NURSE TRAINING AND TEACHING METHODS

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Although Miss Stott (Matron) instituted a preliminary trial class as far back as 1926 whereby nurses were to be orientated to the nursing situation by spending three months in classes before entering the wards, this could not continue as only one Tutor was appointed (?? cases flow inadequate even then) for the education of all nurses in training.

1934 - a notable year - the lowest salary to be paid to Probationer Nurses - £18 per annum.

Training.

Reporting in to the Nurses' Home at 3 p.m. - 8 p.m. on a Friday.

Saturday - measure for pink uniforms; the overalls, collars, belts, shoes and stockings being provided by the probationers.

Sunday - Full duty in respective wards, wearing petticoat under overall. As the latter was buttoned top to bottom at the back, no one really knew there was no uniform beneath.

Monday - 8 a.m. - 11 a.m. In the School. Demonstrations and practice

making beds
- plain and admission
- operation
- Fowler
- Rheumatic

Isolation, urine testing, bed bath, oral hygiene, and all hygiene pertaining to patients.

Temperatures - N.B. - B.P. not taught at any stage in training.

Poultices - millions of them. In our training days the amount of linen used for poultices must surely have stretched from here to the South Pole and the linseed Unna's paste and Kaolin would have covered the tennis courts at least two feet deep.

Cleaning
- involving enamelware used
- sterilizers
- patients' lockers - all wooden then
- damp dusting
- mopping
- sputum mugs - hundreds
- temperature trays
- instruments
- care of linen, etc

This preliminary training lasted two weeks - 8 a.m. - 11 a.m., the remainder of the day being spent in allocated wards.

At the end of this time - full duty.

Lectures.

Quite simple really, but adequate for the times. Simple bacteriology and basic nursing care, anatomy and physiology.

These lectures were given by senior house surgeons who were very shy about teaching nurses, the latter not being much help by sleeping through great lengths of them.

All lectures were attended during off duty time - including days off - and in FULL UNIFORM.

Anatomy and Physiology examination at end of 12 months. (This later became a State Examination for a few years).

After 12 months - junior medicine. Lectures from Tutor and Physicians - again in off duty time. Sleeping increased!! - probably due to 12 months hard work. There was little demonstrated during these lectures.

Examination at eighteen months.

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Second Half of Year. - Junior surgery - Lectures Doctors and Tutor. Dressing techniques and nursing care.

Two and a Half Years. - Senior medicine - in depth lectures.

Three Years. - Senior surgery. Lectures by senior surgeons - tutor follow-up.

Three Years, Three Months. This period had to be completed before sitting Finals and there was no organised practical work relating to lecture situation.

During the three years and three months, time was spent in the Diet Department. This was very beneficial, as many medical conditions were treated by this method. As technology advanced, so the diet system diminished.

Nurses did not go on District work, but they covered children's where babies, who would be covered for by obstetric nurses today, were covered for under difficult conditions.

Nurses were also attached to the abnormal maternity area, this being an annexe of a women's medical ward. This was somewhat difficult for the nurses, having no maternity experience, but they got by. As it happened, one of the abnormal maternity patients contracted Tetanus and, glad to say, she survived.

During training days, Staff nurses and Senior nurses were excellent teachers in the practical situation, along with the Ward Sister.

The sole Tutor was responsible for tutoring all nurses and, as well as this, she sometimes relieved, making her task quite onerous but never changing her congenial manner - change was slow but happened eventually.

It was in 1944 when greater changes took place; new lecture rooms were erected and a number of Tutors engaged. Preliminary - not now Probationer - nurses were able to remain in Preliminary School for periods of six weeks and be orientated to ward routine gradually

CONDITIONS

Work.

Morning duty - Called at 5-5.15 a.m. by Junior night nurse; on duty 6 a.m. but usually at 5.30 a.m. nurses would be climbing out Sisters' sitting room windows to get on duty early. Nursing Home doors were still locked to prevent nurses going on early, but the work load was so great that an early start had to be made. We often thought the Sisters left the windows in their sitting room unlocked as an act of kindness to the conscientious.

Ward Routine.

Much was accomplished before patients' and nurses' breakfasts. All patients were given washes and mouth washes and some were sponged. Beds were made, sputum mugs attended to and breakfast orders taken. High dusting done by nurses. Soiled linen was all counted and a list made and all foul washing done before breakfast. The nurses cooked the eggs (supplied by patients and anything else desired) as there was no cooked breakfast supplied - just porridge, toast, bread, marmalade.

Ward routine continued, Junior nurse doing ward cleaning, scrubbing all lockers, damp dusting bed rails, stools (even the feet of some), screens, window sills, etc., then sponging as allocated to her.

Middle nurse did much the same; even when the Junior nurse retired to the ablution block to clean all basins, pans, mugs, bowls, baths, sterilizers, and everything else in sight, she, the middle nurse, did spongings and routine care.

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Senior Nurse - medicines and treatments after breakfast, but she would have pitched in with the others on the pre-breakfast routine scramble; also spongings. All nurses were present for patients' meals. No nurse could report off duty individually; all work had to be completed and inspected. Consequently, there and then, the greatest team work ever. Seldom were nurses off duty on time and, if there was a lecture to attend (in off duty time), the nurse or nurses returned to finish the work.

Afternoon Duty

Continuing with spongings (four hourly spongings), treatments, temperatures, re-making beds at 4 p.m., cooking teas, treatments, etc.

Lights out in the wards at 8 p.m.

Then there was linen to put away if not done by Ward Sister or Supervisor; everything to be counted. This continued for many years.

All cleaning in Ablution Block to be done again. All trays used, cleaned and re-made up.

Night Duty

Slippers worn, please note.

There was a great deal of routine cleaning for Night Nurses. As well as continuous rounds of patients and attention to treatments, the night nurses had spongings to do, a difficult task in the night and using only a portable hand lamp. Orange drinks were made nearly all night. When finally going off duty, the night nurse reported to the Ward Sister in her respective room in the Nurses' Home. The nurse was required to report on every patient in the ward and anyone whose memory was not good at 6.10 a.m. and inadvertently missed a patient would be reminded that she had missed the '6th' patient on the left side of the ward. The nurse's memory would hastily recover and the name that escaped her would fortuitously return.

The night nurse was awakened at 3 p.n., with a cup of tea; some consolation at least.

When there were a few minutes to spare, or a rest needed from heavy work, there were the dressing drums to replenish, swabs of cotton wool, gauze dressings to be made, splints to re-cover, new valves to be put in air rings, screen covers to change and so on, ad infinitum, six days a week.

When a nurse was the senior reliever in a ward, she did night duty Saturday night, afternoon Sunday and morning on Monday because that suited the ward. This situation was general for many years. At least any nurse knew what day she would be off six weeks at least in advance, by what duty she was doing.

Three months in a ward, then change.

The extra work to be done by nurses every week consisted of:-

Cleaning out clothes room (most patients had clothes kept there) and checking same. Fumigation required occasionally. Cleaning out steam jacketed couldron for boiling water - in kitchen. Cleaning all crockery, cutlery and instruments, bowls, basins, dressing trays. Cleaning out equipment and splint rooms. Sterilising patients' wooden meal trays. These were just washed three times a day following use. Oiling wheels - if no oil, paraffin was quite good! Washing patients' hair. Cleaning inside patients' lockers. High dusting was done on alternate sides of the wards on alternate days.

Every day the beds were pulled away from the sides of the ward to the middle and so allowing ward maid to sweep with tea leaves.

Every time a sponging or pressure area was done, the floor was mopped by the nurse. Trolley wheel marks were smartly eradicated when the trolley had been taken from the w

A contributing factor to the poor recruitment of nurses following the Second World War was no doubt caused by the avenues opening up for employment of women. This was also a factor in manpower loss, the attraction being higher salaries, no shift work and responsibility of a different nature.

CONDITIONS - HOSPITAL

All wards in the older part of the Hospital were long, open wards, with Ablution Blocks at the far end. Verandahs were open; only canvas awnings to occlude the rain when necessary. Sometimes the beds would be quite wet and the wooden floor slippery.

Even the new wards, built and opened in 1928 (old Wards 8, 9, 10) had open verandahs. All verandahs were glassed in in the late 1930s-early 1940s.

In the old long wards nurses had a major task carrying equipment from the Service or Ablution Block.

Portable wooden screens used to screen patients (three required as correct technique and in a 40 bed ward), nurses, collectively, could carry 840 in a day, hence, when some wards had stretchers down the middle and became 60-62 bed wards, one can add another 400 or so screens. We were quite adept at carrying three screens at a time and also three full wash bowls and mouth wash bowls and mugs; four or five bed pans at a time. These made a resounding crash if dropped!

There was no Admission Office until approximately 1935, hence the nurses took particulars of patients and did the necessary notifications.

There was no suction in any of the old wards nor in children's wards. Anaesthetic patients would take 1-3 hours to rouse. Any urgent suction would have to be done by rubber tube connected to glass and be sucked out by nurses.

Suction was eventually connected to all wards, but not before 1948-52, and then only limited.

O_2 cylinders were large and heavy; smaller ones later but few in numbers.

Ward Sisters worked 8 a.m. - 6 p.m. and alternated with S/N doing divided duty 8 a.m. - 2 p.m., 6 p.m. - 9 p.m. Later, in 1947, 9 p.m. was reduced to 8 p.m. then, later still, to 7.30 p.m. Six days a week (5 - 7.30 p.m.)

A daily inspection was carried out by the Matron, commencing 12 mid-day (on the dot) with military precision. All wards were visited and everything had to be ship-shap and all bed casters straight. This wore down as pressure of work increased in war years.

Wellington Hospital became a multiple and complex institution in the war years. In 1940 the Hospital Board acquired the use of the Kilbirnie Hostel, built to accommodate visitors to the 1939 Centennial Exhibition, and this was used as a Nurses' Home with the nurses travelling to and from the Hospital by tram.

Hours of work were changed to a 7 a.m. start some time earlier, otherwise this situation would have been impossible.

Soldiers' ward block, hastily built and opened in 1941, added more pressure and beds

McCarthy Convalescent Home in Belmont was re-organised to take children (long term orthopaedic).

Otaki Health Camp taken over by Hospital to accommodate Geriatrics evacuated from Victoria wards in 1942. All this made extra work for nurses and communication more difficult.

Then Newtown School was taken over for medical patients. Dr. Kemp's old residence opposite the hospital (now demolished) was opened for medical male patients and the Grandstand at Trentham Race Course was acquired by the Hospital for nursing soldiers with outbreaks of infectious diseases; and there was still Ewart and Fever. Patients under Wellington Hospital care rose to 1800 at one stage.

Somehow, by superhuman effort, all the work was done, but days off were missed and daily hours were very long. At times, when nurses were required to attend Diet lectures of two hours, there would be no nurse on duty in the ward. Red Cross, St John aides, were employed and each ward had at least one, and some two. These aides were magnificent, had a great sense of duty and responsibility, and in times of emergency accepted great responsibility, but in no way did they ever presum

There was a sigh of relief when the 210 bed Block was opened in 1944; lovely light cubicled ward, such a contrast to the old ones of which Wards 1, 2, 3, 4, 7 and Eye, Ear, Nose and Throat faced south. The only ones running north were 5 and 6 and the newer wards, 8, 9 and 10.

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Then the Hutt Hospital opened with nurses still travelling to Wellington for lectures

All specialist patients remained in Wellington until Plastic Surgery transferred to Hutt.

Silverstream Hospital, built for American soldiers, was also taken over in 1944. It was up-graded and became the home of long term orthopaedic and children's orthopaedic. Later it was used for Geriatric and other long term patients. Nurses still travelled to lectures in Wellington until further arrangements made later.

Nursing staff was required to live in until 1939 when accommodation problems arose. A grant of £100 per annum was allowed Sisters and Staff Nurses, over and above their salaries, to enable them to live out. It is worth noting that, at this stage, Staff Nurses received £84 per annum and Sisters £120 per annum, rising to £186 in five years.

Staffing became an even more serious problem following the end of the Second World War and, in February 1946, the bed state was reduced by several hundred beds in the Board's Institutions. An increase in salaries was granted by the Minister of Health (Miss Mabel Howard) in April 1948.

Following the relaxation of discipline to a more acceptable standard and improvements in accommodation, together with the salary increases and a determined effort to recruit, staffing levels were slowly increased, but ever so slowly.

It is interesting to note that, as staffing levels increased, the ability of nursing staff to cope with work load decreased, even with increased medical technology which proves that, in times of stress through shortages, nurses do cope.

In 1946 nurses were granted a 40 hour week, but it did not exist in practice through staffing levels, but all were paid a basic percentage to cover the extra 8 hours which, of course, was very flexible - sometimes reaching 12-16 hours in a week.

TYPES OF PATIENTS NURSED

Great numbers of patients were hospitalised for very lengthy periods (not only Geriatric).

Medical Pneumonia

This was a 'killer' disease. Extremely heavy nursing which taxed nurses' skill to the limit, but nothing more rewarding to nurses than to see their patients improve once the crisis passed. They were nursed in Fowler beds by open windows with minimum of noise in the ward. Nurses had to anticipate every need of the patient and be fully prepared. The desperately ill would require two nurses for all attention other than the giving of fluids. No physiotherapy, but many poultices

One is amazed in the change in nursing care and prognosis following the introduction of antibiotics.

Diabetes

Very difficult to control. Insulin limited to one type and given before each meal according to tests. Diabetic Comas were not infrequent and patients were, understandably, very apprehensive.

Typhoid Fever

Strict isolation and long and arduous nursing care. Great skill required here also.

Strokes

Very heavy nursing. No physiotherapy and no early ambulation.

Haemoptyses

Frequently finally diagnosed as Tuberculosis, after a few weeks. Patients very sick and apprehensive. This late diagnosis, because of lack of technology and infrequence of x-rays, no doubt was a reason why so many nurses contracted the disease Medical staff were also vulnerable but fortunately there were few medical staff in contact. T.B. patients later transferred to T.B. Isolation Unit.

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Haematemesis and Gastro-enteritis Bleeds

Long and tedious immobilisation for the patient; illness treated by diet.

Rheumatic Fever

Nursed in blanket beds for long periods.

Syringomyelia

A rare disease but very debilitating for the patient. Long and patient nursing, like so many.

Diphtheria

Also a 'killer' disease. An almost moribund patient saved by an urgent tracheotomy is a sight one never forgets. Strenuous nursing of an apprehensive patient at all times. Highly contagious, requiring expert nursing care both for the patient and the nurse.

Some people, and particularly nurses, became diphtheria carriers and routine swabbing of throats and noses was done, the positive ones being sent off duty.

Renal Conditions

Nursed in blanket beds. No differential diagnosis in the earlier days.

Cardiacs

All heart conditions came under the collective term, 'cardiac' and, apart from long nursing care, there was not a great deal of treatment. They always had their fluids half an hour after meals.

Poliomyelitis

Rarely seen today. Epidemics stretched nursing resources to the limit. Treatment varied over a period of time; as different theories hatched, there were different approaches.

Early epidemics were rarely fatal, but those in the late 1940s and 50s certainly were and there were more adults who contracted the disease. In the 1950s, those smitten with the disease were frequently pregnant women, who were finally delivered in the isolated area in which they were nursed.

It was in the late 1940s - 50s that the iron lung came into being and quite a number were in use; certainly life saving for bulbar paralysis, although a few finally succumbed. This crippling disease often left the patient with a paralysed limb.

It is probably interesting to note the visit of Sister Kenny (from America), a Registered Nurse who produced her own method of treatment which involved hot blanket packs. This treatment was carried out for some years, but finally dropped.

Miss Kenny had a dynamic personality and was intensely interested and involved with her work. She always maintained that the muscle that we would diagnose as being paralysed was, in actual fact, made flail by the opposing one being in spasm, hence the treatment, but theory incorrect.

Measles

Some serious epidemics, which would have no respect for nurses, consequently cut the available staff by 40 or 50 at a time.

Tetanus

There was nearly always a patient with Tetanus. Long and careful nursing and elimination of noise.

Some patients contracted Tetanus whilst in hospital; the padding in certain types of splints and that used under plaster of paris was made of wood-wool and some horse hair, hence the reason for patients with open wounds, or following surgery, contracting Tetanus.

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Gas Gangerene

Not infrequent. A condition which destroyed muscle and tissue. Long tedious treatment for the patient.

Surgical

Apart from the more straight forward appendicectomy/herniectomy, etc who, even so, remained in bed for two weeks and were not immune to thrombosis, the more difficult surgical nursing care comprised:-

Head Injuries - nursed in open wards (the side rooms, if any, being taken up with isolation). Required special nurses. Limited suction. Tactfulness to avoid any cerebral irritation (no available drugs), patience, plus, plus, plus. Surgical intervention rare and only if absolutely necessary.

Thyroidectomy - Crile's method of stealing the thyroid was frequently used. All knowledge of date of proposed surgery was kept from patient and medication given accordingly to calm patient. Quite difficult nursing.

Prostatectomy - Prostatectomy and other abdominal surgery was noted for the presence of many tubes which worked well but, when problems arose, the patient and the bed could be saturated. Hamilton Irving boxes for prostatectomies topped the list for problems.

Orthopaedics

On the whole, and apart from smaller procedures of corrective surgery, these patients were long term.

Fractured femurs treated by immobilisation and traction, as were compound tibial and fibulae and fractures of cervical spine.

Fractured Femur - as the only available portable x-ray machine was liable to cause conflict with the ironmongery of the Balkan Beams and Thomas splints and cause major electrical blow outs, it was seldom used. When it was, everyone sprinted for cover; the only way of checking over-riding of bone fragments was by using a tape measure and checking with the non-injured limb.

All were long nursing care problems. The patients, quite fit and well after initial shock, and the task of assisting the patient mentally was of great priority. Nurses were adept at coping.

Cervical Spine injuries.

Quite common to have five or six at a time in an orthopaedic ward.

Compound Fractures

These posed problems. No antibiotics; open wounds were frequently treated with Carrell-Dakin tubes, inserted by the surgeon after prior cleansing of wound. A continuous flow of solution passed through the tubes and wound. There was a great deal for nurses to learn about these plumbing arrangements.

Tuberculosis

Tuberculosis of joints and spine involved very long term nursing, some patients hospitalised for up to four or five years.

Preparation for orthopaedic surgery, unless urgent, took three days. The area required for surgery was prepared twice daily for three days and if there was to be a graft, the donor area also.

Dressings were time consuming and great in number and no bed-making/mopping allowed during the process.

Osteomyelitis

Painful, debilitating, and difficult to treat. Like tuberculosis, the condition is fortunately seldom seen, through the introduction of antibiotics.

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Conditions of the Eye

Glaucoma - treated by trephining, long bed rest.

Cataract - extraction; nursed in "doubles" (darkness) for long period; no movement.

E.N.T.

Mastoid Surgery, followed by long period of dressings; occasionally causing death of patient.

BENEFITS AND DISADVANTAGES

Benefits

In the earlier years, attitude to nursing was essential for the era. Strict discipline was part of the package. Nurses were in their respective wards for three months; six weeks a.m. duty, six weeks p.m. duty OR- not and night duty three months and patients were, on the whole, long term. Some patients could quite ably instruct nurses; the mobile ones were certainly of paramount help.

Also, by doing work that was unrelated to nursing duties but of prime importance to the welfare of the patients and the smooth running of a large and complex hospital, the nurses certainly gained experience and knowledge of that done by other disciplines today.

Nurses learned tolerance and understanding and were able to cope with crises of any type or kind; this came about because the nurses were in the midst of some degree of crises each day. They had to learn to adapt and improvise because the equipment just did not exist.

Observing the long suffering of their patients and the knowledge that the only road to recovery was by giving all their time and effort and skill to assist had a very stabilising effect on the nurses.

Team work was an important factor; at the same time each nurse was held responsible for her own work.

The nurses accepted change which related to improvements in nursing techniques, improvements in diagnoses,which of course made greater changes, and advancement in technology, but, on the whole were reluctant to accept change, just for the sake of change.

All nursing staff were known to each other by virtue of living in.

Disadvantages

Wastage of nurses' time, in the old system, by nurses doing work other than nursing, but changed when other disciplines employed.

Difficulties met with in the day's work:-

Floor sweeping and mopping - no vacuum cleaners.

Enamelware for all bowls, dressing trays, etc., - arduous cleaning.

Ward sterilizers for kitchen and utility and dressing trays - no package deals for dressings, etc.

Making of all dressings - certainly no wastage. Wards and Departments responsible for making dressings.

Lectures in full uniform and in own off duty time.

Lack of Tutors.

Long hours and one day off per week, sometimes missing out on a day off. This probably caused the high rate of sickness - some serious.

Lectures not related to ward situation - i.e. - type of nursing care/condition being nursed.

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No maternity training in Curriculum.

No psychiatric training either, but many psychiatric patients to care for.

No continual Registered Staff coverage, not even in Casualty or in children's medical which had many tube fed babies. However, nurses were certainly taught by the ward registered staff.

Nursing staff assigned to Fever/Venereal Diseases (old tin shed, relic of by-gone days)having to stay away from main hospital.

Reporting in at 8 p.m., then 10 p.m. This changed in 1939.

NURSING METHODS

Complete sponging, or bathing, of patient on admission; seldom done today.

No early ambulation; quite the contrary today.

No disposable equipment; everying boiled (unless requiring to be soaked in disinfectant).

Rubber tubing for I.V., etc., cleaned with bicarbonate of soda and boiled.

I.V. needles re-sharpened.

No antibiotics until approximately 1942 and very limited with many reactions at first. This technology dramatically changed nursing care and has become of tremendous benefit to the patient in all fields.

No immunisation - thus, as each disease was dealt with by this method of prevention, so the many infections/contagious diseases have been eliminated, or nearly so, and one hopes that the present situation will continue. Pre-immunisation resulted in long periods of nursing care and protracted recovery for patient.

No emergency power for the early life saving machines - i.e. - Iron Lung, Radcliffe Respirator, and when the power failed (frequently) there was an urgent need to work the machines manually, nurses taking turns.

No emergency power for the earlier babies incubators, but these could not be worked manually.

No rubber mattresses; only horse hair resulting in patients requiring frequent pressure area care and often acquiring large bed sores. Even though attention must still be given to all pressure areas, there was absolutely no flexibility in horse-hair mattresses.

No refrigeration in any ward until, probably, 1950s and none in Diet Department until 1940s.

ANECDOTES

1934 Not uncommon, when examinations were approaching, for nurses to sit on their beds, cape around shoulders and uniform still on, swotting in the evening, falling asleep and being wakened by the night nurse calling "ten past five nurse".

1936 Consternation in the psychiatric annexe one day when the patient fell through her bed. The wire mattress was the diamond wire type and she had successfully unpicked some of the interlocking wires and swallowed them. X-ray revealed all.

One Probationer Nurse was asked to scrub out patients' lockers with soda water. She did just that, with soda water from a siphon.

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1956 One observant child realised that one of the sub-matrons accompanied the cleaning supervisor on his rounds and, when the opportunity arose, asked another nursing supervisor "whether she inspected at bed-level, above or below". The child was quite satisfied with the answer, "bed-level".

1934 Not infrequently, when the probationers were asked to collect the eggs for tea, they vanished from the ward to seek the fowl houses. After all, the Hospital gardeners did provide some vegetables.

1942 There was a famous night sister who enjoyed going to the wrestling. One night she put into practice all that she had observed in the "ring". Unfortunately, she downed a detective who, like her, was pursuing a prowler. He congratulated her on her excellent half nelson.