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ABSTRACT

A proposal for a library project for mentally and physically handicapped persons at Custer State Hospital includes a listening library for the residents of the hospital with a cassette player in each resident's room. Tape storage would be at the nurse's station on each floor, and the charge nurse on that floor would be responsible for the tapes. Circulation of the software would be done by resident's aides at the beginning of their shifts. Also proposed are listening booths to be set up on each floor, for those residents who are not bedridden. (AP)

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**PROPOSAL FOR A LIBRARY PROJECT
FOR
SEVERELY-PROFOUNDLY RETARDED, MULTIPLE HANDICAPPED INDIVIDUALS**



CUSTER STATE HOSPITAL

AND

SOUTH DAKOTA STATE LIBRARY

1977

1-422228-090

When the concept of library service was broadened and added emphasis on service to the handicapped was encouraged, the South Dakota State Library Commission decided in 1976 to accept a proposal submitted by the Custer State Hospital for a library program to serve their extremely handicapped residents.

The attached proposal and the report of the project reflect an inovative approach of library service to the profoundly handicapped individual. Full credit for the project is due to Mr. Fridell and his staff. Inquiries about the project may be addressed to him.

Betty Siedschlaw, Consultant to
State Institutions for the
State of South Dakota

PROPOSAL FOR A LIBRARY PROJECT
FOR
SEVERELY-PROFOUNDLY RETARDED, MULTIPLE HANDICAPPED INDIVIDUALS

Agency: Custer State Hospital
Rt. 1, Box 98
Custer, South Dakota 57730

Robert Henry Fridell
Therapy Activities Supervisor
673-4732

Proposed Project Title: Custer State Hospital Listening Library

Population:

Custer State Hospital is a residential institution for the severely-profoundly retarded, multiple handicapped. The age range of our 181 residents is from three to sixty-six. The main difference between Custer State Hospital and Redfield State Hospital and School, the other institution in the state for the mentally retarded, is that Custer's population is generally more physically handicapped, or need closer medical supervision. Very few of our residents are ambulatory and many have very limited use of their limbs. While most of our residents are up for part of the day in wheelchairs or other supportive mobile devices, few can move their own chairs. Our residents are moved from area to area, activity to activity. Turning the pages of a book or turning a machine on-and-off is not feasible for the bulk of our population. Because of the physical handicaps of our residents, expressive language skills are at a minimum, whereas receptive language skills are much more developed. Particularly in the area of music, we see a wide variety of responses. It is probably the medium that we notice the most response, aside from one-to-one interaction, of course.

Physical Layout:

Custer State Hospital consists of three floors. The first floor is made up of the administrative, medical, nursing and therapy offices; the kitchen and dining area; and most therapy activity areas.

The top two floors are the resident living areas. Residents share their rooms with one to three roommates, giving more privacy than open ward living areas, yet too, offering the possibility of sharing stimulus generating equipment (record players, tape equipment, decorations, etc.).

To The Present:

The philosophy of the institution has been evolving in recent years, turning from a purely custodial facility to one that offers developmental programming through a wide range of activities and experiences. Our therapy programs involve sensory stimulation, skill training, motor and language development, physical therapy, recreation, prevocational, evening, and community based activities.

Currently, the library services of Custer State Hospital consist of a 16mm projector that is used four to six times a week to show residents, both in activity programs and in the living areas, movies obtained from the state library. We have a portable video tape machine, which has been used for resident viewing, but it is generally used for inservices and evaluation purposes.

On the 2nd and 3rd floors, televisions, stereos, tape players, and radios have primarily been purchased by individual residents (purchased in their behalf), or brought in by relatives, friends, or guardians. Historically the Institution did buy televisions and the like for resident use, but with the changes Medicaid has brought, the purchase of these items has since come out of personal funds.

Today there are many kinds of audio equipment on the floors, however, the problem arises that few of the systems are compatible with each other. Also, each resident has his own collection of records and tapes, which means that some have considerable accumulations, while others have none. There is also no monitoring system

to keep track of the records and tapes, so many are misplaced, lost, or stolen.

I estimate that the institution itself spends \$200 per year on audio-visual equipment and consumable supplies. This includes repairing and replacing equipment, special film rentals, and the purchase of records tapes, and books for resident use.

Intent:

What we want to see happen, is for a listening medium to develop in the resident living areas that is capable of providing a wide range of listening experiences for all residents, no matter how physically handicapped.

Library Location:

In each resident's room there will be a tape player that will stay in that room, and will serve the residents in that area. If these tape players must be purchased, then those rooms with bedfast residents will be our first priority.

The tape storage area will be at the Nurse's Station on each floor, and the Charge Nurse on that floor will keep the key.

Population Served:

While all residents will have the Listening Library available to them, I foresee those residents who spend the greater portion of their day in bed or in their rooms because of health or positioning problems to benefit the most from the library. Those residents who are not mobile, who must stay in their rooms, are very difficult to provide stimulation and recreation for. We believe this library service will help us provide a variety of stimulating auditory experiences for these residents.

Hardware:

We are now exploring the possibility of obtaining cassette players from the Library of Congress. It is our understanding that the physically handicapped as well as the blind can qualify for their materials. Pillow phones are also being looked into.

If this system or resource does not serve our needs, then the equipment will be purchased using grant monies. What we are looking for is a system that is compatible with all other systems in the resident living areas, can offer a wide selection of software, and can withstand institutional use.

Software:

If we do go with the cassettes, then the tapes will be purchased locally and ordered from the Library of Congress. Again, a wide variety of music is stressed. Also a lockable storage system will have to be made.

Circulation:

A check-out system is being developed where each resident's aide, at the beginning of their shift, will be able to check out a tape for each of the rooms she has residents in that she cares for. During the shift the aide will be able to check in-and-out various tapes to provide a variety of stimulation for the residents in that room. At the end of each shift, all materials will be checked in. All headphones/pillowphones will be checked in and out too.

Inservice:

Behavior Therapy periodically provides Nursing with inservices; it is planned that a portion of each inservice will be spent discussing the Listening Library. New aides will learn the intent and mechanics of the service, and feedback can be received from the experienced aides who are using the system. In this way too, we can monitor the effectiveness of the system and find out what new materials

should be purchased: how can we make it work better.

Something More:

If funding permits, we would also like to set up Listening Booths in the Floor Activities Room on each floor. These are areas where Behavior Therapy provides activities for residents who do not leave the living areas. It is intended that the booths be for residents who are up in wheelchairs. What we are looking for is appropriate use of resident leisure time. The grant monies would be spent in this area on the booth itself, and playback equipment if the Library of Congress equipment does not prove to be the best system in our situation.

Intended Objectives:

Standardization of listening hardware so the equipment in each room is compatible with the equipment in every other room.

Provide auditory stimulation for residents who do not have a radio, record player, radio, etc., in their rooms and who spend the greater portion of their day there.

Provide a variety of listening experience, that is available to all residents.

Post script:

Having played the guitar here for residents, and organized the Rolling Rhythm Band, I have seen how music can influence a resident's behavior. I am quite interested in what the effects of this project will be. I have seen a self-abusive resident calmed by a fife and drum march, and unresponsive/self-stimulating children sit up and listen for a soft guitar. It is just a matter of experimenting.

LISTENING LIBRARY PROJECT
(FY 77 Progress Report--Final)

In July 1976, on the recommendation of Betty Siedschlaw, Institutional Consultant for the South Dakota State Library, Custer State Hospital submitted a grant proposal for a Listening Library for residents to use in their living areas. The grant money is funded under Title I of the Library Services and Construction Act (P.L. 91-600, 20 U.S.C. 351) and is intended to establish and improve libraries in institutions.

The State Library Commission understood that in order to provide a library service for our population of severely-profoundly retarded multiple handicapped non-ambulatory residents, that an innovative approach would need to be developed. The Commission felt that the proposal showed promise, and approved it. In December we received our first monies and began to design, order, and purchase the equipment we would need. By spring, the total amount of the grant monies had been sent to us.

Miguel Apaza, a toy and furniture maker of the Backwoods Shop in Deadwood was contacted. He designed and constructed two cassette storage units capable of holding 200 cassettes each. These cases will house the cassettes in the resident living areas.

Bids were taken from Rapid City music stores, and Budget Tapes and Records gave the low bid for pre-recorded cassette tapes. Many of the titles we wanted needed to be special ordered from the factory, and Kevin Probst of Budget Tapes and Records has been helpful in finding these hard to get tapes for us.

Letters were written to 14 recording companies asking for pre-recorded cassette donations, and Warner Brothers Records, Incorporated, through the efforts of

Bernie Freedman, sent us ten current releases.

Three cassette tape playing machines were purchased from Radio Shack to record our resident Rollin' Rhythm Band and other activities for inclusion in our library selection; to provide machines for those residents who do not qualify for Library Services to the Blind and Physically Handicapped; and to rerecord tapes.

During this initial period, I met with the Direct Care staff aides during their coffee breaks to explain the proposed library system, listened to their suggestions, and found out which residents they felt would benefit from the service. Since it is the Direct Care personnel who will deliver the service to residents, it is of utmost importance to keep them informed about the system, its utilization, and get their feedback.

Once we gathered a list of residents who might benefit and enjoy the service, John Vincent of the South Dakota State Library, Library Services to the Blind and Physically Handicapped, was contacted. For those residents who qualified for the Library's services, cassette machine players and appropriate tapes were ordered.

Throughout the year, Betty Siedschlaw has come to Custer to assist us concerning the selection of materials, finding resources, cataloging tapes and the use of the Listening Library. None of us working at Custer have any experience in the mechanics of library services, and we have relied heavily on Betty's skills.

The establishment of the Listening Library has been a tedious and time consuming task. Wanda Wheeler, our Activities Therapy Aide that works part time on the project, and Robert H. Fridell, Therapy Activities Supervisor, are the only staff members working with the library. I estimate that we can spend at the most ten percent of each week on the project due to our other responsibilities in the

institution. At present we are cataloging tapes, establishing our card file system, and waiting for our tape orders and Library Service for the Blind and Physically Handicapped tape machines to arrive. I estimate that by mid-summer the system will be in the living areas being used by residents.

In the meantime, our activity programs are experimenting with the variety of music, story, and spoken-word tapes we have received, and have found residents attentive and receptive to the medium. We are trying to record those residents' voices who can vocalize and have them listen to themselves. These experiences are the first of their kind for many residents.

Ellen Zahrt, our Speech Therapist, is quite interested in the use of the Library, and has assisted in the selection of tapes for the purpose of improving resident communication skills.

Our goal for the past year has been to organize the Listening Library and ready it for use. In the coming year, we will see it introduced into the living areas, monitor its use, and make adjustments in its utilization as needed. Meetings and inservices will be held with the Direct Care staff to explain the system to new employees, and to get their input in regard to its utilization and selection of materials.

In the coming year, FY '78, should our project be funded again, I would like to

see more cassette tapes purchased to replace those that will be damaged from use, and to expand the variety of tape selection. More tape machines will be purchased for those residents who cannot qualify for the Library Services to the Blind and Physically Handicapped materials.

In the coming year, too, I will investigate the new copyright laws to see if it is possible for us to record our pre-recorded cassettes on longer blank tapes to enable our residents to have longer periods of listening.

The tape players we have received from the Library Service to the Blind and Physically Handicapped have enabled us to set up this library service and have been invaluable to us for that reason. However, as funding permits, we will replace the tape machines with purchased machines due to the unpredictable quality of sound reproduction, and the requirement that the machines must follow the residents to which they are issued. When residents move from one room in the hospital to another, we have had to cancel some machines and order others in order to maintain the library service in each of the semi-private rooms. We have but a limited amount of staff time to devote to the project, and feel it could be better spent improving and monitoring the system, rather than ordering, canceling, and waiting for tape players.

We have found the cassette tapes that the Library Services to the Blind and Physically Handicapped offers are of excellent quality and found their selection of children's stories and music to be appropriate for our population. I would like to see the Service offer more music selections, particularly items which are not currently available on pre-recorded cassettes, such as music from different cultures (Native American for example), international selections.

sound effects, environmental sounds, etc. At the present only a fraction of the records produced are also available in cassette form, and we are therefore limited in what we can make available in our system.

We owe many people our thanks for the opportunity to experiment with this new library service, and for the support and cooperation we have received. I have listed those organizations and individuals whose contributions to our Listening Library have been significant in this development in the following section titled "Resources". An idea that five years ago would not be thought of, is possible today. Our change in awareness, from the legislative to the service delivery levels, have enabled us to develop the Listening Library. As we develop the potential of those we serve, so our own potential grows. Thanks.

Robert Henry Fridell/s/

Robert Henry Fridell
Therapy Activities Supervisor

RESOURCES

State People and Organizations:

South Dakota State Library Commission
South Dakota State Library
Pierre, South Dakota 57501

Dr. Herschel V. Anderson, State Librarian
South Dakota State Library
Pierre, South Dakota 57501

Betty Siedschlaw, Institutional Consultant
South Dakota State Library
Pierre, South Dakota 57501

John Vincent, Director
Library Services to the Blind and Physically Handicapped
South Dakota State Library
Pierre, South Dakota 57501

Businesses:

Miguel Apaza, Toy and Furniture Maker
Backwoods Shop
Lee Street
Deadwood, South Dakota 57732

Kevin Pröbst
Budget Tapes and Records
623 St. Joe Street
Rapid City, South Dakota 57701

Bernie Freedman
Warner Brothers Records, Inc.
3300 Warner Boulevard
Burbank, California 91510

Radio Shack, A Tandy Corporation Company
Baken Park Shopping Center
Rapid City, South Dakota 57701

Catálogos and Guides:

Schwann Record and Tape Guide, Schwann Children's Catalog
137 Newbury Street
Boston, Massachusetts 02116

Cassette Books
Library of Congress
Washington, DC 20542

Print and Non-print Materials Which Might be Considered for Purchase
by Correctional Institutions for Juveniles
South Dakota State Library Institutional Services
South Dakota State Library
Pierre, South Dakota 57501

Tröll Associates
320 Route 17
Mahwah, New Jersey 07430

Custer State Hospital
Listening Library Project
FY 77 Budget Report

Income:

1. Title I, Library Services and Construction Act.....	\$ 2,341.47
	<hr/>
Total Income.....	\$ 2,341.47

Expenditures:

1. Two tape storage units.....	\$ 170.00
2. Cassette tapes.....	2,016.64
3. File boxes and supplies.....	21.26
4. Tape machines and accessories.....	133.57
	<hr/>
Total Expenditures.....	\$ 2,341.47

Income Over Expenditures:	<u>\$ 0.00</u>
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BALANCED INVESTMENT AND LEVEL OF SERVICE

Although the various unofficial standards seem to disagree they are basically the same, as demonstrated in Figure 1 (p. 17). The variance is not a wide one, but it is enough to show that there is room for difference of opinion. Size alone does not indicate a hospital's needs. A specialized pediatrics hospital with a medical teaching function will need a better developed library in its own specialty field than a general-service community hospital of the same size.

The administrator must identify: 1.) where his hospital's library now stands relative to general standards, 2.) the service level he hopes to reach, as adequate to the needs of his own staff, and 3.) the intermediate short-term goals which can be reached on a year-to-year basis, as part of a directed growth plan.

Accreditation teams are perfectly well aware of the inadequacy of many hospital libraries. They know the impossibility of suddenly establishing such service with untrained manpower and inadequate space. What they will look for is an awareness of the existing situation, an honest effort to give as much service as possible from combined local resources and borrowing, and a feasible plan for growth which will produce adequate library service at the local level within a specified period of time.

Regardless of the present size of the hospital, the growth pattern of its library must go through all the development stages of smaller hospitals as it moves toward its goal of large-hospital service. Each growth stage must be fully developed and balanced before moving into the next stage.

The service goal is defeated, if an "instant library" is purchased from a basic list before the hospital can afford suitable space to house it or a librarian to develop its use by the hospital staff.

Where does your hospital now stand in the various levels of service, and how far do you think it could go?

SERVICE LEVEL I

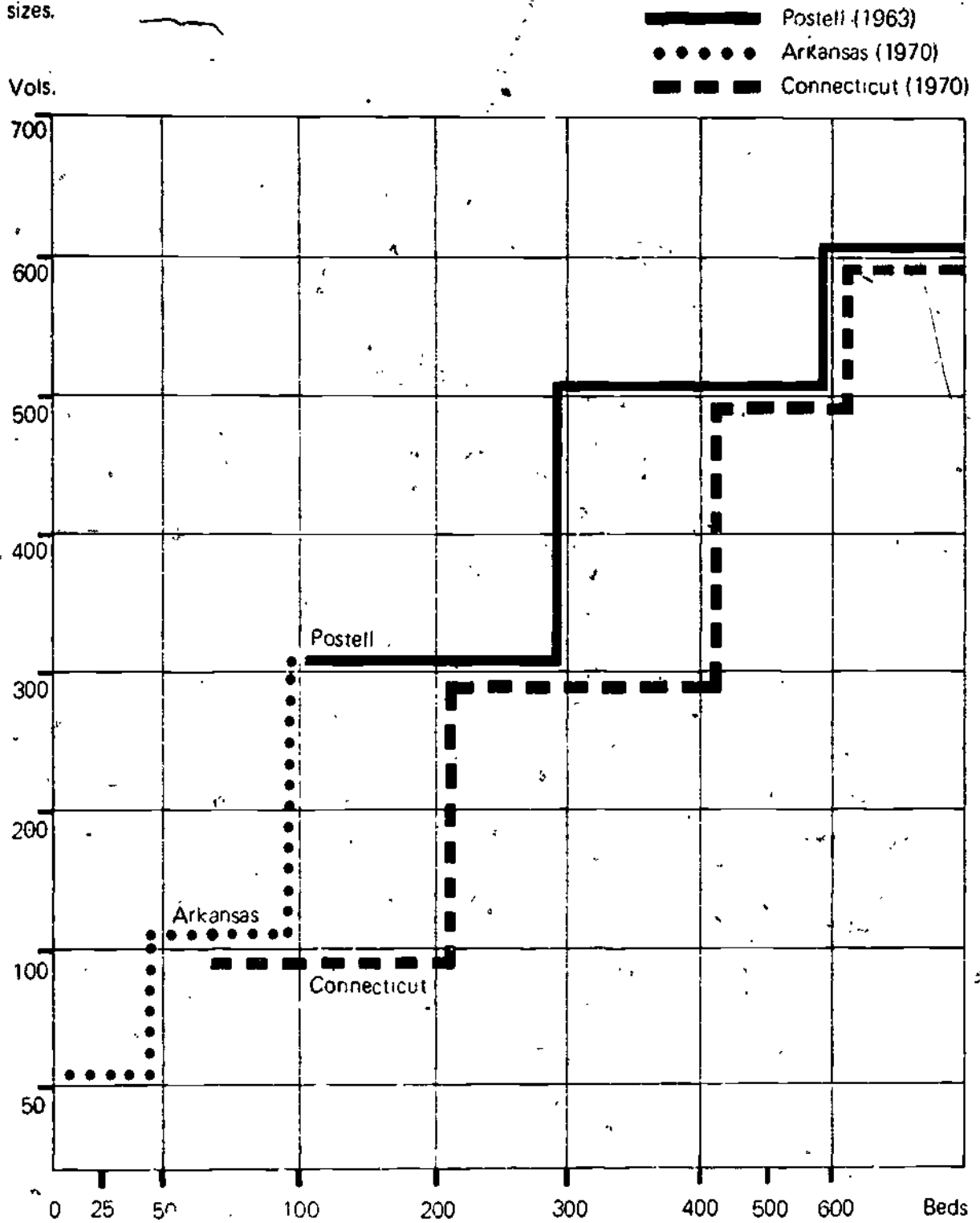
Level I will be given the most detailed description, because it forms the base level for all succeeding service levels. The smallest rural hospital could afford this level of service, and probably already has most of the components to achieve it. At this level a philosophy of service is established. Higher service levels are an elaboration of that basic philosophy.

The community which supports a 35 bed hospital (or less) seldom has local medical specialists. A surgeon may be on the staff, but the general practitioners are usually skilled in the more common surgical procedures. These men, and the nurses who assist them, see too broad a range of medical problems to depend on reading for detailed knowledge of all the specialty fields pertaining to their practice. They depend on a few general-coverage journals to give them a current awareness of trends in medicine, plus consultation with the medical specialists who do read the specialty journals. Continuing education courses give them pre-digested information on the new procedures which will be most useful to them.

The general practitioner has little need for a local supply of specialty journals in his own hospital, but he does need to have some kind of access to case-related specialty information when it is needed, and to printed materials related to his continuing education programs. Allied health workers in the small hospital have similar information needs in their own fields. Specialty information can be provided as needed, through interlibrary loans.

Figure 1

Basic text and reference collection to be collected in the first five years: Three standards proposed for hospitals of various sizes.



Although specialty materials are not heavily used, rural isolation does lead to greater dependence on locally-owned printed materials in general medicine, pediatrics and general surgery. A study of general practitioners in North Carolina shows that the smaller the town, the more journal subscriptions are carried by individual practitioners (excepting towns under 1,000 population).

Fig. 2 Number of Journal Subscriptions Carried by General Practitioners in North Carolina (Peterson, et al., 1956)

Town Population	Under 1,000	1,000-2,499	2,500-9,999	10,000-50,000	Over 50,000	Average for State
Subscriptions per physician	2.7	5.8	4.1	3.4	3.3	1.00

Library Collection. Library service in small hospitals consists of basic reference (finding those routine facts which cannot all be stored in the human memory) and interlibrary loans (obtaining specialized materials from a larger resource library). This can be done from a collection of fifteen to twenty reference books plus three or four bibliographies. Reference questions which cannot be answered from locally-owned materials can be referred to the resource library in the same manner as a request for a known title.

Manpower Time is the resource most scarce for doctors and nurses. Whatever time they have for reading should be spent in reading, not searching. The librarian can help greatly by doing the searching, scanning each issue of journals and bibliographies as they come in. She can find those articles which are pertinent to current cases in the hospital, or to current educational programs. In the small hospital this searching can be done in an hour or two each week.

The librarian could be anyone who is intelligent and inquisitive and sociable, who also spends enough hours in the hospital each day to know what is going on. Because of the need to know hospital problems, a part-time library job of less than twenty hours per week is usually given to someone who has another regular job in the hospital: administrative or medical secretary, education director, or records staff. Although some college training in biology might be desirable, basic intelligence and out-going personality are much more important in this position.

When the right person is located and assigned to the library job, she must learn how to use her reference tools and how to relay special requests to the resource library. The resource library can give advice on training. The Regional Medical Programs and Regional Medical Libraries often provide consulting services and training programs (see addresses on P. 45).

The administrator should assure the librarian that library work is not incidental spare-time busy-work, that it is a regular job for which he expects her to budget a certain amount of time each week. Budgeted library time will include literature searches, checking in new journal issues, interlibrary loan correspondence, and an annual or semi-annual purchase order for new books. Reference questions requiring short, factual answers take little time, and they can be answered whenever they are asked, during blocks of time that are actually budgeted for other tasks such as typing.

The small collection in the small hospital needs no elaborate organization beyond an inventory list and journal check-in records. The librarian will notice missing volumes on a single scan of the reference shelf. She is personally acquainted with all borrowers, but a simple check-out system will probably be needed as an aid to memory.

Space and equipment. The "library" has no designated space of its own in the small hospital. Its bookcase is located next to the desk where the librarian does her other major work, in a centrally-located, easily accessible part of the hospital. Busy hospital workers seldom think of going to the library. Health workers seldom see learning as urgent on a day-to-day basis. Learning can easily be put off until the days add into years and the staff is out-of-date. The library must be located so that the staff can find it without special effort, in the traffic pattern of more urgent activities. The librarian must be in a position to meet and visit with staff members often.

Even though the library described here has no designated space, it is capable of giving full library service through its telephone or postal contacts with the nearest resource library.

SERVICE LEVEL II

As soon as the staff becomes accustomed to the services provided at Level I, they will want to receive materials more quickly than interlibrary loans can provide them. An increase in caseload-related reading will justify the demand for faster local access to library materials.

When the same text or journal has been borrowed several times, there is a clear indication that the hospital should own its own copy. Demand will probably indicate that at least one medical text and two or three texts in nursing and allied fields should be provided in each area: medicine, surgery, obstetrics and gynecology, pediatrics and emergency procedures. (Aquinata, 1968)

As the library grows, the same indexes and reference books will be continued from Level I. More texts and journals will be bought. With the help of a library committee the librarian will study one of the basic book lists and select the specialty fields in which texts and journals should be bought. It is unlikely that smaller hospitals will select the entire Stearns and Ratcliff core library (1970), although the complete list does insure coverage of the major specialty fields. The library committee must use its own judgment in spending its available funds for the subjects most needed.

At this point, the medical staff may decide to pool their own financial resources to buy the books and journals which they all need occasionally, but not often enough to need in their own offices. These purchases need to be placed in a central, accessible place. The hospital library is the logical location.

Most hospital libraries are financed from the combined resources of the hospital's general operating funds and medical staff library assessments. Financed from two sources, and serving all health professionals, the library must have an advisory library committee which represents all elements of its user population.

The growth from Level I into Level II no longer fits into a reference shelf by the librarian's desk. The most-used reference tools will probably stay where they were before, but basic texts and the first year or two of journals will require a full bookcase, three feet wide and six shelves (84 to 90 in.) high. As the collection grows past fifty text titles, and a five-year back file of journals accumulates, a second section of 3-foot-wide shelving must be added.

A study table and one or two easy chairs would be welcome comforts. However, the librarian has one or two other jobs besides the library, and her desk is in the line of traffic. Readers appreciate this easy access to the library but they probably will not stay in the library for prolonged and serious study. The table and chairs will be used for quick reference and for examining materials before taking them to the quiet of home or office. As growth approaches Level III, the administrator might consider remodeling to provide a small library alcove with sound controls. Such an investment would probably give only temporary advantage unless the number of beds in the hospital is expected to remain static. A building program which increases the number of beds should include designated space for the library: a special study room with separate office and work space for the librarian.

More books require more records. The simplest record is the inventory list. Collections of over 50 text titles may need cataloging and a simple subject classification for shelving. (Colaianni & Mirsky, 1970, Wilson, 1970). The librarian must also have a system for recording the texts which have been taken home for study.

More reference questions can now be answered locally instead of referring them to the resource library. Now that more journals are being received, the librarian will scan their contents as she checks them in, and will send pertinent articles to the people who would be interested. She will continue to scan the bibliographies for possible interlibrary loan materials. Library use tends to grow with programs of continuing and in-service education. The librarian begins to spend some time with the director of education. She prepares reading lists and obtains materials on loan from the resource library, in advance of need, for specific educational programs. At this service level the librarian will spend five to ten hours per week in work that is identifiable as library work, plus incidental time as needed for the simpler reference questions.

SERVICE LEVEL III

At first, Level III will appear similar to Level II except that the hospital and the medical staff organization provide more of everything, including more time for the librarian to handle the increased activity, and more space for books, for study, and for the librarian to work. This level would probably be supported by a hospital of 100 beds or more.

At Level III the collection in a general hospital will provide at least one current text in each of the specialty fields covered by the Stearns-Ratchiff core library, even if the exact titles may vary from the core library as listed. The journal collection, especially, will be expanded. A specialized hospital will purchase much more deeply in its own specialty area, rather than following the core library's pattern of balance.

As hospital size increases the medical staff will include more specialists. Medical specialists rely much more heavily on books than do general practitioners (California Medical Association, 1970, p. 37). A survey of physician's reading habits in Utah indicated that surgeons used almost three times as many library materials as did general practitioners, and other specialties showed similar increases. (Storey, Williamson & Castle, 1967?)

More specialists on the staff mean more reference work for the librarian, more inter-library loans, and more requests for compilation of retrospective subject bibliographies from the library's indexes. At Level III the librarian's work will increase to fifteen or twenty hours per week.

When the librarian spends as much as twenty hours per week in the library she will know what is going on in the hospital without having a second, regular job. That is, she will know the hospital's interests, if the library is not hidden in a remote wing or basement.

This point in hospital growth often coincides with a building program which allows designated space for a library. The administrator must be careful that the library remains in the main traffic pattern of the hospital, even though noise controls will be necessary to encourage its use for study. Plans for library space should include office and work space for the librarian, separated from the study area. The librarian must have visual control of the library even though some noise control will be necessary to keep her conferences with staff and her occasional type-writing from disturbing readers. Glass partitions and carpeting are helpful.

If the librarian works 20 hours each week and does not have a second job to keep her in the hospital full-time, then there must be a second person on the hospital staff who can answer the simpler reference questions when she is gone, and keep track of the books which are borrowed. There must also be a procedure for recording more complicated requests, and for holding them until the librarian's return.

SERVICE LEVEL IV

After Level III has been well-established, the growth of the library can be described better in continuing trends rather than in plateau levels. At Service Level IV the collection will include about the same subject areas as in Level III, but gives a choice of two or three titles in each area. Some texts and journals will be added in sub-specialty fields, or for special groups of users such as nurses, aides and housekeeping staff. Some monographs may be added where the subject matter is of general interest to the staff.

A library of 300 books or more will be confusing to readers unless it is fully cataloged, including title and subject cards. It must also be classified into one of the standard systems for shelving (such as the U.S. National Library of Medicine classification).

Changes in hospital staff affect use of the library. Interns and residents in teaching hospitals give heavy use to the same textbooks which were kept on reserve for them at their medical schools. Students, house staff, and their preceptors are heavier users of books and journals than are physicians in private practice. Nursing students need immediate access to the basic core of materials in their nursing school collections, duplicated at the hospital. For hospital-based schools of nursing the hospital library usually incorporates the nursing school collection.

As growth continues, a subtle change is seen in the nature of interlibrary loans. Most of the routine requests can be filled at the local level, but the number of interlibrary loans does not decrease. They become more specialized as to subject content.

At first the half-time librarian puts in a little overtime; then overtime becomes routine (or quality of service goes down). Finally, the librarian points out to the administrator that the extra time might as well be scheduled regularly and included in the budget. The position gradually becomes a full-time job. In a 300 bed hospital with a well-developed library service, it is not unusual for the librarian to help five staff members in an hour, while involved questions must wait for a lull in business. As the service grows, the librarian will need a part-time clerk for her typing so that she can give her full time to service.

The administrator's greatest concern will be maintaining balanced growth so that whatever investment he puts into the book and journal collection returns its full pay-off through increased information delivery to the staff. The more journals are received and the more reference books are available, the more work-hours are necessary to maintain the alerting services and reference service which assure their full use. If the collection outgrows the librarian's time, then the investment in books will not give its full return. It would be comparable to a superbly-equipped and poorly-staffed laboratory.

SERVICE LEVEL V

By the time the hospital reaches about 400 beds its staff will include many specialists and subspecialists, including nurse specialists, physical therapists, inhalation therapists and perhaps clinical psychologists and social case workers. All of these people must have access to professional materials in their own fields.

The collection increases to about 500 book titles, plus journals. Service continues at the same level, but the librarian must be able to work easily in the subject matter of the specialties. Volume of business increases with the increased staff. At this level the librarian often finds that her collection has become a resource library for smaller hospitals. She may be giving indirect service to small communities by serving the specialists who confer with the general practitioners, and to whom cases are referred.