Public Health Nursing in Relation to Child Health Services

LUCILE A. PEROZZI, R.N., F.A.P.H.A.
Regional Nursing Consultant, Division of Health Services,
U. S. Children's Bureau, Denver, Colo.

In the section on Community Health Services of the American Academy of Pediatric Study, only the public health nurse who worked in a program of a general public health character, or who visited families with children was considered.† The nurse whose work was limited to supplying school nursing service was reported only under school health services. No consideration was given to agencies giving special services in tuberculosis, venereal disease or industrial hygiene, since they did not give general service to children.

In evaluating the public health nurse's contribution to community health services, four varieties of services were studied: assistance in well child conferences, home visits for health supervision, bedside nursing care, and school services.

The Study staff took as a standard of adequate nursing service one public health nurse to every 2,000 persons (or one nurse to 500 children). On this basis it was estimated that this country needs more than five times as many public health nurses as there are at present. However, the N.O.P.H.N. recommends that for a basic minimum local public health service for administrative purposes not less than one public health nurse is required for each 5,000 of the population. Where bedside nursing care of the sick at home is offered, additional public health nurses assisted by graduate nurses without public health nursing preparation and practical nurses or other auxiliary workers will be needed up to a ratio of one to 2,000.‡ This would not appear so unattainable as the Academy figure. Even though the ratio of one nurse to 5,000 persons has been achieved in some states, we shall not have sufficient nurses for home bedside nursing in every state for some time to come.

Although public health nursing is considered to be an essential part of any community health program, in 1946 the Academy Study showed that 1,065 of the 3,000 odd counties in the United States had no public health nursing service for children. This is disturbing, yet it follows a pattern that is revealed throughout the study, that of incompleteness or absence of medical, dental, and hospital facilities and personnel in isolated counties. The Study shows that for the country as a whole there was an average of 60 full-time public health nurses per 100,000 children for the metropolitan counties. In the non-metropolitan counties it would appear that

† The Academy staff defined public health nursing as including "registered nurses working full time or part time for community health agencies, both official and voluntary that give general service to children. Excludes nurses giving special services such as (a) nurses working full time in schools, (b) nurses employed by agencies giving only industrial, tuberculosis, or venereal disease service, and (c) supervisors employed by State agencies." Supplement to Child Health Services and Pediatric Education, Glossary, p. v:ii, Commonwealth Fund, New York, 1949.
there were only 23 public health nurses to each 100,000 children.\(^2\)

That was three years ago. There has been a gradual improvement since that time. Our most recent reports show that in the past three years, the total number of public health nurses has been increased by 2,701 graduate nurses. However, we still have, in 1949, 936 counties and 17 cities without any public health nursing.\(^3\) We believe that the growth of public health nursing is occurring in areas already having nurses. This probably indicates that a numerical increase in public health nurses will not necessarily solve our problems of distributing nursing service so as to reach all children, wherever they live.

One of the tables\(^4\) presented by this study serves to focus attention on indices of public health nursing services to children. It shows (1) the number of public health nurses per 100,000 children; (2) the number of home nursing visits during one year per 1,000 children; (3) the per cent of counties giving three types of service, that is, assistance in well child conferences, home visits for health supervision, and school service; and (4) the per cent of counties giving four types of services—the three above mentioned services, plus bedside home nursing.

The wide variation in the amount of service available state by state as shown by this table, raises some questions: Were there reasons that made bedside home nursing of sick children and infants less needed in some states? Were there policies which determined the kinds of nursing service that received higher priorities? Were there sufficient numbers of all types of nurses employed to include bedside home nursing services?

Five states were able to show that all counties provided three types of service but in only 3 states were public health nurses providing all four types of services in all counties. The percentage ranged from 100 per cent of the counties in 3 states providing complete services, to none at all in 1 state.\(^5\)

Even where the traditionally accepted services of limited character were available—that is, where assistance in well child conferences, home visits for health supervision, and school services were reported—great variations were found from state to state. Only 24 states reported that 50 per cent or more of their counties were served by nurses giving these three child health services. Should we ask ourselves whether or not a reevaluation of priorities in public health nursing programs is necessary?

The study also points out vividly in a graph that in about half of the states, children received relatively few nursing visits in their homes.\(^6\) The 10 states with 300 or more home visits per 1,000 children were: Connecticut, Rhode Island, Massachusetts, New Hampshire, New York, New Jersey, Delaware, Michigan, Wisconsin, and Illinois. Metropolitan counties were able to report a rate of over three times as many home visits to children per year as the non-metropolitan counties—338 as contrasted with 95 home visits for each 1,000 children per year.

It may be argued that the indices chosen by the Academy Study staff do not provide a true picture of the types and amount of public health nursing provided for children or that they do not indicate the relative value of one kind of service over another. The findings do, however, raise doubts as to the wisdom of relying on a quantitative measure alone. Too long have administrators and nursing supervisors been satisfied with a pleasing increase in the number of children who receive public health nursing services. It has been repeatedly pointed out that it is not the number of home visits made that is of primary concern, but what is accomplished on those home visits. It is high time that we give much thought to an evaluation.
of public health nursing that is based on a wiser selection of children for home visiting and the record of what is achieved. Then we would be surer of what we are accomplishing.

We are constantly hearing that we must wait for more staff and money before we can undertake certain improvements. I wonder if that is always true. For a few minutes let us consider what we might do, without waiting for more personnel and funds, in order to increase the effectiveness of community nursing services. I have in mind home visits to children for health supervision. This is one activity in which the public health nurse may make a unique contribution.

First, the following questions need to be answered: Is it administratively possible for the public health nurse to allot a reasonable and regular proportion of her time to home visits? Are sufficient funds for travel budgeted or is transportation planned so that she can reach these homes? Is there provision for adequate and continuous nursing supervision so that the field nurse may better select the children and infants who will profit most from this home visit? Can routine home visits be reduced and more time given to selection of families for this service? Can the nursing interview at the well child conference contribute to the decision as to whether a home visit is essential?

Recognizing that we must provide an effective administrative framework in which a nurse can work, it is also essential that we provide the nurse with the right kind and amount of medical and nursing advice and assistance in carrying out her day by day job. These questions have occurred to me as pertinent: Can the nurse better utilize the time and service of special consultants in medicine, nutrition, mental hygiene, health education, and social work? For some nurses, group discussion, centered about case conferences, which illustrate ways of working with other professional workers, may be productive. For other nurses some help in a demonstration of the often ignored technique of "how to listen" might be a way to create and maintain relationships which would help her to accomplish more effective results in her home visits. More frequently than not, a nurse's report of a home visit for child health supervision is limited to "advised immunizations, adequate diet, and personal hygiene." If that is all she records, perhaps she needs only a rubber stamp. What would really be of value for the clinician at the child health conference is to learn 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 the well child conference; if the nurse can discover some reason which would explain why the child does not eat the food recommended by the doctor. The changing of attitudes and feelings is a slow process. Frequently the public health nurse may have "missed the boat" entirely because she was not aware of individual differences in a child's growth and development, or she herself did not have security in her own ability and skill. We might go on with more examples, but I believe the ones I have given illustrate what I mean.

Many public health nurses have already incorporated the new and broad approach to child care and family relationships. The impact of other professional disciplines is greatly influencing her attitudes and relationships. Of course, the public health nurse is not alone in needing to change her approach to child care and family relationships. If we are to think of the total child, then doctors, educators, social workers, nutritionists, and others must commit themselves to the same principles.

As I said before, we can at least improve the quality of public health nursing for children, although for some time
to come we may not be able to solve the problem of the distribution of the limited but growing number of public health nurses in the United States.

The more complex implications of the distribution and the raising of qualifications of public health nurses who are giving child health services could well be the subject of much discussion. It is reasonable to suppose that, as the profession of nursing puts its own house in order and more nearly adjusts the supply and demand for public health nurses, more expert nursing care will be available. The need for better preparation of personnel for community nursing services will be met in part when more nurses are graduated from schools of nursing where all nurses are prepared for first level staff positions.

The Academy Study shows that only one-third of the public health nurses in the United States met the standard of completing one academic year in an approved program for public health nursing. Our most recent report also shows about the same proportion. Miss Heisler goes on to report that in 23 of the states and territories the percentage of qualified public health nurses exceeds the general average and ranges upward from nearly 37 per cent to 86.2 per cent. Fourteen states have reached their all time high in 1949.8

We cannot leave this whole subject of Community Health Services without some consideration of what we as nurses can do about the problems revealed and the questions raised in the Academy Study. First, in addition to reading the nation-wide report, we should study our own state Academy report. These reports are informative and readable. We may agree with what is said or we may wish to take issue with the facts and their interpretation. Many of the facts highlighted are not new to the public health nurse, but it is important to make use of the recommendations in the state reports. These state reports point out in a variety of ways that more public health nurses are needed.

Certainly further study and additional research will reveal many problems that will require the cooperation of a team of professions to solve. Public health nurses are ready and eager to participate in analyzing needs and providing better care for children in their communities.

We public health nurses may turn to a number of state and national organizations for specific help in getting started with a program of action. The National League of Nursing Education has long promoted a National Committee on the Education of Nurses in the Care of the Child. This committee has local or state committees in only a very few states at present. These need to be increased. Recently, in keeping with the publication of the Academy report, the National Committee changed its name to Nursing in Child Health Services.

Inservice educational programs, centered around the care of mother and child have enriched the background of the nurse. They have increased her understanding of the child by utilizing pediatricians, medical-social workers, nutritionists, and experts in mental hygiene, child growth and development. On the national level, many voluntary and official agencies provide a wide variety of consultation by experts in special fields of interest, such as orthopedic nursing, school health services, and mental health. The N.O.P.H.N. Section on School Nursing and the Public Health Nursing Section of the A.P.H.A. are also possible resources which can serve to focus the interest of public health nurses in the field of child health.

For some time the Children's Bureau has been particularly interested in the stimulation and development of advanced programs of study in pediatric nursing. Funds have been granted through state health departments for
the development of more educational centers, strategically located in regions, in order that consultants, teachers, and clinical nursing experts could be filling the gaps in the great demand for more highly qualified nursing personnel both in the fields of public health nursing and nursing education. In many states, provision is made for the granting of stipends and fellowships through the allocation of training funds by maternal and child health divisions in state health departments.

But all of this will not be enough to help nursing meet its obligations in pulling its share of the load. Something else must be added, even though we find more money and people to do our job better. This I should like to think of in terms of a renewed zeal on the part of each of us.

REFERENCES
5. Ibid. Table 68, p. 112.
6. Ibid. Table 69, p. 113.

Summer Course in Food Technology

The Massachusetts Institute of Technology announces a special intensive program in food technology, June 12–30, 1950. Various phases of food handling, processing, and storage will be covered including such specialized fields as high vacuum drying, juice concentrates, and food chemistry and nutrition by the use of "tracer" elements. Academic credit will be given for satisfactory completion of the work. Enrollment is limited and preference will be given to those having a background of technical or executive experience in food industries, faculty members of other schools, government workers in food or nutrition, and advanced chemistry or engineering students. Tuition, $100. Details and application blanks from Professor Walter H. Gale, Room 3-107, Massachusetts Institute of Technology, Cambridge 39.