A STUDY OF IN-SERVICE EDUCATION PROGRAMS IN CONTINENTAL UNITED STATES AIR FORCE HOSPITALS AS THEY RELATE TO THE AIR FORCE NURSE

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A Study of In-Service Education Programs in Continental United States Air Force Hospitals as They Relate to the Air Force Nurse

Thesis directed by Associate Professor Leona Jackson

The objectives of this study were (1) to investigate quantity and quality of in-service education programs for Air Force nurses; (2) to analyze whether major areas of similarity and of difference existed in current programs; and (3) to offer recommendations based on this study, and within the context of Air Force regulations, for increased implementation of the program.

A questionnaire was devised by which to investigate current programs. The questionnaire consisted of multiple choice and dichotomous questions, and contained one free response question.

The study indicated that 92% of all U.S. Air Force hospitals within the continental United States had operational in-service education programs. Of the 78 respondents to the questionnaire, 42 were found to have highly successful programs, and 24 were found to have programs of moderate success. The remainder either had limited programs, or no program at the time of the study. Among the latter 12 respondents, however, several comments were received indicating plans for inauguration of programs as of January, 1960.

It was found that the size of the hospital had no relation to success of the in-service education program; hospitals of all size

groups were among the highly successful category. However, size did appear to influence lack of success in the program. The greatest proportion of hospitals reporting minimal programs, or no programs, were among the group of 50 beds or less.

Among the successful programs, content included outside lecturers, field trips, and attendance at seminars and workshops. The study clearly indicated, however, that opportunities available through local colleges or universities were not being utilized for the in-service education program.

The keynote of the successful programs was participation. The climate of participation was achieved in most instances, through a plan of rotation of personnel as committee members of the In-Service Education Committee.

This abstract of about 250 words is approved as to form and content. I recommend its publication.

Signed Leona Jackson
Instructor in charge of dissertation

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THE PROBLEM AND ITS SETTING

The U. S. Air Force, functioning under a general policy of decentralization of authority, advised its administrators by means of regulations and manuals to conduct in-service education programs. In no instance known to this investigator had a comprehensive study been done on the extent to which these regulations and manuals were being implemented in the case of in-service education programs for the Air Force Nurse.

I. THE PROBLEM

Statement of the problem. The general aim of this study was to investigate in-service education programs for the Air Force Nurse, as they existed in U. S. Air Force hospitals within the continental United States.

Purpose of the study. The purposes of this study were (1) to investigate quantity and quality of in-service education programs for Air Force nurses; (2) to analyze whether major areas of similarity and of difference existed in current programs; and (3) to offer recommendations based on this study, and within the context of Air Force regulations, for increased implementation of the programs.

II. BACKGROUND AND SIGNIFICANCE OF THE STUDY

In accord with the policy of decentralization and the resultant

increase of authority at base echelons, the regulations and manuals offer broad guidelines for the direction and assistance of the administrator.

In the "Specialty Summary" of the position, Nurse, Administrative, Air Force Manual 36-1 specified that the administrative nurse will (1) formulate policies affecting training needs of nursing service personnel; (2) instruct nursing service personnel . . . and demonstrate improved nursing techniques; (3) provide for in-service training of nurses and auxiliary nursing service personnel; (4) co-ordinate with educational agencies to provide for advancement of nursing personnel; (5) participate with professional medical personnel in research; and (6) prepare staff studies on such matters as professional training and competence of nurses and utilization of nursing personnel.[1]

The above excerpts from the total list of duties and responsibilities of the administrative nurse in the Air Force indicated the emphasis placed by the Air Force on the continuing education of its personnel. The study was undertaken to discover how well these responsibilities were being executed, and to offer recommendations that may assist Air Force nursing service administrators in the fulfillment of these responsibilities.

III. JUSTIFICATION

When the nursing process is thought of as a maturing, educating

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[1]Department of the Air Force, Air Force Manual 36-1, Officer Air Force Specialty: Nurse, Administrative, 1 June 1959, p. 547.

instrument, nurses develop experiences that promote constructive learning. The line between education and therapy is becoming much thinner than it was perceived to be 20 years ago.[2]

In an address given at the Institute on Nursing Service Administration, held at Fort Sam Houston, Texas, in 1956, McManus spoke of the objectives and the purposes of an in-service education program. At that time she stated,

> Like all educational programs, the immediate educational objectives of the in-service program for nurses are concerned with the learner, the nurse herself, and with the continuous advancement in her understanding, skill, insight, interest, and value, particularly in respect to her professional role.
>
> . . . . . .
>
> The general purposes of the continuing education program are commonly conceived to be:
> 1. To assist the nurse continuously to adapt her abilities to the nursing services of the institution and to acquire new skills as needed in providing progressively higher quality of nursing care;
> 2. To assist the nurse to continue her professional growth through activities which develop increasingly satisfying interest in her work and willingness and eagerness to prepare to meet changing needs.[4]

Three basic purposes of in-service education were defined and reported in the yearbook of the National Society for the Study of Education (1957), by C. Glen Hass (Associate Superintendent and Director of Instruction, Arlington County Public Schools, Arlington, Virginia). With the transposition of the words "teacher" and "school,"

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[2]Hildegard E. Peplau, Interpersonal Relations in Nursing (New York: G. P. Putnam's Sons, 1952), p. 8.

[3]R. Louise McManus, "In-Service Educational Programs for Nurses," The Yearbook of Modern Nursing, 1956: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1956), p. 212.

[4]Ibid., p. 216.

to those of "nurse" and "hospital," these definitions of purpose applied equally to the nursing profession.

> 1. The major reason for in-service education is to promote the continuous improvement of the total professional staff of the school system. All teachers, administrators, and supervisors must constantly study in order to keep up with advances in subject matter and in the theory and practice of teaching. Continuous in-service education is needed to keep the profession abreast of new knowledge and to release creative abilities.
> 2. An additional purpose is to give the much needed help to teachers who are new in a particular school and to those who are entering a new responsibility or a new field of work within the profession . . . .
> 3. At least for the present, a third purpose of in-service education must be to eliminate deficiencies in the background preparation of teachers and of other professional workers in education . . . .[5]

In the interest of ever improved patient care, the nursing service administrator must have a sincere, active interest in the educational development of her personnel. Since the absence of progress produces retrogression, a serious responsibility accrues to the nursing service administrator to supply the means of progress. The desired means of progress can be found in a well-conceived and well-implemented in-service education program. For the Air Force nurse administrator, this responsibility is inherent in her basic job description.[6]

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[5]C. Glen Hass, "In-Service Education Today," In-Service Education: For Teachers, Supervisors, and Administrators, Nelson B. Henry, editor (The Fifty-sixth Yearbook of the National Society for the Study of Education, part I. Chicago: University of Chicago Press, 1957), p. 13.

[6]Air Force Manual 36-1, loc. cit.

IV. HYPOTHESES

The following hypotheses were to be tested:

1. Quantity and quality of in-service education programs for Air Force nurses would be found to be deficient.

2. Identification of areas needing further study could be made through analysis of the areas of similarity and of difference in the existing programs.

3. Recommendations for increased implementation of in-service education programs for Air Force nurses, based on findings of this study, could be made.

V. DEFINITION OF TERMS USED

Nurse, Administrative. "One who manages nursing service activities, including general medical, surgical, obstetric, pediatric, operating room, anaesthesia, and preventive medicine."[7] In the Air Force, the Nurse Administrative is commonly referred to as the Chief Nurse, which term has been utilized in this study.

Charge Nurse. The nurse in charge of a ward or unit--the head nurse.

Educational Director. A professional nurse, responsible to the Chief Nurse, whose duty it is to plan and implement in-service training and education programs for all categories of nursing service

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[7] Ibid.

personnel.

In-Service Education Program. Formalized program of professional instruction organized for the benefit of duty personnel to the ultimate goal of improvement of patient care.

NCOIC. Non-Commissioned Officer In Charge--A non-commissioned officer designated to be in charge of enlisted personnel of a unit or a group.

Ward Master. NCOIC of a ward unit. Responsible to the charge nurse.

Operation Bootstrap. An Air Force program whereby active duty personnel were granted six months "on campus" at a university to complete requirements for an academic degree.

AFIT. Air Force Institute of Technology civilian institution's program. "Under the program, the Air Force contracts with civilian colleges and universities throughout the nation to provide both graduate and undergraduate education in those subject areas needed by the Air Force."[8] Nursing education was among the subject areas considered needed by the Air Force.

Education Services Officer. "Officer, usually a civilian, responsible for the distribution of information, advice, and assistance

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[8]Department of the Air Force, Career Fact Book for the U. S. Air Force Officer (Revised, 1959), p. 26.

to military personnel on matters and/or problems pertaining to the opportunities for educational advancement in conjunction with the United States Air Force, the counseling of military personnel in their educational and vocational needs and direction of their off-duty education programs."[9] (From an obsolete classification, frequently referred to as the I & E, Information and Education, Officer.)

Continental United States. The 48 states contained within the North American Continent, and the District of Columbia. This term excludes Alaska, Hawaii, and Air Force installations in the Panama Canal Zone.

Normal Duty Hours. Those duty hours considered normal for day duty, usually from 0700 hours (7:00 A. M.), to 1500 or 1530 hours (3:00 or 3:30 P. M.).

VI. SCOPE AND LIMITATIONS

Scope. The study was concerned with all Air Force installations within the continental United States which were officially designated as hospitals. There were 94 installations so designated at the time the study was undertaken. This concept eliminated those patient care centers which carried the designation of USAF Dispensary.

Limitations. The study was limited by confinement to the con-

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[9]Air Force, Technical Air Force (Lowry Air Force Base, Air Base Group, Personnel Services, Education Branch). "Job Description, Education Service Officer." n.d. (typed).

tinental United States. This limitation necessarily negates use of the findings and recommendations in Air Force hospitals in overseas areas, as well as in all USAF Dispensaries.

VII. ORGANIZATION OF REMAINDER OF THE STUDY

The remainder of the study was organized into four chapters with a bibliography and appendices. A review of the literature, primarily in the fields of nursing, education, and business and industry, comprises Chapter II. The method and techniques used in gathering the data prior to analysis and interpretation were described in Chapter III. The analysis, interpretation, and summary of the data obtained by the research tool, appear in Chapter IV. A summary of the study, with conclusions and recommendations made, is found in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

Since it is recognized that the nursing profession has borrowed from general education and from business and industry in the development of in-service education programs, the literature was reviewed in all three fields. An attempt was made to show factors of correlation among the three fields in the areas of (1) the basic concept of what constituted an adequate in-service education program; (2) the objectives of in-service education; and (3) the evaluation of in-service education programs. In order to establish a background for correlation, however, it was deemed necessary to report a brief historical survey of the development of in-service educational programs in each of the fields reviewed.

I. HISTORICAL BACKGROUND

The purpose of this section was to trace the historical development of in-service education in the fields of nursing, general education, and business; and to detect a possible correlation which may have existed among the three disciplines.

Nursing. Nurses and nursing have been cognizant of their need for continuing education for many years.[1] While acting in the capacity

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[1]Mary Annice Miller, "Trends in In-Service Education," The Yearbook of Modern Nursing, 1956: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1950), p. 221.

of Executive Secretary of the National League of Nursing Education, Blanche Pfefferkorn traced the history of staff education in nursing. She pointed out that in its broad implications, educational programs for nurses were as old as organized nursing itself in this country. She went further to say, however, that "the improvement of the graduate nurse as a deliberate pursuit, either for professional or cultural growth, is yet in its infancy (1928)."[2]

To emphasize the early efforts toward graduate nurse education, Pfefferkorn spoke of the American Society of Superintendents of Training Schools, which was established in 1893. The declared purpose of this organization, she said, was "to further the best interests of the nursing profession . . . by promoting fellowship among its members by meetings, papers and discussions of nursing subjects by interchange of opinion."[3]

Miss Pfefferkorn believed that the first major step in graduate nurse advancement was achieved through the organization of alumnae associations, with their monthly meetings, some with definite courses of study outlined, and their scholarship and loan funds. "The alumnae associations provide a measure of great potential power for devising ways and means in graduate nurse advancement."[4]

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[2]Blanche Pfefferkorn, "Improvement of the Nurse in Service--an Historical Review," American Journal of Nursing, 28:700, July, 1928.

[3]Ibid., p. 701.

[4]Ibid.

Professional growth for the individual as well as for the group cannot go forward lacking current professional information.[5] In 1900, the introduction of the journal of the nursing profession, The American Journal of Nursing, constituted a profound early step in the advancement of graduate nurse education. In her historical review, Pfefferkorn referred to the early Journal. "The early issues were plainly concerned with the individual nurse," she said, and added, "The graduate nurse quite obviously looked to her new magazine as an instrument to give her personal, practical help and there is abundant evidence that her expectations were well met."[6]

The next major step in continuing education for the graduate nurse was the establishment of formal post-graduate courses. In the earlier years these courses were offered in the various clinical areas, such as medical and surgical nursing, and later in ward administration and supervision. These early efforts, however, were directed to service rather than to education. "The courses offered in hospitals to graduate nurses have not been postgraduate in the academic sense," Pfefferkorn said, "neither their organization, content, nor instruction has warranted the application of this term."[7]

All the early in-service educational efforts expressed in nursing

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[5] Ibid., p. 703.

[6] Ibid.

[7] Ibid., p. 706.

were the direct responsibility of the individual--reading her journal, attending meetings and lectures, applying for and attending a post-graduate course of study. The institutions accepted no responsibility for the educational advancement of the individual within its employment. Pfefferkorn emphasized this point when she said,

> Closely allied to hospital postgraduate courses in nursing are the opportunities for improvement provided for the staff nurse . . . either within or without the institution. Certainly not much has been done within the institution and little more for encouraging and creating easy contacts for growth without.[8]

From 1929 to the beginning of World War II the postgraduate courses persisted. Little evidence was found of an improvement in attitude during this time, toward the concept of on-duty staff improvement. In 1933, in discussing the merits of the formal postgraduate program as opposed to those of added experience, or staff education programs for workers in service, Isabel M. Stewart said,

> A staff education program is intended primarily to improve service in the employing institution or organization rather than to give the staff members a well-rounded professional preparation for service in other institutions or in the community at large. The work comes first, as a matter of course, and the educational program must be incidental to it.[9]

The service orientation of staff development programs during this period was all too evident in Stewart's statement.

In the period immediately following World War II, the shortages of nursing personnel gave rise to concern within the profession that the

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[8] Ibid., p. 708.

[9] Isabel M. Stewart, "Postgraduate Education--Old and New," American Journal of Nursing, 33:366, April, 1933.

quality of nursing care should not suffer. As Miller stated, "Better utilization of nursing personnel became almost a necessity, and it was becoming apparent that one way of accomplishing this was through in-service educational programs."[10]

The year 1947, two years post World War II, marked the first appearance in The American Journal of Nursing index of the term "In-Service" per se. In that year there were four articles so listed. In the years following 1947, there was a marked, steady increase of nursing literature concerning in-service educational opportunities for all categories of nursing service personnel.

In 1956, Miller made a statement which well depicted the underlying attitude of in-service educational programs in nursing at that time. In this statement can be recognized the transition from service-oriented programs.

> In-service educational programs for all nursing staff in all agencies and institutions are now on the threshold of becoming an accepted and necessary part of the program of organization. It is through in-service programs, that better utilization of available staff will be obtained, that personnel will be better satisfied in their jobs, and the ultimate goal of better patient care will be obtained.[11]

General Education. Within the field of general education there was a much longer history of formalized in-service education than within nursing. Early efforts were in the form of the teachers' institute. At its inception, the institute served to increase the knowledge and

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[10]Miller, op. cit., p. 222.

[11]Ibid., p. 224.

teaching ability of the teacher whose basic educational background was very low. In reference to this, Richey stated,

> In 1890, relatively few teachers had received a high-school education. Those who attended normal schools generally had received all of their formal education in rural ungraded or city elementary schools. Normal schools accepted these students for short terms and organized programs of elementary and secondary level in keeping with their educational attainments. Almost two decades were to pass before any state was to make high-school graduation the minimum requirement for all licenses.[12]

From 1890 to 1930 there was a marked trend to increasing demands for educational and cultural qualifications in teachers, with a resultant improvement in teacher status. During this period of transition, the teachers' institute fell into disrepute. Richey quoted Reudiger as stating in 1910, that,

> . . . as conducted, the institute which had served a useful purpose was rapidly becoming an anachronism. He argued that teachers' institutes should differentiate their programs according to the functions they were serving: (a) a professional training-school for teachers, (b) a meeting to inspire teachers and to acquaint them with the policies of their schools, and (c) teachers' conventions, largely social in nature. The differentiation, he admitted, would result in the disappearance of the traditional institute.[13]

Richey continued by saying that as late as 1933 institutes were still being held, but were steadily losing ground. At that time there were what he termed "unmistakable tendencies" toward substituting other forms of in-service training for them.[14]

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[12]Herman G. Richey, "Growth of the Modern Conception of In-Service Education," In-Service Education: For Teachers, Supervisors, and Administrators, Nelson B. Henry, editor (The Fifty-sixth Yearbook of the National Society for the Study of Education, part I. Chicago: University of Chicago Press, 1957), p. 42.

[13]Ibid., p. 44.

[14]Ibid., p. 45.

Another early form of teacher training was the "Teachers' Reading Circle." Like the institute, this form of education came into being because of the numbers of teachers in service who possessed only a mediocre education and little or no training.

> However, both teachers' institutes and reading circles were agencies designed to advance the performance of teachers, generally deficient in academic attainments and professional skills, a small distance on a wide front. The lowly status of the teacher and inability to provide anything better were the only excuses for their existence. Both continued to flourish in competition with newer and more promising programs of in-service education long after the conditions which explain their origin and early development no longer prevailed.[15]

The "newer and more promising programs of in-service education" of which Richey spoke did not evolve full grown and successful. For a long time, programs designed to up-grade the teaching staff took precedence over all other in-service efforts. This again was due to the varying degrees of competence of teachers. During this period the in-service educational programs were, in the majority, the responsibility of the school superintendent.

> He and the supervisors and principals to whom he delegated a large share of his supervisory function were more experienced than most teachers and were, more often than not, superior to them in culture, education, professional training, and understanding of the advancing science of education.[16]

In the past two to three decades, educational requirements for teachers have increased, both through practice and through law. In consequence, the teacher no longer has a basically inferior education

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[15] Ibid., p. 46.

[16] Ibid., p. 65.

and is in need of training. Rather, she has become a specialist to be consulted.[17] With this transition the concept of superintendent responsibility for in-service education has become obsolete. More and more teachers have become equipped, through extended training and lengthened experience, with knowledge and skills possessed by neither superintendent nor principal and with a body of theory equal or superior to that possessed, in some spheres, by the supervisor.[18]

Out of this situation arose the concept of "staff development" in in-service education, of which Richey said,

> Attempts by teachers, supervisors, administrators, and others to solve problems of common concern constituted in-service education, not of the teachers individually but of the teaching staff as a professional group.[19]

As of 1959 the staff development concept was the latest advance in in-service educational programs within general education. From an early, though slow and hesitant start, the teaching profession had made rapid advances to what was currently a high standard of well organized in-service educational effort.

Business and Industry. From medieval times through the industrial revolution (1750 to 1830), apprenticeship was the accepted method of teaching the new worker an art or craft. Following the industrial revolution apprenticeship methods persisted, although on a

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[17] Ibid., p. 66.

[18] Ibid., p. 59.

[19] Ibid., p. 66.

diminishing basis. As late as 1931 Wissler said of apprenticeships,

> Very little of the traditional apprenticeship survives under the administration of modern industry. While a good deal is being done in Wisconsin for the preservation of the traditional type of apprenticeship, there is a steady narrowing down of apprenticeship to certain special fields . . . Such men [capable of making repairs and adjustments of machinery] require a high degree of skill, which can best be assured by some definitely organized apprenticeship.[20]

Wissler went on to say that, at that time (1931), there existed a considerable amount of informal training in industry. The informal training was partly organized by assigning new employees to older employees who acted as "sponsors." He added that a good deal of training that was supposed to be given by foremen or "straw bosses," was, more frequently, given by friendly fellow workers.[21]

Immediately after the first World War a few pioneer efforts were made in foremanship training but they were stopped by the depression of 1929.[22] These "few pioneer efforts" were the first attempts at formal in-service training beyond apprenticeship. In 1939 the National Association of Manufacturers, in a Declaration of Principles, stated that every industrial enterprise must seek to provide (among other points), "Understanding treatment by supervisors trained to recognize the employee's abilities, appreciate his problems, and

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[20]Willis Wissler, Business Administration (New York: McGraw-Hill Book Company, Inc., 1931), p. 372.

[21]Ibid., p. 373.

[22]H. L. Humke, "Types of Foreman Training," Journal: The Society for the Advancement of Management, 2:143, September, 1937.

assist him in self-development."[23] The declaration offered neither methods nor suggestions for achieving the recommended training of the supervisors, and did not clarify what constituted "self-development" of the employee.

The first major milestone of in-service training in industry occurred during World War II with the establishment of the Training Within Industry (TWI) program, developed by the War Manpower Commission. It was initially designed to improve job performance through what became known as the JIT, or Job Instruction Training program. Later TWI developed training programs for supervisors and managers.[24]

Benefiting from the tremendous impact of the TWI program, in-service education and training in business and industry had progressed rapidly following World War II. Yoder and others incorporated into their Handbook of Personnel Management and Labor Relations, a comprehensive statement of the importance that in-service education programs had achieved by 1958.

> Training is one of the major manpower functions. It is a line responsibility. But, because of the professional and technical nature of the function, staff advice and service are often used to assist line managers. Training is a continuing process because of the dynamic nature of our economy. Organization changes, job changes, . . . methods changes--all of these require

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[23]National Association of Manufacturers, Declaration of Principles Relating to the Conduct of American Industry (New York: National Association of Manufacturers, December, 1939), p. 18.

[24]Dale Yoder, Personnel Management and Industrial Relations (fourth edition; Englewood Cliffs, N. J.: Prentice Hall, Inc., 1946), p. 293.

> modification of understanding, attitudes, and skills on the part of manpower.[25]

II. IN-SERVICE EDUCATION

The purpose of this section was to direct attention to the varying concepts of in-service education, and to establish a basis of in-service education that may have been common to nursing, general education, and business and industry.

Nursing. The difficulties encountered in attempting to define and delimit the concept of in-service education were aptly expressed by McManus in a talk given at the Medical Field Service School, Brook Army Hospital, Fort Sam Houston, Texas. She pointed out that there were few terms that have more different meanings today than that of in-service education. "The meanings," she stated, "vary within and between nursing organizations, service agencies, and educational institutions."[26] She elaborated further,

> Since we learn from experience, the concept may be so broad and unlimited as to relate to the educational values obtainable in all the individual's experiences, or it can be so narrowly and specifically defined as to relate to a specific series of classes planned and provided by an agency for a designated group or individual.[27]

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[25]Dale Yoder, et al., Handbook of Personnel Management and Labor Relations (New York: McGraw-Hill Book Company, Inc., 1958), p. 12.2.

[26]R. Louise McManus, "In-Service Educational Programs for Nurses," The Yearbook of Modern Nursing, 1956: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1956), p. 211.

[27]Ibid.

Later in the same talk McManus defined in-service education when she stated,

> By "in-service education" is usually meant education that is provided by an agency to its employees and is engaged in by them as an integral part of their work without interruption of their period of employment. A program of in-service education for nurses would, therefore, be an organized plan of a wide variety of activities that constitute what is to be done with respect to education of nurses while continuing in service in the specific nursing organization or agency offering the program.[28]

This definition is broad, and directs attention to endeavors beyond the immediate confines of the work-situation--a concept that is in keeping with her attitudes, as expressed at an earlier date.

> If the professional nurse, in whatever position she is practicing, is to continue to maintain her professional judgment at a high level or to improve it, she must assume the responsibility for planning to achieve this by engaging systematically in a variety of activities of educational value.
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> . . . . . .
>
> In many parts of the country, nurses may now attend--on a credit or non-credit basis--college or university workshops, extension and short-term intensive courses, or part-time courses that run concurrently with professional practice.[29]

In the publication Inservice Education For Hospital Nursing Personnel, Miller also gave a definition of in-service education. She wrote,

> Inservice education programs are designed to equate the employee and the job. In a hospital nursing service, inservice education becomes the process of helping to make the nursing service

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[28] Ibid., p. 212.

[29] R. Louise McManus, "What Colleges and Universities Offer the Practicing Nurse," American Journal of Nursing, 54:1479, December, 1954.

> employee's ability to carry out work functions commensurate with her obligations to patients.[30]

She further stated, however, that the challenge of in-service education rested in the fact of recognition of the point where the "equation" is reached; for if reached and retained, nursing care would "become static rather than a dynamic, developing component of medical care with many facets and degrees of skill."[31]

Miller's definition of in-service education was specifically directed to in-service programs confined within the nursing service of an organization or agency.

General Education. As indicated earlier, the most recent development of in-service education in the field of general education is that of staff development. In keeping with this concept, the American Association of School Administrators emphasized personal growth in their thirty-third yearbook (1959).

> Continuous growth in service is highly important if we are to keep pace with a rapidly changing society and apply the newer methods of teaching to education. Improved teaching can result only to the extent that persons concerned (a) recognize their personal and growth needs and the problems affecting their teaching, (b) develop some definite procedures for the solution of their problems, (c) feel some responsibility for the identification of group needs and for helping to plan to meet these needs, (d) develop some criteria for the selection of

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[30]Mary Annice Miller, Inservice Education For Hospital Nursing Personnel (New York: Department of Hospital Nursing, National League for Nursing, 1958), p. 1.

[31]Ibid.

problems to be studied, and (e) share in the responsibility for evaluating the program.[32]

Having stated the responsibilities of the individual to the concept of in-service education, the School Administrators then gave their description of the program.

> An effective inservice education program is based upon the known needs of the staff and is developed co-operatively to meet those needs. Organization must be planned so as to motivate staff participation. Conscientious teachers are more enthusiastic and grow in proficiency when encouraged to define needs and to participate in program improvement.[33]

The concept expressed in the above statement correlates closely with that of Miller, given previously (p. 13), in that it directs attention to activities within the organization.

The following definition of in-service teacher education was quoted from the Dictionary of Education by Smith, in the University of Pennsylvania Bulletin (1951).

> Activities on the part of employed teachers that contribute to their professional growth and qualifications; readings, participation in supervisory and curriculum-development programs, attendance at summer-session courses, etc.[34]

This definition places the burden of responsibility for in-service education upon the individual in the same manner as does McManus' earlier statement, quoted on page 20.

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[32]Staff Relations in School Administration, Thirty-third Yearbook, American Association of School Administrators (Washington, D. C.: National Education Association of the United States, 1955), p. 116.

[33]Ibid., p. 117.

[34]Edward J. Smith, "Problems of In-Service Teacher Education at the Local Level," University of Pennsylvania Bulletin, Education at Mid-Century, Thirty-eighth Annual Schoolman's Week Proceedings (Philadelphia: University of Pennsylvania, September, 1951), p. 32.

Later, (1955), a publication of the American Association of School Administrators stated that in-service education programs must vary to meet differing needs, and listed twelve types of in-service activities which were most widely used at that time.[35] The activities listed included those found in the Dictionary of Education definition.

Business and Industry. The field of business and industry was found to be more emphatic in the belief that responsibility for the in-service program belongs to the administrative element of an organization. Sherwood and Best stated that,

> Every organization . . . has the obligation of developing its employees to their maximum potential; and in most cases this responsibility must fall to the supervisor. Not only must he do what he can to help create such opportunities for his subordinates, but he himself must engage personally in a program of self-development.[36]

Here too, the element of personal responsibility for professional growth was found. Taylor also emphasized the necessity for in-service guidance of the program of personal development of the professional business man when he wrote,

> The relationship between the supervisor and his immediate boss is the foundation of management development. If the supervisor's superior has neither the time nor the ability to guide him in the actual performance of his duties and to help him grow, it is futile to expect outside help to shoulder the burden. Companies should see to it that their senior executives are provided with the time

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[35] Staff Relations in School Administration, op. cit., p. 117.

[36] Frank P. Sherwood, and Wallace H. Best, Supervisory Methods in Municipal Administration (first edition; Chicago: The International City Managers Association, 1958), p. 9.

and tools needed to carry out the basic function of developing their successors.[37]

Evidence stated from each of the three disciplines studied indicated a positive degree of conformity in the conception of what constituted an in-service educational program. All agreed that it was a program conducted essentially during working hours (or on company time), for the express purpose of increasing the knowledge and capabilities of the member either in professional or in technical areas, or both.

III. OBJECTIVES OF IN-SERVICE EDUCATION

This section was undertaken to determine whether a consistency of purpose existed among the three disciplines being reviewed, in their approach to in-service education.

Nursing. "The International Code of Nursing Ethics," which was adopted by the Grand Council of the International Council of Nurses on July 10, 1953, at Sao Paulo, Brazil, recognized the need of continuing education for the nurse in the statement, "The nurse must not only be well prepared to practice, but must maintain her knowledge and skill at a consistently high level."[38]

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[37] E. K. Taylor, "Management Development Begins at Home," Personnel: American Management Association, 34:32, January-February, 1958.

[38] "International Code of Nursing Ethics," The Yearbook of Modern Nursing, 1958-59: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1959), flyleaf.

Heidgerken evolved objectives for an in-service education program from a study differentiating action research from basic research. The purpose of action research, she said, "is directed toward a solution of a problem and the improvement of a specific practice in a specific situation."[39] With this as the foundation, she stated the following as objectives for in-service education.

> An in-service education program should be directed toward helping the nursing staff make a scientific study of its services--objectives, activities, and problems--so that they may make decisions and change practices based on carefully collected data rather than on mere opinion.[40]

Few authors failed to mention the concept of improvement of patient care as a basic objective of in-service educational programs. Perhaps the most emphatic expression of this concept came from Donovan when she wrote,

> . . . We must clearly and persistently bear uppermost in our minds that improved nursing care is the goal or aim of inservice education. It will help us keep our efforts reality-centered.
>
> This aim of improved nursing care also adds to programs a forthright quality which will give them significance if we really mean what we say. It is true that the personnel's professional and personal growth through inservice education is the means by which improved nursing care is achieved, but this is a means and not an end. The end is clearly and unequivocably improved nursing care for patients.[41]

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[39]Loretta Heidgerken, "Inservice Education and Research," Nursing Outlook, 7:474, August, 1959.

[40]Ibid., p. 475.

[41]Helen Murphy Donovan, "Inservice Programs and Their Evaluation," Nursing Outlook, 4:633, November, 1956.

Two further examples of patient-centered statements of objectives for in-service educational programs for nursing service personnel follow:

1 The objective of the staff education program is to improve the nursing care of patients through better preparation of personnel, irrespective of category.[42]

2 Good management, effective supervision, and training for all levels of the nursing service staff are indeed necessary for good nursing care and for economy of operations.[43]

In establishing an in-service education (or training) program for non-professional nursing personnel at the Veteran's Administration Hospital at East Orange, New Jersey, Schlesinger listed a comprehensive, thoughtful group of objectives. These were:

1 To assure more effective, safe patient care, through planned instruction and supervision of the non-professional nursing group.
2 To assure better utilization of non-professional personnel through training, thereby developing increased proficiency in performance.
3 To assure a greater understanding and appreciation of the function of non-professional personnel, as part of the nursing care team.
4 To assist the non-professional worker to gain job satisfaction and thus reduce turnover.[44]

This final example of stated objectives in in-service education

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[42]Lucy D. Germaine, "Educational Programs for Nursing Service Personnel," The Yearbook of Modern Nursing, 1958-59: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1959), p. 220.

[43]Viola C. Bredenberg, "Continuing Education in Nursing Service," The Yearbook of Modern Nursing, 1958-59: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1959), p. 232.

[44]Stephanie Schlesinger, "In-Service Training for Nonprofessional Nursing Personnel," Department of Medicine and Surgery Information Bulletin, (IB 10-45, Washington D. C.: Veterans Administration, September, 1953), p. 24.

for nurses was taken from Miller. The statement of objectives which follows is far more broad and inclusive than the preceding examples, and deserves serious consideration.

> Continuing education--although planned most often as a separate program--might best be thought of as the quality of the educational environment that surrounds nursing personnel, stimulating them to review, investigate, gain added experience, adopt new ideas. These continuing programs will range and change with the interests and growing abilities of the personnel and the leadership given by administrative personnel. With growth, what may have been previously considered not essential becomes essential and is incorporated into the initial basic programs, thus contributing to ever higher standards of patient care.[45]

General Education. Hass wrote that one of the major purposes of in-service education was "the development of common values and goals in the staff of a school, in a group of principals or supervisors, or in any other professional group that must work co-operatively over a period of time."[46] In contrast to the patient-centered approach of nursing, this approach to in-service education is person--or employee centered. This person-centered attitude was amplified later in the same report by Hass when he wrote, "In-service education of all professional personnel is the major key to the building of a greater professionalism among teachers."[47]

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[45]Miller, op. cit., p. 2.

[46]Glen C. Hass, "In-Service Education Today," In-Service Education: For Teachers, Supervisors, and Administrators, Nelson B. Henry, editor (The Fifty-sixth Yearbook of the National Society for the Study of Education, part I. Chicago: University of Chicago Press, 1957), p. 30.

[47]Ibid., p. 31.

In a discussion of the values of action research, the person-centered approach to in-service education was reiterated by Richey. "The trained intelligence of many teachers working together to make the education of children more rational and effective," he said, "serves also to promote in-service growth of teachers and to further advance teaching as a profession."[48]

While the personal approach was the focus of Hass' and Richey's works, methods of teaching constituted the central focus of the objectives set by the American Association of School Administrators.

> Continuous growth in service is highly important if we are to keep pace with a rapidly changing society and apply the newer methods of teaching to education. Improved teaching can result only to the extent that the persons concerned (a) recognize their personal and group needs and the problems affecting their teaching, (b) develop some definite procedures for the solution of their problems, (c) feel some responsibility for the identification of group needs and for helping to plan to meet these needs, (d) develop some criteria for the selection of the problems to be studied, and (e) share in the responsibility for evaluating the program.[49]

Business and Industry. The concept of change and resistance to change holds an important place within the area of in-service training in the field of business and industry. Writing of this, Lawrence indicated that,

> . . . executives and staff experts need, not expertness in using the devices of participation, but a real understanding, in depth and detail, of the specific social arrangements that will be

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[48]Richey, op. cit., p. 63.

[49]Staff Relations In School Administration, op. cit., p. 116.

> sustained or threatened by the change or by the way in which it is introduced.[50]

In this regard, Davis said that industrial change is complicated by the fact that it does not produce a direct adjustment, but operates instead through each employee's attitudes to produce a response conditioned by his feelings toward the change.[51]

In a seminar report by the Society for the Advancement of Management, a statement of the Functions and Objectives of training was given.

> Traditional training programs have aimed at more than just imparting information; they have also been concerned with the development of skills . . . Most leader-training programs today, accordingly provide for:
>
> 1 Imparting information . . .
> 2 Developing skill . . .
> 3 Modifying attitudes . . .
> 4 Creating opportunities for change . . . .[52]

Here again the awareness of the resistance to change was evident. That awareness was amplified, in the same report, by the statement, "We are much more advanced in the first two, imparting knowledge and skill, than in the last two, modifying attitudes and creating conditions necessary for improvement in performance."[53]

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[50]Paul R. Lawrence, "How to Deal With Resistance to Change," Human Relations for Management: The Newer Perspective, Edward Bursk, editor (New York: Harper and Brothers, 1956), p. 348.

[51]Keith Davis, Human Relations in Business (New York: McGraw-Hill Book Company, Inc., 1957), p. 140.

[52]Planning and Training for Effective Leadership (Report on two seminars conducted jointly by the Society for the Advancement of Management, February 24-25, 1955. Ann Arbor: The Foundation for Research on Human Behavior, 1956), p. 8.

[53]Ibid.

Whitehill stated the objectives of training programs for both supervisors and operative employees as,

> Supervisory training . . . must provide a solid foundation in certain basic areas of knowledge. One company . . . identifies five such areas: (1) personal development, (2) human relations, (3) economics, (4) company operations, and (5) technical operations.[54]
>
> . . . . . .
>
> Educational programs for operative employees may be either for orientation or general-education purposes. Orinetation courses, whether for new or experienced workers, are designed to aid in the adjustment of employees to their company, jobs, and associates. General education for workers is offered for the purpose of developing citizens who are enlightened and sophisticated in political, social, and economic matters.[55]

In the area of stated objectives of in-service educational programs, the three disciplines surveyed show a considerably large degree of variance. The field of nursing emphasized the patient-centered approach, rarely speaking only of the development of the individual nurse. Conversely, literature in the field of education concentrated on the development of the individual teacher, with the student and the teaching process as being incidental to that individual development. In the field of business, emphasis was placed on methods to overcome resistance to change. Beyond that point, there appeared to be equal emphasis on personal and on product-centered teaching.

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[54]Arthur M. Whitehill, Jr., Personnel Relations: The Human Aspects of Administration (New York: McGraw-Hill Book Company, Inc., 1955), p. 136.

[55]Ibid., p. 150.

IV. EVALUATION OF IN-SERVICE EDUCATION PROGRAMS

The purpose of this section was to investigate methods of, and criteria for evaluating in-service education programs in the areas of nursing, general education, and business and industry.

Nursing. In the manual, Inservice Education for Hospital Nursing Personnel, Miller constructed the evaluative program under four headings: (1) Why evaluate? (2) What is evaluated? (3) Planning for evaluation, and (4) The evaluation process. Excerpts from the four headings follow,

1 Planned evaluation--both that which is on-going and that which is done once--measures how far the program has gone in meeting its objectives. Evaluation also indicates needed changes that will prevent failure later, promotes realistic goals, unearths gaps in present program and guides future planning.

2 . . . Individual growth in competency, the goal of the employee, and continually better service to patients, the hospital's goal, . . . become synonymous for measurement of effective inservice education.

3 Evaluation is an integral part of the program plan for in-service education; it should not be an afterthought. Objectives that are stated concisely serve as guides to the evaluation process . . .

4 The evaluation process has several logical steps.
   a. Establish criteria
   b. Design the tool, plan method of application and groups involved
   c. Collect data
   d. Interpret data
   e. Draw conclusions, identify implications
   f. Plan indicated or additional activities.[56]

Donovan also emphasized the importance of carefully stated objectives, saying that vague objectives or aims make evaluation of

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[56]Miller, op. cit., p. 58.

the program very difficult and even impossible.[57]

In concert with Miller's concept of evaluation as an integral part of the program plan for in-service education, Germaine stated that,

> Constant evaluation is essential. Through it the program can be kept up to date, a shift in emphasis can be provided for if indicated, and the content and methods of instruction can be kept dynamic.[58]

However, Heidgerken expressed doubt of the effectiveness of the present evaluative systems when she stated that,

> One of the most urgen needs in nursing research today is the development of criteria and tools which can be used to measure and evaluate nursing care. This is one of the real obstacles to carrying out experimentation in nursing, whether it be of a nursing procedure or of an inservice educational program of nursing care.[59]

General Education. The American Association of School Administrators stated as a major function of administration, evaluation of the effects of programs and operations with reference both to the attainment of objectives and to the growth of staff members.

> It is useful as a basis for progressive modification of the organization, the operating plan, the assignment of responsibilities, the allocation of resources, and the methods used to stimulate and co-ordinate the activities of the persons concerned. In the process of evaluation, there should be concern, not only for the achievement of the purposes of the enterprise, but also for the growth and satisfaction of staff members and for the quality of group morale.[60]

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[57]Donovan, op. cit., p. 634.

[58]Lucy D. Germaine, "Educational Programs for Nursing-Service Personnel," The Yearbook of Modern Nursing, 1957-58: A Source Book of Nursing, M. Cordelia Cowan, editor (New York: G. P. Putnam's Sons, 1958), p. 313.

[59]Heidgerken, op. cit., p. 475.

[60]Staff Relations in School Administration, op. cit., p. 21.

Kinnick and others, stating what they termed a "generalization," gave a student, or process-centered criteria of evaluation that opens an area of doubt comparable to that expressed by Heidgerken, when they wrote,

> Evaluation of in-service programs by "evidence" of improved classroom teaching is the best evaluation, but we need many studies to help us discover why and how teachers change their perceptions and how those changed perceptions result in improved learning experiences in the classroom.[61]

Business and Industry. In his Manual for Executives and Training Directors, Rosenberger offered production-centered criteria for evaluation of in-service education and training programs. He wrote,

> In order to evaluate training, one must study the training itself. The results of each unit of training that has been conducted can be studied broadly and quickly in terms of how well the training accomplishes those things which top management expects of it. Such a study will determine, in rapid and comprehensive but detailed inquiry the approximate extent of:
>
> a. Improvement of morale and decrease in turnover.
> b. Preparation of workers for jobs for which "ready-made" employees are not available.
> c. Decrease in the amount of break-in time necessary.
> d. Reduction in time necessary to determine whether or not the new employee is suitable for the job.
> e. Increase in the worker's effectiveness on present job.
> f. Improvement in the product.
> g. Increase in number of workers ready to step into jobs of greater responsibility.
> h. Decreased absenteeism.
> i. Decreased accidents.[62]

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[61] B. Jo Kinnick, et al., "The Teachers and the In-Service Education Program," In-Service Education: For Teachers, Supervisors, and Administrators, Nelson B. Henry, editor (The Fifty-sixth Yearbook of the National Society for the Study of Education, part I. Chicago: University of Chicago Press, 1957), p. 152.

[62] Homer T. Rosenberger, How to Organize and Administer An Employee Training Program: A Manual for Executives and Training Directors, Pamphlet No. 11 (Washington, D. C.: Society for Personnel Administration, 1956), p. 31.

Yoder further pointed out that a "desirable, if not essential," characteristic of all training programs was a "built-in" provision for evaluation. He suggested comparing results of new programs against those of old programs by checks on (1) performance each week during training; (2) training time required to reach standard production; and (3) mistakes and spoilage.[63]

In the Handbook of Personnel Management and Labor Relations, results of a 1952 study by Walter R. Mahler are reported, in which he found that,

> (1) most companies don't know what industrial training has accomplished; (2) training needs are determined primarily on the basis of what the boss wants; (3) most companies have no idea what training methods work best; (4) 1 in 10 companies use systematic research to determine training needs; (5) 1 in 40 companies evaluate efficiency of training methods; (6) testimony or subjective opinion is the basic system of evaluation.[64]

In the area of evaluation, the same basic difference was found in the emphasis of the professions of nursing and teaching, that existed in the area of objectives of in-service education programs. That is, the nursing profession continued to emphasize patient care and the teaching profession, personal development. Since it was shown that evaluation of a program depended upon the objectives set for that program, it was logical that the resulting emphasis should be the same in each area.

Although business literature abounded in studies and reports of evaluation of the individual, of the job process and of the product,

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[63]Yoder, op. cit., p. 303.

[64]Yoder, et. al., op. cit., p. 12.56.

there was a paucity of information regarding evaluation of the in-service training program *per se*. It is true that a composite of evaluation of the above mentioned areas would indicate the effectiveness of the in-service training, but it is of interest--in view of the large amount of information available on the "who, what, when, how" of in-service training--that so little emphasis was placed on the evaluation of the program itself.

CHAPTER III

METHODOLOGY

When this study of in-service education programs in U. S. Air Force hospitals was undertaken, it immediately became evident that a criteria for evaluation of the programs must be found. This chapter deals with choice of the criteria for evaluation, choice of a research tool, and the details of the administration of the tool.

I. CHOICE OF EVALUATION CRITERIA

Although the literature was surveyed in three fields (nursing, education, and business), it was recognized that there would be a positive advantage in having the basic evaluative tool come from the major field of interest. For such a tool, the National League for Nursing publication, Inservice Education for Hospital Nursing Personnel,[1] was chosen because of (1) its recency of publication (1958); (2) the recognized authority of the National League for Nursing; and (3) its complete description of what constitutes an effective in-service education program for the professional nurse.

II. METHOD AND TECHNIQUES USED

The normative survey method of research with the questionnaire

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[1]Mary Annice Miller, Inservice Education for Hospital Nursing Personnel (New York: Department of Hospital Nursing, National League for Nursing, 1958), 73 pp.

as the specific research tool was chosen as the most practicable method of obtaining the data necessary to the study.

The normative survey method. Good and Scates defined the normative survey method of research in the following manner,

> The word survey indicates the gathering of data regarding current conditions. The term normative is sometimes used because surveys are frequently made to ascertain the normal or typical condition (or practice), . . . The term norm also has another meaning in certain contexts--determining upon an authoritative standard, ideal, or model; deciding what ought to be, what is "right" or desirable or good.[2]

Since a major concern of the study was to gather information regarding the current condition of in-service education programs in Air Force hospitals, the survey method of approach to the problem was used. The normative type of survey was used because of its predisposition to relate what is in effect to an authoritative standard--the standard being the National League for Nursing publication, Inservice Education for Hospital Nursing Personnel.

The questionnaire. In view of the geographic distribution of the population to be used for the study, the only realistic method for obtaining the data required was that of the normative survey with the questionnaire technique. Good and Scates stated,

> The questionnaire is particularly useful when one cannot readily see personally all of the people from whom he desires responses or where there is no particular reason to see the respondents

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[2]Carter V. Good, and Douglas E. Scates, Methods of Research: Educational, Psychological, Sociological (New York: Appleton-Century-Crofts, Inc., 1954), p. 549.

personally. This technique may be used to gather data from any range of territory, sometimes international or national.[3]

Regarding the information that can be elicited through the questionnaire technique, these authors also said,

> The questionnaire tends to standardize and objectify the observations of different enumerators, by singling out particular aspects of the situation (regarded as significant to the purpose of the study), and by specifying in advance the units and terminology for describing the observations. . . . As a general rule the questions are factual, intended to obtain information about conditions or practices of which the respondent is presumed to have knowledge.[4]

The information desired for the study could be found only in the hospitals of the U. S. Air Force. The one person within the hospitals who could logically be presumed to have a knowledge of the conditions and practices relating to the study would be the respective Chief Nurse of each hospital.

Using the National League for Nursing publication as a guide, a questionnaire was devised. The questionnaire consisted of 12 major groupings, and had a range of 74 possible answers.

In formulating the questionnaire, The Art of Asking Questions, by Stanley L. Payne,[5] was consulted. Three types of questions were selected; (1) multiple choice; (2) the two-way question; and (3) the free answer question.

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[3] Ibid., p. 606.

[4] Ibid.

[5] Stanley L. Payne, The Art of Asking Questions (Princeton, N. J.: Princeton University Press, 1954), 249 pp.

Where variety is to be considered, Payne suggested the multiple choice question as the one most likely to produce the desired information. "This feature of the multiple-choice question--the listing of a large number of alternatives," he said, "does serve to call them all to each respondent's attention and thereby puts all respondents on the same footing."[6] Since much of the study was concerned with the determination of specific factors from many alternatives, this was considered a satisfactory approach. The largest portion of the questionnaire consisted of questions of this type.

The two-way, or dichotomous question, is one which is intended to suggest only two possible alternatives. Payne stated,

> This type of question is by far the most commonly used of all. It appears to fit the largest number of situations. It reduces issues to their simplest terms and its advocates say that it comes closest to duplicating the types of decisions that people are accustomed to making.[7]

A small number of dichotomous questions were used in the questionnaire. They were arranged to produce information in the nature of an unqualified "yes" or "no."

The questionnaire ended with one free-answer question of the argument type. According to Payne,

> One distinction of the argument variety of the free-answer question is that in the argument question we solicit ideas from all respondents regardless of which side they take on an issue.[8]

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[6] Ibid., p. 76.

[7] Ibid., p. 55.

[8] Ibid., p. 38.

III. THE PILOT STUDY

Pretesting. Authorities are agreed that a plan for pretesting, or tryout, is essential prior to the large scale administration of the questionnaire. In reference to this, Good and Scates wrote that,

> Questionnaires . . . need validation in terms of practical use, in addition to whatever theoretical and statistical precautions may have been taken in the initial preparation of the data gathering instruments. Experienced workers have learned that an individual is not likely to think of all the ways in which a group may respond, and that one cannot anticipate adequately the interpretations of others or the varying complexities of the situations that will arise.[9]

Various plans for pretesting were considered. However, the restrictive nature of the study made it imperative to conduct the pretest among persons who would have a frame of reference within that of the study. Therefore, it was deemed necessary to conduct the pretest among members of the total population of the study. The use of Chief Nurses of U.S. Air Force hospitals for the pretest of the questionnaire would increase the validity of the pretest results, and consequently of the final questionnaire.

As a result of the above considerations, the original questionnaire was mailed to the Chief Nurse of each of eight U. S. Air Force hospitals. The number--eight--was arbitrarily chosen as a reasonable quantity for indication of the validity and completeness of the questionnaire.

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[9]Good & Scates, op. cit., p. 622.

Of the eight pretest questionnaires distributed, seven were returned within the time limit specified. A follow-up letter of a personal nature was sent to the one delinquent respondent, and following further correspondence a final type questionnaire was sent in place of the original questionnaire. This event reduced the pretest to a total of seven, all of whom responded.

Analysis of the seven pretest questionnaires indicated that, with two exceptions, the questionnaire satisfactorily elicited the desired information, and was amenable to analysis. The exceptions were in the form of additional information deemed necessary to completeness of the study. In the final questionnaire, item IV-B was added to determine at what time the in-service education programs were held; during or after normal duty hours. Unit III, item IX-A-1, to determine whether or not attendance at in-service meetings was mandatory, constituted the second addition.

Since the changes required were of such a minor nature, the returns from the pretest were considered to be satisfactory for inclusion within the total study.

Cover Letter. Rummel stated that a cover letter should be so constructed as to solicit the co-operation of the individuals responding. He added, "The purpose of the study should be stated frankly and concisely. It should reveal the nature of the study and reasons why the respondent's assistance is needed."[10]

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[10] J. Francis Rummel, An Introduction to Research Procedures In Education (New York: Harper & Brothers, 1958), p. 99.

A cover letter accompanied each questionnaire, in which anonymity was assured the respondents.

Copies of the final questionnaire and of the cover letter may be found in Appendix B.

IV. THE STUDY

Population. Of the total 94 U. S. Air Force hospitals within the continental United States, seven were investigated through the pretest questionnaire. The final questionnaire was mailed to the Chief Nurse of each of the remaining 87 U. S. Air Force hospitals. Consequently, a universe of all currently existing U. S. Air Force hospitals within the continental United States was included in the study. It will be remembered from the "Scope of the Study," that USAF Dispensaries were not included in the study.

Questionnaire Returns. Although Good and Scates recommended a minimum of 90 per cent returns from the questionnaire in order to prevent bias, they conceded that "questionnaire returns generally have fallen short of the goals described.. . ."[11] They continued,

> The mean percentages of questionnaire returns from a large number of different investigations were as follows: 170 master's theses at Indiana State Teachers College, 71.74 per cent; 204 doctoral dissertations at Teachers College, Columbia University, 70.65 per cent; and 59 research studies reported in the Journal of Educational Research, 80.71 per cent.[12]

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[11] Good & Scates, op. cit., p. 626.

[12] Ibid., p. 627.

V. ORGANIZATION AND TABULATION OF THE DATA

Good and Scates offer three methods for the physical handling of questionnaire returns for purposes of tabulating.[13] The method that was used consisted of an initial list table on which the responses for each questionnaire received single line tabulations. This method permitted a preliminary overview of the results by way of showing what the range was likely to be.

Techniques used for tabulation and analysis. The data was tabulated according to two criteria. First a tabulation was done according to the total of the respondents. Second, the questionnaires were separated according to the criterion of hospital size. This criterion was arbitrarily set at (1) small hospitals, 50 beds or less; (2) medium hospitals, 51 to 150 beds; and (3) large hospitals, 151 beds and over. Basic tabulation was repeated under those conditions.

Distributions were obtained from the tabulation of respondents choosing each of the alternative items in a question. Analysis was based on the distributions of the items in each question.

The questionnaire was comprised of eleven sections and one free response question. Analysis and interpretation of the returns closely followed the basic plan of the questionnaire sections. A table was devised for each section to show the distribution of the numbers of

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[13] Ibid., p. 630.

respondents who chose each alternate response, according to four criteria; (1) total respondents; (2) large hospitals; (3) medium sized hospitals; and (4) small hospitals. The determination of hospital size was established earlier in this chapter.

Although the study was analyzed by the technique of distribution some of the questions were not amenable to this technique and were handled differently. Questionnaire items I-A-2, daily average census; and I-B-1, 2, and 3, numbers of personnel; were reported in mean averages. This was considered to be the most expedient method of reporting large groups of numbers. Questionnaire items III-B, relating to the educational needs of personnel, and XV-C, pertaining to equipment used in the programs, were multiple response questions. They were analyzed by being listed according to the four categories, and placed in rank order from the greatest number of preference to the least number of preference.

The final, free response question was placed into a separate section for analysis. It was broadly classified into four categories; (1) those comments describing successful in-service education programs; (2) those describing moderately successful programs; (3) comments describing plans for establishment of an in-service education program, or for improvement of an existing program; and finally (4) comments of negative interest toward, or success with, in-service education programs.

Copies of the <u>verbatim</u> responses to the free answer question are reported in Appendix A.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF THE DATA

The data obtained by the method described in the previous chapter were analyzed and interpreted in this chapter.

Of 94 questionnaires distributed to the Chief Nurses of continental U. S. Air Force Hospitals, 79, or 84 per cent were returned. One of the questionnaires returned was not amenable to analysis, therefore the analysis was based on the responses of the remaining 78 questionnaires, or on 83 per cent returns.

I. DESCRIPTION OF QUESTIONNAIRE SECTIONS

The questionnaire was comprised of eleven sections, and one free response question. The eleven sections were titled (1) Physical and Personnel Position of the Hospital; (2) Responsibility for the In-Service Education Program; (3) Determining Learning Needs of the Personnel; (4) Participation Planning; (5) Content Planning; (6) Orientation; (7) Ward Conferences; (8) Staff Meetings; (9) Co-ordination Activities; (10) Evaluation of the In-Service Education Program; and (11) Facilities for In-Service Education Program. The divisions of this chapter were designed to follow the same plan as that of the questionnaire, with the single exception that item number XI of the chapter corresponds to questionnaire item number XV, and bears the same title, i.e., Facilities for In-Service Education Program.

The table in each section was arranged to show the distribution of the numbers of respondents who chose each alternate response, according to four criteria; (1) total respondents; (2) respondents from large hospitals; (3) respondents from medium sized hospitals; and (4) respondents from small hospitals. The criteria for hospital size were set in Chapter III, page 43.

The final, free response question was placed in a separate section for analysis.

II. ANALYSIS AND INTERPRETATION ACCORDING TO QUESTIONNAIRE SECTIONS

Section I--Physical and Personnel Position of the Hospital. The first section was designed to indicate the sizes of the hospitals concerned in the study, the numbers of personnel and of patients affected by the existing in-service education programs, and the experiential background of the Chief Nurses who were ultimately responsible for the programs.

Table I, shown on page 47, indicates the responses to questionnaire item I-C, which covers the personnel and career position of the total respondents, and of the groupings of respondents from large hospitals, medium sized hospitals, and small hospitals.

Of the 78 respondents, hospitals represented by size were 11 large hospitals, 34 medium sized hospitals and 33 small hospitals.

TABLE I

PERSONNEL AND CAREER POSITION OF RESPONDENTS ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Duty Capacity:					
a. Chief Nurse	10	30	32	72	93
b. assistant Chief Nurse	0	1	0	1	1
c. acting Chief Nurse	0	3	1	4	5
d. educational co-ordinator	1	0	0	1	1
Total	11	34	33	78	100%
2. Length of Experience in Capacity of Chief Nurse:					
a. under 6 months	0	4	4	8	10
b. 6 months to 1 year	0	1	4	5	6
c. 1 to 5 years	1	11	3	15	20
d. 5 to 10 years	2	8	8	18	23
e. over 10 years	8	10	14	32	41
Total	11	34	33	78	100%
3. Length of Experience in Military Service:					
a. under 7 years	0	0	0	0	0
b. 7 to 10 years	0	1	1	2	2
c. 10 to 15 years	0	6	7	13	17
d. 15 to 20 years	6	26	24	56	72
e. over 20 years	5	1	1	7	9
Total	11	34	33	78	100%
4. Military Rank Held:					
a. Colonel	0	0	0	0	0
b. Lieutenant Colonel	11	9	2	22	28
c. Major	0	21	29	50	64
d. Captain	0	3	1	4	5
e. no answer	0	1	1	2	3
Total	11	34	33	78	100%

A mean average of 21 military nurses, and 11 civilian nurses per hospital were potential beneficiaries of professional in-service education programs. A mean average of 46 non-professional personnel per hospital were available for auxiliary educational programs. Patients potentially affected by the results of in-service education programs averaged 85 per hospital day.

Figure 1, which follows, represents in section A, the total respondents by hospital size. Section B gives the mean average of (1) daily census for each category of hospital; and (2) the various personnel; military nurses, civilian nurses, and non-professional personnel.

FIGURE 1

MEAN AVERAGE, PATIENT CENSUS, AND PERSONNEL; LARGE, MEDIUM, AND SMALL HOSPITALS, AND TOTAL RESPONDENTS

	Large* Hosp.	Medium Hosp.	Small Hosp.	Total Resp.
A. Total Respondents:	10	34	33	78
B. Mean Average:				
1) daily average patient census	240	58	30	85
2) military nurses assigned	53	16	11	21
3) civilian nurses assigned	18	10	8	11
4) non-professional personnel assigned	95	35	22	46

*The mean average in the group, Large Hospitals, is based on ten responses. One hospital, because of its very large size, would have distorted the findings in this analysis, therefore was excluded. The exclusion occurs in this one instance, only, of the study.

The respondents from all of the large hospitals held the rank of lieutenant colonel. Of these, 10 of the 11 respondents held the position of Chief Nurse, while 1 respondent held the position of Educational Co-ordinator. Of these nurses, 8 had over 10 years experience as Chief Nurse and all had over 15 years of military service, with 5 having had over 20 years of military experience.

Of the medium and small hospitals reporting, the majority of Chief Nurses held the rank of major, 21 of 34 so reporting from medium hospitals, and from the small hospitals, 29 of 33 respondents so reported. Although both groups reported nurses functioning as Chief Nurse with less than six months experience in that capacity, 29 of the 34 repondents from medium hospitals had over 5 years experience, and 25 of 33 respondents from the small hospitals were similarly qualified. The largest numbers in both groups had from 15 to 20 years of military experience.

Section II--Responsibility for the In-Service Education Program. The intention of this section was to determine (1) whether a pattern of delegation of responsibility for in-service education programs was evident within the various sized hospitals; and (2) the educational preparation of those to whom the responsibility may have been delegated. The distribution of responses in each of the four categories follows in Table II, page 51.

Of the total respondents, supervision of the in-service education program was retained by 46, or 58 per cent of the Chief Nurses. A

definite pattern of responsibility presented itself. In the medium and small hospitals the Chief Nurse preponderantly retained the responsibility, while in the large hospitals it was delegated to a nurse who was assigned the single duty of educational director.

Outside of the large hospitals only one nurse--in a medium sized hospital--held the single assignment of educational director. In both the medium and small hospitals the position was held as an additional duty in one third of the instances, and in two thirds no nurse was so assigned.

In the same item (1-f), four of the medium sized hospitals reported responsibility for the program as follows:

1. Chairman, In-Service Education Committee
2. Appointed committee
3. Chief Nurse and assistant Chief Nurse
4. Rotated every three months among charge nurses.

From the small hospitals came the following comments regarding responsibility for the program:

1. the anesthetist
2. appointed chairman
3. Chief Nurse, ward charge nurse and I & E Officer
4. The assistant Chief Nurse is also the training officer. The program is planned by the Chief Nurse and the assistant Chief Nurse.
5. We rotate nurses for this assignment, each taking a turn at conducting and presenting a subject. We also make use of films when available.

TABLE II

RESPONSIBILITY FOR IN-SERVICE EDUCATION PROGRAM ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Supervision of Program Delegated to:					
a. Chief Nurse	1	24	21	46	58
b. assistant Chief Nurse	0	1	0	1	1
c. clinical supervisor	1	1	0	2	3
d. ward charge nurse	0	2	0	2	3
e. nurse assigned duty as educational director	7	0	3	10	13
f. other	2	5	4	11	14
g. no in-service education program	0	1	5	6	8
Total	11	34	33	78	100%
2. Duty Assignment, Educational Director:					
a. as a single assignment	7	1	0	8	10
b. as an additional duty	2	11	11	24	32
c. no nurse is so assigned	2	22	22	46	58
Total	11	34	33	78	100%
3. Educational Preparation of Responsible Person:					
a. graduate of 3 year hospital nursing school	1	3	3	7	9
b. some higher education but no degree	2	18	20	40	52
c. graduate of collegiate program with baccalaureate degree	0	1	0	1	1
d. graduate of 3 year school and holding baccalaureate degree	4	7	4	15	19
e. baccalaureate degree plus further education	2	2	0	4	5
f. master's degree	1	1	0	2	3
g. no person is so assigned	1	1	6	8	10
h. no answer	0	1	0	1	1
Total	11	34	33	78	100%

TABLE II (continued)

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
4. Military Rank of Responsible Person:					
a. Lieutenant Colonel	2	5	1	8	10
b. Major	3	18	18	39	50
c. Captain	5	8	6	19	25
d. First Lieutenant	0	1	2	3	4
e. Second Lieutenant	0	0	0	0	0
f. no person is so assigned	1	2	5	8	10
g. other*	0	0	1	1	1
Total	11	34	33	78	100%

*fill-in by respondent.

A consistent pattern was again evident in the educational preparation of persons responsible for the in-service education programs. In the large hospitals the largest single group, or 4 of the 11 responsible persons, were graduates of three year hospital nursing schools and holding a baccalaureate degree, with 3 of the total persons having further education or a master's degree. In both other categories of hospital, the largest single groups were represented in the item, some higher education but no degree. In the medium hospitals, 11 of 34 held a baccalaureate degree or above, while only 4 of 33 held a baccalaureate degree in the small hospitals, with none having education above the baccalaureate level.

Table II, item 1-g, indicates that of the total hospitals responding, 6, or 8 per cent, did not have an in-service education program. All large hospitals reporting had programs. Of the medium hospitals, one did not have a program, and only 5 of 33 small hospitals reported no in-service education program.

One small hospital respondent checked items 4-c and d, and wrote the word "rotation" in the margin, which indicated that supervision of the in-service education program was rotated among nurses holding the rank of captain and of first lieutenant. This response was reported as other in Table II, item 4.

Section III--Determining Learning Needs of Personnel. This section intended to show the means by which the learning needs of the personnel were determined, and the areas of greatest interest to personnel.

In the determination of learning needs of the personnel, 53 per cent of all respondents indicated that a combined approach was used through a combination of the questionnaire technique, direct observation of administrative nursing personnel, and/or committee effort. Although the combination approach showed the largest numbers in each category, the medium and small hospitals both reported fairly high determinations made by direct observation of administrative nursing personnel. A greater proportion of small hospitals worked through committee effort alone than did the others. Table III, page 56, indicates the respondents who chose the various items.

Questionnaire item B of this section, related to pressing educational needs of the staff, elicited multiple answers from 31, or 40 per cent of the respondents. The responses were listed according to the four categories, and placed in rank order from the greatest numbers of preference to the least numbers of preference. The rank ordering of this item is shown in Figure 2, which follows.

FIGURE 2

RANK ORDER OF EXPRESSED EDUCATIONAL NEEDS OF THE STAFF

Total Respondents:	selections per item
1. disaster relief	36
2. a combination of leadership and management development	35
3. new drugs	24
4. nursing trends	21
5. new nursing techniques	19
6. new equipment	17
7. new medical techniques	14
8. leadership development	8
9. management development	5
10. other	4

FIGURE 2 (continued)

	selections per item
Large Hospitals:	
1. disaster relief	45
2. new medical techniques	36
3. new nursing techniques	27
4. a combination of leadership and management development	27
5. nursing trends	18
6. new drugs	9
7. new equipment	9
8. leadership development	0
9. management development	0
10. other	0
Medium Hospitals:	
1. disaster relief	38
2. a combination of leadership and management development	27
3. new nursing techniques	24
4. nursing trends	20
5. new drugs	18
6. new medical techniques	12
7. new equipment	12
8. management development	6
9. leadership development	0
10. other	0
Small Hospitals	
1. a combination of leadership and management development	48
2. new drugs	36
3. disaster relief	30
4. nursing trends	24
5. new equipment	24
6. leadership development	18
7. new nursing techniques	12
8. new medical techniques	9
9. management development	6
10. other	6

The ordering of the responses indicated that disaster relief was the area considered by the respondents to hold the greatest single learning need for the professional staff. Small hospitals alone ranked it third, while the medium and large hospitals both ranked it as the

TABLE III

METHODS OF DETERMINING LEARNING NEEDS OF PERSONNEL ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

Method of Making Determination:	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. questionnaire	1	0	0	1	1
2. direct observation of administrative nursing personnel	1	12	11	24	31
3. committee effort	1	1	6	8	10
4. combination of two or more of above	8	20	13	41	53
5. no determination made	0	1	3	4	5
Total	11	34	33	78	100%

greatest area of educational need.

The second learning need of great importance was a combination of leadership and management development. Although the respondents from the large hospitals ranked this item in fourth place, the stress placed on it by the other two hospital groups ranked it in second place among the total responses.

Nursing trends evolved as another area of marked interest, appearing in rank number 4 of the grouping of total respondents, and in the medium and small hospital groups. The large hospital group ranked this item only one step lower, in place number 5. The remainder of the items in the list were diversified in order of preference by hospital category.

Two respondents from small hospitals made comments under item B-10, which specified other learning needs to be "fire prevention and evacuation," and "interpersonal relationship." The respondent from one medium sized hospital wrote the word "none" as a separate entry.

Section IV--Participation Planning. It was the intent of this section to determine the methods whereby personnel were notified of time and place of meetings, the type of time arrangements that were made for the meetings, and the requirements for attendance at meetings.

In this section, questionnaire items (1) IV-B, "At what time is the in-service education program held?" and; (2) IX-A-1, "Are the in-service meetings mandatory?" were added as a result of the pilot study. Since these questions were not included in the pretest question-

naire, the high proportion of no answer returns is explained.

Table IV, page 59, and Table V, page 60, indicate distribution of items pertaining to this section.

Attendance at in-service education meetings was mandatory in 51, or 66 per cent of the total number of hospitals responding, with 6 of the large hospitals, 25 of the medium hospitals, and 20 of the small hospitals reporting mandatory attendance. In this regard, one small hospital respondent added the comment, "Off duty civilian personnel are invited but cannot be required to attend." It was interesting to note that only 3 of the 33 small hospitals and 5 of the 34 medium hospitals put attendance on a voluntary basis, whereas almost half of the large hospitals did so.

In the large and medium hospitals, the majority of in-service education meetings were held after normal duty hours (large, 8 of 11 hospitals; medium, 18 of 34 hospitals), but in the small hospitals only 9 of 33 hospitals reported programs held after normal duty hours. Both evening and night duty personnel were expected to attend meetings (night duty, 67 per cent; evening duty 50 per cent of total respondents), but there was no apparent correlation between this expectation and the hour at which the meetings were held.

In regard to the time when the in-service education meetings were held, the respondent from one medium hospital entered the comment, "alternating, on and off duty hours." This was reported as other in Table 4, item 2-d.

TABLE IV

TECHNIQUES USED IN PLANNING FOR ATTENDANCE AT IN-SERVICE EDUCATION PROGRAMS ACCORDING TO LARGE, MEDIUM AND SMALL HOSPITALS BY NUMBER; AND TOTAL RESPONDENTS BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Method of Notification, Time and Place of Meeting:					
a. announcement on bulletin board	0	8	7	15	19
b. word of mouth	1	1	2	4	5
c. fixed date and hour, personnel responsible	1	3	4	8	11
d. fixed date and hour, augmented by bulletin board notice	7	11	11	29	37
e. individual, printed notice	0	5	5	10	13
f. other	2	5	0	7	9
g. no meeting held	0	1	3	4	5
h. no answer	0	0	1	1	1
Total	11	34	33	78	100%
2. Time of In-Service Education Meetings:					
a. during normal duty hours	3	10	16	29	37
b. after normal duty hours	8	18	9	35	45
c. no in-service program	0	1	4	5	6
d. other	0	1	0	1	1
e. no answer	0	4	4	8	11
Total	11	34	33	78	100%

TABLE V

ATTENDANCE REQUIREMENT AND TIMES OF IN-SERVICE MEETINGS, ACCORDING TO PARTICULAR RESPONSES; LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; TOTAL RESPONSES, BY NUMBER AND PER CENT

	Response	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Attendance Requirements:						
a. attendance mandatory	yes	6	25	20	51	64
	no	5	5	3	13	17
	no ans.	0	3	5	8	11
no program		0	1	5	6	8
Total		11	34	33	78	100%
b. attendance of night duty personnel expected	yes	5	18	16	39	50
	no	6	14	11	31	40
	no ans.	0	1	1	2	2
no program		0	1	5	6	8
Total		11	34	33	78	100%
c. attendance of evening duty personnel expected	yes	9	22	21	52	67
	no	2	10	6	18	23
	no ans.	0	1	1	2	2
no program		0	1	5	6	8
Total		11	34	33	78	100%
2. Time of Meetings:						
a. held on one day and hour only	yes	10	21	13	44	56
	no	1	11	14	26	33
	no ans.	0	1	1	2	3
no program		0	1	5	6	8
Total		11	34	33	78	100%
b. held on varying days and hours	yes	2	11	13	26	33
	no	9	21	15	45	58
	no ans.	0	1	0	1	1
no program		0	1	5	6	8
Total		11	34	33	78	100%
c. meetings repeated for attendance opportunity	yes	1	3	8	12	15
	no	10	28	19	57	73
	no ans.	0	2	1	3	4
no program		0	1	5	6	8
Total		11	34	33	78	100%

The majority of total respondents (56 per cent), reported in-service meetings held at one day and hour only. Of 33 small hospitals, 8 reported programs repeated at various times for increased attendance opportunity.

Although 29 of the total respondents reported that personnel were notified of meetings by fixed date and hour, augmented by bulletin board notice, the problem of notification procedures presented much diversification. Respondents from three large hospitals reported (in questionnaire item other), that notification was accomplished through the hospital bulletin. Of the medium hospital respondents, comments "paging system," "notice sent to each section, each time," and "a combination of the above," were entered. Small hospital respondents entered the comments "intercom system," and "daily bulletin."

Section V--Content Planning. In this section the intent was to determine the amount of future planning that was utilized for the in-service education programs, and who made the final determination of program content.

Table VI, page 62, clearly shows that the most predominant time for which the programs were planned was, more than one, but less than six meetings. This pattern held true for each of the three categories of hospital.

Content determination in the large hospitals was made by the educational director in 8 of 11 instances. In relation to this point, reference is made to Table II, page 51, which indicates that within

TABLE VI

TIME ELEMENTS OF PROGRAM PLANNING, AND CONTENT DETERMINATION RESPONSIBILITY ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Time For Which Program is Planned:					
a. one year	1	3	1	5	6
b. one year, exclusive of summer months	2	6	3	11	14
c. one meeting only	0	7	3	10	13
d. more than one, but less than six meetings	7	16	14	37	47
e. six meetings	1	1	4	6	8
f. no in-service education program	0	0	4	4	5
g. other	0	1	1	2	3
h. no answer	0	0	3	3	4
Total	11	34	33	78	100%
2. Content Determination Responsibility:					
a. Chief nurse	1	11	9	21	27
b. educational director	5	0	1	6	8
c. assigned committee	1	11	11	23	30
d. voluntary committee	1	3	1	5	6
e. other	2	6	5	13	17
f. no in-service education program	0	1	4	5	6
g. no answer	1	2	2	5	6
Total	11	34	33	78	100%

the category of large hospitals, 7 of 11 hospitals reported a nurse holding the single assignment of educational director.

Within the medium and small hospitals there was no clear pattern of who made the determination of program content. However, the largest single response from the total returns was in the item, assigned committee, which was reported by one third of each of the smaller categories.

The fill-in responses under questionnaire item V-B-5, other, included the following comments in reference to responsibility for content planning;

Large Hospitals:
1 Chief Nurse and educational director
2 committee assigned with consent of the individual

Medium Hospitals:
1 nurse assigned by Chief Nurse
2 Chief Nurse and voluntary committee
3 suggestions voluntary
4 request of nurses and what Chief Nurse considers pertinent
5 Chief Nurse and educational director
6 Chief Nurse and assigned committee

Small Hospitals:
1 the nurses themselves
2 Chief Nurse and assigned committee
3 medical subjects by nurses, administrative subjects by Chief Nurse
4 Chief Nurse and educational director
5 assigned committee with suggestions from the group.

Section VI--Orientation. In this section it was hoped to show the total picture of orientation programs within the hospitals surveyed, as they applied to both professional and non-professional personnel.

Distributions for items in this section will be found in (1) Table VII, page 65; (2) Table VIII, page 66; and (3) Table IX, page 67.

An orientation period for professional personnel of one to three weeks was the predominant plan in all categories of hospital studied. In 54 per cent of all instances, the length of orientation time was determined by a combination of the factors (1) individual basis; (2) necessity of immediate work load; and (3) the formal orientation program. However, 18, or 23 per cent of all respondents reported the time determined on an individual basis.

Regarding the person, or persons, who conduct the professional orientation program, 48 of the 78 respondents reported a combination of administrative nursing personnel. The medium and small hospitals, however, depended quite heavily upon the Chief Nurse for this duty.

In the orientation programs for non-professional personnel, 37 of the 78 respondents reported a plan of one to three weeks, and 17 respondents reported a plan of over three weeks. Here also, the combination approach to persons conducting the orientation was predominant.

One small hospital respondent wrote in the remark, "three days," for the length of orientation time of both professional and non-professional personnel.

A discrepancy was noted in answers to the item, no formal orientation program, within each question of the section. The questions are reproduced here with the corresponding distribution of

TABLE VII

LENGTH, AND DETERMINATION OF LENGTH, OF ORIENTATION PERIOD FOR PROFESSIONAL AND NON-PROFESSIONAL PERSONNEL: ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Length of Orientation Period for Professional Personnel					
a. one day	2	4	0	6	8
b. one week	0	5	8	13	16
c. one to three weeks	6	18	15	39	50
d. over three weeks	2	5	2	9	12
e. no formal orientation program	1	2	6	9	12
f. other	0	0	1	1	1
g. no answer	0	0	1	1	1
Total	11	34	33	78	100%
2. Length of Orientation Period for Non-Professional Personnel:					
a. one day	1	3	1	5	6
b. one week	0	5	3	8	10
c. one to three weeks	7	15	15	37	48
d. over three weeks	2	8	7	17	22
e. no formal orientation program	1	3	4	8	10
f. other	0	0	1	1	1
g. no answer	0	0	2	2	3
Total	11	34	33	78	100%
3. Determination of Length of Orientation Period:					
a. on individual basis	4	9	5	18	23
b. by necessity of immediate work load	1	2	4	7	9
c. by formal orientation program	1	1	3	5	7
d. by combination of above	5	21	16	42	54
e. no formal orientation program	0	1	4	5	6
f. no answer	0	0	1	1	1
Total	11	34	33	78	100%

TABLE VIII

PERSONS WHO CONDUCT ORIENTATION PROGRAMS FOR PROFESSIONAL AND NON-PROFESSIONAL PERSONNEL; ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Persons Who Conduct Professional Orientation:					
a. Chief Nurse	0	6	10	16	21
b. educational director	1	0	0	1	1
c. clinical supervisor	1	0	0	1	1
d. ward charge nurse	0	4	3	7	9
e. combination of the above	9	23	16	48	62
f. no formal orientation program	0	1	3	4	5
g. no answer	0	0	1	1	1
Total	11	34	33	78	100%
2. Persons Who Conduct Non-Professional Orientation:					
a. educational director	0	0	0	0	0
b. clinical supervisor	0	0	0	0	0
c. ward charge nurse	1	4	5	10	13
d. NCOIC	1	1	6	8	10
e. ward master	0	2	0	2	3
f. combination of the above	9	26	18	53	68
g. no formal orientation program	0	1	3	4	5
h. no answer	0	0	1	1	1
Total	11	34	33	78	100%

TABLE IX

EXISTENCE OF FORMAL ORIENTATION PROGRAM FOR VARIOUS PERSONNEL, ACCORDING TO PARTICULAR RESPONSES; LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBERS; AND TOTAL RESPONDENTS BY NUMBERS AND PER CENT

	Response	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. military nurses	yes	6	26	19	51	65
	no	1	1	1	3	4
	no ans.	0	1	0	1	1
no program		4	6	13	23	30
Total		11	34	33	78	100%
2. civilian nurses	yes	5	26	19	50	64
	no	2	1	1	4	5
	no ans.	0	1	0	1	1
no program		4	6	13	23	30
Total		11	34	33	78	100%
3. enlisted personnel	yes	6	25	19	50	64
	no	1	1	1	3	4
	no ans.	0	2	0	2	2
no program		4	6	13	23	30
Total		11	34	33	78	100%
4. civilian nursing assistants	yes	4	23	17	44	57
	no	3	5	3	11	13
	no ans.	0	0	0	0	0
no program		4	6	13	23	30
Total		11	34	33	78	100%

responses pertaining to this item only.

FIGURE 3

RESPONSE, NO FORMAL ORIENTATION PROGRAM, INDICATED WITH CONFLICTING NUMBERS TO VARIOUS QUESTIONS. (REPORTED BY NUMBER)

Response: No Formal Orientation Program	Large Hosp.	Medium Hosp.	Small Hosp.
Total Respondents	78	34	33
1. How long is the orientation period for professional personnel?	1	2	6
2. How long is orientation period for non-professional personnel?	1	3	4
3. How is length of orientation time determined?	0	1	4
4. Who conducts the orientation program for professional personnel?	0	1	3
5. Who conducts the orientation program for non-professional personnel?	0	1	3
6. No formal orientation program is established.	4	6	13

It will be noticed that although the responses from each category indicated, in item 6, that a considerably large proportion of hospitals, 23 of 78, reported no pre-planned orientation program for either professional or non-professional personnel, the questions concerning the length of orientation and who conducted it, presented much lower numbers of responses. This would indicate that although orientation is not

conducted according to a pre-determined plan or formal program, it is, nevertheless, conducted in some manner in most instances.

Section VII--Ward Conferences. A determination of the number of hospitals that had a plan of ward conferences, who conducted the conferences, and the amount of emphasis placed on patient-centered teaching were the purposes of this section.

The distributions of responses to items in this section appear in Table X, page 70, and Table XI, page 71.

The majority of hospitals surveyed either had an active program of ward conferences, or were planning such a program at the time of the study. Of the 78 reporting hospitals, 36 had current programs of ward conferences, while 14 reported current planning toward that goal. The general pattern held true for the three individual categories of hospital, with each having an approximate one third who reported that ward conferences were not being considered.

Of those hospitals in which ward conferences were held, the greatest single number was reported in each category as being conducted by the ward charge nurse. Whereas the greatest single number of respondents reported the programs conducted weekly, almost as many in each category indicated that the programs were presented only occasionally.

A preponderance of all respondents reported that ward conferences, when held, included patient-centered teaching.

The respondent from one large hospital reported that the meetings

TABLE X

DETERMINATION OF PLAN OF WARD CONFERENCES, WHO CONDUCTS SAME, AND HOW FREQUENTLY CONDUCTED; ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. A Program of Ward Conferences:					
a. currently in progress	5	15	16	36	46
b. currently in planning stage	2	7	5	14	18
c. not being considered	4	11	12	27	35
d. no answer	0	1	0	1	1
Total	11	34	33	78	100%
2. Person(s) Conducting Ward Conferences:					
a. ward medical officer	0	2	4	6	8
b. ward charge nurse	3	13	10	26	33
c. clinical supervisor	2	0	1	3	4
d. other	1	4	2	7	9
e. no ward conferences held	5	14	16	35	45
f. no answer	0	1	0	1	1
Total	11	34	33	78	100%
3. Frequency of Ward Conferences:					
a. daily	1	3	4	8	10
b. weekly	3	9	7	19	24
c. occasionally	2	8	4	14	18
d. no ward conferences held	5	13	16	34	44
e. other	0	1	2	3	4
Total	11	34	33	78	100%

TABLE XI

INCLUSION OF PATIENT CENTERED TEACHING IN WARD CONFERENCES, ACCORDING TO PARTICULAR RESPONSES; LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBERS; AND TOTAL RESPONDENTS, BY NUMBERS AND PER CENT

	Response	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
Conferences Include Patient Centered Teaching	yes	5	17	14	36	46
	no	2	3	2	7	9
	no ans.	0	1	2	3	4
no conferences held		4	13	15	32	41
Total		11	34	33	78	100%

were conducted by a combination of the ward charge nurse, the ward medical officer, and/or the clinical supervisor. In the medium hospital group, two respondents stated that the ward conferences were conducted by the charge nurse and the medical officer. A third respondent from the latter group stated, "ward charge nurse, ward master, and OJT [on the job training] training supervisor." From the small hospital group came the replies, "the ward medical officer and the charge nurse," and, "the Chief Nurse."

Section VIII--Staff Meetings. The purpose of this section was to determine the status of staff meetings within the hospitals studied. The numbers of respondents who chose the various responses appear in Table XII, page 73.

An interesting pattern presented itself, in that it appeared that the larger the hospital, the more likely it was to hold staff meetings and in-service education meetings as two separate entities. In the large hospitals the two were held separately in 10 of the 11 instances, the medium hospitals indicated 19 of 34, and in small hospitals only 4 of 33 held separate meetings for the two functions.

The large hospitals were the only group who reported a majority of staff meetings held for military nurses alone. The medium and small hospitals combined military and civilian nurses in their staff meetings. Whereas more large hospitals held staff meetings once a week than at other time intervals, the medium and small hospitals tended heavily to hold meetings once a month.

TABLE XII

STATUS OF STAFF MEETINGS WITHIN HOSPITALS STUDIED, ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Persons Attending Staff Meetings:					
a. military nurses only	6	7	2	15	19
b. civilian nurses only	0	1	0	1	1
c. military and civilian nurses combined	5	25	28	58	75
d. no staff meetings held	0	1	2	3	4
e. no answer	0	0	1	1	1
Total	11	34	33	78	100%
2. Staff Meeting Intervals:					
a. once a week	5	6	5	16	19
b. once a month	4	25	23	52	1
c. less than once a month	2	1	1	4	74
d. no staff meetings held	0	1	2	3	3
e. other	0	1	1	2	2
f. no answer	0	0	1	1	1
Total	11	34	33	78	100%
3. Content Determination Responsibility:					
a. Chief Nurse	8	23	21	52	67
b. educational director	0	0	0	0	0
c. assigned committee	0	2	1	3	4
d. voluntary committee	0	0	1	1	1
e. other	3	8	8	19	24
f. no staff meetings held	0	1	2	3	4
Total	11	34	33	78	100%
4. Plan of Staff Meetings:					
a. held in conjunction with in-service education meetings	1	10	25	36	46
b. held separately from in-service education meeting	10	19	4	33	42
c. no staff meetings held	0	1	1	2	3
d. no answer	0	4	3	7	9
Total	11	34	33	78	100%

In all categories reported, the Chief Nurse was the principal individual who determined content of staff meetings. However, of those hospitals reporting other than the Chief Nurse, there was wide divergence as to who made the determination. The written-in comments under other of this section follow.

Large Hospitals:
1 Chief Nurse and commander of the hospital
2 Chief Nurse and supervisors (two respondents)

Medium Hospitals:
1 Charge nurses and Chief Nurse
2 All have opportunity for discussion of problem areas--operating room, supervisors, clinic, charge nurses, ward nurses.
3 Chief Nurse and assigned committee (two respondents)
4 Commanding Officer
5 charge nurses of section
6 Chief Nurse and staff nurses
7 Chief Nurse and staff--open meeting
8 Chief Nurse and voluntary committee

Small Hospitals:
1 Chief Nurse and open discussion meeting
2 Chief Nurse and voluntary committee
3 Chief Nurse and charge nurses (two respondents)
4 group discussion
5 Chief Nurse and assigned committee
6 Commander
7 Chief Nurse and educational director
8 Combined military and civilian once a week, plus military once a month with the administrative staff of the hospital. (Other comments in this last questionnaire indicated that the military meetings held once a month, were content determined by the hospital administrative director.)

Section IX--Co-ordination Activities. This section was to determine the activities with, and/or between, the hospitals and outside sources in promotion of educational opportunity for nurses. The distribution of responses to this section is shown in Table XIII,

TABLE XIII

EDUCATIONAL COUNSELLING FOR NURSES, ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
Person(s) Giving Counselling:					
1. Chief Nurse	1	5	5	11	14
2. educational director	0	0	0	0	0
3. I & E officer	0	2	5	7	9
4. combination of above	10	27	23	60	77
Total	11	34	33	78	100%

TABLE XIV

EDUCATIONAL CO-ORDINATION ACTIVITIES, ACCORDING TO PARTICULAR RESPONSES; LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS BY NUMBER AND PER CENT

	Response	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. College or University in Community:						
a. hospital receives students for field experience	yes	2	2	2	6	7
	no	8	28	24	60	78
	no ans.	0	1	0	1	1
no school in community		1	3	7	11	14
Total		11	34	33	78	100%
b. nurses attend classes at university	yes	10	27	21	58	75
	no	0	4	4	8	10
	no ans.	0	0	1	1	1
no school in community		1	3	7	11	14
Total		11	34	33	78	100%
c. professors give lectures for in-service program	yes	0	6	0	6	8
	no	10	24	25	59	75
	no ans.	0	1	1	2	3
no school in community		1	3	7	11	14
Total		11	34	33	78	100%
2. Information Given to Nurses Concerning:						
a. Operation Bootstrap	yes	11	34	31	76	98
	no	0	0	0	0	0
	no ans.	0	0	2	2	2
Total		11	34	33	78	100%
b. AFIT Program	yes	11	34	32	77	99
	no	0	0	0	0	0
	no ans.	0	0	1	1	1
Total		11	34	33	78	100%

page 75, and Table XIV, page 76.

To the nurse who was attempting to further her education, assistance and counseling were given by a combination of qualified persons in the great majority of cases reported. Relatively few respondents reported this function being conducted by the Chief Nurse alone, and a still smaller number depended entirely upon the base Education Services Officer.

All respondents who answered the question concerning Operation Bootstrap and the AFIT program, attested to the fact that the nurses were informed of the two programs.

Although only 11 of the 78 respondents reported that there was no college or university in the community, 59 respondents reported that professors from the local universities were not utilized in the in-service education programs. However, 58 respondents reported nurses from their hospitals in attendance at the local universities. Of the 78 reporting hospitals, 6 received students from the universities for field experience. This education activity was dispersed among the three categories, with two small hospitals participating.

Section X--Evaluation of In-Service Education Program. The discovery of methods employed for evaluation of in-service education programs was the purpose of this section. Table XV, page 78, indicates the distribution of respondents who chose each item in the section.

Although in each item of this section the response, a combination of the above, received a large proportion of responses in all cases, it

TABLE XV

PROCEDURES FOR EVALUATION OF IN-SERVICE EDUCATION PROGRAMS, ACCORDING TO LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Methods Used for Evaluation:					
a. progress records	0	2	0	2	3
b. patient survey	0	1	0	1	1
c. medical staff survey	0	0	1	1	1
d. performance evaluation	0	0	1	1	1
e. questionnaire to individual	1	1	0	2	3
f. questionnaire about individual	0	0	0	0	0
g. discussion and verbal judgments	2	11	17	30	38
h. combination of above	8	15	8	31	40
i. other	0	2	1	3	4
j. no in-service education program	0	1	5	6	8
k. no answer	0	1	0	1	1
Total	11	34	33	78	100%
2. When Evaluation is Done:					
a. on a continuing basis	3	11	15	29	37
b. at the close of each meeting	4	3	3	10	13
c. at completion of planned program	1	2	1	4	5
d. every six months	0	1	1	2	3
e. combination of the above	3	15	7	25	32
f. no in-service education program	0	1	5	6	8
g. other	0	0	1	1	1
h. no answer	0	1	0	1	1
Total	11	34	33	78	100%

TABLE XV (continued)

	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
3. Who Evaluated Programs:					
a. all nursing personnel	5	14	14	33	42
b. Chief Nurse	0	6	3	9	12
c. educational director	0	0	0	0	0
d. patients	0	0	0	0	0
e. doctors	0	0	0	0	0
f. combination of the above	6	13	9	28	36
g. no in-service education program	0	1	5	6	8
h. other	0	0	1	1	1
i. no answer	0	0	1	1	1
Total	11	34	33	78	100%

does not represent the first choice of the majority. Figure 4, which follows, indicates each question in the section, with the first and second choice response from each hospital category.

FIGURE 4

EVALUATION METHODS, FIRST AND SECOND CHOICE OF EACH CATEGORY OF HOSPITAL

1 Method Used For Evaluation:

Large Hospitals:

Choice		Of 11 choices
1	combination approach	8
2	discussion and verbal judgments	2

Medium Hospitals:

Choice		Of 34 choices
1	combination approach	15
2	discussion and verbal judgments	11

Small Hospitals:

Choice		Of 33 choices
1	discussion and verbal judgment	17
2	combination approach	8

2 When Evaluation is Done:

Large Hospitals:

Choice		Of 11 choices
1	at close of each meeting	4
2	on a continuing basis	3
2	combination approach	3

Medium Hospitals:

Choice		Of 34 choices
1	combination approach	15
2	on a continuing basis	11

Small Hospitals:

Choice		Of 33 choices
1	on a continuing basis	15
2	combination approach	7

FIGURE 4 (continued)

3 Who Evaluates the Program:

Large Hospitals:

Choice		Of 11 choices
1	combination approach	6
2	all nursing personnel	5

Medium Hospitals:

Choice		Of 34 choices
1	all nursing personnel	14
2	combination approach	13

Small Hospitals:

Choice		Of 33 choices
1	all nursing personnel	14
2	combination approach	9

It will be noticed from Figure 4, that to the question regarding the method used for evaluation, the combination approach, and the method of discussion and verbal judgments alternated in first and second choice. Similarly, in response to the question of when evaluation was accomplished, the choices alternated between the response, on a continuing basis, and that of the combination approach. An exception occurred in this question, however, where the large hospital group selected as its first choice, at the close of each meeting. The last question of the group, Who Evaluates the Program, also followed the pattern of alternation between the response, all nursing personnel, and that of the combination approach.

Section XI--Facilities for In-Service Education Program. The intention of this section was to present a picture of the facilities

available within U. S. Air Force Hospitals for the in-service education program. Questionnaire item XV-C of this section, relating to facilities actually used in the in-service programs, was intended to elicit multiple answers; consequently it was analyzed by the technique or rank ordering. Figure 5, the rank order of responses according to the four categories of the study, appears on page 84. The distribution of the responses to questionnaire items XV-A, and XV-B appear in Table XVI, page 83.

The use of an adequate room at all times for conduct of the in-service education program was reported by 67, or 86 per cent of all respondents. In reporting that meetings were sometimes cancelled because no room was avilable, the respondent from one large hospital added the comment, "occasionally, or rarely."

A consistent pattern evolved in the question concerning equipment available for the educational programs. The items (1) movie films and projector; (2) chalk board; (3) library facilities; and (4) current nursing journals appeared as the four most available in all hospitals. The order was the same as above in the large and medium hospitals, but in the small hospitals, items numbered 3 and 4 of the above list (library facilities and current nursing journals), appeared as numbers 1 and 2 in availability. The remaining four items were equally, and in consistently descending order, available to all. The order of availability was as follows: (1) current nursing publications; (2) slides and slide projector; (3) printing; and (4) art work.

TABLE XVI

FACILITIES AVAILABLE FOR IN-SERVICE EDUCATION PROGRAM, ACCORDING TO PARTICULAR RESPONSES; LARGE, MEDIUM, AND SMALL HOSPITALS, BY NUMBER; AND TOTAL RESPONDENTS, BY NUMBER AND PER CENT

	Response	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
1. Space Available for Meetings:						
a. adequate at all times	yes	10	32	25	67	86
	no	1	1	3	5	6
	no ans.	0	0	0	0	0
no meeting held		0	1	5	6	8
Total		11	34	33	78	100%
b. different room for each meeting	yes	0	1	2	3	4
	no	11	31	26	68	87
	no ans.	0	1	0	1	1
no meetings held		0	1	5	6	8
Total		11	34	33	78	100%
c. meeting canceled, no room available	yes	1	3	2	6	8
	no	10	30	26	66	84
	no ans.	0	0	0	0	0
no meetings held		0	1	5	6	8
Total		11	34	33	78	100%
2. Equipment Available for Programs:						
a. movie projector and films	yes	11	33	27	71	91
	no	0	0	1	1	1
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%
b. chalk board	yes	11	32	27	70	90
	no	0	1	1	2	2
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%

TABLE XVI (CONTINUED)

	Response	Large Hosp.	Medium Hosp.	Small Hosp.	Total Resp. No.	Total Resp. %
c. slide projector and slides	yes	10	22	17	49	62
	no	1	11	11	23	30
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%
d. printing	yes	8	14	14	36	48
	no	3	19	14	36	48
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%
e. art work	yes	3	11	5	19	24
	no	8	22	23	53	68
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%
f. library facilities	yes	11	32	28	71	91
	no	0	1	0	1	1
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%
g. current nursing	yes	11	32	28	71	91
	no	0	1	0	1	1
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%
h. current nursing publications	yes	11	31	26	68	87
	no	0	2	2	4	5
	no ans.	0	0	0	0	0
no program		0	1	5	6	8
Total		11	34	33	78	100%

Figure 5, page 84, indicates a similar pattern of the items actually used in the in-service education program. Respondents from two small hospitals commented, however, that library facilities were "poor," and "limited."

FIGURE 5

RANK ORDER OF EQUIPMENT USED IN IN-SERVICE EDUCATION PROGRAMS, ACCORDING TO AVAILABILITY, BY HOSPITAL CATEGORIES

		selections per item
Total Respondents:		
1.	movie films and projector	62
2.	current nursing journals	60
3.	chalk board	59
4.	current nursing publications	56
5.	library facilities	51
6.	slides and slide projector	33
7.	printing	12
8.	art work	5
	no program for use of equipment	6
Large Hospitals:		
1.	movie films and projector	10
2.	chalk board	10
3.	library facilities	9
4.	slides and slide projector	7
5.	current nursing journals	7
6.	current nursing publications	6
7.	printing	2
8.	art work	0
	no program for use of equipment	
Medium Hospitals:		
1.	movie films and projector	31
2.	chalk board	28
3.	current nursing journals	28
4.	current nursing publications	26
5.	library facilities	22
6.	slides and slide projector	17
7.	printing	6
8.	art work	4
	no program for use of equipment	1

FIGURE 5 (continued)

Small Hospitals:	selections per item
1. current nursing journals	25
2. current nursing publications	24
3. movie films and projector	21
4. chalk board	21
5. library facilities	20
6. slides and slide projector	9
7. printing	4
8. art work	1
no program for use of equipment	5

Summary, Sections I through XI. Of 78 respondents to the study, hospitals represented by size were 11 large hospitals, 34 medium sized hospitals, and 33 small hospitals.

The Chief Nurses of the hospitals responding predominantly held the rank of lieutenant colonel and of major. The majority had over five years experience in the capacity of Chief Nurse, and over fifteen years military experience.

Of the hospitals responding, all large hospitals reported having an in-service education program, while one medium sized hospital and five of the small hospitals reported no program in progress. In the area of responsibility for the program, the large hospitals reported nurses assigned the single duty of educational director. In the other two groups, the Chief Nurse predominantly retained the responsibility.

In the area of learning needs expressed by the respondents, disaster relief assumed an important position. Next in importance was a combination of leadership and management development. Nursing trends evolved as another area of marked interest.

It was found that the majority of respondents required attendance at in-service education meetings as a mandatory function. In both groups of larger hospitals, the meetings were held (in the majority of reported instances), after normal duty hours, but most of the small hospitals held the educational meetings during duty hours. Much diversification was found in communication methods used for notification of personnel concerning meetings.

Diversity was again found in the question of who determined the content of the in-service education meetings. In the large hospitals, where nurses were assigned duty as educational director, that person usually assumed this responsibility. In the other hospitals, however, there was no consistent pattern of responsibility for the program.

The majority of respondents selected one to three weeks as the required time element for orientation. Many indicated that the time was determined on an individual basis, and some responded to time determination by necessity of immediate work load. However, most responses to this question fell into the item, a combination of above.

It was found that the greater proportion of the hospitals surveyed either had an active program of ward conferences, or were planning such a program at the time of the study. Most of the respondents indicated that the programs were conducted weekly by the ward charge nurse.

The findings indicated that the larger the hospital, the greater was the possibility of staff meetings and in-service education meetings

being held as separate entities. Most reporting hospitals combined military and civilian nurses in the staff meetings, but approximately half of the large hospitals held staff meetings with military nurses alone.

It was found that the nurse who sought assistance and guidance to further her education, received that help from a combination of well-qualified people. All respondents reported that the nurses were informed of Operation Bootstrap and of the AFIT program.

Although only 11 hospitals reported that there was no college or university in their community, only 6 of the remaining 67 hospitals made use of the university personnel in their in-service education programs.

Selection of evaluation methods predominantly listed the combination method, with the alternating response to each question being (1) discussion and verbal judgment method; (2) time of evaluation, on a continuing basis; and (3) who evaluates, all nursing personnel.

The availability and use of equipment for in-service education programs presented a consistent pattern among all respondents. Movie films and projector, chalk board, and library facilities were at the top of the lists of availability and of use in programs. Comments from two respondents, however, indicated limited library facilities at their installations.

III. ANALYSIS OF FREE ANSWER QUESTION

The free answer question was devised to give the respondent the opportunity to freely express her opinion concerning the degree of success the in-service education program was enjoying in each individual situation. Of the 78 respondents, four chose not to answer this question.

Successful programs. Reports that indicated a high degree of success in the in-service education program came from eight large hospitals, twenty-one medium sized hospitals, and thirteen small hospitals.

One theme was consistent throughout the responses of successful programs. That theme was staff participation in the selection and preparation of program content. Typical of many responses is the one which said that the in-service meetings were "very interesting and personnel have been motivated by these. I feel it is because the subjects chosen are contributed by the nurses themselves." Another respondent believed the program was successful because "it meets the desire of the staff, is varied, and originates essentially from the group." One hospital, in which a planning committee was used, reported, "The In-service Committee, composed of three nurses, solicits suggestions for future programs from the nursing staff."

Closely allied to the above theme, was the concept that the in-service education program belonged to the nurses themselves, rather

than to the Chief Nurse; that her role was one of consultant. One respondent stated, "The classes are interesting because the nurses plan the programs on procedures etc. that interest them and not through suggestions of the Chief Nurse. She only advises them as needed." Speaking of the staff nurse's responsibility for program content and presentation, another respondent said, "I think this method encourages participation of all nurses and they feel it is their program rather than the program of the Chief Nurse." Still another respondent stated, "Each committee selects their subject of choice. The Chief Nurse acts as a consultant only."

Another focus of the theme of participation was evident in the reports of successful programs, that of active participation in the program itself. An example of this concept is seen in the following response. "Such accepted methods of teaching as; formal discussions, informal discussions, demonstrations, seminars, and audiovisual aids are used; but the keynote is active participation." Another version is found in the statement, "We strive to vary the subjects so that all sections can participate." A final statement is given on this point, which was fairly typical of many of the responses. Following the presentation of the main portion of the program, ". . . a period of discussion follows in which all the nurses participate."

In many instances within this group of respondents, the reason given for successful participation (both in meetings and in content planning), revolved about a plan of committee rotation. A vivid

example of this idea is seen in the following response.

> The tenure of office for the Committee is three months, then a new committee is selected. The nurses are very co-operative as they know that within a period of time, they, too; will be committee members.

The diversity of program content reported, was of interest. Disaster nursing, new treatment procedures, and management in the military nursing service were areas of great interest.

Two specific examples clearly depict the diversity of subject matter. One respondent stated, "The subjects primarily relate to those affecting the nursing service, and methods of providing improved nursing care; however, many allied subjects have been presented." The second respondent commented, "The subjects vary. We do not adhere to nursing subjects--but include such topics as . . . current events."

Complete programs, or program policies, are shown in the following responses.

1 Personalized nursing care of the patient is stressed in this teaching program, and discussions are included on nursing problems, ward management, supervision of personnel, new drugs and treatments, and education of personnel.

2 The several films shown recently have been of great interest to all nursing personnel, e.g., mouth to mouth resuscitation, cardiac arrest, mass casualty evacuation. . . .

3 Although all meetings are basically of a professional nature, a large per cent of our guest speakers are from the adjoining civic community . . . so civic problems and their solutions are tied in with those of the military. Some of the topics covered last year were:
   1. Psychiatry--as it applies to the nurse.
      Speaker--Dr. Zemsky--Director of Child Guidance Clinics of . . . Medical Center.
   2. Nursing Education--its present and future value.
      Speaker--Mrs. Coulter, Dean, School of Nursing, University of . . .

3. Asthma as it affects the child.
   Speaker--Mr. Siey--Administrator, Foundation for Asthmatic Children, . . .
4. Kentucky Frontier Nursing Service--Now act. prof. obstetrics, U. of A. Speaker--Miss Furnas
5. Workshops on Cancer and Community's part is same. Speakers-3 members of local Cancer Society.

4 Some of our programs are as follows:
"Professional Liability Insurance for Nurses" presented by an agent from the insurance company.
"Films and Discussions on Surgical Procedures."
"Films and Discussions of New Drugs."
"Lectures" given by some of the doctors on cardiology.

5 Enclosed is a copy of our program. (Contents of the program follow:)
30 September 1959
Presentation: Discussion of new hospital policies and procedures.
Colonel . . . (position unknown)
Lt. Col. . . . (military nurse)
7 October 1959
Film: Cardiac Arrest--Followed by explanation and discussion.
21 October 1959
Case History: Eleven months old, Hydrocephalic patient.
Etiology--Diagnosis Lt. . . . (military nurse)
Treatment--Nursing Care Lt. . . . (military nurse)
3 November 1959
Report of Symposium conducted by Public Health on Maternity Care held in Columbia 19 September 1959.
Mrs. . . . (civilian), Charge Nurse, Obstetrics.
17 November 1959
Nursing Care of Premature Infants.
Mrs. . . ., Mrs. . . . (civilian nurses)
2 December 1959
Pre-operative Medication, Anesthesia and recovery care of Surgical patients.
Capt. . . . (military) Nurse, Anesthetist
18 December 1959
Principals of Surgery in Managing mass casualties,
Major . . . (military) O. R. Supervisor

Closely related to program diversity, field trips were another important facet of the successful in-service education program. Five hospitals reported successful field trip planning, reports of which

follow:

1 Opportunity for attendance at seminars is provided and those attending bring to the group new trends and concepts in nursing based on their learning experience.

2 Included in our program are field trips to various hospitals, institutions and corrective schools. At the present time we are making plans to visit the Leper Colony. Also included . . . trips through the various aircrafts and departments on the base.

3 We have guests at each meeting from at least two industrial plants in the vicinity. . . . Our guests are invited to tour this installation and in turn we tour their aircraft plants--a most satisfying relationship exists.

4 . . . feel that the program has been very good. For example a trip to Meninger Clinic--only six went, but they reported on their visit when they returned. A trip to Parke-Davis and Upjohn Pharmaceutical Plants included 14 members, enlisted personnel as well.

5 Also we are encouraging military nurses to attend (TDY) in Public Health nursing, Operating Room, Central Supply--etc. so that they can present this information back at their home base--which will help in our training programs, ward management, and better patient care.

Interest or concern with the local professional nurses programs was expressed by only two respondents. One stated, ". . . do think that we could be more active in our local civilian nurses program. This is being encouraged now." The second respondent stated that through the professional in-service meetings, "Contacts with civilian programs for the nursing profession accelerated."

Comments in relation to attendance at meetings were correlated with the question of mandatory attendance in some instances.

1 Attendance, though mandatory, seems to be with full accord.

2 Attendance has been good although it is not mandatory.

3 Many nurses feel it would be a more interesting program if it were not a command performance.

Several respondents, however, made comments to the effect that night duty nurses, or those on days off, although not required to attend, frequently did attend meetings.

It was interesting to note that the respondents of many of the programs that were, here, considered to be successful, reported their programs as "fairly successful," "of moderate success," or "reasonably successful." Several freely commented on what they felt to be shortcomings of the program. Examples of the critical statements follow.

1 From our experience with the In-Service Program at this hospital, it is felt that educational programs conducted on each section are more informative and beneficial than a meeting of all the nurses. However, we still consider it necessary to have one large meeting a month, with such a large group this is the only way we have of reaching everyone.

2 These programs are not as effective as one would like them to be in the respect that they do not seem to stimulate many of the nurses to seek additional knowledge other than that which is presented to them in the programs.

3 Our program would be much more effective if it could be repeated for increased attendance opportunity.

Moderately successful programs. Responses which indicated a moderate degree of success with the in-service education program were received from three large hospitals, seven medium sized hospitals, and ten small hospitals.

Among this group of responses there was no persistent theme, either of why the programs were considered successful in part, or of why they were not considered so. "Response is good," said one

respondent, "except when emergencies occur so the workload is such an additional number must remain on duty." "Due to reorganization of the base and the hospital, plus greatly increased work loads and shortages of personnel," another stated, "our in-service education program has not been established the way we would like to have it." A third respondent said, "It is often difficult to hold meetings because of a tight nursing personnel coverage."

Three respondents made specific comments to the effect that the lack of co-operation from civil service nurses contributed to the lack of success of the in-service education program. These comments follow.

1 We are not reaching civilian personnel as yet. Civilian nurses are invited to attend but programs for professional nurses are held after duty hours and they do not attend.

2 The in-service program is partially effective. Most of our nurses are under civil service. On the day of the program the nurses on the 3-11 shift are requested to come early. Many of them do not attend, although they are given compensatory time.

3 In-service program is not as successful as it could be due to the fact that the nursing personnel is predominantly civil service, and attendance cannot be made mandatory if they are off duty. As a result, only a limited number of on-duty personnel can be spared to attend meetings.

Within the group of moderately successful programs, no respondent mentioned field trips, nor did any include comment of specific program content. The concept of participation, which was so dominant among the group of successful programs, also was missing within this group. Only one comment, a negative one, was found in reference to this idea. "The nurses are much interested in these meetings," the respondent

stated, "but I'm sorry to say, do not contribute much. They all seem to enjoy lectures etc., but would rather let the other fellow do the preparation."

Programs in planning stage. In three instances, the Chief Nurse reporting had been newly assigned to a hospital where no in-service education program had been in progress. All three reported planning in progress for the establishment of a program in January, 1960. A fourth respondent stated that due to hospital renovation over the past six months, no program was in progress, but "Plans are being made to promote an in-service program the first of the year 1960. The program is being planned by the Chief Nurse and the Assistant Health Educator of this base."

The final two respondents of this group reported inadequacy of the current program, and future planning as follows:

1 However, if and when I get an assistant, I hope to establish a program more pertinent to nursing. In the meantime, staff meetings are held with charge nurses, who conduct meetings with their personnel. The age old problem--personnel.

2 We have just recently received our full authorization of nurses and we plan to have a more extensive In-Service Program to start the beginning of the year. At this time, we plan to obtain outside speakers. Also, beginning the first of the year, my two charge nurses will work day duty only. We are planning to have regularly scheduled ward conferences which will include both the professional and non-professional nursing personnel.

Negative comments. Responses indicating negative interest in, or success with, in-service education programs appeared from six respondents.

Comments that appeared more frequently than others regarding lack of success in the programs, were concerned with heavy work loads and personnel shortages. It was recognized, however, that five of the six respondents who made statements of this nature were from small hospitals, where the mean average number of nurses was only 11 military and 8 civilian (see Figure 1, page 48).

One respondent, after commenting on the difficulty encountered in holding meetings for a small group, asked,

> How can I maintain the interest of these various nurses, especially those working in the outpatient clinics and operating room? So many of the common discussions pertain strictly to the inpatient care and these outlying departments feel it to be a waste of time to attend.

Another respondent told of repeated attempts to establish an in-service education program, all of which were thwarted. ". . . emergenices in surgery, out-patient department, and on O. B. often caused such poor attendance the programs were hardly worth while."

The four remining respondents within this group made statements indicating that the small size of the group, and/or the fact that most nurses lived some distance from the hospital rendered in-service education meetings impractical, of not impossible.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

I. CONCLUSIONS

The first hypothesis of this study was proven to be in error. The majority of U. S. Air Force hospitals reporting, showed evidence of successful in-service education programs.

The size of the hospital, whether large, medium or small, had no specific influence on the success of programs, as equally successful programs were reported from all categories. Size did, however, have an influence on the lack of success with in-service education programs. Of the hospitals reporting doubtful success, or no program, the majority were among the group of small hospitals. Reasons advanced for this were persistently in the areas of heavy work load, and shortage of personnel.

The quality of in-service education programs was shown to be excellent in 42 of the 78 hospitals reporting. A great diversification of program materials was presented, and many of the reporting hospitals employed such methods as outside lecturers, field trips and attendance at seminars and workshops. However, there was a marked lack of utilization of the resources of community colleges and universities within the in-service education programs.

The keynote of successful programs was participation. This concept was reported in relation to many phases of the program, and

appeared persistently in the responses from the hospitals reporting the greatest activity in in-service education. One method of achieving a climate of participation was found in the device of rotation of personnel to the assignment of In-Service Education Committee.

II. RECOMMENDATIONS FOR FURTHER IMPLEMENTATION OF PRESENT PROGRAMS

The following recommendations for increased implementation of in-service education programs which are experiencing difficulties, can be offered:

1 Offer alternating programs at different hours, on duty time and off duty time.

2 Use plan of rotating assignment to duty of In-Service Education Committee.

3 Search beyond the hospital for materials to be presented in the programs.

4 Co-operate with local nursing organizations for increased interest and program content.

5 Make the first block of meetings mandatory. After interest has been generated, this requirement may be relaxed.

III. RECOMMENDATIONS FOR FURTHER STUDY

The study indicated clearly that the largest group of unsuccessful in-service education programs occurred within the hospital group of 50 beds or less. It is recommended that further study be done in this area, to determine basic reasons for the lack of success, and to offer suggestions specific to the small hospital situation.

It is further recommended that resources of local institutions of higher learning be more generally utilized in the in-service education programs of Air Force hospitals. This appears to be a question of interest for further investigation.

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APPENDIX A

APPENDIX A

RESPONSES TO FREE-ANSWER QUESTION OF QUESTIONNAIRE

I. RESPONSES TO FREE-ANSWER QUESTION WHICH INDICATED SUCCESSFUL IN-SERVICE EDUCATION PROGRAMS

1 (Medium Hospital)

PROFESSIONAL PROGRAM:

I feel we have a very successful In-Service Program, both for professional and Non-Professional Personnel.

Professional Programs are held twice monthly, January through June, and October through December.

Retraining classes are held once a week on Disaster Nursing.

Professional classes are conducted by the Nurses both Military and Civilian on strictly a volunteer basis. This way they feel as though it is their class and a responsibility delegated to them rather than assigned to them.

The classes are interesting because they plan the programs on procedures etc. that interest them and not through suggestions of the Chief Nurse. She only advises them as needed. These programs are mandatory for Military Nurses, except those on duty, and if patient load permits the evening nurses also attend. Civilian Nurses attend by own free will. The attendance is excellent because the programs are interesting and show much effort and time spent in preparing. Enclosed is a copy of our program. (Program is reproduced on page 91.)

NON-PROFESSIONAL PROGRAMS:

Non-professional programs are held three times a week. Nurses are the instructors on Monday and Wednesday. OJT Supervisor conducts classes on Tuesday.

These programs are made monthly by the Charge Nurses, and classes are held in the Training Unit. Nurses decide where the retraining is needed most, and the programs are made accordingly. They are then presented to the Chief, Nursing Service, for

approval or advice. The programs are typed in the Nursing Service, a copy sent to Director, Base Medical Services; Director, Hospital Services; OJT Training Supervisor who keeps the record; and a copy to each section concerned.

2 (Small Hospital)

Comment #1

"In-Service Educational Program for Military and Civilian Nurses"

General:

1 An in-service educational program for all military and civilian professional nurses is in effect at this hospital. Its purpose is to insure expert nursing service to the patient, to help keep the nurses up to date in their professional knowledge, and to stimulate an interest in further education.

2 This program is so designed as to represent all phases of nursing in our hospital and will be modified from time to time to better meet the needs of the nursing staff and to stimulate their interest. Personalized nursing care of the patient is stressed in this teaching program, and discussions are included on nursing problems, ward management, supervision of personnel, new drugs and treatments, and education of personnel. Such accepted methods of teaching as; formal discussions, informal discussions, demonstrations, seminars, and audiovisual aids are used; but the keynote is active participation.

Objectives:

1 To improve professional skills and to keep abreast with advancements in medicine and nursing.

2 To develop and sustain an "esprit de corps" for greater unity of purpose.

3 To foster new ideas, encourage progress, and provide a means of expression for each nurse.

4 To stimulate an interest in nursing education and guidance, and help each nurse to assume her responsibility.

5 To develop interest in the profession as a whole and stimulate active participation.

6 To help each nurse develop her ability to the fullest capacity both professionally and personally.

Comment #2

"In-Service Training Program For Medical Airmen and Nursing Assistants"

GENERAL:

1 This program is conducted at this hospital and consists of thirty-five hours. One hour classes are held twice a week for medical airmen and nursing assistants working in the hospital wards and related sections. This is a review course for some and a new one for others. The course is seventeen weeks in duration and includes an orientation program and instrumental hours in the fundamentals of nursing for medical airmen and nursing assistants. The practical application is carried out in the classroom situation and the actual patient care under the supervision of a nurse instructor.

MISSION:

1 The mission of this training program is to increase the knowledge and ability of medical airmen and nursing assistants so that they may render effective nursing care of a subprofessional nature in the care and treatment of patients in medical, surgical and OB wards, dispensaries, clinics and related medical activities.

2 To train and guide medical airmen and nursing assistants in order to acquaint them with their duties, responsibilities, and relationships to the hospital and to the patients.

3 To help new personnel feel welcome by giving them a feeling of "belonging" and introducing them to other hospital personnel.

4 To familiarize them with the hospital building plan, other departments, hospital organization, and proper lines of authority.

5 To familiarize them with routines and procedures and to provide opportunity for demonstration and supervised practice.

6 To provide opportunities for guidance and learning in actual "job situations."

7 To provide a basis for insight into interpersonal relationships.

8 To provide opportunities for growth and development of the individual airman or nursing assistant by teaching him or her to help themselves.

3 (Small Hospital)

1 A committee of two nurses (including civilians) are scheduled each month to present the in-service educational program. This is planned on a six month basis. Each committee selects their subject of choice. The Chief Nurse acts as consultant only.

2 During the year the Chief Nurse selects the topic for at least 25% of the monthly meetings. This provides an opportunity to present subjects necessary for job accomplishment.

3 Individual committees presenting subject of choice has increased the interest, participation and attendance of the nurses. This also gives the Chief Nurse an opportunity to evaluate their capabilities.

4 The hours for scheduling the meetings became a problem. The nurses felt their work was not complete and patients were being neglected in order to attend in-service meetings. It was decided among the nursing group that 1500 to 1600 hours [3:00 to 4:00 P. M.] would be most appropriate. At this time, the days work was complete and with the overlap of personnel on duty for one half hour, most nurses were available to attend the meetings. In the past six months attendance of nurses has been 85% or better.

5 A definite date and time each month was scheduled for the in-service meeting. This has prepared the nurses to meet their obligation. Additional notices became unnecessary and plenty of time could be spent on the preparation of the program.

6 At present no unusual problems exist, various and interesting topics are presented and participation is exceptionally good.

4 (Small Hospital)

Our inservice education program is published six months in advance. It is held at 1500 hours [3:00 P. M.] once a month. We make every effort to present some subject informative, necessary and worthwhile for the military and civilian nurses. Those off duty (days off) or on night duty are not required to attend, however often do. In a hospital this small it is not always possible to be present for every meeting, however they are briefed and it is discussed with them later. I feel it is fairly successful. The Anesthetist has ample time to present a select program and I feel the program has been very good. For example a trip to Meninger Clinic--only six went, but they reported on their visit when they returned. A trip to Parke-Davis and Upjohn Pharmaceutical Plants included 14 members, enlisted personnel as well. The majority display a definite interest, even though they are not always able to attend.

5 (Medium Hospital)

1 I feel that our program is quite successful. Prior to 1958, a rather definite line seemed to exist between the military and the civilian nurses. Now all participate--the planning committee consisting of one of each, assigned for one year. They, by contacting the staff, determine both the needs and desires of the girls. They submit to me a tentative plan for the year and I discuss this with them.

Formal meetings are held at 1830 hours [6:30 P. M.] the last Monday of every month, in the Staff room. Meetings are planned for one hour, and limited to this, unless extended by questions, etc., from the girls themselves.

Meetings are mandatory for the military nurses and all civilian nurses are urged to attend.

Although all meetings are basically of a professional nature, a large per cent of our guest speakers are from the adjoining civil community (. . .), so civic problems and their solutions are tied in with those of the military.

Some of the topics covered last year were:

a. Psychiatry--as it applies to the nurse.
Speaker--Dr. Zemsky--Director of Child Guidance Clinics of . . . - on staff of . . . Medical Center.

b. Nursing Education--its present and future value.
Speaker--Mrs. . . ., Dean, School of Nursing, . . . University.

c. Asthma as it affects the child.
Speaker--Mr. Siey--Administrator, Foundation for Asthmatic Children, ...

d. Kentucky Frontier Nursing Service--Now act. prof. obstetrics, University of . . . .
Speaker--Miss. . .

e. Workshops on Cancer and Community's part in same.
Speakers--3 members of local Cancer Society.

6 (Large Hospital)

The In-Service Program is held once a month and is mandatory. The biggest problem is getting a speaker and a subject that will be of interest to a large group. Discussion amongst a large group is more difficult as nurses are less apt to speak up.

Many nurses feel it would be a more interesting program if it were not a command performance. Since this is a day of specialization, the most satisfactory In-Service program would be the type conducted on each section. At this hospital, the NP Service has as about as ideal a program for stimulating interest as is possible. The Supervisor of this section includes all personnel taking care of the patient, in this way the sharing of knowledge is for the benefit of everyone. The doctor is included, when possible, in this period of free discussion because he can tie bits of information together and give a better insight into the background necessary for the better care of the whole patient. The Nursing Service is in the hospital to take care of the whole patient. The only way to do this is by understanding not only his illness but his problems. It takes many people to do this, therefore; sometimes it is wasting time having a clinic or meeting without the personnel who actually are around the patient the most, present, to give more light on the case.

From our experience with the In-Service Program at this hospital, it is felt that educational programs conducted on each

section are more informative and beneficial than a meeting of all the nurses. However; we still consider it necessary to have one large meeting a month, with such a large group this is the only way we have of reaching everyone.

7 (Medium Hospital)

I feel that our inservice education program is successful because:

1 The person conducting the program is an authority in his field--either a Medical Officer if on medical topics--Pharmacy Officer if relating to drugs--Supply Officer if relating to supply etc.

2 Each nurse contributes to the program and therefore actively participates in it by taking turns presenting an additional topic which includes not only medical subjects, but many other topics which she should be informed about, in her status as an officer.

3 After each program, it has been observed that interest has been stimulated and many pertinent questions are presented for answer.

4 Interpersonal relationships are improved, as the physicians and officers of other departments realize that a constant effort to improve the overall efficiency and harmony of the hospital as a whole unit, is the objective of the program.

8 (Large Hospital)

Our inservice program is reasonably successful. The orientation program is considered very good by both nurses being oriented and staff personnel. The indoctrination is very thorough and not hurried. A check list for ward orientation is reviewed a month to six weeks after arrival and questions and problems are clarified.

The lecture programs are well received and doctors are extremely cooperative in giving of their time to discuss topics of current interest and importance in patient care. Civilian nurses and nursing assistants both military and civilian are invited to the programs. This aids in stimulating interest and increasing the attendance. Notes from each lecture are written

and the information disseminated to all departments. While reading notes does not supplant a lecture, it does give the fundamental information to all of the nurses. This portion of the inservice program could be furthered by some type of group participation in the planning.

Although the airmen are not assigned to nursing service they are a part of patient care and formal classes are given to most '10 and '30 [job development] level personnel on OJT. A review class was given to ward masters to better enable them to supervise their personnel. Charge nurses are made aware of the status of personnel and all nurses are informed of responsibility toward teaching and supervising the activities of the airmen. This gives a continuous progression and evaluation of personnel.

9 (Medium Hospital)

I feel that our program is successful because the nurses have expressed their satisfaction. Included in our program are field trips to various hospitals--institutions and corrective schools. At the present time we are making plans to visit the leper colony. Also included as guest speakers have been wing and squadron Commanders and trips through the various aircrafts and departments on the base.

10 (Medium Hospital)

We have our program on the 3rd Monday of each month at 1930 hours [7:30 P. M.] . All can come at this time. The variated programs have had the interest of all nursing personnel. We have guests at each meeting from at least 2 industrial plants in the vicinity. We usually rotate so that each nurse can present a program. Our civilian nurses are greatly interested and are eager and co-operative in assisting with program direction. Even our guest nurses have supplied us with outside speakers.

After the professional hour at our meetings we serve coffee, etc., creating interest and friendship with one another through this social hour.

Our guests are invited to tour this installation and in turn we tour their aircraft plants--a most satisfying relationship exists.

11 (Small Hospital)

I feel our program is fairly successful. Committees are appointed well in advance--in fact the committees for 1960 were announced in September 1959. These committees are appointed for a three month period. They consist of a senior nurse, 2 junior nurses and a civilian nurse. They are responsible for program content and presentation. The only requirement for program material is that it be of interest to everyone. I think this method encourages participation of all nurses and they feel it is their program rather than the program of the Chief Nurse.

Since staff meetings and in-service education programs are combined, any one absent is briefed on any important points brought up in the staff meeting, and all policy changes are published.

12 (Medium Hospital)

A. Training of Medical Technicians AFSC 902X0, [Job Description]

(1) All persons, AFSC 902X0, required to attend classes bi-weekly for lectures, film presentation, and demonstration type instructions.

Result: (a) Individual questioning resulted in overall satisfaction of subjects presented.

(b) No failures in testing for upgrading of technicians in the last two years.

(c) General complaint of having to attend classes on days off or when on night duty (11-7).

B. Professional meeting once a month for all nurses and nursing assistants.

(1) Contacts with civilian programs for the nursing profession accelerated.

C. Weekly meetings with charge nurses and NCOIC's of ward sections:

(1) Dissemination of pertinent information accelerated.

(2) Standardization of ward sections accomplished.

D. An operational inservice education program no matter what type is an absolute necessity.

13 (Large Hospital)

I believe our inservice program is fairly successful. We did not have one until last year and then we had it in the evening. The attendance was good but this year we sent out a questionnaire asking what time they would prefer and the majority wanted it at 1530 [3:30 P. M.] . They were asked for the subjects desired and practically all wanted the physicians to speak on the various specialties. Attendance has been good although it is not mandatory. It is given at 1530 [3:30 P. M.] on the first Tuesday of each month.

We have a formal program for the airmen which covers a four month period with classes twice a week from 1400 to 1500 [2:00 to 3:00 P. M.] . This is part of their OJT [on the job training] and all are required to attend in order to be upgraded from 90230 to 90250 [skill levels] . From 90250 to 90270 [skill levels] they attend the school at Gunter and then receive on-the-job training in the various departments. The airmen in the O-230 field are rotated through all departments.

We receive many of the six month reserves who have attended the basic medical course at Lackland then have approximately three months here. We rotate them through all departments giving them two weeks on each. In the beginning we had classes for the entire time but now we are concentrating their classes into the first two weeks from 1300 to 1500 [1:00 to 3:00 P. M.] each day. These men are nearly all college graduates and some are pharmacists, lawyers, accountants, engineers etc., so they learn very quickly.

We have students from the Mercy Hospital School of Nursing in . . . affiliated with us for their OB-Gyn clinic experience. This affiliation is for one month. We have thirty-six students a year. Their own instructor gives them their formal classroom work.

14 (Large Hospital)

The Inservice program now in operation at this hospital, apparently is successful, in that attendance, though mandatory, seems to be with full accord. The nurses enjoy the programs, volunteer their knowledge and stimulate the interest of others, not in the professional field. A committee of six, are assigned to conduct the meetings--serve on this committee for a period of 6 months. They elect their chairmen and select their own programs, and present them.

Results have been excellent--the quality of nursing care has improved, considerably.

15 (Medium Hospital)

The Program is considered fairly successful because it meets the desires of the staff, is varied, and originates essentially from the group. Opportunity for attendance at seminars is provided and those attending bring to the group new trends and concepts in nursing based on their learning experience. The programs are geared toward improvement in patient care; and occasionally programs relating to the military nurse as an officer are also presented.

16 (Small Hospital)

Our inservice education program is considered to be quite successful because of the interest that has been exhibited in discussions and questions pertaining to the program. We strive to vary the subjects so that all sections can participate. Some of our programs are as follows:

"Professional Liability Insurance For Nurses" presented by an agent from the insurance company.
"Films and Discussions on Surgical Procedures"
"Films and Discussions of New Drugs"
"Lectures" given by some of the doctors on cardiology.

Since our hospital is small the personnel work on different wards at frequent intervals, the discussion of new drugs and the modern treatment of cardiac patients and other diseases and conditions as well help the personnel to keep current in nursing. We have all profited by this program.

17 (Small Hospital)

Believe the program of at least average success as compared to Air Force hospitals. Seven higher-ranking nurses (Capts & 1st Lts), are well motivated toward education and good patient care. Programs offer an opportunity for preparation; and the experience gained from discussion. Promptness at meetings, elimination of chatter etc., and shorter programs have become more appealing. Occasionally informality is the keynote and the nurses' lounge used for meetings and refreshments served. Doctors are welcome as speakers--also base officers speaking on timely subjects. Films requisitioned for doctors' professional meetings are shown before being returned and nursing service personnel invited to see them. Role of the nurse in, and out of the Air Force, is frequently stressed at meetings.

18 (Large Hospital)

The inservice education program is successful. Each service has a chance to present the most interesting phase of their work. Nurses are questioned concerning topics they wish discussed. These things help maintain the interest of the group. When new treatment procedures are inaugurated, the nurses wish them explained to them, i.e., hypothermia. In the past few months the surgeons started to do open heart surgery. The hypothermia anesthesia equipment was procured. All the nurses are now interested in hearing a lecture concerning the use of hypothermia and the nursing care required for these patients.

19 (Medium Hospital)

Until past month the hospital census was higher than authorized and a shortage of 5 or 6 nurses had existed for some time. All nurses were working one to two hours late on every shift and it was felt that management policies needed streamlining. Therefore, the nurses' meetings stressed administrative problems and their solutions. We began to see some progress in wiser use of methods and personnel. At about the same time our nurses came up to strength, we lost all but a few doctors, thereby cutting the in-patient load in half. The nurses have expressed a belief that they really benefit from these monthly sessions especially since the revision of 160-20 and changes pertaining to nursing service. The new nurses fresh from basic training had been taught the new regulations and so there was, for a while, a question of which way was correct--until our meetings enable all to become familiar with the proper procedures.

The several films shown recently have been of great interest to all nursing personnel e.g. mouth to mouth resuscitation, cardiac arrest, mass casualty evacuation. They have stimulated discussions which is a good means of teaching.

Early in 1960 Major . . . is coming from administration school in San Antonio to take over as a full time Chief Nurse. Until that time the CNO [Chief Nurse's Office] is covered by the lone anesthetist here. With an average of four anesthetics per day during the week, it has been impossible to initiate and conduct an active educational program since last July. During the Christmas lull, I am appointing a Captain who is interested in such a program to be educational director so that something of real value may be underway soon. The corpsmen had--until we got down to 8 of recommended 24--a regular OJT [On the Job Training] conducted by Professional Services NCOIC. This we will resume under the direction of a nurse as soon as more enlisted personnel are assigned.

Our aim is to have regular monthly meetings with a guest speaker plus films at other times. The nurses are now invited to attend the physicians and dentists professional meetings.

Much of our present effort is going toward accreditation by the AHA [American Hospital Association] early in 1960.

Can't imagine anyone thinking that education in the medical field could ever be abandoned voluntarily.

20 (Medium Hospital)

We have a growing inservice program. Meetings are held monthly. Attendance is not mandatory, however, most nurses attend, even on their off duty time. The Inservice Committee, composed of three nurses, solicits suggestions for future programs from the nursing staff. The tenure of office for the Committee is 3 months, then a new committee is selected. The nurses are very cooperative as they know that within a period of time, they, too, will be committee members.

21 (Medium Hospital)

Our doctors are most cooperative when nurses approach them on In-Service Education. Nurses play a great part in planning the program thereby getting what they desire most. Attendance is excellent--night nurses frequently attend.

22 (Small Hospital)

We consider our inservice education program very successful in that our hospital is comparatively small and facilities are limited and it brings us up to date on new ideas, drugs, equipment, etc. We hold our meetings on the second Tuesday of the month and each nurse in turn is assigned or can choose her own topic to discuss and then a period of discussion follows in which all the nurses participate. Our meetings usually last 1½ hours and all the nurses here seem to enjoy these periods.

23 (Small Hospital)

The program is considered successful despite mandatory attendance by the military. Attendance of the civilian nurses is voluntary. When a program is of particular interest to the sub-professional staff they are invited to attend. Both the military and civilian nurses participate and discussion groups are held following the lecture. Subjects of interest are submitted to the committee and a suitable speaker is found. The subjects primarily relate to those affecting the nursing service and methods of providing improved nursing care, however, many allied subjects have been presented. The cooperation of the medical staff and their contribution to our program has aided materially in making our program a success.

24 (Medium Hospital)

Our program is well liked as it is more or less informal. It gives the military and civilian nurses a chance to meet and exchange ideas. The nurses themselves usually decide what they want to discuss at the next meeting. So we are always sure of an interesting subject. The doctors, MSC and . . . have been most cooperative in helping us. With a total of 23 nurses and our military strength is usually 2 or 3 short, our attendance is very good. We average about 15 nurses at every meeting. Our night nurses are not required to come but they usually are present.

We are very proud of our program.

25 (Medium Hospital)

This medical treatment facility has been open since June of 1959 and the Inservice education program on a formal basis was

begun in September. The nursing staff has selected the topics themselves and feel that the program gives them a better understanding and knowledge of their profession. Through lectures and open discussion the staff is able to clarify and enlarge their knowledge of the various medical problems prevalent today. The program is more successful since it is a joint effort of all the personnel. The inservice program committee, the topics for discussion and the speakers were selected by the staff.

26 (Medium Hospital)

Both military and civilian nurses are active in our in-service education program, but do think that we could be more active in our local--civilian--nurses program. This is being encouraged now. Also we are encouraging military nurses to attend (TDY) in Public Health Nursing, Operating Room, Central Supply, etc. So that they can present this information back at their home base which will help in our training programs, ward management and better patient care.

27 (Large Hospital)

Our program is successful in so much as we get a great deal of new knowledge from each session. We have recently geared it toward some aspect of disaster nursing so that all nursing service personnel have become more conscious of the role the nurse will be expected to play in case of disaster.

The program has done much to keep the NP, OR and Nurse, anesthetists conscious of the fact that they may be called upon to forget their specialty and do first things first.

Our program would be much more effective if it could be repeated for increased attendance opportunity.

28 (Medium Hospital)

In my opinion, the Inservice Educational Programs for the nurses at this hospital are effective in that the subject matter is of great interest to the nurses, the subject matter is chosen by the nurses from those areas that they feel weak in, the lecturers are well versed in their subject, and every attempt is made to give interesting and enlightening programs.

These programs are not as effective as one would like them to be in the respect that they do not seem to stimulate many of the nurses to seek additional knowledge other than that which is presented to them in the program.

29 (Medium Hospital)

We consider our Inservice Educational program successful. It has been received enthusiastically and attendance has been gratifying. Advancements in medical therapy have necessitated the use of complex equipment, new drugs appear on the market daily, social services are making spectacular advancement. Surely, in the face of all this, nurses must need to be familiar with these advancements and changing trends. The Inservice Education program is a valuable tool towards this end. It serves a purpose and our nurses fully realize they cannot afford to by pass it any longer.

30 (Small Hospital)

This is a new hospital opened within the last year. It operated for six months with five military and seven civilian nurses. All of the nurses with the exception of the Chief Nurse were new to military nursing. A monthly meeting has been held as a combination staff meeting and in-service program. Management in the military nursing service has been the principal theme. The workload for the number of personnel made formal meetings at regular times difficult and the distances personnel lived from the hospital precluded off duty meetings. However, establishing meetings opens better communication among the nursing personnel and also opens the way to a better organized program with participation of all the nurses.

31 (Small Hospital)

The inservice program has definitely increased the job knowledge of both professional and non-professional personnel.

Many of the non-professional personnel are taking advantage of the educational opportunities offered by the Air Force.

32 (Medium Hospital)

We have an inservice education going on and has been going on for several years and we find it very successful. At first the attendance was poor, which necessitated a mandatory attendance. Since then everyone has become interested in it as each one of the nurses in turn has the responsibility of organizing a program. Each program is coordinated with the Chief Nurse for its suitability.

33 (Medium Hospital)

The in-service program for nurses is held once a month. It is not mandatory, however, 90% to 95% of the nurses attend. The subjects vary. We do not adhere to nursing subjects but include such topics as "The Communist Manifesto," and current events.

34 (Small Hospital)

In-service education programs are useful here for many reasons. The professional nursing is no challenge to the young military nurses. A good deal of the time in meetings is used to acquaint them with our type of medical equipment, how it is obtained and the administration necessary to obtain it. Much time is spent, too, in explaining regulations (dry as they are). To repeat, the small hospital is more of a personal than professional challenge for young military nurses.

35 (Medium Hospital)

Our inservice education program has been rather unplanned in the past but quite successful on those occasions when we met. However, a scheduled program has very recently been put into effect and much enthusiasm is evident already.

36 (Small Hospital)

Inservice education programs are held after regular staff meeting. They (the meetings) are very interesting and personnel have been motivated by these and I feel it is because the subjects chosen are contributed by the nurses themselves.

37 (Medium Hospital)

I consider our inservice education program a success as we try to present the subjects that the staff is most interested in and we have staff participation which everyone seems to enjoy.

38 (Large Hospital)

We have an operational inservice education program which we feel has been successful. It brings the nurses together, letting them meet nurses from services other than their assigned section. It also keeps nurses better informed on new nursing techniques, drugs, equipments, etc. It gives nurses an insight into various diseases and problems of the other sections of the hospital.

39 (Large Hospital)

At this USAF Hospital . . . there is a very active in-service program. It is very successful. The subjects are selections from requests which are submitted by the nurses. At this time the nurses are encouraged to ask questions and have a discussion period.

40 (Medium Hospital)

My program is a success because I have it repeated at various hours and all are invited.

Quite often the classroom is filled with other than nursing personnel. Doctors, dentists, nurses aids (volunteers, etc.).

I keep the program very current with the most recent developments.

I also invite anyone of the hospital who wishes to attend. By keeping it current and interesting everyone finds time to attend.

41 (Medium Hospital)

Consider inservice program successful both in attendance and contents for a hospital so limited in personnel and as busy as this one is.

42 (Small Hospital)

The inservice education program is very successful. The nurses are very enthusiastic and a very interesting informal discussion follows each lecture.

II. RESPONSES TO FREE-ANSWER QUESTION WHICH INDICATED MODERATELY SUCCESSFUL IN-SERVICE EDUCATION PROGRAMS

1 (Medium Hospital)

Our inservice education program is fairly active. At this base we have the hospital and then Industrial Medicine Section located at another part of the base. There has been a decided dividing line between the two sections and it has been difficult to break the barrier. We have a program chairman and she selects a nurse from each place for preparation of the monthly meeting. The doctors are very cooperative and give many lectures, demonstrations etc. Drug companies donate time and films as well as salesmen for some of the equipment. The nurses are much interested in these meetings but I'm sorry to say, do not contribute much. They all seem to enjoy lectures etc. but would rather let the other fellow do the preparation.

2 (Large Hospital)

Our inservice program for military professional and sub-professional personnel is fairly successful. Difficulty arises in reaching all personnel. Professional personnel usually attend at least one of the two programs conducted each month. Classes for sub-professional are conducted once a week with the same class being given 5 times during the week. In this way most of the military are able to attend.

We are not reaching civilian personnel as yet. Civilian nurses are invited to attend but programs for professional nurses are held after duty hours and they do not attend. Civilian sub-professional personnel are required to cover wards while airmen attend class.

3 (Small Hospital)

We have started an in-service educational program on a very small scale. This is held the same time as our nursing staff meeting. One of the Air Force physicians or some other hospital department is asked to talk twenty minutes on a particular subject. The hospital is small so the meetings are mandatory except for the night nurse.

4 (Small Hospital)

Once a month, along with nurses' meeting, we have a short in-service program. This may be a talk by one of the nurses on some new nursing trend or some new equipment we have just acquired.

Having only seven military nurses, I believe the in-service program is conducted on an individual basis rather than group project.

I have close contact daily with the nurses and can usually explain policies and answer questions as I make rounds on the wards.

5 (Medium Hospital)

The inservice program is partially effective. Most of our nurses are under Civil Service. On the day of the program the nurses on the 3-11 shift are requested to come early. Many of them do not attend, although they are given compensatory time.

6 (Medium Hospital)

In-service program is not as successful as it could be due to the fact that the nursing personnel is predominantly Civil Service, and attendance cannot be made mandatory if they are off duty. As a result, only a limited number of on-duty personnel can be spared to attend meetings.

7 (Large Hospital)

The inservice education program at this hospital has been proven successful because of the number of airmen who were up-graded in their AFSC's following their planned program. This was especially true in the up-grading of the airmen on the Psychiatric Section.

The former Chief Nurse left early in October and I reported on 29 November 1959. The nurse in charge of the inservice education program also left in early October and a new nurse has been assigned in that area, so the program for the airmen has experienced a little lull. The records are being screened and a full scale program will again be in effect in early January.

The nurses' program has not been interrupted in this period. The orientation of new nurses is especially good. The staff conferences on the psychiatric section also has continued uninterrupted.

8. (Medium Hospital)

Our inservice educational program would be more successful if we had someone to devote full time to planning and operating, also dovetailing this with our enlisted program of teaching.

9 (Large Hospital)

The current inservice education program is fairly successful in some phases. The comments of the newly assigned professional personnel indicate that our orientation program is successful. In the areas of staff development and leadership and management development, I do not consider the program successful. Part of the reason for this is because of the limited experience and qualifications of the individual who is directing the inservice education program. To date the inservice coordinator has not been successful in helping the staff to develop ability in inservice education.

10 (Medium Hospital)

I feel the operational inservice program is fairly successful but could be improved ay assigning a nurse as educational director. We have a newly assigned nurse with the qualifications for this assignment, but due to the heavy workload in the out-patient service, have been unable to spare her for the time to set up a better program. Plans for the future include giving her this assignment if possible.

11 (Medium Hospital)

We have an inservice program for military nurses but since it seems impossible to get enough nurses together during the day, it is held in the evening and therefore, the nurses who happen to be working 3-11 on that particular day can rarely attend the presentation. It is not always the same people who miss the program because our nurses rotate the 3-11 and the 11-7 duty. Our program would be more effective if we could have it on duty time and repeated so that every one could attend at a time of choice.

The inservice program for the enlisted personnel is also a scheduled time and day of the week but unfortunately it sometimes falls on an off duty day or during a tour of 3-11 or 11-7 duty. There are no arrangements for alternate attendance or make up periods. At the present time the program is quite new and is just beginning to have some acceptance among our semi-skilled enlisted ward (or hospital) personnel. We have not been given permission to ask our doctors or other professional personnel for assistance and we have had some difficulty in attempting to maintain the O.J.T. records since the hospital administrative section is unwilling to allow any one else to work on papers of this nature.

12 (Small Hospital)

Our program is moderately successful. Because patient care must come first, attendance is limited. Much of the subject matter covered should be handled in ward conferences. I feel that it would be advantageous to plan meetings twice a month, one for new professional information, the second for review and emphasis of present or recurrent problem areas and for reports by nurses on other meetings or conferences attended.

13 (Small Hospital)

An operational inservice program meeting is held monthly. I feel that it is successful as far as it goes but do believe that formal meetings should be held more often. Follow-ups are done constantly by the supervisors of non-professional personnel to assure that their training is complete. It is hard to schedule a small group of nurses for more meetings as it leaves no one to cover the wards and unless an adequate number attend a meeting one hesitates to use a doctor's time as a speaker.

14 (Small Hospital)

Our inservice nursing educational program seems to work well and is informative. We have formal rounds on all patients daily --all nurses and physicians attend that are on duty.

We have a very fine O.J.T. program for airmen assigned to the Clinical Services. Instruction is by physicians, nurses and non-commissioned officers.

We also have a monthly discussion of the nursing service and nursing care.

15 (Small Hospital)

Because this is a small hospital and we have a rapid turn over of short term patients which are always acutely and at times seriously ill, and at times requiring special nursing, it is often difficult to hold meetings because of tight nursing personnel coverage. Patient care must come first! I do feel that inservice education is of great value to keep up with new trends in nursing and medicine especially materia medica.

16 (Small Hospital)

I feel that an inservice education program is needed in all hospitals. The one we have is not as complete as we desire but an effort is being made to improve our program. I feel that the program we have is successful but we feel the need for more specific information on many subjects.

Sometimes due to work load both for airmen and nurses, it is difficult to include all personnel for these programs.

17 (Small Hospital)

A moderate degree of success has been achieved with in-service program. Inability to attend meetings is, perhaps, greatest contributing factor to lack of success. Married nurses who budget their time find it difficult to return during off duty hours and the immediate work situation where coverage is slim is a frequent hinderance for on duty nurses to attend meetings.

18 (Medium Hospital)

At designated times this installation has an inservice education program. The subjects revolve about disaster control or are concerning some phase of nursing care the majority of nursing personnel feel is needed for better understanding.

Although all personnel in the hospital is informed of these lectures and demonstrations, attendance is mandatory only for those assigned to the nursing service. I feel that if more time could be spent by the medical officers, rather than nurses, in a continuing program, instead of their time being spent with out patients every day, more interest and effectiveness would be created.

A Tactical Hospital usually has several men on temporary duty with little or no notice, which makes adequate patient care difficult and often puts a halt to a formal training program.

19 (Small Hospital)

Due to reorganization of the base and the hospital, plus greatly increased work loads and shortage of personnel, our in-service education program has not been established the way we would like to have it. Our program has improved in the past few months and more interest is being shown. We plan to have a program directed towards the nurses role in different types of disasters and care of mass casualties.

20 (Small Hospital)

Inservice program held in evening. Response is good except when emergencies occur or the workload is such an additional number must remain on duty. Military nurses are normally excused on the evening inservice programs are held.

III. RESPONSES TO FREE-ANSWER QUESTION WHICH INDICATED PLANNING FOR IN-SERVICE EDUCATION PROGRAMS

1 (Medium Hospital)

In the past, our In-Service Programs have been fairly successful. Our speakers have been from our own medical staff and NCO's. We have been very short of nurses and a few programs had to be cancelled because of the patient work load. We have just recently received our full authorization of nurses and we plan to have a more extensive In-Service Program tostart the beginning of the year. At this time, we plan to obtain outside speakers. Also, beginning the first of the year, my two charge nurses will work day duty only. We are planning to have regularly scheduled ward conferences which will include both the professional and non-professional nursing personnel.

2 (Medium Hospital)

Professional meetings have been established as a compulsory attendance by all military nurses. These professional meetings are conducted monthly, excluding the summer months. Various medical subjects and cases are presented and discussed by one of our consultants. The nurses have expressed a favorable opinion of these meetings, therefore I have continued this arrangement. However, if and when I get an assistant, I hope to establish a program more pertinent to nursing. In the meantime, staff meetings are held with charge nurses, who conduct meetings with their personnel. The age old problem--personnel.

3 (Small Hospital)

I have only been assigned since April 29, 1959. They did not have an in-service program. Due to a small hospital and leaves during the summer we did not have an organized program. We used material available. Last week we organized a program and appointed a committee. They will serve for six months.

4 (Small Hospital)

The past six months our hospital has been undergoing renovation. Plans are being made to promote an in-service program the first of the year 1960. The program is being planned by the Chief Nurse and the Assistant Health Educator of this base.

5 (Small Hospital)

Since I have only been here six weeks and no formal inservice program firmly established, this questionnaire has been answered based on the program which will be inaugurated effective 1 January 1960.

6 (Small Hospital)

I have just been assigned the duties of Chief Nurse and intend to start planning an inservice education program as soon as possible.

IV. NEGATIVE RESPONSES TO FREE-ANSWER QUESTION

1 (Small Hospital)

Although I have stated that there is no in-service education program in effect, several attempts have been made to establish one. Regular scheduled meetings were established, but on many occasions had to be cancelled due to illness of nurse, heavy work loads or perhaps lectures were cancelled by scheduled speakers. It is almost impossible to establish a program during duty hours of 7-3. They were usually scheduled for 3:15 P. M., but emergencies in surgery, out-patient department and on O. B. often caused such poor attendance the programs were hardly worthwhile. Since all except six nurses live from 3 to 16

miles from the hospital, they are usually quite reluctant to attend in the evening. Often only the nurses on night duty or on their day off were the only ones able to attend. When it is necessary for the Chief Nurse to perform administrative duties and serve as educational director something is often neglected. In this case the in-service education program seems to suffer most. Plans are now being made to make a more vigorous attempt at the beginning of the new year. Nurses are requested to turn in the subjects which they would like discussed and plans are being made to procure more films.

2 (Medium Hospital)

I'd like very much to have a continuing in-service education program, but with a small group of nurses it becomes difficult to have all attend at the same time. The regular meeting hour is 1530 [3:30 P. M.] (our shifts run 8-4, 4-12, 12-8). In this way I attempt to get most of the nurses to attend. If these meetings fall on days off, I have another complaint added to the already uninterested people that feel nurses meetings are ridiculous. How can I maintain the interest of these various nurses--especially those working in the out-patient clinics and operating room? So many of the common discussions pertain strictly to the in-patient care and these outlying departments feel it to be a waste of time to attend.

3 (Medium Hospital)

Very difficult to have an adequate program in a small hospital. The wards must be covered, however, we have a good group of doctors--they do help with our program.

4 (Small Hospital)

Do not feel that a program is necessary. Because of the very few nurses we have here and the fact that all of us live from 10-14 miles from the hospital. With the working schedule, transportation necessary, and the climate in this area, would mean that perhaps 3 nurses could attend. Under the circumstances, I do not feel a program of this nature would benefit our staff.

5 (Small Hospital)

Inservice education is necessary and desirable but a formal program is highly impractical for the small hospital. There is usually one nurse on duty per shift in each ward or department and she must serve as charge nurse and staff nurse. She cannot leave her patients to attend or conduct meetings. If all nurses on duty during normal duty hours could be available for meetings the number would not exceed four to six.

6 (Small Hospital)

Most of our nurses are civilian Civil Service employees. They are married women with families which is their primary concern during off duty time. They punch in and out by time clock. We attempt to have our programs at a time when the greatest number can attend during duty hours. Interest and participation has not been particularly good.

APPENDIX B

COVER LETTER TO QUESTIONNAIRE

140 South 36th Street
Boulder, Colorado
1 December 1959

Dear Chief Nurse;

As an active duty member of the Air Force Nurse Corps, my current assignment is at the University of Colorado through the AFIT program, where I am doing master's degree studies in the School of Nursing.

For the thesis requirement, I am studying the current status of inservice education programs in U. S. Air Force hospitals, with particular reference to their application to the Air Force Nurse. This study was undertaken with permission from Colonel Lay's office.

Whether you do, *or do not* have a formal inservice education program estabtablished, your contribution in answering the enclosed questionnaire will be of great assistance in the completion of the study. By obtaining answers from a large number of hospitals, valuable information should be provided, which may be helpful toward improvement of the inservice education opportunities for the Air Force Nurse.

Will you co-operate in this investigation by completing the attached questionnaire at your earliest convenience and returning it in the business reply envelope provided for your use? Please return the completed questionnaire not later than 14 December 1959.

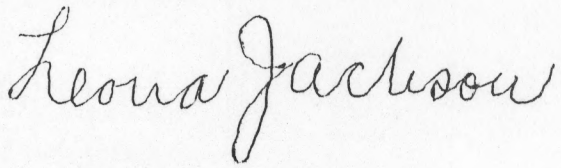
No nurse or hospital will be identified in the results of the study. It is not necessary to sign your name.

Thank you sincerely for your help.

ELLEN M. RESPINI
Major, USAF (NC)

VALIDATION:

Major Ellen M. Respini is a student in the master's degree program of the School of Nursing, University of Colorado.



LEONA JACKSON
Captain, USN (NC), (Ret,)
Chairman, Thesis Committee

QUESTIONNAIRE FOR STUDY OF INSERVICE EDUCATION PROGRAMS IN U. S. AIR FORCE HOSPITALS AS THEY RELATE TO THE AIR FORCE NURSE

The questionnaire is divided into four basic Units. Directions for answering each, will be found directly preceding the individual units.

NOTE: If there *is not* a formal inservice education program at your hospital at this time, please go through the questionnaire carefully. There is a box included in *every* question for this possibility.

UNIT I

I. PHYSICAL AND PERSONNEL POSITION OF THE HOSPITAL:

A. The Hospital; (fill in blanks)
   1. number of operating beds . . . . . (_____)
   2. daily average census . . . . . (_____)

B. Personnel; (fill in blanks)
   1. number of military nurses . . . . . (_____)
   2. number of civilian nurses . . . . . (_____)
   3. number of other nursing service personnel . . . (_____)

C. About Yourself;
   1. In which capacity are you working now? . . . . (check one)
      a. Chief Nurse . . . . . (____)
      b. Assistant Chief Nurse . . . . . (____)
      c. Acting Chief Nurse . . . . . (____)
   2. How long have you functioned in the capacity of Chief Nurse? (check one)
      a. under 6 months . . . . . (____)
      b. 6 months to 1 year . . . . . (____)
      c. 1 to 5 years . . . . . (____)
      d. 5 to 10 years . . . . . (____)
      e. over 10 years . . . . . (____)
   3. How long have you been in the military service? (Include U. S. Army time.) (check one)
      a. under 7 years . . . . . (____)
      b. 7 to 10 years . . . . . (____)
      c. 10 to 15 years . . . . . (____)
      d. 15 to 20 years . . . . . (____)
      e. over 20 years . . . . . (____)
   4. What is your rank?
      a. Colonel . . . . . (____)
      b. Lieutenant Colonel . . . . . (____)
      c. Major . . . . . (____)
      d. Captain . . . . . (____)

UNIT II

DIRECTIONS. Please check (*x*) *one box only* on each of the questions in this unit.

II. RESPONSIBILITY FOR THE INSERVICE EDUCATION PROGRAM:

A. Who supervises the inservice education program in your hospital?
   1. the Chief Nurse . . . . . (____)
   2. the Assistant Chief Nurse . . . . . (____)
   3. the clinical supervisor . . . . . (____)
   4. the ward charge nurse . . . . . (____)
   5. a nurse assigned duty as educational director . . (____)
   6. other (specify) _____
   7. no inservice education program . . . . . (____)

B. Is a nurse assigned duty as educational director?
1. as a single assignment . . . . . (____)
2. as an additional duty . . . . . (____)
3. no nurse is so assigned . . . . . (____)

C. What is the educational preparation of the person who supervises the inservice education program?
1. graduate of 3 year hospital nursing school . . . (____)
2. some higher education but no degree . . . . . (____)
3. graduate of collegiate program with baccalaureate degree . (____)
4. graduate of 3 year school *and* holding baccalaureate degree (____)
5. baccalaureate degree plus further education . . (____)
6. master's degree . . . . . (____)
7. no person is so assigned . . . . . (____)

D. What is the rank of the person who supervises the inservice education program?
1. Lieutenant Colonel . . . . . (____)
2. Major . . . . . (____)
3. Captain . . . . . (____)
4. First Lieutenant . . . . . (____)
5. Second Lieutenant . . . . . (____)
6. no person is so assigned . . . . . (____)

III. DETERMINING LEARNING NEEDS OF THE PERSONNEL:

A. How are educational needs of personnel determined?
1. by questionnaire . . . . . (____)
2. by direct observation of administrative nursing personnel . (____)
3. by committee effort . . . . . (____)
4. by combination of two or more of above . . . (____)
5. no determination made . . . . . (____)

B. Which of the following areas seem to hold the most pressing need for the professional staff?
1. nursing trends . . . . . (____)
2. new nursing techniques . . . . . (____)
3. new medical techniques . . . . . (____)
4. new drugs . . . . . (____)
5. new equipment . . . . . (____)
6. disaster relief . . . . . (____)
7. leadership development . . . . . (____)
8. management development . . . . . (____)
9. a combination of leadership & management development . (____)
10. other (specify) _____
11. unknown . . . . . (____)

IV. PARTICIPATION PLANNING:

A. How are personnel notified of time and place of meetings?
1. by announcement on bulletin board . . . . . (____)
2. by word of mouth . . . . . (____)
3. by fixed date and hour, personnel being responsible . (____)
4. by fixed date and hour augmented by bulletin board notice . (____)
5. by individual, printed notice . . . . . (____)
6. other (specify) _____
7. no meeting held . . . . . (____)

B. At what time is the inservice education program held?
   1. during duty hours (0700 - 1500) . . . . . (____)
   2. after duty hours (after 1500) . . . . . (____)
   3. no inservice program . . . . . (____)

V. CONTENT PLANNING:

A. How far in advance are inservice education programs planned?
   1. one year . . . . . (____)
   2. one year, exclusive of summer months . . . . (____)
   3. one meeting only . . . . . (____)
   4. more than one, but less than six meetings . . . (____)
   5. six meetings . . . . . (____)
   6. no inservice education program . . . . . (____)

B. Who determines content of inservice education meetings?
   1. the Chief Nurse . . . . . (____)
   2. the educational director . . . . . (____)
   3. assigned committee . . . . . (____)
   4. voluntary committee . . . . . (____)
   5. other (specify) _____
   6. no inservice education program . . . . . (____)

VI. ORIENTATION:

A. How long is the orientation period for professional personnel?
   1. one day . . . . . (____)
   2. one week . . . . . (____)
   3. one to three weeks . . . . . (____)
   4. over three weeks . . . . . (____)
   5. no formal orientation program . . . . . (____)

B. How long is the orientation period for non-professional personnel?
   1. one day . . . . . (____)
   2. one week . . . . . (____)
   3. one to three weeks . . . . . (____)
   4. over three weeks . . . . . (____)
   5. no formal orientation program . . . . . (____)

C. How is the length of the orientation time determined?
   1. on an individual basis . . . . . (____)
   2. by necessity of immediate work load . . . . . (____)
   3. by formal orientation program . . . . . (____)
   4. by combination of the above . . . . . (____)
   5. no formal orientation program . . . . . (____)

D. Who conducts the orientation for professional personnel?
   1. the Chief Nurse . . . . . (____)
   2. the educational director . . . . . (____)
   3. the clinical supervisor . . . . . (____)
   4. the ward charge nurse . . . . . (____)
   5. a combination of the above . . . . . (____)
   6. no formal orientation program . . . . . (____)

E. Who conducts the orientation for the non-professional personnel?
   1. the educational director . . . . . (____)
   2. the clinical supervisor . . . . . (____)
   3. the ward charge nurse . . . . . (____)
   4. the NCOIC of enlisted personnel . . . . . (____)
   5. the ward master . . . . . (____)
   6. a combination of the above . . . . . (____)
   7. no formal orientation program . . . . . (____)

VII. WARD CONFERENCES:

A. Is there a program of ward conferrences?
1. in operation at this time . . . . . (____)
2. in the planning stage at this time . . . . . (____)
3. not being considered at this time . . . . . (____)

B. If in progress, who conducts the ward conferrence?
1. the ward medical officer . . . . . (____)
2. the ward charge nurse . . . . . (____)
3. the clinical supervisor . . . . . (____)
4. other (specify) _____ (____)
5. no ward conferrences held . . . . . (____)

C. If in progress, how frequently are ward conferrences held?
1. daily . . . . . (____)
2. weekly . . . . . (____)
3. occasionally . . . . . (____)
4. no ward conferences held . . . . . (____)

VIII. STAFF MEETINGS:

A. With whom are staff meetings held?
1. military nurses only . . . . . (____)
2. civilian nurses only . . . . . (____)
3. military and civilian nurses combined . . . . (____)
4. no staff meetings are held . . . . . (____)

B. When are staff meetings held?
1. once a week . . . . . (____)
2. once a month . . . . . (____)
3. less than once a month . . . . . (____)
4. no staff meetings are held . . . . . (____)

C. Who determines content of staff meetings?
1. the Chief Nurse . . . . . (____)
2. the educational director . . . . . (____)
3. assigned committee . . . . . (____)
4. voluntary committee . . . . . (____)
5. other (specify) _____ (____)
6. no staff meetings held . . . . . (____)

D. Which plan better describes your staff meetings?
1. held as part of formal inservice education meetings . (____)
2. held separately from formal inservice education meetings . (____)
3. no staff meetings are held . . . . . (____)

IX. CO-ORDINATION ACTIVITIES:

A. Who gives assistance and counselling to the nurse who is attempting to further her education?
1. the Chief Nurse . . . . . (____)
2. the educational director . . . . . (____)
3. the I. & E. officer . . . . . (____)
4. a combination of the above . . . . . (____)
5. none of the above . . . . . (____)

X. EVALUATION OF THE INSERVICE EDUCATION PROGRAM:

A. What method is used for evaluation of the educational programs?

1. progress records (____)
2. patient survey (____)
3. medical staff survey (____)
4. performance evaluation (____)
5. questionnaire *to* the individual (____)
6. questionnaire *about* the individual (____)
7. discussion and verbal judgments (____)
8. combination of the above (____)
9. other (specify) _____
10. no inservice program (____)

B. When is evaluation done?

1. on a continuing basis (____)
2. at the close of each meeting (____)
3. at completion of planned program (____)
4. every six months (____)
5. combination of the above (____)
6. no inservice education program (____)

C. Who evaluates the program?

1. all nursing personnel (____)
2. the Chief Nurse (____)
3. the educational director (____)
4. the patients (____)
5. the doctors (____)
6. combination of the above (____)
7. no inservice program (____)

UNIT III

DIRECTIONS. Please answer *every* question with a check (*x*), *either* yes *or* no.

IX. PARTICIPATION PLANNING:

A. Attendance:	*YES*	*NO*
1. Are the inservice meetings mandatory?	____	____
2. Are night duty personnel expected to attend inservice meetings?	____	____
3. Are evening duty personnel expected to attend inservice meeting?	____	____
4. Are inservice meetings held at one day and hour only?	____	____
5. Are inservice meetings held on varying days and hours?	____	____
6. Are inservice meetings repeated at different hours (as on the same day, or in the same week), for increased attendance opportunity?	____	____
7. If no inservice meetings are held, please check here (____)		

XII. ORIENTATION:

A. Is a formal orientation program established?	*YES*	*NO*
1. for military nurses	____	____
2. for civilian nurses	____	____
3. for enlisted personnel	____	____
4. for civilian nursing assistants	____	____
5. If no formal orientation program is established, please check here (____)		

XIII. WARD CONFERRENCES:

A. Do ward conferrences include patient centered teaching?
YES____ NO____

B. If no ward conferrences are held, please check here (____)

XIV. CO-ORDINATION ACTIVITIES:

A. Are the military nurses informed concerning the following educational opportunities?

	YES	*NO*
1. Operation Bootstrap	____	____
2. AFIT program	____	____

B. If there is a college or university in your community;

	YES	*NO*
1. Do you receive students from the school for field experience?	____	____
2. Do some of your nurses attend classes at the school?	____	____
3. Do professors from the school give lectures for your inservice education program?	____	____
4. Check here if there is *no* college or university in your community (____)		

XV. FACILITIES FOR INSERVICE EDUCATION PROGRAM:

A. Space available for inservice education meetings;

	YES	*NO*
1. Is an adequate room available at all times for inservice meetings?	____	____
2. Must a different room be found for each meeting?	____	____
3. Has it ever happened that a meeting must be cancelled or postponed because there was no room available?	____	____
4. If no meetings are held, check here (____)		

B. Is the following equipment made available?

	YES	*NO*
1. movie films and projector	____	____
2. chalk board	____	____
3. slides and slide projector	____	____
4. printing (as for posters, notices etc.)	____	____
5. art work (for posters etc.)	____	____
6. library facilities	____	____
7. current nursing journals	____	____
8. current nursing publications	____	____
9. no program for use of above equipment (____)		

C. (Please check all applicable squares in this section.)
Which of the "Equipment" listed under XV - B above, is normally used in the inservice education program?

1. (____)	4. (____)	7. (____)
2. (____)	5. (____)	8. (____)
3. (____)	6. (____)	

9. no program for use of above equipment (____)

UNIT IV

DIRECTIONS. Please answer *one* of the following questions in full.

I. If you do have an operational inservice education program, please comment on how successful, or unsuccessful, you consider it to be — and why.

II. If you do *not* have an operational inservice education program, please discuss either;

A. the plans you may have to inaugurate one, or

B. why you do not feel that one is necessary in your hospital.

APPENDIX C

LETTER TO CHIEF, AIR FORCE NURSE CORPS

Boulder, Colorado
24 August 1959

Colonel Frances I. Lay
Chief, Air Force Nurse Corps
Office of the Surgeon, USAF
Washington 25, D. C.

Dear Colonel Lay:

. . . . . .

In approaching my thesis, it is my sincere hope to do something that will be of value to the A. F. Nurse Corps. I have chosen as my topic, "A Study of the In-Service Education Programs of Air Force Hospitals Within the Continental U. S., As They Relate to the Air Force Nurse."

First, I would like to know whether this subject meets with your approval. If it does, I have a further request.

In order to establish criteria for evaluation of the study findings, I must have materials that may establish an organized framework for the plan within A. F. hospitals. Would you please have someone send me any letters, directives, or other instructions that may be current in regard to in-service education for A. F. nurses? All that is available to me here is AFM 36-1.

. . . . . .

Sincerely,

Ellen M. Respini
Major, USAF(NC)

LETTER FROM DEPUTY CHIEF, AIR FORCE NURSE CORPS

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON 25, D. C.

11 September 1959

Major Ellen M. Respini, USAF(NC)
140 South 36th Street
Boulder, Colorado

Dear Major Respini:

I'm not sure that I am going to be of much help to you in regard to information for your thesis.

It is a most appropriate subject with a lot of nebulous references and no organized framework on which to rely.

As you know, the Air Force's policy is to decentralize as much as possible and give base echelons more authority, and this goes down to the smallest detail. Hence, there is no established format. All in-service programs are organized to suit the needs of each hospital and the following only imply that there will be a program:

AFM 160-20 Medical Treatment Facilities, Chapter I, Paragraph 16c, Chief Nurse

AFM 123-1 Inspector General's Check List, Medical Section, Nursing Service, Section 4, Training

AFM 160-63 Professional Activities Report, Part VIII, Report of Nursing Service

Copies of these are not available at the moment since they are all in the process of revision or are at the printers. Perhaps you can borrow copies from Lt. Colonel Wanda Fill, USAF(NC), Chief Nurse, USAF Dispensary, Air Force Academy, Colorado; or Lt. Colonel Margaret Kowaleski, USAF(NC), Chief Nurse, USAF Hospital, Lowry Air Force Base, Colorado. I believe these bases are not too far from Boulder.

Various informational letters have been sent out but they are intended to be mere guides, suggestions, crutches or whatever you want to call them but not directive.

Please give Captain Leona Jackson our very fondest regards. Colonel Lay is out on TDY but tell Leona she is getting anxious for February 1960 to roll around when she will be assigned to Headquarters USAFE, Wiesbaden.

Wish I could offer a more positive approach. I just hope that out of this you might find a spark of encouragement.

Kindest regards.

Sincerely,

DOROTHY N. ZELLER
Lt Colonel, USAF(NC)
Deputy Chief
Air Force Nurse Corps