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A study of health and nursing services in greater Lowell, Massachusetts

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A STUDY OF HEALTH AND NURSING SERVICES IN GREATER LOWELL, MASSACHUSETTS

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A STUDY OF HEALTH AND NURSING SERVICES IN GREATER LOWELL, MASSACHUSETTS

THESIS

Submitted by

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CHAPTER I

INTRODUCTION

The importance of trained personnel, efficient local planning, and sound administration in improving the quality of health and nursing services cannot be sufficiently stressed. While these three alone can accomplish wonders, they can be most effective when they are associated with community group thinking, interested in the delivery of health and nursing services. Although group thinking can assist in the quality of care, it is only possible to reach its full potential value for this purpose when it is intimately concerned with other factors. These may include: (1) a health or social problem, (2) a concerned person, (3) a community stimulation or drive, (4) confidence in the democratic method, and (5) ability to work with the people of all groups concerned. The springboard for group planning may be any type of health or social problem. It is not necessary, at first, to understand all phases of the problem. However, it is important to find other people who are interested and willing to plan and take some action.

This type of procedure will prove that its influence is inherent in the total health picture. Interesting a large number of individuals in the present problem is bound to improve quality.

There are many kinds of groups which can be stimulated to the point of leadership through education, association, and understanding of the problem. They should learn what is needed and what can be done with the health services as they exist today. When the problem is approached through the group method, the good work accomplished by any individual reflects credit on the whole group.

1. Selection of the Problem. This study is made for the purpose of determining what constitutes a good health and nursing service program in the Lowell and Greater Lowell area.

The question of the relative need of understanding this program in a community can be answered by a statement that the essential purpose of health agencies is to develop and maintain adequate services to the community. A study will determine the type of service rendered and whether the agencies are operating efficiently. The analysis will reveal strength and weaknesses, overlapping, gaps and duplication. It will be shown that group planning will insure the most economical use of the agencies.

2. Source. Health and nursing services are vital to every community. If there are several agencies offering a health program it can be confusing to individuals because of duplication or overlapping. Lack of coordination of services within a community can be very costly in terms of money and

human endeavor.

3. <u>Justification</u>. The Community Council of Lowell is very much interested in an evaluation and improvement of the existing health and nursing services in the Greater Lowell area. Dracut, Chelmsford, Westford and Tewksbury are part of the present area in need of public health nursing. It is the opinion of this group that this study may prove helpful in tackling the problem of the type of program best suited to this total area.

4. <u>Method</u>. The field study method was used and is confined to the Lowell and Greater Lowell area.

CHAPTER II

RESEARCH PROCEDURE AND TECHNIQUES USED IN SOLUTION

1. Logical Analysis. Communities are faced with a serious problem. Who is going to pay for health services - the private or the official agency? An adequately staffed health agency will suffer if there are not funds available for these health services. Sufficient funds could be provided through State, National, or local auspices.

It is generally recognized that there is no substitute for quality of service in securing public support. It is important to consolidate the standards and essentials of an outstanding public health program before setting up uncharted pathways.

> Whatever combination of method may be adopted it must be never overlooked that the objective is the motivation of individual conduct. Whether the purpose is to promote disease prevention, or better sanitation, or improved nutrition, success in the community depends finally upon whether the individual in the community can be recommended and stimulated to active, rather than mere passive acquiescence.[1]

Good public relations are essential in stimulating individuals within the community to desirable action and interest in the health situation. It is important that agencies clarify their objectives in relation to the total health pro-

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[1] American Journal of Public Health, "Public Relations as Affecting Communities for Local Health Units," (reprint by L. E. Burney, M. D.)

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gram and proceed to fulfill their functions through the group participation method.

2. Data Needed. In preparing the material for this study there is specific data which is essential. Sources of statistical information and definitions follow:

Health Officer: The executive officer of a local health department. He may be employed full or part-time and he may or may not be medically trained. In "proposed personnel" the term is always understood to mean a full-time, medically trained administrative officer.

Other medical administrative personnel include assistants or deputy officers, chiefs of clinician, or full-time physicians who may also be serving as clinic physicians.

Clinician Physicians: Employed part-time in clinical services as in local health departments. These clinics include various bureaus of the department, such as tuberculosis, venereal disease, prenatal, well-baby and pre-school child divisions. The physicians may be paid on a fee basis.

Public Health Nurses and Public Health Nursing Program: This service will include reports of public health nurses currently employed and the suggested number needed. This is based on a generalized program that includes school nursing. The inclusion of bedside nursing in conjunction with special

programs requires an additional ratio of nurses, 1 to 5000 population.

Public Health Engineers, Sanitarians, and Dental Hygienists professionally trained are recommended.[2]

The statistical information will include population, land area, spendable income per capita, assessed valuation per capita, general hospital beds, vital statistics, employment and industries.. Existing personnel and annual budgets for the health and nursing organizations will be used.

Other data has been gathered from interviews with public and private health authorities, books, pamphlets, and studies made by interested professional and lay people. Part of the "Schedule for a Survey of Community Nursing Service" was helpful in accumulating statistical information. This Schedule was prepared by the Joint Committee on Community Nursing Service of the National Organization for Public Health Nursing, American Nurses Association and National League of Nursing Education.

Publications of the National Organization for Public Health Nursing and the American Journal of Public Health offer numerous concurrent articles pertaining to the trends in public health.

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[2] Haven Emerson, M. D., "A Report of Local Health Units for the Nation," The Commonwealth Fund, 1945, p. 7.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to provide and make more effective all types of public health nursing services throughout the country. This is accomplished by maintenance of a clearing house of information; development of standards in policies, practices and qualifications, and advisory services to local, State, and National organizations.

3. Treatment of the Data. Getting states that there is no reasonable explanation why people living in rural areas cannot have the same benefits of prevention, medicine, and other health facilities as those who live in urban areas. Today we possess knowledge for the promotion of good health which can be made available to all of the people. Any individual living in a community serviced by an adequate local health department will receive sufficient medical supervision, avoid certain communicable diseases, and thereby live a healthier, happier, more productive life.

The Local Health Service Act of 1948 provides three objectives:

1. Prevention of illness and injury.
2. Prolongation of life and prevention of untimely death.

3. The improvement of individual health.[3]

The data gathered will be compared with the recognized standards for a good community public health program. It will not include medical care of the indigent, hospital care, environmental sanitation, housing, or plumbing.

4. Assumptions Made. Health is defined as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.

The promotion of optimal health is a community responsibility. The development and maintenance of full-time official public health units and other essential health services are basic to a community planning for health.

Health is a function of the community's total way of life, and planning for health should be correlated with planning for economic and social well-being.

The effective furtherance of health is dependent upon local initiative, interest, aggressive support, and participation of the entire community.[4]

It is hoped that the findings in this study will form

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[3] Vlado A. Getting, M. D., "Local Public Health Services Act of 1948," (Presented to the State and Territorial Officers, April 8-9, 1948.)

[4] Federal Security Agency, Public Health Service, "Planning for Health Services," Bulletin No. 304.

a nucleus for practical suggestions concerning civic planning and action. Principles suggested are broad and flexible. Any democratic planning body in a community can adapt them to its own use. No planning body can ignore such principles and have much success in a democracy.

CHAPTER III

RECOMMENDED STANDARDS, PRACTICES AND PROCEDURES OF HEALTH AND NURSING SERVICES

Organizations vitally interested in maintaining standards, practices and procedures in Public Health attempt to define clearly stated policies and objectives. In order to render efficient services to the community it is essential for individual workers to work under good administration. This thought is well expressed by Gardner, who reminds us that the strength of any organization lies in the ability of each employee's responsibility for carrying out the agency's policies. These principles are recognized as fundamental. They have borne the test of time and are important in the structure. None of these came into existence spontaneously, but are the result of a slow process of evaluation and experience. In a movement that is developing as rapidly as this, there is no such thing as permanency of method, for new problems create new demands. They render useless inappropriate methods, which in other days served their purposes well.[1]

As they stand today, the fundamental principles of health and nursing services may be tabulated under the following twelve headings:

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[1] Mary S. Gardner, Public Health Nursing (New York: The Macmillan Company, 1945), p. 87.

1. Preliminary to the establishment of any nursing service, a study should be made of community needs, to be followed by periodic studies to determine the adequacy of the services in relation to the development of the community.

2. The work should be sponsored by a representative community group, not by an individual.

3. The agency should be non-sectarian and non-political in spirit and in service, without distinction of race, creed, or color.

4. The service should be available to everyone in the community, and may be paid for from public or private funds, or through direct payment for service rendered. Those receiving care not paid for from public or private funds or through some contractual relationship should be required to pay according to their means.

5. The constituted health authorities should be recognized as health leaders in community work.

6. Adequate records should be kept.

7. Every appropriate opportunity for cooperation with other agencies and individuals should be utilized.

8. Only graduate and registered nurses should be employed.

9. Health teaching to patient, family, and community should be considered an essential part of the work of every nurse.

10. Professional ethics should be observed.

11. Provision should be made for systematic educative supervision of the nursing staff.

12. The working hours of the nurses should be specified and vacation periods provided for.[2]

The organization of public health nursing in local health departments varies in different communities. However, there is a tendency to place nursing in a separate division or bureau of the department. Nursing activities are determined by the department program. As a rule, nurses render service in maternity hygiene, infant welfare, pre-school, tuberculosis, social hygiene, and acute communicable disease control. Specific programs include bedside nursing. Recognized leaders in public health strongly urge that official agencies provide these services. In some communities the school health program is in charge of boards of education, and in others it is under the department of health. The modern trend is strongly in favor of placing this in the health department as it is believed professional supervision is more available.

Health department nursing service should be closely integrated with the complete health department program, and nursing activities should conform to general practices and policies. Emphasis on nursing is determined, to a large degree, by the general objectives and interests of the depart-

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[2] Ibid., p. 88.

ment. Selection, training, and supervision of nurses are usually the responsibility of the director of nursing. The nursing program may be either generalized or specialized. In most health departments the nursing service was first organized on a specialized basis, since each department was developed as a complete unit. As programs have become standardized, the trend has been to organize nursing on a standardized basis.

The advantages of this type of organization are first, from the point of view of service to the family. One nurse is prepared to render all types of nursing and can become better acquainted with the family, more understanding of the problems, and better able to advise concerning them. Secondly, from the point of view of the organization, a more mobile staff is able to function as the need arises. When the service is specialized, some phases of the work necessarily overlap. For instance: The school nurse and infant welfare nurse need to know communicable diseases, tuberculosis, and social hygiene procedures in order to carry on special activities. In spite of good administrative direction some overlapping occurs. The generalized nurse gives assistance in special programs and helps to coordinate family health problems. In a department which offers clinical activities it is good administration to assign nurses full-time to the clinics. This will provide for smooth operation and continuity of service to the patients.

Even with this plan, rotation of staff in field and clinical programs makes it possible to keep the whole personnel familiar with all phases of the work. A plan coordinating patient instruction in clinics with teaching in the homes is desirable.[3]

1. Administration. On one administrative point there is definite agreement by all who understand public health nursing, and that is, the necessity for a nurse director of the total program. The director comes to the organization in this capacity because of her outstanding educational qualifications and enriched professional experience. She has executive ability, and demonstrates skills in leadership within the organization and the community.

The executive director spends a considerable proportion of her time in the consideration of questions of policy, in conferences, and in committee work, leaving to subordinates much of the detail of actual procedure. In a privately administered organization, the director is responsible to a board of managers. This is subdivided into various committees, of which the nursing and finance committee is vital. She is a member, ex-officio, of all committees. Directors in an official agency are directly responsible to the health officer or

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[3] Amelia Howe Grant, Nursing: A Community Health Service (Philadelphia: W. B. Saunders Co., 1946), pp. 32-34.

some other designated person responsible for the program.[4]

Regardless of the type of agency, the director has certain responsibilities and relationships. These may be defined as:

1. The responsibility of a director toward her board of managers or the designated officer upon whose final authority she must rely.

2. Her responsibility toward the nurses whose well-being and efficiency lie in her hands.

3. Her responsibility toward the patients for whom the whole organization primarily exists.

4. Her responsibility toward the community which has a right to expect from her expert knowledge, a spirit of helpfulness and cooperation.

5. Her responsibility toward the larger field of public health nursing which lies beyond her immediate area of action, but to which she must make constant contribution if the public health nursing movement is to go forward.[5]

A successful director does not find it difficult to utilize her skills in fulfilling her obligation to the board of

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[4] Mary S. Gardner, Public Health Nursing (New York: The Macmillan Company, 1945), p. 299.

[5] *Ibid.*, p. 300.

managers. In order to clearly interpret the achievements of the staff, the growth and the organization along with the complexity of the health situations, the board should be represented from various parts of the community. Also, successful functioning of the board depends on equal distribution of interested men and women. It is advisable to include professional members as well as lay people.

The executive director should prepare reports periodically which are submitted to the person or group of persons to whom she is administratively responsible. This data collected by the executive director is essential to program planning. Her reports must be complete and accurate in order for the board to understand the program or changes in the activities of the organization. Stimulation and interest will be maintained by the board members if the reports are presented in various ways. This may include case stories presented by the staff, audio-visual aids, demonstrations, and guest speakers. In conjunction with these administrative aids, the reports should contain the following items:

1. A statistical compilation and analysis of work done.
2. Accomplishments of the agency.
3. Reports of problems, meetings, and conferences attended. The reports may conclude with recommendations for the future.[6]

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[6] _Manual of National Organization for Public Health Nursing_ (third edition; New York: The Macmillan Company, 1948), p.28.

The manner in which the executive director presents the reports is very important. If the executive director can make fearless statements, demonstrate wise leadership, sincerity, and loyalty to the board, sound administration will constantly arouse interest and stimulation among board members.

Directors in a publicly administered organization have the same fundamental relationship. The nursing executive is not responsible primarily to a board of directors but usually to a nursing committee, which acts in an advisory capacity. Preparation of meetings and reports must be given careful consideration.

Personal equation in relation to the nurse director and the medical director plays an important part. If he is a man whose ideals, modes of thought along the program planning are identical with her own, the work will be stimulating and challenging to both. Infinite patience is required if the medical director has an entirely different point of view.

One of the most important committees from an administrative viewpoint is the group selected for publicity. A good publicity program offers valuable information to the community.

Continuous publicity is essential. The nurse should become acquainted with local newspaper editors and reporters and find out what they want, how they want it, and when they want it. She should give to the newspapers announcements of

important meetings, reports of board meetings and other meetings, news of special projects, and stories of human interest. Specific information should be given to the public as to the availability of the nurse, hours on duty, office hours, area covered, and type of service rendered. Feature stories are another recognized means of obtaining publicity for the organization. However, if such are used the director should use utmost care to see that the professional aspect of the case does not become distorted. Another very effective method of spreading this information is through the use of a printed leaflet or card, distributed to physicians, druggists, dentists, industries, schools, social agencies, and clubs.[7]

The location of the office with respect to convenient transportation should be considered. Administration should be concerned with the lighting, ventilation, heating, office space for nurse, clerical assistance, and rest rooms for staff. An adequate clerical force is absolutely necessary to carry on the business of the office, telephone calls, correspondence, records, and financial statements. Sufficient room should be allowed so that each employee can operate efficiently. The executive director should have an adequately spaced office for her interviews with staff, board members, and clientele.

An annual audit of the department is important. All persons handling funds should be sufficiently bonded. This

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[7] Ibid., p. 30.

includes the treasurer. A blanket bond to cover the entire group is recommended.

It is good business practice and protection to the agency to carry workmen's compensation insurance for all employees and equipment, particularly on agency owned cars. It is more satisfactory to deal with one insurance agent or broker for all policies. When the use of a car or cars by an organization is an essential economy, the basis of financing has to be considered. Many agencies find it more satisfactory, both for themselves and for the nurse, to have the nurse use her own car. Under this plan it is customary to pay a mileage rate to cover gasoline, oil, insurance, garage rent, and other costs, including depreciation. Whether cars are owned by the agency or by the nurses, there should be adequate insurance coverage.

Careful thought and planning should be given to the organization of a system of records and files. The quality and weight of paper used for record forms should be considered as it is desirable to have them neat and legible. Record forms should be on paper which will stand constant flexing and cracking.

Filing systems will be needed, not only for records, but for correspondence, policies, and educational material, such as books and pamphlets. The filing system which is chosen will depend upon the material being filed, the way in

which it is used, and the frequency with which it must be consulted.

Efficient office administration should be smooth, unobtrusive, and calculated to enhance the whole of the supervisory process. It should not be of so great concern to the supervisor that it overshadows other aspects of the work. Smooth administration paves the way for other phases of supervision, produces serenity and order, and minimum irritation and delay.[8]

It is economical to relieve nurses of clerical detail insofar as possible. The employment of a clerk, or an arrangement for volunteer service is recommended when the amount of routine office work requires the time of a nurse, who is needed for professional service. In a study made by the Statistical Department of the National Organization for Public Health Nursing,[9] in January, 1936, the average ratio of clerical workers to staffs was found to be one clerk for every seven nurses. This need not be interpreted to mean that an agency does not need a clerk until seven nurses are employed. In an agency with a staff of three or more, paid secretarial service will be found economical, since a secretary can assume re-

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[8] Ruth B. Freeman, _Techniques of Supervision in Public Health Nursing_ (Philadelphia: W. B. Saunders Co., 1945), p. 255.

[9] _Manual of National Organization for Public Health Nursing_, _op. cit._, p. 37.

sponsibilities in regard to taking telephone calls, maintaining the business routine of the agency, and other official duties assigned to her by the director.

Clerical personnel must be carefully chosen, particularly the receptionist, since they are the employees who meet the public and give the first impressions of the agency's service.

It is important that newly hired clerical assistants be briefed on the policies of the organization before contact with the general public, or with medical consultants is permitted.

Adequate salaries should be paid and some compensation for overtime should be made, either in the form of extra pay or equivalent time off. Overtime should be planned rather than haphazard. There should be specific responsibilities, procedures, and instructions for the clerical force.

Effective functioning of the office will be maintained if each person's responsibilities are defined. Procedures, instructions and specific duties should be outlined in an office manual.

2. Personnel Policies. Each organization's problems must be analyzed and conclusions reached on the basis of sound thinking. The writer firmly believes that a good health and nursing service should have on hand, at all times, a well-defined, clear-cut statement of personnel policies. These may

include:

1. Personnel policies should be established by each individual agency but may be worked out in cooperation with other health and welfare agencies within a community.

2. Policies cover personnel practices not only for nurses but all employees of the agency.

3. Personnel policies should be in writing, with copies readily available to all members of the staff.[10]

4. Personnel policies should be reviewed at least once a year and written notice of changes sent to all members of the staff.

5. The successful administration of personnel work in public health nursing agencies is dependent upon the qualities of the nurse in charge of the activities of the agency. Every public health agency, regardless of its size, should have someone to assume this responsibility.

6. Every agency should have a personnel committee to serve in an advisory capacity. The size of the advisory committee will depend upon the size of the agency it serves, but whenever feasible should consist of at least five members. Selection of members should be made from the governing board and the employees and should include at least one staff nurse. A representative of the agency's medical advisory committee or

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[10] *Ibid.*, pp. 38-39.

a representative of the local medical society should be asked to serve as consultant on matters pertaining to the health program. In an official or combination agency, the health officer, school administrator, or any other executive officer involved should also serve on the committee.[11]

In a voluntary agency, it is recommended that the personnel committee should be a standing committee of the board. In a health department, this personnel committee might be subordinate to a citizens advisory committee.[12]

The National Organization for Public Health Nursing, and the Massachusetts Organization for Public Health Nursing,[13] have set up a pattern for Personnel Policies, 1945 to 1950, which agencies may use as a pattern.

3. Qualifications. During the years 1935 to 1950 there has been a great expansion of health and public health services, due in large part to the health provisions of the Social Security Act. There is a pressing need for nurses to fill vacancies. Administrators find it increasingly difficult to obtain nurses specifically prepared for the public health nursing field.

Mindful of these trends and realizing that the first

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[11] National Organization for Public Health Nursing, "Personnel Policies for Public Health Nursing Agencies," Public Health Nursing, 1945-1950.

[12] Ibid.

[13] Ibid.

principle underlying the improvement of service is the appointment of qualified personnel, the Education Committee of the National Organization recommends these qualifications for those appointed to public health nursing positions, based on the following principles:

1. That one of the most important requisites in public health nursing is the ability to work effectively with people.

2. That the public health nurse must be a competent nurse with sound basic, theoretical, and clinical preparation in nursing, and with an understanding of its social aspects.

3. That additional study, including supervised field experience, is essential to prepare the graduate nurse for the specific functions of public health nursing.

4. That continued in-service education, including qualified supervision is essential.[14]

While the foregoing qualifications may seem to stress academic preparation and professional experience, personality remains a major factor in successful public health nursing and must always be given due consideration.

Whether the nurse is working on the staff of an official or private agency under direct supervision, the educational standards are the same. The nursing prerequisites include a high school education, or its educational equiva-

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[14] National Organization for Public Health Nursing, "Recommended Qualifications for Public Health Nursing Personnel," *Public Health Nursing*, Vol. 34, No. 1, pp. 24-28.

lent which meets college entrance requirements. Education on a college level is desirable. Basic nursing education includes graduation from an accredited school of nursing, (accredited by the State board of examiners), connected with a hospital having a daily average of 100 patients. A broad clinical experience and affiliation include medical nursing, acute communicable disease, tuberculosis, venereal disease; psychiatric and pediatric nursing, (including the care of children with orthopedic and cardiac conditions); and an understanding of the social and health aspects of nursing, both physical and mental with appropriate use of community facilities.[15]

Post-graduate study includes an approved one year program of study in public health nursing in a university within five years after appointment to the staff. It is essential that graduate nurses working in a public health agency be registered with the State board.[16]

For the nurse working in an official agency her basic educational preparation is the same. It is desirable that the nurse complete her post-graduate study prior to her appointment. In addition to this, she should have at least one year of supervised experience in a public health agency in which family

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[15] Ibid.

[16] Ibid.

health is emphasized.

In addition to carrying on the direct nursing services of the agency, the writer recommends the inclusion of organization experience in the various fields of the agency, thereby enabling the individual to work with lay and professional groups, and to carry on in special situations, such as the school and industry.[17]

Supervisors, in addition to a general education, should have at least three years experience, two years being in a family health program and one year in assisting with administrative functions. This may include in-service training of the staff nurse, supervision of nursing techniques in the home, family health planning, and participation in the student program. Specific courses in supervisory technique are advisable.[18]

General and specialized education of the director or consultant are the same as that of the supervisor. The experience record is increased to five years in more than one type of agency. This includes two years in a family program, two years in supervision, and one year's experience assisting a director with some administrative duties. The duties of the director would be to administer the nursing service in the

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[17] Ibid.

[18] Ibid.

official or private agency, to determine with the administrator official, or the board, the policies and program to be followed. It is important to interpret the needs of the nursing service to the administration officials, to the board, to the standing committees, and to the community. Participation in community planning and action in health and social welfare should be one of the administrator's objectives.[19]

If the agency is large enough to employ a consultant, her duties include analyzation of the total program and development of the service in special fields. These services should correlate with other health and nursing programs in the community. This includes advice regarding policies, techniques, and procedures in the special fields and participation in the supervisory staff education program.[20]

4. Educational Program. It is the responsibility of the nurse to obtain basic preparation for public health nursing before she becomes a member of a staff. If she comes to the organization unprepared, the policy should state that within a five-year period the basic education requisites be completed. This policy should be enforced if the agency is going to maintain the highest level of professional service to the community.

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[19] *Ibid.*

[20] *Ibid.*

Although education is costly, experience proves it pays dividends in the overall program in the community. Stipends or scholarships for basic preparation should be available to nurses.

The agency has a definite responsibility to assist the nurse in application of her public health knowledge. The in-service training includes a picture of the community, agency facilities, and types of services offered to the community. While affiliated with the organization each nurse should seek opportunities for continued growth and learning.

Staff education is a medium which is used for departmental growth. Not only does this type of program develop the nurse's professional capacity for the best services, but also reveals the potentialities of the staff nurse for increased agency responsibilities. Every experience of the nurse should be one of education.

After six months employment an evaluation should be made regarding the capabilities and potentialities of the employee. Mutual understanding at this time can help to eliminate inter-agency problems in the future.

The responsibility for planning the educational program rests with the professional head of the organization or with the educational director. However, in a progressive organization staff suggestions are positive factors in the determination of definite departmental policies.

5. Supervision. The author has found that in general the public health agencies can be criticized due to the lack of administrative and adequately prepared supervisory personnel in public health nursing. This may be due to the following reasons:[21]

1. In spite of the increasing amount of specialization in training among public health nurses as a whole, there are many areas in which the nurse's preparation is not adequate.

2. The work of the public health nurse is becoming increasingly complex. The trend toward unloading certain semi-skilled tasks upon subordinate workers will tend to hasten this development.

3. In the work of the public health nurse, there are many factors which cannot be learned during the pre-inductive period, but which depend upon skillful developing over a long period of time.

4. The public health field is expanding rapidly, and trends in social legislation indicate a continuing expansion.

5. The public is demanding a higher and higher standard of nursing care.

6. The health program, of which public health nursing is a part, is becoming more complex in administration. The trends toward planning to meet health problems on a community

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[21] Freeman, op. cit., p. 1.

basis contribute to this complexity.

The success of any public health nursing program depends largely upon the quality of service rendered by each individual nurse.[22]

Supervision carries a tremendous responsibility for influencing the quality of service, and determining the level of efficiency and satisfaction at which the worker will function. But with this responsibility there are also limits. Supervision alone cannot safeguard the quality of service, nor can it compensate entirely for poor personnel, inadequate policies, or unsound administrative action.[23]

The administrator of the nursing service, whether a nurse, a medical health officer, or a lay person, will look to the supervisor for the efficient translation of agency policies into community action. The supervisor serves as a facilitator, seeing that the general objectives of the organization are realized in terms of the service which is carried on in the field by the various staff members. The director will expect the supervisor to:

1. Administer the details of service in accordance with established policies and standards.

2. Assist with the planning of new policies, and the evaluation of existing ones.

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[22] Ibid., p. 2.

[23] Ibid., p. 18.

3. Coordinate and use effectively the services of other departments or branches of the service or community.

4. Promote optimum functioning of each unit and staff member under her direction.[24]

5. Promote desirable personnel relationships through the development of the contented and efficient staff.

6. Develop new leaders.[25]

A supervisor has a three-fold function. The most important is that of teaching, first, last, and at all times. She must have a closely associated worker relationship with her administrator and staff as well as administrative ability. Capacity for leadership is essential in developing the teaching phase of the program.[26]

In public health, it is important that the supervising instructor have a thorough knowledge of the subject. An effective instructor realizes the patient must be seen in relation to the family and the family in relation to the community. The supervisor, as a teacher, inculcates to the staff a thorough understanding of principles, standards, skills, and techniques already accepted. This, in turn, will develop within the staff nurse a sense of individual responsibility for continued de-

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[24] Ibid., p. 18.

[25] Ibid., p. 18.

[26] National Organization for Public Health Nursing, "Supervision in Public Health Nursing," (reprint from Public Health Nursing Journal.)

velopment and progress. Development of standards through a staff educational program should be the objective of the supervisor's teaching.

Supervision, in terms of a case worker, points out the importance of understanding the individual nurse. This includes assisting the nurse to a constructive approach to her job; understanding her own possibilities, temperament, background, and experience. A good supervisor has an open mind in all kinds of administrative and staff relationships.

Developing teamwork is one of the most important tasks of the supervisor. In this phase of her work she should be a professional guide, philosopher, and friend. Too often executives and supervisors fail to recognize that the staff nurse is the center of the whole scheme; also, that the community point of interest is focused on the public health nurse.

Full participation from the members of the staff depends largely upon the supervisor's point of view and whether the agency is truly democratic. Good teaching and efficient supervision can be accomplished if the organization recognizes the contribution and importance of the individual.

A supervisor can make or mar any organization. However, without proper supervision, gaps and ruts will occur, no matter how capable the executive may be, or how well-intentioned and well-prepared the staff may be. The work will be overemphasized in certain areas and underemphasized in others.

Irregularities in standards mean no standards at all. Unless the supervisor is a leader with vision, the inevitable result is that the organization ceases to act as a unit. It becomes a mere assemblage of more or less isolated units, working without any lift, sense of perspective, or appreciation of the job as a whole. Supervision is a mutual affair --- it is group thinking and group action. The experience of each is made available for all, and out of this develops the indefinable but most vital thing called The Spirit of the Staff. The spirit, understanding, and interest depend upon the supervisor's ability as a teacher, worker, and leader.[27]

There are certain tools which a nurse should have in order to work efficiently. These include:[28]

1. A nursing manual in which is assembled the general policies of the association and its special techniques, also a manual on standing orders.

2. An adequate record system which will increase the powers of observation of the nurse and reveal the actual conditions as found, and action taken.

3. A well-defined program for staff education, which includes introduction of the new nurse, pupil nurses, and continuous growth of staff members. Time should be allowed

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[27] Ibid.

[28] Ibid.

for case conferences, and case visiting.

4. A standard nursing bag, adequately fitted with necessary equipment for nursing techniques.

Family and individual records afford one of the greatest opportunities for teaching. Too often the supervisor's chief contact with the records is to see whether they are accurate or inaccurate, in terms of certain statistical data. If this is the attitude of the supervisor, it also will be the attitude of the nurses. Records should give a true picture of the health situation and show what action was taken.

A review of the records by the supervisor will show certain statistical data that might be helpful in public health nursing. From the daily report sheet, a picture in chronological order of cases seen by the nurse, which gives some indication as to the nurse's ability to plan her day's work in order of importance, and the best use of her time, is presented. From the day book she can get a birdseye view of the amount of work carried by each nurse in her district. This gives a quick summary of visits, content of visits made in each case, and some idea of each nurse's productivity in comparison with other nurses. Geographical factors and types of cases have to be taken into consideration, so no conclusion could be arrived at from a superficial consideration of the number of visits. It also shows the frequency of visits, considered in relation to diagnosis and value in general supervision of the

work. There is an opportunity for understanding the work of the nurse from the medical and social histories. Here should be joined the health picture of each case with a current social and medical history of all action taken.[29]

The supervisor should carefully study each nurse's records. If this is done, it will be possible to bring to each worker a better understanding of omissions and the importance of more complete records. Each record should be studied to see how far it reveals the three-fold purposes of all public health nursing: Health promotion, health prevention, and cure.

Organizations should set up their own guideposts as to the responsibility the supervisor should take in relation to the case load. This may include the following:

1. All new cases.
2. All new cases kept on longer than three days.
3. All cases of acute illness.
4. Families with a complicated health situation, social problems, or financial difficulties. (This includes mental and emotional problems.)
5. All cases of communicable diseases.
6. Cases with long-term illness.

Records should not be closed or carried too long without a conference with the supervisor. Monthly box check with

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[29] *Ibid*.

the staff nurse will be a valuable tool in determining the disposition of a case. Regardless of what type or form of record is used, such records present the best possible teaching material for every phase of the work. They are infinitely more productive of results than all the glittering generalities.

Well-organized and planned individual or group conferences are an important method of pooling the achievements or problems of the staff members.

Efficiency reports should be written objectively. They should be discussed with the director before the staff nurses' conference. The nurse should be encouraged to express her point of view as to her own rating. The report should be one of encouragement for the nurse to strive for higher standards.

The supervisor can be indispensable to the total agency program if the duties of her position in regard to the opportunities and responsibilities of staff nurses are clearly defined.

What are some of the results expected from supervision? The writer feels that these following results are important:

A sense of shared leadership; teaching that presents unity and understanding, not mere conformity; that develops individual initiative and stimulates enthusiasm and insures teamwork. Such supervision sets in continual motion a learning-teaching process for both staff and supervisor. Best of

all, it gives to the community an outstanding public health nursing service.

6. Classification of Services. A good public health nursing program should offer the following types of services:

Health Supervision, which covers all of the services that concern themselves with the preventive and exclusively educational side of public health nursing. Subdivision is made according to the age groups served, such as, infants, pre-school children, school children, and adults.

Maternity Service, which includes all services rendered to mother and child preceding, during, and immediately following birth. Subclassification is according to these periods: Prenatal, delivery, and post partum, the latter including neonatal care and premature care.

Morbidity Service, including all services designed for the care of the sick, whether or not the patient is confined to bed. This may be subdivided into contagious or non-contagious and includes long-term illnesses.

7. Coverage. A complete health program within a community should be well-planned to meet all the existing nursing and health needs. These services should be available to individuals regardless of race, creed, class, color, financial ability, or political preferences.

It is a recognized fact that the qualified local health department is the foundation stone of civic planning for health. Many communities are without the services of full-time, tax supported local health agencies, and most of the existing health departments are understaffed.

Minimum standards at the present time seem to call for one medical health officer for each 50,000 persons, one public health nurse for each 5,000, one sanitarian for each 25,000, one health educator for each 50,000, and one clerk for each 15,000. If a community can spend more money per capita, at least $1.50 per capita for this size staff, the personnel may be expanded. This yardstick may be inexact as it applies to certain communities. However, these figures offer a method for comparison and program planning.[30]

For a population of larger size, (viz. 100,000), it would be practical and economical to include within the staff of the local health department additional administrative health officials. This would include chiefs of communicable disease control, maternity and child hygiene, tuberculosis, venereal disease, or industrial hygiene, sanitary officers and nurses. A clerical staff proportionate to the size of the population, one clerk for each 15,000, should also be provided.[31]

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[30] Haven Emerson, M. D.,"A Report of Local Health Units for the Nation," The Commonwealth Fund, 1945.

[31] Ibid., p. 2.

In a private agency the National Organization for Public Health Nursing recommends 1 to 5,000 where all services exclusive of bedside care are offered and 1 to 2,000 when bedside care is included.

The American Public Health Association, through its Committee on Administrative Practice, issued the following statement on September 26, 1949, concerning the local health department, its services and responsibilities:

The local health department is the basic service unit in the administration of public health. Through daily contact with the public the local health department obtains first-hand information concerning local health needs, and is responsible for providing its community with direct services. A unique combination of medical, dental, nursing, engineering and other technical services, together with statistical, managerial and administrative skills, is made available through a full-time, efficient and well-staffed local health department. Its personnel is specially trained to utilize the health sciences in the public interest through effective community organization.

Further progress in the development of public health services is dependent not only on advancing knowledge in the health sciences but on its application through the establishment of new local health departments to provide nationwide coverage, the strengthening of existing local health departments, the enlargement of their scope of service, and the de-

velopment of highly skilled staffs. Such units will meet their responsibilities most successfully if they have a challenging program and the necessary facilities and qualified personnel with which to work.

Community health programs are not static but undergo a continuous process of change and development. The program of the local health department should be flexible, designed in terms of community health needs and resources, and capable of modification to meet new public health problems as they become recognized.

The concept of the services of the local health department has undergone considerable change. As a result of advancing medical knowledge and public health practice, there has been a sharp decrease in morbidity and mortality from infectious diseases, particularly in infancy and childhood and the early years of adult life. Because of the marked changes in the age distribution of the population and in the spectrum of our health problems, the theory and practice of public health has expanded to include not only prevention of the onset of illness, but also prevention of the progress of disease, of associated complications, and of disability and death.

The "desirable minimum functions" of local health departments -- vital statistics, sanitation, communicable disease control, laboratory services, maternal and child health, and health education -- have been modified recently to include

the control of chronic diseases. Accident prevention, the hygiene of housing, industrial hygiene, school health services, mental health, medical rehabilitation, and hospital and medical care administration are other areas of service and responsibility which have been incorporated into the programs of an increasing number of local health departments. Definitions of local health services and responsibilities based on limited categories of activity have become quickly outdated as a result of this rapid development of health administration. It is essential, therefore, to define the optimal responsibilities of the local health department, to list the general types of service provided, and to indicate the specific methods utilized in the solution of local public health problems.

Responsibility for community health rests jointly on the local health department, the medical, dental and allied professions, the hospitals, voluntary health agencies, and the public generally. The health officer has an overall responsibility to the public in matters affecting community health; he meets this responsibility by rendering certain direct services and by providing stimulation and leadership to assure that other necessary services and facilities are made available by appropriate means. In order to achieve an effective program, the local health department should provide the following general types of service and utilize the following methods:

I. Recording and Analysis of Health Data

A variety of data is necessary to define and locate local health problems and assure sound planning for optimum health. These include information about the characteristics of the population, the incidence and prevalence of disease and impairment, and the disability and mortality resulting from them. Equally important is accurate information on the availability, utilization, and quantitative and qualitative adequacy of health personnel, facilities and services.

In order to obtain such information, the local health department utilizes various procedures, such as:

1. Recording and analysis of reports of births, deaths, marriages, divorces and notifiable diseases.

2. Maintenance of registers of individuals known to have certain specific long-term diseases and impairments.

3. Conduct of special surveys to determine the prevalence and resultant disability from various diseases.

4. Collection and interpretation of morbidity data from such sources as clinics, hospitals, organized nursing services, prepayment plans, industry, and workmen's compensation and disability insurance programs.

5. Maintenance of continuing records on the number and qualifications of all types of health personnel, the quantitative and qualitative resources of available facilities, and the types and extent of health services provided through various

voluntary and public programs.

6. Periodic evaluation of community health needs and services.

II. Health Education and Information

An informed and educated public is one of the best guarantees of effective health service. The health department carries on an extensive and continuous campaign of public education and information on how to achieve optimum health, how to prevent illness and disability, and how to make use of available facilities and services. To this end the health department:

1. Provides individual instruction by public health nurses and other personnel, as in the case of families in which communicable disease has occurred, of mothers attending well baby conferences, or of diabetic and other patients who are taught to follow the regimen prescribed by the family physician.

2. Organizes lectures, classes and courses, such as mothers' and fathers' classes, courses for foodhandlers, classes for diabetics, and lectures to community groups.

3. Stimulates community organization in order to obtain the widest possible citizen participation in health programs, the broad dissemination of health information, and the motivation of the public to improve health services.

4. Uses mass educational and information media, such as newspapers, magazines, pamphlets, movies, radio and tele-

vision.

The health department is also responsible for developing a well-rounded program of professional education, designed to assist the local health professions to maintain and improve the quality of service. A variety of methods are used for this purpose, including distribution of literature, arrangement of lectures and post-graduate courses, and encouragement of organized educational relationships with medical schools and teaching centers.

III. Supervision and Regulation

The local health department has supervisory and regulatory responsibilities covering various fields, such as the protection of food, water and milk supplies, the control of nuisances, the sanitary disposal of wastes and control of pollution, the prevention of occupational diseases and accidents, the control of human and animal sources of infection, and the inspection of hospitals, nursing homes and other health facilities. In carrying out these functions, health departments use a variety of methods, of which probably the most important is public information and individual instruction. Others include the issuance of regulations, laboratory control, inspection and licensure, conduct of hearings, revocation of permits and, as a last resort, court action.

IV. Administration of Personal Health Services

Local health departments should be responsible for the provision or administration of a variety of personal health services. These include:

1. Immunization against infectious diseases and other preventive measures such as the application of fluorine to children's teeth.

2. Advisory health maintenance service, as in child health conferences, prenatal clinics and parents' classes.

3. Case-finding surveys of the general population, such as chest X-ray surveys, serological tests for syphilis, cancer detection programs and school health examinations. Adult health inventories and "multiphasic" surveys for the detection of various groups of diseases may also be included.

4. Provision of diagnostic aids to the physician, such as laboratory services and crippled children's, cancer, cardiac and other diagnostic and consultation clinics.

5. Provision of diagnostic and treatment services for specific diseases such as syphilis, tuberculosis, dental defects in children and expectant mothers, and orthopedic, cardiac and other crippling impairments in children.

There is a definite trend toward increased local health department responsibility in the control of chronic diseases, in the development of mental hygiene services, in the provision of bedside nursing care in the home, in the expansion

of health services for school children, and in the administration of public programs providing general medical care for designated groups of the population.

Effective administration requires that all official health programs be integrated in a single responsible agency. As new programs of public medical care are developed, therefore, their administration can logically be entrusted to the local health department. The well-organized and adequately staffed local health department is fitted for this task because of its strong combination of medical and organizational skills, its accustomed responsibility for a public trust, its emphasis on promotion of health and prevention of disease, and its understanding of the organizational elements required to achieve a high quality of care.

V. Operation of Health Facilities

The local health department can fulfill its responsibilities most effectively if it operates one or more well-equipped health centers providing adequate space for administrative offices, clinic facilities, and an auditorium or classrooms for public and professional education. Health departments may also carry direct responsibilities for the administration of general or special hospitals.

VI. Coordination of Activities and Resources

In addition to administering specific programs and

rendering direct service, the local health department has the general responsibility of providing effective leadership in meeting all types of community health needs. The health department should make available its technical and administrative resources to provide accurate data as a basis for sound planning, to help inform and educate the public, and to assure that the necessary measures are taken by public and private agencies to improve and coordinate the community's health facilities and services. A primary task of the local health department should be to encourage the fullest possible coordination of the work of the various official and voluntary agencies so as to avoid unnecessary duplication and overlapping both in types of activity and in geographical coverage, and to assure efficient and economical administration of both public and private funds for health.

There are numerous examples of excellent health department activity along these lines, such as action to coordinate the activities of the health department, voluntary agencies, hospitals and the medical profession in emergencies such as epidemics of poliomyelitis or disasters due to flood, fire, etc.; coordination with departments of education, the medical and dental professions, service clubs and other agencies to improve school health services; and the development of organized community action to obtain needed additions and improvements in local facilities such as general

hospitals, chronic disease facilities, rehabilitation centers and the like.

Effective implementation of this general responsibility requires that local health department personnel should in every respect be members of the community in which they live and work, and should participate actively in community functions in health and other fields. It requires also that the local health department maintain close cooperative relationships with the medical and other health professions, voluntary health associations, public and private educational and social welfare agencies, and community organizations such as business, farm, labor and other consumer groups. The most effective expression of such cooperative relationships is achieved by a broad community health council which represents these various groups and provides an organizational basis for close coordination of activities and resources.

HEALTH DEPARTMENT ORGANIZATION AND STAFF

The local health department should have the status of an executive department of local government, administered by an executive director who is a full-time medical health officer with formal training in public health administration. The health officer should be advised by a board of health whose members are representative of the various groups and health professions in the community. The board of health should,

because of its official status, be constituted with at least half its members representing the public interest. In addition to advising and assisting the health officer, the board of health may enact local regulations.

As executive director of the local health department, the health officer should be primarily concerned with the development of plans and policies, the provision of overall guidance and stimulation to his staff and the effective coordination of their activities.

The varied functions of the local health department require the utilization of different types of specialized personnel. The types of personnel needed depend primarily on the scope of services, and may include public health nurses, engineers, sanitarians, laboratory workers, health educators, statisticians, physicians, dentists, social workers, office managers, clerical personnel, medical care and hospital administrators, and so forth. They should be employed in sufficient numbers to meet community needs, and this in turn depends on the characteristics of the community, the nature of its specific health problems, the size of the population served, and the comprehensiveness of the services provided. The staff of the health department will be effective only if they are well-trained, well-paid, chosen on the basis of a merit system that is responsive to the special needs of public health service, and provided with adequate leadership on the part of

the health officer.

RELATION TO STATE (PROVINCIAL) AND FEDERAL HEALTH AGENCIES

The local health department has no direct relationship or responsibility to federal health agencies. All relationships between local health departments and federal agencies are carried on through the medium of state or provincial health departments.

The local health department is accountable to the state health agency for adequate performance of those programs which are delegated to it by state law or regulation. It must meet the minimum standards set by the state health department and should be subject to state supervision.

On the other hand, local health departments should be allowed ample scope for the initiative and creative activity of the health officer and his staff. A primary responsibility of the state health department is the strengthening of local health departments in terms of personnel, facilities, services and prestige. To fulfill this responsibility, the state health department should:

1. Provide a statewide coordinated public health program with clear objectives for the guidance of local health departments.

2. Develop an appropriate plan for the coordination of local health services with related hospital and medical

programs which may be developed on a regional basis.

3. Provide financial assistance to supplement the resources of local health departments.

4. Make consultation and other special services available.

5. Assist localities to set up demonstrations on a temporary basis.

6. Establish minimum and stimulate optimum standards of performance.

7. Develop a recruitment and training program for local health department personnel.

8. Delegate certain legal responsibilities of the state health agency, insofar as feasible and practical, to well-organized and adequately staffed local health departments.

9. Carry on all relationships with local citizens and groups through the medium of or in cooperation with the local health department.

Local health departments should be given a voice in the determination of policies and plans for the development of state public health programs. This can best be accomplished by the state health department through regular meetings with the local health officers. Such meetings, similar to those conducted by federal health agencies with the state and territorial health officers, can do a great deal to clarify relationships, achieve closer coordination of programs, and enlarge

the responsibilities and strengthen the role of the local health department.[32]

8. Finances. Public health nursing may be set up under one of several auspices, private, state, community, or municipal. In some localities, there is found a combination of one or more of these.

The question of financing the community health program is one of the first to engage the attention of its promoters. A modest budget needed for minimum operation seems large and frequently causes anxiety. Financing of the agency will depend upon the source of income. If an agency is set up under a municipal plan, it will be tax supported. Should the agency be a voluntary undertaking or sponsored privately, some other method of financing will have to be employed. A few definite sources of income may usually be available. Receipts from patients, and payment for contract visits to the industrial policyholders of insurance companies are the main sources of revenue. Town, city, or county subsidy may be paid to the agency for service. Other contractual arrangements are possible with commercial firms, department stores, and mills. They may buy service or pay the regular fee for a home visit. The balance of the budget must be raised by other means. It

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[32] Statement of The American Public Health Association, September 26, 1949 (Committee on Administrative Practice.)

is the raising of this money that constitutes one of the most important duties of the board, especially the financial committee. As to the best method of performing this duty, it is rather difficult to state any particular one, because of varied local situations.

The Chest method of gaining support for social work has increased the amount given, and the number of givers, enormously. It has also awakened a social consciousness in the general public. However, there is still a lack of community understanding on a strictly cash basis.

The body holding the purse strings, and acting as the financial representative of all the agencies, owes the public from whom the money comes strict adherence to methods of fairness and economy in distribution. The agency's responsibility to the public lies in supplying the service for which it exists. That Chest and agency do not always see eye to eye in regard to the methods employed to fulfill these obligations is understandable.[33]

The multiplicity of drives is going to cause an adjustment on the part of Chests. They will have to find a solution to meet all the financial demands placed before the public.

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[33] Mary S. Gardner, Public Health Nursing (New York: The Macmillan Company, 1945), p. 444.

Raising money is going to be difficult in the future. There will be less money for contributions from those in the higher economic brackets. The competition for the money is going to be more keen. If taxes continue to mount and people feel the pinch, they are going to call a halt in no uncertain terms.

There will be a place in tomorrow's society for the progressive official and non-official agency that meets community needs and is understood by the people. This can be accomplished through the important task of day-by-day interpretation.

[34]Hughes states that public health nursing is facing certain danger signs and pitfalls. He asks pertinent questions which are challenging and may be applied to any local situation.

1. Does public health nursing as it is practiced today fill a need in the community?

2. In business terms is public health nursing a saleable service?

3. Is it possible that public health nursing, despite many expressions of professional opinion to the contrary, still operates in the era of Lady Bountiful?

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[34] Horace H. Hughes, "The Nurse in Public Relations," Public Health Nursing Journal, July, 1944.

4. Is public health nursing as attractive as it might be or is it still based on the assumption that it is provided by the better off in the community for those who are worse off?

5. Do those who provide the money still claim the right to decide what kind of service is to be offered, or do those who are served have a voice in deciding what the standard of care should be?

6. Does the community want something more than public health nursing is giving today?

7. Does public health nursing have its "ear to the ground?"

8. Does it hear and heed the rumblings and mumblings about the overeducated nurse with highfaluting ideas?

9. Has public health nursing listened to the voice of America's workers who are sick and tired of the concept of charity?

10. Does public health nursing think it can know what the community wants if the people whom it serves are not represented on its board of directors and its planning committee?

11. Is the recent decline in the number of patients served by the public health nurses partly due to the fact that the standard of nursing has not met with the approval of the community?

12. Is this attitude a lack of satisfaction or a lack of understanding of the functions of the public health nurse?

13. Is it not true that when people think of public health nursing they think only in terms care of the sick?

14. Is it possible that to these people the care of the sick service rendered by the public health nurse is not as satisfying as hospital care?

15. Is it possible that public health nursing is really public sickness nursing?

16. Is it possible that the public has learned to call the nurse for sickness but has not learned to call her if a dose of health instruction is needed?[35]

He further states that no one is closer to the life of the community than the public health nurse. She sees the coming of life, the problems of life, the disaster of sickness, the happiness of life, the coming of death. She sees the relationship of families to medical care, to schools, to business, and to industry.

Communities need the public health nurse. To do her job well, however, she needs the sympathetic understanding and financial support of the community. She must not be on the defensive, apologizing, begging for money from a quizzical public. She must be a leader in the community, with a voice

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[35] Ibid.

of her own and a power of her own. The public health nurse must do everything in her power to interpret the agency's philosophy to the community.[36] This is most important if good public relations are to be accomplished.

Human beings are at the heart of all our public health nursing activities. Public health agencies exist only to serve people. They exist only because there are people who have needs and there are agencies set up to serve and to meet these needs. We then are but the servants of the people.

The improvement of community, family, and individual health is the goal of public health agencies regardless of the financial source. To win this goal there should be united government and civic action.

This chapter has been devoted to the standards, practices, and procedures of a public health program as advocated by various leaders and organizations. It is not anticipated that this will serve as a solution to all health problems. However, there are certain fundamental concepts and underlying principles that might be given thoughtful consideration by a community interested in evaluating its public health program.

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[36] *Ibid*.

CHAPTER IV

THE PRESENT HEALTH AND NURSING SERVICE IN THE GREATER LOWELL AREA

1. History of the Community. Lowell, referred to as the "City of Diversified Industries," (America's first factory city), is located in Middlesex County, at the junction of the Merrimack and Concord Rivers. It was settled in 1653, incorporated as a town in 1826, and named after Francis Cabot Lowell. In 1836 Lowell was incorporated as a city. The business and industrial areas are adjacent to the Merrimack River, and the residential sections are on the hills that surround it.

The facilities of the Boston and Maine Railroad provide transportation. Busses connect the community with neighboring towns. The population, 101,389, (United States, 1940), is preponderantly foreign-born or second-generation, with large numbers of French-Canadian, Greek, Irish and Polish extraction.

Lowell's early history is identified with the Town of Chelmsford, of which it was a part for many years. Later, West Dracut, (now the Pentucket Mill section of Lowell, considered the principal part of Dracut), was annexed. Middlesex Village now in Lowell was rather an important settlement at the head of the Middlesex Canal. Manufacturing was for the most part carried on in homes, and the fisheries at Pawtucket Falls played an important part in the economy of the community.

The transition from handcraft to manufacturing occupied the period from the end of the Revolution to 1822. The building of canals, the development of water power, the starting of huge manufacturing enterprises were heralds of a new economic system which was destined to uproot the customs and habits of a peaceful countryside and lead to the creation of the first American factory city.

The achieving of independence by the colonies had deeper implications than a change of political forms and control. It meant the unleashing of the energy and enterprise of hard acquisitive powers and eventually the evolution of an agricultural society into a highly developed industrialism.

With outside capital coming in from many sources, principally from the merchants of Boston, one corporation succeeded another. To the cotton manufacturing of the Merrimack Company had been added the Print Works in 1824. The Hamilton Company, with a capital of $600,000, and the Appleton and Lowell Manufacturing Companies were some who took advantage of the water power of the Merrimack.

Lowell reached its peak as a great industrial center in the reckless period of prosperity which followed World War I. A recession began with the minor depression of 1921. Due to the radical changes in textiles the toboggan ride which followed was swift and devastating. Several of the mills moved southward, and other industries were liquidated. An atmosphere of

gloom naturally followed the fall from dizzy heights. However, it now appears that Lowell is "out of the woods" and in the process of recovery. It lost its position as one of the textile centers of the world, but other compensating gains were made. Diversification started in the late twenties and was greatly accelerated.

The Irish people, the first group to join the early English, are now very influential in the social and political life of the city. Each non-English-speaking group that came to this city settled in these ethnic colonies, but each group still has its churches, schools, convents, shops and stores. Each group has retained, to a considerable extent, the culture of its homeland.

The area of the city is only 12.9 square miles. Because of its small area, the working population overflows to the neighboring towns of Westford, Dracut, Tewksbury, and Chelmsford. The present population of Greater Lowell, including these towns, is approximately 127,534.

The economic picture of this city for the year 1946 shows that there were 32,970 employees who received a yearly payroll of $85,752,000. These figures are based on a selective payroll basis.

One may readily observe that Lowell still is an industrial community. Present industries consist of boots and shoes, bakery products, clothing, cotton, woolen, worsted and rayon

goods, dyeing and finishing textiles, electrical wire and appliances, foundry and machine products, gas, (manufactured), home furnishings, knitted goods, leather, malt liquors, printing and publishing, textile machines.

The assessed valuation per capita in 1947 was $961.85, with a tax rate per $1,000 of $45.80. In 1949 this was increased.

Lowell has six hospitals with a bed capacity, including bassinets, of 1097. These include:

St. John's Hospital	224
St. Joseph's Hospital	90
Lowell General Hospital	213
The Shaw Hospital (private)	32
Farris Memorial Hospital (city)	350
Contagious Hospital (health department)	90

Throughout the industrial area there are 14 registered nurses employed within the mills. Some plants are covered by individuals trained in First Aid. Clinic facilities in this community are adequate.

2. <u>Lowell Visiting Nurse Association</u>.

The Lowell Visiting Nurse Association was organized November 1, 1908, with a staff of two graduate nurses. This agency was brought about by agents and representatives of the

Lowell Mills who realized that their employees needed nursing service in the home. The management of the Lock and Canals appropriated $1,000 and requested the Middlesex Women's Club to supervise the work.

It is interesting to note, at this time, a quotation found in the agency's first report: "The prime motive of the work is to help in the care of the sick, and to teach personal hygiene, house sanitation and ventilation in the homes of the poor."

The following is a list of the important high lights over the years 1908-1949.

1. Good Cheer Fund (provides luxuries for the sick room and emergency items.

2. 1910-Contract with Metropolitan Life Insurance Company (providing nursing care to policyholders).

3. 1910-First baby clinic. Objective (to provide medical care for children). At that time, Lowell was second among 17 cities of the middle and eastern States having the highest infant death rate.

4. 1911-Incorporated under the name of the Lowell Guild with 27 charter members (three men).

5. 1911-Infant mortality decreased 15%. (Development of substation for milk distribution.

6. 1912-Six nurses employed.

7. 1913-Ten nurses employed.

8. 1915-Group teaching, formula demonstration to mothers, including prenatal work and school nursing. (Later school nursing was absorbed by the Health Department.)

9. 1915-Affiliated with the National Organization for Public Health Nursing.

10. 1921-Addition of Well Child Conference. Harvard Infantile Paralysis Clinic held at office.

11. 1922-Well Child Conference for Greek children held at Greek School.

12. 1923-1929-School nursing started in smaller adjacent communities.

13. 1924-Community Chest affiliation.

14. 1925-Contract with John Hancock Life Insurance Company.

15. 1926-A delivery service.

16. 1923-Name changed to Lowell Visiting Nurse Association. Diphtheria toxin - anti-toxin immunization.

17. 1930-Hourly nursing introduced.

18. 1936-1949-Increased activities: Group teaching; Home nursing; Girl Scout classes. Post-graduate study for the staff. Newer concept service offered and given to individuals regardless of economic status. Pupil nurses have always been affiliated with the organization.

3. Administration. The revised by-laws of 1947 show that the officers are elected at the annual meeting. The responsibilities of the officers and committees are briefly stated. There is no statement as to regular meetings of the board of managers. Board and nursing committee meetings are held monthly. The others may be called as the need arises. There is an active medical advisory committee.

The executive director is a graduate registered nurse. She has been granted a certificate from Simmons College for post-graduate work in administration in public health. Her past experience reveals thirty years in public health administration. She has been with this agency since 1936. She is responsible to the board of managers for the overall program of the organization.

The assistant director has completed the approved program of study in public health nursing. She has been affiliated with the organization as a staff nurse and has held her present position nearly two years. At the present time another staff nurse is completing the four months public health course in preparation for advancement to a part-time supervisor. The remainder of the personnel have been encouraged to continue their education.

In 1939 the agency's work and staff had grown to such an extent that larger and more suitable quarters were needed.

Fifteen nurses, one assistant director, one supervisor, and five pupil nurses and three clerical assistants compose the

present staff. Adequate desk space is provided for the employees. However, there is no attractive rest room available at the present time.

4. Supervision. The executive director gives careful attention to the quality of service rendered. Frequent individual conferences are held with the nurses for the purpose of discussing financial, nursing, or health problems. She delegates the work to the staff. The assistant is also responsible for in-service training and supervision of the new staff and pupil nurses. The pupils are affiliated with the organization for an eight weeks period. They are recruited from the local schools of nursing. Case visiting with the nurses is done by the director and her assistant.

5. Types of Services. At the present time, the organization provides all types of nursing care. Communicable disease cases are not routinely carried, but the nurse will visit if service is requested by the doctor or the health department.

Mothers' classes for expectant mothers are taught ten months of the year.

Well Child Conferences are held twice a week, 52 weeks of the year. They are under the supervision of a doctor. A staff nurse is always present.

The Harvard Infantile Clinic avails itself of the

agency's clinic room.

6. Area Served. These services are provided to Lowell and the Greater Lowell area which includes Dracut, Tewksbury, Westford, and Chelmsford. One nurse is assigned solely to the Town of Westford. The city is divided into districts. These communities served by the Visiting Nurse Association are related geographically, and in certain instances, socially.

7. Finances. Over the five-year period, 1945-1950, the agency's budget has greatly increased. Income is derived from the following sources: City, State, and Federal subsidy. A small fee is charged to clinic patients. All fees are adjusted to a sliding scale according to the family resources. The remainder of the budget is subsidized by the Greater Lowell Community Chest. The present fee charged is $1.75. Other agency fees vary from $1.25 to $1.50. No individual in the office is bonded. A retirement plan for all employees is in operation.

8. Personnel Policies. The agency's personnel policies are fairly well outlined. However, the writer has learned that salaries at the present time are low.

Separate policies cover the clerical staff.

Records are filed alphabetically with notations as to when the individual is due for a visit. A cross file of records and a date file should be in every office. All new

cases have complete records which are written by the nurses. Records remain in the office. The clerical staff makes notations on the records from the nurses' day sheets. Closed records are checked regularly.

There is a manual for nursing techniques and standing orders. The regulation bag is carried by the nurses.

Publicity is a vital part of the agency program. It is clear that local newspapers are behind the agency and its contribution to the community. Also, there is a fine working relationship with the local health department, doctors, and other community organizations. There is evidence of good public relations on the part of the board members, executive director, staff members, and clerical staff.

Staff morale is high; the agency's philosophy is carried into the homes, thus giving outstanding service to the community.

At this point the writer would like to express a commendable reaction. The essential historical information shows outstanding progress of the agency over the years. Considering the rapid growth of public health nursing, in conjunction with the constant changes in society, the Lowell Visiting Nurse Association has not remained stagnant. It has survived a period of wars, depressions, and economic upheavals. Certain statistical data shows that the organization today is carrying a heavy nursing burden. During the transitional period of World War II to peace, there has been a constant

change in personnel, with an increasing case load. There is no doubt in the writer's mind that today the board members and all personnel recognize and accept one important fact: The Visiting Nurse Association is an outstanding organization in Lowell.

With the organization as it exists today, the following general conclusions may be drawn from this study:

1. In the light of accepted standards for board members it is recommended that the board should be rotated. There should be a definite policy as to the length of time an officer may serve. New and interested members bring an inspiration to the organization. The organization is bound to benefit from this enthusiasm.

2. Board members should be selected on the basis of broad representation from the community. The board should be democratic, vitally interested and concerned with the agency's responsibility in terms of service to the community.

3. With a staff of the present size, there should be an outstanding educational program. The organization would do well to consider the possibility of an educational director. Education of the staff must be continuous.

4. Personnel policies should be defined clearly. This includes all persons employed by the agency. Smooth administration will be the end result if individuals definitely know what their responsibilities are.

5. A recent study of 154 Community Chest reports shows that nursing service agencies receive 49.4 per cent of their total income from the Community Chest. The statistics show that over the past five years, the Chest allocation to this agency has decreased in proportion to the total budget. It is strongly recommended that the Finance Committee urge upon the Chest Budget Committee an increased allocation.

6. A study of the salary scale should be made immediately, in view of present-day standards, and in relation to comparable agencies.

7. It is recommended that individuals handling finances should be bonded.

Lowell Health Department

9. Statistical Report and History of the Organization.

Historical records show that at the time the town was incorporated, in 1826, the city fathers felt the need of a health department. At that time the population was 25,163. A statistical report for the year 1826 shows: Births, 5,010; marriages, 4,500; deaths, 4,186.

In 1903 a State law was passed stating that all cases of tuberculosis were to be reported to the local health department.

1890 and 1903-Severe typhoid epidemic, 454 cases, 123 deaths.
1915-First tuberculosis clinic in Lowell, 213 cases reported.

1918-Diphtheria- 483 cases reported, 24 deaths.
1919-Highest incidence of tuberculosis cases, 288.
1929-Immunization clinic for diphtheria.

1929-1934-Diphtheria cases decreased from 110 to 61.
1943-1947-Over a period of five years no deaths reported.

There was very little change in these figures for the next few years. However, from 1937 to date only 12 cases and 1 death from typhoid fever have been reported. The improvement of health over the past years is due primarily to a change in the sewage system, pasteurization of milk, and strict sanitary food laws.

With the exception of maternity hygiene, this organization carries out the six basic health department functions. Individual cases needing bedside care are referred to the Visiting Nurse Association.

10. Administration. The medical director is a trained, full-time public health administrator. He is responsible to a board comprising one doctor and two lay members. Recommendations from the board of health are referred to the city council.

The health department employs:

1 chief of health inspection
3 clerks
1 health educator
1 health inspector
1 meat inspector
20 nurses for service with communicable diseases, tuberculosis, venereal disease control, and school health supervision

The part-time staff includes:

1 bacterial inspector
1 chemist
1 clerk for the tuberculosis control program
4 clinicians
2 dentists
1 male nurse
1 milk technician
11 school physicians
2 X-ray technicians

Two of the nurses have completed the regulation course in public health. Other staff members have taken sporadic courses. Observation showed that the tuberculosis clinic and school nurses quarters were overcrowded. Clinical space is not adequate for personnel or patients.

11. Supervision. The medical officer supervises the health and educational program. Regular monthly staff conferences are held. Staff members are encouraged to attend institutes and meetings held in the community and also State meetings. Staff education is coordinated with the Lowell Visiting Nurse Association. In-service training consists of one month's period of observation. There is no trained public health nursing supervisor.

12. Types of Services. The program includes the following:

1. Acute communicable disease, tuberculosis, and venereal disease control.

2. Health service to the public and parochial schools.
3. Dental and tuberculosis clinics.
4. Baby welfare immunization clinic.

In the communicable disease control program, cases are reported by the private physician and the nurse visits the home. Homes are placarded according to State law, and certificates are given school children which permit re-admission after the isolation period.

The tuberculosis program includes a diagnostic daily clinic, one evening clinic, Patch test once a week, and children's X-rays weekly. The nurse keeps accurate records on all cases. X-ray reports are referred to the family physician. Follow-up contacts are done by the nurses. Institutional care is provided at the Contagious Hospital.

All public and parochial school pupils receive health services. In 1949, the school population was 16,878. The nurse is responsible for minor illnesses, injuries, and treatments. She is permitted to use her own judgment. Physicians are notified if there is an acute situation. Absences are cleared with principals, and if prolonged beyond three days, a home visit is made by the nurse.

Visual and auditory acuity tests are given by the teachers. Follow-up corrections are made by the nurses. Height and weight measurements are done by the nurses. How-

ever, teachers are responsible for the morning inspections.

Routine visits are made to school classrooms for the purpose of:

1. Nurse-teacher-principal conferences to discuss physical defects.

2. Environmental inspection.

3. Inspection for pediculosis and skin eruptions.

Sick children are taken home by the nurse if a parent is not available. During 1949, 13,085 physical examinations were given by the school physicians. There were 3,681 children with physical defects. Close follow-up with parents, and teachers resulted in correction of 2,624 physical defects, or 71.3%. Dental caries presented an outstanding health problem in all age groups. Home visits also included instruction to the parent regarding the child's illness.

Standard health records and day sheets are kept by the nurse.

For every registered birth in the city, the child welfare nurse makes a home visit. She inspects the eyes, nose, and throat, takes a culture, if necessary, and recommends immunization. The nurses are responsible for birth and immunization records. This is a clerical job which involves considerable expense in time and money.

The baby welfare clinic is held once a week for the purpose of toxoid immunization. Its policy is to serve

families who cannot afford to visit the family physician. However, there is no admission policy which seeks to determine who can pay and who cannot. Three thousand seven hundred ninety-two immunization treatments were given in 1949.

The genito-urinary clinic, which is subsidized by the State, holds treatment clinics twice a week. Infectious cases and source of contacts are visited by the epidermiologist. These cases may be referred by the physician, other State clinics, hospitals, or individuals.

There are no written standing orders nor is there a nursing manual. There is no regulation of bag technique, or contents of bag.

13. Area Served. These services are provided for Lowell only. All nurses are assigned to particular sections of the city.

14. Finances. All funds are provided by the City of Lowell. Reimbursements from the Federal and State governments are provided for the control of venereal disease. The mass tuberculosis control program is partially financed by a voluntary agency. Fees are expected from patients able to pay. The cost per capita for 1949 was $1.43.5. This figure has fluctuated very little over the last five years.

15. Personnel Policies. Each employee has civil service rating which includes the following:

Hours of work - 36 hours a week, 5 1/2 days
Vacation - 2 weeks a year
Sick leave - 12 days, accumulative to 60 days

All personnel, with the exception of the school nurses, work the full calendar year.

An employee may retire at 55 and must at 70.

There is no policy regarding reimbursement for overtime. Personnel salaries do not meet accepted standards.

The Lowell Health Department has reason to be proud of its vital statistics as they compare favorably with those of the Commonwealth of Massachusetts and those of the United States. Concentration on sanitation and food inspection in conjunction with the health program has resulted in a reduction of high mortality and morbidity rates among infants and children. Another important factor is the notable contribution the family physician has made and is making in the pediatric field. In 1949, there were only 53 deaths from tuberculosis. Statistics in this city and throughout the Country show that birth rates are declining, and the population is aging. Mortality rates from cancer and heart disease are increasing.

Ten school nurses serve a population of 16,878. The National Organization for Public Health Nursing recommends a ratio, 1-1800, for school service. According to these figures school nurses are carrying an average load.

Duplication of service is evidenced by the neonatal visits of the health department nurse and the visiting nurse. This is also the situation of a child or an adult ill with a reportable communicable disease needing bedside care. Both organizations provide a Well Child Conference. The health department specifically operates for immunization; the Visiting Nurse Association for immunization and health supervision. The year 1949 showed 3,792 babies inoculated by the health department.

As a result of this study the following recommendations are submitted:

1. It has been previously stated that salaries are low. The board should study the salary schedules in other communities of similar size in terms of program and personnel. The cost per capita necessarily will be increased proportionately.

2. With a staff of this size, the board should create the position of Supervisor. The appointment should be made on the basis of accepted standards for public health nursing. This should not be a political appointment.

3. Staff morale is vital to any organization and should be maintained on a high level. To this end, the writer recommends that school nurses should be employed on a yearly basis. This would call for a definite salary adjustment.

4. Personnel policies regarding vacations should be adjusted according to tenure of service, until the generally accepted four-week maximum has been reached. This policy should cover all employees.

5. The board would do well to make a plan for expanding the present crowded clinics and nurses' quarters.

6. The clerical office is understaffed. It is important that an additional clerk be employed.

7. There should be written standing orders for all divisions of the department which should be available at all times.

8. Nurses visiting in the homes and schools should carry a completely fitted regulation bag. There should be uniformity in regard to bag technique.

9. The board should give serious consideration to the total program on a generalized basis. Setting up districts for the nursing personnel would offer to the community an outstanding service.

10. The board of health membership should be increased to at least five.

11. Every modern health department employs a sanitary engineer. The Lowell Health Department needs at least one sanitary engineer.

LOWELL VISITING NURSE ASSOCIATION

Classification of visits-1949.

Morbidity service----------------------27,155

Communicable Disease service------------ 468

Antepartum service--------------------- 1,699

Postpartum service--------------------- 1,994

Newborn service------------------------ 1,382

Baby Welfare service------------------- 1,874

Not at Home service-------------------- 106

Appointment service-------------------- 405

Social Service------------------------- 184

Total----------------------------------35,271

Cost-----------------------------------$1.65.5

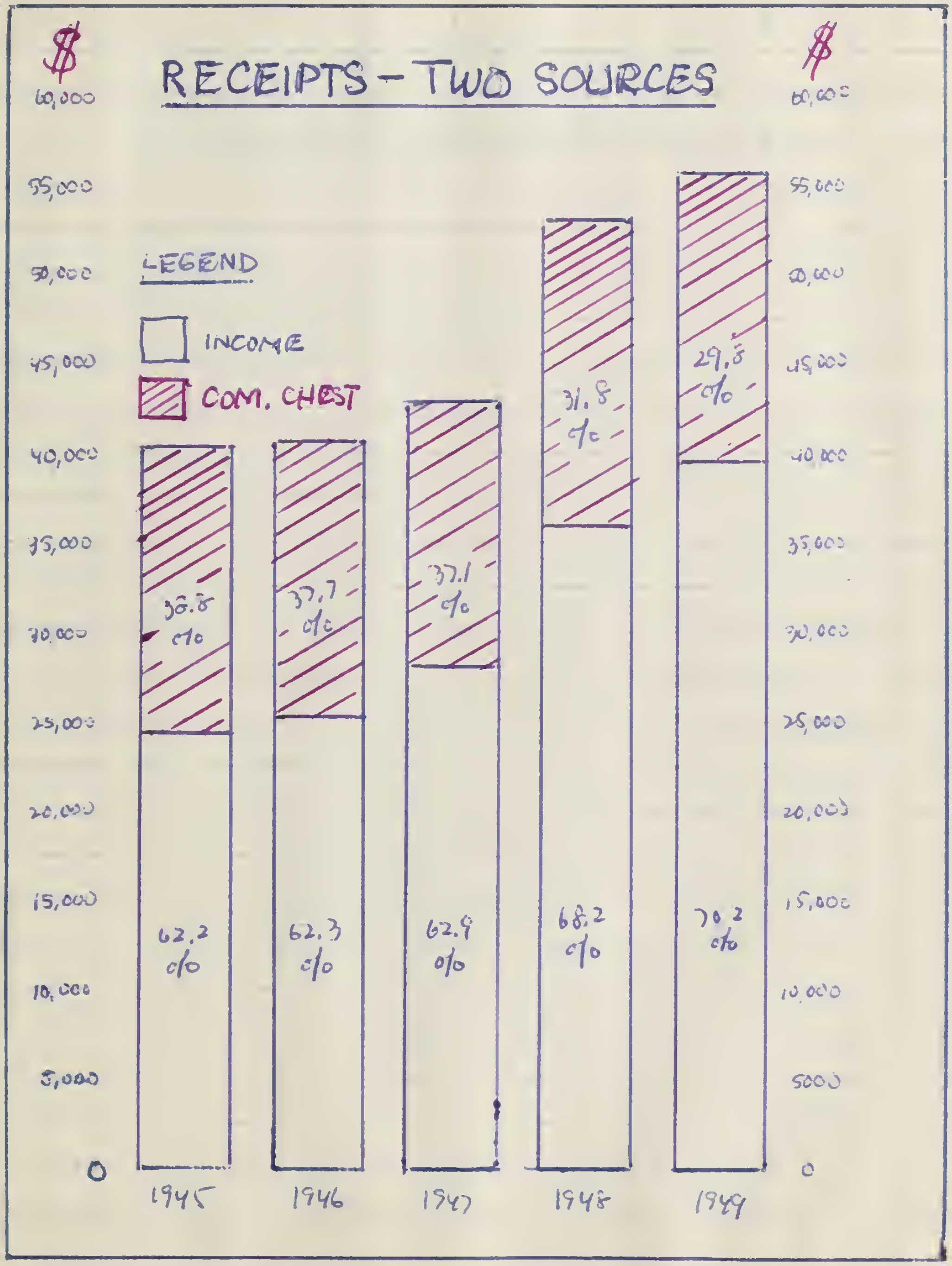
Patients Admitted---------------------- 4,034

Patients Discharged-------------------- 4,010

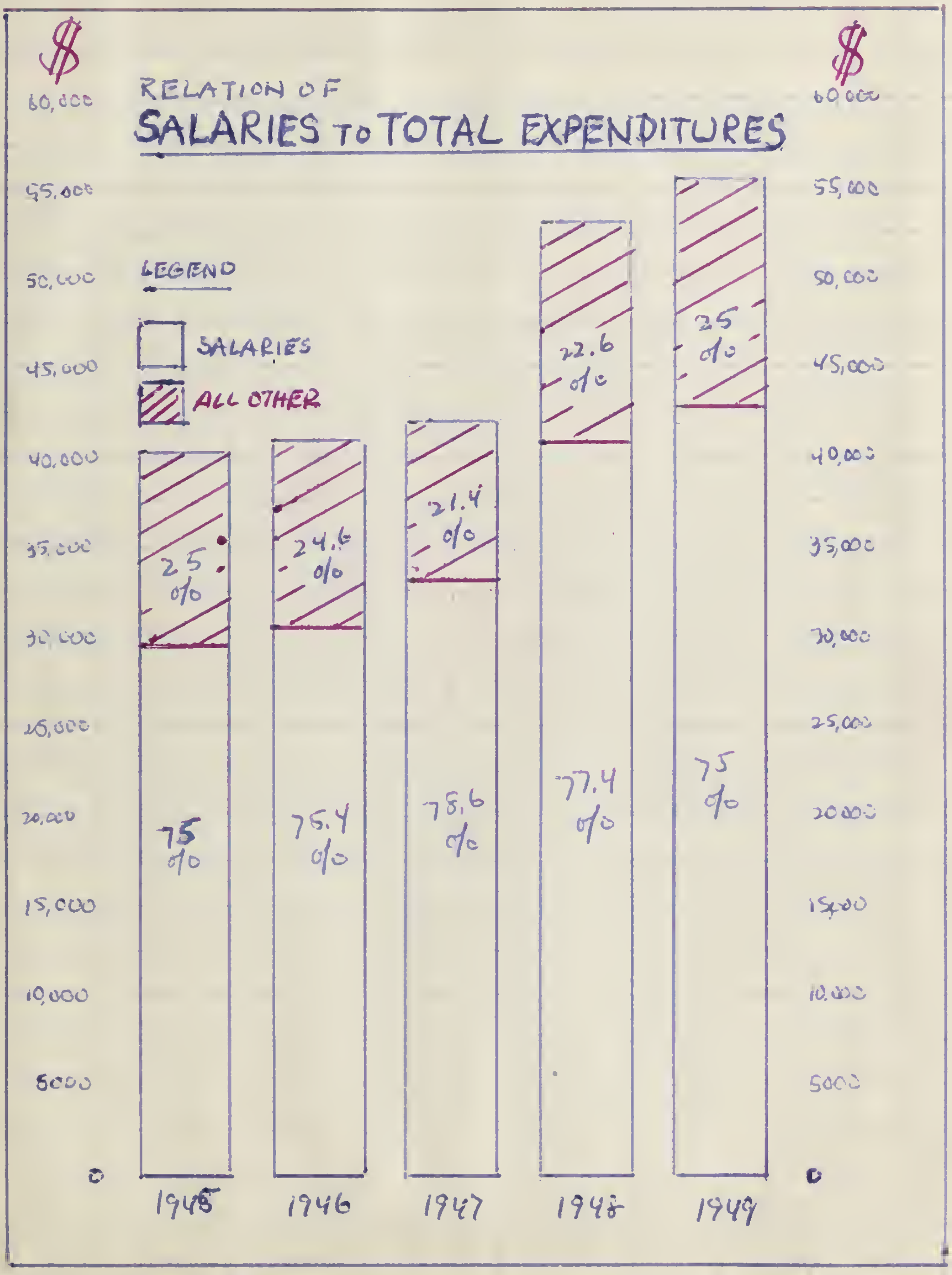
Percentage of income from patients-1945-1949.

	1945	1946	1947	1948	1949
Paid	53	55	54	52	44
Part Paid	27	29	29	32	40
Free	20	16	17	16	16

LOWELL VISITING NURSE ASSOCIATION



LOWELL VISITING NURSE ASSOCIATION



LOWELL HEALTH DEPARTMENT

Budget-1949.

Board of Health	$ 2,310.00
Administration	$ 19,713.45
Tuberculosis Control	$ 16,699.41
Child Welfare	$ 10,038.72
Milk Division	$ 6,562.28
Sanitary Control	$ 17,377.85
School Health Service	$ 31,174.97
Bacteriology) Vaccine) Animal inspection)	$ 2,090.57
Janitor service	$ 3,563.17
Building maintenance	$ 1,098.52
Genito Urinary	$ 7,261.96
Mass X-Ray	$ 4,439.69
Reimbursement for Contagious Hospital	$ 23,093.46
Total	$145,548.36

CHAPTER V

SUMMARY AND CONCLUSIONS

The public health nursing program in the Greater Lowell area shows that 53 nurses are engaged in some type of health program. They are distributed in the following manner:

Lowell Visiting Nurse Association	15
Lowell Health Department	20
Lowell Industrial Nurses	14
Public Health Nurse, Dracut	1
Public Health Nurse, Tewksbury	1
Public Health Nurse, Chelmsford	1
Public Health Nurse, Westford	1
Total:	53

Of the above, 15 are engaged in a program of bedside care. The breakdown again reveals that for a ratio of 1-5,000, the present population requires 24.6 nurses, exclusive of Westford; on the basis of 1-2,000, 67.7 nurses, exclusive of Westford. Considering the population of Lowell one may see another breakdown of figures, 1-5,000, 20.2; 1-2,000, 50.2. Very few communities have been able to achieve this ratio. On the basis of recommended standards of the National Organization for Public Health Nursing, (1-5,000, exclusive of bedside nursing; 1-2,000, including bedside nursing), the figures show that Lowell and Greater Lowell are understaffed.

Limitations of each agency's program should be clearly defined in order to avoid duplication of services. This is

not the situation in the Lowell and Greater Lowell area.

The Visiting Nurse Association is limited to bedside care of the sick, supervision of ante partum and post partum patients, infants, and pre-school children. In the health department, the program is limited to acute communicable disease control, including tuberculosis, venereal disease, and also health supervision of all infants and school children.

Duplication of services exists in a community when more than one health agency operates on a limited program. The foregoing paragraph points out the duplication in Lowell.

A limited program reveals other serious problems. A nurse is delegated to carry out the functions of her agency. She is permitted to give service to certain members of the family. No one nurse in the community is responsible for the total family health. In Lowell public health nurses visit homes, schools, and clinics for specific purposes. No one nurse achieves the satisfaction of giving complete family health supervision, including bedside care.

It is agreed by public health authorities that a maximum of efficiency and economy can be accomplished through a generalized program. Any health factor, positive or negative, affecting one member, influences the whole family life. Total family care should be Lowell's desirable goal.

This type of plan requires coordination, integration

and possibly combination of the existing services within the local community. A plan for adjacent communities must be considered.

The recently published Greater Boston Community Survey, conducted by a committee of citizens, points out that no program of coordination in the complex field can be undertaken hastily. Success can come only through voluntary cooperation on the part of the agencies concerned, after an open-minded study of all the factors in a given situation.[1]

It has been pointed out that in the Greater Lowell area duplication of service exists. The Lowell Council of Social Agencies should form a planning committee. This committee should have broad representation of individuals vitally interested and concerned about the community's health. Members of this committee should form subdivisions and study other phases of health facilities. After all the data has been gathered the planning committee should consider an organizational plan for health agencies.

A committee representing National and Federal agencies concerned with public health nursing has agreed upon these recommendations:

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[1] Survey Conducted by Committee of Citizens to Survey Social and Health Needs and Services of Greater Boston, 1947-1949.

1. That each public health nurse combine the multiple functions of health teaching, prevention and control of diseases, and care of the sick.

2. That the committee should adopt one of three patterns of organization that will provide the type of service most feasible under local conditions. The organization patterns are:

a. All public health nursing service administered and supported by the health department. This is the most satisfactory pattern for rural communities.

b. Preventive services carried on by the health department, with one voluntary agency, working closely with the health department, carrying responsibility for bedside nursing and some special fields. At present this type of organization is usual in large cities.

c. A combination service which is jointly administered by representatives of both official and voluntary agencies, financed by tax funds, earnings, and contributions, in which field service is rendered by a single staff of public health nursing. Such a combination of services is especially desirable in medium-sized and small-sized communities. It provides more and better service for each dollar expended.

In conclusion, the writer has endeavored to evaluate

existing resources and needs in the public health nursing field of Greater Lowell. Some duplication and service gaps in the program are evident. Existing duplication on the one hand, and gaps in services on the other hand, are expensive, inefficient, and confusing. Even more serious is the effect of such a program in the quality of work performed. Careful consideration should be given to the advisability of forming a combination agency, jointly administered and financed by voluntary and official agencies with all field services rendered by trained public health nurses, working under supervision. This will give to the community a balanced public health nursing program to assure provision of adequate service to every citizen in the Greater Lowell area.

Suggestions for further study

1. A study of long-term illnesses with adults in relation to the cost to private and public agencies.
2. A study of illnesses in relation to children and cost to public and private agencies.
3. A study of the cost of illness in relation to all the agencies, public and private.
4. A study of the hospital facilities in relation to referral of cases and community needs.
5. A study of the clinical facilities looking toward the coordination and integration of the total health program.
6. A study of the accident prevention program in the schools, and agencies.
7. A study of the need for a child placement agency.
8. An investigation of the environmental sanitation program, including housing and plumbing.
9. A study to determine the needs of an educational program for geriatrics.
10. A study to determine the needs of an educational program for rheumatic fever.
11. A study to determine the need for a well-planned nutritional program.
12. A study of the industrial hygiene program in the community.

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APPENDIX

APPENDIX A

SCHEDULE FOR A SURVEY OF COMMUNITY NURSING SERVICE

Name of community County State
Name of agency
Community or communities and population served

1. History
   a. Year founded
   b. Date first nurse was employed

2. Organization
   a. Purpose as stated in legal code, regulations, or other form

   b. Name of governing body
      (1) Number
      (2) How chosen
      (3) Length of term of office
      (4) Meetings held how often

   c. List administrative units and title of head of each

   d. Is there a citizens' advisory committee? Number of members and what community interest or activity each represents

   e. Personnel

		Time		Under merit system
	No.	Part-Full	By whom appointed	
Health officers				
Physicians				
Epidemiologists				
Sanitary engineers				
Sanitary inspectors				
Statisticians				
Health educators				
Nurses				
Director and assistants				
Supervisors				
Consultants				
Staff				

Position	Number Employed	General Education	Advanced Education	R. N.	P.h.n. Exp.	% Present Staff
Nursing staff						
Director						
Assistant director						
Educational director						
Special supervisor						
General supervisor						
Staff nurses						
Others						
Other professional workers in nursing unit						
Registrar						
Statistician						
Nutritionist						

(b) How many members of your professional nursing staff are members of
the American Nurses' Association
National League of Nursing Education
National Organization for Public Health Nursing

(c) Is there an organized plan for staff education

(d) Does the agency provide field experience in public health nursing for students

(2) Non-professional staff in nursing unit

Type of worker	Number in nursing unit (Give date)	To whom responsible (Give title)	Average hours of service per worker per year
Paid			
Clerical			
Non-nurse auxiliary			
Other			
Volunteer			
Clerical			
Non-nurse auxiliary			
Other			

d. Personnel policies. What are the general policies concerning:

f. Is the nursing service administered as a separate unit   Combined with other unit or units   Describe

3. Administration of nursing service
   a. Offices
      (1) Location of main office
      (2) Number and location of district offices

   b. Finances of nursing unit
      (1) Income $ Year
         (a) Receipts from tax sources $
         (b) Receipts from voluntary sources
         (c) Fees from patients
         (d) Other (specify)

      (2) Disbursements $
         (a) Salaries (total) $
            Nursing $
            Clerical
            Others (specify)

         (b) Transportation
         (c) Nursing supplies and equipment
         (d) General office expense (total)
         (e) Other - general

      (3) Budget $
         How is it planned

      (4) Cost and charges for service
         Has the cost per unit of nursing service been computed   If so, what is it
         Is there a charge for service   ,if so, what is it per unit of service

   c. Staff
      (1) Professional
         (a) Present requirements for appointment to various positions.

(1) Nurses' hours on duty per week
(2) Full day Half-day
(3) Salaries
(4) Transportation
Number of nurse-owned cars Number agency-owned cars used by nurses If nurse owned, reimbursement to nurse
Does health department reimburse for street car fares

(5) Standing orders and manual
Does the agency have standing orders Approved by what medical group
Does the agency use a nursing manual Prepared by whom

(6) Records and reports
(a) Records
How is number of nursing visits per year ascertained

What use is made of social service exchange information

What kinds of records are kept in family folders

How are data about cases with economic or social problems entered

What facts are routinely secured from dismissed cases

What special studies have been made involving nursing material in past three years

e. Nursing program
(1) Report of fiscal year ending
(a) Field services

Kind of Service	Does program incl. this service		Give the amount of service for the year ending 19		
	Instruction and health supervision	Nursing care	No. cases	No. nursing visits	No. nursing visits per case
Non-communicable disease					
Communicable diseases					
Acute communicable disease					
Syphilis and gonorrhea					
Tuberculosis					
Crippled children's service					
Maternity					
Antepartum					
Delivery					
Postpartum					
Health supervision					
Infant (up to 1 year)total					
Preschool					
School					
Adult					

(2) Does this agency provide specialized tuberculosis service

(3) Does this agency provide school nursing

(4) Are any services given special emphasis through a special program or a special worker

Mental hygiene	Orthopedic
Nutrition	Other

(5) Type of case not admitted but referred to other agencies

(6) Medically conducted health conferences and clinics

(7) Is there a continuous public information program for interpreting the work of the agency to the community

Who is responsible for it

f. Community relationships
  (1) Groups
    Council of social agencies
    Health council
    Nursing council
    Others

(2) Describe any plans for cooperation between the public health nursing service of the health department and local organized professional groups, such as medical and dental

(3) What is the policy as to nursing visits to patients of midwives, chiropractors, and osteopaths

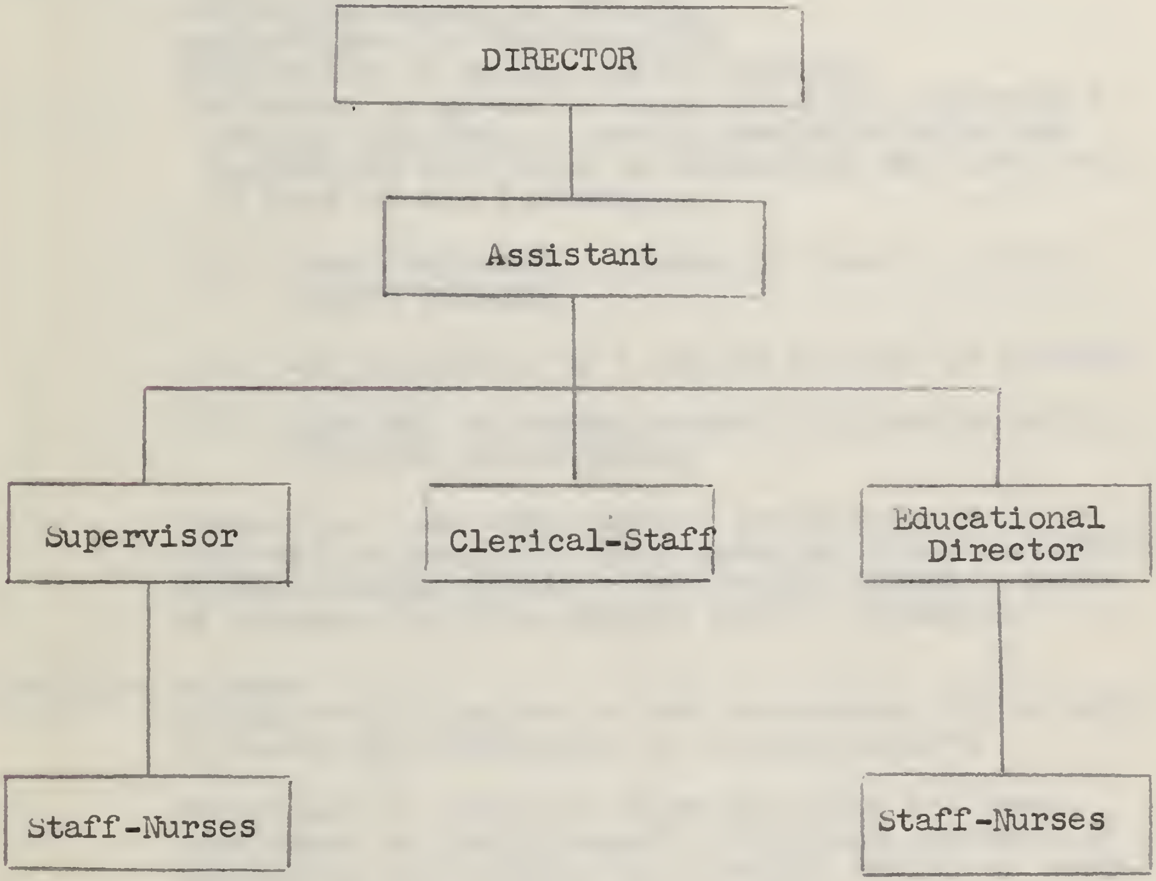
(4) Joint staff meetings Specify with which agencies and give the number held with each during the past year

(5) Joint case conferences and use of social service exchange
  (a) Does the health department register cases with the social service exchange
  Does the health department clear cases with the social service exchange
  (b) Number of conferences in past year with agencies actively interested in the same cases to plan for patient or family
  (c) Agencies in the community joining in such case conferences

g. Unmet needs
  (1) The unmet needs for nursing service as evidenced by requests for services which this agency could not meet or refer to other agencies
  (2) Are reports on referrals provided directly to the referring agencies

APPENDIX B

DIAGRAM SHOWING RELATIONSHIP OF PERSONNEL TO DIRECTOR



Ratio 1 Supervisor to 10 Nurses.

APPENDIX C

VISITING NURSE ASSOCIATION OF BOSTON

Personnel Policies
for
Professional Staff

Requirements for Appointment

Staff Nurse-

High School graduation
Accredited school of nursing
Registration in Massachusetts
Preparation in public health nursing
Preference is given to those who have completed a program of study in public health nursing but applicants will also be considered who have one or more of the following:

a) have completed a course of study in public health nursing

b) are graduates of a degree program in nursing

c) have had an undergraduate affiliation with a visiting nurse agency

Nurses who come with partial preparation will be expected to complete the program of study in public health nursing within a reasonable period. Leave of absence for this purpose may be arranged.

Nutrition Worker-

Baccalaureate degree in home economics with a major in foods and nutrition, or its equivalent.

Preference is given to those who have had some experience as nutritionist, dietitian, teacher of nutrition, or training in a public health or social agency, a food clinic or hospital.

Hours

8:30 a.m. to 5:00 p.m. five days a week, with 45 minutes for lunch. Lunch hour counted from time of leaving last case. Time off is to be planned by the supervisor and may be any day in the week.

New Worker

A new worker is entitled to a day off only if she works

the entire week in her first week with the Organization.

Termination of Service

When a worker leaves the Association she may have a full day off duty only if she works the entire week.

A staff nurse or nutritionist is expected to remain with the Association at least one year after coming on staff. If she leaves inside of a year, her salary is adjusted to that of a substitute as of the date she joined the staff.

Workers shall give at least a month's notice when desiring to resign and will receive the same notice if requested to withdraw from the Association.

The retirement age for all members of the staff is at 60 years of age.

Holidays

The following legal holidays will be granted:

February 22
April 19
May 30
July 4
Labor Day
October 12
November 11
Thanksgiving
Christmas
New Year

No additional time will be given during a holiday week.

Sunday and Holiday Work

Nurses rotate on Sundays and holidays and the time worked will be made up to the nurse hour for hour.

Vacations

A worker at the end of 11 months of continuous service with us will be entitled to 20 working days vacation with pay (a total of four weeks including Saturdays and Sundays). Vacations are scheduled by supervisors and must be taken between May 1 and November 1. No vacation can be planned during the winter months.

A permanent worker who has been on the staff less than 11 months prior to July 1st will be allowed during the first summer 1½ days vacation for each full month of service up to July 1st provided however if she leaves before completing 11 months of continuous service she will reimburse the Organization for her vacation.

A worker leaving after 11 months of continuous service will receive 20 working days vacation plus one and one half days additional for each additional full month of service.

Requesting Pay Checks

Salary checks will be paid on the last day of the month as usual and will be mailed if a forwarding address is left with the bookkeeper. We cannot as a general rule

pay nurses in advance for their vacations and if for any reason staff request advance payment, the bookkeeper must be notified two weeks in advance of vacation date.

Salary

Salary will be paid monthly on the last day of the month, by check.

Salaries for staff nurses are set up with a minimum and maximum in each of the three following grades:

1. Nurse with no preparation in public health nursing or an undergraduate affiliation only.
2. Nurse with partial postgraduate preparation in public health nursing or college degree but no preparation in public health nursing.
3. Nurse with full postgraduate preparation in public health nursing or with a degree from a basic university course which includes public health nursing.

Salaries for all other workers are set up with a minimum and maximum.

Annual increments for staff are at the rate of $100 per year, payable after the worker has been with the organization a full year.

Salary increases for supervisors are based on degree of responsibility educational background and contribution to the agency.

Illness

In case of illness leave with salary is allowed to the extent of ten working days during the calendar year, and one day a month will be allowed in the first year if the worker has been with the Association less than ten months. This time may accumulate so that in each successive year the total allowance will be ten working days plus any number of days up to ten which were not used in the previous year only. The Association reserves the right to ask a worker to consult a physician at any time, and to discontinue service if it seems to be too strenuous for her physically.

Staff members are expected to remain off duty when ill. When a staff nurse or nutritionist is off ill she is to report by telephone to her district supervisor at 8:30 a.m. informing the supervisor as to the probable length of illness and the cases which must be seen, and giving her discharged and new cases. If she is to be off ill more than one day her records are to be mailed to the supervisor immediately. Day sheets should be sent to central office immediately.

The Organization likes to know that its members are receiving adequate medical and nursing care during illness and will give nursing service free to all its members living in Boston.

Usually the nurse's bag should be returned to the district office immediately, but if the nurse is to be off duty for only a short time the supervisor may give her permission to keep the bag until her return.

In most instances it should be possible for a worker to let her supervisor know in the late afternoon whether or not she plans to return on duty in the morning.

The staff will be expected to keep the supervisor or central office informed as to her condition in order that a plan of work may be made.

If a supervisor is off ill she is to report directly to central office.

Leave of Absence

By "leave of absence" is meant any absence for any period during which the employee would in normal course be expected to work. Deduction, therefore, would be made on the basis of 1/261 of the annual salary for each full day's leave of absence.

Permission for leave of absence for any reason is to be requested from central office. When possible it should be requested well in advance in order to make plans for the district. Any absence other than illness should be reported to central office at once, by telegram if necessary. Leave of absence in addition to vacation cannot be planned during July or August.

Study-

Leave of absence for study will be granted according to the length of time requested and the needs of the Association. Ordinarily a worker asking for more than four months leave for study will be asked to resign and re-apply.

Illness in family-

Leave of absence to care for members of a worker's family who are ill will not be granted except in unusual circumstances by special permission of the Director. A short leave may be given to allow a worker to make plans for adequate care.

Death in family-

Three days leave of absence with pay will be given any worker who has a death in her immediate family. Absence for funerals other than in immediate family will be deducted.

Physical Examinations

A physical examination is made every other year at the expense of the Association by a physician appointed by the Association and a written report will be sent to each worker following the examination.

The entire staff is expected to have this physical examination even though they are being followed by their own physician. If any of the staff though they are being found refusing examination by the staff physician, no sick leave with pay is granted.

The entire staff is expected to have x-rays at intervals and arrangements for these x-rays will be made by central office with the Health Supervisor.

Arrangements are made through central office for any of the staff who desire to have typhoid inoculations annually.

Maternity Leave

Staff workers who are pregnant may work through the fifth month provided central office has written permission from the obstetrician. We will not consider re-employing a worker until three months following delivery.

Opportunities for Study and Advancement

While it is not possible to enroll for daytime courses in public health nursing while working, opportunities are available for taking evening courses in the fields of general and nursing education.

Promising staff nurses who meet the necessary qualifications and have demonstrated their ability may be considered for positions of increased responsibility such as student advisor, assistant supervisor and supervisor. Openings with other public health nursing agencies are frequently available for the experienced nurse.

Retirement Plan

After three years employment every employee is eligible to participate in the Harmon retirement plan. This is a joint contributory plan and will be deducted monthly from the payroll.

Insurance

Hospital insurance-Blue Cross, and insurance for medical and surgical care- Blue Shield, are available to our staff. Payment for participation in this plan is made through monthly payroll deductions.

Addresses and Telephone Numbers

It must be possible to reach every staff member by telephone, either through one of their own or a neighbor whom we may feel free to call at all times.

Office telephones may be used for only a limited number of personal telephone calls. The staff member is to reimburse the Association for these calls. Since the office telephone should be kept free for business calls, personal conversations must be brief.

It is essential that the correct address and telephone number of each member of the staff be on file in the district and central office and it is the responsibility of each staff member to notify central office immediately in writing, or Form 29, whenever there is a change.

As a protection to the staff, central office will not give out any telephone numbers or addresses to people who request it. It is impossible for us to know to whom staff members would like to have us give their telephone number and address. We will give them your district office telephone.

Delivery Service

Every nurse is required to take four months on delivery service. This time may be a straight four months or broken periods depending on the needs of the service. For further information on policies relating to delivery service see the Delivery Routines in the Office Manual.

District Changes

Staff members are placed in the districts according to the needs of the districts and may expect to be transferred at any time. All staff members are expected to relieve in rotation for one or more days in districts where they are needed.

Transportation

Carfare or mileage is paid to staff members while carrying on district program. Mileage is only paid to staff members after consultation with central office. Carfare and mileage are not paid members going to and from work to their houses or to meetings other than staff meetings.

Equipment

Any article belonging to the Association which is lost or broken is to be replaced by the nurse or nutritionist.

Time for Attending Meetings

Up to one day a year is allowed on Visiting Nurse Association time to attend professional meetings. The supervisors are responsible for keeping track of this time.

Funds

There are two small funds--the Mrs. Arthur T. Lyman Fund (for nurses only) and the Good Luck Fund--available on vote of the Field Work Committee to workers who have been ill and are in need of financial assistance.

There is a small scholarship fund which is entirely a loan fund from which a worker may borrow to help with getting further education in the public health nursing field.

Accepting Gifts from Patients

In general, it seems a wiser policy not to accept gifts from patients to an individual nurse.

Gifts of money, in particular, should not be accepted. If the patient is insistent the suggestion could be made that the money be given to the Association as a contribution to the work. It is then forwarded to central offices and an acknowledgment is sent to this patient.

An occasional exception may be made if it is a simple gift such as a box of candy or some handmade article that the patient has made particularly for the nurse.

Eating in Districts

It seems best for nurses not to eat or drink in patients' homes for the following reasons:

1) It takes time out which should be spent in visiting.
2) It sometimes does not look well and lays us open to criticism
3) For hygenic reasons there are many homes where we would not want to eat

Therefore, this policy has been made for the nurse's own protection and to make it easier for her to refuse in instances where she would prefer not to.

An occasional exception may be made for a cup of coffee or tea on a very cold day, or iced drink on a hot day.

Staff members may go to a drugstore or restaurant for hot or cold drink if they are tired or hungry. This may not be done in a group except during the regular lunch hour.

These policies are being revised as of July 1, 1950.

APPENDIX D

VISITING NURSES ASSOCIATION OF BOSTON

Salary Schedules -- November 1, 1948

	Minimum	Maximum
Staff.....with school of nursing preparation only, with or without undergraduate affiliation..............	$2200	$2300
With four months preparation in public health nursing or with college degree without public health nursing preparation.........	2300	2800
With nine months preparation in public health nursing or with college degree and public health nursing preparation...............	2400	2900
Physical Therapist.........................	2400	3000
Attendants.................................	2000	2200
Substitutes................................	2100 (without prep)	2200 (with p.)
Assistant Supervisors......................	2800	3000
Supervisors................................	3000	3400
Nutritionists-		
College only............................	2300	2800
College plus experience.................	2400	2900
Non-Nurse Physical Therapist................	2300	2800

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