KING EDWARD'S HOSPITAL FUND FOR LONDON

KING'S FUND CENTRE

CURRENT THINKING ON WRITTEN WARD POLICIES

Report of a Conference held at the King's Fund Centre on

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HOPC:HAB (Fal)

CURRENT THINKING ON WRITTEN WARD POLICIES

In his introduction to the conference, Mr David Downham, formerly Assistant Director of the King's Fund Centre, emphasised that its main object was that members should learn from each other's experience, and that the role of the King's Fund was to stimulate that process and to provide any help that may be necessary. He referred to the survey conducted by the King's Fund into the use of written ward policies, and stressed that what is new about ward policies is that they are concerned not with individuals but with groups of people. This can create problems for doctors, whose training concentrates on the individual. However nurses are trained to be concerned with groups, with the living environment, and with the way in which people work together, and their role is important in providing the impetus for ward policies.

Mr J L Chenery, Divisional Nursing Officer, North Nottingham Health District, began his talk by saying that the function of nursing management is to enable nurses at patient level to provide efficient, sympathetic nursing care that is of the highest standard, and part of this process is to assist in the formulation of ward policies. Ward policies usually result from a dialogue between medical, nursing, and other staff who form part of the ward team, but this cannot be achieved without reference to hospital, District, Area and national policies, and legislation which affects the patient or any member of the staff.

In his opinion nursing management has three duties:-

1. To provide at ward level information in a readily accessible form which will enable the process of forming ward policies.

2. To filter out the relevant parts of policies developed at Area, Regional, or national level which affect the nursing service, and to produce guidance documents which will enable the implementation of these policies.

3. To indicate to all members of the nursing staff that they will have the support of senior nursing management provided they act within the guidance given to them.

How then does nursing management go about this task? Before issuing any policy or procedure document an affirmative response should be obtained to five questions:-

1. Is it necessary?

2. Is it reasonable?

3. Is it readable?

4. Is it correct?

5. Will it work?

When agreed, these policy documents are issued in Mr Chenery's district in a standard format by the District Nursing Officers. Experience with this system indicates that it has a great deal of credibility at ward level, and is welcomed by staff coming into the district, but its efficiency and credibility is only maintained by regular review and monitoring of effectiveness.

Mr Chenery said that recently when job descriptions for various grades of staff have been reviewed, many of these policy documents have been cross-referenced into the job descriptions. This has been a useful exercise as it has given a clear indication to the holder of the job description that a procedure document has been issued on this particular matter. Within each job description is a clause which requires the holder to be aware of and follow these and other policy documents issued to wards. It also requires the holder of the job description to indicate when procedures are becoming unworkable or outdated in order that they can be reviewed. Wherever ward or District or hospital policies exist it is appropriate to use these in relation to disciplinary interviews with members of staff.

If such a system is to be effective and credible, effective consultation is of paramount importance. Mr Chenery described the various methods of effecting this consultative process in his district. Within the nursing management structure there are a number of nursing management workshops at various levels. Nursing membership of medical committees at all levels provides a fairly rapid method of consultation with medical staff, and multidisciplinary management teams also assist in the consultative process. Consultation with Trade Unions and other staff organisations is achieved through the nursing management staff organisation liaison committee. Mr Chenery stressed that although this system works well in his own district, he did not wish to suggest that it would work equally effectively in every district.

Mr M J Allen, Sector Administrator, Warley Hospital, Brentwood, Essex, introduced a team of his colleagues from Warley, and provided a brief outline of how he had become involved with written ward policies.

Mr G Anger, Nursing Officer, described how his involvement with written ward policies began in 1969-70 when an integrated intensive rehabilitation ward was set up, and problems arose because nothing was written down. The rehabilitation team discussed their aims in the unit and drew up criteria for resettlement. When the ward became a training ward, information for trainee nurses was set down on paper. These two documents provided a basis for discussion of aims and objectives by the rehabilitation team, who called in members of other disciplines on an ad hoc basis. The first draft of the resulting document was submitted for approval to the clinical area multidisciplinary team, and eventually accepted as the ward policy. It is available to introduce new members to the ward, and is used as a basis for nurse training, and has proved very valuable.

On another ward the situation was different. There a doctor prepared a written policy document without reference to nursing staff. The nurses subsequently drew up one of their own. It was suggested that the two documents should be put together, and after much discussion this was done.

Mr Anger said that he has found ward policies very useful, especially when new units are set up. When he acts as duty nursing officer he is enabled to understand the working of all units should problems arise. The medical staff can also consult the policy with regard to admissions.

Mr B de Souza, Charge Nurse, has found ward policies very beneficial to new staff, learners, and visitors to the ward from other hospitals and abroad. One great advantage is that in case of sickness or holidays any strange or new nurse has a document available to give an idea of what the ward is trying to do and the ways in which it is trying to achieve its aims. The policy is flexible enough to allow nurses a fair amount of initiative in individual treatment. The ward policy is reviewed six-monthly or whenever new ideas come up, for instance in the journals.

Dr G Sheppard, formerly Registrar at Warley, said he was talking about written ward policies, policies that were flexible and evolutionary in nature, framed in the context of multidisciplinary ward meetings in which all grades of staff participate. He described the background of his own interest in ward policies. He joined St Augustine's as a junior doctor in the early stages of events which led to the demand for an independent inquiry and subsequent publication of a report. He felt that the lack of a ward policy led to a number of avoidable situations which were the cause of great conflict between and within disciplines - these he outlined as follows:-

1. Very poor coordination between different disciplines, and waste of resources and potential.

2. Lack of clearly defined standards leading to a fall in standards. Even when nurses with initiative and drive produced ideas and had them implemented, these ideas died when they left the ward.

3. Tremendous misunderstanding about the limitations of each discipline within the hospital.

4. Stifling of initiative in junior staff because of the hierarchical structure of the hospital.

Dr Sheppard went on to describe the way in which ward policies were set up on the wards in which he worked. He developed a framework for discussion, a series of headings to be discussed, and distributed it to all the staff involved, and asked individuals for information regarding what was happening on the wards. A series of meetings was arranged on individual wards, with invited guests from other departments. Dr Sheppard then integrated the minutes of the meetings and drew up a document which was returned to the wards for comment. After amendements this became the ward policy, to be reviewed every six months or yearly.

The ward policy has produced a number of specific benefits, for example in the provision and laundering of patients' clothing and the reduction of medication. General benefits are that team participation produces a feeling of power at last at the grass roots, that roles and their limitations have been clarified, and that there is greater feedback from junior staff.

For the future, Dr Sheppard is concerned that new ideas tend to die in psychiatric hospitals; he sees written ward policies as a way of maintaining them by institutionalising them. Doctors, he said, are always impressed by publications, evaluations, controlled studies - if ward policies are to gain a hold on the mentality of psychiatrists, there must be publications.

The disadvantage of a democratic approach is the problem of responsibility. It is an illusion that all staff despite their grade have an equal share in the decision making process. Where there is conflict on a ward it is the consultant who makes the final decision, and this causes resentment and bitterness. Consultants deny that this is so - in short, it is a very difficult area.

Questions

Ms H Blacker asked Dr Sheppard for the date from which his project began. Dr Sheppard replied that he joined the Warley Hospital in January 1976 and started on ward policies in February-March. The formal policies were completed inside four months.

Mr W E Burr asked Mr Chenery, with regard to the use of ward policies in disciplinary action against staff, if he felt it necessary to write this into contracts. Mr Chenery replied that the job description forms part of the contract of the employee and is tied to the contract. Ward policies have been used in this situation mainly when somebody has flagrantly disregarded the policy over a period of time. They are mainly used in counselling staff.

Mr D M D'Cruz asked how often meetings were held regarding ward policies past and future, and what the optimum number of people was to meet and discuss them. Mr Chenery said that policy was generated at two levels:- 1) from ward level, at the unit meeting from which policy is passed up to higher levels - these meetings consist of maybe ten people; 2) at the top level is the District Nursing Management Workshop, consisting of the District Nursing Officer, four Divisional Nursing Officers, eleven Senior Nursing Officers, and although this is a larger group it still works well. In the community, Health Visitors and staff from the Divisional Nursing Officer down meet and form a workshop of up to thirty people, which is still a workable size. Mr D'Cruz then asked how the situation is regarded when grass roots decisions are not acceptable at a higher level. Mr Chenery replied that in this situation a 'green paper' - a discussion document - was circulated to all unit workshops so that an idea may be passed up and down the system two or three times, being modified on the way, until it is finalised. This can take 18 months. Dr Sheppard commented that those at higher levels are more likely to listen if ward policies are part of the culture of the hospital. Mr Downham remarked that unless policies are institutionalised they are seen as a threat - isolated representation is seen in a different light from the putting forward of a view from a formal group.

The Panel

Mr J Dutton, Senior Physiotherapist, All Saints Hospital, Birmingham, supposed that the audience might wonder how a physiotherapist was concerned with ward policies. His own introduction to ward policies came when, following a visit, the Hospital Advisory Service recommended that a sick ward be set up, and he thought he should be involved, so attended the meetings held to discuss the new ward. Mr Dutton gave some details of his function in the hospital. Since he is single-handed finding time to attend meetings is a problem, but he commented that he does not feel so lonely any more. He has become liaison officer between the local orthopaedic departments and the staff.

Mr E Francis-Jones, Volunteer Services Coordinator, North Wales Hospital, Denbigh, also became involved with ward policies when a HAS team visited his hospital and recommended their use. There are twenty-four wards, and sixteen now have written ward policies - these differ widely in function and stipulations. To some he is invited as a guest, in others he is a member of the multidisciplinary team. He feels that the voluntary service in the hospital has a lot to offer in ward policy - it helps staff tremendously, as well as patients. There are many visitors to the hospital, and ward policies have proved useful in answering their questions and giving an idea of what each ward is trying to accomplish.

Mr P Webster, Manager, Industrial Therapy Department, Cane Hill Hospital, Surrey, stressed that if advantage is to be taken of future ward policies, they must not just be a replacement for the old ward manuals. He has never been so involved in policy matters, and this involvement is on three levels:- the rehabilitation committee, who feed into ward policies information from paramedical and medical staff, and are now compiling a directory of the treatment available within the hospital; the clinical unit teams, on which he himself advises on general policies relating to rehabilitation; and on the wards themselves, where the industrial therapist is now far more involved in the treatment objectives of patients. He mentioned that one of the best and most efficient wards has its ward policies pinned up on the wall for all to see.

Mr M Brindle, Educationalist, Whittingham Hospital, Preston, described his job as catering for the educational needs of the hospital and other units, assessing these needs and offering educational facilities to staff and patients. He is involved in multidisciplinary meetings and the patient care committee. He feels that ward policies have good and bad points. One good point is that if he goes into a ward it is useful to have something to look at so that he does not cause trouble by anything he does. On the other hand, he finds that he is sometimes let down by a ward policy; having read it and tried to adhere to it, he has assumed incorrectly that it was the opinion of the charge nurse or sister working that day. Although the ward policy has been constructed after a great deal of thought, it may happen that in the implementation of it, staff go their own way.

Ms G Williams, Domestic Supervisor, Glenside Hospital, Bristol, has had, since ward policies were brought in, monthly meetings with Divisional Nursing Officers to find out what goes on in the wards. Domestics are more in contact with the ward than supervisors or the charge nurse, and are now invited to ward meetings. The domestics now feel that they are part of a team, which is very important.

Ms P Edwards, Nursing Officer, Glenside Hospital, Bristol, said that in drawing up a policy for a particular ward all disciplines are involved including consultants, doctors, domestics, occupational therapists, sometimes visitors. Usually the Nursing Officer of the ward or unit is responsible for taking the policy to higher levels, where it is sometimes modified, and is then agreed by District and taken back to the ward to be implemented. A copy of the policy is sent to all consultants, all doctors, and all other disciplines so all are aware of the function of a particular ward or area. Ward policies led to a fuller life for patients, especially where staff have previously had negative attitudes.

Rev. M Fuljames, Chaplain, St Augustine's Hospital, Canterbury, has been involved in two pilot schemes in which teams met to formulate ward policies. As chaplain he is responsible for thirty-five wards, but could not possibly attend thirty-five meetings, and in fact no longer goes to meetings. It was rare that anything arose regarding his role as priest, but he was some-

times able to lead people to consider the implications of certain topics. Sometimes his role was just to keep the peace between other disciplines. Both the pilot scheme teams have now stopped meeting.

Questions

Mr E W Peters said that one objective of ward policies was to improve the quality of the patient's life within the hospital. He asked Ms Edwards if, when reviewing policies three monthly, the team has had much input from patients. Ms Edwards replied that meetings were held weekly or fortnightly with patients at which they could put forward ideas and suggestions. Patients do contribute to policies, and their rights should be considered.

Mr P Mollahan asked Mr Anger if his ward team included patients. Mr Anger replied that patients' meetings were held weekly, although the consultant will not attend. Patients can bring up any matters with the team.

Mr M A Brennan introduced the question of responsibility with regard to people who stick very tightly to the rules, and others who, although doing their job well, may break laws and procedures without being culpable. He asked with whom legal responsible rested, and how policies can be formulated in these circumstances. Mr Chenery replied that all have to accept responsibility. When people do the job strictly according to the book, this can be overcome by creating the right atmosphere with regard to the philosophy of nurse management and of treatment pattern. A "book-minded" person can be made to realise by peer pressure that there a more ways of doing things, and that it is possible to be more flexible and take more chances. Any management system has to accept that at times there must be an acceptable level of risk. Mr Brindle told of a situation in which the medical team's efforts to effect a change in policy came to nothing so the Community Health Council was invited to examine the situation. This resulted in achieving better conditions for the patients.

In the afternoon, delegates divided into six teams for group discussion. Mr R Everest, Principal Nursing Officer, School of Nursing, Bethlem Royal and Maudsley Hospitals, chaired the plenary session.

Questions discussed by the teams (in order of priority):-

Group A:	5	4	2		
Group B:	2	4	1/5 (discussed together)		
Group C:	1	2	3	4	5 (all given equal weight)
Group D:	5	3	4	1	2
Group E:	2	5	4	(1,3 discussed very briefly)	
Group F:	1	4	5		

Other topics discussed:-

Group A: Ward policy as distinct from hospital policy; relationship of ward policies and individual patient treatment policies.

Group C: Where responsibility lies under particular policies.

Group D: Responsibility; personal experiences.

Group E: Definitions; standards of care; legislative policies; ward "nuts and bolts".

Group F: Trade Unions - attitudes and role.

Question 1. "In what way have the various guidelines, working party recommendations and legislation regarding the provision of care for psychiatric patients assisted in the task of formulating ward policies?"

For Group F, Ms S Dawson reported discussion on the availability of documents and whether or not they actually get to the wards. Working party reports, surveys, and so on do not reach the wards. All must help towards formulating policies.

Mr P W Dodds commented on the amount of material coming into hospitals - a large amount of filtering takes place and it is circulated on a "need to know" basis - but by whom is this decided? Ms J Turner said that North Humberside has a good service - a bulletin is circulated which lists all reports, books, etc., available, and these can be ordered. Mr Chenery said that copies of reports were sent to Senior Nursing Officers who had a complete reference library which was accessible to any member of staff. All charge nurses, ward sisters, and above have access to the medical library. Group C felt that legislation or advice from above could actually hinder the formulation of ward policies. For example within health and safety regulations or fire regualtions there is no room for manoeuvre - at the start of each policy it must be stated that these are paramount and cannot be contravened. Mr Downham commented that the theory of the Health Service is that regions should have established standards for monitoring; by now they should have formed a framework within which units, wards, etc., can work. He asked if anyone had come across a regional policy. Mr Chenery replied that he had encountered only one - on furniture and furnishings - which was so bad that it had been thrown back at the standards committee. Mr Everest said that South East Thames Region has policies on mental illness and mental handicap.

Question 2. "How is the balance between ideal standards and minimum standards maintained when formulating ward policies?"

For Group E, Ms Blacker reported that nineteen points had been discussed, which included the following. A policy has to be good or it is not worth having, and it has to be stated at the top level of possibility for resources. It is demoralising if resources fall short. The question had been discussed whether or not people from above could decide standards - this required the collecting-up of standards within the ward to define the ideal. A policy should not state exactly what is to be done, as this may result in just this being done, and nothing more. The group had discussed what happens if the standards of the policy are not achieved - questions of responsibility and discipline. Something above the minimum standard should be aimed at - possibly some other document should state the minimum standard.
Mr A Phillips asked how desirable and achievable standards were to be identified. One difficulty in setting out the policy at first is establishing the standards which should prevail and which it is hoped will be achieved by the issuing of the policy. A policy is not worth anything unless it is dynamic and achieves more than is at present being achieved..

Mr Everest asked if anyone had experience of a policy which represented ground opinion and had been pushed upwards. Mr Anger told of a situation in which rehabilitation policies were failing and were reformulated on the basis of experience at ward level. Ms H Bailey told how nursing staff on a ward had formulated a policy to prevent inappropriate admissions. This had gained support from the consultant who took it to the District Management Team who accepted it.

Question 3. "What constraints does existing legislation and other factors put on the formulation of ward policies?" was not discussed separately as it overlaps with Question 1.

For Group B, Mr L Reinholds reported discussion. Management by leader is a compromise. The ward team has a collective responsibility for formulating ward policy. Implementation is left to individual disciplines and team members. Charge nurses or ward sisters police the policy - see that it is implemented.

For Group A, Mr D'Cruz said that in the end it was the multidisciplinary team at ward level who were to formulate ward policy on a democratic basis, and the policies would give job satisfaction and committment. But there were snags, especially in the timing and size of meetings. Mr Allen said that an advantage of the multidisciplinary team was that it brought about a greater committment to implementing policies. The involvement of minority disciplines was important in that it improved morale. A disadvantage was that there had to be spontaneous enthusiastic committment by all disciplines, which was often lacking, particularly among senior medical staff. Mr Everest asked how this committment could be established. Mr Allen replied that there was a need for inservice education and training - this would encourage staff to innovate. Ms Blacker saw a need for the training of charge nurses and ward sisters in the chairman's role.

Mr Chenery brought up the question of who seeds an idea. Where there is a true multidisciplinary approach, any member of the clinical team or the ward team has a right to initiate a question. On a clinical level doctors, nurses, social workers, occupational therapists, etc., are already involved in working out clinical programmes of treatment for individual patients - a team exists already. Mr Downham commented that it is a big jump from this to discussion about patients as a group. Many consultants have difficulty in making the conceptual leap to talking about the policies within which wards operate. He felt that doctors left this to nurses, and that it was the nurses' responsibility to see policies drawn up and implemented. Dr Sheppard commented that the question of responsibility is very difficult. Each person on the ward has responsibility for drawing up ward policies. His group felt it would be almost impossible to impose a policy on an individual discipline if that discipline opposed it. Individual disciplines need to make up their own minds, arrive at their own decisions, and be responsible for them. There is a problem with areas which fall between disciplines. Mr Downham saw a snag in the individuality of consultants - a multidisciplinary team is multidisciplinary as long as the consultant agrees with it. There is a need for someone on the team, preferably not the consultant, to be a team leader and stimulate conversation.

Question 5. "Assuming that it is agreed to have written ward policies, who should own the responsibility for seeing that the policy is formulated, implemented, maintained, and reviewed?"

For Group A, Mr D'Cruz said that at first the group had agreed that nurses should to a large extent be responsible for implementing and coordinating policy. The groups final conculsion was that it should really be the concern of all functioning at ward level. The Nursing Officer has a key role in initiating and monitoring new policy and giving constructive support.

Ms Blacker placed a strong emphasis on the responsibility of the Nursing Officer. Leadership should not lie too rigidly with ward sisters and charge nurses. They have an authoritive role - other disciplines, except medical disciplines, look to them to enable policies to work or to give reasons why they are not put into practice. Mr Allen said that policy must stem from the top - the Hospital Management Team or appropriate division of psychiatry have the ultimate responsibility for formulating policy - the "nuts and bolts" are the ward's responsibility. Mr Dodds said that if the multidisciplinary team felt it right to implement policy for all disciplines, they should also do so for their own discipline. Until each discipline puts in the same committment as nurses, nurses carry the burden.

Drawing the conference to a close, Mr Downham asked delegates to pass on any ideas or brainwaves they might have in this area. During the discussion there was unanimous support for a proposal that the King's Fund should be asked to produce a booklet giving guidance regarding the compiling of ward policies and giving examples of written ward policies which were being used in different parts of the country.

Mr Downham said that too many issues had been raised for him to summarise them all, but he had been pleased to discover that there had been no violent objections to ward policies, although there had been misgivings and misunderstandings. Every policy's starting point is different - each begins from the existing situation. Policies are seen as a safety measure by some- by others as a burden which the charge nurse is left to carry. The charge nurse is entitled to expect and ask for support.

The value of ward policies is not merely that they are a shopping list, but lies also in the process of drawing up a list. If consensus cannot be achieved, this does not mean that a policy should not be proceeded with. There must be commitment; without it, especially from the nursing staff, ward policies will never be achieved.

It is essential to institutionalise the process; this gives respectiability, orthodoxy. He looks forward to the day when every learner is provided with a copy of the ward policy and has a chance to say when it needs changing and when it does not work. Ward policies should be accepted from the very beginning as part of normal nurse training.