ROYAL VICTORIA HOSPITAL
BELFAST

EVALUATION OF
THE NEW OUT-PATIENT CENTRE

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Report to Belfast Hospital Management Committee

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August, 1970

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FOREWORD

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. The team's report and recommendations were presented to the Belfast Hospital Management Committee in June 1967.

Towards the end of 1969, the Belfast Hospital Management Committee asked the King's Fund to sponsor a review of the operation of the out-patient department since the 1967 recommendations were implemented. Mr A F Gray, House Governor of Moorfields Eye Hospital, agreed to undertake this review for the Belfast Hospital Management Committee on behalf of the King's Fund. His report is presented in the following pages. It is hoped that the report may be of interest not only to Belfast Hospital Management Committee but also to others concerned with the planning and operation of out-patient departments.

Lord Cottesloe

Chairman
Development Committee
King Edward's Hospital Fund

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SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

1. In general the operational policies concerning the use of the building and patient flow have been successfully effected. The policy regarding eye, ear, nose and throat patients, however, should be reconsidered to avoid their dispersal for treatment. All such patients might be treated more satisfactorily in the Eye and E.N.T. Hospital Wing.

2. Waiting times in out-patient clinics are not usually excessive but attempts should be made to reduce the delay between referral by a general practitioner and first hospital consultation, which at present is unsatisfactory in many clinics.

3. The Accident and Emergency Department provides an excellent service which would be improved even further by extending the receptionist's hours of duty. (Her hours of duty have subsequently been extended.)

4. The numbers of nursing staff appear to be adequate but the responsibilities of the new building are such that the appointment of an Assistant Matron and two Departmental Sisters should be considered immediately.

5. A Sister of Departmental status should be appointed for night duty in the Accident and Emergency Department where there is a risk of sudden and heavy demand.

6. In view of the development of the main hospital, the location and function of the Enquiry Office should be reconsidered.

7. Since the dispersal of the Metabolic and Diabetic Department's facilities the appointment of an extra dietitian should be considered.

8. In view of the Special Clinic's heavy work load, the appointment of an additional full-time consultant and the re-grading of the present male assistant should be considered.

9. To improve the efficiency and economical use of the Medical Illustration Department, co-operation and rationalisation between the Royal Victoria Hospital and the University of Belfast should be encouraged.

10. The rest rooms and catering facilities for staff are much appreciated, but rest facilities for porters should be improved and the range of light refreshments provided should be extended. (It is understood that some improvements in the rest facilities for porters have subsequently been effected.)

11. To enable the facilities of the Fracture Clinic to be used more efficiently, the appointment of an additional registrar should be considered.

12. The performance of both the building and its equipment are generally satisfactory. A detailed list of minor comments has been produced separately for the attention of the Belfast Hospital Management Committee.

13. In order to maintain the efficiency of the Medical Records Department, the policy regarding the retention of old patients' notes will soon require urgent reconsideration.

14. To facilitate the maintenance of a new building, the Group Engineer should be included in discussions during the planning design and commissioning phases and should be provided with working drawings as soon as possible.

15. A domestic administrator of higher status is required in the new building if effective co-operation is to be established with senior nursing staff; the appointment of an assistant domestic superintendent is therefore recommended.

16. The domestic services might usefully become the object of various management investigations e.g. to ascertain correct staffing levels, to analyse causes of staff absenteeism etc.

17. The possibilities of training floor cleaning staff and the techniques used should be investigated. Walls should be washed either by a specially trained hospital team or by an outside firm on contract.

18. To reduce the demand for hospital beds, greater use should be made of theatres and treatment rooms for out-patient surgery.

19. An administrative officer should be located in the new building to deal with day-to-day management; the appropriate grade would be either Senior Administrative, or, preferably, Principal Administrative with additional responsibilities.

EVALUATION OF THE NEW OUT-PATIENT CENTRE, ROYAL VICTORIA HOSPITAL, BELFAST

INTRODUCTION

The planning of the new Out-patient Department in the present situation dates from the early days of the Health Service, and, as was the case with many similar projects, it was subject to many changes in concept. Eventually the foundations were commenced in December 1964 and the superstructure in January 1966.

In February 1966 the Belfast Hospital Management Committee asked the King's Fund to arrange a survey of the work in the existing Out-patient Department of the Royal Victoria Hospital, and of the plans for the department then under construction.

The Survey was carried out by a team established by the King's Fund Hospital Development Committee. The team's report was published in June 1967 (Royal Victoria Hospital, Belfast, OPD Organisation and Staffing. King's Fund Hospital Centre Publication).

In October 1969 the Belfast Hospital Management Committee asked the King's Fund to sponsor an evaluation of the new building and its organisation in relation to the Report of 1967. This was undertaken in two periods in January and February 1970 almost one year after the Out-patient Clinics were opened (17th February 1969) and nine months after the opening of the Accident and Emergency Departments (13th April 1969).

It was agreed that the evaluation should be of the walk-around type by a single individual (Evaluating New Hospital Buildings - a King's Fund Report 1969 - Pages 31 & 32) and the author was given complete freedom to decide his own terms of reference and methods. This report (whatever its value to the Belfast Hospital Management Committee or to others interested in the planning and evaluation of hospitals) is therefore subjective and must necessarily be influenced by the background and experience of the evaluer.

The most difficult part of this evaluation has been to preserve an objective outlook and to relate architectural and organisational solutions to problems in the light of the information and experience available at the time to the Planning Team, the Architect and the various hospital authorities concerned with the project. It is not difficult to find detailed faults in any hospital building and to support the conclusion with "evidence" gathered from those who have no knowledge of the restrictions imposed upon the planning team, for hindsight is a relatively cheap commodity.

For these reasons only those architectural, engineering and equipment design features which are of broad application or relate to the survey of the King's Fund Team of 1967 are included in the body of this report. Items of detail which are of interest only to the Belfast Hospital Management Committee, the planning team and the Architect, have been produced in Appendix G to this report.

Similar considerations apply to comments on staffing and organisation as on planning. The King's Fund Team endeavoured to suggest an organisation for a future service, in a building yet to be opened, based on past performance in a totally different environment. Generally the proposals have proved remarkably successful and any comments made in this evaluation (again with the benefit of hindsight) must be regarded as suggested amendments to a successful plan which had its origin in the knowledge and local experience of the very able staff working in the building.

The author has not concerned himself with such matters as the in-patient load of the main hospital or the hospital's work in relation to the needs of the province.

Finally, lest any comments later in this report be construed as critical of the new Out-patient Clinics, let it be said at this point that the author has a genuine admiration for the service that is being provided to the people of Belfast which, particularly in the Accident and Emergency Department, must be of a standard as high as anywhere in the United Kingdom.

METHOD

The evaluation was basically a walk-around survey carried out by one person. It was conducted in two periods, 21st to 30th January and 4th to 11th February 1970. This was preceded by a visit to meet members of the planning team and heads of departments on 29th December, and a meeting with the Architect in London to discuss the planning and historical background to the building project.

The following method was used:-

(a) Discussion with all heads of departments concerned with the running of the new building and the services supplied to it.

(b) Interviews on the relevant floors with the Sisters in charge of clinics followed by an inspection of the clinic or department. At each interview it was explained that the evaluer was looking at the building and its work in relation to:-

  i. The King's Fund Report of 1967, i.e. Staffing, Organisation and Methods of Work, and

  ii. The design of their department or clinics as it affected their work.

  iii. Their environment, i.e. heating, lighting, comfort, finishes and equipment.

(c) Meetings with a group of Physicians and a group of Surgeons to which all the Consultant Staff were invited by the Acting Medical Superintendent. (These were supplemented by informal discussions with individuals.) The tenor of apologies for non-attendance either before or after the meetings, indicated general satisfaction with the building as did verbal comments of several Consultants who did not write.

(d) A letter was sent to all Consultants by the Medical Superintendent informing them of the survey and asking for written comments. Six letters were received.

(e) Personal observation of public areas of the Accident and Emergency Department and of the Out-patient Clinics at various times of the day, including late evenings on weekdays and at weekends.

(f) A survey was conducted by issuing a questionnaire at random to patients in clinic waiting areas. The questionnaire and summary of results are shewn at Appendix "A".

(g) Statistics were gathered by the Medical Records Officer, the Administrative Officer in charge of the building, and the Nurse Administrator to show volume of work, staffing levels and waiting time in clinics and the Accident and Emergency Department.

(h) Discussions were held with selected junior staff operating in key areas, e. g. clinic receptionists and out-patient porters.

(i) Meeting on site with the Architect's and Consulting Engineer's representatives.

Notes taken at the various interviews were amplified by dictating on to the central audio-typing system within three days or less in order to "fix" information for later analysis.

1 REVIEW OF PLANS AND OPERATIONAL POLICY

In this section the present layout and use of the new buildings is compared with the proposals made by the King's Fund Team in 1967. Before doing this, it should be pointed out that it would be wrong to assume that no operational policy existed before the Team visited Belfast and that the new buildings had been planned without consideration of the methods of dealing with patients, or to the inter-relationship between departments such as Casualty, X-ray, Fracture Clinic and Medical Records. This would be a quite unfair reflection not only on the Planning Team which laboured on the subject for many years, but also on the Architects and the Northern Ireland Hospitals Authority who of course bear the final responsibility for any major hospital construction in the province of Ulster.

1.1 As is the case in many schemes that originated in the early days of the Health Service, but languished because of inadequate capital allocations, plans were formulated in the light of existing circumstances but changed, during a long planning period, as priorities changed and the concept of patient treatment changed. It must be remembered that it is only in the last decade that the concept of an orderly programme of operational research to establish need, operational policies, outline brief, sketch plan and cost limits fitting in with centrally advised Building Notes, has come about. In fact, few existing major schemes have been planned, built and tested according to the present formula.

1.2 Therefore the King's Fund Report of 1967 must be recognised only as advice and suggestion on details of the organisation, staffing and equipping of a building which was not only under construction, but for which the operational plan in broad outline had already been determined.

1.3 Plans of the building are attached to this report. (See Appendix "D".) The suggestions for alterations made by the King's Fund team were:-

(a) Change space provided at Level 5 Wing A for staff locker rooms, changing and rest rooms, to rest rooms with snack facilities.

(b) Change cul-de-sac corridor 1/1 on Level 1 into changing accommodation for staff.

(c) Provide a room of 120 sq. ft for the medical social workers' department for the storage of patients' clothes.

(d) Provide a room for distressed relatives in the Accident Department.

(e) Provide a separate room for admission of in-patients.

(f) Omit storage cupboards for CSSD supplies included in the lift lobby of each clinic floor.

(g) Provide clinic reception desks in lift lobbies of Levels 5 to 9.

(h) Install a document hoist to serve Levels 2 to 9.

(i) Increase the area of desk at Level 3 by moving the counter to the line of the columns.

(j) Provide additional offices for the Manager and Nurse Administrator.

Other comments were made concerning the separation of Orthopaedic and Fracture Clinics, provision of X-ray facilities on Levels 6 and 7, and the adequacy of lift provision. These points are referred to in the appropriate sections of this report.

1.4 The suggestions (a) to (j) above were carried out with some minor variation, and have proved their value in working conditions.

1.5 It will be seen from the plans that the main principles involved in the building are:-

(a) A Vertical Plan. This was necessary in order to accommodate a large number of associated activities on a limited site adjacent to existing buildings, e.g. ward blocks.

(b) Separation on different levels of Accident and Emergency Department from Out-patients Entrance.

(c) Establishing the new Accident and Emergency Reception Centre on the same level as the main ward block and accessible thereto by corridors.

(d) Accident Service and Fracture Clinic to be adjacent and to be served by an adjoining X-ray Department for their exclusive use.

(e) Accommodation of medical records and similar services associated with out-patients and admissions in the same building.

2 GENERAL POLICY

2.1 The general policy was to undertake as far as possible all the out-patient and accident and emergency work of the hospital in the new building, and this has been carried out for all practical purposes, including that of the Ophthalmic and Ear, Nose and Throat Departments, about which comments are made later in this report.

2.2 It was also intended that a full twenty-four hour service should be provided in the Accident and Emergency Department with full medical, nursing and administrative cover. This has been successfully achieved and the service is most impressive.

2.3 The basic idea of associating the fracture clinic and accidents with their own X-ray Department is working well, but there is difficulty, as mentioned in the King's Fund report, para. 8.2.2, regarding the separation of the orthopaedic clinics which operate on Level 9.

2.4 A further basic concept of the building was that ambulant patients should enter at Level 3 and all vehicle borne patients through Level 2. Furthermore, those stretcher borne cases arriving by ambulance who require immediate attention should be admitted through a separate entrance thus avoiding the carriage of patients in a distressed condition past other waiting casualty patients. This has worked successfully.

2.5 It was a basic part of the operational policy that all clinic floors should have their own waiting areas, thus avoiding large crowded areas serving several clinics. This necessitated a main waiting area for those arriving early for their appointments, and to accommodate relatives and others not required on the clinic floor. This has been one of the most difficult parts of the operational policy to implement and is discussed fully in paragraphs 3.4 to 3.7. Nevertheless the system is working and is continually improving as patients become familiar with it.

2.6 It was further proposed that patients arriving at the main entrance on Level 3 for the Accident and Emergency Department should be diverted before entering the inner doors of the main entrance hall via an escalator to Level 2. This appeared at first sight to have considerable problems but the system has, on the whole, worked satisfactorily.

2.7 It was anticipated as far as the general policy was concerned, that the sub-waiting areas on the various clinic floors would provide a more comfortable and friendly atmosphere and that the layout of the clinics would give more privacy than had been the case in the past. This object has been achieved as is to be seen from the patients' comments which are summarised in Appendix "A" which indicate that from their point of view, the building and its organisation have proved successful. In subsequent paragraphs the organisation of the individual departments and clinical areas are discussed.

2.8 Casualty Department

2.8.1 The Casualty Department is under the immediate control of two officers in the Medical Assistant Grade, one Surgeon and one Physician. There is no real consultant cover in the accepted sense, but these medical officers were running the department in a most efficient manner.

2.8.2 Generally the procedures suggested in the King's Fund Report, Section 8, are being followed. It was suggested in paragraph 8.1.1 that about 35% of some 200 patients could have gone to their general practitioners rather than to the hospital. The Medical Assistants took note of this, and they are sending a pro forma letter on the subject to every general practitioner in the hope that it will gradually educate them in sending only those patients to the department who require hospital treatment.

2.8.3 The documentation, although varying somewhat from the King's Fund Report, is excellent. The relevant administrative data which can , when required, form the front page of a medical notes

folder in the unit system, is typed at the main registration desk, Level 2. It has been found in practice an advantage to have a receptionist in the casualty sub-waiting area and this not only has the effect of relieving a nurse from a non-nursing duty, but also provides a focal point for the department and a point of contact between the patients and the medical and nursing staffs. From the sub-waiting area patients are directed to cubicles where the registration form clipped on a millboard is hung outside. This enables the casualty medical staff to see at a glance where patients are waiting. They then take the form and enter the cubicle. This system, when observed during a busy time, worked most efficiently. The receptionist is on duty in the sub-waiting area until 5 p. m. and because of her considerable help, the medical staff consider her hours of duty should be extended. (Her hours have subsequently been extended until 10 p. m.)

2. 8. 4 The admission of casualty patients follows the procedure described in the King's Fund Report and the equipment, i. e. Lamson Paragon and Muirfax facsimile transmitter, is in full use. However, the suggestion made in the Report that foot operated dictating machines should be provided in the resuscitation units so that the medical officers could dictate while examining the patients has not been carried out. The two senior medical officers in the department feel that at the busy time of examining patients they do not wish to connect up and operate a dictating machine. They prefer to write their notes afterwards, and feel this is preferable for medico-legal reasons.

2. 8. 5 Another variation on the original recommendations is that the patients' relatives are sent to the reception desk to give full details to the duty clerk for registration. This avoids using nursing staff for the purpose and at the same time helps to remove relatives from the casualty area. The information given to the clerk by relatives is frequently more accurate than details obtained by a nurse from patients who may still be disorientated. The twenty-four hour clerical cover operated in the Accident and Emergency Department complete relieves

nursing staff of clerical work and for this reason alone is to be commended. There is one variation of the original plan which is unfortunate. It is that relatives of seriously injured patients in the resuscitation room are asked to wait in an adjacent area, instead of in the main casualty waiting room. This can be distressing for the relatives.

2.8.6 Where it is decided to admit a patient from the fracture clinic area a member of the admission unit at the main reception desk comes to the fracture clinic to deal with the admission procedure rather than sending the casualty or fracture receptionist with the patient to the admission unit as suggested in the King's Fund Report.

2.8.7 A difficult problem concerning accident patients is that of the Eye and ENT cases. They are at present referred to the Eye or ENT casualty officers at Level 8 in normal hours, i.e. up to 5 p.m. After this time they are referred to the Eye and ENT Hospital Wing. This is at variance with the suggestion made in the King's Fund Report that emergencies should be taken from Level 2 to the separate Eye and Ear Clinic where it was suggested that suitably equipped emergency rooms should be kept after the movement of the rest of the department to the new building. It does appear to be unfortunate that the reception and movement of Eye and ENT patients should vary according to the time of day, and this could be quite confusing to the patient who after initial treatment is asked to return at any time should his condition require immediate attention.

2.8.8 It is appreciated that the Ophthalmologists made a deliberate decision in arranging for casualties to be treated in the ophthalmic clinics where, of course, consultant advice would be immediately available should it be required by the junior medical staff and where the equipment would be readily available. However, bearing in mind that the Eye and ENT building is relatively modern and otherwise self-contained, it might be a matter for further consideration as to whether emergencies for these specialties might not be dealt with in this building and that it should be treated as a separate hospital. In

this connection it was noted that the admission of patients to the Eye and ENT Hospital via Level 8 in the new out-patient building frequently caused problems to the admissions staff and resulted in unnecessary movement of the patients.

2.8.9 It was satisfying to see that all patients who so require are given an appointment for a follow-up and further consultation and that a letter is sent to the general practitioner in every case. An interesting point is that no X-ray request form is used in this department, the basic medical records sheet serves this purpose. Immediate reports are made by the X-ray Department and the collaboration between the two departments is very good.

2.8.10 The decision to admit a patient, which it was suggested should be taken by the "take in" firm of the day is, in fact, being taken by the Casualty Medical Assistants until they go off duty. At night the decision is taken by the "take in" firm's Registrar.

2.8.11 Waiting time in the Casualty Department - The time of arrival and departure of every patient attending the Accident and Emergency Department is recorded and a casual examination of some of the patients' notes indicated that the time involved was approximately 1 hour 10 minutes, including examination by the casualty doctor, subsequent X-rays and other investigations. This confirmed personal observations, not only during normal hours but at night and at weekends, that the department is being managed with efficiency and humanity. The Department was put under intense pressure during the riots in 1969 and the fact that it acquitted itself so well is the best evidence that its layout and organisation are excellent.

2.8.12 It would appear that the main problem of this department will be to maintain the quality of the medical staff in the Medical Assistant Grade because the work, as at present organised, cannot be completely satisfying for a senior doctor (the Physician in the Medical Assistant Grade left during the period of this investigation). It must, therefore, be a matter for the medical staff of the hospital

and the Northern Ireland Hospital Authority to decide whether the duties can be so arranged, e. g. by the formation of a Traumatic Department, that it warrants the upgrading of the post from Medical Assistant to Consultant. This would obviously require the backing of a certain number of beds specifically for accident patients. (It is understood that 60 accident beds will become available in 1973 upon the completion of further developments at the hospital.)

2. 8. 13 The Fracture Clinic is operated as suggested in the King's Fund Report with only minor variations. One is that as orthopaedic patients, both from the waiting list and from the emergency department are admitted to the Musgrave Park Hospital and the folder must go with the patient, it is probable that the Musgrave Park Hospital design of case notes will be followed. This is sensible and a good reason for not using the standard form of case notes for the hospital. The notes of the fracture department are intended to be filed in the casualty file but they are, in fact, being kept in the department. It appears to be convenient and there is no indication that it is causing any undue concern. Another variation is that the Report suggested that as the Orthopaedic Clinic is separated from the Fracture Clinic, the Consultants should divide their sessions between the two areas if necessary, i. e. cold orthopaedic patients at Level 9 and fracture patients at Level 2. In practice the Consultants take the notes and X-rays from the fracture clinic and ask for specific patients either to be sent to Level 2 or Level 9 for examination, as is most convenient. An appointments system for return fracture cases is in operation. The waiting time does not appear to be excessive.

2. 8. 14 From general observation and comment in the department, it would be worth investigating whether an additional registrar should be appointed.

2. 8. 15 At present, the theatres and treatment rooms are used for minor surgery and routine investigations as suggested in para. 3. 2. 4 of the King's Fund Report. However, the excellent facilities of the new building provide opportunities for an even more extensive

programme of out-patient surgery which could make a significant reduction in the demand for hospital beds. The further advantages of out-patient over in-patient treatment in terms of convenience for patients and reduced unit costs are such that the extension of the present range of out-patient surgery deserves serious consideration.

3 PATIENT FLOW

3.1 The King's Fund Report, para. 4, recommended systems for the flow of patients and information supported by outline flow charts. These have been put into operation with only minor variations based on local experience after opening. For all practical purposes, the charts do report the movement of patients and documents.

3.2 In the Accident Department the arrivals on Level 2 are separated into those who have sustained severe injuries and are brought by ambulance to the emergency entrance, and those with minor injuries who arrive at the hospital at Level 3. Some of the latter may also arrive on foot at Level 2. The ambulant patients and those brought in by wheelchair are documented at the reception counter at Level 2. From this point patients are referred via the casualty sub-waiting area to examination cubicles and thence to the X-ray or Fracture Departments as may be necessary. Where admissions are required the receptionists take the casualty folder to the main reception desk where admission to the "take in" ward is arranged. The full details on the casualty folder plus other administrative information are written on the Lamson Paragon register and the top copy scanned by the Muirfax equipment to the Medical Records Department at Level 4. This enables the Medical Records Department to send any previous notes via the note hoist to the reception desk at Level 2, or alternatively, to allot a new number. Thereafter the patient can be sent to the ward with full documentation. This procedure works very well.

3.3 The biggest problem arises from the arrival at Level 3 of both normal out-patients and accident patients. The latter are expected to use the escalator to Level 2 and in practice, most patients find their own way. A few go through to the main hall at Level 3 but the porters and guides are able to re-direct them fairly easily. Detailed comments on the use of the escalator will be found in para. 17.2.1.

3.4 The flow of normal out-patients is via Level 3 (see 3.6 below) and thence via lifts to clinics on the upper levels where they are directed by the receptionists in the lift lobby to the clinic sub-waiting area. Old patients go straight to the clinic sub-waiting area. Patients are checked in by the receptionist in the sub-waiting area against the clinic lists and are fed into the clinics in the manner suggested in the King's Fund Report. The only major difference is that in many clinics there is no difference between "inside" and "outside" nurses. In practice each clinic uses its nursing staff in the manner which is best suited to its own purpose. Specimen testing and other procedures are carried out by the nurses in the procedure rooms before patients enter the clinic and they also give any further advice and explanation to patients after the medical examination. Thereafter the patients leave the clinic area and are given their next appointment by the receptionist in the lift lobby. The present adaption of the proposed system (see para. 10.12) is quite satisfactory, although some congestion is caused in the lift lobby because new patients who are unfamiliar with the geography of the clinics ask for advice at this point and tend to join the queues with patients seeking re-appointments. It is suggested that better signposting is necessary in the lift lobby areas to indicate the nature of the clinics being held in the three wings at each level. This might avoid the crowding at the reception desk. In an attempt to produce a uniform type of notice throughout the building, which is clear but not too obtrusive, there is an obvious lack of information. It might be helpful to have notices of the blackboard and easel type upon which the names of the clinics and the names of the Consultants in charge could be put up each day. Notices such as "Wing A" do not mean a great deal to the patients. However, they usually know the name of the Consultant and the clinic they are to attend.

3.5 Generally the clinic waiting areas are adequate in size, but there are times during the peak periods when a few people stand. Comments on this are made later in this report - para. 4.4 (a).

3.6 At Level 3, two porters and at least one volunteer guide are on duty during clinic hours to divert patients to the main waiting area until their appointment time is imminent. From the main waiting area they are called to the clinic levels by a public address system operated by the receptionists at Level 3. The latter are in communication with the receptionists on each level and are able to judge from the flow of patients when the next block of patients is required. This is working reasonably well because the porters and volunteers are conscientious and vigilant. Without a high grade of hall porter this system could become difficult to control. In practice, patients are gradually learning the procedure and although some, either deliberately or through ignorance, attempt to go straight to the clinics, the staff are of the opinion that the organisation is improving.

3.7 At first sight it seems an expensive method of sorting patients, but when one considers that there would certainly have to be two hall porters on duty for an out-patient service of this size to give occasional assistance to patients and to answer enquiries, it does not, in fact, call for more than a normal staffing level.

3.8 Doubts were expressed in the King's Fund Report as to whether three lifts would be adequate to serve the volume of patients. In fact the lifts do cope, although there are certain delays at times which can be frustrating to members of the staff. Detailed comments on lifts are made under the heading of "Communications".

3.9 The physical medicine and venereology clinics are on Level 3 and each have their own waiting area. There are no particular "flow" problems. It was suggested that the proximity of the venereology clinics to physical medicine and the main waiting area was not satisfactory, but this is a matter of opinion and certainly in London the tendency is towards an integration of venereal disease clinics into the general work of Out-patients Departments rather than to segregate them.

3.10 The method of holding and calling forward patients is greatly assisted by the spacious and well designed main waiting area which is served by a tea bar.

4 CLINIC LAYOUT

4.1 Obviously, considerable thought was given in the planning stage to the design of the clinics. The plans of these are shown at Appendix "D" and a brief history of the planning and construction of the Centre at Appendix "E".

4.2 The floor plan is "T" shaped having consulting suites in the two wings forming the horizontal of the "T" and treatment areas or special departments in the vertical wing.

4.3 The consulting suite consists of a consulting room each with an examination room. There is an extra large consulting suite at the end of each wing for teaching purposes. When not used for teaching, the examination room of the teaching suite can be used as an additional consulting room.

4.4 In discussion with Consultants, it was evident that the great majority were wholly satisfied with the layout, which is now considered to be a standard arrangement by the Scottish Home and Health Department. It has also proved successful for teaching purposes. A very few preferred the system used in the old department where the Consultant shared a large room with his Assistants. The reason given was that the old system enabled complete supervision of junior medical staff to be maintained. There is no doubt that from the patients' point of view the new plan provides privacy and a confidential atmosphere, and the Head Social Worker believes patients give personal details and communicate more readily in such conditions. The senior nursing staff were, apart from points of detail, pleased with the planning of the clinical areas. The nursing procedure rooms were generally appreciated and successful. The principal criticisms were:-

(a) That on occasions the waiting area is too small and does not give sufficient privacy for the receptionist who is frequently in communication with other clinics and departments on confidential matters.

If at times overcrowding occurs, attempts should be made to

reduce the numbers being called forward to the sub-waiting areas. Should this prove unsatisfactory, the problem could be overcome by reducing the number of small tables and re-arranging the chair layout. This would enable the receptionists' desks to be enlarged with a shelf arrangement at her side which would put the patients at a greater distance from her. (See Appendix "F")

A revised furniture layout would also overcome another criticism that some confusion can be caused when the waiting area is shared by more than one clinic.

(b) With only one examination room per suite consultations could be held up by a slow-dressing patient. There might be a case for providing an examination room on either side of each consulting room. Depending upon the nature of each clinic, the second examination room could be used as an additional consulting room if required. This suggestion found some support.

(c) There is no focal point for the nursing staff in the clinics other than the Sister's Office in Wing "A". Some Sisters felt that a duty station should have been provided in each wing.

It would have been useful as a report centre for the staff, and a communication centre out of hearing of the patients.

(d) Some examination rooms had doors opening opposite to the waiting areas causing a lack of privacy.

(e) On each floor one room to be shared by the Medical Social Worker and Dietitian was provided. This has proved to be quite inadequate but the decision of the Head Medical Social Worker to see all patients on Level 5 and leave the room for the sole use of the Dietitian has largely resolved this problem.

Ideally a small waiting room should have been provided for the Dietitian's patients in order to give her greater working space.

These comments are of a relatively minor nature and do not detract significantly from the good working arrangements.

4.1.1 Accident and Emergency Department

4.1.2 The concensus of opinion of the users was that the design of the department was good, saving that the cubicles opening on to two corridors were used as "short-cuts" by members of staff (see also para. 4.2.2).

4.1.3 An important design-in-use comment is that two theatres were provided, the original policy being that a full "scrub-up" was needed as preparation in one but not in the other. In fact clean cases are treated in both theatres and the point was made that if techniques are good and sterile supplies are used, there should not be any cross infection. This raises the question as to whether there is any point in having separate theatres for clean and dirty minor surgery if the total requirement of a theatre suite, including clean and dirty corridors, cannot be provided for patients, staff and goods.

4.1.4 The observation unit of eight beds has been fully used and is a successful feature of the department. Its many uses include holding patients while a decision whether to admit is taken, observation of accident patients with possible head injuries, psychiatric patients, and elderly patients who have had treatment but whom it might be unwise to send home alone. The poisons unit with a complete library and index is conveniently housed here.

4.2.1 Fracture Clinic

4.2.2 There is little criticism of the basic design to be made, saving that in a department of this size two theatres (one entirely for plaster work) might have been provided. However, only one theatre was provided to suit accepted local methods. Another point, which applies also to the Casualty Department, is that because some cubicles face on to a corridor at each end they are used as a "short cut" and this is disturbing to those examining or treating patients.

4.2.3 Because of the division of the Department into separate cubicles and treatment areas, the Sister feels that there is some

sense of loss of personal relationship between her and the patients. This is probably inevitable in a modern department providing many rooms for special purposes.

4.3.1 Eye and ENT Department

4.3.2 The Eye clinic treatment and consulting rooms are at the opposite ends of the clinic which means excessive walking for the nursing staff.

4.3.3 The original arrangement of dark room cubicles was unsatisfactory and they had been opened up to give more space. The revised layout works well.

4.3.4 It was intended that patients should be brought into the consulting room from the waiting area for immediate consultation. In practice some patients are waiting in the consulting room and while this obviously speeds up the clinic, it does reduce the degree of privacy.

4.3.5 It has been questioned whether a sluice room is necessary in an eye clinic.

4.3.6 In the ENT Clinic the treatment room and three cubicles are possibly too small. Moreover, in view of the close connection between diabetes and eye diseases and the more frequent need for urine testing in the Eye Clinic than in the ENT Clinics, it is not satisfactory that the urine specimens for eye patients should be collected in the male WC of the ENT Department.

4.3.7 The Orthoptic Department is rather limited both in space and in functional planning for the volume of work which it undertakes.

4.3.8 The waiting space has to be shared with the accident and refraction patients. This is not altogether desirable considering that the majority of orthoptic patients are children. It would have been desirable if a separate orthoptist room as well as a small office could have been provided, and the treatment area should be divided with some screening so that child patients are not distracted by their neighbours. The Lee's screen on order has not yet been installed.

4.4.1 X-Ray Department

4.4.2 The X-ray Department is situated in a very convenient position in relation to the accident service and fracture clinic. It is also on the same level as the main X-ray Department and wards. This greatly facilitates the transfer of patients.

4.4.3 The Department worked very well under pressure during the riots and the only major comments to be made on the layout are:-

(a) That there is no proper waiting space for patients on trolleys. They are left in corridors which can at times be quite cold, and this also gives the impression that patients are unsupervised.

(b) The X-ray rooms are considered to be too small when there are two tables in each room. When the department was under heavy pressure in the riot period it was necessary to remove one table to allow trolleys to manouevre quickly. The improvement was so apparent that the table has never been reinstated.

(c) It would be desirable to have a separate room for the skull unit. (It is understood that a Neuro-radiological Department with five specialised X-ray rooms will shortly be opened in the adjoining link Block.)

(d) The cubicles are too small for elderly patients who have difficulty in dressing.

(e) The dark room is on the small side for the number of films being processed.

4.5.1 Department of Physical Medicine

4.5.2 This department, which includes physiotherapy, gymnasium and hydro-therapy pool, was planned in consultation with the Director and is a spacious and well laid out department. Apart from points of detail, the major design suggestions are that the present gymnasium might have been one third smaller and the space saved used for fixed apparatus. The treatment cubicles have been divided into two groups, one for use by trained staff and one by

students under instruction. This has proved more satisfactory than the original concept of having one group for heat and massage treatment. Although there is a need to have some cubicles tailor-made, for certain treatments in order to avoid moving heavy equipment, such cubicles should be large enough to accommodate any form of treatment. This makes the use of cubicles more flexible. A further design point is that it might be an advantage to have the walls of cubicles constructed of rigid material instead of curtains to allow shelves and racks for equipment to be fitted. However, rigid walls would reduce the department's flexibility of use and it is a matter of opinion which feature is the more valuable.

4.5.3 If sufficient staff were provided, all the facilities of a day hospital for rehabilitation would exist and this suggestion deserves consideration. In particular, a more extensive and sophisticated occupational therapy service might be established.

4.6.1 Special Clinics

4.6.2 The planning of the Special Clinics 3B1 and 3B2, was largely the responsibility of the Consultant, within the limits of the space available, and the clinics in general work well. There are a few points which are not wholly satisfactory but these arise from a change of operational policy after the planning stage, e.g. the conversion of a Sister's Office into a Social Worker's Room, and finally into a subsidiary consulting room. Similarly, construction of a new building adjacent to the department has caused some rearrangement of accommodation.

5 CLINIC LOADING

5.1 Broadly speaking the clinic timetables are operating as shown in the King's Fund Report, and comprehensive timetables and clinic schedules have been produced.

5.2 There are relatively few consulting and examination rooms which are not occupied morning and afternoon from Monday to Friday. There are some rooms available on:-

Level 5 - Wing 'C'	- Dermatology	- Afternoons
Level 7 - Wing 'B'	- Surgical	- Afternoons
Level 8 - Wings 'A' and 'B'	- Ophthalmology	- Afternoons
Level 8 - Wing 'C'	- ENT	- Mornings
Level 9 - Wing 'A'	- Orthopaedic	- Afternoons

This would provide a margin for future expansion which is necessary in any Out-patient Department since new types of clinics are continually being initiated.

5.3 As an indication of the length of time during which the rooms are being used, it was noted that in most clinics patients were booked from 9.30 a.m. to 12.40 p.m. and from 2 p.m. to 4.40 p.m. A further indication of the patient loading is given by the fact that on the 2nd February 1970 non-urgent medical patients were being booked from two to three weeks ahead, and urgent patients one to two weeks. Non-urgent surgical appointments were being booked seven days ahead and urgent appointments four days ahead. It will be seen, however, from Appendix 'C', that waiting times for non-urgent appointments at numerous clinics exceed the fourteen days that was considered reasonable by the report on out-patients clinics issued by the then Ministry of Health in 1964.

5.4 A cursory examination of a sample of clinic loadings seemed to indicate that certain consultants might be able to increase the numbers of new patients seen at their clinics. Should this prove impossible, consideration may need to be given to the provision of additional consultant sessions.

5.5 However it must be said that patients are frequently brought in at short notice without prior booking at the direct request of the Consultant or other members of the medical staff, and these are presumably of an urgent nature. The frequency of this occurrence has an adverse effect on the appointments system in general causing extra waiting time for booked patients.

5.6 A major cause of delay in arranging appointments is that clinics are not infrequently cancelled, sometimes at short notice, by the Consultants. This leads to a considerable increase in the work load on the part of the Appointments Office as well as some inconvenience to patients. It is to a degree to be expected in a large hospital where apart from normal sickness and study leave, the consultant staff are frequently called upon to travel abroad and attend Court at short notice. However this situation is reaching such proportions that it has been necessary to introduce a "return" for cancellations. In a period of approximately 9 months 337 clinic sessions were cancelled involving the postponement of 2538 old patients and 2147 new patient appointments. It is suggested that the alternative of providing locum tenens either from within the hospital or from outside should be considered in order to reduce the delay before patients are seen.

5.7 A selection of out-patient waiting times is given at Appendix 'B'.

5.8 Generally the survey indicates that waiting time is not excessive and, in fact, in many clinics it is very short. Occasionally, the flow of patients through a clinic is interrupted by an unscheduled teaching session for medical students. Although this is a problem to be expected in teaching hospitals every effort should be made to reduce the effect on the appointment system. In all large out-patient departments unforeseen difficulties will occur from time to time which make for serious delays and the patients' attitude to this is largely conditioned by the manner in which the circumstances are handled by the staff. Where, as at the Royal Victoria Hospital, the waiting accommodation is comfortable and the staff are sympathetic and explain the causes

for delay, very few complaints are heard. (See Appendix 'A' Patients Comments).

5.9 The guide to the work load in the new building as compared with the previous scattered arrangements can be obtained from the following statistics:-

	1968	1969
Casualty Attendances	104, 300 (52, 000 new patients)	89, 500 (56, 600 new patients)
Total Attendances	602, 000 (226, 600 new patients)	591, 700 (232, 700 new patients)
X-Ray Films	191, 700	194, 700

5.10 These statistics are not an accurate comparison between the work load in the new building and the old because the new clinics were opened on the 17th February 1969 and the Accident and Emergency Departments on the 13th April 1969. Moreover the out-patient clinics were disorganised during the riots in 1969. The statistics for radiology include the work of the main department in the old building. Nevertheless it is interesting to see that the number of new patients in the out-patient clinics and accident department have both risen.

6 X-RAY SERVICE

6.1 The X-ray service functions broadly speaking as outlined in the King's Fund Report. Not only does it provide a twenty-four hour service for the Accident Department, but it covers the whole hospital at night. The Senior Radiologist does not agree that a Consultant should be designated to be in administrative charge of the Accident X-ray Department. It was said that the Radiological Committee would prefer to see the staffing of the department improved by the appointment of one or more Consultants providing eleven extra sessions. These sessions were asked for but not granted by the Northern Ireland Hospital Authority. This would enable the Senior House Officer and the Registrar to call upon advice when required.

6.2 No attempt has been made to explore ways and means of spreading the work load of the X-ray Department as recommended in paragraph 9.6 of the King's Fund Report, but as a proportion of the work arises from returned visits of fracture patients, such an exercise should prove profitable. One immediate benefit might be to separate the fracture and orthopaedic patients from the casualty patients who all report for return X-rays on Mondays. This might also mean some adjustment to the times of the fracture clinic sessions.

6.3 The staff of the department, as compared with that recommended by the King's Fund Report which was based on a twenty-four hour service, is as follows:-

	Recommended	In Post
Senior Registrars	33 sessions	11 sessions
Radiographers		
Superintendent	1	1
Senior	5	4
Junior	6	4
Secretarial		
Personal Assistants:		
1 to the Consultant	1	1
1 to the Superintendent	1	1
Shorthand/Typists	3	-
Clerks	5	5

	Recommended	In Post
Porters	3 (8.30 a.m. to 2 a.m.)	3 (8.30 a.m. to 8.30 p.m.)
Nurses	24 hour cover	-

Nurses are called from the Casualty Department when required, and bearing in mind the close proximity of the two departments, this is probably adequate.

6.4 The clerical staff, which it is suggested should work from 8 a.m. to 2 a.m. finish at 10 p.m. and after this time the work is done by an 'on call' radiographer and the receptionist at the Level 2 reception desk. There appears to be a need for a clerk to continue to 4 a.m. particularly at busy times, and this ought to be considered at the next staff review. In general the staff in post is adequate and it is not suggested that more should be provided unless facilities on Level 6 are opened when at least one shorthand/typist will be needed. The three shorthand/typists suggested by the King's Fund are not required and generally speaking the Superintendent Radiographer is satisfied with the staff level, although this situation would have to be reviewed if an additional eleven consultant sessions were agreed.

6.5 The shortage of senior radiologist staff causes unnecessary delays in the department because it is frequently difficult to contact a Radiologist of sufficient seniority. The junior radiological staff are continually referring to the main department for an opinion. If further consultant sessions were granted better cover would be provided and the facilities at Level 2, 6 and 7 could be used as planned.

6.6 The department is dependent upon the Level 2 porters for service after 8.30 p.m. and this is inadequate on occasion because of staff sickness and leave. It results in the Radiographers occasionally being required to take patients to and from the X-ray waiting areas.

6.7 One unsatisfactory feature of the work at Level 2 from the patients' point of view is that they are frequently required to undress

in the Casualty Department for examination, dress to move down the corridor to the X-ray Department, and then to undress again. It is suggested that the Heads of the two Departments should examine ways and means of removing this irritating procedure.

6.8 Most of the equipment is of Swedish or German manufacture and although these companies have local after sales service, there is some doubt in the minds of the hospital staff as to whether all the recommendations made for replacements etc. are necessary. They feel the need for advice from an independent expert and the Northern Ireland Hospital Authority might consider making an appointment, if it does not already exist, of a Radiological Officer as is the case in some of the Regional Hospital Boards in England. Apart from general advice to X-ray Departments, these officers have a great value in advising Radiologists on the purchase and installation of new equipment and the planning of new departments. (It is understood that such an officer has now been appointed.)

6.9 The X-ray room at Level 6 is not being used because of the lack of senior radiologist cover and this means that a discussion between Physicians and the Radiologist during the course of a clinic as suggested in the King's Fund Report cannot be carried out. Although some clinicians would be prepared to read their own films the Director of the Department does not feel that this is satisfactory since there would be no control over the quality of the films or of wrong calculations being drawn from films not adequately processed or not taken from the correct positions. There would apparently be no problem in providing sufficient radiographers for Level 6. A further argument in favour of the provision of more consultant sessions is that the level of reporting in the Accident Department X-ray Unit could be improved and more investigations relevant to the patient's condition could be carried out thus saving time when patients were admitted to the ward.

6.10 It is suggested that with the growth of radiology additional senior registrar cover will inevitably be required, and the view expressed by the Senior Radiologist that either a Consultant or Senior

Registrar should see the films of all spinal injuries should obviously be carefully considered. It is said that Senior Registrars are at present undertaking Consultants' work.

6.11 Apart from the question of medical staffing, it is a matter of consideration as to whether in future planning of an Out-patient Department of this size it is a good policy to provide special facilities at different levels. Although there is an obvious advantage to the patients in not being sent from one part of the hospital to another, there is no doubt that decentralisation produces administrative and staffing problems for the X-ray Department.
Where recruitment of staff is not difficult, however, the balance of advantages is probably in favour of reducing unnecessary movement for the patient.
Since the facilities have been provided, they should be brought into use as soon as possible and the discussions between the Northern Ireland Hospital Authority and the Royal Victoria Hospital concerning the provision of medical or other staff should be resolved.

7 PATIENT/STAFF RELATIONSHIP

7.1 In order to determine the reaction of patients to the new building a survey was made of 100 patients selected at random over various clinics and the Accident Department. A copy of the letter addressed to the patients and the sample questionnaire involved is as shown at Appendix 'A'.

7.2 It will be noted that the general reaction of the patients to the new building is most favourable and that they are particularly appreciative of the attitude of medical, nursing and other staffs. Patient comfort and easy working conditions for the staff provided in the departments make for good relationships. Apart from the reactions indicated in the survey, a casual and unobtrusive observation confirmed that a very happy atmosphere exists in the new "centre".

7.3 It will be noted that the few complaints which were made related generally to waiting time which is not uncommon in very busy out-patient departments, and is difficult to eliminate completely. Most of the favourable comments referred to the atmosphere of comfort and efficiency.

8 NURSING

8.1 The following table shows the level of staff engaged on out-patients and accident services before the occupation of the new building, the establishments proposed by the King's Fund Team and the Northern Ireland Hospital Authority, together with the staff in post at the time of the evaluation:-

NURSING STAFF - OUT-PATIENT CENTRE

GRADE	Previous Establishment	Proposed by KEHF	Proposed by NIHA	Proposed by BHMC	Staff in Post-February 1970
Assistant Matron		1		1	
Departmental Sister	2-Grade A Grade B	1-Grade A	1-Grade A	2-Grade B	2-Grade A Grade B
Sister - Whole time	6	14	12.5 Whole time equivalent	12	7
Charge Nurse - Whole time	1			1	1
Sister - Part time	4	3		1	4
Staff Nurse - Whole time	32	55	28	51	38
Staff Nurse - Part time	1	4	2	1	
SEN - Whole time				17	8
SEN - Part time	1			1	1
SRN or SEN W/T Holiday relief				5	
Nursing Auxiliaries Whole time	2 male	28	22	12	3)1 female 3)2 male
Orderly - Female whole time	1			6	3
Orderly - Female W/T Holiday relief				1	
Orderly - Male whole time	4	4		6	6
Orderly - Male W/T Holiday relief				1	
Student Nurse	29	Supernumerary Not Mentioned		20	27
TOTAL	54 all grades 29 students	110 all grades & Super-numerary students for Special clinics & new clinics	65.50 W/T equivalent. Students not mentioned.	118 all grades 29 students	73 all grades 27 students

Figures supplied by the Royal Victoria Hospital, Belfast.

8.2 The King's Fund Report recommends that student nurses should be recruited as supernumerary, but it will be seen from the table that they are at present included in the work and it is difficult to make a fair comparison between the recommended establishment and the numbers in post. Generally speaking, however, the staff situation seems to be adequate except that at the senior level there should be an Assistant Matron and two Departmental Sisters. There is also an acute need for a Night Sister of Departmental status to be appointed in the Accident and Emergency Department where, in the light of recent experience, there is a risk of sudden and heavy demand. Only relatively junior nursing staff are on duty at night at the present time.

8.3 The Eye and Ear, Nose and Throat Department may be a little understaffed because the clinics have to deal with casualties arriving at indeterminate times and there is a divided responsibility between the clinic and the Eye and Ear, Nose and Throat Hospital.

8.4 Many of the duties upon which the student nurses are engaged could be carried out by an auxiliary grade known in the hospital as "Ward Attendants" leaving a small number of student nurses to observe in the accident department, Level 2. They could undertake such duties as the changing of cubicle curtains, stocking of cupboards and, where necessary, simple chaperoning duties. It is said that in some clinics student nurses are not getting proper training since they are brought in as first year students and therefore have insufficient experience to gain advantage from their attachment.

8.5 It might be advisable in view of the variety of work in the Out-patient Centre and Accident Department for students to be in their second year when they would have more appreciation of the experience available.

8.6 Some members of the medical staff felt that there was a degree of over-staffing in the clinics on the upper floors, but this is probably only an impression gained by seeing staff at the beginning of a clinic when they enter their consulting rooms. They would have little knowledge of the work being undertaken by the nurses outside. This

impression is also probably inspired by the fact that there are from time to time shortages of trained staff on the wards and Consultants might feel that the out-patient staff could be transferred. However it has to be appreciated that many married nurses are willing to undertake part time duties in an out-patient department where they can work regular hours, but would not be so willing to work in the wards.

8.7 However it must be said that the Royal Victoria Hospital does not appear to have a major recruitment problem in any way comparable with hospitals in the United Kingdom. There is no question here of a new building being provided without sufficient staff to run it. All departments are well staffed in terms of numbers throughout the 24 hours in relation to the amount of work they carry.

9 VOLUNTEERS

9.1 The Hospital operates a hospital volunteer organisation which is particularly useful in the new out-patient building where they assist the receptionists and act as guides to patients. In other parts of the hospital they operate trolley shops and the usual types of service which are provided by voluntary helpers. At present, some 50 volunteers serve on a rota system, but if a hospital car service were to be organised as suggested in para. 14.2 this number would need to be increased, and the appointment of an organising officer of a fairly senior status would be justified. It has been found necessary in some London Teaching Hospitals to appoint a whole-time officer of considerable seniority to make the best use of volunteer help. In economic terms a suitable person would more than justify his/her appointment.

10 MEDICAL RECORDS

10.1 The King's Fund Report made specific suggestions concerning the equipping of the Medical Records Department and of the central dictating pool. These recommendations were adopted and the equipment purchased.

10.2 The mobile storage shelves supplied by Acrow Automation Limited were installed, and they provide space for 1,100,000 medical notes and X-ray films in the department. At present about two thirds of the capacity of the shelving has been taken up, but the remainder will be necessary for the incorporation of notes from Dermatology, Neurosurgery, Neurology, Orthopaedic and Urology Departments, as well as giving space for future expansion. New registrations are now amounting to 26,000 per annum.

10.3 The suggestion that the mobile shelves should be motorised was considered but not adopted because of the cost involved. The present shelves are rather heavy to move, but the staff have learned the correct technique of leaning on rather than pushing them. Movement of the shelves can be a somewhat slow process and it is a pity that in this very modern department the money was not available to adopt the refinements suggested. However it has been said that maintenance of motorised equipment might have caused difficulty because of lack of servicing facilities in Belfast.

10.4 The Sankey-Diebold equipment for the master index has been installed and it is working very well indeed and plays a very useful part in the efficient 24 hour service that is provided by this department. It is emphasised at this point that the service is in fact efficient. Some comments have been made by Consultants that their clinics are at times disrupted by lack of medical notes. As is the case in most hospitals, a frequent cause of "lost" notes is that they are removed from clinics to various parts of the hospital (including Consultants' cars!) without the Medical Records Department being notified. No medical records system can function efficiently unless those concerned with the handling of notes submit themselves to the necessary disciplines of the system.

10.5 Although maintenance of the Sankey-Diebold equipment by the manufacturers is satisfactory, it is unfortunate that they will not supply working drawings to the Group Engineer so that some minor repairs could be carried out immediately. The two machines are handling between 520 to 550 references per day.

10.1.1 Appointments System

10.1.2 The procedures indicated in the King's Fund Reports are being followed, with only minor variations, and they are working well. The methods of pre-registration by letter and telephone are being employed. The only significant difference is that re-appointments are made by the receptionist in the lift lobby and not by the one in the clinic sub-waiting area. It was found impossible in practice for one person to act as receptionist and to deal with appointments. Observation at peak periods confirmed this.

10.1.3 The form used by doctors for appointments by post is also used by the admission clerks when requests are received by telephone. It is the Northern Ireland Hospital Authority form which is issued to general practitioners throughout the province. The letter is also used as an information slip in the medical records system. This degree of standardisation is to be commended and it is certainly helpful not only to general practitioners, but to hospital staff moving from one hospital to another.

10.1.4 The circular desk, with a central rotating file, recommended in the King's Fund Report has been most successful, especially as it is served by a GPO six-station extension which enables any person to answer any one of the six extensions.

10.1.5 In addition to making appointments the reception desk at Level 3 is used as an enquiry bureau by patients and visitors. The staff are also in communication with the clinic floors and are able to operate a call system which directs the patients to the clinic sub-waiting areas when necessary. The liaison between the appointments clerks on Level 3 and those on the upper levels in arranging new and re-appointments is good. They also co-operate successfully with the

Consultants' secretaries in arranging appointments after a series of investigations have been completed. An indication of the current time required for a new appointment for patients is given at Appendix "C".

10. 2. 1 Admissions

10. 2. 2 Patients are admitted at Level 2 and when observed they were being dealt with expeditiously at the main reception counter before being passed to the admissions office. As a simple improvement it is suggested that signs should be placed on the counter indicating "Admissions" "New Patients" and "Re-appointments" to assist patients. At times they looked a little lost - not knowing to which clerk they should speak. (These signs have subsequently been erected.) The admissions office works well but is subject to quite heavy pressure at times because of the various quarters from which patients arise in addition to those from the waiting list, e. g. admissions from the Casualty Department, emergency admissions requested by general practitioners and those arising from the hospital's "take in" day for the City of Belfast. The complications of dealing with the Eye and Ear, Nose and Throat Department in this building were apparent because it had been found in practice that patients for these specialties were best referred directly to the Eye and Ear, Nose and Throat building. It again raised the question as to whether it would not be possible to treat this as a completely separate hospital for all purposes.

10. 2. 3 Unfortunately there is no separate waiting room adjacent to the admissions office and there are frequently several patients in the office at one time who can overhear personal details given to the clerks by other patients. There is little privacy, which seems unfortunate, in a country which is particularly sensitive to some personal details. It would be an advantage if some effort were made to find a separate waiting room for this section.

10. 2. 4 The admissions slip, which has been designed by the Northern Ireland Hospital Authority, appears to have some

questions on it which are unnecessary and might be regarded as an intrusion into the personal privacy of the patient.

10.2.5 The admission slips are despatched to Level 4, to the Chaplains, the Northern Ireland Hospital Authority, Enquiry Office and the ward. The new admissions are referred on the facsimile transmitter to Level 4 for registration and as this particular machine is used only for admission purposes, it might be transferred from the reception counter to the admissions office.

10.2.6 In the King's Fund Report the question was raised regarding the Enquiry Office which is controlled by the officer in charge of the admissions department. As a result of a tentative suggestion in the Report that it might be located at Level 2 in the new building, the Chief Engineer of the Northern Ireland Hospital Authority prepared a paper suggesting that the work might be undertaken by telephone operators on the switchboard. He was critical of the King's Fund suggestion and said that "their preconceived ideas of how an enquiry office should function were not related to the needs of the hospital". In fact the King's Fund Report made no specific recommendation and only suggested possible alternatives together with a proposal that a publicity campaign might be started to tell relatives not to telephone the hospital more than is necessary.

10.2.7 This matter was investigated in some depth and it is obvious that the scope of the work undertaken by the enquiry office is much greater than might be realised. Apart from answering enquiries by relatives and friends about patients, it also acts as a general information centre for hospitals in the city. Relatives are not merely informed that a particular patient is not in the Royal Victoria Hospital, but an effort is made to contact other hospitals and the enquirers are so informed. It certainly provides a service of much wider scope than is usually found in a hospital. Several facilities such as the direct lines to individual wards and Muirfax facsimile communication with the admission unit giving an up-to-date index of all patients in the hospital, are features which could not possibly be dealt with by switchboard operators.

10. 2. 8 It is obvious that the redevelopment of the hospital will soon require the Enquiry Department to be moved from its present position to an alternative site. As the work which it undertakes is very much connected with the function of the new building, it seems an obvious place to which it should be moved. There are two possible sites which might be suggested, first the area of the pram park and children's room which do not appear to be greatly used at Level 3. If it were sited here it could be used as an enquiry desk for the hospital as a whole and handle personal calls as well as telephone enquiries. This would relieve the normal reception work at Level 2 and 3. Alternatively, it might be possible to take part of the waiting area in Level 2 and convert it into an enquiry office. The advantage here would be that it is adjacent to an area which is already staffed for 24 hours and duplication of staff might be avoided. The numerous functions of the enquiry office mentioned in paragraph 10. 5 of the King's Fund Report could well be undertaken at the Level 2 reception desk which is manned throughout the 24 hours, provided that some additional staff were allowed. This would not only relieve the pressure on the staff in the enquiry office, but would allow the latter to be closed from 10 p. m. onwards when the number of enquiries falls off. In either case the reception and enquiry office staff should be trained in each others duties so that they could readily relieve each other.

10. 2. 9 It would give more flexibility to the staffing arrangements if either of the above proposals were adopted. There are arguments in favour of each location but it must be a matter for the hospital to decide which is most suitable in relation to its future plans.

10. 2. 10 The matter of the enquiry office is closely connected with the question of providing a new hospital switchboard to replace the existing GPO telephones and the AEI internal telephone system by one PABX3 system. This is discussed later in this report under Communications. The new switchboard would provide more extensions for the enquiry office which are not available at present.

10.3.1 Transmission of Medical Records

10.3.2 Medical records are transported from the various levels by a hoist which has to be routed via Level 4. The other floors cannot send notes to each other without asking the staff at Level 4 to re-route them. It was a planning decision to do this, but it was also apparently impossible to install a self-discharging hoist for technical reasons. However, one doubts the wisdom of restricting the flexibility of communications in this way. Certainly a self-discharging system can work well without losing control over the movement of notes.

10.3.3 The transmission of admission slips between Level 2 and Level 4 is by a Muirfax facsimile transmitter. This apparatus serves the purpose well but it would be interesting to compare its overall performance and flexibility with a pneumatic tube. Has the Department of Health's advice concerning pneumatic tube installations obscured the value of a restricted service ? (See section on Communications below.)

10.4.1 Secretarial Services

10.4.2 The secretarial services provided by the Medical Records Department are as suggested in the King's Fund Report. The audio-typing pool which supplements the individual secretaries attending to the consultant firms has been an outstanding success. Although some Consultants were initially sceptical of the efficiency of the pool, they have largely been converted to its benefits. It is anticipated that the few who do not use it will shortly be convinced of its usefulness by their colleagues.

10.4.3 The system, which has been relatively trouble free, is the Dictaphone Band which was preferred to the Taperiter suggested by the King's Fund Team.

10.4.4 The audio-typing pool has been a good "training school" for medical secretaries for the consultant firms.

10.4.5 The five audio-typists are dealing with about 100 letters per day. One of these typists has been added since the department opened.

10.4.6 As an indication of the efficiency of this department, a superficial look showed that the despatch of letters was only one day behind the date of dictation. In some cases letters were being returned to the clinic on the same afternoon. During the worst stages of the influenza epidemic in December the typing pool was only four days behind. This compares very favourably with hospitals using direct dictation only.

10.4.7 One unsatisfactory feature of the department is that there are no separate rooms for the storage of stationery or for copying. At the moment space is used in the staff cloakrooms. It is suggested that the duplicator and the Xerox copying machine should be placed in a separate office since a room of this sort for a large department is essential. Another point is that the noise level when all the typists are at work is fairly high. The combined sound of typewriters and telephones can be quite irritating and the efficiency and the output might be improved if some form of screening by acoustic materials between desks were provided.

10.5.1 Policy regarding Medical Notes

10.5.2 The hospital policy is to maintain medical notes indefinitely. No decision has been taken on the recommendations of the Tunbridge Committee but unless some decision is taken soon even this new and modern department will not be able to maintain a central library of all medical notes. Currently new files are being raised at the rate of 26,000 per annum. Furthermore the volume of individual notes is continually increasing because of the multiplication of investigations, e.g. ECG, EEG. In addition there are several large stores of old notes in the hospital which are rapidly deteriorating. Soon these will be of little value to anyone because they will be totally unsuitable for retrieval.

10.5.3 The medical staff should reach a conclusion on this subject which will enable all medical notes within a defined period to be kept in the library on Level 4. This means restricting the total number to 1,100,000.

10.5.4 The X-ray films in store take up 75% of the planned capacity. Bearing in mind the growth of radiodiagnostic investigations, the margin for growth is minimal. Any forecast of the long term capacity of the department is limited by insufficient data on future developments in computerising and microfilming. However this is likely to be a very distant prospect because of the sheer size of the problem of reducing existing records to computer language or of microfilming so many documents. Preparation of the papers for either of these processes is an immense task.

10.5.5 Some comment was made concerning the wisdom of providing such a large department in the new building in view of the need for clinical space. However, the construction of the department is such that if at a future date it is decided to reallocate some of this area for clinical purposes, the necessary modifications can be made without undue difficulty. It should be constantly borne in mind that an efficient medical records department is the heart of a hospital and without it chaos would prevail. The Royal Victoria Hospital is fortunate both in the opportunity to deal with the problem and in the manner in which it has been carried out.

10.6.1 Staffing

10.6.2 The numbers of administrative and clerical staff in post at the time of the evaluation are slightly higher in the clerical and shorthand/typing grades than were recommended by the King's Fund Report, but the number of higher clerical officers appointed in slightly less. In general, the King's Fund staffing estimate seems to have been reasonably accurate in terms of overall numbers, but the allocation of staff has had to be revised to suit the changes in departmental needs that have evolved.

11 MEDICAL ILLUSTRATION

11.1 The photographic and medical illustration department is not functioning or equipped entirely in the manner suggested in the King's Fund Report, Section 12, and the reasons for the variations are quite valid. As is quite natural in an exercise of this sort, the member of the King's Fund Team primarily responsible for the recommendations had special interests and views which do not necessarily coincide with those of the present Director. In a department of this very special nature there is a good deal to be said for deferring the final detailed planning and equipping until a permanent Director has been appointed. In the case of the Royal Victoria Hospital basic planning had been completed and the building was under construction before the King's Fund Team visited the site, and the Director paid tribute to the work of the planning team and the Northern Ireland Hospital Authority. As developments were so far forward it would probably have been better to have left this department out of their brief completely and gone ahead with the appointment of a Director. He could then have advised on the final details of planning, purchase of equipment and commissioning.

11.2 It would not be profitable to discuss in detail all the differences between the equipment recommended and that said to be required, variations in use of rooms, or the methods of working. It is sufficient to say that the present Director of Photography appears to be organising a service which is related to the needs of the hospital. However, the following comments on broad policy are submitted:-

(a) There appears to be little co-operation between the hospital and the university in matters of medical illustration. In particular the medical artist works entirely for the medical school and his work is primarily for teaching. It would seem that an effort should be made to set up a combined department.

(b) The suggestion made by the King's Fund Team that an offset litho reproduction service should be provided might be reconsidered in the light of a possible wider scheme being established by the Northern Ireland Hospital Authority.

(c) Until the demand develops or some common policy is decided with the medical school, it is probably more economic to continue to send colour printing to outside processors.

(d) Ophthalmic photography is better carried out by Ophthalmologists.

(e) If it should be decided to develop television for teaching purposes, a working party of clinical teachers and the Director of Clinical Photography should visit established departments of Audio-visual Communications elsewhere.

11.3 The staffing position is as follows:-

	Recommended by King's Fund Team as initial establ:	In Post	Now Suggested
Head of Department	1	1	1
Qualified Medical Photographer	3	2	4
Trainee Photographer	1	3	1
Chartist	-	1	1
Trainee Medical Artist	1	-	1 (at future date)
Receptionist/Clerk	1	1	2

Trainee medical photographers should be seconded from other hospitals for experience.

Excluding the medical artist, the suggestion is for the addition of one to the total of the previous establishment and this should be adequate for some considerable time.

11.4 Some of the very expensive equipment recommended by the King's Fund Team was not in fact purchased because the Director did not think that it was necessary. It is to be hoped that he will be allowed an equivalent amount to purchase equipment that he considers appropriate.

11.5 Detailed notes concerning the facilities in the photographic and medical illustration department are contained in the separate Addendum. (See para. 12 of the Summary of Conclusions and Recommendations.)

12 STERILE SUPPLIES

12.1 Sterile supplies are delivered to a stock room at Level 1 in the new building and thence are distributed on a "top up" basis by CSSD staff to the clinical areas. The system is operating well and is obviously appreciated by the staff.

12.2 It might be preferable, however, to have a stock room at Level 2 thus making deliveries from the main department, which have to be brought by van, easier. If it is possible at a future date to make this change, it might improve the organisation from the CSSD point of view. Should the delivery and return rooms remain at Level 1, they could with advantage be interchanged. Further reorganisations may become necessary when other stages in the hospital's development are completed and Level 1 is used as a general access.

12.3 The plastic coated wire mesh racks used for storage units in the clinic rooms have had a mixed reception; the Operating Theatre Superintendent particularly liked them, whereas some staff would prefer the enclosed glass fronted type.

12.4 When extending the CSSD service to new departments of the hospital this particular point might be worth discussing in detail.

12.5 A creditable effort is being made on the part of the CSSD Superintendent and the Head Porter to ensure that deliveries and returns of sterile supplies are transported in the lifts outside peak periods. There are problems, however, because deliveries to the new building have to be linked with the general delivery timetable of the main department. The problem would have been easier had there been a goods lift in the new building (See Communications).

14 TRANSPORT

14.1 Patient transport arrangements are made at a reception desk at Level 2 and this section copes not only with the Royal Victoria Hospital's patients transport arrangements, but also with the return journeys for all the hospitals in the city. For this reason the establishment of two transport officers as distinct from one recommended by the King's Fund is clearly necessary. In fact it is barely sufficient if there is any heavy incidence of sickness among the staff.

14.2 In order to economise in transport, the Northern Ireland Hospital Authority arranges the return of in-patient to their homes by ambulance on a district rota basis, i.e. some ambulance journeys are only made to some areas on certain days of the week. This means that patients may be kept in hospital for one or more days longer than is necessary on medical grounds. Clearly this is wasteful in terms of use of beds although it may be economic from a transport point of view. The Group Secretary's solution to this problem would be to organise a Hospital Car Service staffed by volunteers and it is certainly a suggestion which merits careful investigation since beds in a highly geared teaching hospital should not be used to accommodate patients who are well enough to be discharged.

15 REST ROOMS AND CATERING SERVICES

15.1 The staff rest rooms now provided, which are in line with the amendments suggested by the King's Fund Report, are a much appreciated facility and obviously help in maintaining good staff relationships. However, the portering staff have been somewhat neglected and they are expected to use the porters rest room in the main building which is a considerable distance from the out-patient centre. This means that in fact they use the patients' canteen and rest areas. This is not a good practice because it can give the patients the impression that the porters are wasting their time, and the porters themselves are unable to relax during their break. (Porters are now permitted to use the Ambulance Crews' rooms.)

15.2 The staff feel that there could be a better variety of snacks in the rest rooms on the upper floors but the facilities at present available are not sufficient to embark upon a wider range. There is clearly little space to spare to cut and prepare sandwiches on a more substantial scale and the only storage space available is in a pipe duct. It is suggested that counter cafeteria units should be provided in all the canteen areas instead of hot water boilers and steam jets. If some rearrangement of the counter and shelving were made, it ought to be possible to provide heated display cabinets for the storage of manufactured pies, sausage rolls and similar snacks which might meet the staff's requirements.

15.3 The service to the patients is good and if any of them require a more substantial meal they are directed to one of the hospital staff restaurants.

15.4 Instead of providing a 24 hour service at Level 2 vending machines for liquid refreshment have been installed to deal with night traffic. As this has been successful it is worth considering whether the range of machines could be extended to include snack meals.

15.5 It is recommended that a change machine should be installed immediately so that patients can obtain the correct coins to insert into the beverage machines.

15.6 No recommendations were made in the King's Fund Report regarding staffing, but the catering officer is satisfied with the present arrangements. With the help of the volunteers, which is appreciated, it should be possible to cope for some time with the rising sales of the various canteen areas.

15.7 The waiting areas for the patients on all levels are comfortable and the main area at Level 3 is particularly agreeable.

16 BUILDING AND ENVIRONMENTAL CONDITIONS

16.1 The general planning of the building is discussed in para. 1.5.

16.2 It obviously works well and is generally well favoured by staff and patients. There are, of course, some minor points to note as is the case in any new building and these have been listed separately. The comments which follow in this section of the report are intended, not as criticisms of a good, working, hospital building, but as suggestions which might improve situations which it would have been difficult to foresee.

16.3 One problem is that there are considerable draughts entering Level 2. These come through the goods entrance, the patients' entrance and down the escalator. The patients' entrance is completely enclosed to provide a covered area for unloading ambulances and it forms a natural wind tunnel. This is no doubt emphasised by the phenomena of air vortex conditions adjacent to high rise buildings. The draught coming down the escalator is caused by air movement from the Falls Road entrance on Level 3 since there is no door at this point. This can be cured by installing doors.

16.4 All the main doors at Level 2 and Level 3 are of the 90^{o} locking pattern. They remain open to allow the passage of trolleys and wheelchairs. It was noted by observation that they were frequently left open by patients and by ambulance attendants. It is understood that it is proposed that the doors should be replaced by flexible swing doors but apart from spoiling the elegant appearance of the entrance it is doubtful if they would be effective. The draught would probably keep them permanently open. Fixing notices on the doors saying "Please close this door" might be effective but this is doubtful. Alternatively the 90^{o} lock might be removed. A more satisfactory solution would be to install self-opening and closing sliding doors, as are used effectively at airports. It is appreciated that they have not found favour in the X-ray Department of the Royal Victoria Hospital but this may well be due to an unsatisfactory floor operating mechanism. A sliding door system would work in well

with a warm air curtain. This would be a great comfort to the waiting patients and the staff working on the Level 2 reception desk.

16.5 In connection with entrances, the ribbed rubber floor coverings on the street side are difficult to keep clean and do not remove foot-borne dirt. It is suggested that nylon-felt type carpet should be used. It is durable, easily cleaned, has a warm appearance and is obviously successful at Ulster Airport. It is being increasingly used in hospitals.

16.6 The problems of the PVC floor are referred to later. If successful, the nylon felt might be extended to the sections of Level 3 and Level 2 which have the heaviest wear should the methods of cleaning suggested in para. 19.4 prove unsuccessful.

16.7 The protection of columns, corners and doors was left until after the building was occupied, in order to show where it was most needed. This was an original but successful idea and the work of fixing was going on during the evaluation period. It is hoped that this work will be extended to the front of the reception counter on Level 2 which is being severely damaged. Hard-wood rails have served not only as aids to handicapped patients but as a wall protection in corridors. It is suggested that this method be extended to both sides of all corridors.

16.8 A further protective measure which would preserve the building would be to fix laminated plastic strips on walls behind the chairs in the patient waiting areas. This would stop scratching and grubby marks. The extent of wall damage indicates that some of the equipment is not designed to avoid it (vide "Damage in Hospitals" - a report to the Architects Branch, Ministry of Health by J. G. Guest, Dip. Arch., Assistant Regional Architect, Wessex Regional Hospital Board, March 1967).

16.9 The design of Levels 2 and 3 is necessarily in considerable depth. This is partly conditioned by the site and partly by the need to make certain departments conjoining, e.g. accident, fracture and X-ray. Although the basic principle of the layout is efficient, it can

produce a rather "maze-like" environment for the staff and by reason of planning in depth, natural daylight is excluded. The latter is not necessarily harmful since a fair proportion of the population have to spend their working day in similar circumstances, e. g. shop workers in large departmental stores. However it seems to the outside observer that the situation has been to some extent aggravated by the mono-chromatic nature of the decoration, floor coverings and lighting.

16. 10 It is suggested that when re-decoration is necessary some areas should be painted in different colours and that cubicle curtains should be in varying patterns and textures in different departments. Lighting can be varied in the corridors so as to give the impression of exterior daylight. Whilst it is appreciated that neutral shades are preferable for floor coverings since they must be seen in relation to various wall colour schemes over the years, the colour and pattern of the floor covering might be changed in some areas. It is suggested that good quality prints should be hung on the walls in the corridors and waiting areas.

16. 11 One rather puzzling criticism by some sisters was that the floor seemed hard in the new building. As the old Out-patient Department had a terrazzo floor which is harder than PVC it is difficult to suggest any explanation other than the walking distances are greater and cause fatigue.

16. 12. 1 Heating and Ventilation

16. 12. 2 The heating and ventilation system was discussed with the Consulting Engineer, Commissioning Engineer and Group Engineer. It consists of perimeter heating providing a temperature of 55°F supplemented by a plenum system which raises the general temperature to 65° - 68°F and in some rooms there is a further warm air booster in the ceiling which can be operated to vary the temperature by a further 3°. The staff complained that some rooms were too hot and others too cold. This might be subjective since there was no general agreement on which parts of the building were unsatisfactory.

16.12.3 The Northern Ireland Hospital Authority had apparently carried out performance tests before accepting and were satisfied that the equipment is performing as planned. The results of these tests have not been passed to the Group Engineer. This should be done. It is possible, however, that the addition of equipment and personnel have made a noticeable variation since then. It is probable that individual reaction to temperature and humidity account for the criticisms. It is also possible that heating problems are caused by the staff opening the windows which are double glazed to prevent heat losses. This can upset the balance of the heating systems. They are intended normally to be kept shut and ventilation is provided by air under pressure from the plenum system. The object of the reversible opening windows is to facilitate cleaning, not to ventilate. The staff should be informed of this.

16.12.4 The Consulting Engineer was aware of problems arising from filters and some heating control units and these were being followed up. Despite individual complaints, conditions appeared to be quite reasonable and it is suggested that wall thermometers be fixed in a selection of rooms on each floor so that the occupants can see the temperature for themselves. If there is a room which is abnormal then a daily record can be kept by the staff which will provide concrete evidence for the Engineer to work on. The cold spots in some rooms on Level 3 may improve when the new link block is completed.

17 COMMUNICATIONS

17.1 Lifts

17.1.1 In general discussion about the new Out-patient Centre the senior staff usually brought up the question of the adequacy of the lifts. There are three, one operating under its own programming system called the "bed lift", and two "passenger" lifts which are programmed together.

17.1.2 At peak periods a casual timing showed that the longest delay was approximately three minutes. This occurred when patients were arriving in large batches at 9.30 a.m. Although three minutes can seem a long time it would not subtract much from the total working day of even the busiest member of staff. One member of the staff made the pertinent comment "No one is in a hurry until he reaches the lift".

17.1.3 One of the frustrating factors is that the lifts are frequently ascending or descending in unison, which is of course mathematically certain to happen when batches of patients arrive for clinics on the upper floors and the lifts are programmed to work out the most economical journeys. It is doubtful whether there is any advantage gained by duplex programming. The two passenger lifts seem to bear a higher proportion of the traffic than the bed lift because of the positioning of the operating panels. The bed lift panel is on the far left side of the lift shaft whereas those for the passenger lifts are in the centre. They naturally attract the attention of the passengers. It would probably be too expensive to change the position of the panels now but in a future building this detail might be borne in mind.

17.1.4 Another factor worth mentioning is that the stairs are not used very much by patients or staff although there would be little hardship in using them for descending or for single floor movement. The reason for this may well be that the stairs are not readily noticeable because the access doors are not immediately at the side of the lift shaft. It might be useful to erect signs pointing to the stairs and notices asking staff to use them for descending.

17.1.5 Although conscientious efforts are being made to programme stores deliveries so as to avoid peak periods, it is probable that the installation of a goods lift in a different part of the building to the passenger lifts (but in addition to them) would have made for more efficient movement of personnel and stores. The goods lift in the Eye and ENT Wing is not used by the staff in the new Out-patient Centre since it would involve excessive movement of trolleys between the two buildings.
It would be of interest to future planning teams at this hospital to know what data was used to determine the number of lifts.

17.1.6 Observation of traffic at peak periods clearly demonstrated the need for lift attendants.

17.2 Escalator

17.2.1 The installation of an escalator is a fairly novel idea in British hospitals and it was interesting to see one in use in such a busy Out-patient Department.

17.2.2 Once the decision had been taken to make the entrance on the Falls Road (Level 3) the main entrance to the hospital for ambulant patients and that on Level 2 for vehicle borne patients, it was obviously necessary to provide a form of quick access from one level to another. But it is pertinent to question whether it would not have been preferable for all accident and fracture patients to have been directed to the Level 2 entrance.

17.2.3 The alternatives are stairs, lift or escalator. Lifts for one-level storey movements are slow and uneconomic. The choice then lies between stairs and escalator and as the difference in level is rather great, the former would have been far too time-consuming for staff and difficult for handicapped patients.

17.2.4 In the circumstances an escalator was a logical choice and it works well. The porters on both Level 2 and Level 3 were equally satisfied that they encountered few problems in directing or assisting patients from one floor to another. Patients who could not use the escalator were taken in the passenger lifts.

17.2.5 The greatest problem occurs in the evening when children are tempted to use the escalator as an "adventure playground" to the annoyance of the staff and patients.

17.2.6 As a door at the top of the escalator is necessary to exclude draught it is suggested that one should be installed immediately and that it should be locked at night. Entry should then be via Level 2.

17.3 Document Transmission Systems

17.3.1 As has been said earlier in this report, the views of the Department of Health in London regarding the general installation of pneumatic tubes should not exclude consideration of providing the facility between a few points having heavy traffic, e.g. Accident Department, Fracture Clinic, Medical Records and Admissions Office. Although more expensive it is more flexible in application than facsimile transmissions.

17.4 Telephones

17.4.1 The hospital, because of its size and because it handles some services, e.g. patient transport, for all the hospitals in the City, has very heavy telephone traffic and at some stage will have to consider an enlargement of its switchboard. The opportunity might then be taken of dealing with three problems which were noted during the evaluation. They are:-

(a) The desk inter communication system installed in the new building is not very popular and is not sufficiently private.

(b) The doctors would like a means of telephoning on the GPO system either in or adjacent to their consulting rooms.

(c) The Enquiry Office will have to be moved and should be given more lines.

17.4.2 If a PABX3 (or a later development) were installed, internal and external calls could be dealt with on the same instrument without using the main switchboard operator. This would remove the need for the separate AEI internal telephone

system and provide a more confidential system than the desk intercom. With the additional extensions available "jacks" could be installed in consulting rooms which would allow consultants to plug in a GPO telephone as required. The direct external dialling facility would also be of great value in a new Enquiry Office whilst reducing the pressure on the main switchboard operations. Abuse of this system can be limited by technical means.

18 MAINTENANCE

18.1 The building was at the time of the visit still in its contractors' maintenance period and the responsibility for the engineering services was still with the Consulting Engineer and the Commissioning Engineer. Nevertheless the Group Engineer, who has a planned maintenance system in operation, had introduced the new building into his programme. Up to the present, the Group Engineer has coped with any maintenance demand with his existing staff, but in view of the sophisticated nature of some of the plant and services, extra staff with special skills may be needed when the engineering services are "handed over".

18.2 There was a consensus of opinion among the engineers that there had been a minimum of "teething" troubles and the engineering services, including lifts, had settled down well. The principal problem was that the firm supplying the heating controls was based in England but arrangements have now been made for a local firm to undertake maintenance under contract. Co-operation with installing contractors had been good.

18.3 The Group Engineer did not seem to have taken part in the planning or design stages and in this respect the Northern Ireland Hospital Authority did not act differently to other hospital planning authorities. However there is much to be said for consultation with him at this stage since it can be of great assistance in commissioning and in subsequent maintenance. Certainly a Group Engineer should be provided with working drawings as early as possible and be given the opportunity of "looking in" on the actual installation.

19 CLEANING

19.1 The cleaning of the new building is the responsibility of the Domestic Superintendent of the Royal Victoria Hospital. Supervision is exercised by her or her supervisors and is not the responsibility of the nurse administrator or the floor sisters. This is the right policy provided that there is a proper liaison between the two officers, since it is difficult for a nurse administrator not to make comments on cleaning standards. At present there is no officer on the Domestic Department staff of sufficient seniority to work closely with the nurse administrator. It is therefore recommended that an assistant domestic superintendent should be appointed for this building. The grade of domestic supervisor is inadequate.

19.2 The staff provided appears to be adequate but a true estimate can only be made if the total hours worked is known, as distinct from the number of people employed, in relation to areas to be cleaned. This might usefully be the subject of a full Work Study exercise.

19.3 The Domestic Superintendent feels that she was not adequately consulted about staff numbers, or the cleaning equipment supplied. She also feels that she might have been allowed to express her views on the floor coverings chosen. However the cleaning aspect is only one consideration in choosing a suitable floor covering in the various areas of a hospital and the planners are usually well briefed on the problem.

19.4 The principal material used for the corridors and waiting areas is PVC which because of its light colour shows considerable marking from rubber heels. PVC is notorious for this and is probably best used in fairly heavily mottled colours and laid in contrasting patterns, e.g. chequerboard. The method of cleaning leaves something to be desired since the main traffic areas are merely wet mopped with some scouring of heavily marked areas. It was suggested that emulsion polish could not be used on Level 2 and parts of Level 3 because these areas were in use throughout the day and night. This is not a valid reason since it should be possible,

with the co-operation of the nursing staff, to rope off areas in turn for 12 hours. The double corridor layout of Level 2 would lend itself to this.

19.5 At present the floor scrubbing and polishing machines are operated by general porters as part of general duties. It is recommended that a floor scrubbing and polishing team should be established to carry out this work throughout the hospital. They should first be properly trained in methods of dealing with different types of floor surface.

19.6 When a good layer of polish has been built up the black scuffing marks will be reduced. The correct cleaning materials are already available in the Domestic Superintendent's store on Level 1.

19.7 Although the hospital cleaning staff was increased to cover the extra work in this new building, no extra provision for changing accommodation was made. The domestic staff are expected to use the hospital changing area in the main building which is not only inadequate for the extra staff but at some distance from the Out-patient Centre. However there are spacious cleaners' closets on each of the upper floors and if these were fitted with a coat hanger they would serve the purpose of an on-site changing cubicle for the staff working in those areas.

19.8 It is suggested that wall washing should be carried out either by a specially trained team of hospital staff or by contract with an outside firm.

19.9 There is some division of responsibility concerning the cleaning of canteen areas and this ought to be resolved by a directive from the administration. The normal practice is for catering staff to clean rooms where they serve meals but in waiting space where there is no boundary this may not be practical. (This division of responsibility has now been resolved.)

19.10 There appears to be a fairly high rate of staff on sick leave and it might pay to ask the Social Studies Department of Queen's University or an industrial psychologist to investigate this.

20 COMMISSIONING

20.1 The King's Fund Report rightly stressed the importance of the establishment of a Commissioning Team and that it should make an early start.

20.2 This was done and the commissioning went so well that numerous members of the staff spontaneously referred to the success of the operation.

20.3 This is a tribute to the officers concerned who obviously co-operated well among themselves and with the Architect. They deserve congratulation.

21 MANAGEMENT

21.1 In the King's Fund Report (paragraph 14) the question of management of the new department was dealt with at some length and the positive recommendation was made that a manager of out-patient services responsible to the Group Secretary for the management of the new wing should be appointed. Emphasis was made on the degree of executive authority that such an officer should have, and it was recommended that an appropriate salary range would be on the scale of an Assistant Secretary provided that some other duties relating to the general administration of the hospital might possibly be associated with the appointment.

21.2 In practice an officer in the Principal Assistant grade was largely responsible for the commissioning of the new building and acted in the capacity of general manager, as suggested in the King's Fund Report, in the early months of the occupation of the new building. Later he was withdrawn for further planning duties although retaining an office in the new out-patient centre. His withdrawal has clearly demonstrated the need for a responsible administrative officer in the building, and this was particularly referred to by the nurse administrator and other senior members of the staff. However in view of the fact that the Royal Victoria Hospital is organised on a very centralised basis, the heads of the various departments, e.g. Group Engineer, Supplies Officer, Domestic Superintendent, are responsible for the services provided in the building and for the work of their staff. In addition there are semi-autonomous departments which have their own professional administrator, e.g. X-ray, Physical Medicine. It would be difficult in these circumstances to justify the appointment of a very senior officer to this post unless he has some other duties. Certainly under present conditions the Assistant Secretary grade without other duties seems hardly justified.

21.3 The alternatives would appear to be either to appoint an officer in the Principal Administrative Assistant grade with some duties additional to the day to day management of the centre, or a

Senior Administrative Assistant without other responsibilities. In the latter case it should be clearly understood in his brief that he would be expected to make frequent visits to all parts of the building and to maintain personal contact with heads of departments. This officer might also take over the recruitment, supervision and training of medical secretaries and the typist pool. This would relieve the medical records officer of some extraneous duties which would give her more time to devote to more important aspects of her very busy department. On balance, the Principal Administrative grade would seem preferable and could be justified by including such duties as planning. Whichever grade is considered appropriate, it is essential that the officer appointed should be located in the new building.

21.4 On the nursing side the recommendation that an Assistant Matron should be appointed has not been carried out, and the present Nursing Officer in charge is in the Departmental Sister 'A' grade. Bearing in mind the number of nursing staff for whom she is responsible, which is greater than some small hospitals, it is felt that the King's Fund recommendation should be implemented forthwith.

21.5 Whilst referring to the management in general of the new Out-patient Centre, tribute should be paid to the quality of the senior staff and the Management Committee are fortunate in having such able and conscientious officers in the key posts.

22 ACKNOWLEDGEMENTS

This evaluation would not have been possible without the co-operation and goodwill of the Group Secretary, Matron and the Consultant Medical Staff all of whom showed great interest in the project. In particular my especial thanks are due to Mr. R. M. English, Miss Galbraith and Mrs. Easterby without whose help and suggestions the task would never have been completed. They made what could have been a tiresome project very enjoyable.

The help of Mr. Roger Farrow in the preparation of the appendices and in the final drafting of this report is gratefully acknowledged.

APPENDIX "A"

PATIENTS' QUESTIONNAIRES

1 Approximately 60% of all patients who completed the questionnaire had attended clinics in the old buildings but showed no significant difference in reaction to those patients who were only acquainted with the new building. The general results of the answers received are shown below:-

QUESTION	YES	NO
Did you attend in the old Out-patient building?	60%	40%
Did you wait longer now than in the old building ?	12% (of those who attended old building)	88%
Do you like the new building ?	100%	-

2 Patients were somewhat imprecise about their likes and dislikes, but the following subjects of approval and disapproval were ascertained:-

(a) APPROVAL	% of TOTAL REPLIES
Comfort, space, brightness of building	50
Kind attention of staff	45
Heating (specific praise)	10

The receptionists and hostesses received particular praise for their prompt, courteous service and it was suggested that the new building enjoyed an improved atmosphere in which a certain degree of informality marked a departure from the "traditional" hospital image.

(b) DISAPPROVAL	% of TOTAL REPLIES
Waiting time	12
Difficulty of car parking	7

Unfavourable comments were received from only 25% of patients and the main source of complaint was waiting time. However, only one patient mentioned the actual period waited (one hour)

and some 8% of patients had spoken favourably of speedy service received (see Appendix "B" for a more accurate survey of waiting times). Congestion in sub-waiting areas was criticised by several patients and two others suggested that privacy in certain clinics was inadequate. One patient complained that the X-ray department was too far from the Accident and Emergency cubicles.

3 SUGGESTIONS

Constructive and feasible suggestions from patients were few but included:-

i. Construction of an adequate car park

ii. Sale of newspapers in main waiting area

iii. Provision of beverage vending machines in sub-waiting areas

iv. Allocation of smoking areas for waiting patients

* v. Removal of magazine tables from sub-waiting areas and inclusion of additional chairs.

* See main Report para. 4.4.(a).

APPENDIX "B"

WAITING TIMES IN OUT-PATIENT CLINICS

DATE OF CLINIC	WAITING TIME IN MINUTES		
	Maximum	Minimum	Average
2. 2. 70	95	1	23
3. 2. 70	70	1	30
4. 2. 70	45	1	18
4. 2. 70	35	1	16
4. 2. 70	115	1	38
5. 2. 70	35	1	16
5. 2. 70	55	1	10
5. 2. 70	150	1	62
5. 2. 70	50	10	29
6. 2. 70	80	1	31
6. 2. 70	10	1	4
9. 2. 70	160	1	36
9. 2. 70	55	1	20
10. 2. 70	190	5	46

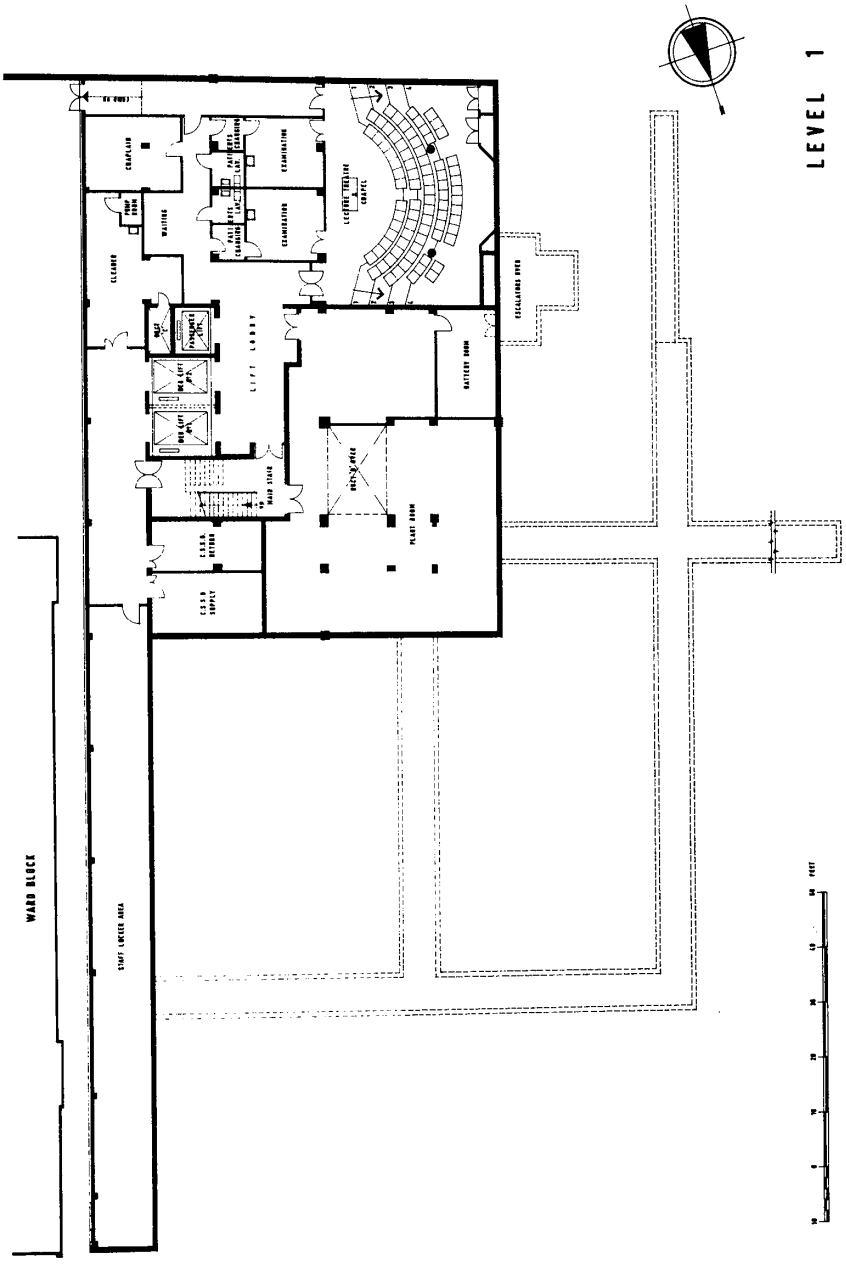
Waiting times have been estimated by subtracting the time of the patient's arrival or of his appointment, which ever was later, from the time at which he entered the treatment or consulting room.

APPENDIX "C"

WAITING PERIOD FOR OUT-PATIENT APPOINTMENTS

CLINIC		Number of Days for Ordinary Appointment	Number of Days for Urgent Appointment
Chest		17	10
Gynaecology		35	9
ENT	Shortest	10	9
	Longest	36	29
	Average	20	15
Thoracic		10	3
Urology		11	4
Varicose Veins		9	2
Vascular		9	2
Skin - Wart		9	9
- Skin		8	4
Ophthalmic	Shortest	9	8
	Longest	25	23
	Average	20	13
Surgical		7	4
Medical	Shortest	14	8
	Longest	23	16
	Average	17	11
EEC		63	Arranged by relevant department as required
Neurosurgical		10	
Neurological	Shortest	22	
	Longest	31	
	Average	26	
Psychiatric		23	
Rheumatic		21	
Department of Physical Medicine	- Open	15	
	- Closed	14	
Metabolic	- Diabetic	16	
	- Metabolic	17	
Orthopaedic	Shortest	17	
	Longest	30	
	Average	26	

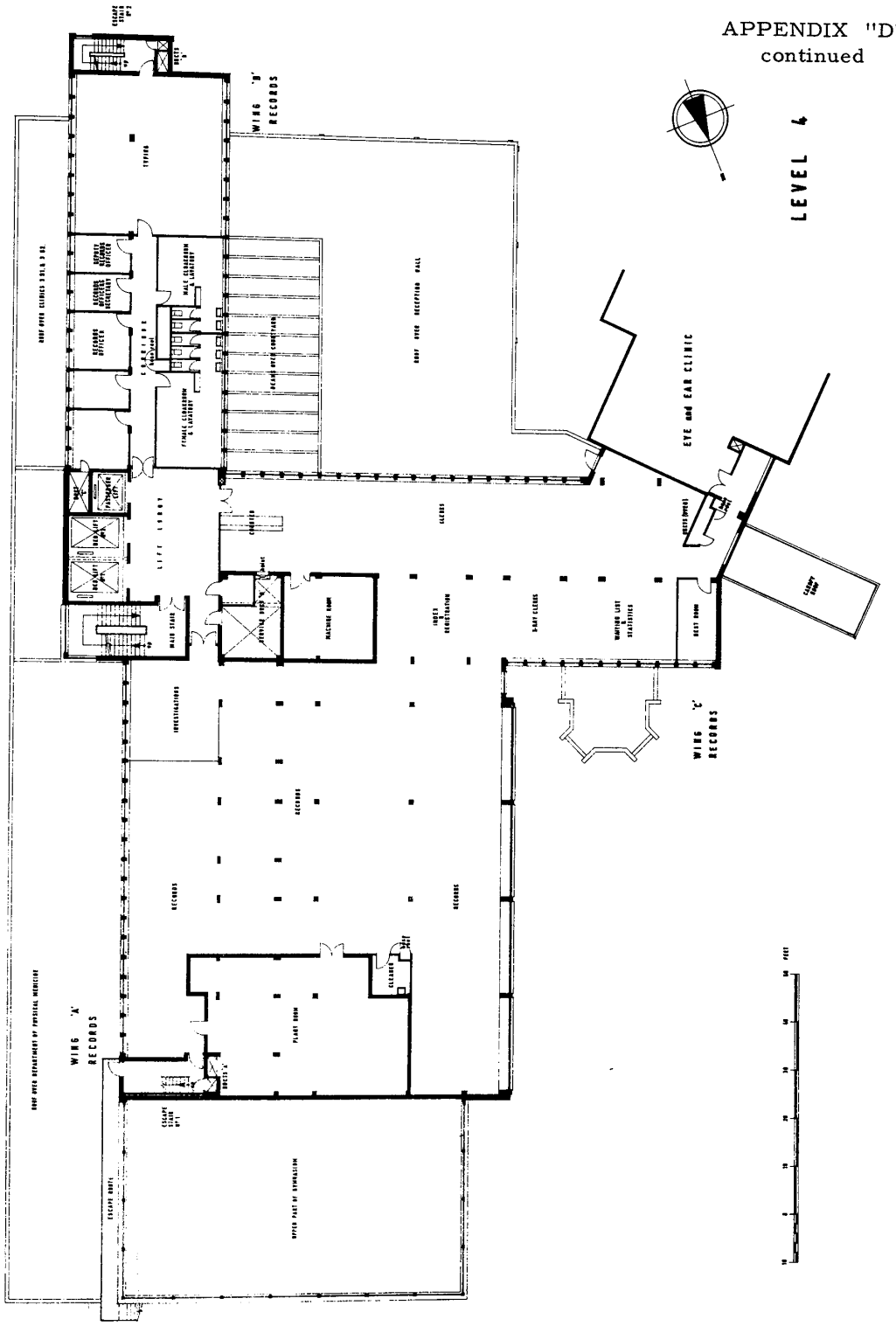
APPENDIX "D"


LEVEL 1
WARD BLOCK
STAFF LUNCHEON AREA
CHAPLAIN
WAITING
EXAMINATIONS
LECTURE THEATRE & CHAPEL
CLEANERS
LIFT LOBBY
MAIN STAIR
PLANT ROOM
BATTERY ROOM
ESCALATORS OVER
C.S.S.D. RETURN
C.S.S.D. SUPPLY

APPENDIX "D" continued

APPENDIX "D" continued

APPENDIX "D"
continued



APPENDIX "D"
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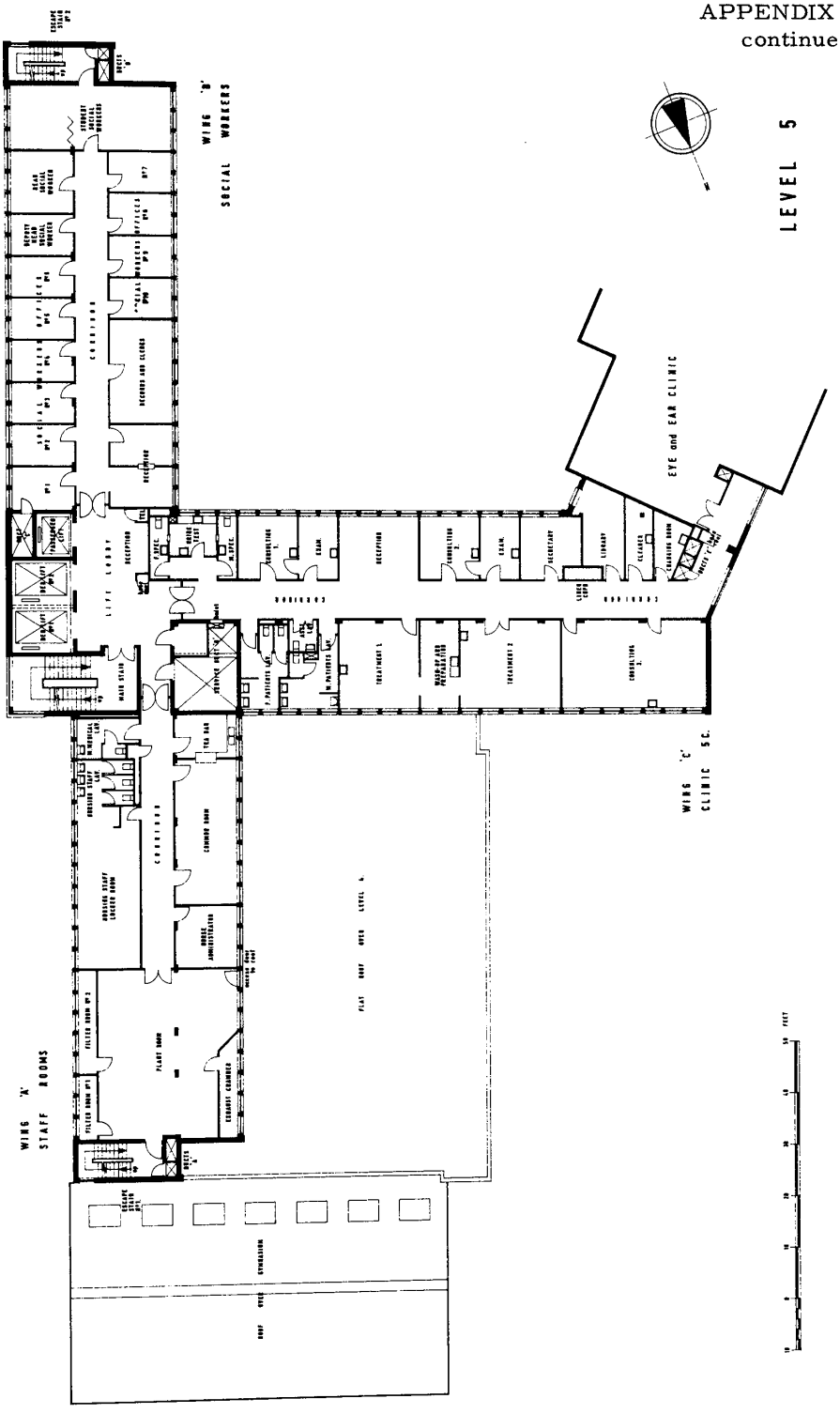

APPENDIX "D"
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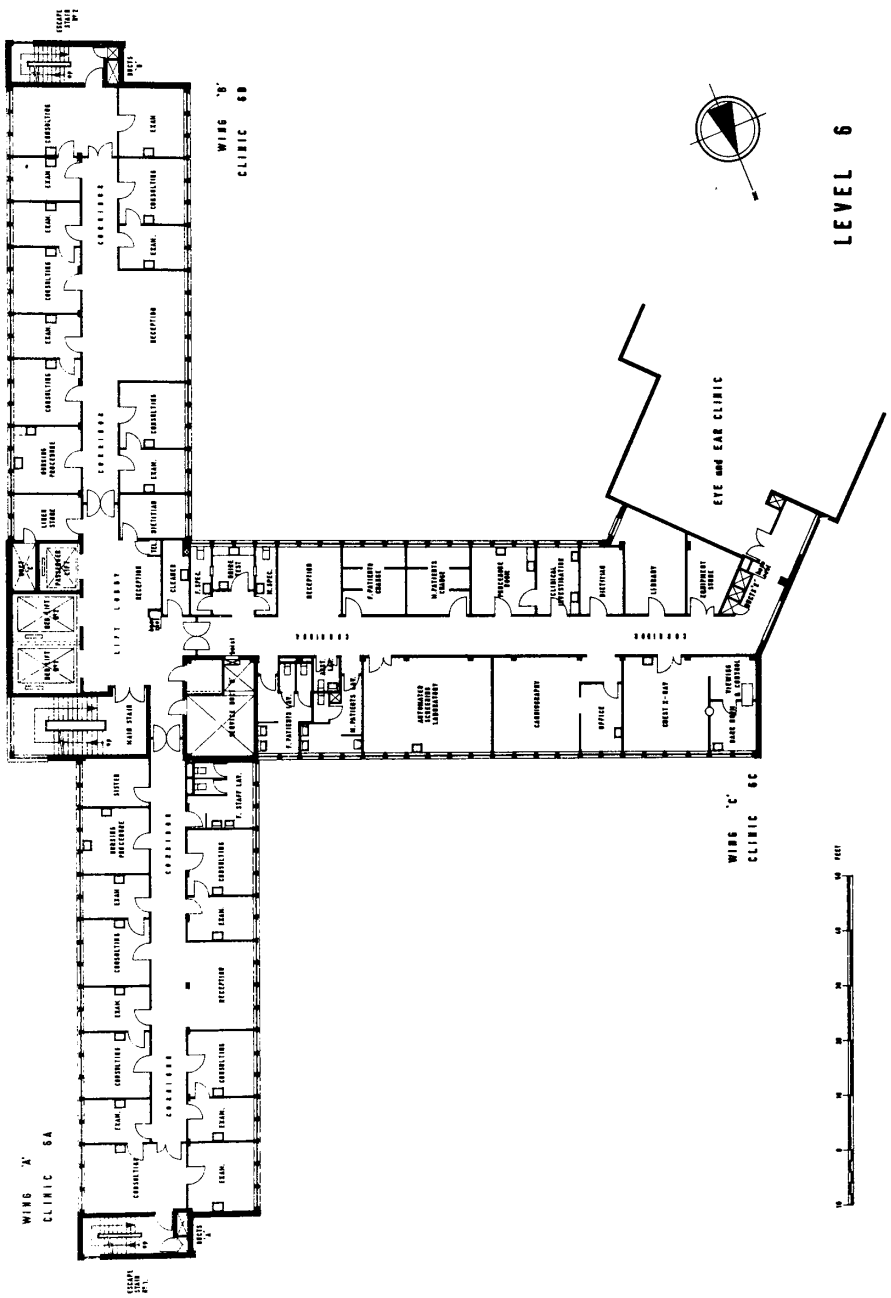

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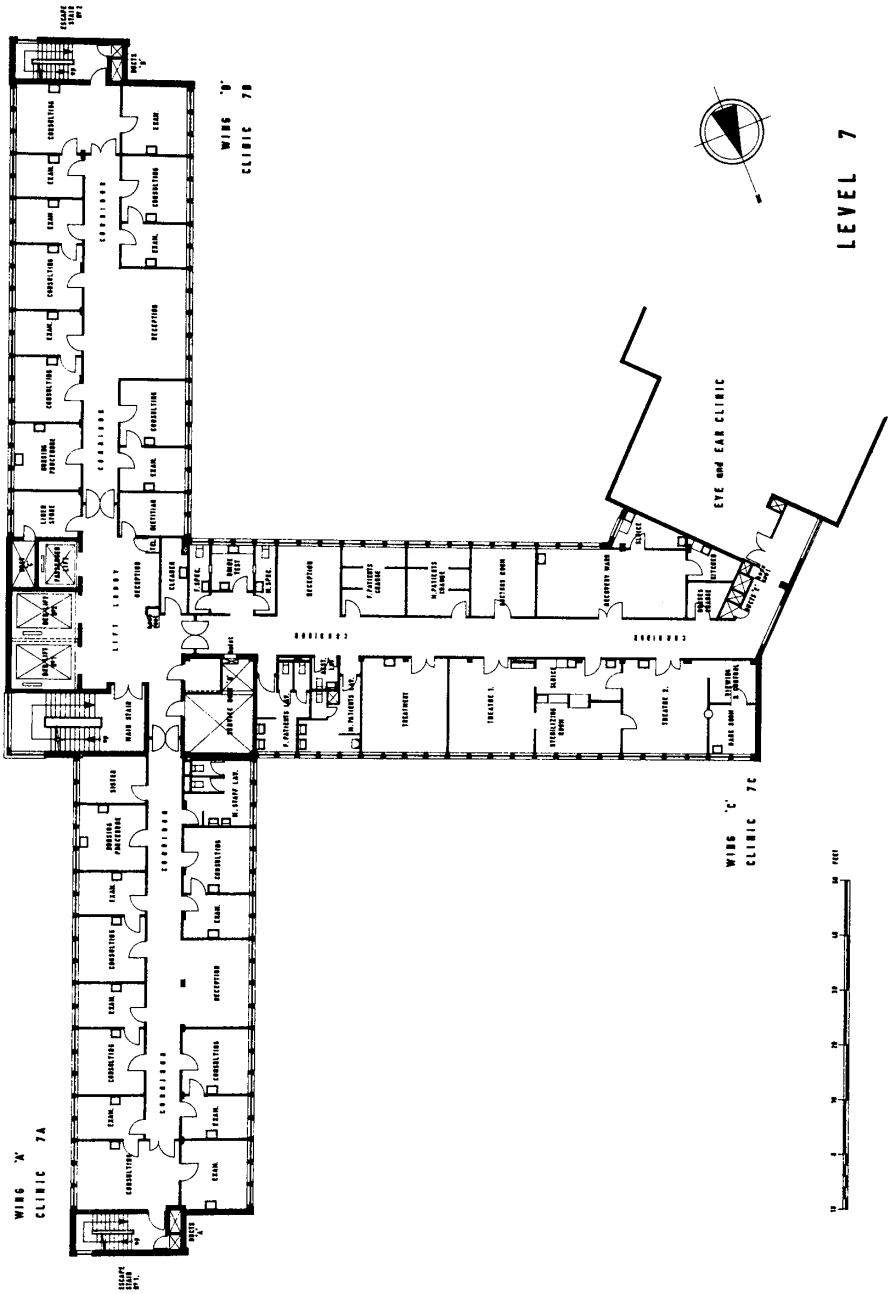

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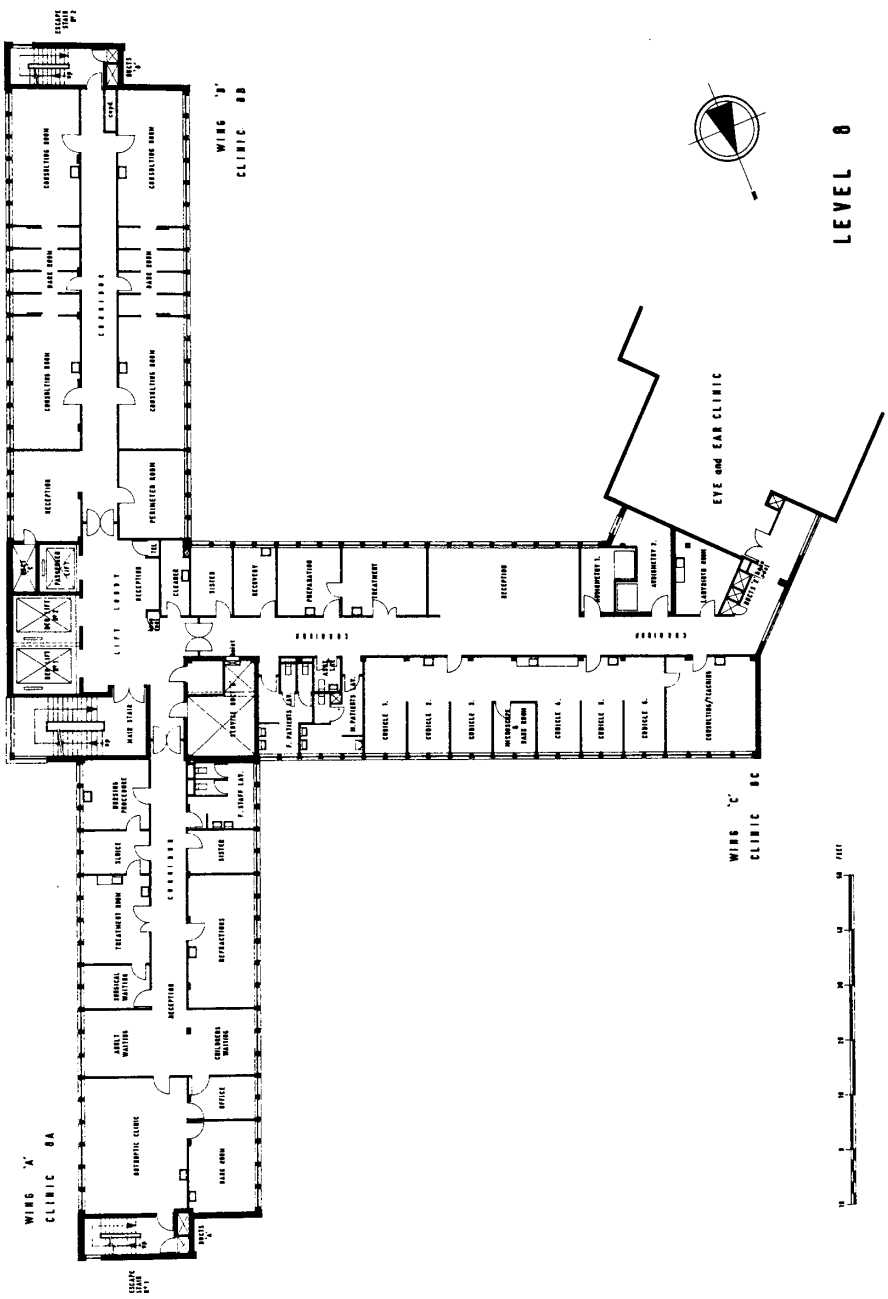

APPENDIX "D"
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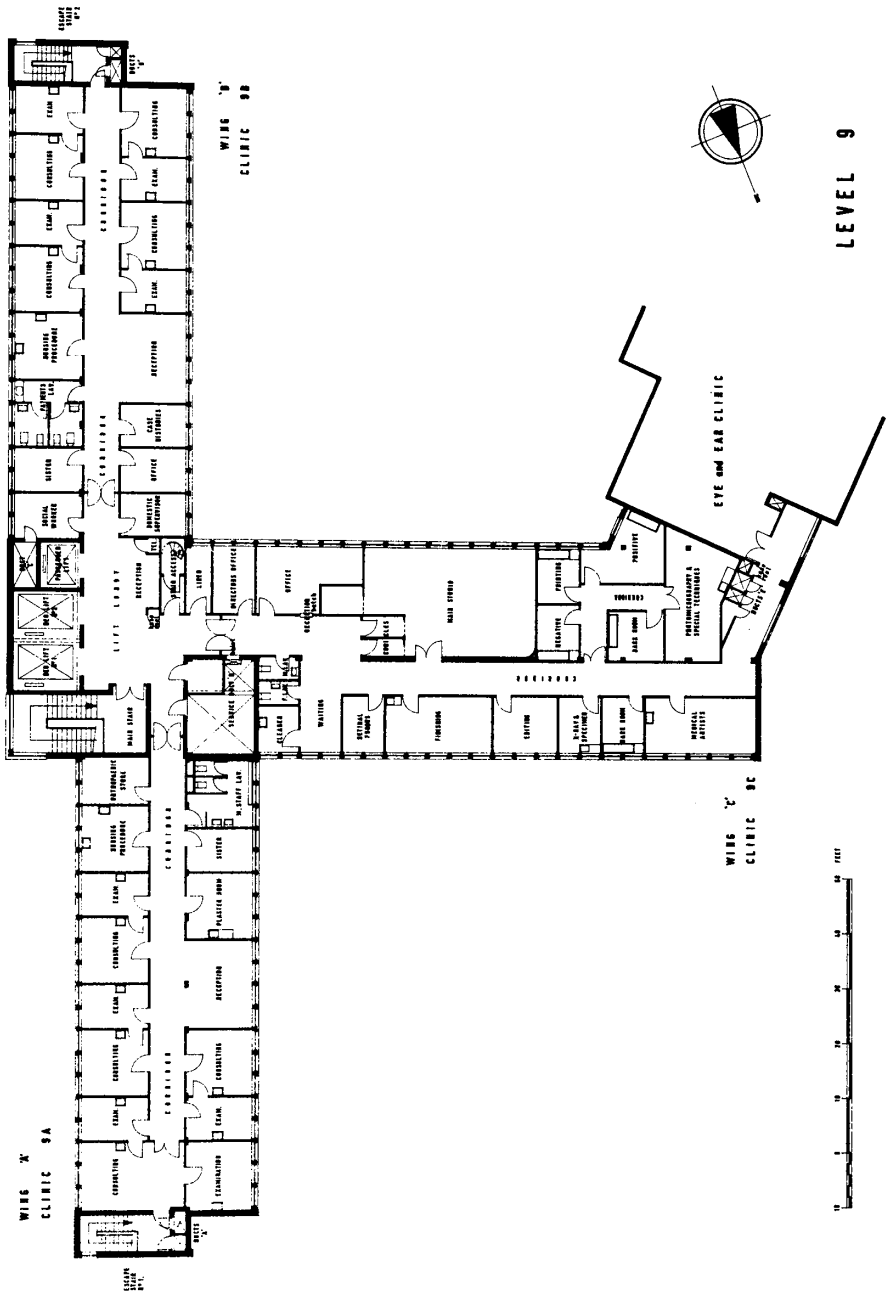


APPENDIX "E"

BRIEF HISTORY OF THE PLANNING AND CONSTRUCTION OF THE OUT-PATIENT CENTRE

1945-1952 During these years a number of reports on overall site development were prepared and discussed by the Board of Governors. From 1950 the Northern Ireland Hospitals Authority were actively engaged in consideration of the overall proposals and assessment of priorities for individual sections of the scheme. The overall design envisaged a series of separate but connected blocks to allow phased building and sited to allow eventual replacement of the existing main wards.

While it was recognised that overcrowding in Out-patients made replacement urgent, limitation of finance, building materials and labour resulted in priority being given to smaller projects.

1953-1954 Studies of the function of clinics, methods of working and space requirements were undertaken and led to proposals for a combined Out-patient, Radiology, Theatre, Fracture Ward complex.

1955 The Northern Ireland Hospitals Authority agreed to set up a committee to implement the Out-patient and Theatre areas; they also asked the committee to consider the implications of setting up an Ophthalmic & ENT Hospital on the site and to advise if the Out-patient and Theatre units could be separated.

1956 Revised proposals for the overall site development were prepared and outline designs for separate units for ENT, Theatres and Radiology and Out-patients were discussed and agreed in principle.

APPENDIX "E"
continued

1956-1957 Proposals for the Out-patient department were carried forward to sketch plans, schedules of accommodation and an estimate of cost. Discussion of the allocation of clinics and methods of working continued and the assistance of Brigadier Welch of the Nuffield Foundation was enlisted.

1958 Revised plans were submitted and approved subject to clarification of the requirements for Hydrotherapy and the Photographic Department.

1959 Detail design work led to requests for numerous changes and a re-statement of the principles and policies was necessary. A programme was agreed and discussions were commenced on the procedures to be followed for clearing the site and preliminary building work by July 1960.

1960-1961 Detail design work halted and studies were carried out to investigate the feasibility of incorporating areas for the reception of Casualties. An examination of the setting up of an Accident Emergency reception unit and re-arrangement of the entrance and reception arrangements led to the abandonment of the design concept as a whole.

1962 Revised plans, schedules and estimates of cost were prepared for a larger scheme including Accident Reception and Treatment.

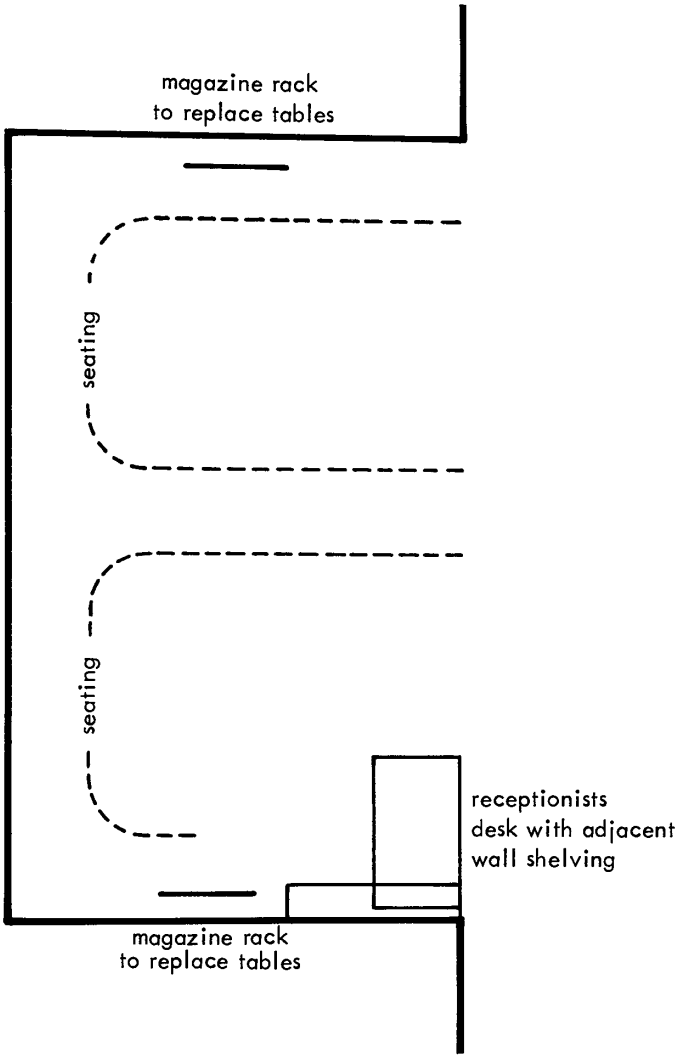
1963-1964 Detail design continued interrupted by further revision of the plans of individual clinic areas.

Preliminary contract for site clearance and foundations.

APPENDIX "E"
continued

1963-1964 continued	Commencement 7 December 1964 completion 4 September 1965.
1965	Basic working drawings - preparation of approximate bills of quantity, schedule of rates - tenders obtained. Lower ground floor - Level 2 - to be considered provisional in layout until Accident Treatment organisation agreed.
1966-1968	Superstructure contract commenced - 3 January 1966. Detail working drawings prepared and issued to accord with contractors programme. Completion contract - 31 January 1969.

APPENDIX "F"



DIAGRAMMATIC LAYOUT SHOWING
REVISED ARRANGEMENT FOR WAITING AREAS

APPENDIX "G"

SCHEDULE OF SPECIFIC DEFECTS NOTED AND RECOMMENDATIONS MADE

LEVEL 1

Staff changing accommodation unheated and damp at one end.

Inadequate staff toilet accommodation.

LEVEL 2

(a) Reception

New and re-appointments could be separated at reception desk. (Signs have now been erected).

Facsimile transmitter should be moved to Admissions Office.

(b) Accident and Emergency

Sub-waiting area should be marked 'Patients Only'.

Inadequate cubicle space for dealing with ambulance cases.

Documentation area too far from ambulance room area.

Inadequate accommodation for patients' relatives.

Medical sleeping accommodation is good but very noisy.

Inadequate lighting in centre of observation wards. (Improved lighting has subsequently been ordered.)

Lack of privacy in resuscitation room (fit Marlyfilm-type doors or curtains ?).

No emergency lighting fitted as original equipment in resuscitation room.

Reception desk has been damaged by floor scrubbing machine.

Inadequate signposting to Fracture Area and X-ray.

Cubicles are used as means of access from one corridor to another.

Elbow taps in theatre are inefficient.

Dark curtains reduce light in cubicles.

Inadequate cupboards in clean utility room (fix wall cupboards over work-top ?).

No pass-through hatch into clean utility room.

"Cleaning up" room is unnecessary.

APPENDIX "G"
continued

LEVEL 2 continued

(c) Fracture Clinic

Inadequate waiting area.

No shower and only one basin in staff changing accommodation.

Cubicles are used as means of access from one corridor to another.

Suction and gas in Fracture Theatre should be provided via pipes on booms. (These fitments have subsequently been ordered.)

X-ray in theatre should be ceiling mounted over table.

Additional theatre is required.

(d) X-ray

Cubicles are too small.

Seats in cubicles should be hinged and not fixed.

X-ray rooms and dark rooms are too small.

Inadequate access to Room 4.

Inadequate bench and shelf space in dark room.

Inadequate storage for chemicals.

Inadequate waiting area for patients' trolleys.

Dark room is too hot.

Silver recovery system not working.

Unsatisfactory procedure for some casualty patients which necessitates undressing twice.

LEVEL 3

(a) Department of Physical Medicine

Standardisation of joinery taken too far.

No method of extracting fumes from Wax Room.

No wax trap on sink in Wax Room.

Waiting area chairs too large and low for disabled patients.

Patients' rest room attached to hydrotherapy pool is too small.

Inadequate facilities for drying costumes and heating towels.

Inadequate storage space, especially for chairs.

APPENDIX "G"
continued

LEVEL 3 continued

(a) Department of Physical Medicine continued

Electric switch fitted over wash basin in one room.

Gymnasium too big (1/3rd of it could form separate room for fixed apparatus).

Gymnasium changing area too small.

No alarms in toilets.

Toilet locks cannot be opened easily from outside.

Split doors for some toilets required.

Atmosphere too dry.

Public address system is too loud.

Hydrotherapy Department floor left very dirty by contractors.

Inadequate transport to collect patients from city.

Built-in furniture in cubicles is too bulky.

(b) Reception and Appointments

Reception counter needs acoustic screening.

(c) Admissions

Lack of privacy (separate room needed).

Walls need protection against damage by chairs.

Install facsimile transmitter moved from Reception - Level 2.

(d) Special Clinic

Office is too small.

Classroom is too small.

Film screen surface is unsatisfactory.

Top section of blackboard is too high for lecturer to reach.

Additional electrical heating appliances are required.

Inadequate consulting rooms.

Male side lacks daylight needed for detecting colour-changes.

Windows at clerestory height unsatisfactory.

APPENDIX "G"
continued

LEVEL 4

(a) Central Dictation

Separate room needed for duplicating and storage of stationery.

Acoustic screening needed between desks to reduce noise.

LEVEL 5

(a) Medical Social Work

Reception office is too small.

Window between waiting area and reception office is too small and low.

Signpost (Level 5) to reception office is too high (this has subsequently been altered).

Signpost to Skin Department is needed to divert enquirers.

Lack of interviewing rooms, especially on Level 7.

Badly fitting doors.

(b) Skin Department

No sister's room or duty room.

Lecture room is too small for 25 students.

Lack of privacy in treatment room (should be divided and two tables provided).

One examination room to be darkened when required.

LEVEL 6

In laboratory, china sink set into formica on blockboard - this is prone to disintegration of adhesive.

Procedure room is too small.

Sub-waiting area is too small.

Staff cloakroom is too large.

Coat hooks needed in urine testing room.

Metabolic and Diabetic

Inadequate urine testing facilities.

Inadequate accommodation for metabolic dietitian.

Mixing of two clinics on one floor causes confusion.

APPENDIX "G"
continued

LEVEL 6 continued

Speech Therapy

Unsatisfactory that patients are seen on three different floors.

LEVEL 7

Endoscopy room is underused.

A door is required to separate toilets and waiting area from theatre and changing rooms.

Inadequate racking and trolleys for patients' notes in consulting suite.

Sphigmomanometer is too low.

Door of examination room opens onto waiting room area thus exposing patients on couch (also applies to Level 6).

Dressing trolleys do not fit under working surface in preparation room (also applies to Level 6).

Eye and ENT

Nitrous oxide not being used.

No cupboards under working surface in preparation room.

No sink in working surface in preparation room.

Treatment room and three cubicles are too small.

Waiting area too small (re-arrange furniture).

Desks in consulting rooms not wide enough.

Wiring in consulting rooms is unsightly when instruments are used.

Unsatisfactory that Eye Department urine testing is carried out in Male WC of ENT Department.

Autoclave in Eye Department said to be unsatisfactory.

No need of sluice room.

Inadequate signposting for ENT, Orthoptics, Refractions etc. in lift waiting area.

APPENDIX "G"
continued

LEVEL 9

Photography

Inadequate space for copying.

Atmosphere too dry, causing static electricity in equipment.

Noisy ventilation system in studio, hampers recording.

Unsatisfactory that safe light and viewing screens in dark room are on the same circuit.

No tiles on wall around developing tanks.

"Wet" bench should be separated from "dry" bench.

Taps should be of "laboratory" type.

Inadequate storage for stainless steel dishes.

Gynæcology

Noisy ventilation system in Sister's office.

Examination room too small for teaching purposes.

Consulting rooms too small for examination couch (move door ?).

CATERING

No change machine near vending machine in canteen area, Level 2.

Inadequate storage space and cupboards badly sited over hot-plate in Refreshment Room, Level 5.

Inadequate range of food in Patients' Snack Bar, Level 2.

DOMESTIC SERVICES

Inadequate storage for cleaning materials on Level 1.

Inadequate demarcation of responsibility for cleaning floors in catering areas (this has now been resolved).

No sinks in cleaners' closets.

LIFTS

Inadequate floor indicator outside lifts.

Duplex programming unnecessary.

APPENDIX "G"
continued

LIFTS continued

Control panel for left hand lift should be grouped with that for other lifts.

Provision of a goods lift would ease congestion, facilitate deliveries.

Speed of lifts could be increased.

Inadequate attention drawn to stairs.

GENERAL

Fire warning extension number should be indicated upon every telephone dial.

Linen disposal recess needed on each level.

Inadequate lighting over lift reception desks.

Original lift reception desks were unsuitable.

Light fittings are difficult to clean.

One collection of waste products per day might be adequate.

Printed in England by Walbrook Supplies Company