Commissioning a new general hospital

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The St James' Hospital, Dublin, is being rebuilt and enlarged to absorb three other hospitals in the same area. This paper is a shortened version of one presented to a conference in Dublin on this subject.

The only qualifications I had to offer when being invited to speak on this subject were that I had the experience of commissioning a small hospital in 1963 of 156 beds, and since 1972 I had been the senior nurse in a Health Authority that is now 75 per cent through the staffing of a 813-bedded acute general hospital. It is with this background I would wish to discuss the various aspects of commissioning a new general hospital.

Planning the new hospital

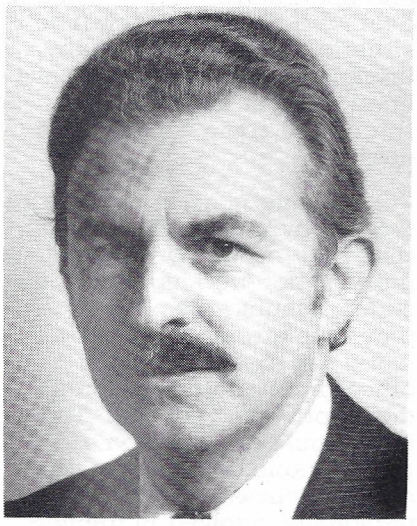
The nurse must be seen to contribute at the earliest stages in the planning of wards and departments in which eventually her colleagues have to work. This is not said from a purely professional standpoint, but with a belief that patients are cared for more effectively if the nurse is allowed to make her own contribution at these earlier stages of planning.

I doubt if I have to remind readers that the ex-Chief Architect of the Department of Health in London upset many people by publishing in the *Nursing Times* a year or so ago that — since being admitted to an old 'Nightingale' type of ward in a London teaching hospital and experiencing for himself nursing care in that environment — he had many misgivings about many of the new hospital projects he had been responsible for. Talks with nurses had more than confirmed the view that few designers had in fact listened to them.

Therefore we have wards giving privacy and modern facilities for patients in numerous rooms over a large square area.

To try and convince hospital authorities that in new hospital buildings up to a third more nurses are required is difficult to pursue successfully.

The most serious complaint I have received from patients is the comparative isolation from nurses when housed in a combination of single and four to six-bedded bays. There ceases to be one centre of co-ordination in the ward, or, if there is, it is unseen by the patient and I would suggest this adds to his state of apprehension. To minimise this situation it is essential to include a full-time nurse in the project team.



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Newcastle project

For over ten years a new hospital in Newcastle had been planned, originally to replace most of one thousand beds in a hospital parts of which were 140 years old. With changes both of policies and financial fortunes this hospital has in fact become the third general hospital in the City. After discussion it was agreed to make the following transfers from other hospitals into the new 813 beds at the new Freeman Hospital (9 units from 6 hospitals):

Units from within Newcastle

(a) a small old hospital of 11 beds used for haemodialysis;
(b) a cardiology unit of 48 beds from a large general hospital;
(c) a 53-bedded urological unit from the same hospital;
(d) a chest disease ward of 25 beds from the same hospital;
(e) 120 beds which was a complete orthopaedic hospital containing both adults and children;
(f) a chest unit of 94 beds from yet another Newcastle hospital.

Units from other hospitals not managed by Newcastle

(a) a 42-bedded cardiothoracic hospital from Sunderland Area Health Authority 16 miles away;
(b) a 111-bedded cardiothoracic unit from Durham Area Health Authority some 22 miles away;
(c) a 26-bedded urological unit from Durham.

I did just wonder at the time if anyone could possibly dream of arranging anything quite so complicated? Out of all this potential confusion came an orderliness that was really quite extraordinary. Again, I have to stress that without a full-time nurse in the commissioning team I am convinced we would

still be trying to transfer the units to this day.

Points on commissioning

In patient care areas it is essential that the nurse has full authority to determine where things like sinks, electric plugs, lights and switches are and where the nurse should be based, use of rooms and equipping these rooms. It is not sufficient to obtain the best price for say 500 beds. Those beds must reach a specification agreed by the nursing staff.

Why is it that doctors and administrators think they can design and equip a ward unaided by nurses, and even believe that it will really work? I remember some years ago a very kindly medical consultant decided for his sisters every aspect of the ward in an upgrading scheme. He had his way, for instance, on where the light switches should be. To be fair to him, during the day they were able to be operated, it was at night when the difficulties arose. You see, the consultant, when questioned, could not remember the last time he worked in the ward in the middle of the night.

Establishing policies

A new hospital is an exciting concept. As the building rises from its foundations, years of discussion, negotiating, and planning begin to take shape. The best finishes that money can buy can be put into the building together with the latest labour saving devices. Superb canteen facilities for staff can be provided together with comfortable modern residences with the latest communication systems. All this can be carried out in minute detail, but there will come a time when the first major problem arises either in the ward with the sister and her staff or in the administrator's office. The problem is partly discussed then someone realises we did not do 'so and so' last time because there was not a last time — at least not in this building — this is the first time. What is missing? Many answers can be given but it is simply that there has not been time to establish a tradition. In the dictionary the word 'tradition' means: 'handing over, oral transmission from one generation to another, bound up with or continuing in the life of a family or community'. The staff within a hospital form a community and the effects of a new building with different systems on staff is not always advantageous. This is why the commissioning team should devise policies both in principle and in detail. This produces a sense of security amongst the staff which benefits both them and the patient. It is also a most glorious opportunity to remove those traditions that inhibit proper change and progress both professionally and from an organisational point of view. A plea, however, not to go too far in abolishing all tradition because it results in staff who are bewildered and confused, and that in turn adversely affects standards of patient care.

It would be exhausting to deal at length with a list of policies here but they must be worked out and written down and taught to all new staff. They are to do with catering, supplies of equipment to wards, linen supplies — clean and soiled — domesting cleaning, portering services, and so on. Staff will not only want to know where the canteen is and the hours of opening for main meals but know that the services are so organised that the queue at say 1pm will not be such that nearly the whole of the lunch-break is spent waiting for a meal. A list of sub-policies and operational plans needed to deal with that one lunch-time situation which affects many disciplines should already have been thought and worked through in some considerable detail.

Nursing policies can only be written by nurses. How can they be written if a full-time nurse is not working with the commissioning team? A part-time attempt at this by using say a senior nursing officer from another hospital does not work very well. The nurse must know in some considerable detail about the related policies and have been personally involved in framing them if the policy is to work satisfactorily. Take, for instance, central sterile supplies. It depends upon which system is in operation as to which surgical dressing procedure is proposed to ward staff. It is vitally important for the nurse to imbibe all the thinking that is developing in the commissioning phase of the hospital development.

Involvement of other hospitals to be transferred

One year away from opening a new hospital is not too early to involve trained nurses from those hospitals to be transferred into the new one. Visits should be arranged, particularly for sisters. They can compare the new facilities with their present ones. Commissioning staff do become very discouraged when the sister from the old hospital criticises some aspects of the new system. Remember "change is not made without inconvenience even from worse to better". The commissioning staff are involved, fulfilled in their task, while the sister faces a major future change where her whole daily routine is to be rather dramatically altered. It can also be an opportune time to discuss with the staff transferring the policies that are to be implemented both in principle and detail. A combination of staff from the three hospitals concerned giving assent to policies they themselves have helped to decide is easier to implement than to try to impose new policies on staff who may be apprehensive about the change anyway. It cannot be emphasised enough that "bricks and mortar do not a building make". An organisation like a hospital has its own separate existence. It consists of people working as teams holding individual and collective values, beliefs, including deeply felt prejudice about developments, and groups of other people. To move three hospitals into one is more than preparing staff professionally. If the move is to be successful it must influence the way people feel towards each other and to the new organisation. This is why I strongly recommend as much involvement in policy making by staff transferring as is possible. To have a nurse doing this bringing together as a professional to a profession really does work. The major aim even before the opening date is announced is to have the transferred staff talking about 'our new hospital' rather than 'the new hospital'. If at the opening of the hospital they still say 'your new hospital' someone is in deep trouble, or should be!

In-Service training

It is important for all staff

to visit the new wards while empty and orientate themselves to the building and its new facilities. At least six months before a unit moves the transferring staff should start to receive in-service training and orientation at the new hospital. The geography of a new building can be very confusing. For those preparing the hospital, having grown accustomed to the short cuts to the different departments, it is easy to forget how many times one was lost in the first week. It is a totally different thing not to know where you are going before the hospital opens but embarrassing for the nurse who can only say "Sorry, I am new here" when approached by an anxious relative trying to find Ward 10. It is even more confusing if the nurse cannot even point the way to an enquiry position. It may not have occurred to some in this audience that most new hospitals build their wards absolutely identical at least from the outside. It can be rather bewildering to find one out of twenty-one! A small, simplified plan of the hospital could be issued to each member of staff and a part of an afternoon given for staff to go round in small groups finding their own way round. The reward for finding the canteen, for instance, can be a cup of tea and a cake. This not only tests the catering facilities but makes reasonably sure no-one is lost in the new building at the end of the day.

"A small, simplified plan of the hospital could be issued to each member of staff"

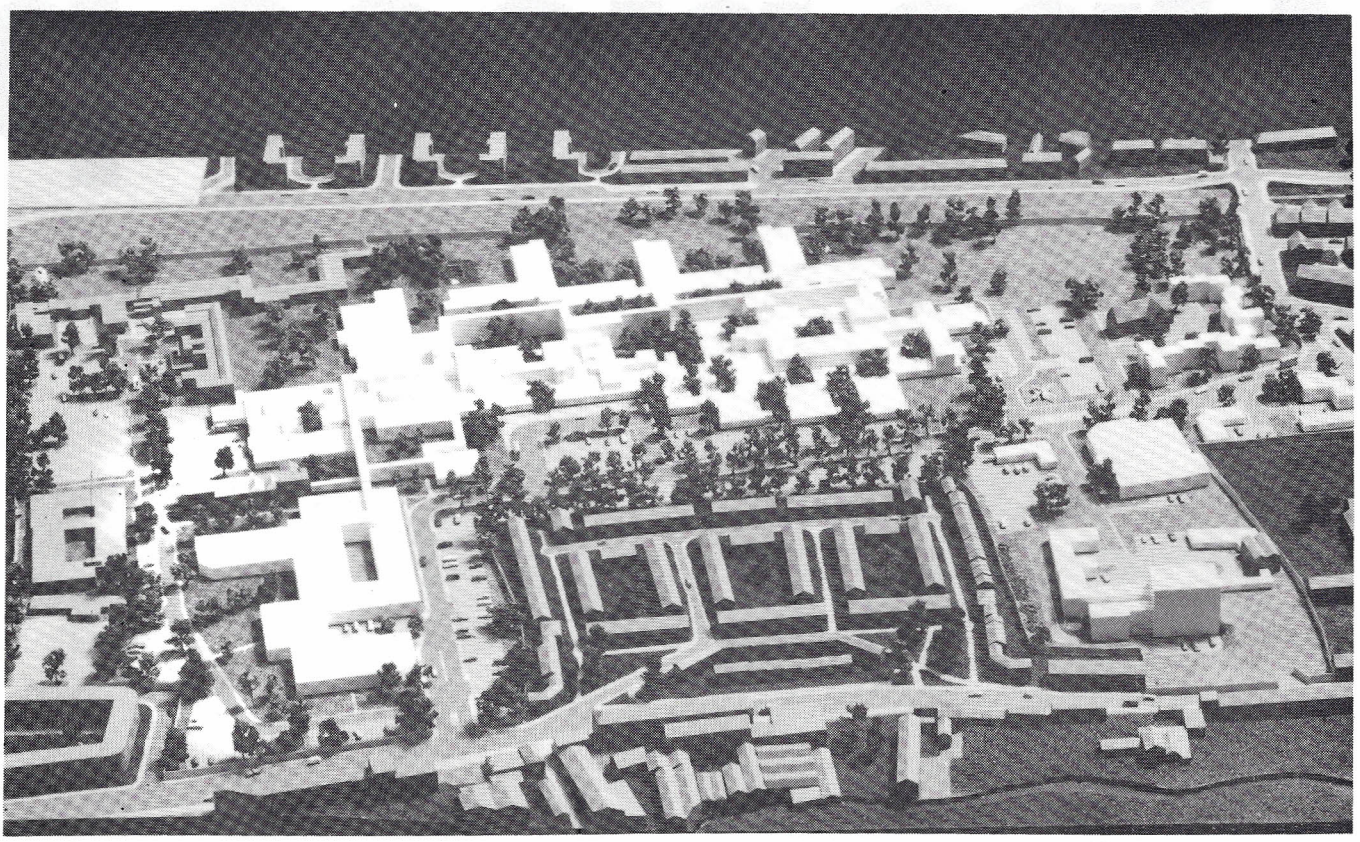
Apart from geographical orientation, the basic policies on wards need to be tested and then taught. Staff should learn how to use the dressing packs and know the routine use of equipment. Fire drill is a very important aspect of in-service training. Can a ward be evacuated quickly? It is very little use the architect saying "Yes" if it is not proved in practice. More fire drills are now practised with the actual evacuation of patients being carried out so that should a real fire occur the staff know exactly what is required of them.

Apart from nursing policies and hospital policies, it is important to teach the personnel policies under which people will work. For instance, sick pay and its supporting systems, any occupational health facilities to be provided, resident accommodation and how it is to be used, the place of trade unions and professional associations, grievance and disputes procedures. These last two systems are mentioned deliberately because in England more than one new hospital has never worked to full capacity, or to total effectiveness, because of disputes with trade unions. If staff know how to lodge a complaint and if it is not listened to, use an agreed system of grievance, it often defuses a potentially serious situation. That is if an effective, sensitive management system is in operation.

Trade Union negotiation

This leads on to how the transferred staff's interests are to be preserved. They will want to know the new hours of work and negotiate if there are different starting and finishing times. If staff have to travel further to the new hospital than if they were working at the old one, what compensation is being offered and for how long.

What form of joint consultation will be proposed by management. By the word 'management' I include the senior nurse in that arrangement whether the title



St. James's Teaching Hospital which serves quarter of a million people in the south west of Dublin. View of the architects' model — new buildings are shown in white.

Architects: Moloney O'Beirne Guy + Hutchinson Locke & Monk, Dublin Architectural photographer: Richard Bryant.

be Matron, Director of Nursing, Divisional Nursing Officer, or any other title. The largest single group of staff is likely to be nursing. It is almost the only group that offers a constant twenty-four hour, seven day a week service. It is therefore vitally important for the most senior nurse to not only take part in formulating management policy, but to be an able negotiator direct with union and staff association officials. I do so hope that the personnel department will not have an executive role in this area of management. Support and advice certainly, but to be the ultimate for what happens to staff and their employment, no. The reason for arguing for this is that experience both in industry and in the health service has shown that if you take away ordinary day to day decision making from the actual manager, in times of difficulty and crisis that manager is bypassed. This will adversely affect his or her performance. In nursing a strong element of discipline must be maintained because of the very nature of the work. The senior manager's hand is greatly strengthened if she is seen to be the major decision maker. Even in the hire and fire situation I maintain the right in the organisation for each divisional nursing officer in charge of hospital or community services to have authority to select and dismiss a whole range of nursing staff from the nursing auxiliary up to and including the nursing officer. In turn, higher nursing authority can dismiss the more senior staff, apart from three senior nurses who work directly with me. Of course the personnel department must see that procedures are being followed and that the health authority is being protected and should be present at interviews involving serious breaches of discipline. The decision taker, however, should in my opinion be the nurse.

> "The geography of a new building can be very confusing"

In all this there must be a right of appeal from staff against the actions of management and that is a necessary safeguard.

Staff Recruitment

I know little about the recruitment situation elsewhere, but once it was known in the locality that a certain hospital was to close, it became difficult or even impossible to recruit staff to replace those leaving. Some leave because they do not wish to work in a large, more impersonal building; others for personal reasons. One critical area was in the cardiothoracic units. Few of the staff wished to travel daily for up to 30 miles each way and, with a delay in completion of the new building of two years, staffing levels became critical. The solution worked out was that staff would be recruited for the new hospital then be seconded to the existing hospital units. Special travel arrangements had to be made and the supervision and discipline of our staff in someone else's hospital did present problems. The new hospital authorities must take to themselves the responsibility of keeping open transferred units until the transfer day. The credibility of the new hospital is judged more on how it handles this situation than any other

that I know. If, as I have forecast, more staff are needed to look after the same number of patients, recruitment should take place before that ward opens. If an opportunity can be given to new staff to be orientated into the new hospital and work for a short period within a unit about to be transferred, this should be encouraged. If the new hospital's policies are right, and if its image has been put over positively, then the new hospital will act as a catalyst for change. If staff first meet on the day of transfer, a potential for conflict exists.

A decision will have to be taken on how many nurses are to be trained in the new hospital. Advice can, of course, be given by the Registration Body responsible to Registration, but the E.E.C. Directives also give guidance. Provision must be made for the whole range of specialties and an estimate of qualified staff required in 3, 5, and 10 years time will assist greatly in reaching a total figure of students required. In turn, this has to be matched against clinical experience and the financial resources available. If there is a choice it would be advantageous to slightly over-recruit in the first year.

The problems of getting the organisation going are great and a shortage of staff increases these problems immensely. Also, managing a large hospital as opposed to running several smaller ones does not just add to the difficulties of management, it multiplies them.

Our plan for Newcastle was worked out by negotiation with all other authorities. It was also influenced by our ability to recruit staff in a City that already had general hospitals of 1,000 beds, 650 beds and 320 beds respectively. A further influence was the other authorities' ability to keep open their transferring units.

It is advisable to test the system of hospital administration by carrying out out-patient appointments. This tests out many of the facilities of the hospital: x-ray, laboratory, portering, domestic, and many more services like catering for staff and so on. Our first patients were elderly people attending a geriatric day unit. Our facilities were really challenged when the haemodialysis unit was transferred. Patients stopped dialysing at 5am on a Saturday. A team of engineers brought cranes and other equipment to remove the machines and install them in the new hospital. By 11am Sunday patients were again receiving treatment, including the night shift patients. This experiment tested many aspects of the hospital administration. It is very important to carefully plan any transfer of patients from one hospital to another. In very quick succession cardiothoracic units were transferred, followed by medicine and chest patients, orthopaedic and urology patients. Between these transfers another authority closed an unsafe hospital containing 100 Newcastle elderly patients. Some of these were transferred to the new hospital. At the same time new wards were being opened to increase provision for rheumatology, medical and geriatric patients.

In-service training could even be extended to staff having

already made up the very beds that the first patients are to occupy. It is essential that the workload amongst in-patients in the existing units must start to reduce so that very few, if any, very ill patients are needed to transfer. It seemed to us that the weekend was the best time to arrange transfers of in-patients. With medical work being reduced at least two to three weeks before the transfer many of the patients will have been discharged. Those left for transfer will need to be medically examined the day before and on the day of moving and it is important that a senior nurse personally assesses each patient for both their fitness to travel and to clearly indicate any particular nursing needs required. Unless the medical and nursing needs can be fulfilled the patient must not be transferred. Obviously, well before the day of moving the relatives of all patients will have been given in detail information of the new hospital, which ward will be used, together with how to reach the ward within the hospital.

If elderly patients are involved then very careful preparation needs to be made. I have seen extreme confusion among the elderly after being moved from one hospital to another. All transferable patients need considerable counselling as well as relatives. On the day of the move a nurse should accompany all patients. The reception of patients at the new hospital should be carefully planned. There is a great temptation to say 'no visiting' the first night. Resist that temptation. Visiting helps to relieve patients of many anxieties and the inconvenience to staff is more than compensated by having contented patients — they may even sleep that night!

Conclusion

With all the difficulties surrounding the opening of a new hospital the experience is extremely exciting. If a nurse is involved in the planning of the new hospital, if a nurse is in the commissioning team, then many problems involving nurses and patients will have been solved. The costs of the new hospital will normally be much higher than the old ones because of the extra space and facilities. These demand in turn more staff.

Give considerable attention to in-service training and allow visits and activities in the empty new hospital. Make the staff feel that it really is their hospital well before the time that the first patient is admitted.

If the medical and nursing staff are sensitive to the needs of patients and relatives during transfer then there is no reason to suppose that the experience of opening a major hospital in Dublin or anywhere else will be anything but the most fulfilling, exciting venture ever undertaken.

Essentially, the whole project is a management task. Peter Drucket has said:

> "The manager has the task of creating a true whole that is larger than the sum of its parts, a productive entity that turns out more than the sum of the resources put into it."

That, ladies and gentlemen, is a perfect description of an organisation called 'a hospital' and it describes the contribution staff will make to it if properly motivated.