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RISING AND BEDTIME

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Common Theme

Review of the reports from institutions on rising and bedtime yields the impression of a core of major, interlocking problems. Policies and practices interlace with limitations in the physical plant and staffing patterns. Though these will be considered individually, it should first be noted that simultaneous modifications at several or all points might be necessary if any change is to be effected - which significantly alters the patients' experience and the staffs' care responsibilities.

This major, common these is one in which the day begins in a regimented way, with a general call to rise. Lights are turned on in the sleeping area, and a staff member announces that it is time to get up. It is necessary, later, for the staff member to return and call individually those who do not arise on the general call.

The regimentation here is related to patients having little or no opportunity to exercise property rights or choice in regard to their daily routine: they have no means of awakening themselves, as they do not own alarm clocks; and they must all be ready at a given time because breakfast is mandatory.

Patients who respond to the general rising call and can prepare themselves are ready for breakfast some time before the breakfast bell rings. The fairly long period for preparation is necessary, however, in order for the ward personnel to respond to the needs of patients who cannot care for themselves completely. It is needed, also, because of other demands on the staff's time — the returns to the sleeping area to call those who are not yet up, passing out clothing and toilet supplies, supervising shaving, answering requests for cigarettes.

Staff responsibility for a considerable portion of post-rising preparations, like its responsibility for patients' rising, is related to other conditions which force or foster dependency. These are that patients have no place to keep their own clothing or toilet articles; even if they had such a place, such items are not individually supplied, but are from a general stock and so, are distributed as needed; lack of individual assignment of supplies and a place to keep them (even to hang up one's clothes at night) means lack of opportunity to practice responsibility for oneself and, presumably, an increased dependency on help from staff; and, within this framework, systematic training in self-help seems not to exist — rather, help from others is given at each point where self-help flags.

Some patients arise before the established hour, and are sent back to bed. They might as well be in bed, as the doors to the lounge area (note the name "dayroom") and, presumably, the outside ward doors are locked; also, supplies are likely unavailable for them to toilet and dress themselves, so they could not go out of the building until the time comes for everyone to leave.

After supper, many patients want to start getting ready for bed, and the staff attempts to keep them up for a while so they will not awaken too early. There is a general bed-time, which is often so early as to mean that patients spend an unusually long time in bed. The hours between supper and the early bed-time are, however, often too long unless patients can go off the ward for activities, as each patient is dependent on personal resources many lack in order to fill in the time — no activities are brought to the ward by rehabilitation staff or volunteers and there is no indication that the ward personnel on duty in the evening conduct special programs (e.g. remotivation therapy) to stimulate interest.

Bed-time preparations involve the same patient dependency and staff responsibility as the rising and post-rising periods. Again, there is regimentation, with sleeping areas unlocked and activity areas locked at a given time so that those who would like to stay up longer are unable to do so. This regimentation, like the earlier one, is related to the unavailability of toilet supplies and clothing except at the given periods — toothbrushes are brought out for bed-time use, night clothes distributed, and day clothes stacked. The "group" care problems are all accompanied by a lack of privacy, in both toileting and dressing.

Major recommendations, then, are that the institutions consider:

> Must breakfast be mandatory?
>
> Could patients on this ward be supplied with alarm clocks so they could assume responsibility for awakening themselves and be given the choice whether to arise in time for breakfast or only in time to report to the first assigned activity?
>
> Can any changes be made in physical plant of this ward (e.g. providing some simple bedside table) which would permit patients to keep their own toilet supplies?
>
> When Patients do not have funds to purchase their own clothing and toilet supplies, might these be individually-assigned instead of distributed from a community supply?

Can any arrangement be made, such as a closet pole installed in the sleeping area, so patients can hang up their clothes at night and select their own garments in the morning?

Can self-help training be given (not necessarily by ward personnel) in care of one's own clothing (washing out underclothes, pressing, mending) and in toieting (e.g. training built into the supervised shaving)?

If patients are up early, or if they choose to skip breakfast, could they make a pot of coffee on the ward?

Must the activity area and outside ward doors be locked from the general bed-time to the general rising hour? Or might patients on this ward who want to stay up late, awaken during the night, or arise early have access to the area and, some, be free to go outside?

Do many patients on this ward want to go to bed shortly after supper? Do most accept an unusually early bed-time without protest? If so, does this reflect an emptiness in the hours after supper?

Are activities brought to the ward, so that patients are not toally dependent on their own resources for finding interesting ways to fill their evening time? Might remotivation programs be offered by aides during the post-supper period? Could patient committees be formed to plan P.M. activities?

Might some leeway for individual preferences in rising and bedtime alleviate to some extent the pressures on staff to help patients in need of toileting and dressing assistance and/or training?

Could some change be made in the physical plant to offer privacy — e.g., curtained dressing areas, partitions or curtains around toilets, individual shower or tub stalls (or a staggered bathing schedule which provides privacy)?

EXPLANATORY COMMENT

The reports summarized were given in answer to open-ended questions. Some insitutions did a pre-summary of reports from ward personnel; others sent the initial ward reports. Both types of reports varied in specificity.

In reading examples, then, if one institution or another seems to be quoted more often about possible problems or about a particular problem, this should not be taken as meaning that the problem(s) are more common there. Rather, examples were selected for their aptness or precision.

Also, it should be borne in mind that "identification" of a problem from the reports was often highly impressionistic, and the impression might well be changed if more complete information had happened to be given on the point involved.

We have tried to keep the reports anonymous. Names of institutions are coded throughout in such a way that the letter used is in no case the first letter of the institution's name.

RISING AND BEDTIME

Specific Problems

MORNING

I. RISING

A. RISING TIME

1. There is great variability, both from institution to institution and from ward to ward within an institution. The times seem to vary according to the kinds of patients, e. g. hospital, geriatric, continued treatment, etc., though at least one staff member reporting on rising time felt that the hour is set on some wards by tradition (Facility C).

2. Though the precise hour varies (largely from 5:30-6:15) most areas have a general rising time. Exceptions noted are:

   Facility K: "... it appears that there is a general pattern on each station by which patients awaken according to their own habits . . . Approximately a half-hour before breakfast time, patients who are still sleeping are awakened."

   Facility J: In (self-care areas) "Patient is responsible for rousing himself without assistance from any employee. He may use an alarm clock, or have another patient awaken him . . . No set time for rising. Patient may elect to skip breakfast, but he is expected to be on time for (other activity) or work detail."

   Facility F: Ward —, working patients, rising time varies, starting at 3:30 A. M. "depending on work area and days off."

   Facility H: In (self-care areas), "Patients in these areas are responsible for arising and getting to work on time..."

   Facility E: Ward —, general call begins at 5:30 but some stay in bed until 7-8 A. M.

   Ward—, "No one is forced to get up and may even stay in bed during breakfast if he wishes but he is encouraged to get up since many would lie on their beds the whole day and never move or socialize."

Exceptions also are sometimes made from a general rising time for patients' days off or for weekends:

   Facility I: Patients who wish to do so may stay in bed until 10 A. M. on Sundays.

Facility J: "In (building —), girls having days-off need not arise for breakfast if they wish, since there is a ward kitchen and the girls may get a snack at a later hour after rising."

In (building —), "He may, however, sleep-in all morning on his day off."

One "exception" seems to need clarification. Some patients at Facility J arise at 6:00 on weekdays and 6:30 on weekends. It would be interesting to learn why they must be up this early on weekends when they do not have a regular activity program then.

3. The establishment of a general rising hour, with a general call to rise, seems related to patients having no individual means of awakening themselves. Exceptions.

Facility J: Note example of alarm clocks (above) in self-care area.

Facility H: Similarly, clocks must be available in the self-care areas (see above).

Facility F: In (building -), the lights are turned on at a general rising time (6:30) but "some have alarm clocks."

In one self-care area, the method of awakening is "their own alarm clocks."

4. The setting of a general rising time also seems related to breakfast's being mandatory. Except for the instances mentioned above, where breakfast is said to be optional, comments about breakfast give the impression that everyone is firmly expected to go to the dining area for this meal, e. g.

Facility E: Ward —, everyone "must be ready when breakfast bell rings about 6:45 A. M."

Ward —, "The rest refuse to get up at 6:45 for breakfast."

That the rising time tends to be early may also reflect the breakfast requirement and the breakfast schedule, as one report refers to consideration whether breakfast might be at a later hour, which would permit a later rising time.

5. Breakfast's being mandatory seems related to general lack of availability of coffee and a snack on the ward if the meal is missed.

6. Setting of a general rising time also seems related, in many areas, to the handling of clothing and toilet supplies (see below), for example with toothbrushes brought out of the ward office for a limited period of morning use.

7. There does not seem to be any permissiveness about patients' rising early. e.g.

Facility B: "Some patients try to get up at 4:00. Have to be sent back to bed."

8. Industrial patients appear to be a special group where rising time is con-concerned. The hour mentioned for calling these patients is sometimes several hours earlier than the general call, starting at 3:30 A.M. (Facility F) with some up at 4:30 (Facilities B,C,L).

The earliest-rising industrial patients in Facility C report to the farm and are served coffee there. No other mention is made of arrangements for early-rising working patients to have AM coffee or to go to breakfast.

The report from Facility D is specially interesting in regard to the very early rising time for some working patients:

". . . Because of this forced self-analysis, many very interesting occurrences were brought to our attention. As a consequence, I have been involved in corrective action so that I can answer your request both from a before and after point of view.

". . . Patients were awakened from 4:00 A. M. to 5:15 A.M. depending upon the ward and work assignment . . . Because of this review, we have changed 'unnatural' work assignments so that the earliest patients have to be awakened at 6:00 A. M. For example, the bakery hours were 4:00 A. M. to 12:30 P. M. This has been changed to 7:00 A. M. to 2:30 P. M. without any ill effects to the food service operation. The same story was true in regard to patients working in the kitchen, laundry, etc. where hours were revised to be more consistent with that found in the outside community.

". . . I must say I was quite amazed at the results of this survey because I felt we had resolved most of these problems five years ago when we had gone into this matter. However, it seems because of habits of patients and lack of communication between industries and wards, we had drifted back into the old patterns but we have found many cases where patients were reporting to work assignments two or three hours before any employees were on duty. There was absolutely nothing for them to do when they got there except sit around in the barns, etc. waiting for the employees to arrive. I must admit this confession has caused me to do a considerable amount of blushing but it does point out how we think we know how something is operating because we want it to operate that way."

9. <u>Incontinent patients</u> seem to form another special group, with the changes of linens and diapering starting as early as 4:00 A. M. (Facility M). Perhaps for this reason, the general rising time for infirmary and geriatric patients tends to be earlier than for others (5:00-5:30) and as early as 4:30 (Facility E).

B. HOW ACCOMPLISHED

1. In general, lights in the sleeping area are turned on and an announcement made to the group, from "Good morning, girls" to "Time to get up". On some wards, the call is personalized by going to each patient and calling him by name, or giving each a pat as he is called, or e. g.

Facility C: "Often times we linger a while to talk to a certain patient, depending on whether or not he feels like doing so."

2. In most areas, if patients fail to respond to the general first call, ward personnel go back (usually at half-hour intervals, though 3 or 4 return trips may be made) to call them by name. The repeat call, however, is sometimes impersonal, e. g.

Facility C: On an area where lights are turned on and each patient called by name at 5:45, at 6:15 "ring bell for ones who haven't started to get up and also signal for medications."

3. Occasionally, music is piped in at rising time (Facility F).

II. POST-RISING

A. PRIVACY

1. Many reports refer to lack of privacy for dressing and/or toileting, e. g.

Facility C: "We do not have curtained partitions to draw around the bedside when most patients dress. Supply of movable screens is inadequate and would be a hazard among the geriatric population - many would stumble over a screen"

On large wards "there often is no partition between the four or five stools or seven or eight wash bowls available to 50-70 patients ... there is often just one tub or at the most two available."

In unremodeled areas "there are no individual shower stalls - several patients are showered in a pit with three or four inadequate working shower heads."

Facility H: "Privacy is very difficult to maintain."

Facility F: Ward —, "more privacy for the residents while washing, dressing, and toileting would be desirable."

Ward —, "There are stalls but no door in front."

Facility M: Ward —, (men), "Very little privacy for dressing - 6 patients to a cubicle."

Ward __, (women), "For bathing, one bathroom with 3 showers and 1 tub for 30 patients."

Facility B: "There are several toilet stools in one room with no partitioning, 3-4 wash basins for 30 people."

Facility H: In areas for people who are in quite good mental condition, "there is very little privacy in toileting and washing."

Facility E: "Most toilets do not have partitions, so there is little or no privacy."

Facility A: Geriatrics, "bathroom is often shared by 2 or 3 other patients."

2. In three of the wards at Facility F, the day room is used for dressing. "They come downstairs in their night gowns and dress in the dayroom." Aides and patient details dress the patients one at a time, apparently while the others await their turn.

   Reports from 2 other of the Facility F wards are that people are dressed "in and near the bathroom", with no indication that "near" refers to a dressing room.

3. Incontinent patients, or those who are unable to walk to the bathroom, may present a special case in regard to privacy. Where diaper changes are mentioned, there is no indication of any provision for privacy. Also, privacy is not mentioned in regard to the following:

   Facility A: "Geriatrics unable to walk and who need complete assistance in toileting use a commode which is brought to the bedside."

   Privacy of another sort, as well as physical, may be a problem in regard to incontinence. The fact of the disability may be made public, as in the following:

   Facility F: Ward —, "no stalls - some must be tied on the stool after meals to attempt toilet training."

   Facility C: Short hospital gowns are used as night clothes for the untidy, and might amount to a "label" of incontinence.

   Ward — , after the patient's gown is changed and he is toileted, some are "sat on a commode chair."

4. That some men choose to sleep in their underwear may be related to lack of privacy for changing clothes.

5. Facility L reports that "We have toilet dividers ordered for all areas and are awaiting their arrival."

6. In only one (Facility J) was provision for privacy considered generally adequate.

B. CLEANLINESS & SUPPLIES

1. Oral hygiene seems to present special problems. Those areas which mention availability of toothbrushes usually indicate that they are kept on a rack in the ward office and are brought out only twice a day (the A.M. time is sometimes before and sometimes after breakfast). Apparently, toothpaste is passed out by ward personnel at the same times (mentioned by Facilities C, F).

   Facility A: "Oral hygiene is perhaps one of the weakest areas in nursing care." (special reference to geriatrics)

   Facility C: Ward --, "Not enough help to give good oral hygiene to patients needing assistance."

   The problem may include lack of provision for dentures:

Facility C: Ward —, "Many patients are edentulous."

Toothpaste is mentioned as an item sometimes in short supply (Facility E, "frequent shortage"; Facility C 1-2 times a year).

2. It is not clear how towels and washcloths are supplied in most areas. One ward from Facility C mentions that only paper towels were available for morning washing but "this will be changed"; the Facility H report refers to paper towels being available, in the areas for people who are in quite good mental condition.

   Another Facility C report states that clean towels are given twice each week, and a third includes towels in a list of items which are laid out each morning, or whenever the need arises, "for those who need assistance."

   At Facility G, "Each patient has his individual bath towel, either one he has bought or one given to him by the hospital."

3. A question about hygiene in washing patients who need help is raised by the following report:

   Facility A: "Geriatrics: Those who are unable to wash themselves are washed by personnel using a 5 gallon pail of soapy H20 and a 5 gallon pail of clear H20. Each patient is washed with a clean washcloth and then rinsed with a clean washcloth."

   The question is whether the water also is clean for each patient.

4. Question in the opposite direction is raised by the following:

   Facility H: Infirmary wards, "As patients go into the dining area their hands are dipped in an H.T.H. solution and wiped just before eating."

5. Several reports state that some men sleep in their underwear, but do not mention how often the underwear is changed, or how often they wash.

6. Soap sometimes is not available. It is included in lists of items passed out at toileting time or given on request (Facilities C,F), so even when in supply may not be available for patient use at all times.

   Facility M: Ward —, "Soap available when patients dependable."

   Facility C: Two areas report having soap dispensers but no soap.

   F Facility F: Ward —, lacks adequate supply of soap.

7. Frequency of baths is not usually mentioned. Where it is, the report generally indicates that additional baths (besides the 1-2 scheduled per week) are given or taken as needed.

8. Facility B reports an occasional lack of Chux, ordinarily used with incontinent patients.

9. In some areas, toilet tissue is dispensed by ward personnel (reported by Facilities C, F).

10. Shaving seems to present special problems in many areas. Electric razors are used on some wards; there is no mention whether these are "community" razors and, if so, what provision is made for having them clean on each use (if any such provision is necessary).

    Shaving sometimes is done in the evening instead of the morning. Where there is mention of how shaving is handled, it seems generally to be a supervised activity, with supplies kept in the ward office.

    There is mention of infrequent shaving (once a week, Facility H) or "when an aide is available to observe" (Facility C), and that more patients could shave before breakfast if an aide were available to supervise use of razors with blades (Facility C).

11. Where personal items are not in the patients' possession (the usual case), ward personnel are kept busy answering requests for "cigarettes, tobacco, hair cream, shaving lotion, etc." in the post-rising period.

    A solution to this pressure is mentioned in the report from Facility A, where patients who can take care of personal items are provided with bed-side tables. Though individual assignment of personal items is on a different nasis at Facility K (re-contamination in infirmary) here too each patient takes care of his supplies: "each has a box with soap, toothpaste and other items for his personal use."

C. PHYSICAL PLANT AND EQUIPMENT

1. The contribution of inadequate equipment to the problems of lack of privacy and individual assignment of supplies has been noted above in many instances (under privacy).

2. At Facility B, faulty equipment contributes further to making self-care difficult. Flushers on some toilets are too high for all patients to reach, and faucets on some wash basins are difficult to operate.

D. CLOTHING

This item is covered further under bedtime procedures(below).

1. When patients are unable to purchase their own clothing, the practice seems to be to have them draw from a community supply, rather than to have garments assigned to them as "their own", e. g.

   Facility C: "Very few patients have their own clothing. Clothing bundles are handed out" and the patients also "help themselves from a supply."

   Ward —, "Patients whose clothing does not fit are taken to clothes room in the basement and are re-dressed."

   Facility F: In some areas, where the day-room is used for dressing, the impression is that the team of aides and patient helpers select needed items of clothing from stacks of supplies. Reports from some other areas refer to "mass production" dressing.

E. TIME LAPSE, RISING TO BREAKFAST

1. On some wards where patients need a great deal of help, it is hard to get everyone ready in time for breakfast in spite of an early starting time, e.g.

   Facility E: "Due to shortage of personnel on wards where patients need complete care, there is a rush to get all the patients ready for breakfast by the time it is ready to be served."

2. The more common problem is that if patients rise at the first call and get themselves ready, there is a lapse of time until the day officially starts, e.g.

   Facility C: "Where the getting up time is 6:00 A.M. because it is traditional, as much as 1½ to 2 hours elapses before breakfast."

   Facility E: "The time lapse for these patients is ½-1 hour."

   Facility M: Ward —, 25-40 minute lapse after ready.

   Facility A: Several wards, 1¼ hour wait.

3. For other patients, there often is a long interval between rising and breakfast, but perhaps this time is needed for preparations, e.g.

   Facility M: Ward —, there are three breakfast shifts, at 6:30, 7:00 and 7:30. Lights are turned on at 5:00 and patients are called at 5:15. There is note that some need help but many take care of themselves. The interval is 1¼ to 2¼ hours.

   Facility L: One hour between rising and breakfast, about ½ of which is needed for preparations.

Within-institution differences in the time interval suggest that there might sometimes be long delays even for those patients requiring special help, e.g.

   Facility M: On one ward (108 patients, 4 aides on 1st shift) diapering starts at 4:00 A.M., and breakfast is at 6:30. Another diaper change starts at 4:30, and breakfast is at 6:15. This ward has 1 or 2 aides on the first shift and 1 on the third for 22 patients. At least in staffing ratio and in having all bed patients, it is comparable to another ward where diapering doesn't start until 5:15.

4. As part of its self-survey, Facility D was able to reduce the post-rising interval: "The elapsed time between completion of dressing and breakfast varied from 15 minutes to two hours but at present we have reduced this to 5 minutes to ½ hour.

F. WHAT IS DONE DURING THIS PERIOD

1. Ward cleaning duties often are carried out, at least partially, before breakfast, but this does not ordinarily seem to use up all the time, e.g.

   Facility I: Ambulatory geriatric patients are awakened at 5:30, with a wait until breakfast of nearly an hour, "Nothing assigned except getting ready for putting ward in order."

   Facility F: Ward —, ½ hour used to get ready, activity during the remaining ½ hour "self-determined by patient and sitting in hallways waiting to be pushed to the dining room."

   Facility A: The doors of some wards are not opened until 7:00 A.M. in order "to avoid a large over-crowded line at the dining-room door."

   Facility M: Ward —, patients who are largely capable of self-care, spend 25-40 minutes listening to records before they line up for breakfast.

   Facility M: Ward —, the question is left unanswered what is done during the 1¼-2¼ hour period from rising to breakfast.

   Facility L: ½ hour for preparations, ½ hour spent listening to the news on individual radios or TV; no cleaning scheduled.

   Facility E: Patients up at the first call who can ready themselves have a ½-1 hour wait. Though many do tasks, hear radio or TV, read, socialize, "some lie down again and go back to sleep until the breakfast bell rings."

   Facility C: In one area, patients pace the corridor.

2. Facility A. reports a partial remedy to a 1¼ hour wait noted; on two of these wards (not all), coffee and crackers are served during the interval.

   Also, some patients there attend 6:45 Mass each morning.

3. Facility M, Ward — Bldg.#6 reports two breakfast times; ½ of the ward (of patients who need to be fed) have breakfast first, then the others. Though apparently all are awakened at the same time, the split breakfast shift might solve some of the post-rising problem if awakening could also be in two shifts.

4. <u>Facility H</u> reports a split breakfast schedule which uses patient helpers to stay with half of the group and help them get ready while the others are escorted to breakfast by an aide. While the particular group with which this system is used seems questionable(active patients needing a great deal of care) the method may be applicable in some instances.

   Similarly one ward of <u>Facility F</u> reports that patients who need a great deal of help are escorted to the dining room by "patient or aide".

5. Part of the activity during this period seems related to practices of locking the sleeping areas (which then must be cleaned by breakfast) as soon as the group is ready, and to the distribution of duties between shifts, e.g.*

   Facility C: "By 6:15 A.M., the majority of the patients are up, have their beds made and are attending to their needs. As soon as a room is empty and in order, it is locked until after breakfast. . .

   ". . .At 7 A.M. the early shift arrives. All the rooms have been locked, medications have been given, and all the patients' personal requests have been taken care of as far as possible."

6. A number of reports suggest that the long interval is related to patients having to depend on staff for supplies (clothing,smokes, toilet articles) and for calls to get them up. This would seem to apply even where patients would be capable of self-care,were conditions such as to allow for it.

7. Other reports suggest that the long interval reflects the time which must be allowed for giving total or near-total care to patients who are unable to ready themselves, with too few staff members having to respond to too many patient needs. This is best exemplified in the following report:

   Facility C: Ward — "Patients wait approximately 1½ hours for breakfast. This varies daily, meals are early some days, late other days. Patients watch TV, listen to the radio, lay on bed or do pretty much as they please before breakfast. People on 2nd floor are too far out of contact to do anything but sit. There is not enough help to give good oral hygiene etc. to the helpless patient. One aide to 22 patients on 1st floor. One aide to 36 helpless,heavy,incontinent, patients on 2nd floor and one aide to 30 patients on 3rd floor. With this amount of help, it is impossible to give good custodial care,personalized or individual care is just something the employees dream about."

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*In regard to staff duties or shift-change patterns,the Facility E report expresses recognition that some differences in practice from ward to ward are related to employee convenience,and is considering these matters in its work on Dehumanization.

EVENING

I. PRE-BED TIME

It should be noted that in the form requesting information from institutions, pre-bed time was defined as "the hour or so preceding bed-time." This definition assumed that there was a post-supper interval preceding a pre-bed period. From the reports received, for many areas pre-bed time would better be defined as beginning immediately after supper.

A. TOILETING AND DRESSING

1. Procedures and problems largely as for post-rising period (lack of privacy, distribution of night clothes from a common supply if the patient has not purchased clothing of his own, "mass production" methods of dressing and undressing patients who need help — with some of the Facility F wards again using the day-room for what sounds like an assembly line process, with each patient changed in front of all the others).

2. Lack of closet space poses a special problem at night, e.g.

   Facility C: "There are few areas where patients have a a place to hang their clothing. Many men prefer to wear their underwear at night and leave outer clothing in a heap on the floor. Most put it on the foot of the bed."

   Facility F: Ward —, three patients help others one at a time, not only supplying night clothes from a supply on a table, but also folding day clothes and putting them in a box.

   Facility J: One ward has two large dorms without personal locker space, which makes it necessary to change clothes in a "change room".

3. In some areas, patients are dressed in night clothes hours before bed-time, e.g.

   Facility M: Ward —, patients are dressed in their pajamas at 7:30 but are up until 9:00. They are helped by industrial patients (early change because of the industrial patients' schedule?).

   Facility H: Infirmary, young patients are readied for bed after supper, then up to 8-8:30.

   Facility E: Geriatric men are readied for bed at 7:00, though bed-time is at 9:00.

   Facility I: Employees start getting geriatric patients ready for bed after the evening meal.

4. There appears to be some latitude, at least for the men, in what or whether they wear to bed, e.g.

   Facility A: Most patients undress for bed, "although there are some males who have slept in their long underwear all their lives and we have not been able to convince them that pajamas are more suitable in the hospital.

Facility E: "Some patients have their own night clothes, and some use night clothes furnished by the hospital. Many patients refuse to wear night clothes and sleep in their underwear. The patients who are able to, put on their own night clothes, and those who need assistance are helped by the aides. Some go to bed with all their clothes on, and some sleep nude."

The underwear was also mentioned by Facility C and question has already been raised (Rising-Privacy whether this preference might be related to lack of privacy for changing.

5. Question was raised earlier (Rising-Privacy) whether use of short hospital gowns as night clothes for incontinent patients (Facility C) involves both lack of physical privacy and "labelling" of patients as incontinent.

B. ACTIVITIES

By and large, three non-dead-time courses appear to be open to patients in the post-supper hours. They can go to bed. If allowed, they can go to activities *off* the ward. Or, if they have enough initiative, they can entertain themselves on the ward with TV, cards, checkers, reading or conversation. (In contrast with other procedures on the ward, involvement in some evening activity seems to be almost totally left up to the individual on most wards.)

If none of these three routes is open to the patients, there would seem to be a considerable period of dead time. That a fourth course is rarely available — one of response to the stimulation of activities planned on or brought to the ward — appears to be one of the most common problems indicated by this survey, and as probably at least a partial cause of the following problems.

1. Many areas indicate a strong preference, on the part of many patients, for an early bedtime, e.g.

Facility F: Ward —, "Patients seem to know when the clock is at 8 P.M. because they will start to get undressed by themselves and if they are stopped they become ugly and will go around pushing other patients. They are in bed by 8:30 P.M." (In bed to 6 A.M.)

Facility E: Ward —, "a great many" choose to go to bed at 6:00-6:30; by 7:00-7:15 all others go to the dorm (bedtime is called at 7:00-7:30) and by 8:00 all are in bed "except those attending activities."

Ward —, "Patients are all eager to retire after the evening meal and start asking around 5:30-6:00."

Facility M: Ward —, "TV is on until 9:00 P.M. Others color, etc. . . majority go to bed between 7 and 8 P.M." (Rise at 5:00 A.M.)

Facility C: One area reports that most patients are in bed by 7 P.M. "Some are kept up until about 9 P.M. as they will sleep better and not be roaming around several hours too early in A.M."

Facility B: "Most of the patients are anxious to retire early" and attempts are made to keep them up to 9 P.M.

2. Where off-ward activites are concerned, reference is made only to organized activities, i.e. there is no mention of patients being able to sit outside, go for walks, or visit friends in other areas, either alone or as a ward group.

Sometimes, reference to off-ward activities makes it clear that these are for patients who "are able", or in some other way there is an indication that not all patients are offered the opportunity to go off the ward to take part in these organized activities, e. g.

Facility M: Ward —, (patients who are mostly able to care for themselves), there are scheduled activities "for industrial patients."

3. On-ward activities lean heavily to watching TV, with patients ordinarily choosing the programs. Thus, lack of opportunity to watch TV may be a problem, possibly in the following instances:

Facility F: Ward —, apparently no TV; usually sing or play quiet games before bed-time

Facility M: Infirmary, patients not on bed rest may watch TV until 9:00 P. M. or engage in other activities; no activities or means of entertainment are mentioned for those on bed rest.

4. Other on-ward activities mentioned are very similar from one institution to the other, largely cards, checkers, reading. Reports from hospitals for the mentally ill do not refer to group games or songs, as do those from some wards for the retarded. Just what is done, however, is sometimes said to depend on staff present and their other duties, e. g.

Facility F: Ward—, evening activities depend on "the time the aides have for extra things."

Facility A: Practices of TV viewing and other activities vary partly with "ward management, personnel on duty."

Volunteer groups' coming to the ward in the evening is practically never mentioned, and where it is, the impression is that these visits are largely restricted to geriatric and infirmary wards (Facility C). No reports refers to staff-brought evening activities on the wards.

Only Facility H reports a systematized use of the on-ward time, in self-care areas: "Aides are present in the evening to assist in regard to things one should know if away from the institution. Hypothetical situations are outlined and discussions held to arrive at solutions for the hypothetical problems." Patients plan parties or activities for themselves or other patients, and have entertained a number of volunteer or community groups. The patients buy the food for parties, and largely handle preparations themselves.

5. Many reports suggest that sleeping areas are locked from rising to bed-time. Thus, even those who find nothing there to interest them apparently are all together in the dayroom during the evening, e. g.

Facility B: "All patients are encouraged to be in the dayroom

for the hour or two before retiring."

The purpose and meaning of this practice is not clear, but it is probably an attempt to put off bed-time. There seems reason to question whether in some instances the practice operates against solitary pursuits.

II. BED-CHECK

Several Facility E wards mention a bed-check, which precedes bed-time for some patients. (Facility F, one ward report mentions that a roll-call is taken at bed-time).

Facility E: Ward—, "At 9 P. M. there is a general bed check which is made verbally at 9 P. M., announcing bed time. All patients go to their beds. After this, some resume watching their TV programs, letter writing or whatever they wish to complete before retiring."

Ward —, patients "must be in bed by bed check time at 9:50 P.M."

III. BED-TIME

1. Bed-time, the time at which doors to sleeping areas are unlocked, policies about turning off lights and TV and locking the "day" room, are largely inseparable. Permissiveness such as the following seems very unusual:

   Facility A: Some wards require TV to be off by 10:30 except on Saturday and Sunday; others permit it to be on to sign-off. If patients are watching a program which lasts beyond the usual time for turning off TB, they are "generally permitted" to watch to the end. Lights are out at 10:30 so those who wish can sleep. "The patients who remain up after this hour are requested to be in the lounge area or recreation room."

2. The usual practice seems to be to have a specific bed-time which applies to all. A verbal warning precedes making night clothes and toilet articles available and distributing bundles of clothing for the following day, turning off hall and day room lights (note Facility A's use of the words "lounge" and "recreation" areas in company with its permitting patients to stay in these areas after most others have gone to bed, while "day room" is the usual term) and turning off TV., e. g.

   Facility E: The report from one ward refers to a hospital rule "that they must be undressed and ready for bed at 9:50 P. M. when rounds are started by PM charge nurse/and night nurse. (While it is not clear whether this rule applies to all wards, reference to the bed check makes this seem likely.)

3. That leeway is not ordinarily allowed the <u>individual</u> patient seems to reflect a "herd" philosophy, in that the bed-time seems subject to change <u>for the group</u>, e. g.

Facility E: Ward --, bed-time is 9:00, but they can stay up later "if special program".

Facility G: Ward--, bed time is by 9:30, "except on various occasions."

Note has already been made that patients who go to off-ward activities may be up later than the general bed-time. A number of reports state that if patients are watching a TV program which continues beyond the usual hour, bed-time can be postponed until it is over.

This flexibility where group or organized involvements are concerned contrasts sharply with the rarity of any mention of provision for those who would like to stay up later as a matter of individual choice. A successful indoctrination of patients into a group routine, as well as staff expectations of conformity, may play heavy roles here (underlining ours):

Facility E: Ward--, "The day patients are admitted, they are oriented to ward by one of the nurses or aides. Brief explanation of routine is given so they know what is expected. Each one is encouraged to help new ones become acquainted with ward and facilities."

Ward --, "I would say that no warning is actually needed as the patients know what time rounds are started. The routines are explained to new patients as they come to the ward and all, almost without exception, feel that 10:00 P. M. is a satisfactory bedtime."

Ward --, "Perhaps patients would like to listen to 10 PM news on TV. No one has ever requested this, but it could be a usual ending for a day."

Facility L: "The majority of the patients are acquainted with and know the hour of retiring for the night, consequently most of them make their preparations for bed without being reminded. Those few who might forget or are preoccupied are then directed."

While accomodation to individual choice may be impossible on some areas, that a re-thinking of the group bed-time may reveal room for leeway is indicated in the Facility D report. This includes, as one of the fruits of its self-survey, "Television viewing and other activities have been liberalized on wards where patients can assume the responsibility so that there is no bedtime hour and they are permitted to watch television, write letters,etc. as long as they do not bother other patients who are sleeping and as long as they can get up in the morning at the required time."

4. As with rising-time, bed-time tends to be somewhat earlier than is usual, and the time in bed somewhat longer. A very common bed-time is 9:30, and it is rare for bed-time to be after 10:00 P.M. (times before 9:30 are more common).

5. Some areas, however, report what seems an unduly early bed-time which, when compared with the rising time, enforces an exceptionally long period in bed, e. g.

Facility G: Bed-time (for adults) is 8:00 during the winter months, except for Monday and Wednesday, when patients stay up to watch TV until 9:30. The Monday-Wednesday routine is the same during daylight saving, with other nights 9:00 (about 10 hours in bed).

Facility H: Infirmary, adults in bed at 7:30-8:30 ($9\frac{1}{2}$-$10\frac{1}{2}$ hours in bed).

Facility M: Perhaps by error, one ward report indicates that lights out is at 6:30 P. M., though there is a change of diapers, clothing and linens at 8:30.

Facility F: A group of "active" patients who need a great deal of care are in bed by 7:15 and not up until 6:00 (note that this is the ward where TV seemed to be lacking, and where the time before bed was not spent actively, but in singing or quiet games).

Older patients, building --, though TV is on until 10 P. M. on one of the wards, it is off at 9-9:30 on three others.

6. As with the group bed-time, the early bed-time may reflect staff expectations that patients will retire early, e. g. (underlining ours):

Facility F: Ward--, (older patients, some on industrial assignments) there are soldom any up later than 8:30-9:00, and "Bedtime is not one of our problems."

7. That the bed-time seems readily subject to postponement if there are "special" activities of interest to the group also makes it seem likely that the usual hour is set earlier than the staff believes is necessary to meet requirements for sleep.

ADDENDUM:

Questions on Matters Other Than Rising and Bedtime Raised by the Reports

1. Note has been made that patient helpers are left with half a ward of active patients who require a great deal of supervision (Facility H) while the others are escorted to breakfast by an aide, and that a patient or aide escorts at Facility F. The general area of assignment of patients to help with other patients might well be one for which precise standards should be worked out, stating which responsibilities patients may be asked to carry, and under what circumstances.

2. Only Facility H mentions systematic self-help training. This includes offering both men and women instruction in "pressing, sewing on buttons, mending a rip, etc." and giving information needed in order to take care of themselves if they go out on a pass.

While many deterrents to self-help are noted (lack of space for one's own clothing, lack of assignment of clothing which can be one's own, limited staff to supervise shaving, etc.), if Facility H can offer systematic instruction, perhaps other institutions can also find the means of so fostering self-help. The Willmar research experience with shaving offers promise of a way out of the massive, continuing dependency on staff.

3. The Facility H report mentions a once-a-month inspection of lockers in which patients keep personal items. The reason given for inspection is "to assure satisfactory sanitary conditions are observed." As it seems unlikely that opening the boxes once a month can truly serve this purpose, perhaps the policy could be reviewed from the standpoint of what it means in terms of privacy.

4. The Facility H lockers, Facility A's bed-side tables and Facility K's boxes for infirmary patients are the only means mentioned by which patients may keep personal items. Perhaps other institutions could adopt one or the other of these methods to allow personal ownership of toilet articles and a limited number of other possessions.

5. The Facility F report mentions staff control over piped-in music, and perhaps also over TV. While the impression is that there is ample opportunity for patients to "enjoy" the music, one wonders whether there is equal opportunity to have it turned off if it is a source of irritation.

6. The rather general practice of keeping dormitory doors locked all day and lounge area doors locked all night is suggested as a matter for review.

7. Adult wards are commonly referred to as "male" or "female". Question is raised whether use of these terms rather than "men" or "women" might convey somewhat the same derogatory flavor as the term "Negress" does to those to whom it is applied (as a usage more commonly applied to animals than people . . . . tigress, lioness, etc.).

8. Use of such terms as "Chronic men" or "disturbed women" seems objectionable. Even if the names of buildings or wards cannot be changed from labels indicating type or severity of disorder, application of a building's label to its residents

seems to warrant question (i.e. "Regressed ward" becomes "Regressed men").

9. Patients having to ask for cigarettes may be an unnecessary extra demand on staff time in some areas.

10. Mandatory attendance at meals, lack of availability of snacks to which one can help oneself, and the question whether meal schedules are such as to worsen or lighten loads on ward personnel might be reviewed.

11. The Facility K report includes instructions on activities which includes many seemingly-arbitrary rules, e. g. a limit on the number of rides one might take and enforced inactivity for some patients from 12:30-2:30 P. M. which one is supposed to discipline oneself to observe. Policies such as these seem to bear review.

12. The industrial patient who starts work before breakfast may present special scheduling problems. No mention is made of arrangements for him to get to this meal. Perhaps his full day's schedule should be reviewed, to ensure his having adequate special provisions at all points for his unusual routine.

13. Staff expectations of group conformity (and uniformity), with indoctrination of patients in the same set would seem a fruitful area for in-service training discussions, as well as for perusal of policies to see how much room is allowed for individual variations.

14. The situation of the patient who is confined to bed may be a very empty and isolated one, particularly since what group activity and contact exists on the wards seems to center around TV. The daily experience of these patients seems to deserve special review. Perhaps a similar review is indicated for all patients who are unable to go off their wards in order to take part in the general hospital program.