Ghanaian nurses at a crossroads : Managing expectations on a medical ward
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“Tidy and touch!” The working routine of nurses on the medical ward

“Nursing at Medical is special. You see all conditions and learn a lot.”
(Edith, senior nurse)

While taking a break in the morning, nurses talk about their work on the ward:

Martha: “I am happy to be at the Medical [ward] now. Here nursing is really done well. You learn a lot, as the people are really sick. I will not move to another ward, but stay in Medical.”

Grace: “But with all this dying, there is no job satisfaction here. You work hard all the time and in the end, the patient still dies. Maternity and other wards are nicer; the people are not really ill there and everybody is happy. Even at Surgery, they do not die as they do here. You know they are not really ill. There is life and colour, but here on Medical, the colour is black and people are sick.”

Ama [an HCA]: “The Medical ward is hard, people are really sick. You need to do everything for them.”

The matron: “Yes, the work is very tedious. But in the end, at least you do something, because most of the people are very weak and they need your care – total nursing care. Though you’re tired, you know you have helped so many people, maybe by bathing, feeding and doing other things, because they all depend on you. Medical nursing is not easy but rewarding.”

This conversation is typical for the feelings of nurses working on a medical ward. Nurses experience the work as very exhausting; the daily routine is seen as tedious work and nurses express feelings of despair and being overloaded. In the same breath, they define their activities as ‘real nursing and caring’ as it is supposed to be. This chapter portrays the daily work on the ward, highlighting both the routine observed and the perceptions voiced. The morning shift is followed while taking up from the night nurses, bed making and wound dressing to admissions and discharges, writing reports and giving medication, until the afternoon shift arrives to take over from them. In the evening, the night nurses will return and start their shift till the next morning. It
concludes with a discussion of how nurses’ work on this particular ward can be understood.

**Taking up and starting the shift**

At 7AM, the janitor opens the doors to let in relatives and friends visiting the patients on the wards. They have been waiting outside, hoping to find their mothers, daughters or sisters in a good state. The ward is soon filled with voices, colours and smells, Christian and Muslim prayers and songs can be heard, food is given and some patients receive a bath. A woman walks over the ward selling items for the patient’s; soap, deodorant, toothbrushes, towels and food. Two nurses and two health assistants are on the ward. Their table is on the very right of the four rows of the ward. During the night they have been sitting there chatting, taking a nap and watching television in between making rounds. The table is filled with patients’ files, charts and the report books. The television is on, but its volume is lowered and the nurses try to finish their work. They need to complete the medication round, record body temperatures and blood pressures in the charts, attend to visitors asking for new prescriptions and write their last nursing notes. The assistants check the vital signs and heat water for patients to make tea or wash down. By 7:30AM, the visiting hour is over and the orderlies order visitors out of the ward by ringing a bell. The first nurses for the morning shift arrive. Most come dressed in their white uniform, but others change into their uniform in the small resting room just outside the ward. Officially, the shift starts by 8:00AM and the nurses are supposed to be in by then. All nurses, students and assistants sign the attendance book at the entrance, indicating the time they arrived. Per shift, two to four nurses are scheduled, assisted by two HCAs and occasional nursing students. The matron has already arrived around 7.00AM; she greets some patients and their relatives, talks to the night nurse and goes to her office outside the ward.

By 8:00AM, the nurse highest in rank in this shift (normally a PNO) starts with the ‘taking up’ procedure. Accompanied by some nursing students and younger nurses, she walks from bed to bed examining the files, checking the medication chart, the documentation of vital signs and the nurses’ notes. The morning medication must be given and signed in the charts; the same must happen to the charts reporting on the fluid balancing of a patient. Incomplete notes, unfinished charts or forgotten medication are regularly discovered. The night nurse is warned to work more accurately. She laughs and defends her negligence: “Oh, here is my signature, I did all but I am hot this morning; we

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43 Vital signs refer to the patient’s pulse, blood pressure, respiration and bodily temperature. All are to be checked at least four times a day. The results are documented in a special chart.

44 The name ‘matron’ is outdated. The official title is Principal Nursing Officer. The reality on the ward is that all nurses and patients refer to the highest nurse in charge as ‘matron’. This is why this terminology is adopted here. A description of the various ranks follows in the next chapter.

45 Some patients are on input - output control. This means all fluids a patient drinks (like tea and water but also soup) or receives as drip over 24 hours must be documented in a chart; the same all output in form of urine, diarrhoea or vomit must be written down.
are so busy. Please, it is OK like that.” Unfinished balance-charts are objected to and the night-assistants are asked to calculate it. Discussions arise over whose responsibility it is: incomplete forms from the previous day shifts prevent correct balancing and the plea for careful and responsible work of the shifts is repeated. In some cases, nurses try to retrieve information from the patient about the previous day in order to complete the charts.

Patients are addressed with questions either in Ga, English or Twi: Auntie, how are you today? Have you taken your breakfast? Have you had your bath already? Did you go to the toilet? The patients hardly react to the questions, their reply is brief: “Sister, thank you, yes, I am fine.” If the night nurse accompanies the group taking up, she gives information on the patient’s condition, tests that are scheduled and finished medication requiring a new prescription. Empty beds indicate that a patient died since last afternoon. Given the seriousness of the medical conditions and the late admission of some patients, many of them die on the ward. The statistics give almost 50% mortality for the Medical Department. During the research period, about one third of the patients admitted on the female ward died, meaning 17 to 26 patients a month.

After the round is finished, one more action has to take place before the night nurses can leave. It is the handing over of certain monies and objects. Nurses sell disposable nappies to incontinent patients. Most patients rely on the nurses’ supply. Nurses buy them outside the hospital and sell them for a small profit. A list is kept on ‘nappy debts’ and are recovered during visiting hours. Similarly, blood sugar strips are sold. New patients and diabetics have their blood sugar level checked regularly. Those strips for blood sugar control are not provided by the hospital and very few patients bring them along but buy them on the ward. This money, strips and nappies are kept by the nurse in charge and handed over to the following shift team. It is a conscientious responsibility of the nurse in charge to guard everything and hand the correct amount to the following shift team. Once this handing over is completed, the matron calls all nurses and nursing students to gather around the table for a short moment of devotion. A nurse says a prayer or starts a song followed by reciting of Psalm 23 or the Lord’s Prayer together and finishing the devotion with the sharing of the grace. Occasionally, a doctor joins the group, but on most mornings, nurses gather alone while the ward is getting busy with doctors arriving and orderlies distributing breakfast. After that religious moment, the matron orders the nurses, nursing students and health care assistants to start with the morning routine.

All mornings have one thing in common: there is no central handing over of information between the shifts. Both factual and possible confidential information is exchanged in English while walking over the ward from bed to bed. Nurses hardly take notes but remind each other during the days. If time allows, they read the reports in the books. This leads to the situation where

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46 Nappies and blood strips are both sold for € 15.000 a piece.
47 The use of English as the language of nursing will be discussed below.
different nurses have different level of knowledge, the matron having most and the junior nurses least.

Tidy the ward

*Cleanliness of the ward and the patient area is very important. The patient is untidy. But if the place is tidy and there’s a lot of fresh air, you see a change. The patients should look neat in their beds (Regina).*

All nurses on the medical wards share this conviction by the deputy director. Making beds in the mornings is part of the tidying process. Nursing students and HCAs form pairs to make the beds of the patients. If there are not sufficient students and more hands are needed, nurses join in. Fresh bed sheets are supplied each morning from the central laundry and distributed by the matron or nurse-in-charge. Given the unpredictable and often insufficient supply, the order in which beds are changed varies each day. Generally, nurses react to the matron’s plan: “Today we have enough bed sheets. You use them both for the bed and to cover the patients. Please, hurry up and make the beds so we finish before the doctors arrive. Form pairs always a young and an old nurse to learn from each other, go!” With this instruction not only bloodstained or faeces-stained but also crumbled and sweat-soaked sheets can be replaced. “We do not have enough sheets to change all beds. Change only the really dirty ones. Look at the bed sheets and top sheets, maybe you can switch them.” This means that whenever possible, no change should be done. In addition, some days are special: On Fridays, the matron keeps sheets in stock for the weekend. Extensive changing is required on Mondays to prepare a tidy ward for the extensive doctors’ rounds that take place. Mobile patients are asked to leave their beds while the bed sheet is changed or straightened. Bedridden patients are rolled from side to side by two nurses who inspect and, if needed, change the sheet; experienced nurses take that moment to check the body on pressure areas or sores. Any pillows, Bibles, mobile phones or money are rearranged and the top sheet is placed to serve as cover. Nurses regularly complain about the shortage of supply. Not being able to change sheets when the patient’s situation requires this and being hindered in presenting the ward in a uniform white colour, leads to frustration. Different sizes of the sheets form an additional constraint to smooth working; not all are big enough to cover the whole mattress while others can be tied together on the top to avoid excessive crumbling. Hence while some beds have short sheets and patients lie partially on the plastic, other beds present colourful sheets from materials brought by the patients themselves. Blue, red and green motives and prints change the face of the white ward. Family members bring them washed and ironed and cover their mothers, daughters and wives with it when visiting the ward, as if leaving their care and love for them in the materials. Neither the matrons nor the nurses support the use of these private sheets though. Their aim is to have a uniform look of the ward and the white colour represents cleanliness and order. The following statement from a matron illustrates this principle: “We don’t want
these house cloths. I do not like all these colours, different colours make the whole place dull.” Only in situations of extreme sheet shortage or with specific conterminous diseases these private sheets are accepted, otherwise they are immediately removed and hidden in the lockers.

Tidying the ward also means clearing up the lockers and spaces around the patients’ beds. Nurse Grace explains it: “Do you know the slogan of the day? Create a tidy and clean environment and touch the patient. Let’s tidy up the place, make the beds, straighten the sheets and clean the lockers. Yesterday, we changed most of the sheets, so today you only change the dirty ones and clear the place. Go and work.”

While the female orderlies wipe and dust the beds, lockers and public spaces on the ward, it is the nursing students’ task to tidy the lockers. They check for old food attracting flies and throw it in the dustbins, clean the spoon and cup of the patient and arrange other belongings properly. Food-related items are to lie on the top of the locker, preferably covered by a white cloth, articles used for washing, toilet paper, creams and alike are put on the second layer. Nurses mention that it is easy to conclude from the state of the locker whether a patient is poor or wealthy. Poorer patients have fewer belongings on their lockers and in their beds; sometimes they don’t even bring a spoon or a cup and hardly have water to drink; richer patients display their belongings on the lockers in the form of cookies, fruit juices, bottled water and occasionally cards from well-wishers. The table at the foot of the bed also has to look neat; the patient’s file, new prescriptions, a box with the needed medication and freshly taken samples of blood or urine are the only things kept there. Every now and then, empty pill-strips are removed, old blood samples that were not sent to the lab in time are disposed of and outdated prescriptions thrown away. Finally, the metallic trolleys used for the wound dressing and medication rounds need to be cleaned every morning. This is a job for the HCAs and they start with it even before bed making has started. There are three trolleys on the ward; two are normally empty and ready for various procedures and the third contains a pre-arranged medical set for inserting an infusion, consisting of cotton wool, plaster, spirit and a box with gloves. The HCA puts on a glove and cleans all wiping them with parazone. Then the needed materials are rearranged on the trolley and put back in its position in the ward.

Making the beds and tidying the ward are crucial elements in the daily routine of nurses. A superior nurse inspecting the ward says: “Now your ward looks tidy. A tidy ward is a white ward. Even more as this is a female ward. You know, we women have all kind of things to keep with us; it is difficult to keep a female ward tidy.”

Admitting and discharging patients

Elizabeth Kwasie, an elderly woman of 59 years living in a village in the mountains, has difficulty in breathing. As her condition worsened over weeks, her family decided to bring her to the city and have her checked in the hospital.
She was immediately admitted and she spent three days in the Emergency Unit. Then the doctors defined a therapy and decided to have her admitted to the ward. She is sitting in a wheelchair pushed by a male orderly. Nurse Catherine is unfriendly to the man, as this case had not been announced, and she returns to the nursing table not saying a word to the new patient. Elizabeth looks up disturbed, she breathes heavily. On her right hand is a drip and she is holding the infusion in her left hand. Two young relatives accompany her carrying a small suitcase, a bucket (an old margarine container), the patient’s file, an envelope with X-ray pictures and some food. Nurse Joyce walks over and brings her to an empty bed that she quickly covers with a sheet. Before Elizabeth is placed in the bed, the drip is hung on a stand. Then she stands up from the wheelchair and lies down on the bed in her clothes. She looks exhausted. Joyce covers her with another sheet; the relatives place the belongings on the floor and follow the nurse to the table. There, several forms and papers are filled and information is exchanged.

The ward has 30 beds, divided into four rows that function as specialised units, dermatology and thoracic, endocrinology, neurology, nephrology and general medicine. The ward has two additional beds on a side ward at the end of the four rows. This small room is used for special patients, so called VIPs. Such women are staff members (sometimes retired) of the hospital (nurses, doctors or physiotherapists) and their direct relatives, or rich patients. They prefer being separated from the main ward with its noise, sight and smell. The room has a small bathroom attached giving additional privacy. The health condition of these patients must be stable as nurses come to this room less frequently and moving beds there is difficult given the limited space. Unless the nurses or doctors are on strike, the ward is filled with 25 to 30 patients each day. In 2005, 465 patients were admitted to this ward staying on average ten days. The relatively high turnover of patients and the fact that almost one third of the patients die on the ward put emotional stress on the nurses working there.

In the morning, a nurse from the administration checks the numbers of empty beds and gives this information to the emergency unit. The doctors there decide during their morning round which patients from the emergency or polyclinic should be admitted to the ward. The telephone system in the whole hospital broke down several months ago and this means that most admissions are not announced but they just appear on the ward around noon. It happens occasionally that a patient is brought in but no bed is available. In such situations, she has to return to the emergency unit, and the nurses complain that the communication between them and the doctors is unsatisfactory. While it is aimed to keep the four units classified, doctors ‘lend’ beds to their colleagues. Martha explains it this way: “We used to have only patients for unit three lying in this row. But now it is different. If a doctor needs to admit somebody or the emergency unit has to bring a patient and a bed is free, we admit the one and shuffle the beds later.”

48 These numbers are taken from the annual report 2005.
The relatives play a role in making an admission smooth. They provide information to the nurse about the patient’s name, address, telephone number of a close relative, tell about the patient’s illness history and receive information from the nurse about the routine on this ward. They are supposed to bring a few articles for the patient: a towel, soap and a sponge with a bucket, a toothbrush, toothpaste and toilet paper, a cup and spoon, completed with drinking water, sugar, tea and milk powder. Given the inadequate supply by the hospital, it is important that each patient has her own things to make the nursing process smooth. While sitting together at the nurses’ table, they learn that this ward has two visiting possibilities a day, thirty minutes in the morning (7 till 7.30) and one hour in the afternoon (16.30 till 17.30). Apart from these times they are not welcome on the ward. Checking quickly in the morning whether new prescriptions were written and medication needs to be bought brings about exceptions to this rule. Others manage to enter the ward bringing food to the patients. Generally nurses are not supposed to give information about the health condition of patients, but they appreciate if relatives talk to them regularly and find out about changes in the treatment, making appointments for examinations like X-ray and ultrasounds, and paying debts resulting from nappies, blood sugar tests or alike. All patients have their blood sugar tested on admission and the relatives are asked to voluntarily pay € 20,000 into a ward fund. From this fund, nurses buy soap, towels, cotton wool and the like which are needed to supplement the equipment on the ward. After that, the relatives are sent to the administration to pay a deposit of € 300,000.

Admitting a patient means entering her in the documentation system of the ward. While the patient rests in her new bed, the nurse has to follow a defined set of actions to make the patient a full member of the ward. The official file provides information about the patient’s medical history, her social background and previous admissions and therapies. Nurses use the information from the medical file to form a first picture about the patient, talking to the newly admitted woman hardly takes place. Several forms and charts must be started: The ‘front index’ gives the name, address, contact information, family status and diagnosis. Much of this information is retrieved via the file and from relatives. For the nurses’ and doctor’s daily check, vital signs’ charts are started for pulse, blood pressure, temperature, respiration and bowel movement, a cost sheet is added to document all supplies used for this patient, the treatment sheet for oral medication and infusions is prepared to be filled in by the doctors and in some cases the balancing form for ‘fluid intake and output’ is prepared. The nurses’ notes indicate the name, age, and diagnosis of the patient next to the name of the ward and the date. It is set up without having talked to the patient. The illness history is taken over from the medical file and standard phrases are written. They read like: “… was admitted at the given time from the SME under Prof [following the name of the specialist] with a history of… she is a referral from polyclinic… [or she is a known patient]. She was well until the above mentioned symptoms started [two] days ago. Several investigations requested to be done. She is currently on … [followed by a listing of the medication prescribed so far]. Her condition on admission is fairly ill [ill].” In
very few cases the patient or her family are asked to tell what happened leading to the admission; this can give a different picture and lead to various versions of the illness history. The general perception of nurses about their patients’ condition is that they “came too late”, they “are afraid of the place and do not tell us the truth” or “are ignorant of diseases and need to be educated well”. After the individual file is completed, the patient’s particulars are written in the admissions book and finally the name and medical condition is written in the 24-hour report book. This book contains next to the admissions and discharges, reports on those that are seriously ill (SIL) and deaths within 24 hours, and read and signed each day by the nursing director of the department.

Once this is done, the nurse or HCA approaches the patient to check the vital signs, measure their blood sugar and look after the medication. It is in the course of the first day that patient and nurse start building up a relationship, and this depends on the condition and age of the patient. Many patients are admitted for the first time and do not know about the routine of a hospital ward. They remain silent in their beds, hardly asking anything and answering briefly to questions posed to them. One nurse explains her role towards these patients: “I have to make the patient comfortable and also make the relatives comfortable. I give the patient a bed. Then I talk to the relatives and orientate them on visiting hours, what they’re supposed to do. You know, people have some anxiety when they are coming to a hospital. I make them understand that there’s nothing to worry. I release their tension and make them feel comfortable. We talk to the relatives; only when a patient comes alone we talk to her directly.”

Some patients suffer from chronic illnesses like leukaemia or sickle cell disease and return to the ward on repeated occasions. The nurses know them and their families well and feel for them when they are admitted. They are welcomed in a friendly manner and are given special beds. Often these patients are young women who appreciate the contact with the nurses and they prefer beds near to the entrance and nurses’ table. Their admission is often announced by rumours and gossips nurses and HCAs bring to the ward when returning from the pharmacy, OPD or their break. “Do you know that Akosua is back? She is at the emergency.”, “I saw Mandy at the lab; she will come to the ward later.” Their admission procedure is characterised by informing each other of what happened since the last discharge. Their file is complex, containing reports of repeated hospital admissions, therapy efforts and extensive bills. If their health condition is stable, they sit with the nurses to chat or watch television.

Most patients stay between one and two weeks on the ward. Generally, patients are discharged when the doctors define their health as improved or stable during their ward rounds. The following example illustrates this:

During their round the doctors attend to some patients. Cecilia, a young patient was admitted with malaria and possible meningitis a week ago. They look at the x-ray

49 Examples will be presented and discussed below.
Whenever time allows, one nurse follows the doctors on their rounds and thereby is informed on discharge decisions. In reality, nurses are often too busy with other nursing activities to participate; then they depend on accurate reports by the ward doctors. In most cases, the files of discharged patients are collected on the nurses’ table. A sticker is attached ‘for assessment’; this means that the clerk of the ward can calculate the final bill. The patient is informed about her discharge either during the medical round or later by the nurse, and she will inform her relatives about the good news and pack her belongings. The most important requirement to make a discharge final is the settling of the bill. Given the length of stay and the large number of medicines administered on the basis of the paid deposit, such a bill can be high.\(^{50}\) Organising the needed amount can be a burden to families and the patient may have to stay a few days longer. This means that doctors pass by the patient and the nurses do minimal care for the patient. Finally if everything is done, the relatives bring the bill-receipt from the administration and the patient can leave. The nurse calls the patient and a close family member to the nurses’ table. She checks for possible outstanding debts with the nurses for strips, nappies and the like. Then she explains when the patient should return to the OPD for a check-up (normally within two weeks) and educates her on the regular use of medication. Then they leave. The nurse writes a discharge report in the specific nurses’ notes and in the 24 hour-report book of the ward. The discharge date, the amount of the bill and the receipt number proving its settlement are documented in the admission/discharge book. Then she archives the file in the cupboard and strips the bed. The orderlies will clean the mattress with a disinfectant before a new sheet is put on and the next patient arrives.

Admitting and discharging patients is in the first place administrative work. Many forms and charts must be filled in, relatives have to have the rules on the ward explained to them and money has to be collected before the patient becomes a member of the ward. The nurses play a crucial role towards the patients and their relatives. They are the first they meet on the ward and present both day and night. They give structure and take away the anxiety of a hospital admission. During discharge, they educate the patient on the follow-up and check the financial aspects. Constraints prevent them from realising their nursing plan in approaching each patient individually: a lack of communication about expected admissions and decided discharges, a shortage of sufficient bed sheets to present an empty bed clean and white, patients staying longer due to unsettled bills and busy routines aggravated by a shortage of nurses per shift, force the nurses to improvise on the learned routine. Given the high number of

\(^{50}\) In case a deposit was paid, this amount is deducted from the final bill. Only in few cases of a short stay, patients receive a refund. Depending on the medication prescribed and examinations undertaken, a two-week admission can cost between € 400,000 and 600,000.
admissions and the shortage of nurses, patients cannot always be given the necessary attention but remain almost unrecognised. Relatives are sent to buy needed medication or pay the bills without having provided all needed information and the file does not always inform the nurses sufficiently to anticipate and provide the needed nursing care. The interplay of nurses, patients, and relatives at the concrete moment of first encounter has influence on how a patient is perceived, informed and integrated in the flowing routine of the ward.

Medication

At 12PM, Martha gets ready to distribute the medication. “I am alone today, I have to start early so I finish in time.” She prepares the trolley with syringes, needles, a spoon, a stone, a small tray, gloves and a pen. She also adds the small heparin and insulin bottles from the fridge. The patients’ medications are in small plastic boxes on the trolley at the foot side of their beds. Pills are in their original box or in small plastic sachets on which the pharmacist wrote the name of the medication. The doctors prescribe the treatment, the dosage and duration on the ‘treatment sheets’. Martha checks the medication; some patients have to swallow up to five pills. She puts the correct number of pills on the small tray and pours it from there in the hand of the patient. She makes sure the patient (chews and) swallows them while she is there; in some cases she hands them their bottle with water. One patient is unconscious and has a feeding tube, she takes the pills and moulds them with the stone in their little sachets, dissolves them in a bit of water poured in a cup and astringes the pulp with a syringe before applying it via the tube. Only few patients get intravenous medication. Martha either applies it directly with a syringe through the drip, or makes a small infusion connected to the drip. Another patient is admitted with a thrombosis in her left leg and is prescribed heparin. Martha looks through the heparin and insulin bottles on her trolley but cannot find hers. It is either finished or not yet bought. Martha makes a dash on the day and time on the treatment sheet and reminds the patient that this important medication needs to be bought soon. “We and the doctors reminded her several times that she needs this heparin, but her family does not buy it.” After giving the medication, Martha signs the ‘treatment sheet’ and writes in the nurses’ notes “Rx given according to plan.” She moves on to finish distributing medication to 30 patients within one hour.

Medical doctors prescribe oral and intravenous medications. They specify the type and mode of intake on the treatment sheet. Some medications are provided by the central pharmacy to patients who paid a deposit, the larger part has to be bought by relatives. It is the nurses’ duty to administer the medications to the patients two, three or four times a day and the unwritten duty to both inform the doctors on finished medication and press the relatives to buy the prescribed drugs. There are three main times when medication is given: at 6AM, at noon and in the evening around 6PM. Most medication is
given twice a day or three times a day (every eight hours). Distributing medication is one of the main tasks of the nurses. Nursing students in their final year assist them at times, but HCAs are not allowed to do this work. Under the current health system, patients are supposed to buy their medication themselves. This is likely to cause a delay, as a medication might be considered too expensive or is unavailable, or the families are not informed about its urgency. Such challenges make the medication round a daily search and ongoing discussion with patients. The most important aspect is to make sure the patient swallows the pills well; in cases of doubt, the nurses check the mouth. Injections and infusions form another part of standard medication. Depending on the supply, nurses wear gloves while injecting insulin and heparin or connecting an antibiotic drip.

Writing and documentation

Documenting the nursing work is an important aspect of the daily routine for nurses working in the hospital. It happens on various levels and degrees, depending on its purpose. The most direct and concrete writing is in the individual nurses’ notes. Each shift is supposed to write down what they did with and for the patient, including the exact time and closing it with their signature. Reading through those notes, standard phrases appear like: “6AM: slept well nocte, vital signs checked and recorded. 8AM: breakfast taken and fair amount taken. 10AM bed linen straightened, patient washed and made neat in bed. Noon: wounds dressed, Rx given. 4PM vital signs checked. 6PM Rx given, dinner served and well eaten, made neat in bed for the night.” Given the functional care aspect, it is often a higher rank nurse writing those comments and not always the nurse who carried out the action. She also goes through the medical file after the doctor’s round looking for a change in treatment or a special examination requested; such changes are mentioned in the nurses’ notes under ‘WR’ [ward round]. Asked for an explanation, a nurse explained thus: “By this we make sure the nurses get to know. Not all do read the medical file, so we give them the important facts.” The separate sheets are filled in by several nurses. The vital signs are charted when taken, the cost sheet is supposed to be filled after every cost-involving nursing activity. Here, supply is listed and added to the patient’s bill on discharge. Typical items written down are plaster, cotton wool, syringe and needle, disposable and sterile gloves. Special and more costly items are urinary catheter and bag and the NG tube. While some nurses neglect filling in this cost sheet regularly, others are stricter. Vivian explains: “We need to fill it in properly. If we lack behind, the patients will not pay and the hospital has less money and will give us less supply. It is in our own interest to fill it in well. With poor patients, I am a bit lenient, but in general, we use for a patient daily four cotton balls, two pair of gloves and two needles and syringes.” The balancing chart for patients on strict intake and output must be calculated every day. The ward doctors look at this chart regularly and fault these mistakes. The day shifts have to remark what they
gave the patient as fluid intake (including infusions) and collected in urine bags, diapers or in the toilet as output. The night nurse will make the balance. The balance is often uneven and reflects thoughtlessness. “Helena has a urethral catheter; she is on a balancing scheme to check the functioning of her kidneys. During the doctors’ round, the balancing sheet reads: intake 450 ml, output 2000 ml. The ward doctor calls the matron in and asks for an explanation. He urges her to be more precise in the following days.” In other situations, the morning shift recognises an imbalance in the chart and tries to recollect information form the previous day to make it more fitting. The treatment sheet is filled in by the medical profession and nurses just sign the given medication. This is done consciously and accurate and the nurses’ shorthand symbols given an overview of who was on duty which day. The admissions and discharge book lies on the nurses’ table during the day; the responsible nurse having done the admission, discharged a patient or carried out the last offices with a deceased woman will fill in the particulars in the book.

While this documentation is done by several nurses, the 24 hour report book is the domain of the matron and nurse-in-charge. Each day, the morning, afternoon and night shift reports on admissions, discharges and death, the condition of the VIP patients and the seriously ill ones (SIL). The full names are given, vital signs reported and information mentioned on the patient’s condition, special treatments and her night rest. In case of a blood transfusion, the pre-transfusion treatment is written down, supplemented with the badge number, exact time and the patient’s (non-) reaction to the fresh blood. The daily report closes with a statistic on occupied and empty beds. The matron, night nurse, supervising night nurse and a member of the main nursing administration sign it. Comparing the nurses’ notes to the reports in the book, the description hardly differs. In both notes, the information is short and factual. Specifics like wound dressing and its healing process, critical health incidents and specific nursing matters (like extensive vomiting, diarrhoea, refused medication or delayed examinations) or views on the emotional well-being of a patient are non-existent. Standard phrases recur on ‘patient reassured and made neat in bed’, ‘patient’s condition is weak and therefore declared SIL’. Most deaths happen ‘suddenly’, a patient ‘was observed to have stopped breathing’ or ‘the condition remained poor and the patient died’.

Writing and documenting is seen as an important part of the work of the nurses. They spend a large part of their time at the table writing the notes and reading previous reports. Asked for an explanation, the foremost reason given is the legal aspect. Nurses of all ranks and positions mention, “The records are our justification. What is not written is not done. If something goes wrong and a patient sues us and we cannot prove having done something, we are lost” (Matron Hilda). Stories about legal complaints against hospitals or nurses make the round. While specifics were difficult and delicate to retrieve, the main concern of the nurses is to be blamed for carelessness. Other reasons are to exchange information and guarantee the continuity of the given nursing care. Regular workshops at the in-service department are offered to discuss the need
to document clearly and reliably and nursing students are taught in the college
to use the writing as a reflection on and justification of their work. The
exchange of information also concerns the aim to control nursing. The matrons
and nurses in the administration use the report book to get an impression on
their nurses’ work and in case of lack of clarity, specific nurses are called to
explain their actions.

Routine work

Depending on the situation on the ward, the nurses carry out several activities.
In the following section, some of these activities are highlighted.

Feeding

After beds are made, patients are served breakfast. Female orderlies bring
porridge, ‘Tom Brown’\textsuperscript{51} or rice water with bread. Some patients prepare
additional tea. All patients are supposed to have their own cup and spoon ready,
and use their own milk and sugar, as these are not provided by the hospital. The
same is true for the lunch and dinner when warm food is served. Food served
varies between kenkey, yam or agido with stew, fish or light soup. Some
patients refuse to eat this food and rely entirely on their family for food
provisioning. Diabetics are asked to wait till they have been given insulin
injection. Younger nurses, students and HCAs are ordered by the matron to
feed those patients who are unconscious or not mobile enough to eat
independently. They stand next to the bed, stir the fluid food, and spoon-feed
the bedridden patients; there is hardly any communication between the two.
Unconscious patients are fed through a tube; students have less experience in
feeding this way and learn from HCAs or nurses how to fill a syringe and
slowly inject the fluids through the tube into the stomach. They learn to flush
the tube thoroughly with water to avoid blocking the tube with cold sticky
porridge. In addition, they give the patient the needed fluid intake. The
patient’s toilet paper is used to clean both tube and cup. Depending on the
amount of supply the nurses wear disposable gloves. With patients on a
balancing scale, they note down the intake.

Bathing

The nurses have to assist several patients in cleaning themselves or bathing
either by accompanying them to one of the two showers or cleaning them in
bed. This happens every morning, and sometimes may be repeated in the
afternoon. Occasionally family members wash the patient. The nurses have
biased opinions about this. Phyllis says “We are not enough so we ask the
relatives to wash them. We talk to them and explain all to them. Only the
seriously ill ones are exclusively washed by us.” But Ernestina, a senior nurse,

\textsuperscript{51} A mush made of moulded corn.
states: “Relatives just wash, they don’t know what to look for. The patients are under our care. The private parts and oral hygiene, the relatives do not do it, so we have to do it. It is our responsibility.” In reality, it is mainly the nursing students and HCAs who are asked to wash bedridden women. These patients are unconscious, too weak or old to stand up or have wounds or bedsores that prevent them from moving freely. The young students prepare a trolley with cold water, warm some water in the electric kettle and look for towel, sponge and soap in the locker. A folding screen is placed around the bed to create minimal privacy. If available, a plastic sheet, called a ‘Macintosh’, is put under the patient to keep the mattress dry. Starting from the face, moving down the body and rolling the patient from side to side, the body is washed, dried, creamed and powdered. This bath can take up to half an hour, especially if the woman is incontinent, has soiled herself and needs to be washed extra carefully.

Students are hardly prepared for this work. Josephine, who is in her final year, exclaims after a bed bath: “I have never before changed diapers, not even with a baby. I did not even know how to open them. Today was my first time of doing such a bath and seeing it all together. It is a shock to do it. On all other wards, nobody needed to be assisted in washing. We just learned about all that in the demonstration rooms in our school; our training is very theoretical. I am exhausted.” The HCAs have more routine already, but sometimes forget certain aspects. The senior nurses regularly chastise them: “Hey you, you forgot to place a screen. Where is the privacy, here or there? Is this the privacy you would want? When you stand at the table you can see everything. Place the screen well!” Matron Mary explains to new incoming students: “Do not give them a ‘top- and-toe’ bath. You know what it is? It means you just dip the towel in water and then you clean the patient; ey, the patient feels sticky. They might think you also do it shallow. They call this ‘Korle Bu bath’, but now you learn to add enough water to clean a patient well. You do it and do it well. It’s only when you come into a hospital bed that you are called a patient. There’s nobody called a patient when they are walking - but when you come into a hospital bed, then we recognise them as patients. Sometimes, you see patients who are even dirty, they haven’t even got a napkin to clean up their bed. You watch out, those are the patients that you should care for. Walk closer to them or they think ‘is it because I haven’t been washed that’s why they are not coming to me?’ Do proper nursing care for them.” In the routine of the day, there is hardly any communication with the patient; it is rather the two nurses who talk to each other. Special wishes or the use of specific cosmetics are not made known to the nurses and patients do not dare to speak up. Having finished, the screen, trolley and bath utensils are cleared up and the patient is bedded either on her back or side. The involved nurses wash their hands and leave.
Wound dressing

Angela is 37-years-old. She is suffering from diabetes and has developed gangrene on her right foot. Rosemond is in charge of wound dressing today. She has prepared the trolley and has just dressed a sterile wound for another patient. She wears a facemask and disposable gloves. “Actually, you should use a forceps for the sterile wounds, but we do not have it. I use two gloves. With the first, I remove the old plaster and gauze, then I remove the gloves and clean and dress the wound. For the sterile wounds I use sterile gloves, but for this I do it with normal disposable gloves.” She places a screen around the bed and looks for dressing material bought by Angela. Then, she opens the package covered in green paper, the sterile kidney cup. Rosemond tears the paper in two, puts one part on the trolley to post sterile cotton balls on it, the other part serves as bed cover under the wound. After removing the old gauze, she pours hydro-peroxide over it to clean the infected flesh. It is a deep wound of about 5 cm, the edges are necrotic. Then she cleans the wound with cotton balls dipped in normal saline. While doing this, her face mask slides off her face and hangs on her neck. Finally, she dips the gauze in iodine and places it on the wound. To cover the wound she uses a bandage and fixes it with a strip of plaster. The dressing was painful to Angela; tears are rolling over her face. There has been no communication with the patient during the procedure. Rosemond says later: “When it comes to dressing, there is no mercy. We have to do it and do it well”. After the dressing, she writes in the nurses’ notes: ‘11 am: wound dressed and cleaned’. Then she brings the trolley back to its place; the used dressing material is thrown away in the rubbish bin. The dressing package is collected in a reservoir to be cleaned before sending it again to the sterilisation department.

There are few patients with fresh scars on the ward. Wounds to be dressed stem from gangrenes (possibly a consequence of badly managed diabetes) and bedsores (due to long lying and/ or reduced mobility) or are the result of drainages (e.g. in the lungs to run off fluids) or infected punctures from drips. This means there are sterile and non-sterile wounds to be dressed. Normally, it is one nurse with an assisting student or an HCA who does all dressings on the ward alone. She prepares the trolley with two or three sterile dressing packages (a kidney dish with two Galli-pots and a set of forceps) that are supplied by the hospital, sterile and disposable gloves, face masks, scissors and plaster, non-sterile cotton wool and cleaning liquids like saline and spirit.

Nurses learn during their training how to dress wounds according to the hygiene standards, for example how to treat sterile ones first. On the ward, they face conditions that challenge the realisation of the learned procedure. It has mainly to do with the shortage of the needed material. The ward has about 5 sterile dressing sets. After one use, it needs to be cleaned and brought to the CSSD (Central Sterilization Service Department) for renewed sterilisation. This means in practise that no more than two or three sets are available. In addition, the supply in sterile and non-sterile gloves, plaster and cleaning liquids (saline, mercurochrome, spirit) is limited. Given the cash-and-carry system of the
Ghanaian health system, patients are supposed to buy dressing material themselves.\textsuperscript{52} Sterile cotton wool, gauze and special articles like hydrogen peroxide or Asmisol, a liquid disinfectant, have to be acquired by patients. This means a successful wound dressing depends on the cooperation and financial strength of the patient. ‘No money’ can lead to ‘no wound dressing’. Only in urgent cases, are nurses willing to borrow these necessities from other patients or decide to buy it from the ward fund or out of their own pocket. The high workload on the ward in combination with the low number of available nurses is another challenge nurses mention. There are days when wounds are dressed without folding screens, and sterile gloves are used instead of sterile forceps. On other days, students and HCAs carry out the work without supervision. The only exceptions are excessive wounds caused by pressure areas or allergic reactions like the Steven-Johnson’s Syndrome.\textsuperscript{53} These wounds are deep and often inflamed and are dressed daily by more experienced nurses in a long procedure.

When asked about the proper performance of the dressing procedure, the nurses express the need to deviate from the learnt standard and improvise. Probing further, knowledge gaps were also disclosed. Only few can explain the difference between a sterile and non-sterile wound and its medical implications for the dressing. “We are a medical ward. Over there at surgical, they have more experience” is the opinion of a nurse, while a HCA says: “I learned dressing here on the ward. I watched it and now I know it.” Nursing students practise dressing on the ward but feel uncertain about the right way. “At school we have had teachers teaching us the cleaning of wounds. We were told that in cleaning of wounds we clean the inside before outside, and when you get to the wards, they clean outside before they clean the inside.” Another student agrees and solves the problem her own way: “They do things really different here. They dress wounds with non-sterile gloves and do not have the correct instruments. I do not feel really happy doing it that way. So when I am on the ward, I avoid being asked to do this work by moving away quietly.” Next to these uncertainties, there is no quality check over time. Different nurses dress the wounds every day, and neither the nurses’ notes nor oral information give any specifics about the development of the wound.

\textit{Vital signs}

Around 10.00AM, a group of nursing students is sent to check the vital signs. They are not sure where to start, and finally split up. Each starts at one row of beds, checking either blood pressure, pulse, respiration or temperature. While one student measures, the other records it in the chart. With one older woman, a student cannot find the pulse: ‘I cannot find it, it always disappears again’. She

\textsuperscript{52} As explained above, Ghana introduced the National Health Insurance Scheme in 2005. The support of this scheme based on yearly contributions is still low, many patients doubt its benefits. The hospital plans to implement the system by 2007.

\textsuperscript{53} This condition is caused by an allergic reaction to sulphates containing medication or herbal treatments. Approximately two patients, mainly young women, are admitted per month on this ward. Given the degree of the reaction, the mortality rate is above 50%.
looks around, asks her friend to help and together they search for the best way to do this work. After some minutes, they turn to the paper, note down a pulse and move on. A few minutes later, another student approaches this patient to check the blood pressure.

Each patient on admission in a hospital has his or her vital signs checked. This means the pulse is controlled next to the blood pressure, body temperature and respiration. This happens four times daily with hypertensive, feverish or seriously ill patients. In addition, the movement of bowels is enquired into each morning. All this information is then documented in the ‘vital charts’ and examined by the medical doctors during their round and by the nurses when taking up their shift. On normal weekdays, nursing students or HCAs are asked to check the vital signs; at weekends or when more nurses are on the ward, they will join them. They split up in two or three groups, one taking blood pressure and counting respiration, the other checking pulse and temperature. The needed instruments are a blood pressure gauge and a stethoscope, a thermometer with cotton wool and spirit, a watch and a red and blue pen. The ward possesses three gauges, but one is dysfunctional due to a broken tube. There are two stethoscopes and two electronic thermometers. All nurses use their own watch to control the pulse. Checking and documenting these signs take a long time and is often characterised by uncertainties. The young nurses lack the experience to use the gauge easily and so lacking self-confidence and feeling uncomfortable they often ask for help. This can lead to a situation commonly known among nurses as ‘free charting’: ‘A doctor wants to examine a patient and asked nurse Catherine: ‘How is she doing today? How are her vitals and how often did she pass any stool?’ Catherine responded: ‘It is better today, but I cannot tell you more. I was not there when they changed their diapers.’ They go to the bedside to see the patient. The woman is lying in bed, weak and silent. The doctor wants to know the actual blood pressure and asks for a blood pressure gauge. He does not hear anything. Agnes tries and her result is 60/40 mmHg, very low, especially for a woman of her age. The doctor jokingly remarks: ‘Women have better ears. But look at the chart: yesterday and this morning it was charted 120/70 mmHg. This must be a blind check and free charting.’ The nurse agrees that it is likely that the vitals were recorded wrongly. She charts the just measured results and the doctor makes a remark in his notes and leaves.’

Such occurrences can be explained by a lack of practical experience and motivation of the students, minimal encouragement and poor supervision by experienced nurses and by the set up.54 The ward follows a functional care approach in which one nurse does the same treatment or action with all the 30 patients on the ward. Unlike the individualistic care, when one nurse does all caring aspects for a few patients from taking up to bathing, feeding, medication and documentation, the functional approach leads to less attachment with and knowledge about one patient’s specific condition and needs. The shortage of nurses, time pressure and the wish to appear knowledgeable increase the stress.

54 Nursing student complain about a missing practical experience and lack of supervision on the ward. This aspect will be discussed in the following chapter and in the chapter on training.
Abnormal and extreme results in blood pressure, temperature or pulse have to be reported to the nurse-in-charge in order to decide on nursing or medical actions like medication, sponging and repeated control. Given the different tasks carried out during the shift, a regular exchange of information is often omitted. Nursing students and HCAs finish their round and wait for the next order from the nurses.

The personal hygiene of patients

The ward has two water lavatories for the 28 patients and one additional toilet for the two patients in the side ward. The male orderlies sweep and clean these rooms several times a day, starting in the early morning and stopping in the evening. This means that the toilets are clean and emit little miasma during the day, while in the night the smell increases and the condition of the place deteriorates. Sustaining one’s personal hygiene is an important element in adult life and subsequently needing assistance is perceived as shameful. Ambulant patients go to the toilets themselves; the preferred moment for moving the bowels is in the morning before the visiting hour. The nurses ask for regular bowel movement daily. Urinating is done either in the toilets or on the ward into a small bucket the women keep under their bed for regular use, and emptied either by them or a family member. When a patient needs help, it is mainly the students’ or HCAs’ task to assist her. They either push them in a wheelchair to the place or place a screen around the bed and provide a bedpan. Immobile patients are prescribed a urethral catheter and they wear nappies. Matron Mary observed: “It is our duty to recognise when a patient needs a catheter or diapers. It is a shame when a doctor has to tell us; we are responsible for it.” The patient is not asked but informed about the decision. A qualified nurse using gloves and a catheterisation-set does the placing of a catheter. While catheters are supplied in several sizes, some experience is needed to choose the correct one and avoid inflicting unnecessary pain on the patient. Insufficient supply means in this situation to borrow the needed catheter from another ward (preferably the gynaecology ward that has the biggest and most varied supply) or delay its placement. Catheter bags are emptied by HCAs three times a day. Diapers are changed when bathing a patient or if she has soiled herself. Nurses do not like to do this job. It is time consuming and can be physically and psychologically challenging. In various situations during the research period, nurses either delayed it till the next shift arrived, commanded students to do it or waited for relatives to come for the visit.

Other regular activities are the attaching of infusions or blood transfusions, collecting medication from the pharmacy and sterilised medical instruments from the CSSD and a spontaneous chat with a patient.
Being there in the night

In addition to the normal work in the day, each nurse has to work two months during one year in the night. Most nurses do not like that period. Recently, this period had to be prolonged. Nurse Joyce explains: “Actually, each nurse is supposed to work two months a year in the night. But this work is stressful. There are nurses who say they will not do it due to health issues or family problems; so I have to do four months. I also do not like it but have no choice.” Only one nurse stated that she likes the night work as she follows courses during the day to eventually go to university. Working in the night enables her to follow that plan.

In the night, the work is different: there are no doctors around, visitors have left, and the major nursing activities have been carried out. Night nurses work in pairs for four nights and have three nights free. The main task is to comfort the patients and enable a quiet and serene atmosphere on the ward for the patients to rest and recover. Nurses look after the patients, check their medication and current health situation and encourage the worried ones. Asked about it, most night nurses perceive the work as ‘busy and tiring’. Nurse Doris observes thus:

This night was OK; only one patient that was admitted yesterday afternoon and died in the early morning, for the rest it was not too busy. We had to check the files. Whenever one sheet is finished or about to be finished, like the treatment chart or the chart for the vital signs, we have to renew it in the night for the coming days. Next to this, we look after the patients, give them the night medication and look around. When a patient has soiled herself, we change the diapers and wash her in bed. Otherwise, the washing is done by relatives in the morning; we do not wash standard in the evening. Some patients are troublesome and do not want to sleep. She will say ‘sister come and give me water’ or ‘sister come and do this or that for me.’ They keep us busy and running.

This statement shows the various aspects of the night work. Many tasks are supportive to the day shifts, like the renewing of charts and sorting of files. In addition, they have to control the vital sign charts and copy results to report books. Caring for the patients is kept to a minimum since they want them to rest and sleep. The anxiety of many patients about their admission and the general fear of darkness turn the night into a difficult period both for nurses and patients. Patients are afraid that death may come in the night and so they ask that the lights are kept on and to have regular contact with the nurses; indeed some patients try to avoid sleeping in the night and are restless till dawn, when they finally sleep a bit. The nurses do not admit openly to that fear but they show dislike for being responsible for so many patients. In the late evening and early morning, they are busy with the medication and making of balances. The morning shift sometimes complains that patients were not washed or their nappies not changed during the night, but generally it seems the night work is done sufficiently. As they form one group of nurses who ‘go in the night’ several weeks each year, they come to appreciate the pressure and learn to cope with it.
Rumours circulate among patients and in the streets that nurses do leave the wards in the night and lock themselves up and sleep in the resting rooms for some hours. During the research period, the researcher had difficulty in getting approval to staying on the ward overnight; probably the nurses felt uncomfortable having an outsider with them in those hours. Arguments used were that the workload was relatively lower, uncomfortable resting possibilities and supposed boredom during the night; “It wouldn’t be of any interest.” Finally, a few nights were granted for participation. During those nights, the nurses worked as described and explained earlier, but they also spent several hours per night to rest outside the ward, leaving the sole HCA behind. The patients were mainly left to themselves. Although most slept, some were clearly uncomfortable with the darkness. They expressed their fears and were worried about themselves and the condition of their fellow patients. In addition to this, patients who die during the night seemed to cause more confusion and troubled the patients.

Conclusion

The activities give a picture of the nursing routine. One feature becomes open to view: the presentation and the appearance of the nurses and of their work. This presentation can be divided into three parts: the ward, the work and the team.

The nurses see the ward as their territory. Presenting it in a clean and tidy way to visitors and doctors means that they take good care and show their sense of responsibility towards the patients. Until the completion of the renovation, this old part of the hospital has to serve as a ward with all its described limitations. Achieving cleanliness here is hindered by the deteriorating structure of the building and insufficient equipment. It is a momentary activity interrupted by medical and nursing activities, emergency situations and visitors crowding the ward during permitted times. But it is an important element in the nurses’ understanding of ‘good nursing’ in the hospital. Roots of this can be found in the historical beginnings of Ghanaian nursing. British Colonial nursing sisters had imported ideas on external hygiene suggesting both their dominance over natural challenges and provocations and the presentation of undoubted moral integrity (see for example Akiwumi 1992, Blavo 1995). Cleanliness as a concept of successful nursing confirms also what Schuster (1980) and Holden (1991) report on present day nursing in Zambia and Uganda respectively. A tidy and uniformly white ward symbolises cleanliness and a supporting environment for the patient to rest and recover. Replacing the colourful sheets also demonstrates the power nurses have over the patients; they decide how the ward has to look and there is no space for discussion.

The hospital is the working place of the nurses. Their understanding of nursing is that of a responsible and a busy profession. It encompasses bedside nursing, writing and documentation and various forms of communication with
patients and other medical groups. Nurses communicate in clearly defined styles with patients and among each other. While private conversations are conducted in Ga, Twi or Ewe, nursing talks and written forms of communication and documentation are in English. All medical and nursing terminology is English. By this nurses show a form of professionalism and educational level, both in speaking and writing. The nursing administration supports and confirms this by checking the written reports on grammar and spelling. Talking to patients is done in English when medical issues are concerned while some of the Ghanaian languages are spoken when shorter questions are asked or the proper use of medication is explained on discharge; the style is plain and determined. Patients who do not speak English are often regarded as less educated and poor. Towards them nurses show their authority in talking English and also mention a diagnosis or treatment only in this language while knowing the women will not be able to understand it (fully). Doing this, nurses display authority and alienation from the (less educated) patient and its embodiment of daily life in the streets of the capital. Patients reply to questions asked calling the nurses ‘sister’, ‘or ‘auntie’, a respectful and dignifying naming even when the nurse is much younger than the patient. In documenting the work, it is noticeable that most descriptions and reports and brief contain limited details. The nurses themselves display by the writing process their control over the patients and the work on the ward as a whole. While the training schools teach a more individualistic and personal approach to nursing and caring, the reality on the wards shows the functionalistic approach to nursing. Personal specifications on a patient’s condition or her psychological state of mind remain blank in the notes. Patients are labelled as cases that are ‘fairly ill’, ‘ill’, ‘ill but conscious’, ‘weak’ or ‘weak and restless’, describing the condition as a whole. While the first term refers to less severely ill persons who are mobile and improving, the latter indicates a serious health threat possibly leading to death. This is never mentioned aloud, indeed there is no structural communication about the patient’s well-being and psych-social position either with the women or among nurses. This reflects one aspect of a social and cultural norm in Ghana. When asked about one’s health, everybody is ‘doing fine’, ‘we are managing’. Depending on the level of intimacy, more detailed information might follow at a later stage of a conversation.\textsuperscript{55} By speaking in English and remaining distanced and emotionally withdrawn from the patient, the relationship stays superficial and the courteous reply ‘I am fine’ remains the only option.\textsuperscript{56} Emotions like fear, uncertainty, grief or doubt are not expressed publicly. Such display of emotions is labelled as ‘childish’ and ‘inappropriate’. Such emotional detachment can also be understood as an attempt to advance the goal of the hospital as a quasi-bureaucratic institution such as to enhance the nurse’s power in the medical encounter. It is difficult to

\textsuperscript{55} This emotional neutrality is also exhibited in Europe and North America.

\textsuperscript{56} While this seems the standard reaction and behaviour, nurses do create an emotional band with some patients. These are often younger women suffering from a chronic disease like leukaemia or Sickle Cell disease, return regularly to the ward or stayed for a longer period. Richer patients can form another group.
estimate whether a patient is aware about the type and severity of her illness and prognosis and how the nurses assess the situation. Following doctor’s instructions and praying constantly are perceived to lead to improved health. Deterioration in health is hardly pronounced. “It will be well”; “we are praying for you” and “the condition is weak but stable” are attempts to describe it. Consequently, nurses follow this unwritten rule in their recordings and do not indicate health aggravation.

In carrying out the work well and handing over a clean and well-ordered ward to the next shift, nurses show responsibility towards their patients. The nurses are aware of their position. They define themselves as knowledgeable and educated and their role is to guide the patients through their stay on the ward in a directive way. Discussions or extensive questioning of their orders and activities through the patients is neither expected nor appreciated. The patients respect the nurses. Being authoritative to them is also the professional role nurses are expected to take on. They often call them ‘auntie nurse’, even when the nurse is younger than the patient, reflecting the high position they are given. Gibson (2004) analyzes the role of nurses in catching the doctor’s attention for a special patient in the South African context. On this medical ward, the risk of ‘falling out of the gaze’ of both doctor and nurse starts during admission through the nurses. As Anderson analysed about a hospital in the north of Ghana (2000), nurses do not treat all patients the same, claiming that many of them, mainly the poorer ones, are less educated and ignorant. The degree of integration and ‘focus in the gaze’ is often determined upon admission and hardly changes till that patient is discharged. Too knowledgeable patients are seen as difficult and destructive for the ward’s routine and patients’ well-being. Senah explains this perspective with the cultural background: “From early childhood, the Ghanaian is made to understand that knowledge is acquired in stages of biological maturation and precocity is evil. Authority is said to be sacred.” (20002: 58). Only few younger or wealthier patients can influence and negotiate their position on the ward and positively catch the regular attention of nurses and doctors.57

The irregular supply of equipment and the unforeseeable order of events during shifts require the nurses to improvise in their work. Procedures learnt during the training need to be adjusted to the reality. This is a process typical for all professions and places (see for example Melia 1987 or Du Toit 1995). Shortcomings must be managed and creatively solved, be it insufficient laundry, understaffed shifts or a large number of seriously ill patients asking for elaborate and individualised nursing care. Being very visible in their white uniforms, nurses represent a shelter in all uncertainties and display control and order. They radiate authority and power. This is also valid for the team of nurses. The role of the matron is important both as a controlling ward manager towards the medical doctors and patients, and as a listening ear motivating and encouraging the nurses. Her appearance and working attitude shape the whole group of nurses. The work is distributed according to clear lines and this

57 See Chapter 14 on doctors and patients for more details.
strengthens and confirms the hierarchy of the nursing profession on the ward and in the hospital as a whole.

The nurses talk about their work, discuss the appropriate form and amount of reward due them, finish their shift and return home to their families. The next day, they will come back to their ward to fulfil their duties. Some perceive the work as tedious and frustrating; others face the challenges and the needed improvisation declaring that working on the Medical Ward means learning a lot. Sister Grace concludes while addressing the nursing students: "We have here two mottos: One is: ‘A clean and tidy environment!’ And the second is ‘Touch a patient before you go home’. Don’t leave the ward like that to meet your boyfriend, but report to me all the time when you have a question. Now move and make the ward tidy and clean. After that start touching the patients. That is nursing on our Medical Ward.”