Ideal Ward Round

Focus Groups – Summary

Three focus groups took place in February and March 2016 altogether 17 People took part. The groups followed on from data we had gathered from questionnaires and a report completed in January 2016.

People's experiences of ward rounds or reviews can be broadly summarised into the below bullet points:

Ward rounds do not feel prepared and have an ad hoc feel to them. Both the support for patients prior to the meeting, the content of the meeting and the location do not have the sense that they are well planned.

There is a power imbalance and the ward round often has a feeling of being a staff meeting with a patient present.

No clarity of staff roles or the purpose for them attending the ward round.

Physical environment is never considered and how this translates to patients comfort and anxiety.

Pre and Post ward round times are not considered as part of the process for patients and the value that could be obtained from this.

Patients rarely have an input into setting the agenda of the ward round meeting.

There is a deficit of advocacy at ward rounds, both through the official advocacy or a recognised advocate role within the meeting.

Clarity of a Carers' role is foggy both for staff and the carers; often confidentially is a barrier or a lack of using the carer as a resource within the treatment plan.

Ideal Ward Round

Focus Groups Process

The Ideal Ward Round project aims to improve the experience of ward rounds/reviews on adult mental health wards. There are frustrations about how they currently run from patients, carers and staff.

The Ideal Ward Round Group was started in August 2014 and is made up of service users, carers, Involvement Team staff, POhWER Advocacy staff, the University of Nottingham, consultants, nurses, OTs, Peer Support Workers and other Nottinghamshire Healthcare Trust staff not included in these groupings. It is an Involvement group with the main membership consisting of service users and carers; as such the process of agreeing to start this project and the approach to all the streams of work in the Ideal Ward Round Project have been led by service user and carer involvement. When staff have run or facilitated sessions the formats and presentations have been co-designed and agreed by the Ideal Ward Round Group.

In order to understand the current experience of ward rounds/reviews on mental health wards the group developed questionnaires aimed at four groups; carers, inpatients, patients discharged from wards, staff. 97 Questionnaires were completed.

We took initial findings and conclusions from this and used it to inform the format and process for focus groups.

Co-designed format of focus groups

The findings from the previous questionnaires formed the structure around the questioning so that we could drill down in a more detailed way the information we had already acquired on those aspects of the ward round. The issues were grouped in the following themes

The Purpose of Ward Rounds

Practical Arrangements in Ward Rounds

Management and Ownership of Ward Rounds

Involvement and Decision-Making in Ward Rounds

Discharge Planning and Recovery Focus in Ward Rounds

Improvements that can be made to Ward Rounds

The Ideal Ward Round Group requested the support of Nottinghamshire Healthcare's Learning & Development Team for a member of staff outside (independent of) the project to facilitate the focus groups. Angela Pemberton, Theraputic Skills Tutor agreed to support us with this and also facilitated the sessions.

With support from Angela the group agreed on a format for the focus group and this was signed off in Dec 2015. See Appendix 1

Promoting the Focus Groups

Advertising and promotion for participation in the focus groups took place in January and February 2016, inviting anybody with an experience of ward rounds to come along to the focus groups. A £15 voucher for taking part was offered to those who were not members of staff.

The focus groups were promoted across Adult Mental Health Services, Recovery College, the Trust membership, Carers Federation and various carers groups across Nottinghamshire, the Involvement Teams, networks linked into Open Dialogue and 3rd Sector organisations such as Framework.

18 Feb, 7 March, 18 March

Three focus groups took place on; 18 February, 7 March and 18 March. The breakdown of those who attended is as follows.

Date	**Staff**	**Service User**	**Carer**	**Total**
18 Feb	0	5	2	7
7 March	1	0	1	2
18 March	4	1	2	8
				17

All three groups lasted for over two hours and there were at least two note takers, (always one service user volunteer) who did not involve themselves in the discussion, present at each group.

Co designing our understanding (Thematic Analysis)

In order for the Ideal Ward Round Group to have a collective knowledge and understanding of the data from the focus groups it was decided that we would run three all day workshops. The aim of this to undertake thematic analysis of the data.

The attendance for each of the session was around 7-9 people on each of three days, with over half those in attendance acting as core group that attended all three sessions.

Prior to deciding themes the group read through all of the notes and we then did an exercise on the themes that we might use to allocate the information. These suggestions were displayed throughout the three days so that we could refer back to them.

We then reintroduced the original themes from the work done on the questionnaires and started to place comments appropriately within those themes. We generated two more themes, taking these from the exercise that we had started with.

The Purpose of Ward Rounds

Practical Arrangements in Ward Rounds

Management and Ownership of Ward Rounds

Involvement and Decision-Making in Ward Rounds (this was split into patient and carer)

Discharge Planning and Recovery Focus in Ward Rounds

Improvements that can be made to Ward Rounds

Advocacy - *added*

Patient/Carer Experience - *added*

As a group we went through all of the notes collectively placing each comment within one of the agreed themes above.

See Appendix 2

Summaries and Conclusion

Each theme was split into positive and negative comments. During this process we ensured no 'ideas' were missed adding them to the 'Improvements that can be made to Ward Rounds' section.

The negative points focussed on experiences that people had of ward rounds that they didn't like or were felt to be unhelpful. The positive column consisted of experiences of good practice or practice that people would like to see.

The group summarised and drew the following conclusions about what we were hearing from the focus groups for each of the positive and negative strands in each theme:

THE PURPOSE OF THE WARD ROUND

Ideal practice

- Shared dialogue about progress and future direction between staff, patients and carer – eg medication / leave

Issues

- Confusion as to their purpose (lack of communication)
- The purpose seems to be more about staff than patient needs (eg focus on assessment rather than update)
- Not recovery focused

PRACTICAL ARRANGEMENTS OF THE WARD ROUND

Ideal practice

- Time – flexibility of changing ward round times length
- Tea / Coffee / Relaxed Room
- Preparation – Follow Up

Issues

- Room too small and too many people
- Having informed and appropriately involved carers
- Feels ad hoc – patients want certainty, the room and meeting aren't planned
- Time – overrunning / late
- Communication – no joined actions and no follow up
- Lack of structure

MANAGEMENT AND OWNERSHIP OF WARD ROUND

Ideal practice

- Preparation – follow Up
- Staffing – the right staff – clear roles – who should/shouldn’t be there
- Co-production – patient ownership
- Identifiable co-ordinator of ward round

Issues

- Feels like a staff meeting
- Lack of consistent staff
- Too many people – unknown presence
- No preparation – lack of carer involvement
- Social Power Environment ie space / power relationship between staff and patient / been done to you / not welcoming - intimidating

INVOLVEMENT AND DECISION MAKING

Ideal practice - PATIENT

- Patient focused not staff focused
- Graded / stepped level of involvement as health improves and the patients capability at the time
- Patients setting an agenda

Issues - PATIENT

- Lack of – Information – Involvement – Influence. Patients often not aware of agenda so no information means they are not involved and can’t influence the decision makin

Ideal practice – CARER

- Nothing

Issues – CARER

- Communication – carers not being acknowledged / remembered
- Confidentiality – lack of clarity for staff

DISCHARGE PLANNING AND RECOVERY FOCUS

Ideal practice

- Discharge planning starts at admission and continues in a recovery focused way
- Good links with Social Care and Carers
- Smooth transmission from hospital onwards

Issues

- Lack of involvement – awareness – communication around discharge
- Lack of support post discharge
- Negative impact of bed pressures
- Discharge decisions made by people who don’t know the patient

PATIENT EXPERIENCE

Ideal practice

- Built therapeutic relationships
- Clear relationships

Issues

- Feeling of being passive and being done to you
- It felt like people were fitted into the business of staff duties
- Patient and carers felt uniformed – about plans for them – when discharge takes place – conversations about them by staff
- Number of people in the room

ADVOCACY

Ideal practice

- Offer advocacy
- Outcomes of advocacy are positive
- The function of Advocacy and who takes on that role
- Regular / constant presence

Issues

- Lack of advocacy
- Lack of offer of advocacy
- Who will be the advocate? and what is their role

What Next?

The summaries and conclusions from the thematic groups should now form areas of work to focus on and consider about best practice.

This is going to be checked against our initial findings from the questionnaires so that we can align the two pieces of data and be clear about what we are 'hearing'.

Areas of best practice will be developed by the Ideal Ward Round group and checked with frontline staff to see about suitability and if it might work in practice.

Areas of work that we need to consider and draw into our model are:

- The Triangle of Care
- Smoke Free Policy
- No Force First agenda
- Work already developed by Vicky Romilly – Speech and Language Therapist
- Accessible Information Standard

.
The Ideal Ward Round Group meetings are:

2pm-4pm
- Thursday 19 May
- Thursday 23 June
- Thursday 21 July
- Thursday 25 August
- Thursday 22 September

For more information contact jonathan.wright@nottshc.nhs.uk or sally.pope@nottshc.nhs.uk
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Appendix 1

Focus Group Format

The purpose of the focus group sessions are:

- To share the feedback we've received about Ward Rounds from the in-patients, discharged patients, carers and staff and continue the conversation more in depth about ward round experience
- To identify aspects of a new model for an Ideal Ward Round
- To discover what an Ideal Ward Round would look like from an individual's lived experience (staff, patient, carer)

9.00 – set up
9.30 – 9.45 –registration

Welcome- 9.30 – 9.45
tea/coffee/biscuits available for early arrivals
House- keeping.
Thanking people for agreeing to be part of the focus group.

Use name cards

Ground Rules – printed out on tables

1. **WE WANT YOU TO DO THE TALKING**-We would like everyone to participate.
2. **THERE ARE NO RIGHT OR WRONG ANSWERS**-Every person's experiences and opinions are important. Speak up whether you support or have a different point of view. We want to hear a wide range of opinions.
3. **EVERYTHING IS ANONYMOUS, BUT NOT CONFIDENTIAL**-We want people to feel comfortable sharing but please be aware that what is said will be used to form the Ideal Ward Round, so will not kept confidential. Think before sharing personal details for yourself or others, a good idea would be to not name wards and staff or patients by name.
4. **RESPECT THE DIFFERENCES OF EXPERIENCE IN THE ROOM** – we all have experience of ward rounds, but will be coming at it from different perspectives from patient, carer, staff member. We have to be open but also agree to accept difference of opinion.
5. **SPACE TO SPEAK** - let's make sure that we give everybody equal time to feed back and share their views .
6. **AIM TO MAKE CRITICISM CONSTRUCTIVE** – it helps us the most if you make sure to give reasons for your views and opinions and wherever possible, what you think are the alternative solutions.
7. **PLEASE TURN OFF MOBILE TELEPHONES/DEVICES** – so we can all focus on the conversation and for politeness to others in the groups, please turn off your mobile phone. If you are expecting an important call, please inform the facilitator.

9.45am
Narrative of project to date and presenting data Short introduction to the group and presentation just covering ‘**Overall Experience of Ward Round**’

1. Introduction on how we’ve got to this point: History / Research background/Idea/Steering Group/Questionnaires/Analysis
2. Present key issues for people to keep in mind when in discussions later.

Ice-Breaker
“If you had a limitless budget, where would you go on holiday?”

10.00 – 12.30 breaks as required

Discussion topics

The Purpose of Ward Rounds
- Discussion, capture comments
- Look at data, comments, idea

Practical Arrangements in Ward Rounds
- Discussion, capture comments
- Look at data, comments, idea

Management and Ownership of Ward Rounds
- Discussion, capture comments
- Look at data, comments, idea

Involvement and Decision-Making in Ward Rounds
- Discussion, capture comments
- Look at data, comments, idea
-

Discharge Planning and Recovery Focus in Ward Rounds
- Discussion, capture comments
- Look at data, comments, idea

Improvements that can be made to Ward Rounds
- Discussion, capture comments
- Look at data, comments, idea

Should Ward Rounds exist?
What have we missed?

Statement on future action – Jonathan
What will happen next
How results will be summarised, interpreted and reported
What other specific actions will be taken
The timescales
Thank participants

Venue and set up 9am	Sally, Angela, Jonathan
Scribes	Sally, Jonathan
Facilitator	Angela
Presentation of project	James
Notepads and pens or pencils Flip chart and markers Cards (or badges, stickers etc) for writing participants' names on Focus group questions Laptop/Projector	Angela
2nd Flip Chart	Involvement
Ground rules printed out	Involvement
Registration sheet/addresses for vouchers to be sent	Involvement
Expense forms	Involvement
Comments sheet	Involvement

Appendix 2

THE PURPOSE OF THE WARD ROUND

- To discuss medication, leave, level of health, to get the professionals together to discuss the patient at the level the patient understands.
- General update for either the patient or carer.
- Confused – who is actually benefitting from the ward round – professional, family or patient.
- A review and a way to have dialogue with staff on medication and leave, there's an opportunity to invite your next of kin.
- Catch up progress with son.
- Different wards have a different ethos
- It should be for the patient.
- I don't know
- Professionals to access patient
- Totally confused by it all
- The purpose is a catch up
- To evaluate progress and assess medication
- To assess your health
- To communicate, by law things have to be communicated.
- Carer: I asked my son, he said he liked the ward round he felt someone was listening he felt he had their attention.
- It feels like it's an update for psychiatrists as he hasn't seen you all week. It's that one moment in time that you've got. It feels like the purpose is for the psychiatrist.
- Communication.
- All our patients are detained – patients want to know where they are at – the ward round is when everyone is on board. It is a progress update for all involved.
- It should be about creating a therapeutic relationship, but relationships need building up and you do this by having agreed outcomes – so then people know what is going to happen.
- Increase the update at where I am at.
- The purpose should be to get a good outcome for the patient that's what it should be.
- The ultimate aim is to get the best result for the patient which is not what it is.
- The purpose is to communicate and get each person's view; staff, carer, patient. Everybody needs to have a voice. People come along with different points of view so it's not working because people are there for different reasons. It has to be pointing in one direction, not in many directions. The purpose is to be honest, transparent and clear. If it is not clear it causes frustration.
- There is a disconnect between the ward rounds intention and what actually takes place. 1:1s can leave you positive, but reviews are negative.
- The purpose wasn't explained to me. Initially I thought the ward round was about me, but it seemed more like an MDT meeting. It was more staff saying what we're going to do with you and then asking are you ok with that?
- I do find that the consultants spend too much time assessing and not getting an update from the patient. I find it odd we use the ward round as an assessment period.

- 18th April
- The needs of the review are quite often for the ward, not the patient.

- Ward rounds are adapted to the wards needs not patient's needs. If we ask people what they want and it can't be given then that creates more disappointment. But even to make it clear around expectations and what will happen would be great.
- Not generally involved in discharge planning – ie patient being discharged with nowhere to go!
- Ward round is medication focused – did not help my recovery.
- Ward rounds are not recovery focused about what you are doing now and medication.
- In my experience ward rounds are not recovery focussed that work is done outside of the ward rounds.
- Discharge is planned outside of ward rounds in my experience the Dr just got an update.
- I felt that recovery should be in the ward rounds more than it was, so I would like more discussion in ward round about recovery.
- They should be for an update not an assessment.
- They are patient's meetings not staff meetings

- Very small room loads of people in there.
- It needs to be a psychologically informed environment (PIE).
- It always depended on which room was available.
- Ward round are cancelled and not always informed.
- Our room is cramped not a conducive environment, despite our reassurances it is overwhelming for a patient.
- Previously we went into a room full of people.
- We opened Bracken House around four years ago. The room for ward rounds is small – you bring everybody in from all the disciplines and there's loads of people in the room.
- (my child) was five months in hospital and ward rounds, there were some good and some bad. Lots of students in there. We were asked questions in front of people and some of the things I wanted to say to the psychiatrist I didn't want to share with everybody (some of the things I wanted to say put conflict in my relations with my son).
- Often why it's happening is missed so patients don't know it's purpose. Expectations are people's opinions and wants are missed. People are not often told how often the ward round will be.
- Too many people in ward round – small/hot rooms – not purpose built the ward round has to fit in with whatever room is available – layout of the room is too formal, intimidating – the use of computer in a ward round.
- Carers do not feel welcome – we had to ask the consultant to introduce us to everyone. Not a very comfortable experience - no refreshments etc.
- Patients on the ward aren't always aware that the ward round meeting is going on and they just walk into the room.
- Times of ward round do not always fit in with the carers lives – ie if someone works in the day they cannot attend, always held in the day to fit in with the consultant not carer/family.
- Only given a ball part time for ward round, when it was delayed my anxiety levels rose and by the time I saw the doctor I was no how.
- I've gone at 9am, had to rearrange my day and then been kept waiting or it's cancelled – it's as though your time isn't important. All of the time your stressed, your son is ill, you need to get to work; just a sorry. I've been there many times. And that's another week gone.

- If they went down a MDT route they wouldn't be cancelled because of waiting for a doctor
- Room set up can be intimidating, so my doctor met me in the quiet room. Maybe there could be sofas, instead of a table and a PC. One minute you in your pyjamas then you're in a suit and tie meeting.
- They felt very ad hoc, my sister thought this too who is a social worker. Mental health patients want certainty and you don't know if it's going to happen. If you don't know it all adds to the stress.
- There needs to be a Maitre D for delays, making a cuppa and looking after everybody.
- My experience was that they always wrote a list of when you were going to be seen. I was always at 5pm, I would like to have had this rotated.
- Ward rounds could go for 4 hours because they've got so many people to see.
- Carer: For my first time I was quite happy, no one cancelled anything, it was an official environment. It would be nice to have a friendly relaxed atmosphere people would feel more relaxed. I felt comfortable in ward rounds but it would have been better if it was a more relaxed setting, tea / coffee.
- Staff: We have long term patients [Bracken House]. We try and make sure that the key staff member is there for the ward round. We plan in CPA a year in advance. Already people attending are finding it better; its coordinated as somebody is actually doing it.
- The room has two tables, a filing cabinet. We've got some rooms downstairs with comfy seats which we don't' use for ward round. If we had collapsible tables we could get rid of them and change the feel of the room. It's the same room we have tribunals and reviews in. When carers are there we offer tea and coffee downstairs as we always overrun.
- I don't think I've done a ward round that doesn't overrun. You feel futile all you can do is apologise. The only way we could do it would be to increase consultant time.
- Time is a big factor – 10 mins and everything is rushed through, so it doesn't give the patient chance to reflect, or a carer to understand what the changes in medication mean, even if ou just extend it by five minutes.
- Cut down on the numbers of people there, meeting to be in a comfy environment – and it's got to be maintained.
- My ward round was in the board room first and then in a little room, so they couldn't fit that many people in there, I was next to the doctor which I preferred.
- There's a set time on a Monday, we then advertise when people will be seen. It might be better to arrange the time with the patients and carers.
- The room has a big desk, staff are at one side, patients at the other side. There's fire regulations on the wall. Comfy sofas would change it, music is a novel idea. Currently it is a sterile clinical environment.
- The environment is important, but the biggest problem is too many people. Often it seems to be more of a training exercise.

- Discussion about you before you go in which you know nothing about and are not told.
- Decisions made in a ward round are often not passed on to staff who have not been in that ward round.
- Each ward round is held in isolation, they are not joined up from week to week.
- Not well planned – no structure – no linking up with the named nurse.
- HCA's who are bank staff have to check on your treatment plan, but they didn't know about it (so decisions made in ward round were not then carried out or communicated to ward staff).

- We need to bring in new ways of communicating. How can it be done as the norm for people who can't ask.
- Don't tell service user and carer running late.
- They would ask about home leave. I would have to say no – but I didn't want to say this in front of my son. So I would ask to see the doctor beforehand but never did.
- When we refer for an advocate it seems hit and miss as to whether we get one. We don't know if they are going to come or not, no communication.
- Staff: I've heard IMHAs say they only get involved in ward rounds. We don't know if POWhER are involved or not, so we're not sure about their involvement.
- Our Welcome Pack has a sheet in – we try to site with patients and explain what to expect on their first ward round. We do adapt our ward rounds, if a patient doesn't like students in the room we organise for them not to be there. We do tell patients who will be in their ward round and how many will be there, we do this on the way to the ward round perhaps we should look at doing this earlier.
- Staff don't de-brief it's not common place.

MANAGEMENT AND OWNDERSHIP OF WARD ROUND

- Need Ward Manager in Ward Round
- There should be the choice of relaxed and informal
- The purpose wasn't explained to me. Initially I thought the ward round was about me, but it seemed more like an MDT meeting. It was more staff saying what we're going to do with you and then asking are you ok with that?
- There should maybe be preparation before the meeting.
- It feels like a tradition. That's just the way it's been done.
- Same doctor every appointment.
- The use of jargon is confusing.
- It feels like it's an update for psychiatrists as he hasn't seen you all week. It's that one moment in time that you've got. It feels like the purpose is for the psychiatrist.
- The ward round questions are usually medically driven as it is run by medics. No research before-hand. The format hasn't changed in the last 20 years how we talk with patients / carers has changed. We prepare all week – talking and listening to patients so we know and they know what will be discussed.
- The purpose should be to get a good outcome for the patient; that's what is should be. It currently feels like it's for the consultant not the patient. I've been an HCA for 20 years and I've been angry about it. As an HCA I was the first person the patient would see and they would come out of ward round and be angry and frustrated. The ultimate aim is to get the best result for the patient which is not what it is.
- Some patients are quite passive and it is just done to them, sometimes it feels a bit sterile.
- Carers do not feel welcome – we had to ask the consultant to introduce us to everyone. Not a very comfortable experience – no refreshments etc.
- Don't always have the same key worker in attendance – comments like ' I don't know I've just comeback off annual leave' not what we want to hear.
- I've sat in reviews (as a PSW) where it has felt like an interrogation. I've worked with patients to get them to ward round and you can see a patient's self-esteem just ebb away during a review. A patient didn't know that he could request a 1 : 1 with the doctor.
- When I moved wards I kept the same consultant but the round was on a different day and time – no one was told so my parents turned up wrong day wrong time.

- There are six people there and then demanding the patient to open up and reveal their inner most secrets – it's not right.
- I've gone at 9am, had to rearrange my day and then been kept waiting or it's cancelled – it's as though our time isn't important. All of the time you're stressed, your son is ill, you need to get to work; just a sorry. I've been there many times. And that's another week gone.
- If they went down a MDT route they wouldn't be cancelled because of waiting for a doctor. Room set up can be intimidating, so my doctor met me in the quite room. Maybe there could be sofas, instead of a table and a PC. One minute you are in our pyjamas they you're in a suit and tie meeting.
- They never really talked to me.
- OT need to be involved and discuss in ward round.
- I do find that consultants spend too much time assessing and not getting an update from the patient. I find it odd we use the ward round as an assessment period.
- We have long term patients (Bracken House). We try and make sure that the key staff member is there for the ward round. We plan in CPA a year in advance. Already people attending are finding it better; it's coordinated as somebody is actually doing it.
- Everybody should properly introduce themselves. It's almost like the professionals don't trust each other, can't they talk to each other so that only a couple of people met the patient.
- We had an experience where two consultants who didn't know my son thought he was well enough to be discharged. A third consultant who knew him well wanted him to stay in. He was discharged it was a disaster.
- The room has a big desk, staff are at one side, patients at the other side. There's fire regulations on the wall. Comfy sofas would change it, music is a novel idea. Currently it is a sterile clinical environment.
- How can staff help doctors to find more time? How can we support them to find or use time?
- The environment is important, but the biggest problem is too many people. Often it seems to be more of a training exercise.
- As the patient I wasn't listened to, wasn't told what was happening. When I moved wards I kept the same consultant but the round was on a different day and time – no one was told so my parents turned up wrong day wrong time. Patients on the ward aren't always aware that the ward round meeting is going on and they just walk into the room.

- Domineered by the doctor.
- Decisions made in a ward round are often not passed on to staff who have not been in that ward round.
- Not well planned – no structure – no linking up with named nurse.
- We'd see loads of doctors so then they would ask me questions that should have been in the notes. One just got to know my son and then another doctor would turn up, so the relationship has to start again.
- HCAs who are bank staff have to check on your treatment plan, but they didn't know about it (so decisions made in ward round were not then carried out or communicated to ward staff).
- During the week something will be said e.g. I could shave so I requested a razor to shave. The HCA had to find out if I could because of my treatment plan; this is the opposite to Open Dialogue.
- People don't know what's going on, wards rounds are done to you.
- Carer: Psychiatrist who knows the person should have the final say. My son went into his ward round (I wasn't there) the Psychiatrist who knew him wanted him to stay in

hospital - there were two other Psychiatrist who thought he should be discharged and go home – he went home and it was a complete disaster. There was nothing for him to do.

- Making sure things are followed up should be the psychiatrist's job.
- Staff: our consultant directs a lot, but nurses manage a lot. A form tells you who is the primary nurse but also what actions need to be carried out.
- However, there is a form for everything so I'm always trying to think what can we get rid of.
- Since introducing the form it gives confidence. This goes hand in hand with Cath who does the discharge planning. The nurses do all the leg work but patients still wait for Drs to say 'yes you can have that leave'.
- On our ward the nurse would organise. There would be two nurses on a shift and one will be on the ward round. There's a list of appointments. The nurse will go through what's happened over the last few days in the review. We don't have any preparation beforehand for patients – maybe we should do that.
- But how well the nursing staff organise, run and interact with the ward round really depends on how confident the nursing staff might be.
- I've worked on three wards and they've all run pretty much the same.
- My experience is the Dr owns the ward round, there's a lot of people in the room who don't talk.
- Yes this is my experience also
- It should be co-produced so that there is joint ownership of it. Co-production is messy. The secret is how you start it all off, it's all down to being transparent. The first thing you do is remove the labels so people are just names. This lifts the level of trust and people talk more openly.
- Power should be shared, currently the consultant has all the power.
- The ownership of ward rounds currently feels very much for staff.
- I'm not convinced many Drs are recovery focussed themselves and the ward rounds are centred around Drs so may they should be.
- Junior doctors often err on the side of caution.
- Patients should discuss what is important to them.
- Transfer of power, control and ownership of wards rounds to patients.

INVOLVEMENT AND DECISION MAKING IN WARD ROUNDS

PATIENT

- Dr Lee (best practice experience) always focused on me, not focussed on the team. Once doctor said to me 'I've never met you mum' and he had loads of times in ward rounds.
- I assumed I was not involved because my son did not want me there, but I was never told this. Someone should have spoken to me and explained what was happening and why I wasn't involved.
- When my son is very unwell he doesn't want family involved – but I know that when he is feeling better he wouldn't think like that he wouldn't want us to worry. Carers should be informed and spoken to so that the professionals get a better picture and the carer will not worry, we don't need to know anything confidential just that our son is ok.
- Some patients are quite passive and it is just done to them, sometimes it feels a bit sterile.

- Put on the spot didn’t want it.
- The patient can decide on the day – if they don’t want family to know anything and we have to respect it.
- I was never given a choice.
- I’ve sat in reviews (as a PSW) where it has felt like an interrogation. I’ve worked with patients to get them to ward round and you can see a patients self esteem just ebb away during a review. A patient didn’t know that he request a 1:1 with the doctor.
- There are six people there and then demanding the patient to open up and reveal their inner most secrets – it’s not right.
- I never knew how long I’d be there. I used to ask if I could go home, but never got a response.
- A practical thing the doctor would always ask me ‘what do you want’? This was a good thing.
- Time is a big factor – 10 mins and everything is rushed through, so it doesn’t give the patient chance to reflect or a carer to understand what the changes in medication mean, even if you just extend it by five minutes.
- Patients don’t come out with an understanding of what’s happened.
- As a PSW when I get chance I support 40% of patients to set an agenda so they can take that into ward rounds. I see better results when this happens.
- Not able to influence decisions made about you.
- When discussions takes place before it isn’t spoken about when you get into the room – no feedback from the professionals discussion so you can’t express how you feel.
- Carer: Psychiatrist who knows the person should have the final say. My son went into his ward round (I wasn’t there) the Psychiatrist who knew him wanted him to stay in hospital - there were two other Psychiatrist who thought he should be discharged and go home – he went home and it was a complete disaster. There was nothing for him to do.
- Making sure things are followed up should be the psychiatrist’s job.
- Never asked what I wanted from the ward round – not always told what your diagnosis is at the ward round, I was diagnosed with Bi Polar did not know what that mean, no explanation.
- I was listened to – I didn’t agree with my meds and wanted them changing – I go what I wanted – I became unwell and I was wrong.
- Everything was explained to me but I wasn’t involved. I was informed as I got better I became more involved.
- The doctor would try and get me involved in medication choices and then they would get pharmacy down.
- Involved me in choice of medication.
- Decisions were made for me when I was poorly but when I got better I made my own.
- One liners:
- You aren’t involved in decision making.
- Not service user/patient led – no acknowledgment we are the expert of our own experience.
- No explanation about things.
- Someone is making notes in the
- Patients who are vocal know what they want to discuss. I worry about those who are passive, who quietly sit; we tell them and they nod.
- We ask what is your understanding of what you want.
- Someone is making notes in the meeting and the patient doesn’t see them.
- Patient no input into discharge, not being asked the right questions, not listening to the patient.

- My son had a discharge meeting. CPN and Social Worker and a package was made for him, but he chose not to engage and ended up back in hospital.
- Sometimes in Ward Rounds they might give you a leave date but the patient isn't involved in that.
- Patient should discuss what is important to them.
- Transfer of power, control and ownership of ward round to patients.

- CARER
- There's a lot of family dynamics; if you bring carers in first the patient wonders what you're talking about. If you don't talk to carers they want to know why.
- It needs to be clear that staff can use the family without break confidentiality.
- Build up communication.
- Times of ward rounds do not always fit in with the carers lives – ie if someone works in the day they cannot attend, always held in the day to fit in with the consultant not care / family.
- I've gone at 9am, had to rearrange my day and then been kept waiting or it's cancelled – it's as though our time isn't important. All of the time you're stressed, your son is ill, you need to get to work; just a sorry. I've been there many times. And that's another week gone.
- I would be happy to be out of the ward round unless needed.
- If a carer isn't allowed in ward rounds they need to explain how it's going but with due regard to confidentiality.
- Carers not notified all the time when there is a ward round – very rarely see carers being involved.
- He used to say "you make it worse mum". I might say something and then he wouldn't get the leave he wanted.
- They would ask about home leave. I have to say no – but I didn't want to say this in front of my son. So I would ask to see the doctor beforehand but never did.
- Carers not involved in discharge planning.
- My son doesn't engage with treatment, so won't work with OTs. My son is discharged too soon and goes into the community, then he would get too ill so goes back to a ward – this has gone on for 7years.
- Carer: Discharge planning was never discussed. I was thinking about how Peer Support Workers might help support them and get them into the community. I don't know whether this took place in the ward round.
- I wasn't informed about leave. I just got a call at 5pm to say can he stay with you at home. I wasn't involved in the discharge and I think I should have been.
- My daughter was kept informed but not involved but this is because she lives 100 miles away – she was well informed.

- PATIENT / CARER
- I've been a carer in ward rounds and afterwards my partner would be asking questions about it, because it wasn't explained.
- Discussion about you before you go in which you know nothing about and are not told.
- My son wouldn't ask.
- We need to bring in new ways of communicating. How can it be done as the norm for people who can't ask.

DISCHARGE PLANNING AND RECOVERY FOCUS IN WARD ROUNDS

- I never knew how long I'd be there. I used to ask if I could go home, but never got a response. They never really talked to me.
- We had an experience where two consultants who didn't know my son thought he was well enough to be discharged. A third consultant who knew him well wanted him to stay in. He was discharged it was a disaster.
- Discharge planning was never discussed.
- Staff: at Bracken House from the beginning we are talking about discharge. We make it clear to patients that we are working towards their discharge – looking at where they go when they leave. Our links with Social Care are good, we refer all patients to Social Care when they are admitted so that they have an allocated member staff, this means that they have a social worker already appointed when they are discharged. Discharge Plans are done during ward rounds – Care Plans from entering to leaving.
- The whole point of Bracken House is that discharge is what it's all about. We have complex people – they don't need to be acute but they can't be in the community. We always ask at ward round 'where do you want to move on to?' The fly in the ointment is always looking for placements.
- Our philosophy is we are based around recovery. We have permanent staff who want to work in a Recovery focussed way and that's why they stay.
- All our discharge and care plans are discharge focused and this is reflected in ward rounds. We look at where the patients is ie Engagement Phase – Rehab Phase – Discharge Phase.
- Carer: it's difficult for people with friends when people are discharged – or preparing for discharge.
- We have good links with social care. We refer everybody to social care first off, so somebody is allocated to that patient. A social worker is then already appointed when discharge is taking place.
- Carer: discharge planning has to be part of their Recovery
- Discharge, planning, recovery, and being involved with the recovery.
- I had a brilliant recovery focussed ward round. From the word go the Dr talked about discharge, which was a bit frightening. Little by little I was discharged.
- I wasn't informed about leave. I just got a call at 5pm to say can he stay with you at home. I wasn't involved in the discharge and I think I should have been.
- Discharge and aftercare was very good. My daughter was kept informed but not involved but this is because she lives 100 miles away – she was well informed.
- Sometimes in ward rounds they might give you a leave date but the patent isn't involved in that.
- Sometimes I's not even the Dr planning the discharge but pressure on the beds in the system, (having to get people in which – which can force people out).
- I went home for a weekends leave and they phoned me to say my bed had gone.
- When you have leave –when you return you don't get the same bed – it all adds up to anxiety around having leave.
- Carer: Psychiatrist who knows the person should have the final say. My son went into his ward round (I wasn't there) the Psychiatrist who knew him wanted him to stay in hospital - there were two other Psychiatrist who thought he should be discharged and go home – he went home and it was a complete disaster. There was nothing for him to do.
- Making sure things are followed up should be the psychiatrist's job.
- Discharge planning – all staff are involved, Psychologist's – a couple of medics – staff working with the patient – social workers.
- Not generally involved I discharge planning – ie patient being discharged with nowhere to go!

- Patient no input into discharge, not being asked the right questions, not listening to the patient.
- Discharge came as a surprise, didn’t know I was being discharged.
- A good experience when I was being discharged my O.T. talked with the ward and arranged a plan for me to access the ward so I could join in the activities for the first week at home, this really helped me.
- Don’t look at support network for when being discharged.
- Carers not involved in discharge planning.
- Once home found everyday things very hard to deal with just ordinary jobs – Crisis Team visited for 7 days which as good just not long enough.
- Ward rounds are not recovery focused about what you are doing now and medication.
- We don’t have a package that is right for discharge off wards – you just go home – then it’s the revolving door, there is not enough support when at home so we end up back on the ward.
- My son had a discharge meeting, CPN and Social Worker and a package was made for him, but he chose not to engage and ended up back in hospital.
- I was put with and enabler when I got close to discharge and this was a good thing.
- We could maybe incorporate into discharge planning the reality about bed pressures, it might be work us talking about a plan B.
- My son doesn’t engage with treatment, so won’t work with OTs. My son is discharged too soon and goes into the community, then he would get too ill so goes back to a ward – this has gone on for 7 years.
- Discharge planning – try not to let people get taken by surprise.

PATIENT EXPERIENCE

- Outpatients has been great because I’ve built up a relationship.
- Some patients are quite passive and it is just done to them, sometimes it feels a bit sterile.
- I asked my son: he said he liked the ward round he felt someone was listening he felt he had their attention.
- The best ones were when my son saw just a doctor and a nurse; just those involved in his care. When there was too many people in there I didn’t want to say anything.
- When my son is very unwell he doesn’t want family involved – but I know that when he is feeling better he wouldn’t think like that he wouldn’t want us to worry. Carers should be informed and spoken to so that the professionals get a better picture and the carer will not worry, we don’t need to know anything confidential just that our son is ok.
- To find out how family member feels and find out what is happening. There was a room full of professionals and my son could not lift his head up (he was really poorly). No one told me the date and times of ward rounds I didn’t know it was happening.
- I’ve sat in reviews (as a PSW) where it has felt like an interrogation. I’ve worked with patients to get them to ward round and you can see a patient’s self esteem just ebb away during a review. A patient didn’t know that he could request a 1:1 with the doctor.
- There are six people there and then demanding the patient to open up and reveal their inner most secrets – it’s not right.
- There is a disconnect between the ward rounds intention and what actually takes place. 1:1s can leave you positive, but reviews are negative.
- Only given a ball part time for ward round, when it was delayed my anxiety levels rose and by the time I saw the doctor I was no how.

- Room set up can be intimidating, so my doctor met me in the quiet room. Maybe there could be sofas, instead if a table and a PC. One minute you in your pyjamas then you're ina suit and tie meeting.
- Drs are in a hurry, it's unbelievable at times!
- They never really talked to me
- They felt very ad hoc, my sister thought this too who is a social worker. Mental health patients want certainty and you don't know if it's going to happen. If you don't know it all adds to the stress.
- My experience was that they always wrote a list of when you were going to be seen. I was always at 5pm, I would like to have had this rotated.
- The environment is important, but the biggest problem is too many people. Often it seems to be more of a training exercise.
- Domineered by the doctor.
- Discussion about you before you go in which you know nothing about and are not told.
- Not able to influence decisions made about you.
- When you have leave – when you return you don't get the same bed – it all adds up to anxiety around having leave.
- When discussion takes place before it isn't spoken about when you get into the room – no feedback from the professions discussions so you can't express how your feel.
- It's no meaningful.
- To me they felt joined up.
- We'd see loads of doctors so then they would ask me questions that should have been in the notes. One just got to know my son and then another doctor would turn up, so the relationship has to start again.
- My experience is positive because I would always ask.
- My son wouldn't ask.
- People don't know what's going on, ward rounds are done to you.
- Sometimes my husband or sister came in with me it was more helpful when they were there.
- Ward rounds are done with you.
- I had to fight to get things done.
- No organisation just happens.
- Un joined up (disjointed)
- Staff: our consultant directs a lot, but nurses manage a lot. A form tells you who is the primary nurse but also what actions need to be carried out.
- Lack of respect for carer's knowledge of their family member. My mum was ignored she could see I was going downhill and becoming unwell and no one listened – so what happens you are a voluntary patient to go into crisis and end up being sectioned.
- Some (doctors) were better at involving you than others.
- I was aware of advocate – didn't get much use from it, just a yes and no.
- Not service user / patient led – no acknowledgment we are the expert of our own experience. No explanation about things.
- Carer: my son worked with an IMHA so that he could leave hospital.
- Carer: Staff never told me why they couldn't/didn't communicate with my, I just assumed it was my sons wishes. They could have told me and it would have been easier for me to understand.
- Discharge came as a surprise, didn't know I was being discharged.
- Once home found everyday things very hard to deal with just ordinary jobs – Crisis Team visited for 7 days which was good just not long enough.

- I moved house prior to discharge. A nurse came with me to sort out gas and electric so it was gradual. I went on a CTO whilst I was in hospital and was then visiting my flat to decorate it.
- Carer: Discharge planning was never discussed. I was thinking about how Peer Support Workers might help support them and get them into the community. I don't know whether took place in the ward round.
- Carer: it's difficult for people with friends when people are discharged – or preparing for discharge.
- It feels like snakes and ladders – all that work then it takes to be long to be seen again that it creates frustration so people then 'jump the fence' and your back where you started.
- I don't like titles.

ADVOCACY

- Sometimes my husband or sister came in with me it was more helpful when they were there.
- A lot of people don't have a carer or advocate.
- I was monosyllabic so I couldn't be involved. If someone hasn't got a carer they should be provided with an advocate.
- When my sister came to ward rounds things got done, my sister is a social worker so could talk the talk. Treatment shouldn't be reliant on someone speaking up.
- My brother could speak very eloquently so that helped.
- I might have been told at first about an advocate, but I don't remember.
- Carer: The first time my son went in to hospital he was asked if he wanted an advocate and it worked really well. My son wanted to leave hospital against staff advice because the advocate was impartial my son listened and that really helped.
- Staff: Advocacy is always spoken about, it is on our Rights Form and is part of the admission process. If someone lacks capacity we contact the advocate on their behalf. When we refer for an advocate it seems hit and miss as to whether we get one. We don't know if they are going to come or not, no communication.
- We have a form asking whether people would like an IMHA or what their capacity is. POWhER seem really quiet – we don't see them anymore. They get diarised to attend and an IMHA doesn't attend it's a bit hit and miss.
- Staff: I've heard IMHAs say they only get involved in ward rounds. We don't know if POWhER are involved or not, so we're not sure about their involvement.
- Patients who are vocal know what they want to discuss. I worry about those who are passive, who quietly sit; we tell them and they nod.
- We ask what is your understanding of what you want.
- The term advocate should be explained.
- NOTE: can't believe that the questionnaire results show that 65% of patients were not informed that they could have an advocate.
- Advocacy is a tough sell to people. An advocate said to me 'can I help you with anything?' I said 'what?' he said 'you have to tell me'. Part of the responsibility of informing about advocacy is on the advocate.
- In an Ideal Ward Round you would have an advocate on every ward round – maybe we look at who takes up this role?
- Set up openly – ask patients who they will bring with them and emphasise they can bring someone with them – you wouldn't let somebody to court without proper representation.

- Advocacy – it would be ideal if an advocate was at each meeting.

IMPROVEMENTS THAT CAN BE MADE TO WARD ROUNDS

- There needs to be a Maitre D for delays, making a cuppa and looking after everybody.
- If they went down a MDT route they wouldn't be cancelled because of waiting for a doctor
- Room set up can be intimidating, so my doctor met me in the quiet room. Maybe there could be sofas, instead of a table and a PC. One minute you in your pyjamas then you're in a suit and tie meeting.
- For my first time I was quite happy, no one cancelled anything, it was an official environment. It would be nice to have a friendly relaxed atmosphere people would feel more relaxed. I felt comfortable in ward rounds but it would have been better if it was a more relaxed setting, tea / coffee.
- Make sure everything is clear.
- Preform what questions we need to ask.
- Play some music.
- How can staff help doctors to find more time? How can we support them to find or use time?
- Open Dialogue would be great.
- Medication form. Consent treatment form. Ward Round review form. The primary nurse has an expectation to hold all of this. Form then goes into a handover file and is used in handover, the leg work for this comes down to the nurses.
- However, there is a form for everything so I'm always trying to think what can we get rid of.
- Since introducing the form it gives confidence. This goes hand in hand with Cath who does the discharge planning. The nurses do all the leg work but patients still wait for Drs to say 'yes you can have that leave'.
- Discharge planning – all staff are involved, Phycologists – a couple of medics – staff working with the patient – social workers.
- We don't have any preparation beforehand for patients – maybe we should do that.
- In The Netherlands Drs have 1:1s with the whole team and then goes and speaks to the patient, this is a better opportunity to build up therapeutic relationships.
- It should be co-produced so that there is joint ownership of it. Co-production is messy. The secret is how you start it all off, it's all down to being transparent. The first thing you do is remove the labels so people are just names. This lifts the level of trust and people talk more openly.
- Power should be shared, currently the consultant has all the power.
- The ownership of ward rounds currently feels very much for staff.
- Our Welcome Pack has a sheet in – we try to sit with patients and explain what to expect on their first ward round. We do adapt our ward rounds, if a patient doesn't like students in the room we organise for them not to be there. We do tell patients who will

be in their ward round and how many will be there, we do this on the way to the ward round perhaps we should look at doing this earlier.

- If it was called a meeting instead of a ward round you would be given an agenda and it needs to be in appropriate language.
- As a PSW when I get chance I support 40% of patients to set an agenda so they can take that into ward rounds. I see better results when this happens.
- My OT was my care coordinator who did something similar to that. I didn't have follow ups, I suppose it was up to me to follow up.
- A system needs creating where Open Dialogue is common place, the current system doesn't allow this because of time resources etc.
- In an Ideal Ward Round you would have an advocate on every ward round – maybe we could look at who takes up this role?
- Don't need to be weekly.
- We could maybe incorporate into discharge planning the reality about bed pressures, it might be worth us talking about a plan B.
- Staff: at Bracken House from the beginning we are talking about discharge. We make it clear to patients that we are working towards their discharge – looking at where they go when they leave. Our links with Social Care are good, we refer all patients to Social Care when they are admitted so that they have an allocated member staff, this means that they have a social worker already appointed when they are discharged. Discharge Plans are done during ward rounds – Care Plans from entering to leaving.
- The whole point of Bracken House is that discharge is what it's all about. We have complex people – they don't need to be acute but they can't be in the community. We always ask at ward round 'where do you want to move on to?' The fly in the ointment is always looking for placements.
- Our philosophy is we are based around recovery. We have permanent staff who want to work in a Recovery focussed way and that's why they stay.
- All our discharge and care plans are discharge focused and this is reflected in ward rounds. We look at where the patients is ie **Engagement Phase – Rehab Phase – Discharge Phase**.
- We have good links with social care. We refer everybody to social care first off, so somebody is allocated to that patient. A social worker is then already appointed when discharge is taking place.
- People do introduce themselves at ward rounds.
- I was put with an enabler when I got close to discharge and this was a good thing.
- Talking therapies are excellent and should be used more.
- A good experience when I was being discharged my O.T. talked with the ward and arranged a plan for me to access the ward so I could join in the activities for the first week at home, this really helped me.
- Better communication
- More involvement for carers
- Better signposting
- Patients given their diagnosis and then a clear explanation so they have an understanding.
- At point of admission patients / carers need an explanation about the purpose of a ward round and if it's their first admission – patients need to be told that they are being observed every 10 minutes so that professionals can then make a decision about your treatment.

- Stop having so many people involved in ward rounds.
- Choice of rooms.
- Professional should meet in the morning to discuss patients – then a couple of professionals meet with the patient/carer in the afternoon to discuss what has been said and decisions made. This should all be done in a nice room with a nice atmosphere ie cup of tea.
- All patients should know about the advocacy service – PSW on each ward, we were told two per team and this is not happening.
- Timekeeping.
- How long should a ward round last.
- More flexible timing ie do they have to be held in the day, can they be held at weekends.
- Patients/carers told what has been discussed – communication is not great.
- More relaxed atmosphere
- Sofas, bean bags – make it somewhere you can physically relax
- Take the table away, sometimes there's a coffee table (that's good)
- On Rowan 2 there were sofas and I thought that was good as it is more relaxing.
- Have ward rounds on time (I know that's not always possible)
- Informed of date and time they take place
- Have decision making groups, so OTs if needed and Drs and nurses
- Consistency across wards, so if you're transferred it's not completely different.
- A facilitator who can support communication
- Make notes before you go in
- Create a review form so a patient completes a review form (with support if needed) the doctor then reads these and feedbacks next week.
- Accessible communication. Make sure somebody who can't communicate is supported. Communication needs will shift as somebody gets better
- Carers to meet doctor beforehand so that not everything has to be said in front of their relative
- Have the same doctor week after week.
- If there was a beginning and end, and pre and a post support they might be less scary
- Not joined up to one another.
- Why don't you have volunteer to make a cup of tea and help support them.
- Need to be with the same doctor.
- Don't always get the same doctor.
- One liners:
- Less people in ward round
- Communication
- Flexibility
- More links with the community.
- You get regular reviews in hospital – nothing when you get out
- Follow up should be better
- Meet with a professional before ward round for discussion – then go into ward round meeting – talk with same professional afterwards to ensure all has been understood.
- Care Plans – they don't seem to follow you through your stay and when you return home. They are done when you are first admitted (and very poorly) but not added on to as you move on and begin to feel better and recover.
- Have discussions with patients and carers about what will happen at discharge
- Make the environment more comfortable – tea/coffee
- Carers really want somebody to speak to them and to feel that there's a warmth in that individual. Most people are lovely but sadly you are going to get one or two that aren't.

- Make the environment more useful
- For me it’s the frequency that needs increasing. If you’re waiting 3,4,5 weeks for the next one. Is there a semi ward round meeting we could have in between? – we could sum up this meeting and email the RC to look over. We need to see everybody more.
- We have morning meetings in the living area, we managed to close off the area and it felt more human. Ward rounds should be in a room patients feel comfortable and familiar with.
- My son said he would like to see a ward round twice a week.
- Improve communication that’s all carers really want
- Remove the formality
- More time – time is a major issue
- More explanation of discharge and recovery plan – plan discharge more
- Limit the number of people
- Better preparation
- Anything that empowers service users
- Patient should discuss what is important to them
- More 1:1 time outside ward round that can then be taken into the ward round
- I want my care coordinator there – they’re who I’ve built up a relationship with
- 1:1 with the person who is the principle person involved in your recovery plan
- Transfer of power, control and ownership of ward round to patients
- Plain talking
- Set up openly – ask patients who they will bring with them and emphasise they can bring someone with them – you would let somebody go to court without proper representation
- Create more time
- Visibility of Drs
- Number of people seen
- Open Dialogue approach
- Change the environment
- Change the culture of where you sit in the room
- Make the meeting more adaptable – what will suit patients and carers not the other way round
- Work done on the power balance
- Offering explanations of decisions
- Invoking empathy in staff sitting in the room
- Keep evaluating the ward round