King Edward's Hospital Fund for London

HOSPITAL VISITING

1960

34 KING STREET, LONDON, E.C.2

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N. Weaver.

KING EDWARD'S HOSPITAL FUND

FOR LONDON

MANUAL FOR MEMBERS OF HOSPITAL MANAGEMENT COMMITTEES AND HOUSE COMMITTEES WHEN VISITING HOSPITALS

1960

Offices :

34, KING STREET, LONDON, E.C.2

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INTRODUCTION

In 1950 King Edward's Hospital Fund brought together in one booklet some of the subjects which had been selected over many years as suitable for enquiry on the part of the Fund's hospital visitors. In an introductory note it was suggested that the booklet might help to meet the need for a manual or guide to suggest to members of Regional Boards, Hospital Management Committees and others undertaking visits to hospitals points to which attention might profitably be given. This proved to be the case and there was an unexpectedly large demand for the Manual for Hospital Visitors, as it was then called. The demand has continued even since the manual has been out of print. This new manual suggesting subjects for enquiry and observation during hospital visits has therefore been prepared.

Several points should be made clear:

(a) It is essential that a member of a hospital committee should gain first-hand knowledge of the hospital and its work, should know and be known by members of the staff in the wards and departments as well as in the offices, and should then be able to bring sound judgement to bear on needs and problems as they arise and on proposals brought forward in committee. The visits should be as informal as possible, and the visitor should give the impression that he calls to learn and to see where help is needed. His own powers of observation may often be a surer guide than answers to questions, however sincerely given. On the other hand, the very asking of a question may sometimes be useful in reminding the staff of the importance of the subject and the need for action, e.g. "What steps have been taken to eliminate noise at night?" Often it is well to avoid questions which either invite the reply "Yes" or depend for an answer on an expression of individual opinion, e.g. "Is the service of meals satisfactory?" "Is the heating in the nurses' home adequate?"

(b) Different sections of the manual may be used over a series of visits—it is not of course suggested that all the questions should be gone into in the course of one visit.

(c) A manual of this kind cannot be a comprehensive guide to hospital practice, but is intended to help those not previously familiar with the organization and day-to-day work of hospitals to get their bearings, and to suggest some lines of investigation for more experienced visitors. It does not pretend to give a comprehensive list of all the questions that should be asked, or all the matters that could be looked into. The financial aspect of administration is omitted, as are matters of medical policy. It directs attention to subjects which lend themselves to enquiry or observation in the course of relatively short visits and discussions.

(d) There is a good deal of "background knowledge" which the Committee member should have before he begins going around the hospital. This should be supplied by the administrative officers and might include the following:

i. An outline of the history of the hospital, and the age of its buildings. It may be useful to see a ground plan before going around. In the case of scattered buildings such as mental and orthopaedic hospitals and sanatoria, it is certainly important to see a plan of the various blocks and departments and their disposition in the grounds.

ii. The total number of beds. How they are apportioned between male and female patients and children, general medicine and surgery, and special departments. Numbers of amenity beds and pay-beds. Numbers of new out-patients and of total out-patient attendances and casualties.

iii. What relationship the number of beds bears to the needs of the district it serves (i.e. is there great, increasing, or diminishing demand for beds?) Is the local population increasing? (Numbers on waiting lists are not necessarily a true indication of the position).

iv. The hospital budget. What capital expenditure has been possible since the National Health Service came into existence and what further capital projects are (1) approved, (2) under consideration, (3) needed? Would any of these be likely to reduce

annual maintenance costs (e.g. new boilers to replace an obsolete heating system), or enable the hospital to deal with more patients?

v. Whether the hospital is a training school for nurses, assistant nurses, midwives, radiographers, physiotherapists, dietitians.

(e) It is valuable, as well as a matter of courtesy, for the visitor to meet the matron as head of the nursing service and hostess in the hospital. In the case of official visits, or visits to consider a specific project, she would usually be asked to accompany the visitor. The ward sister is hostess in her own ward, and it is well to address some questions to her.

(f) The visits may and should be made in such a way that they indicate to the patients that care is being taken to see that their stay in hospital is as happy and comfortable as possible. Patients appreciate a friendly word when visitors are going around, though this need not take the form of direct questioning.

(g) It is inadvisable that matters of policy should be discussed, or promises made to members of the staff, while going around the hospital.

(h) The arrangement of the visits may be different in every hospital visited, and should indeed vary from time to time in a particular hospital. The sections of this Manual may therefore be used in varying order. Some may prefer to begin by observing the various entrances to the hospital, the arrangement for the reception of casualties and so on, others may concentrate first on the wards. The pattern followed herein has been to begin with the patients, for whom the hospital exists, and to work outward from that focus, but hard and fast divisions cannot be made, and many questions could be asked under other headings.

(i) Many visitors will feel it is better not to appear to be making notes at all (except possibly of statistical or financial information obtained at a preliminary talk with the hospital officers) nor indeed to have the Manual in evidence, but it may be valuable to make brief notes immediately after the visit, for reference at a later date.

MENTAL AND MENTAL DEFICIENCY HOSPITALS

It cannot be expected that all the questions will apply in all hospitals. In particular, the mental and mental deficiency hospitals have many problems of their own which the new visitor will need to study with the help of the physician-superintendent, secretary, matron and chief male nurse, and other members of the staff. Often these hospitals have a legacy of old and inconvenient buildings, but in recent years much has been done to improve the appearance of the wards and corridors in many of them.

As a general guide, it may be said that the mental hospital is more of a community, and that the aim is to enable the patients to live as normally as possible, with minimal restraints and with ample opportunities for useful occupation, recreation and a range of interests. Many patients may be away from the wards for a great part of the day. There may be communal dining-rooms, and social and recreational centres for patients and staff, as well as the occupational therapy departments which play an important part in the life of the patients.

Patients should be encouraged to take part in the life and work of the hospital, and to make their contribution in such activities as gardening, carpentry, sewing, arranging entertainments etc.

Living conditions and amenities for nursing staff still leave a good deal to be desired in some mental and mental deficiency hospitals owing to financial stringency in the past. These hospitals have special problems of recruitment owing to the nature of the work and to the fact that often they are situated in somewhat isolated or remote positions. It is, therefore, the more important that everything possible should be done to bring the standards into line with those generally accepted as desirable for staff at the present day.

34 King Street,
London, E.C.2.
October, 1960.

HOSPITAL VISITING

I IN-PATIENTS

1. ADMISSION AND RECEPTION

What are the arrangements for receiving in-patients and their relatives on arrival at the hospital?

What are the arrangements for conducting patients to the wards?

Most hospitals now recognize the desirability of a friendly reception to patients and their relatives on arrival. For stretcher cases the first contact should be with the nursing staff. For others a kindly receptionist can do much to allay apprehension. The porters should be carefully trained, and should have smart, clean uniforms. The first introduction to the ward staff and fellow-patients is very important. Particular care needs to be taken to see that emergencies admitted at night are given a reassuring welcome.

Who sees the relatives before they leave?

What happens to the patients' own clothing on admission?

Is it readily available as soon as they get up?

How much notice is given to admissions from the waiting list?

In what form is the letter of admission sent to them?

In some hospitals it is the practice to send an informative and friendly letter to patients before admission, advising them what to bring with them, what the visiting times are, etc. Others go further and give new patients a leaflet of welcome explaining the hospital routine and amenities.

2. APPEARANCE OF WARDS

Is the first impression of the wards pleasing, and therefore likely to be reassuring to patients?

Are the decorations light and attractive, and has good use been made of colour on the walls, curtains or screens and bedspreads?

Even an old ward of bad proportions can be transformed by these means.

3. LIGHTING

Is the central lighting good, without exposing the patients to glare?

Is there bed-head lighting which enables the patients to read with comfort, and which they can switch on and off?

What lighting system is there at night to enable the night nurses to work in a given area, or an individual patient to be examined, without disturbance to other patients?

These are matters which are easily overlooked, as visits usually take place during daylight hours.

4. OVERCROWDING

Do any of the wards appear overcrowded?

The accepted minimum standard is eight feet between the centres of beds.

5. UP-PATIENTS

What accommodation is provided for patients who are allowed to get up?

Now that patients spend much less time in bed than formerly, it is necessary to improvise day accommodation which is adequate, comfortable and "homely". A fire to sit by is much appreciated. If a day room can be set aside it is a great convenience—one side ward can serve several wards if suitably converted and accessible.

Is the day room well warmed and furnished with comfortable chairs and small tables?

Can the up-patients take meals together in comfort?

6. WASHING FACILITIES AND SANITARY ANNEXES

What is the condition of the bathrooms and sanitary annexes?

Here again much modernization needs to be done if reasonably good facilities are to be available, since many ward annexes were planned when only a small minority of patients were allowed up to use them. It may be well for the visitor to ask to see the washing and lavatory

facilities, and to decide whether he would regard them as sufficient, and as allowing enough privacy for himself or his relatives if they were patients.

Are they sufficiently heated?

Patients who go out to wash in the early morning should not have to exchange a warm ward for an unheated and often draughty annexe.

What is the average number of patients who are allowed to get up to wash (and shave)?

How many wash-basins are there for them?

Are any of these inside bathrooms which may be in use?

If not, are they in cubicles, curtained or otherwise?

Are the baths cubicled, if not in separate rooms?

What aids are there to help patients in and out of the bath?

How many water closets are there for patients?

Can they be locked, or, if this is not thought advisable, is there some means of indicating when they are occupied?

One type of lock can be used by the patients, but in case of need opened from the outside by a special key kept by the sister.

Is there a hand-basin for the patients near the water-closets, or do they have to go across to the bathroom to wash their hands?

Are paper hand-towels provided?

Is there a water-closet for ward staff?

What are the methods in use for:

(a) washing bedpans?

(b) sterilizing bedpans (in wards where this may be needed)?

(c) storing and warming bedpans?

Is the equipment in the sanitary annexes as up to date as that in the wards?

7. WARD EQUIPMENT

Are basins and taps conveniently placed in the wards themselves and in side wards for washing hands, scrubbing up, filling patients' washing bowls, etc?

Many unnecessary steps have to be taken if water is available in annexes only.

Is the method of supply and issue such that there are adequate supplies of linen, bedpans, china, cutlery, hardware, etc. at all times?

Do all patients have individual thermometers?

Are the mattresses really comfortable?

Hair, interior spring, or foam rubber mattresses may be regarded as suitable for most cases, provided they are in good condition.

How often are they renewed, or re-made where practicable?

Are all beds curtained?

If not, is it for financial or other reasons?

If the nurses still have to move screens around beds, are these light or heavy?

If beds are grouped in small units or are in single wards, are there efficient and quiet means by which a patient can summon a nurse at all times?

This is particularly important at night.

Have the patients access to bells in the bathrooms and sanitary annexes?

Are there any special amenities or labour-saving devices which the hospital has installed or would like to install?

8. WARD KITCHENS

Does the kitchen look clean and tidy?

Is the equipment (sinks, draining-boards, refrigerator etc.) modern?

What arrangements are there for heating food or keeping it hot, cooking eggs, making toast, making tea in large quantities, or individual drinks?

Is the refrigerator large enough?

Is there a separate refrigerator for blood, plasma and antibiotics?

Does the food come to the ward in a heated trolley?

Is the trolley taken around the ward when the sister serves the meals, or does she serve it from the kitchen?

The former method can give the patients the impression that they have more choice. It also reduces the distance the nurses have to walk.

Do the patients who are in bed have individual trays, with their own pepper and salt containers?

Is the patients' cutlery and crockery in good condition?

What provision is there for sterilizing ward china?

9. REFUSE

What arrangements are made for the disposal of refuse

(a) in the ward kitchens:
are the waste buckets sufficiently large?
are they kept clean and covered?
is the waste food kept carefully in separate containers, to be used as pig swill?

(b) in the sanitary annexes:
do the bins have to be carried through the wards?
how often are they emptied?
are the bins and buckets or their lids noisy?

Some hospitals have replaced metal bins and buckets or their lids by rubber or plastic non-clattering materials.

10. OTHER WARD ANNEXES

Has the sister a room off the ward where she or the medical staff can talk with patients' relatives or other visitors (e.g. almoner or chaplain)?

Is there a sterilizing room off the ward, with sufficient space for all dressing trolleys etc.?

In some hospitals space has had to be found for either or both of these by giving up one or two beds and partitioning off the space.

Is there a flower room, and is there space for storing wheel chairs?

11. NOISE

As in many other matters, the visitor will make his own observations rather than rely on answers to questions. Sometimes it will be stated that it is useless to aim at quiet as the hospital is near a busy

thoroughfare, but the patients are far more troubled by small avoidable noises than by a steady inevitable noise like traffic. Much depends on whether the staff are aware of the need for quiet. In some hospitals one can quickly sense a tradition of quiet, whereas others are so noisy that individual effort to be quiet seems wasted. The Fund has published recommendations on Noise Control in Hospitals (see Appendix).

What steps have been taken to reduce noise:

(a) arising within the ward units (e.g. rattling trolleys and windows, creaking floorboards, clatter of washing-up in sanitary annexes or kitchens)?

(b) reaching the wards from other parts of the hospital (e.g. banging of lift gates, oxygen cylinders)?

(c) from outside the building (e.g. metal bins, baskets of milk bottles, vans delivering stores, motor horns)?

What steps are taken to minimize the disturbance caused by noisy or confused patients?

Can they be isolated from the other patients?

12. THE PATIENTS' DAY

At what time is early tea taken around the ward?

Do the lights go up earlier than this?

Are any patients wakened before this (other than those needing special preparation for operation or investigation)?

Do the patients have an undisturbed rest period after the mid-day meal?

The complaint is frequently made, not only that patients are wakened very early, but that they have no opportunity of making up sleep at other times, and are tired by the very busy atmosphere of the ward and the many members of the staff who visit them in the course of the day.

At what time in the evening do the patients' lights go out?

Can those whose condition admits of it have undisturbed sleep at night?

13. BROADCASTING

Are headphones or pillowphones available to all patients?

Can each patient have a choice of programme?

Is the wireless equipment in good working order?

If there is television, is it in a separate room so that patients who dislike noise or are very ill are not troubled by it?

Complaints are made about the impossibility of escaping from radio or television when it is broadcast to the whole ward.

14. VISITING

How often in the week may patients have visitors?

At what hours?

Daily visiting is allowed in many hospitals.

Is there any restriction on the number of visitors a patient may have?

While it is important that visitors—particularly those who have come from a distance—should not be turned away without seeing the patient "for the sake of a rule", care needs to be exercised that seriously ill or weak patients are not exhausted by their visitors.

Can a visitor see the ward sister at any visiting time, or a doctor on request?

Are children allowed to visit their parents?

What are the arrangements for visiting child patients?

Some think that mothers should spend as much time as practicable with their children in hospital.

Is there a place within the hospital or its grounds where visitors who arrive in advance of visiting hours can wait under cover?

Are visitors' lavatories provided?

It is undesirable that visitors should use the ward lavatories.

15. PATIENTS' RELATIVES

Who is responsible for communicating with patients' relatives as to an operation, arrangements for returning home, transfer to another hospital, placing on the danger list, etc.?

What are the arrangements for dealing with enquiries from patients' relatives, by telephone and otherwise?

Practice varies, but in many hospitals the calls are put through to the sisters in the wards as it is felt to be more satisfactory for relatives to be able to receive first-hand and accurate information. On the whole the ward sisters welcome this procedure.

16. RELATIVES OF VERY ILL PATIENTS

Are relatives conducted to the ward sister, i.e. not merely directed?

Can relatives obtain a doctor's opinion, either orally or in writing?

Is there a special waiting place available at all times for the relatives?

They need comfortable seating accommodation by day, e.g. when the patient is in the theatre for several hours, and there should be suitable arrangements for them to sleep at night.

Can they obtain meals without adding to the claims made on the ward staff?

A few hospitals have arranged accommodation in the form of flatlets, where visitors can more or less look after themselves.

17. PATIENTS' LETTERS, NEWSPAPERS AND TELEPHONE CALLS

What are the arrangements for collecting and posting patients' letters?

Too often a patient in bed has the anxiety of wondering whether the nurse or orderly to whom he gave an urgent letter has remembered to post it when she left the ward. A box for outgoing mail should be clearly indicated in all wards, and all boxes should be cleared at regular intervals daily.

How are the patients' in-coming letters given out?

Is anyone responsible for seeing that the letters are not delayed, either on delivery at the hospital or when they reach the wards?

Can patients in all wards purchase daily newspapers (morning and evening)?

Have patients in all wards access to public telephones?

Now that so many patients get up, it is valuable to have call boxes easily accessible to the wards. Some hospitals have installed tele-trolleys which can be wheeled to the bedside of patients who cannot get up.

II CASUALTIES

1. ACCOMMODATION FOR CASUALTIES

Is there a department providing a night and day service for accident cases and other emergencies?

Can accident cases be brought in and attended to without distress to other patients or visitors in casualty, or in the out-patient department if adjoining?

This applies specially to cases brought in by ambulance.

2. PROCEDURE FOR CASUALTIES

Is every admission to the casualty department seen by a doctor?

It should be a rule of the hospital that no patient in need of medical attention should ever be turned away without seeing a doctor.

What system is used to ensure that really urgent cases are seen without delay?

Patients waiting to see a physician or surgeon in casualty should be under the eye of a suitably qualified person to ensure that an urgent case is given priority.

Is a member of the consultant staff on call at the week-end for casualties, as well as at all other times?

What are the arrangements for access to the dispensary, X-ray diagnostic department, etc. at night and over the week-end?

What are the arrangements for blood transfusion at these times?

What are the arrangements for casualties if they need:
to be detained?
to be admitted?
to see the almoner?
to be referred to another hospital?

In the case of casualties or their relatives detained some time, are there facilities in or near the department for obtaining refreshments?

Where a patient is asked to attend the casualty department for subsequent visits for dressings etc., is there a method in operation for giving him an appointment to save waiting time?

III OUT-PATIENTS

The out-patient department should provide a consultative and specialist service to which general practitioners can refer patients. Its smooth working is greatly facilitated if there is a senior administrative officer in charge of appointments, registration, records, and medical secretaries, and responsible for the lay staff dealing with waiting lists, admissions and discharges.

1. CONTACT WITH GENERAL PRACTITIONERS

Are patients expected to bring doctors' letters?

Constant care is needed to safeguard the "consultative" function of the out-patient department. Patients arriving without doctors' letters should normally be referred to the casualty department.

Are patients referred back to their own doctors whenever and as soon as possible?

Is it the practice of the hospital always to send to general practitioners reports on cases referred to the hospital by them?

These should be sent without delay.

2. REGISTRATION OF PATIENTS

Is the method of registration of patients on their arrival speedy and efficient, from the patients' point of view?

Are particulars taken and passed on in such a way that patients do not have to repeat the same information (e.g. age, address) if they are sent on to other departments or admitted to a ward?

Are the staff carefully selected and trained to adopt a helpful and reassuring manner to the patients?

Patients attending hospital may be in pain or worried. It is important that their first impression of a hospital and its staff should be reassuring.

3. APPOINTMENT SYSTEM

What is the appointment system for out-patients, and who is in charge of it?

Systems of varying degrees of efficiency have been inaugurated in many hospitals, but complaints of the length of waiting time are still among the most frequent comments made on hospitals. Where there is a system which still allows too much waiting, efforts should be made to profit by the experience of hospitals where many of the difficulties have been overcome. It is recognized that some patients come very much in advance of their appointment and then complain that they have to wait, but this is only one factor and once there is an efficient system it can be made clear to the patient that there is no point in arriving an hour or more too early. When patients have to come by an infrequent bus or train service this should be taken into account when their appointments are made.

What is the longest waiting time?

If there is unavoidable delay (e.g. consultant called away for an emergency) does someone explain this to the waiting patients?

4. CLINIC TIMETABLE

Do the clinics get booked up a long way ahead?

How long may new patients have to wait for their first appointment in each clinic?

What system is there for reviewing the clinic bookings and if necessary increasing the numbers of the clinics?

5. LAYOUT OF THE DEPARTMENT

Are the routes to the various departments to which a patient may have to go (e.g. dispensary, X-ray, almoner) clearly indicated by signs?

Directions by word of mouth are often not fully grasped.

Is there a canteen at which refreshments may be obtained throughout the time the department is open?

Is anyone specially responsible for seeing that the out-patient procedure from arrival to departure is working without confusion or unnecessary delay?

In a number of hospitals it has proved valuable for a receptionist or some other responsible person in the department to make periodical tours to eliminate local hold-ups.

Are the waiting rooms made as comfortable and cheerful as possible?

There was for too long a tradition of wooden benches in large draughty halls. Many hospitals have now introduced modern furnishings and lighting in smaller waiting rooms. Where the appointment system is effective, the waiting space need no longer be large enough to contain at one time all the patients expected to attend the clinic.

Are there suitable waiting arrangements for children, both when they come as patients and also when they accompany a patient?

Is there sufficient space in a convenient situation for parking perambulators?

Are there sufficient dressing cubicles, and what provision is made for patients' clothes?

Do the arrangements for taking histories, etc. provide for privacy?

If the various branches of the department are on different floors, is care taken to ensure that aged and infirm patients do not have to negotiate stairs?

6. WAITING LISTS

What arrangements are made to ensure that the Management Committee of the hospital is kept regularly informed of the pressure on beds in the hospital?

Are the waiting lists for the various departments presented at regular intervals?

IV MEDICAL RECORDS DEPARTMENT

One of the main responsibilities of this department is to ensure that patients' notes and records are complete and readily available, both when the patient attends the hospital as an in- or an out-patient, and when the records are required for research or statistical purposes. The records should, therefore, (as suggested in Section III), be in the charge of a responsible officer with the necessary experience and personality to secure the active co-operation and interest of the medical staff. This is facilitated if there is a records committee consisting mainly of members of the medical staff with the records officer as secretary.

1. RECORDS COMMITTEE

Is there a Records Committee?

It is important that an active interest in the work of the records department should be taken by the medical staff.

Is there a suitably qualified officer responsible for carrying out the decision of the Records Committee?

2. COMPLETION OF RECORDS

Who is responsible for writing the abstract after the discharge of an in-patient?

How soon is the abstract completed?

The abstract should normally be completed within a week, and should not in any case take longer than ten days as it is important to get the notes back to the records department before the patient concerned attends out-patients.

What check is there to ensure that records are complete?

This should be the responsibility of a member of the medical staff.

3. CLERICAL ASSISTANCE

What clerical assistance is provided for the medical staff?

What accommodation is there for dictating notes and reports?

Are dictaphones available?

What check is there to see that a report is sent to the general practitioner in every case?

4. LIAISON WITH OUT-PATIENT DEPARTMENT

How are the records collected and prepared for the various out-patient clinics?

Where there is an appointments system in force the work of the records staff is facilitated as they are able to look out the patients' folders before the clinics and obtain any special reports or X-rays not later than the day before the patients are due to attend.

5. LIAISON WITH DIAGNOSTIC DEPARTMENTS

What system is used to ensure that reports from the various diagnostic departments are collated with the patients' records, and that X-ray films are obtained when required in addition to the X-ray reports?

X-rays are usually of different sizes and are too unwieldy to store with the records; it is therefore necessary to devise some system whereby they can be collated as and when required.

6. NIGHT SERVICE

Are records available in an emergency after the department is closed, and what check is kept on records taken out in this way?

7. STORAGE OF NOTES

Is the record storage accommodation adequate?

In many hospitals it has been found that storage space is wholly inadequate and material which might be valuable for research purposes is lost through bad or inadequate storage. Some hospitals have adopted microfilming although it is not favoured everywhere as a satisfactory solution of the storage problem.

Are records readily available for research or follow-up purposes after the patient has ceased to attend the hospital?

V THE AGED AND CHRONIC SICK

One of the problems of the day is to provide accommodation and staff for those generally referred to as the chronic sick, i.e. patients (usually old people) requiring some degree of medical and nursing care more or less permanently. It is important to ensure that there is an active programme of rehabilitation for all those capable of responding to it and of going home or to other accommodation.

The problem is often social rather than medical, and the long waiting lists for these beds may contain the names of many whose doctors have recommended them for admission, but who could remain at home if certain services were provided. Similarly, others could be discharged from hospital if home conditions were more favourable, or if some assistance or supervision could be given. The problem is of course made greater by the increasing numbers who live entirely alone.

It is essential that the waiting lists should be checked regularly in order to ensure that only the names of persons genuinely needing admission remain on them. It can happen that a waiting list is inflated with the names of those who no longer need admission. This may lead to a defeatist attitude.

1. THE SOCIAL ASPECT

Is there an almoner or other person with special responsibilities for investigating the social factors involved in each case referred for admission, or ready for discharge?

Are steps taken to refer suitable cases to district nurses?

Are there any other arrangements in the area to assist those for whom there is no vacancy in hospital, e.g. "meals on wheels", home helps, home laundry service etc.?

Is there any arrangement for keeping in touch with local authorities dealing with the same problems?

2. THE MEDICAL ASPECT

Is the hospital following an active policy in the treatment of chronic and aged patients?

Are full facilities for physiotherapy and occupational therapy available?

Does a member of the medical staff undertake domiciliary visits to decide on urgency of need for admission?

Does the hospital (or group) provide geriatric beds and chronic beds corresponding to the needs of the area?

Are there any special out-patient clinics for these patients?

Often much can be done by physiotherapy, chiropody, etc., to keep old people active.

3. GERIATRIC AND CHRONIC WARDS

Are the geriatric and chronic wards made as cheerful and attractive as possible?

This is perhaps even more important than in the acute wards, where most patients stay only a short time. For many the chronic ward is in fact their only home. They should be given freedom to have some of their own possessions around them, and latitude in receiving visitors who may come outside the official visiting hours—if indeed such are necessary in these wards. A flexible attitude towards rules and routine, and tolerance of individual vagaries, are very desirable, though admittedly not easy to achieve with the low ratio of nursing staff often found in these wards. It is here that older part-time staff, including assistant nurses and nursing auxiliaries, can often make their most valuable contribution.

Is the day-room accommodation warm and comfortable?

It may be practicable to have a common-room for both male and female patients. If this serves patients on different floors, lifts that will take wheel-chairs must of course be available. Someone must be responsible and on call for the day-room at all times when it is in use.

VI OPERATING THEATRES

Attention has been lavished upon the operating theatres for many years past, and it is nowadays rare to find an operating theatre which suffers from defects apparent to a casual observer. Unless professionally interested, the visitor is probably well advised to avoid spending much time in operating theatres and their immediate precincts.

1. ACCESS TO THEATRE, ETC.

Is the access to the theatre and anaesthetic room placed satisfactorily from the patients' point of view?

There should be a suitable place for patients to wait. This should be free from draughts. The anaesthetic room should be fully screened from the theatre, care being taken to ensure that no instruments are in evidence. Cross traffic, particularly to children's wards, should be avoided.

2. RECOVERY UNIT

Is there a recovery unit attached to the theatre, and staffed from it?

This may be a small ward where patients remain until the effects of the anaesthetic have worn off, or it may be an intensive nursing unit for patients who need constant skilled post-operative care.

Do patients operated on in the evening or at night remain in the recovery unit until the next morning, to avoid disturbances in the wards?

If there is no recovery room, who accompanies patients to the wards after operation?

In the past this has too often been left to an inexperienced student nurse.

VII X-RAY AND PATHOLOGICAL DEPARTMENTS

There should be close co-operation between these departments and the records department to ensure that reports when completed find their way without delay to the patients' folders.

1. X-RAY DEPARTMENT

Is there an effective appointments system?

Is sufficient seating accommodation provided, and is this comfortable?

Is there adequate dressing-room accommodation?

Are patients protected from chill while awaiting X-ray?

Are there always enough dressing gowns of suitable size and in good condition?

What arrangements are there to ensure that patients sent down from the wards do not have to wait?

Is the ventilation of the dark room and throughout the department satisfactory?

2. PATHOLOGICAL LABORATORY

The second question above may usefully be asked in this department also.

Is the patients' convenience studied?

Frequently patients have to attend in quite unsuitable places (e.g. near the post-mortem room) and may have to walk long distances.

Where the numbers attending are rapidly increasing, the arrangements originally intended for much smaller numbers may be wholly inadequate and may result in queues. The visitors should make a point of asking to see the accommodation provided for patients awaiting examination.

VIII PHYSICAL MEDICINE, OCCUPATIONAL THERAPY AND REHABILITATION

1. PHYSIOTHERAPY

Is there sufficient and up-to-date apparatus, both gymnastic and electrical?

Are arrangements for privacy adequate?

Is the ventilation good and is the air kept fresh even when the department is in full use?

2. OCCUPATIONAL THERAPY

Are any arrangements made for occupational therapy?

If so, is it:

(i) for in-patients (chronic, long-term, or any who may benefit)?

(ii) for out-patients?

(iii) for day-hospital patients, where there is one?

3. REHABILITATION

Who is ultimately responsible for rehabilitation in the hospital?

A Ministry of Health circular emphasizes the importance of physiotherapy, remedial gymnastics and occupational therapy in the medical rehabilitation of disabled patients and recommends the appointment of a responsible member of the medical staff at all larger hospitals to supervise the rehabilitation services, and ensure close liaison with the Ministry of Labour disablement resettlement officers.

IX MEDICO-SOCIAL SERVICE OR ALMONERS' DEPARTMENT

1. STAFF OF DEPARTMENT

Can enough professionally qualified almoners be obtained?

If not, what steps are taken to supplement their services?

There have been 250 *known vacancies in the country for some time, and many hospitals employ social workers who have not qualified as almoners.*

What clerical staff is provided for the department?

Is this found to be sufficient?

There is no generally accepted standard of staffing for medico-social service departments, and there are wide divergencies between hospitals in other respects comparable. Teaching hospitals especially tend to have a much higher ratio of almoners to patients than non-teaching hospitals, partly because the recording of social data is often an important requirement of medical research. The ratio in teaching hospitals will, therefore, rarely be lower than 1 *almoner per* 100 *beds and associated out-patients, and sometimes considerably higher. In non-teaching hospitals the social conditions prevailing in the area and the size of the out-patient department should be the main influencing factors.*

2. INTERVIEWING

Do the almoners interview all patients referred for admission, to see if they need help or advice?

Do they make a point of seeing all patients who have been admitted overnight as casualties or emergencies?

3. CONVALESCENT HOMES

Are the almoners finding difficulty in getting patients placed at convalescent homes?

The King's Fund publishes a Directory of Convalescent Homes which is widely used in hospitals. It gives details of homes taking patients from the London area. (*see Appendix*).

Is there difficulty with regard to certain categories of patients?

If so, is it because of conditions existing within the convalescent homes (e.g. no lifts or ground-floor bedrooms for cardiac patients). or because of long-standing rules?

Do some patients have to go home while waiting for a bed in a convalescent home?

4. SAMARITAN FUND

Have the almoners an adequate Samaritan Fund at their disposal for cases of hardship outside the scope of statutory arrangements?

X CHAPLAINS AND CHAPELS

1. CHAPLAINS

Is there a full-time chaplain?

How often are services held in each ward?

Are all new patients visited by their respective chaplains?

It is important that the names of patients admitted since each chaplain's previous visit should be readily available to him.

Are chaplains of all denominations available if sent for to see particular patients?

2. CHAPEL

Has the hospital its own chapel?

If so, what impression does it give?

If not, is there a quiet room available at all times to staff, patients, the chaplains?

Is it suitably furnished?

In some hospitals there is no suitable place for the chaplain to talk with anxious or bereaved relatives.

Who is responsible for the care of the chapel or quiet room?

Is it available to all chaplains?

3. MORTUARY CHAPEL

Is there a mortuary chapel?

Who is responsible for its care, for seeing there are flowers, etc.?

Who accompanies relatives to the mortuary chapel and looks after them:

during the day?

at night?

In many hospitals it is thought well for senior members of the nursing staff to carry these responsibilities.

Is the approach to the mortuary chapel entirely separate from the approach to the post-mortem room?

XI ACCOMMODATION FOR MEDICAL STAFF

Is the accommodation for the resident medical staff sufficient and of good standard?

Are married quarters provided for registrars and house officers?

Outlying hospitals have great difficulty in attracting junior medical staff.

XII THE NURSING SERVICE AND SCHOOL

1. RECRUITMENT OF TRAINED AND OTHER NURSING STAFF

Can the hospital recruit sufficient:

sisters?

staff nurses?

staff midwives?

enrolled (assistant) nurses?

nursing auxiliaries?

If the trained staff is not up to the authorized establishment, what means of recruitment are employed?

Is there full freedom for trained staff to be non-resident?

Has the hospital provided, or is it planning, any "flatlet" accommodation where staff may live on a non-resident basis?

This is becoming increasingly popular. If there is special difficulty in obtaining trained staff for night duty, it may help if some part of such accommodation is reserved entirely for those on night duty.

Does the hospital keep a register of suitable accommodation in the neighbourhood?

Is the fullest possible use made of part-time staff?

Are the resources of the neighbourhood fully explored?

As the marriage age comes down, and the proportion of unmarried women decreases, it becomes more and more necessary to augment the services of full-time staff by employing part-time helpers, notwithstanding administrative problems—e.g. those with home claims may not be free at peak hours of ward work or at week-ends. Those who will work two or three nights a week are particularly valuable.

To what extent are nursing auxiliaries employed?

What training does the hospital give them?

2. RECRUITMENT OF CANDIDATES FOR TRAINING

Can the hospital recruit sufficient:

student nurses?

pupil (assistant) nurses?

pupil midwives?

What methods are used to recruit candidates for training?

Has the hospital a minimum educational standard or entrance test for student nurses?

The General Nursing Council recommends an entrance test for all who have not attained a stated educational standard. It is proposed to make this compulsory from 1*st July*, 1962.

Is the hospital in touch with the Nursing Recruitment Service?

The King's Fund has maintained this as a service to hospitals since 1940. *Hospital matrons who have a surplus of candidates may help other hospitals if they refer candidates whom they are refusing, or who are unwilling to join the waiting list, to the Nursing Recruitment Service, to be guided to other hospitals for which they may be eligible.*

If the Recruitment Service is notified of vacancies and kept informed of entrance requirements, it may be possible to send candidates, though of course the Service has no powers of direction, and recruitment to a particular hospital must depend largely upon its reputation and circumstances (*accessibility, type of work, etc.*)

Does the hospital train male nurses?

If so, is there residential accommodation for them?

If the hospital is a training school for assistant nurses, is a part-time course available to those with certain home claims?

3. ECONOMIZING THE TIME OF NURSING STAFF

Is everything possible done to conserve the time of nurses, e.g. by the employment of ward orderlies for non-nursing duties formerly carried out by the nurses, by giving the ward sisters some clerical

help, by the elimination of routine procedures which have become unnecessary, by a constant study of methods to this end and by the fullest use of labour-saving devices?

Nurses spend a great deal of their time walking to and fro in the wards, and often the equipment they need could be placed more conveniently.

4. SCHOOL OF NURSING

Do the lecture rooms and classrooms have a pleasant appearance?

Are they light, warm and well ventilated?

Is the equipment fully up to date and does it correspond exactly with that in use in the wards?

What capital expenditure, if any, has there been on the school in the last ten years?

While there are Area Nurse Training Committee funds for the maintenance of the school, any capital expenditure on it must compete with all the other needs of the hospital and may fail year after year to gain the necessary priority.

Is there a library in the nursing school?

Is it freely available every day to all members of the nursing staff, trained and in training?

Does it appear to contain sufficient books for these numbers?

Sometimes a shelf or two of books is referred to as "the nurses' library".

Are medical and nursing periodicals available?

Is the library furnished and arranged in such a way as to encourage nurses to spend time there?

Do the nurses have to attend lectures or classes in off-duty time?

Many hospitals now have the block system of training, whereby nurses are withdrawn from ward duties for a short term of study each year. In some other hospitals students have a weekly study day.

What part do the ward sisters take in the teaching of the nurses?

Do they have any preparation for their teaching responsibilities? (see 8).

Is there a Nurse Education Committee?

5. NURSES' HOMES

Is the accommodation for the nurses in keeping with modern standards?

Is there sufficient accommodation for all who wish to be resident:
student nurses?
trained nurses?
auxiliaries?

Could the hospital recruit more nursing staff if more accommodation were available?

Are there single bedrooms for all?

Are they well heated?

Do they have wash-basins with hot and cold water?

If not, are there curtained or partitioned washing cubicles near all rooms, in sufficient numbers?

What are the facilities for:
making hot drinks and occasional meals?
hair-washing and drying?
doing personal laundry (including drip-dry arrangements)?
ironing?

What is the ratio of bedrooms to: bathrooms?
water-closets?

Suggestions for minimum requirements may be found in the Memorandum on the Supervision of Nurses' Health (*see Appendix*).

Do the resident night nurses have a separate home, floor or wing which is kept quiet during their sleeping hours?

6. RECREATION AND OFF-DUTY TIME

What facilities are there for recreation and exercise:

(i) indoor?

(ii) outdoor?

How long in advance do the nurses know their off-duty time?

Is it often necessary to change this at short notice?

Uncertainty about off-duty time and difficulty in arranging to meet friends are frequent causes of complaint. A schedule of off-duty times can be drawn up for at least a month so that a nurse may know when she is off duty each day, apart from changes due to real emergencies.

7. SUPERVISION OF NURSES' HEALTH

Who is in charge of the nurses' health?

The appointment should be held by a senior physician, or by an experienced general practitioner who can give sufficient time to the work.

Is there a daily clinic which any nurse may attend?

Are the recommendations of the King's Fund in respect of health care of staff observed?

These have been endorsed by the Ministry of Health and General Nursing Council, and widely adopted (*see Appendix*).

Are individual staff records kept of routine medical examinations, tests and immunizations, illness etc.?

Standard record forms for use by hospitals have been drawn up and published by the King's Fund. They are now in use at many hospitals. Samples and current prices can be obtained upon application. (*see Appendix*).

What accommodation is there for sick nurses, and who looks after them?

In many hospitals, the post of sister in charge of the nurses' health is now a full-time one. It is only in smaller hospitals that the work should be combined with administrative or home sister's duties.

8. FURTHER TRAINING

What opportunities of further education, if any, do the trained staff have?

This may take any of the following forms:
experience in some chosen specialty within the hospital,
study days for ward sisters and staff nurses,
short periods of experience in the tutors' department,
in-service training in administrative duties,
study leave to attend outside courses.

Subject to certain conditions, hospital authorities may second members of staff on study leave with full pay. Various courses are available at the Royal College of Nursing and elsewhere. The King's Fund has two residential Staff Colleges for nurses. At one, twelve-week courses are offered in preparation for ward sisters' duties, and four-week refresher courses for experienced ward sisters and male charge nurses. At the other, one-year courses in nursing administration are given, and four-week refresher courses for matrons and chief male nurses and their deputies. Special courses are arranged at both Staff Colleges for staff from mental and mental deficiency hospitals, who are also eligible for all other courses.

9. ATTENDANCE OF MATRON AT MEETINGS

Does the Matron attend all meetings of the:

House Committee?

Hospital Management Committee or Board of Governors?

Ministry of Health Circular H.M. (59) 21 *recommends that matrons should attend all meetings of the House Committees of their hospitals, and also meetings of Management Committees where matters directly or indirectly affecting their departments are being discussed. Also that the matrons of all hospitals in a group should be represented at meetings of the Management Committee by one of their number.*

In mental hospitals these considerations should apply to chief male nurses also.

XIII CATERING DEPARTMENT

These notes and questions apply primarily to hospitals with more than 100 beds.

The catering department is responsible for the feeding of all the patients and staff and should be under the control of a qualified catering officer supported by a trained staff. When the catering officer is not a dietitian the hospital should employ one for special diets, wherever practicable. The King's Fund has published various catering manuals, which are referred to in this section, and listed in the Appendix.

1. ADMINISTRATION OF THE CATERING DEPARTMENT

Is there a qualified catering officer in charge of the department?

Is there a dietitian on the staff?

If there is no dietitian in the hospital there may be one within the Group who could give advice on the arrangements for special diets.

Alternatively, since there is a great shortage of dietitians, an attempt might be made to find a dietitian living in the neighbourhood—perhaps married—who could serve in a part-time capacity. In the absence of a dietitian the catering officer often has to take responsibility for the special diets. He may then derive help from the Fund's Memorandum on Special Diets, and from the ward sisters. (*see Appendix*)

2. CATERING STAFF

Is there a shortage of trained staff, and, if so, what steps are being taken to remedy the situation?

Does the hospital participate in the Ministry's apprenticeship scheme for the training of hospital cooks?

Is satisfactory provision made for dining-rooms and changing-rooms for the catering staff?

Are kitchens and other working premises provided with proper lighting and are they adequately ventilated?

Are hand-basins provided for staff to use after going to the lavatory?

Are notices displayed enjoining the staff to practise hygienic methods in their work and to maintain a high standard of personal hygiene?

3. BUYING

Does the catering officer buy all the provisions or does he place orders through the supplies department?

It has been suggested that a fully qualified catering officer in a hospital serving more than 500 *midday meals should be responsible for the buying of all foodstuffs and that the less experienced catering officers in smaller hospitals should place their orders for provisions through either the hospital secretary or the supplies officer.* (*See Chapter* 5 *of the Third Memorandum on Hospital Diet published by the King's Fund*).

Are there any local markets for fruit, vegetables, etc., and if so does the catering officer visit them regularly?

4. STORAGE AND REFRIGERATION

Is the buying of commodities limited by accommodation in the provisions store?

Have the cold rooms/refrigerators sufficient capacity, particularly during the warmer months of the year?

Suitable dry and cold storage accommodation is essential to the economical running of the catering department.

Are all goods received in the store checked for weight, number and quality by a responsible member of the catering department?

5. SERVICE OF MEALS

(a) Patients:

Are the heated trolleys or other equipment used in transporting meals to the wards efficient and do the patients receive their food really hot?

As catering and nursing staff share the responsibility for the service of patients' meals, close co-operation is essential, particularly between the ward sisters and the catering officer, who should visit the wards regularly.

Do the patients have a choice of dishes?

Do they express satisfaction with their meals?

(b) Staff:

To what extent are staff offered a choice of dishes, and at what meals?

The Third Memorandum on Hospital Diet recommends a wide choice of dishes. This is more easily achieved where there is a common staff dining-room with a good service counter and a cafeteria type of service, spread over as long a period as possible.

Is the supervision of meals in the staff dining-rooms satisfactory?

No matter how good the food may be, the enjoyment of a meal is dependent in no small degree on the manner in which it is served.

It is therefore essential that dining-room staff receive training in at least the elementary techniques of waiting or counter service.

Do the night nurses have their meals freshly cooked?

6. PREPARATION AND COOKING

Does the layout or equipment of the main kitchen limit the variety of the menu?

Is food, particularly for the midday meal, prepared long in advance of the time for service?

The need to serve all patients' meals at the same time often leads to this, or imposes a heavy burden on a large hospital kitchen. The situation could be alleviated if meal times in the wards could be staggered.

7. WASTE

What weight of waste food goes into the swill bins each week?

In an efficiently run catering department, food waste of all kinds from wards and kitchens should not exceed 10 *ozs. per head (patients and staff) per day.*

XIV HOSPITAL CLEANING AND DOMESTIC MANAGEMENT

1. GENERAL MANAGEMENT

Is there a long-term programme of redecorating and wall-washing to cover all parts of the hospital?

How often is it reviewed?

Who is responsible for maintaining the cleanliness of corridors, staircases and departments (walls and floors)?

These parts of the hospital often show signs of neglect, due in some cases to lack of clear definition of responsibilities.

2. DOMESTIC MANAGEMENT

Who is in charge of the domestic staff?

In some hospitals the supervision of domestic staff is shared by an assistant matron or administrative sister who has many other duties, home sisters, catering officer and ward sisters.

The Fund's Memorandum on the Employment of Domestic Staff in Hospitals urged that domestic supervision should be a full-time job in all but the smallest hospitals, and that there should be a suitably qualified domestic superintendent responsible for the recruitment, training, allocation, and supervision of domestic staff, and for acting as welfare officer. In large hospitals he or she should have supervisors to assist. His or her line of responsibility should be through the matron or such other senior officer as the Committee may appoint. Obviously there should be the closest collaboration with the nursing staff, particularly in the wards. (*see Appendix*).

Has the hospital experienced difficulty in finding a domestic superintendent with appropriate training and experience ?

Are the responsibilities of the post clearly defined, and is corresponding authority given ?

3. DOMESTIC STAFF

Is there a shortage of domestic staff :

full-time ?

part-time ?

Is the turnover rate of domestic staff :

high ?

increasing ?

less than formerly ?

What was the turnover rate in the previous year ?

Is there an active recruitment policy ?

What steps are taken ?

Are there any arrangements for the induction and training of the domestic staff ?

> *The ward staff seldom have sufficient time to give to the training of new domestics. A training scheme not only pays dividends in increased efficiency, but also may help to reduce wastage of staff, by instilling pride in work and a sense of contributing towards the patients' well-being.*

Are they taught the care and proper use of electrical cleaning and polishing equipment ?

What arrangements are there for the regular inspection and maintenance of equipment used by the domestic staff ?

Is there sufficient accommodation for all the resident domestics who could be recruited and does it appear satisfactory ?

Do the living conditions appear to be in line with modern standards (e.g. as to heating, washing facilities, sufficient bathrooms and water-closets, sitting-rooms) ?

Are there suitable changing-rooms for non-resident domestics, with washing facilities, lockers with keys, provision for wet coats and umbrellas etc. ?

XV LIBRARY SERVICE

The responsibility for providing reading matter for patients rests with the Hospital Management Committees. The following provide library services :

Order of St. John.

British Red Cross Society.

Public Library authorities.

Hospitals' own Libraries.

Toc H., W.V.S., and other voluntary bodies.

Is there a library service for patients and staff ?

What organization supplies it ?

How often does the book trolley visit each ward ?

Is the service fiction and non-fiction ?

Is there also a library/reading room which ambulant patients can visit?

This question would only be appropriate in large hospitals, but in all hospitals there should be working space for the librarian, as well as storage space for books. It is specially valuable for mental patients to have a reading room.

How long is it open during the week ?

Can patients generally get the books they require from stock ?

If not, are books obtained specially ?

"The standard of books provided in hospitals should be that of books provided to the general public by the best public libraries. This applies both to the types of book made available and to the condition of the books. The committee cannot too strongly emphasize their view that hospital patients have a right to at least as great a consideration of their reading needs as have other members of the public." Report of an Independent Committee which made a Pilot Survey of Hospital Library Services, sponsored by the King's Fund. (see Appendix).

Do staff use the library freely ?

Are the books in good condition ?

XVI ADMINISTRATIVE MEASURES TO REDUCE NOISE

This and the following sections relate mainly to matters of general management. A few of the questions have already been suggested for use in the wards and departments, but they are grouped here in a form which might lend itself for discussion with the chief administrative officers.

What is done to reduce or eliminate noise from outside the hospital altogether ?

Hospitals sited close to railways or traffic thoroughfares are at an obvious disadvantage, and the elimination of noise may be impossible or prohibitively expensive. Expert advice may be taken on the noise-reduction likely to result from the use of double-glazing, baffle-doors, acoustic panelling and tiles, etc. "Hospital—Quiet Please" notices strategically placed may be of help.

How are the areas for delivery, collection or removal of such things as milk bottles or churns, oxygen cylinders, stores, laundry or dustbins situated in relation to the wards ?

Could any changes be made to reduce the noise reaching the wards?

These noises often occur at hours when patients should be asleep.

Is motor transport within the hospital grounds routed to pass close to the wards ?

How close to the wards are the waiting areas or traffic-ways for out-patients, visitors or staff ?

The design and lay-out of the hospital may rigidly determine the various service areas and traffic routes, but in some cases it may be possible to re-arrange them so that there is less danger of disturbance to in-patients.

Is there a routine system for the inspection and maintenance of such things as doors, lift-gates, windows, castors and wheels, etc. ?

Is any mechanical cleaning equipment unduly noisy ?

When new equipment is being bought, is care taken to select the quietest, provided it is suitable ?

Are notices used to invite the co-operation of visitors and others in keeping the hospital as quiet as possible ?

The hospital staff themselves can obviously do more than anyone else to control noise in the hospital. Ward sisters and heads of departments hold a special responsibility for obtaining the co-operation of their staff in reducing noise to a minimum.

Is the question of noise continually under review, and by whom?

Noises that have occurred for some time may not be observed by the staff of the department. Various practical suggestions are made in the Fund's leaflet on Noise Control in Hospitals (see Appendix).

XVII STAFF ACCOMMODATION AND WELFARE

It has sometimes been said that hospital authorities lag behind other organizations in the provision of adequate arrangements for the care and welfare of their staff. It is important that proper attention be paid to this aspect of management.

Are there sufficient changing-rooms of good standard for all non-resident staff ?

Are they well equipped ?

If accommodation is lacking, has consideration been given to the possibility of adapting existing premises for the purpose ?

Is a restaurant or canteen provided for all non-resident staff ?

What are the washing and changing facilities for staff who may be engaged in dirty work (e.g. porters, stokers)?

What arrangements are there for such matters as joint consultative committees, suggestions schemes, staff amenities, and other matters that might come under the broad heading of personnel management?

XVIII MAINTENANCE AND SAFETY PRECAUTIONS

1. CONDITION OF BUILDING AND GROUNDS

Is the external appearance of the hospital attractive, and such as to give a good impression ?

Does the building appear to be in a good state of repair ?

Are the grounds surrounding it kept in a satisfactory manner ?

Could the appearance be improved by shrubs, trees, or turf ?

Who is directly responsible for organizing and supervising the work of the maintenance staff ?

2. DIRECTION SIGNS

Are the direction signs easily seen and understood, up to date and reasonably uniform ?

Are they kept in a fresh, clean condition ?

3. FIRE PRECAUTIONS

What degree of liaison exists with the local fire authority ?

Are regular fire drills held ?

When was the last fire drill ?

Who is responsible for checking the fire appliances and equipment installed in the hospital ?

4. SAFETY PRECAUTIONS

What action is taken to analyse and investigate the causes of any accidents to patients or staff ?

Every hospital authority has a moral and legal responsibility for the safety of its patients and staff, and constant attention is necessary if high standards of safety are to be achieved and maintained.

What precautions are taken to minimize the risk of confused or restless patients falling out of bed ?

Are the floors slippery ?

Accidents have occurred to both patients and staff because ward floors have been slippery. Some floor seals obviate slipperiness.

Is the general lighting of the hospital and grounds adequate at night?

What system is in force for the routine inspection and maintenance of mechanical equipment, such as autoclaves, kitchen machinery, physiotherapy apparatus, etc. ?

Are there adequate safeguards against the misuse or neglect of gas or electric installations (e.g. fires, irons, washing and drying machines), particularly in nurses' homes ?

Are time-switches used to control the use of such things as lights, fires or irons ?

Responsibility for such matters tends at times to be somewhat ill-defined. The proper training of staff, followed by proper control and supervision, pays good dividends in the form of better standards of safety and efficiency.

5. PRECAUTIONS AGAINST INFECTION

Is one officer or committee responsible for constant vigilance in regard to the control of infection ?

What steps are taken to ensure that catering, domestic and other staff are infection-free and fit to work in the wards or elsewhere ?

How are non-professional staff made aware of the importance of health and cleanliness in any work concerned with the patients ?

Medical, nursing and other professional staff are generally very well aware of the risks of cross-infection and of the precautions that need to be taken. Insufficient attention is sometimes paid to the part which other staff may play in reducing the risks of spreading infection.

Is there equipment for sluicing all foul linen centrally ?

This should never be done in the wards by nurses or orderlies. Not only may hands be contaminated, but too often in the past the rinsed linen has been hung up to dry in ward annexes (see the Report of the Committee on Hospital Laundry Arrangements).

Have the other recommendations of the Committee on Hospital Laundry Arrangements been put into effect? (see Appendix).

One of the most important is that all counting of soiled linen in the wards and departments should cease. Soiled linen when taken off the beds should be placed immediately in containers which are sealed and sent to some central collecting point.

XIX MISCELLANEOUS

1. VOLUNTARY HELP, AMENITY FUNDS

Is there a League of Friends ?

In what ways does it help ?

In some Leagues the members give personal service to patients or to the hospital. This may take such forms as visiting patients who have no relatives in the neighbourhood, writing letters for elderly or blind patients, taking patients out, staffing canteens and so on. Other Leagues raise funds which provide valuable amenities—for example, mobile telephones for the use of patients who cannot leave their beds, wireless installations, the curtaining of beds in open wards to give some measure of privacy, the furnishing of day rooms for patients who get up, and capital contributions towards a new chapel, or a recreation hall for the staff.

2. WORK STUDY

Have work study experts been called in to advise on any aspects of the work of the hospital ?

If so, what are the results ?

If not, are there any plans for a study of methods with a view to saving labour ?

3. TELEPHONE AND CALL SYSTEMS

Is the external telephone system adequate as regards the number of lines and extensions ?

Is there a sufficient staff of telephone operators to avoid delays ?

Are there special lines for use in an emergency, which can be kept free of incoming calls ?

Is there an efficient call system for locating members of the staff, without undue disturbance of the patients ?

What is the procedure for dealing with telephone requests from general practitioners for the admission of emergencies?

It is very desirable that general practitioners should be given prompt and definite answers.

APPENDIX

Publications which have been mentioned in the text, or which hospital visitors might find useful for reference.

A.

PUBLICATIONS OF KING EDWARD'S HOSPITAL FUND FOR LONDON, OBTAINABLE FROM 34 KING STREET, LONDON, E.C.2.

HOSPITAL ADMINISTRATION

Hospital Administrative Staff College. Prospectus. Free.

Hospital Bed Occupancy, 1954. Report of a study group at the Hospital Administrative Staff College on the problems relating to hospital bed occupancy. 2s. post free.

The Internal Administration of Hospitals, 1951. Being evidence submitted by King Edward's Hospital Fund to the Committee on Internal Administration of Hospitals appointed by the Central Health Services Council. Free.

Hospital Visiting, 1960. 2s. post free.

NURSING ETC.

Memorandum on the Supervision of Nurses' Health, Second Edition, 1950. 3d. post free.

Health Record Forms for Nursing Staff. Designed to fulfil the requirements of the above Memorandum. (Samples and price lists on request.)

Nursing Staff. Considerations on Standards of Staffing, 1945. 6d. post free.

Domestic Staff in Hospitals, 1946. 9d. post free.

Staff College for Ward Sisters. 1. *Prospectus.* 2. *Notes on Practical Experience* (for students at the Staff College). Free.

Staff College for Matrons. Prospectus. Free.

HOSPITAL CATERING

Third Memorandum on Hospital Diet, 1959. 2s. post free.

Memorandum on Special Diets (second edition). 2s. post free.

General Hospital Diets: a guide to the cost of feeding patients, with menus and recipes (third edition, 1959). 5s. post free.

Catering Circulars. From time to time circulars on hospital catering and diet are published by the Fund's Hospital Catering Advisory Service.

At present the following circulars are available:

Care of Equipment .. .. 2s. post free.
Layout and Design .. .. 1s. post free.

School of Hospital Catering at St. Pancras Hospital. Prospectus. Free.

CONVALESCENT HOMES

Directory of Convalescent Homes. A directory containing details of nearly 200 convalescent homes, both National Health Service and independent, accepting patients from the four metropolitan hospital regions, published annually. 7s. 6d. post free.

MISCELLANEOUS

Noise Control in Hospitals. A short report of an enquiry into noise in hospital wards together with suggestions for its control, 1958. 1s. post free.

Report of Sub-Committee on Mental and Mental Deficiency Hospitals in the London Area, 1955. Free.

Time-table of Out-patient Clinics at Hospitals in the Greater London Area, published annually. 1s. post free (Free to general practitioners).

Hospital Library Services—A Pilot Survey. Report of an Independent Committee sponsored by King Edward's Hospital Fund, 1959. 2s. 6d. post free.

Annual Reports of the King's Fund. Free.

B.

REPORTS OF THE CENTRAL HEALTH SERVICES COUNCIL, MINISTRY OF HEALTH, OBTAINABLE FROM HER MAJESTY'S STATIONERY OFFICE

The Reception and Welfare of In-patients in Hospital (1953) 9d.

Report of the Committee on the Internal Administration of Hospitals (1954) 3s.

Report of the Joint Sub-Committee on the Control of Dangerous Drugs and Poisons in Hospitals (1958) 2s.

Report of the Committee on Hospital Laundry Arrangements (1959) 1s. 3d.

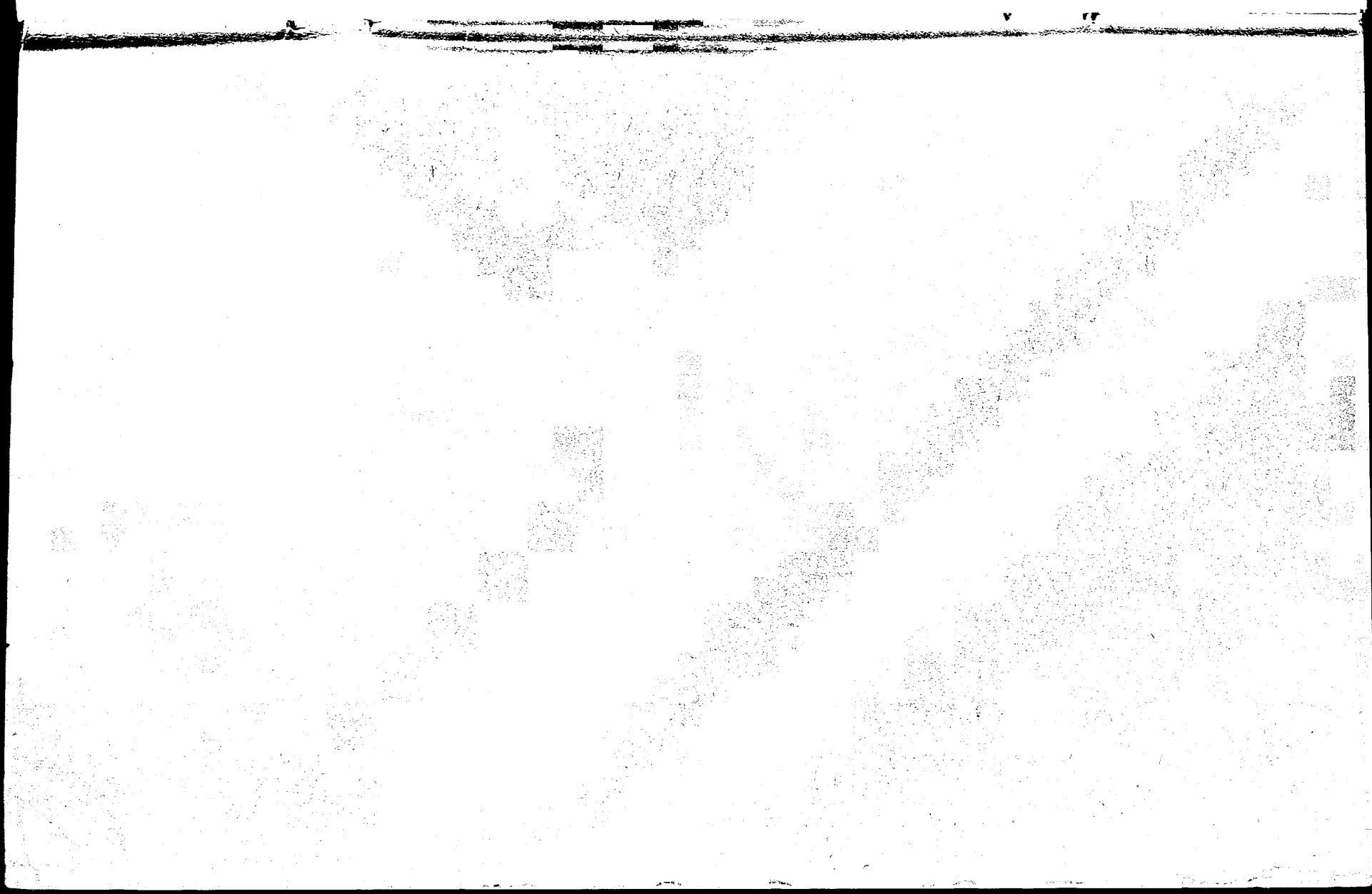
C.

HOSPITAL O. AND M. SERVICE REPORTS, OBTAINABLE FROM HER MAJESTY'S STATIONERY OFFICE

1. *Out-Patient Waiting Time* (1958) 1s. 3d.
2. *Medical Records and Secretarial Services* (1959) 2s.
3. *Chest Clinics* (1959) 1s. 9d.
4. *Organization and Management of Domestic Work in Hospitals* (1960) 2s.

DIVISION OF HOSPITAL FACILITIES

It has been the policy of this Manual to avoid detailed discussion of hospital design, structure and equipment. Those who require information of a technical nature are invited to consult the Division of Hospital Facilities at the headquarters of the Fund at 34, King Street, London, E.C.2.



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