A sluice by any other name...

Nurse returner Jane Bates remembers her early days in the ‘dirty utility room’

It was a shock to find, when I started my return-to-practice course, that my old friend the sluice now has a different name. In our hospital it is called the ‘dirty utility room’, which seems to me ungainly and rather insulting. The sluice and I go back a long way, to the days when I started out as a very green probationer. We students were a key part of the workforce then – foot soldiers rather than apprentices. When I see today’s young nurses with all their confidence and evident learning, it makes me wonder at the skills I first acquired more than three decades ago.

On my first ward (women’s medical) I learned that I should have listened to my careers mistress at school and become a librarian. My next cognitive leap was to learn about all the best known boxes of chocolates. Most important of all, I got to know the inside of the sluice.

Bodily functions

When we arrived at our teaching hospital with our A levels, four months in the sluice was not what we expected. It gave us rather a distorted view of The Patient as two bodily functions (three if we were unlucky) rather than a whole person. We were allowed to run, apart from car diac arrest and fire, was to transport a fresh sample to the path lab. We would rush through the sluice clutching our steaming packet, crying ‘hot stools’ like a Victorian costermonger on the make.

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Just to ring the changes, we would scoot down the ward with a commode, and then – guess what? – take it back again.

There was always someone who would ask for a bedpan at an inappropriate time (when we had put the trolley away) and sister would pin us to a bedpan at an inappropriate time (when we had what? – take it back again.

We took them to the lavatory and back again.

It was always advisable to stack the bedpans sensibly, especially on the homeward journey. I once took a bend on the homeward stretch too fast, and the entire top tier of used bedpans shot all over the floor. I was not popular.

There was lots to do in the sluice. There were bottles of 24-hour urine samples, which always seemed to belong to the patient whose urine you had just tipped down the sink. There were vomi bowls, bedpans and test-tubes to clean. In the days before dip-sticks (of the urinalysis variety) we had to test wee for the usual anomalies with chemical reagents in test-tubes. The solutions would boil and bubble and burn our fingers, while a hydrometer bobbed in the remaining urine to establish the specific gravity.

We tested faeces for occult blood; one of the only times nurses were allowed to run, apart from cardiac arrest and fire, was to transport a fresh sample to the path lab. We would rush through the sluice clutching our steaming packet, crying ‘hot stools’ like a Victorian costermonger on the make.

With lavatory attendants now known as wash-room technicians, I am sure we could come up with a more imaginative name for the 21st century sluice. How about Bodily Waste Processing Unit? Or the Bureau for the Assessment and Disposal of the Products of Metabolism, although that may be too stuffy and Eurocratic. So, forgive me, but how about the aptly acronymic Central Repository for Alimentary Products? [1]

Jane Bates works in outpatients in Hampshire

Traditional health education to prevent coronary heart disease might not work for women on low incomes

Coronary heart disease is the largest single cause of premature death in women, with almost 6,000 dying each year before they reach the age of 65. And mortality rates from coronary heart disease (CHD) are not falling among women on a low income, as they are in other groups.

The aims of our study were to ask women on low incomes to consider their lifestyle, and their experiences of lifestyle change, in relation to CHD risk factors (smoking, diet and exercise). Three factors influencing attempts at lifestyle change emerged from the interview data: demand, control and social support.

Home is a place of work for mothers and the characteristics of the model that emerged from the data analysis were:
- High workload demand from self, partner and children.
- Lack of control or low latitude for decisions relating to conditions inside and outside the home.
- Absence of social support, both emotional and instrumental.

These three areas emerged clearly from the data as exerting a potentially negative effect on the women’s lifestyles and related to both the paid and unpaid ‘work’ the women did inside and outside the home. A quarter of the women interviewed were in paid work, but none was earning enough to escape benefits.

This finding may mean that interventions to reduce the risks of CHD need to focus on reducing demand and increasing control and support, alongside or instead of traditional behaviourally based health education practice. This study has formed the basis for one of 12 papers commissioned for the National Heart Forum’s Young@heart campaign (Harker and Hemingway 2001) launched at the House of Lords in February.

Ann Hemingway is Lecturer at the Institute of Health and Community Studies, University of Bournemouth

REFERENCE


Charles Miller the wall with a deadly look.

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