

The origins of a two-tier profession: a nursing school at a Poor Law infirmary

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After initiating a system of nursing and nurse training in general hospitals, Florence Nightingale turned her attention to infirmaries for the poor in the 1860s. St Marylebone Infirmary in London benefited from one of the first Nightingale schools in a Poor Law institution. Formal training raised the quality of care and offered a professional career to young women of lower social class. However, infirmary nurses were considered inferior in status to their counterparts in general hospitals.

Although training was equalised by state registration in 1919, the need for a lower tier of nurse is a recurrent theme in nursing. As a new associate nurse is being introduced in the UK, this article considers lessons from history in shaping the structure and status of the profession.

Introduction

The 19th-century workhouse infirmary was a fearsome place (McDonald, 2004). There was the putrid odour of gangrene, blackened toes devoid of sensation and amputation of the lower leg merely delaying death as the disease spread to other parts of the body. There was also the desperate cough of the consumptive cases and their purulent, blood-streaked sputum, profuse night sweats, and gradual wasting of the body—pulmonary tuberculosis was 'the greatest scourge that ever visited mankind' (Bell, 1900: 108).

Outbreaks of dysentery were compounded by cramped wards and inadequate sanitary facilities. Medical resources were hopelessly inadequate and there were no trained nurses (McDonald, 2004).

On its opening in 1881, St Marylebone Infirmary was a model hospital, greatly superior to typical facilities for the sick poor of Victorian London. It also boasted one of the first nursing schools in a Poor Law institution. Although infirmary nursing was

undoubtedly improved by formal training, Nightingale had devised a qualification of lower status to that gained in her general hospital schools. Consequently, until the advent of state registration in 1919, nursing in Britain was socially divided. While educated 'ladies' nursed in the prestigious teaching hospitals, infirmary nurses were from the lower social stratum.

Data sources

The primary sources of data for this article were the original documents of the St Marylebone Infirmary (held at the London Metropolitan Archives), and correspondence between the matron and Nightingale (held at the British Library).

The Poor Law and infirmaries

The Elizabethan Poor Law was becoming unsustainable by the early 19th century, as cities grew rapidly during the industrial revolution. The Poor Law Amendment Act of 1834 radically changed the administration of parish support, demarcating the 'deserving' and 'undeserving' poor, and denying outdoor relief to able-bodied people who could pay their way in life.

With its deliberately austere conditions and harsh discipline, the workhouse would be the last resort of the destitute (Higginbotham, 2012). These institutions grew in size as parishes combined into unions for economy of scale. People entered voluntarily, but normally because they had no other means of survival. They included the unemployed, disabled, vagrants, the frail elderly and young women bearing a child out of wedlock. Often whole families were admitted, but husband and wife were separated from each other, and from their children.

The workhouse was run by the master, assisted by the matron (often this duo was a married couple). Inmates were expected to contribute to the upkeep of the institution,

and they spent day after day in tedious and injurious work such as picking oakum or breaking stones. Daily quotas were imposed by the taskmaster, with respite only on the sabbath. Disobeying any orders of the house was punished by solitary confinement on bread and water, or flogging. The novels of Charles Dickens drew attention to the dreadful plight of the poor in workhouses, and social reformers pursued a more human system (Richardson, 2012).

Many inmates suffered from acute or chronic illnesses. Larger workhouses had an infirmary block, attended by a single medical officer, with nursing mostly performed by unpaid and illiterate female inmates. Alcohol was ubiquitously prescribed, and workhouse nurses were notorious for indulging in brandy intended for patients (Longmate, 1974). Concerns were raised by the medical profession, and a damning report by the Lancet Sanitary Commission for Investigating the State of the Infirmaries of the Workhouses in London (Lancet, 1865:14) described such places as 'a disgrace to our civilisation'.

Care of the sick poor was an early and enduring concern for Nightingale, who had been a lady visitor to the St Marylebone Workhouse in the 1840s. On returning from Crimea, she wanted to develop nursing in the workhouse infirmaries. This would be an onerous task.

As an invalid who had barely survived her ordeals in a war zone, Nightingale rarely ventured out, organising and campaigning from home, where visitors were seen by appointment only. Nightingale's heroic deeds at Scutari were honoured by the Nightingale Fund, which she used to open the first nurse training school at St Thomas' Hospital, London, in 1860. Thus began the modern profession of nursing. Her book *Notes on Nursing: What it is and What it is Not* (Nightingale, 1860) emphasised hygiene and sensitivity to patients' feelings. The

Nightingale system of nursing had three governing principles:

- Matron has absolute authority over nursing staff
- Nurses must be trained
- A nurse's character is as important as technical skill. (Abel-Smith, 1960)

Meanwhile Nightingale became acquainted with philanthropist William Rathbone (Woodham-Smith, 1950). As an honorary visitor for the District Provident Society in Liverpool, whose impoverished masses included thousands of Irish people displaced by the potato famine, Rathbone witnessed the suffering of sick people in their squalid homes. In 1859 he deployed a nurse in domiciliary care, beginning what became the first district nursing service in the world.

Rathbone strove to improve care at the Brownlow Hill Workhouse Infirmary in Liverpool, and Nightingale responded enthusiastically to his request for trained staff (Nightingale, 1989: 246–7). In 1865, Agnes Jones and 12 nurses from St Thomas' were sent to supervise pauper nurses. Likening the wards to Dante's *Inferno* (Woodham-Smith, 1950), Jones performed admirably as lady superintendent, but in 1868 she caught typhus and died at the infirmary, aged 36.

Troubled by conditions in the London infirmaries, in 1865 Nightingale presented an 'ABC' of workhouse reform (White, 1978):

- Separate institutions for children, the sick, imbeciles and insane, who required special nursing care away from the pauper workhouse
- A single central administration
- Consolidation of provision with a general rate charged to all parishes.

The Metropolitan Poor Amendment Act 1867 began the separation of medical care from poor relief. Described by historian Brian Abel-Smith as a significant step in English social history, this was:

'The first explicit acknowledgment that it was the duty of the state to provide hospitals for the poor.'

Abel-Smith, 1960: 101

Parishes and unions in London were combined in six sick asylum districts, and in 1870 the North-Western Fever Hospital opened in Hampstead—the first state hospital in England.

Nightingale (1989: 260) envisaged a nurse training school and a St Thomas'-trained matron in every London workhouse

infirmary, explaining to social reformer Edwin Chadwick (Nightingale, 1989: 470–6) that 'sickness is not parochial; it is general and human'. In her book *Notes on Nursing for the Labouring Classes*, Nightingale (1868) recommended deployment of pauper girls aged 14 to 16. This was pragmatism: Poor Law institutions were unattractive to trained nurses. An opportunity arose in 1868, when the chairman of the Poor Law Guardians of St Pancras asked Nightingale to instil nurse training at a planned infirmary in Highgate. In the following year matron Elizabeth Torrance and nine nurses went to the new St Pancras Infirmary, a capacious building that impressed Nightingale with its efficient division of patients, and long wards allowing a nurse to see all in her charge. The Nightingale Fund was tapped to create the first nurse training school in a London infirmary, but this 'daughter' to St Thomas' failed to flourish. When an untrained matron was appointed, the Nightingale Fund withdrew its support, leading to closure in 1877.

Opening of St Marylebone Infirmary

The first workhouse for St Marylebone opened in 1730 (Neate, 1967). This was replaced by a building for 40 inmates, but 20 years later it had 220 occupants and was infested with rats from an adjacent burial ground. In 1775 the parish guardians opened a much larger institution, with capacity for a thousand paupers, described in its stone inscription as: 'St Marylebone Workhouse for the Poor being Lamé Impotent Old and Blind'. Despite several extensions, including an infirmary block, the workhouse became severely overcrowded, reaching 2264 inmates in 1846.

A visit by the Lancet Sanitary Commission in 1865 revealed deficient ventilation and sanitation, lack of segregation by illness, and woefully inadequate medical staffing. While the infirmary had 323 beds, hundreds more inmates with chronic diseases were dispersed around the workhouse. Mortality was exceptionally high: in 1864, 624 died in an average population of 1800.

On 7 July 1879 the foundation stone was laid for a separate infirmary two miles away in Notting Hill. This institution, with 744 beds, was formally opened on 29 June 1881 by the Prince and Princess of Wales. The 'pavilion plan' afforded air and light between the five ward blocks, and Nightingale praised architect

Henry Saxon Snell for his progressive design (McDonald, 2004: 477).

Elizabeth Vincent was appointed as matron on a starting salary of £100, with furnished rooms and a servant. Vincent, who had been matron at Lincoln Infirmary, had impressed Nightingale during her training at St Thomas'. Assistant matron Anne Fryer was paid £50, the night superintendent £32 and trained nurses £28 to £39; all lived in the administration block (St Marylebone Infirmary, 1885). In a letter of 8 December 1881 recited at a meeting of the Association for Promoting Trained Nursing in Workhouse Infirmaries, Nightingale thanked the St Marylebone Guardians:

'For the enlightened example which they have set in the organisation of the nursing staff of this noble infirmary'.

McDonald, 2004: 478–9

Nightingale also encouraged the guardians to take a step further in building a nurse training school (McDonald, 2004: 478–9).

In 1880 a second Lancet Commission on Workhouse Infirmaries (Lancet, 1880: 955) reported a 'distinct advance in the treatment of the sick pauper' and congratulated Poor Law guardians for constructing new infirmaries that were equal to other hospitals in design and equipment. The inspectors noted that only in the amount of medical and nursing staff to deal with the 'overwhelming amount of sickness and suffering had the guardians been niggardly', and opined that there was no better place to learn nursing than in an infirmary for the poor.

The nursing school at St Marylebone

Following consultation with Nightingale, in 1884 the St Marylebone Guardians erected a nurses' home and training school at the infirmary. The building contained lecture rooms and living quarters for 40 probationers. In Nightingale's view, supervised lodging were as essential as tuition; by living in, young women were inculcated to the discipline required in the wards. A plaque at Nightingale House, which today houses two psychogeriatric wards, commemorates the official opening: 'This Home for Training Nurses, in connection with the Nightingale Fund, was erected by the Guardians of St Marylebone, and was opened by Her Royal Highness Princess Christian, 22nd July 1884.'

Vincent corresponded regularly with Nightingale on the progress of nurse training at St Marylebone. Her letters are preserved at the British Library (although Nightingale left a vast archive, her letters to Vincent are lost). Clearly a strong leader, Vincent appears to have treated her charges considerately, unlike the autocratic matron of The London Hospital, Eva Luckes, who notoriously pressed nurses to work when sick (Palmer, 2012). The fourth annual report for the St Marylebone Infirmary (1885) shows that Vincent's salary had increased to £140 per annum.

By the end of the century, the use of pauper nurses was considered disreputable. Many had proved unfit for training, and as the qualification was an incentive for recruitment, the wheat could be separated from the chaff. As shown by Vincent's letters, applicants were frequently rejected for being too young or old, too short or lacking in physical strength. Eligible women were aged 22 to 32, and single or widowed. Successful candidates became probationers after a 2-month trial period to assess their suitability. Instruction was given by a head nurse, with lectures by medical officers. On completing the training, the probationer was entered on a register of certified nurses, and was required to work and reside in a Poor Law infirmary for at least 2 years. An incremental pay rise was awarded after the first and second years of employment (St Marylebone Infirmary, 1895a).

The work of infirmary nurses was mostly basic care and domestic chores, but technical skills were increasingly necessary. Probationers learned to dress wounds, apply poultices and leeches, give subcutaneous injections and enemas, manage uterine trusses and catheterise female patients. Aseptic principles were emphasised, and probationers were 'expected to become competent to make gruel, arrowroot, egg flip, puddings, and drinks for the sick' (St Marylebone Infirmary, 1895b). Probationers rose at 5.45am, worked on wards from 7am to 8.30pm and, after supper at 9pm, repaired to their dormitories by 10pm. A little reading was possible before gas lights were extinguished at 10.30pm. They were also required 'to attend morning service in the infirmary chapel in their turns'. Vincent gave sterling service until retirement in 1900, when she was succeeded by Miss Ramodem.

A photograph from 1906 of Ramodem and 28 young women in starched dresses from the London Metropolitan Archives

shows that infirmary nurses looked the part. However, the status of these nurses and their working environment contrasted starkly with nearby St Mary's in Paddington, which was associated with a medical school and had modern surgical equipment. In the teaching hospitals, patients were fee-paying, or of the 'respectable' working class (many contributing to their care through occupational health schemes), and Nightingale believed that the social grace and intellect of middle-class women was necessary in relating to doctors and patients in such settings (White, 1978).

'Nursing in St Marylebone Infirmary was not for the faint-hearted, and the work was arduous and poorly rewarded'

Pauper patients received care from pauper nurses, presenting a historical illustration of Tudor-Hart's (1971) inverse care law, whereby the segments of society in most need receive the least treatment. Infirmary nurses were paid less and worked longer shifts; unlike the 'angels of mercy' image of the Nightingale ladies, Poor Law nursing was stigmatised. Although a pension scheme was provided, many infirmary nurses left before retirement age because of exhaustion (White, 1978).

When the state register was introduced in 1919, nurse training was standardised to a 3-year course. In 1922 the General Nursing Council approved the school at St Marylebone Infirmary for training nurses to the national syllabus. However, the Poor Law Training Schools body feared that the bar was set too high for the ability of infirmary recruits. This has caused persistent debate in nursing: raising academic standards is always desirable, but risks excluding caring talent.

From workhouse infirmary to general hospital

The main source of patients at St Marylebone Infirmary was the workhouse, but it served a broader constituency. While voluntary hospitals treated the poor free of charge, those with incurable illnesses were turned away, as were cases of venereal disease. Consequently, many people who were not destitute went to the infirmaries. Cramped dormitories allowed

germs to fester, and infirmary nursing was a hazardous vocation. Until bacteria were understood, fevers were believed to arise from breathing foul air. Luckes at The London Hospital regarded mortality in the nursing staff as a necessary sacrifice (Palmer, 2012).

The danger of contagious disease to St Marylebone nurses receded once cases of scarlet fever and typhus were sent to the Central London Sick Asylum District Hospital in Hampstead. However, infirmary nurses were constantly exposed to tubercular infection, and safe handling of sputum was vital. Although the bacillus for tuberculosis had been discovered by German microbiologist Robert Koch in 1885, a cure remained elusive. Numerous tuberculosis sanatoria were built by the authorities in the early 20th century (Kirby, 2010), where lives were prolonged by a pastoral regime of fresh air and exercise.

The population of workhouses steadily declined following the Old Age Pension Act 1908 and National Insurance Act 1911, which began the shift from parish relief to state welfare. By the end of 1914 the St Marylebone Workhouse roll had fallen to 1443 (Neate, 1967). However, the workhouse continued to provide health-related services for the community, including wards for maternity, chronic sickness, elderly infirm and mental observation. The Poor Law system was finally abolished by the Local Government Act 1929. On the appointed day of 1 April 1930, the functions of the Metropolitan Asylums Board and the 25 boards of guardians were transferred to the London County Council (LCC). Adopting 141 institutions of various types, including St Marylebone Infirmary, the LCC Health Department became the largest hospital authority in the world (Kirby, 2006). Meanwhile, the teaching hospitals remained independent. Infirmaries such as St Marylebone needed modernisation, and the LCC invested in new operating theatres and X-ray equipment. In vogue at this time was ultraviolet treatment, which was believed to counteract the adverse environment of the urban poor: groups of patients with their nurses sat blindfolded under the lamp with its supposedly healthful rays (Woloshyn and McEnroe, 2015).

The LCC was a benevolent employer, and recruitment difficulties were ameliorated by relatively generous pay and pensions. The post of matron-in-chief was created, to lead a staff of 10 000 nurses. Dorothy Bannon, previously

matron of St Mary's Hospital, took her place in a pioneering tripartite management system alongside the senior medical officer and head administrator. Matrons of infirmaries such as St Marylebone attended meetings with Bannan at County Hall, but centralisation reduced their autonomy. A corporate identity was forged, and nurses were contracted to the LCC rather than a specific hospital. The LCC reduced nurses' working week to 54 hours in 1935, before this was achieved in the teaching hospitals. Orderlies relieved nurses of housekeeping duties (Kirby, 2006).

In 1934 the Labour Party led by Herbert Morrison won control of the LCC. Conscious of lingering prejudice towards former Poor Law infirmaries, Morrison wanted an equitable health service for Londoners. Some prominent members of the small but influential Socialist Medical Association were LCC doctors, who envisaged a free-for-all system that was eventually realised as the NHS in 1948. St Marylebone Infirmary was renamed St Charles' Hospital in the NHS, and under its looming towers it continues to serve the local community of north Kensington, an area of socioeconomic extremes and cultural diversity.

Implications for the workforce today

Although infirmary nurse training ended with state registration, a lower tier of nurse reappeared in Britain with the Nurses Act 1943. With staff shortages in the Second World War, the Ministry of Health allowed suitably experienced assistant nurses to be enrolled on a separate part of the state register. In the 1960s a training programme was introduced. On a shorter course, 'pupil nurses' prepared for the status of state enrolled nurse (SEN), while the term 'student nurses' was reserved for those en route to full qualification as a state registered nurse (SRN). Enrolled nurses became a large proportion of the nursing workforce, particularly in unattractive areas such as psychiatric and geriatric care. In practice, there was little demarcation between the work of SENs and SRNs, and often enrolled nurses were running wards.

In the 1980s the nursing regulator imposed clearer boundaries between the two tiers of nurse, and SENs were required to pass a test in administering medication (McCrae and Nolan, 2016). A national grading structure was introduced, and the Project 2000 strategy for nurse education announced the end of

SEN training (United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), 1987). Conversion courses enabled many enrolled nurses to become fully registered. Remaining SENs found their scope of practice curtailed to little more than that of higher-grade nursing assistants. After giving valuable service they had become surplus to requirements. However, a study showed higher job satisfaction in SENs compared with those who had converted to fully registered status, the latter having reduced patient contact with increased administrative burden (Iley, 2004).

'Infirmary nursing was socially as well as professionally inferior to that of the general hospitals, and enrolled nurses had a similarly disadvantaged status'

Project 2000 signalled the shift in nurse training in hospital-based schools to institutes of higher education, and from an apprenticeship to supernumerary status on clinical placement. Critics argued that nursing was becoming too academic, and that people of caring qualities but limited intellectual prowess were prevented from entering the profession (Glasper, 2016). Popular media presented a parody of the university-trained nurse as 'too posh to wash'.

With an imminent crisis in nursing recruitment, the British government has introduced a new level of 'associate nurse' (Department of Health, 2015). Purportedly, this would bridge the gap between healthcare assistants and registered nurses, allowing the latter to spend more time in clinical care. A syllabus has been devised, with programmes beginning in 2017. Arguably, the associate nurse initiative is a reinvention of the wheel that has previously fallen off the nursing vehicle. Inevitably, problems will arise with role demarcation and career progression, with concerns about exploitation of 'cheap labour' while distancing fully registered nurses from patient contact.

A study of 243 hospitals across Europe showed that for every 10% reduction in the proportion of qualified nurses, patients'

risks of death rise by 11%. Clearly there are hazards in replacing fully trained nurses (Aiken et al, 2016).

Nonetheless, deployment of associate nurses may raise standards in services for vulnerable groups such as older people with dementia, where deprofessionalisation is evident. The new role is also a result of recent scandals in the NHS, which emphasised the primacy of compassion over other attributes or attainments. Iley (2004) argues that nurses should be 'knowledgeable carers' but not necessarily scientifically astute graduates. Indeed, the favouring of evidence from positivist research does not reflect the holistic approach of nursing (McCrae, 2013). Nurses have various 'ways of knowing', and as a study of enrolled nurses converting to full registration indicated, such understandings vary as much by setting and experience as level of training (Dearnley, 2006).

A two-tier structure may enrich nursing by encompassing different attributes and approaches to patient care, but history has important lessons. Infirmary nursing was socially as well as professionally inferior to that of the general hospitals, and enrolled nurses had a similarly disadvantaged status. As discussed by Smith and Mackintosh (2007), the nursing workforce has ethnic imbalance, with areas perceived as least prestigious (such as care of older people) disproportionately staffed by black and Asian nurses. Enrolled nursing institutionalised this disparity, with many underestimated recruits from abroad directed into SEN training, stunting their career progress (McCrae and Nolan, 2016). Associate nurses should be supported in developing their skills, with a clear route to full registration for the able and willing.

Conclusion

Contrasts may be drawn between the nursing staff of St Charles' Hospital today, who originate from diverse countries and cultures, and the young women of the late 19th century raised in the shadow of the workhouse. Nursing in St Marylebone Infirmary was not for the faint-hearted, and the work was arduous and poorly rewarded. Nurses in Poor Law institutions were of inferior status to those in the teaching hospitals, but a shortened course with lower entrance criteria was vital to the improvement of nursing in a system functioning as a de facto health service. State registration in 1919 equalised training, but debate on the structure of the

nursing workforce continues. Despite its legally protected status, the term 'nurse' has a broader meaning in society, which has not been persuaded of the need for academic credentials.

In the current NHS, as employers frequently recruit workers from abroad, the introduction of associate nurses is a pragmatic response to perpetual staffing problems. Caring for the frail and sick is the essence of a civilised society, and nurses should be appreciated for their work, whatever their level of qualification. **BJN**

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