The reception and welfare of in-patients at hospitals / report by the Standing Advisory Committee on Hospital and Specialist Services.

DEPARTMENT OF HEALTH FOR SCOTLAND

SCOTTISH HEALTH SERVICES COUNCIL

The Reception and Welfare of In-Patients at Hospitals

Report by the Standing Advisory Committee on Hospital and Specialist Services

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STANDING ADVISORY COMMITTEE ON HOSPITAL AND SPECIALIST SERVICES

Report on Reception and Welfare of In-Patients at Hospitals

I. INTRODUCTION

1. In December, 1949, the Committee set up a Sub-committee with the following remit:—

"To consider arrangements at hospitals in the National Health Service for the reception and welfare of in-patients and to report thereon with recommendations to the Standing Advisory Committee on Hospital and Specialist Services."

The members of the Sub-committee were

Captain J. Steel (Chairman)—Chairman, Board of Management for Crichton Royal, Dumfries.

Lady Broun Lindsay—Chairman, Board of Management for East Lothian Hospitals.

T. Bryson, Esq., M.B., Ch.B., Medical Superintendent, Glasgow Royal Infirmary.

Miss Helen I. J. Chalmers, B.Sc., A.M.I.A., Head Almoner, Aberdeen Royal Infirmary.

Dr. M. Esslemont, M.A., B.Sc., M.B., Ch.B., D.P.H., General Practitioner in Aberdeen.

W. F. Ferguson, Esq., F.H.A., Secretary and Treasurer, Board of Management for the Royal Infirmary of Edinburgh and Associated Hospitals.

Miss E. G. Manners, R.G.N., S.C.M., Matron, Glasgow Royal Infirmary.

Miss Eleanor Stewart, M.B.E., J.P., Member of Board of Management for Glasgow Maternity and Women's Hospitals.

Miss M. O. Robinson of the Department of Health attended meetings by invitation of the Sub-Committee, and Mr. J. B. Hume of the Department acted as Secretary.

The following Report is almost entirely the work of the Sub-Committee since their Report was accepted by the Standing Advisory Committee with only very minor modifications.

2. It was clearly impossible to visit every hospital in the National Health Service in Scotland, and unsatisfactory to ask them all to send written descriptions of the arrangements for the patients' welfare. Accordingly, the Sub-Committee resolved that consideration of existing arrangements and any recommendations they might have to offer should be based on

(*a*) visits to a sample number of hospitals of different types in different parts of the country;

(*b*) evidence from a number of professional Associations;

(*c*) their own experience of different aspects of hospital administration.

3. Hospitals were visited by members normally in groups of two or three and the following types were included—General (both in cities and less populous areas), Maternity, Tuberculosis, Mental, Infectious Diseases, Children's Hospitals. We are grateful to the Boards of Management for the facilities which were granted, and for the helpful way in which enquiries were answered.

4. We are also indebted to the following Associations for the valuable statements they gave in reply to a series of questions about welfare arrangements in hospitals and possible lines of improvement:—

The Institute of Almoners
The Medical Superintendents' Society (Scottish Branch)
Scottish Matrons' Association
The Royal College of Nursing (Scottish Board) (Ward and Departmental Sisters' Groups)
The Tuberculosis Society of Scotland
The British Medical Association (Scottish Committee)
The Scottish Association of Occupational Therapists.

In the absence of any body representing Chaplains in hospitals the Sub-Committee also received a Memorandum from the Chaplain of Edinburgh Royal Infirmary.

5. We recognise that financial or other considerations may make it difficult for some of our recommendations to be put into effect at once. Only a minority of our recommendations, however, involve additional expenditure on any appreciable scale. The others either require no expenditure at all or alterations in the objects of existing expenditure. We have not in general judged it part of our task to consider how far and in what circumstances the cost of particular items should be borne by the patient, normal hospital running costs or endowment funds—though in most cases the responsibility seems fairly clear. *There is a great deal which can be done immediately to improve arrangements for patients' welfare without the expenditure of a single additional penny, and we see no reason why financial stringency should prevent the carrying out of most of our recommendations if they are accepted.*

II. GENERAL

6. The Hospital Service is one of the very few organisations which have to care for their clients for 24 hours each day.

A newsagent is efficient according to whether he provides his customers with newspapers they require: a restaurateur is a good restaurateur in so far as he offers good food in pleasant surroundings. Neither is concerned with providing for more than a strictly limited part of his customers' mental or material needs, since in a few minutes the customer is gone and his other needs are met elsewhere. A hospital, too, may seem to be concerned with only part of a man's life—the care and repair of his body—but the discharge of this duty requires the patient to live, move (if at all) and have his whole being in the hospital. Hospitals have therefore a responsibility for people as people in addition to the immediate responsibility of dealing with the bodily ailment which is the cause of the patients' presence in hospital.

7. This is easily forgotten since, apart altogether from the presence of many patients who are too ill to be concerned about anything else, there is a natural, and to a large extent commendable, tendency for hospitals to " get on with the job," concentrate on restoring the patient's bodily health and see him back to normal life again. Such an attitude, however, fails to recognise that most patients cannot and should not, after entering hospital, cease to be people with personalities, needs and interests of their own and become merely bodies. It results in a tendency to treat people merely as cases, and identify the patient only as " the duodenal in the first bed on the left." To distinguish between hospitals which care for people and those which deal with cases is not merely to play with words: it is to recognise a profound difference in the whole atmosphere of the two, which can be very apparent and of great importance to the patient.

8. We have not sought to define " welfare " and have understood our task to be the consideration of how hospitals should cater for the ordinary human needs of patients apart from the question of medical care. Although there is often a connection between a patient's physical condition and his general welfare, as for example when he is worried by personal or domestic problems, we have not sought to deal in any way with welfare as a factor in clinical treatment. The " ordinary human needs " which we have in mind are set out in the sections which follow.

III. INFORMATION FOR PATIENTS

9. People respond to directions and instructions much better if they are given full information about what they have to do and the reasons for doing it. Such a policy induces their more active co-operation, and also recognises something of the dignity of human personality. How far is it followed in our hospitals to-day?

Information before entry

10. Very few hospitals seem to offer any written information to patients before they arrive in the wards. In emergency cases only very brief verbal instructions can often be given, and in the widely varying circumstances at different hospitals it is impossible to have any general plan which can be applied everywhere. We consider it of great importance, however, particularly in cases where the patient receives advance notice that he is to go into hospital, that full information in writing should be given about what he and his relatives should do.

11. Where a patient is put on a waiting list for entry to hospital, it seems best to let him have as soon as possible a letter in informal and personal terms giving all the necessary information. When a bed is available a post-card could give instructions about time and place of arrival. There may be cases in which the two can be combined. Information on the following points should be included:—

(*a*) *What the patient should bring with him:*—

(i) Whether toilet requisites, pyjamas, etc., are required:

(ii) What forms and documents are needed (e.g., ration books; medical insurance card; identity card).

(*b*) *The procedure for admission:*—

Where the hospital is situated; what trams or buses pass nearby; where the patient should report; the circumstances under which travelling expenses can be paid or transport provided.

(*c*) *The disposal of out-door clothes and blankets:*—

Whether clothes may be kept at the hospital; if not, whether a relative or friend should accompany the patient and bring a suitcase in which to take away clothes or blankets; any other means of disposal.

(*d*) *Money and valuables:*—

How much should be brought; what opportunities there are within the hospital for safe custody.

(*e*) *Visiting arrangements:*—

At what hours visitors are allowed; how many may come at once; whether cards are necessary; whether children are allowed; canteen arrangements for visitors, if available.

(*f*) *Address:*—

Number of ward; address and telephone number of hospital.

(*g*) *National Insurance certificates:*—
Arrangements for issue to patients in hospital.

(*h*) *Enquiry about patient's condition:*—
To whom enquirers may write; at what times and in what circumstances it is convenient to telephone the ward.

12. In certain circumstances, it might not be possible to give all this information in the preliminary letter. Some information under (*f*), for example, might have to be left to the final postcard. *It is very important that patients should preserve the letter carefully until they are admitted to hospital, and should show it to relatives, since much of the information is as important for them as for the patient.*

INFORMATION AFTER ENTRY

13. Most patients when they arrive in hospital for the first time find it a formidable and bewildering institution. Even a preliminary letter as proposed above does not tell them much about hospital routine or procedure. An explanation of this, along with points of importance for his welfare, could form the subject of a short brochure or leaflet containing:—

(*a*) A short description of the function of the hospital, and the part it plays, and has played, in the life of the community. This, if well produced, might do something to persuade the patient that although he has temporarily forsaken the fellowship of home and employment, he is being looked after, not by an impersonal machine, but by a group of people with a tradition of service behind them. His stay will be all the more pleasant if he can let himself become part of this new fellowship, and accept its outlook and methods.

(*b*) An explanation of hospital routine—why beds are made so often; why he is wakened so early in the morning when there is nothing to do all day but lie in bed.

(*c*) Meal times.

(*d*) What the almoner can do to help the patient; when she can be seen.

(*e*) Welfare arrangements.
(i) When library books come round; what types are available.
(ii) If and when newspapers are delivered and magazines distributed.

(*f*) The names of the chaplains of different denominations who offer their services to the hospital; how the patient can get in touch with a chaplain if he wishes to do so; the times and places where services of different denominations are held.

(*g*) Rules about smoking in wards.

(*h*) Arrangements for the collection and delivery of mail.

(*i*) Reasons why visiting periods and the number of visitors must be limited.

14. In addition, patients who were admitted as emergency cases and who did not have a letter as in paragraph 11 above, should be given a copy since much of its information is important to them and their relatives.

15. We cannot stress too much the importance of giving the patient as much information as possible about life in the hospital. It helps him to adjust himself to the new conditions under which he must live; it lessens the number of enquiries of the nursing staff; and it makes patients feel that they are still people with human needs and interests, not merely cases requiring medical attention.

IV. RECEPTION ARRANGEMENTS

16. First impressions often remain with a patient after later ones have gone. It makes a great difference at a time when his morale is not normally at its

highest if he is greeted in a friendly fashion when he arrives at hospital. If he is kept waiting aimlessly in cheerless corridors an unfortunate impression is created which will be difficult to erase, no matter how excellent the subsequent attention in the wards; and the best administrative arrangements for dealing with the arrival of patients may be marred if impersonal efficiency has no room for sympathy and understanding. The following are some practical suggestions for dealing with the arrival of patients, but perhaps none is so important as the obligation on all staff who deal with them to show something of the milk of human kindness.

17. Emergency admissions

Hospitals have, because of differences in function, tradition and structure, a variety of methods for dealing with emergency cases. We are concerned here only with the desirability that the patient's feelings should be looked after as well as his body.

(*a*) There is considerable advantage in having a separate department where emergency patients can be taken on admission and for preparation for an operation, if necessary. It is often undesirable that a patient about to have an operation should be in close contact with other patients who may unwittingly promote unnecessary alarm. If a separate emergency ward is provided, patients in the ordinary wards are not disturbed by the arrival of emergency patients, and the latter cannot feel so " lost " as they may be in the busy routine of a large one.

(*b*) Relatives arriving with patients often have to wait for some time. They and the hospital authorities would find it convenient if canteen and waiting accommodation could be provided. The nursing staff should make a special point of speaking to the relatives and trying to answer their questions.

(*c*) Every effort should be made to deal quickly with patients and not have them lying for long periods without explanation and, apparently, without anyone being concerned about them.

18. Non-emergency admissions

(*a*) It is important that the patient should have as much notice as possible of the date of his admission to hospital. This is dependent on the hospital staff giving adequate notice of the other patients' discharge, and it seems there might be much more attention paid to this responsibility. Inevitably, there are personal matters to be attended to and it is indefensible not to give notice at the earliest possible date.

(*b*) So far as large hospitals are concerned, patients on arrival should not have to report at the out-patient department. We attach the utmost importance to the personality and suitability of the person who first receives the patient.

(*c*) Large hospitals confuse one's sense of direction. This confusion can be lessened by adequate sign-posting and indicators, and there is room for considerable improvement in this respect at most hospitals.

(*d*) In some hospitals lifts are at present available which are not for the use of patients. It seems unfortunate that such services should be denied, especially to old people, and where lifts are installed patients should have the use of them if at all possible.

(*e*) There is much to be said for having a side room or other suitable accommodation attached to the ward, and under the care of staff from the ward, in which to accommodate patients who are seriously ill, or are awaiting or recovering from an operation.

(*f*) The times of patients' arrival should be chosen so that there will be as little delay as possible in dealing with them, and if necessary, should be phased. At the ward a senior member of the nursing staff should deal with the patient and arrange for his settling down.

V. ENQUIRIES ABOUT THE CONDITION OF PATIENTS

19. Relatives and other persons concerned are naturally anxious to know how patients are progressing. It is important that they be given as much information as possible, having regard to any expressed wishes of the patient. Although it may seem on occasion an unnecessary interruption of hospital routine, all staff, both medical and nursing, should try to deal with these natural anxieties considerately and sympathetically.

20. Enquiries may be made in several ways.

(*a*) By Telephone

If the initial letter sent to patients and seen by relatives makes it clear when telephone enquiries may be made and to whom they should be made, there should be little difficulty in dealing with them. We do not approve of the arrangement at some hospitals by which an operator at the central telephone exchange, equipped with a bulletin showing the condition of patients, deals with calls of this sort, since there is inevitably an impersonal quality in any information which can be given in this way. It is much better that enquirers should be able to speak to those who are actually looking after the patient, and thus feel that they are in touch with someone who knows the position at first hand. Normally, the sister-in-charge or her deputy should reply. The character of her reply can do much to make or mar happy relations between relatives and the hospital.

The situation of the telephone in the ward is important. It should be placed so that conversation cannot be overheard, and nurses may speak in complete privacy without embarrassment.

(*b*) By Letter

Few enquiries are made by letter to hospitals, but it seems best that on these occasions the reply should be signed by a member of the medical staff.

(*c*) By Interview

Visitors are often anxious to speak to some member of the staff during visiting hours, and most hospitals do have an arrangement whereby this can be done. We think it should be general, and that it should be made clear to visitors, how, where and when these interviews can be arranged. Normally, the sister should conduct the interview, but in certain cases it may be necessary for this duty to be undertaken by a doctor.

21. We would again emphasise how important it is that the desire to help should be quite evident in the manner in which staff deal with enquiries. Patients are not part of hospital property with which the public have no concern: most of them matter supremely in the life of someone outside.

VI. ALMONERS

22. The work of almoners in hospital is very closely related to the welfare of patients. Almoners are not only concerned with the patient's physical condition but with his whole personality. Patients in hospital are often incapable themselves of dealing directly with a variety of problems arising from their absence from home and work. Such personal problems—the care of dependants, financial worries, what happens to his job when he is in hospital, and so on—may make the patient restless and worried, and the almoner can do much to help.

23. It seems on the whole that more could be done in hospitals generally to make almoners' services available to patients. There is, of course, a shortage of almoners, but there does seem to be some evidence that they have been employed on work which might, perhaps, be more appropriate to the administrative staffs. In small hospitals there is often no means by which patients can see an almoner, and though it is clearly impossible for each hospital to have an almoner on the staff, there could, we suggest, be arrangements whereby an almoner is attached to a group of hospitals. In brief, we consider that every patient in the National Health Service in Scotland should have some means of having the help of an almoner if desired.

24. Patients are often reluctant to discuss private matters with an almoner when they may be overheard by other patients in the ward. Cramped conditions in hospitals at present make it very difficult to obtain the kind of privacy which is necessary, but we urge that all hospitals ensure somehow that patients are able to speak to almoners freely and without embarrassment.

VII. VISITING HOURS

25. Visiting hours are not merely an interruption of hospital routine. They are a means by which the patient is kept in touch with the world which he knows and understands, and make it easier for him to fit into it on his return. Above all, contact with his friends and relatives helps to brighten the days.

26. With this in mind, we have considered the question in some detail, and from examination of visiting hours, at a number of hospitals, have come to the conclusion that they are sometimes inadequate. In general it seems that short and frequent visiting-periods are most satisfactory since patients often find it tiring to speak or listen to visitors for a long period, while they would welcome it for a short while. It is not possible to lay down general rules, and local circumstances—including particularly the local half-day holiday—will to a large extent determine the pattern adopted, but the general aim should be to give patients the opportunity of having a visitor sometime each day.

27. In large centres of population frequent visits of short duration seem quite practicable. It would be advisable, however, to have at least one longer visit each week to cater for those visitors who have to travel long distances. In less populated areas, where a greater proportion of visitors have long journeys to hospital, the visiting periods should perhaps be longer and fewer. Provision should also be made—especially in more populous centres—for some visiting periods to be held in the evening in order to help visitors who cannot get off work during the day. If possible, these visits should be in addition to and not in substitution for afternoon visits.

28. Normally, there should be two chairs at each patient's bedside: two visitors seem, in our view rightly, to be the normal quota, and it should not be necessary for one of them to sit on the bed. If possible, a type of chair should be used which can be stacked conveniently when not in use.

29. In some hospitals it seems that child visitors are discouraged either because they tend to disturb the quiet of the ward or because they may be carriers of infection. Other hospitals, however, do not recognise these as valid reasons why children should not visit their parents, and we see no reason (except in sanatoria where children should not be subjected to infection from open tuberculosis, and of course I.D. hospitals) why any hospital should make such a bar. Parents will naturally wish to see their children and preserve contact with them.

30. In children's wards it seems to be the general practice that visits should be infrequent, since there is often emotional disturbance in the child after the

parents' visits. On the other hand, it has been observed that if the visits are too seldom, the children lose touch with the parents and readjustment to parental control may be difficult. On balance, although not ignoring the possibility of infection, we feel that visits of parents and others to children's wards should be more frequent than in general they have tended to be.

31. Patients who are dangerously ill may have visitors at any time and a special problem arises when relatives have to attend the hospital for fairly long periods at irregular hours. Provision for their comfort during long waits is difficult with the present restricted accommodation, but the staff should try to ensure that they are made comfortable in accommodation as near the ward as possible during their periods of waiting.

32. In many cases patients who would welcome a visitor have none either because they have no friends or relatives or because their potential visitors are too far away to be present at every visiting period. The fact that these patients cannot have visitors as often as they would like is, however, no reason why other patients should not be able to see their friends as frequently as possible, and visiting hours should not be restricted on this account. Patients without visitors of their own might be visited by members of local welfare societies who can in this way do much to preserve the voluntary spirit in hospitals.

33. Whatever the arrangements for visiting periods, hospitals should be prepared to make exceptions in exceptional circumstances.

VIII. SUPPLY OF BOOKS AND NEWSPAPERS

34. Time may be the great healer but most patients would wish his work were done more quickly. One of the best means of helping them to overcome monotony is to ensure a supply of books, magazines and newspapers.

35. BOOKS. At present hospitals have a great variety of ways, some good, some not so good, of providing books for patients. The arrangements which are adopted will no doubt depend on the local facilities but there seems no reason why each hospital should not, by one or more of the following means, ensure that a good supply of books of all types is available for patients:—

(*a*) arrangements with local authority libraries;

(*b*) arrangements with voluntary organisations who are prepared to organise libraries in hospitals;

(*c*) hospitals themselves can accumulate libraries. The general practice seems to be that the chaplain, a member of the clerical staff or a patient looks after the care and distribution of the books.

Hospital libraries should not consist merely of books which someone else has discarded.

36. NEWSPAPERS. Normally, agents are allowed to sell papers in the wards and this seems to be the most satisfactory method of enabling patients to buy the morning and evening papers they prefer. In sanatoria and I.D. hospitals where this method is not practicable it may be necessary for the hospitals to collect orders (and cash) from the patients and themselves buy the newspapers.

37. MAGAZINES. In the past large numbers of magazines were sent to hospitals, both by individuals and societies, but it appears that since the inception of the National Health Service this supply has fallen substantially. Hospitals should let it be known to those who have been in the habit of supplying magazines that the need is still as great as ever, and that they would welcome gifts of magazines of all kinds in good condition.

IX. FACILITIES FOR UP-PATIENTS

38. How much special provision need be made for up-patients depends largely on the type of hospital. In general hospitals the need is perhaps not great, but even they may have up-patients of two distinct types—

(*a*) those who are at the convalescent stage but who must remain in the hospital either because of the treatment required or because there is no convalescent home available;

(*b*) those who are able to get up but are not yet convalescent.

39. Wards are designed primarily for the needs of those in bed, and up-patients may often be an embarrassment. It is clearly preferable that separate adequately heated sitting-rooms should be provided where they can have greater comfort and be out of the way of staff attending to patients in bed. This may not be possible in present circumstances, but the provision of small comfortable armchairs in the wards is an immediate requirement well within the bounds of possibility.

40. In two types of hospital the question of providing for up-patients is very important:—

(*a*) SANATORIA. Generally speaking conditions seem to fall short of what might be hoped.

With imagination and sympathy all kinds of things can be done to keep patients active and contented. They can be encouraged themselves to organise a social and recreational committee responsible for running activities such as billiards, bowls and darts (and even a hospital magazine) indoors, and putting greens and bowling greens outdoors. In this way patients should assume responsibility for helping each other, but the capital equipment for such activities must be provided by the hospital.

In addition there should be lounges and a hall in which shows and meetings can be held. Patients whose treatment is sufficiently far advanced are sometimes allowed to go outside the hospital, either individually or in organised parties. It is important that long-stay patients should have such opportunities of keeping in touch with the world outside the hospital, and we recommend the granting of such opportunities in suitable cases where this is not at present done.

(*b*) MENTAL HOSPITALS. Some mental hospitals have provision for recreation very highly developed on lines similar to what is suggested above. At others, however, there is scope for considerable improvement. It is a common practice that mental patients should be encouraged to take part in the work of hospital and, provided it is appropriate to the patient's condition and there is no suspicion of exploitation, it seems very satisfactory.

41. At all hospitals where there is a substantial number of up-patients, a canteen—which can be self-supporting—is a very desirable and popular amenity.

X. CHAPLAINS

42. Chaplains can play a very important part in helping patients, since they are concerned with the patient as a whole personality with requirements and interests other than the immediate material needs which brought him into hospital.

43. Memoranda R.H.B. (S) (48) 33 and R.H.B. (S) (50) 13 made provision for the appointment of chaplains to hospitals and it ought to be possible for all patients to call upon the chaplain of his own denomination when he wishes. The extent of a chaplain's work in a hospital will, of course, depend on the scope of his appointment, but especially in large hospitals where a full-time chaplain is appointed he will be able to have a general interest in all aspects of the patient's welfare.

44. It has been suggested to us by the British Medical Association that there might be more co-operation than there is at present between chaplain and doctor in the clinical treatment of patients. This is perhaps not strictly within the remit, but we advance it as useful evidence of how factors other than the purely biological are important in the treatment of patients.

XI. WARD FURNISHINGS

45. Hospital staffs nowadays are anxious to do everything possible to make wards bright and attractive and to lessen the " institutional " atmosphere. The design and furniture of wards increasingly pay attention to other than purely clinical considerations, but much can still be done to unite clinical efficiency with aesthetic satisfaction on the one hand and the patient's comfort on the other.

46. *Lockers* are provided almost universally but there are great variations in the standard of design. We recognise that a study has already been made to determine the most suitable design, and would welcome more extended use of types found most convenient for patients and staff.

47. *Chairs.* As in paragraph 28 above we consider that there should be two chairs for each bed. Since it may be undesirable to have two solid chairs standing all the time at the bed, some form of collapsible chair or a type which can be stacked one on top of the other might be used. Each ward should also have armchairs for up-patients.

48. *Wardrobes.* Few hospitals are at present in a position to give wardrobe space to patients for their outdoor clothing. The universal provision of wardrobes (standing in some side room rather than in the ward itself) is probably difficult on the grounds of expense both of money and space, but so far as possible in existing hospitals, and certainly in planning future hospitals, a serious attempt should be made to provide for the storing of patients' clothing. This will, of course, require a separate locked wardrobe for each patient, and again there is scope for a standard design capable of storing clothes neatly in the minimum space.

49. *Bed Screens or Curtains.* It is very important that patients should be able to have privacy on certain occasions, and if the means of securing this, for example portable screens, are heavy and difficult to handle, the number of occasions on which they are likely to be used will be kept to the minimum. With this in mind we have considered carefully whether the screens which are in general use at present might not be replaced by curtains which can be very easily pulled round the bed. The argument would seem to be all in favour of curtains since they are much easier to handle and thus lessen the work of the nursing staff. It has been suggested that they are not hygienic and easily collect dust, but this difficulty could be overcome if suitable easily washable material, were used.

We would therefore urge all hospitals to consider providing curtains in place of screens, thus lessening the nurses' work and making it easier for the patients to have privacy.

50. *Layout of Wards.* In future planning—and perhaps in certain circumstances at present—hospitals might consider the advantages of the " parallel bed arrangement " and partitioning large wards into a number of bays. This permits the segregation of patients and greater privacy, and eliminates the formal impersonal atmosphere of the large ward.

51. *Trolleys.* The general comfort and hygiene of the ward is enhanced by using trolleys to ensure the speedy removal of soiled linen.

52. *Beds.* A bed becomes of great importance when it has to be one's resting-place for 24 hours each day. Close attention should be given to the condition of pillows and blankets and in all future provision of bedding, hospitals should ensure that a comfortable and easily-cleaned form of mattress is used.

53. *Bed-Tables.* Another item of equipment which is provided only in a certain number of hospitals at present is the self-supporting bed-table which allows the patient to support trays of food without resting them precariously on his lap. The provision of these tables for trays should be the aim of every hospital.

54. *Bed-Rests.* These can make a great difference to a patient's comfort and where they are not used at present they should be provided.

55. *Calling Signals.* Few hospitals have means, electrical or otherwise, whereby a patient can attract the attention of the staff by means other than word of mouth. It would be a great help to certain patients if at each bed there were a press-button switch calling a member of the staff.

56. *Lighting.* Some wards are very poorly lit at present and it is difficult for patients to read either in daylight or in artificial light. There are inevitable difficulties, of course, as a result of having more beds in wards than was intended when they were built. So far as possible, however, patients should be in a position where they can read by daylight, and above each bed there should be an artificial light. The latter helps not only the patient but can also be of considerable assistance to the staff when carrying out dressings or examinations. In considering both existing lighting schemes and those which may be provided in the future, hospitals should bear in mind the results of recent researches on lighting technique and standards.

57. *Heating.* Heating in hospitals is generally satisfactory. In summer, however, when it is normally turned off, there are often days when the temperature in unheated wards and bathrooms is too low for patients' comfort. The provision of some kind of auxiliary heating would be an advantage in such weather.

58. *Pictures and Colour Schemes.* A pleasant colour scheme does much to brighten a dull ward. Unpleasant colours can spoil an otherwise bright and cheerful one. In planning such schemes hospitals should again give close attention to the results of modern research and experiment. Some hospitals have had the happy idea of obtaining pictures for decorating walls. They add a pleasant touch and do something to diminish the austerity.

59. *Wireless.* We consider very strongly that there should be no loudspeakers in hospital wards. To be forced continuously to listen to programmes which one has no desire to hear can be wearing in the extreme even when in the best of health. The ideal is that ear-phones should be provided for each patient from which he can get a choice of programmes without interfering with anybody else. Where this is not immediately possible the loudspeaker should be used only with the greatest discretion.

XII. OCCUPATIONAL AND DIVERSIONAL THERAPY

60. Although some activities are undertaken with a clear clinical end in view (occupational therapy), and others merely in order that patients may be helped to pass the time in an interesting way (diversional therapy), there are many marginal cases and the line between them is difficult to draw. Occupational therapy, properly speaking, is primarily for long-stay hospitals where it is part of the treatment and where special staffs are provided. Although the clinical aspect may be the more important, it clearly helps also to promote the patient's

general welfare and we would urge its provision in all suitable cases. Diversional therapy is of particular value in children's wards.

It appears that in a number of sanatoria there is considerable room for improvement in the provision of both occupational and diversional therapy. It is in this type of institution that it could be most valuable, and we see no reason why some hospitals should appear lax and unimaginative in this direction when others show considerable skill in meeting the needs of patients. (See Section IX.)

61. Various arrangements exist for the provision of materials for occupational therapy and for the disposal of the goods when made. There is room for abuse of these facilities unless they are fairly closely controlled. We suggest that the best method is for the hospital to provide the tools and materials and to allow the patient—or one of his ward-mates—to buy the finished article if he wishes to do so. If not, the hospital should have some arrangement with an outside firm for the sale of any articles which cannot be disposed of in this way. Such a system will then be self-supporting.

62. While occupational therapy is primarily for long-stay hospitals there is room at all hospitals for diversional therapy. It should, of course, in no sense be compulsory, but patients may welcome the chance of employing their time usefully.

XIII. FOOD

63. We recognise that to embark on any comprehensive consideration of hospital catering generally is outside the remit, but it is impossible altogether to omit food when dealing with patients' welfare. Meals loom large in the patient's day, and the greater the anticipation with which he can look forward to them, the more pleasant does life become. We have, with one exception, limited our recommendations to the service of food as it reaches the patient in the ward, and have not dealt with the whole machinery of purchasing, storing, and cooking food.

64. One of the most important factors in determining the standard of feeding seems to be the staffing arrangemens made for buying and preparing food in large hospitals; for example, it seems best when a catering officer (another name such as food supervisor is sometimes used) is in general control of the menus and of the kitchens, and cooks carrying out the actual preparation of the food. In smaller hospitals, the drawing up of menus and the supervision of catering arrangements are often of necessity left to the matron, usually with satisfactory results. Sometimes, however, the services of a food supervisor might give even more satisfactory results, and this would relieve the matron of what should not really be part of her duty. It is clearly impossible to have such a supervisor in every small hospital but on the analogy of organisation in the large one it might be possible to have the food supervisor attached to a group who would prepare menus and generally supervise the work of cooks in the individual hospitals.

65. The following are a number of points concerning the service of food which we feel should be considered carefully.

66. *Trolleys.* If wards are at a distance from the kitchen, heated trolleys designed to be as noiseless as possible should be used to ensure that food is hot when it reaches the patient. To serve cold and unattractive food is to lose much of the value of the meal.

67. *Tea.* It seems to be the practice in some hospitals to put milk and sugar in the tea before it is handed to the patient, and he has therefore no choice as to how much milk and sugar he should have or if he should have any at all.

While it may not be immediately possible to give each patient a teapot with separate milk and sugar, we suggest this is the ideal which should be pursued. Even if there are no individual teapots, however, patients should be given tea alone and allowed themselves to add milk and sugar to taste. Perhaps it may be necessary to give them their own weekly allowance of sugar.

68. *Crockery.* The shortage of crockery has affected hospitals no less than other users. Even if only very plain types can be obtained they should at all times be free from cracks and chips.

69. *Water Jugs.* Each patient unless prohibited on medical grounds should have at his bedside a carafe filled with water so that he may have a drink of water at any time without troubling the nursing staff.

70. *Times of Meals.* There can, of course, be no general time-table applied everywhere, but the aim should be to serve meals at a time which will break up the day for patients and will not result in their having long fasts. It is not unknown for patients to have no food between 6.30 in the evening and 8.30 next morning. If some hospitals can provide a hot drink and a biscuit later in the evening, it seems possible for others to do likewise.

Although it appears to be an unwritten rule that meals should not be served while a doctor is visiting a patient, there is a fairly strong feeling among members both of the medical and nursing professions that it is unjustifiable to hold up the rest of the patients' food for this reason.

71. *Choice of Food.* It is impracticable to offer a choice of food to everyone at every meal. It does seem possible, however, to send to each ward two dishes for each course, the total number of portions being equal to the number of patients, and the responsibility resting on the Sister to ensure that patients in turn during the day have the chance of making a choice.

XIV. MISCELLANEOUS

The following are other miscellaneous points of importance.

72. *Time of waking in the morning.* One of the strongest complaints from patients about life in hospital is that the waking hour, apparently without reason, is too early in the morning. It is only when the night is far advanced that some patients get to sleep, and it is naturally annoying to be wakened soon after at what seems an unnecessarily early hour. We recognise that the night staff must waken the patients and make the beds before going off duty, but after examining the time-table at different hospitals find that even where the time of the doctor's visit is the same and other circumstances are comparable, there is a considerable variation in the time at which patients are wakened. Some hospitals, for example, can leave the patients undisturbed till comparatively late, and we suggest that, whatever the routine followed, no patient should have to be wakened before 6 a.m.—and later if possible.

73. *Entertainment.* In the provision of entertainment for patients there is scope for all kinds of voluntary effort by individuals and organisations. Especially in long-stay hospitals concert parties, film shows, etc., can do a great deal for patients' morale.

74. *Noise.* Even patients who are not perhaps very ill sometimes find the noise in hospitals very disturbing and to patients who are seriously ill it can be extremely distressing. Noise is created by badly-designed equipment or by careless handling; the banging of doors and lift gates; heavy shoes worn by the staff: chattering groups of people in corridors and other types of thoughtlessness. The design of some hospitals also tends rather to magnify than reduce noise. All these matters except the last can be put right without much difficulty,

and we cannot stress too strongly that the elimination of noise should be taken seriously and attacked with an energy appropriate to its importance.

75. *Sanitary equipment.* This should receive the closest attention from the point of view of the comfort of the patient. All equipment of this sort should be up-to-date and hygienic. We consider that every ward should have adequate facilities for the sterilisation of bed-pans, etc.

76. *Cleaning and Painting of Wards.* We understand that this is sometimes done, no doubt because of shortage of accommodation, without patients being removed from the wards. The resulting disturbance and turmoil cannot but be unpleasant for the patient, and we strongly urge hospitals to find some means of removing patients before starting such work.

77. *Male Wards.* Most hospitals have an arrangement by which a barber comes in to do shaving and hair-cutting where necessary, and we recommend that this service should be available in all hospitals and as frequently as possible.

XV. DISCHARGE OF PATIENTS

78. During their stay in hospitals patients become accustomed to receiving guidance and help from members of the staff. When a patient is about to leave, full and clear instructions should be given about what he may do and what he may not do in order to follow up successfully the treatment he has had. If instructions are not given or if they are too brief the patient may well find the transition to independence abrupt and difficult.

79. Hospitals should ensure that the patient's own doctor is informed of his discharge as soon as possible. While it is not practicable to give advance warning in all cases, this is very desirable in certain types of case.

80. On their discharge from hospital many patients have problems other than medical, and hospitals should try, through almoners or other staff, to ensure that adequate provision is made to receive them at home and that any personal difficulties are looked after.

XVI. CONCLUSION

81. We have not thought it necessary to summarise all our recommendations since they are already in fairly concise form. It might, however, be useful to recapitulate some of the more important ones—

(1) In all their dealings with patients and their relatives, members of the staff should endeavour to show the utmost consideration and understanding. (Paras. 6 - 8.)

(2) Before entry patients should, if possible, be sent a letter telling them what they require to bring to hospital and giving other information such as visiting hours. After entry they should be given a brochure describing hospital routine and procedure, and the arrangements for their welfare. (Paras. 9 - 15.)

(3) Reception arrangements should ensure that the patient is looked after quickly and sympathetically. (Paras. 16 - 18.)

(4) Relatives should be told how they can most conveniently learn about a patient's condition. When they make enquiries they should be given as much information as possible. (Paras. 19 - 21.)

(5) Visiting periods should be frequent and generally fairly short. Visiting arrangements should, however, take account of local circumstances such as the half-day, and the distance which visitors have to travel. (Paras 25 - 33.)

(6) Special arrangements should be made, especially in long-stay hospitals, to ensure that up-patients are given facilities and equipment so that they may either entertain themselves or employ themselves usefully. (Paras. 38 - 41.)

(7) Bed curtains rather than screens should be used to give patients privacy in large wards. (Para. 49.)

(8) Ear-phones should replace loudspeakers in wards. (Para. 59.)

(9) Meal times should be spaced so that patients have no long fasts. (Para. 70.)

(10) Patients should not be wakened earlier than 6 a.m. and later if possible. (Para. 72.)

(11) A serious effort should be made in all hospitals to reduce noise to the absolute minimum. (Para. 74.)

(12) Hospitals should ensure that a patient's doctor is informed as soon as possible of his discharge, and that there are suitable arrangements at his home for his reception. (Paras. 79 - 80.)

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