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CLINICAL REFLECTION

Undervalued and overlooked: the importance of private space in liaison psychiatry

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SUMMARY

Access to private space for psychiatric assessments is crucial to facilitate the effective gathering of salient information while preserving the dignity of patients. In this article, we discuss the current availability of private space for liaison psychiatry services on in-patient wards in general hospitals and reflect on how this affects communication with patients. Additionally, we propose solutions for healthcare trusts in addressing this issue.

KEYWORDS

Psychiatric assessment; communication; private space in general hospitals; clinical governance; risk assessment.

At the centre of every assessment in psychiatry is the rapport and relationship that is built between practitioner and patient. It enables valuable information to be gathered for formulation, diagnosis and management of psychiatric disorders, while ensuring patients feel comfortable within the privacy and defined boundaries of the conversation. The importance of private space to conduct psychiatric assessments is recognised by the Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network (PLAN) standards, which recommend: 'where clinically appropriate, the team has access to, and use of facilities that offer dignity and privacy to conduct assessments' (Baugh 2020). This standard is classified as level 1 or 'essential', which if not followed would result in significant threat to the patient's safety, rights or dignity. However, conducting psychiatric assessments in private spaces on in-patient hospital wards is becoming increasingly difficult to achieve for liaison psychiatry services.

The availability of private spaces in which to conduct psychiatric assessments in general hospitals has decreased further s a result of the COVID-19 pandemic. During the pandemic, rooms that were previously used for family discussions were not needed because of the restricted visiting rules. Therefore, previously designated private spaces have been repurposed as additional staff-rooms to combat workplace burnout or storage rooms for personal protective equipment (Saqib 2020). In a survey we carried out between September and November 2021 across 57 in-patient wards in four general hospitals in south-east England, 31% of wards had a private space available for psychiatric assessments. Now that healthcare systems have learned to manage COVID-19, it is important to re-evaluate the role of private space in general hospitals and, if necessary, advocate for a widespread change in its availability.

Is lack of private space affecting patient care?

In contrast to the PLAN guideline, in the majority of wards that our liaison psychiatry team visits, an appropriate private space is not available. In response to the decreased availability of private space, liaison psychiatry teams are assessing patients in communal ward bays within earshot of other patients. The information discussed during these assessments is highly confidential and sensitive; it is inappropriate to discuss suicidal ideation, previous trauma and potentially stigmatising topics in a physical environment that is not private. Preserving patient confidentiality is very challenging in these instances and on many occasions, patients ask to discuss sensitive topics another time or in a different location, which limits the value of each assessment. Instead of disclosing the entirety of the information, patients are holding back for fear of others overhearing (Campbell 2018). In addition, the absence of a private space on in-patient wards results in more interruptions during consultations, which can be hugely damaging for the rapport being built between patient and practitioner. They can also be distracting for the practitioner, who could be stopped during a line of questioning that is never returned to.

It might be possible to relocate patients off the ward to a hospital area with private space for assessment. However, this is reliant on the physical health of the patient and discriminates against patients who have poor mobility or are bed-bound. In addition,

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there is a considerable time and resource cost associated with relocating each patient reviewed, as porters need to be requested if patients are not ambulatory. Relocation is only be possible for formally admitted patients, so is not be suitable for the emergency department. An alternative solution is to temporarily remove other patients from ward bays while an assessment is taking place. However, this is rarely viable as it requires substantial nursing input and is also reliant on other patients being mobile enough to vacate the ward.

Although this reflection focuses on in-patient wards, the emergency department presents unique challenges to assessment of psychiatric patients. The high throughput of patients in this department can be overstimulating and can cause further agitation for patients in mental health crises (Clarke 2007). Also, psychiatric patients who do not have serious physical health problems can have considerable waiting times before being assessed, which can exacerbate their distress and risk (Clarke 2007). Although psychiatric assessments in emergency departments comprise the vast majority of the workload for our liaison psychiatry team, it is our observation that the highest-risk patients are admitted to in-patient wards and require active surgical or longer-term medical treatment for self-harm and suicide attempts.

Without a suitable physical environment, communication failures between patients and doctors can result in substandard care being received and patient complaints. In a report commissioned by the General Medical Council, having an inappropriate physical environment in which to have sensitive conversations was identified as a key contributing factor to communication failures (Campbell 2018). Patients commented that they 'desired a communication environment that encourages them to express their feelings and problems' (Garden 2016). Therefore, an inappropriate physical environment not only puts the patient's dignity at risk, it also inhibits the information that can be gathered from encounters because the patient is uncomfortable disclosing information and the doctor is uncomfortable asking. In psychiatry this is especially pertinent, as the history a patient gives is crucial to diagnosis, risk assessment and management. This is having a detrimental effect on the experiences and safety of patients seen in the acute hospital setting. A recent cross-sectional survey based in the UK reported that only 29% of patients felt comfortable during assessments and just 31% found liaison psychiatry contact helpful (Guthrie 2021).

Solutions to the current situation

The availability of private spaces in general hospitals is highly variable and depends on the design of the healthcare facility (Stiller 2016). Newly built hospitals are being designed with a greater proportion of single-bed rooms as they have been shown to reduce rates of hospital-acquired infection and to improve sleep and privacy (Stiller 2016). In hospitals with a high proportion of single-bed rooms there is a relative abundance of private spaces. However, it is a recognised problem that in conventional hospitals, where the majority of beds are in bays of four to six, there is a lack of privacy.

In existing hospitals, a logical solution to the current low availability of private spaces on wards might be to convert staff-rooms into private room space. However, this has potentially harmful consequences for staff well-being. At the time of writing, the healthcare workforce is under substantial pressure managing COVID-19, with many staff members experiencing a decline in their own mental well-being as a result of increased patient mortality and rota gaps due to staff sickness leave. In response to this, hospitals in the UK have promoted 'wobble rooms', which are safe spaces away from clinical noise that encourage mindfulness and psychological resilience (Saqib 2020). Removing such spaces could have a detrimental effect on staff. In contrast, good communication with patients reduces errors and subsequent cost to hospitals from legal action and from risk-related incidents on the wards (Stelfox 2005; Nagpal 2012). When the COVID-19 pandemic has ended and patient visiting restrictions have been fully eased, 'wobble rooms' will need to be weighed against the increased demand for private spaces for patients.

An alternative solution may be to create private spaces on the ward, for example by converting a single-bed side-room into a communal private space that can be reserved for parts of the day. Another solution could be to have a single private room shared by several wards. Each ward would have the ability to 'book' the private room when required. If this system is to work, there needs to be an easily accessible and transparent system for booking the room, as it is likely that there will be high demand for the private space among healthcare professionals and relatives.

Recalibrating the perception of private space

It is crucial to adjust the perception of private space among healthcare professionals and hospital management in general hospitals, so that they come to view it as a necessity for every patient. Psychiatric assessments in private spaces should be viewed akin to sending patients to a separate area for imaging investigations for physical health problems; the physical environment the assessment takes place

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in hugely influences the quality of the information that can be gathered.

Conclusions

Here we have highlighted the current lack of availability of private spaces for psychiatric assessments in general hospitals as a significant problem within liaison psychiatry and for patients. Inadequate physical environments for assessments puts the communication between patients and healthcare professionals under strain. The lack of privacy for psychiatric patients on in-patient wards is likely a widespread problem which now needs raised awareness among healthcare professionals and hospital management.

Data availability

The data for each hospital surveyed is freely available on GitHub (https://github.com/bookej/Private-spaces-survey.git).

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Author contributions

J.B. and V.C. were responsible for the conceptualisation of the article and article design. J.B. was responsible for data collection, data analysis of the survey of in-patient wards and writing the manuscript. V.C. was responsible for making substantial revisions to the final manuscript prior to article submission.

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Declaration of interest

None.

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