Geriatric Nursing

A study of the work of geriatric ward staff

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PREFACE

GERIATRIC DEPARTMENTS, a recent innovation in hospital services, were originally defined as "wards in a general hospital reserved exclusively for elderly patients, all of whom are undergoing investigation or active treatment and rehabilitation so that in due course they may be discharged either to their own homes or, after classification, to other appropriate accommodation." There are now many hospital centres in the British Isles working to this end, most of them developed by renovation or reconstruction of out-dated chronic sick hospitals. Wakehurst House, the geriatric department of the Belfast City Hospital, is an example of this, and is more fortunate than most in having a new wing built to original design specifically for geriatric rehabilitation.

Policies for geriatric development, and the design of new departments, have been published from time to time, but apart from an investigation of geriatric nursing problems recently completed in the Whittington Hospital,* the day-to-day duties of a nurse in a geriatric ward have not been the subject of methodical study. There is little precise information available to indicate how these duties compare with those in general wards, how many nurses geriatric wards require, what auxiliary help they need, or how to deploy the staff to the best advantage.

In Wakehurst House we appeared to have the environment and facilities necessary to fill these gaps in our knowledge of geriatric nursing by a systematic inquiry, and we were encouraged to attempt it because nursing in the general medical and surgical wards of the hospital had been studied in 1960 by a trained team whose services, experience and former findings offered a unique opportunity to compare nursing activities in geriatric and general medical wards.

* An Investigation of Geriatric Nursing Problems in Hospitals (1962). National Corporation for the Care of Old People

The Northern Ireland Hospitals Authority and South Belfast Hospital Management Committee willingly supported a proposal to make this inquiry, and we are grateful to them for their practical help in providing the staff of the work study team for the survey period from June to December 1961. We are deeply indebted to the Northern Ireland Committee of the Nuffield Provincial Hospitals Trust and especially their Secretary, Professor D. C. Harrison, for their encouragement, and for the generous grant of £3,000 which they sought from the trustees to cover the expense of consultant advice from Production Engineering Ltd., who planned and supervised the activity sampling and time-study of work in the geriatric wards. We wish to acknowledge our appreciation of the expert advice given by Mr. H. C. McMullan, the Senior Consultant from this firm. He directed the original study in the main hospitals and gave us continuous and invaluable help in this follow-on. We particularly wish to thank Mr. G. McLachlan, Secretary of the Nuffield Provincial Hospitals Trust, for his interest in this project from the outset.

Our thanks are due also to Miss D. H. Lynn, Matron of the Belfast City Hospital, for her constant support and interest; Miss Lynn initiated the earlier nursing research in the hospital and established the nursing team; this survey was prompted by her special interest in the problems of geriatric nursing, and her desire to resolve them from a basis of factual knowledge of the geriatric nurse's work. We must record our gratitude to the Assistant Matron, Miss Moffitt, the ward sisters and the nursing staff of Wakehurst House for their active and interested co-operation, and for their cheerful acceptance of an invasion which might well involve a revolution in their way of life in the wards. The senior ward staff were Sisters I. Sinnamon, S. Kinney, P. McLean, P. McGrath, E. Graham and Charge Nurse W. H. Ryan; by their initiative and hard work they have replaced a rigid caretaker system of oppressive privation with a régime that is the essence of good nursing, the mainstay of the system of geriatric care in Wakehurst House, and the subject of this inquiry.

We are especially grateful to the team of three nurses, Sisters Kathleen Lynch and Ruth Adams and Staff Nurse Margaret McMullen, who were kindly made available for the studies by the Matron of the Belfast City Hospital, and to Sister Mollie Duncan

and Staff Nurse Susan Scott who later joined them to help in the analysis and practical application of their work. Whilst the principles of work study may be acquired by almost anyone, conscientious recording of investigations, accurate repetitive calculations, and the application of new methods (frequently in a sceptical atmosphere), call for versatility and diplomacy, and the team never failed in these qualities.

Finally we wish to thank Mrs. Vera Stewart for her skilled help and patience with the technical details and preparation of the report.

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INTRODUCTION

Increasing appropriation of hospital services by old people

1. Old people claim much more hospital service now than they once did; patients aged 60 and over comprise almost half of the admissions to general hospital wards, or about twice the proportion admitted fifteen years ago. This reflects the influence of several social and medical factors, but more especially the increased proportion of old people in the population and the corresponding increase in illness caused by degenerative diseases. A recent inquiry[1] indicated that 1,154,000 people of pensionable age in England and Wales were housebound, and a further 98,000 were confined to bed through illness and disability, representing 18 per cent of pensioners in 1959 compared with 11 per cent in Sheldon's Wolverhampton survey[2] in 1947. Increased admission of such old people to hospital is also an index of the demand for better standards of care for the aged, and of the steady improvement in hospital services available to them which creates its own demand. Another probable reason for the mounting proportion of old people amongst admissions is a decline in some "hospital" diseases of earlier life, or perhaps more effective domiciliary or out-patient care of them. Whatever the cause, good reasons exist for the belief that "old age will provide the hospital service with its principal challenge in the next twenty years."[3]

Hospital policy in the past

2. Former policies in our hospital services encouraged the voluntary and teaching hospitals to maintain a rapid turnover of patients in acute illness, leaving to local authority institutions the responsibility for the failures of medical progress—the homeless or destitute chronic invalids. Most of them were old people, and concentrations of them, in chronic or terminal illness, filled vast

numbers of beds in overcrowded, understaffed wards with grossly inadequate facilities. Without means for investigation and accurate diagnosis, or the staff and resources for effective treatment and restoration of activity, this system created many helpless cripples to fill beds in chronic sick hospitals. Its false economy is underlined by the success of the active approach to illness in old age, introduced by Dr. Marjory Warren and others to replace the passive custodial care of the old days. The service they devised in geriatric units attached to general hospitals can provide more comprehensive hospital care for greater numbers of the aged sick, and in fewer hospital beds.

The purpose of a geriatric unit

3. The functions of such units are to bring order into the former chaos of chronic wards by classification and segregation of patients on a basis of proper diagnosis; to distinguish human disability from the diseases related to it; to co-ordinate the medical, nursing and auxiliary services of the hospital in a régime of treatment suited to the needs and slow rate of recovery of old people in illness; to restore as many of them as possible to activity and independent life, however restricted, reducing chronic incapacity to a minimum; and to make life more tolerable than it was in the old chronic hospitals for those who fail to respond, providing them with the high standards of nursing care and personal service that they need.

4. It is difficult, if not impossible, to attain these objectives in a general hospital ward. The old people compete with the priority which must be given to the younger acute sick, the housewives and wage-earners who support the community, and although the older patients share the high standards of medical and nursing care in the ward, they may be denied the continuous personal attention and the *time* they may need to make the most of recovery, because pressure to maintain a quick turnover may dictate premature discharge home or to a chronic ward.

5. There are now many geriatric centres established or being developed in the British Isles. They have been made possible by the National Health Service, by the hospitals authorities who have reconstructed or renovated out-dated institutions and provided

the wherewithal to staff and equip them, and by a reorientation of outlook within the medical profession towards the aged sick. But "geriatric" is a much abused adjective. It does not follow that because an out-dated chronic sick hospital has been renamed a geriatric unit, it has been redesigned, equipped or staffed to the standards required of a modern rehabilitation centre for the elderly sick. There are still too many of the old chronic sick wards, a little improved perhaps by paint and patchwork and re-named geriatric hospitals, where the tolerance, good-humour, and capacity for sheer hard work of the average nurse are still exploited under working conditions which beggar description (Sheldon 1961).[4] In many reports on hospital services for the aged, eloquent tributes have been paid to the harassed nurses who made what they could of primitive conditions and rudimentary appliances, "meeting this difficult situation with a devotion inconceivable in any other profession".[5] It is a reproach to the Health Service, and to leaders of the medical and nursing professions, that nurses are still called upon to do so, not only in some unaltered hospital slums, but even in modernised wards overwhelmed by a mounting load of long-stay patients.

The nursing responsibility

6. Good nursing is the keystone of geriatric care—without it new administrative policies and medical progress are as nothing; but although the devoted work of the nurse in chronic sick wards has so often earned golden opinions, and her hardship and difficulties have attracted so much sympathy, little effort has been made, even within the profession, to alleviate her lot. Yet her problems were appreciated, and future trends in this field of nursing were clearly understood by those who wrote the Report of the Working Party on Recruitment and Training of Nurses in 1947.[5]

7. The authors of this report stressed the need for research and reforms to grapple with the social and medical problems raised by growing numbers of chronic invalids, and "to prevent the deterioration of many patients into bedridden wrecks who might otherwise not have become so". It is clear that they considered the need to provide the right kind of nursing for these patients was in itself a specific problem, inseparable from the others, and that a

solution to it would go far towards solving the others. They believed that the chronic sick should share the benefits of teaching and research in all general hospitals and opposed the system whereby these patients, the assistant nurses recruited to attend them, and the institutions in which they were abandoned, were cut off from scientific study and progress. Indeed, they opposed perpetuation of the assistant nurse grade and desired nursing, properly defined, to be the prerogative of the state registered nurse assisted by carefully selected and trained ward orderlies who would undertake certain routine and repetitive ward duties and techniques under supervision.

8. The Nuffield Report on "The Work of Nurses in Hospital Wards"[6] reiterated the belief that nursing is the "proper task" of the trained nurse; it should not be thought of as predominantly a matter of exercising special technical skills, nor should basic nursing be delegated to an auxiliary grade.

9. These recommendations do not seem to have impressed those who direct policy within the profession. A change of name from assistant nurse to enrolled nurse does not change policy, and continued support of an assistant nurse grade, recruited primarily to care for the aged and the chronic sick, implies failure to move with the times and recognise that these patients need the services of the fully-trained nurse more, not less, than most patients in general wards. Nursing in general hospitals is one with the image of Florence Nightingale, but geriatric nursing is associated in too many ill-informed minds with the image of Sairey Gamp. There is a tendency to disparage the nursing skill necessary for the care of sick old people; to write down their needs as little more than "loving care", and to imply that their nursing can be relegated to a staff grade without the intellect or ability required of the state registered nurse. These false beliefs, fostered by the divided responsibilities of the former hospital system, are cherished by those who, having had no first-hand experience of the work, cannot appreciate either the full extent of the need for reform under the old order, or what is required of the nurse in a geriatric ward under the new.

10. In the old chronic wards the trained nurse undoubtedly was denied the opportunity to do her work properly, and some

descendants of Mrs. Gamp were to be found in them, but the need for skilled nursing was there, even if the staff had neither time nor facilities to do it. A senior nurse, with long experience of geriatric nursing old and new, explained this very well when she observed "we weren't nursing the patients in those days, we were just looking after them". An intelligent junior staff nurse commented that her work on night duty in charge of a geriatric ward was more exacting than comparable work in a general medical ward, and that the intellectual effort to get into the minds of her patients, and think for them, was more tiring than the physical effort her duties entailed.

11. In the modern geriatric ward the work is very different. The patients no longer include the convalescent invalids or pauper assistants once recruited as ward auxiliaries. These conscripts have disappeared to convalescent or welfare residential homes and are replaced by ill, often very ill patients who need most able nursing. Moreover, the work of the active rehabilitation wards of a geriatric unit, whilst sifting and restoring to activity many patients who might have been condemned unnecessarily to a bedfast state in the past, has radically changed the character of the long-stay wards. They now accommodate very high proportions of mentally clouded, helpless, incontinent old people to whom good nursing is everything and medical care means relatively little. Indeed it would be true to say that the challenge before our hospitals now is the nursled survival, not the medicated survival, of so many old people. It is unreasonable that this heavy and growing responsibility should be rejected by any one group of hospital nurses, to be carried on the overburdened shoulders of another.

Special nursing problems of old age

12. It is not always appreciated that the nurse in geriatric wards needs all the skill and experience she is required to bring to her work in general wards, and in addition she needs the ability, mentioned earlier, to "think for" her patients. Their senses are often blunted in old age, or intellect is impaired and consciousness clouded by illness so that they are only aware of discomfort but do not grasp the cause, be it thirst, hunger, lack of warmth, retention or a loaded rectum. Noisy and eccentric behaviour may express the need they cannot explain, and the nurse must have patience,

intuition and experience to unravel the cause, and to reassure patients bewildered by nursing procedures they do not understand, and by the sudden change to the unfamiliar hospital surroundings.

13. Elderly invalids are often utterly helpless and unable even to move in bed or reach for a glass of water, so that frequent changes of position, movement of limbs to prevent contractures, spoon-feeding of all food and drink, washing, toilet and general hygiene, the most meticulous care of skin and pressure areas, and constant changes of linen, call for conscientious nursing attention for much longer periods in age than in youth. In terminal illness, prolonged sometimes for months, prevention of contractures, treatment of bedsores and the management of bowel and bladder require special nursing skill.

14. A few weeks in bed induce feebleness and lethargy in old people which younger patients would only experience after several months, and in convalescence the nurse must assess from experience how much exertion she can ask of the elderly patient who is beginning to sit out of bed, to dress, to attend to personal needs, and eventually to walk again. Incentives to regain activity are weaker in age than in youth, and many old people acquire a negative outlook on disability—concentrating on what they have lost by stroke, arthritis or fracture, and forgetting the capacities that remain. The nurse who constantly attends the patient can do more than anyone else to change this outlook towards positive attributes and optimism.

15. This work, with a single individual or a small group of patients, can be rewarding and satisfying, if not as dramatic and stimulating as work in the wards with younger people, but nursing large concentrations of old folk in chronic or terminal illness can be soul-destroying labour, and this is the strongest argument against former hospital policies. The progress made in the development of new hospital departments, and in medical and social services for the care of the elderly, has to be matched by the changes necessary to provide appropriate nursing care. The problem to be solved by the nursing profession is not how to find a substitute for the trained nurse to whom responsibility for the aged sick and chronic invalids can be handed over, but to face the challenge of the increasing proportion of the aged sick necessarily

being admitted to hospital, and to decide how the nursing of those who fail to recover and require long-stay care can best be shared by available trained staff, and what auxiliary help this staff will need.

CHAPTER I

THE SETTING OF THE INQUIRY

The chronic wards of the Belfast City Hospital

16. Geriatric hospital care in Wakehurst House is the product of changes in administrative and medical policy, in the building, which has been extensively reconstructed, and in the system of nursing. The stages of development will be described briefly because the nursing that is the subject of this study is directly affected by the changes in policy and structure.

17. In 1948 the Northern Ireland Hospitals Authority inherited, amongst other antiquated hospital buildings, a block of six large wards housing the chronic sick of the Belfast Union Infirmary, now the Belfast City Hospital. The patients and the staff in these wards shared the shortcomings described in surveys of similar institutions in the British Isles, and there was obvious need for the plans for improvement drawn up in July that year under the new Health Service.

Classification of the original patients

18. A preliminary survey of all the patients was made at that time to assess the need for hospital care for each patient from a review of the diagnosis, physical and mental capacity, and social background, and to determine whether further treatment might restore activity in any of the bedridden invalids.

19. The patients in these wards had been defined as chronic sick, but the survey distinguished four groups—recovered, infirm, bedfast, and remediable. The first were a few active people, recovered from former illnesses, who were social misfits retained to help in the short-staffed wards, instead of being discharged

or returned to the workhouse. The second comprised homeless old people, disabled by infirmities which had justified their continued existence in hospital although they could attend to their own needs and required no service that could genuinely be described as nursing, and no medical attention that would not normally have been given by the family doctor had they been at home. Some of these patients too were employed on ward chores. The largest group were the long-stay invalids for whom the block was originally intended. The fourth group comprised a small number of patients who seemed capable of response to further treatment. Most of these were invalids handicapped by neurological, arthritic or traumatic locomotor disorders, who seemed to have been consigned to life in bed, owing to social misfortune and lack of time under proper supervision to make the most of recovery from the acute phase of their illnesses.

20. The almoner was able to resolve social problems and make alternative arrangements for most of the patients in the first two groups with relatives, in lodgings, or in residential accommodation. The bedfast invalids were redistributed within the department to avoid over-loading any one ward with an excess of the heavier nursing of incontinent, confused invalids, and the fourth group, the potentially remediable patients, became the nucleus of a rehabilitation centre—the geriatric unit.

Development of a geriatric unit

21. These remediable patients were congregated in one male and one female ward; the sections they occupied became the rehabilitation unit, but part of each ward was retained for long-stay cases on the principle that each ward sister should share some of the load of less rewarding nursing. Beds were eventually released in sections of two more wards for medical admissions, that is, patients with cardiovascular, respiratory, metabolic and other disorders with less marked emphasis on physiotherapy in treatment than was necessary in the locomotor disorders admitted to the other two wards. In the rehabilitation wards it was found that if staff/patient ratios were adequate the ward sister could admit 16-20 new patients each month, supervise treatment and restoration of activity in 24 acute sick, and at the same time give efficient nursing care to 16 long-stay invalids (40% of her patients).

22. Previously there were no direct admissions to this block, patients being transferred to it after investigation in the main hospital, and they were often transferred back again for appropriate care in a relapse or in terminal illness. This policy was continued for a few months until the heterogeneous mixture of invalids was sorted out. It then became possible to accept direct admissions to the rehabilitation wards and gradually the numbers of these increased until they exceeded the transfers. As apathy and inertia gave way to activity, and the pace of admission and discharge increased, efforts were made to improve the wards and standards of treatment, and to simplify nursing techniques by new appliances, labour-saving devices and various make-shifts.

Reconstruction of the wards and rebuilding

23. Each of the old wards accommodated 65 beds in four rows in an area 150 feet long and 30 feet wide, with a small kitchen partitioned off at one end, and a wall dividing the ward into an upper section 75 feet long and a lower 60 foot section. Renovation of the two intended for rehabilitation began in 1952 and was completed by 1953.

The upper end of each ward was divided by glazed partitions into two subsections, one in the ward centre holding 10 beds for new admissions, a single-bed ward, and sister's station, and the other, with 12 beds, was fitted with parallel bars and other facilities for exercises (Fig. 1). The lower end carried 19 long-stay beds, and a day-room and a clinical side-room were provided. The wards were re-floored with lino tiles, lighting was improved by new windows, central ward lights, and individual bed lamps, and the battered ward furniture was replaced by modern beds, lockers, bed tables, easy chairs and bed-curtains. The ward annexes and sluice-rooms were altered and equipped to conform with modern standards.

By this re-arrangement of a ward the sister was able to watch the progress of patients from the acute stage of illness towards convalescence and restoration of activity in the upper end of the ward, and to provide long-stay care for others, whose eccentricities were well known to her, who had failed to respond to treatment, and so had migrated to the lower end because they could not return home.

24. Three of the remaining old wards were similarly reconstructed, and at the same time plans were being drawn for two 40-bed wards in a new wing to replace top-floor accommodation declared unsuitable for old people owing to the fire risk. Experience had shown that disturbed patients in the lower end of the old wards could upset those in the upper sections, and that even with a reduced number of beds there was not enough space in the renovated wards for all the active patients needing exercise.

The new wards were therefore designed in an L shape so that the long-stay section, in the smaller arm of the L, is isolated from the rehabilitation ward in the longer arm, each having its own annexe and sluice room. There are sixteen beds in the long-stay section in four 4-bed bays, 24 beds in four 6-bed bays in the rehabilitation ward, and one single-bed room. The bays are divided by glazed partitions, designed to give as much privacy as possible to the patients without denying reasonable observation throughout the ward from the nurses' station at the angle of the L. To overcome the difficulties experienced through lack of space for exercises in the old wards, a wide exercise bay is incorporated in the rehabilitation ward opposite to the beds. Instead of an enclosed day-room there is an open day-space at the angle of the L, beside the kitchen, and under direct observation from the nurses' station (Fig. II).

Much of the new equipment and ward furniture was specially designed to meet the needs of old people and the staff of geriatric wards, and to make the best use of new ideas in geriatric care derived from this and other geriatric centres.

25. This reconstruction provides seven wards in Wakehurst House. Six have each a single-bed cubicle and the seventh has two 2-bed cubicles, which may be used for men or women according to need. Of the 281 beds, about 65 are "active" and the remainder are long-stay. The new wards hold 25 rehabilitation beds and 16 long-stay, and two of the renovated wards each hold 8-10 beds for male and female general medical admissions. This provides $3\frac{1}{2}$ long-stay beds to each active bed, and 2 female to each male bed.

26. This is a stage in progress, not a finished plan, because there are still three wards in the department entirely devoted to the care of long-stay invalids. Without them it would be impossible to

maintain an effective turnover in the rehabilitation beds, but the sisters in charge of these three wards should have their share of active treatment in some beds. It will only be possible to give them this when there are more long-stay beds available in Belfast and when this kind of nursing is shared by all nurses of all hospitals. The ratio of geriatric and chronic sick beds to the local population is only 0.7 per thousand—less than half of the estimated need, and the nursing staff of the City Hospital, especially in Wakehurst House, carries a disproportionate load of chronic sick nursing.

The changing pattern of nursing care

27. Over the years these alterations have been accompanied by great changes in the quality and quantity of ward work.

> Formerly about 400 patients were transferred from the main hospital each year to fill the 360 chronic sick beds. In the 10 years from 1948-1958, an average of 650 patients were admitted each year to the 240 beds remaining in the department when bed complements were reduced and two wards had been evacuated to comply with fire regulations. The average age of these admissions, men and women, was 76, but 55 per cent of them recovered independence and were discharged home or to residential care.

More than half of these patients were direct admissions with acute illness. Neither these, nor the long-stay invalids are transferred to the main hospital now, except in a surgical emergency.

28. The present staff therefore nurse much more acute illness than their predecessors, both in new admissions and in terminal illness of long-stay patients. They also help the physiotherapists and occupational therapists in the programme of ward exercise, which could not be carried out without their active co-operation on the scale necessary in wards full of old people. Even the long-stay wards are busier than they were when all the patients were confined to bed; many now prefer to sit out in a chair for a few hours daily, and the help they need from the staff is justified by improved general condition and diminished incontinence amongst the patients.

29. Our nurses, therefore, have had a fourfold responsibility. They have brought to this backwater of the hospital the standards

of nursing required for acute illness in any general hospital ward; they have helped to develop systematic rehabilitation; at the same time they have successfully nursed very high proportions of chronic invalids, and they have shown beyond doubt that these services can be welded into the routine work of a single ward unit. For the past twelve years they have practised so-called progressive patient care without losing continuity of care for the individual patient.

Nursing and auxiliary staff

30. It has not been easy to do this because, to provide the necessary staff, successive Matrons in the Belfast City Hospital have had to overcome prejudice within the profession against geriatric nursing derived from traditional acceptance of inferior standards and working conditions, and they have had to do what they could to compensate for deficient staff ratios allowed on establishment for nursing in "chronic sick" wards; (the approved ratio until quite recently was only 1 nurse or orderly to 5 patients; it is now 1 to 3, making no distinction between geriatric and long-stay or chronic sick wards). The department is effective only because it has invariably had the Matron's whole-hearted support, her recognition of the value of experience in geriatric nursing to the student nurse, and her appreciation of the old people's need for the experience and ability of the trained nurse.

31. Changes in design, ward structure, and policy were made according to plan, but there was no blueprint of hospital geriatric care to guide corresponding changes necessary in the system of nursing, and it has had to develop by trial and error. The present Nurses' Training School of the Belfast City Hospital was originally founded on the general wards of the Poor Law Infirmary and obtained formal recognition in 1925. It has every reason to be proud of its record of achievement. However, in those days the staff allocated to look after 65 beds in the block of chronic wards was a sister, one senior nurse, a probationer nurse and a pauper assistant recruited from the Workhouse. An unusually prolonged tour of this hard labour was sometimes the penalty paid by a nurse for a transgression of discipline in the main hospital.

32. Twenty-five years ago the Matron then in charge of the Infirmary decided to improve the standard of auxiliary helpers by

recruiting, as ward orderlies, men or women with a sense of vocation for nursing, and some knowledge of it acquired in organisations such as the Red Cross or St. John Ambulance Brigade.

33. There was little change in these arrangements until 1948, when the Northern Ireland Hospitals Authority approved a proposal to send four sisters to Dr. Warren's unit in the West Middlesex County Hospital to obtain tuition and experience in her concept of geriatric medical care, and they returned to put a new look on nursing in their own wards. It was agreed that ward personnel should be increased by adding more trained staff (two staff nurses to each ward), by allocating each student nurse from the City Hospital School of Nursing to the geriatric wards for 3-4 months of her clinical training, and by bringing in more auxiliary help. These increases came slowly, and it is only very recently that ratios of 1 staff to 2 patients in rehabilitation wards and 1-3 in long-stay wards (with equal numbers of student nurses and orderlies in both) have been achieved.

34. Unfortunately the changing pattern of nursing responsibility in Wakehurst House has always outstripped the resources of the administration, and staff problems have been a sea of troubles to the Matron. The approved establishment has never kept pace with the heavier nursing load, with the demand for better nursing standards, or with the necessary reduction in working hours, first to a 96 hour fortnight and now to the 44 hour week. It has been difficult, therefore, to allocate enough nurses to cover the needs of so many elderly sick, without prejudice to a balanced curriculum of student nurse training in the hospital. An enrolled nurse training scheme recently introduced does not solve the problem, because of the difficulties inherent in trying to organise training for the Register, and the Roll, in one hospital, under present regulations. Until something is done to alter the compulsory predominance of chronic sick nursing in the work of pupil assistants, and to change the prejudice against their mixing with student nurses in training on the same wards, many pupil assistants will be driven by a sense of apartheid to seek their experience in smaller hospitals, without schools for state registration, where they can enjoy work and privileges equivalent to those of the student nurse. Exclusion of the student nurse from

wards reserved for the enrolled nurse training only deprives student nurses of useful experience and encourages the delusion that the care of the long-stay patient is not "proper" nursing.

35. It became increasingly clear that although standards of nursing care in the geriatric wards had vastly improved over the years, they lagged behind progress being made in nursing elsewhere in hospital departments, and it was suspected that the benefits of ward renovation, re-building and re-equipment were not being used to the full advantage of patients or nurses. There could be several explanations for these misgivings, but the most obvious one was that the wards seemed to be constantly short of staff. The consequences of this are disastrous on geriatric wards, especially when there are too few nurses and too many auxiliaries.

The adverse effects of staff shortage

36. As all the staff are swamped equally by a nightmare round of routine basic nursing, some of the more specialised work must go overboard, denying patients the particular care required to prevent contractures, the meticulous toilet of those who are helpless, the scrupulous management of incontinence, the time needed to divert and solace those who are anxious and bewildered, or the help needed with their remedial exercise. These must often give way to the bare essentials of routine medication, injections, supervision of oxygen or intravenous therapy, specialling very ill patients, and efforts to maintain a tolerable standard of general hygiene and patient care. The Ward Sister, obliged to throw in her best efforts to help in this work, is unable to fulfil her proper role in ward management and student nurse training. The trained staff are misused, and instead of assuming the responsibilities they have been taught to accept, find themselves sharing routine work on equal terms with junior nurses and auxiliaries, often with the responsibility of being nominally in charge as well. The student nurse is wearied by her treadmill existence with no time for formal instruction, and orderlies are given undesirable independence of action with the risk that, being permanent staff in the ward, they may assume a dominant role in ward management that they are neither trained nor competent to perform.

37. It must not be assumed that this dismal picture represented conditions constantly prevailing in Wakehurst House. The staff were well aware of all they owed to the unstinted support long given to the department by successive Matrons and by the Hospital Management Committee. They were also aware, however, that this support was only made possible by stretching to breaking point limited resources, and a nursing establishment, incompatible with the changed and increased responsibilities of the department; they realised that staff deficiencies could be related directly to archaic views on the standards of nursing necessary for the aged sick (Chapter 5); and they felt that, because of this, their experience and opinions carried little weight at levels of policy direction in hospitals generally, or in their profession.

Shortcomings in ward routine

38. Apart from difficulties directly attributable to being short-handed, the senior nurses in the department were searching their own hearts about details of ward management. New equipment and labour-saving devices were not always used to the best advantage, mainly because the nurses, orderlies and domestics were obliged to adapt themselves to novel appliances without any systematic instruction in their use. Moreover, although the principles of geriatric nursing were uniform in practice throughout the department, there were wide variations in the details of organisation and routine in different wards. The exchange of original and progressive ideas may have been encouraged by this, and might be discouraged by too rigid uniformity, but some sisters considered that it would benefit the junior staff if the teaching and practice of certain activities were standardized.

39. These points were often discussed but it seemed unlikely that increased staff, and other means to resolve them, would be found easily, in competition with growing demands on nurses elsewhere in hospital, unless facts were available to support opinions. When the 44 hour week for nurses had to be considered, the present Matron suggested that it should be planned from a study of nursing duties in the geriatric wards acquired by the team who had performed the nursing study in the main hospital. The proposal was accepted without hesitation, and this inquiry is the direct result.

CHAPTER 2

THE STUDY

Terms of reference

40. The problem was to determine the proper staff for geriatric wards. The purpose of the inquiry and details of procedure were agreed in discussion with the geriatric physician, who tried to avoid bias from personal opinions so that the inquiry should remain factual and objective. The agreed terms of reference were these:

(*a*) to establish the needs of patients, in terms of the variety and frequency of the activities involved in attending them by day and by night in a geriatric department;

(*b*) to determine the grades of staff best fitted to carry out defined activities;

(*c*) to suggest possible improvements in methods of work;

(*d*) to estimate the time to be given to each activity each week;

(*e*) to plan schedules of ward work from the most effective and economical sequence of activities;

(*f*) to estimate the number of staff in each grade needed to perform the work defined in the schedules;

(*g*) to try out the schedules on a ward;

(*h*) to compare the proved needs of geriatric wards with those previously determined for medical wards;

(*i*) to report upon the findings.

Preliminary discussions

41. It was realised from the outset that there were two phases of the inquiry, the objective phase of measurement and replanning of ward work (which would raise decisions essentially external,

clearly defined, and able to be checked), and the subjective phase involving estimations of the frequency of ward activities, their proper allocation to different grades of ward staff and the efficiency of their methods; (these estimations would be biased by the training, experience and judgment of the individuals concerned and those who assessed them).

42. It was clear, therefore, that recommended changes involving divisions of authority on the ward, areas of responsibility for different levels of staff, and the allocation of specific activities to them, should take account of the considered opinions and experience of senior ward staff and should not be imposed by cut and dried formulæ, even though these might lend themselves more readily to exact measurement and proof.

43. It follows that whereas work study methods could suggest the pattern of the study, and be used to obtain basic data from the existing situation (and later to revise ward organisation), the success of the study would depend more on subjective decisions. We were fortunate, therefore, in having the support of a team of qualified nurses, already trained in work study methods at the Belfast City Hospital, of a Matron and administrative staff who appreciated the potential value of the work, and of ward sisters in Wakehurst House with a background of solid experience in modern methods of geriatric nursing.

44. The programme of work was planned in stages:

(*a*) *Planning*—involving preliminary discussion; determination of the method of study to be used; the time to be given to each stage, and discussion with the staff in charge of the wards, so that objectives and methods to be used in the study could be explained.

(*b*) *Study*—a planned series of analytical studies on geriatric and medical wards, recording of the work of all ward staff, and the methods used.

(*c*) *Analysis*—to show from the recorded information the time spent on the defined activities by different grades of staff.

(*d*) *Development*—to determine policies for patient care and standards of service, defined in terms of the time to be made available for different activities at different levels of

staff; to consider also the allocation of work to the different grades of staff, and set appropriate standards for each activity. Possible improvements in methods would be considered at this stage.

(*e*) *Recommendations*—revising ward organisation, staff requirements, and changes in methods.

(*f*) *Discussion*—to obtain agreement, from those responsible for the wards, to the changes proposed and to modify them when necessary.

(*g*), (*h*) and (*i*) were three further stages, corresponding with the last three terms of reference given above, to try out modified proposals on the wards, make comparisons and report results.

The patients and the wards

45. The demand for admission of elderly patients to Wakehurst House is heavier during the winter months than in the summer when this study was made. However, although the numbers on the waiting list fall in the summer months, there is little change in the general pattern of patient care in the wards which have a 98 per cent occupancy rate throughout the year, and Appendix 3, compiled in September, is fairly representative of the population at any given time.

46. There were 250 patients (one ward not being fully occupied owing to renovation). They were classified according to their physical and mental capacities and their personal needs as patients (Table A):

"*Walking*" (3%) implied full independence and referred to patients about to be discharged.

"*Semi-ambulant*" (28%) were predominantly rehabilitable patients progressing towards independence, but included some infirm old people either awaiting discharge, if suitable arrangements could be made, or likely to remain as long-stay cases.

"*Chairfast*" (54%)—this group included some potentially rehabilitable invalids recovering from acute illness, but the majority were long-stay invalids with a high incidence of incontinence and mental confusion, who were physically able and

willing to be helped out of bed to sit in a chair for part of each day.

"*Bedfast*" (4%)—all these were long-stay bedfast invalids, too ill to sit out of bed and approaching terminal illness. Almost all were incontinent.

"*Acutely ill*" (11%)—these were recent admissions or long-stay invalids who had been overtaken by an acute illness but had reasonable hope of a response to treatment and ultimate recovery. Many were incontinent and confused.

47. These arbitrary categories do not conform strictly to the classification normally used when defining groups of old people according to the kind of domestic or institutional care they need.[7] Our purpose in this study was to investigate nursing in the geriatric wards in terms of the needs of individual patients, and the classification was designed to assist the work study team in their activity sampling.

Table A

POPULATION OF WAKEHURST HOUSE BY PATIENT CATEGORIES ON 5th SEPTEMBER, 1961

Category	Continence				Mental State				Feeding				Total	
	Continent		Incontinent		Mentally Normal		Mentally Confused		Self Feeding		Needs Feeding			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Walking	9	100	–	–	7	78	2	22	9	100	–	–	9	3
Semi-Ambulant	43	62	26	38	49	71	20	29	65	94	4	6	69	28
Chairfast	37	28	97	72	61	46	73	54	87	65	47	35	134	54
Bedfast	3	27	8	73	7	64	4	36	4	36	7	64	11	4
Acutely Ill	9	33	18	67	10	37	17	63	10	37	17	63	27	11
Total	101	40	149	60	134	54	116	46	175	70	75	30	250	100

48. Appendix 3 was coded to show the numbers of patients in these categories in the different wards, giving an indication of the two types of ward recognised in the geriatric department: rehabilitation and long-stay. The main difference between these two kinds of ward was that the rehabilitation ward carried 45 per cent or more potentially rehabilitable patients, whereas in the long-stay ward less than 20 per cent of the patients were rehabilitable. Plans of a renovated ward (used as a long-stay ward) and of a ward in the new wing (a rehabilitation ward) are illustrated in Figures 1 and 2.

49. As all the wards in Wakehurst House were designed to hold 41 beds, and most of them actually had at least 39 patients during the period of the study, all estimates of staff needs, ward methods, and subsequent proposals derived from the studies of ward organisation and activities, were based on a "standard" or average ward of 40 beds.

Recording the work

50. There are several different means of work measurement and method study which might have been used to record and analyse the work on the wards, but previous experience in the main hospital indicated that time studies, continuous production studies, or constant observation studies were too time-consuming for the period available to the team, and conventional activity or random sampling procedures would neither permit sufficiently detailed activities to be recorded nor show the pattern of work on the ward throughout the day. A compromise was therefore devised from the main hospital analysis, involving systematic sampling, at frequent intervals, of the work on one ward at a time. By this means seven members of the ward staff could be studied by one observer at intervals of four or five minutes, which approximated to the average duration of many of the ward activities, and ensured that cyclic activities (Appendix 16) would be recorded. This method clearly showed the sequence of work carried out by each member of the ward staff and gave simultaneous information on the total time devoted to each activity. Also, one type of activity could be isolated when necessary thus simplifying re-planning of ward organisation.

51. There were nine main work groups:

1. Basic Nursing
2. Technical Nursing
3. Dietary
4. Domestic
5. Clerical
6. Teaching
7. Human Relations
8. Absence from Ward Unit
9. Unproductive time.

52. Within these groups 82 separate activities were defined, and these are set out in Appendix 1.

(*a*) The times recorded in studies of existing work and later used in modified work schedules were expressed initially as a proportion of the total duty period and then converted to standard units of measurement known as "ward minutes" (Appendix 16). They were the number of minutes to be worked on a "standard" ward every week for each patient in the ward, and were calculated for each of the 82 activities both for day and night duties.

(*b*) Day duty covered the period from 8 a.m. to 8 p.m. and night duty the remainder of the 24 hours. Duties on normal days and on visiting days were considered separately.

(*c*) Schedules were prepared (Appendix 5) to study the work in two rehabilitation wards, four long-stay wards in the geriatric department, and two medical wards in the main hospital, recording the following data:

(i) the staff grade doing the work
(ii) the rate of working
(iii) whether the work was done for a patient or was part of the general work of the ward
(iv) activity code
(v) the time of day, date, observer's name
(vi) the location in the ward where the work was performed (i.e. ward, side-room, kitchen, sluice room etc.)

(*d*) Five grades of ward staff were recognised: ward sister; staff nurse; student nurse, enrolled nurse (trained or in training); ward orderly and domestic. Performance rating for each staff member was assessed from the British Standard Institution scale of rating (Appendix 16).

(*e*) The categories of patients defined earlier were also coded in the schedules, because it was thought that there might be significant variations in the demands made on nursing services by patients in rehabilitation wards, compared with those in long-stay wards. However, these were not used in the subsequent analysis, because the sampling showed that the categories were only useful as a general guide to the

broad differences between rehabilitable and long-stay patients, and could not be used to analyse the finer points of nursing care amongst multiple sub-divisions of patients.

Trial studies

53. After discussion and explanation of the proposed inquiry with the senior staff of the geriatric department, the sampling began. The best pattern of study work was found to be two or three days of observation, followed by two or three days of analysis of the results. In this way, trends in the results of the studies were noticed, predictable degrees of accuracy were obtained from the main work groups, and tiring study work was relieved by the desk work of analysis.

54. After two trial studies a consistent method of observation and recording was adopted by the team, so that any member could replace another at any time, recording could continue during meal breaks, and members on duty could be reinforced at peak periods, when the maximum number of ward staff were on duty at one time.

55. Statistical analysis of preliminary observations in the same work groups on different wards showed that some outwardly similar long-stay wards were organised so very differently that they could no more be compared with each other than with rehabilitation wards. It was decided, therefore, to draw general conclusions from observations collected from all the geriatric wards, and to show the variation from an "average" ward based on these, by a series of separate investigations for both long-stay and rehabilitation wards. In this way the findings from five wards, with an approximate complement of 200 beds, gave a cross-section of "average" activity in a 40 bed ward which could be used for comparisons between different wards in the department.

Study of ward methods and equipment

56. Whilst the measurement of activities was useful in itself, the general pattern of ward work that emerged as the study progressed was equally helpful as a guide to the subsequent investigation and analysis of existing ward methods, and could be used as a basis for proposals to improve them.

57. There were wide variations in the methods used to carry out specific activities on the wards. Some made the best possible use of the modern equipment available, others, following practices more hallowed by tradition than efficiency, did not. Although it was only possible to measure and record the actual time taken over each activity, this was influenced by other factors which could not be measured and which varied with different types of activity. These factors were the physical exertion sometimes involved and the increasing need for precautions to avoid cross infection on hospital premises. Method also had an effect and when the initial work measurement was finished the team made certain special studies including some aspects of the control of cross infection, special nursing techniques related to incontinence and pressure sores, patients' dress, laundry needs, ward cleaning, kitchen routines and other miscellaneous duties. This was not a special study of the use of different types of equipment in routine ward activities, because it was assumed that this was covered by the report of the Whittington Hospital investigation, which would be published in due course. Our purpose was to determine where the methods in the wards fell short of desirable standards and what changes were necessary in the time taken for some activities, and their distribution within the day's work, in order to give the most practicable standards when drafting new work schedules. The team reviewed the methods used in those activities which occupied the greatest proportion of the ward staff's time, and gave special consideration to the points listed in Appendix 15.

CHAPTER 3

DEVELOPMENT OF THE RESULTS OF THE STUDY

Objectives

58. The information acquired from the study of ward activities was used as the basis of a new programme for ward work, to be built up in four steps:

(*a*) An improved level of nursing care, which we have called "the modified level of care", was defined in terms of the patients' needs, incorporating suggested improvements in methods, setting standard times to be given to various ward activities, and revising the frequency of performance of some activities.

(*b*) The work involved in this revised version of ward activities was then allocated to appropriate staff grades (nurses, nursing orderlies or domestics).

(*c*) The number of staff required in each grade was estimated.

(*d*) This revision of work was drawn up for each ward in a work schedule (Appendix 10).

59. It was appreciated that any change towards fixed work schedules could only be made with the co-operation of the ward sisters. Apart from the importance of the contribution they could make from their experience, and the reasons they might have for methods and timing of activities which conflicted with the objective opinions of the study team, it was necessary to explain what advantages might be gained in return for the loss of flexibility in ward management implied by a fixed programme of work.

60. The merits claimed for the schedules were these :

(*a*) Each member of the ward staff would know exactly what they were expected to do, and when to do it throughout the 24 hours.

(*b*) The work of the ward staff was to be precisely defined and set out on paper so that it could continue according to plan whether the ward sister was available to direct it or not. (This had a distinct appeal to wards where the senior trained staff, available to act as deputies for the sister, are apt to change with kaleidoscopic frequency according to needs elsewhere in the hospital.)

(*c*) A more even distribution of work over 24 hours might be arranged, to avoid excessive peaks.

(*d*) More consistency in methods and techniques in all the wards of the department might be obtained, because the sisters would have formal plans of ward work to discuss and rearrange by mutual agreement. Practical experience and teaching amongst junior staff and auxiliaries would gain more uniformity from this and, although some restriction of independent action was inevitable, the sisters would still retain their privilege of adapting the details of schedules as they thought best to meet the needs of their patients.

(*e*) It is always difficult to reconcile the sequence of ward work with the time and the staff available, and the work schedule would have to be a compromise. It seemed, however, that a compromise between the objective views of the study team with their background of orthodox nursing, and the subjective opinions of the ward sisters with their original ideas of geriatric nursing, would approximate better to the perfect ward system than the sister's intuitive approach.

(*f*) The working week for the nurses had to be altered to 44 hours, and a trial of a revised work programme was preferable to guesswork, as a means of applying the change and estimating the numbers of staff necessary in different grades.

Defining the patients' needs

61. It is recognised that the needs of the patient in the general hospital ward call for the highest standards of nursing, but this does not hold good in the minds of many people for the elderly sick in geriatric wards (paragraph 9). Having completed and analysed the studies of activities on the wards, the main task of the team was to define a standard for the level of care in geriatric wards. The standard, decided according to the needs of the patient, would determine the amount of ward work necessary and hence the number of staff required. The team arrived at the level of care finally accepted by discussing the details of their proposed standard with the staff of the geriatric department.

62. The needs of the patients were defined in terms of what had to be done (content of work), how long it took to do it (duration of work—how long it took to do each job each time it was done), and how often it had to be done (frequency of work). It is important to emphasise that it was the last factor, the frequency of work, that alone determined the level of care, because the team found it quite unnecessary to add any new activities or to prolong the duration of those in normal use on the wards.

63. It should not be assumed that the increased time allotted to the various tasks in the revised level of care in Appendix 8 is an indication that the wards were previously failing in their care of individual patients. This clearly was not so, but the compromise method used in the study of ward work had definite limitations (paragraph 50), and could not give truly representative information on each of the 82 activities, especially those which occurred with least frequency. Therefore, differences between times estimated in the original geriatric ward studies, in the general medical ward studies and in those devised for the modified level of care, should be interpreted with caution in Appendix 8.

64. The sisters willingly agreed to try out the work schedules, though they anticipated certain difficulties. The first was the problem they all shared of keeping ward staff up to the theoretical establishment; they were well aware that however difficult it had been to maintain proper standards with inadequate staff in the past, it would be much more so in the future if they were denied the flexibility in re-arrangement of duties that they formerly used to compensate for lack of staff. The sisters also observed that only

those with experience of geriatric nursing could appreciate how difficult it was to arrange set programmes of ward work for patients whose needs were so unpredictable and fluctuated so wildly from day to day or even within the same 24 hours. It might be thought that in geriatric wards a population of patients that changed so slowly, compared with those in general wards, would lend itself readily to a fixed pattern of work; in practice, however, a day without crises, or a tranquil night, in a geriatric ward was the exception, not the rule.

65. They also had misgivings about the possibility of allocating precise times in which to get all their patients up and dressed and to give the help necessary to those needing exercise, because these two activities occupied a very large part of the time available at the beginning of each day. A proposal to distribute the load over morning and afternoon was rejected because the physiotherapists and occupational therapists were only free to work with them in the mornings, being engaged with out-patients in the afternoons.

66. These reservations were considered by the study team, who went through the list of ward activities with the sisters and discussed possible improvements that had accurred to them from their observation of methods, of the sequence of ward work, and of the time devoted to some activities. Their decisions on the needs of the patient were influenced by the points discussed, in more detail, in the note on methods and equipment (Appendix 14), and agreement was reached on the sequence, the frequency, and the time allowed for activities which would serve the best interests of the patients, satisfy the aims of both study team and the ward sister, and be within the capacity of her staff.

Setting time standards

67. The time to be allowed for each activity within the modified level of care was then determined, using the information from the studies as a guide, but incorporating any changes in the frequency of activities which seemed necessary in order to effect improvements. These standards are shown in detail in Appendix 8.

Allocation of work to appropriate staff grades

68. Having settled the amount of work expected from the staff to provide an optimum level of care for the patients, it was then

necessary to distribute this work amongst the nurses, the nursing orderlies and the domestic staff. Each activity was considered separately, to reach agreement on which member or members of staff should perform it. Certain duties were appropriate for nurses, or orderlies, or domestics alone, others required two people, staff nurse and nurse, or nurse and orderly. The complete list is shown in Appendix 6, and in Appendix 8 the estimated distributions of ward work before and after the modified level of care was introduced are shown.

Preparation of work schedules

69. An example of a work schedule prepared for the day duty of a rehabilitation ward is illustrated in Appendix 10. It attempted to give as even a distribution of work as possible between day and night staff, to avoid excessive peaks of work, and to be a guide to the sister in ward organisation, not a rigid and inflexible directive. It was assumed that most ward activities would be carried out by teams of two—usually a nurse and an orderly. The nurse could be either a staff nurse or a student nurse with experience and proficiency; a less experienced nurse should work with a staff nurse or senior student. Two orderlies should never work together as a team, unsupervised.

70. Activities occurring at key times during the day (e.g. patients' meals) were entered as fixed points in the schedule and other activities were filled in around these in a compromise between the study team's and the ward sister's opinions on the most logical and practical sequence and timing.

Estimating the staff required

71. The staff required in each grade to perform the work was calculated from the set time standards and the amount of work allocated to each grade. Some slight adjustments of the work allocated to the different grades were made so that whole numbers and not fractions of staff were obtained. This calculation was made for each of the three varieties of ward—geriatric rehabilitation, geriatric long-stay and "average" geriatric ward (see paragraph, 55). The results for the two rehabilitation and five long-stay wards were combined to give the total staff needs for Wakehurst House, shown in Appendix 13.

72. The staff for Wakehurst House could vary, depending on three different circumstances:

(i) Whether the nurses worked a 96 hour fortnight or a 44 hour week.

(ii) Whether the original ("basic") or the revised ("modified") level of care was adopted.

(iii) Whether the department continued to have an average of 252 beds in use, or was extended to its maximum of 281 beds.

73. In Appendix 11 the original staff establishment is compared with the numbers required to comply with these alternatives, and the differences are illustrated graphically in Appendix 12.

If the 96 hour fortnight had been retained, it was thought that ward organisation and methods at the basic level of care could have been revised with a saving of about 9 members of ward staff (compare Stages 1 and 2).

Alternatively the 44 hour week could have been introduced with the revised basic level of care at a saving of $3\frac{1}{4}$ staff (instead of the additional $5\frac{3}{4}$ which would be expected on a pro rata basis—compare Stages 1, 2 and 4).

Improvement of standards from the basic to the modified level of care, and introducing a 44 hour week, would involve an increase of $17\frac{3}{4}$ staff: to allow for the full use of 281 beds in the department $29\frac{1}{2}$ additional staff would be required.

Table B

THE EFFECTS OF STAFF ESTABLISHMENT OF POLICY CHANGES RELATED TO THE STUDY

Stage	Change due to	Saving of Staff		Extra Staff	
		Number	Percentage	Number	Percentage
2	Revised organisation	9	−6·1	–	–
4	Introduction of 44-hour week	–	–	$5\frac{3}{4}$	+3·9
5	Raised level of patient care	–	–	$17\frac{3}{4}$	+12·1
6	Increase from 252 to 281 beds	–	–	15	+10·2
	Nett effect	–	–	$29\frac{1}{2}$	+20·1

NOTE.—Stages 4, 5 and 6, and the total effect, assume that the revised organisation is in use. Each of the extra numbers would be increased by 9 should the original method of organisation be retained. [Refer to Appendix 11 for details of the different stages.]

74. These changes are summarised in Table B, compiled from Appendix 11. The increase in staff was greater than had been anticipated at the outset of the inquiry. It had been hoped that reorganisation might bring in the 44 hour week with the existing staff, and Stage 2 of Appendix 11 suggests that theoretically this might have been possible, but the reorganisation was not attempted in practice. It was decided that the schedules of work adopted should be based on the modified level of patient care and this involved the greatest single increase needed in the numbers of staff available (12.1 per cent—Table B). Additional staff would have been required in any event, to bring the full complement of beds into use when the additional 30 beds became available in the renovated wards. The estimated number required, allowing for a 44 hour week and the modified level of care, was 15, a 10.2 per cent increase. The total effect of these changes was an increase in staff of 20.1 per cent.

Staff grades

75. The work required in hospital wards has been defined by the authors of the Nuffield Report[6] under three headings :

(*a*) Nursing—which comprises all the care given to the patients whether directly related to the treatment of their diseases or not.

(*b*) Organizational—which relates to the running of the ward.

(*c*) Domestic—which covers the cleaning and maintenance duties necessary in any inhabited building.

Nursing duties were further sub-divided into :

(i) Basic nursing which involved daily hygiene, maintaining comfort in bed, feeding the patient and elimination of body waste.

(ii) Technical nursing which included all the nursing tasks concerned with the treatment of disease.

76. Basic nursing and technical nursing in this sense correspond approximately with the "simple" nursing and "skilled" nursing defined in the Birmingham Report[8] on the care of the ageing and chronic sick.

77. The 82 activities which comprised the entire ward work of the present study were grouped under nine headings (paragraph 51 and Appendix 1) to reduce the code numbers into smaller sub-groups more easily remembered by the study team. The terms "basic" and "technical" were used for the first two of these, without direct reference to the Nuffield Report[6], and although they include some of the procedures defined under the headings given above, they do not correspond exactly, nor were they meant to do so. Basic nursing was a term used, amongst others, in the Nuffield Report, as in ours, to simplify the work study, not to define limits to the responsibilities of the nurse, and it is unfortunate that it is sometimes used in this latter sense. For example, there are those who describe the duties assigned to the enrolled nurse as basic nursing, whereas the curriculum for the Roll requires her to be proficient in many of the procedures within the Nuffield definition of technical nursing.

78. The authors of the Nuffield Report clearly supported the ideal of the unity of nursing, and we share their belief in this. The domestic work of cleaning and maintenance is a relatively clear-cut entity which can be assigned to domestic workers; nursing work, and in this we have included the organizational ward work, belongs properly to nurses. In it there is the work concerned with the health of the patient—the nursing care, which requires the attentions of the trained nurse, and the work concerned with the patient's general well-being, which we prefer to call personal service, not basic nursing. This is the care that any sick person obtains at home from relatives or attendants other than trained nurses; in hospital, however, it becomes a nursing responsibility, although the nurse may make use of auxiliary help to fulfil it. We believe that this help should be given by nursing orderlies, carefully selected and given formal in-service training. They should work with the nurses on the many ward tasks that are too much for one nurse but do not require the services of two, and some routine personal services can be delegated to them. Their help is as necessary in general hospital wards as in geriatric wards.

79. In the work schedules for Wakehurst House the activities were therefore divided amongst nurses, nursing orderlies and domestics. "Nurses" included sisters, staff nurses, student nurses

or enrolled nurses, trained or in training. The work of the domestics could not encroach on any nursing responsibilites. The work of the orderlies was less easily defined; in some tasks they helped the nurses, some they performed alone, and occasionally they helped with domestic work (e.g. collecting dishes). Similarly there was an overlap in the work of trained staff, student nurse, and orderly.

80. Apart from these factors the establishment of different staff grades were subject to certain limitations :

(*a*) *Staff nurses.* It was recognised that the ward sister should be assured of support from a reliable and experienced deputy. The number of full-time trained staff available in the hospital was limited, and increasing numbers of part-time staff nurses were being recruited. This decided the allocation to each geriatric ward of one full-time and two part-time staff nurses.

(*b*) *Student nurses or equivalent staff.* For reasons given earlier, "nurses" within this group included student nurses, and enrolled nurses, trained or in training. The number of student nurses available to the geriatric ward was limited by the demands of the training syllabus, and administrative policy precluded more than five students being allocated to each geriatric ward. The estimated need was for seven students, and the deficiency was made good by enrolled or pupil enrolled nurses.

(*c*) *Nursing orderlies.* It was proposed that work allocated to auxiliary helpers could be adjusted to employ from two to five nursing orderlies (assuming they were properly selected and trained). As it was thought that suitable nursing orderlies could be recruited more readily than nurses, the maximum number of five nursing orderlies was finally agreed. (It is interesting to note that in similar circumstances in the survey of the main hospital the choice in the 40 bed medical ward was to employ one, two or three orderlies; only one was employed, and the work theoretically available for the other two was allocated to student nurses.)

81. The allocation of staff finally decided is shown in Appendix 13 and in Table C (condensed from Appendix 11) where the staff in the wards at the start of the inquiry is compared with the recommended establishment which was intended to meet the demands of Stage 6—the nurses working to a 44 hour week, with the revised ward organisation and modified level of care, and with the full complement of 281 beds in use. It was appreciated that whilst the principles behind many of the proposed changes could be applied elsewhere, those which were most effective in Wakehurst House might not necessarily succeed in other geriatric departments; the proposals might have to be modified according to the size of other units, their ward arrangement, distribution of patients and organisation, and the influence of local geriatric services on the kind of patients admitted to the department.

Comparison of the work in geriatric and general medical wards

82. When the activity studies in Wakehurst House were completed, an indentical investigation was made of the work in a medical unit of the main hospital. The unit comprised a 40-bed male ward and a 32-bed female ward. The information was compiled and recorded as before in "ward minutes" (paragraph 54), the findings were set out alongside the original ward data for Wakehurst House (Appendix 8), and comparison of them was most instructive. Basic nursing activities were recorded as single items in the list of activities (Appendix 1), but in this list various technical activities were coded together. It is difficult therefore to compare details of technical treatment, but the broad conclusions drawn from comparison were these :

There was only one activity recorded in the general medical wards that was not being practised in the geriatric wards during the weeks of study; this was the tepid sponging that was being given in one of the medical wards to a patient with hyperpyrexia.

In general the nursing care of the geriatric patients required a higher proportion of personal service (basic nursing) and a lower proportion of technical nursing than was the experience in the medical wards. However, this does not imply that technical nursing amongst the geriatric patients was negligible;

on the contrary it was very considerable and in certain activities exceeded the amount required on the medical wards. Moreover, the times recorded for geriatric ward activities in Appendix 8 are those estimated for an "average" 40-bed ward (paragraph 55) and make no distinction between rehabilitation and long-stay wards. Therefore, the higher proportion of technical nursing practised in the rehabilitation wards was reduced in this average by the lower rate in the long-stay wards.

In the geriatric wards there appeared to be less bed-making and bed-tidying. This was probably attributable to the high proportion of the geriatric patients who were up, dressed, or sitting out in chairs. Much more attention was necessary in geriatric than in medical wards to personal hygiene (face and hand-washing, oral hygiene, bottle and bedpan rounds and bathing), and to the care of pressure areas.

The most outstanding difference between the two departments, however, was the amount of time devoted in geriatric wards to "assisting patients" which included all the attentions constantly needed (or demanded) by old people, such as lifting or changing position in bed or chair, fetching and carrying for them, finding lost property (handkerchiefs, dentures, or newspapers), and answering casual, but often necessary, calls.

There seemed to be too few water rounds on geriatric wards compared with medical wards, a difference probably more apparent than real, because particular care to avoid dehydration was standard practice with the geriatric patients. However, fluids were given out more by random attention to individuals than by the systematic rounds subsequently included in the modified level of care.

There were only two marked differences noted in technical procedures between the geriatric and medical wards. Twice as much time was given in medical wards to recording temperature, pulse, respiration and blood-pressure, to testing urine and to the administration of medicines. On the other hand, the medical wards only gave half the time devoted in the geriatric wards to dressings, changing intra-gastric tubes and catheters, giving enemata and collecting specimens. The time recorded in geriatric wards for exercising patients was not noted in the

medical wards, and there were no differences between the two in the time required for preparation and clearing of trolleys or other technical procedures common to both.

Feeding the patients (i.e. attending those unable to feed themselves) was a much heavier commitment amongst the geriatric patients, and the responsibility it involved with the high proportion in acute or terminal illness was equivalent to a technical nursing procedure. Geriatric patients also required a higher proportion of special diets than were issued in the medical wards.

83. The impression gained by the study team was that nursing work in geriatric wards exceeded in quantity, and equalled in quality, the work of the nurse in the medical wards, and they were interested to note that precisely the same time was given to clinical teaching of bedside nursing in both departments.

Table C

STAFF AT POST FOR A 40-BED WARD IN WAKEHURST HOUSE AT THE START OF THE INQUIRY COMPARED WITH STAFF RECOMMENDED FROM THE STUDY

Type of Duty	Stage	Sister	Staff Nurse*		Student S.E.A.N. or P.A.N.	Orderly	Domestic
			Full Time	Part Time			
Day Duty	At start of inquiry	1	1 or 2	1 or 2	5	4	3
	Proposed for rehabilitation ward	1	1	3	7	5	3†
	Proposed for long-stay ward	1	1	2	7	5	3†
Night Duty	At start of enquiry	–	1	–	1	1	–
	Proposed for all wards	–	1	–	1	1	–

* A part-time staff nurse works approximately three-quarters of the hours of a full-time staff nurse.

† Domestic staff was reduced to 2, with a relief on days off, equivalent to a total of 2½. In practice, however, this proved to be inadequate and 3 domestics were required on each ward.

CHAPTER 4

SUMMARY OF RESULTS AND COMMENTS ON REVISED WARD ORGANISATION

Summary of the study

84. The stages of the inquiry and the conclusions which influenced the new work schedules applied to the wards, were these:

(*a*) The information obtained from observation of geriatric ward activities and methods was used, after discussion with the ward sisters, to define the needs of the patients, in terms of the content, duration and frequency of work (paragraph 62).

(*b*) A revised or "modified" level of patient care was planned, incorporating suggested improvements in methods, setting standard times for ward activities, and changing the frequency of performance of some activities (paragraphs 58—63 and Appendix 8).

(*c*) Work schedules were prepared, at the modified level of care, allocating duties to the appropriate staff grades on the basis of a 44 hour week for nurses, and with the full bed complement of the department in use (paragraphs 68-81).

(*d*) The study team found that the care of the patients on geriatric wards involved more nursing, in its true sense, than the care of patients in two general medical wards (paragraphs 82-83). The proportion of personal service, or basic nursing (in the sense defined in the Nuffield report)[6], appeared to be greater, and of technical nursing less, in the geriatric wards than in general medical wards; this was probably more true of the work in the long-stay wards than of the rehabilitation wards, and some technical

nursing procedures were more extensively used in the geriatric wards than in medical wards.

(*e*) The study team found no reason to recommend any new activities, or to abandon any of those in use on the wards. The kind of nursing care the patients needed was being given, but some activities were performed less frequently than was thought desirable, the reason being that the wards had not enough staff to do the necessary work.

(*f*) Some improvement might have been made by re-allocation of duties between nurses, nursing orderlies and domestic staff, and by some changes in methods; but this reorganisation could not have increased the frequency of some necessary tasks to the level of care considered desirable, introduced the 44 hour week, and made use of the full bed complement. An increase in staff was necessary to fulfil these conditions.

(*g*) The kind of staff needed, and the duties required of them, were more clearly defined as a result of the work study than would have been possible without it.

(*h*) The work in the wards comprised:

(i) *Nursing work*—which included ward organisation, technical nursing procedures, and personal service to the patient. These were considered to be the responsibilities of the nursing staff, who performed the duties at different levels of responsibility either alone, in pairs, or with auxiliary help. It was thought that this auxiliary help should be given by trained nursing orderlies who should always work under supervision, and who should be paired with proficient nurses in a team, not with another orderly.

(ii) *Domestic work*—ward maintenance and cleaning. This should be the duty of domestic staff, also trained, and helped in some tasks by nursing orderlies.

(*i*) The recommended staff for a 40-bed geriatric ward was one sister, one full-time and two part-time staff nurses, (three in rehabilitation wards), seven nurses (five student, two enrolled or pupil-enrolled nurses), five orderlies, and three domestics (Table C: Appendix 13).

(*j*) The nursing establishment of the hospital could only be built up gradually, bringing the new staff ratios, and the 44 hour week to one ward at a time. There were delays for other reasons, but by February the new work schedules had been introduced on six wards—on two for about ten weeks, and on the most recent wards for less than a fortnight. A longer period of trial in the whole department would have been preferred, but the estimate of time for the study had already been exceeded, and the ward sisters had to be asked for their comments at this stage to conclude this report.

Comments from discussion with the ward sisters

85. Ward organisation reflects the experience, the qualities and the administrative ability of the sister-in-charge, and her staff become accustomed to the system of work she prefers, more by precept and practice than by a programme committed to paper. The atmosphere and the nursing routines practised in the geriatric wards were the product of the initiative and ability of the ward sisters, who had found that, in order to provide proper standards of care for the aged sick, they were obliged to add various original expedients to the principles of good nursing accepted elsewhere. Their established order may well have earned the description they gave it of "organised chaos", when hard-pressed by staff shortage from time to time, but since 1948 it had proved its worth beyond any doubt.

86. These sisters accepted the activity study with goodwill. If their co-operation was tempered with reservations, it was because of the healthy scepticism natural to senior nurses, who had given much of their professional lives to develop a system of nursing which was seldom understood outside their own immediate circle and wards. They supported this inquiry because they knew that their work would stand on its merits, and because they believed that the study could no nothing but good, if only to promote a wider knowledge in their profession of the proficiency in good nursing, and the ability, required of staff in charge of the elderly sick.

87. The sisters viewed the revised ward organisation with mixed feelings. They realised that in drafting the work schedules the study team had been instructed to avoid split-shifts in the arrange-

ment of off-duty for nurses within the 44 hour week, and that the timing, frequency, and sequence of ward activities had to comply with the level of patient care agreed in preliminary discussions. There were distinct limits to the latitude the study team could allow the sisters in such schedules and, when presented with them, the sisters admitted that they could not have done better themselves. They were reluctant to comment on the trial period because it had been so short, and because, owing to winter ailments and reactions to vaccination amongst the staff, none of the wards had ever had its full establishment at work for more than a week. However, the following observations were elicited.

88. The virtues of the straight-shift system of fixed off-duty as an attraction to part-time staff were acknowledged, but it was not conceded that all nurses necessarily welcomed it, and the consequent loss of flexibility in ward administration was regretted. This should not be interpreted as a reactionary desire on the part of the sisters to exploit their juniors to suit their own convenience. The rearrangement of duties to cover ward emergencies caused by the unpredictable vagaries of the aged patient, or by sickness amongst the staff, was no longer possible with a fixed duty rota and no reserve pool of staff to draw upon.

89. This loss of flexibility was also felt when organising the day's work. It was realised that the work schedules were intended as a guide towards this, but the ward sisters and the study team found it difficult to reconcile the revised hours of duty for staff, and the ward routine, because the ward work was so heavy in the mornings. There were two reasons for this; first, because all but a few of the 40 patients needed help to get up and to dress for the hours they spent out of bed each day, and secondly, because many of the patients, especially in rehabilitation wards, needed supervision in exercises which the physiotherapists alone could not give them. The sisters found that they had too few staff available in the morning, and too many in the afternoon, especially on visiting days, and on Sundays. The suggestion that some of this work should be deferred until the afternoon was countered by the arguments that the patients preferred to be up in the mornings and objected to being deprived of a post-prandial nap in the afternoon; that they were easier to supervise when up, fed themselves

better, did not slop their food as much, and were less often incontinent. As one sister explained, "the patients find it a very long day if left in bed during the morning and they are as cross as badgers at the end of it". Apart from the increased risk of pressure sores, more time was lost in changing the beds of those who were incontinent than was gained by denying them their clothes and a comfortable chair in the mornings. Finally, the staff themselves were fresher, "better able for the heavier work", and keen to get through it early in the day.

90. The sisters also observed that unpredictable "miscellaneous activity" was spread over the whole day and night in geriatric wards, and it was most difficult to adhere to a set pattern of work with patients who were quite unable to conform to it. "Old people spill, lose, or want things far more than the patients in general wards".

91. The rearrangement of night duty came under heavy fire. The former night staff, consisting of one staff nurse or senior nurse, a junior nurse and one orderly, had thrown too much routine work on the senior member at the expense of the time available to her for supervision. Even with the reorganised work schedule the staff nurse was beset by exertions, mental as well as physical, which could not have been recorded in the objective study of her activities (paragraph 12). The Matron endeavoured to remedy this by allocating to the staff-nurse responsibility for two 40-bed wards, one with a nurse and two orderlies, the other with two nurses and an orderly; the staff nurse would have responsibility appropriate to her training and experience and could deploy staff to meet troubles as they arose in either ward. In practice, however, it seemed that 80 beds were too many for one staff nurse to supervise effectively at night, unless she had exceptional ability and stamina, and reconsideration of this arrangement was requested. Some further observations from an experienced Night Sister, indicating how the experimental night staff work in practice, are given in Appendix 14.

92. The sisters were also conscious of the fact that the efficiency of their ward management had always hinged upon the student nurse, and although their staff/patient ratios were better, the gain was relatively greater in the long-stay wards than in the rehabilita-

tion wards, and it was made mainly with part-time trained staff and nursing orderlies. The number of student nurses remained the same as it had been for many years on the long-stay wards, and was actually reduced on the rehabilitation wards. The enrolled nurses to make good the deficiency were not forthcoming. The part-time staff nurses were most welcome and many of them, returning to nursing after some years away from it, warmed to the changed work in the wards which they had known under very different conditions in the past. The sisters emphasised, however, that for deputies they were dependent on the more consistent services of the full-time staff nurse, who needed to be posted to the wards for four months at least so as to be fully conversant with her work and responsibilities. It was also observed that the balance of the work would be upset, and standards would fall, if the establishment of nursing orderlies was exceeded (paragraph 36), and that the sooner formal training for them, and for the domestics, was introduced, the better.

93. Despite their criticism, the ward sisters recognised the value of the more uniform system of ward organisation in the department made possible by the work study. The value of a set programme of work for individual wards, available to the sister's deputy and staff in her absence, was also acknowledged, with the reservations mentioned earlier. These were the limited capacity of elderly patients to conform to a set pattern, and the ability, training and experience of the senior nurse in charge and of the other members of staff, particularly the nursing orderlies. In the long run it was more the willingness and proficiency of individual members of staff, than the work schedule, that would determine the level of nursing in the ward. The sisters had settled down to adapt themselves to yet another change, and to hammer out another compromise. They trusted that this would be founded on the established facts, and that they had the assurance of the quality, grades and numbers of necessary staff, estimated from the results of the inquiry, to maintain the best standards of care for their patients.

CHAPTER 5

POLICY IN GERIATRIC NURSING — THE PAST AND THE FUTURE

94. Many hospitals in the National Health Service have not enough trained nurses, and "crisis in nursing" has been much discussed recently. This is not new or strange. There have always been hospitals short of staff, but the shortage has not always been assessed by the same criteria because opinion on the number of staff necessary is influenced by, amongst other things, the quality of service, the standards of proficiency required of the staff, and their working conditions. As for crisis, one contributor to the *Nursing Times* aptly remarked "which crisis"?, implying that the profession has never been without one. Since training was introduced by Florence Nightingale in 1860 the supply of trained nurses has never kept pace with the development of hospital services, and the infirmaries always felt the pinch most. There were good reasons for this.

95. Hospitals were once refuges for the sick poor. Prosperous people, when ill, could depend on relatives or paid helpers to nurse them, and every woman was potentially a nurse in the sense defined by Florence Nightingale—she might be called upon at any time to take charge of the personal health of another.

96. Until the middle of the nineteenth century no formal training was thought necessary for a nurse. Families employed "handy-women" in an emergency on the same basis as domestics, and women were employed in a similar capacity to look after the sick in the infirmaries. Training became necessary as demands on hospitals increased in the latter half of the century, and as new nursing techniques and ideals developed from the Nightingale

reforms, to accompany progress in medical care, and replace the old haphazard methods.

97. The trained nurse naturally evolved in hospital, where the opportunity to learn and the need for her services was greatest. Progress, though slow, leapt forward in the larger voluntary hospitals, compared with that in the Poor Law infirmaries and smaller institutions. The voluntary hospitals commanded prestige, status through association with the leaders of the medical profession, and prospects of promotion. Many of them had traditions of medical teaching, and they had the appeal of varied activity and interest in wards which concentrated on the care of acute illness and resisted the admission of the aged and chronic sick, who might occupy beds too long. Staffing presented no problem to these progressive hospitals, and nursing at every level could be delegated to educated, well-trained nurses attracted to them by their reputations, attractive locations, good working conditions, marital opportunities and popular matrons. By the end of the First World War nursing had attained the dignity of a profession for these women, assured in their vocation by Royal Charter and then by state registration in 1919.

98. Progress in the infirmaries, on the other hand, was bedevilled by impediments aptly described as "the severe obstacles to improvement of curative services in any establishment which is primarily intended to be a deterrent"[9]. The Commissioners responsible for the Poor Law amendment in 1834 wished to dissociate the care of sick persons from the repressive legislation thought appropriate for paupers, but more often than not the victims of destitution, whether sick or well, abled-bodied or infirm, young or old, were bundled into congested workhouse wards under a primitive system of custodial care which has since become notorious. The sick received attention, by rough and ready methods, from employees comparable to the untrained handywomen, and similarly inured to hard living. They were helped by pauper assistants recruited from the workhouse. Being rate-aided institutions, opposition to staff training and reforms was stronger than that encountered in the voluntary hospitals. Rathbone and Florence Nightingale devised the appointment to the Liverpool Workhouse Infirmary in 1865 of Agnes Jones, who showed the economy and worth of properly selected and trained staff in such

institutions, but even as late as 1909 the Minority Report of the Royal Commission on the Poor Law could state that:

> "in spite of all the efforts of the Local Government Board which have, in the past two decades, effected great improvements, there are still many rural workhouses without even one trained nurse, still scores in which there is absolutely no nurse, trained or untrained, available for night duty; there are even some, so far as we can ascertain, in which there is no sort of salaried nurse at all. Everywhere the Master and Matron have still to employ pauper assistants to help in attending the sick."

99. Trained staff from the voluntary hospitals were unwilling to accept such conditions; anyway most of them were absorbed by these hospitals, by services outside hospitals or by private nursing. In some large infirmaries the wealthier local authorities introduced training schools, and although their probationers were considered to be, and indeed often were, the social inferiors of those in the voluntary hospitals, they were excellent nurses. In general, however, staff deficiencies in the Poor Law infirmaries continued to be made good by unqualified, untrained auxiliaries who gradually replaced the pauper assistants.

100. Present difficulties in recruiting and retaining women in nursing may be attributed to the attraction of rival occupations, to the limits on the number of girls of suitable age and educational attainment available, to the expansion of hospital and other medical services, to the increased staff establishments made necessary by better terms of employment in hospitals, and to the deterrent effects of years of exploitation of the nursing profession. But these factors alone do not entirely explain why there have always been too few nurses, especially in the years between the wars, when the relationship between their earnings and onerous duties meant even less than it does now to women who are primarly attracted to their profession by a sense of vocation. The explanation lay in the unrealistic policies of their leaders in nursing. They failed to face the facts that too few girls, able or willing to attain the standards of proficiency for State registration, were coming forward to meet national needs; that the main need came from the infirmaries and smaller hospitals; that these needs arose from a growing burden of long-term illness attributable to old age and degenerative disease; and that the problem of provid-

ing a standard of nursing for these invalids, comparable to rising standards elsewhere, was intensified by policies that excluded these patients and their nurses from the centres where real progress was being made—the general wards of the hospitals.

101. These policies arose from the belief that old people with long-term illness, and the chronic sick, did not need the services of the State registered nurse. It was thought that "a little training would go a long way" with such patients, and that the trained nurse, in looking after them, would be denied the opportunity to use the skills and ability required of her in the voluntary hospitals. This thinking determined a wretched fate for hundreds of elderly invalids throughout the country, perpetuated the miserable pattern of custodial care, instead of nursing, which was thought adequate for them, and created the paradoxes that the patients condemned to spend the most time in hospital had to endure privation and the least attractive conditions, and that many of those whose need for good nursing (as distinct from personal service) was greatest were denied it. Even when control of the infirmaries passed to the County Councils by the Local Government Act in 1930, which empowered them to bring their institutions more into line with modern hospital practice, the customary opposition of the voluntary hospitals to the admission of patients with long-term illnesses was adopted in the modernised wards, and such patients were relegated to neglected backwaters to stagnate under conditions no more attractive to nurses than before.

102. The nursing profession had to decide whether to stand by the Nightingale concept of the unity of nursing and, by accepting less stringent tests than those they had devised for entry and qualification, draw upon a wider range of recruits to the register, or to recognise another nursing grade and introduce training for women anxious to nurse but unwilling or unable to qualify for the register. The leading nurses were faced with an unhappy dilemma, and it would be interesting to know how many of those who were called upon to resolve the problem had every nursed, much less trained, in the hospitals where the shortage of trained staff was felt most. They never reached a decision, and it was finally made for them in 1943 by the Nurses' Bill, which implemented the recommendations of the Athlone Committee and established the Roll for assistant nurses.

103. This plan, however, carried the seeds of its own defeat in the compulsory link between the assistant nurse grade and the chronic sick. This virtually excluded patient and nurse from the general wards of hospitals. The sense of discrimination and other difficulties this arrangement entailed must have biased recruitment, and the plan never fulfilled the hopes based on it. Unqualified untrained personnel continued to fill the vacancies in hospital staffs, and in 1955 yet another grade, the nursing auxiliary, was recognised by the Whitley Council, and accepted by the profession without dissent, and evidently without much practical interest. Although the General Nursing Council insists that instruction in the proper performance of basic nursing techniques is an essential part of the training of a student nurse, thousands of nursing auxiliaries perform such duties in our hospitals to this day without this formal training.

104. It would seem that former administrative and medical attitudes towards the care of the aged and the chronic sick dictated corresponding policies in nursing, and dissociated the nursing needs of these patients from those of sick people in general. Legacies from these attitudes are perpetuated in attempts to make "geriatric" synonymous with "chronic sick", and in the belief that chronic sick beds in a hospital have an adverse effect on recruitment. This bogey would soon be laid if nurses in all hospitals were responsible for some of these patients, and were encouraged to regard their work with them, not as drudgery, but as the privilege it is under proper conditions. What influence, if any, are the medical and administrative changes, responsible for the development of geriatric departments, to have on nursing policy in the future?

105. It is fallacious to believe that in geriatric nursing there is a wide field of opportunity for a secondary grade of nurse. When the grade of enrolled nurse is criticised, the criticism is often taken to be directed at the nurse herself, and this error gives rise to many mis-conceptions about her duties and her future in the hospital service. The resource, ability, and devoted work of enrolled nurses is universally admired, but it is irrelevant to quote these qualities of the individual nurse in defence of a legislative expedient which misused them.

106. What is wrong with the enrolled nurse grade is that it presupposes different standards of nursing for different patients.

Patients may be "graded" according to individual need, determined by their illness, the disability it causes, and their social circumstances. If assessment of these indicates simply a need for food, shelter and domestic attention, these may be given under some roof other than a hospital. But if the assessment indicates a need for hospital care the only standard of nursing offered there should be the standard set by the best of our hospitals. There are precious few old people in modern hospitals, including the geriatric wards, who do not need such nursing. For this reason we have adhered throughout this report to a concept of unified nursing, acknowledging the authority, clinical experience and administrative responsibility required of the ward sister, the experience and ability required of the trained staff, and including the enrolled nurse, pupil or trained, with the student nurse in the allocation of nursing duties. With the help of nursing orderlies these nurses unite to set a uniform standard of nursing care in the ward.

107. Geriatric departments differ from general hospital wards in that responsibility is accepted both for the patients who respond to treatment and are restored to activity, and for those who do not, and who must remain in hospital for long-stay, or terminal, care. The nursing required by one group may be described as active, and by the other as passive, but both need good nursing from the same kind of nurse.

108. In Wakehurst House both groups of patients are nursed in the ward unit, though segregated from one another. This seems to be the only plan likely to provide staff to nurse the aged sick in the future. The move towards improved and more uniform standards in hospitals cannot by-pass the homeless incurable invalids. Well-intentioned schemes to house them in isolated hospital blocks will no more provide the care they need than did the workhouse wards, because the qualified nurse, who alone can give it, will not go to them. Nor can geriatric departments cope with the entire burden of long-stay nursing if they are to avoid the reputation of the old chronic wards and constant staff problems. The geriatric wards must accept high proportions of chronic invalids because so many elderly patients admitted to them fail to respond to treatment. General hospital wards could be redesigned to accommodate a proportion of long-stay invalids, smaller that that in the geriatric

wards. This might do more than anything else to restore a proper sense of values relating to the nursing of old people and chronic invalids, among nurses in general.

109. In this study we set out to examine the day-to-day duties of the staff in geriatric wards, to see how they met the needs of the patients, and to compare them with those in general medical wards. It seems, from our results, that although there is some bias towards more technical nursing in our medical wards, and towards more personal service or basic nursing in our geriatric wards, the differences are not striking. In wards of comparable size the main difference could conveniently be expressed as equivalent to the amount of work appropriate to nursing orderlies; the 40-bed geriatric ward can employ five, the equivalent medical ward, three. The comparison of activities in these wards suggests that the work of nurses in all hospital wards could be used to better advantage if coupled with the help of appropriate numbers of trained nursing orderlies.

110. We can see no more need to have two streams of training to provide nurses for these two kinds of wards than there would be for two streams of medical training. Most nursing is straightforward work which calls for the proficiency of the good general practitioner in nursing. It is no less dignified or less important, whether practised in general or geriatric wards, than the work at the top of the profession, open to those with talent and desire to acquire skill in administration, teaching or specialised clinical nursing.

111. We believe that many difficulties in the hospital service, particularly some of those relating to the recruitment of nurses, would be solved if geriatric nursing were given proper recognition by the nursing profession, if it were included in the curriculum for student nurse training, and if clinical teaching and the practice of it, were accepted as at least a part of the medical nursing experience required for state registration. The importance of medical care to ensure treatment based on accurate diagnosis for the elderly sick is unquestioned, but the importance to them of good standards of nursing is infinitely greater.

Appendix 1

LIST OF WARD ACTIVITIES

1. BASIC
   - (a) Bed making
   - (b) Bed tidying
   - (c) Bedpans: urinals
   - (d) Admission and discharge of patient
   - (e) Last offices
   - (f) Blanket bath
   - (g) Pressure points
   - (h) Dressing or undressing patient
   - (i) Bathing in bathroom
   - (j) Washing, brushing teeth and hair
   - (k) Transporting patient to and from the toilet
   - (l) Assisting patient

2. TECHNICAL
   - (a) Pre and post-operative care
   - (b) Temperature, pulse, blood pressure, fluid balance
   - (c) Dressings, specimens, catheters, passing tubes, enemas, suppositories, tube feeding
   - (d) Local treatment, injections, drugs, O_2, medicines, taking blood, E.S.R.
   - (e) Preparing and clearing trollies, pharmacy baskets, checking drugs
   - (f) Attend or assist medical staff
   - (g) X-rays—portable
   - (h) Packing drums
   - (i) Weighing patients
   - (j) Testing urines
   - (k) Exercising patient, A. Bed-end exercises, slings and springs, splints
   - (l) Exercising patient, B. Walking
   - (m) Tepid sponging
   - (n) Special appliances
   - (o) Specialling patient

3. DIETARY WORK (Non-Technical)
   (a) Preparation of food and drink—giving out cutlery, delft, etc.
   (b) Distribution of food and drink
   (c) Collection of dishes and trays
   (d) Feeding patients
   (e) Water rounds
   (f) Preparation of meals for staff

3. DIETARY WORK (Technical)
   (k) Collection of special diets
   (l) Preparation of special diets, i.e. diabetics, etc.
   (m) Distribution of special diets

4. DOMESTIC
   (a) Brushing or vacuuming floors
   (b) Washing and polishing floors
   (c) Washing basins, sinks, baths and toilets
   (d) Cleaning ward equipment, i.e. trolleys, bowls, syringes, etc.
   (e) Wash, brush or tidy kitchen
   (f) Wash, brush or tidy linen room and sluice room
   (g) Wash dishes
   (h) Dry dishes
   (i) Clean medicine cupboard
   (j) Collecting, sorting, checking and storing linen (laundry in)
   (k) Handling soiled linen (laundry out)
   (l) Checking or sorting linen for sewing room (sending or receiving)
   (m) Clean (dust or wash) walls, windows, lights, curtain rails and blinds
   (n) Sterilizer
   (o) Hanging cubicle curtains
   (p) Get crockery replacements from store
   (q) Collect sputum cartons
   (r) Tidying ward, washing and dusting furniture, e.g. tables, lockers, bedheads
   (s) Arranging flowers

5. CLERICAL
   (a) Preparing patients charts; charting (T.P.R's, fluid balance)
   (b) Send for W.L. patients, write up admission and discharge, i.e. Ward Admission Book
   (c) Daily bed state
   (d) Reports—staff and shift report, accident form, laboratory forms
   (e) Nurses' duties and rotas
   (f) Requisitioning pharmacy, special diets, meals, cleaning materials, dressings, maintenance of equipment
   (g) Checking and handing over drugs, D.D.A. book
   (h) Requisitioning and checking dirty laundry
   (i) Recording fire roll, religion roll

6. TEACHING
   (a) Formal talks, practical demonstrations, marking schedule
   (b) Student receiving formal talks, practical demonstrations, having schedule marked

7. HUMAN RELATIONS
   (a) Instruct, direct, praise or reprimand staff
   (b) Students receiving (a) above
   (c) Relationships with patients
   (d) Relationships with relatives
   (e) Communications with other hospital personnel
   (f) Health education—patient or relative
   (g) Communications with health visitors, clergy, etc.
   (h) Telephone

8. ABSENCE FROM WARD UNIT
   (a) Visits to X-ray
   (b) Visits to Physiotherapy and other departments
   (c) Meals
   (d) Personal
   (e) Off-duty

9. UNPRODUCTIVE
   (a) Walking within ward when not actively engaged on any of the above activities
   (b) Unoccupied
   (c) Tea break

Appendix 2

CODING OF PATIENT CATEGORIES

Category	Degree of ability or condition
Walking	Can walk unaided; can dress self
Semi-ambulant	Can walk with assistance; can dress self with or without assistance
Chairfast	Can be assisted to chair; may need help with dressing
Bedfast	Confined to bed; cannot dress self
Acutely ill	Confined to bed, cannot dress self, and acutely ill
Continent	Having voluntary control
Incontinent	Having less than complete control
Mentally normal	Normal comprehension and behaviour
Mentally confused	Irrational behaviour, disorientation etc.
Self feeding	Feeds self (even if supervision necessary)
Needs feeding	Unable to make any effort to feed self, or to reach for drinks

Appendix 3

WARD POPULATION IN WAKEHURST HOUSE BY PATIENT CATEGORIES ON 5th SEPTEMBER, 1961

Index	Continency	Mental State	Feeding	Ward Number 1	3	5	7	2	4	6	Total
	Walking										
11	C	N	S	–	1	–	2	3	–	1	7
12	I	N	S	–	–	–	–	–	–	–	–
13	C	C	S	–	–	–	1	–	–	1	2
14	I	C	S	–	–	–	–	–	–	–	–
15	C	N	F	–	–	–	–	–	–	–	–
16	I	N	F	–	–	–	–	–	–	–	–
17	C	C	F	–	–	–	–	–	–	–	–
18	I	C	F	–	–	–	–	–	–	–	–
	Semi-Ambulant										
21	C	N	S	–	4	2	2	11	10	6	35
22	I	N	S	2	–	2	–	4	–	3	11
23	C	C	S	1	3	–	–	–	–	1	5
24	I	C	S	–	2	3	1	4	1	3	14
25	C	N	F	1	–	–	2	–	–	–	3
26	I	N	F	–	–	–	–	–	–	–	–
27	C	C	F	–	–	–	–	–	–	–	–
28	I	C	F	–	–	1	–	–	–	–	1
	Acutely Ill										
31	C	N	S	1	–	1	–	1	3	1	7
32	I	N	S	–	–	–	–	–	1	–	1
33	C	C	S	–	–	–	–	–	–	–	–
34	I	C	S	1	–	1	–	–	–	–	2
35	C	N	F	–	–	–	–	–	–	–	–
36	I	N	F	1	–	–	–	–	–	1	2
37	C	C	F	–	–	–	–	1	–	1	2
38	I	C	F	4	–	1	1	1	3	3	13

Index	Continency	Mental State	Feeding	Ward Number 1	3	5	7	2	4	6	Total
	Chairfast										
41	C	N	S	2	3	4	14	1	4	3	31
42	I	N	S	4	2	4	3	6	–	3	22
43	C	C	S	1	–	1	–	–	–	–	2
44	I	C	S	4	9	4	1	3	10	1	32
45	C	N	F	–	–	1	1	–	–	1	3
46	I	N	F	–	–	–	1	–	1	3	5
47	C	C	F	–	–	–	–	1	–	–	1
48	I	C	F	4	10	10	8	–	5	1	38
	Bedfast										
51	C	N	S	–	1	1	–	–	–	–	2
52	I	N	S	1	–	1	–	–	–	–	2
53	C	C	S	–	–	–	–	–	–	–	–
54	I	C	S	–	–	–	–	–	–	–	–
55	C	N	F	–	–	–	–	–	–	1	1
56	I	N	F	–	1	–	–	1	–	–	2
57	C	C	F	–	–	–	–	–	–	–	–
58	I	C	F	–	1	1	–	2	–	–	4
Total				27	37	38	37	39	38	34	250
Percentage of long-stay patients in ward				86	94	97	89	55	50	65	–

Coding: Continency: C = Continent
I = Incontinent

Mental State: N = Normal
C = Confused

Feeding: S = Self Feeding
N = Needs Feeding

OBSERVATION SHEET FOR SAMPLING STUDIES

Column codes: 1a b c d e f g h i j k l m n 2a b c d e f g h i j k l m n o p 3a b c d e f g h i j k l m n 4a b c d e f g h i j k l m n o p q r s 5a b c d e f g h i

Right-hand codes: j k l m 6a b c d e f 7a b c d e f g h i j k l 8a b c d e f g h i j 9a b c d e

NAME	
	TIME
	ACTIVITY
	RATING
	LOCATION

REMARKS

Admissions		Discharges		Staff Grade		Date		Vis.	
S. Ill C.		S. Ill I.C.		Mins. on Duty		Ward No.		Sun.	
Ill		Ambulant		Code List		Sheet No.		Nor.	

Appendix 5

SCHEDULE OF SAMPLING STUDIES

Study Serial No.	Wakehurst Ward No.	General Ward No.	Type of Study
1	4		Normal day
2	1		Normal day
3	1		Night
4	4		Night
5	4		Visiting day
6	5		Normal day
7	2		Normal day
8	1		Visiting day
9	3		Normal day
10	2		Night
11	5		Night
12	6		Night
13	5		Visiting day
14		14	Night
15	2		Visiting day
16		14	Normal day
17		14	Visiting day
18		8	Visiting day
19		8	Normal day
20		8	Night

Appendix 6

ALLOCATION OF WARD ACTIVITIES TO STAFF GRADES

Percentage of all work allocated to each staff grade (day duty)

Activity Code	Ward Staff				
	Sister	S. Nurse	Student	Orderly	Domestic
1 (a)	–	10	50	40	–
(b)	–	–	50	50	–
(c)	–	–	55	45	–
(d)	25	25	40	10	–
(e)	–	50	50	–	–
(f)	–	15	40	45	–
(g)	–	15	40	45	–
(h)	–	10	40	50	–
(i)	–	10	40	50	–
(j)	–	–	100	–	–
(k)	–	–	50	50	–
(l)	5	5	80	10	–
2 (a)	10	45	45	–	–
(b)	–	25	75	–	–
(c)	–	50	50	–	–
(d)	–	50	50	–	–
(e)	–	20	80	–	–
(f)	60	30	10	–	–
(g)	–	–	100	–	–
(h)	–	–	10	90	–
(i)	–	–	50	50	–
(j)	–	25	75	–	–
(k)	–	50	50	–	–
(l)	–	25	45	30	–
(m)	–	25	75	–	–
(n)	–	75	25	–	–
(o)	–	25	75	–	–
3 (a)	–	–	–	100	–
(b)	8	16	40	36	–
(c)	–	–	–	–	100
(d)	–	10	50	40	–
(e)	–	–	–	100*	–
(f)	–	–	–	100	–
(k)	–	–	–	–	–†
(l)	–	50	50	–	–
(m)	–	50	50	–	–

Activity Code	Ward Staff				
	Sister	S. Nurse	Student	Orderly	Domestic
4 (a)	–	–	–	–	100
(b)	–	–	–	–	100
(c)	–	–	–	–	100
(d)	–	–	–	100	–
(e)	–	–	–	–	100
(f)	–	–	–	–	100
(g)	–	–	–	–	100
(h)	–	–	–	–	100
(i)	–	–	100	–	–
(j)	–	–	–	100	–
(k)	–	–	–	100	–
(l)	–	–	–	100	–
(m)	–	–	–	–	100
(n)	–	–	–	100	–
(o)	–	–	–	50	50
(p)	–	–	–	–	–†
(q)	–	–	–	100	–
(r)	–	–	–	100	–
(s)	–	–	–	100	–
5 (a)	25	50	25	–	–
(b)	50	50	–	–	–
(c)	90	10	–	–	–
(d)	50	50	–	–	–
(e)	100	–	–	–	–
(f)	90	10	–	–	–
(g)	50	50	–	–	–
(h)	–	–	–	–	–
(i)	–	–	–	–	–
6 (a)	50	50	–	–	–
(b)	–	–	100	–	–
7 (a)	50	50	–	–	–
(b)	–	5	55	20	20
(c)	20	20	35	25	–
(d)	50	50	–	–	–
(e)	75	25	–	–	–
(f)	75	25	–	–	–
(g)	50	50	–	–	–
(h)	50	25	25	–	–
8 (a)	–	–	–	100	–
(b)	–	–	–	100	–

NOTES.— (i) For the full list of activity codes, refer to Appendix 1.

(ii) • = under supervision.

(iii) † = by Porter.

(iv) The remaining activities cannot be allocated to individual staff grades.

Appendix 7

REVISED DUTY ROTA FOR 44-HOUR WEEK

ON DUTY ROTA FOR ONE WEEK

WAKEHURST HOUSE — WARD NO.....

WEEK COMMENCING.....

NURSING STAFF

Grade Name	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Student	8–6	1–8.15	8–12.30	DAY	1–8.15	8–6	8–8.15
Student	1–8.15	8–6	8–8.15	8–12.30	DAY	1–8.15	8–6
Student	DAY	1–8.15	8–6	1–8.15	8–8.15	8–6	8–12.30
Staff Nurse	1–8.15	8–8.15	8–6	8–12.30	DAY	1–8.15	8–6
Sister	8–12.30	DAY	1–8.15	8–6	8–6	8–8.15	1–8.15
Student	1–8.15	8–6	1–8.15	8–8.15	8–6	8–12.30	DAY
Student	8–8.15	8–6	8–6	1–8.15	8–12.30	DAY	1–8.15
Student	8–12.30	DAY	1–8.15	8–6	1–8.15	8–8.15	8–6
Student	8–6	8–12.30	DAY	1–8.15	8–8.15	8–6	1–8.15
No. of F.T. Nursing Staff on duty	M. A. E. 5 5 4	M. A. E. 5 5 3	M. A. E. 5 6 4	M.A.E. 5 5 4	M. A. E. 5 4 4	M. A. E. 6 5 4	M. A. E. 5 6 4

PART-TIME STAFF NURSES

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Staff Nurse	8–1	1–8	8–1	1–8	8–1	DAY	1–8
Staff Nurse	1–8	8–1	1–8	8–1	1.15–8.15	8–1	DAY
Staff Nurse	8–1	1–8	8–1	1–8	8–1	DAY	1–8

ORDERLIES

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Orderly	8–12.30	8–5	8–5	8–5	8–5	DAY	10–7
Orderly	8–5	8–5	8–5	8–5.30	8–5	8–12	DAY
Orderly	8–5	8–12.30	DAY	8–5	10–7	8–5	8–5
Orderly	10–7	10–7	10–7	10–7	8–12.30	10–7	DAY
Orderly	8–5	8–5	8–5	8–12.30	8–5	8–5	DAY

TOTAL NO. OF STAFF ON DUTY

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Trained Staff	M. A. E. 3 2 2	M. A. E. 2 2 3	M. A. E. 3 3 2	M. A. E. 3 3 2	M. A. E. 3 2 1	M. A. E. 2 1 2	M. A. E. 1 4 3
Students	4 4 3	4 5 2	4 4 3	3 4 4	4 3 4	5 4 2	4 4 3
After 10 a.m. plus	1	1	1	1	1	1	1
Orderlies	4 4 1	4 4 1	3 4 1	4 4 1	4 4 1	3 3 1	1 2 1
After 10 a.m. plus	1	1	1	1	1	1	1
Total	11 10 6	10 11 6	10 11 6	10 11 7	11 9 6	10 8 5	6 10 7

DOMESTICS

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Domestic	8–5.30	8–5	8–5	8–5	8–5	8–12	DAY
Domestic	8–12	8–5	8–12	8–5	8–12	8–5	8–5
Domestic	8–5	8–12	8–5	8–12	8–5	8–12	8–5

For Sister, an 8–3.30 duty replaces the second 1–8.15.

The 8–8.15 is a split duty, from 8–1.15 and 5–8.15.

On Sunday, staff start duty at 2 p.m. instead of 1 p.m. and work until 9.15 p.m. instead of 8.15 p.m.

•• Sunday split duty is from 8–10.15 a.m. and 2.30–9.15 p.m.

Appendix 8

SUMMARY OF WARD WORK UNDER ORIGINAL AND MODIFIED CONDITIONS (DAY DUTY)

Activity Code	Estimated Duration of Activity in Ward Minutes			% Change (Col. 4 as % of Col. 2)		Modified Level of Care	
	Basic Level of Care for Average Geriatric Ward	Basic Level of Care Medical Ward	Modified Level of Care Geriatric Ward	Increased by (%)	Reduced to (%)	No. of Staff	Frequency Per Week
1 (a)	1,924	2,349	1,924	–	–	2	7
(b)	147	921	426	290	–	1	7
(c)	1,192	1,045	2,522	219	–	2	42
(d)	66	383	66	–	–	1	6
(e)	149	–	60	–	43	2	2
(f)	428	80	2,240	523	–	2	7 (×8)
(g)	4,344	1,483	4,344	–	–	2	21
(h)	1,639	324	1,639	–	–	1½	14
(i)	434	436	2,560	590	–	2	2 (×32)
(j)	768	523	768	–	–	1	7
(k)	628	592	628	–	–	1	7*
(l)	2,103	843	2,103	–	–	1	7*
Totals	13,822	8,979	19,280				
2 (a)	–	–	Not Applicable	–	–	–	–
(b)	410	880	410	–	–	1	7
(c)	1,338	380	1,338	–	–	2	7
(d)	1,034	2,295	1,034	–	–	1	7
(e)	1,390	1,360	980	–	71	1	70
(f)	679	758	679	–	–	1	7
(g)	–	–	Not Applicable	–	–	–	–
(h)	129	59	129	–	–	1	7
(i)	155	338	155	–	–	2	1
(j)	40	–	70	175	–	1	7
(k)	42	–	42	–	–	1	1*
(l)	165	39	165	–	–	1	1*
(m)	–	–	Not Applicable	–	–	–	–
(n)	–	–	Not Applicable	–	–	–	–
(o)	511	–	511	–	–	1	1*
Totals	5,893	6,109	5,513				

Activity Code	Estimated Duration of Activity in Ward Minutes			% Change (Col. 4 as % of Col. 2)		Modified Level of Care	
	Basic Level of Care for Average Geriatric Ward	Basic Level of Care Medical Ward	Modified Level of Care Geriatric Ward	Increased by (%)	Reduced to (%)	No. of Staff	Frequency Per Week
3 (a)	1,366	1,495	1,366	–	–	2	7*
(b)	1,840	2,254	1,840	–	–	1	7*
(c)	727	952	727	–	–	1	7*
(d)	2,008	791	2,008	–	–	1	7*
(e)	87	355	420	483	–	1	14
(f)	137	249	137	–	–	1	7*
(k)	–	241	–	–	–	–	–
(l)	272	67	272	–	–	1	7
(m)	130	53	130	–	–	1	7
Totals	6,567	6,457	6,900				
4 (a)	1,124	1,143	1,260	11	–	1	14
(b)	1,220	1,354	210	–	17	1	7*
(c)	310	301	210	–	68	1	7
(d)	1,066	1,858	630	–	59	1	7
(e)	743	998	420	–	57	1	7
(f)	64	280	240	38	–	1	7*
(g)	1,154	1,011	1,134	–	97	1	7*
(h)	834	962	215	–	26	1	7*
(i)	61	179	60	–	–	1	1
(j)	544	232	240	–	44	1	7
(k)	331	10	–	–	Elim.	1	7*
(l)	25	80	25	–	–	1	1
(m)	395	836	240	–	61	1	7
(n)	121	101	120	–	–	1	7
(o)	–	–	150	–	–	1	½
(p)	21	–	–	–	Elim.	1	1
(q)	–	10	280	–	–	1	7
(r)	1,684	1,758	1,684	–	–	1	7
(s)	123	436	120	–	–	1	7
Totals	9,820	11,549	7,238				

Activity Code	Estimated Duration of Activity in Ward Minutes			% Change (Col. 4 as % of Col. 2)		Modified Level of Care	
	Basic Level of Care for Average Geriatric Ward	Basic Level of Care Medical Ward	Modified Level of Care Geriatric Ward	Increased by (%)	Reduced to (%)	No. of Staff	Frequency Per Week
5 (a)	438	1,228	420	–	96	1	7*
(b)	33	112	40	12	–	1	6
(c)	23	14	70	304	–	1	7
(d)	445	1,035	420	–	94	1	7*
(e)	113	239	60	–	53	1	1
(f)	151	180	140	–	93	1	7
(g)	66	84	200	303	–	2	14
(h)	143	67	–	–	Elim.	1	7
(i)	18	22	20	11	–	1	1
Totals	1,430	2,981	1,370				
6 (a)	–	23	840	–	–	1	7*
(b)	–	46		–	–	5	7*
Totals	–	69	840				

Activity Code	Estimated Duration of Activity in Ward Minutes			% Change (Col. 4 as % of Col. 2)	
	Basic Level of Care for Average Geriatric Ward	Basic Level of Care Medical Ward	Modified Level of Care Geriatric Ward	Increased by %	Reduced to %
7 (a)	418	331	418	–	–
(b)	506	607	506	–	–
(c)	584	1,004	584	–	–
(d)	183	579	183	–	–
(e)	299	433	299	–	–
(f)	21	14	21	–	–
(g)	51	87	51	–	–
(h)	278	628	278	–	–
Totals	2,340	3,683	2,340		
8 (a)	95	98			
(b)	546	946			
(c)	20	–			
(d)	275	308	Not Applicable. (Standard Allowances Made: 3% of Total Time for Absence; 8% for unproductive, except for orderly allowed 5% for absence including visits to other units)		
(e)	–	–			
Totals	936	1,352			
9 (a)	1,492	1,605			
(b)	2,048	2,191			
(c)	622	966			
Totals	4,162	4,762			

NOTES.— (i) For Activity Codes refer to Appendix 1.

(ii) • = Composite figure.

(iii) (x8 = For eight patients.

Appendix 9

COMPARISON OF DISTRIBUTION OF WARD WORK

GERIATRIC WARDS—TABLE I—AS A PROPORTION OF ALL THE WORK OF EACH STAFF GROUP

Work Group		Sister		Staff Nurse		Students S.E.N./ P.A.N.		Orderly		Domestic	
Ref.	Description	Present	Proposed	Present	Proposed	Present	Proposed	Present	Proposed	Present	Proposed
1	Basic nursing	9·6	4·3	34·7	35·5	48·0	56·0	40·5	48·5	0·2	0·0
2	Technical nursing	24·0	18·4	25·5	25·5	21·5	14·5	3·3	1·5	0·0	0·0
3	Dietary	12·2	6·3	9·5	12·6	11·6	11·6	19·0	22·5	17·5	10·8
4	Domestic	6·7	0·0	1·5	0·0	6·3	0·0	20·5	13·0	68·2	76·6
5	Clerical	18·8	26·0	8·6	7·2	1·5	0·4	0·1	0·0	0·0	0·0
6	Teaching	0·0	2·5	0·0	0·8	0·0	3·5	0·0	0·0	0·0	0·0
7	Human relations	22·0	31·5	9·4	7·4	3·4	3·0	2·4	1·5	0·9	1·6
8	Absence	3·5	3·0	2·1	3·0	1·2	3·0	2·6	5·0	2·0	3·0
9	Unproductive	3·2	8·0	8·7	8·0	6·5	8·0	11·6	8·0	11·2	8·0
	Total	100·0	100·0	100·0	100·0	100·0	100·0	100·0	100·0	100·0	100·0

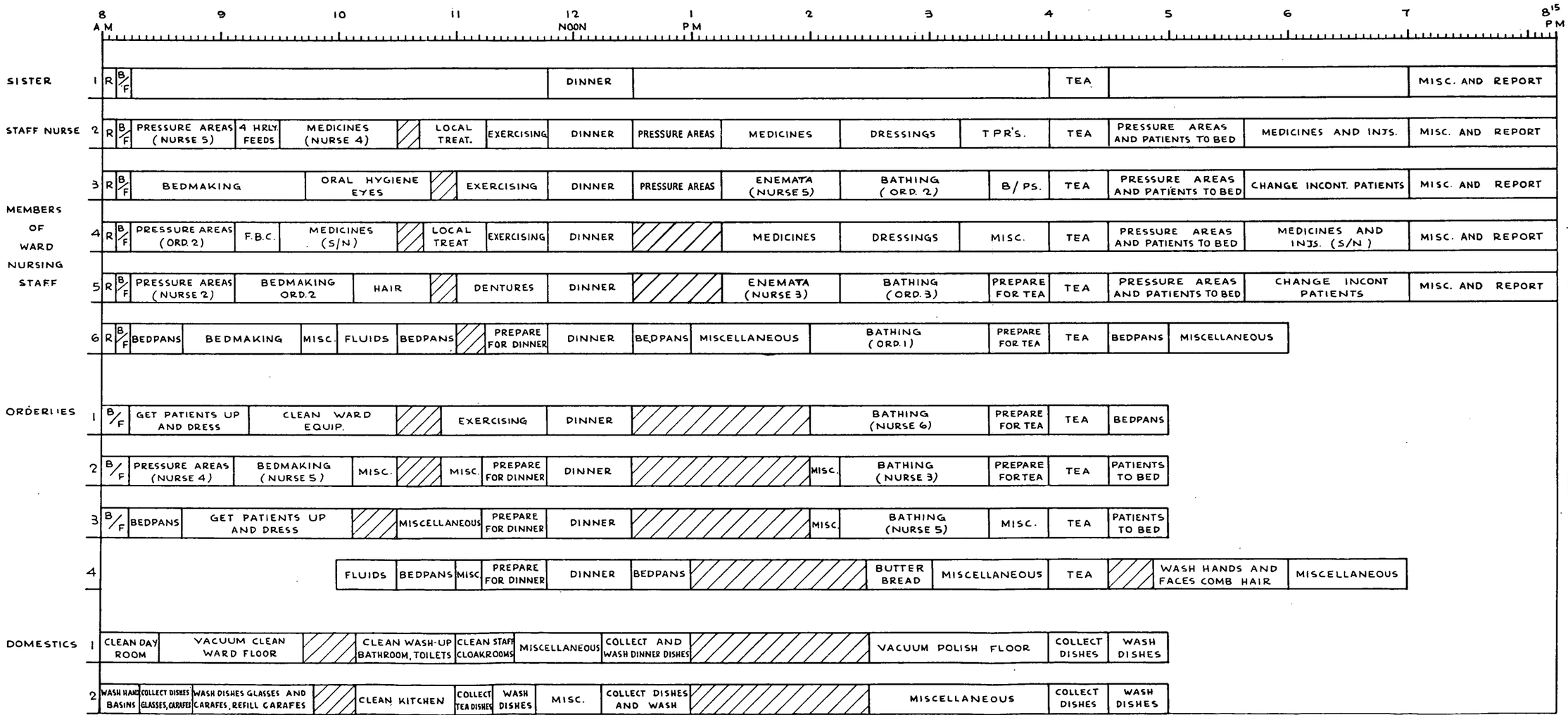
GERIATRIC WARDS—TABLE II—AS A PROPORTION OF ALL THE WORK IN EACH WORK GROUP

Work Group		Sister		Staff Nurse		Students S.E.N./P.A.N.		Orderly		Domestic		Total	
Ref.	Description	Present	Proposed	Present	Proposed	Present	Proposed	Present	Proposed	Present	Proposed	Present	Proposed
1	Basic nursing	2·6	0·6	17·5	15·2	48·0	53·0	31·8	31·2	0·1	0·0	100·0	100·0
2	Technical nursing	14·5	8·7	29·8	39·4	49·6	48·5	6·0	3·4	0·1	0·0	100·0	100·0
3	Dietary	7·3	2·4	10·6	15·5	26·8	30·0	33·5	41·5	21·8	10·6	1000·	100·0
4	Domestic	2·8	0·0	1·2	0·0	10·3	0·8	25·7	23·5	60·0	75·7	100·0	100·0
5	Clerical	44·5	50·0	40·5	44·5	14·0	5·5	1·0	0·0	0·0	0·0	100·0	100·0
6	Teaching	0·0	8·3	0·0	8·3	0·0	83·4	0·0	0·0	0·0	0·0	0·0	100·0
7	Human relations	35·0	35·0	29·0	27·0	21·5	25·0	11·5	9·0	3·0	4·0	100·0	100·0
8	Absence	13·8	4·5	15·8	14·5	21·0	33·0	33·0	36·5	16·4	11·5	100·0	100·0
9	Unproductive	3·0	5·5	16·2	17·5	25·3	37·6	33·0	25·6	22·5	13·8	100·0	100·0

Appendix 10

SCHEDULE OF WARD WORK

WORK SCHEDULE FOR NURSES, ORDERLIES AND DOMESTICS–REHABILITATION WARD



CODE

- B/P's = BLOOD PRESSURES
- T.P.R's = TEMPERATURES, PULSES · RESPIRATIONS
- INJS. = INJECTIONS
- INCONT = INCONTINENT
- ORD. = ORDERLY
- S/N = STAFF NURSE
- B/F = BREAKFAST
- MISC. = MISCELLANEOUS ACTIVITIES NOT SCHEDULED ELSEWHERE
- R = REPORT
- P. A. PRESSURE AREAS TEACHING IS INCORPORATED IN OTHER ACTIVITIES

▨ MEAL BREAKS.

Meal breaks not shown are arranged by Interchange of staff.

Appendix 11

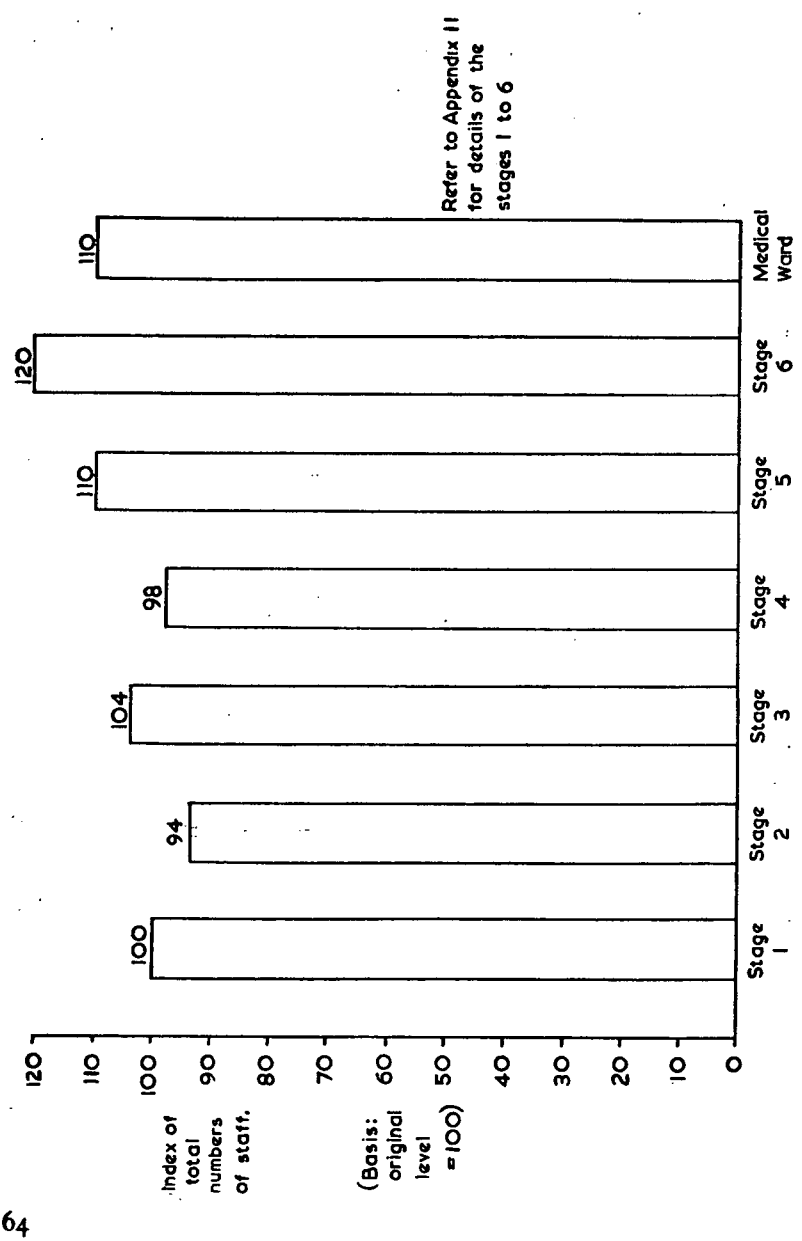
EXISTING AND PROPOSED WARD STAFF FOR WAKEHURST HOUSE

(No Allowance made for Sickness or Holidays)

Stage	Description	No. of Beds	Nurses' Duty hrs. per Week	Method of Organisation	Level of Care	Staff on Duty		Extra Allowances		Total Staff	Index		Method of Assessment
						Day Duty	Night Duty	Night Relief	Students All		Day Duty	Total Staff	
1	At commencement of study	252	48	Original	Basic	103½	22	15¾	5½	146¾	100	100	Average for 12 months to August 1961
2	With revised organisation	252	48	Revised	Basic	96	22	15¾	4	137¾	93	94	Work study proposal, with 13½ staff per long stay ward (day duty) and one extra part-time staff nurse for two rehabilitation wards
3	Original conditions but with 44-hour week for nursing staff	252	44	Original	Basic	108½	22	15¾	6¼	152½	105	104	Includes five extra staff on day duty, with extra student nurse allowance
4	With revised organisation	252	44	Revised	Basic	101	22	15¾	4¾	143½	98	98	Includes five extra staff on day duty, with extra student nurse allowance
5	With modified level of care and 252 beds	252	44	Revised	Modified	117¼	22	15¾	6¼	161¼	113	110	Allows for one more orderly and 1½ more students, or equivalent, per ward (day duty) to do extra work
6	With modified level of care and 281 beds	281	44	Revised	Modified	127½	22	15¾	11	176¼	123	120	Allows for additional staff to increase wards to full capacity
–	Equivalent Medical Ward	(40 × 7) = 280	44	Revised	Basic	(16 × 7) = 112	(5 × 7) = 35		(2 × 7) = 14	(23 × 7) = 161	108	110	Actual staff on ward, following work study recommendations

Appendix 12

COMPARISON OF STAFF REQUIREMENTS FOR WAKEHURST HOUSE AT STAGES OF STAFF MODIFICATION



Appendix 13

STAFF FINALLY RECOMMENDED FOR WAKEHURST HOUSE

STAGE 6

	Sister	Full-Time Staff Nurses	Part-Time Staff Nurses		Students/ S.E.N./ P.A.N.	Order-lies	Domes-tics	Total
			Actual No.	Equiva-lent to Full-Time				
Proposed staff for day duty	7	7	(16)	12	49	35	17½*	127½
Proposed staff for night duty	1	7	–	–	7	7	–	22
Night duty relief	–	–	(7)	5¼	5¼	5¼	–	15¾
Total	8	14	(23)	17¼	61¼	47¼	17½	165¼
Add 22% for students in block	–	–	–	–	11	–	–	11
Total	8	14	(23)	17¼	72¼	47¼	17½	176¼
Add allowance for sickness and holidays:								
Staff due 6 weeks holiday 18·4%	1½	–	–	–	–	–	–	1½
Staff due 5 weeks holiday 16%	–	2	(3½)	2½	2½	–	–	7
Staff due 4 weeks holiday 13·7%	–	–	–	–	4½	6½	2½	13½
Total	9½	16	(26½)	19¾	79¾	53¾	20	198¼

NOTE.—It is assumed that of the 49 students and others at post, 35 would be students.

* Also assumed that there would be two domestics and one relief per ward (but refer to Table C in text).

Appendix 14

COMMENTS ON NIGHT-NURSING IN GERIATRIC WARDS

E. M. Graham, S.R.N.

For the last six months the night staff of Wakehurst House have been grouped as experimental teams of nurses and orderlies supervised by staff nurses. The composition of these teams has been criticised from time to time, and I have been asked for my comments as Night Sister. I have now completed a period of ten weeks on night duty in the unit and the criticisms and suggested amendments which follow are made as a result of my own observations and from consultation with members of staff.

Each experimental team consists of seven people appointed to two wards of approximately 80 beds (paragraph 91 of main report).

Ward A. One student nurse, two orderlies.

Ward B. One student nurse and one pupil nurse (or two student nurses), and one orderly.

One staff nurse acts as supervisor between these two wards.

Under the old staffing arrangements, each ward of approximately 40 beds had one staff nurse, one student nurse or pupil nurse and one orderly. The new ratio is three and a half persons per ward as against three. All staff who worked in the unit prior to the new system agree that despite some of their criticisms, they have derived benefit from it. On the whole the standard of nursing care given to patients is high, but to maintain this high standard the staff have to work very hard, and this is particularly true of the nurses, who, come what may, are in the long run responsible for patient care.

From observation I feel that each 40-bed ward needs four members of staff at night, and this is especially true of the long-stay wards with few rehabilitable patients and large proportions of incontinent chronic invalids. The new arrangement seems to work reasonably well on the two rehabilitation wards because more of their patients are progressing towards independence and fewer are incontinent, and although more of the rehabilitable patients need toilet training and specific treatments than

those in the long-stay wards, both rehabilitation wards have two nurses and one of these can often do this work on her own or with minimal assistance.

The ideal team would be one staff nurse, two nurses and one orderly to each 40-bed ward, the nursing grades depending on the establishment of student and pupil nurses available, and the team should be composed with the following points in mind:

(a) The staff nurse should be an adviser and supervisor, not an active working member in the same sense as the nurse or orderly. In theory at present she is a 'half person per ward', but in fact, to get the work done, she becomes a fourth person in one ward or the other, to form two teams of two working together. She is responsible for attention to ill patients only as her schedule allows.

(b) Three people on a geriatric ward cannot function efficiently. The nurse works with one orderly and this leaves one person to work on her own. But one person cannot deal effectively with the helpless and incontinent patients who form a large proportion of total bed occupancy of long-stay wards. The single worker can attend to a 'light' patient who can co-operate, can empty bedpans and urinals or give drinks etc., but this leaves the other two to do a round of close upon 30 patients three times nightly, with is a heavy and time-consuming job, quite apart from necessary two hourly care and attention to mishaps.

(c) The peak periods of work on these wards unavoidably fall at the same time, i.e. 8 p.m.-10.30 p.m., 2 a.m.-3 a.m. and 5.30 a.m.-8 a.m. With four people working the patients could be settled down earlier and be awakened later, and the staff would have an easier work-load distributed more evenly between two pairs of workers. To gain this ratio at present the staff nurse must become the fourth member on the first and third peak period on the ward with two orderlies, and on the second peak period in the ward with two nurses and one orderly. Therefore she loses her true function of supervisor and this is regrettable. Indeed she is worse off than under the old regime where she only had one ward to run, even though then much of her time was spent doing basic nursing work.

Points raised by working members of team

Staff nurses

1. Almost unanimously this group agree that 80 beds are too many to supervise even if wards are adjacent.

2. Wards on which there are two nurses and one orderly are considered easier to supervise than a ward with two orderlies and a nurse. If establishment would allow it, only one orderly should be employed in each team of four on a ward unit.

3. The staff nurse spends most of her time in the ward that only has one nurse. In the morning especially the one student nurse has an excess of work which only she can do, e.g. tube feeds, oral hygiene, local treatments, etc., and the staff nurse has to help her junior with these. This problem does not arise on wards with two nurses.
4. As explained earlier, the staff nurse must supervise but is unable to do so.
5. Part-time staff nurses provide the relief for permanent staff nurses and give excellent service. They are posted to the same ward and are a stable unit which appeals to them. Mostly they are married women and on the whole of an older age group than permanent staff nurses. This seems to be to their advantage in supervising orderlies.

Student Nurses

1. The student nurses feel that they have learned from worthwhile experience in nursing. They write the reports on their patients, give out treatment under supervision, feel that they have responsibility, and have the added assurance of a staff nurse to advise if in doubt or difficulty.
2. On wards with only one student nurse, it was observed that work which only a nurse can do piles up in the morning, and she is dependent on the staff nurse to help her out. (This point was made by the staff nurse too.) Both agree that two nurses are needed to each ward irrespective of orderly allocation.

Pupil Nurses

1. Pupil nurses are sound members of the team, keen to learn, and they agree that they gain good experience in basic nursing.

Orderlies

There are several problems relating to this group.

1. The quality of orderlies selected in the past has often been unsatisfactory. Those newly appointed in this hospital are much superior, and as they increase in numbers on night duty they should ease the load carried at present by the nurses.
2. Many of the orderlies on night duty now have worked for several years in the same wards. Often they are old enough to be the mothers of the students or staff nurses. They are set in their ways, resent taking orders from 'youngsters', and need constant close supervision which is difficult and trying to maintain.
3. These older women naturally have a slower working rate than nurses who at the most are 20-25 years old, and whilst they are kind in their way to patients, the help they give is so slow and inefficient that the

nurses who work with them are obliged to carry an unduly heavy proportion of the burden of routine work in the wards. To get through the work quickly and easily, the nurses are apt to work together, instead of being paired with the orderlies. They say that they get twice as much work done in the same time as a nurse working with a slow-moving orderly. This means that with three in a ward the nurses do the bulk of the work and it makes life harder for them during their spell of night duty.

4. Many of these orderlies joined the hospital service as young women but as the years pass they are trying now to do heavy manual work which is beyond their capacity. Nurses, by promotion, can leave the heavier basic nursing to new recruits to nursing, but this does not apply to orderlies whose duties remain unchanged throughout their working lives.
5. Absenteeism and sickness rate is high amonst the orderlies partly because the women are too old for the heavy work, and also because the older members, and indeed some of the new recruits, feel little sense of loyalty to their jobs. The rate of absenteeism is higher amongst the women than in the men.
6. The work study recommendation that orderlies work from 8.30 p.m. to 8 a.m. has been unanimously acclaimed. They are available for peak periods of work.
7. Extra pay for week-end duty was a bone of contention when nights off were fixed, but this is being remedied by a rota of nights off duty similar to those given to nurses.

All the nursing staff agree that the biggest single problem with the orderlies is that the majority of them need such constant supervision. The good ones are good, and work on their own initiative, but others will take all the short-cuts possible if they think no one is looking. I feel sure that the new scheme of in-service training and improved quality of staff recruited, will reduce this problem.

Appendix 15

NOTES ON THE METHODS AND EQUIPMENT USED IN THE WARDS

The first concern of the nursing team who studied the ward activities was the time taken to perform them, and their frequency throughout the 24 hours. However, when the ward work was revised to prepare work schedules, it was evident that the proposed time allowances and distribution of activities made in them were influenced by both the physical exertion involved in certain jobs, and by the precautions necessary to reduce the risks of cross infection. These factors were related to the activities that absorbed the greatest proportion of the time of ward staff and the points discussed below were brought out by observation of the methods in routine use, and by some specially designed method studies. Equipment and methods have not been considered in great detail, because it was appreciated that these were the special subjects of the Whittington Hospital survey, whereas ours were ward organisation and the deployment of ward staff.

1. *Labour saving devices*

The range of new equipment and specially designed appliances available on the wards was impressive, but this did not imply that it was always used to the best advantage. Sometimes this was a matter of convenience, especially when staff were short-handed and it saved time, for example, for a nurse or orderly to obtain help from one or two others to lift a heavy patient, rather than make use of a slower, but less back-breaking, method employing a hydraulic lifting device. At other times it appeared that lack of clear instruction in the use of appliances lay at the root of their misuse, a criticism that applied equally to nurses and auxiliary staff. The lack of consistency in methods used in different wards (a cause of concern before the inquiry began) was confirmed by these studies; for example, in some wards day staff made beds and the night staff gave breakfasts; in others this was reversed. There seemed to be scope for improvement on these lines in technical nursing methods, in the work of nursing auxiliaries, and in domestic tasks.

2. *Cross infection*

The staff of all clinical hospital departments have become much more conscious of the risks of cross infection in recent years, especially from resistant strains of staphylococci. The geriatric department is no exception to this, and the staff appreciated that fulminant staphylococcal bronchopneumonia following epidemic upper respiratory infections was more likely to carry off the newly admitted patient, ostensibly brought in for rehabilitation, than the chronic invalid long accustomed to the ward. Formal instruction in the possible sources of cross infection, and means of preventing it, must be supported by clinical instruction in preventive practices on the ward, using approved methods and equipment under effective supervision.

When compiling the work schedules care was taken to allow time for hand washing for the staff between attention to different patients, and for patients themselves after the use of bottles or bedpans, and the methods of cleaning in the wards were investigated. Particular recommendations included:

(i) The use of a hexachlorphane soap or soap solution on the wards.
(ii) Alterations to provide elbow-operated taps on several hand basins.
(iii) The use of a bactericidal detergent for dish washing.
(iv) The use of bactericidal agents to clean all handles, especially in toilets, and other surfaces used commonly by patients and staff.
(v) The more frequent use of the mobile toilet trolley available on the wards, to make hand washing easier and quicker, and therefore more likely to be done.
(vi) The elimination of any type of vacuum cleaner likely to exhaust particles into the ward atmosphere to an appreciable extent.
(vii) Formal instruction of nursing orderlies and domestic staff in techniques designed to reduce cross infection.
(viii) Care to ensure that any change in method did not increase the opportunity for spreading infection.

Some conflict of opinion between ward sisters and study team was resolved from time to time by amicable discussion, and each side gained points towards the general betterment of standards.

3. *Incontinence*

The high incidence of incontinence amongst the population of the geriatric wards was perhaps the greatest single factor affecting general conditions and the work of all grades of staff. Despite all the thought and much research given to it in the past 15 years, relatively little progress has been made towards reducing the unpleasantness and drudgery for patients and staff caused by this complaint. In isolated instances, or small numbers, quite effective control is possible with unremitting care, but with large numbers of old people suffering from advancing cerebral

degeneration the situation can get out of hand very rapidly if the ward is short staffed. On the five long-stay wards it was not uncommon to find that less than 10 of the 40 patients were reliably continent, and most of the 10 would depend on very regular attention to ensure this.

The heated trolleys used to house and transport bedpans were effective, but it was often noted that the heater was not being used; indeed, one junior nurse busy delivering bedpans from a trolley did not know it had a heater, a reminder of the need for instruction of staff in the proper use of modern equipment.

The wards were equipped with modern automatic bedpan washers, but their efficiency left much to be desired. They were chosen and installed in 1958 after months of investigation and trial. The steam-sterilizing version was deliberately avoided because the machines could not be relied on to clean a really dirty bedpan. They will wash a bedpan effectively after micturition or use with an enema, but a heavily contaminated bedpan, such as commonly obtains in geriatric wards, simply came out with excreta steam-baked to its surface, infinitely more difficult and unpleasant for the nurse to remove. The hot-water washers at least remove the worst of the damage and it is not too difficult, however unpleasant, to clean off the rest by hand. It is a poor reflexion on the medical and nursing professions that they have not yet induced any British firm to produce a thoroughly effective automatic washer that will relieve the junior nurse or nursing orderlies of this unpleasant duty. All these difficulties would be solved by the use of disposable bedpans, but to replace the present modern equipment by these, on the scale necessary in this department, would be prohibitively expensive.

A neat plastic female urinal, suitable for chemical sterilization, was introduced for patients with the intelligence to use it and was very successful in some instances.

Pyrex glass urine bottles were used in the male wards, delivered in convenient trolleys which carried nine at a time. They were washed in the automatic washers and chemical sterilization was recommended using a hypochlorite solution.

Experiments with incontinence pads had been in progress for some years and the cellulose and cotton pads introduced originally were still preferred to newer, but less effective, paper and cellulose pads. Similarly plastic material to replace rubber under-sheets was tried out but not with success.

The atmosphere of geriatric wards with a high rate of incontinence inevitably becomes heavy at times of bed-changing and especially in male wards with numerous pipe-smokers and vigorously expressed resentment of open windows. The study team, more accustomed to general hospital nursing, and not as conscious as the ward sisters of the improved state of the wards now compared with bygone days, felt that more effective use might be made than was being made of normal ventilation and of the ozone producing air purifiers available on the wards.

4. *Dusting, polishing and floor cleaning*

Observation in the wards indicated the need for more consistency in the methods of ward maintenance if they were to comply with the recommendations of the Ministry of Health Report on Organisation and Management of Domestic Work in Hospitals.[10] Floor cleaning should follow, not precede, dusting which should be done with damp cloths, and ideally 30 minutes should elapse after dusting before the floors are cleaned, using suction cleaners. In practice, the team were unable to achieve this ideal within the work schedules for the wards, but better arrangements were made for the collection of rubbish, and the system of floor cleaning was investigated.

Various methods were used in the different wards to clean the floors, and there was a varied assortment of equipment available for the work. The floors were scrubbed at intervals of some weeks, polished, and then maintained with such cleaners and intermittent polishing (by electric polishers) with periodic wet-mopping to deal with spilt food or fluids. The patients in geriatric wards readily scatter food, tobacco, papers, fruit peelings and other litter, or spill liquids, urine bottles or bed-pan contents to a much greater extent than do their counterparts in the general hospital. Maintenance of the ward floors therefore presents a much more time-consuming (and exasperating) problem to the staff than their colleagues experience elsewhere in the hospital.

There were two types of electric polisher in use on the wards, but neither was considered suitable, because their dust filters were not reliable, and because having no paper bags fitted to gather dust and rubbish, they disseminated dust widely when being emptied and cleaned. A search was made for a combined, electrically driven, suction floor cleaner and polisher. This type of machine would permit dry-cleaning of ward floors leaving the wet-mopping solely for isolated patches of spilt food or urine, and avoiding wet scrubbing of floors. Two of these machines were tried out and found to be moderately effective in polishing floors and in collecting some of the dust disturbed by the polishing, but neither of them kept the floors really clean throughout the 24 hours. The machines were unable to collect any particles more than about $\frac{1}{16}$ in. thick. It was decided therefore to retain one vacuum cleaner and one suction floor polisher on each ward.

Several alternative types of vacuum cleaners were tried, but were rejected for various reasons. One much-publicised machine is probably as effective as is claimed in preventing the discharge of bacteria-laden dust into the ward atmosphere whilst working, but little attention has been paid in the design of the machine to the risks of contamination when the machine is being emptied and cleaned. Another low-priced vacuum cleaner, approved and extensively used in hospitals, appeared to have lethal potentialities for the distribution of dust when in use, because there was no paper bag filter and the exhaust was directed horizontally over the floor. A removable elbow designed to direct the exhaust air vertically

was available but did not make this machine safe. A tank-type vacuum cleaner was finally specified which had a proper dust bag, two cloth filters, and a diffuser bag as well as a long flexible hose with appropriate attachments. The machine chosen was quiet in use and proved to be popular with the domestic staff. This cleaner was used to clean the floors every morning, following the dusting of furniture and equipment, and the attachments were used to clean sills, ledges, curtain rails and high surfaces. It was suggested that the suction floor polisher should be used in the afternoon to re-finish the floor surface, collecting dust at the same time. This machine was too noisy, but was the best available and maintained a reasonably good floor surface. Each of the two machines had a disposable paper bag attached to hold large pieces of rubbish which had to be picked up by hand.

There are many theories about the best type of floor surface appropriate for hospital wards, and about types of wax or sealant for floors. An emulsion wax polish was finally chosen for the lino tiles of the geriatric wards, spread by a hand sprayer and applied every four to six weeks. As the correct use of the emulsion wax sprayer was found to be beyond the ability of the ward domestic staff, and because the suction floor polishing machine supplied to the wards was not ideal for polishing off the wax, it was recommended that two of the domestic staff on the department should be specially trained to use a non-suction, rotary brush floor cleaner and that part of their duties should be the regular four to six weekly wax cleaning of floors.

In concluding these comments on floor maintenance it must be admitted that the system recommended for the wards has not been satisfactory in practice. Partly because of uneven flooring laid on the old wooden floors of the renovated wards, and partly because of the incurable habits and failings of the elderly patients, most of the wards have reverted to periodic scrubbing to maintain a presentable surface, and, as in some other aspects of ward organisation, a compromise method is being evolved.

The work study team gave much time and thought to this part of the inquiry and feel disappointed because at the end of it they had little to show for their efforts. They found it difficult to apportion blame for this, if any existed, to any one quarter. Some of their difficulties undoubtedly arose from the lack of training and the quality of the domestic staff who felt happier when they could see the result of their labours as dirt in a bucket than when it was concealed within the fabric of some infernal machine. In this particular investigation, as in other method studies, the team would have appreciated information from some central agency, where the results of similar inquiries, which must have been made in many hospitals, would have been correlated and made generally available. As it was, information had to be sought from many different sources on floor cleaning equipment, polishes, standards and different types of floor surfaces, and none of these inquiries was complete in itself.

5. *Dish washing*

The use of yellow bar-soap for washing up, and the drying of crockery with cloths, were condemned. Domestic dish-washing machines were used in some wards, but their capacity was only one-quarter of the ward's needs, and too much washing up was done by hand.

The use of a liquid, bactericidal detergent was recommended, especially as rinsing with water at 180°F to obtain sterilization could not be done because water of this temperature was not available.

The use of tea cloths was discouraged, and plastic-covered wire crates were specially designed to fit the stainless-steel ward sinks and to hold the stock sizes of ward crockery. One double-purpose plate or saucer crate, holding one row of large plates or two rows of small plates to be stacked, and one crate of cups, were the only racks needed. Unfortunately the improvements suggested in this ward task were also frustrated by the difficulties with domestic staff mentioned earlier, and a satisfactory routine, acceptable to and applied by all wards, was still to be found.

The supply of linen to the wards, its laundering and repair, were also considered by the study team with particular reference to the recommendations of the Ministry of Health (Cunliffe) Committee on Hospital Laundry Arrangements (1959).[11] A system of disposal of foul-linen in separate bags, sent directly to the laundry to be given preliminary washing, had been in use for many years on the geriatric wards, but systematic supply and disposal of linen in the department was planned to operate from a central linen-pool which has yet to be built. The building will include a unit for disposal of foul-linen, and improved facilities for the disposal of rubbish, and therefore no specific recommendations were made on these points.

The practice of providing mid-morning and afternoon tea for auxiliary staff in the ward kitchens was condemned and arrangements were made for these to be served, during appropriate breaks in the ward routine, in a common-room attached to the geriatric department. This had many advantages, not the least of them being the clearer field of action left for the domestic staff in the ward kitchens and more effective control of tea intervals by the ward sister.

The main conclusion reached by these studies was that recommended changes in methods and ward organisation were completely subordinate to the over-riding importance of proper selection of nursing orderlies and domestic staff, and effective training and education of all staff in the purpose and proper use of the mechanical devices which now play such a large part in the work of hospitals.

Appendix 16

GLOSSARY OF TERMS USED

Content of Work: The detailed make up of a specified job, from its elements.

Cyclic Activities: Those that occur at long or short repetitive intervals.

Level of Care: The defined service given to individual patients or to the ward as a whole.

(a) *Basic Level:* The level determined from the original studies.

(b) *Modified Level:* The level proposed for future use.

Patient Category: Refer to Appendix 2.

Performance Rating: The assessment of worker's rate of working relative to the observer's concept of the standard rating (see B.S. 3138).

Shifts: (a) Straight Shift: A duty period worked without interruption, other than a meal break.

(b) Split Shift: A duty period interrupted by a period off-duty.

Ward Minutes: Units of measurement expressing in minutes the work required from all the ward staff each week, for each occupied bed in the ward. Calculated separately for each individual activity, and for day and night duties, as:

$$S \times D \times O$$

where S = average number of staff in the team carrying out the activity

D = average duration of the activity, per patient (minutes)

O = number of planned occasions per week for the activity.

Work Study: For definitions of terms used in work study, refer to B.S. 3138, 'Glossary of Terms in Work Study'.

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References are noted by their numbers in the text

PLAN OF RENOVATED WARD

LONG-STAY WARD

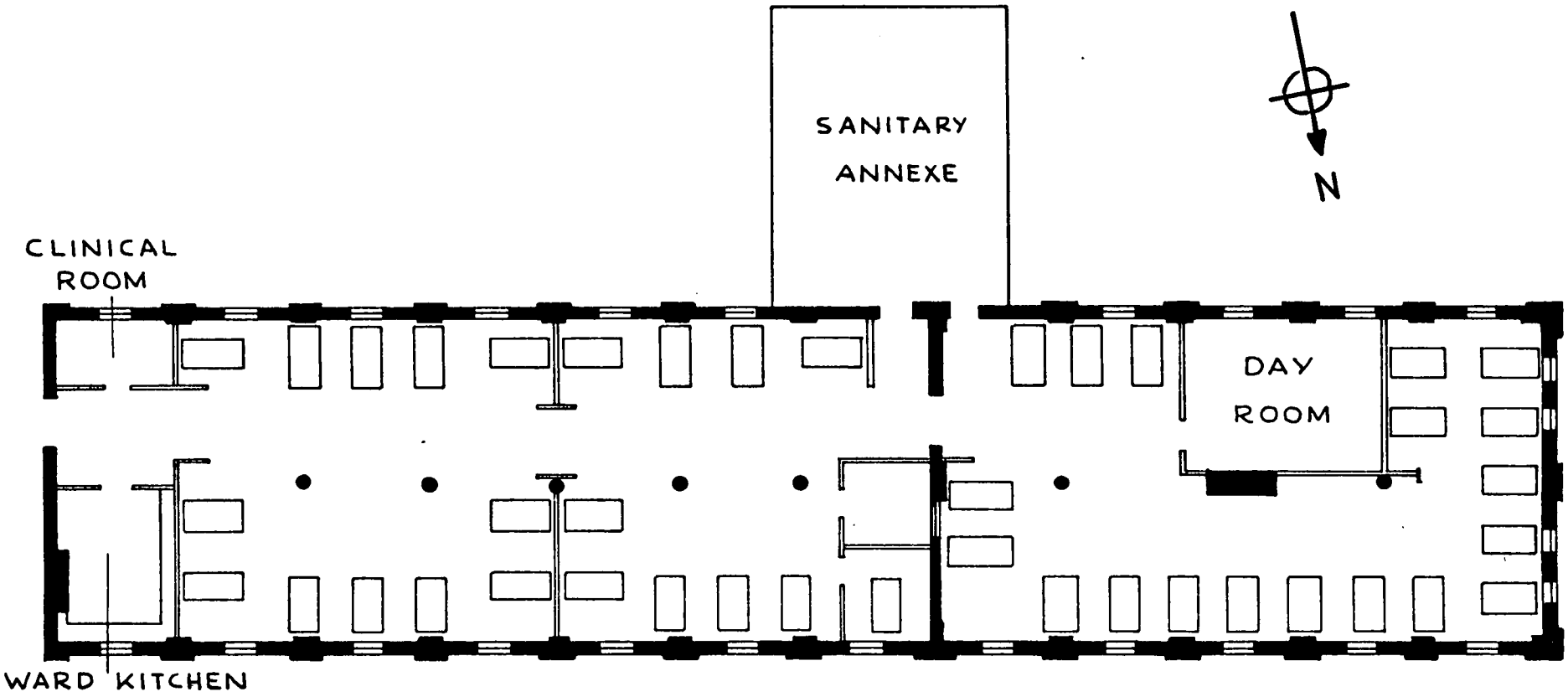

FIGURE 2

PLAN OF NEWLY-BUILT WARD

(REHABILITATION WARD)