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An Annual Evaluation of Ward Living Conditions

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IN MINNESOTA we have attacked the problem of dehumanization through use of a scale that rates living conditions on the wards. The scale, based on a questionnaire, was devised early in 1965 by the Medical Services Division of the State Department of Public Welfare. The questions deal with objects that make the ward more attractive and livable, practices involving the patients, and general ward operations. They were formulated to give a broad view of the quality of the patients' lives.

Scores on the first questionnaires, completed in May 1965, resulted in a baseline rating for almost every ward in the state's institutions for the mentally ill and the retarded. Each ward was rated on a sliding scale from one to five, with five as the highest rating; arbitrary standards were set for each gradation on the scale. The questionnaire was revised after the first rating, and the wards were rated again in November 1965; at that time inequities in the ratings were corrected. Annual ratings have since been made in April 1966, 1967, 1968, and 1969. Comparisons of annual scores indicate almost universal improvement in the surroundings and practices on the wards.

New ratings are made each year by comparing responses on the most recent questionnaire with previous ones. For each question, if the ward has improved, a plus is given; for negative responses, a minus is given; and a zero is given for no change. A maximum of one point can be gained for every improvement noted. The results are treated statistically, and if the ward appears to have improved significantly (by approximately one standard deviation), its over-all rating is increased. If the ward has regressed significantly (by one standard deviation), its rating is decreased. Continued improvement after a ward has received the highest rating is indicated by a plus, as 5+, 5++, 5+++, or 5++++.

The questionnaire contains 47 categories; many questions have several parts, and the answers require clarification or elaboration about ward facilities or practices. The first of three broad groups of questions concerns objects on the ward. The questionnaire asks the number of beds, live plants, pictures, dressing tables, full-length mirrors, outlets for electric shavers, showers, bathtubs, and toilets. It asks if the toilets are separated by partitions, if the

Dr. Barton and Mr. Lucero devised the ward living conditions scale described in this paper when they were associated with the Medical Services Division, Minnesota Department of Public Welfare, where Dr. Barton served as consultant and Mr. Lucero as state research coordinator. This paper was prepared with the assistance of David J. Vail, M.D., medical director of the department.

partitions have doors, and if the toilets have seats.

Questions in that group also ask if the ward has clocks, bulletin boards, and calendars easily accessible for the patients, curtains, a piano or other musical instruments, recreational equipment, stoves, a snack room, irons, a washer and dryer, a cold drink machine, a water cooler, and a telephone for patients.

The second group of questions deals with ward practices. Among the questions are, Is the ward open? How many patients are now in seclusion? Are patients allowed a nap at some time? Are patients allowed to smoke in the lounge after bedtime? How many patients have a place to keep personal possessions? Do patients carry their own money? Are there areas where more than one patient can talk with visitors in private? Can patients go by themselves to the canteen? How many have access to toiletries such as lipstick and shaving lotion? Is current reading material, such as a daily newspaper, available to them?

Miscellaneous questions constitute the third group. Typical ones are, How many patient-care personnel do you have, including the night shift? How many and what kinds of patients live on the ward? Does the ward have an odor? How many volunteers participate in ward activities? How many food service personnel, student nurses, and psychiatric technicians are in training on the ward? How many patients may watch the midnight show on television? The final question is, What would you like to see improved on your ward?

AN APPROPRIATE NUMBER of questionnaires are sent by the Medical Services Division to the director of nursing service of each institution for the mentally ill and the retarded in the state. She gives one questionnaire to the person in charge of each ward, who completes it in consultation with other ward staff. Patients have been unofficially included in those consultations, but future plans call for including them officially. The questionnaires are returned to the division for scoring.

After the initial rating in May 1965, representatives of the division visited the wards during that month and in June and July to check their impression of each ward against its rating. They noted some factual inconsistencies. Staff suspicion and resentment had been expected and were found, but a series of meetings between division personnel and institution supervisory staff, and workshops and visits with ward staff, helped bring greater understanding and cooperation. Division representatives revisit the wards from time to time to make sure that the consistent improvement shown in the ward ratings does indeed reflect improvement in ward conditions. Supervisory staff are also asked for an explanation when the replies on the questionnaire seem inconsistent, unlikely, or unusual.

OCCASIONALLY the responses to the questionnaires reveal foolish concessions, such as letting patients watch late television shows indiscriminately, and pointless rituals, such as getting patients up before 6 a.m. Such practices are discussed at staff meetings, their purposes are examined, and a consensus of staff views is obtained. Although division representatives attend the meetings and express their views, the purpose of the meetings is not to find fault with the staff, but to give staff members an opportunity for self-appraisal.

In 1967 a graph was prepared comparing the median results of each hospital's answers to 20 of the questions that year with the results in 1965. The graph, which was presented to hospital staff along with discussions of the objectives and dimensions of hospital care, showed that the number of plants, pictures, curtains, washers, and full-length mirrors in the hospitals had often doubled or tripled. In addition, fewer patients had been in seclusion, and more patients were going to bed later, around 9 p.m., and getting up later, near 7 a.m.—hours more closely resembling those in community life.

Comparisons of the 1965 and 1967 results in three hospitals showed that the percentages of patients who had a place to keep personal possessions had increased from 82 to 95, from 70 to 75, and from 33 to 60. In the same three hospitals, the percentages of patients who had access to toiletries such as lipstick and shaving lotion had risen from 50 to 80, from 10 to 20, and from 15 to 40.

How a ward's newest rating compares with the previous one is always of great interest to the ward staff. Although some comparisons between wards are made occasionally, the results are made known only to supervisory staff and others who must make decisions about priorities, future programs, and policy. General comparisons between wards are often invalidated by such factors as transfer of patients, different use of buildings, and renovation programs.

Administrators of the hospitals, through their support of the program, have helped ward staff better understand the dimensions of hospital care and the importance of their role. As a result, staff attitudes have improved. But perhaps most important is the stimulus the program has provided to change conditions and to direct limited resources into areas where they are most needed. •