Old people in hospital

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Old people in hospital

a survey of opinions of patients, visitors and staff

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St John's Hospital, London
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WR and JM
1979

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Preface

Over the past decade anyone interested in the provision of health care in Britain, whether as an administrator, professional or researcher, has had reason to be grateful to Winifred Raphael. Her series of surveys on how patients view life in hospitals, sponsored by the King's Fund, the first of which was published in 1969, broke new ground and provided new insights.

In the transformation of attitudes towards the provision of health care, in the gradual recognition that patients are more than passive recipients of care, Winifred Raphael's surveys played an important part. They showed that patients could express sensible views about those aspects of hospital life about which they know more than anyone else: those aspects about which they are, by definition, the experts — the impact of the daily routine of hospital life on those who are being cared for. In particular, they drew attention to what might be called the 'pea under the mattress' syndrome: the fact that a disproportionate amount of irritation can be caused through lack of thought about minor and remediable aspects of hospital life such as noise at night. If those who work in hospitals have become more aware of the needs and preferences of patients, no little measure of credit is due to Winifred Raphael.

This, sadly, is the last such survey carried out by Winifred Raphael. She died soon after completing her report. But the impact of her work will not die with her. For one of the characteristics of her surveys was that these were not just designed as a once-and-for-all investigation into the specific circumstances of particular hospitals. They did, indeed, yield a great deal of new and highly interesting information about patients' views. But, perhaps even more important, they provide a do-it-yourself kit for administrators and others who wish to use such surveys as a means of reviewing their own performance in terms of its impact on patients. In this respect, Winifred Raphael's contribution was not merely to test the technical feasibility of such surveys but also to demonstrate that they could be made acceptable to the staff concerned. Her work showed that surveys are not necessarily threatening — indeed the reverse turned out to be the case, since they demonstrated that most patients are highly satisfied with the personal care they get from nursing and other staff — and that they can therefore be used as a routine tool of management.

Equally important, and particularly relevant to this report, Winifred Raphael extended our ideas about what was possible in the way of interviewing patients about their experience. Her first survey dealt with patients in general hospitals. Her second survey, published by the King's Fund in 1972, dealt with patients in psychiatric hospitals. This survey deals with long-stay patients in geriatric hospitals: precisely those, in other words, where it might be thought that the patients would be least able to participate in a survey. In the event, it turned out to be possible to interview two-fifths of the patients in the hospitals taking part in the survey. And if the result is not necessarily a generalisable picture of life on the geriatric ward, the survey does provide the kind of very specific, down-to-earth insights into what pleases and worries patients which can make so much difference in terms of making life more pleasant for them.

It is to be hoped, therefore, that its publication will encourage widespread imitation; once again, it is clear that such surveys do not precipitate a torrent of negative or hostile criticism — indeed the expectations of patients, compared to staff, are modest in the extreme — but, on the contrary, tend to elicit helpfully constructive suggestions for improvements. Interviewing patients in long-stay institutions may be rather more difficult that in acute hospitals. It is even more important, however, because such patients lack the option of exit if they do not like their environment, and are unlikely to be vocal even if conditions are less good than they should be.

This report is written with characteristic sensitivity to the texture of hospital life. For if Winifred Raphael's surveys over the years have helped to extend our perceptions of what it means to be a patient, if she provided a mirror in which those running hospitals could see themselves in a new light, it was because her work drew on a sympathetic understanding of the strains and tensions which fall on both health service providers and consumers.

RK
1979

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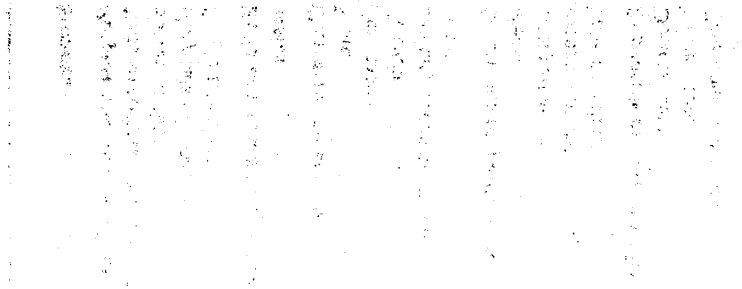

Summary

Purpose and method of survey

This survey in six geriatric hospitals was planned to compare views of long-stay patients and their visitors with those of the staff. Two survey organisers held semi-structured interviews with 377 people — 143 patients, 63 visitors, 96 ward staff and 75 other staff. Questions were asked on twelve topics (fifteen for staff) and the ratio of comments that were favourable was found for patients (including visitors) and for staff. Each person was then asked what he/she liked best and least about the hospital.

Comments on specific topics

There was no significant correlation between the ratio of satisfaction expressed by patients (including visitors) and by staff on different topics. The former had a higher ratio of satisfaction than the staff.

Wards (Dormitories) Wards on ground floors were liked, with windows almost to the floor. Patients appreciated small rooms but staff preferred larger ones. Both thought rooms should be made more homely.

Day rooms Any day room was better than none but they served so many purposes, often conflicting, that it was advisable to have at least two sitting areas, one with television, one quiet. They should have a lively outlook, access to the garden, a homelike appearance, with chairs in groups and lavatories near.

Furniture Patients found their beds comfortable and liked continental quilts; staff deplored any shortage of adjustable-height beds. Patients and nurses liked cot sides but doctors wanted their use to be limited. Chairs were generally liked but more high-seated chairs were needed. Wheelchairs often needed a clip-on back and their maintenance tended to be poor. Tall lockers were liked but some modifications were suggested.

Sanitary accommodation Staff were far more critical than patients but both deplored lack of privacy for washing, shortage of lavatories and cold sanitary annexes.

Noise The two main problems were confused patients continuously shouting and uncontrolled television. Noise came worst in the patients' ratio of favourable comment.

Meals The quality, quantity, variety and service of meals received much approval, though some staff and patients thought the suppers were too heavy and this caused waste.

Occupations More comments were made on this topic than on any other — mostly appreciation of what they had but also requests for more, organised by either professional or voluntary workers. There was need for more occupational therapy and physiotherapy, for chances to go out of doors and for ward entertainments. The few art classes were much liked.

Freedom of choice Patients tended to say either that they were happy about their freedom of choice, or that they had little say but that this was inevitable due to shortage of staff.

Patients' relations Patients varied greatly in their liking for social contact with each other; staff therefore needed to take great care in seating and sleeping arrangements.

Doctors' care The quality of care was excellent but the quantity was sometimes deficient due to shortage of doctors and frequent changes of junior medical staff. Therefore, some patients suffered from minor disabilities (for example, in vision) that might be remedied. Both patients and their relatives felt they lacked information from the doctors.

Nurses' care Great admiration was expressed for the care given by the nurses but this was coupled with sympathy about the shortage of staff. Pressure of work sometimes caused nurses to feel that they lacked time to do all they wanted to for the patients.

Care from other people The Friends of the Hospital and the chaplains received much appreciation. The activities of the voluntary workers were greatly valued in some hospitals. In others it was said that more care should be taken in finding where they would be most useful and in training them for particular jobs. The standing of the hospital in the local community varied as did the attitude of the local press. Open visiting was liked.

Staff conditions Three extra questions were asked of the staff — on their training, consultation and relations. They were very happy about staff relations at all six hospitals. More induction training was needed, also some training for specialist nurses and for auxiliaries. Greater consultation between departments and wards would be useful. The views of the staff should be obtained about proposed changes in structure and equipment.

Liked best and least in hospital

Each person was asked what he/she liked best and least about the hospital. The staff gave more criticisms than the patients. Both groups gave care of patients as what they liked best but differed in what they liked least. A large majority of the staff criticised the physical environment, but the patients were almost equally divided between criticism of staff shortages, environment and planning of daily life.

Follow-up and extension of use

Each hospital received a full report on its own results for discussion about possible action, and most have decided on a number of changes. It is hoped that other hospitals will be stimulated to conduct similar surveys and instructions are given to assist in this. A checklist is also provided for those hospitals unable to carry out full surveys.

The questionnaires and checklist at the end of the book may be photocopied for use by hospitals and there is no need to obtain permission to do this from the publisher.

Purpose and method of survey

Need to compare patients' views and staff views

In geriatric hospitals long-stay patients face an experience quite different from that of short-stay patients. With the latter, priority has to be given to rehabilitation, mental and physical, to enable them to return to the community. However, after about three months it often becomes clear that certain patients will remain too ill or too confused for home care and will need to stay in hospital for the rest of their lives. Convention demands that the staff maintain an optimistic attitude and, indeed, all patients should be helped to be as independent as possible, to feed, dress and wash themselves. But for long-stay patients the emphasis must be to make their remaining days pleasant and dignified.

This survey, supported by the King's Fund, compares the views of long-stay geriatric patients with those of the staff responsible for them. The patients' views were supplemented by those of their visitors since many patients were too ill or confused to interviewed. Thus priorities for change expressed by patients, visitors and staff could be compared and information obtained on how limited resources could best be used to implement patients' wishes and to help staff to give them the best care.

Survey method

Six geriatric hospitals were visited during 1977, usually by two organisers but sometimes by one. The organisers stayed for a few days and held semi-structured confidential interviews with

Patients All who had been there three months or longer and were capable of participating and willing to do so.

Visitors Those who came frequently to see their relatives and friends. Some were interviewed, others given a questionnaire with a reply-paid envelope addressed to the King's Fund Centre.

Staff About four or five from each ward were included (usually the sister, a staff nurse, SEN, auxiliary and sometimes a domestic). Some general staff were also interviewed — medical and nursing officers, administrators, department heads such as physiotherapists, occupational therapists, social workers, caterers, domestic supervisors, voluntary work organisers.

The most important preliminary to the survey was the willing and active support, first of the senior staff of the hospital and then of the ward staff. Discussions were held with the senior staff to plan the survey.

A letter was duplicated, usually signed by the administrator, and a copy was given to each person who might be interviewed, inviting participation and explaining that all comments would be confidential but that a report would be sent to the hospital for possible action to be considered. A typical letter is shown on page 40. The medical records department was asked to prepare a list of all patients who had been in hospital three months or more. The wards were visited in turn to explain the survey and to find which patients were mentally and physically able to participate. Very few patients refused to be interviewed — four out of 147 — and no staff refused. Interviews were held as privately as possible.

Experimental questionnaires were used at the first two hospitals as a basis for interviews. The first was general, to discover which topics were raised spontaneously: the second was more detailed. Then three questionnaires similar to those shown on pages 41, 43 and 45 were prepared for patients, visitors and staff respectively. All these were alike except that the one for staff had three extra questions on staff conditions — training, consultation and relationships.* The questionnaires were used as the basis for semi-structured interviews during which the wording was modified to ensure that the questions were fully understood and that the answers concerned both the satisfactory and unsatisfactory aspects of the topic.

At the end of each survey a report was prepared, confidential to that hospital, and a number of copies sent for circulation among the staff so that the action could be considered. Usually the organisers were invited to return to discuss the action taken.

*They were sufficiently similar to the experimental questionnaires for all six hospitals to be included in the final analysis.

Hospitals included

The six hospitals were in no sense typical samples of geriatric hospitals but were chosen as varying in size and age. Probably they tended to be above average in efficiency so as to avoid the more obvious defects due to very poor buildings or exceptional staff shortages.

Size Varied from 352 to 26 beds. Three had over 125 beds.

Past use Four had been workhouses, one a maternity hospital and one an infectious diseases hospital.

Location Four were within 20 miles of London, one in East Sussex and one in Wiltshire.

Patients All the hospitals received patients from one or more acute hospitals. The proportion suitable for rehabilitation varied, and in one small hospital all patients likely to be rehabilitated had been excluded before coming. In some hospitals the wards were divided into rehabilitation and continuing-care wards but the division was not always very accurate. A very few patients were seen who alternated periods at home and in hospital.

People interviewed

Results were obtained from 377 people — 143 patients, 63 visitors, 96 ward staff and 75 other staff.

Patients

The 143 patients interviewed formed 40 per cent of the 360 patients who had been in hospital three months or more. Most of the remainder were too confused to participate, some too deaf or ill, but only four refused. At the start of each interview the patient was asked for some personal particulars and on the basis of the accuracy of the answers, checked against their records, and of their subsequent comments they were classified into three categories

		per cent
A	Alert	43
B	A little confused at times	43
C	Rather confused	14

Sex distribution	73% women, 27% men	
Age distribution	50-59	2
	60-69	10
	70-79	39
	80-89	37
	90-100	12

Visitors

Many visitors came surprisingly often — some, every day. Regular visitors to long-stay patients in each ward were asked to give their views and 63 did so. When patients were unable to participate their visitors could, to some extent, represent them. If the visitors did not come when the survey organisers were present the ward sister gave them a copy of the questionnaire and of the letter requesting participation, together with a reply-paid envelope addressed to the King's Fund Centre.

Ward staff

The 96 ward staff interviewed consisted of a cross section of four or five people from each ward. The sister or charge nurse was always seen, also available staff nurses, SENs, auxiliaries and sometimes a domestic. All agreed to be interviewed when requested and were usually willing to give much time and thought, sometimes requesting a second interview.

General staff

This varied group of 75 people included from each hospital medical and nursing officers, the administrator and heads of the physiotherapy and occupational therapy departments. Usually interviews were also held with the social worker, caterer and voluntary help organisers, and sometimes with others such as the chaplain, head gardener, porters. All were most cooperative and contributed many ideas.

Classification of participants

When reporting comments, those given by patients and visitors are combined and marked P, and those given by staff, whether ward or general staff are combined and marked S. When comparing numbers of comments it must be remembered that there are 206 people in the P group but only 171 people in the S group.

Ratio of favourable comment on specific topics

The patients' and visitors' questionnaires were divided into two parts. The first twelve questions were each on a specific topic and posed in a general way, for example, 'What about the patients' meals — what is good about them and what could be improved?' At the end two general questions were asked: 'What do you like best about the hospital?' and 'What most needs altering in the hospital?' The staff questionnaire had three extra questions on staff conditions.

The comments on the twelve specific topics were divided into those expressing satisfaction and those giving suggestions for improvement. Usually, but not always, the suggestions could be taken as tantamount to criticisms. On each topic a rough measure of satisfaction could be expressed by the ratio of favourable comment. For each hospital these ratios were calculated for patients (including visitors) and for staff. Table 1 shows the results in terms of the median (or middle) figure for the six hospitals. (If the six hospitals are ranged in order of the size of ratio, the median is the figure coming halfway between the third and fourth hospital.)

The following sections describe the views given on each of the twelve topics. Five are on environment, four on the daily life of the patients and three on the care given to them. Each topic is summarised under subheadings and illustrated by comments. Those given by the 206 patients and visitors are marked P, those by the 171 staff are marked S. It is not surprising that often both favourable and critical comments are made on the same matter, for people vary in their experience, tastes and standards. It is impossible to generalise, as if patients were all of a pattern, and the same consideration holds for staff members.

It is clear that

a the patients have a far higher ratio of satisfaction than the staff — median of 71 per cent compared with 51 per cent

TABLE 1 Ratio of favourable comment on specific topics (given in order of satisfaction expressed by patients)

	Patients		Staff		Comparison of rank order	
Topic	Rank order 1 = top	Median ratio	Rank order 1 = top	Median ratio	Patients higher	Staff higher
Furniture	1	76	10½	38	9½	
Freedom of choice	2	75	4	59	2	
Sanitary accommodation	3	73	12	30	9	
Ward (dormitory)	4½	72	6½	51	2	
Meals	4½	72	1	69		3½
Help (not medical or nursing)	7	71	2	67		5
Doctors' care	7	71	3	65		4
Patients' relations	7	71	6½	51		½
Occupations	9	67	5	53		4
Nurses' care	10	66	8	47		2
Day rooms	11	62	10½	38		½
Noise	12	46	9	39		3
Total		71		51		

Correlation r = .16 ± .12

b there is no significant correlation between the order of satisfaction on the twelve topics expressed by patients and by staff

c the order of satisfaction about nurses' care comes surprisingly low. This is primarily due to the many comments on staff shortages.

a There are probably two main reasons why patients (including visitors) expressed a higher ratio of satisfaction than the staff, the chief being gratitude. Again and again general comments were made such as *'I am so lucky being here', This is a wonderful place', 'I hope to spend the rest of my life here'.* Old people and their elderly visitors appreciated the great contrast between modern geriatric hospitals and memories of old workhouses, expecially when the same buildings were used. Second, patients have no knowledge of some matters familiar to the staff, including modern hospital furniture and sanitary accommodation — the two topics with the widest gap in rank order between patients and staff. A patient finds her bed comfortable and it does not occur to her that it cannot be adjusted for height. A bathroom is clean and warm and the patient is ignorant of such things as bath hoists. Staff often felt frustrated when their requests for such aids were ignored or when their advice was not asked on choice of equipment.

b The fact that there was no significant correlation between the order of satisfaction expressed by staff and patients is partly explained by the greater knowledge of the staff about hospital equipment. It is also due to the variations in priorities between patients and staff described later in this report in the section on 'Liked best and least in hospital'. Patients tend to stress the care given to them and their daily life while staff emphasise the physical environment.

c Nurses' care comes low in rank order with both patients and staff. This is very surprising as, when the patients were asked what they liked best about the hospital, a very frequent answer was the care and kindness of the staff, especially the nurses. The explanation is that the great majority of suggestions concerned staff shortages — that the nurses were too hard pressed and there was need for more of them. To a lesser extent similar comments were made about the shortage of medical staff.

Comparison of visitors' and patients' views

Although the views of visitors were similar to those given by the patients some matters were more strongly emphasised, including the shortage of physiotherapists in continuing-care wards and that little effort was made to improve or even retain patients' ability to walk. Some visitors expressed distress at hearing patients calling out and no one going to them. Many of these were confused people who called out constantly but sometimes nurses were so hard pressed that they had to delay going to people who really needed help. Visitors would like more information from doctors, but it often never struck them to ask for it. Some visitors of confused patients said their relatives preferred a passive life and were content to sit and look at each other. Visiting arrangements were appreciated, especially when visitors were able to come at any time.

Comments on environment

Ward (Dormitory)

	Number of comments	Percentage favourable	Order (out of 12)
Patients	179	72	joint 4
Staff	237	51	joint 6

Situation of ward

Wards on the ground floor were said to have great advantages because patients could easily go into the garden and to other parts of the hospital. The risk in case of fire was reduced — a very real source of fear with a few patients as well as with the staff. A veranda was much appreciated as some patients could go there independently and feel in touch with the world outside. Windows should be low enough for those in bed to see the garden. Comments on the situation of the ward were made more often by patients than staff: this is not surprising as some patients were in the ward, as distinct from the day room, all the time and the rest spent long hours there.

P *Doors open to garden.*
Very pleasant outlook.
Should have windows to floor so that patients can see out.

S *Good to have windows on both sides of the ward.*

Size and divisions

Patients and staff tended to differ in their views on ward structure. Most patients liked fairly small rooms or, if the ward was one long room, to have divisions in it to promote privacy and quiet. A few said they wanted single rooms. The staff mostly preferred a long ward to ease observation of patients needing help. This is specially important at night when few staff are on duty, as it was very rare to have a nurse-call system for each bed. However, staff said they needed one or more single rooms for patients who were very ill or infectious.

The advantages of plenty of space around each bed were stated by both patients and staff. When this is lacking, it is difficult for nursing procedures to be done in privacy in very small curtained cubicles. Room for a bedside commode prevents much inconvenience to the many patients who cannot walk as far as the lavatory. In some wards that have no day room attached, a space has been arranged where patients can sit together as a group by pushing back some beds during the day. Patients and visitors commented on the depressing atmosphere of those wards where each patient sat by her own bed with no one but her neighbours to talk to. A very narrow ward gets cluttered with tables and chairs and, the staff say, this makes it difficult for patients to practise walking.

P *Our ward is very nice and roomy.*
Too many people in one room.
Would like a single room, quiet to myself.
Patients each stuck by her own bed.

S *Ward of 30 too big, should be divided into four sections.*
Smaller wards more personal.
Need two single rooms on every ward — cannot isolate infectious, noisy or dying patients.
Arrange ward so that patients can sit together.

Appearance and cleanliness

Patients and visitors often spoke of the appearance of the ward — that it was bright and cheerful or that it was drab and needed redecoration. Some cubicle curtains were admired; in other cases the staff regretted that the patients had not been allowed to choose them. Window curtains were lacking in some wards; the windows looked bare, and the patients said that they were woken by the early light. Patients and visitors frequently praised the cleanliness of the ward but staff evidently took this for granted as they seldom mentioned the matter.

P *Light and airy.*
Beautifully clean.
Brighter colours and pictures would add variety.

S *Repainted and has new lights.*
Easy to clean.
Have curtains at windows.

Homeliness

For long-stay patients the ward is often their only home

and all their possessions are in or on a small locker. There were surprisingly few comments about this though the occasional patient wished for a shelf for flowers or hook above the bed to hang a picture. Often the survey organisers where shown with pride the pitifully few reminders of home — a photograph of grandchildren or even of a cat. One patient had two birds in a cage on a table by her bed and she and her neighbours enjoyed these. Several members of the staff said that more room for home treasures would help. A person's bed and surroundings should be his own little kingdom, but in one ward there was a most unfortunate practice of regularly shifting patients' beds to different positions. A strong reaction against this was expressed by both staff and patients.

P *Would like somewhere to put my family photographs.*
Like my own corner place.

S *More pictures needed.*

Day rooms

	Number of comments	Percentage favourable	Order (out of 12)
Patients	102	62	11
Staff	178	38	joint 10

Purpose of day rooms

Staff and patients criticised the day rooms heavily so that with both the topic came nearly at the bottom of the twelve, the staff being even more critical than the patients. It was, of course, counted even worse when there was no day room and the patients remained in the dormitory all the time, each by her own bed or sitting back to back along the centre of the room. The difficulties with the day room came from the fact that one room had to serve so many, often conflicting, purposes.

a **Social life** A sitting room for talking to fellow patients and receiving visitors, with some degree of privacy.

b **Meals** In most hospitals patients sat around a large central table for their meals; in others each was served on a small table or tray fixed to or in front of her chair. Only one hospital had a dining room common to all wards where the more able patients had their meals at small tables.

c **Entertainments and occupations** In most day rooms there was a television or radio switched on for much of the time, though in one hospital these were not allowed in the day room. The room was also a centre for entertainments, games and sometimes for informal occupational therapy and for religious services.

d **Resting and reading** Some old people are happy to pass the day resting, dreaming their life away, and many others enjoy an occasional snooze. Reading is a popular activity with some but it is difficult to concentrate in a noisy room.

e **Store** In one ward the day room was primarily used as a store for spare wheelchairs as the staff said there was nowhere else to put them.

The combination of these various purposes in one room means that some people have to suffer and the solution most often given by both staff and patients was to provide a second day room — one room quiet and the other for television. If only one room is available it should be divided by a screen as noiseproof as possible. The provision of small alternative areas — a veranda, space in a hall or a broad passage — makes a lot of difference. The control of television — a matter central to this problem — is discussed later in this report under the headings, 'Noise' and 'Television and radio'.

P *Very pleasant and good company.*
It is a change to go there.
Sit in chapel next door as it is quiet.
Full of old noddies parked along the walls.
Don't like it there.

S *Need to have two day rooms, one with TV, one quiet.*
Purposely have no TV in day room so it is a quiet refuge.
Patients choose between day room and veranda.

Location and size

A lively view was counted a great asset by both patients and staff and the windows needed to be large and low enough for the view to be seen when seated. Enthusiastic praise was given at one hospital to a wide view over town and harbour. At another the day room looked over a main road with buses and with children going to school. An ideal position was described by one staff member as *'overlooking a High Street preferably opposite Woolworths'.* A view over the garden was liked if some action could be seen such as traffic along the hospital drive, or a sports field used by a local club: even squirrels in the trees or birds clustering around a bird table were better than a view with no movement. Patients appreciated a door from the day room into the garden, but with a gentle ramp instead of steps.

P *One of the best views I have ever seen.*
Cheers you up to see people outside.
Windows too high to see out when sitting down.

S *Outlook nice — garden, traffic passing.*
Large windows and good views.
Like seeing life not just trees.

Proximity to lavatories is another important aspect of the location of the day room, and some patients prefer separate lavatories for each sex. Quick access to lavatories is regarded, particularly by the nursing staff, as of prime importance. Otherwise patients become embarrassed, both the incontinent and their fellows, and the room develops a permanently unpleasant odour. In one hospital the lavatories were so far away that patients actually used a commode in the day room.

P *Room stuffy and smells.*
Awkward to share toilet with the men.

S *Every time I wheel a patient up the long corridor I hate the architects who designed the new toilets and never asked us.*

One day room shared by several wards was considered (mainly by the staff) too large to be friendly and suffered the further disadvantage of having a steep ramp leading to it. But many more day rooms were heavily criticised as being too small and overcrowded. This meant that the furniture could not be arranged in a way that led to a friendly atmosphere. Usually the chairs were placed in straight lines around the walls and not in small groups. Some day rooms had a single, large, central dining table instead of several small tables which are useful to the patients who generally have to bring with them all they need for that day — handbag, book or knitting. A spacious day room is good for meals, for ward entertainments or diversional therapy, but as already stated, alternative rooms or sitting spaces are much appreciated by those who want to gossip with friends, see visitors privately and get away from the noise of television. Staff found some day rooms too narrow to wheel the patients about easily.

P *Lovely room.*
Should be less formally set out.
Very overcrowded.

S *Space to move patients around to get variety.*
Overcrowded.
Very full, especially when day patients come in.

Appearance and ventilation

Most of the day rooms were well decorated but some looked institutional. These needed a more cheerful domestic appearance, and both patients and staff asked for pictures and wallpaper. Several people suggested that birds in a cage or an aquarium would enliven a room and that plants and a bookshelf with paperbacks and magazines would be attractive. Chairs, they said, should be varied in colour and shape. The question of floor covering resulted in a variety of opinions, none completely satisfactory. A carpet certainly makes a room more home-like, but with many incontinent patients and food often dropped on the floor it becomes dirty and smelly — even washable carpets are difficult to keep pleasant. Many day rooms were described as overheated and stuffy, and this made the smell worse. A number of patients said the day rooms were too warm, with insufficient ventilation: none said they were too cold.

P *Bright, sunny and well decorated.*
A homely atmosphere, nice flowers; some goldfish would be interesting.
Pongs.
No ventilation.
Extractor fan needed.
No one looks at the thermometer.

S *Pictures changed regularly.*
Could be more homely with wallpaper, should be decorated in brighter colours.
Need lino floor as carpet smells.
Would like fish tank, plants, clock and long mirror.

Furniture

	Number of comments	Percentage favourable	Order (out of 12)
Patients	226	76	1
Staff	354	38	joint 10

The staff were a good deal more vocal and far more critical about the furniture than the patients were — the topic came top in percentage of favourable comment with the patients, and penultimate with the staff. This difference is probably due to the staff having greater knowledge of the furniture available; to their frustration at not having their advice asked before new furniture was bought; to delays over repairs and to some furniture being heavy to move.

Beds

Nearly all the patients said that their beds were very comfortable and those with ripple beds said they had been helped by them. The bedding was described as very clean, frequently changed, and the continental quilts used in one hospital were greatly liked. No criticisms of cot sides were made by patients (except by one woman who said she could not reach her locker through them) and several people praised them as they liked the feeling of security. Adjustable beds were far the most frequent topic with the staff — appreciation when they had enough, bitter complaints when they had not. Staff said gratefully they could get as many ripple beds as they needed. Continental quilts were liked for comfort, appearance and ease of bed making, but it was necessary to have a generous supply if many patients were incontinent. Some doctors were against having cot sides without express medical permission. The nurses wanted to be free to use cot sides for restless patients in high beds who might hurt themselves trying to climb down or wandering about the dormitory.

P *I thank God every night when I get into my lovely bed.*
Very comfortable.
Marvellous bed, has cured my bed sores.
Would like an adjustable bed as I have to be helped out.
I like the sides — feel safe.
Can pull yourself up on the sides.
Sheets so clean — changed if a spot on them.
Love continental quilts.

S *Would like more adjustable beds.*
Nurses no longer get bad backs if beds can vary in height.
Patients like cot sides, especially short ones.

Would like new three-cornered type pillows.
Got 'monkey poles' for people to pull themselves up.
Continental quilts good as don't restrict movements and they make bed making much easier.

Chairs

Most patients liked their chairs: indeed, they became possessive about their 'own' chair. The few complaints were about the kind of chair in which a patient could not rest his head because the back was not high enough, or the chair with a front table which locked the patient in. In some day rooms there were many types of chairs, but in others the staff said the variety was not wide enough to allow them to find the right chair for each individual and mark it with his name. Sometimes there was a shortage of high-seated chairs from which patients could rise easily. And in one hospital, chairs had been heightened by blocks which made them potentially dangerous. Many hospitals had geriatric chairs which were essentially armchairs on small wheels. These were well padded and had head rests, and were well liked by the patients. However, the staff found them very heavy to move for more than short distances and the fact that they were so cumbersome contributed to the formal arrangement of many day rooms.

P *Super chairs in day room.*
Very comfortable.
Like chair with high back.
Nowhere to rest head, need high backs with corners.
Tired of being hemmed in with tray.

S *Got a wide variety.*
Can choose the best chair for each person and label it.
Need greater variety of chairs.
More chairs should have high seats.
Some geriatric chairs very heavy to move with people in them.

Wheelchairs

The hospitals used three types of wheelchairs in addition to the geriatric armchairs with wheels described above — a chair wheeled by a helper for taking patients about the hospital or into the garden; a chair propelled by the patient in which he sometimes remained all day; a few battery-powered chairs. The patients usually remained only a short time in the first type of chair and generally were satisfied with it, though the staff sometimes found this type heavy to wheel and in need of servicing. The self-propelled chairs need to be chosen to suit the individual and to be kept for his specific use. Many were praised by patients for being easy to manipulate; others were criticised for having a low back, and several people suggested that a clip-on back should be added. Others had uncomfortable foot rests, broken or at the wrong height, but in one hospital a technician had successfully constructed a movable horizontal extension for arthritic patients. Powered chairs were liked but patients felt some resentment if they were not allowed to take them into the garden.

A complaint expressed by the staff in nearly all the hospitals was of poor maintenance of wheelchairs. The wheels did not get the frequent oiling needed and brakes were sometimes unsafe or even missing. There were often serious delays when the chairs were sent away for repair; in some cases there were so few wheelchairs that commodes had to be used instead. Hospitals tried to select chairs suitable for individual patients, but sometimes this took a very long time. One of the ward staff said that the best way to get a chair for a patient was to wait till another patient died, and not to return his chair to the general store.

P *Nice wheelchair.*
Went to France in mine.
Can use with one hand.
Good turning circle.
Sit in chair all day and need a high back.
Clip-on back needed.
Need board to put feet on.
Not allowed to go out in electric chair.

S *Want more light self-propelling wheelchairs.*
Some wheelchairs too narrow.
Have to send away to be serviced — very slow.
Need servicing more often.
Some without brakes.
Brakes wobbly.
Should have wood extensions so that feet do not drop.
Footrests need adjustment for individual patients.

Lockers

Both patients and staff liked the wardrobe lockers and were thankful to have a place where clothes could be hung without being creased. In wards that had both short and tall lockers the latter were sometimes taken by patients as a status symbol. Although most staff liked the wardrobe lockers and often asked for more, they had three criticisms of most types. First, that they were heavy to move for cleaning; second, that some lacked a place to hang up damp towels; third, that they sometimes blocked light from the windows. The staff asked for communal cupboards in addition to individual lockers, for outdoor coats and a stock of ward clothes. They also needed some store place for wheelchairs.

P *Beautiful.*
New tall lockers a great improvement.
With small lockers clothes have to be bundled up like rags.

S *Tall lockers good for those who get up.*
No place to hang towels.
Need lockers on well-oiled rollers for easy cleaning.
Not enough room even in tall lockers for possessions of active patients.
Need place in ward to hang coats now that so many patients go out.

Sanitary accommodation

	Number of comments	Percentage favourable	Order (out of 12)
Patients	90	73	3
Staff	208	36	12

There was great disparity between the views of patients and staff on this topic. Patients' views were far more favourable — the topic came third in order of percentage of favourable comments, whereas with staff it came bottom, and the staff made more than twice as many comments as the patients. The patients emphasised the cleanliness of the sanitary annexes but this was barely mentioned by the staff — perhaps they took it for granted. The staff complained particularly about a new annexe that superficially looked excellent but was so unsatisfactory that patients often had to be given sanitary attention in the ward. This annexe was very cold, there was no privacy when washing, and baths and lavatories were inconvenient. Complaints from the staff were more bitter as they had been hopeful about the longed-for annexe although their advice had not been sought. Similar complaints were made about other annexes.

P *Ideal.*
Super.
Spotlessly clean.
Very well kept.
Very cold.

S *Freezing cold.*
No privacy for washing incontinent patients.

Bathrooms and washrooms

Patients often said they appreciated their weekly bath and, although some would like a bath more often, few of them (unlike the staff) spoke of any shortage of baths. Both staff and patients complained of the cold in the some annexes and of the lack of privacy in many washrooms, with the basins fixed closely side by side and no curtains in between. Many patients were naturally embarrassed at having to wash completely in public between their weekly baths. Staff in some hospitals spoke of the need for showers to clean heavily soiled patients and that these showers should have flexible heads to avoid soaking the nurse. Some bathrooms had no hoist, or a hoist that did not fit under the bath, and others had no bars by which the patients could pull themselves up.

P *Adore weekly bath.*
One can bath as often as one likes.
Would like a bath more than once a week.
Cold, room should be heated.
Should have curtains between washbasins.
More privacy needed for washing.

S *Bath all patients at least once, most twice a week.*
Need second bathroom.
Very cold.
Should have heater in bathroom.
Need bath lift.
Shower does not work.
Lack of privacy for washing.

Lavatories

Shortage of lavatories is a main trouble in many wards. Patients have to queue in the mornings and in one hospital it was described as '*chaos*' with '*fights breaking out*'. One patient attributed his troublesome constipation to the fact that he was often hustled out of the lavatory. Some lavatories were too far away. It has been found that many elderly patients with urinary urgency need to be within 30 feet of a lavatory, but this need was seldom met for all the patients, either in dormitories or day rooms, and was a frequent cause of incontinence. Some lavatories were so narrow that wheelchairs or sanichairs could not enter: others were so wide that patients could not reach the grip or toilet paper. Some pedestals were too high.

P *New toilets big enough for wheelchairs.*
Short of toilets.
Patients have to be lifted as toilets too small for wheelchairs.

S *So short of toilets that patients fight to get in.*
WCs are at end of ward, a long walk, should be central.
Need indoor toilets for elderly visitors.
Too narrow so can't use sanichairs.
Difficult locks so patients leave doors open.
Grips should be horizontal or diagonal, not vertical.

Commodes

Staff reported that some commodes and sanichairs were uncomfortable for the patients to use and that more modern types were needed. They stressed that the provision of commodes (especially at night) for patients who found it difficult to walk to the lavatories saved the indignity and hard work caused by wet beds. Few patients had anything to say about commodes.

S *Very good — got three types of commodes.*
Not enough commodes.
Wooden commodes hard on patients' backs.
Need more plastic commodes.

Noise

	Number of comments	Percentage favourable	Order (out of 12)
Patients	101	46	12
Staff	102	39	9

Patients greatly minded the amount of noise in the hospitals — indeed it was the topic that came bottom in the percentage of favourable comments. The staff was also critical but less so than the patients. There were two main problems: the noise made by an all too vocal minority of

confused patients and that caused by uncontrolled television and radio. Some people also spoke of noisy staff.

The possibility of a ward or day room being too quiet was mentioned by a few people, both patients and staff: '*Want a bit of life*', '*Just enough noise to be nice and friendly*'.

Other patients

In many wards there are one or more confused patients who talk, sing or shout incessantly — often day and night. A visitor was appalled that her mother — a very sensitive woman — should be constantly exposed to the awful screaming of a fellow patient. No solutions were offered about this disturbing and painful noise except that such patients should be segregated and kept together in one room. Very few wards had nurse-call systems and when patients shouted for help at night from the nurses some of their fellows were disturbed. Quite often, survey interviewers were disturbed by neighbouring patients talking or singing to themselves.

P *Ward is like Waterloo Station.*
No peace because of one noisy patient.
Noisy at night as no nurse-call system.

S *One patient shouts, one bangs, one screams — otherwise it's quiet!*
Keep very noisy ones together in small ward.
Nurses get used to patients making noise.

Television and radio

Patients vary greatly in their liking for television and radio, and in their choice of programmes. In some wards television or radio is played almost continuously, often very loudly to suit deaf people, and left on whether anyone is listening or not. In other wards no television is permitted in the day room or dormitory as it had been found such a nuisance. It is better for the television to be away from the main day room, and for the patients to decide the most popular programmes. Further views on television are given in the section on occupations.

P *TV in dormitory drives me mad.*
I have a bed next to the TV and I hate it.
Continuous pop music in the day room is very distracting.
TV left on regardless of programme and who is listening.

S *Continuous trouble between patients because of TV and radio.*
Pop music played for long periods.
Radio in morning is really for the benefit of the domestic staff who like it loud so that they can hear while cleaning.

Staff

Both patients and staff complained of the noise made by a few of the cleaning staff during the day and of the auxiliary nurses at night, chiefly from not keeping their voices down. They said that both groups needed training on this matter; they were not conscious of the patients' need for quiet.

Comments on patients' daily life

The topics included here are patients' meals, occupations (with many subheadings), freedom of choice, and relations between patients — all matters that affect the quality of the patients' daily life.

Meals

	Number of comments	Percentage favourable	Order (out of 12)
Patients	298	72	joint 4
Staff	337	69	joint 1

Meals are the high points of the day for many patients. They, as well as the staff, had much to say about them, mostly very favourable. People who expect hospital meals to be dull or distasteful are right out of date. Indeed, with staff, meals came top of the twelve topics in the ratio of favourable comments. The staff paid many tributes to the catering managers and cooks, saying that they got to know each patient's tastes by visiting the wards and were always willing to cook 'specials'.

Quality and variety

Patients' tastes varied enormously but appreciation was most often expressed for soup, chicken, fried fish, fresh (instead of tinned) vegetables, puddings and fresh fruit. Some said they would like more fruit, that salads were difficult to chew with false teeth, and that they had mince, ice cream, baked beans and salads too often. On the whole, breakfast was a popular meal except in one hospital where it took the form of egg sandwiches served in bed. A choice of main meals was offered at some hospitals and the menu was taken around the previous day to be filled in. The staff considered this a good plan even though some patients forgot what they had chosen. Occasionally it was said that the choice was too often made by staff on behalf of the patients, depriving them of independent selection. If a patient disliked what was offered, an alternative was generally prepared. Many patients and a few staff praised the diet meals, but others complained of their monotony. Snacks and hot drinks were enjoyed, also the fact that patients were allowed alcoholic drinks provided by their visitors. Special mention was made by several patients of the birthday cakes given to each patient, usually by the Friends of the Hospital, and served in a party atmosphere.

P *I love my meals.*
Eating is one of the pleasant things I do.
Couldn't be improved.
Lovely variety.
Like choosing.
Wonderful meals for reducing diet.
Study me as a diabetic.
Kosher meals.
Not enough alternatives.
Need wider variety for diet — too much plain steamed fish.
Need more fresh fruit.

S *Food extremely good.*
Catering manager gets you what you want.
Generation gap in views on food — staff would like patients to have salads, wholemeal bread and bran, patients prefer other food.
Good dietician.
Different diets well catered for.
Have fresh fruit salad every week as many patients find apples and other fruit difficult to peel or to eat with dentures.

Quantity of food

Without exception patients and staff agreed that the quantity served was very adequate, indeed many said that the amount was excessive, especially at supper, resulting in waste. It was considered unnecessary to have a two, or even a three course cooked supper, after a large cooked lunch. Supper has to be served early because of the hours of the staff and a number of people suggested that soup and a pudding would be preferred, with sandwiches available later from the ward kitchen for those who wanted them. Some patients complained that their helpings were too large, and in one hospital with 'plated' meals they appreciated being able to choose between a small, medium or large helping.

P *Plenty of it.*
Can't eat all I'm given.
Can always ask for more if needed.

S *Two cooked meals a day too much.*
Suppers should be lighter — soup or tea, with sweet or bun and sandwiches later.

Supper should be sausage rolls or ham sandwiches plus sweets.
So much that we have two baskets full of waste at supper.

Service

Most patients stressed that the meals were hot and nicely served but a few said that the patients were hurried too much. Several of the staff wished there were more voluntary workers to help patients who needed to be fed. In one hospital a voluntary worker took round the menus for patients to choose the next day's meals: this made a pleasant regular contact with someone from outside the hospital and also saved the time of the staff. The separate dining room at one hospital used for all able patients was well liked.

P *Hot and served with a smile.*
Meals pleasantly laid out.
Patients hurried too much.

S *Plated meals work well.*
Use liquidiser if patient can't chew food.
Serve breakfast in bed at 7.30 (egg and bacon sandwiches): should be later as some patients too sleepy to eat.

Occupations

	Number of comments	Percentage favourable	Order (out of 12)
Patients	470	67	9
Staff	573	53	5

General comments

More comments were made about occupations than about any other topic. Some were in general terms, either favourable or critical, including remarks both from visitors and staff about those patients who preferred a passive life of day dreaming. They said that if a patient enjoys activity, or can be aroused to enjoy it, he should be offered a wide choice of occupations. However, if he is too confused to participate he should be helped to be as independent as possible in dressing, eating and washing, but otherwise allowed to lapse into inactivity if he wants to. There is, however, a third category — the patient capable of certain activities who prefers just to rest and agrees with the well known epigram 'I want to do nothing for ever and ever'. Staff need to be very sensitive when determining whether such people should be stimulated or not. It may bring a new interest to their lives or it may make them feel bullied. '*God help anyone who tries to make me play bingo*', as one said.

P *Never bored, my goodness no.*
Could do with a 48 hour day.
Have lost interest though I have been active all my life.
I wish I had more to do.
I like the way they leave you alone.
Content to just sit and look at each other.

S *Voluntary organisers have helped enormously to give patients interest.*
Boredom biggest killer of the lot.
Day dull, nothing to do and nothing to look forward to.
Unfair to change a quiet person into an active one.
Some want rest, not continuous stimulation.
Many too confused to be bored.

Specific activities

Questions were asked about five groups of activities and Table 2 shows the results for patients and staff. It is arranged in order of the percentage of patients' comments that were favourable.

The ratio of favourable comments by the staff was only slightly lower than that by the patients for four activities, and much lower about occupational therapy and physiotherapy. This difference may be because staff know that large amounts of therapy are done in rehabilitation wards but the patients were grateful for what they got, even though it was very little in most long-stay wards. Only about half of the comments on television and on entertainments were favourable, both with staff and patients. Many said more entertainments were needed.

TABLE 2 **Comments on specific activities**

Group of activities	Number of comments		Ratio of favourable comment	
	Patients	Staff	Patients	Staff
Reading	71	29	78	69
OT, PT, Art, Handwork	93	143	74	40
Going out	82	110	67	66
Television and radio	93	69	56	41
Entertainments	54	89	52	45

Reading

In all the hospitals voluntary workers took a library trolley around the wards and this was much appreciated by those patients who liked reading. Usually it included some large-type books for those with poor eyesight — some patients particularly enjoyed illustrated books. A few wards had bookshelves with some paperback books. Daily papers were delivered in most wards but only a few patients bought them. It was usually found that a few patients read a lot, but most did not read because of poor eyesight or because they were too confused. Some visitors and staff thought more people could read if suitable spectacles were provided — optical examinations were said to be seldom given.

P *Good library.*
Read a lot.
Daily papers sent in.
Cannot read as need new specs.

S *Have nice library with large type books.*
Getting talking books.

Occupational therapy, physiotherapy, art, handwork

The proportion of patients benefiting from these activities varied enormously in the different hospitals. In one, all suitable patients went to the combined OT and PT department every morning for group activities and every afternoon for individual activities. In another hospital the senior therapist had trained aides and voluntary workers to bring diversional therapy to the wards, and held a popular weekly afternoon session in the dining room, followed by a tea party. Occasionally a few patients visited associated day hospitals where they were offered some occupational therapy or physiotherapy. In other hospitals nothing was offered to the long-stay patients, and the therapists themselves emphasised that their work should be therapeutic and not diversional. Patients and their visitors complained of physical regression and wished some physiotherapy could be given on long-stay wards, if only as group sessions. A central problem is the national shortage of occupational therapists and physiotherapists: priority has to be given by professionals to rehabilitation so long-stay patients often have to depend for their activities on voluntary workers. The supply of such workers varied in the different hospitals, and also the extent to which they had been trained by the occupational therapists and physiotherapists to help the patients with constructive activities and therapeutic movements and not to concentrate entirely on childish games or bingo.

At two hospitals, sessions with an art teacher had been provided by the local authority. In one of them activities in the studio made all the difference to the lives of a few patients who had become ardent painters and saw themselves as potential 'Grandma Moses'.

P *Go to OT and PT daily — ball games, cards, quizzes.*
Unit makes cakes etc.
Go twice a week, sometimes they come to the day room.
PT does me good.
Enjoy painting lessons.
Not enough OT.
Used to have PT, not now, wish she came.

S *Patients enjoy OT.*
Like PT.
Art teacher does marvels.
Skilled OTs feel diversional therapy not their job.
Desperate need for diversional OT: patients very bored.
Patients should be allowed to help with simple jobs in ward kitchen.
Need physiotherapists to take classes in wards as patients sit too much.
Could train aides or voluntary workers to give group classes in wards.

Going out

It is difficult for most people to imagine what it would be like to be confined indoors for months or years on end, yet this happens to many long-stay patients. The more fortunate go out

a into the garden or on a veranda
b walking or in wheelchairs to local churches, shops, hairdressers, pubs
c in their visitors' cars, often to visit relatives
d in a minibus, generally supplied by the Friends of the Hospital, to local places of interest.

a **Gardens** can be a great source of pleasure for old people especially if, in addition to trees and flowers, there are centres of interest such as goldfish ponds, a bird table, or squirrels. Some gardens were well used, others were unsuitable for wheelchairs, with no hard paths or flat places to push them, or with high edgings to lawns or steep ramps from the doors. One hospital was fortunate to have a beautiful garden which could be shut off from a dangerous main road. Some patients were happy sitting on verandas overlooking the hospital gardens. In most hospitals the gardeners took great pride in their work and took advantage of even small areas to provide a blaze of colourful flowers.

b **Church, shops and other places** In a few hospitals patients were taken out, either walking or, more often, in wheelchairs, to churches, shops, hairdressers, pubs, local commons — a welcome taste of ordinary life. Sometimes they were accompanied by relatives, more often by voluntary workers or members of church guilds. These were generally ladies, and one visitor said how her husband would appreciate being taken out sometimes by a man. At one hospital the administrator was nervous of such expeditions because of insurance problems should an accident occur outside the hospital.

c **Visitors' cars** Patients enjoyed being taken out for

drives, especially to visit other members of their family. Some visitors showed by their comments that they did not realise this was allowed, even encouraged, by the hospital. Where a patient had no visitors with cars there was generally no way for him to visit home or relatives.

d **Trips by minibus** Patients greatly enjoyed trips to local places of interest in a minibus and most of the hospitals had one available, part-time; usually it had been provided by the Friends of the Hospital, often for the use of several hospitals jointly. Patients enthusiastically described being taken to Buckingham Palace and to the seaside. Even incontinent patients could go on minibus trips because the seats and floors could be wiped down. One hospital had arranged a holiday exchange with some patients from another geriatric hospital.

Unless a patient can walk by himself or can propel himself in a wheelchair, he can only go out if there is someone to take him. The nurses would like to do this but are generally too busy, so patients have to depend on voluntary workers and on visitors. When a booklet is provided for visitors it should emphasise the pleasure patients get from going out, whether walking, in a wheelchair or by car, and voluntary workers should be given the same information during their training. The ward sister must be consulted, however.

P *Lovely garden.*
Enjoy fish pond.
Sometimes go home.
Enjoy minibus.
Longing to go out.
Want to see my sister who is housebound, but can't as no vehicle.
Would like to go outside and have a breath of air.

S *Often wheeled out to beautiful gardens.*
Take tea out in summer.
Encourage relatives to take them out.
Fairly regular expeditions in minibus.
Need minibus.
Patients do not go out enough.
Wheelchairs sink into grass.
Patio exposed to wind.
Need volunteers to take patients into the garden and to shops etc.

Television and radio

Praise and criticism for television and radio were almost balanced; the staff, as usual, being more critical than the patients. Reference has already been made to some of the problems in the sections on day rooms and on noise. Certainly television gives much pleasure to the minority of patients who can see, hear and understand it, and some who cannot like seeing some movement. Programmes on sport are especially popular with the men.

Much of the trouble occurs when sound is left on continually; possibly younger people on the staff are more used to perpetual, indiscriminate music and do not appreciate the sufferings of an older generation. With varying tastes there can be no solution acceptable to all so, as suggested previously, there is need for two day rooms, one quiet and one for TV and radio. Even so there needs to be some kind of agreement among the patients on which programmes to choose and how long to have them on, and the staff should be observant of whether patients are listening or not.

A few patients have their own transistor radios, and hospitals rightly insist on earphones being used with them. Only one of the six hospitals encouraged individual patients to have portable television sets. The wages clerk reminded each patient fortnightly of the amount of money that had accumulated in his or her account and this had the successful result that many had bought their own portable television sets. It was pleasant seeing them sitting up in bed in the evening, each listening to a preferred programme, using padded rubber earphones. A private radio station for a hospital is much liked; two hospitals had these but the staff deplored that they were not working.

P *I am close to TV and I love it.*
Like to watch sport.
Enjoy watching even if I can't hear it.
Good that don't have TV all the time.
No TV in ward, thank goodness.
Listen on own transistor.
Sometimes sing with radio.

S *Place TV near those that enjoy it.*
Even some of the confused ones like it.
TV controlled by patients.
Once TV is on it remains on.
TV on too much.
Patients squabble about TV.
Need radio for those who can't see TV.
Trying to get hospital radio station back into use.

Entertainments

Few patients commented on entertainments and of these only half the comments were favourable. Some patients enjoyed the entertainments they had but wished these were more varied; others did not like them. Most entertainments took the form of concerts or singsongs in the wards and patients particularly enjoyed 'old time' music. At one hospital a volunteer pianist had retired and was much missed. More varied entertainments were suggested by staff and patients including puppets, guitar players, recitations and, especially, amateur holiday films made by patients' visitors or staff members, accompanied by a commentary. Entertainments should be in the afternoon as many patients were too tired to enjoy them in the evening. Ward entertainments tended to be more popular than ones given centrally; at one large hospital the staff said it was difficult to persuade patients to go to a central hall and transport of wheelchairs was a problem. However, at a smaller hospital with a stage in the dining room, the patients greatly liked seeing shows put on by the staff several times a year. A few of the more active patients said that there was too much entertainment around Christmas and too little in the rest of the year.

P *Church guild comes weekly.*
Nice singsongs in the ward.
Staff gave a good show.
Would like more frequent films.
Don't have enough entertainments.
Don't really enjoy them.

S *About half the patients enjoy the entertainments.*
Patients enjoy concerts and bingo with prizes.
Give concerts in nurses' dining room with refreshments.
Enjoy seeing doctors and nurses in staff shows.
Local dramatic societies don't come.
Need projector and screen to show amateur films in wards.

Freedom of choice

	Number of comments	Percentage favourable	Order (Out of 12)
Patients	102	75	2
Staff	109	59	4

It was sometimes difficult to explain during interviews what was meant by 'freedom of choice' or 'having enough say'. When the concept was illustrated by asking whether patients could choose the times for going to bed and getting up, answers were often limited to this topic. With this proviso it can be seen that three-quarters of the comments from patients and visitors were favourable and that the staff was also fairly contented.

Patients tended to say either that they were happy about their freedom of choice or that they had little say but did not mind this. They often explained that those who were able to dress themselves could decide when to go to bed or get up, but the rest depended on the staff available and it was reasonable that their times were controlled because of shortages. Very few people, whether patients, visitors or staff, felt that the patients were over-managed. Some staff thought that too much pressure was exercised on the confused patients who became worried at having to make a choice. Some doctors and social workers were anxious to stimulate patients to have more say about their own conditions by forming ward committees — a few suggested the inclusion of relatives. In two hospitals such committees had just been started but so far had made little impact — they were mentioned very occasionally by ward staff and never by patients.

P *Patient uses will of her own.*
Do what you want about getting up and going to bed.
Select TV programmes.
Can't choose but don't want to.
I feel lazy.
No say but don't mind.
Got to do what they tell you.
In their hands aren't I?

S *Try to get them to feel free.*
Staff's job is to make social atmosphere stimulating.
Many if left would do nothing so have to be encouraged.
Should have discussion groups of patients, relatives and staff.
Can't alter bed times because of pressure on staff.
Timetable is function of staff.
Patients have quite enough say at present.

Patients' relations

	Number of comments	Percentage favourable	Order (out of 12)
Patients	105	71	7
Staff	162	51	joint 6

Patients were happier about their relations with each other than the staff were about them. This may be because those patients who could be interviewed had more friends than those who were unable to participate in the enquiry. From their comments, often rather sad, patients seemed divided into three groups — those who are friendly with each other, those who prefer to remain solitary and those too confused to make social contact. There is a small additional group, those who would like to be sociable but are too shy or too new to join in without encouragement: some had lived a solitary life before coming to the hospital and needed help to become sociable. Since many patients are physically unable to move their position it is important to segregate these types both in the dormitory and in the day room, otherwise the sociable and solitary suffer alike from each other's company. Sensitive staff can do much to see which patients are friends, or could become so, and arrange for them to be near each other. The patients expressed all shades of opinion from *'friendly nice people'* to *'making yourself agreeable to other people is the hardest part of being here'*. To help integrate shy people, one ward had a welcoming committee for newcomers. Others suggested appointing a ward host or hostess to look after each new patient. The staff said that group activities, whether in the occupational therapy department or in the ward, helped to promote friendliness and instanced good results from jigsaws, card games and singsongs.

Seating arrangements have an effect on sociability. The worst arrangement was found in long wards where there was no day room (or one that was barely used) and each patient sat by her bed. In other wards some beds were pushed aside during the day so that patients could sit in a group. Mention has already been made of the best arrangment for chairs in day rooms — in groups rather than in lines along the walls. Patients tend to be possessive about the position of their chairs and it is important that others, especially day patients, do not invade territorial rights. All the rearrangement of sitting positions has to be done with sensitivity and not arbitrarily.

Several wards had joint day rooms for men and women and this was liked. Only one ward had complete integration with men and women sharing the dormitory and sanitary accommodation. No strong feelings were expressed by staff or patients but the impression was received that most did not like it.

P *We are all pals.*
Our entertainment is each other.
Get on well with everybody.
Up to you to be friendly.
Affable but not very sociable.
Some patients best left alone.
Don't believe in chatting.
Should keep senile people together.
Never talk to anyone.

S *Most make friends.*
Try to put friends together.
A lot are not sensible but are friendly.
Hope to have a new central club.
Many come in very shy.
Good integration between day and residential patients.
Friends or fight.
Often shut up in themselves.
All in own little world.
Need go-between to establish friendship — voluntary worker, nurse or friend.

Comments on care of patients

There is a strong similarity in the comments offered on patients' care, whether the comments were made by patients or staff, and whether the comments were about care given by doctors, nurses or by other people. Nearly all stressed that the quality of the care was excellent but the quantity was deficient due to low staff establishments or staff shortages. The patients sympathised with the staff for being overworked, and the staff regretted that they had to concentrate on fundamental needs and could not give the extra attention that would add to the patients' contentment.

Doctors' care

	Number of comments	Percentage favourable	Order (out of 12)
Patients	158	71	7
Staff	150	65	3

Most of the comments on doctors given by staff and patients were concerned with shortage of doctors and the fact that in some hospitals they were so pressed for time that they could only examine the more seriously ill patients, and hardly ever discussed a patient's condition with him or with his relatives.

Medical care of those who were very ill was said to be excellent but often those with minor disabilities that might have been cured felt comparatively neglected. For example it was said that insufficient attention was given to optical, aural or dental conditions, need for pedicure, or to incontinence. Staff said that there were no regular medical rounds in some long-stay wards and patients were only seen if unwell. Indeed, some patients did not even know there was a doctor responsible for them to whom they could apply for help. Patients and visitors were often diffident about asking a busy doctor for information they were anxious to have, but some doctors received an accolade for volunteering information or making questions easy.

P *Doctor's care is very good.*
Helpful and informative to relatives.
Little interest in long-stay patients.
Got to be your own doctor and ask.
Never see doctor.
Never tells you how you are getting on.

S *Need more doctors more often.*
Doctors just whip around.
Talk to patients, don't talk down to them.
Little contact with relatives or consideration of home circumstances.

In all the hospitals visited there was at least one consultant who specialised in geriatrics and was anxious to introduce new methods and to interest the rest of the staff in these. Sometimes he was backed up by a local general practitioner, available at all times when the hospital was not otherwise covered medically, and who had often known some of the patients in their homes. Although some of the junior doctors were interested, many remained in the hospital only for a short time and old people found it confusing to have constant changes, sometimes complicated by the language difficulties of doctors from overseas. Although most doctors were said to be interested in long-stay patients and sensitive to their needs, a few were described as failing to consider patients as human beings or criticised for seeing all patients in a group where everyone could overhear what was said.

P *Medical care excellent, both consultant and others.*
Have a lot of faith in the doctor.
Doctors come and go, mostly foreign and very young.

S *Very progressive.*
The doctor has a lovely way with old people.
Cultural differences of some overseas doctors a problem.

In some hospitals doctor-nurse relations were excellent, the doctors holding joint meetings with the nurses and giving, or organising, lectures on geriatric care. In other cases relations were less happy and there was little contact in the ward between the doctor and the nursing staff, even to the extent (witnessed by one survey organiser) of a doctor showing reluctance to come, at the sister's urgent request, to examine a patient who had fallen and cut her head badly.

S *Doctors easy to work with.*

Discuss treatment with nurses.
Doctors should listen to nurses more.
Doctors don't talk to nurses.

Nurses' care

	Number of comments	Percentage favourable	Order (out of 12)
Patients	248	66	10
Staff	212	47	8

Since most of the patients and many of the staff expressed great admiration for the nurses, it is clear that the comparatively low ratio of favourable comment is due to criticisms on staff shortages. This was given even in those hospitals where the nursing staff was up to establishment. It was said that establishment figures had been fixed when most patients remained in bed and were now too low because almost all the patients got up and needed more help. In two of the hospitals, staff shortages were such that some patients were kept in bed — in one hospital every other day, in the other on Sundays. Some hospitals were not up to establishment or had a disproportionate number of nursing auxiliaries instead of trained staff. The staff complained that they had not time to give care of a standard they would like to maintain on such matters as frequency of baths, hair washing, pedicure and, especially, talking to the patients. The nurses said overwork caused some to suffer from strain and ill health. Things were worst in the evening and, especially, at weekends.

Patients were enthusiastic about the care given by most of the nurses and frequently described them as *'dears'*, *'angels'*, *'lovely'*, and *'wonderful'*, the sisters receiving particular praise. Patients said the nurses mostly talked to them as far as time allowed and that they were tolerant of difficult patients. However, in all hospitals the patients found a few nurses who were abrupt, inconsiderate or slow at attending to toilet needs. Occasionally nurses were said to talk to the patients as if they were young children — hurtful to the patients and their relatives alike. Other nurses were insensitive to the amount that confused patients understood, remarking on their deficiencies in front of them. The staff considered that middle-aged nurses were better than young girls with the elderly, though students and pupils should have a period of training in the long-stay wards as well as in the rehabilitation wards.

P *Sisters and nurses capable and kind.*
Always cheerful.
Very attentive.
Overworked.
Some nurses have a terrible lot to contend with from poor old things.
Talk to patients, even the senile.
A few speak roughly.
Sometimes they shout at you.

S *Nursing staff give love as well as medicine.*
Nurses now accept patients should not only be up and about but out and about.
Sister has an impressive caring attitude.
Communicate well with patients and relatives.
Short of nurses so get very tired.
Some nurses volunteer as escorts on days off.
Some bully — haven't enough patience with old men.
Should get more information about patients from relatives.

Care from other people

	Number of comments	Percentage favourable	Order (out of 12)
Patients	116	71	7
Staff	256	67	2

The question was planned to find reactions to people other than doctors and nurses, whether working voluntarily or on the staff. Patients and, especially, the staff were very appreciative of the help given by voluntary workers and of visits by the chaplains. Fewer comments were made about the staff, probably because their work had been frequently mentioned earlier in the interviews when discussing meals, occupational therapy and so on.

Friends of the Hospital

The hospitals were said to owe a deep debt to the Leagues of Friends who had raised funds by various means such as bazaars, 'nearly new' shops or straight gifts. The money had been spent on television sets, plants for the garden, and often on a large project such as a new day room or a minibus fitted for wheelchairs. The patients enjoyed the birthday cakes and the Christmas cards and presents provided for each one of them in most hospitals. One League of Friends was said to have bought furniture that should have been provided by the Department of Health, such as geriatric chairs and ripple beds. At only one of the hospitals had the League of Friends *'folded up'*.

P *League of Friends does a lot.*
Appreciate League of Friends' trolley shops.
Enjoy having a birthday cake.
Like birthday presents.

S *League of Friends has given a lot — TV rental, electric chairs, garden seats etc.*
Help with birthday cards and presents.
As hospital is remote needs drive to get minibus.
Money spent on equipment that should have been supplied by the Department.

Voluntary workers

The staff commented on the voluntary workers far more often than the patients did, but both expressed gratitude and had few criticisms except for the need for more of such workers: some staff said they tended to be directed to the rehabilitation wards. Three of the hospitals had voluntary work organisers as members of the staff (in one hospital,

full-time) and the others had organisers who were themselves volunteers. The organisers' duties were threefold: to find where volunteers were most needed and would be welcomed by the staff, to recruit suitable people as volunteers and to train volunteers in their work including their relationships with the staff. The staff stressed that to be useful voluntary workers must attend regularly and that on the whole, adults were liked best, men as well as women, but some school leavers and senior school pupils were acceptable. Younger children such as Scouts and Wolf Cubs had been tried in two hospitals but the experiment had failed. Often the voluntary workers were recruited through an organisation such as the WRVS, the Red Cross or Church League. Preliminary training by the organiser should cover such matters as the hospital organisation and hierarchy of control, the need to keep matters confidential that might cause embarrassment, and attitudes towards elderly patients. In addition, voluntary workers should be trained in their specific duties by the nurses or sometimes by the occupational therapists and physiotherapists. Some had had no preliminary training and had found themselves worried at not knowing how to help, and often gave up the work. Conversations were best initiated if the volunteer was doing a job she could discuss with the patient.

Many comments have been quoted in this report, both on the help given by voluntary workers or on the additional help they could give if there were more of them. Most comments were made by the staff but some were from the patients. The various topics covered are summarised below to avoid repetition.

Meals Helping with patients who cannot feed themselves. Taking menus around for patients to select next day's meals: this, incidentally, initiated conversation.

Reading Circulating library trolleys and shop trolley through wards. Helping patients choose books.

OT handwork Helping patients to obtain and undertake craft work, knitting, and so on. In some hospitals the occupational therapists train the voluntary workers and help them obtain equipment.

Taking patients out Taking patients to the garden or to local churches, shops, hairdressers, and so on. Sometimes patients could walk with help, more often they needed to be wheeled in chairs.

Minibus Accompanying patients on trips in the minibus, thus reducing the number of nurses who needed to be spared for this job or who volunteered to do it in their spare time.

Singsongs Organising singsongs in the wards, sometimes with a volunteer pianist.

Games Playing games with individuals or small groups — ludo, cards, bingo, and so on. Some patients said they enjoyed this, others found it patronising. It is one of the most usual activities for voluntary workers if the organiser has failed to find specific jobs where they are needed.

Conversation Talking to patients who have few visitors or who are blind.

Entertainments The organisation of entertainments is often done by individuals or bodies apart from the regular voluntary workers, such as Rotary Clubs, Townswomen's Guilds, amateur theatrical clubs, carol choirs, local schools. These entertainments were usually enjoyed but tended to be concentrated around Christmas, leaving the rest of the year unprovided for.

P *Voluntary workers very good.*
Like singsongs.
Join in games.
Would like someone to visit me.
Have two or three excitable schoolchildren in ward.

S *Excellent voluntary workers.*
Organise a lot of social activity.
Patients enjoy being taken out.
Need more voluntary workers on a regular basis to help at meals, to teach crafts, to organise singsongs etc.
Need volunteer drivers.
Schoolchildren as volunteers get helped themselves, but are not old enough to cope with patients.

Chaplains

Many patients spoke about the chaplains, Church of England, Roman Catholic and Methodist. They were much appreciated, especially if they came frequently, knew the patients by name and talked to patients other than those of their own faith. Regular services in the ward were liked, whether held weekly or monthly. In one hospital a chaplain was criticised because he only visited the hospital when specifically asked to come, apart from taking monthly services.

P *Chaplain a marvellous man.*
Comes regularly.
RC priest ever so good.
Have services in the ward every Thursday.
Take communion.
Chaplain does not come to see me.

S *Chaplain visits regularly.*
Knows everyone by name.
RC chaplain comes daily and talks to everyone.
Chaplain goes round and chats.
Chaplain takes part in entertainments.
Some people go to chapel and more would like to if they could be taken there.

Local community

A number of comments from the staff, but none from the patients, concerned relations with the local community. One hospital was described as the 'community hospital': it was easy to recruit part-time trained staff, generally mature married women who lived locally. Relations with the local press were good. Another hospital, centrally located, was said by the staff to be very much part of the community; it received a lot of help from local bodies, largely through the influence of the doctors, nurses and chaplains. It was completely different in another large hospital where the local community, and even the community health council, were said to be unfriendly. The hospital had retained its image as a workhouse and the local press seized every opportunity to be critical and never reported improvements or favourable occurences.

S *Neighbours think it a lovely hospital.*
Local public opinion has woken up and people near do a lot.
Frequent articles about hospital by the local paper, eg, on art training.
Very little known about hospital as it is so hidden away.
Get bad press.
Improved hospital but this was never acknowledged in local paper.

Visitors

Most of the comments on visiting came from the visitors themselves, some from the patients, but very few from the staff. Great appreciation was expressed about the fact that visitors could come at any time and also (in some hospitals) that they could buy meals at the staff canteen and visit the ward kitchens. The patients enjoyed visits from children, whether their own relatives or children of the staff. Some of the staff's children came regularly, brought their friends, and sometimes gave little entertainments. A patient's pet cat brought from her home by her sister was a welcome visitor in one hospital. A staff member suggested that visitors' meetings should be held.

P *Visiting encouraged.*
Can have as many as one likes.
Visitors can come at any time.

S *Some patients not visited because friends cannot afford fares.*
Could Red Cross arrange transport for elderly visitors to remote hospitals?
Should have occasional meetings for regular visitors.

Staff members (other than doctors and nurses)

Comments from staff and patients about occupational therapists, physiotherapists and caterers have been reported earlier. Some appreciative remarks were also made, mainly by the staff, about administrators, social workers, domestics, gardeners and hairdressers. One administrator was praised for promoting good coordination between the office staff and the rest of the staff. In one hospital with a lovely garden, the gardener brought flowers to patients who had none and he attended to patients' pot plants.

P *Domestics friendly to talk to.*
Feel better after hairdresser has been.

S *Social worker a gem.*
All staff put patients first.

Comments on staff conditions

The staff, but not the patients or visitors, were asked additional questions on staff training, consultation and relations. On all these topics staff gave a high ratio of favourable comment — higher than on most of the topics concerning patients. On staff relations the ratio was far higher than on any other topic.

	Number of comments	Percentage favourable
Training	153	64
Consultation	120	61
Relations	160	82

Training

Induction and interdisciplinary training

One hospital had excellent induction training. Talks were given periodically to all new staff, whatever their department, by the administrator, social worker, organiser of voluntary workers and others. At another hospital interdisciplinary meetings were held regularly for some members of all occupations in direct contact with patients, including domestic workers and porters. Several people suggested that there should be a staff handbook given to all new staff members.

Training should be given on social responsibility.
Night staff get no training though need it more than others.

Trained nurses

Nursing officers and sisters appreciated attending conferences and special meetings. At one hospital a fund had been raised to pay for conference expenses but at another individuals had to pay for their own, as well as taking the time as leave. Some doctors and nurses said that some specialist nurses should be trained, thus becoming experts on, for example, incontinence or on drugs. These in turn could train their colleagues and perhaps the community nurses also. All the hospitals had occasional study days, usually for all trained nurses although in one hospital they were restricted to SRNs, and SENs were excluded. When the study day was at the local general hospital it tended to be on general subjects not always directly useful to nurses in geriatric hospitals, but when given at their own geriatric hospitals it dealt with their own problems. Visits to other geriatric hospitals and to hospices were found very useful and more of these would be welcomed. One hospital had regular study sessions with talks by consultants, speech therapists, social workers and others, for nurses of all grades. Part-time staff often missed meetings and different arrangements were tried to meet this difficulty. Some part-time nurses felt that it was unfair to expect them to go in their own time.

Trained staff should be encouraged to go on courses.
Enjoy going on study days or weekends at different colleges or hospitals.
Sisters' day held monthly at parent hospital.
SRNs and SENs need more lectures on psychogeriatrics.

Nursing auxiliaries

A lot of criticism was levelled at the training of auxiliaries — in some hospitals it was described as deplorable. In one, auxiliaries did not even have instruction in basic nursing or in making beds. In others it was much better, such as the hospital where auxiliaries had inservice training with a clinical teacher, in addition to a course of twelve lectures. In several hospitals the auxiliaries were taught lifting and bedmaking by a physiotherapist or attended a nursing course given by the Red Cross. Many of the auxiliaries worked part-time and the same difficulties arose, as with other staff, when training was organised outside their regular hours — in some cases it meant attending without pay. Training was seldom given to night-nursing auxiliaries.

Nursing auxiliaries taught in the ward.
Have marvellous course of lectures.
Need training in basic nursing, lifting etc.
Used to be trained by Red Cross, not now.

Other staff

Supervisors, catering, domestic and porters, had been sent on management courses at two of the hospitals and some catering staff attended courses at a local technical college. Because of the national shortage of physiotherapists and occupational therapists, some professionals had trained aides, paid or voluntary, to work under their supervision. In other hospitals they did not cooperate with volunteers

and had no aides. No mention was made of training office staff.

Catering and domestic supervisors should be pressed to do more training of staff.

Consultation

Within any one discipline, consultation, formal or informal, was usually said to be good. For example, regular meetings were held for ward nursing staff with reports on individual patients and time for questions, though sometimes nursing auxiliaries were excluded from these. Part-time staff working on the afternoon shift were often not informed, even about important matters. Some domestic supervisors had periodic meetings of their own staff. As with all staff meetings some chairmen had the gift of promoting discussion, others were merely informative with an 'I'm telling you' attitude. Informal consultation was generally considered good: seniors were said to leave their juniors free to use their initiative but ready to listen to problems and be helpful.

There was often a lack of interdisciplinary consultation between people from different departments. Most hospitals had regular meetings between doctors, nurses and therapists but only a few extended these meetings occasionally to include representatives of other staff such as social workers, office staff, caterers, domestics, porters. Where this was done it promoted understanding of each other's problems; for example, nurses wanting to help patients to dress at the same time as domestics wanting to get on with the daily cleaning. Sometimes there were disagreements between nurses and domestics as to who cleaned up which mess.

More acute problems resulted from lack of consultation between hospital and experts from the district or area, especially when buildings were being altered or extensions planned. If new sanitary units or other major alterations were carried out without consultation with staff who had been working for years in the ward, there was much bitter feeling. In some hospitals the day rooms were new or newly adapted and the staff had dreamed of the perfect day room. When reality revealed flaws of size, position or equipment there was great disappointment. Similarly, they regretted the installation of a lift too small to take the new beds. Even when the staff's advice cannot be followed it helps if they are given the reason; for example, that the lavatories had to be sited some distance from the day room because of the construction of the drainage system. In one case the staff said '*If this is so why didn't they explain it to us?*' Some problems could easily have been prevented by early consultation — doors too narrow, ramps too steep, long delays in getting new equipment delivered to the stores into the wards, or in having essential equipment repaired. Advice should be sought not only from nursing officers and sisters but also from junior staff, including those on night shifts, so that all can feel members of the team, able to provide suggestions and understand difficulties.

Have meeting weekly of medical and nursing staff, PT and OT and sister's meeting for ward staff same afternoon.
Heads of departments' meeting every other month.
Staff consultative committee with union representatives.
Need more consultation between wards and departments.
Ward meeting a one-way affair with no discussion.
Recommendations from staff meetings don't go above hospital level (eg, training of pupil nurses).
Hear hospital news first from the local paper.
Changes thrust on us.

Relations

Staff expressed enthusiasm on relations in all six hospitals surveyed. This can be seen from the fact that 82 per cent of their comments were favourable, a figure far higher than for any other topic. The hospital was repeatedly described as '*a very happy place*' and having '*a good team spirit*'. In some hospitals certain groups were specified: '*good relations with the union*', '*good race relations*', '*sisters and domestic staff get on well*'. The small size of some of the hospitals was often cited as the cause of their excellent relations: '*in a small hospital everyone knows everyone*', '*cheerful village atmosphere*', '*small, stable staff who know each other well*'. Specially good relations were sometimes quoted: '*nursing administration sociable and democratic*', '*nurses come into the OT room and join in the singing*'. Relations among staff were summed up in two comments: '*happiness is who you work with*' and '*patients are happy as nurses are happy*'.

Many of the nursing staff worked part-time; indeed in one hospital only the nursing officer and sisters worked full-time. Although this arrangement posed certain problems, the part-time nurses said how satisfying they found it to work near their homes; there was a community spirit among them and many were friends at home. Quite often they brought their children and even their pets to see the patients, making them feel part of the local scene.

The few critical comments about relationships were mostly concerned with interdisciplinary clashes, often with the administrative staff: '*administrative staff very remote*', '*departments should come more to wards, better than sending notices*', '*office and domestic staff are a race apart*'. More staff amenities were occasionally requested; for example, a staff club room with games in one large hospital, and the upgrading of staff-changing accommodation in another.

Nice atmosphere everywhere in the hospital.
A good crowd and all put patients first.
Very friendly hospital.
All staff local — most have been here a long time.
Good social functions with associated general hospital.
SENs are efficient nurses but know little about management.
Administrative staff never visit the wards.

Liked best and least in hospital

At the end of each interview two questions were asked: 'What do you like best about the hospital?' and 'What most needs altering in the hospital?' These differed from the previous questions in that no indication was given of the topic to be covered and therefore the choice gave information on priorities. Some people found these questions difficult to answer and replied in general terms, usually favourable: '*like everything*', or '*nothing needs altering*'. Many praised the hospital in general terms: '*I wouldn't be anywhere else in the world*', or, from a visitor, '*very expensive private homes not a patch on this hospital*', '*very happy atmosphere for staff and patients*', It was very rare indeed to have adverse general comments such as '*nothing good about this hospital*'. Some of the staff spoke about staff conditions, especially the excellent staff relations, rather than about conditions for patients. An analysis of the replies it given in Table 4, dividing the topics under three main headings: Patients' care, Environment and Daily life. General comments have been excluded and comments on staff conditions are given separately in Table 3 but not included in the percentages in Table 4.

Comparison of the views of patients and staff

The following points emerge from studying Tables 3 and 4.

a Staff are more critical: in Table 4 they give almost as many comments on what they like least as on what they like best: patients give less than half as many.

b Both groups give care of patients as what they like best, the patients in higher proportion than the staff.

c The staff, unlike the patients, strongly emphasise that environment is what they like least but the patients were almost equally divided between staff shortages, environment and daily life, particularly lack of occupations.

d The staff conditions were more often chosen by staff under 'liked best' than any other topic except the care of patients.

The findings reinforce the information obtained from other questions — that the patients concentrate their likes on the care given to them by the staff, and their dislikes, sympathetically, on staff shortages, but the staff focus their dislikes on poor premises and equipment which prevent them giving their best care to the patients.

TABLE 3 Staff conditions included by staff in liked best and least

	Number of Comments	Equivalent additional percentage
Liked best	55	35
Liked least	5	3

TABLE 4 Percentage of topics liked best and least

Liked best	**Patients**		**Staff**	
Number of replies	180		156	
Patients' care		59		41
Staff	59		41	
Environment		22		35
Wards and day rooms	16		23	
Grounds and site	6		12	
Equipment	0		0	
Daily life		19		24
Other patients	6		6	
Meals	5		3	
Freedom, open visiting	5		3	
Activities, entertainments	3		12	
Total	100	100	100	100
Liked least				
Number of replies	65		148	
Patients' care		35		22
Staff (mainly shortage of staff)	35		22	
Environment		31		60
Wards and day rooms	23		43	
Grounds and site	6		3	
Equipment	2		14	
Daily life		34		18
Other patients and patients' relations	6		3	
Meals	3		2	
Freedom, opening visiting	11		3	
Activities, entertainments (lack of)	14		10	
Total	100	100	100	100

Outcome

Follow-up of survey

Each hospital was sent a number of copies of a full report on its own results for distribution to the staff and discussion about possible action. After such consultation, the survey organisers were usually invited to attend a meeting to discuss what action had been taken or planned. Generally, there had been a satisfactory number of modifications on such matters as staff training, the provision and care of equipment, service of meals and utilisation of voluntary workers.

Extension of use of survey

Other hospitals may wish to conduct similar surveys and for their assistance instructions are given on pages 37-39. If a hospital is unable to find a suitable survey organiser with the necessary time and knowledge available it may prefer to use the checklist shown on pages 47-50. Both these survey methods give results useful for staff discussions and study days — often it is stimulating to ask staff to guess the results ahead and to compare these with the results actually obtained.

The questionnaire forms and the checklist may be copied for use in hospitals. There is no need to obtain permission from the publisher to do so.

Reflections on survey findings

Rehabilitation versus long stay

Is more attention given to patients who are likely to improve enough to return home and, if so, is this right? Which patients are more important — those likely to recover or those for whom the hospital will be their home for the rest of their lives? Do the former have better opportunities in terms of occupational therapy and physiotherapy, medical attention, nursing care, and help from voluntary workers?

Stimulation versus rest

The old often feel tired and just want to rest. Should this be allowed or should they be stimulated to be as active as possible? Should they be pressed to take part in activities and games or should they be allowed to snooze as much as they want, sleeping on their beds after lunch and occasionally getting up later or staying in bed all day?

Boredom

What can be done to reduce the boredom of institutional life, especially of being one of a group who lead similar lives, have little outside contact, and therefore have nothing fresh to talk about? Can more effort be made for individuals to have different experiences — to go out more with relatives or voluntary workers, to go by themselves or with a friend to local shops, pubs and so on? Can patients be given more opportunities to exercise any talents they have — for playing the piano, painting, gardening, cooking? Is it possible for patients to keep pets or have an allotment in the garden or help with the library?

Money

Can patients be helped to spend their allowances in ways that give them pleasure — such as individual television or radio sets (with earphones), personal clothing, local cinemas or theatres, alcoholic drinks, presents for friends and relatives. The absence of these experiences of normal life could indeed be regarded as an infringement of human rights.

Noisy and antisocial patients

There are often a few patients who are noisy, day and night, who pilfer or are unpleasant to others. Should these be isolated as far as possible or given calming drugs, or would this have a bad effect on them? It seems wrong to allow a few to disturb the serenity of so many others; on the other hand, difficult patients have rights too.

If your mother needs care

If her doctor recommends that your mother should go into a geriatric hospital, how would you feel about it. Suppose she is aged 80, badly arthritic, mildly incontinent and slightly confused, and that none of the family can house her. What would be your hopes and fears? If you could afford it would you send her to a private nursing home?

Probable advantages of an NHS hospital

Better medical attention with a geriatrician in charge.

More constant nursing; less change of staff; nursing officers and sisters experienced in geriatric care.

Occupational therapy and physiotherapy; more active rehabilitation.

Better equipment such as adjustable beds, hoists, special baths.

Probable disadvantages of an NHS hospital

Little or no solitude; one of a group in dormitory and day room.

Can take very few personal possessions — often not even own clothes.

Noisy — television, other patients talking. Some trying companions.

Frequent change of junior doctors so that minor complaints are not attended to.

Nurses often seem, and sometimes are, overworked so patients do not like to ask for minor attentions.

Possible criticisms from friends if they associate the geriatric hospital with old workhouse.

Probable advantages of a private nursing home

Likely to have private room and use of a communal sitting room.

Can take more possessions, sometimes including furniture and pictures.

Smaller number of patients so both patient and family can have a closer association with the staff.

Free to change to another nursing home if unhappy there.

Probable disadvantages of a private nursing home

Heavy expense.

Patients sometimes left alone for long periods and nurses slow in coming to help.

Fewer facilities for the very ill.

Building usually less good.

Instructions for conducting survey

Preparation

1 Support for the general idea of a survey should first be obtained from the senior medical, nursing and administrative officers and from relevant committees. It is important that all these should be interested and prepared to consider the results seriously.

2 A survey organiser should be chosen. He or she would be responsible for conducting the survey, reporting back and following up subsequent action. This is a time-consuming job and needs a person with ability, analytic skill and knowledge of hospitals.

The most important attribute of the survey organiser is the ability to enlist and maintain the willing and active cooperation of the senior and ward staff. This requires tact, sensitivity and patience. Without it, the survey is unlikely to yield useful information, and could well be impossible to conduct.*

The survey organiser could be a member of the CHC, a 'friend' of the hospital or a management trainee but should not be a member of the hospital staff.

3 The staff and patients should know all about the survey and be assured that their contributions will be confidential. This information can be given by meetings, notices or internal broadcasts.

4 The following forms should be duplicated.

a A letter somewhat similar to that shown on page 40, signed by the administrator.

b The three questionnaires, preferably on different coloured paper.

c A form for each ward with the following six column headings

Name	Mr, Mrs or Miss	Date of birth
Date of entry	Note by S or C/N	Classification

The first four columns should be completed by the medical records department for all patients who have been in the hospital three months or more.

Participants

5 The following groups of people should be invited to participate but no pressure should be used.

a **Patients** All those who have been in the hospital three months or more and are not too confused, deaf or ill.

b **Ward staff** In each ward whose patients have been included, the sister or charge nurse should be interviewed and four or five other staff including at least one staff nurse, SEN and auxiliary and sometimes a domestic.

c **Other staff** The sample should include a consultant, other medical staff, nursing officers, administrators, heads of departments such as physiotherapists and occupational therapists, social workers, caterers, domestic supervisors, organisers of voluntary services and some other staff.

d **Visitors** Regular visitors of long-stay patients should be interviewed if they happen to be there at the time. If this is inconvenient or they visit at a different time, the sister or charge nurse should give each visitor a copy of the letter, the questionnaire and a reply-paid envelope marked 'confidential' and addressed to the survey organiser.

6 The number of patients plus visitors included should be roughly equal to the number of ward staff plus other staff. The order in which people are seen is not important but it is best to start with one or two nursing officers or administrators to get a general idea of the hospital organisation. As far as possible, one ward should be completed before starting on the next. It is often advisable to interview staff at times when the wards find visitors inconvenient, such as before 10 am and from noon to 2 pm.

Conducting interviews

7 **Place of interview** The organiser should sit with the participant in as quiet a place as possible so that the answers will not be overheard. Patients, ward staff and

* These sentences were inserted after the report was completed. Mrs Raphael had these qualities in abundance, and would have been too modest to make the point herself. JM

visitors are generally seen in the ward, but other staff are seen in the organiser's office. This office is also used for storing forms but completed questionnaires should be taken home daily by the organiser.

8 **Introduction to ward** A preliminary talk should be held with the ward sister or charge nurse as to how the survey can be most conveniently conducted; to fill in column 5 of the ward form with particulars of each patient, such as relevant disabilities; to obtain suggestions on which ward staff to see (largely based on length of service); to give explanations about the procedure with visitors.

9 **Interviews with patients** Letters should be given out in advance. The interview should start with the organiser introducing himself, asking if the patient has read the letter and, if need be, reading it out and then asking for the particulars requested at the top of the questionnaire. Answers are entered whether accurate or not, as the organiser can then decide whether the patient is sufficiently alert to continue with the rest of the questionnaire.

10 **Interviews with staff and visitors** A copy of the letter and of the questionnaire are shown to staff members (and if possible to visitors) in advance. Staff and visitors can keep a spare copy of the questionnaire with them while questions are being asked.

11 **Asking opinions** Questions 1 to 12 (and for staff 14 to 16 in addition) should be asked in as neutral a way as possible, balancing what is considered good with what could be improved. For example, 'How do you like the meals?', 'What is good about them and what could be improved?' Then ask question 13 — the two parts separately — 'What do you like best about the hospital?' then 'What most needs altering in the hospital?' If answers are given in terms of general approval or disapproval, try to obtain replies on specific matters. At the end of the interview, remember to thank the interviewer for the help given.

12 As far as possible, record the main points given on each topic verbatim, favourable comments in the left hand column, suggestions and criticisms in the right. Try to include any typical and telling phrases suitable for quoting in the report. If an answer is given in general terms — 'very nice' or 'I don't like it' try to get more exact information.

13 **Classification of patients** If a patient has given incorrect information on such matters as age or length of stay, add the correct information on the questionnaire. Patients who are interviewed are classified into three groups based on their accuracy and on their comments during the interview.

A = Alert
B = A little confused at times
C = Rather confused

The appropriate letter is written on the questionnaire and in column 6 of the ward form. If any patient does not want to be interviewed his refusal is also entered in this column. Any other reasons for not interviewing him, such as 'too deaf', should also be entered.

Analysis of comments

14 Each survey is, in a sense, an essay in detection to find which aspects of the hospital seem satisfactory to the various groups and which need improvement. Far the most difficult and lengthy part of the survey officer's job is to summarise the information obtained and present it in such a way as to show clearly the differences between the views of the different groups interviewed. For this it is usually necessary to make a rough analysis, a final analysis, and then to calculate the ratio of comment that is favourable for each topic.

15 **Rough analysis** Prepare a number of double sheets of lined foolscap or A4, the left-hand side for favourable comments and the right for suggestions or criticisms. Rule four columns on the right half of each page, one for the results of each of the four groups of people interviewed. Use a different coloured ink for each group. Take the first topic — Meals. Look through some questionnaires from each group to find the main points raised and consider what subheadings to use for this topic: these might be quality, quantity, choice and variety, service and times, general. Write these subheadings on the left of each page. Go through all the patients' questionnaires, entering typical comments under the appropriate subheadings. At the same time put a tick in the first column for each entry. If it would be useful to analyse by ward, put a letter instead of a tick. When a comment is repeated or a similar comment made, add a + sign after the comment. When all the comments on meals by patients have been entered, continue with those given by visitors, using a different coloured pen, adding a + sign as before when a comment is repeated and putting a letter for each entry in the second column. Repeat for ward staff, then for other staff, in each case using different coloured inks so that the actual comments given by each group can be quoted separately.

16 **Final analysis** Prepare a number of similar sheets with four columns on the right, one for each group. The rough summary always needs some regrouping and revision before the data are copied on to the sheets. The entries in the columns should be in total figures, not in individual letters or ticks. Different coloured inks should be used as before to differentiate results from each group.

17 **Calculation of ratios** For each of the first twelve topics, find the ratio of comments that are favourable for patients plus visitors and then for staff. Then prepare a table of the topics in order of the size of the ratios by patients plus visitors, in the second column giving ratios by staff. This table should be similar to that shown in Table 1 (page 11) of this report. Calculate whether there is any correlation between the order

given by patients plus visitors and by the staff. Calculate separately the ratios for the three questions (14 to 16) that are answered only by the staff.

18 **Liked best and least** (Question 13) Enter comments from answers to this question in a similar way to those on individual comments but divide the pages into five main sections: Care of patients, Environment, Daily life, General and Staff conditions. Write appropriate subheadings under each section according to the main points raised. The number of comments made by patients plus visitors and by staff should be found for 'liked best' and 'liked least', for each main section and subheading. Tables should be similar to Tables 3 and 4 (pages 31 and 32) in this report.

19 **Report** The main purpose of the report is to give information on those aspects of the hospital that receive approval and those where change is desired, so that staff can consider possible improvements. It is interesting to note differences in attitude between the four groups interviewed. The report should be kept fairly short (otherwise it will not be widely read) and be illustrated by revealing comments. Care should be taken that the promise of confidentiality is respected and that no comments can be traced to individuals. Enough copies should be duplicated for distribution to staff of all disciplines and grades, to patients' committees, to the Friends of the Hospital, to the divisional officers and to the local community health council. Sometimes a short summary can be sent to the local press; this is better than sending the full report.

20 There is no hard and fast rule about the construction of the report but a convenient order of sections is: Aim of survey, Method used, Sample included, Analysis of comments, Table summarising, Numbers and ratios on each topic. Main comments given on thirteen topics: Meals, Ward, Furniture, Noise, Sanitary accommodation, Day room, Occupations, Freedom of choice, Patients' relations, Doctors' care. Nurses' care, Help from others, Staff conditions. Liked best and least. Action recommended. Acknowledgements.

21 **Action** A survey on which no action is taken and results not widely reported is worse than no survey at all. A meeting of the senior officers (including at least one member of the medical staff) should be held for general discussion on findings and to determine ways of stimulating action. Often the best method is to appoint a small working party with the survey organiser as secretary. An early meeting (or two if there are many working on shifts) should be arranged with the staff — sisters, charge nurses, department heads and others likely to be interested. Staff and patients should be thanked for their cooperation and for the appreciation they expressed, and should be assured that their suggestions are being considered. If possible, examples should be cited where changes have already been made as a result of the survey. Similar information should be sent to the CHC and the local press.

22 After about three months lists should be compiled by the survey organiser of the changes that have been made as a result of the survey and of those changes that remain to be made.

Letter inviting participation (suggested wording)

Opinion survey on conditions for long-stay patients

Will you help the hospital by answering a short questionnaire either at an interview or in writing? A number of staff, patients (who have been here three months or more) and their visitors, will be asked what they think is good about the hospital and what could be improved. Questions will be asked about meals, the ward, patients' activities and the care given.

The survey organisers are not on the staff of this hospital. They are .....

Your comments will not be known to come from you but, together with those from other people, will be summarised in a report. The hospital will then be able to consider action on the various suggestions.

Hospital Administrator

Patients' questionnaire

Confidential

Please help the hospital by saying what you like about it and how you think it can be improved. Your answers will be confidential but your views will be seriously considered, together with those of many other patients, visitors and staff members. Answer each question and add explanations and suggestions.

Hospital ..... Ward ..... Date .....

Name ..... Mr/Mrs/Miss Age..... Time in hospital .....

Previous visits ..... Previous job.....

1 What is good about meals?	What could be improved about the meals?
2 What is good about the ward itself?	What could be improved about the ward?
3 What is good about the furniture (beds, chairs, wheelchairs, lockers)?	What could be improved about the furniture?
4 Is the ward generally quiet enough?	What could be improved about the noise?
5 What is satisfactory about bathrooms, lavatories, commodes?	What could be improved about bathrooms, lavatories, commodes?
6 What is nice about the day room?	What could be improved about the day room?
7 Is there enough to interest you — reading, TV, radio, knitting, occupational therapy, entertainments, going out, and so on?	What could be improved about things to do?
8 Do you have enough say in what you do, bedtime, waking up time, and so on?	What could be improved about having a say?
9 Is it easy to make friends with other patients?	What could be improved about making friends?

Continued overleaf

10 Do the doctors take good care and tell you enough?	What could be improved about doctors' care?
11 Do the nurses take good care and talk to you enough?	What could be improved about nurses' care?
12 Does anyone else help you — chaplain, physiotherapist, voluntary workers?	What could be improved about other help?
13 What do you like the best about the hospital?	What most needs altering in the hospital?

Other comments

Thank you for your help

Visitors' questionnaire

Confidential

Please help the hospital by saying what you like about it for your friend (the patient you are visiting) and how you think it can be improved. Your answers will be confidential but your views will be seriously considered together with those of many other visitors, patients and staff members. Answer each question and add explanations and suggestions. If you have not time to finish it while you are here please ask for a reply-paid envelope and return it within three days.

Hospital..... Ward ..... Date ..... How often do you come? .....

Patient's name ..... Length of stay ..... Your relationship .....

Confused ..... In bed.....

1 What is good about the meals?	What could be improved about the meals?
2 What is good about the ward itself?	What could be improved about the ward?
3 What is good about the furniture (beds, chairs, wheelchairs, lockers)?	What could be improved about the furniture?
4 Is the ward generally quiet enough?	What could be improved about the noise?
5 What is satisfactory about bathrooms, lavatories, commodes?	What could be improved about bathrooms, lavatories, commodes?
6 What is nice about the day room?	What could be improved about the day room?
7 Does your friend keep interested — reading, TV, radio, knitting, occupational therapy, entertainments, going out, and so on?	What could be improved about interesting your friend?
8 Does your friend have enough say in what he/she does, bedtime, waking up time, and so on?	What could be improved about giving your friend more say?
9 Has your friend made friends with other patients?	What could be improved about making friends?

Continued overleaf

10 Do the doctors care well for your friend and tell you enough?	What could be improved about doctors' care?
11 Do the nurses care well for your friend and talk to him/her enough?	What could be improved about nurses' care?
12 Does anyone else help your friend — chaplain, physiotherapist, voluntary workers?	What could be improved about other help?
13 What do you like best about the hospital?	What most needs altering in the hospital?

Other comments

Thank you for your help

Staff's questionnaire

Confidential

Please help the hospital by saying what you like about it and how you think it can be improved. Your answers will be confidential but your views will be seriously considered together with those of many other staff members, patients and visitors. Answer each question and add explanations and suggestions.

Hospital..... Ward or Department..... Date .....

Name..... Job ..... Time in hospital.....
(Mr/Mrs/Miss)

1 What is good about the patients' meals?	What could be improved about patients' meals?
2 What is good about the ward itself?	What could be improved about the ward?
3 What is good about the furniture (beds, chairs, wheelchairs, lockers)?	What could be improved about the furniture?
4 Is the ward generally quiet enough?	What could be improved about the noise?
5 What is satisfactory about bathrooms, lavatories, commodes?	What could be improved about bathrooms, lavatories, commodes?
6 What is nice about the day room?	What could be improved about the day room?
7 Is there enough to interest the patients — reading, TV, radio, knitting, occupational therapy, entertainments, going out, and so on?	What could be improved about enough to interest?
8 Have the patients enough say in what they do, bedtime, waking up time, and so on?	What could be improved about giving patients more say?
9 Do most patients make friends with other patients?	What could be improved about patients making friends?

Continued overleaf

10 Do the doctors care well for the patients and tell them enough?	What could be improved about doctors' care?
11 Do the nurses care well for the patients and talk to them enough?	What could be improved about nurses' care?
12 Does anyone else help patients — chaplain, physiotherapist, voluntary workers?	What could be improved about other help?
13 What do you like best about the hospital for the patients?	What most needs altering in the hospital for the patients?
14 What is satisfactory about staff training?	What could be improved about staff training?
15 What is satisfactory about consultation with the staff?	What could be improved about staff consultation?
16 What is satisfactory about staff relations?	What could be improved about staff relations?

Other comments

Thank you for your help

Checklist

Environment	Yes/No	Action
Ward or dormitory		
1 Do the cubicle curtains give real privacy and are they bright and cheerful?		
2 Are there curtains or blinds for the windows?		
3 Can bed-bound patients see out of the windows?		
4 Can the large wards have light divisions to form some single rooms and some with two to six beds?		
Day room		
5 Are the chairs in the main day room arranged in groups rather than stiffly round the walls?		
6 Is there at least one other sitting area — room, covered veranda or even passage — where patients can go to be quiet or receive visitors?		
7 Is the view from the window interesting and lively, overlooking road, garden with bird table?		
8 Is there a door with ramp into the garden?		
9 Are there pictures, books, plants, aquarium, mirror, clock, calendar?		
10 Is there a thermometer and someone responsible for controlling the temperature?		
Furniture		
11 Are there enough adjustable beds, and divans for the more able?		
12 Are blankets being replaced by continental quilts?		
13 Are cot sides only used for patients who either need them or like them?		
14 Are all the lockers tall enough for patients to hang their clothes? Are they easy to move and have they a place to hang towels?		

		Yes/No	Action
15	Is there a shelf above each bed, and a picture hook, for patients to keep personal possessions?		
16	Has each patient a chair of the right height and width, labelled with his name, and a table close by?		
17	Has each patient who needs one got his own wheelchair? Have the chairs clip-on high backs and adjustable foot rests? Are they easy to move?		
18	Is all furniture regularly and quickly maintained, particularly wheelchairs?		

Sanitary accommodation

19	Are there enough lavatories readily accessible to wards and day rooms and are they wide enough for wheelchairs?		
20	Is there adequate heating in washing areas and lavatories?		
21	Are there curtains and enough space between washbasins and between baths to ensure privacy?		
22	Are the baths easy to use with hoists, bars, and so on, and have the showers got flexible heads?		
23	Are there enough comfortable commodes?		

Noise

24	Can patients be protected from noise made by demented patients?		
25	Is the use of radio and television restricted according to patients' wishes?		
26	Do domestic and other staff understand the importance of quiet?		

Daily life

Meals

27	Do patients have enough fresh fruit, vegetables and roughage? Are individual tastes considered and do patients have a free choice?		

	Yes/No	Action
28 Is supper too heavy and would patients prefer a lighter meal, with sandwiches and drinks available later for those who want them?		
Occupations		
29 Could more be done for long-stay patients by professional OT and PT staff?		
30 Could aides and volunteers be trained to provide occupations by OT and PT staff if the latter are in short supply?		
31 Will the local authority provide an art teacher?		
32 Could a voluntary pianist or guitarist be encouraged to come regularly to lead singing?		
33 Are visitors or voluntary workers actively encouraged to take patients out in the garden, to shops, local events, or to patients' homes, by car, wheelchair or walking? Is this suggestion included in the visitors' handbook?		
34 If there is no minibus available for outings, could the Friends of the Hospital be stimulated to collect for one?		
35 Do patients choose television and radio programmes? Are they encouraged to use their own money to buy individual sets with earphones?		
36 Are small entertainments put on in the wards, such as amateur films, school plays or choirs, preferably in the afternoon throughout the year, not only at Christmas?		
Freedom of choice and patients' relations		
37 Are patients given as much choice as possible about their neighbours in dormitory and day room?		
38 Can the more independent patients get up and go to bed when they want to? Are the wishes of the others considered as much as possible?		
39 Is there a ward committee and are there arrangements to befriend new patients?		

Care of patients

		Yes/No	Action
	Doctors		
40	Are junior doctors trained to take the initiative in offering information both to patients and their relatives?		
41	Is enough attention given to minor medical conditions affecting teeth, hearing, vision, foot comfort and other ailments important to the patient?		
	Nurses		
42	Is it made easy for senior nurses to attend conferences and courses?		
43	Are there study days on geriatric nursing and visits arranged to other geriatric hospitals?		
44	Is organised training given to nursing auxiliaries and is it available to all shifts, including the night shift?		
	Staff (general)		
45	Is there induction training for all new staff and do all supervisors see that their staffs have opportunities for further training?		
46	Is there adequate consultation with junior as well as senior staff?		
47	Are joint consultative meetings held regularly and do they cover all shifts?		
	Voluntary workers		
48	Is there an organiser responsible for recruiting, training and supervising voluntary workers?		
49	Does the organiser study where volunteers will be most welcomed and see that the regular staff understand their function?		
	Community		
50	Are efforts made to stimulate the active interest of the local community, including the local press, CHC, voluntary organisations, churches and schools, and to encourage people from them to visit the hospital?		

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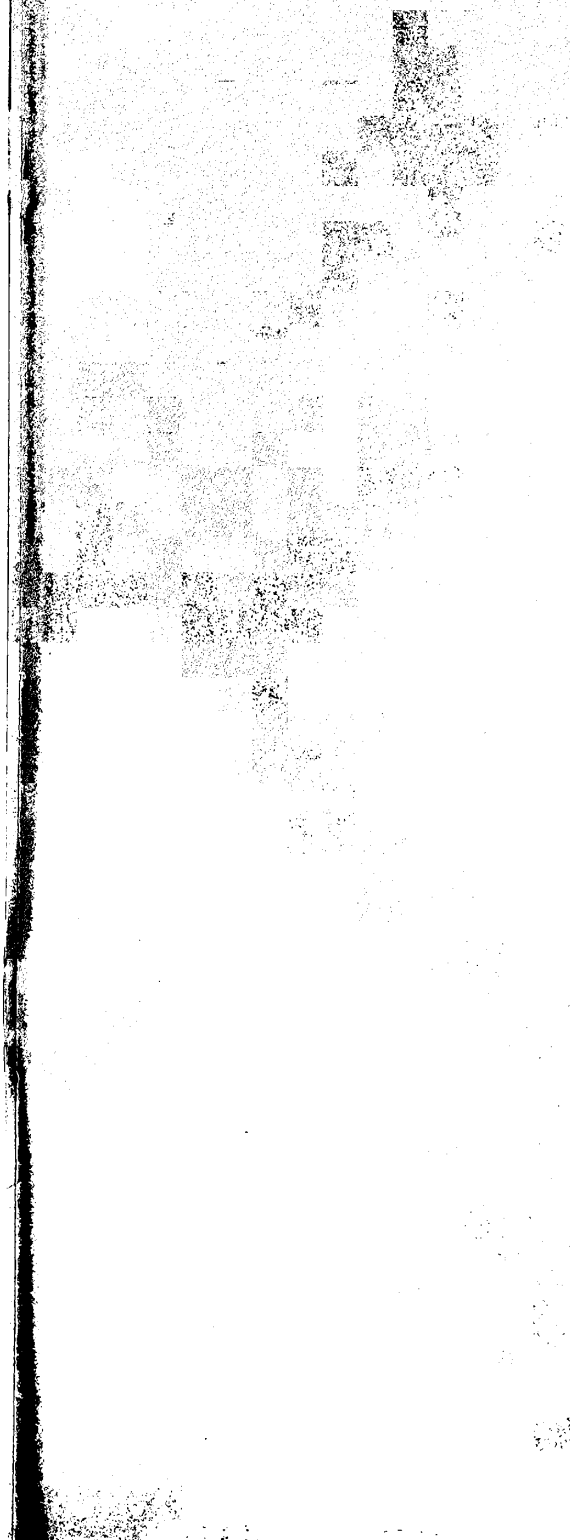

Old People in Hospital

by Winifred Raphael and Jean Mandeville

In this report, Mrs Raphael and her co-author Mrs Mandeville describe the views of old people who are likely to spend the rest of their lives in hospital, together with the views of their visitors and the hospital staff. Full instructions are given for conducting similar surveys.

This is the fourth in the series of do-it-yourself surveys of hospitals published by the King's Fund. Professor Rudolf Klein, in his foreword, says of them 'They showed that patients could express sensible views about those aspects of hospital life about which they know more than anyone else . . . they drew attention to what might be called the "pea under the mattress" syndrome: the fact that a disproportionate amount of irritation can be caused through lack of thought about minor and remediable aspects of hospital life . . . If those who work in hospitals have become more aware of the needs and preferences of patients, no little measure of credit is due to Winifred Raphael.'

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