Brit. J. Psychiat. (1976), **129**, 82–5

Patients Have Been Let Out of Wards; Why Not Nurses Too?

By ROGER MORGAN

Summary. Tradition retains the practice of attaching mental nurses to wards rather than to groups of patients, even though the wards are increasingly empty as patients come to lead more active lives in hospital. A system is described which enables nurses to relate more fully to the people in their care instead of having to confine their activities to the place in which only a part of the care is provided. This system involves all ward nurses in leaving their wards empty in 'working hours', being relieved of the care of their intercurrently ill patients and undertaking in exchange the complete day care of their fitter patients in both wards and workplaces. The consequences of these changes are attractive to many nurses and helpful to many patients.

Mental hospitals are copies of general hospitals in many aspects of their structure and organization. For example, mental nurses are allocated to work in wards. The result of this is that nursing attitudes and activities are ward-orientated in mental hospitals just as they are in general hospitals. This is surprising, for in general hospitals all the patients are physically ill and the bed in the ward is not only where they sleep at night but also the place where all their general treatment is provided during the day. Indeed, rest in bed is even a treatment in its own right. It is therefore perfectly logical for general hospital nurses to be ward-orientated, since the ward (containing its quota of beds) is the key unit in the general hospital.

By contrast mental hospital patients are not by definition physically ill. Indeed, with certain exceptions, they are physically well, and they get up and dressed as part of their treatment every day. For most of them their bed in hospital is of no more use to them than their bed at home. It is where they sleep at night. For economic reasons hospitals put a lot of beds into one big room and call it a dormitory. They have to add lavatories, bathrooms and storage space for clothes. This is as far as some other institutions go; for instance in a barracks you eat, sit, work and play elsewhere. But in a mental hospital the ward has come to include so many other facilities that it can and does, if necessary, provide so comprehensively for a patient that he does not have to leave it for weeks, months or years on end. It is well to remember, of course, that not long ago historically all wards were locked and many patients never did leave them. The bad old days may explain why it used to be legitimate for nurses to have a ward-bound outlook. The fact that they still do must mean that the problem has not been thought out anew, even though conditions, both custodial and clinical, have changed out of all recognition.

Recent progress (say over the last 20 years), in changing the pattern of the mental patient's life in hospital coupled with the relatively unchanged deployment of nurses, has had some unfortunate and incongruous results. For example, the following three propositions would receive most people's approval as good principles of psychiatric patient care.

1. The better the ward, the nearer it is to empty during conventional working hours (say 9 am–5 pm). The patients should if possible be at work somewhere outside the ward.

2. The right place for the nurse is with his or her patients. Indeed it is difficult to imagine how nursing can be done otherwise.

3. The more experienced and highly-trained

https://doi.org/10.1192/bjp.129.1.82 Published online by Cambridge University Press

the nurse, the more he or she has to offer to patients. (One has to assume that the training syllabus is broadly appropriate and that refresher courses, etc, serve to keep people up to date.)

The traditional pattern of ward-orientated nursing care fails almost completely to reconcile these three propositions. Usually no nurses leave the ward. If any nurses do accompany patients to work, they are invariably the most junior nurses. It is always held that the Charge Nurse or Sister must stay behind, and this is very understandable if what they are in charge of is 'the ward'. The most senior ward nurse, therefore, has minimal contact with the majority of patients. Furthermore, the sociology of ward life dictates that the most able patients are the ward workers who stay behind in contact with the senior nurse; while the more disabled patients who could probably do with his attention more are the ones who are sent out to work and have least contact with him.

No matter how ill-adapted to modern practices and patients' needs this ancient system obviously is, all the powerful forces of tradition and precedent are fully mobilized to maintain it. Any doctor reckless enough to question it or suggest a change is met with a barrage of objections. How would the ward get cleaned, who would receive the dry stores or the laundry, what would happen if the office rang up and found nobody here?—etc.

In 1961 the opening of a new hospital (Morgan, Cushing and Manton, 1965) gave the writer the opportunity to take part in the planning of a new pattern of nurse deployment and nursing care. His colleagues (co-authors of the above paper) were the Nursing Superintendent and the Hospital Secretary. These three devised and instituted without much difficulty the system now to be described. It has been in use for 13 years and works very well.

Ward nurses stay with their patients throughout the day. Each trio of 20-bed wards is attached (organizationally not geographically) to a workshop. The workshop is as much the nurses' territory as the wards. All workshop supervision is provided by the ward nurses (one could equally well upend that and say—all ward nursing is done by workshop supervisors). The wards are empty of ward nurses and patients during working hours (8.45 am–12 noon and 1.15–5.15 pm), the ward nurses being in the workshop together with 60 to 90 per cent of the patients; the remainder of the patients being at work in other workplaces (e.g. gardens, domestic group, clerical section, etc) under the supervision of non-ward nurses or others.

The wards are cleaned by patients from other wards under lay domestic supervisors (Martin, 1972). Beds are made by individual patients themselves. Tables are laid and cleared by a rota of designated patients outside working hours. Washing-up is done in a machine in the main kitchen tended by patients whose assignment is to work there. Dry stores are topped-up on Saturday mornings when the workshop is closed and people are in the wards anyway. The laundry is delivered by a porter and put in the ward's locked utility room to which he holds a duplicate key. The office rings the workshop to contact the nurse in workshop hours.

During the week the wards are largely ignored and unvisited (apart from the cleaners) during workshop hours. The focus and balance of the hospital is shifted then to the workshops. That is where the people are, and the ward and workshop administration and much of the clinical work is done there. The case-notes, medicine cards, weight charts, Modecate calendars, serum lithium charts, etc, etc, are in the workshops. The doctor's routine and other visits are paid there. The Nursing Officer belongs there in preference to the empty wards. Of course, in the evening, at night and in the early morning, as well as at weekends the wards are where people are, and, for example, the medicine cards are taken across to the wards at the end of each day's work.

To fit in with this policy nurses work three day shifts (there is a separate small night nursing staff). The precise times of the shifts have varied over the years to fit the nurses' shortening working week which was 44 hours in 1961 and is 40 hours now. In principle, the morning shift works from 7 am–2.30 pm, the afternoon shift from 1.30–9 pm and there is a 'workshop' shift from 8.30 am–5.20 pm.

https://doi.org/10.1192/bjp.129.1.82 Published online by Cambridge University Press

Each nurse rotates through the three shifts, getting days off in the week while on morning or afternoon shift, and every third weekend off after the week on workshop shift. This shift system theoretically provides twice as many nurses on duty in workshop hours as there are on duty outside workshop hours, but the incidence of days off reduces this proportion and keeps a fairly suitable balance of people in wards and workshop at different times of the day and week. The content of the job of a Charge Nurse who is working within this system has been described previously (Cheadle, 1971).

Given a policy which removes nurses from the wards for a large part of the day, it is of course necessary to provide special arrangements for those patients who break down and are too ill mentally to remain in circulation or who acquire some intercurrent physical illness which temporarily lays them low. Our answer to this is 'the Clinic', a separate building with a separate nursing staff under a Charge Nurse. It has eleven beds in single rooms, and apart from epidemics these have been enough for the needs of 240 patients in the rest of the hospital (but we have very few patients over the age of 60.) Any patient who is too ill to remain in circulation is transferred from his ward bed into the Clinic and remains there until he is well enough to return. With single rooms and suitable toilet arrangements Clinic beds can be used flexibly and interchangeably for men or women patients.

The Clinic, in other words, is a little hospital within the hospital. The in-patient service it provides to patients from the rest of the hospital has just been described, and it also provides an 'out-patient' service. Patients go there to see the doctor, or to get dressings or drops or injections or a blood test, or first aid, or ECT. The wards are thus relieved of all medical chores apart from the giving out of tablets or medicines. The Clinic also handles appointments for patients to see specialists at general hospital out-patients, arrangements for X-rays (four miles away in our case) visits of experts such as dentist, chiropodist and so on. This has many advantages. To name only three, everyone in the hospital knows where help is available in the event of an emergency, a doubly trained nurse (mental and general) works where all physical treatments are given, and equipment can be concentrated and sited very economically.

There are some interesting consequences of this system, not all of which were foreseen. The conventional role of the ward mental nurse undergoes a big change. In exchange for the many tedious and time-consuming activities which he used to carry out for his intercurrently sick patients, he how undertakes workshop supervision, which allows him instead to work constructively on the healthy parts of his healthier patients. For many mental nurses experience of doing this is enlightening. They share everyone's difficulty in saying what mental nursing is, but they usually start off convinced that workshop supervision is not part of a mental nurse's job. They usually find out, however, that a structured work setting provides an excellent framework in which they can get to know patients, form relationships with them, observe, advise, influence and teach them; and surely these are things that mental nursing is really all about. To put it another way, once they have been relieved of physical duties (into which some would take flight), some of them do not know what to do, because they have never before been confronted with a situation in which nothing but mental nursing is required of them. Their dilemma is resolved in one of two main ways; the majority learn and grow in professional stature, the others eventually leave.

The personal commitment of trained ward staff is increased by the fact of acquiring workplaces as their own territory—as opposed to the territory of other nurses or other disciplines, where it was not possible for them to belong in the same way. The work setting also becomes much more meaningful for student and pupil nurses, in contrast to their conventional experience of being seconded for a required period to an alien place, which many never come to understand or belong in either.

The nurse who within a few weeks has been with his patient in a variety of settings throughout the waking day quickly acquires for his own professional use a more complete knowledge of that patient. He is also able to provide the

https://doi.org/10.1192/bjp.129.1.82 Published online by Cambridge University Press

doctor with much better reports from this knowledge which he has acquired at first-hand. Through visiting the workshop routinely, the doctor too builds up a better first-hand knowledge of his own.

Communication and co-ordination between ward and workshop cease to be a problem. Integration of the patient's occupational and ward treatment needs is woven into the very fabric of his experience, instead of being intermittently adjusted, if he is lucky, by liaison somewhere higher up the hierarchical tree. Staff-patient relationships are healthier in a work setting (Bennett, 1970) than in the ward, and it is good for ward staff to share in these. Their levels of expectation of their patients generally rise as a result.

The problem of motivating the more difficult patients to occupy themselves is not eliminated, but it is made much easier for the nurse. The impact of a mass exit from the ward by 95 per cent of its occupants is hard for the remaining 5 per cent to resist; most of them get carried along in the stream.

The existence of the Clinic has a subtle influence in modifying the patient's sick role. Conventionally this applies to all patients in hospital. In this hospital, the sick role is reserved for those patients in the Clinic, and they number at most eleven at any one time. Patients in the ordinary wards, going to work daily, are not regarded locally as sick, and this has a profound effect on role performance and expectations.

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(*Received 17 October; revised 8 December 1975*)

https://doi.org/10.1192/bjp.129.1.82 Published online by Cambridge University Press