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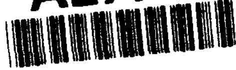

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A STUDY OF THE ROLE OF THE ARMY HEALTH NURSE IN THE INFANT AND PRESCHOOL PROGRAM IN THE UNITED STATES ARMY

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by

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Submitted as a Small Study in Partial Fulfillment of the Requirements for the Degree of Master of Public Health
University of Minnesota

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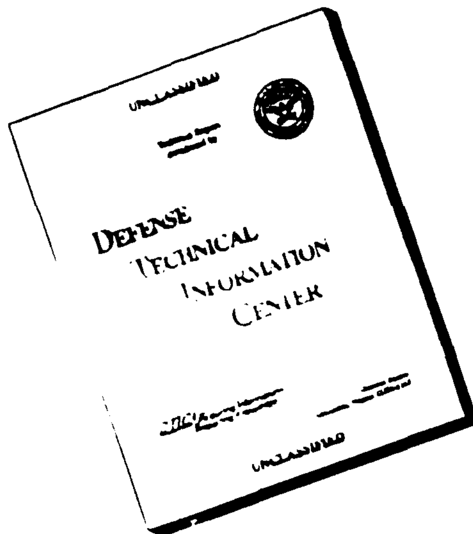

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TABLE OF CONTENTS

	Page
PREFACE	iii
LIST OF TABLES	iv
LIST OF ILLUSTRATIONS	v
Chapter	
I. INTRODUCTION	1
Statement of Problem Studied	3
Reasons for Selecting Problem	3
Objectives	4
Limitations of the Study	5
Definition of Terms	6
Method of Procedure of Study	6
II. REVIEW OF LITERATURE	10
III. ANALYSIS OF DATA	17
IV. SUMMARY AND CONCLUSIONS	43
Summary	43
Conclusions	44
Clinics	44
Home Visits and Other Activities Relating to Infant and Preschool	49
General Information	51
V. RECOMMENDATIONS	52
APPENDIX	54
BIBLIOGRAPHY	60

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PREFACE

As an Army Health Nurse in the U.S. Army Nurse Corps, the writer undertook this study because of the comparative recency of such a program being incorporated in the Army Nurse Corps and Preventive Medicine Section.

The research presented, represents an investigation of the different methods the Army Health Nurses throughout the United States are using in organizing their health services. It is hoped that some sort of standardization in one service she offers, that of the infant and preschool program, may be arrived at through this study.

The writer wishes to extend her sincere appreciation to Miss Marion Murphy, Professor and Director, Program in Public Health Nursing, University of Minnesota, whose guidance and encouragement have been invaluable in the preparation of this paper. She also wishes to acknowledge her appreciation for the suggestions offered by Helen Wallace, M.D., Professor, Maternal and Child Health, School of Public Health, University of Minnesota; Karl L. Lundeberg, M.D., Commissioner of Health, City of Minneapolis, formerly Colonel, Medical Corps, U.S. Army, Preventive Medicine Officer, Retired; Agnes Maley, Colonel, Army Nurse Corps, Chief Nurse Headquarters Command Areas; Gladys Hanes Thomas, Colonel, Army Nurse Corps, Chief Nursing Service, U.S. Army Hospitals, Reserve Component.

LIST OF TABLES

Table		Page
1.	Response of the Group Questioned	17
2.	Clinics in Which the Army Health Nurses Participate.	18
3.	Facilities Available for the Infant and Preschool Child.	20
4.	Referrals to Local Health Departments for Babies Living Off the Post	28
5.	Army Health Nurse Supervision.	34
6.	Supervision Given to Facility by Nurse (Ranked in Order of Frequency)	35

LIST OF ILLUSTRATIONS

Figure | Page

1. Approximate Number of Deliveries per Month per Installation. 25

2. Operation Span of Army Health Nursing Programs in U.S.A., 1950-1957 40

14

patient load she may have to handle. The National Organization for

CHAPTER I

INTRODUCTION

The advent of the Army Health Nurse into the generalized medical program of the Department of the Army came as a need arose for continued service to the members of the armed forces and their families. The program, now a part of army regulations dated June 27, 1950, is under the Preventive Medicine Section of the Medical Corps.

> Preventive medicine is no longer concerned exclusively nor primarily with the control of communicable diseases as it was previously known. Tangible proof of the coming of age of preventive medicine as a section of medical practice is the formation in 1948 of the American Board of Preventive Medicine and Public Health to function parallel to the specialty boards in surgery, medicine, pediatrics, etc. It is the total of all the services required to prevent disease and keep people in good health. It has come to concentrate more on those diseases which undermine human efficiency, which maim and incapacitate rather than kill.[1]

This Preventive Medicine Section on any army installation is comparable to a local health department organization. The Army Health Nurses are public health nurses under the supervision of the Preventive Medicine Officer and/or area surgeon and are administratively responsible to the chief nurse of the hospital. Their programs are patterned after a generalized family health service in civilian life. They are qualified by virtue of education, training and experience in the field of public health. It is their job to maintain the level of individual health within a military installation by rendering service to individuals, families and community.

The scope of the program is varied. It includes, where possible,

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[1]Report given at the Preventive Medicine Institute, Walter Reed Army Medical Center, Washington, D.C., Sept. 1952.

approach to child care and family relationships. She feels that

a generalized field of health education, maternal and child health, school health, contagion, etc., to mention a few. To explain this further and so give a clearer picture of her activities we could say:

1. The Army Health Nurse assists in the prevention and control of communicable, infectious and crippling diseases by case finding and reporting.

2. She teaches and counsels in family health such as maternal and child health classes, demonstrations, group discussions, interviews, and conferences; also infant and child health conferences, home visits, and school health programs.

3. She maintains a close liaison with the school nurse if there is one and is recognized by the local and state agencies, and attends meetings and institutes at the local and state level.

4. She assists in solving physical, emotional and economic problems affecting family health and welfare by arranging, through the medical officer, proper treatment or referrals to appropriate agencies on or off the army installation, such as city health departments, university medical clinics for evaluations, heart associations, cerebral palsy societies, multiple sclerosis foundations, etc.

5. She gives or arranges for the administration of medications and treatments prescribed by the attending physician.

6. She evaluates home situations for nursing care in the home as well as premature infant's care in the home.

7. She maintains records of care given, which are available to the attending physician on request.

8. She participates in community organizations and conferences in view of developing her program.

Introducing to other clinic workers patients coming to the

The Preventive Medicine Section maintains a liaison with the state health department in said state and participates in programs such as immunizations for poliomyelitis. It also shares in the educational drives of other agencies such as Diabetic Detection Week, the activities of American Cancer Society, community programs for exceptional children, etc. The Army Health Nurse's program may be enlarged to include the field of geriatrics and cardiac patients.

This is her scope. How the program is carried out depends upon individual differences of persons involved, such as the Post Surgeon, Preventive Medicine Officer, Chief Nurses, and Army Health Nurses of the various installations. There may be one or two nurses assigned to duty depending upon the size of the installation; however, there are still some posts that do not have any Army Health Nurses assigned.

Statement of Problem Studied

Working in the capacity of an Army Health Nurse since 1951, the writer found that, of the three programs which she had organized, no two were alike. It is with much interest that the writer is pursuing this small study on the role of the Army Health Nurse in the infant and preschool program.

Reasons for Selecting Problem

Because of certain restrictions, there is much variability in the services the Army Health Nurse may offer. Some of these are: To whom is she administratively responsible for assignment? Is there a pediatrician assigned to the installation? If the obstetrical cases do not deliver at the installation to which she is assigned, how can

she best coordinate an infant program? How much knowledge does the medical staff have of the services the Army Health Nurse may offer? These questions could go on, but illustrate problems affecting the service of the Army Health Nurse.

The writer feels that if questions were directed to the various installations that have Army Health Nurses throughout the United States, with questions relating only to one field of all the services she offers, that perhaps some conclusions might be reached as to the fundamental principles of its organization.

The planning for an adequate Army Health Nursing service is dependent to a great extent upon how the nurse's time is expended in the various services she offers. Therefore, it would seem important to study how one of these services functions, namely the infant and preschool program.

Objectives

To secure information relative to the following:

The role the Army Health Nurse plays in the organizational structure of this installation in terms of the infant and preschool program.

The facilities made available for the care of the infant and preschool child.

The organization of facilities for the infant and preschool child and their function.

The Army Health Nurse as a clinic participant and a non-clinic participant.

The method by which the immunization program is conducted and

TABLE 2

its continuity.

The supervision the Army Health Nurse gives to the nursery school, baby sitting service, or other infant care facilities.

The criteria used for selection of cases needing special attention, such as home visits.

The method of referral used.

Knowledge of available community facilities as resources for referrals.

The field of service in which the Army Health Nurse feels her program to be most effective.

Limitations of the Study

The writer had hoped to include the services available for the exceptional child, how they were organized and their functions. In order to get a better picture of why certain facilities were not offered at the installations, at first it seemed necessary to direct a questionnaire not only to the Army Health Nurse but to the Chief of Nursing service, and Preventive Medicine Officer and/or Post Surgeon of the installations. Furthermore, the physical organization of the hospital should have been included to give a more complete picture of each installation as a community.

To have added all this to my study would have indeed made it too involved for the time allotted and too complex a questionnaire. It is hoped that the experience in working on this paper will in some way be of help to the Army Health Nurses, and perhaps, may motivate someone to continue the study for individual services, whereas time did not permit me to do so.

19

Fourteen answered the question in the affirmative; eight in the

Definition of Terms

Liaison - that contact or intercommunication maintained between parts of an armed force to insure mutual understanding and unity of purpose and action.

Installation or Post - a military installation or location at which troops are stationed. A post may be a camp, depot, fort, hospital, proving ground, station, arsenal, air base, air field, etc.

Non-clinic participant - one not taking an active part in clinic functions.

Referral - a two way exchange system of information between two or more individuals of two or more agencies interested in providing continuity of patient care.

Army Health Nurse - a commissioned officer of the Army Nurse Corps, why by virtue of previous experience and training in public health nursing, provides public health nursing services to the soldier and his dependents in residence on an army installation or a specified area in square miles of an army installation.

Medical specialist - an enlisted man who was trained at a service school and who is assigned to the Army Medical Service to serve in a medical element assigned, attached, or in support of a combat unit.

Surgical technician - an enlisted person doing work requiring special training in surgery.

Preventive medicine officer - a medical officer who is attached to a military command to supervise the sanitary arrangements of the command and the measures that are taken to prevent the spread of disease. He is an assistant to the surgeon of the command.

Surgeon - a senior medical officer in charge of the medical detachment or unit of a military organization or station. He is usually a staff officer and he advises the commander on medical matters.

Area Command Headquarters - The United States Army Headquarters areas are divided numerically into 1st Army, 2nd Army, etc., through 7th Army. In each army area is a representative Headquarters Company for all army sections, which acts as an administrative body over all army installations in that area.

Method and Procedure of Study

The professional group, to which the questionnaire is directed,

and preschool child on your post?" "Facilities" as used here,

consists of some thirty-five Army Health Nurses throughout the United States, or more simply to the Army installations having an Army Health Nurse assigned to them.

Perhaps, to have a more complete study, it would have been better to make a direct survey by observation of each of these installations, or by the study and summarization of monthly reports sent in by Army Health Nurses to Area Command Headquarters, but this would have presented time limitations as well as financial difficulty.

Setting up the procedure for this study has taken some five months. It was difficult to decide which one of the many services the nurse offers should be studied and to whom to direct the questions. As was previously stated under the limitations of the study, it was thought that possibly the service to the exceptional child in the infant and preschool group could be included. Also that the questionnaire could be sent to the Chief Nurses, Preventive Medicine Officers, and/or the Surgeon of these installations. Conferences with the faculty advisor proved the study to be too inclusive and it was evident that there would have to be definite limitations.

The present questionnaire, after much consolidation, was sent by mail. Both the closed question, which is in effect a check-list, and the open-end question technique were utilized.

Assistance for pretesting the questionnaire was generously given by several individuals in related fields of Maternal and Child Health as well as the Preventive Medicine Section. They are:

Helen Wallace, M.D., Professor, Maternal and Child Health, School of Public Health, University of Minnesota.

Karl L. Lundeberg, M.D., Commissioner of Health, City of Minneapolis, formerly Colonel, Medical Corps, U.S. Army, Preventive Medicine Officer, Retired.

Agnes A. Maley, Colonel, Army Nurse Corps, Chief Nurse Medical Section Headquarters Sixth Army, Presidio of San Francisco, Calif.

Gladys Hanes Thomas, Lt. Colonel, Army Nurse Corps, Chief Nursing Service, U.S. Army Hospitals, Retired.

Mercedes Fischer, Major, Army Nurse Corps, assigned for study at Johns Hopkins University for the Degree of Master of Public Health.

Jane McNeil, Captain, Army Nurse Corps, assigned for study at the University of Minnesota for the Degree of Master of Public Health.

The aforementioned individuals, with the exception of Dr. Wallace, from whom much assistance was obtained, were selected because of the direct supervisory and administrative contact each has with the Army Health Nurse in the organizational arrangement. Dr. Wallace's assistance was prevailed upon from the pediatrician's point of view.

It was found that some questions could be more inclusive and rewording them resulted in changing the code and tabulation method. Suggestions for rearrangement of questions, word changes, and sentence structure for clarity were offered from those persons whose opinions were being solicited. The questions were felt to adequately represent the objectives which had been set up for the study.

The questionnaires with the covering letter explaining the purpose of the study were then mailed out to the thirty-five Army Health Nurses within the continental limits of the United States.[1]

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[1]See Appendix for questionnaire and letter.

Two weeks after the questionnaires were sent out about two-thirds of the replies were in. A follow-up letter[1] was sent out to those that did not respond initially. It is gratifying to report that all but one questionnaire were returned.

The analysis of the data compiled from the questionnaires forms the basis of this study of "the role of the Army Health Nurse in the infant and pre-school program."

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[1]See Appendix.

CHAPTER II

REVIEW OF LITERATURE

Although no studies or materials were available relating specifically to the role of the Army Health Nurse in the infant and preschool program, a number of articles have been written for public health nursing in this field. The objectives and principles are the same even if situations are variable.

At the present time two Army regulations outline and define the nurses' qualifications and duties in infant and preschool health. In the first army regulation, dated June 27, 1950, it outlined general information on the Army Health Nurse, her responsibility, administration, qualifications, and the records she will maintain. In stating her responsibility as to the service she will give the infant and preschool child, we note:[1]

> Supervising child health, including immunization, home visits, school health programs in designated installations, group instruction, nurse-teacher-parent conference, assistance in "Well-Baby-Clinic," and physical examinations.

In the army regulations dated August 17, 1955, the outline was completely rewritten beginning with a new statement, that of the purpose of the Army Health Nurse. It then outlines general information, administration, the Army Health Nurse's responsibility, and provision of necessary equipment and transportation. The Army Health Nurse's responsibility also was rewritten to define her work more closely as

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[1] Army Regulations No. 40-50, Department of the Army, Washington 25, D.C., 27 June 1950.

it relates to the infant and preschool child:[1]

> Teaching and counseling in family health including that of prenatal, maternal, and child health by conducting classes, demonstrations, group discussions, interviews and conferences.
> Supervising child health through clinic conferences, home visits and school health programs.
> Evaluating the home situation of patients to determine the feasibility of supervised nursing care in the home.
> Establishing and maintaining a liaison with the local and civilian public health nursing services and other health and welfare agencies on matters relating to the Army health nursing program.

In the aforementioned listing not all the nurse's responsibilities were included, but only those that are related to the infant and preschool child.

In reviewing literature, the child health conference provides supervision for the infant and preschool child through cooperative efforts of several agencies interested in child health. With conditions differing as they do in all communities throughout the country, it is impossible to present suggestions for organizations of child health conferences that would meet the requirements of all situations. Details of organization in each locality will need to develop according to the local requirements.[2]

> An area without a public health nurse should not attempt to organize a child health conference without a public health nursing follow-up service.[3]

> An organized public health program, when properly conducted, does not displace the family physician from a central role in any way. It supplements it and reinforces the position of the family physician. For example, specific services may be provided through

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[1] Army Regulations No. 40-551, Department of the Army, Washington 25, D.C., 17 August 1955.

[2] The Child Health Conference (Suggestions for Organization and Procedure), Bureau Publication No. 261, U.S. Department of Labor; U.S. Government Printing Office, Washington 25, D.C., 1941, pp. 4-5.

[3] Ibid.

> the program which are beyond the resources of the family physician. When the services are made available locally, the child can continue under the family physician's general care and not have to be transported to another community for the purpose.[1]

The "Child Health Conference" may be known as "Well Baby Clinic," "Child Health Station," "Infant Welfare Station," "Infant and Preschool Conference," and any number of variations of these.

> Most child health conferences are for infants; only about one-fourth carry children through the preschool years. Although in theory the term can include children of all ages, in actual practice it rarely includes school-age children, because the supervision of their health is more likely to be a part of a school health program. Neither does the term include care of sick children, special agency services (such as orthopedic) or health supervision under a private physician.[2]

> Through mass screening, abnormalities may be suspected and children brought under the family physician's care for further diagnosis and treatment.[3]

> The minimum conference staff in the child health conference includes the physician (preferably a pediatrician or a physician interested in infants' needs), the public health nurse, and from one to three volunteer helpers to work in the reception room, the weighing and measuring. Where possible, a nutritionist, dentist, and a social worker in the capacity of consultants add to the completeness of the conference service.[4]

An important function of the nurse is to interpret medical advice and to give practical help to the parents in carrying it out by visits to the home. It is important also that the efficient management and smooth operation of the conference are only a part of her larger responsibility of making certain that the educational potentialities of each conference are fully realized for each mother.

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[1] Edward R. Schlesinger, Health Service for the Child, (N.Y.: McGraw-Hill Book Company, Inc.) 1953, pp. 16-17.

[2] Health Supervision of Young Children, The American Public Health Association, Inc., New York, 1955, p. 96.

[3] Schlesinger, op. cit., p. 18.

[4] The Child Health Conference, loc. cit., p. 18.

relationship between the number of infants in attendance per session

Aside from obtaining a good medical history regarding the child's background, it is important that the doctor and nurse find out what the mother considers to be the problems regarding the child and the points on which she may need help.[1]

To explain this further, we find health needs are all inclusive from giving an immunization to prescribing feedings for infants in detail, without giving specific consideration as to size, emotional responses to his care, etc. The child health conference should be aware of related subjects and not isolate infants' needs, as it tends to do. The total health needs of a child at one age are determined to a great extent by past experiences. They in turn influence future problems and needs.

> Many problems are transitory, but others are based on emotional needs, such as infants' needs for affection and security may have a long-time significance. A poor mother-child relationship may produce different effects on feeding and nutrition at succeeding ages. . . . These tend to resolve themselves, but because of disturbing relationships tend to have lasting effects upon the personality and emotions of the child and can be reflected in his dietary and other habits.

Through the years it has been noted that health services can be made effective only by influencing the child as he grows. A mother should be able to come for counsel not only for instruction. The child health conference should be directed toward helping parents with normal every-day problems in growth and development of their children.[2]

To evaluate the role of the public health nurse, one must consider the varied activities she is engaged in, as well as the large

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[1] *Ibid.*, p. 20.

[2] Harold C. Stuart, "Meeting the Health Needs of the Child," *Public Health Reports*, November, 1952, p. 1076.

Five of the nurses did not rank their answers but only checked

patient load she may have to handle. The National Organization for Public Health Nursing and the American Public Health Association have recommended that there should not be less than one public health nurse for each 5,000 population; and that if bedside nursing services are to be included, the population base should be reduced to 2,000.[1]

Lucille Perozzi, in her study of "Public Health Nursing in Relation to Child Health Services," points out that nurses need to learn to listen. That it is being studied with increased interest, that whether during the nurse's interview at the Well Child Conference it couldn't contribute to the decision as to whether a home visit is essential? At a home visit, child health supervision is limited in the nurse's report as to: advised immunization, adequate diet, personal hygiene, etc. It becomes a rubber stamp type of record. In her article she questions if it wouldn't be more valuable to the clinician at the conference to learn from the nurse's visit if this mother and child react differently from one another in or away from home; if this child and his mother understand what to expect when they visit the doctor's office or clinic; or if the nurse can discover some reason why the child does not eat the food the doctor recommends. She also states that many times the nurses miss the boat entirely because the nurse was not aware of individual differences in a child's growth and development or she is not secure in her own ability and skill. The public health nurse as well as everyone who comes in contact with the child from social workers, educators, etc., needs to change the

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[1]Hanlon, John J., Principles of Public Health Administration, St. Louis: The C.V. Mosby Company, 1955, p. 469.

discolors fourth.

approach to child care and family relationships. She feels that the changing attitudes and feelings is a slow process, but the nurse has an excellent opportunity to give improved nursing service to communities when making home visits to children for health supervision.[1]

For satisfactory examination of the child and conference with the mother, one study found fifteen minutes was required. New cases would require longer; therefore, appointments should be so spaced.[2]

In making a study of broken appointments, Hansen[3] found the immunization status appeared to be important in determining whether an appointment was kept. Children who had completed their immunizations broke more appointments than those who had not. Race was not a significant factor; other factors were of borderline significance. Illness in the child or family accounted for nearly half of the reasons volunteered by the parents as causes for their failure to keep appointments.

Hortense Hilbert summarizes in "Public Health Nursing Services in Clinics" the nursing functions to include the following:[4]

Clinic management.

Instruction, assignment, and supervision of volunteers and paid auxiliary help.

Taking medical, social, interim, and contact histories.

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[1] Lucille Perozzi, "Public Health Nursing in Relation to Child Health Services," American Journal of Public Health, April 1950, p. 397.

[2] C. H. Gundry, Beverly Hall, and Trenna Hunter, "Anticipatory Guidance in Child Health Centers," Public Health Nursing, July 1952, p. 378.

[3] Ann C. Hansen, "Broken Appointments in a Child Health Conference," Nursing Outlook, July 1953, p. 417.

[4] Hortense Hilbert, "Public Health Nursing Services in Clinics," Public Health Nursing, May 1944, pp. 209-287.

Two nurses stated they had no pediatrician assigned to the

Introducing to other clinic workers patients coming to the clinic for the first time.

Individual conferences with patients before medical consultation, examination or treatment.

Observing signs of illness among children to isolate them from a group, if necessary.

Assist the doctor with examination and treatment. Discussing with him when necessary any facts pertinent to the patient's condition and progress.

Give general instruction with or without use of visual aids or demonstration.

Interview patients before leaving clinic.

Review with doctor the recommendations and plans for carrying them out.

Review individual service records for completeness and accuracy.

Refer patients to other community agencies.

Selection of patients requiring home visits by the public health nurse.

Inasmuch as public health nursing is carried out by the Army Health Nurses and since it is relatively a new service in the armed forces, it seems unrealistic to expect just one or two Army Health Nurses (as are assigned to our installations) could possibly have as thorough a program as has been related above. However, it is hoped, since this study includes all the programs of the Army Health Nurse in the continental limits of the United States, that perhaps a fairly complete picture may be obtained as to what her functions in the infant and preschool services really are, and that this information may help improve health services to mothers and children.

or only if qualified experience of the nurse warrants it.

CHAPTER III

ANALYSIS OF DATA

The following tables, figures and interpretations have evolved from the data which were received in the questionnaires. An analysis of these data will describe the functions of the Army Health Nurse in the infant and preschool program.

Table 1 depicts the responses obtained from the group tested. Only one questionnaire was not acknowledged even with a second reminder.

TABLE 1

RESPONSE OF THE GROUP QUESTIONED

Group	Response Without Reminder	First Reminder	Second Reminder	Total Returned
Nurses	25	8	1	34

In summarizing the returns on question one: "Does the Army Health Nurse participate in the clinic functions of your hospital?" "Clinic functions," as the term is used here, refers to various clinics the nurse may work in, such as the obstetrical clinic, pediatric clinic, immunization clinic, well child conferences, and others. These are listed in Table 2.

Since Table 2 does not include "any other clinics" in which the Army Health Nurses may participate, they are listed here. Ten Army Health Nurses responded to "any other clinics" in this manner:

she doesn't make home visits to all alike. Is she equally able to

TABLE 2

CLINICS IN WHICH THE ARMY HEALTH NURSES PARTICIPATE

Clinics	Yes	No	No Response to Question	Total Reported
Obstetrical	20	8	6	28
Pediatric	14	12	8	26
Immunization	18	10	5	28
Well Child Conference	27	3	3	30

Five nurses participated in the Salk vaccination programs.

Two of the nurses said they worked in the preschool clinics.

One worked in the gynecological clinic.

One worked in the postnatal clinic.

One nurse listed the cancer detection clinic.

Seven of the nurses wrote comments on the type of service Army Health Nurses should give in these clinics; one said the nurse's function in the obstetrical clinic was for health education only. Four stated they participate in the obstetrical clinic only to lecture to the patients. One commented that the only immunization clinic she participated in was the mass Salk vaccination program. One stated that well child conferences were "not applicable." In rechecking the questionnaire it is noted that the "not applicable" mentioned here may refer to the fact that no pediatrician was assigned to the installation, so the nurse felt it was not applicable.

The second half of the question was related to the "no" in Table 2, although it also answers the "no response to the question." The question was: "If the Army Health Nurse is a non-clinic participant do you feel that she could become a clinic participant in your hospital?"

32

Whenever possible, the nurse should arrange to attend seminars and case discussions that are related to her work. Observations

Fourteen answered the question in the affirmative; eight in the negative; eight made no response to the question; and one said it was not applicable. Those that said "no," gave the following reasons: One stated her role was that of an Army Health Nurse not one of general duty; another stated that as an Army Health Nurse she was an educator and had no time for clinics; and the other commented that the Army Health Nurse should participate in the clinics only where she can teach, not do general out-patient clinic duties. Another said she could not take on clinic duties unless the obstetric clinics or well baby conference hours changed as they were held at the same time; two stated the nurse should participate in the clinics but more health nurses would be needed. Another who worked in all clinics but the obstetric clinic stated that patients in prenatal clinic were seen by appointment; another felt the nurse was valuable in well child conferences but her time was limited for others. The eight who made "no response" to this question were found to be clinic participants so no doubt found the question not applicable, as one did so state. Perhaps the question could have been stated more clearly. It is also felt that to get a better response a question about home visiting could have been added. It is the writer's understanding that some nurses are only clinic participants and do not make home calls. Of the fourteen that answered the question "yes," all but two were clinic participants and these two apparently in answering "yes" felt they had reason to participate in some clinic functions. Again, adding a question as to what duties were performed by the nurse might have proven useful here.

Question two was: "What facilities are available for the infant

20

In answer to types of cases referred the nurses listed the

and preschool child on your post?" "Facilities" as used here, refers to well baby clinics (under one year); child growth and development clinics (one to five years); nursery schools; baby sitting service; and others to be specified. These are listed in Table 3.

TABLE 3

FACILITIES AVAILABLE FOR THE INFANT AND PRESCHOOL CHILD

Facility	Yes	No	No Response to Question	Total Reported
Well baby clinic (under 1 yr.)	29	2	3	31
Child growth and development clinic (1-5 yrs.)	9	19	6	28
Nursery school	23	6	5	29
Baby sitting service	11	14	9	25
Others				11

Since there were so many no responses to the question, as shown in Table 3, it might well indicate that there was some difficulty in understanding the question. Three of the nurses who answered "yes" to the well baby clinic, stated as follows: one saw only the infant to six weeks of age; another said one clinic visit is made when the infant is two weeks old, then he is referred to other clinics; the third one said the Army Health Nurse held the conference alone. Three of the nurses who answered "yes" to the child growth and development clinic added the following comments: one said this conference was offered by the nurse alone; another said one check-up was offered in

One said the Army Health Nurse supervises the civilian nurse.

this clinic. This leaves a total of six who perhaps see the children in the one to five year age group. Those listed under "other facilities" available were the following: Two nurses listed kindergarten and nursery school combinations; two had kindergartens; one listed "Post Nursery"; one labeled it "Child Care Center"; another, "Youth Center for Trailer Site"; two listed "Day Nursery"; two wrote in "unrelated." This points out a different use of terms for a baby sitting type of nursery as distinguished from a nursery school or kindergarten. Since these are usually set up by voluntary organizations on the installation, services offered vary. In phrasing this question it was difficult to use terms familiar to all, which distinguished nursery care from that of a nursery school. Perhaps this is the reason for so many negative responses under baby sitting service as shown in the table. From the list of "others" at least seven could be transferred to the affirmative column.

The second part of question two was concerned with, "whether the infants are referred to local health departments and well child conferences if living off the post?" Twenty-two responded with "yes" to the question; twelve responded with "no." Two nurses offered the following comments to the affirmative section: "only special cases," and "with parental choice."

Question three was: "How is the well baby clinic (under one year) staffed?" Twenty-three had pediatricians in their clinics; sixteen were in the clinic full time, and seven were in the clinics part time. Only one clinic had two pediatricians. Five clinics were staffed with general practitioners. Only one clinic had him assigned

full time. The other four clinics had clinicians assigned part time. Two nurses had the chief of out-patient department and his assistant act as pediatrician.

Two of the Army Health Nurses held the clinics themselves with a pediatrician for consultation if necessary; two had no well baby clinics; one stated that infants under six weeks only were seen, and then referred to other clinics; one offered no response to the question.

The other part of the question was: "What ancillary help do you have at the well baby clinic?" It was answered as follows:

Eight nurses had medical specialists.

Four had voluntary registered nurses to assist.

One nurse had a surgical technician.

One nurse was assisted by a volunteer who completed three of her four years of training.

One nurse worked with a paid or hired nurse to assist in the clinic three afternoons per week.

Thirteen had an aide from the Grey Lady Service.

One had a civilian public health nurse and Red Cross Nurse's Aide to assist her.

In one clinic the nurse was assisted by a "WAC" (Women's Army Corps), but whether she was a medical or surgical technician was not specified.

Six nurses did not respond to the question.

Two nurses stated they had no assistance.

Perhaps to further clarify the question where surgical technician and medical specialist was mentioned the term "WAC" or male attendant should have been included. The writer is aware that the soldier (medical specialist or surgical technician) does at times assist the nurse.

The next part of question three asked: "If your service includes

follows: One nurse said that she excluded all children who were ill;

a child growth and development clinic for the one to five age group, does it differ in organization from the well baby clinic (under one year)?" The responses were as follows:

One nurse stated her situation was different insofar as she was not in the clinic for interviews or conferences, but that the patient was referred to her for action.

Two nurses stated that the children in the one to five age group were seen in pediatric clinic by appointment; and another also said they were seen in general pediatric sick call.

Five nurses said there was no child growth and development clinic.

Nine stated their clinics did not differ in organization from the well baby clinics.

Fourteen made no response to this question. These fourteen and the five who had no clinic, coincide with the nineteen in question two who stated there was no such clinic facility available.

The third part of this question asked: "How many days a week, and what time of day, is the well baby clinic held?" The days scheduled were listed as follows, from one-half day to five days per week:

Clinic was held one-half day a week by four nurses.

One day per week by ten nurses.

Two days per week by eleven nurses.

Three days per week by two nurses.

Five days per week by four nurses.

Three nurses made no response to this question.

The time of day the clinics were held were listed as follows from the morning to the afternoon:

Two Army Health Nurses stated the well baby clinic was held all day.

One divided the time and stated those infants up to six weeks of age were seen from 8:00-9:30 in the morning, the three-month-olds, six-month-olds, and one-year-olds were seen from 9:30-11:00 in the morning.

27

The third part to this question was: "Do you think it bene-

Seven others held the clinics in the forenoon which varied from 8:00 A.M. to 10:00, 11:00, or 12:00 noon.

Thirteen stated the clinics were held in the afternoon, from 1:00 until 3:30 or 4:30.

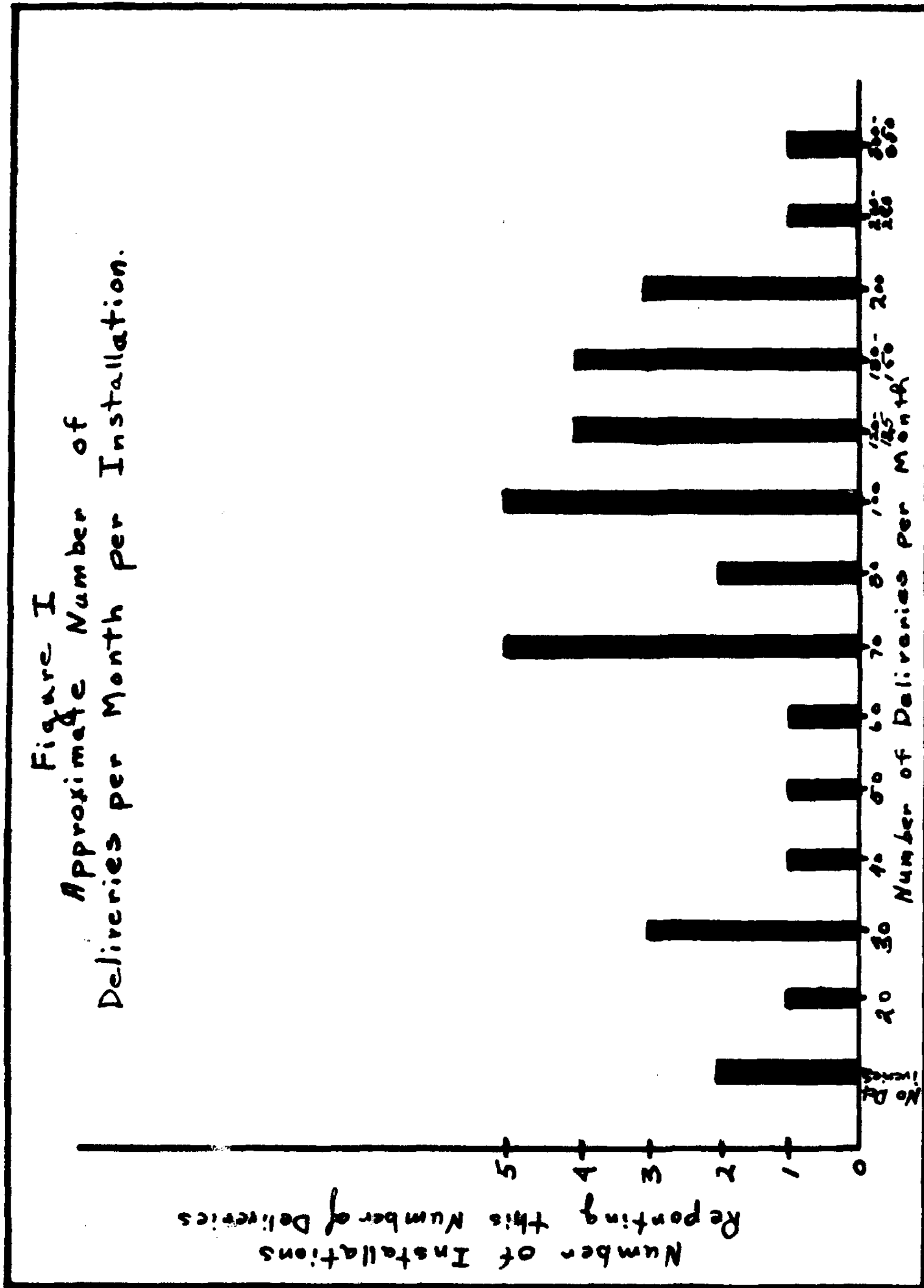
Eight others commented that their clinics were held with sick call or on any appointment basis in the pediatrics clinic.

Three made no response to this question.

Question four was: "Approximately what proportion of the infants delivered at your hospital are seen at the clinics?" It appears that this question was not interpreted correctly at all, for instead of listing the approximate number of infants seen at clinics in relation to the number of deliveries they had, the answers received were the percentage of deliveries occurring at the hospital. Further, this question had three subdivisions, the first was "the approximate number of deliveries per month." Figure 1 portrays this. Thirty-two of the installations responded, with a range of deliveries per month from no deliveries to three hundred and fifty, the median of which is sixteen or one hundred deliveries per month. This figure has a direct relationship to the number of days per week well baby clinic is held. In this instance, the number of hospitals (which is about sixteen) having one hundred deliveries per month more or less, have well baby clinics (of which there are seventeen) two or more times per week.

The second subdivision of question four was: "Approximate number of infants in attendance at well baby clinic (under one year) per session." Twenty-nine installations reported that the attendance at well baby clinic sessions ranged from eight to forty-five, with a median of approximately fourteen and five-tenths or about twenty in attendance at well baby clinic sessions. Here also there is a direct

Other Army Health Nurse activities mentioned as being effective



25

problems. One nurse mentioned the importance of close association

relationship between the number of infants in attendance per session and the number of clinics per week. Six Army installations held well baby clinic three to five days per week, and at least nine Army Health Nurses stated they had twenty to forty infants in attendance per session. It is reasonable to assume that those Army installations having more deliveries per month would have to offer more clinic services for the infant.

The third subdivision of question four was: "Approximate number of children in attendance at child growth and development clinic (1-5 yrs.) per session?" Eleven made no response to this question. Nineteen Army Health nurses said they had no such clinic. One nurse said she had two in attendance; one had five; one had fifteen; and one nurse stated she had fifteen to twenty children from one to five years old in attendance per clinic session.

Question five was: "Check groups of children for which the Army Health Nurse has some responsibility for follow-up after clinics." (The nurses were to rank the list of priorities.)

<u>Ranked First</u> were the following:

Premature . . . . .by nineteen nurses.
Physical handicaps. . . . . .by three nurses.
All school children . . . . .by one nurse.
Positive card serologies. . . . . .by one nurse.
Behavior disorders. . . . . .by no one.
Four nurses did not respond to this part of the question.
Six nurses only checked ( ) this part of the question, but did not rank anything.

<u>Ranked Second</u> were the following:

Positive card serologies . . . . by six nurses.
Physical handicaps . . . . by six nurses.
Behavior disorders . . . . by three nurses.
Prematures . . . . by three nurses.
Newborns . . . . by two nurses.
Rh negative transfusions . . . . by one nurse.

40

Figure II

Five of the nurses did not rank their answers but only checked ( ) the question.
Eight did not answer this part of the question.

<u>Ranked Third</u> were the following:

Physical handicaps. . . . . by eleven nurses.
Behavior disorders. . . . . by four nurses.
Positive cord serologies. . . . . by two nurses.
Uncertain parents . . . . by one nurse.
Ten nurses did not respond to this part of the question.
Seven nurses did not rank this question; they only checked ( ) it.

<u>Ranked Fourth</u> were the following:

Behavior disorders. . . . . by eight nurses.
Positive cord serologies. . . . . by four nurses.
Nutrition problems. . . . . by two nurses.
Physical handicaps. . . . . by one nurse.
Ten nurses made no response to this part of the question.
Three nurses did not rank their responses but only checked ( ) the question.

<u>Ranked Fifth</u>:

Behavior disorders. . . . . by two nurses.

<u>Ranked Sixth</u>:

Family difficulties . . . . by one nurse.

Comments made on this question follow:

One Army Health Nurse stated she had no routine home follow-up program for well baby clinic; two stated that referral is made in rare instances; one stated there were very few requests from the pediatrician; and one nurse said there was no follow-up as yet, they have had no prematures, etc., since the service was established. (In this instance the health nurse's program was only four months old.)

In summary, it appears that prematures were ranked as first by nineteen nurses; physical handicaps and positive cord serologies each were ranked second on the list of priorities by six nurses; eleven nurses ranked physical handicaps as third; and eight nurses ranked behavior

large number listed all the nurses assigned to an installation, and

discusses fourth.

The second part of question five was: "Does the local health department accept referrals for follow-up of babies living off the post for reasons above mentioned?" This is shown on the following:

TABLE 4

REFERRALS TO LOCAL HEALTH DEPARTMENTS FOR BABIES LIVING OFF THE POST

Referrals to Health Dept.	Yes	No	Referrals Made for Routine Visits
	20	4	11

One nurse further stated that referrals were rarely made. Another said the referrals were made on a limited basis. One nurse said referrals were only made to the crippled children's center and county health departments for communicable disease reports.

Question six was: "If there is no program for the well baby clinic (under 1 yr.) or the child growth and development clinic (1-5 yrs.) at your installation at the present, have you thought how such a service could be included?" Seven of the nurses replied that they have not thought how it could be included. Seventeen left the question unanswered. One stated it was not applicable, that she would like to see one well baby clinic work well before starting a new one. Since half of the nurses did not respond to this question, perhaps it could have been reworded for clarity.

The seven nurses that replied in the affirmative were asked to explain how it could be included. The reasons given were as follows:

found to be assigned in the following manner:

Two nurses stated they had no pediatrician assigned to the hospital, but felt if they had one they would like to start this service.

Two said it was not agreeable to the administration, as they had no pediatrician. If they had one apparently administration would consent to such a service.

One hospital was soon to move and would set up a clinic of this kind which previously they had not offered.

One nurse said she had a civilian pediatrician for the nursery alone. If she had one for the clinic, the service could be offered.

Another added there was no child psychologist for the child growth and development clinic, and felt the staff should include a pediatrician, psychiatrist, psychologist, and a mental hygienist, and it should be held for those over six months of age.

One nurse said she had two pediatricians, no child growth and development clinic and hasn't thought how it could be included.

It is noted that in the majority of instances mentioned, the lack of a pediatrician on the installation curtails the establishment of a child growth and development clinic service. The writer does not understand why seventeen of the nurses left the question unanswered; it is difficult to speculate here. Perhaps the question needs to be reworded so it would be all inclusive for the varied installations.

Question seven was: "Do you think the Army Health Nurse should volunteer to start a screening and referral program in child growth and development on her own, pending development of official interest? These referrals needed would be made to the pediatric clinic." Fourteen said "yes" the Army Health Nurse should volunteer to start a screening and referral program, pending development of official interest. Eleven said "no." Nine made no response to the question. The eleven that responded in the negative were asked to explain the reason why. The answers received were varied:

Two stated not unless the nurse had special work in the field;

CHAPTER IV

or only if qualified experience of the nurse warrants it.

One nurse said it should be offered on a selective basis only.

One said the children at her post were referred to the clinics in town; the Army clinics had sick call only.

One felt too much time was allotted for clinics now. She spent four mornings and one afternoon in clinics at the present time.

One said pediatric clinic was very busy at the present time.

Another said that the clinics should not be held without a physician.

One said she was holding such a clinic at the present time.

One nurse said she felt the nurse should offer it to develop official interest.

Another felt screening is being done through school health, home visits, in receiving and disposition, and other sources.

One stated this is an Army Health Nurse's activity, as it is done all the time.

Another said nearly all posts having kindergartens could have preschool physical exams as a requirement for entrance through which referrals could be made.

One nurse said her hospital has no separate pediatric service; it is a small hospital.

Another said such screening is desirable but no staff is available.

Another said it is desirable. She doesn't offer this service now, but if it were to be started it would need close supervision and advice from medical personnel.

These comments are noted with interest. It is true the nurse is screening, more or less, whenever she undertakes a home visit, school or clinic visit. But it is also well recognized that the preschool child has limited facilities available to him, and from a medical point of view is often a neglected period of a child's life. If the preschool child is to be given an adequate service, does the Army Health Nurse get into enough homes where there are preschool children? Maybe

44

to decide which one of the many services the nurse offers should

she doesn't make home visits to all alike. Is she equally able to be present in all the pediatric clinics for screening? The writer questions this strongly. Just what kind of a service does she offer to the preschool child and is it complete? It is recognized by the writer that in order to start such a conference the preventive medicine officer, pediatrician, chief nurse, administration and all channels of communication must be consulted. The question remains, however, whether the nurse could stimulate interest in such a clinic by offering a child growth and development conference and screening, pending development of official interest with referrals made to the pediatrician or general practitioners? It is the infant and preschool period which was the source of interest for this study. The writer would like to have opportunity to question some of the nurses who made these statements to further clarify their answers. A public health nurse, for the most part is constantly screening children and adults alike and referring them in to the physician because of patient complaints or suspicious behavior. It is agreed that some public health nurses do not feel competent to carry on a generalized program. Would it at best be possible for each nurse to evaluate what she is capable of and do something about it?

Freeman states:[1]

> When the situation is one in which the nurse feels less familiar a more detailed review of the factors involved may be necessary. If there are few cases of tuberculosis included in her case load, she may wish to review the current literature relative to the use of streptomycin, since patients will almost always make some inquiry regarding this . . .

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[1]Freeman, Ruth B., Public Health Nursing Practice, (Philadelphia and London: W.B. Saunders Company, 1950), p. 75.

unrelated to them. It is the writer's understanding that some

Whenever possible, the nurse should arrange to attend seminars and case discussions that are related to her work. Observations of new procedures in the hospital, or attendance at special lectures arranged for students in hospitals or medical schools may also be arranged.

The next section of the questionnaire deals with "Home Visits and Other Activities Relating to Infant and Preschool."

Question one was: "If the Army Health Nurse does not participate in clinic functions, is she able to get any referrals for home visits to the infant and preschool child?" Twenty-five answered in the affirmative, no one answered in the negative; however, nine made no responses to the question.

A second part to this question dealt with "Approximately how many referrals per week?" Of the sixteen installations reporting, it was noted that there was a range from less than one referral a week (or two a month) to twenty or thirty referral s per week; with a median of approximately eight or about five to ten referrals per week. Other responses to this question were: Occasional referrals were made; referrals were rare; unlimited referrals were made; referrals were made on a selective basis only; and in one instance the service was in progress only a short time and it was difficult to evaluate it.

It is apparent that there is a need for better interpretation of the Army Health Nurse's role to the nursery personnel and the pediatric service. Again, Freeman states:[1]

> Sometimes action in health matters fails to occur because of poor management. There may be poor articulation between health agencies, or between workers in the same agency, . . . with the result that information is not available at the right place at the right time.

[1]Freeman, loc. cit., p. 148.

services offered vary as much as terminology.

In answer to types of cases referred the nurses listed the following:

Newborns	six
Physical handicaps	five
Prematures	five
Any child	five
Malnutrition	four
Pediatric problems	three
Behavior problems	three
Communicable diseases	two
Cord serologies	two
Acute morbidity	one
Post partums	one
Tuberculin patients	one
Preschoolers	one
School children	one

Question two was: "Does the Army Health Nurse have a separate immunization clinic set up in relation to her infant and preschool clinic?" There were thirty-three replies to this question of which twelve responded in the affirmative and twenty-one in the negative. One did not respond to this question, and two nurses stated that they only worked in the mass Salk immunization clinics.

Another part to this question was: "Is she responsible for total immunization clinic supervision?" Only nine nurses stated they were responsible for the supervision of the clinic, and twenty-three said they were not responsible for this supervision.

The third part to this question was: "If No, please state who supervises the immunization clinic?" The replies were as follows:

Fifteen stated the out-patient department nurse.

Three said the pediatric clinic nurse.

Three nurses said the army nurse assigned to the immunization and treatment room.

One said the pediatric and out-patient department nurse.

sixteen) having one hundred deliveries per month or more have well

One said the Army Health Nurse supervises the civilian nurse.

Question three was: "Do you have available a listing of resource community agencies such as exceptional children's schools, clinics, welfare agencies, policies of hearing clinics, schools for the blind, etc., for use of pediatricians, clinicians, and new army nurses reporting to your installation?" Twenty-seven of the nurses said they had such a listing available; two did not have; two made no response to this question; one said she was working on it; and another stated the State Department in her locale was preparing a "Directory of State and Local Agencies" in pocket book form, and it would be accessible to the Army Health Nurse in the area.

Question four was: "Does the Army Health Nurse give any supervision to the following?" This is summarized in Table 5.

TABLE 5

ARMY HEALTH NURSE SUPERVISION

Supervised	Yes	No	No Response
Nursery school	25	5	1
(Kindergarten and nursery school combination)	2	-	-
Baby sitting service	8	19	5
Other: Kindergarten	3	-	-
Post Nursery School	1	-	-
Day Nursery	2	-	-
Grade School (1-8)	1	-	-
Post Youth Center	1	-	-
No supervision	-	1	-

This table shows that at least thirty-three out of the thirty-

48

which leaves only eight who considered it. Perhaps because of the

four nurses who were questioned had some facility on the installation for the preschool child, whether it was a nursery school or a baby sitting service. The names or terms associated with each facility are variable.

Question five was: "What type of supervision does the Army Health Nurse find she is asked to give most frequently to the nursery school, day nursery, etc.?" Replies were to be ranked 1, 2, 3, etc., in order of frequency. This was summarized in the following table.

TABLE 6

SUPERVISION GIVEN TO FACILITY BY NURSE
(RANKED IN ORDER OF FREQUENCY)

Ranked in Frequency by Numbers of Nurse	1	2	3	4	5	6	7	8	9	No Response	Checked Item
Communicable disease inspections	11	3	4	1	2	0	0	0	-	10	2
Mental hygiene counseling	0	2	2	0	3	2	3	1	-	19	1
Sanitation of nursery	6	7	4	0	2	1	0	0	1	7	5
Immunization of children	3	5	2	4	1	0	1	6	-	16	0
Physical inspection of workers	1	1	1	4	1	3	1	0	-	17	4
Physical set-up of building	0	2	4	2	2	4	2	1	-	12	3
Screening for other health reasons as observed by nursery personnel	2	2	4	6	1	1	1	0	-	8	4

Other replies listed and ranked, not included in the table, were as

follows: One nurse said that she excluded all children who were ill; and another said she made home visits on teacher referrals. Neither of these was ranked but the writer feels they could be included in the last item of Table 6, as it is all inclusive of children screened from school for health reasons by the nursery personnel. Visual defects were listed by one nurse and ranked fourth. Another listed speech defects and ranked this fifth. The writer believes these two are included in the last item of the column as health reasons (malnutrition, orthopedic defects, etc., as observed by nursery personnel) could very well include speech and visual impairments. Perhaps the question could have been clearer, as it also shows that many made no responses to the items. The reason for this is unknown because from question four more than two-thirds of the nurses do have this facility on their Posts, and it seems this would be an excellent place to make preschool contacts.

Question six was: "Does the Army Health Nurse have any authority in policy matters for the day nursery school?" Fifteen replied in the affirmative and sixteen in the negative. Other comments were by two nurses who said they had no day nursery on the Post; one nurse explained further that her position was in an advisory capacity; and another said she was a member of the Nursery Council. Only one nurse made no response to this question.

The second part to this question was: "Does she participate in board meetings of the nursery?" Of the twenty-eight who responded, nine said "yes" and nineteen said "no." One nurse added she might be able to participate in the future as a nursery school was newly constructed on the Post.

The third part to this question was: "Do you think it beneficial to her to be able to participate in policy development and board meetings?" There were twenty-seven who replied in the affirmative, one nurse answered in the negative, and there were six who made no response to the question. The one who replied in the negative was asked to give her reason, which was that the nursery school was a separate project and had no board meetings. Other comments made to this question were: One nurse said she was always asked to be on the board at other Posts to which she was assigned, but this was not so at her present assignment. Another nurse added it would be well for the nurse to participate in the meetings of the board, but there were no board meetings at her Post other than the regular officers' and non-commissioned officers' women's clubs who held the meetings.

Question seven was: "Where do you feel the Army Health Nurse's activities are most effective in the infant and preschool programs?" This was answered by the nurses in the following manner:

Child health conferences	sixteen
Postnatal classes on the wards	five
Home visits	four
Prenatal work, counseling and guidance	four
Mother and baby classes	three
Preschoolers	three
Referrals and newborn follow-up	two
Nursery school screening	two
Liaison activity with questions five and six (which has to do with policy development and board meetings of the nursery school and day nursery)	two
Clinic activity of the Army Health Nurse	one

There was one nurse who made no comment to the question; and one answered the question with "yes" which doesn't seem applicable here.

Other Army Health Nurse activities mentioned as being effective singly were: education in nutrition and immunizations, screening children prior to seeing the doctor, guiding the mother in proper feeding and helping her understand her youngster, early training, guidance and helping parents with behavior problems, counseling with parents, Parent Teachers' Association volunteers to assist with preschool examinations, telephone conferences, and immunization clinics.

Question eight was: "Is there any other aspect of infant and preschool care that the Army Health Nurse includes in her program that has not been mentioned in this questionnaire? If so, please explain." There were twenty-two nurses who made no response to this question. It is not certain why this occurred, perhaps they had no new information to relate. Others made the following comments: teaching on rooming-in wards; "Infant Care" classes; home safety program; another felt kindergartens on many posts reach a larger part of the preschool children than does the nursery school; therefore supervision including health education can be carried out through this part of the program. Others stated that the Army Health Nurse works through local agencies off the post in planning for school physicals; home visits of newborns two weeks of age; expectant parents' classes; Parent Teachers' Association council meetings; distribution of instruction sheets to obstetric patients on care of self and infants, thereby introducing the Army Health Nurse's program to the patient. One of the nurses mentioned that the hospital facilities were being relocated in a new area and they hoped to develop better services. Another said that beside the Army personnel the Navy and Air Force families were seen by the Army Hospital for major health

CHAPTER V

problems. One nurse mentioned the importance of close association with the Visiting Nurse Association and public health organizations in her area, to keep up with changing state regulations. Another nurse stated an important function of hers was the cradle round-up, where complete physical examinations of all preschool children on the installation were done in a three to four day period. In this round-up five doctors, two nurses, and seventeen volunteers participated.

The third section of the questionnaire was entitled "General Information," and included the following questions:

Question one was: "How long has the Army Health Program been in operation at your installation?" Figure 2 portrays this:

This graph can be summarized by stating that nine of the programs in the United States are one year or under as to length of time in existence; nine are from two through four years old. There has been a gradual increase of Army Health Nursing programs in the continental limits of the United States as well as the European and Far Eastern areas.

In this last section, the second part of question one asked for the number of nurses assigned to the installation. The answers received were as follows: twenty-eight stated they had one Army Health Nurse; four stated they had two Army Health Nurses (one installation had one of the Army Health Nurses do general duty and she acted as relief for the nurse in charge); two nurses stated they had one Army Health Nurse and one hired civilian public health nurse to assist them.

For purposes of clarity, this question should have requested the number of Army Health Nurses assigned to the installation, as a

clinic visits to well child conferences, pediatric services, or any

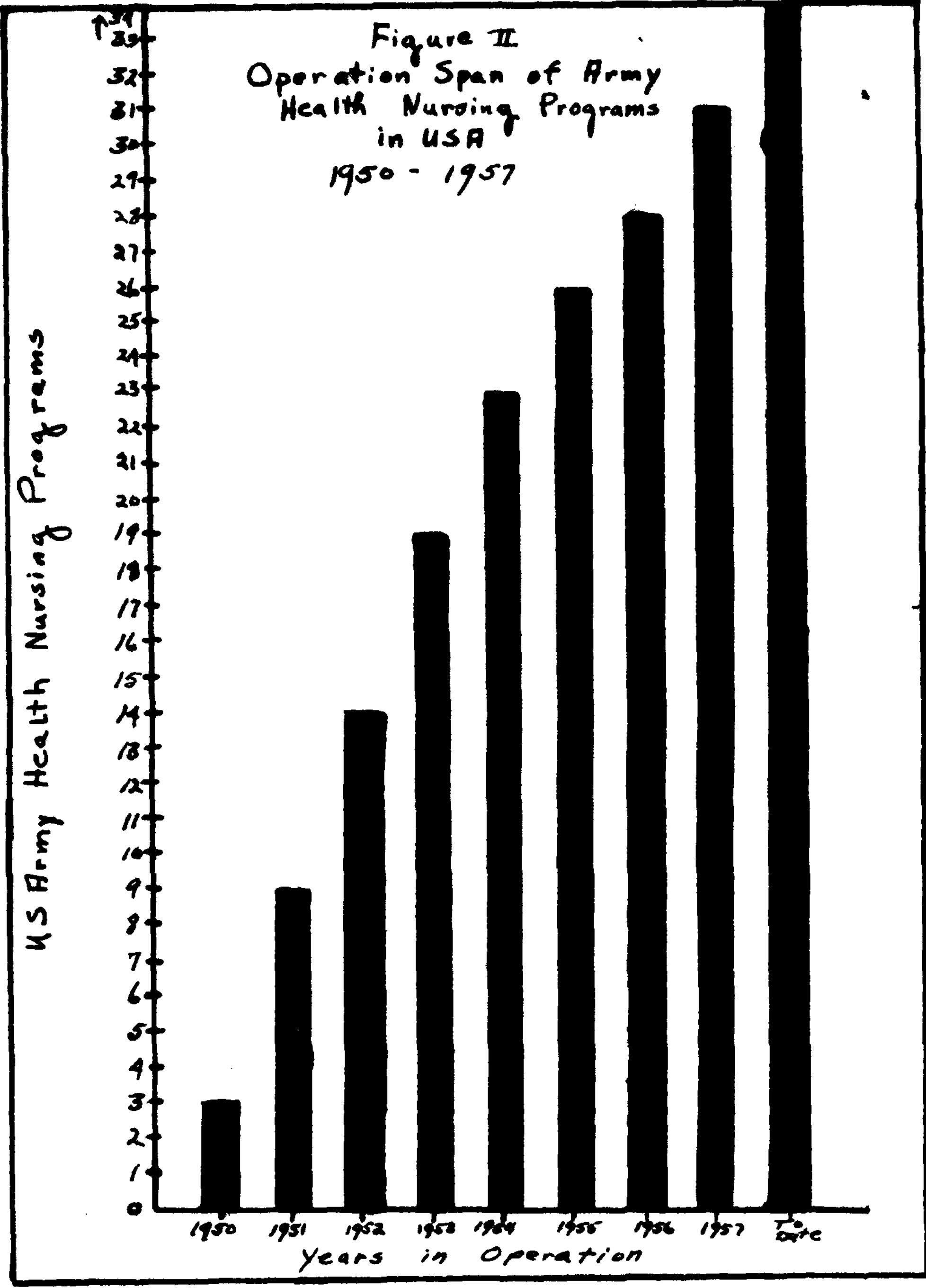
Figure II
Operation Span of Army
Health Nursing Programs
in USA
1950 - 1957
US Army Health Nursing Programs
Years in Operation
1950
1951
1952
1953
1954
1955
1956
1957
To date

large number listed all the nurses assigned to an installation, and the list of Army Health Nurses had to be "weeded out" from the totals.

Question two which was: "Where is the Army Health Nurse's office located in your installation?" was answered as follows:

Location	Number
Preventive Medicine Section	sixteen
Out-patient department	five
Obstetric clinic	two
Pediatric clinic	two
Health Center	two
In a separate building near the out-patient and pediatric clinic	two
The out-patient, obstetric, and pediatric sections are in one section and the office is located in this section	one
Surgical Clinic building	one
In the front entrance of the hospital near the Chief Nurse's office, and Hospital Surgeon's office	one
In the Hospital Information and Education office where her classroom was also located	one

The second part of this question asked: "Do you think it could be located to better advantage for your work? If yes, where?" Fourteen replied in the affirmative to this question and twenty in the negative. Of those who said "yes" the following were listed as desirable locations:

Location	Number
Out-patient department	eight
In a large building to include immunizations, etc., to keep dependents from crowding the out-patient clinic so badly	two
Pediatric clinic	one
Out-patient department or prenatal clinic	one
Preventive medicine section	one
Closer to clinic situation	one
Closer to hospital or preventive medicine section, as the nurse's office was three miles away in the out-patient department	one

Question three in this section asked: "To which department or section is the Army Health Nurse assigned for duty?" They were

found to be assigned in the following manner:

Post Surgeons . . . . fourteen
Chief of Preventive Medicine. . . . . thirteen
Post Surgeon and Surgeon,
  U.S. Army Hospital being combined . . . four
Nursing Service section . . . . two
Surgeon, U.S. Army Hospital . . . . one

This answer seems to be dependent on the size of the installation and whether or not it has a Preventive Medicine Section. If the post does not have a Preventive Medicine Officer the Post Surgeon and/or Surgeon of the Army Hospital seems to be the Preventive Medicine Officer in most instances.

CHAPTER IV

SUMMARY AND CONCLUSIONS

Summary

Since the advent of the Army Health Nurse into the generalized medical program of the Department of the Army is a comparatively new development; and since there are no studies and materials available defining her role in the infant and preschool program, this study was designed to learn more about present practices as a basis for determining what the role should be. To achieve this definition of her activities in this one service of the infant and preschool child, it was necessary to ask: To whom was she administratively responsible for assignment? What facilities if any were available for the infant and preschool child? What were the organization and function of these facilities? Was the nurse a clinic or non-clinic participant? What supervision did she maintain of the existing facilities? Were referrals made, to whom, and where? Were home visits made? And, in which field of service did the nurse feel her program to be most effective?

Other methods considered by the writer were: Direct surveys of the installations; personal interviews with the Army Health Nurses; summarization of the nurses' monthly reports that are submitted to Area Command Headquarters. These methods did not seem feasible, however, because of the time involved, as well as the expense.

Thus, the most practical method for investigating this problem of "functions" seemed to be the mail questionnaire. It was difficult

What ancillary help do you have at the well baby clinic? (Check number of each type).

Surgical technician____
Medical specialist____
Voluntary R.N.'s to assist

to decide which one of the many services the nurse offers should be studied and to them to direct the questions. Assistance for pretesting the questionnaire was generously given by several individuals in the related fields of maternal and child health, as well as the preventive medicine field. Of the thirty-five Army Health Nurses surveyed in the group, thirty-four replied to the questionnaire. The results were coded, tabulated, and analyzed.

Conclusions

Since the questionnaire is divided into three major sections, such as "Clinics," "Home Visits and Other Activities Relating to the Infant and Preschool Service," and "General Information," it seems best to discuss the results of the study in this sequence.

Clinics

The Army Health Nurse's role as a clinic participant is variable. It appears that in the majority of installations the Army Health Nurse does participate in obstetrical, pediatric, immunization clinics, and well child conferences. However, when the nurse was asked if she thought she should become a clinic participant if she was not one at the present time, only half of the respondents replied affirmatively. The twenty-five percent that did not feel that they should participate felt that their responsibility was for health education only and not to do general clinic or out-patient department work; others felt that more nurses were needed if they were to participate in clinic functions. The other twenty-five percent made no response to the question. Perhaps the question needed clarification, or they may have felt it was

Home Visits and Other Activities Relating to Infant and Preschool

1. If the Army Health Nurse does not participate in clinic functions, is she able to get any referrals for home visits to the infant and preschool child? Yes____ No____

unrelated to them. It is the writer's understanding that some nurses are only clinic participants and make no home visits. If this assumption is true then the question would need further clarification.

Well baby clinics were found to be available in twenty-nine of the thirty-four installations. However, a number of these were giving very limited services. Three installations were seeing only infants to six weeks of age; one installation saw the infant at two weeks of age and then referred him to the pediatric clinic; and in two others, the Army Health Nurses conducted the clinics alone without a physician present.

Child growth and development clinics were offered in only nine of the thirty-four installations. The services offered here were also limited. Of the nine, only six installations offered this clinic to the one to five age group. The other three varied in that, in one clinic conference the Army Health Nurse offered the service without a physician, but proper referrals were made. In the other installation only one check-up was offered; and in another only the one to four age groups were seen.

It appears that all thirty-four have either a baby sitting service or a nursery school facility available at their respective installations. There does seem to be a different use of terms at each installation. A baby sitting service may be called a "Child Care Center," "Youth Center for Trailer Site," "Post Nursery," as well as "Nursery School," and "Day Nursery and Kindergarten" combinations. Since these are usually set up by voluntary organizations on the installations,

8. Is there any other aspect of infant and preschool care that the Army Health Nurse includes in her program that has not been mentioned in this questionnaire? If so, please explain. ____________

services offered vary as much as terminology.

Referrals to local health departments apparently are not always made. Of the thirty-four nurses questioned, twelve made no referrals. It may have proven worthwhile to follow through with a questionnaire as to why not. It was noted, however, that at least nine programs were under one year in existence. Since nine programs are relatively new, then this may be the answer to why twelve made no referrals, as it does take time to set up a good referral system.

The staffing of well baby clinics included pediatricians in twenty-three of the twenty-nine clinics, and the majority seemed to be on a part-time basis, the others full-time. Five had general practitioners, part-time, and the others had only Army Health Nurses in the clinics with referrals to the pediatrician for consultation.

The staff of the child growth and development clinics offered by nine of the installations did not vary much from the well baby clinic staff; except that in some instances the clinic was included in general pediatric sick call; or they were seen in the pediatric clinic by appointment. In one other, the nurse screened the clinic applicants with pediatric referral as needed.

All but two had some ancillary help in staffing the clinics. It has been the writer's experience that with volunteers the nurse can extend her work to a maximum and can obtain invaluable support for her program as a whole.

The figures on the number of deliveries per month have a direct relationship to the number of days per week well baby clinic is held. In this instance, the number of hospitals (which is about

sixteen) having one hundred deliveries per month or more have well baby clinics (of which there are seventeen) two or more times per week. The figures obtained on the number of infants in attendance per session at the clinics and the number of clinics per week also have a direct relationship. In this instance the number of children in attendance ranged from eight to forty-five, with a median of approximately twenty attending the well baby clinics. Clinics, for the most part, were held in the afternoon, two had them all day, and others held them with sick call on an appointment basis at pediatric clinic. The children seen in the child growth and development clinic varied from two to twenty with a median of about five. It is noted, however, that only nine installations offered this service.

Those infants for which the nurse has some responsibility for follow-up after clinics were ranked in a priority list. Nineteen nurses ranked prematures as first; six ranked physical handicaps and positive cord serologies as second; eleven nurses ranked physical handicaps third; eight nurses ranked behavior disorders fourth; two ranked behavior disorders fifth; and one nurse ranked family difficulties as sixth. Referrals to local health departments for any of the aforementioned are made in thirty installations; eleven refer them for routine visits.

It appeared that half of the nurses questioned had strong feelings about offering a program for well baby clinics or child growth and development clinics if there was no such service at the present time at their respective installations. Nine had not thought of how it could be included; seventeen did not respond to this question,

which leaves only eight who considered it. Perhaps because of the large number who made no response to the question, it was not understood or not clear. Those who had thought of implementing such a service stated that they would like to see such a service established. Some felt that this was not agreeable to administration as there was no pediatrician; another hired a civilian pediatrician for the hospital nursery only; and another installation that has two pediatricians did not offer a child growth and development clinic nor did they feel it could be included.

When asked if the nurse should volunteer to offer to start a screening and referral program in child growth and development on her own pending development of official interest; only fourteen felt that she should, nine made no response, and eleven said no. When asked to explain why not, their answers were: One felt it should be on a selective basis only; another, that the nurse should have experience or special preparation in this field; others referred the children to clinics in town; some said that only sick call was held; some felt too much time was spent in clinics now; one stated she was too busy; another said they had lack of staff; one nurse said that installations having kindergartens could have preschool physicals through which referrals could be made; or that screening was done through school health, home visits, and in the receiving and disposition office of the hospital.

It is agreed the Army Health Nurse is screening, more or less, whenever she undertakes home visits, school, or clinic visits. But it is also a well recognized fact that the child needing help isn't in school and needs it before he gets to school. The preschool child

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has little or no facilities available to him and from a medical point of view it is often a neglected period of a child's life. If the preschool child is to be given a service, does the nurse get into enough homes where there are preschool children? She may not make home visits to all alike. Is she able to be present in the pediatric clinic for screening? If not, then what actual service does she offer the preschool child? Is it an accidental type of case finding and referral? It is understood, of course, that the type of clinics offered are dependent on administration. If the Army Health Nurse is eager or stimulated concerning the need for such a service, can she not instill some of this enthusiasm in selling this to administration? Or is the nurse not aware of individual differences in child growth and development, or is she not secure in her own ability or skill in working with this age group?

Home Visits and Other Activities Relating to Infant and Preschool

Seventeen respondents who were non-clinic participants stated that the number of referrals they obtained, ranged from "rarely" to thirty per week with a median of nine. It appears that there is a need of better interpretation of the Army Health Nurse's relationship to the nursery personnel and pediatric service of the hospital as the bulk of her referrals may come from these services. The referrals that were made included prematures, morbidity, cord serologies, communicable diseases, physical handicaps, post partums, active tuberculosis contacts, behavior problems, preschool and school children.

In most instances there was no separate immunization clinic set aside for the infant and preschool clinics. Only nine of the thirty-

two respondents have to supervise the immunization clinics; in the majority of the installations this is a function of the out-patient department nurse or pediatric clinic nurse.

Listings of available community resource agencies are kept for the use of pediatricians, clinicians, and other nurses by the majority of the Army Health Nurses.

Thirty-three out of the thirty-four Army Health Nurses give some supervision to the nursery schools or baby sitting facility on the installation. The type of supervision given to the facility was communicable disease inspections of the children and sanitary inspections of the nursery which is all too frequently a requirement by those in administration; while mental hygiene counseling, immunization of children, and physical inspections of workers receive little attention. In this instance these also received the majority of no responses. It was noted that while two-thirds of the nurses have this facility on their posts, there was still a large number of no responses to each type of supervision listed. However, it appears this would be an excellent place to make preschool contacts.

The majority of the nurses did feel it would be beneficial to them to be able to participate in policy development and board meetings in regard to the nursery school or baby sitting facility at their posts.

The fields of service in which the nurses felt their programs were most effective included child health conferences, postnatal classes, home visits, and prenatal counseling.

Other aspects of infant and preschool care that the nurses include in their programs not mentioned in the questionnaire were parent-teacher meetings, council meetings, teaching on the rooming-in

ward of the hospital, expectant parents' classes, and close association with voluntary and official agencies in the nurses' area to keep abreast with changing regulations.

General Information

There has been a rapid increase of Army Health Nursing programs in the continental limits of the United States in the past seven years. Of the thirty-two nurses that responded, it was noted that the duration of the programs ranged from one year to those five to seven years in existence, with a median of about five years. Twenty-eight of these thirty-two have one Army Health Nurse assigned for duty.

The location of the Army Health Nurse's office in relation to desirability for performance of services offered seemed to be in the Preventive Section, in about one-half of those who responded. However, the location of the nurse's office is dependent on to whom she is assigned for duty, the Post Surgeon and/or the Surgeon of the Army Hospital, or whether or not there is a Preventive Medicine Officer. In this study it appears that the nurses felt that the Out-patient Department was the most desirable location.

CHAPTER V

RECOMMENDATIONS

As indicated by the returned questionnaires, the Army Health Nurse's role in the infant and preschool program is indeed a varied one. Clinic situations and facilities available in this one phase of her program seem to depend upon individual differences of persons involved, such as the Post Surgeon, Preventive Medicine Officer, Chief Nurse, and the Army Health Nurse of the various installations.

How much more variable than are all the other services the nurse offers the families living on or off the installation?

Doing this study in a somewhat limited area has stimulated the writer to wonder if perhaps further thought could be given to an investigation of all the activities of the Army Health Nurse? Would it be possible to have a thorough study of her clinic activities alone? Where is her clinic activity most valuable? Could the time the few devote to supervision of the immunization clinic be used more profitably? Since the majority of installations have only one Army Health Nurse, perhaps a more thorough study of the physical organization of the hospital should be included to give a more complete picture of each installation as a community. Nurses' activities in home visits also may need further study. Some may not be doing home visiting, and it is not a valid comparison of relative emphasis if one program consists of clinics and home nursing services; while another is carried out through home visits alone, or clinic participation alone. It would also be of interest to note if there has been any change in

clinic visits to well child conferences, pediatric services, or any other clinic service being offered at the installations since the new dependents care bill went into effect under which families are free to seek civilian hospital care.

Thus, one very small study raises questions which may prove to be a challenge to further investigators.

APPENDIX

108 East Comstock Hall
University of Minnesota
Minneapolis 14, Minnesota

Dear

I am an Army Health Nurse enrolled in the Master's program in the School of Public Health at the University of Minnesota.

I am interested in undertaking a small study to learn something of how Army Health Nurses in various installations are working with infants and preschool children. This seems to be an age group for which the health supervision programs vary considerably depending upon the type of installation to which the nurse finds herself assigned.

If this study is to be worthwhile it is important that it represent practices and opinions of as broad a group as possible. I hope for this reason that you will fill in and return the attached questionnaire.

I shall be glad to share my findings with you and hope they will in some way be beneficial to all concerned.

Yours sincerely,

GENEVIEVE R. POTOCHNIK
Captain ANC

QUESTIONNAIRE

Instructions:

This questionnaire dealing with the Army Health Nurses' participation in the infant and preschool program is divided into three parts: Clinics, Home Visits, and General Information.

a. Your signature on this questionnaire is not required.
b. I realize you may not be able to answer all these different situations. I'd appreciate your answering those you can by an appropriate check mark ( ) to the Yes and No questions, and to others as indicated.
c. If you have been reassigned, please use your last assignment as a basis for your answers.

Clinics

1. Does the Army Health Nurse participate in the clinic functions of your hospital?
   - Obstetrical clinic Yes____ No____
   - Pediatric clinic Yes____ No____
   - Immunization clinic Yes____ No____
   - Well child conferences Yes____ No____
   - Any other clinics ____________________

   b. If the Army Health Nurse is a non-clinic participant do you feel that she could become a clinic participant in your hospital?
   Yes____ No____
   If No, please explain: ________________________________

   ____

2. What facilities are available for the infant and preschool child on your post?
   - Well baby clinics (under 1 yr.) Yes____ No____
   - Child growth and development clinics (1-5 yrs.) Yes____ No____
   - Nursery schools Yes____ No____
   - Baby sitting service Yes____ No____
   - If other, please specify____________________.

   b. Are babies referred to local health departments and well child conferences if living off post? Yes____ No____

3. How is the well baby clinic (under 1 yr.) staffed? (check where applicable)
   - With pediatrician Yes____ No____
   - Is he in the clinic part time ____ or full time____?
   - With general practitioner Yes____ No____
   - Is he in the clinic part time____ or full time____?

What ancillary help do you have at the well baby clinic? (Check number of each type).

Surgical technician____
Medical specialist____
Voluntary R.N.'s to assist____
Grey Lady service____
Clerical assistance____

b. If your service includes a child growth and development clinic for the 1-5 age group, does it differ in organization from the well baby clinic (under 1 yr)?
Yes____ No____
If Yes, describe briefly________________________________

____

c. How many days a week ____ and what time of day ____ is the well baby clinic held?

4. Approximately what proportion of the infants delivered at your hospital are seen at the clinics?

Approximate deliveries per month______
Approximate number of such infants in attendance at well baby clinic (under 1 yr.) per session______
Approximate number of children in attendance at child growth development clinic (1-5 yrs.) per session______

5. Check groups of children for which the Army Health Nurse has some responsibility for follow-up after clinics. (Please rank the list as to priorities you use: 1, 2, 3, etc.)

Prematures______
Children with physical handicaps_____
Behavior disorders_____
Positive cord serologies_____
If other, please specify____________________

b. Does the local health department accept referrals for follow-up of babies living off the post for reasons above mentioned?
Yes____ No____ Routine visits____ None____

6. If there is no program for the well baby clinic (under 1 yr.) or the child growth and development clinic (1-5 yrs.) at your installation at present, have you thought how such a service could be included?
Yes____ No____
If Yes, please explain how it could be included.________________

____

7. Do you think the Army Health Nurse should volunteer to start a screening and referral program in child growth and development on her own pending development of official interest? Those referrals needed would be made to the pediatric clinic.
Yes_____ No_____
If No, please explain.________________________________

____

Home Visits and Other Activities Relating to Infant and Preschool

1. If the Army Health Nurse does not participate in clinic functions, is she able to get any referrals for home visits to the infant and preschool child? Yes____ No____
   Approximately how many referrals per week?__________
   Type of Cases?__________________________

2. Does the Army Health Nurse have a separate immunization clinic set up in relation to her infant and preschool clinics?
   Yes_____ No_____
   Is she responsible for total immunization clinic supervision?
   Yes_____ No_____
   If No, please state who supervises the immunization clinic?____________

3. Do you have available a listing of resource community agencies such as exceptional children's schools, clinics, welfare agencies, policies of hearing clinics, schools for the blind, etc., for use of pediatricians, clinicians, and new Army Health Nurses reporting to your installation?
   Yes____ No____

4. Does the Army Health Nurse give any supervision to the following?
   - Nursery school Yes____ No____
   - Baby sitting service Yes_____ No____
   - If other, please specify ______________________________.

5. What types of supervision does the Army Health Nurse find she is asked to give most frequently to the nursery school, day nursery, etc.? (Please rank 1, 2, 3, etc. in order of frequency.)
   1. Communicable disease inspections______
   2. Mental hygiene counseling____________
   3. Sanitation of the nursery____________
   4. Immunization of children____________
   5. Physical inspections of workers________
   6. Physical set-up of building in use______
   7. Screening for other health reasons (malnutrition, ortho-pedic defects, etc. as observed by nursery personnel________
   8. Others (please list by number) ____________ _________
      ____________ _________

6. Does the Army Health Nurse have any authority in policy matters for the day nursery school? Yes_____ No______

   Does she participate in board meetings of the nursery:
   Yes______ No______

   Do you think it would be beneficial to her to be able to participate in policy development and board meetings? Yes_____ No_____
   If No, please give your reasons.______________________________

   ____

7. Where do you feel the Army Health Nurses' activities are most effective in the infant and preschool programs?______________________

   ____

8. Is there any other aspect of infant and preschool care that the Army Health Nurse includes in her program that has not been mentioned in this questionnaire? If so, please explain.__________

____

General Information

1. How long has the Army Health Nursing Program been in operation at your installation? Y__________

   b. Do you have one____, two____, three____, or more _____ nurses assigned at your present installation? (Check one)

2. Where is the Army Health Nurses' Office located in your installation? (Check one)

   Out-patient department__________
   O.B. clinic__________
   Pediatric clinic__________
   Preventive medicine section__________
   If other, please specify__________

   b. Do you think it could be located to better advantage for your work?
   Yes_____ No_____
   If Yes, where?__________

3. To which department or section is the Army Health Nurse assigned for duty?
   (Check one)

   Chief preventive medicine section__________
   Post surgeon__________
   Surgeon, army hospital__________
   If other, please specify__________

165 West Comstock Hall
University of Minnesota
Minneapolis 14, Minnesota

Dear

According to my check list you have not responded to the questionnaire of the Army Health Nurse's role in the infant and preschool program sent to you on February 15, 1957. While I know that you are busy, I hope that you will be willing to supply this information. The response has been good, but your contribution will make the study more valuable, and although not identified by name, will add much to the findings.

If you have mislaid the questionnaire, can you please let me know and I shall send you one immediately.

May I expect your reply?

Yours sincerely,

GENEVIEVE R. POTOCHNIK
Captain ANC

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