King's Fund Hospital Centre

ROYAL VICTORIA HOSPITAL BELFAST
OUT-PATIENT DEPARTMENT
ORGANISATION and STAFFING

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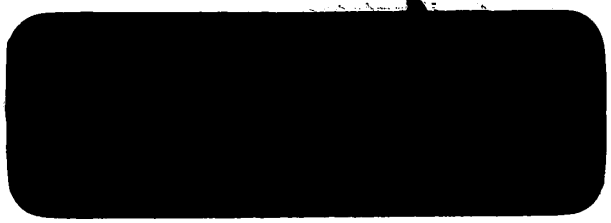

ROYAL VICTORIA HOSPITAL BELFAST
OUT-PATIENT DEPARTMENT
ORGANISATION and STAFFING

Report to Belfast Hospital Management Committee

June, 1967

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1 INTRODUCTION

1.1 In February 1966, the Belfast Hospital Management Committee asked the King's Fund Hospital Centre if they would be prepared to arrange for a survey to be undertaken of the present out-patient work in the Royal Victoria Hospital and of the plans for the department under construction, with a view to making recommendations on operational policies for the new department. The Fund's Hospital Development Committee agreed that this should be done and a multi-professional team was established for the purpose.

1.2 The terms of reference were:
"to examine the administrative arrangements in all out-patient departments currently functioning in the Royal Victoria Hospital, including the casualty and fracture units; to examine the approved working drawings for the new out-patient department currently under construction; to prepare a detailed functional analysis covering all floors of the new out-patient building having regard to present circumstances in existing out-patient departments and to the agreed working drawings; to examine the organisation and flows of medical records for out-patient and casualty purposes; and to make recommendations to the Belfast Hospital Management Committee."

1.3 In discussion of the terms of reference it was subsequently agreed that the report would include recommendations on staffing, management, methods of running clinics, medical illustration service (including equipment). It was not to include general administrative details of day-to-day operation nor recommendations on the organisation and staffing of the department of physical medicine, the special treatment clinic and the medical social workers' department.

1.4 The work began in October 1966 and members of the team have visited Belfast on seven occasions for investigation and discussion. Three meetings have been held with the Medical Steering Committee and there have been weekly team meetings in London.

1.5 This is a very busy out-patient and accident department. In 1966, the total attendances numbered 512,000 of which 200,000 were new patients. This figure included 112,000 casualty attendances (incl. 58,000 new patients). A detailed analysis of these figures is given in Appendix 1.

1.6 In order to measure the present activity of the out-patient clinics, a survey was undertaken during a period of four weeks beginning 9th January 1967, of the numbers of patients attending all consultative clinics and the accident department. Record was made of such details as the number of new and return patients attending each clinic, the number who failed to keep appointments, the number of escorts, the mode of transport to the hospital, clinics' duration, etc. This provided us with a picture of the pattern and volume of the work which has been most helpful to us in our consideration of matters of organisation and operation. The help and co-operation of the medical records, nursing and medical staffs during this survey is gratefully acknowledged. Summaries of some of the data obtained are given in appendices 2 to 6. We suggest that consideration might well be given to setting up a system for the routine collection and analysis, preferably by computer, of data relating to the work of the clinics and other departments concerned with out-patients.

1.7 In preparing this report the team has not attempted to answer the many questions of operational and procedural detail which will

have to be dealt with during the commissioning period before the new building is opened; such an object is not, in our view, attainable through a study of this sort. The aim has rather been to produce a sound framework into which the detailed procedures can be fitted as the work of commissioning progresses. The importance of the commissioning stage is discussed in section 15.

2 SCHEDULE OF ACCOMMODATION

LEVEL ONE

lecture theatre
patients' changing rooms and examination rooms
stores
cssd stock room
clean supplies
dirty returns

LEVEL TWO

circulation and waiting area, including tea bar

casualty

staff changing rooms
resuscitation room
4 ambulance cubicles
sub-waiting area
clean and dirty treatment rooms
7 casualty cubicles
8 consulting/examination rooms
(2 banks of 4 divided by 2 secretaries' rooms)

fracture clinic

sub-waiting area
6 examination cubicles
4 plaster cubicles
reduction theatre
rehabilitation and rest room
splint room and appliance store

septic and clean theatres

staff changing rooms for each theatre
patients' changing cubicles for each theatre
2 recovery wards of 3 beds
recovery ward of 2 beds
2 single bed wards

x-ray department

reception
waiting and changing area
4 x-ray rooms
viewing room
dark room

LEVEL THREE

pedestrian entrance and waiting area, including tea bar
central appointments bureau and enquiry desk

department of physical medicine

waiting area
reception
wax room
plaster room
3 chest rooms
24 treatment cubicles
2 consulting rooms
hydrotherapy pool
ultra-violet room
gymnasium
functional assessment unit
revocational training unit
staff common room

special treatment clinic

female waiting area
reception and records
female consulting room
2 gynaecological examination rooms
female treatment room
teaching room
laboratory
male waiting area
reception and records
male consulting room
2 male treatment rooms
entrance lobby
reception area

LEVEL FOUR

medical records department

library for case notes and x-rays
control point
investigation
addressing machine and central index
waiting list room
statistics office
offices for records officer, deputy records officer, secretary
stationery store
staff rest room
cloakroom, lavatories

LEVEL FIVE

Wing A

medical staff lavatories and lockers
nursing staff lavatories and lockers
staff common room

Wing B

medical social workers' department

12 offices for medical social workers
student's (medical social worker) room
records and clerks
receptionist
waiting area

Wing C

dermatology clinic

2 consulting/examination suites
demonstration theatre
2 treatment rooms with wash up and preparation room between
waiting area

LEVEL SIX

medical clinic and medical treatment

Wing A
3 consulting/examination suites
2 consulting rooms
nursing procedure room
waiting area

Wing B
5 consulting/examination suites
nursing procedure room
waiting area

medical treatment

Wing C
waiting area
nursing procedure room
clinical investigation room
dietitian's office
library
cardiography room
chest x-ray room
automated screening laboratory

LEVEL SEVEN

surgical clinic and surgical treatment

Wing A
5 consulting/examination suites
nursing procedure room
waiting area

Wing B
5 consulting/examination suites
nursing procedure room
waiting area
room for medical social worker/dietitian

surgical treatment

Wing C
2 treatment rooms

x-ray room with urology table
recovery ward
doctors' room
male and female changing areas
waiting area

LEVEL EIGHT

opthalmic, orthoptic and ENT clinics

Wing A
orthoptic clinic
refraction room
treatment room with waiting room
nursing procedure room
adult waiting area
children's waiting area

Wing B
4 consulting rooms
8 dark rooms
perimeter room
waiting area

Wing C
consulting/teaching room
6 cubicles
dark room
labyrinth room
treatment room
recovery room
preparation room
audiometry room
waiting area

LEVEL NINE

orthopaedic and gynaecology clinics, medical illustration

Wing A orthopaedic clinic

4 consulting/examination suites
consulting room
nursing procedure room
waiting area

Wing B gynaecology clinic

4 consulting/examination suites
nursing procedure room
waiting area
office for domestic supervisor
office for medical social worker

Wing C medical illustration

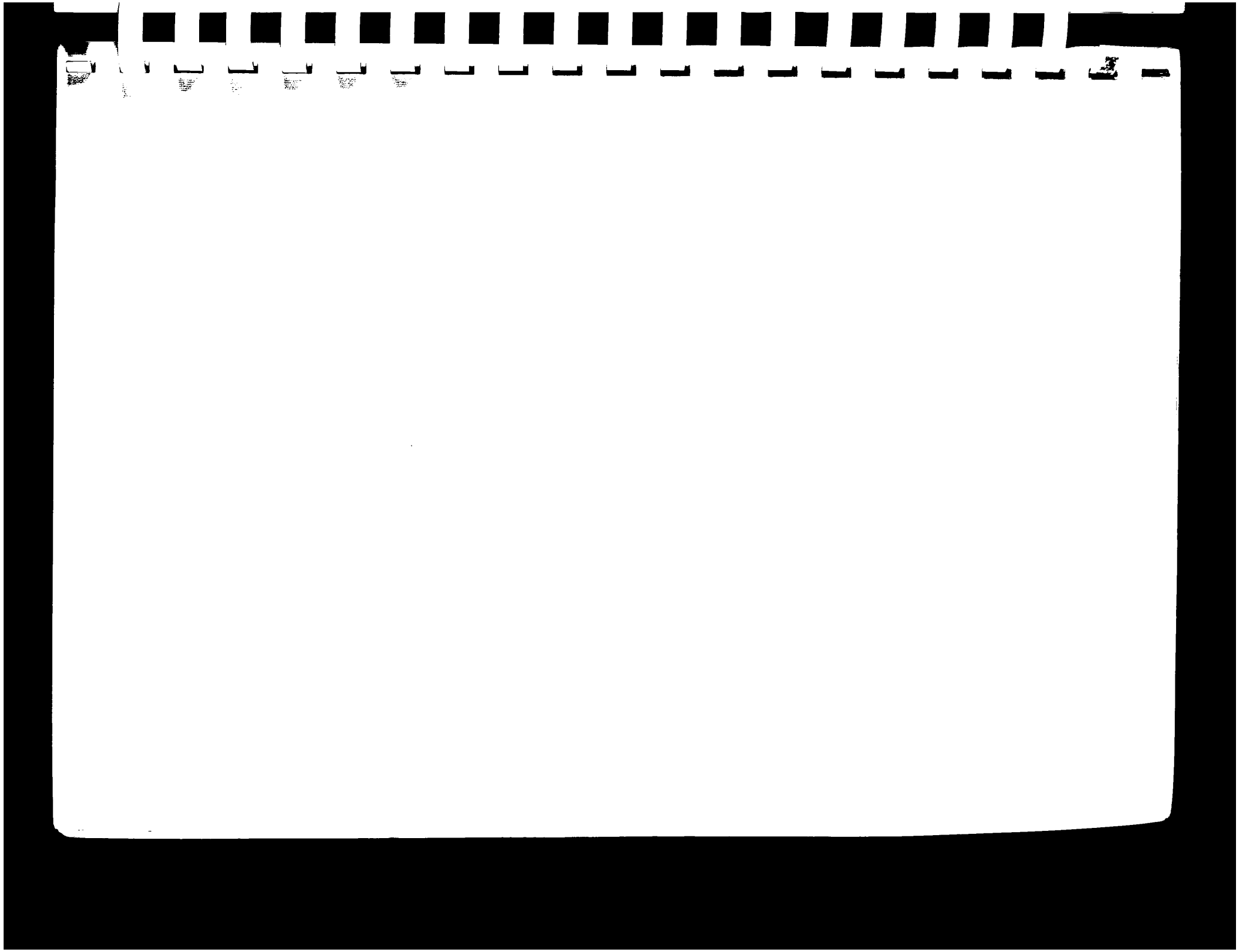
waiting area
retinal fundus room
medical artists' studio
main studio and ancillary rooms
finishing room
editing room
x-ray and specimen room
2 dark rooms
room for special photomicrography and special techniques
general office
director's office

3 REVIEW OF PLANS

3.1 It was accepted at the outset that the recommendations concerning organisation and operation to be made in this report must be within the constraints imposed by plans already agreed. The two exceptions to this are the layout of the medical records department, level 4, and of the medical illustration department, level 9. See sections 5 and 12. We would like to acknowledge that the fact that this limitation has been less frustrating than it might have been is due to the functional design produced by the architects, Messrs. Cusdin, Burden and Howitt.

3.2 There are several aspects of the layout on which we should like to comment; some of them have been discussed already with the planning committee.

3.2.1 In our view, the space provided in level 5, wing A, for staff locker rooms, changing and rest rooms will be barely adequate even for the nursing staff who will be working in the new building; see section 13 for estimate of staffing. We would prefer to see changing and locker rooms provided elsewhere and the available space at level 5, wing A, devoted to the provision of adequate rest rooms, to include snack facilities and a 'sandwich room' for doctors, nurses, technicians, receptionists and clerks working in the building. We have noted that no provision has been made in the new building for locker rooms for domestic staff and we understand that the intention is to provide these elsewhere, either in the existing room on the basement corridor or in the Nissen huts. The existing accommodation for domestic staff lockers is already inadequate and the extra lockers needed for the additional domestic assistants in the new building could not satisfactorily be placed there. We would therefore suggest that advantage be taken of the cul-de-sac area at level 1, marked on the plan 'corridor 1/1', to provide changing and



locker space for all grades of staff working in the new building. The area available is slightly more than 1,000 square feet and it could be sub-divided in a way which would provide for any desired separation of staff, for example, between domestics, nursing auxiliaries, staff nurses and sisters. This arrangement would also make possible the supervision of the area during most of the twenty-four hours.

3.2.2 The orthopaedic clinic is on level 9 and the fracture area is on level 2. It is unfortunate that it was found necessary to separate them in this way since their work is closely related. See 8.2.2 for a recommended method of working.

3.2.3 An additional room of approximately 120 square feet is required by the medical social workers' department for the storage of patients' clothes.

3.2.4 The surgical and medical treatment wings are important elements in the new department and will make it possible to extend the treatments which can be carried out on an out-patient basis, thus making a valuable contribution to a reduction in the load on the in-patient beds. For example, we envisage that the treatment rooms and recovery beds in the surgical wing will be used for such procedures as removal of sebaceous cysts, varicose vein injections, cystoscopies and biopsies. We doubt, however, if the separate x-ray rooms provided in each of these wings is economically justified. They will be expensive to staff and difficult to supervise, and we suggest that the way in which these outposts function should be kept under careful review.

3.2.5 We recommend that a room for distressed relatives should be provided in the accident department. This should be in a position which is close by the emergency treatment facilities so that the

relatives do not feel that they are being taken somewhere remote from the patient. At the same time, it is important that they should be out of sight of activities which could be upsetting to them. It seems to us that the examination room 2/154 with the curtain replaced by a door might well serve this purpose.

3.2.6 The original intention was that the registration of patients for admission should be dealt with over the counter of the main reception desk at level 2. We consider that this procedure should be undertaken in conditions of privacy and reasonable comfort and that a room ought to be provided for the purpose. We recommend therefore that room 2/15 'telephone enquiries' should be allocated as an admissions interview room, the enquiry switchboard remaining in its present position. See section 10.6 for recommendation on future arrangements for dealing with enquiries about the condition of in-patients.

3.2.7 We recommend that the positions of rooms 2/100 and 2/105 should be inter-changed with rooms 2/90 and 2/109 so that the casualty and fracture sub-waiting areas can be controlled by receptionists.

3.2.8 We recommend that the storage cupboards for CSSD supplies included in the plans in the lift lobby of each clinic floor should be omitted. See section 11 for recommendations on supply of items from CSSD.

3.2.9 We recommend the provision of clinic reception desks - to be manned by 2 or 3 receptionists - in the lift lobbies of levels 5 to 9.

3.2.10 We fear that the three lifts may prove to be inadequate for the large numbers of people, staff, patients and escorts, who will be moving up and down this building. All the consultative clinics are

above level 4. We consider that it will be important to take all possible steps to eliminate unnecessary lift travel by staff. For example, movement to a central point for morning and afternoon breaks should be avoided. All three lifts should be manned during clinic hours and careful consideration should be given to the way in which their movements are 'programmed'.

3.2.11 We have already recommended that an electrically operated documents hoist (large enough to carry x-rays) should be installed to serve all floors between levels 2 and 9.

3.2.12 We recommend that the area of the desk at level 3 marked on plan 'reception 3/59' should be increased by moving the counter to the line of the columns. This will make it possible to plan the area in an efficient way for use as a central appointments bureau, see 6.1.3.

3.2.13 If our recommendations on management are accepted, three more offices will be required somewhere in the building.

4 THE FLOW OF PATIENTS AND INFORMATION

4.1 The efficiency of the service given by a hospital's out-patient and accident department depends upon many factors, among the most important of which must be included the calibre of the staff, the effectiveness of the systems employed and the pattern of management adopted. Many diagnostic treatment and service departments are involved in the out-patient effort and the pattern of relationships which exists between them is complex. The medical records department occupies a key position in the situation. Some inter-departmental traffic and service relationships are illustrated in figures 1, 2 and 3.

4.2 Simply stated, the dual object of the out-patient organisation is to move patients and information (including, especially, case note folders) from one place to another as easily and as punctually as possible. The two are interwoven. Recommendations are made in the following sections of the report on how this object might best be achieved. The text is supplemented by 'flow charts', figures 5 to 14. These set out the steps in the various processes in visual form.

4.3 The charts included are simple outline versions to which it is possible to add many more details. They are included because not only are they sometimes easier to understand than written explanations, but, more important, they represent a technique which could be an extremely useful tool during the commissioning of the building. Their preparation imposes a worthwhile discipline on the planners and the charts themselves facilitate discussion between those concerned; they can also be used later in orientation courses to explain new methods and procedures to staff. A recent publication by the Nuffield Provincial Hospitals Trust includes a

fuller explanation of this approach and examples of more sophisticated charts [1]. The University of Southern California School of Medicine has also published a volume of flow charts of hospital records procedures [2].

1 Nuffield Provincial Hospitals Trust, The flow of medical information in hospitals, Oxford University Press, 1967.

2 Moore, F. J., Health information systems, vol. II, Flow charts of record procedures in current use in three public institutions, University of Southern California School of Medicine, 1962.

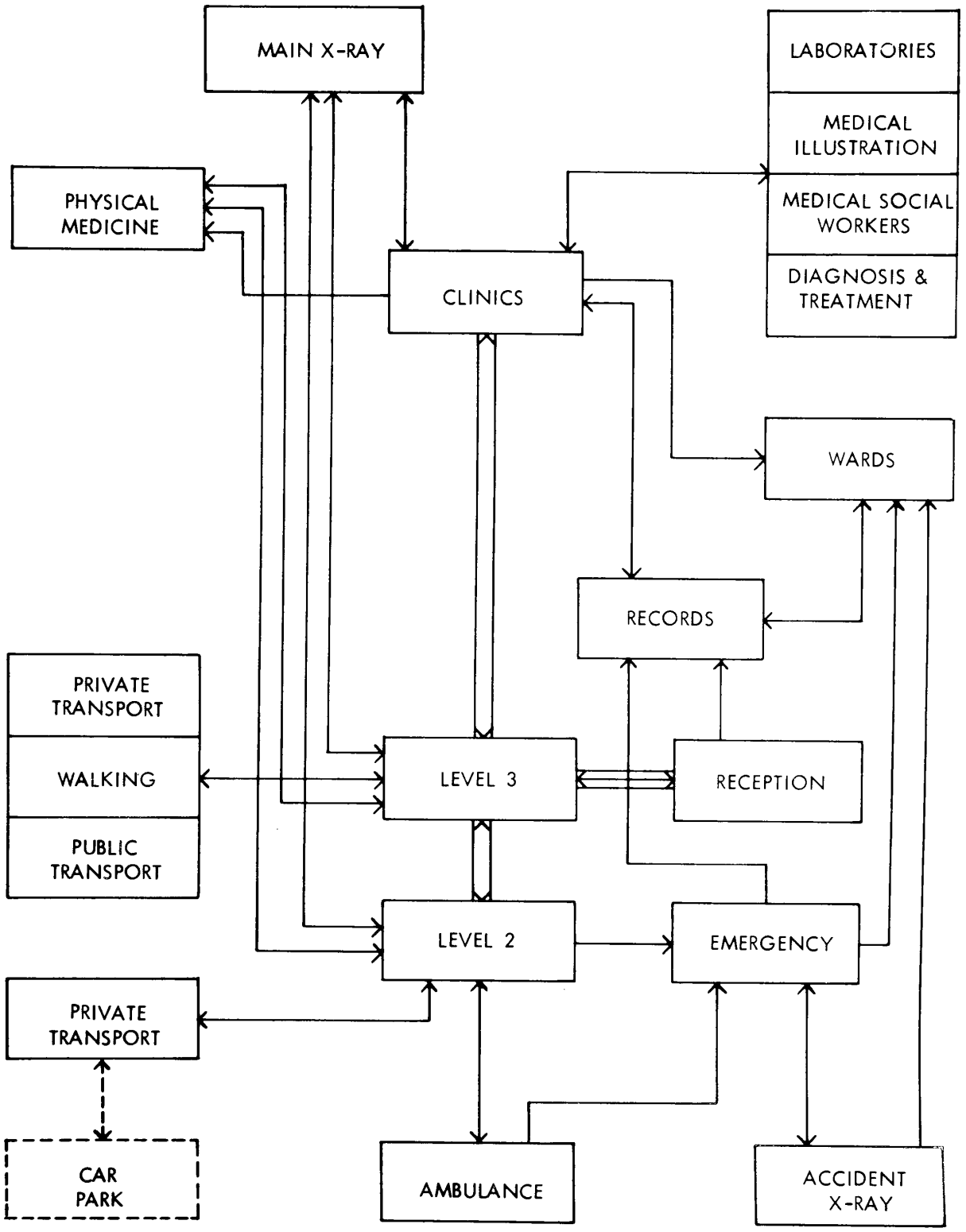


Figure 1

OUTPATIENT DEPARTMENT

INTER-DEPARTMENTAL TRAFFIC FLOWS

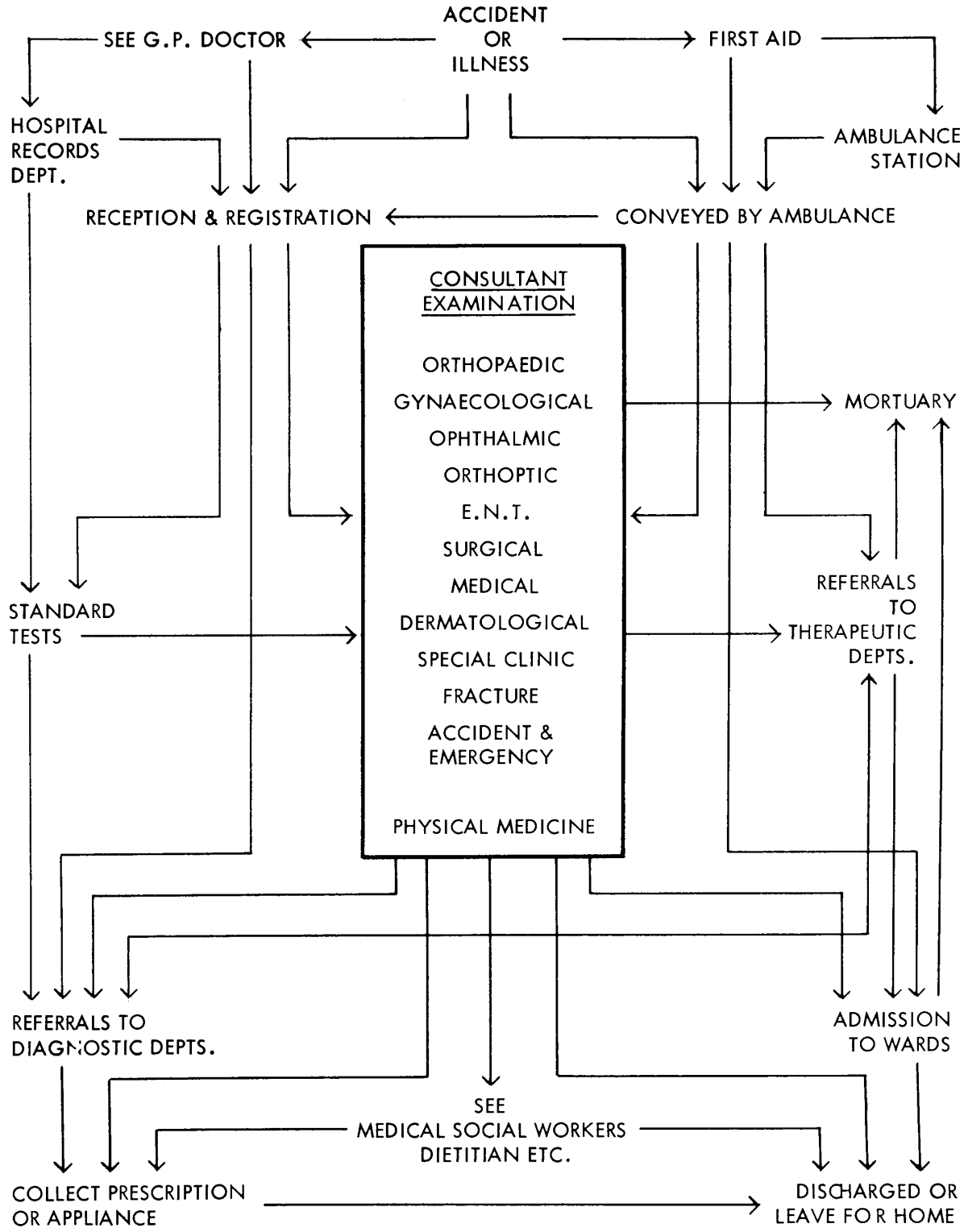


Figure 2

OUTPATIENT SERVICE RELATIONSHIPS

Based on diagram in Architects Journal 7.12.66

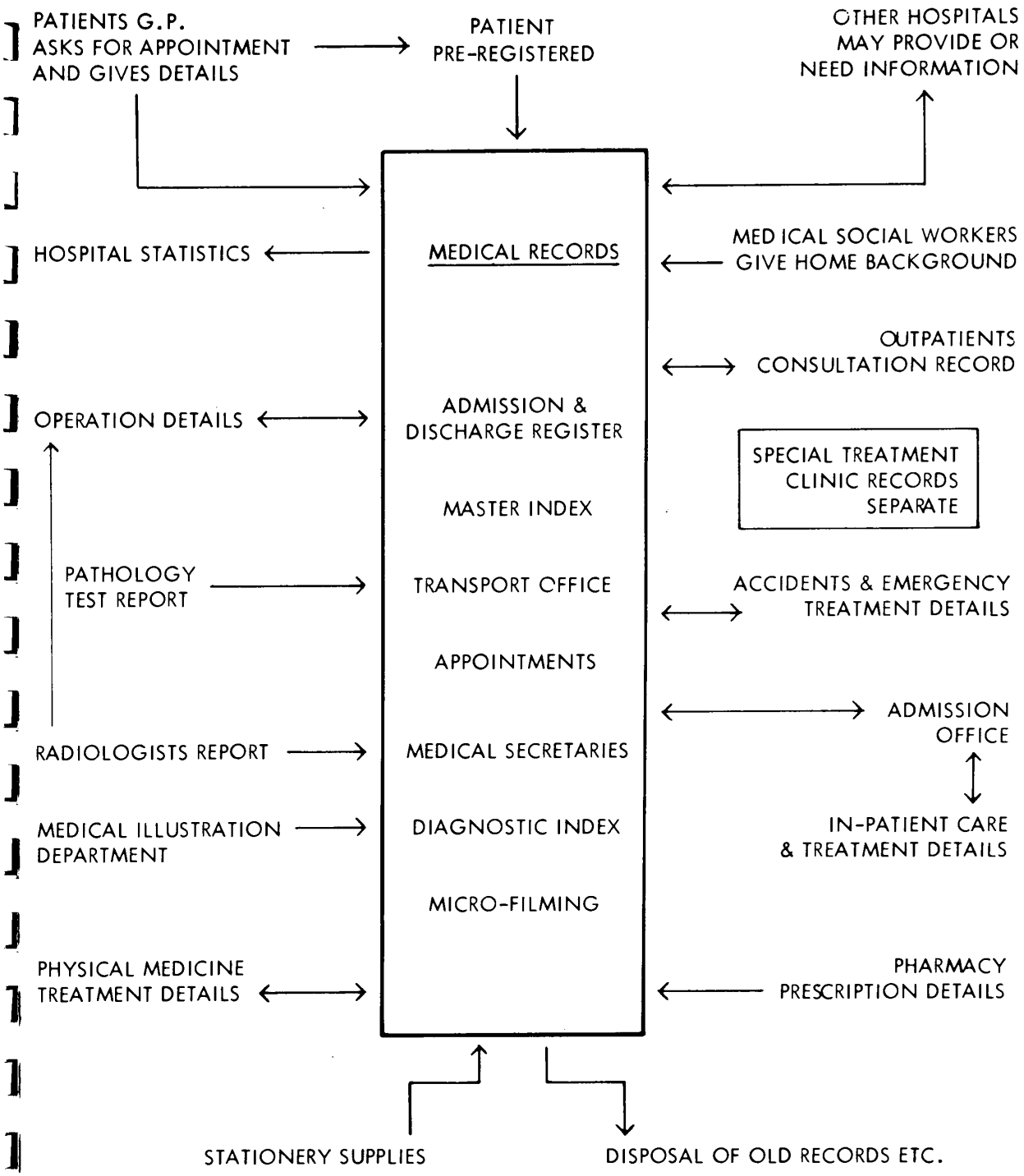


Figure 3

MEDICAL RECORDS RELATIONSHIPS

Based on diagram in Architects Journal 7.12.66

5 MEDICAL RECORDS DEPARTMENT

5.1 Layout

5.1.1 The few changes made and agreed to the original plan are calculated to improve the flow and control of case notes and x-rays within the department.

5.2 Equipment

5.2.1 Filing of case notes: consideration has been given to various ways of filing case notes; the following types of filing systems have been considered and several installations inspected:-

circular filing cabinets
fixed shelves
mobile shelves - manually moved
mobile shelves - mechanically moved.

5.2.2 The aim has been to provide for the filing of the largest number possible in the space available. It was hoped that it would be possible to provide for the filing of 10 years' case notes and x-rays at level 4. It is considered reasonable to store notes older than this in a secondary store elsewhere to be available at short call (within $\frac{1}{4}$ hour).

5.2.3 At present the notes of the following specialities are outside the main system:- dermatology, neurosurgery, neurology, orthopaedic, urology. It is suggested that the main library should be equipped with mobile shelves for the filing of both case notes and x-rays. Reports and budget quotations have been obtained from J. Glover and Sons Ltd. and Acrow (Automation) Ltd. Both of these firms are capable of undertaking this work satisfactorily. Consideration should be given to the need for motorised shelves for x-ray film storage in view of the weight involved. This decision will have to be related to the details of shelving layout which will

need to be worked out in consultation with the architect by the firm chosen. With a mobile installation it will be possible to store more than 1,100,000 folders.

5.2.5 Facsimile transmission equipment: there will be a need for speedy communication between levels 2 and 3 reception points and the main index room at level 4, see 6.2.2. Equipment is now available which makes it possible to transmit written information (whether typed or handwritten) between two points at a speed of 11 seconds per inch.
It is recommended that the following equipment should be installed:-
at level 4 1 Courier 500 Facsimile receiver
at level 2 1 Courier 500 Facsimile transmitter
at level 3 1 Courier 500 Facsimile transmitter.
A detailed quotation for this equipment has been handed to the group secretary.

5.2.6 Master index: the master index is a cross reference in strict alphabetical order and records the personal details and hospital number of patients on cards, size $2\,^{3}/_{8}$" x 3". At present about 500 references a day are made to the index. The present size of the index is approximately 300,000 cards and this will increase to the order of 800,000 by 1975. The index is contained at the moment in 11-drawer card index cabinets. It is considered that this large index could be more efficiently managed by the use of automated filing equipment. This would enable one member of the staff to be made responsible for retrieval of information from the index. Two types of equipment have been inspected. We recommend the installation of two Sankey-Diebold Super Elevator Files (No. 66242) which will provide a total filing capacity of 830,000 cards. A detailed report and quotation has been handed to the group secretary.

5.2.7 Addressing machine: there are four types of addressing equip-

ment:-

Addressograph - in use at the Royal Victoria
Elliott - using stencils
Pitney-Bowes - using metal plates
Bradma - using plastic plates.

The Bradma embossing machine is relatively quiet in operation and uses a standard typewriter keyboard. The plates produced can easily be read for a direct check on accuracy and are easily filed. It is recommended that two embossers and one printer should be purchased. A quotation has been handed to the group secretary.

5.2.8 Hoist: we have already confirmed our recommendation that an electric hoist should be installed to operate between levels 2 and 9, see 3.2.11. We consider that this will make a big contribution to the efficient functioning of the records/clinic organisation. It will also help to reduce the number of messengers using the lifts.

5.2.9 Dictating equipment: the Scottish report refers to the wide variety of means used for dictating case notes and letters to doctors in the hospitals which were surveyed. There are, likewise, many differing methods employed by the consultants in the Royal Victoria Hospital. We have considered how dictating equipment could best be used to help tackle the problem of records and correspondence. A room for medical secretaries is provided at level 4 and it occurred to us that a remote dictation system between this room and the consulting/examination room might provide the solution for all the out-patient notes and correspondence with GPs but we rejected this because it was not possible to propose an arrangement which would integrate this part of the work with that which should properly continue to be undertaken by consultants' secretaries located, as they are, elsewhere in the hospital. We understood also the reluctance which some consultants might feel to using a central system rather than personal secretaries who are

well versed in the work and terminology of the speciality concerned. One of the common problems which doctors seeing out-patients face is that of sending the letter to the general practitioner promptly after seeing his patient for the first time. Delay in receiving this first indication of the consultant's view is one of the criticisms most frequently levelled at hospitals by general practitioners. Although this problem does not appear to be acute at the Royal Victoria we consider that it would be advantageous to separate this piece of routine correspondence, which ought to be dealt with immediately, from the recording of case notes and subsequent letters which may be written following investigations. We therefore recommend that a remote dictation system should be installed between the consulting/examination rooms and the secretaries' room at level 4 for use only in the dictation of letters to general practitioners about new patients. If letters are dictated after each patient has been seen, they can be typed progressively so that it will be possible for the consultant to sign all the letters at the end of the clinic. (The letters can be sent from level 4 via the hoist to the clinic floor.) The remainder of the correspondence, we suggest, should continue to be dealt with by the personal secretaries. This arrangement possesses one other advantage in that it provides a training school for medical secretaries, who we understand are as difficult to recruit in Belfast as in London. These junior secretaries would be supervised by a senior, experienced secretary whilst becoming acquainted with medical terminology in a manner which would not affect in any way the efficiency of the medical firms' work. A report and quotation from Taperiter Ltd. has been handed to the group secretary.

6 CONSULTATIVE CLINICS

6.1 Appointments and registration

6.1.1 The first link in the chain which leads to a consultation in the hospital's out-patient department will normally be forged in the surgery of the general practitioner. It is not part of our brief to consider the trends in general practice and the development of health centres but the work of the hospital out-patient department in the future will have to be related to changing practice in these areas. It can be expected, for example, that there will be a greater proportional increase in the demand for the hospital's diagnostic and 'day-therapeutic' facilities than in the demand for specialist consultations. We have discussed with the Medical Adviser to the General Health Services Board the plans for health centres in the vicinity of the Royal Victoria and it appears that these developments will not have any significant effect on the hospital's out-patient work in the forseeable future.

6.1.2 The general practitioner, having decided to seek a consultant's opinion, either arranges, or asks his patient to arrange, an appointment with the hospital. This is the first point at which it is possible to do something to ease the journey of the patient through the department when he attends for his appointment.

6.1.3 We recommend that the central appointments bureau should be placed at level 3 and should deal with all requests for new appointments, however received. It will be necessary to have a short counter to deal with patients who call to make appointments personally. A substantial part of the work, however, will be by telephone and it is suggested that the most satisfactory arrangement will be to provide a circular desk with provision for six telephone positions, each of which can take external and internal calls. The appointments registers would be housed in a rotating unit standing

at the centre of the desk. The appointments books for returning patients will be sent from the appointments bureau to the clinics at the start of each session, so that the clinic receptionists can book return appointments directly. The books will then be returned to the central appointments bureau at the end of the clinic.

6.1.4 An out-patient consultation can be arranged in one of the following ways:-

(a) a request for appointment on hospital 'pre-registration' form. See 6.1.5 and figure 4
(b) a letter from a general practitioner
(c) a telephone call from a general practitioner
(d) a telephone call from a patient
(e) a visit by a patient, bearing a letter from his general practitioner
(f) referral by one consultant to another.

6.1.5 We consider that as many new patients as possible should be registered before arrival. This will greatly reduce the time needed to register a patient on arrival at the hospital and will eliminate, or almost eliminate, the need for the receptionist to ask questions of the patient at a time when he may well feel anxious and agitated. This will help to produce a reception environment which will be relaxed rather than tense. An example of a suitable form for pre-registration is shown in figure 4. This form can be printed with the hospital's address on the reverse side and postage may be pre-paid.

6.1.6 Procedure following receipt of pre-registration forms:

(a) forms are sent to the main index room, level 4, for checking in the alphabetical index
(b) forms for former patients of the hospital have the hospital number inserted in the space provided on the form; forms

TO: Medical Records Officer
Royal Victoria Hospital
Belfast, 12.

DOCTOR'S STAMP

Please send direct to patient
appointment for ..... CLINIC

DATE .....

The clinical history is:

SIGNATURE .....

fold from top to here

TO PATIENT: Please complete below, fold over and post

SURNAME: ..... DATE OF BIRTH

FIRST NAMES: ..... DAY MONTH YEAR

ADDRESS IN FULL: .....

.....

OCCUPATION .....

THE NUMBER ON YOUR MEDICAL CARD: .....

Have you been an in-patient or an out-patient in any part of The Royal Victoria Hospital or Eye and Ear Clinic?

YES	NO

If YES show your HOSPITAL NUMBER .....

or give year ..... and name of doctor who treated you .....

Figure 4

COMBINED APPOINTMENT REQUEST / PRE-REGISTRATION FORM

for patients who have not attended the hospital before, have hospital numbers allocated and case notes prepared by the addressing machine

(c) the forms are sent from the main index to the central appointments bureau, level 3, see 6.1.3, where an appointment is booked in the appropriate clinic register and a card notifying the date and time of appointment is sent to the prospective patient

(d) the pre-registration form is sent from the central appointments bureau to the medical records library, level 4, for filing in the case notes folder.

6.1.7 Procedure following receipt of letter requesting an appointment:

(a) the patient will be sent an appointment by the central appointments bureau together with a form similar to the one shown in figure 4 (but omitting the appointment request) for completion and return

(b) the form will be checked on return against the main index

(c) if there is already a hospital number this will be inserted on the form which will be sent to the central appointments bureau for the number to be noted in the appointments register and on the original letter of request

(d) the form and letter will then be returned to the medical records library for inclusion in the case notes folder

(e) if there is no existing hospital number for the patient, a number will be allocated and the addressing machine will produce case notes, the form then being returned to the central appointments bureau for the new number to be noted in the register.

6.1.8 Procedure following a telephone call from a general practitioner or a visit by a patient, with a GP's letter: in both cases the central appointments bureau will give an appointment and

arrange for completion of the pre-registration form. The subsequent procedure will be as in 6.1.6 above.

6.1.9 Procedure following referral by one consultant to another: the clinic receptionist will normally make any necessary appointments with other consultants through the central appointments bureau.

6.2 Reception

6.2.1 Patients with appointments will arrive at the department (with, it is hoped, their appointment cards) either at level 2, usually stretcher and wheel chair cases, or level 3, usually pedestrians.

6.2.2 It is important that a note on the appointment card should request new patients to report to the reception desk at either level 2 or level 3 where the receptionist will check by her clinic list that the patient has been fully pre-registered. If he has, he can proceed directly to the clinic floor. If not, the receptionist will obtain the missing personal details and convey them to medical records, preferably, we suggest, by means of facsimile transmission equipment, see section 5. This will enable case notes to be prepared and sent directly to the clinic where they should arrive at about the same time as the patient.

6.2.3 Old patients can proceed directly to the clinic floor but, in order to avoid unnecessary congestion in the clinic waiting areas, it is suggested that a note should be included either on the appointment card or in the explanatory leaflet to out-patients, see section 15.6, to request patients who arrive more than 30 minutes early to wait in the main waiting area at level 3 until nearer to their appointment time. (A voluntary worker should be made responsible for seeing that patients do not linger longer than they should.)

6.2.4 At level 3, the receptionist will direct or, when necessary, arrange guides for patients to clinics, diagnostic and treatment departments and her desk should therefore be the base for volunteers undertaking escort duty. At level 2 the receptionist's station is within the main registration and enquiry desk.

6.2.5 At the clinic floor:

(a) the patient will report to the clinic receptionist in the lift lobby

(b) the receptionist will take the patient's appointment card and check it against the clinic list

(c) the receptionist will give the patient an arrival slip (which shows name, number, time of appointment and time of arrival) and will direct him to the clinic waiting area

(d) the nurse outside the clinic (or it could be a voluntary worker) takes the arrival slip and hands to the appropriate nurse inside the clinic, 6.4.4 (a)

(e) the receptionist will check with the clinic the need for return transport for new patients. When necessary she will send a request slip via the hoist to the transport desk at level 2.

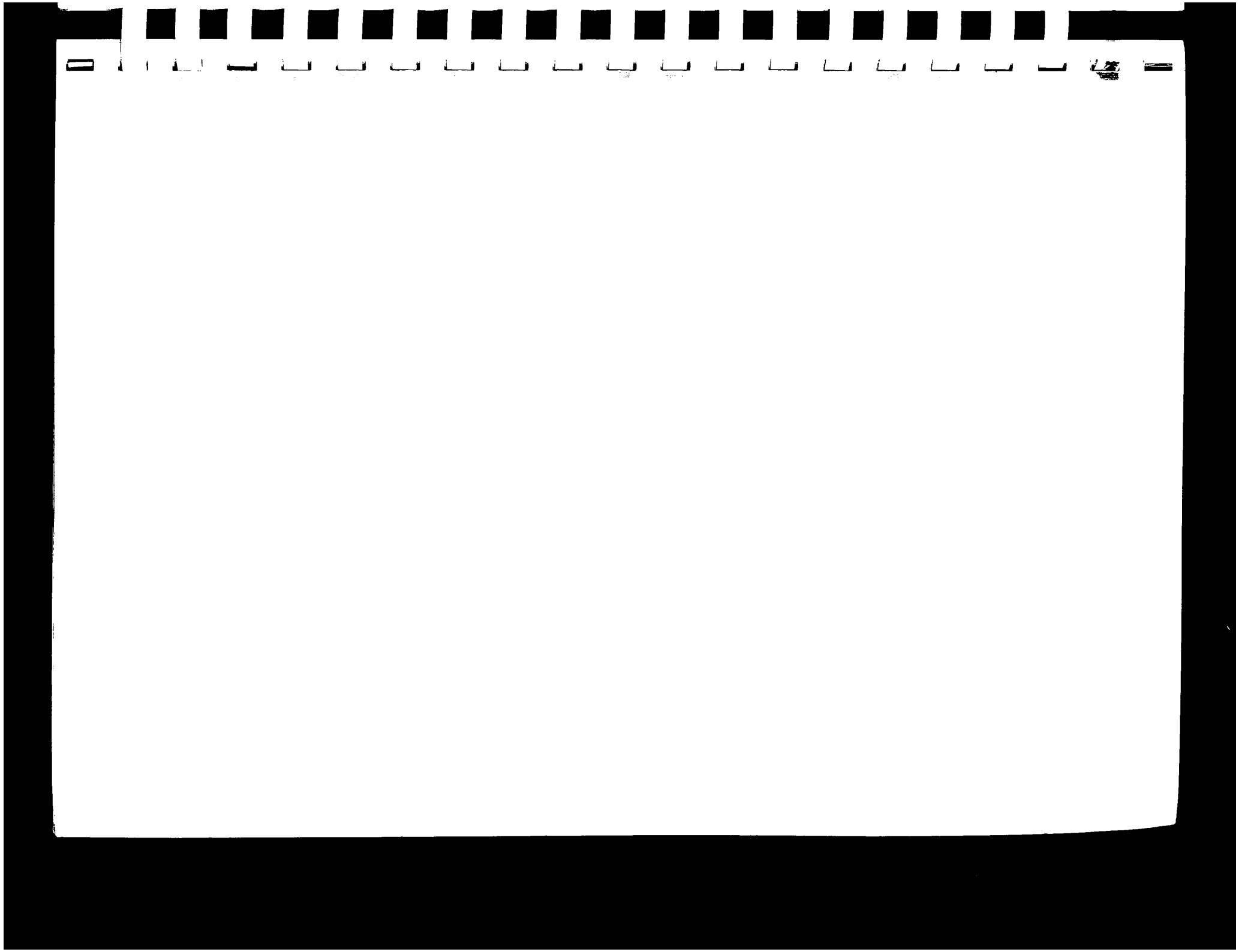
6.3 Re-appointments and referrals

The clinic receptionist will

(a) make any necessary re-appointment by making an entry in the register from a slip given to the patient in the clinic and returning the appointments card to the patient

(b) receive requisition for transport for the next visit where required and will send these at the end of the session to the transport desk at level 2

(c) direct, or arrange escorts, for patients referred to ancillary and diagnostic departments, checking request forms and making appointments where appropriate



(d) telephone the central appointments bureau for an appointment for any patient being referred to another consultant, see section 6.1.9.

6.4 Methods of running clinics

6.4.1 The Scottish Home and Health Department has recently published a report on the organisation and design of out-patient departments[3]. This is a comprehensive and thorough-going review of the subject, based on two years' research. We have studied the recommendations in this report during our consideration of the situation at the Royal Victoria. In particular, we have found the section of the Scottish report which deals with methods of running clinics to be of the utmost interest and value.

6.4.2 There are two general points on which we must comment:

(a) in the Belfast plans nursing procedure rooms are provided in the clinic areas and many of the minor procedures which the Scottish report recommends should be undertaken in the consulting/examination rooms, for example, venepunctures, minor surgical dressings, instillation of eye drops, could conveniently be carried out in the procedure rooms. We accept however the Scottish view that it is preferable for as much as possible of the out-patient care during a visit to be given in one place, i.e. the consulting/examination room, and suggest therefore that the nursing procedure room should normally be used for procedures which (a) are necessary before consultation, or (b) would cause a hold-up if undertaken in the consulting/examination room

3 Scottish Home and Health Department, Organisation and Design of Out-patient Departments, Hospital Planning Note No. 6, 1967.

(b) we consider that in most clinics the case notes and x-rays could be sorted in advance according to the doctor who will see the patient and placed in the appropriate consulting room before the start of the clinic.

6.4.3 The proposals which follow are based, subject to the qualifications in the preceding paragraph, on the Scottish report, to which the reader is referred for a full explanation and description of the surveys and trials which were undertaken as the basis for the methods proposed.

6.4.4 Clinics where patient remains dressed at the beginning of consultation:

A. surgery (except for some return patients), gynaecology, dermatology, new orthopaedic clinics.

Sequence of activity:

(a) patient is conducted by nurse on duty outside the consulting rooms, 'outside nurse', from clinic waiting area to consulting/examination room and handed over to nurse on duty in the consulting room, 'inside nurse'

(b) patient's outdoor clothes removed and patient seated at consultant's desk

(c) patient's case notes and any x-ray films taken from existing pile and placed on desk

(d) consultation

(e) patient taken to examination area (this may be either a screened area in consulting room, or an examination room adjoining) where he undresses and may be weighed

(f) examination by doctor, diagnostic or treatment procedures carried out or requested

(g) doctor returns to desk and writes notes while the patient dresses

(h) a few patients return to the desk for final consultation or instruction

(j) if required, nurse repeats explanations to patient or gives further instruction

(k) nurse shows patient from room and doctor dictates letter to GP

(l) 'inside nurse' hands over the patient to the 'outside nurse' who shows the patient either to:

(i) the reception desk where receptionist makes re-appointment or other arrangements, see 6.3 or

(ii) the nursing procedure room, see 6.4.2, thence after treatment to reception point as in (i) above.

Note: if the patient is not to be examined in the screened area items (e) to (h) are omitted.

B. medical-type clinics

Sequence of activity:

(a) patient collected by the 'outside nurse' from the clinic waiting area and conducted to clinette. Nurse goes to adjacent test room, tests specimen and records result

(b) patient conducted by 'outside nurse' to the consulting/examination room

(c) patient's outdoor clothes removed, patient weighed by the 'outside nurse', if required, and seated at consultant's desk

(d) patient's case notes and any x-ray films taken from existing pile and placed on desk. Results of weighing and specimen tests entered in case notes. 'Outside nurse' returns to reception area

(e) consultation starts with arrival of doctor and 'inside nurse'

(f) patient taken to examination area, undresses and has weight confirmed prior to examination if necessary

(g) examination by doctor and diagnostic or treatment procedures ordered

(h) doctor returns to desk to write notes while the patient dresses

(j) a few patients return to desk for final consultation or instruction

(k) if required, nurse repeats explanations to patient or gives further instruction

(l) nurse shows patient from room and doctor dictates letter to GP

(m)inside nurse hands over the patient to the outside nurse who shows the patient either to:-

(i) central room for blood collection in medical treatment wing and / or

(ii) nursing procedure room and / or

(iii) reception point where receptionist makes re-appointment or other arrangements, see 6.3.

Note: if the patient is not to be examined in the screened area, items (f) to (j) are omitted.

6.4.5 Clinics where patient is undressed at the beginning of consultation: orthopaedic return and fracture patients, some surgical return patients.

Sequence of activity:

(a) patient conducted by nurse from clinic waiting area to consulting/ examination room, case-notes taken from existing pile and placed on desk. X-rays put in viewing box

(b) patient is taken to examination area, patient undresses and is assisted to examination couch

(c) consultation/examination by doctor and diagnostic or treatment procedures ordered as required

(d) doctor returns to desk to write notes while the patient dresses

(e) a few patients return to the desk for final consultation or instruction

(f) if required, nurse repeats explanations to patient or gives further instruction

(g) nurse shows patient from room and doctor dictates letter to GP

(h) inside nurse hands over the patient to the outside nurse who shows the patient either to:

(i) nursing procedure room

or

(ii) reception point where receptionist makes re-appointment if required.

6.4.6 Clinics where few or no patients undress:

A. Ophthalmology clinics

Sequence of activity:

(a) Either:

(i) patient conducted by nurse from clinic waiting area to consulting/examination room and seated, or

(ii) patient conducted by nurse from clinic waiting area to nursing procedure room for instillation of eye drops and then to waiting area, where patient will remain until ready to be seen by the doctor

(b) consultation with and examination by doctor who makes notes as required

(c) diagnostic or treatment procedures ordered

(d) patient escorted by nurse either:

(i) for special investigation (e.g. refraction) and, afterwards, to the reception point where the receptionist makes a re-appointment if necessary, or

(ii) direct to the reception point.

B. ENT and psychiatric clinics and some fracture and dermatological clinics

Sequence of activity:

(a) patient conducted by nurse from clinic waiting area to consulting/examination room and seated

(b) patient's case notes and x-rays taken from existing pile and placed on desk

(c) consultation/examination by doctor who makes notes as required

(d) diagnostic or treatment procedures ordered

(e) patient escorted by nurse either:

(i) for special investigation and, afterwards, to the reception point where the receptionist makes a re-appointment if necessary, or

(ii) direct to the reception point.

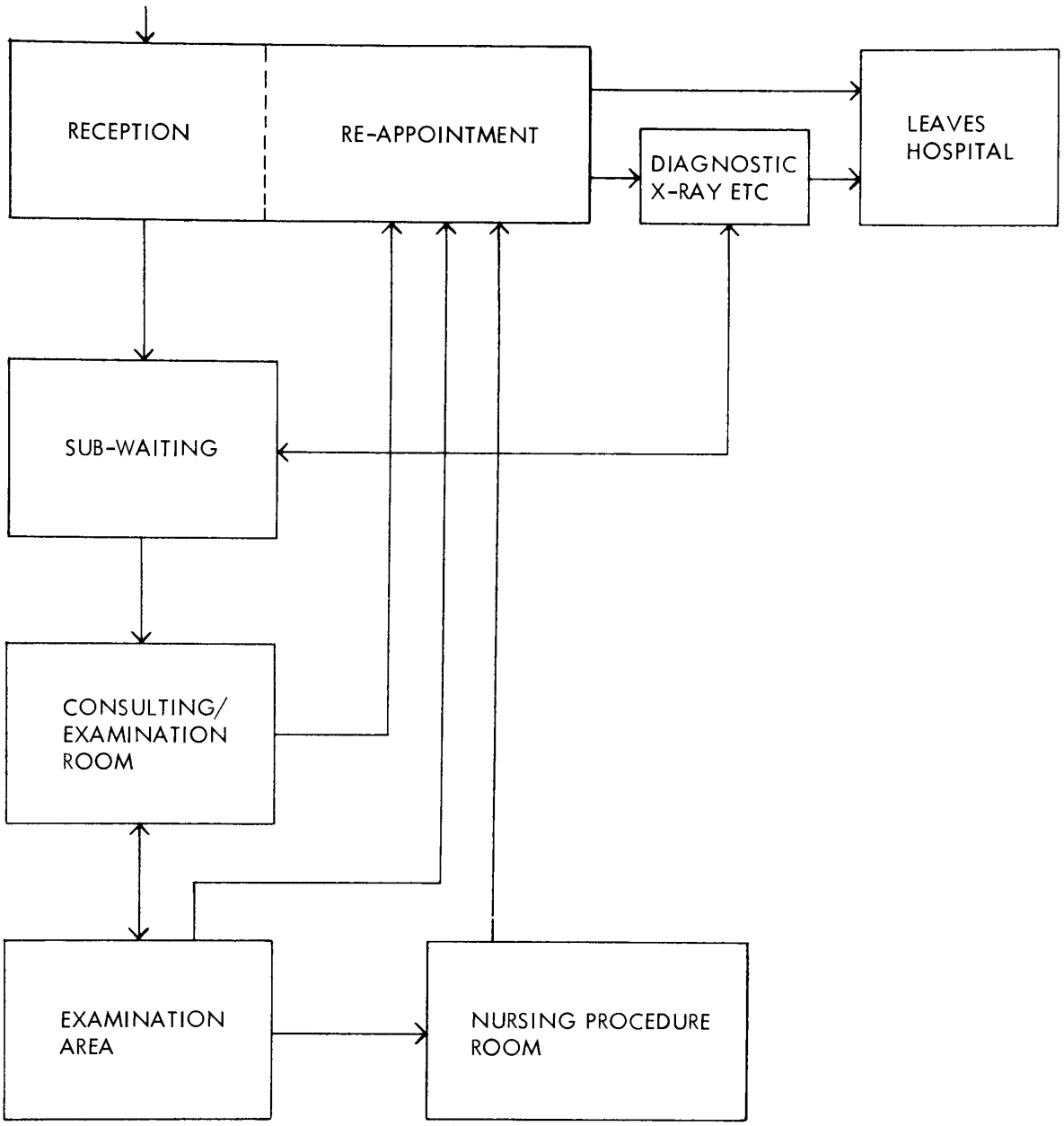
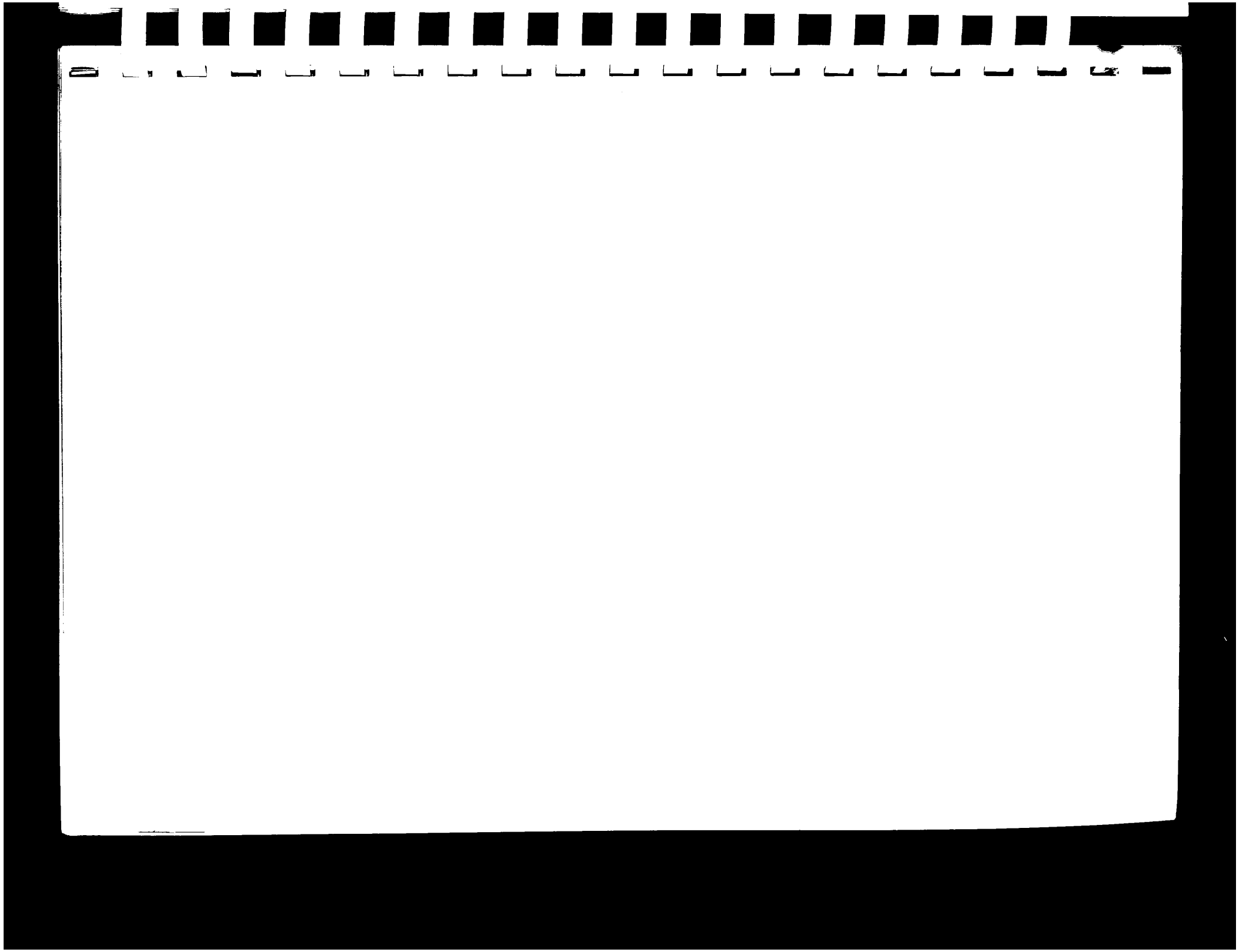


Figure 5

FLOW CHART FOR PATIENTS ATTENDING

SURGICAL, GYNAECOLOGICAL, & ORTHOPAEDIC CLINICS



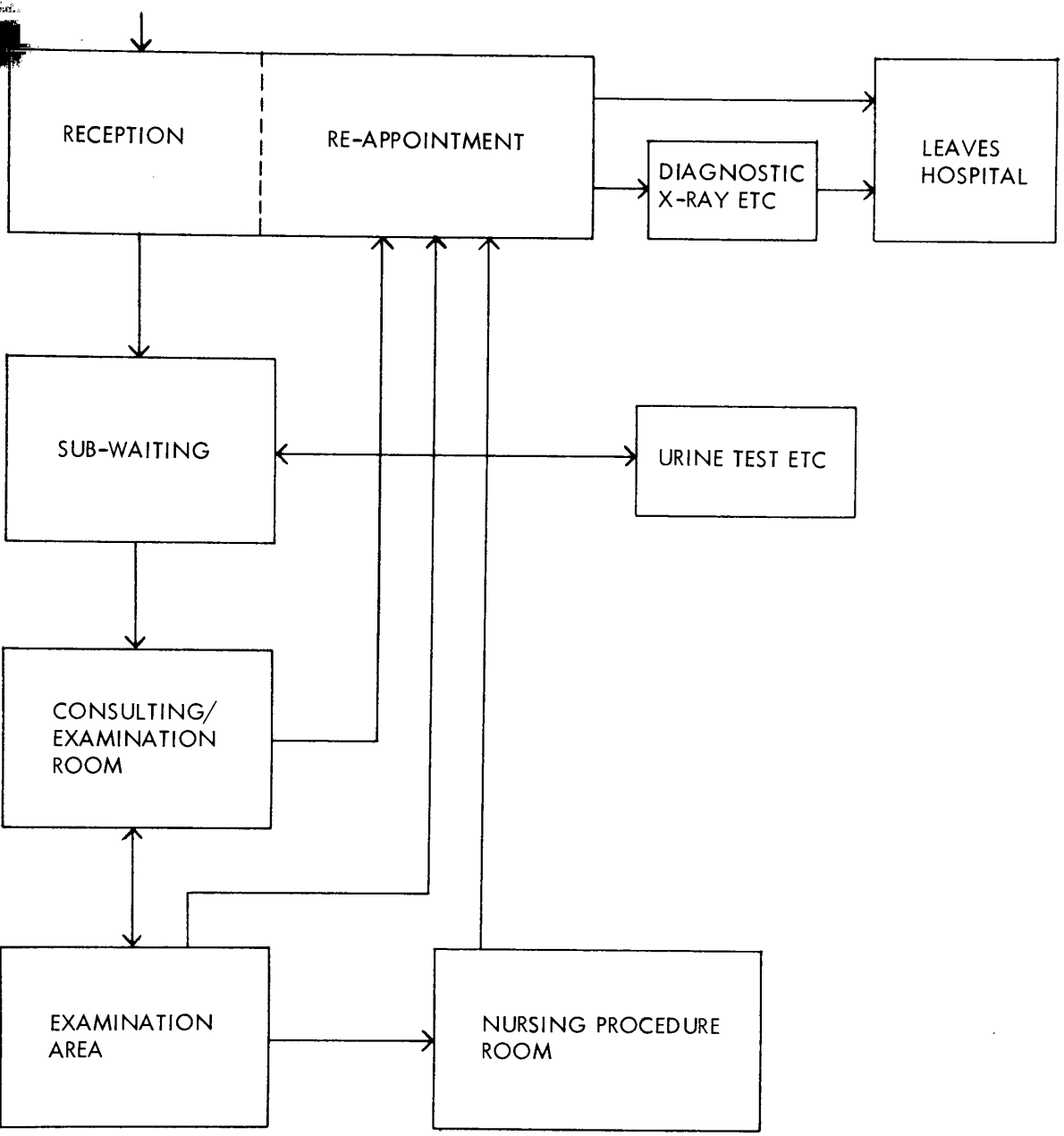


Figure 6

FLOW CHART FOR PATIENTS ATTENDING MEDICAL CLINICS

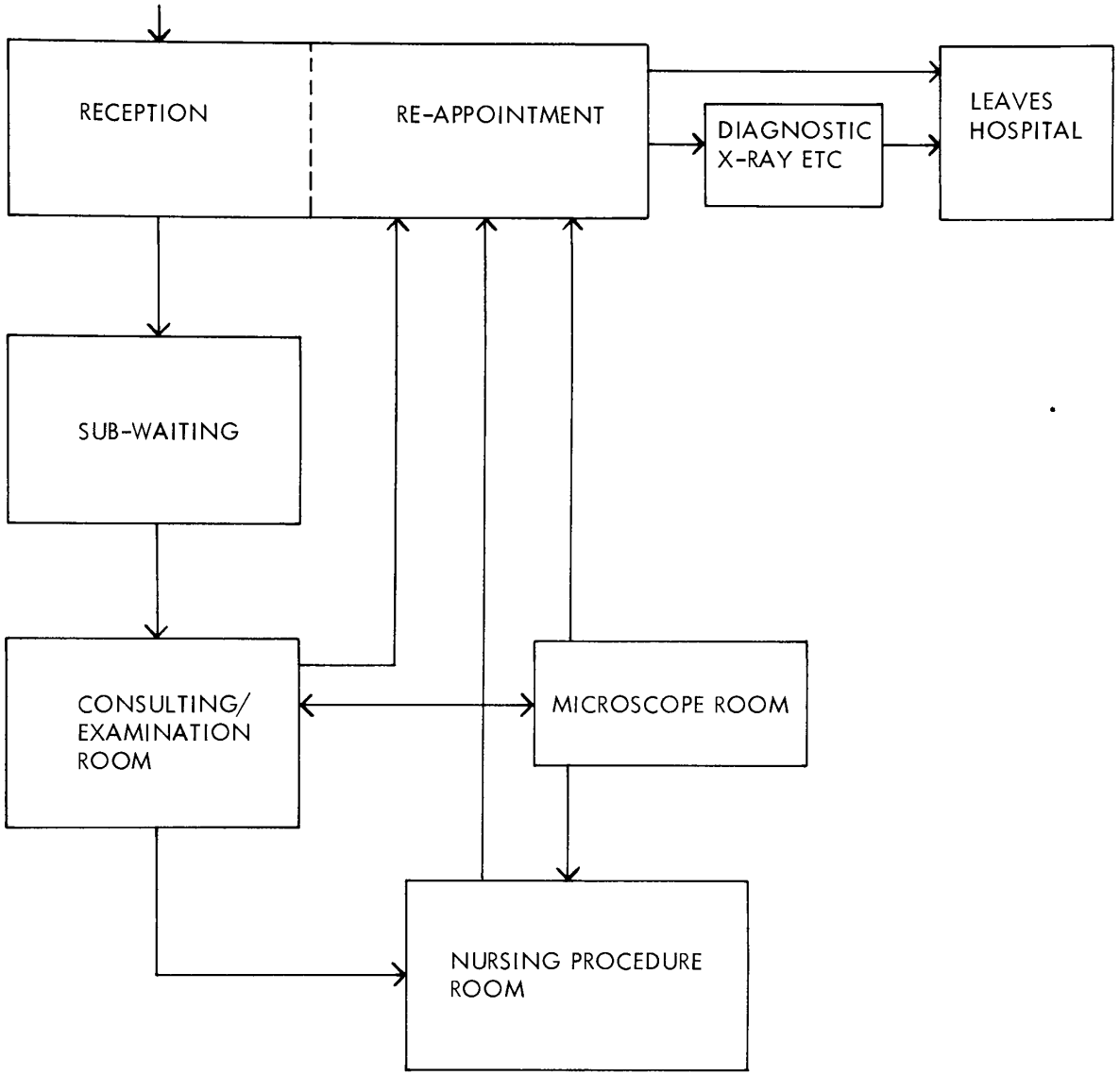


Figure 7

FLOW CHART FOR PATIENTS ATTENDING E.N.T. CLINIC

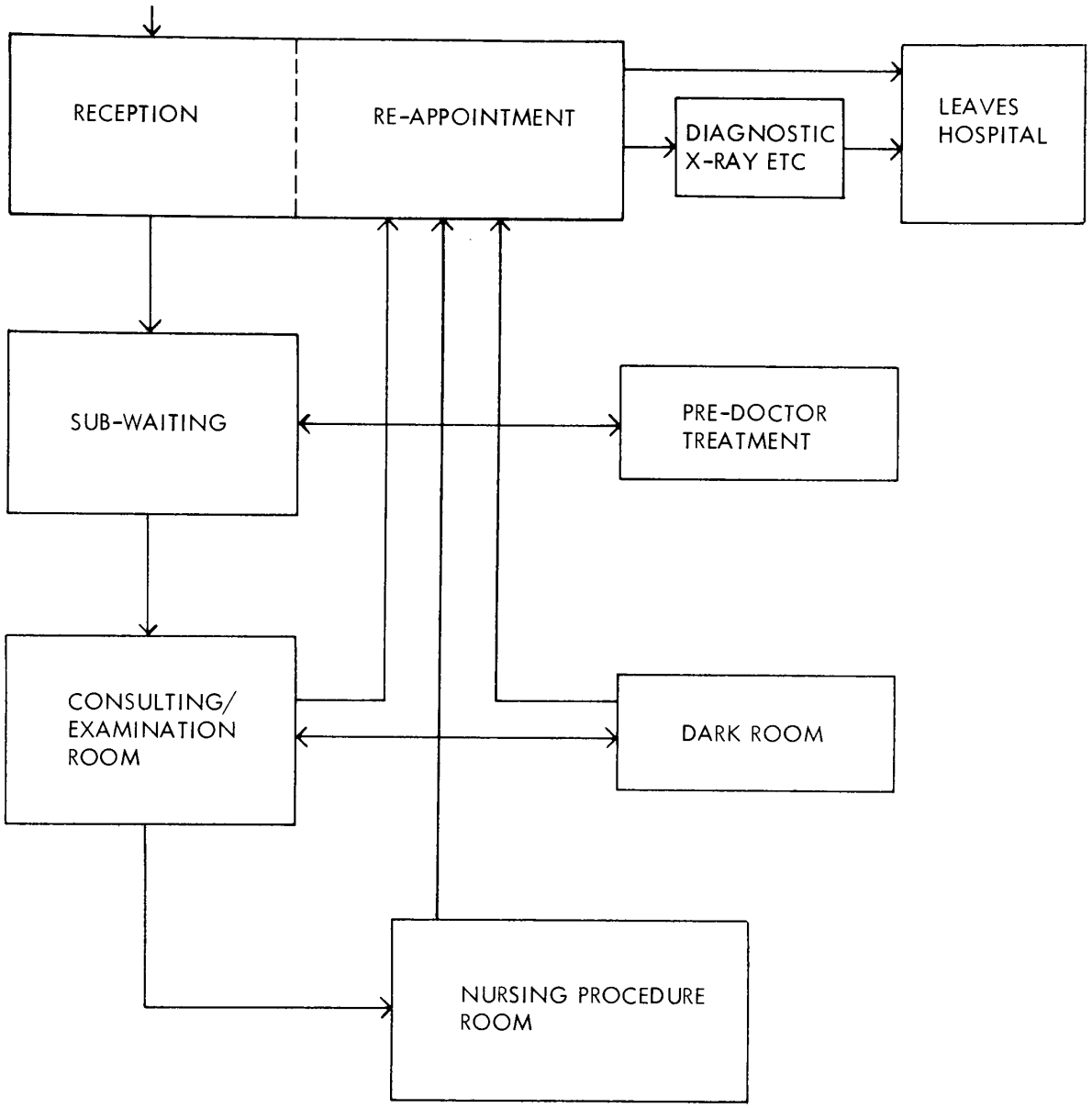


Figure 8

FLOW CHART FOR PATIENTS ATTENDING

ATTENDING OPHTHALMOLOGY CLINIC

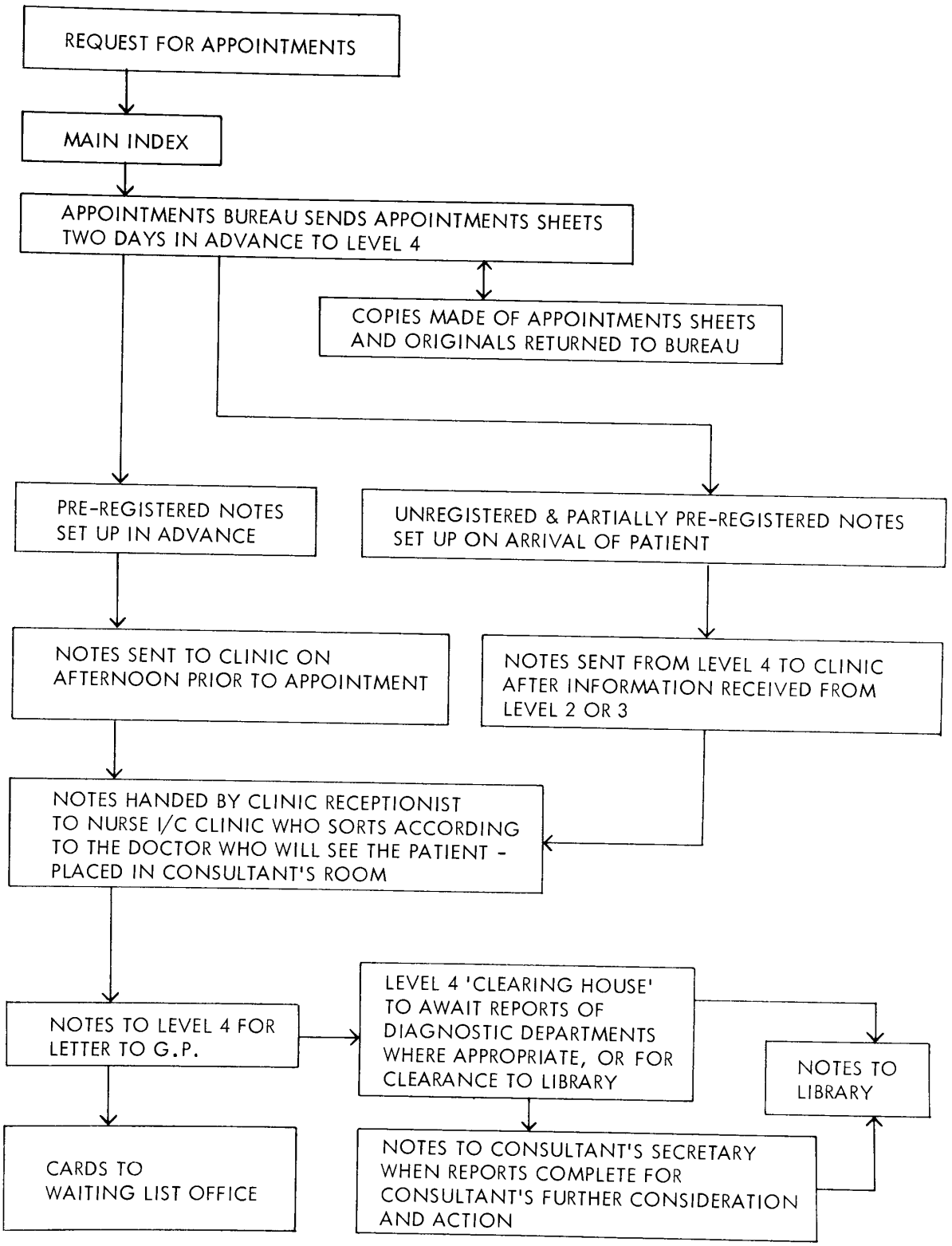


Figure 9

FLOW CHART FOR NOTES OF NEW PATIENTS

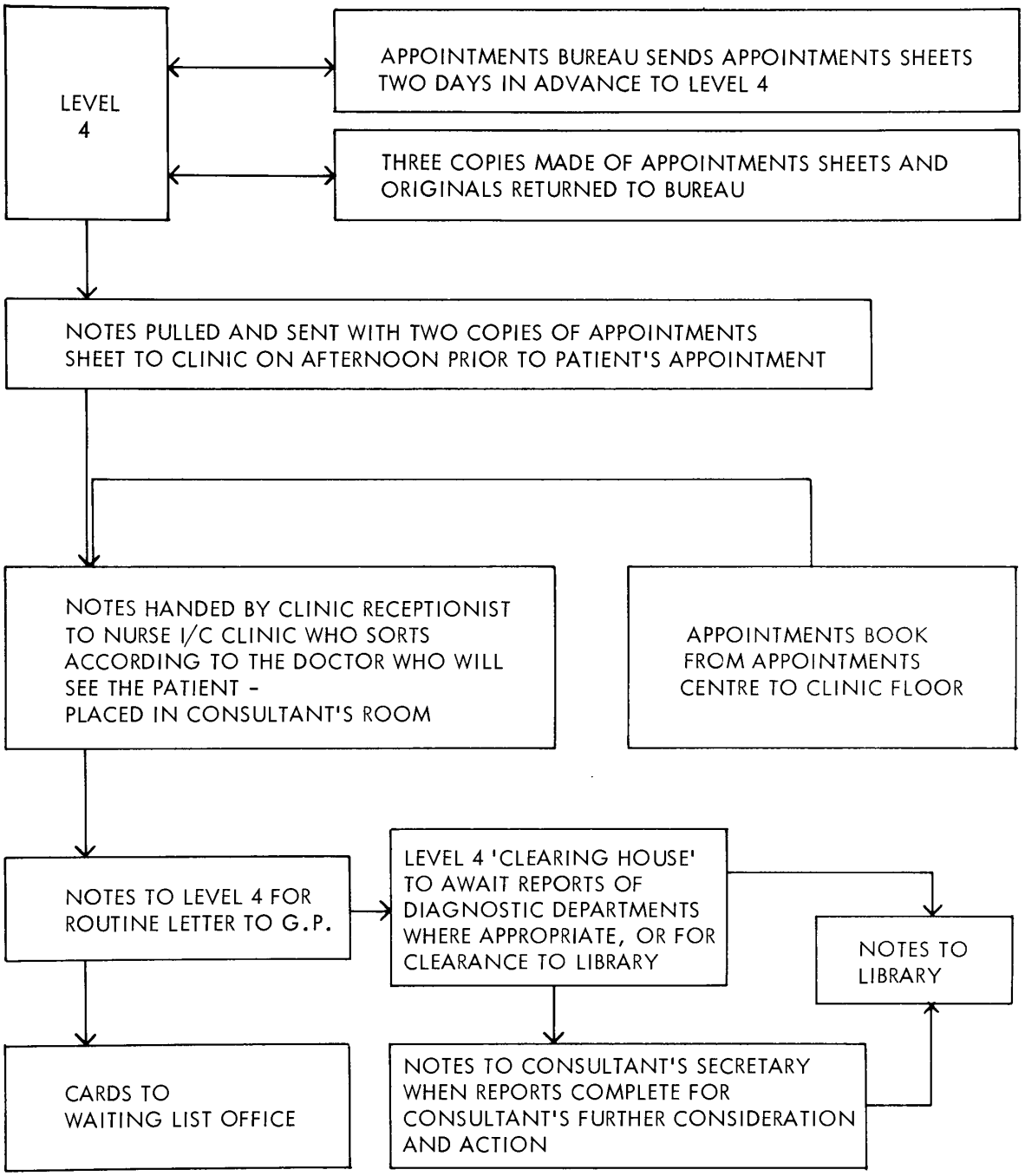
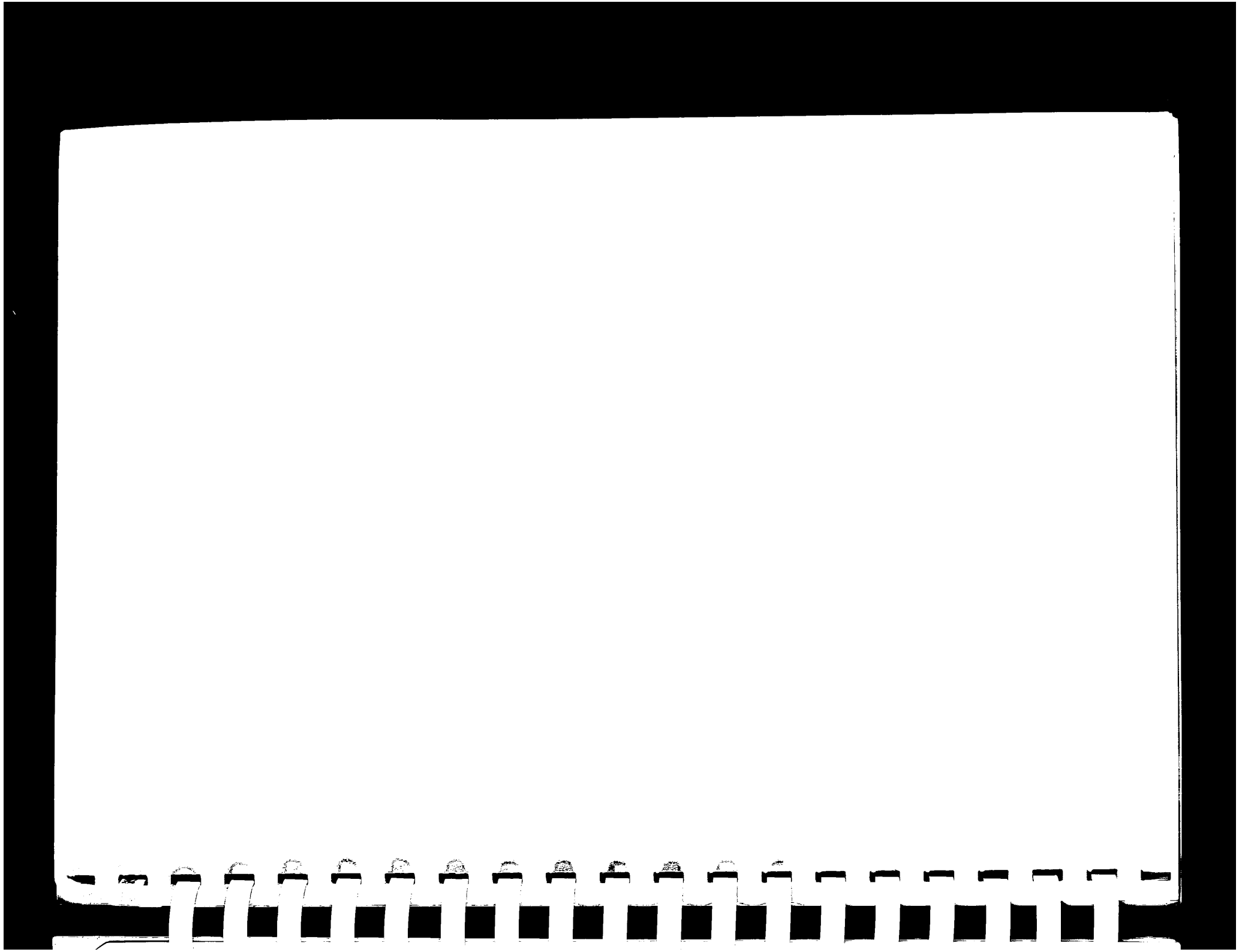


Figure 10

FLOW CHART FOR NOTES OF RETURN PATIENTS



7 DRAFT CLINIC TIMETABLE

LEVEL 5

DAY	WING A	WING B	WING C	
	STAFF ROOMS	MEDICAL SOCIAL WORKERS	CLINIC	MEDICAL STAFF
Mon. a.m.			Skin Dr. Beare	1 consultant 1 registrar
Mon. p.m.			Skin Dr. Hall Psychiatry Dr. Nixon	1 consultant 1 registrar 1 consultant 1 registrar
Tues. a.m.			Skin Dr. Burrows Warts Dr. Boyd	1 consultant 1 registrar 1 clinical asst.
Tues. p.m.			Psychiatry Dr. Norris	1 consultant 1 registrar
Wed. a.m.			Skin Dr. Beare Warts Dr. Boyd	1 consultant 1 registrar 1 clinical asst.
Wed. p.m.			Skin Dr. Beare Warts Psychiatry Dr. Norris	1 consultant 1 registrar 1 clinical asst. 1 consultant 1 registrar
Thurs. a.m.			Skin Dr. Hall Dr. Burrows	2 consultants 1 registrar
Thurs. p.m.			Skin Dr. Burrows Warts	1 consultant 3 registrars 1 clinical asst.
Fri. a.m.			Skin Dr. Burrows	1 consultant 1 registrar
Fri. p.m.			Skin Dr. Beare	1 consultant 3 registrars

Draft Clinic Timetable (continued)

LEVEL 6

DAY	WING A		WING B		WING C
	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF	TREATMENT WING
Mon. a.m.	Medical Dr. Weaver Rheumatic Dr. Roberts	1 consultant 1 registrar 1 s.h.o. 1 consultant			
Mon. p.m.	Medical Dr. Pantridge Chest Dr. Campbell	1 consultant 3 registrars 1 consultant	Adrenal (2nd p.m. in mth.) Metabolic (1st evng. in mth.)	1 consultant 1 consultant 1 registrar	
Tues. a.m.	Medical Dr. Womersley Medical Prof. Wade Dr. Elwes	1 consultant 1 registrar 1 s.h.o. 2 consultants 2 registrars	Metabolic Dr. Montgomery Dr. Weaver	2 consultants 1 registrar 1 clin. asst.	
Tues. p.m.	Medical Dr. Pantridge	1 consultant 3 registrars 1 s.h.o.	Neurology Dr. Miller Dr. Hurwitz Metabolic (evening) blood tests	2 consultants 2 registrars 1 s.h.o.	
Wed. a.m.	Medical Dr. Weaver Medical (Haematology) Dr. Nelson Rheumatic Dr. Roberts	1 consultant 2 registrars 1 s.h.o. 1 consultant 1 registrar 1 consultant	Metabolic blood tests weights		
Wed. p.m.	Medical Dr. Logan Medical (Dr. Pantridge) Chest Dr. Campbell	1 consultant 1 registrar 1 s.h.o. 2 registrars 1 consultant	Metabolic Dr. Montgomery Dr. Hadden Dr. Skeley	3 consultants 2 registrars 1 s.h.o.	

Draft Clinic Timetable (continued)

LEVEL 6 (contd.)

DAY	WING A		WING B		WING C
	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF	TREATMENT WING
Thurs. a.m.	Medical Dr. Boyle Rheumatic Dr. Roberts	1 consultant 2 registrars 1 consultant	Metabolic glucose tolerance tests	nursing staff only	
Thurs. p.m.	Medical Dr. Fulton Medical Dr. Logan Chest Dr. Coyne	1 consultant 2 registrars 1 s.h.o. 1 consultant 1 consultant	Metabolic (endocrine) Dr. Montgomery Dr. Weaver Dr. Hadden	3 consultants 2 registrars 1 s.h.o.	
Fri. a.m.	Medical Dr. Womersley Rheumatic Dr. Roberts Mental Health Prof. Gibson	1 consultant 1 registrar 1 s.h.o. 1 consultant 1 consultant	Metabolic Dr. Montgomery Dr. Hadden	2 consultants 2 registrars 1 clin. asst.	
Fri. p.m.	Medical Prof. Bull Medical (prothrombin) Dr. Nelson Dr. Boyle	1 consultant 2 registrars 1 s.h.o. 1 consultant 1 consultant 1 registrar	Neurology Dr. Miller Dr. Hurwitz	2 consultants 1 registrar 1 s.h.o.	

Draft Clinic Timetable (continued)

LEVEL 7

DAY	WING A		WING B		WING C
	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF	TREATMENT WING
Mon. a.m.	Surgical Mr. McMichan Mr. W. Wilson	2 consultants 1/2 registrar	Radiotherapy Dr. Lyons Gastric funct. service Dr. Connell	1 consultant 2 registrars 1 consultant	
Mon. p.m.	Surgical Prof. Rogers Mr. Irwin (fortnightly)	3 registrars 1 consultant 1 registrar	Leukoplakia (monthly) Prof. Rogers Mr. Whitlock Dr. Jones	3 consultants	
Tues. a.m.	Surgical Mr. Clarke Mr. Morrison	1 consultant 1 registrar 1 s.h.o. 1 consultant	Radiotherapy Dr. Edylstyn Gastric funct. service Dr. Connell	1 consultant 2 registrars 1 consultant	
Tues. p.m.	Surgical - V.V. Mr. Irwin Surgical Mr. McMichan	1 consultant 1 registrar 1 registrar	Neurosurgical Mr. Gordon Gastric clinic Dr. Connell	1 consultant 1 registrar 1 consultant 1 registrar	
Wed. a.m.	Surgical Mr. Irwin Mr. Livingstone	2 consultants 2 registrars 1 s.h.o.	Radiotherapy Dr. Lynch Neurosurgical Mr. Taylor Gastric funct. service	1 consultant 2 registrars 1 consultant 1 registrar	
Wed. p.m.	Surgical Mr. Loughridge alt. with Mr. Kennedy Liver (fortnightly) Prof. Rogers Dr. Fulton	2 consultants 1 registrar 2 consultants 1 registrar	Nephrology Dr. McGeown	1 consultant 3 registrars	

Draft Clinic Timetable (continued)

LEVEL 7 (cont.)

DAY	WING A		WING B		WING C
	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF	TREATMENT WING
Thurs. a.m.	Surgical Mr. Kennedy Surgical Mr. Wilson	1 consultant 1 registrar 1 consultant	Radiotherapy Dr. Lyons Neurosurgical Mr. Gledhill Gastric funct. service Dr. Connell	1 consultant 2 registrars 1 consultant 1 registrar 1 consultant	
Thurs. p.m.	Thoracic surgery Dr. Bingham Mr. Sunley Mr. Stevenson Colon clinic Dr. Connell	3 consultants 2 registrars 1 consultant 1 registrar	Plastic Mr. Hughes Mr. Dickie Hand Mr. Braidwood	2 consultants 2 registrars 1 consultant	
Fri. a.m.	Surgical Prof. Rogers Mr. Johnstone	2 consultants 4 registrars	Radiotherapy Gastric funct. service Dr. Connell	1 consultant 1 registrar 1 consultant	
Fri. p.m.			Urological Mr. Morrison Surgical (Mr. Clarke)	1 consultant 1 registrar	

Draft Clinic Timetable (continued)

LEVEL 8

DAY	WING A		WING B		WING C	
	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF
Mon. a.m.	Refraction	2 refractionists	Eye Mr. Martin Mr. Corkey	2 consultants 2 registrars 1 s.h.o.	ENT Mr. Hunter Mr. Craig	2 consultants 2 registrars 3 s.h.o.s
Mon. p.m.			Eye Mr. Baird	1 consultant 1 registrar	ENT Mr. McCrea Mr. Smyth	2 consultants 2 registrars 1 s.h.o.
Tues. a.m.	Refraction	2 refractionists	Eye Mr. Martin Mr. Corkey Mr. McGuire	3 consultants 2 registrars	ENT Mr. Aitken	1 consultant 2 s.h.o.s
Tues. p.m.	Refraction	1 refractionist	Eye Mr. Martin	1 consultant 1 registrar 1 s.h.o.	ENT Mr. Hunter Mr. Smyth	2 consultants 1 registrar 2 s.h.o.s
Wed. a.m.	Refraction	1 refractionist	Eye Mr. Baird Mr. Cowan	2 consultants 2 registrars 1 s.h.o.	ENT Mr. Hunter Mr. McCrea	2 consultants 1 registrar 1 s.h.o.
Wed. p.m.			Eye Mr. McGuire	1 consultant 1 registrar	Radiotherapy Dr. Lynch Mr. McCrea Mr. Shepperd,	4 consultants Dr. Edylstyne
Thurs. a.m.	Refraction	1 refractionist	Eye Mr. Baird Mr. Corkey	2 consultants 2 registrars 1 s.h.o.	ENT - Mr. Hunter Mr. Craig	2 consultants 3 s.h.o.s
Thurs. p.m.	Refraction	1 refractionist	Eye Mr. Martin Mr. McGuire	2 consultants 2 registrars 1 s.h.o.	ENT Mr. Shepperd Vertigo Mr. Smyth Allergy (Mr. Millar)	1 consultant 1 registrar 1 consultant 1 registrar 1 registrar
Fri. a.m.	Refraction	2 refractionists	Eye Mr. Corkey Mr. Martin Mr. Cowan	3 consultants 2 registrars 1 s.h.o.	ENT Mr. Aitken (dual antrum puncture) Mr. Shepperd	1 consultant 1 s.h.o. 1 registrar 1 s.h.o.
Fri. p.m.					ENT Mr. Hunter	1 consultant 1 registrar

Draft Clinic Timetable (continued)

LEVEL 9

DAY	WING A		WING B		WING C
	CLINIC	MEDICAL STAFF	CLINIC	MEDICAL STAFF	MEDICAL ILLUSTRATION
Mon. a.m.	Orthopaedic Mr. Lowry	1 consultant 1 registrar	Gynaecology Prof. Pinkerton Dr. Whitfield Endocrine Dr. Harley Dr. Montgomery	1 consultant 2 consultants	
Mon. p.m.			Speech therapy Miss Kay	3 therapists	
Tues. a.m.	Orthopaedic Mr. Martin	1 consultant 1 registrar	Gynaecology Mr. Boyd	1 consultant 1 registrar	
Tues. p.m.			Speech therapy Miss Kay	3 therapists	
Wed. a.m.	Orthopaedic Mr. Osterberg	1 consultant 1 registrar			
Wed. p.m.			Speech therapy Miss Kay	3 therapists	
Thurs. a.m.	Orthopaedic Mr. Wilson	1 consultant 1 registrar	Gynaecology Prof. Pinkerton	2 consultants 1 registrar 1 s.h.o.	
Thurs. p.m.	Psychiatry Dr. Robinson Dr. Knox Pain clinic Prof. Dundee Dr. Gray	2 consultants 1 registrar 1 consultant 1 registrar	Speech therapy Miss Kay	3 therapists	
Fri. a.m.	Orthopaedic Mr. Wilson	1 consultant 1 registrar	Gynaecology Mr. McClure	1 consultant 2 registrars 1 s.h.o.	
Fri. p.m.	Psychiatry Dr. Nixon	1 consultant 1 registrar	Speech therapy Miss Kay	3 therapists	

8 ACCIDENT SERVICE AND FRACTURE CLINIC

8.1 Reception and registration

8.1.1 Patients coming to the accident department are divided between those who have sustained moderate or severe injuries and are brought by ambulance to the emergency entrance at level 2, see figure 11, and those with minor injuries who will usually walk into the hospital at level 3, see figure 12. The work of the accident department includes a proportion of cases which are not accidents at all but 'casual' patients. The hospital continues to deal with them since many would otherwise go without treatment. A survey of casualty records was made to see what sort of proportion these non-urgent casualties represented of the whole, and it was found that 35% of a sample of 200 could have gone to their general practitioner rather than to the hospital. Casualties and the ambulant injured will arrive during the day at level 3 and will be directed by the receptionist to level 2 via the escalator or lift. It is assumed that the intention will be to close the level 3 entrance during the night.

8.1.2 Procedure for reception and registration of ambulant patients:

(a) patients will be received at the main registration desk level 2 where details of name, date of birth, address, name and address of general practitioner will be recorded on the casualty record which should be in the form of an envelope capable of being opened to form the first history sheet for inclusion in the case notes folder;

(b) the patient will be asked to take this record to the casualty sub-waiting area and hand it to the receptionist there;

(c) the receptionist will hand the casualty folder to the nursing staff who will be responsible for calling the patient into an examination cubicle;

(d) if examination proves the injury to be a fracture the patient is passed directly to the fracture section, see figure 13;

(e) many patients will be referred for x-ray, either from a casualty cubicle or from a fracture cubicle. Special attention should be given to signposting the way to the x-ray department;

(f) if it is decided to admit the patient, the casualty or fracture receptionist will take the casualty folder, stamped 'admit ward', to the level 2 reception desk where admission to the 'take in' ward is arranged. In cases where the need for admission is in doubt, the decision should be taken by the 'take in' firm;

(g) the personal details on the casualty folder, plus information on next of kin and nearest relative, will be written on a portable Lamson-Paragon register and the top copy 'scanned' by the Muirfax equipment to the main index at level 4 where the details will be checked against the alphabetical index for existing notes;

(h) if there are existing notes they will be sent immediately via the hoist to the main desk at level 2, otherwise a hospital number will be allocated and case notes prepared on the addressing machine. The casualty folder can then be opened and included in the standard case notes folder as the first clinical history sheet. The folder is then sent to level 2.

8.1.3 Registration of stretcher patients.

Registration of more seriously injured patients will be carried out either by the nursing staff (for very ill patients) or by a casualty clerk going to the patient in the resuscitation or examination room and recording the personal details on the casualty record card. A foot-operated dictating machine should be provided in the resuscitation room so that notes can be dictated during examination.

The casualty secretary will transcribe and type case notes.

8.2 Fracture clinics - return patients

8.2.1 Following the new fracture patient's departure from the department, his details, as recorded on the casualty card, will be 'scanned' to the index, see 5.2.5; the existing case-notes or the new set will be sent down to level 2 for the next visit, the casualty record being included to form the first clinical history sheet. The fracture clinic will then have a collection of standard case-note folders instead of specialist cards as at present.

8.2.2 Patients with fractures will attend the fracture clinic on level 2, see figure 14. Their appointment can be made and a card given to them by the fracture clinic receptionist (during the day) or the main receptionist (during the night). We suggest that the clinics for return fracture cases should be treated as nearly as possible as a consultative clinic. As the orthopaedic clinic floor will be separated from the fracture clinic area, a formal way of dealing with return fractures is indicated as this would make it possible for orthopaedic consultants to divide their sessions into two parts when necessary, the cold orthopaedic cases on level 9 and the fractures at level 2. It is suggested that considerations should be given to the installation of an appointments system for return fracture cases. Such systems have worked well elsewhere[4]. The timing of appointments would need to be considered with some care as they would have to be related to the availability of orthopaedic consultants and would have to avoid the known peak periods for new patients.

4 Guest, R., Casualty Appointments System, Nursing Mirror, 27th January, 1967.

8.3 Emergencies requiring special ophthalmic or ENT attention will be taken from level 2 to the eye and ear clinic building where it is suggested suitably equipped emergency rooms should be kept when the rest of the out-patient work is moved to the new out-patient department.

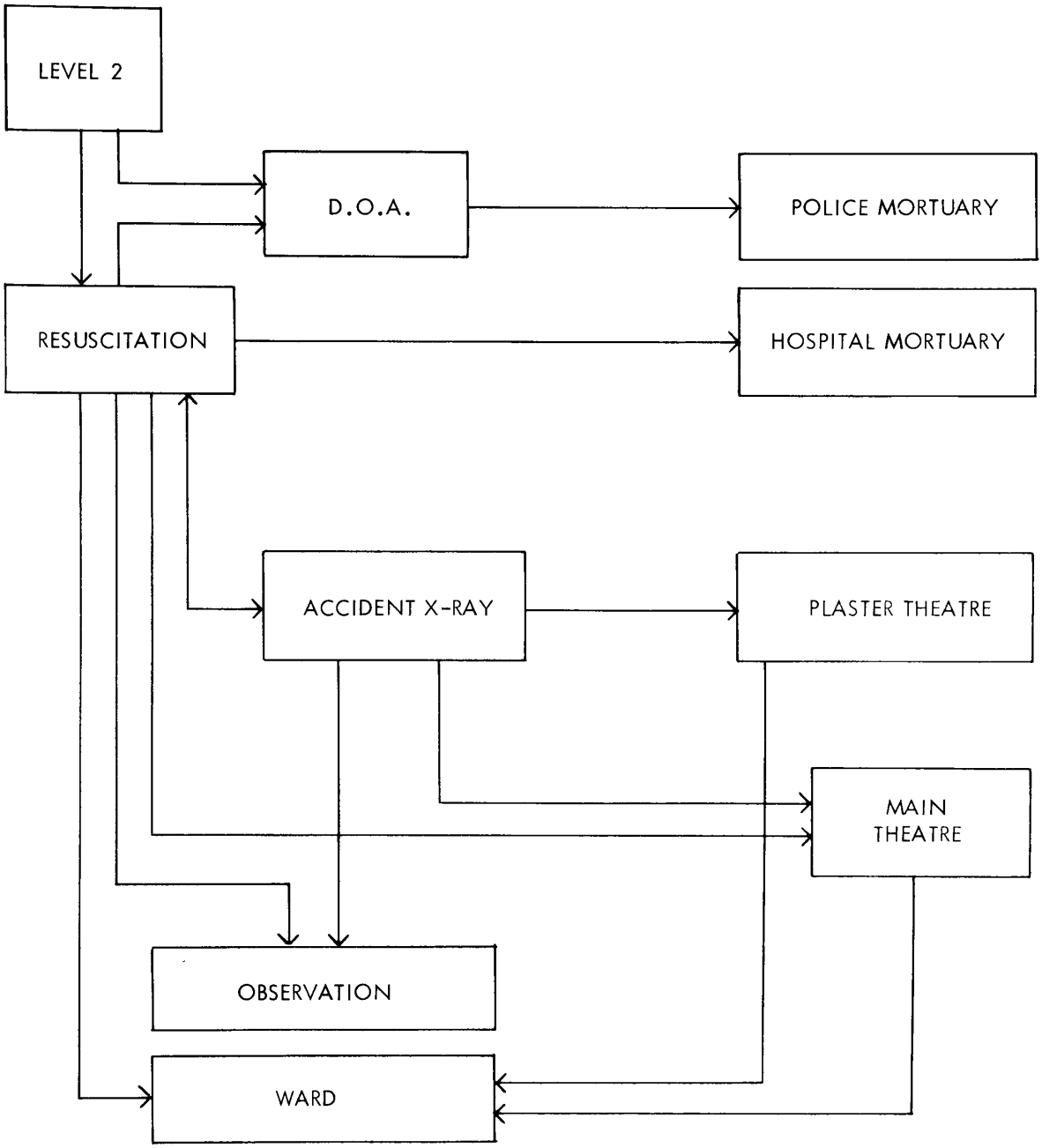


Figure 11

PATIENTS' MOVEMENT THROUGH ACCIDENT DEPARTMENT

SEVERE CASES

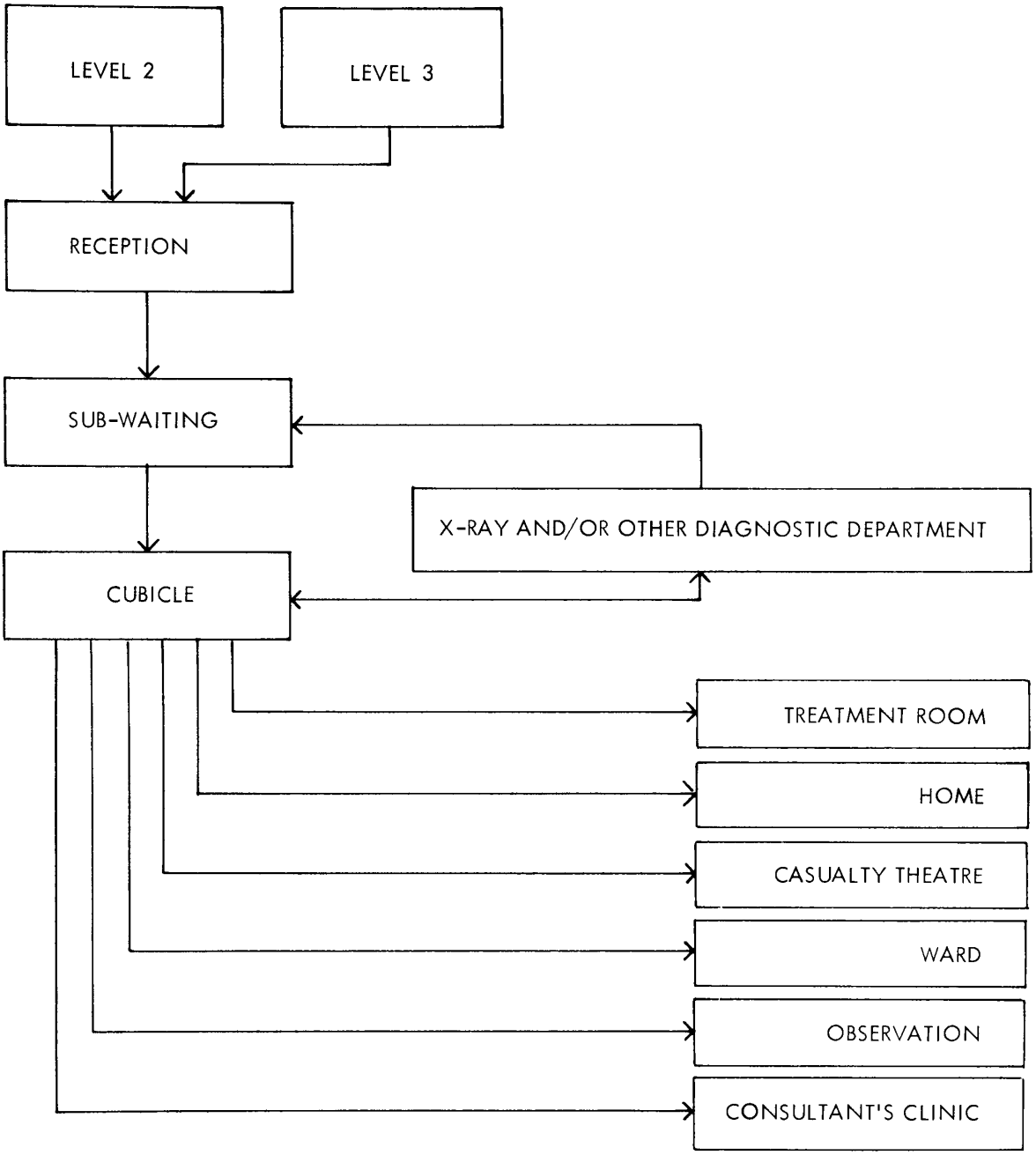


Figure 12

PATIENTS' MOVEMENT THROUGH ACCIDENT DEPARTMENT

NON-SEVERE CASES

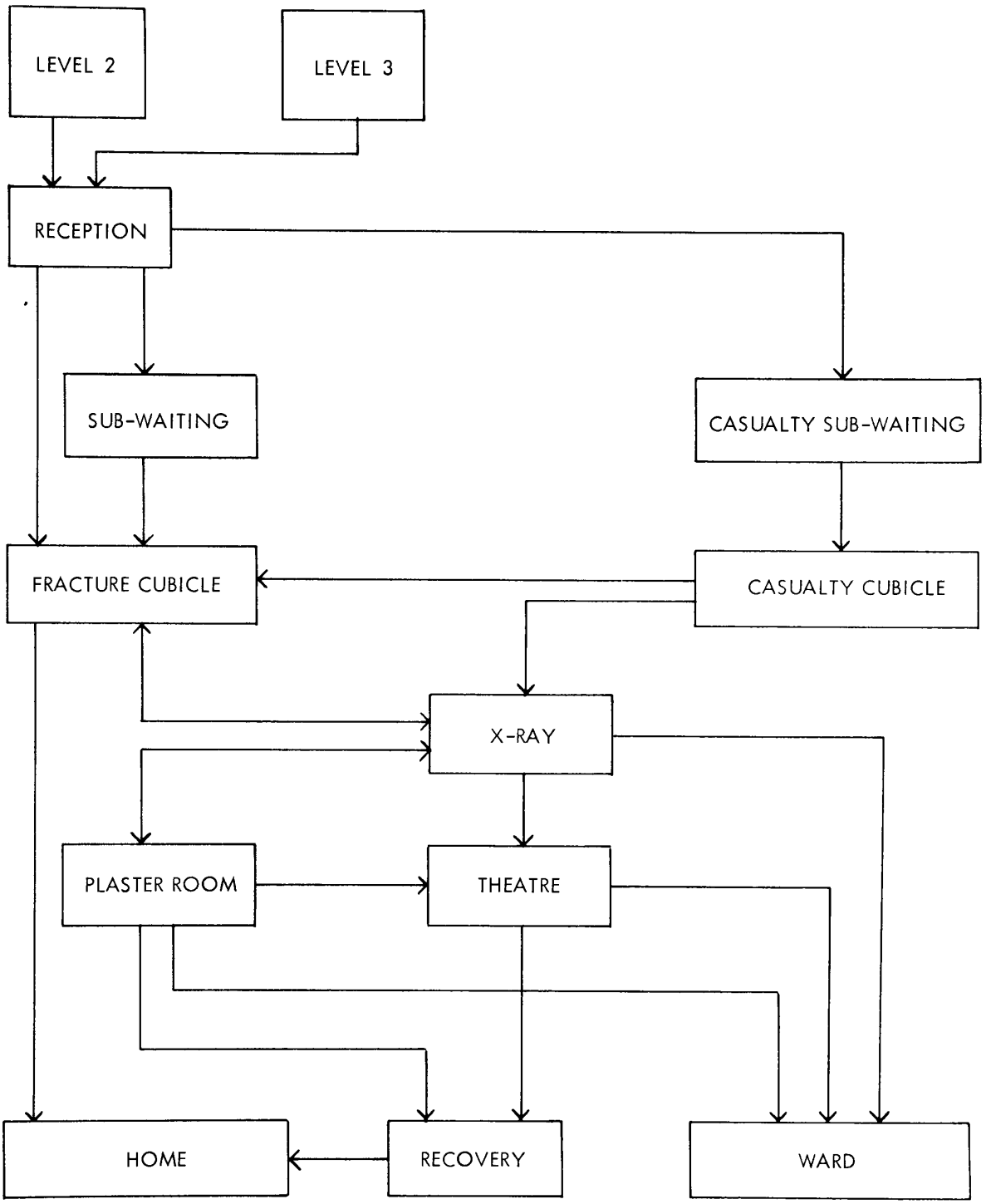


Figure 13

FLOW CHART FOR NEW FRACTURE PATIENTS

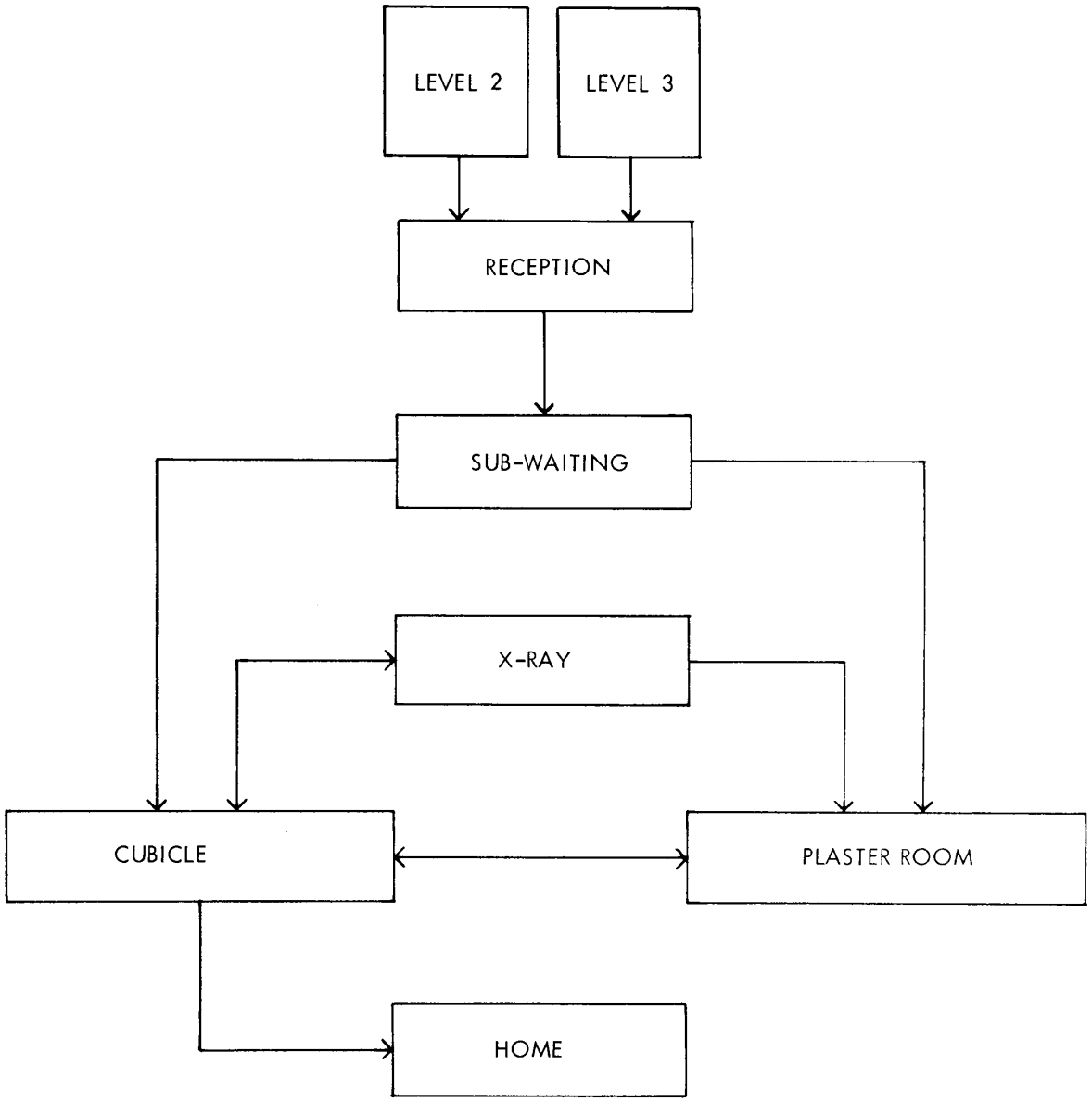


Figure 14

FLOW CHART FOR RETURN FRACTURE PATIENTS

9 X-RAY SERVICE

9.1 It is understood that the aim will be to provide a 24-hour x-ray service from the department at level 2. For an accident service of this size this is clearly desirable. This will require a radiologist of senior status (consultant or senior registrar) to be always on call. We feel that it would be an advantage if there were a consultant designated to be in administrative charge of the accident x-ray department.

9.2 With automatic processing, it is now possible for most films to be reported upon whilst the patient is still in the hospital. On level 2, when the films have been processed (and, usually, reported upon), they will be placed in appropriate racks at x-ray reception to be collected by the fracture clinic secretary or the casualty secretary. As we recommend that the offices of these two secretaries should be almost opposite x-ray reception, see 3.2.7, this will not present a difficulty.

9.3 On the medical clinics, level 6, the number of routine chest films taken will vary from clinic to clinic, but routine films are becoming more popular and the number of angles is increasing.

9.4 During medical clinics, an experienced radiographer will attend at level 6 together with a senior radiological registrar and a typist so that the physician will have ready access to reported films. With the radiologist present it will be possible for the clinician to discuss films whilst the patient is in the clinic and, perhaps, to arrange for more technical films to be taken at main x-ray on the same day. In the x-ray room in the surgical treatment wing, level 7, a radiologist should be made available when required.

9.5 We suggest that to speed the process of reporting on films the

usual procedure should be for the radiologist to dictate directly to a typist. Additionally a dictating machine should be provided for non-urgent work.

9.6 A large proportion of the x-ray departments work (both accident and main x-ray) is immediate, see appendices 5 and 6. It is impossible to eliminate entirely peaks of activity, which cause delays to patients and additional strain on staff. We feel it would be worthwhile to study ways and means of spreading the load as evenly as possible[5].

5 Kanon, D., Scheduling System for x-rays Prevents Overtaxing of Facilities, Hospitals J.A.H.A., 1st January, 1967.

9.7 Staffing

In order to provide a 24-hour service at level 2 and a periodic service geared to clinic requirements at levels 6 and 7, the following staffing is recommended:-

Radiologists

16 consultant sessions

33 senior registrar sessions (or registrars of more than 2 years' standing)

Radiographers

1 superintendent

5 senior

6 junior

Secretaries

2 personal assistants -
1 for the consultant
1 for the superintendent radiographer (shared with main department)

3 shorthand typists (one of whom will spend clinic times at level 6)

Clerks

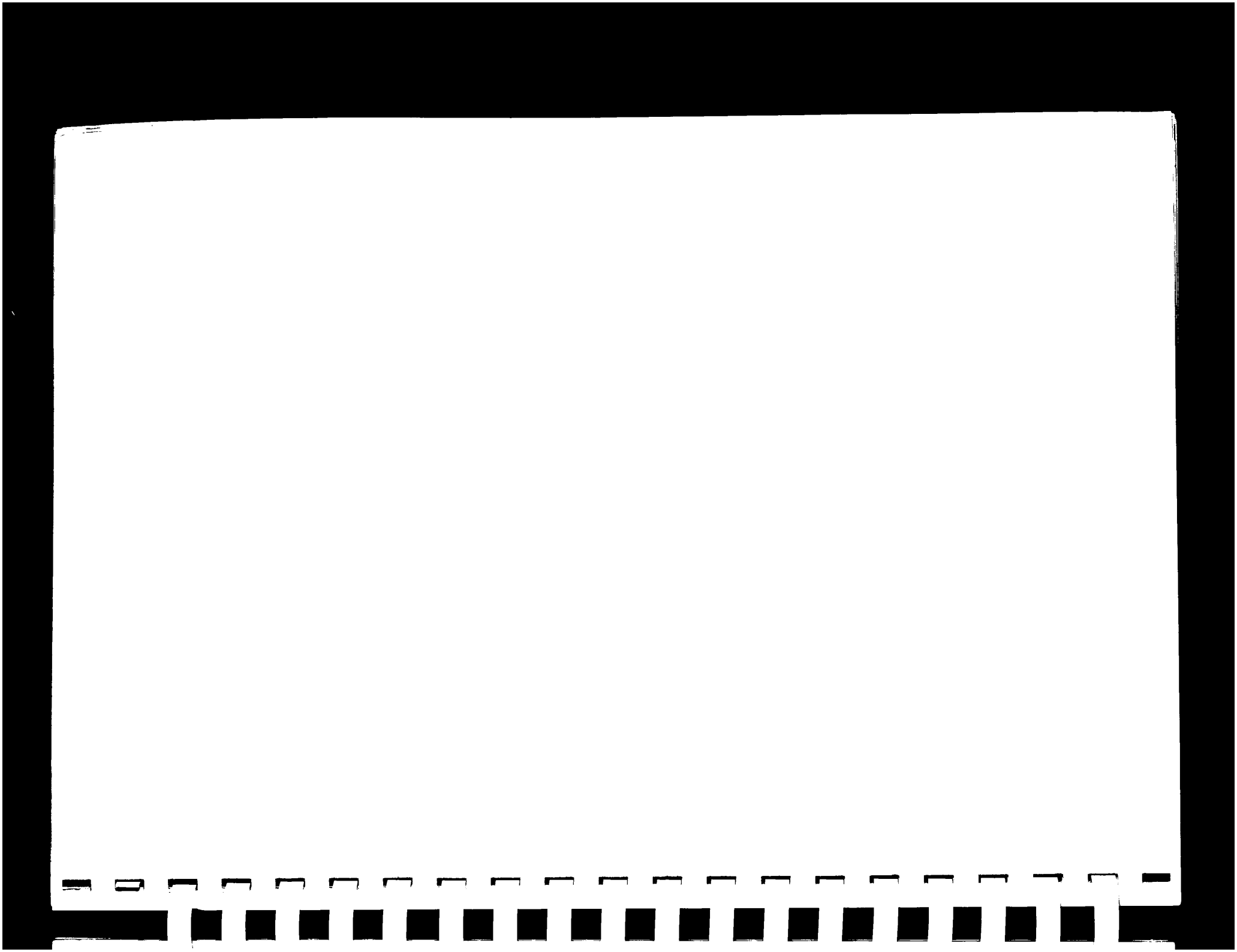
5 (8.30a.m. - 2a.m.)

Porters

3 (8.30a.m. - 2a.m.)

Nurses

24 hours' cover. see section 13



10 ADMISSIONS FROM WAITING LIST

10.1 When a patient is sent for to be admitted from the waiting list, the letter, figure 15, should include a form of acceptance for use by the patient, giving personal details not taken on registration as an out-patient, i.e. name, address and telephone number of next of kin and nearest relative.

10.2 This will make it possible to complete the case notes and send them to the ward before the patient arrives. Similarly the form of notification of the patient's arrival which is sent to various departments can be prepared in advance. All patients for admission will be directed on arrival to the reception desk at level 2. Their names having been noted, those fully pre-registered can be escorted direct to the ward.

10.3 There will still be patients whose registration, for one reason or another, has not been completed in advance. These should be directed to the main reception desk at level 2 and their registration completed in the adjoining interview room, see 3.2.6. From here patients will be conducted by voluntary workers or porters directly to the ward.

10.4 The majority of patients who come for admission having been on the waiting list will arrive during normal office hours. It is suggested that their times of arrival should be staggered.

10.5 The existing admissions office at the entrance to the casualty department carries out the following duties:-

(a) registers patients for admission

(b) deals with general enquiries

(c) deals with telephone enquiries from relatives and friends about patients' condition

ROYAL VICTORIA HOSPITAL
BELFAST 12

DATE .....

Dear Sir/Madam,

As you know, your name is on our waiting list to come into hospital.

Would you please come for admission on ..... at ..... reporting to the Admissions Desk on Level 2 by the Falls Road entrance.

It would be helpful if you would provide the additional information requested below, returning the tear off part of this letter in the envelope provided.

Yours sincerely,

Medical Records Officer

TO: Medical Records Officer
Royal Victoria Hospital.

I confirm I will attend for admission on the date and at the time shown above.

Please make any alterations necessary to bring this up to date

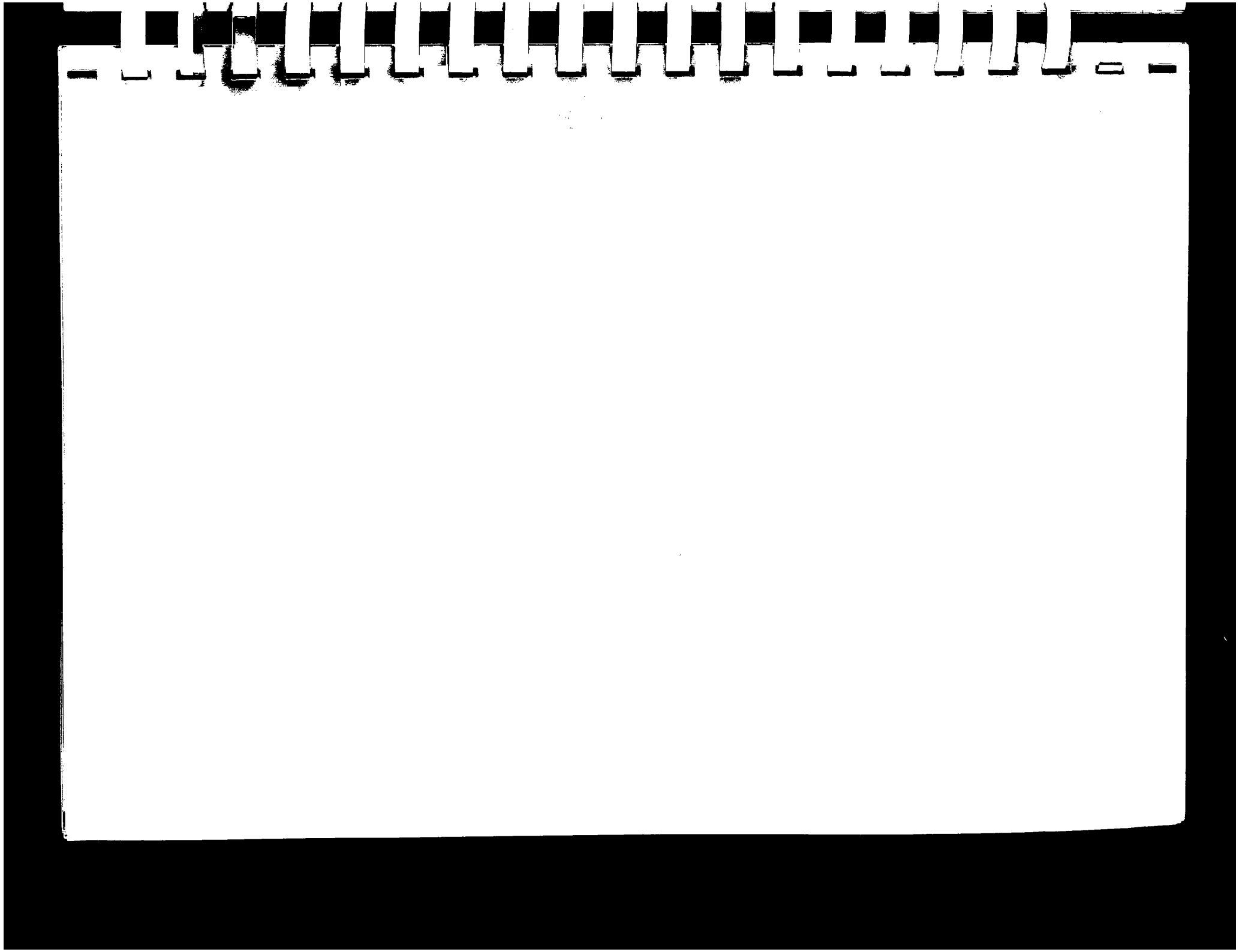
SURNAME Mr./Mrs./Miss HOSPITAL No.
CHRISTIAN NAMES AGE & DATE OF BIRTH
ADDRESS
OCCUPATION
NAME & ADDRESS OF G.P.

(label showing detail already recorded from O.P. attendance)

NAME & ADDRESS OF NEXT OF KIN
OR NEAREST RELATIVE .....
(with telephone number, if any)
.....

Figure 15

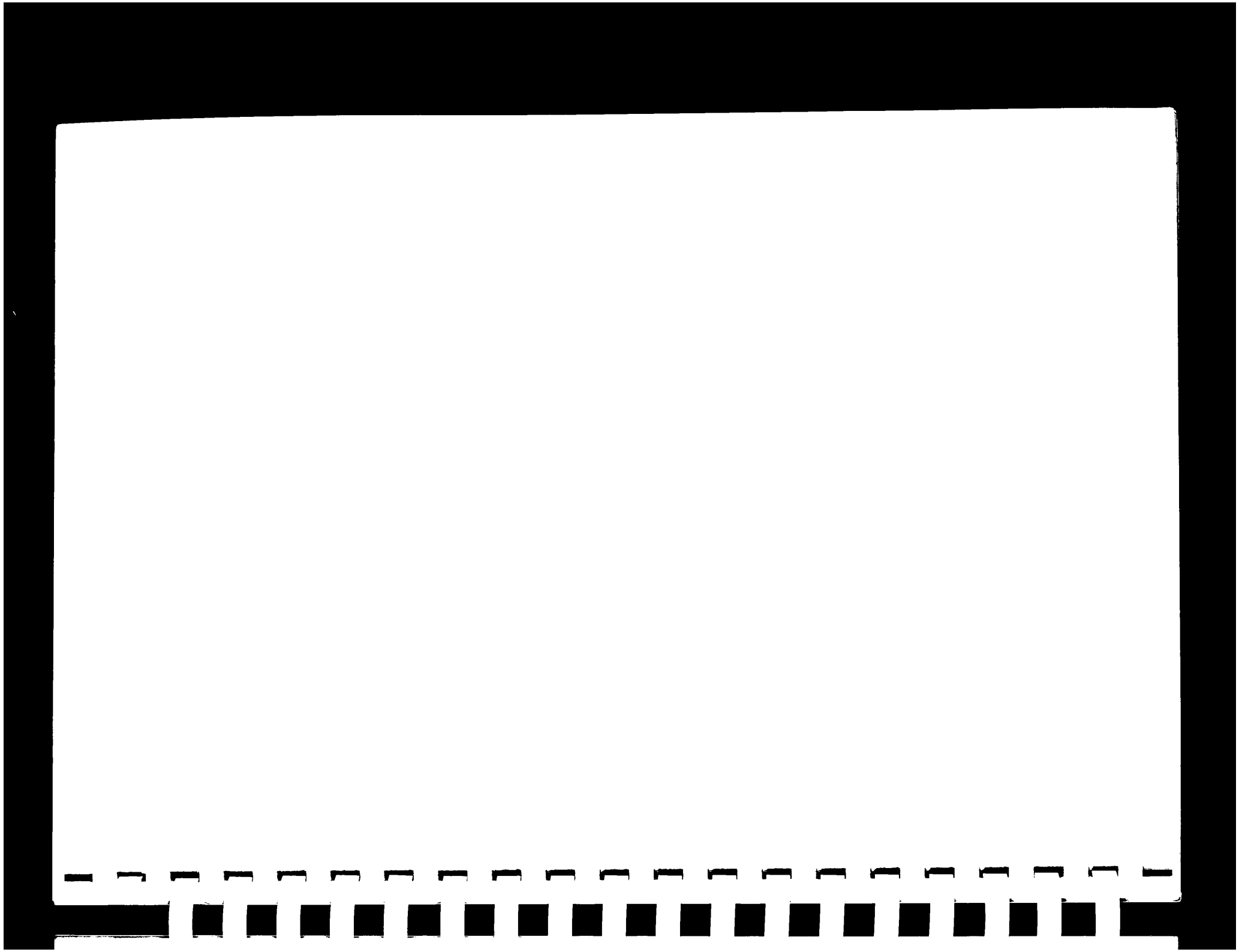
SUGGESTED TEXT OF LETTER TO PATIENT FOR ADMISSION
AND CONFIRMATION OF ACCEPTANCE



(d) maintains record of bed availability in each ward (including periodic check on position in take-in ward)
(e) contacts next of kin on request from ward
(f) arranges for emergency oxygen supply to patients' homes at request of general practitioners
(g) checks accounts for supply of emergency oxygen
(h) arranges official taxi journeys and checks accounts
(i) calls for maintenance staff out of normal hours
(j) arranges hospital transport out of normal hours for patients
(k) arranges delivery of emergency blood supplies
(l) issue of medical certificates for in-patients

10.6 When the new wing is opened most of these tasks will be performed at the main reception desk, level 2. We recommend that the enquiry switchboard should not be transferred. Telephone enquiries about the condition of in-patients at present go through to this subsidiary switchboard from where they are transferred again to the appropriate ward. We understand that in Belfast it is customary for every member and close friend of the family to telephone daily for news of the patient. This means that the present load is very heavy and the present system seems to us to be an expensive way of dealing with the situation. We suggest that consideration should be given to other possible solutions.

10.7 One alternative, for example, might be for the enquiry operators to have bulletins on the condition of patients to which they could refer and give direct answers about those where the answer is routine. Only a proportion of calls would then have to be transmitted to the wards. However, in this hopsital with its high turn-over, about half the enquiries would have to be put to the wards and the potential advantage of this method is therefore reduced considerably.



10.8 If the volume of enquiries could be reduced (perhaps by including a request in the booklet to in-patients and on the visiting cards that one member only of each family should make telephone enquiries of this sort) it would be possible for the main switchboard to put the callers through to the wards directly. Even if an extra operator were needed to do this, it would still represent a saving in staff.

10.9 We recommend that medical certificates for in-patients should be dealt with by the ward clerks rather than by the admissions office.

11 STERILE SUPPLIES

11.1 The intention is to supply the clinics and accident department from the CSSD stock room at level 1 which will be replenished from the main CSSD store.

11.2 We recommend:

(a) that storage units at the following points should be supplied on a 'top-up' basis by CSSD staff:-

Level 2	recess next appliance store	2/71
	clean utility room	2/78
	clean utility room	2/125
Level 5	treatment room	5/13
	treatment room	5/15
Level 6	nursing procedure room	6/3
	nursing procedure room	6/31
	nursing procedure room	6/53
Level 7	nursing procedure room	7/3
	sterile room	7/22
	nursing procedure room	7/53
Level 8	nursing procedure room	8/2
	treatment room	8/4
	preparation room	8/26
Level 9	nursing procedure room	9/3
	nursing procedure room	9/54

(b) that from these local storage points wall-mounted dispensers in individual rooms should be kept stocked by departmental/clinic staff

(c) that shelf space for preparation should be provided in the vicinity of the dispensers in every case. Three shelves (either open or in the form of cupboards) 3 feet in length and 18 inches in width, placed 24 inches apart should be adequate.

12 MEDICAL ILLUSTRATION DEPARTMENT

12.1 Function and layout

12.1.1 The prime function of the Medical Illustration Department is to provide a service to the consultant medical staff of illustrative material using either art or photography as seems appropriate to the occasion. This could include a photographic 'on call' service to casualty on level 2 if medically justified. It should also be the centre from which advice appertaining to visual aids can be obtained by the administrative and medical staff. Lastly it should mount and maintain a duplication service using whatever medium is best (e.g. xerography or offset photolithography) for all sections of the hospital. To equip and staff an illustration department of this size adequately and then to regard it as only a photographic department is unsound. Likewise the area allocated to medical illustration in the new out-patients department of the Royal Victoria Hospital and the medical school should be discouraged as they can only lead to unnecessary duplication of photographic apparatus and personnel.

12.1.2 Recommendations have already been made, and accepted, on the layout of the department, see plan of level 9.

12.2 Request cards and filing systems

12.2.1 All requests for photography and medical art should be covered by a request card as without one work in progress may become mislaid or lost or the intended dead line forgotten. Three cards should be available (a) for clinical photography only
(b) for other than clinical photography
(c) for medical art.

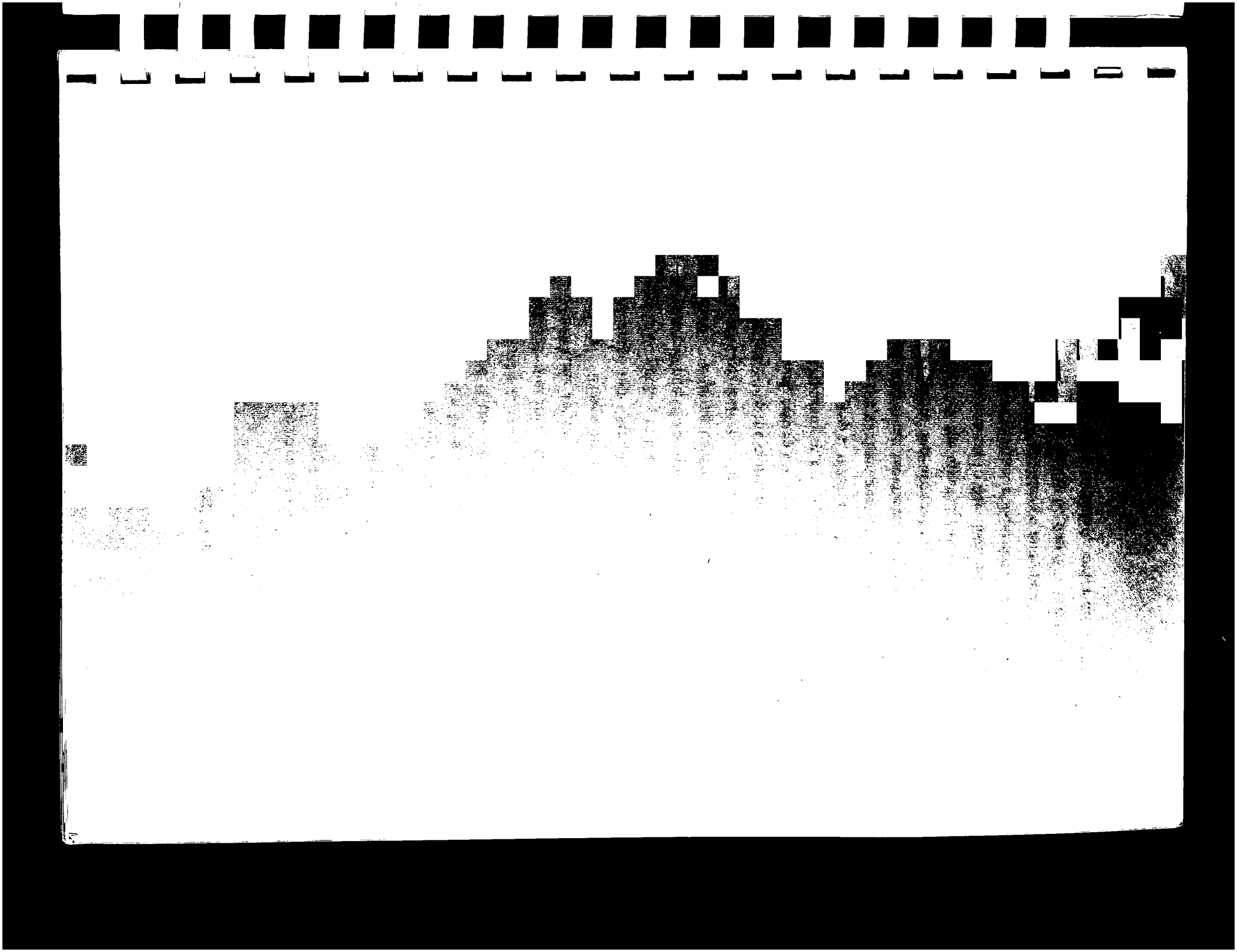
12.2.2 It is usual for the consultant in charge of the patient to sign the request card but this procedure may have to be modified if

found impracticable owing to the infrequent visits of the consultant or for some other cause.

12.2.3 The items to be filed are (a) the request card (photographic and art), (b) a print, and (c) the negative. The retrieval system adopted must be such as to enable all of the above to be found at will.

(a) Request cards should be filed alphabetically under the patient's name.

(b) A contact photographic print of each clinical negative should be filed under a disease classification. The one recommended is the World Health Organization manual of the international statistical classification of diseases, injuries and causes of death. Only the main headings need be used until such time as more specialisation is desired or found necessary. These prints are best kept in loose leaf books and mounted in as simple a manner as possible (e.g. double sided Sellotape). In this way economy of time, flexibility and convenience of viewing large batches of prints is achieved. It is not considered desirable or practical to hold a master collection of colour transparencies. These are best issued to the consultant, who, if he needs a duplicate, must return the original to the Medical Illustration Department for copying. It has been found very difficult to keep a master collection of transparencies intact because for various reasons requests are made to borrow them and some inevitably are never returned. Contact prints from non-clinical negatives should also be filed but because of the diversity of subject matter it is usually more convenient to file them under the name, or specialty, of the consultant concerned. In this way, for instance, orthopaedic appliances and special gadgets for the handicapped can more easily be found. Irrespective of what other information is included, under all prints the



negative number must be stated to enable the negative concerned to be found at once.

(c) All negatives should be filed numerically.

12.3 Procedures

12.3.1 All requests for photography or medical art should be received in the Medical Illustration Department by the receptionist or secretary and entered in the Day Book.

12.3.2 Clinical photography should receive priority over all other requests.

12.3.3 As far as possible, clinical photography of out-patients and ambulant ward patients who are able to leave the ward should be dealt with in the studio, the comfort and well-being of the patient being always the first consideration.

12.3.4 Clinical negatives should be developed the same day in darkroom 9/34, but not necessarily whilst the patient is in the studio unless there is a good reason for adopting this procedure. Exceptions to the rule might be when taking infra red pictures or immediate pre-operative pictures when the chance of a re-take is non-existent.

12.3.5 Clinical negatives should be printed the following day in darkroom 9/33. This is a counsel of perfection, but at least the prints should be in the patient's case notes before the consultant next sees the patient.

12.3.6 One print should be issued to the consultant and one file print made. Any more prints should be made only on request. Similarly one transparency should be supplied to the consultant, any more to be by prior arrangement.

12.3.7 Non-clinical negatives to be processed and printed as soon as possible after taking, using darkroom 9/30 and 9/31. This applies especially to the production of lantern slides for lecture purposes. It is recommended that the 2" x 2" slide is adopted as a standard both for colour and monochrome, likewise the camera size should be 5" x 4".

12.3.8 A standard scale of reproduction should be adopted. In this way prints of one patient should be comparable both with another suffering from the same disease and with previous prints of the same patient.
Full length - not to scale but with scale included in picture.
Recommended scales are -

trunk	1:6
chest	1:4
head and neck	1:3
face	1:2
skin lesions	1:1
eyes	1:1

12.3.9 The prints for the case notes should be mounted and finished in room 9/22 before being issued via the general office 9/37 and then taken by the receptionist to the medical records department for insertion in the notes or distribution to the wards.

12.3.10 The processing of colour transparencies and colour negatives should not be undertaken within the department until the amount of work justifies the appointment of a full time colour processor. Until then the material should be posted to a satisfactory colour laboratory.

12.3.11 Ophthalmic photography, including retinal fundus pictures, should be carried out in room 9/21 but with the active co-operation

of the consultant ophthalmologist. As a beginning, the consultant or one of his medical staff should undertake dilation of the eye prior to photography, but later on there is no reason why the head of the photographic department should not do this, except in exceptional circumstances. It is better that general photography of the eye should be dealt with in the Medical Illustration Department and not done, as at present, in the eye clinic.

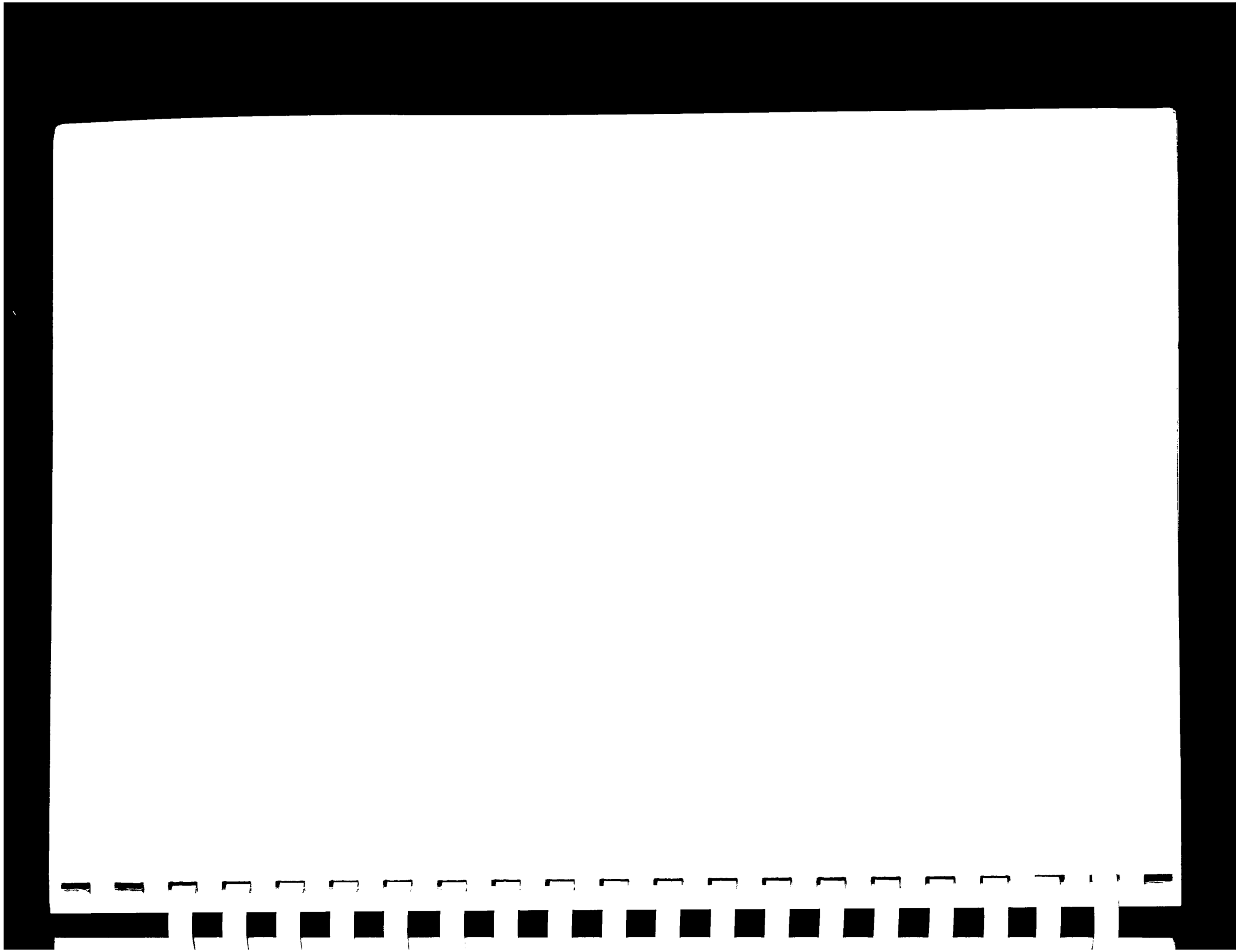
12.3.12 Whilst photomicrography and any special photographic techniques should be tackled in room 9/29 using darkroom 9/30 and printing room 9/31 for developing and printing it is envisaged that room 9/29 will also be used to contain the copying set up for the production of prints and slides for lecture and display purposes.

12.3.13 The photography of morbid specimens and x-ray reproductions has a room set aside for the purpose - 9/24 - where it will not inconvenience the photography of patients. Darkroom 9/25 is available for developing the negatives and these can be printed in either 9/33 or 9/31.

12.3.14 Room 9/23 should be used for editing motion picture film taken either in the studio 9/35 or in the special technique section 9/29 or on the wards or in the theatre. The actual film stock should be commercially processed and a cutting copy always made to save damage to the master material. This room could also be used as a preview theatre for both slides and film.

12.3.15 There is sufficient room for a medical artist and assistant in room 9/26. It has a north light.

12.3.16 In the introduction reference was made to a duplication service. The apparatus for this should be housed in the general office 9/37 where it would be under the supervision of the head of



the department and operated by a secretary or typist (after a period of training).

12.3.17 Provision has been made for TV outlets in level 1. It should be pointed out that if there is to be a television link between the various departments of the hospital then the logical siting of the control console is in the Medical Illustration Department (director's office 9/38) from where most, if not all, of the static display material will originate.

12.3.18 Arising out of the possible teaching possibilities of TV it is envisaged that the Medical Illustration Department will provide a projectionist whenever required in the main lecture theatre assuming that the provision and maintenance of the projection equipment is to be the responsibility of this department.

12.4 Staffing

It is impossible to state how many staff will be needed to man this Medical Illustration Department, but the initial establishment recommended is

head of department (qualified)
3 medical photographers (qualified)
receptionist
trainee medical photographer
trainee medical artist.

(At present (December, 1966) there is a staff of 2 full-time and 1 part-time photographers, none of whom are qualified medical photographers within the Whitley Council definition.)

12.5 Apparatus

12.5.1 It is recommended that a 5" x 4" camera is used for clinical photography in the studio and whenever possible on location. The exception to this rule might be in the operating theatre and in some

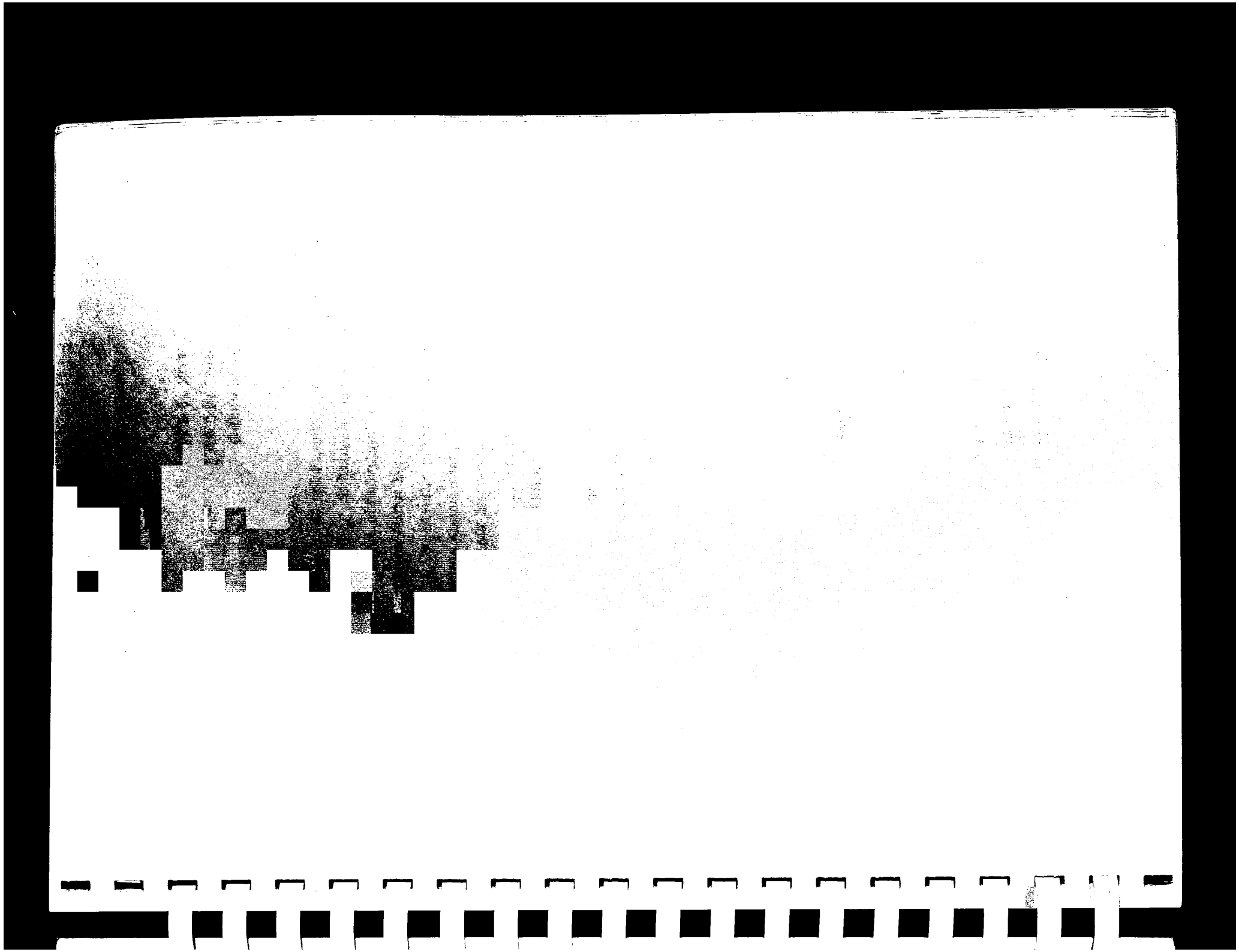
out-patient clinics when a $2\frac{1}{4}$" square camera should be available. The 5" x 4" negative is large enough for contact printing for routine purposes and yet can yield demonstration material when enlarged. Two enlargers will be needed to cope with the different negative sizes. Colour photography is best handled by a modern 35 mm. single lens reflex camera equipped with lenses of the appropriate focal length. A copying camera will be needed for the production of prints and slides from original material, either journals, books, charts or diagrams. Likewise an apparatus for the reproduction of radiographs either as slides or prints.

12.5.2 Lighting for clinical photography should be by electronic flash, there being sufficient illumination for full length pictures in colour as well as monochrome. A portable flash unit should be used in the theatre or clinic for a similar purpose. Tungsten lamps will however be needed for specimen photography, document copying and the photography of apparatus etc.

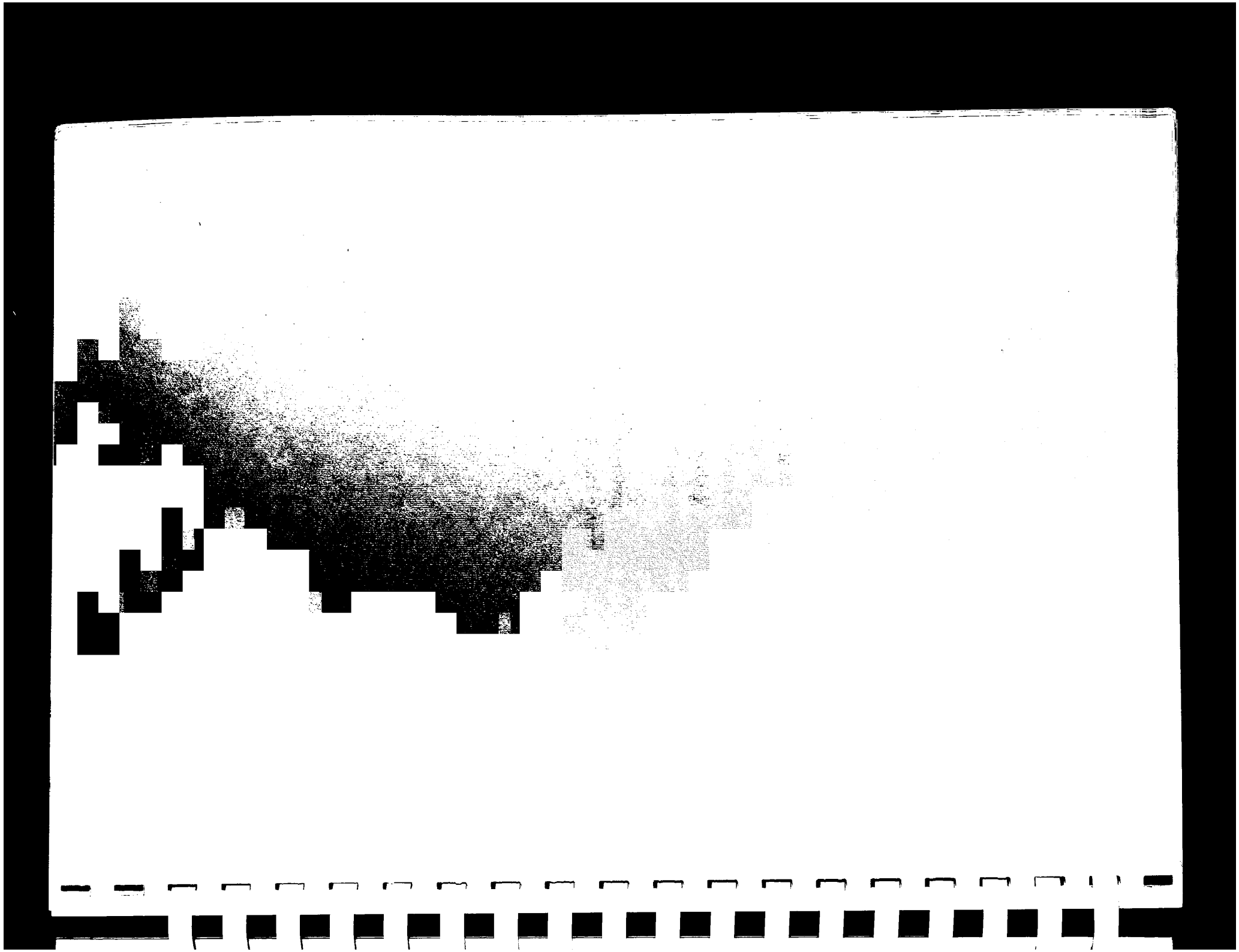
12.5.3 As labour is almost certainly going to be at a premium it is recommended that from the start photographic prints for routine purposes should be made via the latest method of stabilisation. This will obviate the time consuming procedures of washing and glazing and enable a 'rush' print to be produced in under 10 seconds. The quality of these prints is not yet as good as the conventional bromide print but is rapidly approaching it. The cost is slightly higher and the permanence of the prints is not archival but as the negatives will always be in the department this latter point is not of major significance.

12.5.4 The following items of major equipment are recommended:-

1. 5" x 4" MPP Camera fitted with F 4.5 6" lens
   and F 4.5 4" lens



2. $2\frac{1}{4}$" square Hasselblad Camera fitted with F 2.8 lens (80 mm.). 2 extension rings, 2 film backs, and prism finder.
3. Pentax 35 mm. SLR Camera with 55 mm. and 105 mm. lenses.
4. Durst 5" x 4" enlarger.
5. Leitz Focomatt IIC enlarger and baseboard.
6. Kodak Drying Cabinet.
7. Kodak Glazer.
8. Strobe Electronic Flash.
9. Mecablitz Portable Flash Unit.
10. Copying Camera 5" x 4" and lights.
11. Ademco Dry Mounter and Tacking Iron.
12. 16 mm. Cine Camera, preferably Arriflex.
13. Photomicrographic Outfit, $\frac{1}{2}$ plate - possibly R. and J. Beck make.
14. 35 mm. Leitz Prado 250 Projector.
15. 16 mm. Film Editor.
16. 16 mm. Sound Projector, preferably Siemens.
17. Fundus Camera, preferably Carl Zeiss, Oberkochen.



13 STAFFING ESTIMATES

13.1 Tables 1 to 4 set out our recommendations for the staffing of the new out-patient department under the various categories of staff. They have been assessed on the basis of the procedures and methods of operation recommended in this report, on the anticipated work load of the department and, in the case of nurses, on the principle that nurses should not be employed to carry our duties not requiring the skills of a qualified nurse[6].

13.2 It is always difficult to make precise forecasts of staffing requirements in new departments and these figures should therefore be regarded rather as a provisional estimate than the final establishment. It is therefore suggested that, if possible, a financial reserve should be made to provide for additional appointments found to be necessary after the opening of the new building[7].

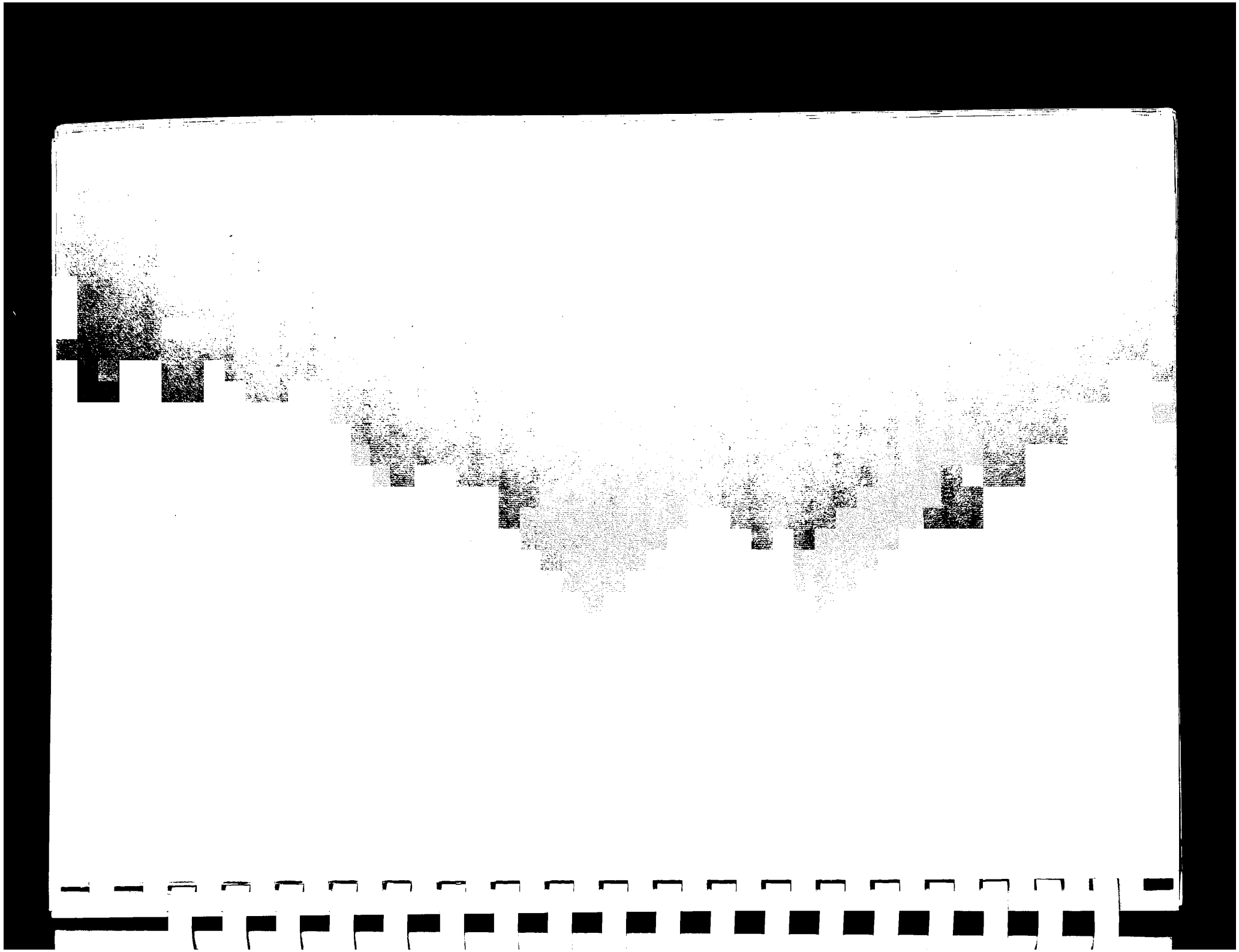
13.3 We have not found it possible to make valid comparisons with the staffing of other departments since no new, or even recent, comparable department exists elsewhere in Britain.

13.4 Recommendations on the staffing of the x-ray service in the building and on the department of medical illustration are included in the sections dealing with those departments.

13.5 We consider that the appointment of two full-time clinical assistants in the accident department is a sound policy. One

6 Ministry of Health, Duties of Nurses in Out-patient Departments, Standing Nursing Advisory Committee, HMSO, 1965.

7 King's Fund, Commissioning New Hospital Buildings, 1966.



doctor has been in post since May and the need is evident for a second to share the work in this very busy department.

13.6 We have excluded from our estimates staffing in the department of physical medicine and the special clinic.

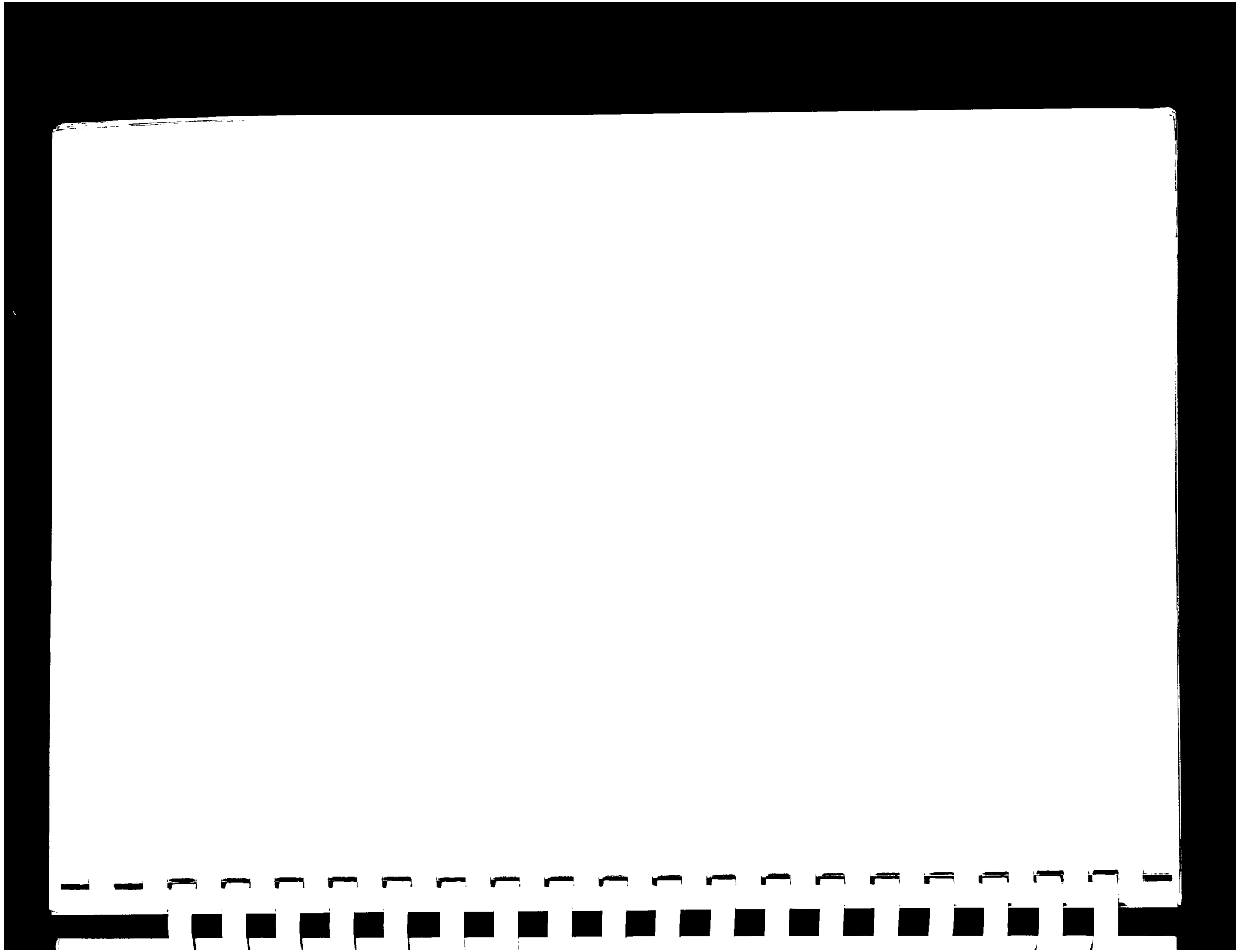
PROVISIONAL STAFFING ESTABLISHMENT
MANAGEMENT

Manager of out-patient services, see section 14

Assistant Matron, see section 14

2 Secretaries

TABLE 1



PROVISIONAL STAFFING ESTABLISHMENT

NURSING STAFF

Level 2: staff for accident service, casualty, fracture clinic observation unit and x-ray department.

1 departmental sister, grade A

Day duty (8.30 a.m. - 10.30 p.m.)	Night duty (8.30 p.m. - 8.30 a.m.)
6 sisters	3 sisters
8 staff nurses	5 staff nurses whole-time
2 staff nurses part-time (6.30 - 10.30 p.m.)	2 staff nurses part-time (one on two nights per week, one three nights per week)
6 nursing auxiliaries	
2 plaster technicians	
2 theatre porters	

(there will also be a number of student nurses supernumerary to the establishment)

Level 5:

3 staff nurses whole or equivalent part-time

1 enrolled nurse

2 nursing auxiliaries

Level 6:

1 sister (floor)

1 sister part-time (metabolic)

12 staff nurses whole or equivalent part-time

4 nursing auxiliaries

Level 7:

1 sister

1 sister part-time (treatment wing)

12 staff nurses whole or equivalent part-time

6 nursing auxiliaries

TABLE 2

Level 8:

2 sisters (one eye clinic, one ENT)

8 staff nurses whole or equivalent part-time

6 nursing auxiliaries

Level 9:

1 sister (gynaecology clinic)

1 sister part-time (orthopaedic)

6 staff nurses

2 staff nurses part-time

4 nursing auxilaries

SUMMARY

Level 2:

1 departmental sister, grade A

9 sisters

13 staff nurses

4 staff nurses part-time

6 nursing auxiliaries

2 plaster technicians

2 theatre porters

Levels 5 - 9:

5 sisters

3 sisters part-time

42 staff nurses

22 nursing auxiliaries

TABLE 2 (cont.)

PROVISIONAL STAFFING ESTABLISHMENT

MEDICAL RECORDS STAFF

Section	Staff
Administration	Medical records officer
Level 4:	secretary
	deputy medical records officer
waiting lists and statistics	1 higher clerical
	5 clerical
master index and addressing machine	1 higher clerical
	6 machine operators
	1 clerical (index)
	1 clerical (pulling notes for admissions and assisting index)
medical typing room	1 supervisor
	4 trainee secretaries (shorthand typists)
	1 higher clerical
	3 clerical
collecting room	1 higher clerical
	4 clerical
library	1 higher clerical
	12 clerical
Level 2:	
main reception desk	1 higher clerical
	6 clerical (reception/registration)
	3 clerical (admissions)
fracture clinic	1 receptionist
	1 secretary
casualty clinic	1 receptionist
	2 secretaries
Level 3:	
central appointments bureau	1 higher clerical
	5 clerical
enquiries	2 receptionists
Level 5:	2 receptionists
Level 6:	3 receptionists
Level 7:	2 receptionists
Level 8:	2 receptionists
Level 9:	2 receptionists

TABLE 3

PROVISIONAL STAFFING ESTABLISHMENT

OTHER STAFF

Section	Staff
Level 3:	
entrance	1 porter
tea bar	2 voluntary workers
Level 2:	
entrance	4 porters (day) 4 porters (night) - note a.
accident service	4 orderlies
lifts	3 lift attendants
transport office	1 transport officer
tea bar	3 voluntary workers
patients' guides	15 voluntary workers: level 2 3 level 3 2 levels 5 - 9 10 1 organiser of volunteers (general administrative grade) - note b.
CSSD supply	2 orderlies
whole department	42 part-time cleaners (3 hours shifts) - note c. 7 part-time cleaners (1 hour a day)
whole department	pool of 3 porters - note d.

a. also serve wards with blood and oxygen during night

b. the number of voluntary workers and the increasing contribution which they are making to the hospital's work justifies a paid, full-time organiser. Many hospitals are now making such appointments and we recommend that serious consideration should be given to this new appointment.

c. this number assumes adequate supervision, sound methods and proper equipment

d. controlled and based at level 3

TABLE 4

14 MANAGEMENT

14.1 The efficient functioning of the departments in the new building will depend to a large extent on the proper co-ordination of the efforts of many different departments and their staffs, and this immediately raises problems concerning management. The Ministry of Health has published a study on this aspect of the work of out-patient departments[8]. The effectiveness of this co-ordination will have to be regularly measured at many points; measures to remedy deficiencies will have to be devised and implemented; objects will have to be regularly assessed and adjusted. All this indicates the need for adequate management and in our view the decisions on the management pattern to be adopted and on matters consequent upon it are most important ones.

14.2 The new wing, containing as it will all the hospital's out-patient clinics, accident service, department of physical medicine and several other important ancillary and service departments, will be of a size and complexity to justify its own management sub-structure which will have to be related to and set within the overall management pattern of the hospital and of the group.

14.3 We have no doubt that the content of the supervisory and administrative tasks which will relate to the work of the nurses in the several departments in the wing justifies the appointment to matron's staff of an assistant matron. Her functions would be generally those envisaged as appropriate to the out-patient superintendent in the report of the Standing Nursing Advisory

8 Ministry of Health, A study of some management problems in the out-patient department, (Hospital Memorandum with HM(64)102, 1964.

Committee[9].

14.4 The second largest section of staff is in the medical records department. We consider that the day-to-day work of this department is well controlled despite present difficulties, shared by many other departments, caused by inconvenient accommodation.

14.5 We have considered whether the functions of management mentioned in 14.1 could be undertaken satisfactorily by the assistant matron and the medical records officer working together with a joint responsibility. This arrangement is used in other places and sometimes works reasonably well. There are however, always disadvantages attaching to situations of dual control and in this case, also, the assistant matron and the medical records officer would be responsible to different people.

14.6 We have come to the conclusion, therefore, that the right thing to do, subject to the remarks in 14.7 below, is to appoint a manager of out-patient services to be responsible to the group secretary for the management of the new wing. The manager would, as we see it, act as the hospital secretary of the building. Individual departments within it, such as physical medicine, social workers, medical illustration, would retain their internal administrative autonomy but their work would be co-ordinated within the whole by the manager with whom also departmental heads would be able to discuss administrative problems of their departments directly.

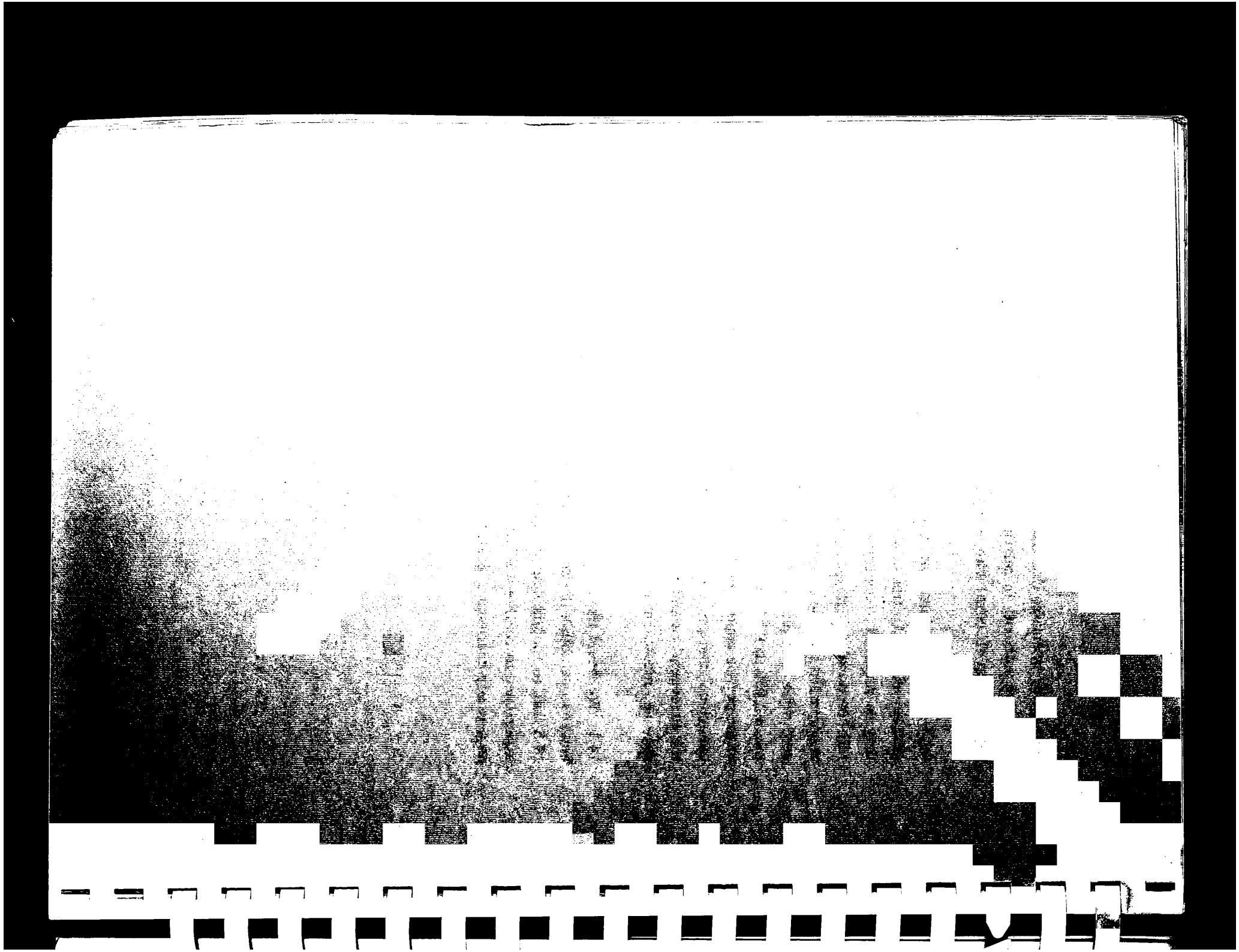
14.7 To justify such an appointment and the grading which will, in our view, be appropriate for the potential scope of the post it will be

9 Ministry of Health, Duties of Nurses in Out-patient Departments, Standing Nursing Advisory Committee, HMSO 1965.

necessary to ensure that the manager has a proper degree of executive authority in relation to the heads of service departments (often group officers) with whom he will have to deal.

14.8 We understand that there are other duties relating to the general administration of the hospital which this officer, if appointed, may be required to undertake. With this in mind, and assuming full functional delegation by the group secretary to the manager, we recommend that the appropriate salary range for this important post would be equivalent to the scale for an assistant secretary, viz. £2,030 to £2,530. We feel that the professional background of the person appointed is of less consequence than training, experience and proved ability in management. The background of the successful candidate might well, therefore, be in medicine, nursing, medical records or general administration.

14.9 We would like to add the rider that in our view it would be better to establish the dual pattern of management discussed in 14.5 than to appoint someone not fully qualified by training and experience to realise the full potential of what should be regarded as a really challenging post.



15 COMMISSIONING

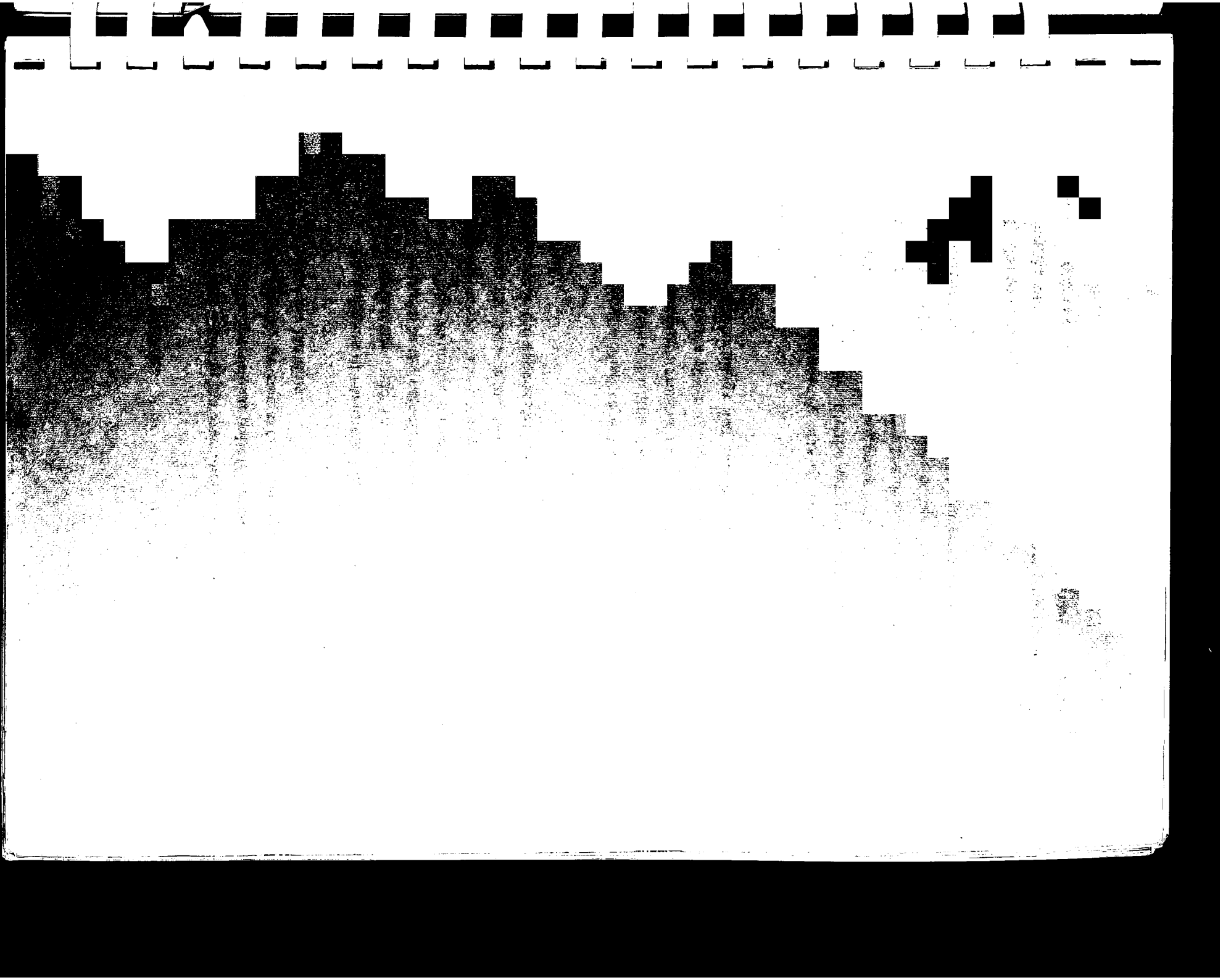
15.1 As was noted in the introduction, the aim in this report has been to evolve operational policies rather than detailed procedures. Our work should, we suggest, be seen as the start of the process of opening the new building.

15.2 The process of commissioning, as it has come to be termed, is an important one, and we recommend that early consideration should be given to the establishment of a commissioning team which should include a doctor, a nurse, an administrator, an architect and an engineer. The manager of out-patient services, if appointed, should lead the team and be responsible to the group secretary for the successful completion of the commissioning operation.

15.3 The King's Fund report on commissioning, already referred to, contains material which may be helpful during the setting-up of the commissioning arrangements. In particular, it includes a check-list of items which require attention during the commissioning of new hospital buildings that may be found of immediate practical value.

15.4 It will be necessary, during the twelve months before the building is handed over, for the matters dealt with in this report to be refined by the commissioning team to a greater degree of detail and for other questions besides to be identified and answered. There are a number of aspects with commissioning implications to which we should like to refer briefly.

15.5 Car parking arrangements:
As can be seen from appendix 4 a significant proportion of patients arrive by private transport. No doubt this proportion will steadily



increase. Consideration should therefore be given to the rules which will apply to car parking when the new building comes into operation. The arrangements should be made known to out-patients before they arrive, perhaps through the medium of an information booklet to out-patients, see 15.6.

15.6 Information to out-patients:
We suggest that the production of a booklet for the guidance of out-patients before their visit for consultation is well worth while. Some hospitals have combined the information leaflet with an appointments card and one of the best, (that produced for Poole General Hospital), is of this type. Information given might include a map of the department, where and what refreshments are available, call-box telephones, arrangements for safe custody of valuables, procedure for x-rays, blood tests etc., importance of letting hospital know if appointment cannot be kept, need for punctuality, significance of staff uniforms, transport arrangements (ambulance/hospital car), car parking, advice to wear clothing that can be easily removed, request to refresh memory on medical history before consultation.

15.7 General supply and disposal services:
Supplies of linen, stationery and provisions will be brought by porters. Times, exact places and frequency of deliveries will have to be agreed. Supplies generally should be completed before 9 a.m. and disposal of refuse dealt with after 6 p.m.

15.8 Fire precautions:
Fire drill instruction notices should be prepared in consultation with the local fire brigade.

15.9 Maintenance procedures:
A programme of planned preventive maintenance of the equipment in

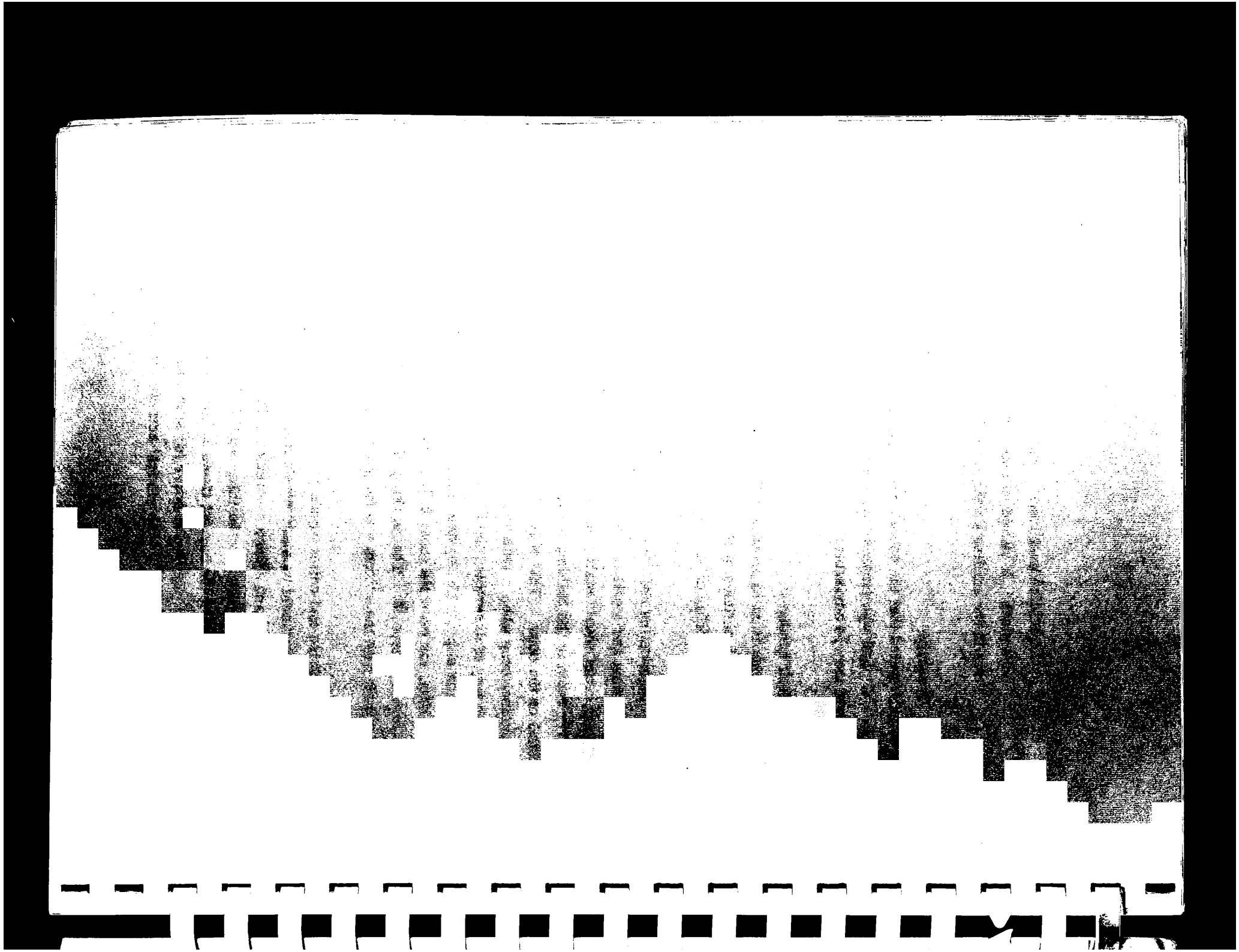
the new wing should be prepared. This may require an increase in the engineer's staff. It should be noted that no provision has been made for this in the staffing establishment.

15.10 Security:
It is anticipated that the entrance at level 3 will be closed during the night. A night watchman's round of the clinic floors at irregular intervals may be advisable.

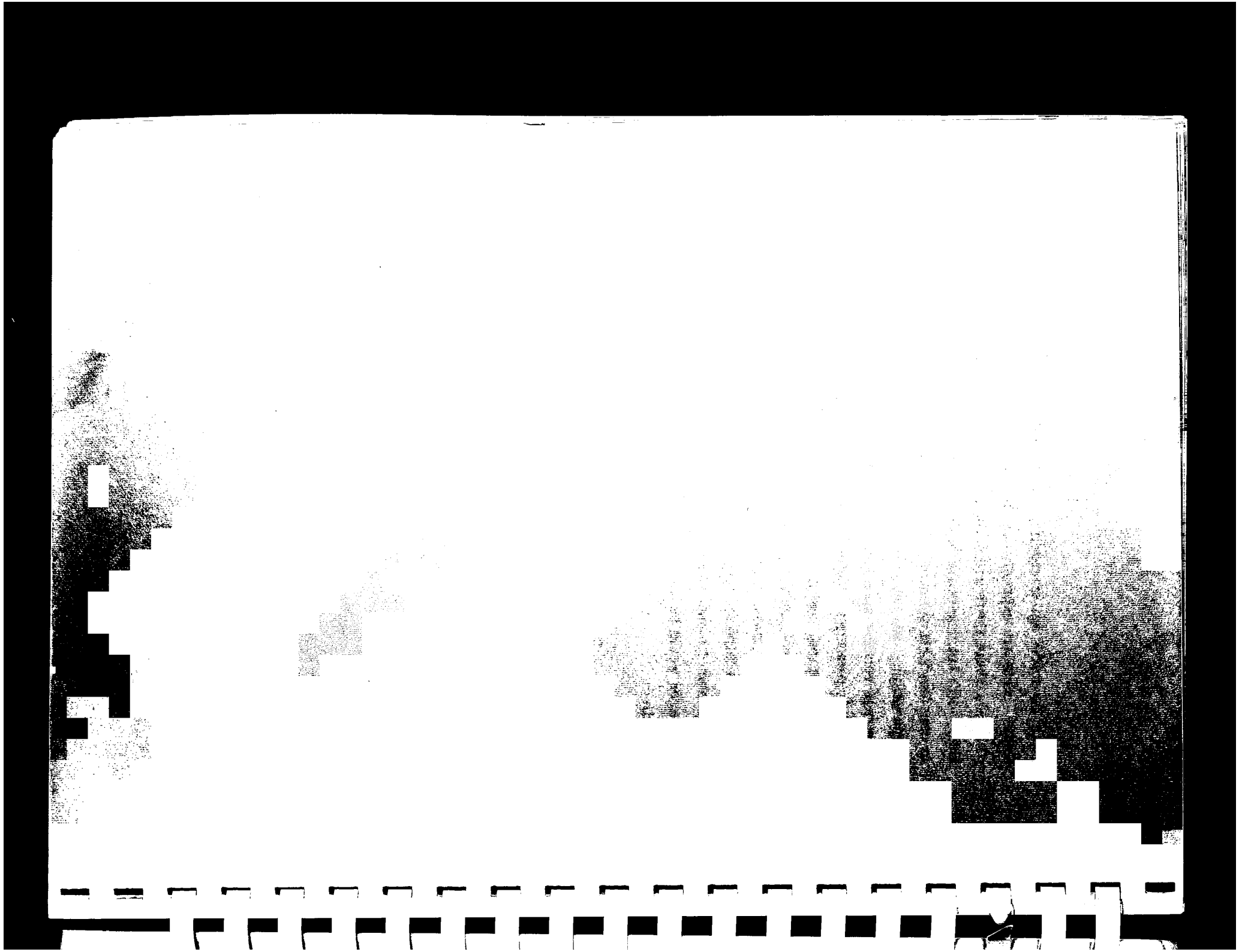
15.11 Staff handbook:
It will be important to produce a handbook for staff giving guidance on the working policies of the department. Its production should be the responsibility of the commissioning team.

15.12 Signposting and door-labelling:
The wording and location of signposts is a lengthy business but the project team should start their work on this at an early stage. Every room in the building should be uniquely identified by a discreet label on the door. This will not only be extremely helpful during commissioning when rooms are being equipped, but it is also the easiest way of describing the location of rooms e.g. on repair requisition slips. The system adopted should identify the room's floor also, for example room 2/31 is room 31 at level 2; room 8/9 is room 9 at level 8. The marking of lift buttons must be consistent with the system - G for ground will have no meaning.

15.13 Staff tea and coffee breaks:
Arrangements should be made which avoid staff moving to a central point for morning and afternoon breaks. Such movement would add an avoidable traffic load to the lifts, section 3.2.10. Also these breaks occur during the busiest times in the clinics' work and we cannot see that the problem of cover for staff away from the department at the height of the clinics' activity morning and afternoon



could be solved satisfactorily. Trolleys taken to clinics and departments are expensive from a staffing point of view and look bad in areas where there are patients. There are no utility rooms in the clinics but it appears to us that the commissioning team will have to consider arrangements which will make possible local beverage preparation. We have considered the application of automatic beverage vending machines; their installation on each floor would certainly provide a trouble-free, always-available service (perhaps for patients too), but at this stage in the contract alterations to provide the necessary services to these machines would clearly be inadvisable. However, it is, we suggest a possibility which might be borne in mind for the future. We would certainly advocate the installation of some automatic machines at level 2 so that beverages would be available during the hours when the buffet is closed.



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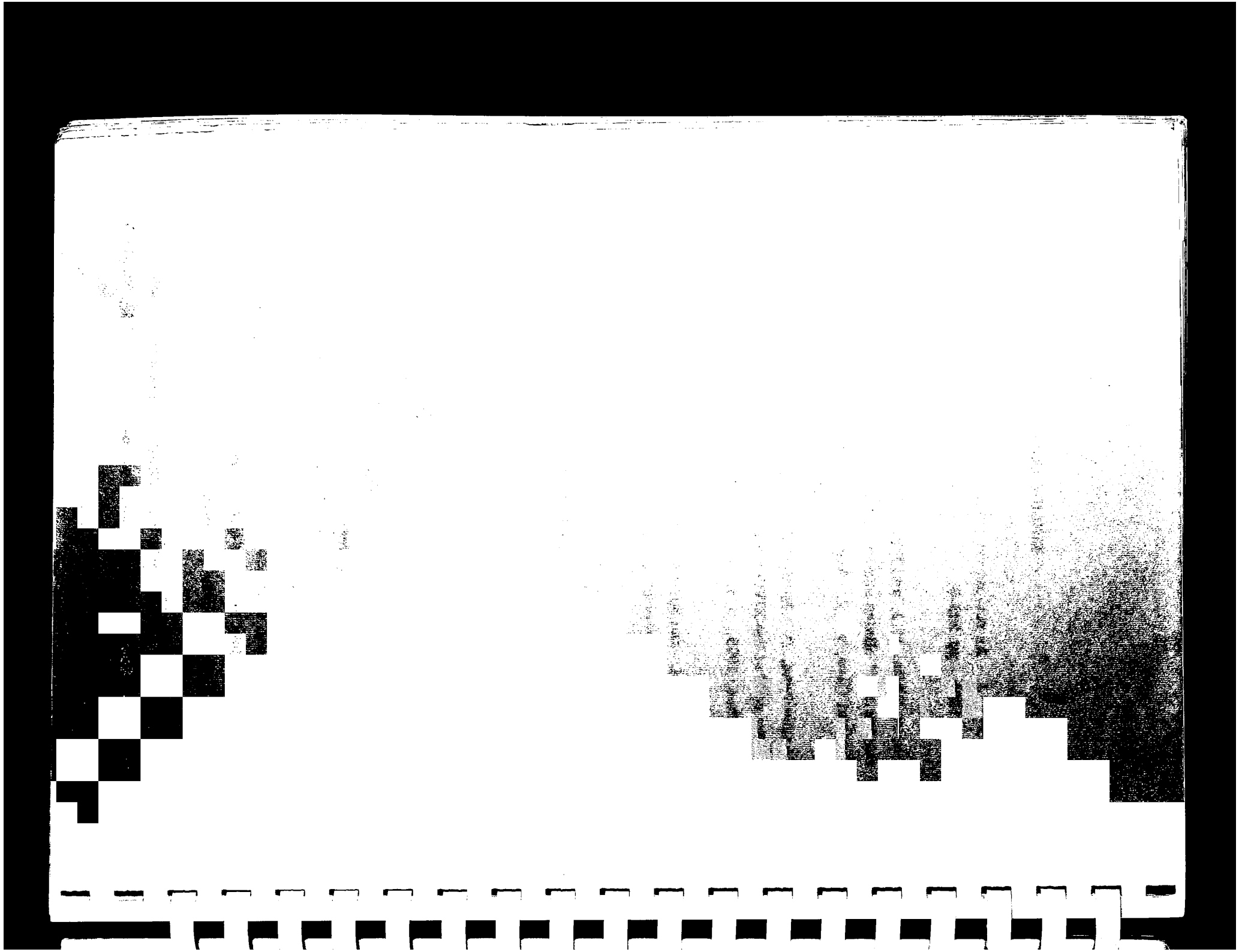

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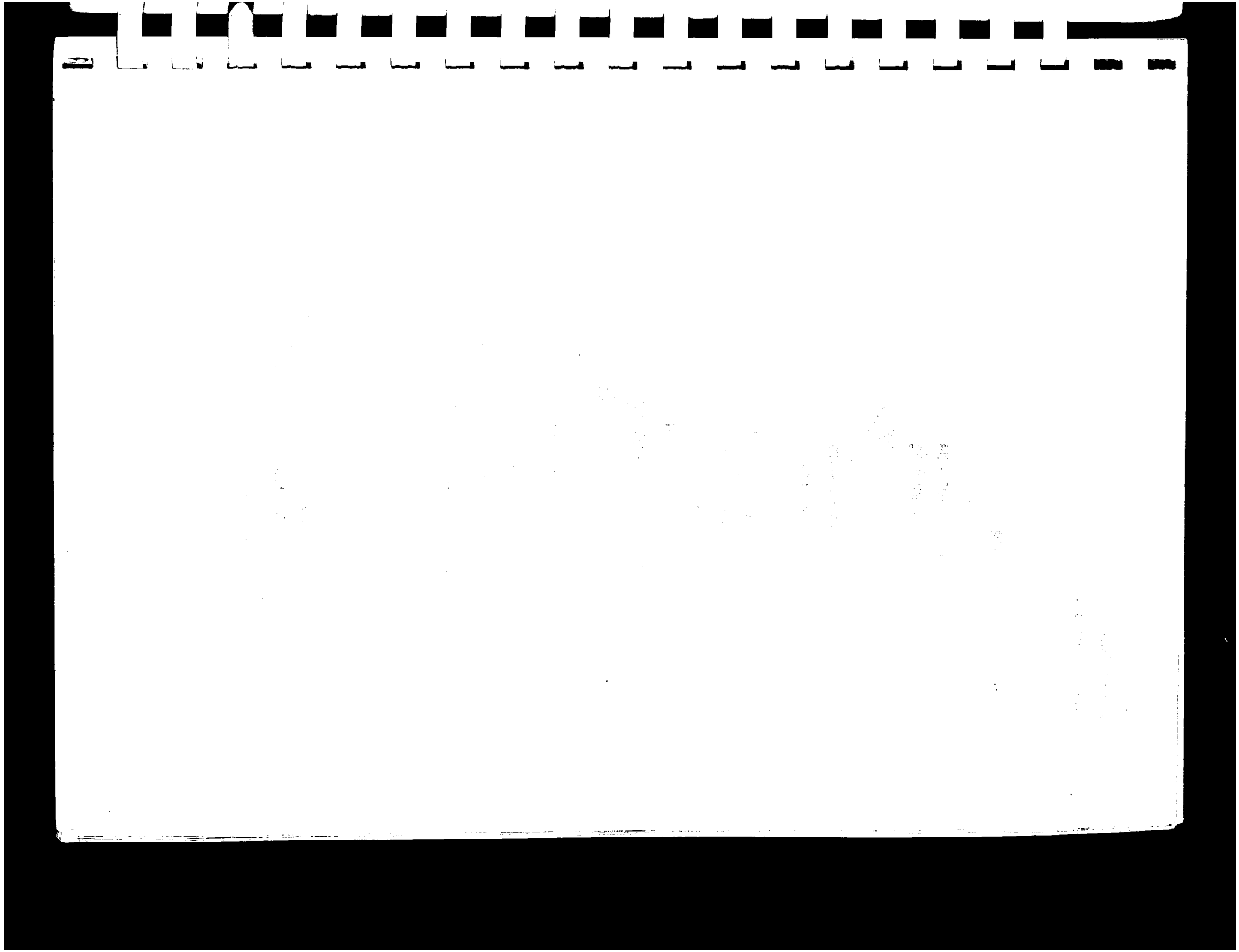

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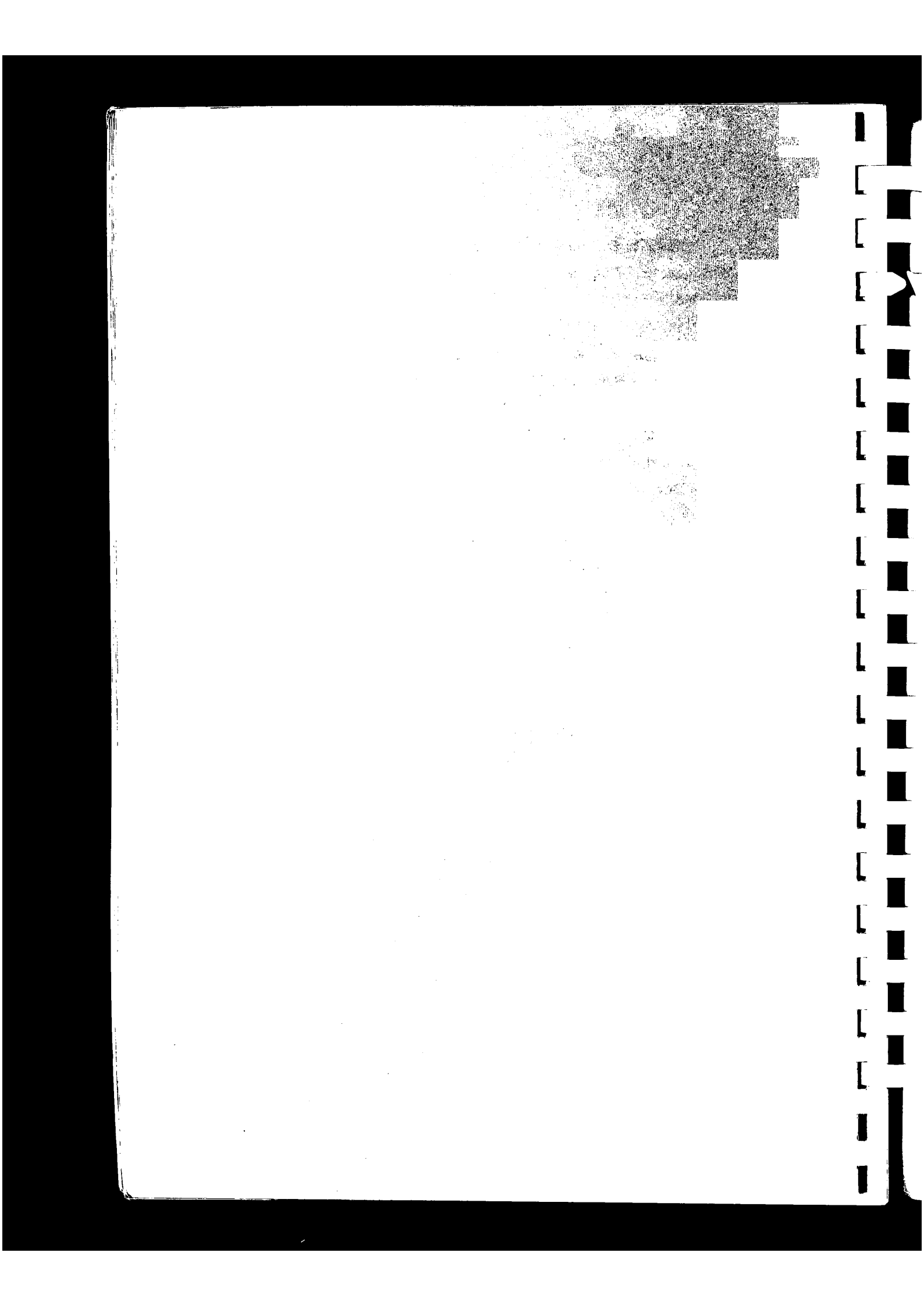
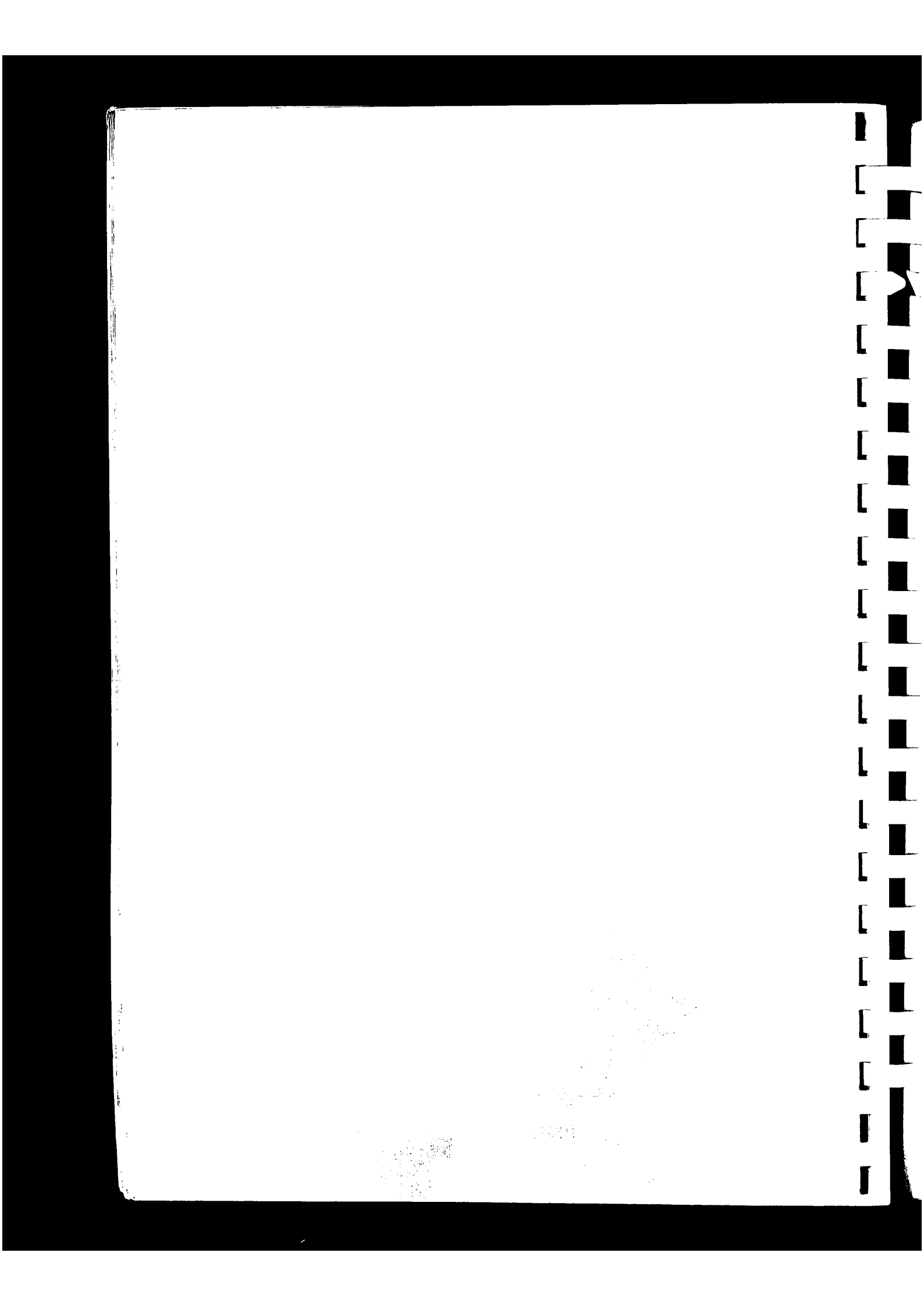


ACKNOWLEDGEMENTS

We wish to express our appreciation to all those who helped us during the preparation of this report. In particular, we would like to thank Mr. R. T. Spence, group secretary, Colonel T. E. Field, group medical superintendent, Miss M. K. Robb, matron and Mrs. J. Easterby, medical records officer. Their friendly co-operation and help during our visits have made our task not only easier but also enjoyable.

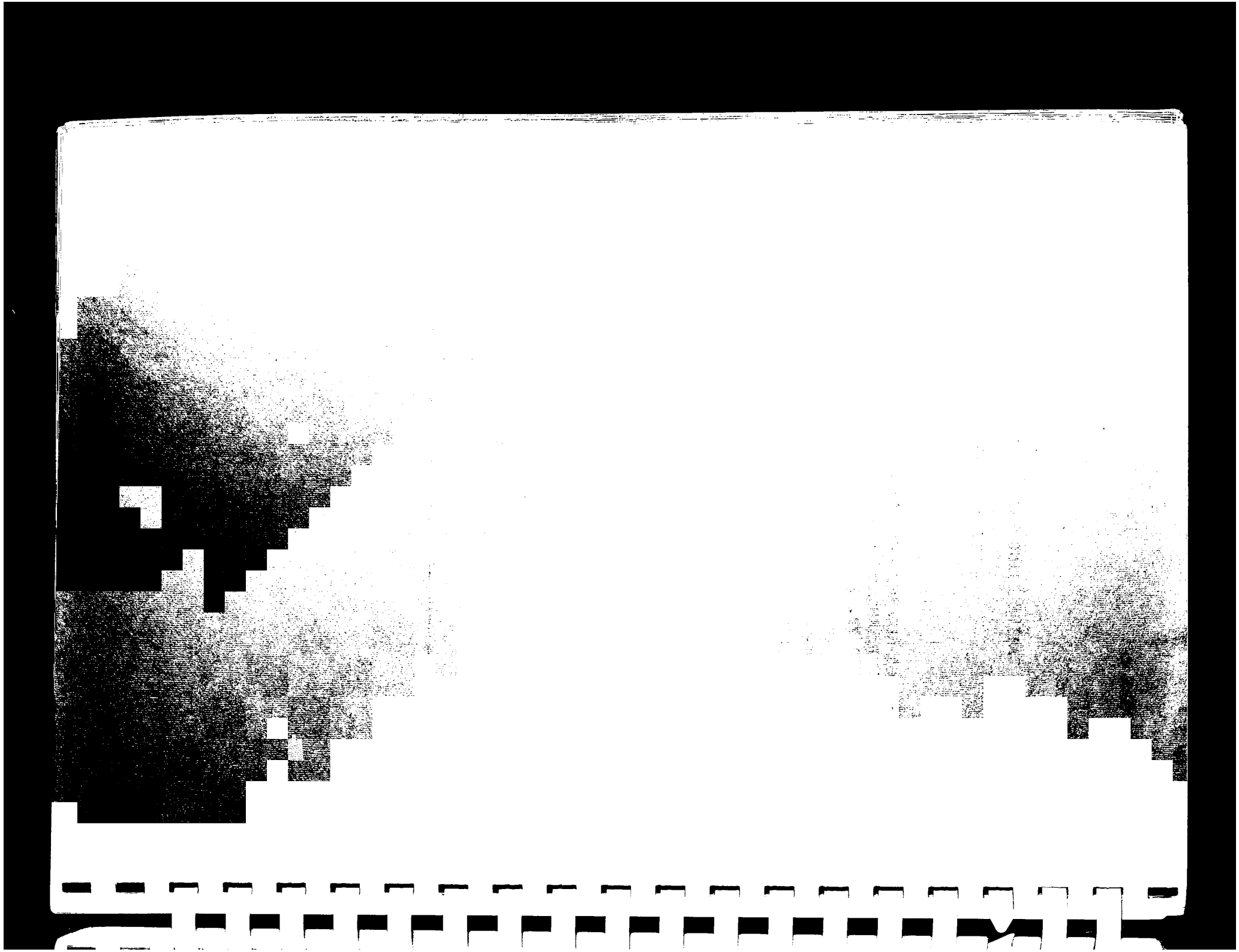


ANALYSIS OF TOTAL OUT-PATIENT ATTENDANCES - 1966

anti-coagulation	5,758
audiometry	5,887
chest	1,558
dermatology	10,788
dietetics	4,040
ECG	5,644
EEG	1,877
ENT	21,542
fracture	18,766
medicine	15,453
surgery	18,344
gynaecology	7,029
hand	308
dental	37,981
hearing aid	11,597
metabolic	23,772
nephrology	693
neurology	2,137
neurosurgery	2,374
ophthalmology	25,539
orthopaedic	8,931
orthoptic	8,415
pernicious anaemia	196
physical medicine - consultations	4,976
physical medicine - treatments	43,273
plastic surgery	2,043
psychiatry	2,358
radiology	67,682
radiotherapy	11,128
rheumatic	3,834
speech therapy	1,142
test meals	307
thoracic	1,334
urology	754
varicose veins	571
venerology	17,851
chiropody	1,143
appliances	2,925
casualty	112,660
	512,610

MAIN CONSULTATIVE CLINICS: DOCTOR SESSIONS and PATIENTS' ATTENDANCES

SPECIALITY	AVERAGE NUMBER OF DOCTOR SESSIONS PER WEEK	AVERAGE NUMBER OF NEW PATIENTS PER WEEK	AVERAGE ATTENDANCES PER WEEK (NEW and RETURN PATIENTS)
dermatology	24	93	250
medicine	35	113	350
metabolic	18	16	266
surgery	34	207	305
ophthalmology	32	112	408
ENT	26	100	474
orthopaedics	10	51	116
gynaecology	9	50	145



MAIN CONSULTATIVE CLINICS

ANALYSIS OF PATIENTS' ATTENDANCES (MAXIMUM FIGURES)

	Monday		Tuesday		Wednesday		Thursday		Friday		Totals
	am	pm	am	pm	am	pm	am	pm	am	pm	
dermatology	82		46		50	27	45	38	20	37	345
medicine	41	40	53	35	47	64	30	59	27	43	439
metabolic			93			16		53	142		304
surgery	49	37	69	12	89	39	73		69	20	457
ophthalmology	86	34	88	33	74	30	76	45	98		564
ENT	73	72	54	71	62		74	88	96	9	599
orthopaedics	41		22		27		31		22		143
gynaecology	22		33				48		48		151

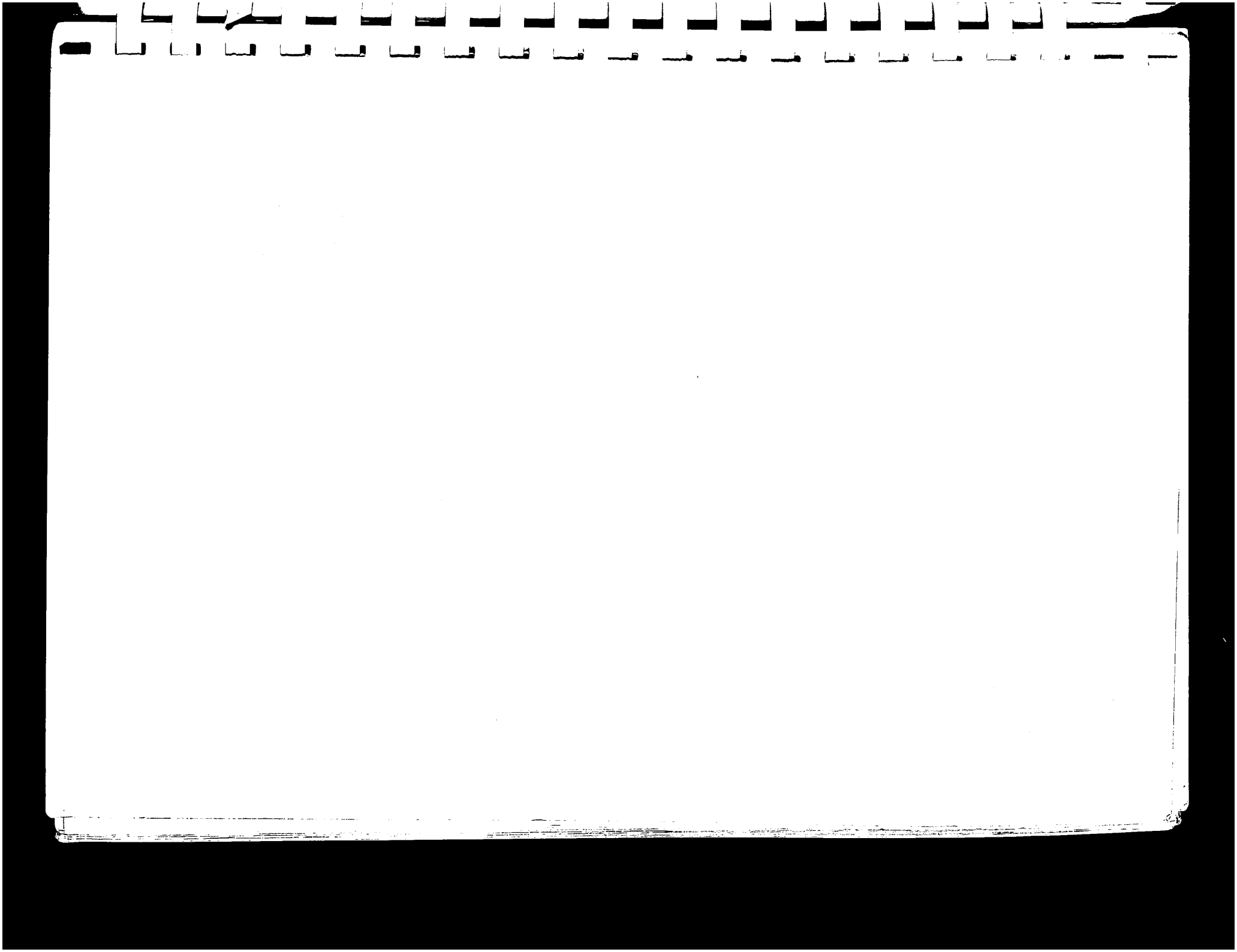
APPENDIX 4

ACCIDENT DEPARTMENT

	Attended		Source				
Date	New	Old	GP	Home Accid.	Road Accid.	Work Accid.	Other
9/1	135	164	33	21	6	31	38
10	128	120	42	11	10	41	24
11	156	116	54	6	5	33	58
12	126	126	24	18	3	37	46
13	181	128	59	16	3	36	67
14/15	177	126	36	18	3	25	95
16	174	146	49	23	5	29	68
17	159	109	48	21	8	35	47
18	146	109	50	5	3	31	57
19	145	111	31	18	10	28	64
20	153	139	47	16	9	28	53
21	151	104	23	11	5	18	94
22	107	28	10	14	6	7	70
23	196	169	77	6	7	26	80
24	159	117	51	4	2	38	64
25	151	107	49	10	7	31	54
26	133	118	33	5	6	37	52
27	169	117	57	16	6	33	57
28	139	103	29	18	9	14	69
29	104	36	9	23	4	11	57
30	187	163	62	12	8	41	55
31	160	133	59	4	1	44	52
1/2	137	117	39	9	5	32	52
2	159	108	58	6	6	35	54
3	176	133	53	12	15	37	59
4	170	82	30	21	12	23	84
Totals	3978	3029	1112	344	164	781	1570

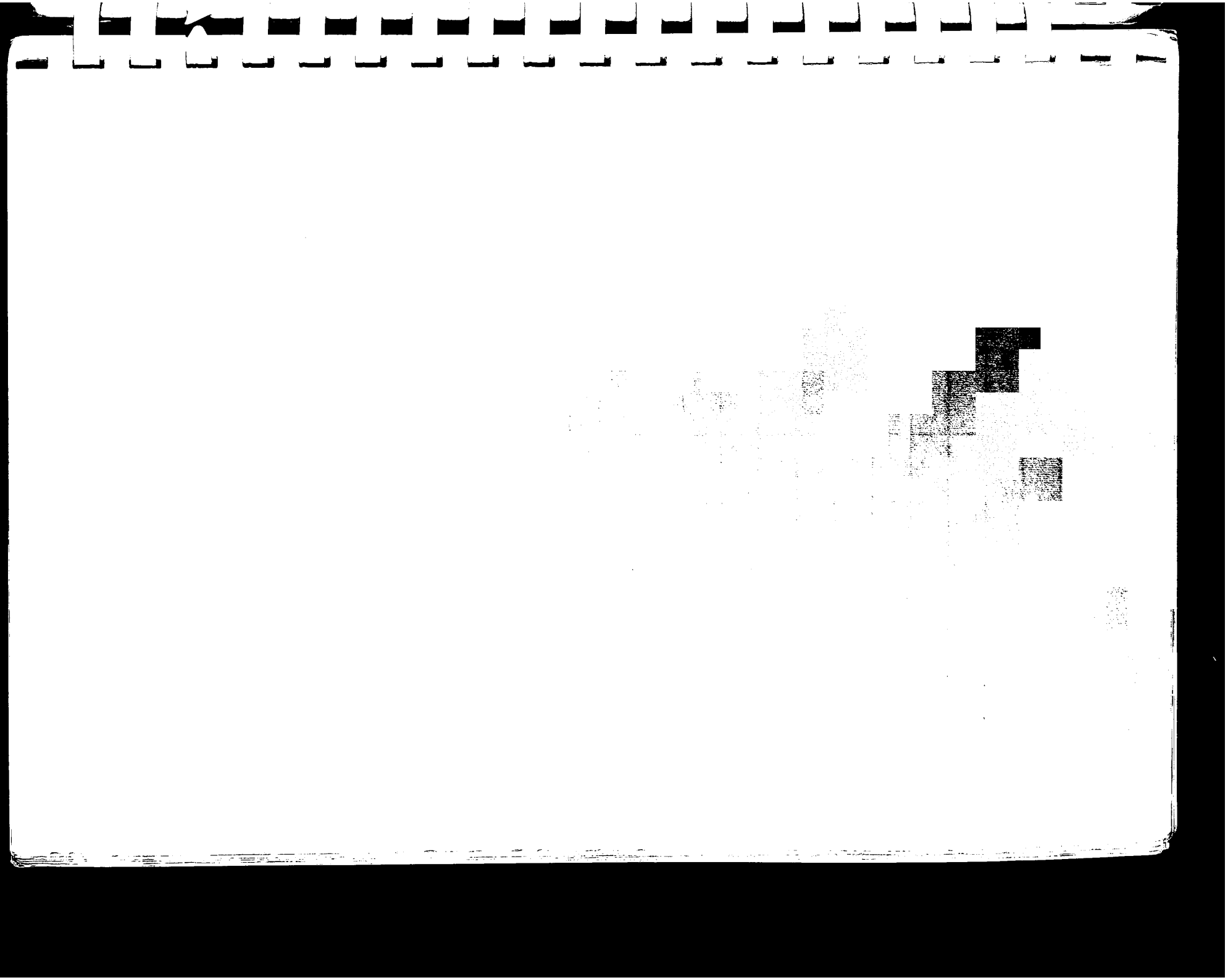
PATIENTS' ATTENDANCES DURING 28-DAY PERIOD

Disposal					Arrived by			
Home	GP	Fracture	OPD	Admit	Foot	Public Transport	Private Transport	Ambulance
163	2	10	20	8	61	133	75	15
208	10	3	14	16	37	114	70	27
206	11	15	29	26	47	102	89	29
218	5	6	20	9	45	107	74	26
252	7	14	27	22	69	123	83	34
251	11	7	16	24	60	125	93	26
267	11	12	20	22	72	139	73	36
224	3	9	24	16	47	132	75	19
207	11	12	23	14	50	133	53	19
210	4	11	20	20	53	97	79	27
241	10	8	20	21	56	107	94	35
227	-	3	9	16	51	106	80	18
109	1	6	12	13	34	37	52	12
306	6	14	35	18	58	163	110	34
223	9	13	25	18	50	127	68	31
218	5	6	15	18	61	85	84	28
212	8	9	20	11	51	116	64	20
253	7	4	9	17	44	121	88	33
175	4	13	29	24	36	99	82	25
114	3	7	9	19	19	44	65	12
282	17	10	29	22	56	166	96	32
256	4	8	16	17	58	126	93	16
212	8	11	21	13	49	119	65	21
196	5	11	38	28	36	111	93	27
261	8	6	18	20	40	151	80	38
207	9	11	11	23	34	109	83	26
5698	179	239	529	475	1274	2992	2061	666



NUMBER OF PATIENTS REFERRED FROM CONSULTATIVE CLINICS TO MAIN X-RAY DEPARTMENT DURING 28-DAY PERIOD

CLINIC	Weeks	BY APPOINTMENT		FOR IMMEDIATE X-RAY	
		9 am - 5.15 pm mon. - Fri. 9 am - 12.30 pm Sat.	5.15 pm - 9 am Mon. - Fri. 12.30 pm Sat. - 9 am Mon.	9 am - 5.15 pm Mon. - Fri. 9 am - 12.30 pm Sat.	5.15 pm - 9 am Mon. - Fri. 12.30 pm Sat. - 9 am Mon.
Medical	1	52		122	5
	2	50		125	4
	3	61		101	6
	4	43		104	6
		206		452	21
Surgical	1	50		23	
	2	53		40	
	3	48		46	
	4	64		40	
		215		149	
Gynaecology	1 - 4	12		14	
ENT	1	)		45	)
	2	)		63	)
	3	) 21		52	) 11
	4	)		46	)
				206	
Ophthalmic	1 - 4	1		27	8
Metabolic	1 - 4	8		55	
Special	1 - 4	2		13	
Skin	1 - 4	-		11	
Thoracic	1 - 4	7		18	
Therapeutics	1 - 4	1		6	
Dept. of Surgery	1 - 4	9		4	
Urology	1 - 4	31		16	
Nephrology	1 - 4	9		25	
Rheumatic	1 - 4	5		96	



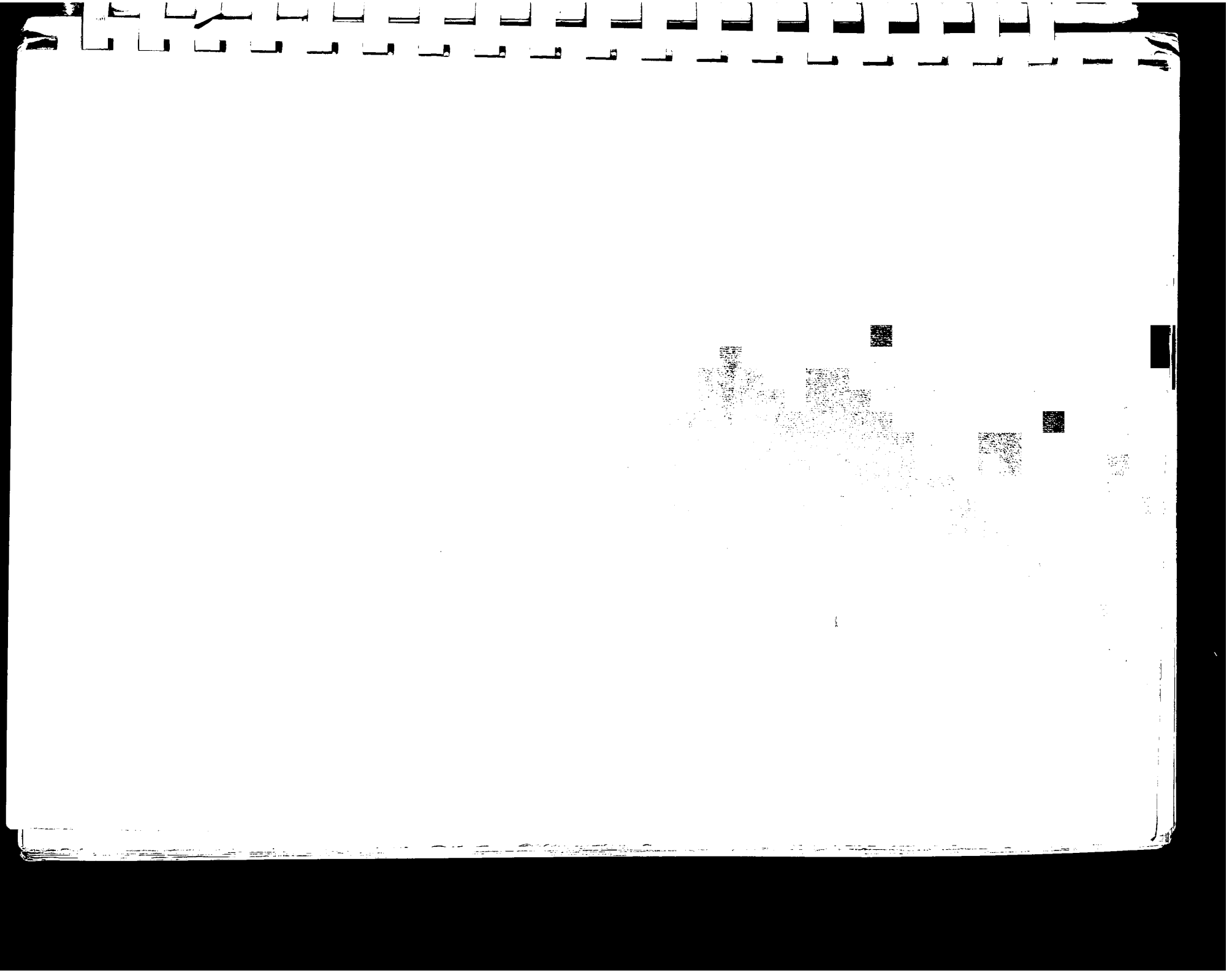
CLINIC	Weeks	BY APPOINTMENT		FOR IMMEDIATE X-RAY	
		9 am - 5.15 pm Mon. - Fri. 9 am - 12.30 pm Sat.	5.15 pm - 9 am Mon. - Fri. 12.30 pm Sat. - 9 am Mon.	9 am - 5.15 pm Mon. - Fri. 9 am - 12.30 pm Sat.	5.15 pm - 9 am Mon. - Fri. 12.30 pm Sat. - 9 am Mon.
Radiotherapy	1 - 4	5		81	
Chest	1 - 4	1		63	
DPM	1 - 4	-		19	
		533		1296	

SUMMARY

No. of patients referred from OP clinics:	by appointment	533*		
	immediate	1296†	1829	
No. of patients referred from elsewhere:	by appointment	89		
	immediate	111	200	2029

* of these 421 were med./surg. patients

† of these 622 were med./surg. patients



NUMBER OF PATIENTS REFERRED FROM ACCIDENT AND FRACTURE DEPARTMENT TO CASUALTY AND MAIN X-RAY DEPARTMENTS DURING 28-DAY PERIOD

			To make appointments Totals	Immediate X-Ray Totals
Casualty and fracture departments (9 am to 5 pm Monday to Friday and 9 am to 12.30 pm Saturday)	Fracture X-ray	Week 1		208
		Week 2		192
		Week 3		174
		Week 4		180
				754
	Small casualty X-Ray	Week 1		190
		Week 2		193
		Week 3		181
		Week 4		170
				734
	Main casualty X-Ray	Week 1		128
		Week 2		118
		Week 3		128
		Week 4		106
				480
	Main department X-Ray	Week 1	8	27
		Week 2	4	23
		Week 3	6	19
		Week 4	3	24
			21	93
(5.15 pm to 9 am Monday to Friday and 12.30 pm Saturday to 9 am Monday)	Main department X-Ray	Week 1		277
		Week 2		252
		Week 3		289
		Week 4		296
				1114

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