table 1). Thirty-one (34%) had a pre-ward round meeting to organise information prior to starting the ward round. The senior house officer normally writes in the notes at most ward rounds (83 cases, 90%), although in 11 (12%) and 25 (27%) of cases, the specialist registrar and consultant take this role, respectively.

The majority of consultants saw their patients in the ward round (97%). Sixty-eight consultants (74%) expect their junior staff to present a full history and 74 (80%) use the ward round for teaching. The median number of people, including students, attending ward rounds was 7 (range 1–11). Table 1 shows the professional background of ward round attendees. While nursing and medicine are strongly represented, other disciplines are not. Only 62% of ward rounds have a further discipline present, with social work being the most likely. Psychologists were present at 6.5% of ward rounds and pharmacists were completely absent.

https://doi.org/10.1192/pb.29.5.171 Published online by Cambridge University Press

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Table 1. Background of ward round attendees

Staff	Regularly present at ward round *n*=92[a] (%)
Consultant	91 (99)
Associate specialist	14 (15)
Specialist registrar	36 (39)
Staff grade	37 (40)
Senior house officer	81 (88)
Social worker	46 (50)
Nursing staff	91 (99)
Occupational therapist	38 (41)
Psychologist	6 (6.5)
Healthcare support worker	9 (10)
Pharmacist	0 (0)
Relatives/carer	53 (58)
Students[b]	50 (54)
Others, e.g. advocate	21 (23)

[a]Four questionnaires had missing data.

[b]Any discipline.

Ward round etiquette

The purpose and function of the ward round was explained to patients by 69 of the responding consultants (75%). All consultants introduced both themselves and team members. When students are present then 82 consultants (89%) note their presence and request patient permission for the student to remain. A minority of consultants use an appointment system for reviews (37, 40%) and few (4, 4%) operate a request/aide memoire form. Pre-arranged seating prior to starting the ward round is requested by 85 consultants (92%) and half (46, 50%) have refreshments at the ward round. In the cases where the clinical team have refreshments then in only 5% of ward rounds are patients offered refreshments. If a patient does not wish to attend the ward round their request to be seen elsewhere is accommodated by 79 of the consultants (86%).

Additional comments

Forty-two consultants (46%) added comments. Two common themes emerged which were: time pressures (12) and empathy with patients for the potential anxiety provoking nature of the ward round (10). However, 3 consultants observed that the presence of all appropriate staff facilitated good decision-making and communication.

Discussion

The high response rate for a postal survey helps to understand current ward round practice in the West Midlands. However, our study focuses on the organisational aspects and does not have a consumer view or incorporate the views of other professionals attending the ward round. We also restricted our survey to substantive consultants. The inclusion of locums may have introduced greater variation. The pro forma we designed was Procrustean, although there was scope for additional comment.

The nursing and medical professions constitute the core of ward rounds. This lack of multidisciplinary input to acute wards has been noted (Rix & Sheppard, 2003). However, the mean number of attendees was seven. Armond and Armond (1985) explored the impact of professional etiquette and numbers on patients attending a ward round. In the first part of their study they found that the number of professionals in the room did not correlate with patient anxiety, but not knowing the reason for a particular professional being there did. Approximately one-third of patients found the ward round provoked anxiety. A quarter of patients held an unfavourable view of the ward round but this did not relate to diagnosis, previous admission or demographic details. They noted that the simple measure of introducing each professional and stating their role significantly reduced anxiety (from 31 to 15%, $P<0.0001$) but did not alleviate concerns about confidentiality, which remained at 19%.

While the shift of professionals to the community has been noted, it may be that the structure of the ward round diminishes its importance or usefulness to other professionals. Fewtrell and Toms (1985) observed the pattern of discussion in a traditional and a novel ward round procedure. They noted an inequality in airtime between professionals, with medical staff dominating in the traditional ward round. When other professionals spoke it was often to supply medical information. The novel ward round initiative resulted in qualitative changes in speech of all the professionals present and a shift towards socially orientated factors. Their paper also indicates that professional roles are changing for in-patient care, for example 'Occupational therapists who probably spend more time with the patients than any other member of the multidisciplinary team'. The inequality of roles in ward rounds is not confined to psychiatry. Birtwistle *et al* (2003) reported the positive evaluation of a surgical ward round by doctors, but their nursing colleagues expressed dissatisfaction with many aspects of the ward round. Both professions thought that the round should change from its present format to promote quality in-patient care. Overall, patients expressed predominantly neutral feelings towards the ward round, although a significant minority expressed concerns over confidentiality.

McBride (1988) reviewed the ward round practice of consultants he had worked for during his psychiatric training. One noticeable change in the 15 years between his study and ours is that 'Patients were routinely seen during, or immediately following, the round in 6 instances (40%), otherwise rarely'. He notes that 4 professional groups were represented and that 8 trained staff attended the ward (range 6–15).

The majority of responders see the ward round as a compromise between professional efficiency and patient satisfaction. Not one respondent suggested viable alternatives, although we cannot exclude that non-responders

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had such alternatives. User groups have suggested ways for improving the experience for patients. Many of these suggestions may also apply to other meetings such as CPA reviews. However, it is more likely that patients attending these reviews will be more familiar with the system than a patient admitted to an acute psychiatric ward for the first time.

Acknowledgements

We thank those psychiatrists responding to our survey.

Declaration of interest

None.

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https://doi.org/10.1192/pb.29.5.171 Published online by Cambridge University Press