CONDITIONS AND PROBLEMS IN THE NATION'S NURSING HOMES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

FIRST SESSION

Part 7.—Portland, Maine

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FRIDAY, AUGUST 13, 1965

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Portland, Maine.

The subcommittee met at 10 a.m., pursuant to notice, in room 211, city hall, Portland, Maine, Senator Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Neuberger, and Muskie.

Staff members present: Frank C. Frantz, staff director of the Subcommittee on Long-Term Care; and John Guy Miller, minority staff director of the Special Committee on Aging.

Senator Moss. This hearing will now come to order. Let me say right at the outset we are going to have some problems with sound here today, because of the construction that is adjacent to the building. I must admonish my colleagues to speak in the microphone, and also the witnesses who testify. I think if we make a special effort to speak in the microphone we will have the ventilation we need on this, I should not say warm day in Maine but a pleasant day in Maine, and yet cope with the noise from the construction.

We are pleased to be here in your city and your State today to continue the hearings of the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. I welcome all of you who have come to assist this subcommittee with your testimony, and those who have come to listen to these proceedings. All of you are indicating your interest in the improvement of care for our infirm aged citizens.

Medical science has made great progress in combating the illnesses which cut life short. But these achievements in curative medicine have brought with them new demands in the field of chronic and long-term care. Facilities and services for health maintenance and rehabilitation of the aged patient with chronic conditions are assuming new importance in the spectrum of health care. The medical profession is beginning to recognize this expansion in scope of medical practice and to give greater emphasis to the care of the long-term patient and to the facilities where this care is rendered. The nursing home is changing from a traditionally custodial kind of institution to one which is a site of health care for the chronically ill aged.

The professions, the nursing homes, and Federal and State programs are lagging behind in meeting the demands brought about by these changes, but the problems are now being recognized. This subcommittee was formed for the purpose of making a thorough examination of the conditions and problems in nursing homes and other institutions,

to gather information on the facilities and services needed to provide the benefits of modern health care to our aged citizens, and to develop recommendations for changes in our programs which will help assure that this care will be available.

The studies and hearings we have conducted in cities across the country have shown wide variations in the quality of the services available. We have found attitudes among physicians and medical organizations which vary from organized efforts to bring medical leadership and supervision into nursing homes in some localities to complete indifference in others. We have found almost everywhere extremes of good and bad in the nursing homes themselves; some which offer a broad range of services and maintain professional standards and others characterized by incompetence, neglect, and, at worst, abuse. We have seen vigorous and positive programs by some State and local agencies to upgrade and maintain standards, and we have seen the tired and jaded attitudes expressed by the excuse "if we closed the substandard homes, where would we put the people."

As Federal programs become increasingly involved in the development of new facilities and the purchase of services, the Federal taxpayer has an increasing stake in the encouragment of modern and high-quality care and the elimination or correction of inadequacies and substandard conditions. Modifications and additions to our Federal programs affecting the long-term care field probably are needed to encourage the further development of services geared to modern methods of caring for the long-term patient, and to strengthen the hands of State and local agencies in carrying out their responsibility for assuring the quality of such services. The witnesses who have participated in our hearings in other cities, and those who will speak today, are among the principal sources of information which will guide our efforts.

I wish to point out that this subcommittee has held hearings as far west as Los Angeles, in various cities all the way across the continent. We have been in Denver and the Middle West. We were in New York last week and in Boston on Monday of this week. So we have gathered information from many areas of the country, and we probably will yet visit other areas in this broad look at the subject.

Currently there is no legislation pending before the Senate or before this subcommittee to which we are addressing ourselves. We are simply making an inquiry into this general field because it is a field of change, as I have pointed out, one where the growth of our elderly population and the new environment that we have created by the growth of suburbs and metropolitan areas require that changes be made in the facilities available for our elderly citizens.

I am very pleased to have today here as members of the subcommittee who work with me two of the most active members of the subcommittee. I am faced with a dilemma. I should, of course, introduce your own Senator first, yet I should introduce my lady colleague, Senator Maurine Neuberger. I think I will defer to the ladies and introduce Senator Neuberger of Oregon first for any comments she wishes to make at the beginning of this hearing.

Senator NEUBERGER. Thank you, Senator Moss.

It is a pleasure to be in Maine with your distinguished Senator, Senator Muskie, but I shall be busy during the noon recess writing post cards home from Portland, Maine, to Portland, Oreg. Since

I have only been here briefly, one night a couple of years ago, this is my first chance to really see what I consider the mother city of Portland. I look forward to our meeting with you people here today.

Senator Moss. Thank you, Senator Neuberger.

Your own Senator from Maine, who is my close neighbor where he lives in Washington and also my seatmate in the Senate, since we sit side by side, my good friend, Ed Muskie. [Applause.]

Senator MUSKIE. Thank you very much, Senator Moss.

I think at the outset we might suggest that if the Gannett Publishing Co. believes in the public's right to know, it could help by reducing this construction noise behind us. I hope that we find it possible, despite the background noise, to have a good hearing, one that we are all able to hear.

I would like to welcome Senator Moss and Senator Neuberger to Maine, each of whom has been here before. I think Senator Moss last visited with us in 1959 when he came to Maine as a member of the committee headed by Senator Kerr of Oklahoma to hear testimony in Augusta on our water resources problems. This, of course, is another subject area with which I have been concerned. So it is a pleasure to welcome him.

But I might say to all you "Maineacs" that Senator Neuberger and Senator Moss both plan to spend the next 2 days in Maine enjoying the beauties of our coastline, after hearing something of our problems. Senator Neuberger was here 2 years ago speaking in Waterville. I suppose I should not mention the occasion, but it happened to be a Jefferson-Jackson day dinner. She was very welcome at that time, as she is this morning.

They are both outstanding Senators in this field, having conducted most of the hearings across the country; so they are very knowledgeable, very much interested and very effective in communicating to the Senate as a whole something of the nature of the problems and their recommendations as to what ought to be done.

I have an opening statement, Mr. Chairman, which I will simply file for the record in order that we may preserve our time for the witnesses.

May I say that it is our hope here, as it was in Boston earlier this week and as it has been with the committee across the country, to conduct a constructive hearing designed to make the nursing home a more effective instrument for serving the needs of our senior citizens and our chronically ill. This is the positive, constructive note which the committee has undertaken to strike across the country, and will here. We want to know what the problems are. We want to know what the difficulties are. But we also want to know what good work is being done and how it is possible to do better.

Thank you very much.

(Senator Muskie's formal statement follows:)

PREPARED STATEMENT OF SENATOR EDMUND S. MUSKIE

I think it is important to establish at the outset exactly what we intend to accomplish through these hearings. In my opinion there is only one legitimate objective: improvement of medical care for the chronically ill through the cooperative efforts of the medical professions, and the governmental agencies concerned with the health of the American public.

During the course of our inquiry we should bear in mind the fact that nursing homes are assuming a new importance in the practice of modern medicine.

Many of them—probably the majority—are ready to assume their expanded responsibilities. If others are not, we must help them adjust to their new role.

We will serve no useful purpose if we do nothing more than compile a catalog of problems which may beset individual nursing homes.

If we intend to gain a balanced perspective on the quality of nursing home care in Maine, there are certain general facts we must place on one side of the scale before we weight the other with specific illustrations.

The first essential fact is that the increase in life expectancy has produced a dramatic increase in the aged population. The average life expectancy has risen from 49.2 years in 1900 to an estimated 69.9 years at present.

Health problems are a major concern of the aged population. People over 65 are twice as likely as those under 65 to have chronic illnesses which may partially or completely limit their activity.

As a result, the medical professions are focusing new attention on techniques of chronic care and rehabilitation to meet the needs of our older citizens.

A second fact we must bear in mind is the rising cost of medical care in short term general hospitals. The modern hospital represents an awesome concentration of expertise and scientific equipment which has all but conquered acute illness and has greatly reduced the number of days the acutely ill patient stays in the hospital.

But in many cases, chronic illness does not require the resources of the general hospital after initial treatment.

To maintain chronically ill patients in a general hospital after they no longer need acute treatment facilities is prohibitively expensive and an unnecessary drain on hospital personnel and equipment.

Another type of facility is needed to meet the special needs of patients who require long-term chronic care and rehabilitation.

Nursing homes are assuming the responsibility for providing that care—which in its own way requires as much skill and expertise as acute care.

It is a fact that the nursing homes too frequently have been stereotyped as inadequate and inefficient.

It is also a fact that in too many instances the nursing home has been denied its legitimate place in the general scheme of medical care.

It has had no meaningful contact with the general hospital from which it receives its patients. Too often there has been no cooperation between the hospital and nursing home in planning transfer of patients from one to the other; in arranging for followup conferences between hospital and nursing home staff; or in periodic reevaluation of the patient's treatment program.

I think the medical professions and the general hospitals would be the first to admit that as far as meeting the medical problems of the aged is concerned, they are still in the learning stage.

But many of them are making great strides in developing comprehensive care programs which assume responsibility not only for acute treatment, but also for cooperation with the nursing homes in working out long-term care plans.

Thus the hospital and nursing home are in communication before the patient is transferred: the patient arrives at the nursing home with a course of treatment already planned; and the two institutions continue to work together until the patient is finally discharged.

Here in Maine, where people over 65 constitute 11.1 percent of the population—nearly 2 percent above the national average—several community hospitals have undertaken pioneering programs in cooperation with nursing homes.

If we bear in mind through this hearing the fact that we are making new demands on the nursing home:

The fact that the role of the nursing home in comprehensive patient care is in an evolutionary stage;

And the fact that our increased awareness of the medical problems of the aged has generally turned the spotlight on all facilities which care for our elder citizens.

I think we will emerge from this chamber with a new insight into the problems facing our nursing homes, and we will be in a much better position to help them resolve those problems.

Senator Moss. Thank you, Senator Muskie.

Our first witness this morning will be the Honorable Catherine Carswell, who is the house chairman of the Committee on Health and Institutional Services, of your house of representatives here in Maine. I understand that Mrs. Genevieve Gardner and Mrs. Alma Oaks will accompany Mrs. Carswell.

We will ask the witnesses to come forward and be seated at this table. We have a table mike. When the witnesses speak, we will ask them to keep very close to the microphone so that the volume will overcome the construction noise.

Mrs. Carswell, we are pleased to have you and your associates here. You may proceed from your statement, or you may wish to insert the statement in the record and comment on it. The witnesses are free to choose the way they would like to present testimony to this subcommittee.

STATEMENT OF HON. CATHERINE CARSWELL, HOUSE CHAIRMAN, COMMITTEE ON HEALTH AND INSTITUTIONAL SERVICES, MAINE HOUSE OF REPRESENTATIVES, ACCOMPANIED BY MRS. GENEVIEVE GARDNER AND MRS. ALMA OAKES

Mrs. CARSWELL. Thank you very much, Senator.

Mr. Chairman, Senator Neuberger, Senator Muskie, welcome to Maine. I am very pleased that you could come here to listen to the problems that we feel we have, with the prospect of having some Federal legislation initiated to help solve some of these problems.

I requested Senator Muskie to launch a Federal investigation into the licensing procedure of the Health and Welfare Department in the area of nursing and boarding homes for a number of reasons. Having been a member of the State legislature since 1957, I have heard numerous grumbles about nursing homes. A Press Herald story dated October 21, 1964, made by Mrs. Alma Oakes, a member of the health and welfare advisory board, disturbed me to the degree that I asked Health and Welfare Commissioner Dean Fisher to investigate charges of deplorable conditions in some of the State's nursing homes.

The answer I received from Dr. Fisher was anything but helpful, to my way of thinking, and very evasive. It included the following: "It is inevitable that there will be a considerable variation in the quality of services extended by the many private institutions offering this kind of care." Also included in this letter was, however, a general statement simply suggesting "some kind of so-called deplorable conditions existing in nursing homes in general does not give us very much information on which we may prosecute."

I submit a copy of Mrs. Oakes statement that was printed in the Press Herald, and also Dr. Fisher's letter.

(The information referred to follows:)

REPRESENTATIVE OAKES RAPS "CONDITIONS" IN SOME STATE NURSING HOMES

Representative Alma H. Oakes of Portland spoke out Tuesday night against "deplorable conditions" in some of the State's nursing homes and asked her audience of some 50 Republican women at the Smith Street home of Mrs. Thomas A. Merrigan to join her in a fight for better conditions if she is reelected.

Mrs. Oakes said she had spent months "in the line of duty" surveying homes for the aged in Maine. In many of them, she said she felt shame at seeing the treatment given those who had done so much for Maine during their active years.

She asked her audience to bring "this disgrace" to the attention of friends and to write her with suggestions on how to combat the problem "during the next legislative session in which I hope to serve you."

Mrs. Oakes praised the nursing home located in the annex of Buxton-Hollis Hospital as an example of the best of its kind in Maine.

STATE OF MAINE,
DEPARTMENT OF HEALTH AND WELFARE,
Augusta, October 30, 1964.

Hon. CATHERINE HENDRICKS CARSWELL,
Portland, Maine.

DEAR MRS. CARSWELL: We are very much interested in the standards of operation of nursing and boarding homes in Maine and we are interested in doing everything possible to improve the standards of care extended to patients in such institutions. It is inevitable that there will be a considerable variation in the qualities of services extended by the many private institutions offering this kind of care.

We are anxious to have sound reporting to us of any conditions in any home that appear to be detrimental to the patients in any way and when such reports are received we make every effort to make whatever investigation is required to either substantiate the existence of such conditions or reassure us that such conditions do not exist. As a result of such investigations we have not been reluctant to take the necessary steps to secure either punitive action or license revocation. However, a general statement simply suggesting that some kinds of so-called deplorable conditions exist in nursing homes in general does not give us very much information on which we may prosecute.

We are in the process of completing the analysis of a very extensive study of conditions in a sampling of all the nursing homes in the State and when this information is tabulated it will undoubtedly give all of us a much better idea of the actual conditions as they exist for this study will reflect all opinions of a team consisting of a physician, a nurse, and a social worker which made the study visits for us.

Sincerely yours,

DEAN FISHER, M.D.,
Commissioner.

Mrs. CARSWELL. The newspaper story may have been vague, but I also felt that Dr. Fisher's letter to me was vague. I was not satisfied to let this serious matter go without further investigation. I went to Augusta and talked to an individual in the Bureau of Criminal Investigation, Maine State Police. Contained in a report which I received from this department was the following:

Miss Martha Robbins, welfare worker, was entrusted with the inspection of nursing homes in and around the Portland area for a number of years, until, being advised by her immediate superior, Lillian Nash, that she was a chronic complainer and that she was not to inspect any of the homes on which she had turned in complaints, Mrs. Nash took over the inspections. All complaints of a derogatory nature were referred to the Augusta Office to Lillian Nash and Director Dean Fisher, and, according to Miss Robbins, they were entirely disregarded. Detailed information, including reports of abuse and death of a patient, are included in a supplementary report with witnesses testifying.

One of the witnesses indicated she felt there must be something between Mrs. Nash and Mrs. X, the operator, because all the other homes I have worked in they have to abide by the rules and regulations very strictly and if something is wrong in their inspection it has to be remedied immediately. But this is not so at X nursing home.

There are many more eye-opening statements in this State police report. I will submit this to you.

Senator MOSS. That will be made a part of the record.

(The report referred to follows:)

MAINE STATE POLICE, BUREAU OF CRIMINAL INVESTIGATION

Case No. HC–8847.
Case originated at Portland, Maine.
Report made at: Augusta, Maine.
Date: February 3, 1964.
Period for which made: January 28, 29, 30, 1964.
Report made by: Detective James Milligan.
Title: Miss Martha Robbins, Department of Health and Welfare, Portland, Maine.

Type of case: Investigation of Sunrest Nursing Home, 837 Brighton Avenue, Portland, Maine.

Synopsis of facts: Miss Martha Robbins, welfare worker, was entrusted with the inspections of nursing homes, including the above-mentioned home, in and around the Portland area for a number of years until being advised by her immediate superior, Lillian Nash, that she was a chronic complainer and that she wasn't to inspect any of the homes on which she had turned in complaints. Her duties were relieved July 9, 1963, at which time Lillian Nash took over the inspections. All complaints of a derogatory nature were referred to the Augusta office, to Lillian Nash and Director Dean Fisher; and, according to Miss Robbins, they were entirely disregarded. Practical nurses who were, at one time, employed at the aforementioned home have entered complaints to Miss Robbins, relatives of patients at the home have also entered complaints to Miss Robbins, all of which were turned over to the Augusta office, have been disregarded. This investigator talked with two practical nurses, former employees of the Sunrest Home, who have verified through conversation that the complaints rendered by them were true and both nurses would be willing to testify as such before any hearing that the department of health and welfare would have.

Details: This investigation was predicated upon a request of the Governor's office on January 27, 1964, to conduct an investigation reference the mistreatment of State welfare patients, most of them elderly, at the Sunrest Nursing Home at 837 Brighton Avenue, Portland, Maine, licensed to a Mrs. Meda A. Weston.

This investigator contacted Miss Martha Robbins at the Health and Welfare Building, Portland, on January 28, 1964. Miss Robbins proceeded to show and tell this investigator of the complaints she had received and which had been sent to her main office in Augusta, also of the bruises she had observed on the different State patients at the Sunrest Nursing Home. Miss Robbins stated that she had continually, both in writing and orally, told her superior, Miss Lillian Nash, of the condition of the patients at the afore-mentioned home and of the continued complaints being received; and that on January 9, 1964, Miss Nash relieved Miss Robbins of inspecting the homes in the Portland area about which the complaints had been rendered. During the interview, Miss Robbins mentioned three or four practical nurses who, at one time, had been employed at this home. Two of them were contacted by this investigator, and their complaints, which had been previously given to Miss Robbins were verified by this investigator and both stated they would gladly attend any hearing that the department of health and welfare should have and tell what they had seen in regards to the mistreatment of the State patients mentioned in their original complaints.

The two practical nurses contacted by this investigator and their original statements verified were (1) Mrs. Marjorie Gardner, 880 Brighton Avenue, Portland, Maine. Mrs. Gardner is now employed at Maxfield's Nursing Home at 43 West Street, Portland. (2) Mrs. Fredrick Aikens of 727 Congress Street, Portland, Maine, was contacted by this investigator and her original complaints were verified. She also would be willing to attend any hearing held by the department of health and welfare in regard to the Sunrest Nursing Home. (Mrs. Aikens is known personally by this investigator.) This investigator has known her for a number of years and she was a former employee at the Weston Convalescent Home in Weston, Mass., where this investigator's mother-in-law is employed.

Other people concerned with this investigation were contacted by this investigator, but their names have been withheld because the majority are connected indirectly with nursing home operation and do not want to make hard feelings or enemies as a result; however, all who were contacted did state that they had heard through nurses, either now employed or formerly employed, of some of the sadistic manners which were used in the treatment of the State patients at the Sunrest Home.

A Mrs. Alma Oaks was contacted but could not advise this investigator of anything other than what had already been stated, but did advise of some people who could be contacted to verify the complaints that the welfare worker had received.

Due to the time element of this complaint—extending back to 1961, 1962, and the first part of 1963—and to the age limits of the State patients involved, it is the opinion of this investigator that the health and welfare commissioner, under the Revised Statutes, chapter 25, sections 265 through 274, should call Mrs. Meda Weston in for a hearing with the two practical nurses as witnesses and also the welfare worker, Miss Robbins, on the State-issued license.

JAMES MILLIGAN, *Detective.*

SUPPLEMENTARY REPORT—SUNREST NURSING HOME, 837 BRIGHTON AVENUE, PORTLAND, MAINE

On February 3, 1964, this investigator was advised via the Governor's office reference another incident occurring at the Sunrest Nursing Home sometime during the month of October 1963. Mrs. Sarah Valente, nurse's aid now employed at the White Haven Nursing Home, Portland, Maine during the month of October worked for a period of about 4 days at the so-called Sunrest Nursing Home in Portland. On a Friday, during her employment, Mrs. Valente assisted the proprietor Mrs. Weston in giving a so-called high enema to a patient, Mrs. Margaret Concannon, an elderly woman. At this time, Mrs. Valente expressed concern to Mrs. Weston that this should not be done, however, the enema was given and, as a result, Mrs. Valente stated the patient went into a state of shock. On the following morning, Saturday, a Dr. Sylvester visited Mrs. Concannon and immediatly ordered her to the Mercy Hospital where she died October 27, 1963. A copy of the death record is attached to this report.

Mrs. Sarah Valente was contacted by this investigator on February 4, 1964, at which time she verified the statement which is included in this report regarding the aforementioned incident. Mrs. Valente further stated that if health and welfare should hold a hearing in regard to this home, she would gladly attend to testify as to what she has seen and the existing conditions of the home.

Further conversation with Mrs. Valente was as follows: "I don't understand how the State can license and allow to operate a nursing home like the Sunrest here in Portland. There must be something between Miss Nash and the owner Mrs. Weston because of all the other homes I have worked in, they have to abide strictly by the rules and regulations and if something is wrong on their inspections, it has to be remedied immediately, but this is not so at the Sunrest."

This ended the interview with Mrs. Valente who was then in room 131 at the Maine Medical Center as a patient undergoing a series of tests.

On this same date, a Dr. S. B. Sylvester was interviewed. This is the physician who attended Mrs. Concannon prior to her being at Sunrest and also on her transfer to the Mercy Hospital in Portland. Dr. Sylvester stated that he had treated Mrs. Concannon off and on for a period of about 5 years. He stated that she had had extreme difficulty in the past with her bowels and had also had small shocks which would not be uncommon for a woman of her age. She was admitted to the Sunrest from her daughter's home supposedly for a short period of time because of the daughter entering the hospital for examinations. Dr. Sylvester does not recall issuing orders for an enema but did have notes stating to the nurse at the Sunrest that if she complained of stoppage, she would have to be and I quote "dug out." Dr. Sylvester stated he received a call on a Friday afternoon from Mrs. Weston stating that the patient, Concannon, was in a downward slump. The doctor immediately asked for her pulse and temperature and blood pressure, but received a reply that these were not given at this home. On the following morning, Dr. Sylvester made a call on the home and immediately had Mrs. Concannon removed by ambulance to the Mercy Hospital where she died the following morning. Dr. Sylvester was asked reference the death certificate which he signed, as to the cause of death. The doctor stated that the infuretion of bowel and mesentric thrombosis was a guess on his part to the cause of death but knowing the patient in the past, having shocks or thrombosis and also bowel stoppage, this was his main reason for signing the death certificate as that. However, no autopsy was performed and due to the time element, it would be impossible to ascertain the exact cause of death.

It is still the opinion of this investigator that the department of health and welfare should definitely have the Sunrest Nursing Home in for a hearing in regards to the incidences which have been mentioned in these reports.

JAMES MILLIGAN,
Detective, Maine State Police.

Mrs. CARSWELL. Having been greatly enlightened by the State police report, and shocked at the same time, I requested the attorney general's department to investigate the nursing homes situation. The attorney general's report was made after a brief investigation, and it would make your blood chill. It included the smothering to death of a patient who obviously was in a coma and taking too long to die. The operator wanted to go on a shopping trip, but wanted to

be present when the funeral director came for the patient. A pillow was used to smother the patient.

Another patient who had been up and around when last seen by the witness, was in a coma when seen next. Reports were that the patient became difficult, so she was thrown on the bed and started screaming. A washcloth was stuffed in her mouth, and a bath towel placed over her face. She was held down until a shot of morphine became effective. Every time the patient showed signs of rallying, she was given a shot of morphine. She drowned in her own fluids, her chest was so filled up.

Other reports on this same home will be listed in this black book which I will submit to the committee. It would take all day to go into details.

Homes do not give patients water at night for fear of bed wetting. Hypos and syringes are used on one patient to another without having been sterilized. Diabetes patients get no special diet. There are not enough blankets for patients who feel cold and ask for them.

This attorney general's department report contains so many horrifying details of abuse, unsanitary conditions, and sadistic activities that it would take a great deal of time to outline. The report shows that standards are not made to follow but are made to fit the home. Much information is contained in this black book which I ask be made part of the record.

Senator Moss. Yes; that will be made part of the committee's files. It looks too lengthy to be printed otherwise.[1]

Mrs. CARSWELL. I feel that the strong lobby and professional representation of the nursing and boarding homes in this State make it rather difficult for the ordinary layman to put his point across and get this mess cleaned up. I presented legislation to define nursing homes and ran into considerable opposition until I was able to speak up and inform my colleagues of the bad situation. I received an "ought to pass" report for my bill, but while I was recuperating from an operation one of my committee members tried to kill the bill, which he signed "ought to pass". When I heard the news on the radio, I got out of the sickbed and traveled to Augusta to find the nursing home lobby getting around.

I lobbied my bill and spoke on the House floor for it, and my opponent walked to the rear of the house of representatives, spoke to the nursing home people, and came back to the floor of the house and withdrew his motion. The bill was passed.

The attempt to kill this bill caused me to become more determined to get at the roots of this problem. So I wired Senator Muskie for a Federal investigation into the licensing procedures of nursing and boarding homes.

When your staff member came to Portland, I supplied him with material and names. So I will not go into a great detail on much of the information which I received. However, I do have letters which I will go into briefly.

I have a letter from a Mrs. Irene Asselyn, who writes:

After 10 years in nursing homes, my mother, who will be 79 years old in December, has run out of money. My sister and I found it necessary to apply for old-age assistance. At this time she was staying at X nursing home in a certain part

[1] The report referred to is held in the files of the subcommittee.

of Maine. She has stayed at this home for 3 or 4 years. This assistance seems to have removed the last shred of dignity allowed my mother, my sister, and myself. Mother was taken from her room and put into an attic under very unsanitary conditions, and not one of the three of us were ever allowed to forget that we were not taking care of mother. To quote,

"I don't know what you are complaining about. You are not taking care of her. You know that. The State is."

This statement was made many times to us by the matron of this home. And it is signed "Irene Asselyn."

I will submit Mrs. Asselyn's signed statement.

Senator Moss. It will be printed in the record.

(The statement referred to follows:)

PORTLAND, MAINE, *August 11, 1965.*

CATHERINE CARSWELL,
State Representative, Portland, Maine.

DEAR MRS. CARSWELL: After 10 years in nursing homes, my mother, who will be 79 years old in December, has run out of money. My sister and I found it necessary to apply for old-age assistance. At this time she was staying at Hillside Rest & Nursing Home, 84 Broadway, South Portland, Maine. She has stayed at this home for 3 or 4 years.

This assistance seems to have removed the last shred of dignity allowed my mother, my sister, or myself. Mother was taken from her room and put into the attic, under very unsanitary conditions and not one of the three of us were ever allowed to forget that we were not taking care of our mother. To quote, "I don't know what you are complaining about; you are not taking care of her, you know; the State is." Unquote. This statement was made many times to us by the matron of this home.

IRENE C. ASSELYN.

Mrs. CARSWELL. I also have a statement here from Mrs. Alma Oakes, who is with me at the table. I will read the letter to you, because Mrs. Oakes is not feeling too well. However, she wanted to be here so that she could back up anything she might feel she was capable of doing at this time.

Representative CATHERINE CARSWELL. In 1963 I was elected to the house of representatives. After serving 3 or 4 months telephone calls and letters regarding nursing homes started to come in. I visited X nursing home, which I found so filthy that I called Miss Robbins, State inspector of nursing homes. I wanted to find out about another home that I had received many complaints about, which is called X nursing home, in Portland.

Miss Robbins has sent reports on these homes to Augusta. I was not too satisfied, so I made an appointment for October 28, 1963, with Governor Reed for Miss Robbins so she could explain the condition of these homes. Governor Reed had an investigation at that time. Things did not improve.

On January 27, 1964, Miss Robbins and I were in Augusta and had the files open at Miss Nash's office. Many promises but not much satisfaction from her. When we went to Dr. Fisher's office and was promised an investigation, we still were not satisfied. Miss Robbins and I then went to Governor Reed and gave him the report about something that had happened at X nursing home and Mrs. So-and-so had died. The nurses aid said it was carelessness and cruelty.

We had a private investigation, again, which called for a public hearing October 9, 1964, at Auburn, Maine. There were four witnesses for the State. Mrs. X's death was the reason that we had this investigation. Very little was said by the State on Mrs. X's death. The full report of this hearing is at Auburn courthouse, or at Dr. Fisher's office. I had promised Mrs. X's daughter, Mrs. X, that I would not make this public. At this time she thought her mother was in good care.

I spoke before a group of women about the deplorable conditions in some of our nursing homes which I turned over to the press. I am pleased that Representative Carswell has brought on this investigation, for I feel that our senior citizens have been degraded and forgotten.

ALMA H. OAKES.

I will make that part of the record.

Senator Moss. It may be printed.

PORTLAND, MAINE, *August 12, 1965.*

Representative CATHERINE CARSWELL: In 1963 I was elected to the House of Representatives. After serving 3 or 4 months, telephone calls and letters regarding nursing homes started to come in.

I visited Randall Hall which I found so filthy that I called Miss Robbin, State inspector of nursing homes. I wanted to find out about another home that I had received many complaints which is called Sunrest Home, 837 Brighton Avenue, Portland, Maine. Miss Robbin had sent reports on these homes to Augusta. I was not too satisfied so I made an appointment for October 28, 1963, with Governor Reed for Miss Robbin so she could explain the condition of these homes Governor Reed had an investigation at that time. Things did not improve. On January 27, 1964, Miss Robbin and I were in Augusta and had the files opened at Miss Nash's office. Many promises but not much satisfaction from her. We then went to Dr. Fisher's office and was promised an investigation—we still were not satisfied.

Miss Robbin and I then went to Governor Reed and gave him the reports about something that had happened at Sunrest Home. A Mrs. Concannon had died. The nurses aid said it was callousness and cruelty. We had a private investigation again which called for a public hearing April 9, 1964, at Auburn, Maine. There were four witnesses for the State. Mrs. Concannon's death was the reason we had this investigation. Very little was said by the State on Mrs. Concannon's death. The full report of this hearing is at the Auburn courthouse or at Dr. Fisher's office.

I had promised Mrs. Concannon's daughter, Mrs. Canavan that I would not make this public. At that time she thought her mother was in good care.

I spoke before a group of women about the deplorable conditions in some of our nursing homes which I turned over to the press.

I am pleased that Representative Carswell has brought on this investigation for I feel that our senior citizens have been degraded and forgotten.

ALMA H. OAKES.

Mrs. CARSWELL. Another woman by the name of Effie Verrill complained she was told not to enter the nursing home where her elderly mother lay dying. She complains she was verbally abused by the operator and made a complaint to the welfare department in regard to this situation, and later on was allowed to go to the home.

Another lady complains that her mail is being opened against her will and her State checks taken out.

Another lady complains about the poor conditions under which she worked in a nursing home, including no sterilization of catheters and other equipment.

Several letters complained about conditions in Eastport nursing homes, and one is shocked to learn that a mentally retarded person who has cruel tendencies cares for mentally ill, bedridden patients in a cellar room with no other attendant around to protect these patients from abuse.

May I comment that a number of mentally ill persons had to be removed from a certain boarding home which was licensed by the State department of health and welfare, when it was learned by a certain institution that the patients were in very poor condition generally and some of them were abused.

I will submit these letters which I have briefed you on, and hope that they can become a part of the record.

Senator Moss. They will be included in the record.

(The letters referred to follow:)

PORTLAND, MAINE.

DEAN H. FISHER, M.D.,
Commissioner of Health and Welfare,
Augusta, Maine.

Dear Sir: I am interested in the middle and lower class aged of the State of Maine and what is being done for them, especially in the field of boarding and nursing homes.

Eleven years ago I lost my father. Mother refused to accept this fact and became most unhappy and difficult to care for. Consequently I found it necessary to turn to the boarding and nursing homes. I have seen and heard some most shocking things during this time. Conditions, one would not believe, unless they knew me as a truthful person, or saw for themselves.

In the past year mother has run out of money and we found it necessary to apply to the State for old age assistance. Since that time, we have never been allowed to forget it by the home operator; and now she has taken mother from the bed that has been hers for about 3 years and put her in a room in the attic, where there is no bath, nor even a flush, no place to wash her hands, except a small pan of water that is used over and over again and emptied once a day. There are four ladies up there, they use pails for toilets and the stools are allowed to remain until the stench has permeated the whole third floor.

I have reported this to one of your inspectors, but to be absolutely sure you hear about this condition, I am writing directly to you. I am a semi-invalid or I would have come in person. I find these things most difficult to get in a letter, due to the length.

The question I am interested in at present is, does this home operator have the right to put mother in this attic, just because she has become, as the home operator puts, it "a State case"?

I wish, Dr. Fisher, I might have the privilege of talking to you in person, but not being able to do so, may I please expect an answer soon.

Yours truly,

IRENE C. ASSELYN
Mrs. Ernest J. Asselyn.

JULY 5, 1965.

Upon my getting to Bishop's Nursing Home late in the afternoon, Mrs. Connors and daughter left for their home. Only this young, untrained girl was the only attendant in the home until her mother arrived. Her mother is a nurse at Bishop's.

My mother is dying from Parkinson's disease and circulatory trouble. She is completely helpless. Mother has sores that have been discharging on her ankles and now on her back. Mother asked me to raise her head. This was done and her pillow fluffed. The spread is always pulled up to mother's neck. Mother asked me about the sores. I am a nurse with diploma. To reassure mother, I would pull back the spread and tell her that everything was coming along fine. Her body would be hot and uncomfortable. I would pat lotion on to cool her, not on her legs.

About 3 weeks ago, mother was set in a chair to soak her feet. Mother fell to the floor. She was shook up but no damage was done at the time, that was noticeable. I asked the nurse if she didn't put a restrainer around mother's waist when she put her in the chair. She said, "No; your mother's skin is too tender. Over a housecoat there should be no danger of mother's skin bruising. Several days later mother fell out of the chair again and upon my getting there late in the afternoon, I was horrified at mother's appearance. She had a bandage across her nose which had bled profusely, a bruise on her forehead, a bad looking bruise on her temple, and the right eye looked bad. Her hand was cut bad. There was blood on her johnny and bed. I asked if a doctor had been called. The nurse said, "Yes. I called Dr. Pentor and told him of her condition. He said, "Oh, yes, she had an accident this morning. I gave an R.N. instructions over the phone what to do. I said "She may have concussion, Doctor." He said, "Oh, no; she has no broken bones. I cannot do her any good but will see her tomorrow morning." It was 24 hours before he saw her. Visitors at the nursing home saw the condition my mother was in. I called another doctor. He said, he couldn't interfere with Dr. Pentor's patients. I told him to just please look at her and he would get paid as soon as he did. The answer was still no.

I have heard one nurse berate a patient other than my mother. This patient is a genteel, refined person and it hurt deep to hear what was said. She was grieved but just took it.

Mrs. Connors called me a damned fool. She said, "You are not paying for your mother's care. I own this house and I forbid you to enter into this house again. You have no right to touch your mother. She is in my care." She has a nurse there that has begged mother's money from her. One night mother was turned to the wall and $11 taken from her pocketbook. Mrs. Connors could not pinpoint the blame but Mrs. Connors didn't offer to make good this money.

Mother had a $560 check come to her. It was back pay from social security. Mrs. Connors kept this check in her possession for nearly 3 months, never mentioning it to the family. The State got in touch with me, the first I knew about it. I asked mother about it and she said Mrs. Connors was banking it. We got to the bank just in time as Mrs. Connors was passing the check over. We had quite an understanding in the bank. I told her to return the check to mother. She said, "I was going to give my personal check to pay any bills your mother owed." I told Mrs. Connors she was supposed to nurse Mother and provide care for her but the business end of it was in my department. Mrs. Connors was very angry but she did return the check to the selectmen of the town.

Mrs. Connors notified the selectmen to remove mother. She told them my mother had been a long hard pull. The selectmen asked her to reconsider, although there was another first-class nursing home ready to receive her.

Her nurse was very abusive to my daughter and myself. She acted like a fishwife, screeching as loud as she could. I told her she was disturbing the patients. She dared me to stay until she could get Mrs. Connors at the home.

The only R.N. there is Mrs. Connors. Some days she is not there during the day. This young lady, whose first name is Sandra, is nursing at the home. She is not a practical nurse and to my understanding the only training she has had in this field is what her mother and Mrs. Connors has coached her. She wears the cap and uniform. To my belief a check upon the nurses at Mrs. Connors should be checked. There are some very seriously ill patients there including my mother who is 87 years old and completely helpless. These patients need trained help, not hit or miss.

There are thieves there; Mrs. Connors has been putting chains on her deep freeze to protect her property while she is not there. But the patients cannot put chains on their property. It is a poor nurse who will beg money from a patient who is entirely dependent on her to be turned over during the night.

I do not believe the State would stand for these things, but not knowing the ins and outs, what can the State do?

Mrs. Connors gave me orders and demanded me never to step in her door or her place again as she owned that place and would get a court order to keep me out. I am the only child.

Sincerely,

EVA E. VERRILL.

GRAY, MAINE, *August 8, 1965.*

Mrs. C. CARSWELL,
26 Panoramic View Drive, Portland, Maine.

DEAR MRS. CARSWELL: Thanks for your notice of hearing. I was in hopes you could of called here so I could of gone over this matter with you again.

I have made many visits at the nursing home since seeing you. No trouble at all. Tonight is the first time though that I have been able to see the condition of my mother's body. Very bad. It is amazing how she still clings to life.

You came through wonderfully for me and I am deeply indebted to you.

Mrs. Connors is a liar. She abused me terribly with her tongue. Now she denies the things she said.

Yes; I want to be at the hearing, if possible. My daughter does not care about attending for various reasons.

I will probably be ordered to remove my mother. In my opinion this would be fatal for her.

There are so many distinguished men that will be at that hearing, I think this is one reason my daughter is not anxious to attend.

I know you are a very busy lady. If you could drive out and talk to her personally I am sure it would help.

You are doing a wonderful thing in demanding this investigation. I feel that we owe it to you to do what we can to shed light on this situation.

I cannot get over my mother lying for 24 hours without a doctor examining her after she was so badly hurt. There is more than one doctor in Portland.

Also the abuse this nurse at the home that night subjected us to, should not happen to anybody else.

The health and welfare told me they had two versions of this affair. Mine and Mrs. Connors. To my understanding Mrs. Clonan (investigator) and Mrs. Connors are very good friends.

When Mrs. Connors told me she did not care what I promised my mother, that I did not pay her bills, this surely got me. Am I supposed to close my eyes and shut my ears in my mother's dire need?

Believe me, if possible I will be there. I need my daughter there and hope she will consent to take me and be there herself.

Sincerely yours,

EVA E. VERRILL.

P.S.—My daughter thinks our signed statements should speak for themselves.

Mrs. CARSWELL. Aside from letters, I would like to read a portion of an item written by a registered nurse. The item appeared in the Express of July 7, 1965.

"There are many homes in this area that are State licensed and operated under State approval, but I certainly would not want to place my mother or father in one." This lady finished her statement by saying, "I only hope this letter will help to stir up some of the public interest in the conditions of boarding homes and nursing homes in this area." It is signed by "Rose Bishop, South Portland, Maine, owner of Bishops Nursing Home for Senior Citizens."

Mr. Chairman and members of the committee, the word "nursing home" has become a horrible word to mention, and I can only compare it to the term "snake pit" used many years age when mental hospital was a horrible word to mention. I hope that our nursing homes can overcome the terrible stigma attached to them because of some of the horrible conditions existing in the care of the aged. I hope that Federal legislation to upgrade standards for public assistance patients will be a result of your findings after your hearings are completed. I do feel that more money for recipients is a must in order to encourage better conditions in nursing homes.

I thank you.

Senator MOSS. Thank you, Mrs. Carswell, for your statement, one that does depict conditions that we must inquire into here and elsewhere.

Do either of the ladies with you have any statement to make, or are you simply here to answer questions?

Mrs. CARSWELL. At my right is Mrs. Alma Oakes.

Would you care to elaborate on any of my comments, or do you have anything to add?

Mrs. OAKES. I will answer questions.

Senator MOSS. All right, Mrs. Oakes. We may have some questions.

Senator NEUBERGER. Who is Mrs. Oakes?

Mrs. CARSWELL. She is a member of the health and welfare advisory committee. It is a committee that studies problems over the State and then tries to advise the health and welfare department what might be necessary to correct certain conditions.

Senator NEUBERGER. How does she get her appointment?

Mrs. OAKES. By the Governor.

Senator NEUBERGER. That is what I wanted to know.

Senator MOSS. The other lady is Mrs. Genevieve Gardner. What is your position, Mrs. Gardner?

Mrs. GARDNER. I do practical nursing.

Senator MOSS. You are a practical nurse?

Mrs. GARDNER. Yes.

Senator Moss. Now, Mrs. Carswell, the State of Maine does license nursing homes, and boarding homes as well; is that correct?

Mrs. CARSWELL. Yes, that is correct.

Senator Moss. But your criticism here this morning is directed, then, not to the lack of a licensing law, but to a lack of enforcement of some licensing standards. Is that basically correct?

Mrs. CARSWELL. It is basically correct, but we need to upgrade the standards, too. We need additions to the present rules and regulations. Some of the rules and regulations should become State statutes, I believe.

Senator Moss. So the State of Maine needs action in two areas: one, to raise the standards themselves; and, secondly, then to enforce them vigilantly so that they are observed by nursing homes and boarding homes.

Mrs. CARSWELL. That is correct, Senator.

Senator Moss. Now you have been chairman of this committee in your house of representatives for how long?

Mrs. CARSWELL. I am a Democrat, so I just became chairman the last election. But I have been on that same committee since 1957.

Senator Moss. Since 1957. So you have had quite a number of years of experience on the committee.

Mrs. CARSWELL. That is right, Senator.

Senator Moss. The things that you have related to us, of course, are very disturbing. How common would you say this condition is among your nursing homes? Are these just a scattered few, or is this quite widespread?

Mrs. CARSWELL. Senator, I would rather have the attorney general's department answer that, because for fear of causing trouble I did not stick my nose into any of the nursing homes. I did not go out looking for trouble. However, the attorney general's department did a brief study and turned up much information, and he would be better able to answer that question.

Senator Moss. All right. We are going to hear from the attorney general a little later, so we will reserve that question for him.

Do you know what the welfare payment is for an older person that is confined to a nursing home?

Mrs. CARSWELL. I believe the payment for a nursing home patient is $200 a month.

Senator Moss. Is it a common complaint of the nursing homes that this is inadequate and that is one reason they do not give good care?

Mrs. CARSWELL. I understand this is one of their complaints.

Senator Moss. I am going to defer to my colleagues. They may have some questions. I will ask Senator Muskie first, if he has any questions of Mrs. Carswell.

Senator MUSKIE. I gather, Mrs. Carswell, that you made your opening statement for the purpose of focusing the committee's attention on the reason for your interest and that we will get into more details with the other witnesses that follow.

Mrs. CARSWELL. That is right, Senator.

Senator MUSKIE. I should say at the outset that this hearing is not strictly in response to your request for an investigation, as you know. Since nursing homes are not a Federal responsibility under current law, it did not seem feasible or possible to launch a formal investi-

gation. But it struck me that, since this hearing was scheduled as part of a national study of nursing home problems that this might be an appropriate forum for you to present your story and this information. That ought to be clarified so that it is not misunderstood as an investigation of this particular situation.

Mrs. CARSWELL. I understand that, Senator.

Senator MUSKIE. With that, I want to express my appreciation to the chairman for having scheduled this hearing on the nursing home problem. The subject of nursing homes has been one of increasing concern to me. One of the reasons is that primarily we want to see them serving the needs of our chronically ill. I think it is highly appropriate that we should have this broad study. Certainly this is an appropriate forum for Mrs. Carswell, who has a longstanding interest, to present her story.

Senator MOSS. Thank you.

Senator Neuberger.

Senator NEUBERGER. I am glad Sentaor Muskie clarified that point. I was going to ask you if this were not a State problem. Why do you think a Federal Senate committee should conduct an investigation, when this is a State problem?

Mrs. CARSWELL. Senator Neuberger, I feel that if the Federal Government is a caretaker of the taxpayers' funds, then we, the taxpayers, should let the Federal Government know what our problems are so that they can better legislate our tax dollars.

Senator NEUBERGER. Of course, we are all anticipating the increasing use of nursing homes and probably the growth of nursing homes because of the passage of the recent health care bill.

Does your State make use of the Kerr-Mills provision for aid to low-income persons?

Mrs. CARSWELL. I believe it does.

Senator NEUBERGER. You do not know how much of the welfare program is trickling into Kerr-Mills?

Mrs. CARSWELL. Dr. Fisher could answer that, whereas I might be taking a guess.

Senator NEUBERGER. For the sake of argument, counteracting a little bit your testimony, do you think that some of the complaints that you have received might be deflated a little bit on actual investigation? There are always people who have a chip on their shoulder, or who are being insulted, or who present a tale that on investigation does not bear out all the charges. Do you think that might be true?

Mrs. CARSWELL. I find that oftentimes these things happen. That is why I asked the attorney general to do the investigating rather than myself. He, with his professional experience, could turn in the records that he thought were worthwhile.

Senator NEUBERGER. I think those of us in political life, as you are and as we are, realize that we just can't take on face value every complaint that comes.

Mrs. CARSWELL. That is right.

Senator NEUBERGER. Sometimes investigation shows that somebody was mad at the superintendent. What we are trying to bring out here is a real picture. I am sure that the attorney general will give us that.

Mrs. CARSWELL. I appreciate that.

Senator Moss. Thank you, Mrs. Carswell, and thank you ladies who have come to the stand here. We appreciate having this as part of our record.

Mrs. CARSWELL. Senator, I think inadvertently Mrs. Gardner has been forgotten. I believe that she might have a brief statement to make.

Is that correct?

Senator Moss. Very good. We are most happy to have you make a statement, Mrs. Gardner. This is Mrs. Genevieve Gardner. You are a practical nurse.

Mrs. GARDNER. Yes, sir.

The report is in Augusta. I appeared at one hearing, I was subpenaed. I appeared at one hearing. I said in that report it was all facts. There was not sufficient evidence, apparently. There is no pressure on my part. I have worked in six nursing homes. Three of them I would say were of high quality. The other three, I am sorry, but I can't say much for them.

Senator Moss. I am afraid we did not understand the last part.

Mrs. GARDNER. I have worked in six in the last 3 years. Three of the six gave high quality care. But the other three were just the opposite.

Senator Moss. So you are saying that there are some well-operated nursing homes here in Maine and some of them are not. This was the point of a question I asked earlier. The picture should not be created if it is not the truth, that all nursing homes are deficient.

Mrs. CARSWELL. Senator Moss, I have been in some very, very fine nursing homes. I certainly don't want to create the idea that I believe all nursing homes are snakepits. But those that are, are pretty bad snakepits, and those are the ones that I want to bring to the light and have corrected.

Senator Moss. Thank you, Mrs. Carswell.

Senator MUSKIE. May I say, Mr. Chairman, that 4 or 5 years ago similar hearings were held. The kind of story you have told here was heard quite often across the country. I think that the exposure of those conditions to the light of public knowledge has resulted in improvements to the point that in the hearings across the country this year these stories are much much less frequent. So I think it is a constructive thing to bring these accusations out; to look at them, check them, investigate them, and make sure that the abuses are eliminated.

So I want to express my appreciation to you, Mrs. Carswell, and your colleagues, for bringing us a statement on the problem.

Senator Moss. Thank you very much, ladies. You have been fine witnesses. We appreciate your appearance and your giving the information to the subcommittee.

Mrs. CARSWELL. Thank you, Senator, and have a fine time while you are in Maine.

Senator Moss. Thank you very much.

I am not sure whether our sound system is back working or not. Does it seem to be working now?

All right, we will proceed. We have asked as our next witness the Honorable Richard J. Dubord, who is the attorney general of the State of Maine.

We are pleased to have you, Mr. Dubord. We look forward to hearing from you.

I hope you can make the microphone work.

STATEMENT OF HON. RICHARD I. DUBORD, ATTORNEY GENERAL FOR THE STATE OF MAINE

Mr. DUBORD. Well, Senator, I think if I were an electronic technician I would be of more value to you.

Senator MOSS. Thank you, we look forward to hearing you.

Mr. DUBORD. I am appearing at the request of Mr. Frantz of your staff. My knowledge of this subject and my experience in it is extremely limited. I just don't know just what value my remarks will have.

My experience with this subject is a limited one, and my connection with it I would like to explain to the committee. I will try to be brief. My office became involved in this matter at the request of Representative Carswell, your previous witness, who earlier this year, in connection with some proposed legislation, asked our office to conduct an investigation of the nursing home situation she has described. I explained to her that we were neither equipped with staff, or finances, or personnel to conduct any sort of widespread investigation. She wanted us to review a report which she had and to see what else we could find, so that our investigation was a very limited one and included the homes to which she referred in her testimony.

Our compilation in connection with that consisted of obtaining a report of a previous investigation of this one specific home which had been conducted by the State police at the request of the Governor in January of 1964. The conditions which Mrs. Carswell described in this one particular home were substantiated by the bureau of criminal investigation of the State police and a hearing was subsequently held before our administrative hearing officer in connection with the license renewal of this specific home.

After hearing, the license was renewed by the hearing officer, somewhat, I might say, to the distress of those who had been involved in the investigation.

Secondly, we learned of a perhaps worse situation which we uncovered in a home which had been investigated by a sheriff's department in one of our counties, and the county attorney in that county. The deputy who conducted the investigation, I might say, was an experienced investigator, a former captain of the State police, subsequently retired.

As a result of interviewing some nine witnesses, it was concluded that there were six deaths which had occurred in the home of a suspicious nature. These all occurred some time previously, from 2 to 3 years. The county attorney selected one which he thought was the most reprehensible from a criminal standpoint. The body was exhumed and an autopsy performed, but because of the physical condition, it was impossible to obtain enough evidence for a criminal prosecution. However, the record is replete with instances of abuse of patients in this particular home.

I might say that reports were gotten back to the licensing division, but this home to my knowledge is still licensed and still operating.

Now, we got into another home because of a suspicious death in February of this year. This was in a boarding home, not a nursing home. A patient had been delivered by the operator of a boarding home to the nursing home, and the operator of the nursing home complained to our department because of the terrible condition, physical condition, in which this patient was delivered to her. The patient expired within a few days. Again, there was evidence of physical abuse, but an autopsy disclosed medical evidence was not obtainable to the point where it would warrant a criminal prosecution.

When these instances do occur, because of the advanced age of the patients, their general physical disability, it is frequently difficult to establish a cause of death or a hastening of death as a result of any abuse.

Now these are the only three specific instances which we investigated and in which we clearly defined these abuses. There were only three reports, written reports, compiled on these investigations. One was made available to Mr. Frantz of your committee staff several weeks ago, so that I don't see anything to be gained by repeating names or other details. You have it for whatever use your committee cares to make of it. As I told Mr. Frantz when he asked me to appear here, I felt that I could not contribute too much to the overall problem other than to point out that these instances did exist in these three specific homes.

However, I would be the last to draw any conclusions from such a cursory study as to how widespread these abuses may be. I know from personal experience that we have some excellently run nursing homes. We have some bad ones. These three were bad ones, among the worst that we could find. They were, as I say, compiled to point up the abuses that do exist in some areas.

Again, to qualify my remarks, I do not feel that we have any evidence on which to base any widespread conclusions from these matters.

I might point out also, as perhaps Mrs. Carswell did, that our legislalative research committee, which will be working toward the next legislature in January 1967, has this problem under its consideration and is looking into it as a committee of the whole. I think they are just getting organized, but hopefully they will get in a fairly detailed study over the next 18 months with a view of trying to write or propose whatever corrective legislation might be indicated, if any is indicated.

Senator Moss. Thank you, Mr. Dubord.

Since the evidence was not of a sufficiency or quality to sustain criminal action in any of these three cases, the remedy should come through the administrative procedure on the license. Is that your opinion?

Mr. DUBORD. Yes; that is correct.

Senator Moss. Yet when the hearing was held, on one of them at least, the license was renewed in the face of considerable evidence of failure to meet a minimum standard?

Mr. DUBORD. That is correct.

Senator Moss. This, of course, is a State problem that has to be dealt with administratively, by the licensing agency of the State.

Mr. DUBORD. I would agree with that.

Senator Moss. Underlying what Senator Muskie said before, from the Federal angle we have no direct licensing jurisdiction; but there is a possibility, because of the involvement of Federal moneys to a con-

siderable extent, that it may become desirable to require certain minimum standards at the Federal level and then allow the State to build its standards higher if it cares to do so.

As I say, we have no legislation before us at this time, but this is certainly one of the areas which we want to inquire about.

Would it be your opinion that this might be desirable to have some minimum Federal standards?

Mr. DUBORD. I think it might. We, of course, have State minimum standards, but I think the problems arise apparently in reissuance of licenses and investigations, and the enforcement of those standards. I think undoubtedly some of the later witnesses will be more competent to testify on that score than I would be.

Senator Moss. Thank you.

Senator Muskie.

Senator MUSKIE. Has all of the information you developed in these three cases been given to the department of health and welfare?

Mr. DUBORD. No; it has not been given to the department, Senator.

Senator MUSKIE. Should it be?

Mr. DUBORD. Some of it has come to the department from other sources. It has not come from our department, because our purpose was in connection, at the request of the legislature and a special subcommittee which was appointed, to which the materials were given. We, frankly, treated them confidentially for the purpose of the legislation, and because of the fact that we did not want to make wild charges on the basis of a lot of hearsay, which much of this is.

Senator MUSKIE. So that your information was all turned over to the legislative committee?

Mr. DUBORD. That is correct.

Senator MUSKIE. It involved three different homes?

Mr. DUBORD. Yes.

Senator MUSKIE. Do you know whether or not there was any followup by the department of health and welfare of these cases other than the one to which you have already referred?

Mr. DUBORD. In the first one, of course, there was the hearing. The second one, which was to my mind the most flagrant one, the home I believe was investigated. And presumably these facts came to their attention, because these were reports in the hands of law enforcement officials. I am quite sure they were given to the division within that area of the State. As I say, the home still is licensed. As far as I know, all three homes are still licensed.

Senator Moss. Senator Neuberger.

Senator NEUBERGER. I realize that your office, General, is not the enforcement agency. But we have witnesses coming up and I don't know which ones we are going to ask about this poor enforcement. We have the commissioner of health and welfare. We have the director of the bureau of social welfare. They get tax money which is spent here. And the director of the Hill-Burton program and director of the hospital licensing. Which one of these areas is responsible for the enforcement and the investigation?

Mr. DUBORD. I suppose the ultimate responsibility for administration would lie with the commissioner of the department of health and welfare. How he has those responsibilities divided down the line, I am not completely aware.

Senator NEUBERGER. You are the chief legal officer of the State?

Mr. DUBORD. Yes, ma'am.

Senator NEUBERGER. Therefore, you do know about the law. Is the law specific and adequate so that enforcement can be made?

Mr. DUBORD. Well, there are some divergent views on that. This was one of the bones of contention in the legislature which led to some of this—a definition of "nursing home" in the statute which was sought to be changed, and about which there existed a difference of opinion between the members of the legislature, members of the committee, between the department, itself, and between the Nursing Homes Association.

The issue was resolved in somewhat of a compromise. As a matter of fact, we have in the office a request for an opinion as to the meaning of the new definition by the commissioner of health and welfare, which we have not completed yet. This is one of the areas.

Senator NEUBERGER. Then something is wrong with the law that you can't enforce it, I would think. I would not see how a licensing agency could continue to give a license to a place that has all these abuses, unless there was a loophole in the law.

Mr. DUBORD. Frankly, I can't see how some of them continue to be licensed with the evidence that we have at hand. As I say, short of a criminal offense, our responsibility ceases and our authority ceases.

Senator NEUBERGER. Do you have a distinction in the law between a boarding home and a nursing home? And what is it, if any?

Mr. DUBORD. We do have a distinction, but I would prefer to let Dr. Fisher answer that. I think he would be able to give you a more accurate answer.

Senator NEUBERGER. In your opening remarks you spoke of poor enforcement and thought it was a lack of money.

Mr. DUBORD. Yes. I think with all due respect to the Equal Rights Act, it is difficult for women social workers, many times, to enforce some of the situations they run into in some of the poorer run establishments. It is in the nature of things, it is tough for a woman to be a police officer. She is not an enforcement agency. She should have somebody she can call on and say this is a direct violation.

Senator NEUBERGER. I want to reiterate what Senator Muskie has said. Do you think there is a place for a Federal law as regards standards?

Mr. DUBORD. I think there is if the State is failing to meet its responsibility in this regard. We do have laws, we do have rules and regulations of the department which seek to correct these situations where they exist. As I say, our own legislature will be studying the problem for 18 months. I assume if they fail to come up with any corrective measure, then as in so many other cases it will be proper for the Congress to give consideration to Federal legislation in the field.

Senator NEUBERGER. Yes, because of the Kerr-Mills money.

Mr. DUBORD. Yes.

Senator NEUBERGER. Fine.

Senator Moss. Does the commissioner of health and welfare also consider physical features of a home, like fire protection, and so on, in its licensing?

Mr. DUBORD. Yes, in conjunction with other State agencies such as the insurance division, which is charged with fire protection laws,

fire escapes, exit doors, firewalls, kitchens—this type of thing—the homes presumably have to meet the requirements of the insurance department as well.

Senator Moss. Have you had any severe condition occur here in the last 4 or 5 years resulting from a fire in a nursing home or other natural disasters?

Mr. DUBORD. Not that I can recall from my personal recollection, Senator.

One area that I hope our own committee will look into is somewhat of an overlapping of licensing functions. I think there are too many different agencies involved with the various features of licensing a home. I think if you had more of a central licensing we would be better off. We have had instances where you might get turned down by one bureau for a nursing home license and then go somewhere else and get a boarding home license. The same patients are still there and the same place is still operated. One hand does not know what the other is doing.

Senator Moss. They are sort of fishing in the barrel until they get the right fish.

Mr. DUBORD. Right.

Senator Moss. Thank you very much, we appreciate it, Mr. Dubord. Your testimony has been very helpful.

Mr. DUBORD. Thank you very much, Senator.

Senator Moss. Our next witness will be Dr. Dean Fisher who is the commissioner of health and welfare here in the State of Maine. I understand Mr. Stephen Simonds who is the director of the bureau of social welfare will accompany Dr. Fisher. Also Mr. Woodrow E. Page, director of the Hill-Burton program, Mr. William Carney, director of the division of hospital licensing and Mr. Robert Wiley, and that is a very fine panel.

I hope we can bring the chairs around so that we can have them all at the table together. So, Dr. Fisher, if you will introduce each of these gentlemen with you we can make their acquaintance and direct our questions to them if we care to.

STATEMENT OF A PANEL CONSISTING OF DR. DEAN FISHER, COMMISSIONER, HEALTH AND WELFARE DEPARTMENT; STEPHEN SIMONDS, DIRECTOR OF BUREAU OF SOCIAL WELFARE; WOODROW PAGE, DIRECTOR OF HILL-BURTON PROGRAM; WILLIAM CARNEY, DIRECTOR OF DIVISION OF HOSPITAL LICENSING; AND ROBERT WYLLIE, SOCIAL WORK CONSULTANT—DIVISION OF FAMILY SERVICES, THE STATE OF MAINE

Dr. FISHER. Senator Moss, Senator Neuberger, Senator Muskie, I am Dr. Fisher, the commissioner of the department of health and welfare. I have a general statement which I shall make, myself, and then I will introduce the other individuals who are with me.

We have divided our departmental presentation into five parts in general, my own and rather brief statement, again somewhat general in nature, by Mr. Simonds the Director of our Bureau of Social Welfare, and then perhaps next in order might be Mr. Page, who will speak of our activities in the field of long-term care as they have been

influenced by the Hill-Burton program and Mr. Wiley, who will speak of the interrelationships between long-term care and our public assistance programs and Mr. Carney who will speak in relationship to our licensing activities and responsibilities.

Obviously and naturally we will be very happy to answer any questions you have and obviously in view of the rather specific presentation by each of the various individuals, their particular kind of presentation should indicate the individual most likely to be able to answer your questions, or we shall give you a composite answer to your question if you so chose.

Senator Moss. Thank you, Dr. Fisher.

Dr. FISHER. We have some complex problems. I would just like to say this in the beginning but I am rather disturbed when the Attorney General makes an assumption that we are not discharging our responsibilities under our licensing requirements.

I think we will try to point out some of the complications that are involved in this responsibility and perhaps show you that these responsibilities are shared and that in some instances at least the ways in which these responsibilities are shared are not clearly set forth in our statute. Therefore it is difficult at times under our particular statutes to properly identify the method of procedure, as a matter of fact, even the proper agency to which to turn for enforcement purposes.

As I said a moment ago our statements will consist of several sections. I will introduce the people concerned. I am not going to direct my statement particularly to the matter of nursing home licensing. I should like to speak in somewhat broader terms and then our presentation will be sharper as we go down the line.

We have had an opportunity to review the reports of some of your previous hearings on this subject of long-term care and long-term care facilities. We see little reason for any major substantive disagreement with the opinions, problems and needs which have been expressed to you in your previous hearings.

Therefore there is very little need for us to belabor in detail these points of general agreement. Thus our statements generally will be somewhat outline in nature and will treat our own problems rather than attempting to develop all of the concepts that may be involved in the total process of meeting long-term care needs.

Incidentally, I will read this statement. I did not have enough facilities available to make enough reproductions of all of our material for you. I will, however, leave this with you and I shall be very happy to furnish you additional copies of this material by mail and they will probably be available this afternoon.

Senator Moss. Thank you, Dr. Fisher.

You just proceed with your statement. It won't be necessary to duplicate it later because we will get the transcript in a matter of a very few days.

Dr. FISHER. As you wish, sir.

Now I judge to some extent at least attention is being focused in this hearing on the unit in the gamut of long-term care resources which is commonly referred to as the nursing home. We are currently using other terms such as "long-term care facility." "Nonintensive care facility." "Progressive patient care facility and so forth."

(Discussion off the record.)

Senator Moss. We will come to order and make a fresh start to see if we can improve the acoustics in the room. Will the room please be in order so that we may resume our hearing? Dr. Fisher is just beginning his statement. We look forward to hearing you, Dr. Fisher. You may proceed.

Dr. FISHER. In this field of long-term care we are currently using other terms such as "long-term facility," "nonintensive care facility," "progressive patient care facility," and so forth, none of which necessarily means the same thing as the term "nursing home." Which usually has a legal definition rather than a function definition simply by virtue of the fact of its antiquity as a unit and the fact as a unit it has been recognized in law prior to the development of some of the concepts that we now recognize as being important in this total field of long-term care.

The term "nursing home" implies some kind of self-contained unit for the provision of some range of services as they may be defined in statutory regulations. The other terms may refer as much to concepts as to structures and certainly there is less implication of independent structure. For the purposes of program and probable analysis it is probably better to use these functional terms rather than the legal term which obviously may well differ from place to place. This does not necessarily mean that in an ultimate plan for providing services there may not be a role for what we call the nursing home.

It is unfortunate that for—that some 10 or 15 years ago we were not able to predict the rapidity with which the problems of providing for long-term care would develop as a result of modern medicine and social changes—the magnitude or even the complexity of the problems that were so created were not predicted at this time. Consequently very little sound, comprehensive integrated anticipatory planning was done. One of the very early, obvious and urgent needs was the simple need for the means of paying for the services that were available and generally this meant the need to pay for nursing home care as it existed at that time.

This created major financial problems even at the level of costs and services of the time and some States have not yet been able to progress very much beyond this point. I think I have to list our State in this category.

Here at least, by here I mean in our State, our nursing homes are expected to assume with relatively little support or preparation a level of responsibility for which they were ill equipped by experience or resources. As proprietary institutions they were denied access to some community resources which might otherwise have been available. Furthermore they were to some degree isolated from the mainstream of medicine and the mainstream of community services.

I think some recognition is due for their progress under these conditions. Obviously the system of proprietor ownership does have some peculiarity and disadvantages under certain circumstances.

The term "hospital" has a meaning that is generally understood; namely, a facility to house people who are acutely ill. However, the terms "nursing home" and "boarding homes for aged" were not as clearly understood. The basic difference between the two is that in nursing homes the patients are sick people, requiring some form of nursing care, whereas in boarding homes the boarders are essentially well people with no requirement for nursing care.

When one considers the age group of the population in nursing homes and boarding homes for aged it becomes apparent that it is often difficult to distinguish the proper facility for housing the individual. As an aged person in a nursing home becomes better, he could perhaps be more appropriately housed in a boarding home; and as an aged person in a boarding home becomes ill he could perhaps be more appropriately housed in a nursing home.

At all times there is a small percentage of people in both of these types of facilities that might be more appropriately housed in a facility requiring greater or lesser care.

The major difference between a boarding home for aged and an eating and lodging place is that supervision of a boarder is required in boarding homes for aged, whereas no supervision of the lodger is required in an eating and lodging place. This identifies another problem area in distinguishing whether or not an aged boarder requires supervision or whether he remains self-sufficient in a licensed eating and lodging place. On occasion, there are some people in eating and lodging places that may require the supervision of a boarding home for the aged for a period of time.

This series of definitions and distinctions was given to indicate the fluctuation in the amount of care and supervision required by some people in the age group currently housed in nursing homes, boarding homes for aged, and certain lodging places.

The term "boarding home for aged" is a misnomer for some of our licensed homes. Within the past few years approximately 20 percent of our licensed boarding homes for aged have been accepting mentally retarded adults placed by the Pineland Hospital and Training Center for the Mentally Retarded. These are young adults, some in their early twenties, who represent a good example of the problem of deciding where they should be most appropriately housed, in a nursing home, boarding home, eating and lodging place, or State institution.

To cite an example, our own administrative review officer system which is established almost specifically to protect all licensees of all State agencies against capricious acts on the part of a licensing agency. This is for all practical purposes a part of the judicial system. It is established at the level of a major judicial position.

Now it has been only within the past 2 or 3 years that the need, and I speak here in general, not necessarily in relationship to the State of Maine alone, but the need for comprehensive regional planning has been given some general professional and legislative recognition.

However, even this simple step has not yet gained universal acceptance for many reasons, some of which, such as established practices existing after the legal problems, are obvious.

Perhaps a simple example of this is some of the legal problems which are associated at least, the legal profession feels, are associated with the requirement for some kind of affiliation between nursing and—between nursing homes and hospitals.

Where do the responsibilities and liabilities begin under these kinds of circumstances? Perhaps this is an area in which we do need some legal assistance and perhaps legislative clarification.

The concept of progressive patient care, this very simple matter of relating patients' needs to services, facilities, and costs, even in a single institution, is just beginning to gain some degree of positive consideration. However, the necessary adaptations and adminis-

trative practices, public attitudes, staffing patterns, building design, medical staff and attitudes, and so forth are just beginning.

Even the modern insurance plans have not yet generally made the kind of adaptations needed to fit into medical care patterns that are not almost entirely oriented to a general hospital and acute care system.

There is a current trend to move patients out of our State mental hospitals and Federal Veterans' Administration facilities into our licensed boarding homes for aged. This group, too, is younger in age and together with the mentally retarded adults present some unique problems in our boarding homes.

Supervision in boarding homes is much less than that expected in nursing homes. Well, no training is required of boarding home operators. Yet, demands for greater skills are being required for them as more and more of the mentally ill are being placed in boarding homes. Fire safety regulations for sprinkler systems were first enforced against hospitals, then nursing homes and only recently has this been a requirement for boarding homes for the aged.

The physical facilities of licensed boarding homes for the aged are for the most part not comparable with the physical facilities of licensed nursing homes. Today no one builds a facility with the specific purpose of becoming a licensed boarding home for the aged. Economics is a factor here with the current public assistance rate for boarding care patients at $110 per month as compared with $200 per month for the patients in a nursing home.

Thus we continue to be faced with the many problems of large old family residences being reconstructed into boarding homes for the aged.

These various licensing categories have been outlined in order to give you a frame of reference for a more particular discussion of licensed nursing homes.

On January 1, 1946, the date the first hospital and nursing home licensing law went into effect, there were 81 licensed nursing, convalescent, and rest homes. In 1956, the date that current licensing standards for nursing homes went into effect, there were 221 licensed nursing homes in the State providing 2,963 beds. Today there are in Maine 186 licensed nursing homes containing 3,856 beds. Thus, in 1965, there are 35 fewer nursing homes but 893 more nursing home beds than in 1956.

In 1956, 29 percent of the homes were 15 beds or larger in size.

In 1965, 58 percent of the homes were 15 beds or larger in size.

In 1956, homes of less than 10 beds represented 44 percent of the total.

In 1965, homes of less than 10 beds represented 21 percent of the total.

Nursing homes range in size from 1 to 375 beds. It is apparent from the above facts that the trend toward larger nursing homes has started. There is also a trend away from the reconstruction of houses into nursing homes. The larger new homes are today being specifically constructed as nursing homes. The division of hospital service currently has inquiries for new construction of 10 nursing homes as follows:

Bangor, 90 beds; Waterville, 74 beds; Sanford, 72 beds; Bangor, 72 beds; Augusta, 70 beds; Farmington, 70 beds; Dixfield, 50 beds; Rockland, 50 beds; Rumford, 36 beds; and Pittsfield, 30 beds.

Of the 186 licensed nursing homes only 5 are nonproprietary. Proprietary nursing homes have filled a gap in medical care in Maine created by our ever-increasing aged population, a need unmet to date by our nonproprietary community hospitals. The proprietary nursing homes in Maine have served as a valuable and necessary community resource for the care of our aged citizens.

Over the 4-year period, 1960–63, more patient days of care have been rendered in nursing homes in Maine than in our acute general hospitals. Nursing homes are the largest, fastest growing institutional resource for the care of the physically ill in the State of Maine.

I am sure that hospitals will not willingly and anxiously move into the field of long-term care under these same ground rules. Finally perhaps I should remind everyone that licensing laws do not bear the entire responsibility for controlling conditions in nursing homes. There are laws relating to assault and battery, manslaughter, all kinds of things. The illegal practice of medicine and so forth. I also remind you, quite unnecessarily I am sure, that all people and all law enforcement agencies have responsibilities in the enforcement of these kinds of laws.

If evidence will not support such charges it is very difficult indeed for us to take what is essentially the same charge before the administrative hearings officer and have the license revoked.

Senator Moss. Thank you, Dr. Fisher. Now would you prefer to have the other gentlemen make their statements before we question you?

Dr. FISHER. I think it might be better because their statements might answer some of your questions. Perhaps the total presentation will give you a better background against which to ask questions.

Senator MUSKIE. I would like to ask a question directly in reference to Dr. Fisher's statement. As I understand your statement, Dr. Fisher, you said that the standard you ought to use in judging whether a license should be revoked ought to meet the same criteria of proof that a criminal charge would. I think you ought to clarify this.

Dr. FISHER. I did not say that.

Senator MUSKIE. I think this is the point we ought to clarify.

Dr. FISHER. Let us assume a case where some kind of what we might call assault has been alleged. The law enforcement agency itself, this may be the county attorney, the sheriff, or anyone else, says I have not any evidence that I can take before the court.

Now we have to go before the administrative hearings officer, which for all practical purposes is a court procedure. Someone asks us what kind of evidence do you have. The first thing we know it is brought out in court or in our hearing that this same situation has been reviewed by other legal and law enforcement agencies and it has been determined by them that they have no basis for proceeding.

On this basis the hearings officer says, you know; "it was nice to know you".

Senator MUSKIE. You are talking now about a single charge. But some of the evidence or testimony we have had this morning is to the effect that there may be a pattern of lack of care or lack of proper care and concern for the condition of patients.

Now that is a different kind of question and problem than a specific charge of assault or any other criminal charge.

Dr. FISHER. Precisely. Even here with the experience that we have had, and I might say even without the administrative hearings officer, a decision on my part to revoke a license was subject to review in court and therefore I would not be very likely to revoke a license unless I had some reason to believe that if it were taken into court, my position would be supported.

Senator MUSKIE. I take it that a court would base its decision upon the validity of your charge, based upon the standards of care that you require and not upon the criminal charge that may be involved in specific instances?

Dr. FISHER. Yes; but nevertheless the kinds of problems we have are not the objective kinds of things. You don't find the body with the bullet hole between the eyes and this kind of thing. This is poor food, poor diet, dirty. If it is dirty, in the hearings it comes out that this is the only day of the month—and we get six people in opposition who say this is the only day in the month—that the patient was dirty.

These are the problems you have. In the final analysis you still have to have some of—some kind of objective data on which to proceed.

Senator MUSKIE. Let me put it the other way. How do you go about supervising homes so that you can avoid the kind of home where for example, a patient is denied a blanket when he is cold or where he is denied water in the evening because he might wet his bed?

How do you avoid this?

Dr. FISHER. There is only one way to avoid it. This kind of thing obviously cannot be avoided even by repetitive inspection. You would have to have someone there 24 hours a day and somebody—obviously then these practices would not take place. There is only one way to do it and this is to build up the quality of nursing and nursing homes and the quality of people and the quality of service in nursing homes in the same way that it has been done in the hospitals, so that for all practical purposes they are self-policing.

Senator MUSKIE. Let me ask you another question. If you are morally certain that this kind of lack of concern and abuse is going on, what kind of a new legislation should you consider, what kind of supervision should you get?

This is the kind of abuse you ought not to shut your eyes to, and I know it is not your intention to shut your eyes. How do you deal with it, if you are morally certain on this kind of evidence that this kind of home is operated?

How do you get rid of it?

Dr. FISHER. You are asking me to set forth some of our tricks. Under certain circumstances, and I think Mr. Carney will dwell on this in more detail, but in certain circumstances, where you have considerable reason to believe that something is a mistake and you may have some shred of evidence that this is true, that something is amiss, you can inspect to the point where you become such a nuisance that it is entirely possible that the operator will decide to sell out.

There are ways in which you can make yourself quite obnoxious as a licensing agency without reaching the point where the licensee has the right to appeal to the hearing officer. But even here he can appeal to the hearing officer on the basis that you are simply—I don't know what the legal term is—but you would be essentially nagging him.

As a matter of fact, he has redress on this point.

Senator MUSKIE. A lot of these kinds of abuses are directly traceable to the character of the operator of the home. Is there any control that can be exercised over this in the licensing procedure?

Dr. FISHER. We have a provision that is in the law that we don't have to license if we think the individual's character—or something of this sort, I don't remember the exact terminology—does not justify it, or something like this.

Well, there are instances where this is quite obvious and quite flagrant where we have refused a license purely on this basis.

There is a little section here which says that we have some right to determine whether or not we feel that the individual has the resource necessary to properly provide for care. This can lead us into an investigation of the individual's financial circumstances, to determine whether the individual has enough financing to conduct a business without having financing of such uncertainty that it is likely to result in some kinds of conditions that may affect the quality of care. But I think you will recognize that both of these are extremely difficult and extremely dangerous areas in which a State agency can operate.

It is very easy, as I am sure you know, to say we don't think your character justifies issuing you a license. Very promptly we get letters from 99 prominent local citizens of various ilks, characters, and so on and so forth all saying he is a very wonderful person. As a matter of fact, I remember one particular circumstance somewhere there was some question and as a result of I don't know or remember whether we actually canceled that license or refused to issue it, but I think I probably got a stack in relation to that particular licensee, I got a stack of 25 or 30 letters. I suspect you have some in your files all certifying to the highly desirable character of the individual concerned and questioning very seriously our judgment in the matter.

Senator MUSKIE. I have not had a chance to study the files of the attorney general but it seems to me from what I have seen of them on the basis of evidence that he considers credible on the point of character of care, whether or not it would support a criminal charge, that there is considerable and cumulative evidence that suggests the character of care in the home is not that which ought to be approved for State licenses.

How about making that a test case and trying it?

Dr. FISHER. I would be happy to take a case such as this before the hearing officer. I simply remind the attorney general it would be his job to defend my position.

Senator MUSKIE. A test case might be worth while doing. Thank you, Dr. Fisher.

Senator Moss. Dr. Fisher, I was going to raise a similar point. The administrative action as to whether a license should be granted is not akin to the criminal action of prosecuting a person committing a crime. Now the standard of proof is different. One is "beyond reasonable doubt." The other is simply "a preponderance of the evidence."

Using your own words, having poor food, a dirty home, and not giving water at night, none of those is criminal but if the preponderance of the evidence is that this was being done in the home it might be a reason for denying the license. It would be quite a different thing.

Dr. FISHER. I think you will agree that this depends a little bit on the ground rules that the hearing officer, himself, establishes on which he makes a decision. Establishing what you call a preponderance of evidence in these kinds of problems is sometimes difficult.

You have one person on this side and one person on this side and one person here equal to four on this side. You know, these are the kind of things that you obviously get into. There are very sticky problems.

Prior to the time of the administrative hearing officer establishment I could revoke licenses. I could revoke a license and the individual concerned had the right to appeal from my revocation to a court. Now under some circumstances my revocation would stand until it was heard in court. On the other hand the individual might be able to secure a court order which would require me to permit the individual to continue until the case was heard in court. At least this left a considerable degree, at least a first round decision, in the hands of the department.

In a fair number of instances when this device was used you could effectively discourage the individual from appealing further so that this has been a change in mechanism. I cited an example of legislation designed essentially to protect licensees against capricious acts on the part of State agencies. I am not particularly one to try to discuss the pros and cons of this but I think in this particular area we must be dealing with subtleties, unprovables, in the legal sense, and that somewhere in this particular area where so much is involved, the problem is complex, the circumstances are peculiar, that licensing agencies perhaps could have the right to some degree of capriciousness.

Senator MOSS. Does your department have any authority to suspend or give a conditional renewal of a licence based on meeting certain standards?

Dr. FISHER. Not really.

Senator MOSS. So it is either a license or no license at all?

Dr. FISHER. As a matter of fact, it is far easier to refuse to issue or refuse to renew than it is to suspend a license, once it has been issued.

Senator MOSS. Have you refused to renew any in the last years?

Dr. FISHER. Mr. Carney has the answer.

Senator MOSS. Maybe we had better proceed with the other gentlemen and then return to the questions. I think your objective, which is the same as ours, to have all nursing homes and personnel meeting proper standards, might need a little nudging through this licensing procedure. Well, we will hear you next, Mr. Simonds.

Mr. SIMONDS. I feel that perhaps Mr. Carney should be next on your docket because it would seem to be in better sequence than my comments. Mine will be very brief; a very few observations related to the adequacy of our public assistance programs to share its responsibility for care in the long-term field.

Senator MOSS. That will be fine, Mr. Simonds, and your full statement will be printed in the record at this point.

STATEMENT OF STEPHEN SIMONDS, DIRECTOR, BUREAU OF SOCIAL WELFARE

My name is Stephen Simonds, director of the bureau of social welfare. The bureau encompasses the traditional public welfare programs including public assistance and medical assistance for the aged. Mr. Wyllie has already discussed them in some detail.

My comments will be brief, a few observations of a general nature concerning the adequacy of our public assistance programs in carrying its assigned role in long-term care and the relationship of public assistance programs to our social insurance system. I am certain that similar observations have been placed before this committee throughout the course of its hearing and my purpose is merely to underscore their importance, and to indicate their direct bearing on two of our most basic problems: money and staff.

It is our hope and belief that the Nation's social security system will eventually cover all of the major risks of loss of income and medical costs. Substantial progress has been made but not fast enough at the lower income levels. Public assistance is still required to supplement social security income for a large number of aged beneficiaries in their own homes, in boarding homes, and in nursing homes. Nearly 60 percent of Maine's old-age assistance recipients also receive social security benefits. This will give you some idea of the extent of overlap and duplication of programs designed essentially for the same purpose: to maintain income.

Substantially higher minimum social security benefits are needed chiefly for two reasons: To support a more adequate health, safety, nutrition, and housing, thus preventing the need for long-term care, insofar as possible; and secondly, to release public assistance resources to meet urgent needs in areas not covered by social insurance. At a time when staff is in short supply and is needed in the long-term care field, it seems a terrible waste of manpower to employ the public assistance mechanism with its highly individualized methods of determining eligibility, its multitudinous and complex requirements, policies, and procedures, its means test and its periodic redetermination of need merely to supplement an inadequate social security benefit.

But even with substantially increased benefit levels public assistance will continue to assume a large share of the cost of income maintenance and for providing the full range of medical care that the Nation now expects to be made available to the aged and to others. This will be true for the foreseeable future and public assistance costs will rise accordingly. Social work staff will be needed in increasing numbers to provide a range of social services to assure satisfactory living arrangements for the aged, particularly to promote and arrange for care and services in his own home, to assist him and his family in arranging boarding, family or nursing care as needed, for promoting and supporting progressive care, for giving protective services, for arranging home care, guardianship, if necessary; in short, for giving the all important helping and knowledgeable hand when it is needed at all levels of care and in all living circumstances.

These factors combined with the rapidly growing aged population and the trend here and throughout the Nation toward placing institutionalized patients back into the community add up to an increased demand for public welfare services. The need for efficient administration and productive use of staff time was never greater, and in this light, there is an urgent need to overhaul the public assistance machinery.

Outdated and useless features such as "categories" of aid, old-age assistance, aid to the blind, aid to permanently and totally disabled and aid to dependent children, and the complex, time-consuming and costly procedures required to fit needy persons into one of such categories, should be abolished and replaced by a single comprehensive public assistance program for all needy persons with a uniform Federal matching formula in all grant and medical assistance programs. These complexities are multiplied when, as in Maine, municipalities and local relief authorities carry some welfare responsibilities including medical assistance. A third level of government thus becomes directly involved with the patient with still a different set of eligibility and benefit policies, all related, by the way, to the archaic "settlement" and "pauper laws" still on our books.

Eligibility requirements not related to the question of need such as durational residence requirements and lein laws should be prohibited by Federal law and relative responsibility laws as they pertain to adult recipients should be eliminated. In this connection, we are pleased to report that Maine recently abolished all durational residence requirements in public assistance and substantially modified the relative responsibility laws. We have no lien law and we will soon be experimenting with a simplified eligibility determination patterned after our medical assistance for the aged application procedure.

Much credit for these progressive steps relating to residence and relative responsibility goes to H.R. 6675. Title XIX, the new medical assistance title in the Social Security Act, contains these prohibitions. They should now be extended to the grant programs.

Federal matching formulas as they relate to both levels of grants and medical care should be reexamined and adjusted with a view to more nearly compensating States for their relative abilities to finance public welfare programs. Maine's tax effort, the amount paid per capita to finance public welfare programs, is comparatively high; 13th in the country. Still, the State can afford only minimal grants and very limited medical coverage. Maine ranks 34th in per capita income; a neighboring New England State ranks 4th, but the percentage participation by the Federal Government is 65 and 50 percent respectively, a spread of only 15 percent. States at the high end of the income scale are capable of supporting a higher grant plus comprehensive medical coverage with the same and in some instances a lower tax effort.

Finally, we see the need to maintain a careful balance in our plans for extending the scope and coverage of medical care for the medically indigent and public assistance recipients and some extension of medical service is in prospect with newly appropriated funds. But at this moment only hospital care, nursing home care, and a very limited, almost negligible, amount of clinic service is provided in our programs. Our medical expenditures constitute 35 percent of our total public assistance costs and we have yet to move into physician care, drugs, nursing, and homemaker services and other home care services, and dental care.

Then there is a serious question of balance between the basic maintenance grants which now average $54 per month per aged individual and medical expenditures. Our grants are inadequate and our standards need updating. We could find ourselves in the position of starving people out of their own homes into institutional care. Therefore, we must take into consideration the full gamut of needs of the aged and make very judicious use of the funds available to us.

The Congress did recognize the broad nature of these needs in the recent social security amendments, and made many striking and welcome improvements in areas outside of medical care per se. With the obvious concern and help of this committee, this is only the beginning. Thank you for giving me this audience.

Mr. SIMONDS. As you may have read in our nursing home patient care study, roughly 50 percent of the patients of nursing homes in Maine are public assistance recipients. Basically our problems come down to money and to staff.

Essentially, we need to look to the State appropriations to improve our programs and our ability to pay for adequate service. And this, of course, is in order to generate the available requirement under the Federal matching programs. However, there are other methods which I would like to touch on briefly which I expect have been called to your attention in previous hearings. My purpose is simply to underscore certain items and certain improvements that might take place and in this might call for some Federal action that would assist us greatly in making maximum use of the funds and the staff that we are now using.

First and foremost, I think that the social security benefit, minimum benefit, needs to be raised substantially. It would have two effects. One of helping people raise, particularly aged persons, raise their living standards and provide for themselves better living, health and nutrition and perhaps means for long-term care.

Secondly it would release substantial numbers of staff, staff time and moneys, for use in fields not covered by our social security system. I think we all look to the day when the social security insurance system will cover the major risks of loss of income and medical care but progress has been very slow.

Sixty percent of our old-age recipients are currently receiving social security payments, and it seems in a day of short supply of money and staff a terrible waste of manpower to invoke our public assistance machinery with all of its complications and complexities, its detailed policies, its means tests, and so on, simply to supplement an inadequate social security benefit.

Now regardless of what may happen in the social security field, public welfare will continue to carry a major share for providing income maintenance, providing grants to aged, for medical care and particularly for services. I suspect one of the key factors in the provision of good long-term care for public assistance patients at least will be the availability of the social work staff to see that they get the service that is needed.

There will be greater demand upon staff. There is no other outlook in the foreseeable future. So, a great premium is placed on efficient administration, streamlined operations, and in this connection I would like to urge a substantial overhaul of the public assistance machinery in the country.

Useless and outdated features such as the so-called categories where people need to be fitted into one of four or five different assistance categories no longer serve a useful purpose. They are costly, complex, and should be discarded. There is another complexity involved in our present system; namely, where welfare services are divided. The responsibilities are divided among different levels of government and, as in this State, with towns and municipalities a third level of government is involved usually directly with the individual with its own and separate plan, policy, and eligibility requirements and I might add in this State what is known as the pauper law and our archaic old settlement laws.

I would like to see these systems replaced by a single comprehensive public assistance program of Federal matching available to all who are in need eliminating categorical distinctions and with a uniform Federal matching policy, the same for grants as for medical assistance. There is a certain amount of vertical categorizing, too, which you may be aware of. Different policies and different matching formula applied, depending on whether we are using grant money or using medical money. This fine distinction between whether a person is receiving medical services or basic maintenance grants is sometimes difficult to make and is a serious and obvious administrative complexity.

We would also like to see other outdated and unproductive eligibility requirements that are now related to need eliminated from the Federal act such as residence laws, durational residence requirements, relative responsibility laws for adults, and lien laws and so forth.

Senator NEUBERGER. Did you say you would like those?

Mr. SIMONDS. We would like to see those eliminated. I am pleased to report that Maine did recently eliminate all of its durational residence requirements in public assistance programs and modified its relative responsibility laws and does not have a lien law. Thirdly, it would be helpful to us in Maine if the Federal matching formulas could be reviewed with a view to adjusting them to more nearly compensate States for their relative ability to provide welfare services.

The State of Maine is 34th in the Nation in terms of per capita income. A neighboring New England State is fourth. However, in the matching formula for medical assistance programs there is only 15 percent spread; 50 percent for the more well-to-do State, 65 percent for ours. By the way, our tax effort is high. It is not that the Maine citizen does not contribute as much as he can out of his own pocket for welfare service. We are something like 13th, I think, in per capita tax effort for our welfare service.

So, there does seem to be a pattern of those who are perhaps at least able financially to provide the services having minimal grants and the minimal services. Finally, I would simply like to call attention to our need, and we believe the Federal agency's need, to maintain balance in its legislative program, particularly as the appropriate funds for various aspects of public welfare, the balance between various components of medical care, which is primarily our problem, and balance between appropriations for medical care and for basic maintenance grants, which is to some extent a Federal problem.

At the moment we are spending 35 percent of our total assistance payments, 35 percent for medical care. This includes only at this moment hospital care and nursing care. We have no physician service, no drug service, no dental care, no nursing home care or home care. This is 35 percent of our total grant.

I think we know we do need to be careful that in planning our program and allocating our funds we do not starve people out of their own homes into institutions. I think Congress has recognized the broad gaged nature of these needs, for the new bill, the medical care bill, has made some striking improvements in areas outside of medical care per se.

With this committee's continuing concern I suspect this is only the beginning.

Thank you.

Senator Moss. Thank you, Mr. Simonds, for a very excellent statement. We may have a question or two but I think we will proceed to the other gentlemen who are here and then when each has spoken in his field we will then ask our questions.

Mr. Woodrow Page, director of the Hill-Burton program in Maine. You may go ahead, Mr. Page.

Mr. PAGE. Mr. Chairman and members of the committee, I have prepared a short factual statement regarding the Hill-Burton program of which copies have been furnished to the committee. I would like to make just a few comments on it.

Senator Moss. You may proceed. The entire statement will be placed in the record in full. You can comment on it as you see fit.

Mr. PAGE. Thank you, sir.

(The document referred to follows:)

PREPARED STATEMENT OF WOODROW PAGE, DIRECTOR, HILL-BURTON PROGRAM

The Hill-Burton construction program in Maine has had experience with 12 long-term care facility projects to date. Three new project applications have been received recently (table I). Of these 15, 12 are or will be additions or adjoining general hospitals.

Table II indicates the current requests for Hill-Burton funds for long-term care facilities.

The Hospital Advisory Council has become increasingly interested in recent years in comprehensive planning for hospital construction and the expansion of the general hospital into the long-term care field.

In 1955 the Council provided for special priority for applications of nursing home projects by general hospitals.

In 1963 the council provided that the sponsor of a nursing home project (if other than a general hospital) must furnish assurance that formal affiliation will be arranged with one or more local general hospitals for the continuity of excellent patient care.

In 1964 the council provided that when the proposed long-term care facility is not an integral part of a general hospital, the minimum size will be for 35 beds, and provision must be made for the full range of required services.

In July 1964 the hospital advisory council met with the executive committee of the recently established health facilities planning council to explore their common aims and goals. They agreed that henceforth the advisory council would consider the recommendations of the planning council before decisions are made on Hill-Burton grants to specific projects.

CONCLUSIONS

1. There is an obvious need for an increase in public funds for the construction of long-term care facilities to permit hospitals to expand into this field and to replace uneconomical facilities.
2. To encourage more comprehensive project planning it may be advisable to allow for advance allotments under the Hill-Burton program to sponsors for planning purposes.
3. To encourage additional use of Hill-Burton funds countrywide for long-term care facilities it may be advisable to allow States to participate in projects above their State's allotment percentage, up to 66⅔ percent.

TABLE I.—*Long-term care facilities approved under the Hill-Burton program in Maine, fiscal years 1948–64 inclusive*

Facility	Location	Year completed	Number of beds	Total project costs	Hill-Burton funds
A. COMPLETED PROJECTS					
1. Bangor Chronic Disease Hospital	Bangor	1950	31	$180,950.14	$45,754.92
2. Thayer Hospital	Waterville	1957	34	380,406.30	190,000.00
3. St. John Valley Security Home	Madawaska	1960	26	219,438.59	109,000.00
4. Aroostook Health Center	Mars Hill	1962	24	260,000.00	130,000.00
5. James A. Taylor Osteopath N.H.	Bangor	1962	36	362,658.48	176,000.00
6. Jewish Home for the Aged	Portland	1963	34	439,432.35	160,000.00
7. St. Joseph Hospital	Bangor	1964	27	894,494.97	278,196.50
8. Thayer Hospital	Waterville	1965	28	793,102.48	305,504.50
9. Osteopathic Hospital of Maine	Portland	1964	24	201,836.88	100,000.00
Total			264	3,732,320.19	1,494,455.92
B. UNDER CONSTRUCTION					
10. Regional Memorial Hospital	Brunswick		40	550,000.00	200,000.00
C. PROJECT NOT YET UNDER CONTRACT					
11. Calais Regional Hospital	Calais		30	307,000.00	100,000.00
12. Maine Medical Center	Portland		40	1,066,500.00	100,000.00
Totals to date			374	5,655,820.19	1,894,455.92
D. CURRENT PROJECT APPLICATIONS [1]					
13. Cary Memorial Hospital	Caribou		46	[2] 400,000	
14. Methodist Home, Inc	Rockland		50	[2] 450,000	
15. Peoples Benevolent Hospital	Fort Kent		45	[2] 700,000	
Total			141	1,550,000	

[1] Additional project grants requested by Calais Regional Hospital and Maine Medical Center.
[2] Estimated.

TABLE II.—*Long-term care facilities; current requests for Hill-Burton funds*

Facility	*Requests*
Calais Regional Hospital	$53,500
Maine Medical Center	433,250
Cary Memorial Hospital	200,000
Methodist Home	225,000
Peoples Benevolent Hospital	350,000
Total	1,261,750

The President's budget for fiscal year 1966 allows only $464,282 for long-term care facilities for Maine. On this basis we lack nearly $800,000 in Hill-Burton funds to satisfy the needs of currently planned long-term care facilities.

Mr. PAGE. During the 1950's we only had two or three long-term care facility projects. To date we have 12 at a total cost of construction of about five and a half million dollars which produces about 374 beds for long-term care.

This current year we have requests for one and a quarter million of Federal funds for five separate projects. Four of these projects are for general hospitals, for addition of long-term care facilities, both nursing home and the chronic disease hospitals category. One is a nonhospital applicant but it will be adjoining a general hospital and affiliated with the general hospital. At this rate of a million and a quarter in this current year for requests the President's budget for this fiscal year allows Maine only $464,000.

Therefore we have a deficit of $800,000 to meet the needs in this current year. I would have three recommendations regarding the program countrywide. There is an obvious need for the increase in public funds for the construction of long-term care facilities to permit hospitals to expand in this field and replace uneconomic facilities.

Secondly, to encourage more comprehensive project planning may be advisable to allow for advance allotments under the Hill-Burton program to sponsors for planning purposes.

At the present time a project sponsor, after they do get a grant and build, after they have expended funds and the project is nearly half completed, then they get their first partial pay and on what they pay, including architectural and consultant's fees. But I think better planning could be done on an areawide basis if the project sponsor could get pre-planning funds a year in advance and have satisfactory planning done. He would do this I think with the cooperation of the program anticipating the cost in advance rather than waiting a year or so later after the project is nearly completed.

Thirdly, to encourage additional use of Hill-Burton funds countrywide for long-term care facilities it may be advisable to allow States to participate in projects above their States allotment percentage up to the 66⅔ percent.

At the present time States have an allotment percentage of between one-third and two-thirds as you know for long-term care facilities the State may elect one of three different methods, the highest of which would be 50-percent participation in a project. Some States in the country, I understand this year, with the increase in the funds for long-term care facilities, may have difficulty using up their funds due to low percentage of participation, particularly those in the one-third area. If this could be loosened up so that they could use a maximum, up to two-thirds, you would get this long-term care facility construction rolling, I think this would be helpful countrywide.

That is all.

Senator MOSS. Thank you, Mr. Page. You raise some very interesting points that we may want to ask you questions on. Mr. Carney, are you next? Mr. William Carney, director of the division of hospital services. You may go ahead, Mr. Carney.

Mr. CARNEY. Thank you, Senator Moss and members of the committee. I have prepared a statement in the required number of copies which are here on the table if your secretary would like to distribute them. I would like to highlight some of the comments and supplement them if I may.

Senator Moss. You may and the entire statement will be placed in the record. Then you may comment on the statement or supplement it as you see fit.

(The document referred to follows:)

PREPARED STATEMENT OF MR. WILLIAM CARNEY, DIRECTOR, DIVISION OF HOSPITAL SERVICES

The department of health and welfare is granted the authority to license hospitals and nursing homes by title 22, chapter 405, section 1811 of Maine R.S. 1964. The division of hospital services currently licenses 72 hospitals with 4,904 beds and 186 nursing homes with 3,856 beds.

Under title 22, chapter 1, section 5, Maine R.S. 1964, the division of hospital services is also responsible for licensing of boarding homes for aged. At the present time there are 172 licensed boarding homes for aged with 1,809 beds. It is important to emphasize one fact in connection with boarding homes for aged by quoting a section from the statutes: "The term 'boarding house or home' as used in this section shall mean a house or other place having more than two boarders not related by blood or marriage to the proprietor."

Please note that any person may house two boarders in their home without benefit of a license. By statute, such persons are exempt from licensing and not under the control of the division of hospital services.

The department of health and welfare, through its division of sanitary engineering, has authority to license eating and lodging places in accordance with title 22, section 2481, chapter 561 of Maine R.S. 1964. There are 7,275 currently licensed eating and lodging places.

It is important that we share a common understanding about the meaning of the terms "hospital," "nursing home," "boarding home," "eating and lodging places." The rules and regulations of the department make the following definitions:

HOSPITAL

"A general hospital is an institution or place furnishing bed care for medical, surgical, and maternity patients when equipped to do so. In general, the definition applies to places caring for patients who are acutely ill and require hospitalization for relatively short periods of time, but is not to be interpreted as limiting the period during which a patient may be cared for in such places."

NURSING HOME

"A nursing home is an establishment in which treatment or nursing service is given to persons ill with chronic disease, who are crippled or infirm or may be convalescing from an illness or from surgery."

BOARDING HOME FOR AGED

"A boarding home for aged is a residence or home which provides care, for a consideration, for three or more elderly ambulatory persons, not gainfully employed and not related by blood or marriage to the proprietor, and who are significantly dependent on the personal services of others by reason of age and physical or mental impairments, but who do not require skilled nursing care of any significant extent."

EATING AND LODGING PLACES

"The words 'eating and lodging place' or 'lodging place' shall mean every building or structure or any part thereof kept, used as, maintained as, advertised as, or held out to the public to be a place where eating and sleeping or sleeping accommodations are furnished to the public as a business; such as, hotels, motels, guest homes, and cottages."

The term "hospital" has a meaning that is generally understood; namely, a facility to house people who are acutely ill. However, the terms "nursing homes" and "boarding homes for aged" are not as clearly understood. The basic difference between the two is that in nursing homes the patients are sick people, requiring some form of nursing care, whereas in boarding homes the boarders are essentially well people with no requirement for nursing care. When one considers the age group of the population in nursing homes and boarding homes for aged it becomes apparent that it is often difficult to distinguish the proper facility for housing the individual. As an aged person in a nursing home becomes better, he

could perhaps be more appropriately housed in a boarding home; and as an aged person in a boarding home becomes ill he could perhaps be more appropriately housed in a nursing home. At all times there is a small percentage of people in both of these types of facilities that might be more appropriately housed in a facility requiring greater or lesser care.

The major difference between a boarding home for aged and an eating and lodging place is that supervision of a boarder is required in boarding homes for aged, whereas no supervision of the lodger is required in an eating and lodging place. This identifies another problem area in distinguishing whether or not an aged boarder requires supervision or whether he remains self-sufficient in a licensed eating and lodging place. On occasion, there are some people in eating and lodging places that may require the supervision of a boarding home for the aged for a period of time.

This series of definitions and distinctions was given to indicate the fluctuation in the amount of care and supervision required by some people in the age group currently housed in nursing homes, boarding homes for aged, and certain lodging places.

The term "boarding home for aged" in a misnomer for some of our licensed homes. Within the past few years approximately 20 percent of our licensed boarding homes for aged have been accepting mentally retarded adults placed by the Pineland Hospital and Training Center for the Mentally Retarded. These are young adults, some in their early twenties who represent a good example of the problem of deciding where they should be most appropriately housed—in a nursing home, boarding home, eating and lodging place, or State institution.

There is a current trend to move patients out of our State mental hospitals and Federal Veterans' Administration facilities into our licensed boarding homes for aged. This group, too, is younger in age and together with the mentally retarded adults present some unique problems in our boarding homes. Supervision in boarding homes is much less than that expected in nursing homes. No training is required of boarding home operators. Yet, demands for greater skills are being required of them as more and more of the mentally ill are being placed in boarding homes. Fire safety regulations for sprinkler systems were first enforced against hospitals, then nursing homes, and only recently has this been a requirement for boarding homes for the aged. The physical facilities of licensed boarding homes for the aged are for the most part not comparable with the physical facilities of licensed nursing homes. Today no one builds a facility with the specific purpose of becoming a licensed boarding home for the aged. Economics is a factor here with the current public assistance rate for boarding care patients at $110 per month as compared with $200 per month for the patients in a nursing home. Thus, we continue to be faced with the many problems of large old family residences being reconstructed into boarding homes for the aged.

These various licensing categories have been outlined in order to give you a frame of reference for a more particular discussion of licensed nursing homes.

On January 1, 1946, the date the first hospital and nursing home licensing law went into effect, there were 81 licensed nursing, convalescent, and rest homes. In 1956, the date that current licensing standards for nursing homes went into effect, there were 221 licensed nursing homes in the State providing 2,963 beds. Today there are in Maine 186 licensed nursing homes containing 3,856 beds. Thus, in 1965, there are 35 fewer nursing homes but 893 more nursing home beds than in 1956.

In 1956, 29 percent of the homes were 15 beds or larger in size.

In 1965, 58 percent of the homes were 15 beds or larger in size.

In 1956, homes of less than 10 beds represented 44 percent of the total.

In 1965, homes of less than 10 beds represented 21 percent of the total.

Nursing homes range in size from 1 bed to 375 beds. It is apparent from the above facts that the trend toward larger nursing homes has started. There is also a trend away from the reconstruction of houses into nursing homes. The larger new homes are today being specifically constructed as nursing homes. The division of hospital services currently has inquiries for new construction of 10 nursing homes as follows: Bangor, 90 beds; Waterville, 74 beds; Sanford, 72 beds; Bangor, 72 beds; Augusta, 70 beds; Farmington, 70 beds; Dixfield, 50 beds; Rockland, 50 beds; Rumford, 36 beds; Pittsfield, 30 beds.

Of the 186 licensed nursing homes only 5 are nonproprietary. Proprietary nursing homes have filled a gap in medical care in Maine created by our ever-increasing aged population, a need unmet to date by our nonproprietary community hospitals. The proprietary nursing homes in Maine have served as a valuable and necessary community resource for the care of our aged citizens.

Over the 4-year period, 1960–63, more patient-days of care have been rendered in nursing homes in Maine than in our acute general hospitals. Nursing homes are the largest, fastest growing institutional resource for the care of the physically ill in the State of Maine.

In the course of this growth, as with the rapid growth of all new enterprises, problems have arisen, solutions have been offered, many changes have occurred, and in the next 2 to 3 years, as the impact of the medicare program affects nursing homes, many more changes will take place. It may be appropriate for this committee to consider an objective comment concerning the needs of older people in Maine, as submitted by Wilson G. Smillie, M.D., and Jean A. Curran, M.D., in the study, "The Unmet Needs in Medical Care of Rural People, State of Maine, 1956":

"We have not evolved a solution for satisfactory medical care of our old people. This is true of the United States as a whole. It is particularly true of Maine which is facing currently a situation that must be faced by the country as a whole within 25 years. Within a short time 12 to 15 percent of Maine citizens will be over 65 years of age. Chronic illness will become an ever-increasing burden. We do not have proper facilities nor organization to meet this need. It is particularly pressing in rural areas.

"Maine at this moment is a splendid field in which to study the special needs of older people and to work out adequate provision for their care. Procedures that are developed in Maine will be directly applicable to similar areas of the whole Nation. It must be remembered that within a relatively few years our Nation will be truly an 'aged' people."

In 1956, the current standards and requirements for nursing homes were adopted by the department of health and welfare. At that time there were two classifications of facilities in terms of levels of care. One classification consisted of nursing homes and so-called convalescent homes with another group called rest homes. In 1960, responsibility for licensing boarding homes for aged was transferred from the bureau of social welfare to the division of hospital services. In 1961, all nursing homes and convalescent homes and some rest homes were grouped under one license as "nursing homes." Other rest homes and some nursing homes were grouped with the facilities turned over by the bureau of social welfare and one classification "Boarding Homes for Aged" was established with rules and regulations adopted in 1962.

At the present time consideration is being given to one of the recommendations of the nursing home patient care study to the effect that another facility classification be established. The term "nursing home" would then be reserved for those facilities that are staffed and equipped to render skilled nursing care. A classification of so-called personal care homes would be established. This type of facility would accept some of the patients now in nursing homes, not requiring skilled nursing care, and some of the persons in boarding homes requiring more than mere supervision.

In 1956, the division of hospital services was granted two positions for registered nurse supervisors to inspect the nursing homes in the State. In 1960, when the boarding home for aged licensing program was transferred to the division of hospital services, an additional registered nurse was added to assist in this program. Fully staffed, the division of hospital services has four nursing positions and it is possible to make on an average of at least three visits a year to every nursing home and boarding home in the State with more frequent inspections of problem situations as necessary. In July 1964 two of the four positions were vacated by retirement. As of September 7, 1965, the division of hospital services will again be fully staffed. This will provide three professional nursing field staff, one professional nursing supervisor, and an administrative director for the division.

The 1956 standards for nursing home licensure are in need of change. They were a valuable set of guidelines that served to raise the standards of nursing homes for a few years after they were adopted. Even today they serve a useful purpose but it has been recognized for sometime that they are in need of revision.

It should be pointed out at this time that the statutes of Maine require prior approval from the State insurance department before the department of health and welfare may issue or annually renew a license for a nursing home. This is a worthwhile law that involves prior approval from fire safety experts before the department may issue a license to any nursing home in Maine.

In 1960, the State insurance department adopted the building exits code and nursing homes in Maine started to add some essential safety features such as fire detection systems and sprinkler systems. These were costly expenses, and it did not seem economically appropriate to promulgate more stringent health

and welfare standards while nursing homes were trying to financially program for these safety improvments. One cannot divorce increased nursing home standards from increased nursing home rates, because approximately 50 percent of all patients in nursing homes in Maine are public assistance patients and as standards increase this must be equated with rate increases. At this point it is important to call your attention to the fact that public assistance rates also tend to become the minimum basic rates for private patients. Thus, the impact of any change in nursing home standards, equated with a public assistance rate increase, must also be considered from the point of view of the rates charged to private patients.

In July 1963 a medical advisory committee to the health and welfare department was organized under the chairmanship of George E. Sullivan, M.D., Fairfield. This group now consists of about 40 members, representing physicians widely dispersed throughout the State, together with representation from various ancillary health groups. The medical advisory committee concerned itself with many different areas of health services. In the fall of 1963, a subcommittee was appointed under the chairmanship of James H. Bonney, M.D., of Portland, charged with the exploration of nursing home patient care. This committee of 5 members solicited the assistance of consultants in the field of medicine, nursing, and social work and conducted an extensive study based on a random sample of 309 public assistance patients in 109 nursing homes throughout the State. This study was conducted during the year 1964 and approved by the medical advisory committee on January 20, 1965. The nursing home patient care study served as a valuable prelude to a departmental revision of nursing home standards. The basic intent of the study was primarily an educational one, to allow the medical advisory committee to inform itself relative to the level of medical care in nursing home and the physical conditions of these facilities so that the committee could make meaningful recommendations to the department of health and welfare.

For the first time a team approach was used in the evaluation of patient care, each team consisting of a social worker, a nurse and a physician. In May of 1965 a series of meetings was held in Portland, Lewiston, Waterville, Rockland, and Bangor to which all nursing home operators were invited. The commissioner of health and welfare, the chairman of the nursing home subcommittee, all of the principal consultants and most of the interviewers in the study attended one of these sessions to describe the techniques of the study and answer any questions by the nursing home operators. There was designed into this study a close involvement with the Maine Nursing Home Association because the medical advisory committee felt that improvements in patient care in nursing homes could best be accomplished through the mutual effort of physicians, nursing home administrators and the department of health and welfare. The study was never intended as a pure research effort but rather as a useful mechanism whereby all concerned could have a firm point of departure from which to discuss the common purpose of better patient care for our elderly citizens.

The nursing home patient care study indicates some of the problems encountered in improving the quality of care in our nursing homes. One problem is the quality of professional staffing. There is no requirement in our existing standards that there must be a licensed registered nurse in a nursing home. It is obvious to day that this is a weakness in our standards, but in 1956, at the time of their adoption, this seemed to be the best that could be expected. This weakness will be corrected in our new standards. A committee of the Maine State Nurses Association, comprised of registered nurses from the division of hospital services, nursing homes, and a representative from the Licensed Practical Nurse Association has been meeting for the past several months to develop recommendations that may solve this problem. Even though our existing standards do not require professional registered nurses, it is significant to point our that the nursing home patient care study revealed that in comparison with the "1961 National Inventory of Nursing Homes and Related Facilities Report" published by the Public Health Service, Maine nursing homes had a higher percentage of full-time registered nurses on their staff than reported in the national average.

The quantity of people required to care for patients in nursing homes is spelled out in our existing standards; namely, "an institution must provide a minimum of an average of 2½ hours of nursing staff time per patients per day up to and including 20 patients and 2 hours per patient per day for patients in excess of 20 up to a total of 35 patients." In some instances this requirement has not been rigidly enforced. The quantitative measurement of the amount of time required to care for a patient is an arbitrary figure without too much meaning

unless one makes an evaluation of the amount of care needed by the patient and unless one also makes a determination of the qualifications of the person providing such care. Our new standards will make such a determination of staff qualifications and the department has initiated a study aimed at developing a mechanism whereby the patients' needs may be evaluated.

As one considers the quality of professional nursing supervision for patients in nursing homes, one must also consider the quality of medical supervision. A nurse cannot practice in a vacuum, she needs a diagnosis, medical orders, nursing care directions. The nursing home patient care study pointed out that in a disturbing number of instances this type of information was not available in nursing homes. There are several factors that should be considered when one attempts to evaluate medical supervision of patients in nursing homes:

(1) The geographic distribution of nursing homes in Maine is not comparable to the geographic distribution of physicians. Most of our physicians are grouped into our larger, urban medical centers, whereas a high proportion of our nursing homes are distributed throughout our more rural areas. Thus we have the problem of travel time for our limited number of physicians.

(2) The department of health and welfare at the present time is in no position to pay for physician services to public assistance patients in nursing homes. The patient may not have any of his own resources for payment. Sometimes the nursing home administrators may underwrite this cost, but, at the present time, there is no effective system for payment of physicians rendering services to public assistance patients in nursing homes.

(3) There is a difference of opinion between the physicians and the general public as to how much professional medical care a senile, bedridden patient actually needs. I think this has been brought out in prior testimony before the committee. It should be pointed out here that the nursing home study revealed that 55 percent of the public assistance patients in nursing homes were over 80 years of age and had been in nursing homes a median of 2 years at the time of the study; 13 percent of the patients had been in a nursing home longer than 6 years.

(4) There is a lack of resources for physicians in nursing homes; for example, laboratory facilities are unavailable, physical therapists are in short supply, rehabilitative services are practically nonexistent. When one considers resources, one must also consider the awkward methods of payment for services or medications that are ordered for public assistance recipients. Maine still functions under some archaic settlement laws that require that the town of settlement of the individual should be responsible for the payment of his justifiable bills. Some of our smaller communities cannot afford extensive bills for medications—others make it dificult for nursing home administrators to be reimbursed for the expenses they incur for their patients.

One of the recommendations of the "Nursing Home Patient Care Study" offers the solution to the problem of physician care for public assistance patients. The first recommendation of the Medical Advisory Committee is that all public assistance patients be evaluated and classified, if possible before admission, or as soon after admission to a nursing home as possible, by a team of physician, nurse, and social worker. The patient should again be evaluated by the team at least every 6 months.

Some of our licensed nursing homes today do not comply with the minimum standards of 100 square feet of floor space in a private room or 75 square feet of floor space per bed in a multiple bed room. Most of the nursing homes in Maine are in reconverted private dwellings. The architecture of older, larger homes that lend themselves to conversion to nursing homes was such that they were not easily divisible by 100 or 75 square feet. Many of the homes with alcoves, gables, circular staircases are being allowed to house patients at less than the minimum space requirements because it seemed reasonable to allow one patient in a 9-by-10 room that had good window area and was well lighted, or to allow three patients in a room that measured 210 square feet, if there was good bed spacing and the bed was accessible for patient care. The reconversion of large old family dwellings into nursing homes is a thing of the past in Maine. The Building Exits Code requires a minimum of 8-foot-wide corridors and it is not economically or architecturally feasible to reconvert dwellings into nursing homes under this standard. The department will probably continue to apply a reasonable interpretation to spacing requirements in existing homes.

There are various resources utilized by the division of hospital services in its licensing program. All plans for new construction are reviewed by the State insurance department, the staff of the division of hospital construction and the division of sanitary engineering. Departmental nutrition consultants are available to hospitals, nursing homes, and boarding homes. The "Maine Diet Man-

ual," a publication that has in the past been available only to hospitals, has now been made available to nursing homes and selected boarding homes. A publication, Food News, is distributed monthly to all licensed facilities. Several nursing home administrators have received stipends from the department to attend various courses particularly at the Northeastern University Center for continuing education. In the past few years there have been a series of institutes for nursing home personnel held by the department. At the present time the division of hospital services is working with the Committee on Education of the Maine Nursing Home Association and the U.S. Public Health Service in developing a series of institutes on the "Use of Medications in Nursing Homes" which is scheduled for the fall of this year in Portland, Bangor, and Presque Isle. It is planned to continue similar institutes on various subjects at least semiannually in the future. The division of public health nursing has recently acquired the services of a nursing education consultant who will be able to establish educational programs for nursing staffs of nursing homes, personal care homes, and boarding homes. For professional nurses, the goal of this program will include updating of nursing knowledge and skills and the development of teaching, supervisory, and management skills. An additional focus of the program will be aimed at assisting nursing home and personal care home administrators in the training of nonprofessional nursing personnel. This program is in accordance with recommendation 8 of the "Nursing Home Patient Care Study."

It seems appropriate to discuss the present methods by which the division of hospital services answers complaints that are brought to its attention. Your attention was called to this matter this morning. Legitimate complaints are investigated as soon as possible depending upon the gravity of the situation The complaint may be handled immediately or it may be brought to the attention of the nursing home inspector for investigation within 1 or 2 days.

The most frequent complaints are on food, patient abuse, and cleanliness. Of the three, cleanliness is the easiest to inspect for and to correct. The problems of food service can be detected only at the time of meal preparation or serving. Planned menus are required to be posted 1 week in advance in every nursing home. When, upon inspection, poor quality of food service is detected, it is often excused by the administrator as being an unusual meal contrary to the regular menu for some reason or other. It is then necessary to reinspect the facility, on more than one occasion at mealtime, to see if violations to the required menu is a pattern. The most difficult type of complaint to investigate is that of patient abuse. Too often the complainant reports heresay, which is sufficient to justify an investigation, but insufficient to proceed with legal action. Obviously, abuse is not enacted at the time of a nursing home visit by the division of hospital services. It is difficult to interview people in a nursing home setting where the abused must report on the abuser knowing that he will continue to be cared for by that person. The senility and mental condition of many nursing home patients is such that their testimony on any subject is questionable. In order to act against any home for alleged complaints, evidence of the quality that may be admissible in a court is a necessity. This is often difficult to acquire, particularly on the matter of physical or even more specifically, mental abuse.

One major problem for the licensing division is the procedure for suspension or revocation of an existing license because of violations of departmental rules and regulations. Authority was first given to the department of health and welfare to license hospitals and related institutions by Public Law 1945, chapter 355. At that time the legislature saw fit to give the department authority to suspend or revoke a license in accordance with the following excerpt from chapter 22, section 253-G:

"The department is hereby authorized to suspend or revoke a license issued hereunder on any of the following grounds: violation of any of the provisions of sections 253-A to 253-J, inclusive of the rules or regulations issued pursuant thereto; permitting, aiding, or abetting the commission of any illegal act in such institution; conduct or practices detrimental to the welfare of the patient. Provided that before any such license hereunder is suspended or revoked, 30 days' written notice shall be given the holder thereof."

This authority remained with the department until Public Law 1961, chapter 394 was adopted. This act created the Administrative Code and established the position of administrative hearing officer. This act removed the power of suspension and revocation from within the authority of the department. It also created a time gap much longer than the 30 days of the previous legislation. Current legislative authority for revocation is quoted from Maine Revised Statutes, 1964, title 22, section 1817:

"The department may file a statement or complaint with the administrative hearing commissioner designated in title 5, chapters 301 to 307, requesting suspension or revocation of any license on any of the following grounds * * *."

Only one case has been brought before the administrative hearing commissioner. This is the case of a nursing home in Portland. On January 29, 1964, the assistant attorney general assigned to the department of health and welfare was asked to file a complaint with the administrative hearing officer. The hearing was held on April 9, 1964. The hearing commissioner's report is dated August 17, 1964. It is significant to compare the time differential of 7 months for action under the current statutes with the 30 days under previous statutes which gave authority to the department to suspend or revoke the license.

On July 1, 1965, the division of hospital services requested another hearing on this same case. As of August 13, 1965, no date for a hearing has been scheduled by the administrative hearing commissioner. The problem in this particular nursing home is one of alleged patient abuse. In the first hearing the administrative hearing commissioner found the licensee of the home in violation of some, but not all, of the charges and placed the home on somewhat of a probationary status indicating that "the defendant's license to operate a nursing home is hereby suspended for a period of 30 days, which said suspension shall not take effect at this time, but may be added to any penalty imposed for any further violations occurring on or before August 1, 1966."

The division of hospital services has reason to believe that abuse of patients may be continuing in this home, but because of the physical condition of these patients, in order to obtain satisfactory evidence in support of this impression, a deposition is needed from the individuals themselves who alleged they were physically abused or from eyewitnesses to such alleged abuse. The assistant attorney general to the department of health and welfare advised the division of hospital services this week as follows: "No depositions can be taken until the complaint is issued through the administrative hearing office. If 30 days must elapse before a hearing is scheduled, this will mean a delay until almost the 1st of October."

The current procedure for suspension and revocation is both cumbersome and unweildly, as well as against the best interests of patients in nursing homes.

On August 19, 1965, these facts are to be brought to the attention of the Legislative Reserch Committee of the 102d Maine Legislature with a recommendation from the department that the power of suspension or revocation of nursing home licenses be returned to the licensing authority of the department of health and welfare.

In view of these problems relative to suspension and revocation the mechanism of control now used most frequently by the division of hospital services is to refuse to renew a license rather than to attempt to suspend or revoke it. There are some inherent weaknesses in this procedure in that the licenses are renewable annually. Other techniques used are to request voluntary discontinuance of the license by the operator under the threat of suspension, revocation, or refusal to reissue. During the past year such actions have resulted in the closing of five nursing homes and a transfer of license in three other nursing homes that were not satisfactorily operated under the previous nursing home administration.

Mr. CARNEY. I would also like to introduce at this time for the committee's information the nursing home patient care study developed by the medical advisory committee to the department of health and welfare. I will refer to this, too.

Senator MOSS. Thank you. That will be part of the record of this committee for our reference.

(The document referred to is reprinted as app. A beginning at p. 855.)

Mr. CARNEY. The department of health and welfare is granted authority to license hospitals and nursing homes by Maine statutes. The division of hospital services licensed 72 hospitals with 4,904 beds and 188 nursing homes with 3,856 beds.

The division of hospital services is also responsible for licensing of boarding homes for aged. At the present time there are 172 licensed boarding homes for aged with 1,809 beds. It is important to emphasize one fact in connection with boarding homes for aged by quoting a section from the statutes.

The term "boarding house or home" as used in this section shall mean a house or other place with more than two boarders not related by blood or marriage to the proprietor. Please note that any person may house two boarders in their home without benefit of a license. By statute such persons are exempt from licensing and are not under the control of the division of hospital services.

In one of the cases mentioned by both the attorney general and Mrs. Carswell in this morning's presentation this occurred in a home that had less than two boarders in it and was absolutely out of the jurisdiction of the division of hospital services.

This was the case of the patient that was transferred from a home exempt from licensing by statute to a nursing home and conditions were reported there. This is something entirely out of our control. Now the department of health and welfare through its divisions of sanitary engineers has authority to license eating places. There are 7,275 currently licensed eating and lodging places in the State.

It is important that we share a common understanding about the meaning of the terms "hospital," "nursing home," "boarding home," and "eating and lodging place."

The term "hospital" has a meaning that is generally understood; namely, a facility to house people who are acutely ill. However the terms "nursing home" and "boarding homes" for aged are not as clearly understood. The basic difference between the two is that in nursing homes the patients are sick people, requiring some form of nursing care, whereas in boarding homes the boarders are essentially well people with no requirement for nursing care.

When one considers the age group of the population in nursing homes and borading homes for aged it becomes apparent that it is often difficult to distinguish the proper facility for housing the individual. As an aged person in the nursing home becomes better, then he could perhaps be more appropriately housed in a boarding home; and as an aged persons in a boarding home becomes ill he could perhaps be more appropriately housed in a nursing home. At all times there is a small percentage of people in both of these types of facilities that might be more appropriately housed in a facility requiring greater or lesser care.

I think it is important here to comment on one of the references made by Mrs. Carswell which relates to the fact, as she indicated, that the department of mental health and correction was forced to remove some individuals from a boarding home and place them elsewhere. The facts of the matter here are quite contrary to that statement.

I became aware of the fact that an institution or a house was housing six patients, many retarded adults from the Pineland Hospital and Training Center. I believe I found out about this on a Friday. I called the operator and indicated she would have to release these patients immediately. I called the Pineland Hospital and Training Center. I offered them these two alternatives, either remove the patients from this unlicensed home right now or I would go to court against these people for operating a home without a license and you will be forced to remove them. Within 2 days at my order or at my request here the social worker from the division of mental health and corrections moved the boarders from this home.

We have subsequently refused to license this as a boarding home on the grounds that an indication of the character of this particular woman was the fact that she had operated this unlicensed facility.

In your opening remarks, Senator Moss, you mentioned this is a field of change. So I will omit some comments relating to Maine about this change and get into the question of staffing of our division.

Fully staffed, the division of hospital services has four nursing positions and it is possible to make on an average of at least three visits a year to every nursing home and boarding home in the State with more frequent inspections of problem situations as necessary. In July 1964, two of the four positions were vacated by retirement. As of September 7, 1965, the division of hospital services will again be fully staffed. This will provide three professional nursing field staff, one professional nursing supervisor, and an administrative director for the division.

The 1956 standards for nursing home licensure are in need of change. They were a valuable set of guidelines that served to raise the standards of nursing homes for a few years after they were adopted. Even today, they serve a useful purpose, but it has been recognized for some time that they are in need of revision.

It should be pointed out at this time that the statutes of Maine require prior approval of the State insurance department before the department of health and welfare may issue or annually renew a license for a nursing home. This is a worthwhile law that involves prior approval from fire-safety experts before the department may issue a license to any nursing home in Maine.

In 1960, the State insurance department adopted the building exits code and nursing homes in Maine started to add some essential safety features such as fire detection systems and sprinkler systems. These were costly expenses and it did not seem economically appropriate to promulgate more stringent health and welfare standards while nursing homes were trying to financially program for these safety improvements.

One cannot divorce increased nursing home standards from increasing nursing home rates, because approximately 50 percent of all patients in nursing homes in Maine are public assistance patients and as standards increase this must be equated with rate increases.

At this point, it is important to call your attention to the fact that public assistance rates also tend to become the minimum basic rates of private patients. Thus the impact of any change in nursing home standards, equated with public assistance rate increase, must also be considered from the point of view of the rates charged to private patients.

In July 1963, a medical advisory committee to the health and welfare department was organized under the chairmanship of George E. Sullivan, M.D., Fairfield. This group now consists of about 40 members, representing physicians widely dispersed and throughout the State, together with representation from various ancillary health groups. The medical advisory committee concerned itself with many different areas of health services.

In the fall of 1963, a subcommittee was appointed under the chairmanship of James H. Bonney, M.D., of Portland, charged with the exploration of nursing home patient care. This committee of five members solicited the assistance of consultants in the field of medicine,

nursing, and social work and conducted an extensive study based on a random sample of 309 public assistance patients in 109 nursing homes throughout the State.

This study was conducted during the year 1964 and the report approved by the medical advisory committee on January 20, 1965. [1] The nursing home patient care study served as a valuable prelude to a departmental revision of nursing home standards. The basic intent of the study was primarily an educational one, to allow the medical advisory committee to inform itself relative to the level of medical care in nursing homes and the physical conditions of these facilities so that the committee could make meaningful recommendations to the department of health and welfare.

For the first time a team approach was used in the evaluation of patient care, each team consisting of a social worker, a nurse, and a physician. In May of 1965 a series of meetings was held in Portland, Lewiston, Waterville, Rockland, and Bangor to which all nursing home operators were invited. The commissioner of health and welfare, the chairman of the nursing home subcommittee, all of the principal consultants and most of the interviewers in the study attended one of the sessions to describe the techniques of the study and to answer any questions by the nursing home operators.

There was designed into this study a close involvement with the Maine Nursing Home Association because the medical advisory committee felt that improvements in patient care in nursing homes could best be accomplished through the mutual effort of physicians, nursing home administrators, and the department of health and welfare.

The study was never intended as a pure research effort but rather as a useful mechanism whereby all concerned could again have a firm point of departure from which to discuss the common purpose of better patient care for our elderly citizens.

The nursing home patient care study indicates some of the problems encountered in improving the quality of care in our nursing homes. One problem is the quality of professional staffing. There is no requirement in our existing standards that there must be a licensed registered nurse in a nursing home.

It is obvious today that this is a weakness in our standards, but in 1956, at the time of their adoption, this seemed to be the best that could be expected.

This weakness will be corrected in our new standards. A committee of the Maine State Nurses Association, comprised of registered nurses from the division of hospital services, nursing homes, and a representative from the licensed practical nurse association has been meeting for the past several months to develop recommendations that may solve this problem. Even though our existing standards do not require professional registered nurses, it is significant to point out that the nursing home patient care study revealed that in comparison with the "1961 National Inventory of Nursing Homes and Relative Facilities" report, published by the Public Health Service, Maine nursing homes had a higher percentage of full-time registered nurses on their staff than reported in the national average.

I have a comment on the quantity of nursing care which I will omit from my remarks but I would like to make a comment on your

[1] Please see app. A.

reference, Senator Moss, in some States where you have found some indifference among the various professions relative to the problem of nursing home care.

I don't think you will find this kind of indifference here in Maine and I think that the medical advisory committee is a good example of this in the nursing home patient care study.

Here we involved 38 different physicians throughout the different sections of the State to participate in the study. I used this as a good example of their interest in the problem.

As one considers the quality of professional nursing supervision for patients in nursing homes, one must also consider the quality of medical supervision. A nurse cannot practice in a vacuum—she needs a diagnosis, medical orders, nursing care directions. The nursing home patient care study pointed out that in a disturbing number of instances this type of information was not available in nursing homes. There are several factors that should be considered when one attempts to evaluate medical supervision of patients in nursing homes:

(1) The geographic distribution of nursing homes in Maine is not comparable to the geographic distribution of physicians. Most of our physicians are grouped into our larger, urban medical centers, whereas a high proportion of our nursing homes are distributed throughout our more rural areas. Thus we have the problem of travel time for our limited number of physicians.

(2) The department of health and welfare at the present time is in no position to pay for physician services to public assistance patients in nursing homes. The patient may not have any of his own resources for payment. Sometimes the nursing home administrators may underwrite this cost, but, at the present time, there is no effective system for payment of physicians rendering services to public assistance patients in nursing homes.

(3) There is a difference of opinion between the physicians and the general public as to how much professional medical care a senile, bedridden patient actually needs. I think this has been brought out in prior testimony before the committee.

It should be pointed out that the nursing home study revealed that 55 percent of the public assistance patients in nursing homes were over 80 years of age and had been in nursing homes a median of 2 years at the time of the study; 13 percent of the patients had been in a nursing home longer than 6 years.

(4) There's a lack of resources for physicians in nursing homes; for example, again laboratory facilities are unavailable, physical therapists are now in short supply, rehabilitative services are practically nonexistent. When one considers resources one must also consider the awkward methods of payment for services or medications that are ordered for public assistance recipients.

Maine still functions under some archaic settlement laws that require that the town of settlement of the individual should be responsible for the payment of his justifiable bills. Some of our smaller communities cannot afford extensive bills for medications—others make it difficult for nursing home administrators to be reimbursed for the expenses they incur for their patients.

One of the recommendations of the nursing home patient care study offers the solution to the problem of physician care for public assistance

patients. I think the suggestion is a team evaluation by a nurse, physician, and social worker prior to the patient being in a nursing home and 6 months thereafter.

There are various resources utilized by the division of hospital services in its licensing program. All plans for new construction are reviewed by the State insurance department, the staff of the division of hospital construction and the division of sanitary engineering. Departmental nutrition consultants are available to hospitals, nursing homes, and boarding homes. The Maine Diet Manual, a publication that has in the past been available only to hospitals, has now been made available to nursing homes and selected boarding homes. A publication Food News is distributed monthly to all licensed publications.

Several nursing homes administrators have received stipends from the Department to attend various courses particularly at Northeastern University Center for continuing education. In the past few years there have been a series of institutes for nursing home personnel held by the Department. At the present time the division of hospital services is working with the Committee on Education of the Maine Nursing Home Association and the U.S. Public Health Service in developing a series of institutes on the "Use of Medications in Nursing Homes" which is scheduled for the fall of this year in Portland, Bangor, and Presque Isle. It is planned to continue similar institutes on various subjects at least semiannually in the future.

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An additional focus of the program will be aimed at assisting nursing home and personal care home administrators in the training of nonprofessional nursing personnel. This program is in accordance with recommendation 8 of the Nursing Home Patient Care Study.

It seems appropriate to discuss the present methods by which the division of hospital services answers complaints that are brought to its attention. Your attention was called to this matter this morning. Legitimate complaints are investigated as soon as possible depending upon the gravity of the situation.

The complaint may be handled immediately or it may be brought to the attention of the nursing home inspector for investigation within 1 to 2 days.

Mrs. Carswell this morning referred to a Mrs. Verrill who indicated she could not get access to a nursing home to visit her mother. This condition was brought to the attention of the division of hospital services in the morning. The division of hospital services contacted the nursing home operator. That afternoon the lady was allowed to visit her mother.

This kind of situation will be added to our file on this particular nursing home and we will use this in our judgment as to the character of this particular operator and whether or not she should be continued to operate this home. I point this out as a specific example of an immediate reaction by the hospital services division.

The most frequent complaints are on food, patient abuse, and cleanliness. Of the three, cleanliness is the easiest to inspect for and to correct. The problems of food service can be detected only at the time of meal preparation or serving. Planned menus are required to be posted 1 week in advance in every nursing home. When upon inspection, poor quality of food service is detected, it is often excused by the administrator as being an unusual meal contrary to the regular menu for some reason or other. It is then necessary to reinspect the facility, on more than one occasion at mealtime, to see if violations to the required menu is a pattern.

The most difficult type of complaint to investigate is that of patient abuse. Too often the complainant reports hearsay, which is sufficient to justify an investigation, but insufficient to proceed with legal action. Obviously, abuse is not enacted at the time of a nursing home visit by the division of hospital services.

It is difficult to interview persons in a nursing home setting where the abused must report on the abuser knowing that he will continue to be cared for by that person. The senility and mental condition of many nursing home patients is such that their testimony on any subject is questionable. In order to act against any home for alleged complaints, evidence of the quality that may be admissible in a court is a necessity. This is often difficult to acquire, particularly on the matter of physical or even more specifically, mental abuse.

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This authority remained with the department until Public Law 1961, chapter 394 was adopted. This act created the administrative code and established the position of administrative hearing officer. This act removed the power of suspension and revocation from within the authority of the department. It also created a time gap much longer than the 30 days of the previous legislation. Current legislative authority for revocation is quoted from Maine R.S. 1964, title 22, section 1817:

> The department may file a statement or complaint with the administrative hearing commissioner designated in title 5, chapters 301 to 307, requesting suspension or revocation of any license on any of the following ground * * *

Only one case has been brought before the administrative hearing commissioner. This is the case of a nursing home in Portland. On January 29, 1964, the assistant attorney general assigned to the department of health and welfare was asked to file a complaint with the administrative hearing officer. The hearing was held on

April 9, 1964. The hearing commissioner's report is dated August 17, 1964.

It is significant to compare the time differential of 7 months for action under the current statutes with the 30 days under previous statutes which gave authority to the department to suspend or revoke the license.

On July 1, 1965, the division of hospital services requested another hearing on this same case. As of August 13, 1965, no date for a hearing has been scheduled by the administrative hearing commissioner. The problem in this particular nursing home is one of alleged patient abuse. In the first hearing the administrative hearing officer found the licensee of the home in violation of some, but not all, of the charges and placed the home on somewhat of a probationary status indicating that the defendant's license to operate a nursing home is hereby suspended for a period of 30 days, which said suspension shall not take effect at this time, but may be added to any penalty imposed for any further violations occuring on or before August 1, 1966.[1]

The division of hospital services has reason to believe that abuse of patients may be continuing in this home, but because of the physical condition of these patients, in order to obtain satisfactory evidence in support of this impression, a deposition is needed from the individuals themselves who alleged they were physically abused or from eye witnesses to such alleged abuse. The assistant attorney general to the department of health and welfare advised the division of hospital services this week as follows:

> No depositions can be taken until the complaint is issued through the administrative hearing office. If 30 days must elapse before a hearing is scheduled, this will mean a delay until almost the 1st of October.

The current procedure for suspension and revocation is both cumbersome and unwieldy, as well as against the best interests of patients in nursing homes.

Now in the testimony of both the Attorney General and Mrs. Carswell this morning there was reference made to a nursing home that the division of hospital services brought to the attention of the administrative hearing officer.

In case there is any doubt in anyone's mind the comments that I am reading now relate to one of these homes.

On August 19, 1965, these facts are to be brought in this to the attention of the Legislative Research Committee of the 102d Maine Legislature with a recommendation from the department that the power of suspension or revocation of nursing home licenses be returned to the licensing authority of the department of health and welfare.

In view of these problems relative to suspension and revocation the mechanism of control now most frequently used by the division of hospital services is to refuse to renew a license rather than to attempt to suspend or revoke it. There are some inherent weaknesses in this procedure in that the licenses are renewable annually.

Other techniques used are to request voluntary discontinuance of the license by the operator under the threat of suspension, revocation, or refusal to reissue. During the past year such actions have resulted in the closing of five nursing homes and a transfer of license in three other nursing homes that were not satisfactorily operated under the previous nursing home administration.

[1] The decision of the administrative hearing commissioner is reprinted as app. B beginning at p. 897.

Now, Senator Moss, in the course of the question which have been raised indicated that many of the comments here are State problems.

I omitted from this statement comments on our action against boarding homes because I thought it would be more interested in nursing homes. One additional comment if I may. The attorney general cited three cases that have been brought to his attention. I have alluded to two of these in my testimony already. I indicated that one of the homes that has been brought to the attention of the attorney general's office is by statute exempt from licensing by the division of hospital services. This is one of the homes having less than two boarders.

The second case that the attorney general referred to is the same case I just cited in our difficulties with the administrative hearing commissioner. The third case is one in which the first notice of problem of abuse came to the attention of the division of hospital services through the assistance of the attorney general assigned to our department.

There was a rather extensive investigation by the sheriff's office and county attorney's office before we knew of this matter. There was a decision to renew the license in this home. It was a calculated decision made in conjunction with the assistant attorney general then assigned to the department of health and welfare. No action on the charges of abuse were filed by the county attorney or the sheriff's office and our investigation revealed that, in our opinion, we did not have enough factual information on this matter to act.

This home is still under close surveillance and by our department. As a matter of fact, I have a plant in this home that is supposed to relate to me any abuse that is indicated by any of the patients therein. If she calls me at 7 or 8 o'clock in the morning I can go up and see the patient that was abused.

This is the factual kind of evidence that I need, not hearsay.

This concludes my comments, Senator. I shall be pleased to try to answer any questions you might have.

Senator Moss. Thank you very much, Mr. Carney. You have a very full and fine statement. I am sure we will have a number of questions. We have come to the point, however, we have run a little beyond the luncheon period. I think we will have to recess at this time. We still have not heard from Mr. Wyllie. If—well, it is now about 23 minutes to 1. We will resume at 2 o'clock promptly if you gentlemen will return and take your places.

(Whereupon, at 12:40 p.m., the subcommittee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The subcommittee reconvened at 2 p.m., Senator Frank E. Moss, chairman of the subcommittee, presiding.)

Senator Moss. The hearing will now come to order.

We appreciate your having come back to be with us this afternoon, especially the five gentlemen who are testifying. Senator Muskie will be just a little late in returning. He has another commitment that will delay him but he will be here very shortly.

In the meantime we will go on with the hearing.

We have heard now from Dr. Fisher, Mr. Simonds, Mr. Page, and Mr. Carney but we have not had a chance to hear from Mr. Wyllie who is a social work consultant in the division of family services.

Mr. Wyllie, we would like to hear from you.

Mr. WYLLIE. Ever since September of 1957 when payments for nursing care were begun, the Maine Division of Family Services has had an increasing concern about, and an increasing economic involvement in, nursing home care in the State.

In part, this increased concern relates to the steady increase in the numbers of public assistance recipients requiring nursing home care over the past 5 years (see exhibit A). As of June 1965 there were over 1,800 public assistance recipients in licensed nursing homes. This represented a net increase of 545 patients, or a 30-percent increase, during the 5-year span. These figures are more significant when it is pointed out that the total number of recipients of adult categories of public assistance benefits has decreased in the same period.

Initially, payments were made to both licensed nursing homes and licensed rest homes at a rate differential. Because of administrative complications and an increasing need to stay within budgetary limitations, as of May 1, 1961, payments for rest home care were deleted and a concerted effort made to provide adequate reimbursement for required nursing care.

Since September of 1957 when nursing care payments were first made, there have been five rate adjustments representing a span from the initial $150 monthly to the present monthly rate of $200. This reimbursement figure includes payment for maintenance, nursing supervision and care plus routine laxatives, nonprescription analgesics, and rubbing lotions (Maine Public Assistance Policy Manual). The periodic rate increases primarily reflect availability of funds and recognized increased costs of nursing home operations.

Another significant change in reimbursement for nursing home care occurred in February of 1961 when direct vendor payments to the nursing home were instituted, thereby assuring the client of continual coverage as long as nursing care was indicated or from nursing home to hospital and return.

It also assures the respective nursing home of reimbursement for those patients classified in need of nursing care. At present we not only continue to make direct vendor payments but, if indicated, provision is also made for a 2-month retroactive payment to the nursing home in those instances when the recipient is determined to be in need of nursing care but for some reason a classification decision has been delayed.

The report of the recent study of nursing home patient care conducted by the medical advisory committee, notes that more than 50 percent of nursing home patients in Maine are public assistance recipients. Since we, at present, do not provide for nursing home payments under our medical assistance for the aged program, this percentage is believed to have more significance.

We are vitally concerned, therefore, about the types of facilities housing these patients, the personnel providing this care, the recipients receiving this care, and the level of care given. It would seem appropriate here to define the role of the social caseworker in the division of family services in regard to nursing homes. (1) We do not rou-

tinely, at present, arrange the nursing home placement; that is, select a home for the client and arrange for his admission. This remains the responsibility of the hospital, the family, the friends, or the local municipality.

We do provide a listing of licensed nursing homes in the area where the person is to be placed. (2) Because we do not, at present, participate in the selection of the nursing home for the individual client, any licensed nursing home in a given area would be listed despite the level of nursing care provided or the ability of the nursing home to meet the particular needs of the individual recipient.

We would not, however, provide the name of a potential placement if the home has known to be in direct violation of nursing home licensing regulations. (3) We refer to the division of licensing any nursing home which, in our opinion, violates the established licensing regulations or where there is indication of a situation injurious or detrimental to the client's well-being.

Such complaints or reports are made with the knowledge of the nursing home proprietor. (4) Once a recipient is in a nursing home we assume responsibility for determination of level of care required and implement said decision. The agency caseworker retains responsibility to gather all pertinent information to enable the making of a valid decision regarding need for nursing care with the assistance of medical consultation as necessary.

I should like to add here also there was some discussion given this morning about those homes that do not need to be licensed because they have two or fewer patients in the home. Sometimes these complaints do come to our attention since we are the agency often giving financial assistance. Then if these complaints come to our attention we would certainly do some investigation regarding the complaints. Although we do not move these persons we would refer the situation either to the division of licensing if this division were involved or in some instances Pineland Hospital may have placed this person and continued to provide some follow up care in which case we would be in contact with them regarding the situation.

Otherwise we would be in contact with the guardian or conservator if there were such a person, the family, or local communities or municipality if that were the situation.

A review of the patient's situation is completed at least once a year but may occur more often if necessary for classification purposes.

During this 8-year interval of providing for nursing care payments we have noted a lack of uniformity among nursing homes in the quantity and quality of services available to the patients. This is related to availability of paramedical services, nursing time available, the physical facility, personnel employed, and so forth. From my personal knowledge, although a small home cannot financially provide the gamut of services required by its patients, it may well be providing the emotional environment conducive to better health and rehabilitation, while in the larger home providing more services the individual patient may not be able to use such services because of lack of warmth, acceptance, and individualization.

However, it is recognized that tender loving care is not the only need of the patient, and particularly does not meet the needs of those who require and can use a variety of services in order to achieve a measure of rehabilitation. Such a range of services should be avail-

able to each patient in a nursing home to enable him to achieve the level of independence of which he is capable.

We have experienced difficulty at times in obtaining beds for public assistance recipients in their own locality. Some nursing homes do not take public assistance recipients and others have an alloted number of beds for recipients which may mean a client is necessarily placed in a home some distance from his family because of the lack of space for public assistance recipients in his own area.

This, in turn, obviously has meaning in such areas as adjustment to the home, motivation for increasing self-help, and meaning of nursing home placement. The answer to this difficulty is partly an economic one. If we were to pay a higher monthly fee for nursing care it would undoubtedly result in additional beds, but the answer does not wholly lie in an increased payment because a concomitant increase in demand for a more complete range of services must accompany such action, otherwise the goal of providing a more comprehensive range of services in nursing homes is sabotaged. The complete answer to this difficulty would appear to involve both an increase in rate paid with revised nursing home licensing requirements.

We have many times observed a lack of recognition of the patient's need of a social and recreational nature. These are considered of vital importance in a well-rounded comprehensive program for nursing home patients. Interested community groups, including church organizations, need to become more aware of these needs and become more involved in assisting to meet them.

The recent nursing home study plus our own experience indicates that there is a need to again consider payment of an intermediary level of care on behalf of that group of persons requiring more than a simple boarding home care but less than intensive, skilled nursing care. The establishment of adequate evaluative classification criteria is a prerequisite to such action, however, and this problem is currently being studied by the department.

It is recognized that the needs of the prospective family services nursing home patient could best be served by a team evaluation as suggested by the recent nursing home study. Also through such a joint evaluation by at least physician, nurse, and caseworker possible alternative planning may be a more realistic and appropriate plan of action than nursing home placement.

Also periodic team evaluations of the nursing home recipient could be of tremendous benefit to the caseworker and client in their planning together of attainment of goals. However, until such time as additional numbers of caseworkers are permitted by legislature and additional moneys available to hire same, caseload size is prohibitive in implementing the recommendation in its entirety.

To provide the most effective nursing home care requires the cooperation of the client, the nursing home proprietor, the agency, and the larger community. Our agency is admittedly limited in the amount of service it can provide to the individual client because of large caseloads per adult caseload worker.

If additional casework staff were to be authorized by legislature and appropriations increased to support this additional staff our division could (1) assume a more active role in nursing home placements as we should do, (2) play a more active role in community organization to help meet some of the needs of our nursing home patients, (3) participate more extensively in a team approach to the evaluation of both

public assistance recipients in nursing homes and those who are prospective nursing home patients.

Such adequate planning would be expected to result not only in the best placement, but also in the most effective care and treatment of the recipient. It is believed that such an approach is valid not only for a social viewpoint but from an economic one as well.

The majority of this statement has dealt directly with our experience with nursing homes and nursing home care but a complete picture would not be given without at least brief mention of the problems we are currently facing with other types of institutional and noninstitutional placements of our recipients. Mention of these is important because again to provide the needed quality and quantity of services required by these recipients, additional staff and appropriations are necessary.

First of all it is important to point out that nursing care is paid for out of medical care funds while boarding home care is financed out of grant funds. If additional medical care money is made available without an accompanying increase in grant funds, it becomes increasingly difficult to provide similar services to all public assistance recipients.

Our State institutions are anxious to move some of their patients out into the community and in almost every instance our division would be involved because of the financial need. These applicants often require considerable more investment then of the agency's caseworker's time than the usual applicant: (1) Because it is frequently necessary to involve a third party in the eligibility determination, (2) because our workers usually has some involvement in the appointment of a guardian or conservator, (3) because there is the necessary coordination of activity and communication with the institution from which they came. Again the limitations of our caseworker's time militate against giving the quantity and quality of service required by any large number of these clients.

Until such time as staff and money are available (and our request for these commodities to handle placements out of institutions has been twice refused by legislature) we shall have to continue providing a limited service to a limited group of these individuals.

One final thought relates to those recipients who may be either in their own home or in homes not required to be licensed because of number of boarders. I specifically refer to that group of recipients who are in need of a considerable amount of supportive action by our caseworkers to enable them to remain in the setting. This supportive action may require a more protective role on the part of the worker in order that the client not be exploited. It may often involve a more active role in the arranging for necessary medical care, and a more active role in ferreting out community resources to meet a particular need it involves.

Contact with the client more frequently than once yearly is necessary if this necessary quantity and quality of service is to be given. Again, however, the provision of these recognized needed services cannot be routinely provided by the adult caseload worker at the present time because of the sheer numbers of individual recipients for whom an annual review must be accomplished in order not to jeopardize our whole grant-in-aid program from the Federal Government.

On the other side of this coin there is the related problem of disbursement of funds for nursing or boarding home care which amount in Maine is, undoubtedly, disproportionate to similar expenditures in other States where a comprehensive home care program is in operation. At the present time Maine essentially provides only for reimbursement of hospital and nursing home and boarding home care for family service recipients. In addition, there is a limited amount of clinic and home care service. If we were able, however, to provide a comprehensive home care program for all our recipients including adequate social service, I am certain that there would be (1) an economic impact resulting from the avoiding or delaying of institutional placement with an accompanying decrease in expenditures for needed care, (2) a healthier emotional environment for the recipient who prefers to remain in his own home as long as possible and such a plan is determined feasible with the availability of comprehensive home care services.

At present such a total program of comprehensive home care is impossible to implement despite its recognized need and validity from both an economic and social point of view. The impossibility of implementation is again related to staffing limitations and limited funds.

Exhibit A, previously referred to, follows.

Thank you, Mr. Chairman.

EXHIBIT A

DEPARTMENT OF HEALTH AND WELFARE,
State House, Augusta, Maine, August 11, 1965.

To: Robert Wyllie, medical assistance for the aged.
From: Vance Springer, director of administration.
Subject: Nursing home care.

Expenditures

Fiscal year:	
1957–58	$173,226
1958–59	830,580
1959–60	983,139
1960–61	[1] 1,573,238
1961–62	2,475,621
1962–63	2,530,254
1963–64	3,144,069
1964–65	3,404,692

[1] Effective Feb. 1, 1961, direct grant to clients was reduced to $5 personal allowance and payment for care was made direct from medical care accumulation fund.

Rate of payment

Date	Nursing home	Convalescent or rest
Sept. 1, 1957	$135	$110
Feb. 1, 1958	155	
Oct. 1, 1958	165	120
Nov. 1, 1958		130
Jan. 1, 1961	180	
May 1, 1961		(1)
Feb. 1, 1962	190	
May 1, 1964	200	

[1] Discontinued.

Number of recipients in nursing homes, June of each year

Year	Number of recipients	
	Nursing homes	Convalescent or rest homes
1960	923	446
1961	1,342	(1)
1962	1,522	
1963	1,726	
1964	1,814	
1965	1,887	

[1] Rest home care classification discontinued May 1, 1961.

Senator Moss. Thank you, Mr. Wyllie. Do I understand that there are no funds available for you to use where a person might remain in his own home but needs some supplemental assistance?

Mr. WYLLIE. We do make public assistance grants to these people in their own homes on the basis of a personal care grant. It was referred to this morning as the 110 level. When I speak of home care I am thinking in terms of a person who could remain in his own home for a longer period of time if there were homemaker service, visiting nurse service, all of the components to enable this person to receive the care he needs in his own home from a medical standpoint.

Senator Moss. You have no authority to provide that sort of home service now?

Mr. WYLLIE. We do not provide it because we do not have the funds to do so except in a limited way under our medical assistance to the aged program.

Senator Moss. You point out in your statment that funds for those elderly who live in a boardinghouse with boarding care is grant money you say. Is that old-age assistance funds?

Mr. WYLLIE. Yes.

Senator Moss. Whereas the nursing home patients would be cared for with Kerr-Mills funds?

Mr. WYLLIE. No; we have no nursing home payments under our Kerr-Mills Act.

Senator Moss. You do not use those at all?

Mr. WYLLIE. No.

Senator Moss. What do you mean by medical funds?

Mr. WYLLIE. These are medical care funds which come to the State rather than the direct grants in aid. It is still old-age assistance.

Senator Moss. Thank you very much. Now let me say to all of you gentlemen I think you have covered a very wide field and done it very well. I compliment you all on your statements. It is a sort of mixed blessing to have you all go before we question, but perhaps that is the best way to get at it. If we don't direct the question to the one who can answer best you are at liberty to hand it off to another.

One of the problems, Dr. Fisher, seems to be the number of inspecting personnel, the number of people available to examine these nursing homes. I think you have 188 nursing homes. How many inspectors do you have, and how many do you think are needed?

Dr. FISHER. We have three at the present time plus a fourth coming along the first part of September. We are inspecting roughly

180 nursing homes and 170 boarding homes. So this is about 350 institutions.

Essentially in our inspection staff we have three key workers. This is basically what this has resolved itself into. To this leaves 110, somewhere in this neighborhood, institutions to be inspected by each. They are not necessarily divided numerically but rather geographically, because the attempt to equalize the job load in terms of the additional requirements of travel and so forth.

Now along with the inspection and licensing of places we are very, very frequently requested to, in a sense, preinspect for the prospective applicant. At times we are asked to preinspect several potential pieces of real estate, to give our advice as to how adaptable they may be for this anticipated use.

So that with the inspection of places which are licensed at the moment because these kinds of inspections that are related to prospective applicants and so forth, this probably left—leaves the workload for each worker perhaps on the order of a couple of hundred odd institutions per worker per year.

This obviously is quite a workload. I think that our staff has done very well indeed to be able to average something on the order of three inspections per licensee per year plus the additional inspections that are required on the basis of complaints and the reptition of inspection in those places where we have some reason to give repeat attention.

It would seem to me that if one were to be able to inspect let me say something on a monthly basis and this would not be unreasonable, clearly not unreasonable, this is probably a matter of I would say doubling our present staff, at least.

Senator Moss. If one of these inspectors had about 300 for a caseload he would hardly have more than 1 day a year if he only worked a 5-day week to get around.

Dr. FISHER. He would be lucky to make one inspection a year taking everything into consideration.

Senator Moss. Do you inspect every home annually or semiannually or any given period?

Dr. FISHER. We would rather set three as a reasonable schedule for inspection under present circumstances. This is essentially what we inspect at the present time. This is three inspections per year.

Let us not forget that these are the inspections that we make. The Pineland inspection people make at least one other inspection per year from their point of view. Preceding the expiration of an existing license or previous to the issuance of an initial license and if the fire insurance people have requirements they will make subsequent inspections until they are able to certify to us that their requirements have been met.

So if these inspections are added to ours, then nursing homes are seen by an official agency of the State probably on the order of four to five times a year under present circumstances.

Senator Moss. I believe you pointed out that there were four different types of homes that you licensed beginning with the hospital, the nursing home, the boarding home for the elderly, and the eating and lodging. Does it require more than an annual inspection of the eating and lodging home, too?

Dr. FISHER. We are able to make on the average of 1.4 inspections a year of eating and lodging places. Here again the additional inspections are made that may be required as a result of complaints.

We have a very obvious problem in this area with a very large number of seasonal places to be inspected.

This means, for all practical purposes during the summer season, all of our inspection people in the division of sanitary engineering which licenses eating and lodging places plus a summer addition to this crew is devoted almost entirely to seasonal places opening about the middle of June and closing about Labor Day.

I think the main reason we brought this point out is to simply show there are some kinds of interrelationships between this very wide range of institutions in this field pertaining to long-term care. The individual, for example, who may function as a straight eating and lodging place during the summer, for the winter season may essentially convert to a boarding home kind of facility for the elderly people, for example.

This creates inspection and licensing problems obviously. I cite as a simple example the hotel here in Portland during the winter has a great many elderly people who come into the hotel for the winter. They are quite able to take care of themselves. Yet you have to ask yourself sometimes whether or not this does function in truth as something of a boarding home for aged people during the winter season of the year.

I am sure the management would not wish us to suggest this in too loud terms but this is the way in which this problem does not easily confine itself within nice definable limits.

Senator Moss. Do you have jurisdiction over it or do you exercise any powers of requiring a transfer or change in the case where you would find, for instance, in a boarding home, elderly people who really were nursing patients and require nursing care?

Dr. FISHER. Yes. We are in this process almost continuously. Less so now than when we began to increase our efforts to improve boarding home standards. At that time this was a serious problem. In what you might call our first one or two or three major sweeps through boarding homes we required and forced the transfer of a rather considerable number of people whom we considered to be inappropriately located in a boarding home. We are not concerned with the other direction, that is with a patient in a nursing home who does not necessarily need nursing home care but could be placed elsewhere.

At least from the licensing point of view we are not concerned from this sort of problem of public assistance payment but not from the point of view of licensure. The other way around we are. We are concerned at times when an eating and lodging place may also convert itself either temporarily or solely over a period of time into an institution which is providing service beyond the level authorized by the license which they possess.

Senator Moss. Your way of bringing pressure to enforce that would really be through the licensing function?

Dr. FISHER. Yes our approach here is that in the instance of a boarding home, with a patient requiring the nursing home level of care, our approach is here very simple. The boarding home is operating a nursing home without a license. We can proceed on this basis in court.

Senator Moss. Mr. Carney, I think you pointed out that the law did not have any requirement for a registered nurse to be available or affiliated with in any way with the nursing home. I wondered if you did not have power to require this in your rules and regulations.

Mr. CARNEY. That is correct, we do.

Senator MOSS. But it has not been implemented that way?

Mr. CARNEY. That is right.

Senator MOSS. This would be an obvious area where we could begin to upgrade the care, is it not?

Mr. CARNEY. This is one of the points I mentioned in our testimony. We recognize it is an admitted weakness and we hope to correct it.

Senator MOSS. I aksed some questions before on the degree or extent to which action had actually been taken on suspending licenses or denying licenses and tried to get a numerical figure. I think the answer was that very few had. The staff talked to one of the former inspectors, a nurse inspector, and I would like to read this letter and have your comment on it, Dr. Fisher.

This is addressed to me and is signed by Elizabeth C. Stanley. It says:

DEAR SIR: In response to a telephone call from Mr. Frank Frantz of your staff I am at his request sending you a few of my personal opinions as to some of the ways to improve the care in our nursing and boarding homes.

(1) A much more careful checking on those requesting licensure, personal character as well as experience and training.

(2) Putting teeth into our laws and recommendations of a few stiff fines where orders are not followed, a revoked license or two when needed would do a lot. These are mentioned in the books of rules and regulations but rarely done. In 10 years of inspecting these homes in two States I have never known of a fine being imposed and only about three homes closed when many more should have been.

(3) Less leniency to be allowed just because of knowing or getting in touch with a VIP. This unfortunately keeps many from needed corrections.

Hoping these may be of some assistance in your work.

Very truly yours,

ELIZABETH STANLEY.

Will you comment on that for me, please, Dr. Fisher?

Dr. FISHER. I think perhaps we might start with the fines. The word fine implies a court process. This is the only agency that can levy a fine so far as I know. The base under which we may reach courts is limited. We may reach courts with a complaint for operating without a license, for example.

However, when it comes to infractions of our rules and regulations we have no means of reaching court and therefore no means for fines. Our only approach then is by way of hearings, a hearing officer and revocation of a license. The process of fining is not associated with either of these.

Senator MOSS. Well, operating without a license could bring on court action.

Dr. FISHER. Operating without a license can be brought into court and a fine can be associated with this.

Senator MOSS. Another point she made is that she thinks there should be some more revocations or refusal of license. She thought many more were warranted.

Dr. FISHER. Mrs. Stanley is in no position to know the number of applications for licensure which came in our central office, therefore, she had no way of knowing those applicants for licensing whose applications may have been discouraged in the process of applying and who may, for all practical purposes, have been refused licenses, merely in the process of discussion with us as to whether or not we might sometime in the future considering licensing them. These never

appear on the records for the simple reason that they are never licensed.

I have no way of knowing offhand the numbers of such instances but I think perhaps Mr. Carney can tell you at least of some in his rather short term of experience in this position and these are individuals who have come to us and said I intend to apply for a license and what requirements will I need to meet.

As a result of our discussions no license has been requested.

Now the actual number of revocations. Again this involves a formal process of revocation and does not include those instances where the reissuance of license may have been refused. That is the renewal of license.

The actual revocation based either on revocation by the department during the periods of time when the department had that authority—I can think of three that I revoked on this basis and two of these were finally appealed to the superior court. I think I won one and lost one. I would not swear to my batting average but it is something then on that basis.

Now since the administrative hearing officer arrangement has been with us, which has been 3 years now, I guess, we have submitted one case to him about which we have had some discussion. We have tended to lean on the process of discouragement persuasion and so forth rather than the process of revocation.

Senator Moss. Apparently though what she was referring to is some homes that are in business and do have licenses she thinks should be divested, not those who are applying and are discouraged from coming in.

Dr. FISHER. This may very well be so. I might find myself in agreement with her in some instances but I am not sure I know the mechanics which can be used to achieve the purpose.

Senator Moss. I think we recognize there is an obstacle course to be run in the enforcement of any public standard of this sort.

Dr. FISHER. Perhaps you would like Mr. Carney to speak to this. Do you have any figures as to the numbers you have discouraged or dissuaded?

Mr. CARNEY. Now, I have not.

Dr. FISHER. I might say for that part of the process of discouragement or dissuasion also includes fire inspectors, requirements and very frequently fire inspectors also will preinspect a piece of property that the applicant hopes to subsequently use as a basis for application for a license. Very frequently the fire insurance inspectors requirements also provide a very serious degree of discouragement to the applicant.

Senator Moss. Since you have difficulties in getting support for your efforts to revoke or suspend a license and since you, under the statute, have the power to make reasonable rules and regulations for nursing homes, wouldn't it be a reasonable approach to make specific and more stringent perhaps some of the regulations such as our reference to the RN requirement which would then specifically be in your regulations and you could readily prove there was a failure to comply with the regulations?

You might be on stronger ground when you appeal to the administrative hearing officer or appeal to the court. Is that right?

Dr. FISHER. Yes. There are ways that you can devise regulations which, in the sense, can establish the kind of things that can be seen

or measured and, therefore, the kind of things that can be certified present or absent and, therefore, not subject to opinion and, therefore, far more easily used as a basis of some kind of enforcement action.

This is quite true. I rather suspect that some of these requirements you speak of will be included in the revised regulations of which we speak. I should also like to point out to you, perhaps this is unnecessary, that we have been closely allied with nursing homes or dependent on nursing homes for a variety of services since 1950. This has been 14 or 15 years. During much of this time a very real part of our responsibility we have felt has been to support improved and assist nursing homes in improvement themselves.

This then has to be something of a parallel effort related to enforcement. To some extent we have to keep these two approaches in balance. When you finally have invested all you think reasonably can be invested in a program of improvement or assisting in improvement, then you can begin to lean somewhat more completely perhaps on the process of enforcement per se.

Senator Moss. Can you tell me what the division and number is between proprietary nursing homes that you have and the nonprofit, charitable kind of nursing home?

Dr. FISHER. If I remember the division we have something like five or six nonproprietary, nonprofit institutions which leaves approximately 180 proprietary homes. I would simply say in relationship to these that the great, great majority of them by far are reconverted dwellings.

Senator Moss. Your problems from sheer numbers alone would come mostly with the proprietary but do they arise in connection with any of your voluntary and nonprofit types?

Dr. FISHER. No. Our nonprofit voluntary types in general are new. The one in Madawaska is 5 or 6 years old. The Marcotte home is the largest one. This is an old, very well-established, very well-recognized, very well-run home which has a religious affiliation. The Jewish Home for the Aged here, Mars Hill, and which is under the Hill-Burton program. The Jewish Home for the Aged was extended and expanded with Hill-Burton money. We have two osteopathic hospitals, one the osteopathic hospital in Bangor and the other the osteopathic hospital in Portland.

These are small in size. For example, the Mars Hill only provided 10 beds plus a few hospital beds, 31 beds in Madawaska; 37 beds in the Jewish home, 10 beds in the home in Jones Port. Two osteopathic units are actually more a chronic disease unit in the sense that they are closely related to chronic hospitals. Those are 35 beds or roughly 40 or 45 beds in Portland.

Senator Moss. Do you have any appreciable number of your proprietary homes that have an affiliation with a hospital?

Dr. FISHER. If you are using this term in some kind of formal affiliation I rather doubt if any of them have this. There are working agreements. The Central Maine General Hospital in Lewiston at the moment, at least a couple of weeks ago when I last talked with the administrator, is in the process of trying to work out with a group of a half dozen or so ho nes in its service area some kind of formalized affiliation agreement but essentially the answer to your question is "No."

Senator Moss. I assume you would agree that it would improve greatly the service if there were affiliation so that the records would coincide and be transferred from one to the other, is that right?

Dr. FISHER. I agree wholeheartedly. As a matter of fact it seems to me that this process may be absolutely an essential part of bringing proprietary homes into an acceptable system of medical care facilities. In my remarks this morning I did point out however that at least as far as we are concerned here the lawyers associated with at least two general hospitals that I know of, one in the medical center in Portland and one in the Central Maine General Hospital in Lewiston in both instances here the legal counsels of the hospitals have advised the hospitals that this is a very, very difficult and very uncertain kind of area into which hospitals may be moving.

This is probably the result of the peculiarities of our State statutes in which liabilities and things of that sort as I understand are not very clearly defined and therefore they must place perhaps more than the usual dependency upon court law rather than written law.

In this area I think some of the lawyers tend to treat rather carefully. So it is entirely possible that as time goes on and the need for this kind of affiliation becomes very obvious and a crying need, and I am sure it will become so, we can probably need some special statutory recognition of this need and perhaps some statutory provision under which this kind of affiliation can be developed without legal reservation that apparently are felt now by a fair proportion of our legal people.

Senator Moss. Thank you. I just have one more question. I do not want to take all the time. I want Senator Neuberger to have time to ask some questions.

Mr. Simonds, you said in your testimony that one of the crying needs is to raise the social security benefits to a more adequate level. I think we all agree with that. I just wondered if you had a figure in mind. How much do you think it ought to be raised in order to do the job?

Mr. SIMONDS. I am not sure I can give you an exact figure, Senator Moss. The principle I think we should establish is that the minimum social security requirement for retirement and disability benefits should be subsistence needs. Whether this should be at the $85, $95 or $100 figure I can't say. But the principle of meeting subsistence needs should be established.

Senator Moss. You believe in some flexibility so that when the need becomes greater there is a greater payment to meet it; is that right?

Mr. SIMONDS. Yes. I do. I am not advocating a departure from the wage related principle except particularly in the medical field where there is the obvious departure and perhaps this would take care of most of the extra need particularly in the long-term care field.

Senator Moss. Thank you.

Senator Neuberger.

Senator NEUBERGER. During our hearings we have had some innovations suggested and one of you, I think it was you, Mr. Wyllie, approached that with the home-care idea. In Boston a professor of preventive medicine at Tufts said that with a going program there they could take care of some of these patients for less than $5 a day versus the $7.74 a day, I think it was, that the welfare department pays.

This has long been used in the Scandinavian countries where there is great encouragement to keep these people in their own homes and

nursing assistants go out, so I am glad you are thinking about it because it looks as if that is one of the things we should work toward.

I am wondering if some of you gentlemen who have worked directly with this think there should be a point system for grading of nursing homes. That is, obviously there is great variation in the services offered. Some are just minimal. Others provided rehabilitation and recreation therapy, nursing care for 24 hours a day. Would it be good to have a point system so that some homes got $5 a day and others got $11 a day, depending on the service they offer? Is this feasible?

Mr. CARNEY. I am personally in favor of a point system because I think this is an objective way of measuring differences in quality and I believe that one of the recommendations of the nursing home study is in part an answer to your question, that they suggested that there be a better equation between the needs of the patient and the service rendered by a nursing home.

Hopefully both could be measured by a point system. Actually at the present time we have a group here in Maine studying the possibility of this very system. In fact, your neighboring State of Washington has such a point classification system for patients that we are thinking of using here in Maine.

Dr. FISHER. May I expand on that.

Senator NEUBERGER. The AMA has a committee on ethics, for its members which is going—which is very effective. There seems to be in the study a very casual reference to the Maine Nursing Home Association. It says obviously the State is short of funds, short of inspectors to do the job. Would it not behoove the nursing homes, themselves, to organize rather rigidly into an association comparable to the AMA to police itself, because one rotten apple in the barrel brings, of course, criticism of all. We have had testimony today of some extreme cases. We know there are many of the 188 homes that are doing a fine job. Why is the nursing home association so lax or ineffective? You are the licensing man, aren't you?

Mr. CARNEY. Yes.

Dr. FISHER. Then it really does not make much difference who answers the question. You will probably have an opportunity to hear from the nursing home association itself. At the moment I am making no plea for them but in answer to your question I would like to say two things. First, that we do have a very active State nursing home association, that it has been extremely active in the matter of establishing as you call it, a self-policing system where they themselves have established a rather high level of operation as a prerequisite for membership in their association. There is also a national program of accreditation of nursing homes and as an active association our State association has participated.

So I would simply like to leave any further answer to this particular question to them.

Senator NEUBERGER. I can give you more of a general kind of impression that I have rather than some specific things. One of them is, of course, that you are very short of money. You don't have nearly enough inspectors. In one of your statements you referred—someone always reports an abuse, your inspector never finds it out. That struck me as odd because many places that we have had these hearings, the homes are inspected much much more than they are in Maine.

Now that means a bigger staff. That means that the legislature is more generous and you can only work within your appropriation. How well I know that. But I thought that was an interesting thing, that nobody ever said our inspector found. It was always that some parent's child or a nurse reported it. I think this shows something is wrong with the inspection system.

Now what worries me through all of this is not what Maine does. This is up to you, how much money your taxpayers want to pay, how much money your legislature will appropriate.

But, first of all, Federal money comes in to match old-age assistance. So we have an interest there. Obviously you are not making very good use of the Kerr-Mills legislation.

That would also indicate penuriousness on the part of the legislature because the Federal Government only does so much to match the State. If the State did not take advantage of Federal money, then that is the State's loss I would say.

Now comes along with another bill which is going to provide definite provisions through social security that many more people can be provided for, even people with mental illness, that we have not even discussed today. So you can see there has to be some Federal regulations.

Do you think very many of these nursing homes in Maine could survive under some Federal standards?

Dr. FISHER. Well, this is a rather difficult question unless I had an idea of what the standards might be. But I would assume that as a practical matter your standards are so stringent we would not be able to diverge too far from what one might estimate as something of the median condition in the United States.

I would say on that basis the percentage of our nursing homes that would survive this kind of screening compared to the median for the United States would be a percentage of which I would not be particularly ashamed.

Senator NEUBERGER. The reason I wonder is because another thing that strikes me throughout all your presentation is that so much of this is done by rules and regulations rather than by law.

Therefore, very much depends on the administrator. He can be strict in enforcing the rules or regulations or he can be lax. I was absolutely amazed to read in this study—I guess this is one of the rules and regulations.

"In consideration of a licensed nursing home an establishment must meet the following minimum qualifications of nursing service or supervision." Now here is a peculiar anomaly.

"To fulfill the requirements of acceptable training or experience the person supervising nursing care shall be either (*a*) a registered nurse, (*b*) a licensed practical nurse, (*c*) be a graduate of an approved school of nursing"—going right downhill as fast as we can until you can meet the qualifications if you have at least 2 years of high school education or 5 years of acceptable experience.

Now I don't think that any Federal standards are going to allow you to run the gamut like that. In other words, what you could say in this instead of using all these examples is—I don't know, are these rules or are these just study?

Dr. FISHER. Those are primarily study.

Senator NEUBERGER. What we could say is that minimum qualifications in Maine are 2 years of high school education plus 5 years of

experience. If you want to go beyond that nobody is going to stop you. That is a pretty flimsy regulation for a nursing home to take care of sick aged people.

Dr. FISHER. This is quite true. We recognize this full well. Let me point out as a part of this whole process it has been only in the last 5 or 6 years, something like this, that we have had any means whatsoever for training practical nurses or so-called LPN's, up to this time our LPN's were licensed in the few instances that they were under a grandfather clause which essentially says that anybody who can find two people or three people, whatever it was I don't remember, that will say you have been a practical nurse for so many years, ipso facto you have a piece of paper and you are a practical nurse.

So that again these kinds of things have to be interpreted to some extent against this kind of background.

Senator NEUBERGER. Then in the next section it says: "One fifth of the required staff hours must be provided by nurses meeting these qualifications." And the qualification is 2 years of high school.

Dr. FISHER. Plus 5 years of experience.

Senator NEUBERGER. Yes, plus 5 years of experience. But can that nurse administer certain medicines and supervise things? In the State of Maine are they licensed?

Dr. FISHER. Well, I might say that we have asked for some interpretation recently as to what constitutes nursing practice and what constitutes an infringement of our laws related to nursing practice and we have an opinion which essentially says that anybody can do any of these kinds of things as long as some physician tells them to do it. Am I quoting that roughly correctly?

Mr. CARNEY. That is correct.

Dr. FISHER. So that here again, our nursing practice act appears to have far more holes in it than you think when you read it initially. When you begin to ask these kinds of questions this is when you begin to find some of these holes.

Senator NEUBERGER. I come from a State that has a great rural area just as Maine does. I am so well aware of the problem of staffing. In fact, I did something that probably not many politicians would do. I urged that a Hill-Burton grant not be given to a hospital in my State where it was requested by the doctors. The reason I did was that the doctors did not want to travel 50 miles up the road to see their patients. They wanted to see them near at home. But we found there were only five nurses within an area of 200 miles to take care of them. So I thought it was ridiculous to set up another hospital.

What I wonder though is, again from the Federal standpoint, if the Federal Government would consider that your standards are adequate from the nursing standpoint.

Now because we must hurry along, I have not had answered satisfactorily to my mind where the responsibility lies on this licensing and revoking of license, it seems to me there are so many places here you can go and get—it is buck passing it seems to me. I might be wrong, I might be missing something.

I am wondering if there is a laxity because you need the beds, you need the homes. I have a feeling that there is a defense—a defensive comment here rather than a constructive one about these licenses.

Maybe we will hear more during the afternoon that will satisfy me on that.

Dr. FISHER. The only thing I can do is set forth the statutes under which we have to work. I simply do not have authority to revoke a license. It is just as simple as this.

Senator NEUBERGER. Do you go to the legislature and ask for the authority?

Dr. FISHER. The only thing I can say is that I have gone for the authority and the legislature chose to remove this authority from me along with the authority of almost all other State licensing agencies when the administration code hearings officer system was established 2 or 3 years ago. Now this is the only thing I can tell you. I referred to this in my statement this morning when I said that it has seemed—not said, but I think I implied—that it seemed to me that at least in some legislation discussions in the past 2 or 3 years that there has been a very major kind of an effort to establish additional protections for the public against actions of State agencies. Now you can't put it in any other words because very specifically all licensing agencies, all licensing functions of all State agencies in our State, were subjected to this final decision or in fact enforcement authority removed and transferred to this one central agency which for all practical purposes is the agency which is established to protect the rights of the licensee.

Now this is exactly what was said at the time. It was said that this would establish something of a uniform system by which licensing would be reviewed, for removal of licenses.

Senator NEUBERGER. If you do not mind, I will say that we ought to go on. I just wanted to tell you the impression I have. I think that is a State matter. It does not concern us.

Dr. FISHER. I will give you my impression in a very few words, Senator, If you wish me to describe some of the obstacles which I think have been placed upon our licensing responsibility.

Senator NEUBERGER. I want you to know that we are not trying to run the State.

Dr. FISHER. I could give you my impression. It would be in very short terms but I would prefer not to write the headlines for the evening paper.

Senator MOSS. Thank you very much, Dr. Fisher. Senator Muskie indicated to me he would forgo any questioning because we are now pressed for time. We have had a fine panel of witnesses and you have done a good job. You are the men who have the responsibility in these various areas and I am sure we could profitably spend the whole afternoon discussing the matter back and forth with you here.

We do appreciate your statements and your answers to our questions. They have helped us in putting together a record. As I explained in the first place we are simply probing, trying to find out, and trying to get as much of this information as possible to evaluate not only for Maine but for other parts of the country, and in this way get a composite picture.

We recognize the problems you face. Let me say I am sure you are doing your utmost to meet those problems, to upgrade the standards to provide better care for the elderly citizens in Maine. We thank you very much.

Dr. FISHER. Thank you, gentlemen.

Senator Moss. Our next witness is Mr. Frederick Bird who is an accountant with the Simplified Business Service, Rockland, Maine. Is that right, Mr. Bird?

Mr. BIRD. That is right. May I address you a moment, please, sir?

Senator Moss. Certainly.

(Discussion off the record.)

Senator Moss. Mr. Bird indicated that recognizing the number of people yet to be heard, and some of them are from out of State, he is willing to submit his statement and to just very briefly summarize part of it and leave himself available for questions.

We appreciate your cooperation, Mr. Bird. We shall be glad to proceed in that manner.

STATEMENT OF FREDERICK BIRD, ACCOUNTANT, SIMPLIFIED BUSINESS SERVICES, ROCKLAND, MAINE

Mr. BIRD. Mr. Chairman and members of the committee, my name is Frederick Bird, Rockland, Maine. I am an accountant and business consultant. I have been dealing with a number of nursing homes in the State of Maine. I am familiar with their financial and business problems.

The main point which I would bring out today would be that the nursing home business or industry or profession, as you would have it, in the State of Maine has grown like "Topsy" overnight without too much real business knowledge behind it until recent years. Recently it has become the concern of authorities as to what is taking place. One problem that we have is financing, as always.

The return on the fees, the difference between cost and income, leaves so little profit that many of these homes when faced with regulations, improvement regulations, which are necessary, find they do not have the money. Our local banks have been reluctant to finance nursing homes because of the very nature of its being such a personal business. It starts with a nurse, and that is the heart of the business. Many of our good nursing homes have been driven to seek what I call crash financing, which is money on a second mortgage basis. This is supposed to cure all ills—to pay off the bills outstanding, take up some of the small financial paper they may have. However, this money comes to them from outside of the State, in most instances, and the borrower is not made aware of exactly how the loan is put together. They receive a sum of money.

As an example, in this particular case, the administrator of the nursing home received $8,000 and had to pay $500 to the attorney for drawing up the mortgage. When the administrator's attorney later looked up the mortgage in the county courthouse, he found it was for $15,000, which meant there was an interest charge of some $7,000 added to the amount which she borrowed, and the $500 which she had to give to the attorney. With this kind of financing, you can see that nursing homes rapidly get in trouble. The Government financing programs, FHA and SBA, are so strict as to requirements that none of these homes can qualify. A newly constructed home could, but then you get into costs which reach hospital costs, which everybody says we are trying to avoid for this nursing home type patient.

So it is somewhat of a dilemma that we are all in. I think the Maine nursing home operators are doing generally an excellent job. The

State department has cooperated in every way, but I think Senator Neuberger put her finger on it when she said that probably primarily the requirements are not quite strict enough for licenses to keep up the standards—there should be some regard for their financial ability as well as their nursing ability, because a good nurse can be ruined by bills she can't pay.

Thank you very much.

Senator Moss. Thank you, Mr. Bird. Your full statement will appear in the record.

(Mr. Bird's full statement follows:)

STATEMENT OF FREDERICK C. BIRD, SIMPLIFIED BUSINESS SERVICES, ROCKLAND, MAINE

Mr. Chairman and members of the committee, my name is Frederick C. Bird. I am an accountant and business consultant. In this work I have dealings with a number of Maine nursing homes and I am familiar with their financial and business problems.

Maine nursing home administrators sincerely try to do a creditable job. Their biggest fault may be that, all to often, they are better nurses than businessmen.

Over the years many nurses, both registered and practical, have been urged, coerced and begged by the medical profession to take elderly and other chronically ill people into their homes. In other words, to establish a nursing home.

Health and insurance authorities have become increasingly aware of the less than desirable physical situation this has often created. These authorities have, with good reason, called for improved health and safety precautions on the part of these nursing home administrators.

Since elderly people are often limited as to funds, the return to the homeowner allows little financial latitude for financing many of these required improvements. Local banks have been reluctant to finance all the needs of their neighbors who administer nursing homes. This has forced many fine, conscientious, and hard working administrators of limited financial means to turn in desperation to "crash financing."

Through solicitation by direct mail advertising several Maine nursing home administrators have been lured by easy sounding terms to second mortgage financing. They are not told the true facts of the amount and terms and rates of interest of these loans. They suddenly find themselves confronted with a substantial monthly payment and dire threats if they do not pay promptly. Here is a typical example of the loan of one administrator.

The second mortgagee offered this administrator $8,000 to consolidate bills and provide a small amount of working capital. But first the borrower had to pay the mortgagee's attorney $500, leaving $7,500 to the borrower in cash.

At a later date when the administrator's attorney checked the mortgage deed at the county courthouse, he found the mortgage principal was $15,000. Over $7,000 in added interest—a basis of over 18 percent per annum for interest on a 5-year payoff.

Senator Moss. What you are saying is that many of these nursing home proprietors, because of inexperience and being pressed for money to improve their standards, have been victimized because they weren't able to get reasonable financing either from government programs or from local banks. Perhaps through the services of their association or otherwise, they ought to be counseled and advised about financing, to avoid these pitfalls.

Mr. BIRD. That would be a great contribution.

Senator Moss. I can see this as a service that could be provided with the Nursing Home Association so that a person would not inadvertently get into a situation such as the one that you mentioned.

Are there any questions, Senator Muskie?

Senator MUSKIE. Is the illustration that you gave us a typical one?

Mr. BIRD. It is an extreme case, Senator. I would say it is an extreme case.

Senator MUSKIE. To what extent do these nursing homes have to depend upon these unusual, costly sources of financing?

Mr. BIRD. They do to quite a degree in many instances. There are other types of financing, too, that extract a large penalty for interest, say equipment loans. If they go to a regular bank they get used very well. But there are certain other types of financing that prove very costly to the borrower.

Senator MUSKIE. The illustration that you used, is that a source within the State?

Mr. BIRD. No, that is outside the State.

Senator MUSKIE. Was it a bank?

Mr. BIRD. No, a private individual.

Senator MUSKIE. A private individual?

Mr. BIRD. Yes.

Senator MUSKIE. Is that done a great deal?

Mr. BIRD. I know of three cases. There may be more.

Senator MUSKIE. To what extent have the nursing homes tried to use FHA and SBA?

Mr. BIRD. I, myself, have gone to them for a number of homes probably a half dozen times, and we always seem to run up against the problem of the terrifically high requirements, but some unnecessary requirements.

Senator MUSKIE. But necessary as to plant, physical facilities?

Mr. BIRD. That is right.

Senator MUSKIE. Has SBA or FHA gone into any of these established homes, these older homes in the State, to your knowledge?

Mr. BIRD. Not to my knowledge.

Senator MUSKIE. They have gone into new homes, have they not?

Mr. BIRD. The last time I talked to FHA, they had not been successful in financing one up to that time.

Senator MUSKIE. That is all, Mr. Chairman.

Senator Moss. Thank you.

Thank you, Mr. Bird. We do appreciate your coming to give us this information. And you in your particular experience are one well qualified to tell us about this. This is a matter about which we should be concerned. Thank you.

Mr. BIRD. Thank you, Senator.

Senator Moss. Our next witness is Dr. George E. Sullivan, who is president-elect of the Maine Medical Society and chairman of the medical advisory committee to the health and welfare department.

I understand that Dr. James H. Bonney, chairman of the subcommittee on nursing homes of the medical advisory committee, will accompany Dr. Sullivan.

Will these gentlemen come forward now? We will be glad to hear from them.

We are very glad to have you gentlemen. You may proceed however you would like.

STATEMENT OF DR. GEORGE E. SULLIVAN, PRESIDENT-ELECT, MAINE MEDICAL SOCIETY AND CHAIRMAN, MEDICAL ADVISORY COMMITTEE TO THE HEALTH AND WELFARE DEPARTMENT; ACCOMPANIED BY DR. JAMES H. BONNEY, CHAIRMAN, SUBCOMMITTEE ON NURSING HOMES OF THE MEDICAL ADVISORY COMMITTEE

Dr. SULLIVAN. Mr. Chairman and members of the committee, it is a privilege for me to appear before you today and read this brief statement. Incidentally, I don't think you want it since I wrote this at 1 o'clock this morning, when I was through my work and I don't believe you can read it. If you would like, I can have it typed.

At the present time I am doing full-time anesthesiology at Seton Hospital in Waterville. I have been doing this since 1954. Prior to this, I was a general country practitioner in a small town in Maine for 16 years.

Mr. Frantz invited me to come here today to tell you something of what physicians have done in the long-term care and particularly nursing homes. We have recognized for some time now that the area of nursing homes had some problems. Accordingly, the house of delegates of the Maine Medical Association, in June of 1961, gave approval to a pilot study by Dr. Willard and his group in Waterville. The observations of this study, I am sure that you probably have. They were published in the Journal of the Maine Medical Association.[1]

In July of 1963, an advisory board to the Department of Health and Welfare was set up, with the help and approval of the Maine Medical Association. This group has been quite active and have met almost monthly since that day.

In addition, the subcommittees of this same group have also been meeting at more frequent intervals. This group numbers over 40, and of these there are 28 physicians, as well as nurses, dentists, pharmacists, hospital administrators, hospital association representatives, psychologists, and a representative of the Health Facility Planning Conference. This group has been vitally interested in the area of long-term care and nursing homes, as evidenced by the fact that we have formed several subcommittees; namely, (1) the nursing home study committee, which Dr. Jim Bonney was chairman of, and I am sure you have his report; [2] (2) a noninstitutional care committee; (3) a utilization committee; (4) a committee on hospital costs and accounting; and (5) Rockland pilot project committee. This committee was to study the effects of complete out-of-hospital, home care on this population.

Since 1963, I have been sitting as chairman of this committee.

I should like to point out that the nursing home study alone involved 55 physicians who are interested in the problems of long-term care across the whole geography of the State. The interest of the physicians in Maine in problems of long-term care is also evidenced by the growing number of chronic care facilities being built and set up in association with the acute general hospitals. Physicians' interests along this line have been moving hospitals into this area.

[1] The report referred to is reprinted as app. C beginning at p. 905.
[2] See app. A.

I personally am pleased to see the development of long-term care units in connection with hospitals, because this will no doubt provide the best opportunity for continuing care under high-quality supervision. But I must admit that this is not a panacea. It does not solve the problem for all the people of Maine. For example, it will not eliminate the need for the independent nursing home in the smaller areas that do not have access to hospitals.

In conclusion, I would like to add that the bulk of the medical care to chronically ill patients is still being furnished in the State of Maine by the general practitioners who see these patients day in and day out, and in their own homes. These are the men who recognize that deeds are ofttimes better than words, and who agree with an ancient Hebrew proverb, "An old man in the house is a good sign in the house."

It is my opinion that the physicians in Maine have a sincere and abiding interest in the area of long-term care.

Thank you.

Senator Moss. Thank you, Dr. Sullivan, for a very fine statement. I was interested in your comment that the medical profession and hospitals are taking greater interest in the field of long-term care as against the acute illness, the type of work in which the medical practitioners almost confined themselves at one time, and which still seems to be accentuated over the work being done in the long-term field. Our testimony elsewhere would indicate that this is generally taking place now in the medical profession.

Dr. Bonney, do you have a statement that you could give us at this point?

Dr. BONNEY. I just have a comment, no formal statement.

As chairman of the subcommittee on nursing homes, of the 298 patients that were studied, I studied personally close to 50 of them, myself. This took me into many nursing homes all the way from Kittery to Machias. Every patient I saw was clean and dry. The oriented ones were happy, the disoriented ones were happy. I would not have wanted to tell any of these patients that they would have to move.

The nursing home operators were very helpful, very pleasant. They impressed me with their urge to want to give good care. They were most cooperative, and I think that the headlines of tonight's paper is one of the most unjust criticisms of any group that I have ever seen.

Senator Moss. I haven't seen tonight's paper, so I don't understand the comment.

I am very glad to have your report. Your inspection indicated nursing home patients generally are cared for very well.

Dr. BONNEY. Yes. This was my impression. Maybe there is something wrong with me, but when we got all the physicians—this included about 37 others—on adequate medical care, 91½ percent put down "Yes". This was clear across the State. They were getting adequate care.

The physicians did not have a chance to draw an examination on the patient. We don't know whether some of the physicians interpreted it as overall care, or just care adequate for that facility. So we did not use that figure.

Senator Moss. How many of these nursing homes have any kind of affiliation or relationship with a hospital?

Dr. BONNEY. None that I know of.

Senator Moss. Would the medical care available, then, be simply on a doctor-patient relationship, as a doctor would drop in and see his patient in the nursing home? Or would there be any physicians who would be available for all of the patients in the nursing home?

Dr. BONNEY. There are different setups in many places. Mainly nursing homes have what they do call their house doctor, who is always available if they can't get the attending physician.

Senator Moss. It there any system for getting a standardized, uniform system of recordkeeping on patients in nursing homes?

Dr. BONNEY. Yes, there is supposed to be. Some of the records were very good, some were fair.

The recordkeeping seemed to reflect somewhat on the doctor's interest in the area. What is the sense of keeping an order book, if the doctor never writes an order in it; or a progress book, if the doctor never writes a progress report in it? The nursing home directors just do away with it. But in areas where doctors will do that, there are very good records kept.

Senator Moss. Would it be your recommendation, Dr. Sullivan, that there should be affiliation or relationship between hospitals and nursing homes?

Dr. SULLIVAN. I believe there should, Senator Moss. This, we are working toward.

Senator Moss. There could be ready transfers both ways, according to the needs of the patient.

Dr. SULLIVAN. So-called transfers that the AMA spoke about. This is the idea. This is a little more difficult to effect in Maine, as I mentioned before, because of our large geography and spread of population. But this is what we are working toward.

Senator Moss. I appreciate the fine work that the Maine Medical Society has been doing in this field. Obviously, you are conscious of the problems and you are making your contribution to finding solutions. My colleagues may have some questions.

Senator Muskie.

Senator MUSKIE. Dr. Sullivan, following up on the last question, you say it is the objective of the Maine Medical Association to establish affiliation between doctors and these nursing homes?

Dr. SULLIVAN. I think Senator Moss said nursing homes and hospitals.

Senator MUSKIE. Is there any program by anybody to establish more adequate affiliation between doctors and nursing homes? This may not necessarily be a good objective. I am just interested in getting your comment on it.

Dr. SULLIVAN. Actually, we are trying throughout the State. One of the reasons that we had some 55 physicians take part in this nursing home study, was to interest doctors in this area. Because, obviously, there have been some problems in this area. But as far as some official bodies doing this, we are just encouraging this and making the doctors as a whole aware of the fact of what could be done.

When doctors do take an interest in nursing homes, nursing homes automatically are better nursing homes.

Senator MUSKIE. You are familiar with the pilot project in Waterville which was reported in the Journal of the Maine Medical Association.[1] There are some interesting observations made on this subject.

[1]See app. C.

I wonder if you would care to comment on your evaluation of the project, how valid these observations are?

Dr. SULLIVAN. I think they were honestly done, but I think that they were trying to show what was wrong with nursing homes totally, rather than trying to assess them as a whole. I think in that article they mentioned there were some 10 volunteers of which they picked 6. As I recall, some of the comments were that it was an unstimulating sort—do you have them there?

Senator MUSKIE. Yes. Here are some of them. These are observations made by the doctors concerning their own attitudes on the project: "I could not get interested. All a doctor can do clinically, is to postpone death. The main needs are social and economic, and I can't arrange for more attentive families, more money, or more hobbies."

Another was, "I can't feel as much responsibility for State patients as I do for private parties."

Another one, "It was interesting for the first few visits. Then there was nothing more to contribute. I was glad when the project was over."

"I wasn't bored. Each visit strengthened my previous convictions. However, the problems seemed too difficult to solve."

Then, "It is not a pleasant task to work with patients who are so unstimulating and so unresourceful as those who are rejected by their own families."

Dr. SULLIVAN. Actually, this project or this pilot study was endorsed by the Maine Medical Association in, I think, 1961. But it was endorsed only as a pilot study. I think the purpose in mind of the pilot study would be to study the feasibility of a total study. At the time, I asked the various doctors who took part in them, "How come these comments are being published?" As I recall, the circumstances at the time had something to do with it. In the area studied there were four nursing homes, one of which is a little depressing to visit. Following a visit to this home, they, the participating doctors, were sitting in a roundtable discussion, and the question that brought up these answers was: "How would you like to do this type of work for a living?" I think if the answers were given in this context, probably this would have a little less harmful meaning.

I am not particularly proud of this article.

Senator MUSKIE. These comments might have been in response to some such question as you have suggested. That may be so. I think that is probably so.

Do you, and does the medical profession as a whole, see in the nursing home a facility which must be relied upon increasingly as a health facility dealing with the problems of the aged and the chronically ill?

Dr. SULLIVAN. We sure do.

Senator MUSKIE. Do you feel as a whole that the standards of care in the nursing homes in Maine need improvement?

Dr. SULLIVAN. As a whole. I would say everything—even the standards of medicine need improvement.

Senator MUSKIE. My question was not designed to elicit a criticism of nursing homes, but rather to elicit a judgment as to the level at which the nursing home ought to be operating, in your judgment, to meet the needs which you foresee.

Dr. SULLIVAN. I think they are operating at a satisfactory level. They can be improved. My view is that as more doctors take an interest, they will be more effective.

Senator MUSKIE. Do you think that the nursing homes as a whole—I know some of them are better than others—ought to have a greater content of professional medical or nursing care than they now have, or than the State's standards now require?

Dr. SULLIVAN. It would be ideal.

Senator MUSKIE. Do you think it is necessary, in terms of the foreseeable future—I am thinking of the future in which hospitals are going to be increasingly overcrowded, the cost of hospital care is going to rise, the percentage of aged is going to rise—foreseeing all of this, do you think that the nursing home ought to in this State become more of a medical or health-care facility than it is today?

Dr. SULLIVAN. Yes, I do.

Senator MUSKIE. What do you see as the principal obstacles in reaching that objective? Is it economics?

Dr. SULLIVAN. Part of it. I think the recommendations of the nursing home study, the six recommendations will probably summarize it.

Senator MUSKIE. Thank you.

Senator MOSS. Senator Neuberger?

Senator NEUBERGER. I have a question for Dr. Bonney. It follows a little bit on what Senator Muskie said. Do you think that most of the nursing homes, Dr. Bonney, in this State are satisfactory?

Dr. BONNEY. Yes.

Senator NEUBERGER. And yet in this advisory report for which Dr. Sullivan signed the introduction, it says approximately a thousand patients are under the care of persons not registered as professional nurses nor as licensed practical nurses.

Dr. BONNEY. That says "satisfactory," it does not say "ideal."

Senator NEUBERGER. Thank you. That is all.

Senator MOSS. Thank you very much, Dr. Sullivan and Dr. Bonney. We appreciate your coming and giving us your testimony. We are glad to have you.

Our next witness will be Mrs. Elinor Nackley, a registered nurse, who is president of the Maine State Nurses Association.

Mrs. Nackley, we are very glad to have you.

STATEMENT OF MRS. ELINOR NACKLEY, R.N., PRESIDENT, MAINE STATE NURSES' ASSOCIATION

Mrs. NACKLEY. Mr. Chairman, members of the committee, I am Elinor F. C. Nackley, president of the Maine State Nurses Association which is the professional organization of registered nurses in Maine. I am speaking in behalf of that association. We are a constituent of the American Nurses' Association.

The ultimate purpose of our organization is to provide the best possible nursing care for all people. To fulfill this purpose, we recognize as one of our fundamental responsibilities, the enunciation of standards which will insure safe and effective nursing practice.

In 1960, the American Nurses' Association published a "Statement of Standards for Nursing Care in Nursing Homes" which had wide distribution and was generally regarded as a very valuable guide for

nursing home administrators and other interested persons. This statement has been superseded recently by a new publication—"Standards for Organized Nursing Services in Hospitals, Public Health Agencies, Nursing Homes, Industries, and Clinics." These standards offer guidance in upgrading nursing practice. Following the release of the nursing home patient care study in this State, the Maine State Nurses' Association recognized the need for an enunciation of standards for nursing practice in nursing homes in Maine. Subsequently, a special committee on standards for nursing personnel employed in nursing homes was appointed. The recommendations from this committee will be presented to our board of directors in the near future. Following the adoption of the standards by the association, they will be made available to serve as a guide for nursing practice in nursing homes.

We have worked closely with Manpower Development and Training Act personnel in assisting with course outlines for the nursing aid programs in Maine. In this way, the nursing profession has been concerned with a level of practice which we consider safe for this employee.

The quality of nursing care available to patients is affected by three primary factors: (1) the quality of available medical supervision, (2) the standards of the employing institution, and (3) the knowledge, judgment, and skill of the nursing service personnel.

Basically, we believe it is extremely important that professional nurses be responsible for planning and directing the nursing care of patients. While nursing aids may be taught to assist in the care of patients, the judgment and skill required for the application of nursing, based upon specialized knowledge, should be done only by the professional nurse. It is important that the nursing aid be carefully instructed and supervised by the professional nurse.

The problem of assuring adequate nursing care in our nursing homes is a serious one. Higher standards and improved quality generally mean higher costs. The existing shortage of qualified professional personnel is recognized. The current trend of establishing nursing homes within the general hospital compound will upgrade nursing care.

The Maine State Nurses' Association believes that the high standards of nursing care are an attainable goal which will require the cooperative support and assistance of many groups who are responsible for the health care of all people.

I thank the committee for this opportunity to present the views of the Maine State Nurses' Association.

Senator Moss. Thank you, Mrs. Nackley, for a very fine statement.

Let me ask you this. I am sure there is a shortage of registered nurses in Maine. There seems to be in every part of our country. How acute is this shortage? Are there adequate registered nurses to be available to all of your acute care hospitals and still have supervisory nurses for the nursing homes here in Maine?

Mrs. NACKLEY. Senator, I would like to defer to Miss Flaherty, who will be the next speaker. She has some statistics on registered nurses in the State.

Senator Moss. Then I will defer that.

Do you think it would be advisable to require that there at least be supervision by a registered nurse in all nursing homes as a requirement for licensing?

Mrs. NACKLEY. If we accept the definition of a nursing home as one giving nursing care to patients, then I certainly do think it is pretty important that the nursing care be supervised by a professional nurse.

Senator MOSS. That, generally, is the definition given this commitee. If the older people are not in need of nursing care we would expect them to be in a boarding facility of some sort. But some need nursing care, some are perhaps quite advanced in their chronic disease condition and should be in nursing homes; and you would recommend that there be a registered nurse responsible for directing the nursing service given in that home?

Mrs. NACKLEY. I certainly would.

Senator MOSS. Senator Muskie.

Senator MUKSIE. If registered nurses are not available—and I think Miss Flaherty may testify that they are not, on the scale suggested by Senator Moss—what is the alternative?

Mrs. NACKLEY. Senator, I am not completely convinced they are not available, because we do have evidence that there are professional nurses who are available for employment under certain conditions. I think that, again, the least that we can expect is that this care is going to be supervised by a professional nurse. Now, how much supervision would be the question, if there is the problem of obtaining this kind of person.

Senator MUSKIE. Does this require each nursing home have at least one professional nurse?

Mrs. NACKLEY. Yes. For how much time, I am not prepared to say. But what I am saying is that the care of the patient should be planned and directed by the professional nurse.

Senator MUSKIE. I think that is a standard that is pretty hard to quarrel with. It has been my impression, and this is the only information I seek, professional registered nurses are scarce even in terms of hospital requirements in Maine.

Am I misinformed on that point?

Mrs. NACKLEY. Actually, in Maine we are better off than in many other sections of the country. We do have a higher ratio of professional nurses to population. We have had a lower ratio of the licensed practical nurses, because we were a little slower in establishing schools of practical nursing.

I come from an area, for instance, where we have recently opened a hospital. When I went there 2 years ago, I learned there were 75 registered nurses in the area. Yet we have a nursing home there that did not have one registered nurse on the staff.

Senator MUSKIE. Do you know how many registered nurses there are in the State, those who are active and those who are not?

Mrs. NACKLEY. Again, this is the kind of statistic Miss Flaherty will have.

Senator MUSKIE. How many schools are there in Maine producing registered nurses now?

Mrs. NACKLEY. Five.

Senator MUSKIE. How many graduate each year?

Mrs. NACKLEY. These are the statistics she has.

Senator MUSKIE. Thank you very much.

Senator NEUBERGER. Would you consider a nursing home satisfactory which has no nurse, registered or licensed as practical?

Mrs. NACKLEY. No, I would not.

Senator MOSS. Thank you, Mrs. Nackley, for a very fine statement. We appreciate your coming here to appear before our committee.

We will call Miss Agnes Flaherty, who is also a registered nurse. She is the executive director of the Maine State Board of Nursing.

Miss Flaherty, we are glad to have you.

STATEMENT OF MISS AGNES FLAHERTY, R.N., EXECUTIVE DIRECTOR, MAINE STATE BOARD OF NURSING

Miss FLAHERTY. Mr. Chairman and members of the committee, the Maine State Board of Nursing, by law (title 32, ch. 31, Revised Statutes of Maine, 1964) is authorized and empowered to promulgate the law that regulates the practice of nursing in this State and to adopt such rules and regulations as are necessary to carry out the mandate of said law.

The board of nursing wishes to comment on nursing practices as defined in the Maine law. However, before these comments are developed, the following excerpts from the publication, Nursing Home Patient Care (Nursing Home Patient Care, a study January 20, 1965 compiled by the Office of Health Education, Department of Health and Welfare, Augusta, Maine) will provide a focus for the need to interpret proper nursing practice.

I have studied this report and have selected four paragraphs which indicate that in the mind of the participant in the study there were violations of the Nursing Practice Act.

CHAPTER II. NURSING HOMES MEAN DIFFERENT THINGS TO DIFFERENT PEOPLE

To the professional nurse, the minimum qualifications of nursing services or supervision of nursing home patients in Maine are perilously below minimum for the safe care of patients.

To the Maine Division of Hospital Services, the licensing authority, current standards and requirements for nursing homes are administratively unmanageable because the qualitative standards for nursing staffing are in conflict with the Nurse Practice Act, and the quantitative standards for nurse staffing are not economically feasible for small nursing homes (p. 4, 6th par.).

CHAPTER VI. RESULTS OF THE STUDY

B. Staffing of Nursing Homes. A major problem is indicated by the fact that 32.1 percent of the homes in Maine have neither a registered nurse nor a licensed practical nurse in comparison with 13.3 percent nationally. Thus, approximately 1,000 patients are in nursing homes without the benefit of a licensed nurse. This has implications not only for patient care, but also for possible violations of the Nurse Practice Act (p. 21, 2d par.).

I would like to interject that Mr. Carney did not identify that Maine has a higher ratio of professional nurses in nursing homes than nationally. It is in the number of licensed practical nurses that Maine does not measure up.

CHAPTER VII. CONCLUSIONS AND RECOMMENDATIONS

The patient: A measurement of the quality of care needed is the estimate that 78.2 percent of the patients required registered nurse care but only 32.5 percent received such care. Yet, it was estimated by the nurse interviewer that 21.8 percent of the patients required no registered nurse care, 7 percent required supervision of activities only, and 41.3 percent required less than one-half hour of registered nurse time (p. 51, 4th par.).

The rest of my statement is devoted to the interpretation of proper practice of the two types of persons we license, the registered nurse and the practical nurse.

The board of nursing has, for the past several months, actually been working quite closely with the division of hospital services. We were requested by Mr. Carney, the director, to look at practice in nursing homes to see whether or not there was violation of the law in relation to the definition of nursing which is in the law. So I would like to cite the definitions for you as I think there is a need in many areas to more clearly understand what is proper practice for the professional nurse and for the practical nurse.

The Maine statutes provide for licensure of two categories of nurses, the registered professional nurse and the licensed practical nurse. Each group has a defined educational background deemed essential to the safe practice of nursing.

The following legal definitions are found in the Maine statutes, revised 1964, title 32, chapter 31.

The practice of "professional nursing" means the performance for compensation of any of the services which necessitate the specialized knowledge, judgment, and skill required for the application of nursing as based upon principles of biological, physical, and social sciences in the—

(*a*) Observation and care of the ill, injured, or infirm;

(*b*) Maintenance of health or prevention of illness of others;

(*c*) Supervision and teaching of other personnel;

(*d*) Administration of medications and treatment as prescribed by a licensed physician or dentist. The foregoing shall not be deemed to include diagnosis of illness or the prescription of therapeutic or corrective measures.

The practice of "practical nursing" means the performance for compensation of services in the care of the ill, injured, or infirm as selected by and under the direction of a registered professional nurse or a licensed physician or dentist which do not require the substantial specialized skill, judgment, and knowledge required in professional nursing.

The Maine law regulating the practice of nursing requires that any person who for compensation practices or offers to practice professional nursing or practical nursing as a licensed practical nurse shall be licensed.

Both registered professional nurses and licensed practical nurses are employed as practitioners of nursing. This is differentiated from the aid, because she (the aid) is not identified as a practitioner of nursing. The differentiation of functions is based, primarily, on the basic education of the practitioner.

Presently, in Maine, the registered professional nurse is educated either in a 3-year hospital diploma educational program or a 4-year university educational program; in September 1965, a 2-year associate degree program in nursing will be initiated at Westbrook Junior College in Portland. The graduate of each of these programs is eligible for admission to the licensing examination for registered nurses. There is a basic educational requirement enunciated by the board of nursing which each program must meet. (Standards for Nursing Schools and Requirements for Licensure, July 1960, Maine State Board of Nursing, and Standards for Educational Programs Preparing Practical Nurses, May 27, 1963 (revised), Maine State Board of Nursing.) There is a minimum standard which all programs must meet, and this is why the graduates are eligible for the same licensing examination.

The practical nurse is educated in a 1-year vocational educational program. The outstanding difference in these two distinct types of educational programs may be illustrated by the minimum curriculum requirements in the sciences.

Biological and physical sciences: Professional program, 270 hours; practical program, 90 hours.

Social sciences: Professional program, 210 hours; practical program, 45 hours.

As many judgments/observations of patients must be made by men of an understanding of normal/altered physiological and emotional response, it is apparent that the professional nurse is the practitioner educationally equipped to anticipate and recognize signs and changes in patients' conditions.

There is emphasis in each educational program of the importance of the practitioner knowing and understanding the cause and effect of any therapeutic technique or medication which she administers.

Whether or not patients are admitted to nursing homes for specific treatment of a chronic illness or to be assisted to achieve their full potential for self-care or independence or to be cared for and protected because of unpreventable progressive mental and physical deterioration—the major purpose for admission to a nursing home is for nursing care.

According to law and according to common practice in accredited institutions that care for the sick, a safe standard for nursing service identifies the proper function of practitioners of nursing.

What is the proper function of practitioners of nursing in nursing homes?

A basic requirement for the rendering of specific care to patients is a medical care plan. Each patient admitted to a nursing home should have a nursing care plan which has been developed from (1) the medical therapeutic plan prescribed by the physician, (2) the diagnosis of the patient, (3) the goal for patient recovery/activity (hopefully arrived at through physician-nurse conference). With this information, the professional nurse is able to (1) determine the type of nursing personnel best able to care for the patient safely and adequately, and (2) anticipate future needs/changes of the patient which may require modification of the nursing care plan.

If information about the patient's medical therapy, diagnosis, prognosis, and goal of care is not available, an effective nursing care plan cannot be developed.

I might interject here that Dr. Sullivan pointed out that qualitative medicine promotes qualitative care in other health institutions. There have been studies on the employment of nurses which have indicated that qualified nurses tend to seek employment in an institution or a community in which there is a high quality of medical care.

According to the definition contained in the Maine law regulating the practice of nursing, the registered professional nurse is responsible for the direct rendering of nursing care which requires professional judgment; she must also determine when part or all of a patient's nursing care may be assigned to a licensed practical nurse or auxiliary nursing personnel such as aids, attendants, and orderlies.

The supervision and teaching of other personnel designated in the definition is an established and accepted function of the registered nurse in organized health care facilities, independent of the physician.

Any patient care that the nurse renders is dependent on medical

orders or general medical direction, but in the teaching and supervision of the other personnel, it is common practice that the professional nurse is quite independent [1] in this area.

In a memorandum titled, "Guide for the Assignment of Licensed Practical Nurses in Patient Care Situations," circulated to all health agencies employing nurses in Maine in 1964, the board of nursing cited that the unique role of the practical nurse in patient care today is a dual one (Orem, Dorothea, "Guides for Developing Curricula for the Education of Practical Nurses," 1959, U.S. Department of Health, Education, and Welfare):

(1) The care of patients whose clinical state is relatively stable and of minimum scientific complexity, and

(2) Assistant to the registered nurse in more complex patient care situations in which professional judgment is essential.

I think a good illustration of this would be our so-called intensive care units today where the patients are critically ill and require constant and immediate professional nursing care.

The licensed practical nurse who is a graduate of a State-approved school may be capable of caring, with a minimum of supervision, for patients when (1) the nursing functions require a limited scientific background (goes back to our basic educational requirement), and (2) the patient's condition does not indicate that changes in nursing measures will be necessary.

It may be well to note, in closing, that nursing personnel who do not understand cause and effect of a nursing act cannot safely carry out physician's orders. This is without the professional nurse's direction. As auxiliary personnel in nursing receive only on-the-job training for specific tasks, it is logical to assume that they do not have the basic knowledge to safely administer medications to groups of patients or to make observations demanded for safe administration of selected medications. It is reasonable to assume, also, that a person who has not had the basic education of a registered professional nurse or a licensed practical nurse is not capable of developing a nursing care plan on the basis of diagnosis, medical history, and physician's orders.

Senator Moss. Thank you, Miss Flaherty, for a very fine statement. The charts which you have prepared will appear at the conclusion of your statement in the record.

(The charts referred to follow:)

Licenses issued 1960–64

	By examination		By endorsement	
	Professional nurses R.N.	Practical nurses L.P.N.	Professional nurses R.N.	Practical nurses L.P.N.
1960 to 1961	165	75	143	19
1961 to 1962	195	89	213	17
1962 to 1963	188	82	234	15
1963 to 1964	210	86	228	18

[1] Lesnik and Anderson in publication, "Nursing Practice and the Law," state "Characterization as independent or dependent is not based upon exclusiveness of performance of all functions without a particular area, but upon the majority of them" (p. 261).

Licenses renewed, reinstated, and in effect, 1960–64

	Professional nurses		Total licenses in effect [1]	Practical nurses		Total licenses in effect [1]
	Renewed	Reinstated		Renewed	Reinstated	
1960 to 1961	6,028	264	6,645	509	24	627
1961 to 1962	6,235	327	6,970	575	20	701
1962 to 1963	6,473	323	7,218	651	35	783
1963 to 1964	6,792	305	7,535	723	40	866

[1] The total number of licenses in effect includes some licenses that may have been issued in the previous fiscal year, as all licenses initially are in force from the date of issue until 1 year from and after the 1st day of the following January. Subsequently, licenses must be renewed annually.

Maine State Board of Nursing—Inventory of currently licensed practical nurses, June 30, 1965; licensed practical nurses employed in Maine, license renewed for 1965–66

County	Total number renewed	Number actively employed	Type of employment				Age groups of licensees			
			Hospitals	Private duty	Nursing home	Doctor's office, etc.	21 to 30	31 to 40	41 to 50	51—
Androscoggin	63	47	30	4	10	3	24	6	14	15
Aroostook	95	72	68	2	0	2	38	12	24	17
Cumberland	95	76	54	12	8	2	33	10	20	27
Franklin	16	7	2	2	2	1	6	1	7	2
Hancock	26	18	11	1	6	0	13	3	3	4
Kennebec	84	70	53	5	9	3	26	7	19	31
Knox	19	16	11	5	0	0	3	3	2	2
Lincoln	8	3	2	0	1	0	2	1	1	2
Oxford	24	17	12	2	2	1	6	5	5	8
Penobscot	75	52	38	9	5	0	17	2	18	41
Piscataquis	5	4	4	0	0	0	1	1	1	3
Sagadahoc	9	7	6	0	1	0	6	1	1	1
Somerset	36	22	17	1	2	2	13	2	9	14
Waldo	6	4	1	0	3	0	0	1	1	4
Washington	14	7	2	1	4	0	4	2	3	4
York	16	25	19	3	2	1	5	5	11	6
Total	591	447	330	47	55	15	197	62	139	181

Senator Moss. I am interested in your report that on the number of registered nurses available Maine is a bit above the national aveage, but in practical nurses, Maine is below. Do you know the reason for that?

Miss FLAHERTY. I believe the biggest reason is that under our manpower development and training throughout the country there have been developed a great many practical nursing programs. In Maine, we do use manpower development and training funds. We are very protective, however, of our standards for qualitative schools, and we have been able to work with manpower to hold on to these standards. Also, it has been a fact that all of the classes in the present schools have not been filled. Our three schools of practical nursing under the vocational education department of the State admit two classes yearly, usually September and March. The September admission poses no problem, has not for a number of years; but the quota for the students has not always been filled in March.

You might be interested to know that since 1954, when the first school under the vocational education department of the State was established, there have been 559 students to graduate from those programs. We do have another practical nursing program in a Catholic hospital in the State. They have graduated one class. They will be graduating the second class in August.

Senator Moss. The fact that there are approximately a thousand of your patients in nursing homes that do not have available to them licensed nursing service would indicate that there is a considerable demand for licensed practical nurses as well as registered nurses, and I would assume that this would add considerable pressure to the desire to graduate more in the State.

Miss FLAHERTY. Yes. I think that is true, Senator Moss. I think it would be of interest to the committee to look at the inventory of the practical nurses in Maine. This has been prepared for June 30, 1964, and also June 30, 1965. You will note that in 1964, 421 actively employed licensed practical nurses there were only 51 employed in nursing homes.

Also, for June 30, 1965, 447 actively employed (these are renewal of licenses only, does not include those licensed for the first time), there were only 55 employed in nursing homes. So I believe that we must look at something more than the number of licensed practical nurses we have in the State. I think we need to look at why the practical nurse is not being employed in nursing homes.

Senator Moss. Miss Flaherty, the nursing functions which meet your definition of professional nursing, are these common and recurrent functions in nursing homes?

Miss FLAHERTY. I could not answer directly. My experience with nursing homes actually is quite limited. I would agree, however, with Mrs. Nackley that there should be some professional nursing supervision.

Senator Moss. If there are people in the nursing home that have various degrees of illness incident to age, it would be necessary for somebody to perform those functions that you described, which are the functions of a nurse. Therefore, if there were no licensed nurse available, there would be nobody competent, at least under the standards laid down, to perform those services. Is that right?

Miss FLAHERTY. This is true.

Senator Moss. So it follows, then, your further statement when you say you agree with Mrs. Nackley that there ought to be a licensed nurse available or at least supervising the work done in every nursing home?

Miss FLAHERTY. That would be true. I do believe this. I would say that again the Division of Hospital Services did request the board of nursing to evaluate nursing needs of the patients in a selected nursing home, which I did do for the board. Now this was done in one home only, so I cannot generalize on the findings. At this one home, study of the physician's orders, and the nursing techniques needed by the patients indicated that there should have been a professional nurse. In fact, the board agreed there should be a professional nurse in this particular home.

In discussing with the operator at the time of the visit about his intent to get a professional nurse, he did identify that economically this was very difficult for him. In fact, he said that he had a nurse available, but he could not afford to pay her.

Senator Moss. Thank you.

Senator Neuberger.

Senator NEUBERGER. The reason that this large percentage of patients in nursing homes do not have a nurse might not be due to the lack of supply, but the unwillingness of the nursing home to employ someone. Could that be possible?

Miss FLAHERTY. I don't know whether it is or not, Senator Neuberger. I think if you will look at the professional and registered nurses in Maine—this is the 1963 report, you will note of the 5,960 total number of nurses in the State, that 58 percent of these were actively employed. So that we had over 2,000 nurses throughout the State who were not actively employed.

Senator NEUBERGER. Would you consider it satisfactory that over 50 percent of the nursing homes in Maine, according to this report signed by Dr. Sullivan, do not have a registered nurse? Would you call those homes satisfactory?

Miss FLAHERTY. No, I do not. I believe the registered nurse should be in there. The question of supply and demand, I think, cannot be answered until we really know why——

Senator NEUBERGER. I think there might be a tendency in the nursing home where they receive such poor care—and I consider it terribly inadequate for these old-age assistance people—to cut down on every possible costly service that they could perform. But the thing that bothers me most of all—and I agree that some care to patients can be done without a registered nurse—but here you have the doctor taking care of the patient. As you yourself said, there is nobody in the home, no nurse to carry out what the doctor prescribes. So, it would almost look as though standards weren't high enough or the licensing was wrong, or some link is missing.

Miss FLAHERTY. I think you have here the standards in effect and they do not at the present time require a registered nurse. I think that the Professional Nursing Association, and the Board of Nursing also, do need to think in terms of the future and what the impact of the medicare is going to be on nursing homes and how you are going to provide some professional nursing supervision for every home.

I think there are many ways we can do this. But it seems we have to sit down with the nursing home people and decide what is feasible for our State to bring about the standard of care which is required.

Senator NEUBERGER. I think you have to give them enough income so that they can afford to take care of them.

Senator Moss. Senator Muskie.

Senator MUSKIE. I hesitate to ask any more questions. We have several more witnesses. Let me ask just one question, though. Would it follow that in most of those homes that have no registered nurse that violations of the Nurse Practicing Act are occurring regularly'?

Miss FLAHERTY. If it is in violation in the area of practice, Dr. Fisher cited that we had an attorney general's recent interpretation that aid nursing personnel could work under the direction of the physician. Actually, this does not refer to the registered nurse or practical nurse. He gave an exception which is cited in the second paragraph of the statute in which it says:

> This chapter does not affect or prohibit the employment of persons functioning under supervision as nursing aids, attendants, orderlies, or other auxiliary workers in private homes, hospitals, nursing or rest homes, or institutions.

The attorney general's interpretation here was that the law did mean supervision of auxiliary personnel could be done by a licensed physician or a dentist, as was so stated. However, if a person were doing professional nursing practice, then, yes, there would be a violation of the statute and prosecution of the individual could be initiated.

It would mean finding and identifying the specific act of a specific person.

Senator MUSKIE. You would have to have proof.

Miss FLAHERTY. That is right.

Senator MUSKIE. But you would think it is inevitable that if there is inadequate coverage of a nursing home by a licensed nurse, either registered or practical, that if nursing care is being provided there must thereby be violations of the Nursing Practice Act?

Miss FLAHERTY. Yes, I would think there probably are.

I would like to make this one remark. Dr. Fisher, I think, referred in his testimony which was by observation when he said that the earlier concept of nursing homes, you know, has long been outdated but there is still some hangover in this area.

I think this is so true, because in the areas of medication, I observed in this home personally, it was the "patient in a home" concept rather than a 20-odd patient institution for specialized or skilled care.

Senator Moss. Is there reluctance on the part of the licensed nurses to work in nursing homes?

Miss FLAHERTY. I would say that from the number who are employed that there may be. I think it does go back to this: quality care and quality practice do attract qualified nurses. I think, too, it might be related to—I don't know whether it was Dr. Sullivan or some of the questions Senator Muskie had about physicians—when there isn't a dynamic program nurses may not be as attracted to the care of patients whose prognosis might be poor.

Senator Moss. Thank you, Miss Flaherty. We do appreciate your testimony. Your testimony has been excellent. We wish we had more time to talk with you.

Mr. Philip Reiman, the administrator of the Maine Medical Center. Is Mr. Reiman here?

We are glad to have you, Mr. Reiman. We look forward to your testimony.

STATEMENT OF PHILIP REIMAN, DIRECTOR, MAINE MEDICAL CENTER

Mr. REIMAN. Thank you, Senator Moss.

I am director of the Maine Medical Center, a 400-bed nonprofit general hospital.

Mr. Frantz has suggested several areas in which I might have some information that might be of interest to the committee. In view of what has been said already, I can make it extremely brief.

Basically, our experience with nursing homes in this area in Portland has been favorable. We have been able to arrange transfer of our patients needing nursing home care with a minimum of difficulty. I am pleased to be able to state that in the main the patients that are returned to us from nursing homes because of acute problems have come to us in good condition.

Obviously, we, as many others, would like to see more larger, newer, better equipped nursing homes. It is a known fact that general acute hospitals must have places like nursing homes to transfer these patients to. They should not use general medical surgical beds for long-term care. This is the reason for hospitals establishing utilization committees and many other pertinent things.

Now one of the areas that Mr. Frantz thought might be of interest would be the kind of things that a general hospital might anticipate hoping to find in nursing homes if a nursing home were to affiliate with a general nonprofit hospital.

I feel that the basic premise to start on such an exploration would be to follow the recommendations put out by the American Hospital Association, which I have been told by Mr. Frantz the committee has, the 11 points which say that they shall have beds for patients' care and be licensed, and so on.

To me, the important thing I might add is, in the State of Maine how might such a discussion be initiated between general hospitals and nursing homes. The Maine Hospital Association, the president has just told me, has a newly appointed committee to explore the liaison between hospitals and nursing homes. We, the hospital association, have been working with the Maine Nursing Home Association, and it would appear evident to me that if these two organizations could work together that we could meet many of the demands that the nursing homes need and they could meet some of the things we would need. So that we could work out an affiliation agreement.

Senator MOSS. Thank you, Mr. Reiman. I take it that you don't have any formal affiliation arrangement with nursing homes, but that you have a rather loose understanding that works out very well. Is that right?

Mr. REIMAN. Exactly so. Twenty-seven percent of our patients are medically indigent. Many come from nursing homes. Many leave us and go to nursing homes.

Senator MOSS. Do you have any problems that arise in connection with patients' records in transferring between hospital and the nursing home?

Mr. REIMAN. We have trouble with some of our house officers, interns, and residents, in not preparing as complete a record as they should, so that the nursing home operators have adequate knowledge of what treatment has been done and what should be done.

Senator Moss. The performance I take it may be a little better from the nursing home into the hospital than from the hospital back into the nursing home?

Mr. REIMAN. Yes; and I think a little different. On our staff we have the house staff to help take care of the patients for the private physician. So we can build up a record more easily. This is one of the problems of our medical education department, to try to instill in our young men the necessity for adequate records to be transmitted with the patients.

Senator Moss. When the medicare bill becomes operative and your elderly patients are entitled to nursing home care up to a hundred days provided they are transferred from a hospital first, do you see a great increase in the problem that you have of moving people then from the hospital into nursing homes? Do you think this is a wise provision or would you think it would have been better if they could go straight to a nursing home?

Mr. REIMAN. I am not sure I am qualified to answer. Certainly the hospitals in this area of the State are all taxed to their capacity at the present time. Finding more patient-days in an acute hospital is going to be difficult. I don't know. It is going to present problems. Yes.

Senator Moss. I think your answer that your hospital capacity is taxed now and that any sizable increase would place maybe an intolerable burden is partly an answer to what I was asking. On the other hand you might expect some degree of relief when elderly people are entitled to go to a nursing home. You could perhaps release some now who remain in the hospital when they could properly be cared for in an adequately staffed and supervised nursing home.

Mr. REIMAN. This is so but to go back to the beginning I said that basically we had no real problem in being able to transfer our patients out. That does not mean that there are not exceptions. Overall we are reasonably pleased with what we are able to do today.

Senator Moss. A hospital of course would be quite concerned with the standards observed by the nursing home in sending their patients on to be cared for in a less specialized institution than the hospital?

Mr. REIMAN. Certainly.

Senator Moss. Thank you.

Senator Muskie, do you have any questions?

Senator NEUBERGER. No questions.

Senator Moss. Thank you very much, Mr. Reiman. We appreciate your very fine testimony.

Senator Moss. Mr. Ralph Farris, Jr., counsel to the Maine Association of Nursing Homes. Also with him will be Mr. Kenneth Robinson, executive director, Maine Association of Nursing Homes. We will be glad to hear you gentlemen.

STATEMENT OF RALPH FARRIS, JR.; ACCOMPANIED BY KENNETH ROBINSON, THE MAINE ASSOCIATION OF NURSING HOMES

Mr. FARRIS. I am Mr. Farris. I believe the committee does have my statement which was prepared.

Senator Moss. We do have this before us, Mr. Farris. I may say that I will be glad to have the entire statement placed in the record and you may highlight such parts as you wish to do or point out any specific additional information you want us to have.

Mr. FARRIS. Thank you, Senator. I will not read the complete statement and I may highlight parts of it but there have been so many questions directed to various people that I would like to take most of the time to provide an opportunity for the committee to ask questions.

I have made some notations in regard to questions which have already been asked and if we cannot supply answers we can give the reasons for some of these problems.

Senator Moss. Very good.

We will place your entire statement in the record, Mr. Farris.

(The document referred to follows:)

PREPARED STATEMENT OF RALPH W. FARRIS, JR., COUNSEL, MAINE ASSOCIATION OF NURSING HOMES

My name is Ralph W. Farris, Jr., of Gardiner, Maine, counsel for the Maine Association of Nursing Homes.

The association has exercised leadership toward improving general conditions in Maine since its formation in 1954 for the purpose of promoting the highest possible standards in care, sanitation, and safety for patients. It cannot afford a full-time staff but has maintained an active executive committee which meets periodically with the commissioner and staff of the department of health and welfare as well as with various other medical and health organizations. The relationship between the association and the department has for the most part been harmonious. We have, however, engaged in some heated controversy. I can recall in 1958, when Senator Muskie was Governor, the association publicly criticized the department for its failure to improve nursing home standards. The commissioner's reply was that the State could only establish standards commensurate with rates that could be paid from legislative appropriations. Two years later the department was again severely criticized by the association for not "clamping down" on low standard homes. The commissioner's view was that the standards established by the department represented "a compromise between the ideal and what the nursing home operators can practically do." This was not an excuse but a basic fact and our inadequate State aid rate structure is still a basic problem.

In 1960 the State was paying a monthly rate of $165. In 1964 the rate was increased to $200 but this does not begin to absorb the increased cost of operation. The cost increase for general commodities since 1960 is common knowledge. There have, however, been additional factors in Maine which have tended to more rapidly accelerate rising costs than would normally be anticipated. The Nurses' Act which became effective in 1962 did not contain any so-called "grandfather rights." These women with years of experience in practical nursing and in many instances, trained graduate nurses, were reduced to the status of nurses aids. Nursing homes had just about completed installation of activated fire alarm systems when it became imperative that they be replaced with sprinklers. The association endorses sprinklers but we do point out that installation represents a substantial financial investment particularly in rural areas where public water supply is nonexistent. Proprietary homes have been exempt from coverage under the State minimum wage law due to their status as semipublic health facilities and for the further reason that legislatures until this current year have recognized that the State has not paid an adequate rate for patient care. These homes are now to be included under minimum wage and even though the domestic employees are the only ones who are legally affected, it will inevitably cause another round of wage increases for employees currently receiving more than the minimum. In September of this year laws liberalizing workmen's compensation and employment security benefits become effective. The association was not opposed to legislative changes in these latter two categories but we mention it to show that payroll costs will be substantially increased. Thus it can be seen that the industry is experiencing what might be termed a peaking period in the cost of operation.

Proprietary owners have traditionally attempted to maintain a homelike atmosphere and it is hoped that we are not heading into an era where this atmosphere will be replaced by one of institutionalization. We are not resisting change but for the most part the changes which are now being undergone will not drastically improve patient bedside care.

Maine has a large geographical area but is sparsely populated. This renders it impractical to operate the more profitable large-bed nursing home. Patients dislike being too far removed from their local community because of the difficulty for visitation by friends and relatives. These visits are important and many other aspects upon which we sometimes place primary significance are, from the patient's viewpoint, actually of secondary importance.

Our nursing homes have for many years cooperated and participated in various workshops and seminars relating to their business and recognize the importance of continuing education even to the extent that they have enrolled for special courses at Northeastern University in Boston. There has been active participation in the Maine Multi-Disciplinary Health Study Committee as well as the medical advisory committee to the State department of health and welfare. In 1957, the association established a standards committee which has actively worked toward improvement of general conditions. The association was quick to endorse the recent recommendations of the medical advisory committee as actually this was more or less a compiiation of many recommendations which the association had singly recommended to the industry over a period of years. Some which are utilized in most homes and will soom be imposed upon all will include:

1. Adoption of definition of "nursing home" as established by the Federal Government.
2. Evaluation and classification of patient at the time of admission by a team comprised of physician, nurse, and social worker.
3. Establishment of periodic team reevaluation of patient.
4. Conducting of continued educational programs for nursing home staff.

The association is presently giving consideration to the matter of absentee ownership and will undoubtedly submit recommendations to the department of health and welfare or, even possibly to the State legislature. The State aid rate structure is also being reviewed and possibly there should be a return to the system of flexible rates such as existed a few years ago. This presents problems but it is nonsensical to pay a higher rate to homes which are currently below desirable standards.

The association has constantly offered its services to the department of health and welfare, office of the attorney general, and legislative committees. The Department is the only one to have utilized our services and there have been several instances where our cooperative efforts have resulted in the homeowner surrendering his license without fanfare and without the necessity of litigation. Voluntary compliance is much more effective and much less expensive than compulsory enforcement.

A most serious problem confronting our Maine nursing homes is their public image. For example, most people are under the impression that this committee has convened in Maine because a State legislator "demanded a Federal investigation." News media which have been fair in editorials have been somewhat irresposible in their reporting. More people read headlines and lead stories than editorials and therefore editorial content does not create the public image. A few years ago a newsman wrote a series of feature articles on nursing homes. The true picture was so distorted that upon completion of the series, the managing editor ordered the newsman to write an additional article. The writer's position is best explained in his own words:

"Unfortunately, a writer is faced with the problem of making sure some people read his articles. Standard newspaper practice is that you lead with the semi-sensational. If you don't, the theory goes, no one will read the stuff. The semi-sensational is not usually the better side of something; it is, again by standard newspaper practice, very often the worst side. Now, this is not to condone usual newspaper practice. There is plenty of room for change, plenty of room for improvement. Several times * * * I would submit articles and changes would be made, primarily in what came first * * * I also do not write the headlines on the stories."

This type of irresponsibility is too often characteristic of some publicity-seeking politicians. The association has attempted to be responsible and we ask that public office holders and newspapermen make the same attempt.

In conclusion, we feel that three important areas for consideration are:

1. Payment of an adequate rate for State aid patients.
2. Intensive specialized training in geriatric nursing for bedside care.
3. Encouragement in developing medium size homeowner nursing homes.

Inasmuch as similar hearings have been held by this committee in other parts of the country, it is hoped that the news media will be made aware of the fact that its appearance in Maine is simply a part of a nationwide inquiry to ascertain whether the Federal Government is receiving proper dollar value for expenditures at the State level in care of the elderly.

Mr. FARRIS. I am particularly disturbed at the public image that is being portrayed today in relation to nursing homes. Of course this committee realizes, having been here and having heard the testimony, that this is pretty much of a fiction and certainly not representative of the facts as have been found to exist.

I do feel it is unfortunate that Senator Neuberger was unable to be in the room when Dr. Bonney told of his experience in traveling from Kittery to Machias and interviewing 50 patients, all in different nursing homes, and observing how happy and contented they were.

We feel this is much more typical of what is actually the situation in the State of Maine. We recognize that there is more to be done but we do feel that we have come a long way in the field of nursing care. The association does stand ready and has, as may be seen from the statement, given cooperation to all agencies.

Senator Neuberger inquired as to the activity of the association. I might point out that it does not have a full-time staff by any means, one reason being that it has not been a particularly profitable business in the State of Maine. In particular, there have been questions in regard to the 2 years as related to nursing in the State of Maine.

One would have to be somewhat familiar with the history of nursing in the State to understand this. Following World War I the hospitals made an effort to obtain young ladies who had completed 2 years of high school, and that is what the law required, to come into the training program in the hospitals.

There was a shortage of nurses at that time. They were trained, graduated, and many of them became registered. Then subsequently 4 years was made the prerequisite to becoming an R.N. However, many who were graduated and who became registered nurses had 2 years of high school.

There were many who went into hospital training programs. There were also many who graduated from accredited hospitals but who did not obtain their license even though they continued to work in the nursing field. For example, we have had graduate nurses in hospitals serving in a supervisory capacity as superintendents but when the Professional Nurses Act was written in 1959 there was no grandfather provision. If they could not pass the examination they could not have status as a nurse and if they did not have the 4 years high school they could not take examination until they acquired 4 years high school or its equivalency.

But time will take care of this problem and very shortly. That is the reason for the regulation Dr. Fisher promulgated. It ties in with the history of nursing in the State of Maine. Now as I say, I cannot help but feel that what has been presented as a bad side in regard to nursing homes has been pretty much fiction.

I became very much disturbed or interested when Mrs. Gardner was here with Mrs. Carswell and when she mentioned she worked in six nursing homes and only three met a desirable standard. So, I obtained a copy of the hearing officer's findings in the case that was mentioned earlier.[1] This was about a year ago when he made his findings and at that time Mrs. Gardner did testify. In the hearing

[1] See app. B.

officer's findings he refers to the testimony of Mrs. Gardner and he says:

A practical nurse employed by the defendant for several months in 1962 and 1963 lacked credibility. Mrs. Gardner stated that some patients were frightened when the owner entered their room, that they screamed and hollered and that "at least two begged me to help them get out." Mrs. Gardner also admitted she had a drinking problem at the time. That on three or four occasions she felt the effects of drinking when she came on duty but she did not have the DT's not while I was employed there. Rev. Walter Colby, a minister, testified on several occasions after Mrs. Gardner had been drinking he would help her get into condition to report for work and he interceded in order to help Mrs. Gardner retain her job.

In other words, obviously the witness in that case was not a credible witness, obviously would not be credible to present, to have testimony acceptable under these circumstances, as of that time at least.

It would have to be brought up to a much more current date so that we would know more about the individual and what the circumstances are in more recent times. Now one other matter which I would like to mention, because Mrs. Carswell created the impression that the nursing home lobby was somewhat sinister. I have been in the State legislature and therefore I am familiar with many of the problems. I would like to point out that the association supported the principle of adopting the Federal standards for nursing homes.

I have the correspondence to the chairman of the committee on health and institutional service, which was Senator Carter, he is the senate chairman and Mrs. Carswell is the house chairman, and at that time we pointed out that we did support the Federal standards but felt that they should be in a rule and regulation as recommended by the Federal Government and its standards put out by the Health, Education, and Welfare Department.

Senator Moss. I am not sure which standard you are referring to.

Mr. FARRIS. Standards in relation to definition of a nursing home. Mrs. Carswell did introduce a bill into the legislature in the last session in which, legally, there was established, by statute, a definition of nursing homes. The association was opposed to having the definition cemented into a statute. In other words, we feel, as does the Federal Government, that it is better to have the flexibility of rules and regulations so that you can change with the changing times.

In any event if it were to be law and a definition by statute, we pointed out some of the inadequacies in the first legislative bill that was presented and corrections were made. Then we pointed out that an interpretation of this could be difficult. In other words, it might be necessary under her definition to have a registered nurse on duty all the time in a nursing home. Of course that would be desirable, but in the State of Maine, as a practical matter, it is absolutely impossible to have a registered nurse on duty all the time. We do have them available to be called in.

You will recall Mrs. Carswell mentioned that she came from her sickbed and spoke on the bill in the legislature and that a representative came back and spoke to one of the lobby. Mr. Robinson and myself were both there after she was asked if it would be legislative intent under this law that it would be necessary to have licensed nurses on duty 24 hours a day. Mrs. Carswell's reply was that the legislative intent would be to have a professional nurse available to administer the necessary drugs and so forth.

Once this legislative intent was established in the record the association had no great objection to the legislative document being enacted into law even though, preferably, it should be handled by rules and regulations.

There have been some questions in regard to the hearing officer set up in the State of Maine. It happened that I was senate chairman of the committee on judiciary when we created the position of a hearing officer to handle hearings for violations by license holders.

The original act called for the creation of the office and set up an adequate salary and so forth, but, legislation being what it is—I don't imagine it is much different in the Congress—money was short and the plan was devised to combine the duties of the hearing officer to handle hearings on all license questions with the duties of the man who handles the hearings on violations of the liquor law and liquor regulations.

That is a full-time job just in handling violations by liquor licensees. When they put the additional duties on the same man, I think they only added a thousand dollar salary and that was with great reluctance, it just was not good legislation and this problem falls squarely in the lap of the legislature for correction.

Senator MUSKIE. Are you saying that his workload is too great now?

That is the reason for the delay?

Mr. FARRIS. Yes. It is the same position that Representative Hathaway held at one time when he was the hearing officer for the liquor commission. Then he left and another gentleman was appointed in his position as hearing officer and then it was decided to combine the liquor commission hearing officer with a hearing officer position which would handle hearings on all other license violations such as nursing homes.

Senator MUSKIE. They are combined now?

Mr. FARRIS. Yes.

Senator MUSKIE. So the workload is too great now?

Mr. FARRIS. The workload is too great. There is only one man. The setup is a part-time job. It just is an inadequate system and it should be made at least a full-time job. I think the problems are big enough so that you need a liquor commission hearing officer separated from the hearing officer on all other license matters. I point this out and I am probably not being too clear but this is the reason for that situation.

Senator MUSKIE. You were senate chairman of the committee when the hearing officer legislation was enacted. Who was behind that legislation?

Mr. FARRIS. I believe it originated from the attorney general's office. There was no uniformity in the conducting of hearings by various department heads or their representatives on matters of license suspension.

Senator MUSKIE. In other words, the pressure for the establishment of the hearing officer did not come from the people whose activities were being regulated.

Mr. FARRIS. No.

Senator MUSKIE. But from the governmental agency which had the responsibility for administering?

Mr. FARRIS. That is correct.

Senator MUSKIE. I see.

Mr. FARRIS. I might also point out, in highlighting portions of the statement, that this is not a new problem on the matter of standards. The association has, for a long time, been pushing for improved standards. You will recall, Senator Muskie, when you were Governor in 1958 that the association did criticize the department for not more rapidly raising standards, and the commissioner gave the same reason then as still exists. And 2 years later, in 1960, we again had the criticism, and his answer was the same, and the same basic problem is here, at least one of the factors and that is an inadequate State aid rate structure.

Senator MUSKIE. May I reconstruct that situation a bit? Was it not the 1957 legislature which approved the program of State aid to nursing homes?

As I recall the recommendation was a half million dollars.

Mr. FARRIS. I think it would have been 1957.

Senator MUSKIE. So the program really started in the latter part of 1957 or 1958 when for the first time the State made a contribution, financial contribution, to the care of patients and felt it could begin to control the standards of care. That began in 1958. As I recall it was the feeling that it ought to proceed slowly until the State gained some experience.

I think it was in 1958, shortly after the program started, that there was this disagreement as to whether or not the State was starting off with adequate standards and it was the substandard——

Mr. FARRIS. It was the substandard home that we were complaining about.

Senator MUSKIE. The argument was that the State was starting at too low a level as to standards and inevitably as to payments, too.

Mr. FARRIS. Yes; now we have had recently a peaking period in the cost of operations. That has come about through the necessity of installing sprinklers to replace the activated alarm systems. We just got the activated alarm systems going and installed when the change came to put the sprinkers in. Of course in a rural state where we do not have a public water supply it becomes even more expensive to install these systems. Then our workmen's compensation laws and employment security laws have been amended, and rightly so, so far as I am concerned, to give greater benefits and that, of course, is going to be reflected in your payroll premiums on what is compensation and also there will be an increase in the employment security law.

Now for the first time in Maine, and probably there is not much justification but still it is a fact of life, the nursing homes will be under the minimum wage laws. They had previously been exempt. Those who are sole proprietors at least are included. The nonprofit is still exempt from the minimum wage.

We have had a committee that has worked on standards. We have tried to police our organization's nursing homes and have been reasonably successful. We did adopt the recommendations of Dr. Bonney's committee wholeheartedly and have a fine working relationship with the Maine Medical Association and the Maine Hospital Association and all of the various disciplines in the health field.

The recommendations are in the statement. We have offered our services to the attorney general and Mr. Robinson as executive director of the association has on occasions gone out with Mr. Carney,

the director of licensing who testified this morning, and they have been successful in prevailing upon people who are not meeting good standards to surrender their license because they were not doing themselves any good, they were getting themselves further in debt and certainly they were not doing the industry or their patients justice.

That of course is the best enforcement, voluntary compliance. And we are continuing programs in the association and we certainly will be adopting all recommendations and also supporting legislation which will bring about improved standards. Actually the three important areas we have considered, and I think they have been well aired today, is on this matter of payment of an adequate rate for State aid patients. I also think we are going to be compelled, if we are to have good nursing care, maybe not professional nursing care, but bedside nursing care, to explore the possibility of establishing special training programs in geriatric nursing.

We are working on it—we feel that possibly a 6 months program—and bring them right in, let them work in the nursing home as part of the program and become geriatric nurses and be licensed for that purpose. Because we cannot begin to fill the need through the professional nurses. For example, in the Veterans' Administration in the State here licensed practical nurses start at $4,500. That is not much money in New York City. It is the same salary scale in the Government, whether in Maine, or Oregon, New York City or Philadelphia but that is a lot more money in the Maine economy than even your registered nurses are being paid in the private hospitals or in the nonprofit hospitals.

We also do want to encourage in developing the so-called medium-sized-home owner nursing home. We feel that the absentee owner will not be able to provide the same care.

That is not necessarily the nursing care but the same interested care as can the homeowner who is there on the premises every day and becomes acquainted with the patient and his problems like Mr. Robinson and his home which I know because in our town he is more or less a father to all the patients, or a brother, and becomes involved in the family affairs.

Absentee ownership eliminates that close person-to-person relationship which I think is one of the reasons that Dr. Bonney found all the patients he saw, the 50 across the State and in the various homes, were happy and contented.

He did not want to have to tell them they must leave that particular home. I think one of the reasons is because of the personal relationship that has been developed. When you consider almost 60 percent of your patients are over 80 years of age there is not a great deal you can do with most of them other than keep them happy.

There are so many things that I would like to have covered and touched upon this afternoon but it is late and I know this committee has things to do.

I would like in the meantime to be available for questions by the members of this committee and Mr. Robinson also will be happy to answer any questions.

Senator Moss. Thank you, Mr. Farris. We appreciate your contribution here today. You have clarified a number of things for us. Do you have any prepared statement, Mr. Robinson, or are you just available for questioning?

Mr. ROBINSON. I am available for questioning.

Senator Moss. Fine. I wanted to ask, What are the requirements for eligibility to belong to your association?

Mr. ROBINSON. No. 1, you have to be a licensed home and for the first period of time we had our own investigating party that went out for the members. We were advised by the American Nursing Home Association that we are affiliated with that any home being licensed within the State should be taken in as a member. A lot of the reason for that was rehabilitation.

I might say then it worked quite well. Several of them at the time were a little bit questionable and through coming to the meetings and workshops we were able to make them to—into much better homes.

Senator Moss. That was the next question I wanted to ask. What program you had for helping to upgrade the homes that were substandard and might tend to give a black eye to the whole association. Mr. Farris mentioned that you sometimes went out on inspections made by the licensing people.

You say you have workshops in addition to that in your association where you try to point out to the home operators how they can improve their standards and do a better job and encourage them to raise the standards.

Mr. ROBINSON. That is right; also, we had several of the members take a course at Northeastern to upgrade the home. In regard to the inspections, just from the last year one home in Belfast whose condition was not exactly right, Mr. Carney and I went down on Friday. On Monday we went out again on another complaint. There was not any nurse in this home between 5 and 7 o'clock in the afternoon.

We found that there were two nurses there. Just last week we had a member of our association who was in a little bit of trouble personally called and asked them if they would not surrender their license which they did.

Senator Moss. Do all of the nursing homes belong or do you only have a percentage of them that belong to your association?

Mr. ROBINSON. We only have a percentage. I say this in all kindness. Here in Maine we have a lot of people in the State of Maine who just don't like to become associated with associations or unions. We have tried our best. Some of them are freeloaders. That is why we are not able to come up with a full-time executive director. We have tried our best. We have made personal calls on at least 90 percent of the homes in the State. Dr. Fisher I think will verify it, that members of the association are not too much of a problem.

Senator Moss. Senator Muskie?

Senator MUSKIE. How many members do you have?

Mr. ROBINSON. We have about 96 at the moment. We have the largest number of beds. We have all the newer homes including the Marcotte home, the Jewish home.

Senator MUSKIE. You represent a little more than 50 percent of the homes?

Mr. ROBINSON. Yes.

Senator MUSKIE. What percentage of the beds?

Mr. ROBINSON. Eighty percent.

Senator MUSKIE. Are you in your association familiar with the crash financing problem Mr. Bird talked about?

Mr. FARRIS. Yes, Senator. I had that marked down here and I just noted I had not touched on it. You asked the question, you mentioned it might be well for the association to counsel. We have counseled and we have warned our members time and time again to make every effort to obtain financing at local institutions.

Mr. Robinson has personally gone to the local banks and helped obtain financing. I know at least in one case that it would not have mattered. It was not a need because of the home operation for the financing, it was a personal problem that the man became involved in.

Senator MOSS. In this connection do you recognize the name Joseph Kosow?

Mr. FARRIS. I don't recognize the name.

Mr. ROBINSON. I don't recognize the name.

Senator MOSS. There is another group, Jacobs Associates, that is in the financing business.

Mr. ROBINSON. I recognize that. They sent out postal cards to I think practically all the licensed homes in the State, if you wanted money, money was available. We said it is much better to deal with the local banks. In case you have trouble they are liable to give you more help so that you could work your way out of it. We have discouraged all along going to the loan sharks.

Senator MOSS. The Jacobs Associates solicited the homes by mail to your knowledge?

Mr. ROBINSON. Yes, I got one myself.

Senator MOSS. What is the name of the home you operate?

Mr. ROBINSON. The Robinson Nursing Home.

Senator MOSS. I appreciated your statement, Mr. Farris, on this absentee owner problem because I think the testimony before the committee would be pretty much along the line as you suggested, that it is difficult indeed for the operator of a nursing home to be devoted fully and wholly to the care and benefit of the patients with absentee ownership.

Are the majority of your homes here locally owned and operated by the owner?

Mr. ROBINSON. They are, Senator Moss. We met with people out of State coming in with the big syndicates. There is one concern here in Maine that has three homes. They do a very nice job. We have syndicates that come in with fast money, could not care less about the patient care.

Senator MOSS. This is something that bears watching, especially with the anticipation of expansion now under the medicare bill, that we do not let this thing get out of bounds, or that the States do not, and we at the Federal level will be very much concerned about it, too.

Do you have any questions, Senator Neuberger?

Senator NEUBERGER. No.

Senator MOSS. Senator Muskie?

Senator MUSKIE. No questions.

Senator MOSS. We appreciate very much your testimony, Gentlemen. I want to make it very clear here that we certainly are not here to pass judgments either one way or the other. We hope that all sides of these problems are aired and made a part of the record.

In fact, I will announce now that any person who has not been able to testify personally here today is invited to submit a statement which can be mailed to me or can be mailed to Senator Muskie or Senator Neuberger as a member of the committee.

If it is a statement that is factual and pertains to the matters that we have been discussing, it will be put in the record and be part of the record and be considered.

I have one letter already which has been submitted to me by Clare B. Connor and that will be included in the record because it is a fair and factual statement that she should be entitled to have in there.

There may be others who wish to be heard in that way. So we will excuse you now, Mr. Fairis and Mr. Robinson.

Mr. ROBINSON. I may say that to the best of my knowledge all the nursing homes which are members of the association do have an affiliation with the hospitals. They have a working condition with all the local hospitals.

Senator MOSS. All your members?

Mr. ROBINSON. All our members. Also they have a doctor on call at all times.

Senator MOSS. Those are two fine additions. I am glad that you put those in the record. These are the things I keep looking for.

Mr. ROBINSON. I thought I was going to be asked that question.

Senator MOSS. Thank you, gentlemen.

We have Mr. Raymond Gobeil, president of the Vermont Nursing Home Association, accompanied by Mr. Berkley Bennett, consultant to the association.

I probably should apologize for not being a very good host here in leaving Vermont until the end of the list. Perhaps I can compensate by reciting the old rhyme about the last and best of the game or something like that.

Mr. Gobeil, will you introduce your associate and proceed with your statement?

STATEMENT OF RAYMOND GOBEIL, PRESIDENT, VERMONT NURSING HOME ASSOCIATION, ACCOMPANIED BY BERKLEY BENNETT, PUBLIC RELATIONS AND ACCOUNTING CONSULTANT TO THE ASSOCIATION

Mr. GOBEIL. Thank you, Senator. We appreciate the opportunity to be here this afternoon.

My associate here is Mr. Berkley Bennett. He is the public relations consultant and also the accounting consultant to the association.

Senator MOSS. Thank you.

Mr. GOBEIL. I am Raymond Gobeil, president of the Vermont Nursing Home Association and owner of the Patenaude Rest Home in Derby, Vt., an 18-bed facility accredited by the National Council for the Accreditation of Nursing Homes.

As necessary background on Vermont, there are 104 nursing homes as of August 1, 1965: 95 are proprietary and 9 are nonproprietary. The average size is 19.7 beds and the patient mix is made up of 60 percent welfare and 40 percent private and there are 2,032 beds. Welfare rates run from $175 to $205 per month.

The Vermont Nursing Home Association represents 55 homes or 57 percent of the total beds—93 percent of the proprietary homes are owner administered while only 7 percent are absentee owned. Until recently there was one other chain home until they defaulted on their mortgage payments and it was found that they had four other mortgages. We use the term "administrator" in Vermont because we feel we have very few operators.

The owner-managed home is primarily a dedicated husband-and-wife team concerned with the care of their patients and with the constant improvement of staffing and facilities. The tender, loving care given in these homes is an important part of the patient security factor in the happiness of the patient, and I stress this. In a nursing home the total patient is treated and not just a condition or disease. Owner, staff, physician, and family must all be brought in on the orientation of the patient and to establish the goal of the care.

The Vermont Nursing Association is proud of its contributions to higher standards. We felt the need for a nursing home advisory committee to act as an adjunct to the State board of health and then to the commissioner of health and encouraged the establishment of this appointed group to assist in the writing of the rules and regulations for better inspections, patient standards, fire safety, sprinkler systems, rehabilitation, evacuation planning, recreation, diversional therapy, and education.

We promoted the classification of homes on the basis of intensive, skilled, and personal care in 1962. When this grouping went into effect in July 1963 only 10 percent of the homes qualified for the top rating. As of August 1, 1965, 65 percent of Vermont nursing homes are classified as group I. This means that 64 percent are staffed by full-time registered nurses.

We successfully helped the department of health in obtaining additional funds to employ another nursing home inspector and the association sponsored a bill in cooperation with the welfare department to establish a nursing home rate-setting committee. Both of these were passed in the 1965 legislative session. Incidentally, we consider our inspectors more as consultants than as policemen.

Northeastern University in Boston reports that a higher percentage of nursing home administrators from Vermont' have attended their administration course than from any other New England State. The association has worked closely with the education department and the health department to develop courses within the State for subjects vital to the managing for a home. Last fall a 5-week course on rehabilitation was conducted; for 2 years a nutritional course for nursing home cooks and administrators has been given; we cooperated in a licensed practical nurse course for licensure under waiver in 1963; two 1-day pharmaceutical courses; and in 1964 the Darling Inn Convalescent Home in Lyndonville was the first nursing home in the United States to qualify under the Manpower Retraining Act for funds to train nurses' aids. There have been seven such courses here since that time.

The association is cosponsor with the department of health for three courses in September; one for charge nurses, one on purchasing, and now another on accounting and finance.

In working with the department of social welfare and we have provided authentic cost studies for 45 member houses for the past 3

years used as a benchmark for welfare payments. These studies have received wide circulation in some 30 other States.

The cost figures came from a standardized manual of accounts as recommended by HEW. We will shortly be cooperating with the new rate setting committee and the welfare department in further accounting refinements based on medicare requirements. We hope to have close to 100 percent of the homes on standardized accounting. To aid further upgrading we publish job descriptions and employment applications for our members.

While not yet a regulation we are supporting minimum educational and financial requirements for licensure and a comprehensive study of areawide planning for all medical facilities. We have also established liaison committees to work with the Medical Society, Registered Nurse Association, and Pharmaceutical Association, Hospital Association, Practical Nurse Association, and the American Nurse Foundation.

In the area of diversional therapy we are using the volunteer services of the Grey Ladies in many homes, but more important is the youth volunteer program developed by us for teenageers and subteens called Sunshiners and Sunflowers. Girl Scouts, 4–H, and church groups, are regularly oriented and scheduled to read to patients, write letters, run errands, play games, et cetera, with patients.

The rapport between oldsters and youngsters is great to see.

But with all this we still have marginal homes in Vermont. Homes that can't cope with changing regulations and patient needs who will surely be phased out in future years. As in all businesses you are bound to have a certain amount of attrition, as in all businesses or professions you have marginal producers whether in manufacturing, retailing, law, medicine, and/or other services.

The well-run homes are using profits, bank money, and SBA loans to constantly improve the minimal level, especially for the number of hours devoted by husband and wife. Still in checking with Senator Aiken and Senator Prouty they have had no letters of complaint about nursing home care or conditions.

We have been interested in the various testimonies presented both here and in the Boston area as to the wants of the various groups. It seems to us that no one has asked the question: What does the patient want, what standards of care, what kind of facility, who should administer their care?

The subcommittee is here to determine nursing home needs and we submit the following areas for further study.

A better working and transfer arrangement between hospitals and nursing homes and an understanding that history and records of patients are necessary.

Greater cooperation from the medical profession not only in patient recordkeeping and in consulting with nursing staffs but in taking an active interest now in geriatric education and practice.

An awakening by the public and the community of the place of the nursing home in our total health services. Also an understanding by the press—not the typical type of sensational journalism that appeared after these hearings in New York and Boston, and I might add, those in Portland.

Overcoming the mass guilt complex that people acquire when they place their loved ones in a nursing home is certainly a large order.

Flexibility in planning for future requirements at the national and local level is particularly important because of the vast differences

between rural and urban needs. Why should it be necessary to orient the farmer to big city living at the age of 75 and vice versa?

Recognition of the shortage of geriatric nurses and an ostrich approach of schools of nursing in training nurses. The glamor of modern hospitals and the learning of operating room techniques are important but what about the psychology of dealing with the elderly. And what about the education of older women who are so well suited to this type of work, and who need to perform duties that are useful and helpful to humanity.

A clarification of the terms "profit home" and "nonprofit home" is a must. Is the implication that profit homes are not as well managed as nonprofit homes?

Is there a difference between the administrator of a nonprofit home on a large salary that shows a loss and he must go to the community with his hand out, and the proprietary manager with a large investment who takes $10,000 for living and no return on his money?

Proprietary homes accept a standard set amount for welfare patients—nonprofit homes cannot operate on this payment and in effect each welfare payment must be additionally subsidized by the community.

Conversely, the more money a physician earns, the better doctor he is—if a nursing home makes a profit they are considered a blight on society. They are milking the public. The experience in Vermont is that homes run by hospitals cannot survive. The De Gosbri Hospital in Burlington was the last hospital in the State to close their long-term care unit in 1964 because the costs were prohibitive.

A more realistic approach to the cost of care. Many States are concerned but few face up to the fact that there must be more adequate compensation if standards are to be raised and even maintained in these days of rising costs, higher wages, increasing governmental control and the larger number of long-term and chronically ill patients.

Thank you, sir.

Senator Moss. Thank you very much, Mr. Gobeil, for a very excellent statement. [Applause.]

The applause is well deserved for this certainly is one of the finest statements we have had in this series of hearings.

Appended to your statement is an article entitled "Good Nursing Homes Make Good News" and also some forms.

These will appear in the record following your statement.

(The documents referred to follow:)

GOOD NURSING HOMES MAKE GOOD NEWS

IF YOU WANT GOOD PUBLICITY, YOU HAVE TO WORK FOR IT BUT THE EFFORT OF WAGING A CONSTRUCTIVE, CONTINUING PUBLIC RELATIONS CAMPAIGN PAYS OFF, VERMONT NURSING HOME ADMINISTRATORS DISCOVERED

Jane Barton

In the face of a discouraging barrage of bad publicity, exposé articles, Senate investigations, and a general feeling that nobody loves a nursing home, the Vermont Nursing Home Association has found a way to make headlines that bring joy to the nursing homes and understanding to the public.

The way to get good publicity, the association members decided, is to create it, and they are waging a vigorous and continuing public relations campaign. The major effort during the 2 years the campaign has been conducted is tied in with the President's proclamation of the month of May as "Senior Citizens' Month."

Governor proclaims week

This year, and last, the week of May 17–23 has been proclaimed by Gov. Philip H. Hoff as Vermont Nursing Home Week, a salute to the elderly citizens in nursing homes and a recognition "of the valuable services of licensed and accredited nursing homes in our towns, cities, and villages, and the contributions they make to the medical and social needs of our older citizens who have been stricken with chronic or long-term illness."

According to Berkeley V. Bennett, public relations consultant to the association, who has guided the membership through the campaigns, the first nursing home week in 1964 was a sensational success. The 1965 week was even better because the individual home owners caught the spirit of the thing and did their own promoting without relying entirely on the efforts of the association's public relations committee.

While nursing Home Week is a statewide project, Mr. Bennett explains, its basic purpose is to help the individual owners and administrators realize what they can do on their own to make friends with press and public, and, incidentally, to build the morale of their employes and patients.

Here is the way he goes about it:

"The first thing we have the nursing homeowners do is contact their local news media to tell them there will be a Nursing Home Week so they can be alerted to possible stories and also potential advertising from suppliers and interested parties in the area. We encourage them to run their own ads along with invitations to visit the home.

"The second thing is to plan a rather extensive open house (see panel on p. 52) in which they announce to the community that they are open for inspection. In planning this, of course, they must work with their employees and outside people.

"The next thing is to contact either a volunteer group that might be working in the home, such as our Sunshiners or Gray Ladies, to help participate, and also talk to church groups, women's clubs, and service clubs to see how these organizations might take part in the open house and Nursing Home Week.

"Florists are encouraged to advertise about sending flowers to patients in nursing homes during this week.

"Finally, we suggest that they contact a local service club or other group and offer to give a talk on some aspect of nursing home work."

The association asks the Governor to proclaim Nursing Home Week, and copies of the proclamation are distributed to the participating homes for display. The homes also display a "welcome" banner provided by the association and their association membership shield. A number of booklets about nursing homes are made available to the homes to hand out to visitors, Mr. Bennett says.

Leaflet tells what to do

Aware that most people know little about what makes news, and less about the best way to approach a newspaper editor, Mr. Bennett issued a 4-page leaflet on "Publicity—Arm of Public Relations," in which he listed topics that have story possibilities and briskly summarized what to do and what not to do when submitting news.

Some of the subjects that offer possibilities for news items which Mr. Bennett listed include:

Anniversaries, awards.
Promotions, deaths.
Club and civic group work.
Sponsored sports.
Forecast of business.
A poll, survey, testimonial.
Nursing home renovation, new building, or addition.
Organization of a tour.
Aid given during a disaster.
Patient's history or lifework.
Rehabilitation programs.
Volunteer aid work in the home.
Weddings, showers, parties.
General policy matters.

"Every one of these items is news," Mr. Bennett pointed out, "but in order to get the most value from news, the nursing homeowner must handle it the way newsmen handle it. Just follow a few easy principles:

"Keep your news stories short and to the point—just essential information—no tributes or glowing adjectives.

"Use names and more names—they make news and help build circulation.

"Photographs are helpful. Call the editor if the event is newsworthy enough and he will send his own photographer, or submit your own print of people doing something. Write the caption on a separate piece of paper.

"Rushing a routine story to the editor minutes before his deadline never has won many friends. Plan ahead; know what the deadline is. The fate of a release often depends on its timing.

"Submit news while it is 'hot'—when practical, no later than the day it happens. If it is days old, it is no longer news."

Explaining that editors all over the country are unanimous in their insistence on a clear, accurate presentation of the story, the public relations consultant included precise instructions about setting up a news release. (See panel on this page.)

He reminded the nursing home officials that radio and television stations like to keep up with local news, too, and suggested that they get in touch with the news editor of the station "to find out how you can assist him."

The advice and encouragement provided by the association produced the desired results. "One of the best things about it was that so many nursing homes did their own publicity," Mr. Bennett reports.

They got plenty of publicity—all good.

Tangible evidence of what a sustained community action campaign can do was provided by the special sections on nursing homes published during Nursing Home Week by two leading Vermont papers, the Times-Argus of Barre-Montpelier and the Rutland Daily Herald, and excellent stories in other papers thoughout the State.

The nursing home owners learned, to their pleased surprise, that newspapers don't insist on running only lurid stories of death and disaster—if the nursing homes can produce lively readable copy stressing the constructive aspects of nursing home care.

A case in point was the story in the Burlington Free Press about a talented musician, a resident in a nursing home for 6 years, who still enjoys playing the piano at the home for the entertainment of the other patients.

This story continued with a subtle bid to kindhearted neighbors to visit another patient in the same home who is alone in the world:

"Not all the patients are as fortunate as Mrs. Blodgett in having a large family to visit her. Miss Bessie Silverthorn, another patient there, has no relatives at all.

"One of her friends * * * sends her a card every week, but this is all the mail she receives. But the 16 women and 4 men in the home are all friendly and happy, and particularly look forward to the visitors who will come to chat with them next week."

An even greater benefit of Nursing Home Week, Mr. Bennett asserts, is the upsurge of interest in giving volunteer service to nursing homes, without regard to whether they are proprietary or nonprofit. Dearest to his and the nursing home owners' hearts are the teenage volunteers attracted by the publicity.

The "Sunshine-Sunflowers"—teenage volunteers—demonstrate the affinity between the very young and the very old. Bright-eyed and uninhibited, the youngsters read to patients, write letters for them, take them for walks, work on handicraft projects, and, best of all, just listen. They perform no service that should be handled by a professionally trained staff member, but they do perform an invaluable service as liaison and interpreter between the nursing homes and the adult community.

"When the kids go home and tell their parents all about the nursing home and what's going on there, the parents get interested, too," Mr. Bennett says.

The teenager program is also being used as a lure to create interest among the girls in considering nursing as a career.

Summarizing the results of the two Nursing Home Weeks, Mr. Bennett observed that "community relations scored high, with many organizations and groups of individuals participating by assisting in various open house activities."

He noted that some homes has fewer people attending the open house programs this year than last—"perhaps because the newness has worn off"—but that the people who attended this year were the "people who count," civic leaders and representatives of community organizations.

"It was a good step in personnel relations, too," Mr. Bennett said. "All homes report that the staff members were interested, cooperative, and enthusiastic. Some of the comments on personnel reaction:

" 'Very cooperative and proud of home.'

" 'Showed great interest by giving extra time.'

" 'Very enthusiastic—employees furnished flowers for tea table and purchased punchbowl for the tea.'

" 'It made employees more aware of the importance of their job and proud of the home.' "

As for the patients, "they loved every minute. They dressed up and took a new interest in their personal appearance. You could have an open house party for them every month."

It's a splendid idea.

How To Plan an Open-House Program

Planning an open house for Nursing Home Week, a grand opening, or an anniversary celebration requires the same basic rules.

Essentially it would seem that an open house should be conducted very much as you would entertain at home. The warmth and friendliness of the reception and attention paid to the guests would be most important.

Here are some specific items to consider:

Be sure to set a definite date and time.

Hold a staff meeting; tell of your plans; seek suggestions. Employees are generally enthusiastic.

Fix up, spruce up, paint up, do some of those odd jobs you've been wanting to get to for some time.

Send personal invitations to doctors, dentists, bankers, hospitals, pharmacists, town officials, clergymen, other opinion leaders (use a formal handwritten card).

Invite Gray Ladies, Sunshiners, Sunflowers, women's clubs, senior citizens' groups, Girl Scouts, 4-H'ers, service clubs to arrange for tea or punch, to help make it a party.

Advertise in the newspaper for the public to see your home.

Notify the radio station for the social events calendar.

Call the news department of the paper to come for a story about the event, about your patients, about your home.

Assign the staff or volunteers to act as tour guides. Corsages or flowers add a festive touch.

Post your VNHA welcome banner prominently on your door.

Give out a booklet to each visitor to take along (*i.e.* ANHA's "Thinking About a Nursing Home" or AMA's "What To Look for in a Nursing Home").

Have everyone sign a guest book so that your patients might read it later.

Remember that you are proud of your home, of your patients, of your staff—you are proud of being a quality VNHA member.

This is the second in a series by the Vermont Nursing Home Association designed to help member homes to create their own public relations program.

Setting up Your News Release

1. Type double space on one side only of 8½ by 11-inch paper. Leave ample margins both right and left for editor's notations.
2. In the upper left-hand corner type the company name, address, phone number, and person to contact for further information or questions about the story.
3. The upper right-hand corner should state the release date—or when you would like to have the story appear.
4. Start the story about one-third of the way down the page and keep it short. If it runs to a second page add (more) to the bottom of the first page. Always end a story with (30) or # # #.
5. Write the most important information first with less important items near the end. Get the what, why, who, how, and when in every story. Try to make each paragraph self-contained so that the editor can cut without affecting the continuity of the story.
6. Do not title the story—editors like to write their own headers.
7. Do not ask the editor for clippings and don't "thank" him for running the story—he doesn't do it as a favor—it's news.

JOB DESCRIPTION

Title: DIRECTOR OF NURSING SERVICE	Monthly Salary Range	to
	In Pay Schedule Group	to

JOB SUMMARY

Supervises and administers nursing service, Assigns duties to professional nurses and non-professional personnel, and supervises and evaluates work performance. Provides for nursing care of patients in unit and cooperates with other members of nursing home team and personnel of other departments in providing for patient's total needs. Identifies and studies nursing service problems and assists in their solution. Periodically visits patients to insure maximum care and to ascertain need for additional or modified services. Supervises maintenance of nursing and medical treatments and related services executed by nurses. Insures availability of supplies and equipment. Adherence to all sanitary regulations to insure that cleanliness standards are being maintained. Assists with research related to improvement in nursing care. Supervises and evaluates the dietary service to insure nutritional and therapeutic diets are served to patients. Performs other duties as assigned.

PERFORMANCE REQUIREMENTS

Responsibility for: Direct administrative and technical supervision of nursing program. Interpreting operating procedures and policies and reviewing work performance to determine conformance to recognized standards. Maintaining quality of patient care, including compliance with physicians' orders and nursing home policies. Investigating and studying trends and developments in nursing practices and techniques and evaluating their adaptability to needs of specific nursing program. Developing, revising, and adapting work techniques and methods for resolution of unusual or complex nursing problems.

Physical Demands: Good physical and mental health. Finger and hand dexterity to handle and manipulate instruments and equipment. Visual and aural acuity to detect changes in patient's condition.

Special Demands: Must have a genuine interest in geriatric nursing. Willingness to work with realization that errors and incompetence may have serious consequences for patients. Understanding, patience, and tact in dealing with patients, their families, and visitors. Memory for details. Ability to maintain good working relationships among staff supervised. Initiative and judgement in determining needs of nursing service and in maintaining patient care in conformance with recognized standards. Skill in identifying problems and in planning their solution Ability to make frequent decisions regarding nursing and administrative problems within nursing home.

QUALIFICATIONS

Education: Graduation from accredited school of nursing; current registration with state board of nurse examiners; advanced preparation in administrative nursing techniques, including ward management and principles of supervision.

JOB DESCRIPTION (Continued)

Training and Experience: Some experience in which administrative and supervisory ability has been demonstrated is preferred but not necessary.

Job Knowledge: Comprehensive knowledge of general nursing theory and practice, including those basic knowledges related to nursing such as drugs, biological, physical, social, and medical sciences, and their application, for better understanding of patient-care problems. Thorough knowledge of principles and methods involved in in-service instruction of nursing and auxiliary personnel, in demonstrating techniques and methods of patient-care services, and in instruction of patient's needs. Familiarity with organization and functions of all departments; and with policies, regulations, and procedures of nursing home. Knowledge of application of principles of personnel administration in assigning, supervising, and evaluating activities of staff.

EMPLOYMENT VARIABLES

Normal working hours may vary to insure adequate supervision of all shifts.

WORKING ENVIRONMENT

Works in well-lighted and ventilated rooms. Subject to minor cuts from instruments and burns from sterilizing equipment. May be exposed to patients having communicable diseases. Possibility of strains due to moving patients or equipment, or injury from irrational patients.

WORK PERFORMED

See JOB SUMMARY

I, _____, have read the above job description, and fully understand the conditions set forth therein, and if employed as, DIRECTOR OF NURSING SERVICE, I will perform these duties to the best of my knowledge and ability.

Date:_____ _____

Signature.

Published by the Vermont Nursing Home Association

JOB DESCRIPTION

Title: NURSE, STAFF, GENERAL	Monthly Salary Range In Pay Schedule Group	to

JOB SUMMARY

Renders nursing care to patients within an assigned unit. Observes and reports symptoms and conditions of patients. Takes and records temperature, respiration, and pulse. Administers medications as prescribed by physicians and notes reactions. Sets up treatment trays, prepares instruments and other equipment, and assists physician with treatments. Assists in administering highly specialized therapy with complicated equipment. Maintains records reflecting patient's condition, medication, and treatments. Bathes and feeds infirm or acutely ill patients. Assists with research related to improvement in nursing care. Assists in maintaining a physical, social and psychological environment which will be conducive to the best interest and welfare of patients. Performs other duties as assigned.

PERFORMANCE REQUIREMENTS

Responsibility for: Knowledge of patient's condition at all times. Providing nursing care according to physician's orders and in conformance with recognized nursing techniques and procedures, established standards, and administrative policies. Recognizing and interpreting symptoms, reporting patient's condition, and assisting with or instituting remedial measures for adverse developments. Assists the physician in diagnostic and therapeutic measures, and administers medication and treatment as prescribed. Assumes responsibility for proper care of complicated apparatus used in treating patients. Maintains accurate and complete records of nursing observations and care. Studies trends and developments in general nursing practices and techniques and evaluates their adaptability to specific nursing duties. Assists in teaching patients good health habits. Assists in training and supervision of nursing service personnel. Cleanliness of area.

Physical Demands: Good physical and mental health. Finger and hand dexterity to handle and manipulate instruments and equipment. Visual and aural acuity to detect changes in patient's condition.

Special Demands: Must have a genuine interest in geriatric nursing. Willingness to work with realization that incompetence and errors may have serious consequences for patients. Understanding, patience and tact in dealing with infirm, chronic or acutely ill patients. Tact and courtesy in dealing with patients, their families and visitors. Ability to maintain good working relationships with personnel of unit and with nursing home staff. Memory for details. Alertness and skill in recognizing and identifying symptoms, iniative and judgement in selecting proper treatment for unusual or unfavorable conditions. Resourcefulness in emergency situations. Works under general supervision.

JOB DESCRIPTION (Continued)

QUALIFICATIONS

Education: Graduation from accredited school of nursing; current registration with state board of nurse examiners.

Training and Experience: Receives in-service training in special areas.

Job Knowledge: Good knowledge of general nursing theory and practice, including those basic knowledges relating to nursing, such as drugs, biological, physical, social and medical sciences, and their application, for better understanding of patient-care problems. Thorough knowledge of principles, methods and techniques involved in performing general nursing services and adapting or modifying standard nursing practices for care of specific cases. Familiarity with organization, functions, policies, regulations and procedures of nursing home as they relate to nursing services. Knowledge of literature and new developments in nursing field.

WORKING ENVIRONMENT

Works indoors in well-lighted and ventilated wards and rooms. Possibility of cuts or minor burns from instruments and equipment. May be exposed to communicable diseases. Possibility of strains due to moving patients, or injury from irrational patients.

WORK PERFORMED

See JOB SUMMARY

I, _____, have read the above job description, and fully understand the conditions set forth therein, and if employed as, NURSE, STAFF, GENERAL, I will perform these duties to the best of my knowledge and ability.

Date: _____ _____

Signature.

Published by the Vermont Nursing Home Association

APPLICATION FOR EMPLOYMENT

NAME MR. MRS. MISS _____ (LAST / FIRST / INITIAL) SOCIAL SECURITY NO. _____

ADDRESS _____ (STREET & NUMBER / CITY / STATE) PHONE _____

NEAREST RELATIVE _____ ☐ WIFE ☐ HUSBAND ☐ OTHER RELATIVE'S ADDRESS _____

BIRTHDATE _____ (MO. / DAY / YEAR) MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED PROFESSIONAL LICENSE NO. _____ TYPE _____

NUMBER OF CHILDREN _____ OVER 18 _____ UNDER 18 OTHER DEPENDENTS _____ (WHAT RELATIONSHIP TO YOU?)

TYPE WORK DESIRED _____ WAGES EXPECTED _____

PREVIOUS WORK EXPERIENCE (LIST LAST EMPLOYMENT FIRST)

DATE	EMPLOYER	SUPERVISOR	POSITION	REASON FOR LEAVING
FROM -	NAME	NAME	TITLE	
TO -	ADDRESS	TITLE	SALARY	
FROM -	NAME	NAME	TITLE	
TO -	ADDRESS	TITLE	SALARY	
FROM -	NAME	NAME	TITLE	
TO -	ADDRESS	TITLE	SALARY	

RECEIVED PAYMENT

UNEMPLOYMENT INSURANCE	WORKMEN'S COMPENSATION	DISABILITY INSURANCE
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
DATE	DATE	DATE

LAST SCHOOL _____ (NAME / GRADE / VOCATION) ☐ YES ☐ NO DIPLOMA

PHYSICAL INFORMATION

HEIGHT WEIGHT CONDITION OF HEALTH ☐ EXCELLENT ☐ GOOD ☐ POOR

HAVE YOU EVER HAD TROUBLE WITH? HEART LUNGS HERNIA

ANY DEFECTS IN? SPEECH SIGHT HEARING BACK

OTHER AILMENTS OR DISABILITIES (SUCH AS ASTHMA, SINUS, BACKACHES, ETC.). LIST:

CHARACTER REFERENCES (PERSONS WHO KNOW YOU WELL, DO NOT INCLUDE RELATIVES OR EMPLOYEES.)

NAME	OCCUPATION	STREET	CITY	STATE	YEARS KNOWN
(1)					
(2)					
(3)					

I certify that all statements made in this application are, to the best of my knowledge, correct. Should any of the statements be subsequently proved inaccurate, I understand the employer may cancel any employment agreement made with me. You have permission to contact my previous employers.

DATE _____ SIGNED _____

(OVER)

VERMONT NURSING HOME ASSN.
STOWE, VERMONT 05672

THE REYNOLDS & REYNOLDS CO., CELINA, OHIO — DALLAS — LOS ANGELES LITHO IN U.S.A.

NAME _____

EVALUATION AND RESULT OF APPLICATION

INTERVIEWER'S ESTIMATE: ☐ DESIRABLE ☐ CHECK EMPLOYERS ☐ NOT SUITABLE

REFERENCES' ESTIMATE: ☐ STRONGLY FAVORABLE ☐ MODERATELY FAVORABLE ☐ ROUTINE
☐ NEGATIVE WHY?

ACCEPTED: JOB ASSIGNMENT STARTING PAY $

DATE TO REPORT DATE STARTED

REJECTED: ☐ KEEP FILE ACTIVE ☐ POSSIBLE PROSPECT ☐ DO NOT CONTACT FURTHER

PERIODIC EVALUATION OF EMPLOYEE

	FIRST MONTH	SIX MONTHS	FIRST YEAR	SECOND YEAR	THIRD YEAR
PROMPT					
DILIGENT					
COOPERATIVE					
RELIABLE					
QUALITY OF WORK					
COMMENTS					

EMPLOYMENT RECORD

JOB CHANGES		RATE CHANGES					
DESCRIPTION	DATE	DATE	RATE	DATE	RATE	DATE	RATE
			$		$		$
			$		$		$
			$		$		$

TIME AWAY FROM JOB

VACATIONS DATE	DATE	SICK LEAVE	ABSENT	TIME OFF	EXPLANATION
			•		

TERMINATION OF EMPLOYMENT

DATE OF TERMINATION:

BASIS OF TERMINATION:

CONFIDENTIAL: SHOULD EMPLOYEE BE RECOMMENDED?

SHOULD EMPLOYEE BE RE-HIRED IF APPLYING?

LAST CHECK: $	AMOUNT	DATE	CHECK NUMBER	DATE PAID

CLAIMS DUE (EXPLAIN):

MAILING ADDRESS:

Senator Moss. I like especially your recommendations which were excellent and follow along my thinking very much. The statistics you gave us about Vermont indicate that about 10 percent of your homes are nonproprietary with about 40 percent of the beds?

Mr. GOBEIL. We represent 57 percent of the total beds. This is the association, itself.

Senator Moss. Have you encountered in Vermont any of these problems of high-cost financing such as we were talking about with Mr. Farris and Mr. Robinson?

Mr. GOBEIL. As pointed out in the presentation we have some absentee homes operating in the State of Vermont. These homes again were bought by corporations from out of State. We have no knowledge of their operations except for the one that we have had an encounter with for the reason that one of our former members had sold the home to this corporation and has recently taken the home over because of default of payment.

This is when they found out there were four mortgages attached to the home that nobody was knowledgeable about.

Senator Moss. Can you identify that corporation?

Mr. GOBEIL. Mr. Bennett is more familiar with this situation.

Senator Moss. All right, Mr. Bennett.

Mr. BENNETT. I was involved with a nursing home that did sell to an out-of-State corporation. Their standard operating procedure seemed to be to come in and make a rather large offer for a home but when the chips are down they will take over the current mortgage and the balance of the purchase price is assumed as a second mortgage by the seller. The second mortgagee of course has no recourse.

Senator Moss. Can you tell me the name of the corporation which was involved in the one you were referring to here?

Mr. BENNETT. This one I am referring to is owned by a man by the name of Kaufman. I am not sure what name they go under. They are located in Boston, however.

The other corporation that we were referring to that defaulted was owned by Mr. Gens and that is out of Massachusetts, too.

Senator Moss. Thank you.

One figure that I would like to underline from your statement, Mr. Gobeil, is that 64 percent of your Vermont nursing homes are staffed by full-time registered nurses.

That is a good high percentage. Is it even higher when you relate it to beds than to just the number of homes?

Mr. GOBEIL. Yes. This would represent a larger number of beds percentagewise. I would like to clarify the full-time registered nurse here. A full-time registered nurse means 40 hours a week, not around the clock. I just wanted this for clarification.

Senator Moss. I am glad to have that. Of course I would expect that in some of the homes there would not be a registered nurse on around the clock but she would be the responsible person to supervise all nursing that went on in the home and would be available at the time that specialized nursing was required.

Mr. GOBEIL. That is right. This does not exclude the fact that some of the homes do have registered nurses around the clock.

Senator Moss. Does your association continue actively to solicit membership from the other nursing homes who do not yet belong?

Mr. GOBEIL. We try to get as many members as we can on the basis, of course, that the stronger association we become the better we can

organize ourselves to elevate the standards and to have everybody understand our philosophy of what a nursing home should be.

We have problems in that area. We have marginal institutions in our State as well as in other States. These people are reluctant to change and they do not seem to want to take the initiative or even to accept the responsibility of belonging to an association which would elevate their own standards and their own principles of nursing homes.

Senator Moss. Is your licensing agency in Vermont quite active in trying to enforce higher standards through the licensing procedure?

Mr. GOBEIL. I am very happy to report that they are. I think this is a venture that we have undertaken together. We want to try to eliminate the people who are hurting us, the people who have not the initiative to run the good homes.

We know that these people hurt us badly as we have seen today. This is right throughout the country, I am sure.

Senator Moss. I am sure it is.

Senator Muskie?

Senator MUSKIE. No questions.

Senator Moss. Senator Neuberger?

Senator NEUBERGER. Because I have been so interested in classification and you are the first one I have heard testify to that today I would like to ask you about it.

What do you do to reward the person who gets the No. 1 rating?

Mr. GOBEIL. The classification is based on a point system. The emphasis is placed on staffing and equipment. I am coming to your question but I have to give a little background here. Whoever is in class I will get 205. Whoever is in class II will get 190. Whoever is in class III gets 175. Other than classification of homes we have classification of patients which I do not advocate.

This is certainly not a good procedure. I think the welfare department is seeing eye to eye with us now on this section. Under this the patient who is classified as the "skilled" patient gets the 205. If he is classified as a personal care patient not requiring necessarily the skills of a nurse, then the nursing home receives only 175. Assuming they are in group I, and then down the scale.

Senator NEUBERGER. Obviously 54 percent of your nursing home owners thought it was worth while to uplift the standards which I think is very good.

Mr. GOBEIL. It was an incentive.

Senator Moss. Thank you. Mr. Frantz has a question he would like to ask.

Mr. FRANTZ. Just one point. Have your members in Vermont received this direct-mail solicitation from the Jacobs Associates offering to lend money?

Mr. GOBEIL. I have never personally received anything but I recall some members mentioning this.

Mr. BENNETT. This Mr. Kaufman soliciting homes to buy, that is the one I recall. This is within the last 4 months.

Mr. FRANTZ. This operation that we heard described earlier today apparently has not been taken into Vermont yet.

Mr. GOBEIL. No.

Senator Moss. Thank you very much, Mr. Gobeil and Mr. Bennett. Your testimony has been excellent and has been very helpful.

Let me say to all you people who have been here today, and many of you have stayed through the entire day of the hearings, we appreciate your presence. It shows your interest and concern with the area in which we are making inquiry.

Let me emphasize again that we as a committee are simply seeking information. We are trying to look at all sides of the question to find out what the problems are and what is being done to meet them in the various States and areas of our country.

So we are not here to pass judgment. We are not here seeking any sensation. If that has occurred, that there has been some sensational report, we regret that because that is not our purpose at all.

You have been a very fine and cooperative group here today. We talked mainly and almost entirely about nursing homes. I would like to emphasize as we close this hearing that we are concerned with the whole problem of long-term care.

Perhaps we did not have enough time to talk about types of long-term care other than the nursing home such as home service, or supplementary services permitting elderly people to continue to live in their own homes and in their own environment. This is superior in my opinion to any transfer to an institution so long as it can be adequately accomplished in the homes of the elderly people.

We certainly need a lot of additional information about that and experimentation as to how we can prolong the length of time that our elderly people can continue to be independent and lead a meaningful life and have interests and ideals and accomplishments even though there their years may grow long in number. And many of our older people are doing this. This is certainly the objective that we want to accomplish.

Let me say once again that anyone who has additional information that they think ought to be before this committee they are invited to submit in writing what they would like to have the committee examine If it qualifies as a factual statement and it is in this general subject area it will be included or printed in the record.

Everything we have done today as well as in the other hearings has been recorded by a court reporter. These hearings will be printed eventually. Any of you who want a copy of the hearings may write to the subcommittee, to me, to Senator Muskie, to Senator Newberger, and we will be glad to furnish you a printed copy so that you again may read the testimony that was given here as well as that which was given in the other cities.

I know I speak for both my colleagues in expressing our appreciation to all of you and to the city of Portland and the State of Maine for the opportunity we have had of coming here today.

The hearing is now adjourned.

(Whereupon, at 5:35 p.m., the subcommittee adjourned, subject to call.)

NEW HAMPSHIRE ASSOCIATION OF LICENSED NURSING HOMES

My name is Louise C. Ford, president of the New Hampshire Association of Licensed Nursing Homes which is organized for the purpose of improving and promoting the standards of care in nursing homes in New Hampshire and bringing about a closer working agreement with the departments of health and welfare and other medical and safety departments.

During the past 2 years we have been working closely with the Department of Health and Welfare in setting up standards to meet the needs of today. However we do not always concur with some of the rulings.

There are 166 licensed nursing homes in New Hampshire which includes such homes as the Odd Fellows home, soldier's home, and Catholic charities.

There are 3,585 welfare patients at present. Fifty to sixty percent of the welfare patients are in licensed proprietary homes. The average size of the homes in New Hampshire is 15 to 20 beds.

Maximum payment for welfare recipients since 1959 has been $5.50 per day or $165 per month—360 days of the year. County homes and infirmaries are paid $6 per day. Hospital payments for MAA patients has been $13.61 and will now go to $16.61 as of July 1, 1965.

Hospital payments for OAA was $13.61 and as of July 1, 1965, goes to $15.61.

In 1959 minimum wage rates in New Hampshire were 85 cents per hour; in 1960, $1; in 1964, $1.15; and in 1965, $1.25.

The minimum wage rate in county and nonprofit homes is 95 cents per hour and they are not subject to the tax levies imposed on privately owned homes, and have access to surplus Government foods and much labor is done by resident personnel.

Social security tax has gone from 5 percent in 1959 to 7¼ percent at the present time and due to rise sharply.

Nursing homes will not be eligible for medicate payments unless they can provide licensed practical nurses and registered nurses around the clock.

Let us be realistic about the existing conditions. Sixty percent of the States welfare cases are in small nursing homes. The average cost of care per day is $7.15 to $7.75. In the larger homes the rate paid by patients per day averages $8 to $15 and the larger homes are reluctant to accept welfare cases.

Small nursing homes average $7 to $10 for private patients.

We are now faced with the problem of requiring licensed practical nurses around the clock and at the present time, and although we would certainly agree to that, we, as well as hospitals, find it impossiible to find them.

As of July 1, 1965, nursing homes in New Hampshire have been granted a raise of 50 cents per day or $180 per month for 360 days of the year. Now we are not exempt from wages, cost of food, light, heat, and taxes for 5 days of any year. The care of these persons is on a 365-day, 24-hour basis and we have to pay for every day of the year.

We are not unmindful of the needs for improvement and enforcement of higher standards in some of our homes, and we are not opposed to paying higher wages, but, although the health and welfare agents are aware of the lack of funds, the legislative bodies fail to recognize the needs for adequate payments for standards we wish to establish and maintain.

By agreement with the State fire marshal it has become mandatory in New Hampshire to have fire detectors in all homes. Sprinklers are almost prohibitive due to the lack of water supplies in many rural areas, and most of the patients come from rural areas.

It is our aim to provide for patients an atmosphere as close to the environment they are used to as is practical. In our opinion, the large institutional-type building is no better than the small homelike nursing home giving excellent care.

Our nursing home operators are participating in various workshops at Northeastern University and participating in educational conventions under the auspices of the American Nursing Home Association and numerous other educational fields.

New Hampshire is largely a rural State and the small- and medium-sized nursing home is more desirable. Patients are reluctant to be moved from their local community because of the difficulty for friends and family to visit, and this is important to the geriatric patient.

BISHOP NURSING HOME,
Westbrook, Maine.

To the Subcommittee on Long-Term Care:

In reference to the complaint of a Mrs. Eva Verrill that she was refused to visit her dying mother: she was never refused admission. I do not have any restrictions concerning visiting hours. People come and go as they wish.

I did request Eva not to disrupt her mother's care and to cease speaking of the dead and dying within her mother's hearing.

Her mother is still alive—very ill to be sure, but the incidence referred to above happened back in May or June.

The health and welfare department representative did not tell me to admit Mrs. Eva Verrill to my nursing home because there had been no refusal in the first place.

Sincerely,

CLARE B. CONNOR, P.N.

P.S.—Ordinarily I would not give this any more thought than any of Mrs. Verrill's previous tirades over the past several years. But—as it is on record—I felt I must speak.

STATEMENT TO BE SUBMITTED TO THE SENATE SUBCOMMITTEE INVESTIGATING NURSING HOMES

Mr. Chairman and members of the committee, I submit these observations and recommendations on nursing homes in the South Portland, Maine, area for your consideration.

The care that is offered in nursing homes and homes for the aged has traditionally been considered as the fulfillment of the precepts of Christian charity. As a clergyman, therefore, I am naturally concerned with this question and encourage all efforts to help these institutions to better fulfill their important role.

From observations gathered in visits to patients in nursing homes and homes for the aged I feel that the majority of those with which I am familiar offer excellent care and the personnel take a wholehearted interest in each patient. The nursing staff seems adequate and conditions of cleanliness, etc., are very good. The conditions in these homes demonstrate the validity of the argument that adequate rates must be charged before health and safety requirements can be properly met.

There are, however, homes for the aged for persons who receive quite limited welfare funds. Naturally they cannot offer care comparable to homes in which a higher rate is charged. It would be disastrous, however, to legislate these homes out of existence simply because they could not fulfill legal requirements which entail large expenses. It is my hope—not that proper health and safety measures will not be enforced—but that sufficient funds will be allocated either to the patient so that he is able to pay a higher rate, or directly to the home so that the expense of these measures can be met.

Finally, any possible legislation which can insure greater personal dignity to the sick and the elderly, enable them to contribute more of their talents and keep them profitably occupied should be given careful consideration.

Respectfully submitted.

REV. J. RAYMOND MCKENNA,
Assistant Pastor, Holy Cross Church,
South Portland, Maine.

APPENDIXES

APPENDIX A

NURSING HOME PATIENT CARE—A STUDY

January 20, 1965

Compiled by Office of Health Education, Department of Health and Welfare, Augusta, Maine

DEAN FISHER, M.D.,
Commissioner, Department of Health and Welfare,
State House, Augusta, Maine.

DEAR DOCTOR FISHER: On January 20, 1965, the medical advisory committee to the department of health and welfare voted to accept the report on nursing home patient care that is transmitted with this letter.

James H. Bonney, M.D., chairman of the subcommittee that prepared this report, has asked me to make particular mention of the spirit of cooperation extended by the nursing home people who were visited in the process of accumulating this data to those who conducted this study. I feel sure that much can be accomplished to improve the care of our chronically ill by a continuation of this mutual effort among physicians, nursing homes, and the department of health and welfare as we all strive to achieve our common goal of better patient care for our elderly citizens.

It is the hope of the medical advisory committee that this report will be of benefit to the department of health and welfare, expecially as it plans for the care of public assistance patients in nursing homes.

Sincerely yours,

GEORGE E. SULLIVAN, M.D.,
Chairman, Medical Advisory Committee.

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Medical consultants: John J. Lorentz, M.D., Bath
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SUBCOMMITTEE, MEDICAL ADVISORY COMMITTEE

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Subcommittee members: Edward T. Newell, D. O., Kennebunk; Wilfred A. Poirier, Winthrop; Carl E. Richards, M.D., Sanford; Warren G. Strout, M.D., Bangor.

Principal medical consultant: John J. Lorentz, M.D., Bath

Principal nursing consultant: Miss Eleanore Irish, R.N., MPH, Yarmouth

Principal social work consultant: Andrew Johnston, ACSW, Waterville

Statistical consultant: Edson K. Labrack, MPH, Augusta, director, Research and Vital Records, Maine Department of Health and Welfare

Statistician: Dale Welch, Division of Research and Vital Records, Maine Department of Health and Welfare

Study coordinator: William J. Carney, MSPH, Augusta, Public Health Adviser, U.S. Public Health Service

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Miss Virginia Bates, R.N., Bangor.
Mrs. Dorothy Burgoin, R.N., Lewiston.
Mrs. Elaine Murray, R.N., Westbrook.
Mrs. Nancy Nichols, R.N., B.S., Augusta.
Mrs. Margaret Russell, R.N., B.S., Augusta.

Social work participants:
Miss Margaret E. Fuller, ACSW, Augusta.
George V. Greeley, ACSW, Augusta.
Henry B. McCrillis, ACSW, Hallowell.
Miss Edith M. Sherman, MSW, Togus.
Smith T. Theiman, Jr., ACSW, Gardiner.

I. THE MEDICAL ADVISORY COMMITTEE

In July 1963, a Medical Advisory Committee to the Maine Department of Health and Welfare was organized consisting of about 25 physicians and representatives from ancillary health services. This group has increased in size until it now contains approximately 40 members. The committee is under the chairmanship of George E. Sullivan, M.D., of Fairfield. Monthly meetings are held in Augusta.

The advisory committee adopted as its statement of purpose the following: "To assist the department of health and welfare in program planning for medical services, i.e.:

"A. Establishing priorities in terms of budget limitations and primary basic medical care needs.

"B. Policy formation regarding amounts and types of care with proper quality and quantity controls so that the department is purchasing at all times the highest standards of medical care attainable in quality as well as—in accordance with appropriate medical need and budgeting limitations—in quantity.

"C. Continuous liaison function between the department and the professional groups represented for interpretation of the department's program; assistance in resolving problems, and carrying out policy between the department and the professions to enable and maintain professional cooperation and relationship indispensable to the adequate administration of a medical care program."

In the fall of 1963, a subcommittee was appointed under the chairmanship of James H. Bonney, M.D., of Portland charged with the exploration of nursing home patient care. This group of five members solicited the assistance of consultants in the fields of medicine, nursing, and social work and determined that a more precise knowledge of nursing home patient needs was indicated.

A questionnaire was prepared, pretested by the consultants, reviewed by members of the Maine Nursing Home Association, and approved by the subcommittee in the spring of 1964. A random sample of 309 public assistance patients in 109 nursing homes was selected for the study.

The State was divided into six geographic areas. A physician chairman was appointed in each area. During the months of April and May a series of community meetings was held in each area to which were invited all of the nursing home operators. At these meetings the techniques of the study were described by the consultants, and those who were to conduct the study in each area were presented.

In June, July, August, and September, the patients were visited by the various physician, nurse, social worker teams. The data was forwarded to the department of health and welfare, division of research and vital records for coding. On November 12, 1964, the first complete copy of all of the tabular data was presented to the consultants.

On November 18, 1964, the tabular data was presented to the medical advisory committee and on December 16, 1964, the first draft of the narrative was presented to the medical advisory committee. On January 20, 1965, the medical advisory committee approved the contents of the narrative and voted to accept the "Conclusions and Recommendations" that are herewith presented.

II. NURSING HOMES MEAN DIFFERENT THINGS TO DIFFERENT PEOPLE

To the patient, nursing homes are the final place of residence prior to death.

To the patient's family, nursing homes are crowded, the quality of care is difficult to evaluate and family members must often be placed in homes at some distance from their usual place of residence.

To the public, disturbed by what they read in McCalls, Consumer Reports, newspapers, and the like, nursing homes are an enigma, with the costs of long-term care a threat to their life's savings.

To nursing home owner, patient care is a business. Only 5 of the 186 licensed nursing homes in Maine are nonproprietary institutions.

To the Maine taxpayer, patient care costs for nursing home services to public assistance recipients amounted to $3,144,088 for the fiscal year ending June 30, 1964.

To insurers, the need for adequate nursing home standards and some form of accreditation, is basic to third party coverage of vendor payments.

To medical economists, there are obvious inequities in the present system of payment for public assistance recipients in nursing homes ($200 per month for all) regardless of the amount or quality of care needed by the patient and regardless of the size, physical facility or staff of the nursing home.

To medical care planners, the fact that in 1962 and 1963 nursing homes in Maine offered more patient-days of care than did acute general hospitals raises questions as to whether nursing home standards should be increased to create hospital-like facilities or hospitals should expand into chronic care facilities.

To physicians, writing in the March 1963 issue of the "Journal" of the Maine Medical Association, nursing homes offer a medical care environment where they find little stimulation in the care of the chronically ill and elderly.

To the professional nurse, the minimum qualifications of nursing services or supervision of nursing home patients in Maine are perilously below minimum for the safe care of patients.

To hospitals, nursing homes represent a resource for the care of the long-term chronically ill patient, but leave unanswered the question of how and when hospitals themselves should enter the long-term care field.

To nursing home administrators, there is considerable concern over the present system of classifying patients in the nursing care ($200 per month rate) or family care ($110 per month rate) category; the criteria are not clearly understood, nor are they uniformly applied, and due to the limited number of nursing home case workers available for this service the frequency of reclassification is limited.

To the division of State fire prevention, nursing homes are usually seen as reconverted old houses requiring many structural changes, safety devices, and sprinkler systems.

To the Maine Division of Hospital Services, the licensing authority, current standards and requirements for nursing homes are administratively unmanageable because the qualitative standards for nursing staffing are in conflict with the Nurses Practice Act, and the quantitative standards for nurse staffing are not economically feasible for small nursing homes.

To the medical advisory committee of the department of health and welfare, a study of nursing home patient care was needed in order to try to clarify some of these above factors so that nursing homes might mean one thing to all people.

III. NURSING HOMES IN MAINE

Nursing homes are the largest, fastest growing institutional resource for the care of the physically ill person in the State of Maine.

1. Patient-days of care

During the year 1960, general hospitals in Maine rendered 956,859 patient-days of care while nursing homes rendered 773,535 patient-days of care. During the year 1963, general hospitals in Maine rendered 1,024,240 patient-days of care while nursing homes rendered 1,044,880 patient-days of care. Over this 4-year period, patient-days of care in general hospitals increased 67,381 days while at the same time patient-days of care in nursing homes increased by 271,345 days. The use of nursing homes during this period increased five times as fast as the use of hospitals.

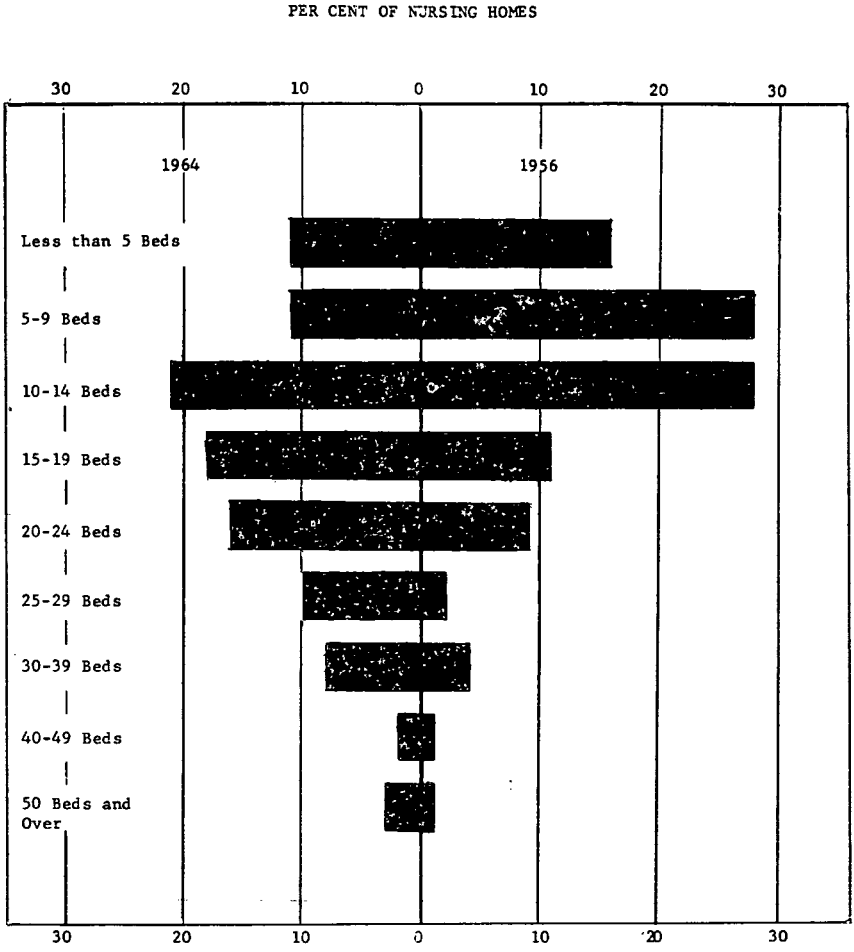
In 1962 and 1963 for the first time nursing homes exceeded general hospitals in the number of patient-days of care rendered to the public in Maine.

The growth of nursing homes in Maine can best be described by comparing current data with a study conducted in the summer of 1956 by the department of health and welfare, the Maine Nursing Home Association and the Maine Committee on Aging, entitled "Nursing Homes in Maine."

2. Size of nursing homes in Maine

(See chart 1 following:)

CHART 1. PERCENT OF NURSING HOMES BY NUMBER OF BEDS, MAINE, 1956 AND 1964



A. Number of homes and beds

On July 1, 1956, there were 221 licensed nursing homes in the State providing 2,963 beds.

On December 1, 1964, there were 186 licensed nursing homes in the State providing 3,623 beds.

Thus, in 1964 there were 35 fewer nursing homes, but 660 more beds than in 1956.

B. Size of homes and bed capacity

In 1956, 29 percent of the homes were 15 beds or larger in size.

In 1964, 56 percent of the homes were 15 beds or larger in size.

In 1956, 44 percent of the beds were in homes 20 beds or larger in size.

In 1964, 66 percent of the beds were in homes 20 beds or larger in size.

Note particularly what has happened to the smaller nursing homes.

In 1956, homes of less than 10 beds represented 44 percent of the total with 18 percent of the beds.

In 1964, homes of less than 10 beds represented 22 percent of the total with 6 percent of the beds.

Nursing homes range in size from 1 bed to 330 beds. It is apparent from the above that the trend toward larger homes has started. There is also a trend away from the reconstruction of houses into nursing homes. The larger new homes are today being specifically constructed as nursing homes.

Of the 186 licensed nursing homes, only the following are nonproprietary:

	Beds
Marcotte Home, Lewiston	330
St. John Valley Security Home, Madawaska	31
Aroostook Health Center, Mars Hill	10
Jewish Home for the Aged, Portland	74
Resthaven Nursing Home, Jonesport	10

IV. NURSING HOME PATIENT CARE STUDY

I. Design and personnel

A. Design alternatives

Two alternatives were discussed in selecting the design of this study. It was agreed that the study should utilize the team approach of physician, nurse, and social worker. However, there was considerable discussion as to whether or not only one, or at most three or four, teams of the highly trained specialists should conduct the entire study; or secondly, whether many people should be involved.

The advantages to the first possibility were increased objectivity and validity of the data. By minimizing differences in interpretation and by limiting the study to highly trained specialists the quality of the data would be of a high level. It is unquestioned that if pure research were the goal, the first alternative would have been chosen.

The goal of this study was to obtain data that could be applied in Maine. It was felt that this goal could be achieved by applied research techniques rather than by pure research techniques. The committee was particularly impressed by the honesty of the physicians who participated in the Thayer Hospital, Waterville, Maine, study, "Demonstration of Rehabilitation Potential of Patients on Home Care or in Nursing Homes 1959 to 1963." A quotation from the summary of "Physiciains Observations in Nursing Homes" is as follows: "Most doctors are frankly not interested in the care of the chronically ill and elderly in the nursing home environment." Another quotation from the same report, "The medical profession has not become interested in this problem and yet their leadership is vital if effective methods are to be found to improve nursing home care."

The choice of study design was intended to involve a large number of Maine physicians in every area of the State so that they might identify more closely with the problems of medical care in nursing homes.

B. The consultants

The principal consultants are: Medical Consultant John J. Lorentz, M.D., medical director, Hyde Rehabilitation Center, Bath, Maine; Nursing Consultant Miss Eleanore Irish, R.N., MPH, public health nursing consultant, Maine Department of Health and Welfare, Portland, Maine; Social Work Consultant Andrew S. Johnston, ACSW, Director of Medical Social Work, Thayer Hospital, Waterville, Maine.

The consultants participated in the development of the questionnaires, conducted the pretest, recruited nurse and social worker interviewers, evaluated the data, and prepared the final report.

The State was divided into 6 areas and 6 social workers, 7 nurses and 38 physicians participated in the study. Each nurse and social worker saw approximately 50 patients while the number of patients seen by each physician ranged from 1 to 50 patients.

C. Physician interviewers

Many studies have pointed out that improved clinical care in nursing homes and the ability of nursing homes to attract qualified nursing staffs is directly dependent upon the amount of physician interest in the care of the chronically ill in the nursing home environment. The fact that this study of nursing home patient care was conducted under the aegis of a statewide medical advisory committee facilitated physician recruiting and allowed this experimentation in

applied research. The decision on choice of design was reached with the understanding that some objectivity and validity in the physician data might be sacrificed for the principle of involving many physicians in a team analysis of nursing home patient care. It is hoped that this involvement procedure will have some benefit in the acceptance of the findings, the application of the recommendations, and result in more physician interest in nursing home patient care.

The 38 physician interviewers were well distributed geographically throughout the State. A physician chairman was appointed by the subcommittee chairman in each of the six areas. This area chairman was given the responsibility of recruiting physician interviewers. Each area chairman acted as moderator for the regional educational sessions and the invitations to the nursing home operators in that area to attend such a meeting were submitted in his name.

One purpose of the area education sessions was to indoctrinate the physician interviewers in the purpose of the study and acquaint them with the contents of the questionaire. Although there was good physician participation at these sessions, not all of the physician interviewers were able to attend.

D. Nurse interviewers

In recruiting nurses for the study, special consideration was given to background and competency in care of chronically ill patients. The nurses selected had preparation and successful work experience in home nursing and rehabilitative care of chronically ill, disabled, and aged patients. The nurses were recruited from different areas in the State. In most instances the nurse conducted interviews in nursing homs in the section of the State where she lived.

The consultants believe that the nursing data is the most worthwhile from the point of view of objectivity, validity, and content. This was to be expected because the major needs of these patients are nursing care needs. The seven nurse interviewers had the benefit of the most intensive indoctrination to the questionnaire and techniques of the study.

E. Social work interviewers

The consultants have agreed that the quality of social work data was limited by the study design. In preparing the questionnaire there were limitations placed on the content and scope of the social work data. The social workers were asked to look at only one small segment of the total patient in an institutionalized setting without recourse to the patients' home environment or family attitudes, nor was there any attempt to analyze the social atmosphere of the nursing home.

The decision to restrict the social workers' role was made because limitations of time prohibited this expansion in the scope of the study. The importance of social aspects of nursing-home care was acknowledged by the consultants, but means for studying these were not a part of this study.

The six social worker interviewers had the benefit of some indoctrination, however. They were all recruited from the Augusta area. Three came from the Veterans' Administration hospital at Togus, two were employed by the Augusta State hospital in addition to the principal consultant from the Thayer Hospital in Waterville.

F. The team approach

Probably the most interesting facet of this study was the team approach. So far as is known this is the first instance of this approach. Other nursing-home studies have generally been conducted with nurse interviewers. In this study, each nursing home and each patient selected for study was visited by a social worker, a nurse, and a physician.

Patients and homes in the study were first visited by the social worker, followed by the nurse and physician in separate visits. Each completed his own part of the study and made his own evaluation on a series of schedules. Several questions were common to all. The team was required to meet at the completion of the individual evaluations and complete a team answer to these common questions.

The nursing homes were alerted prior to the visit of each team member. It was agreed that an attempt would be made to schedule an appointment with the operator prior to the interview. The social worker had the names of the patients selected by the division of research and vital records. Alternate patient names had been selected prior to the social worker's visit in the event the patient originally selected had moved or died. The social worker reviewed the public assistance case record before his visit. The social worker completed schedules A, B, and C. Schedule B was completed in triplicate with one copy to the nurse and one copy to the physician.

Usually the nurse visited the case after the social worker. The nurse completed schedules F, G, and H. The physician was usually last to visit the patient. The physician completed schedules D and E. In 40.9 percent of the visits, the physician followed the social worker into the home by a period of 4 weeks or longer. Interpretations of some of the data should be weighted by knowledge of this fact. Upon completion of visits by each team member, the three gathered together and completed schedule J which contained all of the questions common to the three schedules.

G. Method of preparing final report

The tabular data was prepared by the division of research and vital records. On November 12, 1964, the consultants were able to review the total data for the first time. The nurse and social worker data has had the benefit of review by all of the interviewers who participated in the study. The medical advisory committee did discuss various aspects of the results of this study at their October, November, and December meetings. In addition, the consultants prepared a series of drafts which they reviewed and approved prior to compilation of final report on January 20, 1965.

2. The sample

It must be emphasized that this study is concerned only with the care of public assistance recipients in nursing homes. This decision was reached because public assistance patients make up more than 50 percent of the total patients in nursing homes and because of the danger of infringing on the physician-patient relationship if private patients were used.

The sample consists of 309 public assistance recipients in 109 nursing homes. At the time of selecting the sample there were 1,738 public assistance recipients for whom vendor payments were being made during the month of February 1964. There were 182 licensed nursing homes at this time that contained one or more public assistance patients.

To be included in this study, the nursing home patient had to be a public assistance recipient for whom payment was made to a licensed nursing home during March 1964. The sample was selected from the bills submitted to the department of health and welfare during March and reflecting February patients.

Specifically excluded from this study were 123 patients in 7 facilities other than nursing homes. It can be seen from this sampling technique that nursing homes that did not have public assistance recipients, either by chance or by choice, in February 1964, were excluded from this study.

There are only eight nursing homes in the State that did not accept any public assistance patients in 1964, so that the data on nursing homes is applicable to all licensed nursing homes. Homes which accepted more public assistance patients had a higher degree of probability of being included in the sample. However, the data on patient care is applicable only to the public assistance patients and should not be interpreted to include private patients in nursing homes.

The design of the sample was such that the short-term chronically ill public assistance patient was not included in the study. The February patients selected from the March bills were not seen until June. Therefore, no patient in a nursing home 3 months or less was included in this study.

The sample of 309 patients in 109 nursing homes was selected by probability sampling methods. The sample frame was monthly bills from nursing homes which list individual public assistance patients in the home.

The sample is a single stage random sample, but the sample of actual patients to be studied was selected in two steps. The first step was to make a list of nursing homes in the State, arranged in order of size, with a progressive count of patients. This has the effect of assigning a number to each patient in each home. The number of patients to be sampled in each home was determined by consulting a table of random numbers; e.g., the number 1,326 on the table of random numbers would select the 1,326th patient on the list, who is in a nursing home which contains patients No. 1318–1342 (25 patients). Selection continued in this manner until 309 patients in 109 nursing homes had been chosen.

At this stage only the number of patients in each home was known, none by name. The second step was performed by using the bills referred to above. The patients in each home were numbered and the appropriate number selected by use of a table of random numbers. One or more supernumeraries in each home were selected to take care of patients leaving the home.

The use of the bills as a sample frame turned out satisfactorily. Only 11 patients and 3 homes were lost from the original sample list. This sample technique resulted in an actual study of 298 patients in 106 homes.

3. The schedule

The study schedule contains 34 pages of questions and observations, 22 pages of which concern the facilities of the nursing home and 12 of which concern selected characteristics of the patient, his needs for care, and an evaluation of the care he is receiving. The questions were selected from a variety of sources. The division of pages may seem to indicate that the study was designed to collect more information concerning the nursing home than concerning patients. This is not the case. Data on the 12 pages concerning the patient requires 3 full IBM punchcards to record, while data concerning the home requires 1½ punchcards.

The schedule structure is somewhat highly organized with self-coded multiple choice responses for most questions. Some questions were purposely designed as "open ended" ones because no one knew what kind of answers to expect. Interviewers were also given an opportunity for free expression in special narrative sections which invited, but did not require, their comments on the nursing home, its staff, and the patient. These comments make very interesting reading and many contain perceptive and succinct descriptions of the facilities and general atmosphere of the home.

The schedule is broken into 10 sections, some of which are questionnaires with direct questions to be asked of the nursing home administrator and some of which are schedules of questions to be completed by the interviewers, based on their observations.

In general, the questionnaire attempts to quantify nursing home facilities and patient needs in order to make an objective evaluation of facilities and care. There are also some questions which require the interviewers to make professional judgment based on their observations.

The schedule breaks down as follows:

Schedule A is a caseworker nursing home questionnaire. It contains 20 questions to be asked directly of the nursing home administrator. These questions concern the size and physical facilities of the home, the number and type of patients, the types of patients they are equipped to handle, and the types of patients they prefer to have.

Schedule B contains information from the case record about the patient on file in the division of family services, department of health and welfare. The social worker completes the schedule and furnishes copies to the nurse and physician before they make their visit. This schedule contains information about the diagnoses and institutional care during the past 5 years.

Schedule C is the social worker's evaluation of the patient's need for nursing home care and his rehabilitation potential. The social worker completes this schedule after observing the home and the patient. It asks such questions as: "What was major reason for admitting this patient to the nursing home?" "Does patient need continued nursing home care?" "What is rehabilitation potential of this patient?" etc.

Schedule D is the physician's questionnaire. It contains 17 direct questions to be asked of the nursing home administrator. These questions attempt to quantify the adequacy of the medical care of the patient. It asks questions about the content of the medical record, the extent of medical information made available to the nursing home at admission, frequency of episodes of disease, progress notes, medical orders, physician visits, etc.

Schedule E contains the physicians' observations concerning the patient. This schedule contains the same questions on the need for care as the social worker's schedule plus some additional questions such as: "Do you consider the current treatment regimen of this patient to be adequate?" "In your opinion could this patient benefit by a short period of hospitalization for any of the following—for diagnostic test, for intensive treatment, for rehabilitation?" And questions on the need for assistive appliances, use of excessive sedation, etc.

Schedule F is the nurses' schedule concerning the nursing home. It asks 17 questions concerning the number of staff and their training, and on nursing practices in the home. It also contains the nurses' observations concerning the cleanliness and orderliness of the home, the adequacy of nursing equipment, and efforts to maintain mobility, safety, and optimal health for the patient.

Schedule G is the nurses' questionnaire about care of an individual patient. There are 17 direct questions on the needs of the patient for care. These questions concern feeding, mobility, dressing, hygiene, continency, etc., of the patient.

Schedule H is the nurses' observations. It contains an evaluation similar to that in the social worker and physician sections plus questions on the nursing record for the patient, personal hygiene, decubiti, diet, need and receipt of direct nursing care and assistive appliances.

Schedule J contains the question in common to all interviewers. It is the team summary of the needs and potential of the patient.

There were three revisions and two pretests with the questionnaire. Each revision involved discussion with the coordinator, presentation of new drafts to the consultants for their suggestions, and final presentation of the revised draft to the medical advisory committee for approval. When, in everybody's opinion, the questionnaire appeared to be satisfactory, the consultant team pretested it in three nursing homes (none of which was in the study) and, after making the necessary revisions, interviewing started in June. After all revisions, however, there were still some deficiencies in the schedules.

V. THE MAINE NURSING HOME ASSOCIATION

The 1964 study "Nursing Home Patient Care" could not have been conducted without the support of the Maine Nursing Home Association. Although this organization does not represent all of the licensed nursing homes in the State, it served as a most effective liaison with the nursing homes. With very few exceptions, all of the interviewers reported being received graciously by nursing home administrators and their staff as the interviewers disrupted their schedule to ask the many questions of the study. This study was entered into and conducted with a fine spirit of cooperation among interviewers, nursing home operators, and the medical advisory committee. If the recommendations are to be successfully applied, much credit will be due to the open approach with which the study was conducted.

In January 1964, as has been stated before, the medical advisory committee voted to conduct a study of nursing home patient care.

In February, Mr. Milton Merrill[1] and Mr. Kenneth Robinson, president and executive director of the Maine Nursing Home Association respectively, were presented the first draft of the questionnaire proposed for use. Later that same month, a special committee of the association reviewed the second draft of the proposed questionnaire.

In April, representatives from the association reviewed the final draft and gave acceptance to the study.

In May, meetings were held in Portland, Lewiston, Waterville, Rockland, and Bangor, to which all nursing home operators were invited. The commissioner of health and welfare, the chairman of the nursing home subcommittee, all of the principal consultants and most of the interviewers in the study attended each of these sessions to describe the techniques of the study and answer any questions by the nursing home operators.

On November 19, 1964, all of the data in tabular form was presented to the membership of the Maine Nursing Home Association at their regular monthly meeting. The association made some contributions to the content of the questionnaire, particularly the area concerning frequency and duration of acute episodes of disease. The association has also made some contributions to the analysis of this data having been specifically requested to make comments and recommendations of its own to enhance the value of the study.

RESULTS OF THE STUDY

I. Facilities of nursing homes

A. Financing of care

This study was limited to nursing homes accepting public assistance patients. The occupancy rate of 87.2 percent was consistent for homes of varying size. Only one patient in three in the homes under study paid for their care with their own resources. Public assistance funds financed the care of 60.1 percent of the patients with 53.2 percent of the patients being financed at the nursing care rate of $200 per month. A licensed nursing home may accept boarding care patients. There is a tendency for the smaller homes, those less than 10 beds in size, to accept boarding care patients. It was found that 6.9 percent of the patients in nursing homes were being financed at the family care rate of $110 per month, or the boarding care rate of $80 per month.

B. Staffing of nursing homes

For the purpose of this study, nurses were classified in only three categories within the meaning of the Act To Regulate the Practice of Nursing, title 32, of the Revised Statutes of 1964. The categories are registered nurse, licensed practical nurse, and nurses aid.

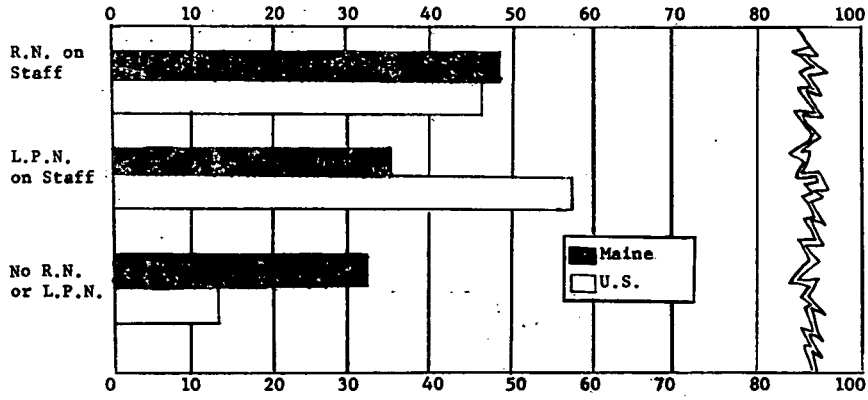
[1] Since deceased.

The use of the term "nurses aid" means any person not licensed to practice nursing in the State of Maine. However, it encompasses a wide range of extremes in the quality of an individual. A nurses aid could mean a graduate of a school of nursing with several years of experience who never applied to become a licensed professional nurse. A nurses aid could also mean anyone without any training who is now employed in a nursing home.

The Maine Nursing Home Association has expressed a willingness to acquire the services of more registered professional nurses and licensed practical nurses. Supply and demand is a problem. Personnel policies, salary, lack of facilities for nurse training in Maine and lack of motivation to care for the chronically ill contribute to this problem.

A comparison of Maine's staffing of licensed nursing homes with the 1961 National Inventory of Nursing Homes and Related Facilities shows the similarity in the registered nurse category. The major difference is that nationally 57.5 percent of the homes have a licensed practical nurse on their staff in comparison with 34.9 percent of the homes in Maine. A major problem is indicated by the fact that 32.1 percent of the homes in Maine have neither a registered nurse nor a licensed practical nurse in comparison with 13.3 percent nationally. Thus, approximately 1,000 patients are in nursing homes without the benefit of a licensed nurse. This has implications not only for patient care but also for possible violations of the Nurse Practice Act.

CHART 2. PERCENT OF NURSING HOMES BY PRESENCE OF SPECIFIED KINDS OF NURSING PERSONNEL IN HOME DURING WEEK PRIOR TO STUDY, MAINE, AND PERCENT OF HOMES WITH SPECIFIED PERSONNEL, UNITED STATES, 1961



In order to appreciate the significance of this chart, the following is extracted from the "Amendments to Standards and Requirements for Licensed Nursing Homes of the State of Maine, Department of Health and Welfare, Division of Hospital Services":

"In consideration of a licensed nursing home, an establishment must meet the following minimum qualifications of nursing service or supervision:

"I. To fulfill the requirements of acceptable training or experience, the person supervising patient care shall be either (*a*) a registered nurse; (*b*) a licensed practical nurse; (*c*) a graduate of an approved school of nursing; (*d*) or a person who is a high school graduate and has had any combination of training in recognized schools of nursing or practical nursing and acceptable experience totaling 4 years; (*e*) at least 2 years of high school education plus 5 years of acceptable experience.

"II. To be licensed as a nursing home, an institution must provide a minimum of an average of 2½ hours of nursing staff time per patient per day up to and including 20 patients and 2 hours per patient per day for patients in excess of 20 up to a total of 35 patients. One-fifth of the required staff hours must be provided by nurses meeting the qualifications of paragraph I. If the operator of the institution is personally providing patient care, she will be assumed to be providing no more than 60 hours per week of patient care. In institutions of over 35 patients, the department will determine staff adequacy in each instance."

C. Availability of nursing time

Less than 1 percent of the homes provided registered nurses full time, 24 hours a day, 7 days a week prior to the interview; 50.9 percent of the homes did not provide any registered nurse that week and 33.0 percent provided neither a registered nurse nor a licensed practical nurse.

TABLE 8.—*Percent of homes and patients in homes by average daily amount of nursing time [1] available during week prior to study*

Average hours of nursing time per patient per day	Homes	Accumulative percent	Patients	Accumulative percent
Total	100.0	100.0	100.0	100.0
1.0 to 1.4 hours	2.8	2.8	7.6	7.6
1.5 to 1.9 hours	13.2	16.0	25.3	32.9
2.0 to 2.4 hours	35.0	51.0	37.5	70.4
2.5 to 2.9 hours	25.5	76.5	19.3	89.7
3.0 to 3.4 hours	9.4	85.9	4.8	94.5
3.5 to 3.9 hours	3.8	89.7	2.0	96.5
4.0 to 4.4 hours	4.7	94.4	2.6	99.1
4.5 to 4.9 hours	.9	95.3	.1	99.2
5.0 and over	4.7	100.0	.8	100.0

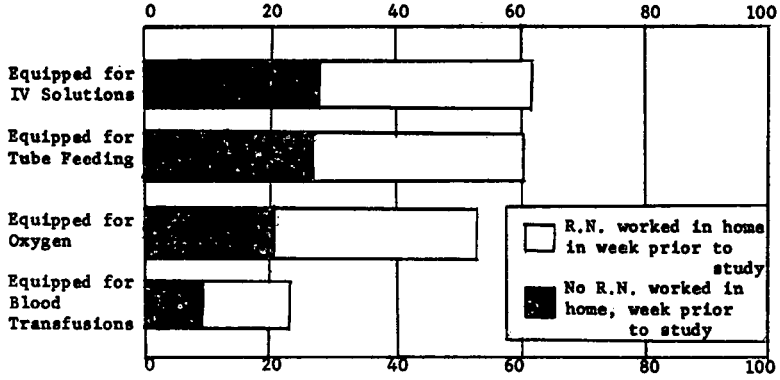
[1] Includes time of registered nurses, licensed practical nurses, and nurses aids.

There are 16 percent of the licensed nursing homes caring for 32.9 percent of the patients that are below a weekly average of 2 hours of nursing time per patient per day and 51 percent of the homes housing 70.4 percent of the patients that are below a weekly average of 2½ hours of nursing time per patient per day.

D. Availability of specific medical services

The significance of the problem of staffing becomes even more apparent when it is related to questions on availability of specific medical services within the nursing home.

CHART 3. AVAILABILITY OF SPECIFIED SERVICES IN NURSING HOMES BY PRESENCE OF REGISTERED NURSE DURING WEEK PRIOR TO STUDY



62.3 percent of the homes said they were equipped to admit a pateint requiring intravenous solutions, yet 43.8 percent of these homes did not have a registered nurse working in the home during the week prior to the study.

60.4 percent of the homes said they were equipped to admit a patient requiring tube feeding, yet 46.9 percent of these homes did not have a registered nurse working in the home during the week prior to the study.

54.7 percent of the homes said they were equipped to admit a patient requiring oxygen, yet 41.3 percent of these homes did not have a registered nurse working in the home during the week prior to the study.

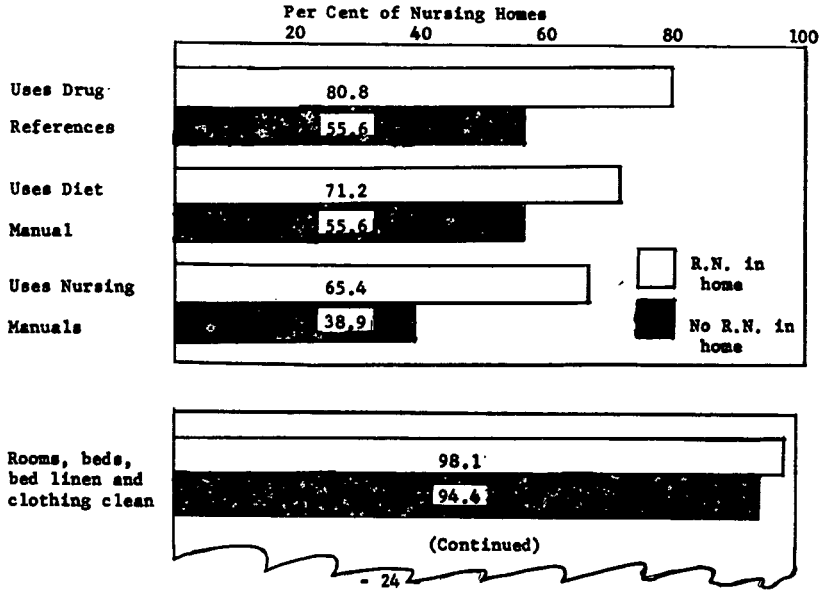
24.5 percent of the homes said they were equipped to admit a pateint requiring blood transfusions, yet 34.7 percent of these homes did not have a registered nurse working in the home during the week prior to the study.

It is significant to relate nurse staffing to the quality of nursing care when you consider that 93.4 percent of the homes expressed no preference as to the type of patient they would accept; 2.8 percent of the homes said they did not want intensive care patients and 83 percent of the homes use narcotics.

E. Skilled nursing care

The data reflected in this chart shows certain components of nursing care in homes staffed with a registered nurse and those homes without a registered nurse.

CHART 4. SELECTED CHARACTERISTICS OF NURSING HOMES WITH AND WITHOUT REGISTERED NURSE IN THE HOME DURING WEEK PRIOR TO STUDY



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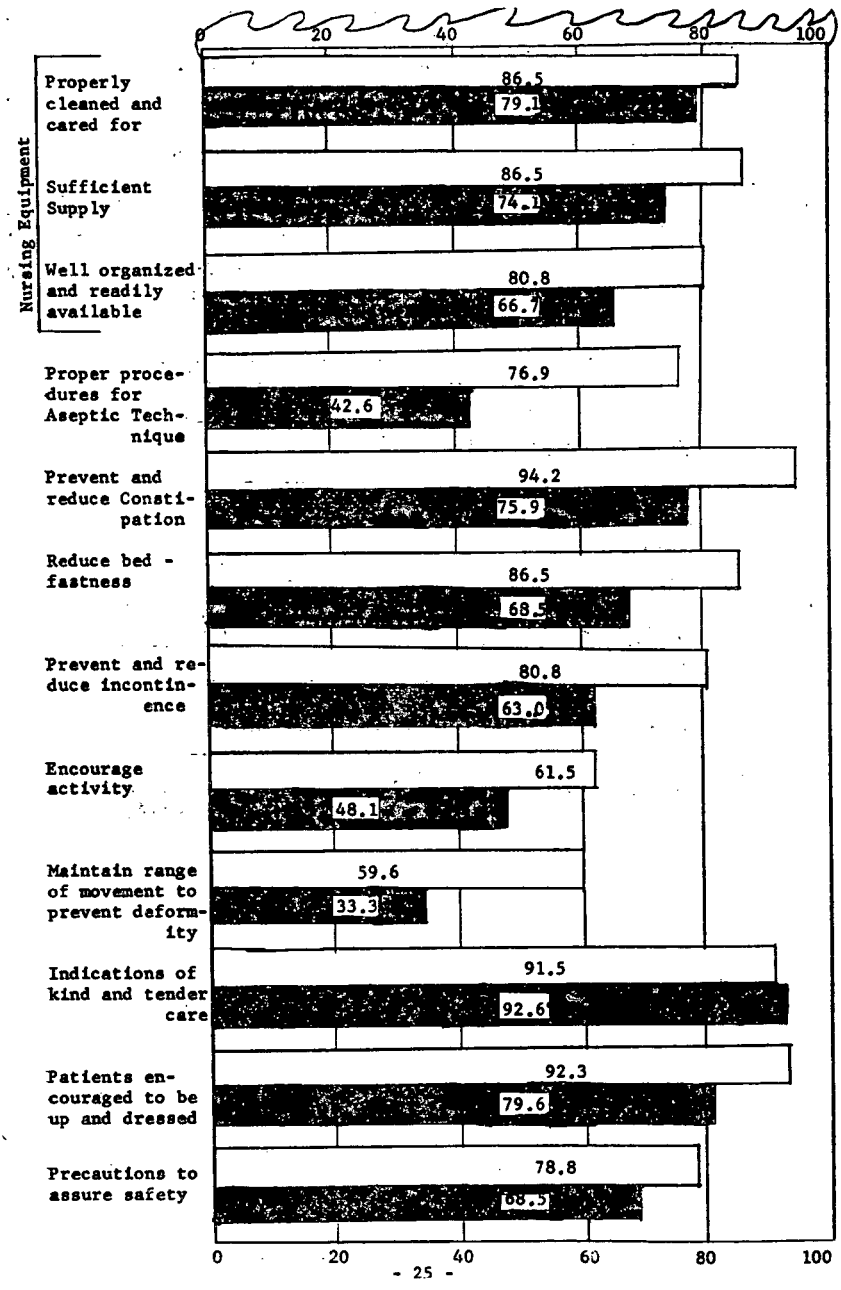


In those areas of nursing practice where professional nursing knowledge and skills and sound judgment are essential for effective practice, the nursing homes with professional nursing staff achieve a higher quality of nursing practice. There is evidence, however, that where professional nurses are employed, nursing practices still need to be improved. For example, aseptic technique is satisfactory in 42.6 percent of homes without registered nurses compared to satisfactory aseptic technique practices in 76.9 percent of the homes that did employ

registered nurses. Similar differences occur in such nursing practices as encouraging activity, 61.5 percent with registered nurses, 48.1 percent without registered nurses and maintaining range of motion to prevent deformities, 59.6 percent with registered nurses, 33.3 percent without registered nurses.

The difference with respect to the use of drug references, with 80.8 percent of the homes with a registered nurse using drug references while 55.6 percent of the homes without a registered nurse use this material, has particular significance in relation to good nursing care. It is common for individual drug prescriptions to contain only a prescription number and no drug name on the label. The homes containing drug references would find them of little use in such circumstances. Patients' reactions to medications cannot be evaluated accurately if the drug being administered is unknown. Good nursing practice does not allow administration of a drug unless one knows what it is and what reactions to expect.

2. Characteristics of the public assistance nursing home patient

A. The public assistance nursing home patient and the community

CHART 5. LIVING ARRANGEMENTS OF PUBLIC ASSISTANCE PATIENTS PRIOR TO ADMISSION TO THIS NURSING HOME

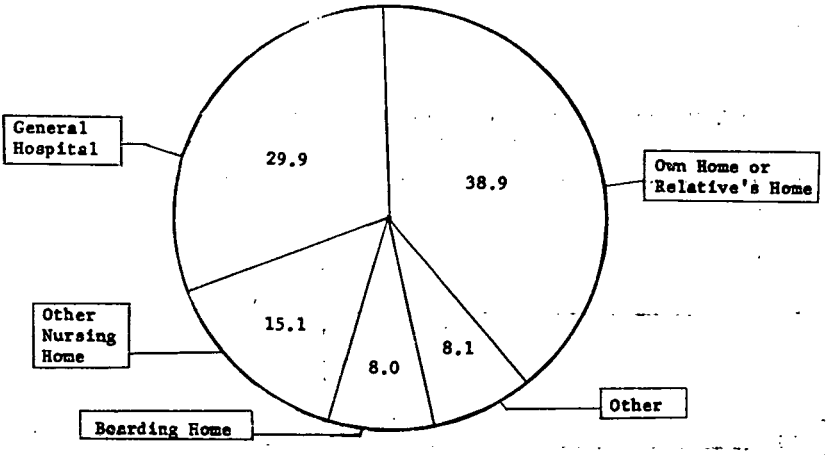
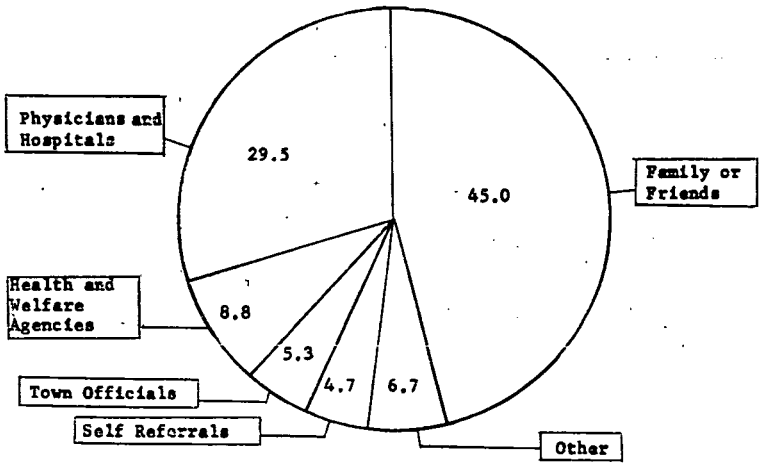


Chart 6. Sources of Referral for Public Assistance Patients



These charts refer to the location of the patient prior to admission and source of referral to the nursing home. The fact that 38.9 percent of the patients were in their own home or that of a relative and that 45.0 percent of the referrals came from family or friends has implications when one considers future material covering the adequacy of medical and nursing information on the patient at the time of admission. When the patients were housed in a general hospital prior to admission, in the opinion of the nursing home administrator the admission data on the patient was adequate in 90.0 percent of the cases as compared with only 48.3 percent of the cases admitted from their own home or the home of a relative.

It is important to note that 15.1 percent of the patients were admitted to the nursing home under study from another home. This factor will be referred to later when considering data on duration of patient stay in a nursing home.

B. Age distribution and duration of patient stay

In analyzing the data on patient characteristics, reference is made to a study titled "Nursing Homes in Maine" conducted in 1956 by the Maine Department of Health and Welfare.

The sex ratio of 2 females to 1 male remains the same. In 1956, 68 percent of the patients were 75 years of age or over. Today, 72.5 percent of the patients are 75 years of age or over. In 1956 the median length of residence of patients in nursing homes at the time of the survey was 1.3 years. The median length of stay of patients in this study is 2 years. The effects of longevity are seen in an older age group of patients remaining in nursing homes a longer period of time.

CHART 7. PERCENTAGE DISTRIBUTION OF PUBLIC ASSISTANCE PATIENTS IN NURSING HOMES BY AGE

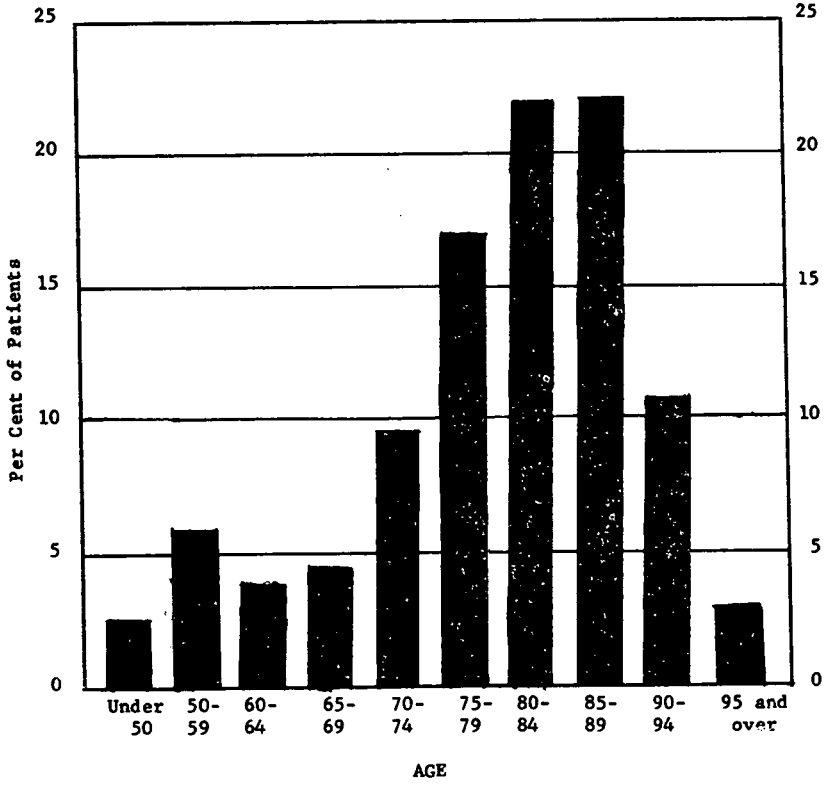
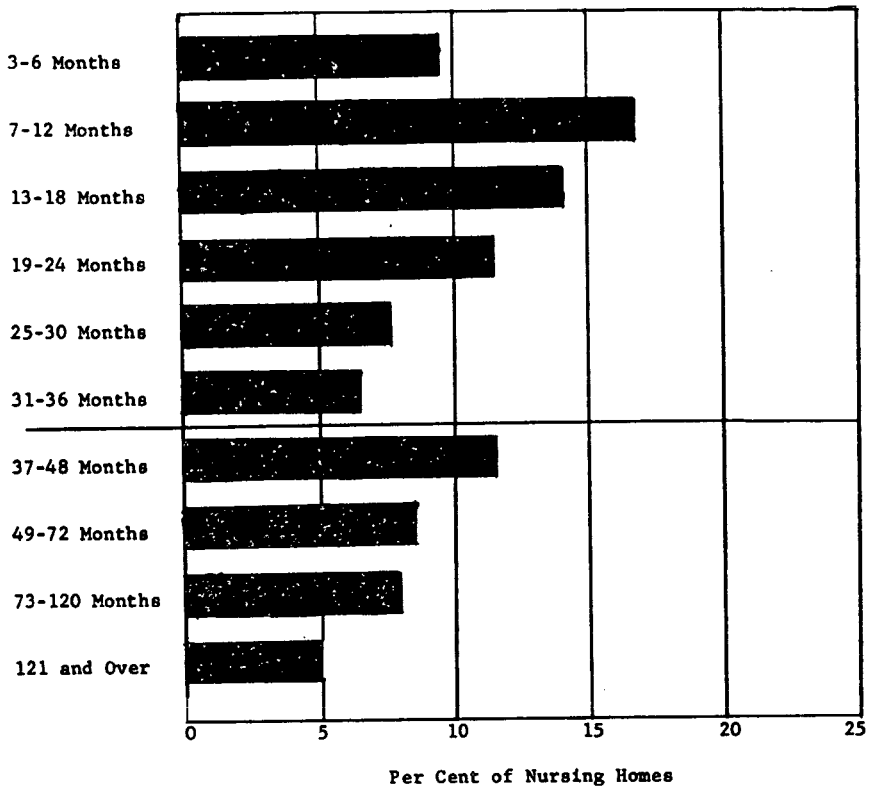


CHART 8. PERCENT OF PUBLIC ASSISTANCE PATIENTS IN NURSING HOMES BY LENGTH OF STAY SINCE ADMISSION AT TIME OF STUDY



These charts are significant not only in themselves but also in their relationship to other information. The fact that 55.4 percent of the population studied was 80 years of age or over, and that 32.9 percent had been in the nursing homes more than 3 years, has implications when one considers the data on rehabilitation potential and need for continued nursing home care.

Chart No. 8 reflects duration of patient stay in the home being studied at the time of the interviewer's visit. There is an understatement of patients in the home 6 months or less due to the design of the study which eliminated all patients who were in the nursing home 3 months or less. If one is considering duration of stay in a nursing home, it should be recalled that 15.1 percent of the patients were admitted to their present home from another nursing home and 29.9 pereent were admitted from a general hospital that could have been preceded by a nursing home stay.

The economics of nursing home care can be visualized in chart 8. There were 8.1 percent of the patients who had been in a nursing home between 6 and 10 years. This amounts to 142 individual public assistance recipients. At the current $200 per month rate of payment, it would cost the department of health and welfare in excess of $2 million to care for 142 patients in a nursing home for 6 years. There were 5 percent of the patients in the nursing home more than 10 years. This amounts to 87 individual public assistance recipients. At the current $200 per month rate of payment it would cost the department of health and welfare in excess of $2 million to care for 87 patients in a nursing home for 10 years.

Questions could be raised about the clinical status and nursing needs of the patients confined to nursing homes for prolonged periods. Was this type of care the most appropriate that could have been provided during this period of time? Could more astute evaluation at time of admission, with periodic subsequent re-evaluation, have prevented these long-term stays.

C. Nursing care factors

The public assistance nursing home patient is very old. About half of their number are confused at least part of the time. There are about 30 percent who have difficulties of comprehension and about 25 percent with speech impairments. Approximately 50 percent of the patients are independent or need only minimum assistance in self-care activities such as mobility and management of personal hygiene. There are 83.6 percent who are totally dependent on another person for personal needs such as manicures, pedicures, shampoos, and shaving. In some instances the nursing home personnel stated that they did not allow this confused elderly group of patients to be independent in these personal care areas because of the danger of accident from the sharp instruments used in nail cutting and shaving. There are 79.2 percent who feed themselves unaided and 60 percent who are able to dress with some help.

Table 21 reveals that only 62.4 percent of the public assistance patients are rarely or never incontinent of urine and 71.5 percent are rarely or never incontinent of feces. This data is consistent with table 20 which indicates that 26.8 percent of the patients were unable to manage toilet functions by themselves. The fact that 29.5 percent of the patients are incontinent of urine and 24.2 percent of the patients are incontinent of feces has implications in terms of costs for the nursing home operator.

The series of tables 9 to 22 on patient characteristics reveals some costs that a nursing home must assume in personnel and equipment to render services to their patients. Staff time is required to dress, feed, shave, and assist a person to walk. Diapers, wheelchairs, walkers, and lifts are expenditures appropriate to the care of that number of patients reflected in these tables.

3. Chronic illness factors

A. Diagnoses

The diagnostic data in table 23 contain the usual array of problems of the chronically ill. The problems of coding morbidity data in a meaningful manner were magnified in this study because this age group of institutionalized people usually have a variety of medical problems any one of which may be more significant than another at any given time. Morbidity is at best a transient phenomenon that is even more difficult to analyze statistically than it is to diagnose accurately in this age group.

B. Frequency of acute episodes of disease

Tables 23, 24, 25 present data that describes the frequency and duration of of acute episodes of illness in the study population. This group of questions was inserted because nursing home operators stated that their patients fluctuated considerably in their needs for care. The data indicates that about 40 percent of the patients had acute episodes of disease less often than once a year. Approximately 30 percent of the patients have not had any acute episodes of disease since admission and an additional 20 percent had their last episode at least 6 months ago.

A question on recordkeeping revealed that the most recent acute episode of disease was significant enough to call a physician for 86 percent of the patients. However, this fact was noted in the record for only 67.9 percent of the patients.

4. Care of patients

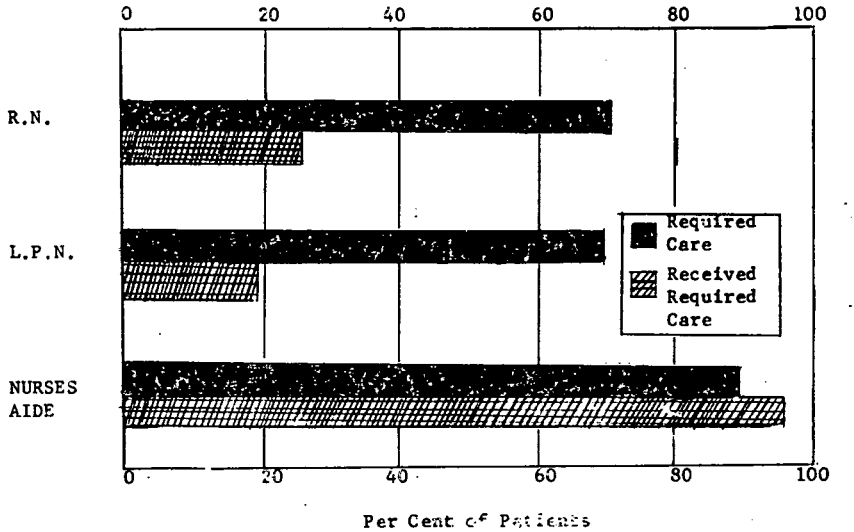
TABLE 28.—*Percent of assistance patients in nursing homes by daily amount of time needed for care and daily amount of time received on day prior to inter view as estimated by nurse interviewers.*

	R.N.		L.P.N.		Nurses aid	
	Received	Estimated requirement	Received	Estimated requirement	Received	Estimated requirement
Total	100.0	100.0	100.0	100.0	100.0	100.0
No nursing care	67.5	21.8	72.5	27.8	2.4	7.1
Supervision of activities only	5.4	7.0	7.7	.7	1.0	1.3
Direct care:						
Less than ½ hour	16.8	41.3	10.7	10.4	.7	.7
½ to 1 hour	8.0	27.9	6.4	36.6	12.4	12.8
1 to 2 hours	.7	2.0	2.4	18.8	24.9	33.2
2 to 3 hours	1.0	0	0	5.7	25.7	20.8
3 to 4 hours	.3	0	0	0	9.7	8.7
More than 4 hours	.3	0	.3	0	23.2	15.4

A. Nursing care time

The above table summarizes the answer to two questions asked by the nurse interviewer. In one question the nurse interviewer was asked to estimate the amount of nursing received by the patient on the day prior to the interview, by a registered nurse, a licensed practical nurse, and a nurses aid. The other question asked the nurse interviewer to estimate the amount of care needed by this patient. The following chart compares the nurse interviewer's opinion of direct nursing care received by the patient with the direct nursing care required.

CHART 9. ESTIMATED PERCENT OF PUBLIC ASSISTANCE PATIENTS REQUIRING NURSING CARE, BY TYPE OF NURSING CARE, AND PERCENT OF PATIENTS WHO RECEIVED ESTIMATED REQUIRED AMOUNT OF CARE ON DAY PRIOR TO NURSE'S INTERVIEW



It was estimated by the nurse interviewers that—

71.2 percent of the patients needed the direct care of a registered professional nurse.
27.1 percent of the patients actually received direct care by a registered professional nurse on the day prior to the nurse's interview.
71.5 percent of the patients needed the direct care of a licensed practical nurse.
19.7 percent of the patients received such care.
91.6 percent of the patients required the direct care of a nurses aid.
96.6 percent of the patients actually received such care.

The wide difference between the amount of registered professional nurse care received and the estimated amount required can be explained by the fact that there is no specific requirement in the State of Maine that a nursing home must be staffed by a registered professional nurse.

It must be emphasized that this data attempts to measure only the quantity of time received and required. No attempt was made to measure the quality of nursing care other than to indicate quality by the three categories of nurse personnel.

B. Nursing care costs

There is an opportunity in table 28 to gain insight into some of the inequities of the present policy of paying a flat rate of $200 per month for all public assistance recipients in nursing homes regardless of the amount or quality of care needed by the patient and regardless of the size, physical facility, or staff of the nursing home.

The nurses estimated that 58.6 percent of the patients received more than 2 hours of nurses aid time on the day prior to their visit with 32.9 percent of the patients receiving more than 3 hours of nurses aid time and 23.2 percent receiving more than 4 hours. The current rate of payment amounts to approximately $6.66 per day. When one relates these time factors to the present vendor pay-

ments, adding nursing staff other than aids, costs of food, linen, equipment, overhead and return on investment, the inequities of the present fixed-rate system are obvious.

C. Conflict between State standards and statutes

Table 27 reveals that the nursing care of 56.1 percent of the patients was supervised by a licensed professional or licensed practical nurse. Supervision was interpreted by the nurse interviewers to include direct supervision or availability for advice and decision such as an "on call R.N." There were 43.9 percent of the patients without the supervision of a licensed professional or licensed practical nurse.

The qualifications for the person supervising patient care have been pointed out previously in this paper. "The Standards and Requirements for Licensed Nursing Homes in the State of Maine" require that the minimum acceptable training or experience for the person supervising patient care shall be "at least 2 years of high school education plus 5 years of acceptable experience." These licensing standards permit staffing by nonlicensed personnel in nursing homes that admit patients requiring professional nursing care.

In order to appreciate the significance of table 27, it is important to become acquainted with some sections of An Act To Regulate the Practice of Nursing, title 32, of the Revised Statutes of 1964. There is a conflict between the qualitative standards for nursing supervision outlined in "The Standards and Requirements for Licensed Nursing Homes in the State of Maine" and the Nurse Practice Act, a portion of which is excerpted here:

"PRACTICE OF NURSING

"SECTION 1. PURPOSE.—In order to safeguard the life and health of the people in this State, any person who for compensation practices or offers to practice professional nursing or practical nursing as a licensed practical nurse in this State shall hereafter be required to submit evidence that he or she is qualified so to practice, and shall be licensed as hereinafter provided. After December 31, 1961 it shall be unlawful for any person not licensed under this chapter to practice or to offer to practice professional nursing in this State; or to use any sign, card or device to indicate that such person is a professional registered nurse or a licensed practical nurse.

"This chapter does not affect or prohibit the practice of practical nursing by any person not representing himself or herself to be a licensed practical nurse, nor does it affect or prohibit the employment of persons functioning under supervision as nursing aides, attendants, orderlies and other auxiliary workers in private homes, offices, hospitals, nursing or rest homes or institutions.

"SECTION 2. DEFINITIONS.—

"I. 'Board' means the State Board of Nursing.

"II. The practice of 'professional nursing' means the performance for compensation of any of the services which necessitate the specialized knowledge, judgment and skill required for the application of nursing as based upon principles of biological, physical and social sciences in the—

"A. Observation and care of the ill, injured or infirm;

"B. Maintenance of health or prevention of illness of others;

"C. Supervision and teaching of other personnel;

"D. Administration of medications and treatment as prescribed by a licensed physician or dentist. The foregoing shall not be deemed to include diagnosis of illness or the prescription of therapeutic or corrective measures.

"III. The practice of 'practical nursing' means the performance for compensation of services in the care of the ill, injured or infirm as selected by and under the direction of a registered professional nurse or a licensed physician or dentist which do not require the substantial specialized skill, judgment and knowledge required in professional nursing.

"IV. A 'license' is an authorization to practice nursing as a professional nurse or practical nurse designated thereon.

"V. The terms 'professional nurse', 'registered nurse' or 'registered professional nurse' mean a person who is licensed under this chapter and who practices professional nursing as defined in subsection II.'R.N.' is the abbreviation for the title of 'registered professional nurse.'

"VI. The term 'licensed practical nurse' means a person who is licensed under this chapter and who practices practical nursing as defined in subsection III. 'L.P.N.' is the abbreviation for the title of 'licensed practical nurse'."

D. Nursing care of patients

There is a high level of care of personal services to public assistance recipients in nursing homes.

94.3 percent of the patients were offered food on the day prior to the nurse interviewer's visit that conformed to the dietary needs of the patient.
93.0 percent of the patients have evidence of good personal hygiene.
93.0 percent of the patients are free from decubitus ulcers.
91.5 percent of the homes were providing their patients with kind and tender care.
89.6 percent of the patients did not have any accidents resulting in injuries since admission.
89.3 percent of the patients in nursing homes could not benefit from a short period of hospitalization.
85.8 percent of the homes encouraged their patients to be up and dressed.
84.9 percent of the homes had a program to prevent and reduce constipation.

These facts are to the credit of nursing homes and the abilities of their employees.

E. Treatment of patients

The physician interviewers were asked to render an opinion as to whether or not the patients whom they visited were receiving an adequate treatment regimen at the time of their visit. The answer was "Yes" in a high percentage of cases, but in the process of interpreting the data the physicians felt it was necessary to clarify the circumstances of this question.

(1) The question was asked at a time when many patients, because of their age, length of stay in a nursing home, and physical limitations of long duration could not have benefited by a different treatment regimen.

(2) The question was asked in the present tense: "Do you consider the current treatment regimen for this patient to be adequate?" No consideration was given to the adequacy of a past treatment regimen. The interpretation of this question was also weighted by the fact that the design of the study precluded a review of any patient admitted less than 3 months prior to the physician's visit. Another fact to be considered was the time interval of 4 weeks or more between the social worker's and physician's visits in 40.9 percent of the patients.

(3) The question itself had major inherent weaknesses. Neither the term "adequate" nor the meaning of the words "treatment regimen" was defined for universal application by all 38 physicians in the study.

(4) The fact that 28.5 percent of the patients had no medical record contributes to the difficulty of making a judgment on adequacy of treatment regimen particularly when a thorough history was not taken and a physical examination was not performed by the physician interviewers.

All of these factors lead to the conclusion that the question of whether or not the patients in this study had an adequate treatment regimen remains unanswered. The qualitative evaluation of this question needs more definitive study using objective questions and interviewing techniques designed specifically for this purpose.

5. Nursing home records

A. Admission records

TABLE 32.—*Public assistance patients in nursing homes by information made available to nursing home at time of admission*

Medical information	Percent of patients		
	Yes	No	Not specified
Administrator considered medical admission data adequate	60.4	38.3	1.3
Information made available at time of admission:			
Medical history	47.9	51.6	.5
Recent physical examination	41.3	58.2	.5
Diagnosis	72.8	26.7	.5
Relevant laboratory findings	20.6	78.9	.5
Medical orders	73.2	26.3	.5
Diet	52.1	47.4	.5

This table describes medical information made available to the nursing home at the time of admission. The administrator considered the medical admission data adequate in 60.4 percent of the patients. Yet, only 47.9 percent of the patients came to the nursing home with a medical history, 41.3 percent had a recent physical examination, and 52.1 percent had information on diet. The fact that 45 percent of the patients were referred to a nursing home by family or friends contributes to an explanation of this lack of information at the time of admission. At least a diagnosis and medical orders were available in approximately 73 percent of the patients. However, the converse of this statistic may be even more significant. How do you care for the 27 percent of the cases without a diagnosis, or medical orders, and presumably without any of the other data needed for adequate treatment. The data in this table raises two questions: How can anyone expect a nursing home to function in a professional manner without sufficient medical information on the patient at the time of admission? Why should a nursing home accept a patient without adequate medical information?

The medical information at the time of admission was best when the patient was housed in a general hospital prior to admission. Of the patients who were admitted to a nursing home from a general hospital, 90 percent had adequate admission data. Only 48.3 percent of the patients coming from their own home or that of a relative had adequate admission data.

B. Medical records

Data was collected on availability of selected medical records; 71.5 percent of the patients had a medical record, 86.9 percent of the patients had provisions to keep progress notes and 94.3 percent of the patients had provisions to keep medical orders. In discussion of this question the physician interviewers admitted that although the means to keep medical records are available in most homes, the physicians did not use the means provided for them. On the other hand the nursing home operators were also remiss in recordkeeping. Provisions to keep progress notes were reported on 86.9 percent of the patients. Yet, the most acute episode of disease was noted in the record in only 67.9 percent of the cases.

C. Nursing records

TABLE 33.—*Public assistance patients in nursing homes by nursing information made available to nursing home at time of admission*

Nursing information	Percent of patients		
	Yes	No	Not Specified
Administrator considered admission nursing data adequate	44.0	55.0	1.0
Information made available:			
Immediate and long-term prognosis	51.3	47.3	1.4
Specific nursing instructions	61.8	37.2	1.0
Information on patient's limitations which might influence nursing care plans	58.1	40.9	1.0

This table records nursing information made available to the nursing home at time of admission. Nursing home personnel rendered the opinion that they lacked sufficient written information to plan for nursing care for 55 percent of the patients studied. Medications and treatments performed are recorded for 94.0 and 90.3 percent of the patients. Yet, nursing care directions for performing these nursing functions were reported for only 73.8 percent of the patients and 33.2 percent of the recorded care given to patients does not include indentification of the person giving care.

Some basic nursing philosophy may help to interpret the above data. Nurses, in order to give nursing care to the sick, must have a diagnosis and written medical orders. If information relative to the patients' limitations, prognosis, and directions for care are not available, no effective nursing care plan can be developed.

The legal implications of professional nursing personnel performing certain treatments and administering certain medications in the absence of medical orders, or of a nurses aid doing the same things without supervision or direction, should also be considered when reviewing this data.

6. Services for nursing home patients

A. Rehabilitation potential

TABLE 37.—*Percent of public assistance patients in nursing homes by potential for rehabilitation*

Rehabilitation potential	Team	Social worker	Nurse	Physician
Total	100.0	100.0	1000.0	100.0
Could be rehabilitated to care for self completely outside of institution	1.0	2.0	1.0	1.3
Could be rehabilitated to care for self but needs supervision for feeding and lodging	7.4	6.0	7.0	7.7
Could be rehabilitated to function more adequately, but needs nursing supervision	9.1	11.7	17.1	12.1
Patient has no rehabilitation potential	81.8	79.9	74.5	75.2
Not answered	.7	.4	.4	3.7

The above table presents data on the rehabilitation potential of the patient. The setting of this question is important. It was asked of a population, institutionalized for a median of 2 years, of whom 55.4 percent were 80 years of age or over. When one considers the rehabilitation potential of this group, the term "no rehabilitation potential" includes those totally disabled as well as the patients who appear to be functioning to the maximum of their ability.

The perspective of the interviewer is also evident in this table. The nurse interviewer could see a potential for functional rehabilitation in 17.1 percent of the patients while the physician could see this in only 12.1 percent of the patients and the social worker in 11.7 percent of the patients.

The group was consistent in their opinion that 8.4 percent of the patients, 147 individuals, could be rehabilitated to care for themselves outside of the nursing home.

In analyzing this question and the setting in which it was asked, one must consider possibilities for a followup study using this same team approach and asking this same question at the time a public assistance patient is admitted to the nursing home, rather than asking the question of an institutionalized population. If 8.4 percent of the patients in the study could be rehabilitated to care for themselves outside of a nursing home, one wonders what the percentage might have been if the question had been asked earlier, and what would be the economies in dollars and benefits to the patients.

B. Facilities for care

The physician interviewers were of the opinion that 89.3 percent of the patients could not have benefited from a short period of hospitalization.

The data in tables 38, 39, and 40 is concerned with placement of patients and services that would make it possible for a patient to live outside a nursing home.

TABLE 38.—*Public assistance patients in nursing homes by type of facility most appropriate for care as indicated by social worker-nurse-physician team*

Type of facility	Percent of patients as indicated by—			
	Team	Social worker	Nurse	Physician
Total	100.0	100.0	100.0	100.0
Nursing home	83.9	88.9	79.5	83.9
Boarding home	7.7	6.0	6.7	7.4
Own home	1.7	.3	4.4	.3
Mental hospital		1.4	1.4	1.4
Rehabilitation facility	.3	.0	1.3	.3
General hospital	.7	.0	.3	1.3
Other	5.0	2.0	5.7	2.0
Not answered	.7	1.4	.7	3.4

Table 38 shows there is a good degree of consistency among the team of interviewers on the most appropriate facility for the care of the patients studied. The fact that 83.9 percent were, in the opinion of the team, properly housed in a nursing home speaks well for the present system of classification with its admitted weakness in numbers of nursing home caseworkers.

One way of looking at the 7.7 percent of the patients who could be housed in a boarding home is from the point of view of economics. At the present time the public assistance nursing-care rate is $200 per month while the boarding-care rate is $110 per month. Based on the 1964 fiscal year expenditures of $3,144,088 an annual saving in the neighborhood of $150,000 could have resulted to the department if these patients had been in boarding homes rather than nursing homes. The 5 percent who could have been housed in facilities other than those mentioned were a group that could have profited from foster home placements. This is a type of facility that could probably be grouped between the nursing home and the boarding home. Foster home care may provide a more individualized level of personal care than does a boarding home.

TABLE 39.—*Public assistance patients in nursing homes by reason for need for continued nursing home care as indicated by social worker-nurse-physician team*

Reason for need	Percent of patients as indicated by—			
	Team	Social worker	Nurse	Physician
Total	100.0	100.0	100.0	100.0
Do not need continued nursing home care	13.1	7.1	17.4	8.4
Need continued care (total)	86.9	92.9	82.6	91.6
Patient could not be cared for at home because of extent of illness	82.6	87.9	69.2	59.7
Patient could not be cared for at home because of other family problems	.7	0	3.0	3.7
No other place to go	1.3	2.0	5.0	11.7
Terminal care	1.7	1.0	3.7	13.1
Convalescent care	.3	.7	0	3.4
Other reason	.3	.7	1.0	0
Not answered	.3	.6	.7	0

In this table the differences of opinion between the three interviewers need interpretation. When the nurse interviewer differs from the social worker and physician a matter of 9 percentage points, this is a difference of approximately 150 public assistance patients that in the nurse's opinion do not need continued nursing home care in comparison with the opinion of the social worker and the physician.

It is noteworthy that in the team consideration of this question the social worker and physician were influenced by a nurse so that the team opinion is closer to the nurse's opinion than it is to either of the other two interviewers. In the opinion of the team, 13.1 percent of the public assistance patients in nursing homes do not need continued nursing home care.

There could be criticism of the wording of this question. The choice of "terminal care" was a poor alternative. Neither the social worker nor the nurse felt comfortable with making this judgment because of professional limitations. Most physicians prefer not to make this type of classification.

There may be significance in the fact that as an individual interviewer the physician believed that in 11.7 percent of the patients, the reason for continued nursing home care was that the patient had no other place to go. Yet, after consultation with the social worker and nurse, the team believed that this response was valid in only 1.3 percent of the patients. This variation could be interpreted as lack of community orientation to alternatives to nursing home care on the part of the physician which through the process of team discussion the nurse and social worker were able to point out. The changes in opinion between the individual and the team are indicative of the fact that some interaction occurred when the social worker, nurse and physician met to produce a team opinion on this question.

It seems important at this time to discuss the fact that this study indicated that only 13.1 percent of the patients did not need continued nursing home care in contrast with other studies that indicated 50 percent of the patients in nursing homes did not need continued nursing home care. One must look at the universe

under study to expalin this apparent inconsistency. This study of nursing home patient care was concerned only with public assistance recipients. Such a patient is screened by the Division of Family Services at the time of admission and periodically thereafter. This fact distinguishes the public assistance patient from the private patient. Data from other studies including both private and public patients that indicate 50 percent of the patients do not need to be in nursing homes are not inconsistent with the data from this study, when one considers the difference in the groups under study.

D. Community services

TABLE 40.—*Percent of public assistance patients in nursing homes by kinds of community services which might make it possible for patient to live outside nursing homes, as indicated by social worker-nurse-physician team*

Service	Essential				Desirable			
	Team	Social worker	Nurse	Physician	Team	Social worker	Nurse	Physician
No service	85.6	88.3	76.2	83.9	85.6	88.3	76.2	83.9
Visiting nurse service	6.7	4.3	11.4	4.4	.7	.3	2.3	2.3
Regular physician visits	6.4	5.0	13.1	3.0	2.3	1.3	3.4	3.0
Homemaker service	2.7	2.3	5.7	5.0	.7	0	1.3	.7
Social service	2.7	1.3	6.7	1.7	2.3	3.0	1.0	.7

This table presents data concerning a hypothetical question; if certain community services were available, would it be possible for the patient to live outside the nursing home? Only four services were suggested: visiting nurse service, regular physician visits, homemaker service, and social service. The choices do not add to 100 percent as this is a duplicated count; for example, the patient who could manage outside the nursing home with visiting nurse services would also need regular physician visits. It is again important to emphasize the setting of this question when interpreting the data. It was asked of a population, institutionalized for a median of 2 years, of whom 55.4 percent were 80 years of age or over. If this question had been asked at the time of admission, it is probable that a different result would have been presented.

The team's opinion that 85.6 percent of the patients could not have been able to live outside the nursing home, regardless of the availability of selected community services, is consistent with the results in table 39 that 86.9 percent of the patients need continued nursing home care and with the results in table 38 that 83.9 percent of the patients are appropriately housed in a nursing home. There is a high degree of internal consistency in the team opinion in these three tables, as shown by the following charts:

CHART 10. PERCENT OF PUBLIC ASSISTANCE PATIENTS IN NURSING HOMES BY POTENTIAL FOR REHABILITATION AS INDICATED BY TEAM

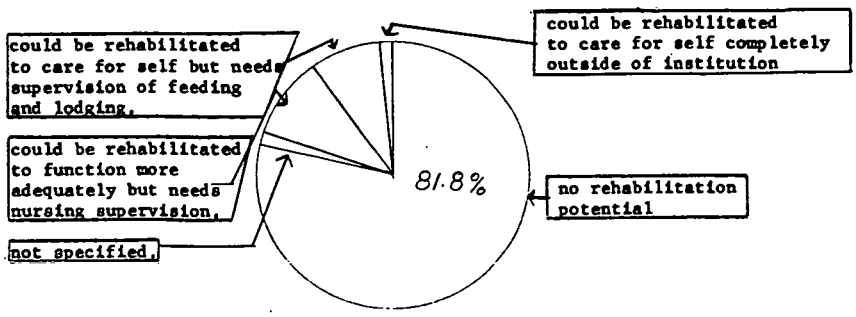


CHART 11. PERCENT OF PUBLIC ASSISTANCE PATIENTS IN NURSING HOMES BY FACILITY MOST APPROPRIATE FOR CARE AS INDICATED BY TEAM

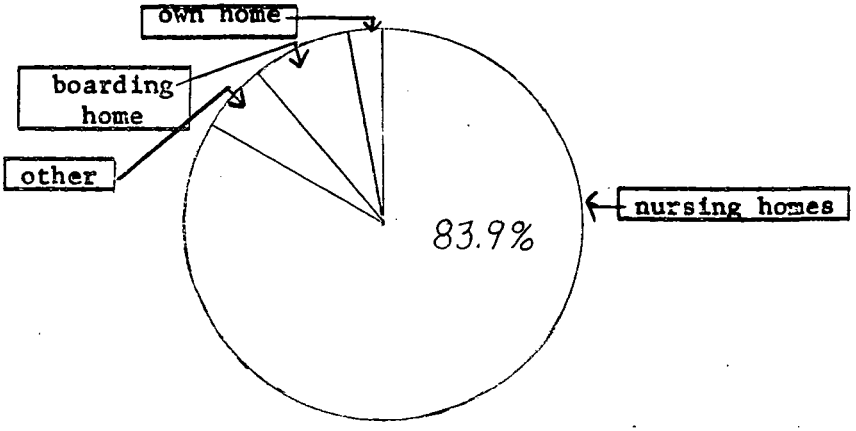
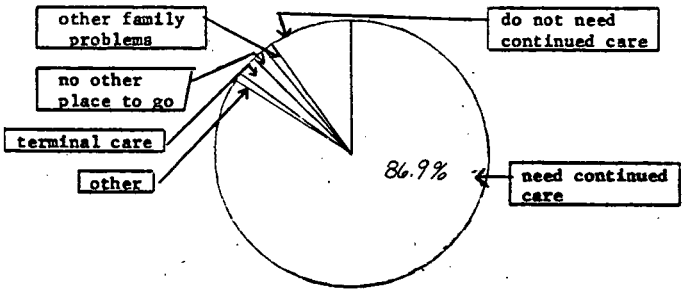


CHART 12. PERCENTAGE OF PUBLIC ASSISTANCE PATIENTS IN NURSING HOMES BY REASON FOR NEED FOR CONTINUED CARE AS INDICATED BY TEAM



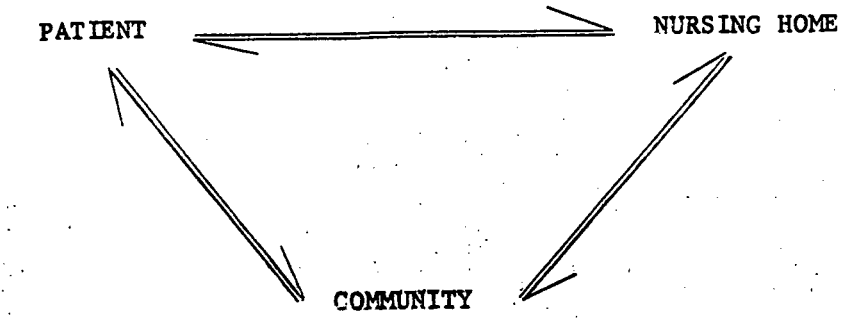
In table 40 the nurse interviewers felt that 23.8 percent of the patients could live outside a nursing home provided community services were available. This figure represents more than 400 public assistance patients costing in excess of $700,000 per year. It is recognized that the community services suggested as an alternative to nursing home care would be new programs in many areas. The problem of geographic distribution of these cases is also acknowledged. However, an analysis of the nurse data on this chart raises some interesting possibilities for community services that might make it possible for a patient to live outside a nursing home. Visiting nurse services and regular physician visits are the most frequent community services mentioned.

The nurse indicated the need for regular physician visits more often than the physician because of a difference in perspective between the nurse and the physician on this question. The physician marked this choice only from the clinical point of view whereas the nurse marked this choice because she could not render home nursing care of the sick without direct medical supervision.

The data in tables 39 and 40 is open to the interpretation that economies would result from a nurse evaluation rather than a social worker evaluation of the patients' need for continued nursing home care. The nurse interviewers felt that 17.4 percent of the patients did not need continued nursing home care in contrast with the social worker interviewer who believed 7.1 percent of the patients did not need continued nursing home care. The nurse interviewers felt that 23.8 percent of the patients could live outside the nursing home if certain community services were available in contrast with the social worker interviewers who believes only 11.7 percent of the patients could manage outside the home.

VII. CONCLUSIONS AND RECOMMENDATIONS

The problem of providing care for the public assistance nursing home patient consists of trying to maintain the equilibrium of an equation involving three factors, the patient, the nursing home, and the community.



The goal is to equate the public assistance patients' needs with the nursing home that can provide services to meet these needs, with the community matching the patient to the home when care is needed, and the community paying an equitable rate for the services rendered.

The community in this equation represents State government with its licensing standards and its system of nursing home payments. The community also represents local government, the patient service area of a local hospital, the area of service covered by a medical practitioner and such resources as home nursing services, homemaker services, rehabilitation facilities, boardinghomes, and clinics.

The patient in this equation must be carefully evaluated with clear definitions established. What is the medical diagnosis and prognosis of this patient? Does this patient need skilled nursing care? Are there other community resources that could meet this patient's needs? This equation is a continuing one. In order to maintain this equilibrium the evaluation questions must also be asked on a continuing basis.

The nursing home in this equation must be defined in such terms that it can be properly identified by the patient and the community. The term "nursing home" means a facility or unit, however named, which is designated, staffed, and equipped for the accommodation of individuals not requiring hospital care but needing nursing care and related medical services prescribed or performed under the direction of persons licensed to provide such care, or services in accordance with the laws of the State in which the facility is located. Many of the nursing homes examined in this study do not fit this definition.

The catalyst of this equation is education: Education of the community to provide alternative resources for the patient who doesn't need intensive nursing care; education of the nursing home personnel to provide a high quality of care; education of the patient and his family to recognize that nursing homes providing intensive nursing care will not be as widely distributed as the facilities we are calling nursing homes today. A patient may have to travel some distance from his own home in order that his medical and nursing needs can be matched with a facility that can provide services to meet these needs.

The equilibrium of this equation can be maintained by careful patient evaluation when nursing home placement is first considered and periodically thereafter, such evaluation to be conducted by a team of physician, nurse, and social worker. Adequate standards uniformly accepted and enforced will clarify the definition of a nursing home. A system of payment that conforms more closely to what the patient needs and what services the nursing home offers is the incentive needed for the better quality homes to improve and expand their services. With education as a stimulus, the equilibrium of this equation can be maintained.

All factors in this equation must be adjusted simultaneously or one of the components may swing out of balance. If there is a desire to define more clearly what is meant by a nursing home by strengthening standards, a review of the present patient classification system and an adjustment in rates is also necessary at the same time.

The patient

The present system of classifying the public assistance nursing home patient can be improved.

This study did not utilize the current definitions of "nursing care" and "family care" as are now being used by the nursing-home workers of the Division of Family Service when they classify a patient. It was thought that a classification system might evolve from the data rather than to require the inverviewers to conform to a preconceived definition.

The fact that 83.9 percent of the patients seem to be in the facility most appropriate for their care at the time of the interview speaks well for the current system which is carried out by nine caseworkers at the time of admission and, hopefully at least, annually thereafter. When it is realized that there are 1,750 public-assistance patients residing in nursing homes, to which must be added the cases that are admitted and die there, the cases that are rejected, and the requests for review, it is obvious that the current system does well to keep 83.9 percent of the patients appropriately placed. However, the data indicate that there is a wide range of care required by these patients.

A. In the opinion of the nurse interviewer, 58.6 percent of the patients received more than 2 hours of nurses' aid time on the day prior to her interview. This figure does not include the registered nurse and licensed practical nurse time received. It is a quantitative measurement only. A measurement of the quality of care needed is the estimate that 78.2 percent of the patients required registered-nurse care but only 32.5 percent received such care. Yet, it was estimated by the nurse interviewer that 21.8 percent of the patients required no registered-nurse care, 7 percent required supervision of activities only and 41.3 percent required less than one-half hour of registered-nurse time. The difficulties of accurately making this subjective judgment without a thorough evaluation of the patient is acknowledged. However, the impression remains that there is a wide range of skilled care required with approximately 30 percent requiring no skilled care, or supervision only, 30 percent requiring more than one-half hour of skilled nursing care and 40 percent requiring less than one-half hour of skilled nursing care on the day prior to the interview.

B. The patient characteristic data contributes to the conclusion that the present classification system could be improved with such facts as: 69.8 percent of the patients comprehend simple instructions; 89.6 percent of the patients have normal speech or only a mild speech impairment; 58.4 percent are in bed only to sleep and rest; 46.3 percent of the patients are ambulatory; 79.2 percent of the patients feed themselves unaided; 60 percent of the patients can dress themselves unaided or with the aid of another person 62.4 percent of the patients are rarely or never incontinent of urine, and 71.5 percent of the patients are rarely or never incontinent of feces. This data cannot be judged alone. It must be related to other data in the study to evaluate its significance. It does point out that there is a fair degree of mobility in these patients. It does not reveal whether or not they need skilled nursing care.

C. The patients in this study are old—55 percent being over the age of 80. One-half of the patients had been in a nursing home 2 years or longer. The question on potential for rehabilitation was asked of this population and 8.4 percent of the patients in this study could have been rehabilitated beyond the need for a nursing home. If this is accepted of a population in this age bracket, institutionalized this period of time, two questions seem significant. What would be the percentage of people with a rehabilitation potential if this area were properly evaluated at the time of admission to a nursing home? What would have happened to the 5 percent of the patients institutionalized more than 10 years, and the 16.5 percent institutionalized between 4 and 10 years, if their rehabilitation potential had been periodically evaluated? Perhaps these areas need further study but the data is open to the interpretation that periodic skilled evaluations would result in dollar economies and patient benefit.

D. The nurse member of the team judged that 17.4 percent of the patients did not need continued nursing home care and that 23.8 percent of the patients could live outside the nursing home provided certain community services were avaialble. Major dollar economies would result if these judgments are valid. The most significant community services that could make it possible for a patient to live outside the nursing home are home nursing services and regular physician visits. The same reasoning must be applied to the question on community services that was applied to the question on rehabilitation potential. What economies and patient benefit would result if this question was evaluated by a team of a physician, nurse and social worker at the time of the patient's admission to the home and periodically evaluated thereafter?

It is recommended:

1. That all public assistance patients be evaluated and classified, if possible before admission, or as soon as possible after admission to a nursing home, by a team of physician, nurse and social worker to determine the patient s requirements for care and to assure admission to a nursing home offering a level of care that can meet these needs. This recommendation presumes a classification of nursing homes into skilled nursing homes, and personal care homes without skilled nursing. The patient should be again evaluated by the team at least every 6 months. It is suggested that a public health nurse, specially trained in the care of the chronically ill, be used to make quarterly evaluations and respond to requests for reclassification by nursing home or personal care home operators.

A possible patient calssification system was explored.

The study data seems to indicate that it may be possible to develop a simple objective system for the classification of public assistance patients for purposes of making payments in accordance with the needs of the patient for care. Preliminary mathematical analysis seems to indicate that the patients' needs for care are directly related to certain physical characteristics. Among these are:

(*a*) Continency and the need for aid in performing toilet functions;

(*b*) Needs for assistance in personal care to include management of personal hygiene, dressing, feeding;

(*c*) Mobility;

(*d*) Ability to communicate.

These characteristics are significantly correlated with the amount of nursing time required for patients as estimated by the nurse interviewer. Other characteristics such as diagnoses and frequency of acute episodes of disease, were tested and found not to be significantly correlated.

A tentative scoring system, based on estimates of correlation and weighted nursing time required to care for the patient, was established and applied to a subsample of 100 patients. When scored under this system, patients needing total care would receive a score of 100 while those who are completely independent would receive a score of zero. The possibilities for the development of a mathematical scoring system for the classification of public assistance nursing home patients are most intriguing and have widespread implication. However, the components used in the above comparison were not specifically designed for classification purposes and need considerable refinement. Many elements of skilled nursing care were not included in this analysis. The system discussed here represents preliminary concepts that need further analysis. Greater reliability could be obtained by the use of questions concerning attributes which were specifically designed for this purpose, both qualitative and quantitative measurements related to a time cost study of nursing home patient care.

It is suggested that the team evaluation (recommendation 1) be financed by a project grant over a period of time long enough to determine some more definitive classification data.

The nursing home

This study of nursing home patient care emphasizes the need to revise the Standards and Requirements for Licensed Nursing Homes in Maine.

The term "nursing home" means a facility or unit, however named, which is designated, staffed, and equipped for the accommodation of individuals not requiring hospital care but needing nursing care and related medical services prescribed or performed under the direction of persons licensed to provide such care or services in accordance with the laws of the State in which the facility is located.

Approximately 1,000 patients, in one-third of the licensed nursing homes in Maine, are under the care of persons not licensed as registered professional nurses nor as licensed practical nurses. Approximately 1,000 patients, in 16 percent of the nursing homes in Maine, average less than 2 hours of nursing time availability each day. When this fact is related to the fact that 62.3 percent of the homes say they are equipped to admit patients requiring intravenous solutions; 54.7 percent of the homes say they are equipped to admit patients requiring oxygen and 83 percent of the homes use narcotics, it is evident that the minimum qualifications of nursing service or supervision are perilously below minimum for safe care of patients and in some instances may be in conflict with the Nurse Practice Act.

It is recommended:

2. That the current Standards and Requirements for Licensed Nursing Homes in Maine be revised to conform with the above cited definition of a nursing home. It is suggested that a committee be appointed under the chairmanship of a member of the medical advisory committee with the responsibility of preparing this revision and recommending its adoption by the department of health and welfare.

It is suggested that this committee consist of members appointed by the Maine Nursing Home Association with additional committee members selected from nursing homes not members of the association, and representatives of the Maine Medical Association, Maine Osteopathic Association, Maine Hospital Association, Maine State Nurses Association, Maine Pharmaceutical Association, Administrators of Boarding Homes for the Aged, and the general public.

It is recommended:

3. That a third category of care be considered—personal care homes to handle those patients not requiring professional nursing care but with less complex needs which can be met by licensed practical nurses under the supervision of a registered professional nurse. This type of home would accept those patients classified in between nursing homes and boarding homes. It is suggested that the above-named committee also consider standards for this type of facility.

It is recommended:

4. That an adjustment be made in the amount of payments to these three classes of facilities in proportion to quality of service being provided. These recommendations presume that the patients will be classified according to their requirements for care. It is not the intent of this recommendation to state that all facilities to be classified as nursing homes in the future should be paid a higher rate for all of their public assistance nursing home patients regardless of need. It is the intent to equate patient needs with services rendered at an equitable remuneration. It is conceivable that a facility classified as a nursing home in the future could accept patients classified for personal care at a rate of payment equitable to the needs of this patient.

It is recommended:

5. That the above recommendations for classification of patients and classification of nursing homes be accepted only if the recommendation for a periodic team evaluation of the patient care be accepted. The suggested classification system will not work without a continuing mechanism for the team evaluation of the patient.

The community

One of the major problems outlined in this study is the lack of adequate communication between community hospitals and physicians when a patient is first admitted to a nursing home. This problem is defined by the following facts. At the time of admission: 27.2 percent of the patients had no diagnosis; 26.8 percent of the patients had no medical orders; 47.9 percent had no recommended diet; 52.1 percent of the patients were admitted without a medical history being available to the nursing home; 58.7 percent of the patients were admitted without evidence of a recent physical examination; 48.3 pezcent of the patients did not have any specific nursing instructions, and 41.9 percent of the patients were admitted without sufficient information on limitations that might influence nursing care plans.

How can nursing homes be expected to provide quality care when the hospitals and physicians do not provide them with sufficient medical information on the patient at the time of admission? Why should a nursing home accept a patient without adequate medical information?

It is recommended:

6. That the guides for medical care in nursing homes and related facilities approved in June 1959 by the Council on Medical Service of the American Medical Association, the Governing Council of the American Nursing Home Association and the AMA–ANHA Liaison Committee, be followed, namely:

(1) "Each patient admitted should have a personal physician who knows of the admission arrangements and agrees to assume responsibility.

(2) "Each patient admitted should come with a complete history and physical examination, or should have such examination immediately upon entering the home, including chest X-ray, necessary laboratory work, an evaluation of his potentialities for rehabilitation, at least to self-care, and full orders for treatment. These orders should be kept up to date by daily nursing notes and periodic progress notes by the physician as well as written directives for care and medication as they are changed."

The acceptance of recommendation 1 on the team evaluation of the patient would help considerably in effecting compliance with the second guide quoted above.

It is recommended:

7. That the committee on nursing home standards consider a requirement that every nursing home shall have, within 1 week from the date of admission, a medical record for each patient to include a diagnosis, history, physical examina-

tion, diet, medical orders, and specific nursing instructions supplemented by daily nursing notes.

In the 106 nursing homes in the study, there were 826 full-time nursing employees: 72 registered nurxes, 44 licensed practical nurses, and 710 nurses aids. Nursing homes, personal care homes and boarding homes will always require a large number of untrained and semitrained staff. In this study 86 percent of the full-time nursing staff were not licensed. The data measuring the components of skilled nursing care indicates that there is need for improvement in the quality of nursing services that are now being offered. In the opinion of the nurse interviewer a continuous effort to reduce bedfastness was being performed in only 77.3 percent of the homes, encouragement of activity was programed in only 54.7 percent of the homes and a program to maintain a range of movement to prevent deformities was being carried out in only 46.2 percent of the homes. The comparison of homes staffed with registered nurses versus homes without registered nurse staffing reveals the value of the professional nurse. Yet, even in homes with registered nurse staffing there is need for improvement in nursing skills. The need for improving professional nursing skills, as well as training and supervising the nonprofessional aids can be met only by a continuous program of staff education.

It is recommended:

8. That educational programs be established for nursing staffs of nursing homes, personal care homes, and boarding homes. It is suggested that the department of health and welfare acquire a team of nursing educators, trained in the care and rehabilitation of the chronically ill patient. For professional nurses, the goal of this program should include updating of nursing knowledge and skills and the development of teaching, supervisory, and management skills. An additional focus of the program should be aimed at assisting nursing home and personal care home administrators in the training of nonprofessional nursing personnel.

NURSING HOME PATIENT CARE STUDY

Because this study is based on sample data, a certain amount of error can be expected as a result of chance alone. The following table shows expected maximum sample error at the 95-percent confidence level. Reference to this table will aid in assessing the reliability of any statistic in these tables. For example, if a certain characteristic is present in 10 percent of all nursing homes in the study, there is a 95-percent probability that if all nursing homes had been studied, the characteristic would be present in not less than 6.2 percent nor more than 13.8 percent of all nursing homes in the State. Similarly, if a certain characteristic is present in 10 percent of the patients in the study, there is a 95-percent probability that if all nursing home patients were included, the characteristic would be present in not less than 6.9 nor more than 13.1 percent of all public assistance nursing home patients in the State.

Percent shown in tables	Sample error	
	Nursing homes	Nursing home patients
1 and 99	±1.3	±1.0
2 and 98	±1.8	±1.4
5 and 95	±2.7	±2.2
10 and 90	±3.8	±3.1
15 and 85	±4.5	±3.7
25 and 75	±5.5	±4.4
40 and 60	±6.2	±5.0
50	±6.3	±5.1

FACILITIES OF NURSING HOME

TABLE 1.—*Percent of nursing homes by bed capacity and percent of nursing beds occupied*

Number of beds	Available beds		Nursing beds occupied
	Nursing	Boarding	
Total	100.0	19.8	87.2
Less than 10	13.2	17.9	91.0
10 to 19	37.7	.9	85.5
20 to 39	41.5	.0	88.6
40 and over	7.6	1.0	85.7

TABLE 2.—*Percent of all patients in nursing home by source of payments for care*

Source of payment for care	Percent of total patients
Total	100.0
Patient's own resources	33.7
Public assistance (total)	60.1
Nursing care rate ($200 per month)	53.2
Family care rate ($110 per month)	6.5
Boarding care rate ($80 per month)	.4
Not reported	6.2

TABLE 3.—*Percent of nursing homes reporting time worked by registered nurses and licensed practical nurses during week prior to study, by number of occupied beds*

Occupied beds	Number of nursing homes	Nursing staff		
		Registered nurses	Licensed practical nurses	No registered nurses or licensed practical nurses
Total	106	49.0	34.9	32.1
Less than 5	7	28.5	14.3	57.2
5 to 19	47	40.4	34.1	38.3
20 to 39	43	55.8	39.6	25.6
40 and over	9	77.9	33.4	11.1

TABLE 4.—*Percent of nursing homes by number of hours worked by registered nurses and licensed practical nurses during week prior to study*

Hours worked during week	Registered nurses and/or licensed practical nurses	Registered nurses	Licensed practical nurses
Total	100.0	100.0	100.0
168 hours or more	1.9	.9	----
144 to 167 hours	2.8	1.9	----
120 to 143 hours	4.7	2.8	.9
96 to 119 hours	2.8	.9	1.9
72 to 95 hours	8.5	5.7	2.8
48 to 71 hours	20.8	14.2	9.4
24 to 47 hours	19.8	18.9	12.3
8 to 23 hours	5.7	3.8	7.6
None	33.0	50.9	65.1

TABLE 5.—*Percent of homes and patients in homes by average daily amount of nursing time [1] available during week prior to study*

Average hours of nursing time per patient per day	Homes	Patients
Total	100.0	100.0
1 to 1.4 hours	2.8	7.6
1.5 to 1.9 hours	13.2	25.3
2 to 2.4 hours	35.0	37.5
2.5 to 2.9 hours	25.5	19.3
3 to 3.4 hours	9.4	4.8
3.5 to 3.9 hours	3.8	2.0
4 to 4.4 hours	4.7	2.6
4.5 to 4.9 hours	.9	.1
5 and over	4.7	.8

[1] Includes time of registered nurse's, licensed practical nurse's, and nurses' aids.

TABLE 6.—*Percent of nursing homes using various methods for sterilization of syringes and catheters*

Method of sterilization	Syringes	Catheters
Total	[1] 100.0	[1] 100.0
Boiling	58.5	50.0
Sterile disposables	46.2	39.6
(Sterile disposables exclusively)	[2] (29.2)	[2] (22.6)
Autoclave	11.3	8.5
Steam sterilizer	6.6	.9
Chemical bath	.9	1.9
Other	.9	6.6
Not answered	.9	5.7

[1] Percentages do not total to 100 percent because some nursing homes used more than one means of sterilization.

[2] 17 percent used sterile disposables for some, but not all patients. Cost was cited as the reason for not using sterile disposables for all patients in 66.7 percent of these homes.

CHARACTERISTICS OF THE PUBLIC NURSING HOME PATIENT

TABLE 7.—*Public assistance patients in nursing homes by age*

	Percent of patients
Total	100.0
Age group:	
Under 50	3.0
50 to 59	6.1
60 to 64	4.0
65 to 69	4.7
70 to 74	9.7
75 to 79	17.1
80 to 84	20.8
85 to 89	20.8
90 to 94	10.8
95 and over	3.0

TABLE 8.—*Public assistance nursing home patients in nursing homes by length of stay since admission at time of study*

	Percent of patients
Total	100.0
Stay in months:	
3 to 6	9.4
7 to 12	16.8
13 to 18	14.1
19 to 24	11.4
25 to 30	7.7
31 to 36	6.7
37 to 48	11.4
49 to 72	8.4
73 to 120	8.1
121 and over	5.0
Not answered	1.0

TABLE 9.—*Public assistance patients in nursing homes by mental condition*

	Percent of patients
Total	100.0
Mental condition:	
Always clear	40.3
Confused part of the time	36.9
Confused all of the time	22.8

TABLE 10.—*Public assistance patients in nursing homes by mental condition at time of interview by physician*

Mental condition:	Percent of patients
Total	100.0
Clear	54.7
Confused	41.3
Not answered	4.0

TABLE 11.—*Public assistance patients in nursing home by ability to comprehend simple instructions*

Status:	Percent of patients
Total	100.0
Comprehends simple instructions	69.8
Does not always comprehend simple instructions	18.8
Does not comprehend simple instructions	10.7
Not answered	0.7

TABLE 12.—*Public assistance patients in nursing homes by ability to communicate*

Speech ability:	Percent of patients
Total	100.0
Norman speech	73.5
Mild speech impairment	16.1
Severe speech impairment	7.1
Verbal communication impossible	3.0
Not answered	0.3

TABLE 13.—*Public assistance patients in nursing homes by amount of time spent in bed*

Patient is in bed:	Percent of patients
Total	100.0
Only to sleep and rest	58.4
Except when put in chair	24.8
Except for meals and toilet	2.7
All the time	12.8
Not answered	1.3

Table 14.—*Public assistance patients in nursing homes by ability to move about when out of bed*

Ability to move about:	Percent of patients
Total	100.0
Moves about at will	32.5
Walks when encouraged by staff	13.8
Sites in chair except for toileting	13.4
Remains in chair	27.5
In bed all the time	12.8

TABLE 15.—*Public assistance patients in nursing homes by means of moving about*

Means of moving about:	Percent of patients
Total	100.0
Unable to move about	31.2
Moves about unaided	25.2
Moves about with help of other person	21.1
Moves about with help of mechanical aid	17.8
Moves about with help of mechanical aid and other person	3.4
Not answered	1.3

TABLE 16.—*Public assistance patients in nursing homes by ability to climb stairs*

Ability to climb stairs:	Percent of patients
Total	100.0
Unable to climb stairs	79.2
Climbs stairs unaided	7.4
Climbs stairs with aid of another person	11.1
Climbs stairs with cane(s) or crutch(es)	1.0
Climbs stairs with mechanical aid and aid of another person	.7
Not answered	.6

TABLE 17.—*Public assistance patients in nursing homes by management of personal hygiene*

Management of personal hygiene:	Percent of patients
Total	100.0
Totally dependent on other person	50.0
With assistance from other person	38.2
Unaided	11.1
Not answered	.7

TABLE 18.—*Public assistance patients in nursing homes by means of caring for specific needs such as manicures, pedicures, shampoos, etc.*

Means of caring for specified needs:	Percent of patients
Total	100.0
Totally dependent on other person	83.6
With assistance from another person	13.4
Unaided	2.3
Not answered	.7

TABLE 19.—*Public assistance patients in nursing homes by ability of patient to feed self*

Ability to feed self:	Percent of patients
Total	100.0
Feeds self unaided	79.2
Feeds self with aid of another person	12.1
Feeds self with assistive appliances	.7
Unable to feed self	7.4
Not answered	.6

TABLE 20.—*Public assistance patients in nursing homes by ability to dress and undress*

Ability to dress and undress:	Percent of patients
Total	100.0
Unable to dress self	38.6
Able to dress unaided	21.8
Able to dress with aid of another person	38.2
Able to dress with aid of another and assistive appliance	.7
Not answered	.7

TABLE 21.—*Public assistance patients in nursing homes by means of performing toilet functions*

Means of performing toilet functions:	Percent of patients
Total	100.0
Unable to manage by self	26.8
Unaided	26.8
With help of another person	25.2
With assistive appliance and aid of other person	15.1
With assistive appliance	4.7
Not answered	1.4

TABLE 22.—*Public assistance patients in nursing homes by continency of urine and feces*

Continency	Percent of patients	
	Urine	Feces
Total	100.0	100.0
Incontinent all the time	29.5	24.2
Incontinent at night	5.4	2.0
Rarely incontinent	27.5	29.2
Never incontinent	34.9	42.3
Not answered	2.7	2.3

CHRONIC ILLNESS FACTORS

TABLE 23.—*Percent of public assistance patients in nursing homes by diagnosis [1] at admission and at present, and by source of data*

Diagnosis and ISC codes [2]	Admission (source)		Present
	Case record	Administrator	
Neoplasms (140–239)	5.7	5.0	5.0
Diabetes (260)	7.0	4.4	4.0
Other allergic, endocrine, metabolic and nutritional diseases (240–289 excluding 260)	6.7	4.7	3.4
Mental, psychoneurotic and personality diseases (300–326)	14.4	12.1	13.8
Vascular lesions (330–334)	24.2	11.4	8.7
Other cerebral paralysis (352)	8.1	9.7	10.7
Other diseases of nervous system (340–367 excluding 352)	15.4	13.1	13.4
Diseases of the sense organs (370–398)	8.1	5.0	7.7
Diseases of the heart (410–443)	37.9	13.1	12.8
General arteriosclerosis (450)	21.5	7.0	7.0
Other diseases of circulatory system (400–402) (444–468 excluding 450)	14.4	6.7	7.4
Diseases of the respiratory system (470–527)	5.7	1.7	0.3
Diseases of the digestive system (530–587)	8.7	6.4	7.4
Diseases of the genitourinary system (590–637)	9.1	4.0	3.4
Diseases of the skin and cellular tissue (690–716)	3.7	2.0	1.7
Arthritis and rheumatism (720–727)	15.1	10.7	13.4
Other diseases of the bones and organs of movement (730–749)	5.0	13.4	3.4
Senility (794)	8.1	9.7	9.4
Symptoms and ill defined conditions (780–795 excluding 794)	5.4	19.8	17.4
Fractures and injuries (800–999)	10.1	10.4	4.7
Amputations (Y70–Y79)	3.4	2.4	3.0
All other diseases (residual)	5.0	2.3	3.0

[1] 3 diseases or conditions were selected for tabulation from case record, and 2 were selected from those furnished by the administrator and present diagnosis by the interviewing physician.
[2] International statistical classification of diseases, injuries, and causes of death.

TABLE 24.—*Percent of public assistance patients in nursing homes by frequency of acute episodes of disease as reported to nurse and physician interviewers*

Frequency of episodes	Interviewers	
	Nurses	Physicians
Total	100.0	100.0
Once a week	7.4	6.2
Twice a week	5.0	4.7
Once a month	10.1	10.4
Every 3 months	13.1	12.9
Every 6 months	10.1	12.4
Once a year	7.7	8.8
Less than 1 a year	41.6	34.2
Inappropriate	4.0	
Not answered	1.0	10.4

TABLE 25.—*Public assistance patients in nursing homes by length of time since last acute episode of disease*

Time since last episode:	*Percent of patients*
Total	100.0
None since admission	30.2
Within 30 days	21.5
1 to 3 months ago	11.7
3 to 6 months ago	13.1
6 to 12 months ago	7.7
1 to 2 years ago	7.4
More than 2 years ago	3.7
Don't know	2.7
Not answered	2.0

TABLE 26.—*Percent of public assistance patients in nursing homes by length of most recent episode of disease*

	Interviewer	
	Nurses	Physicans
Total	100.0	100.0
Less than 1 week	44.0	42.5
1 week	13.8	19.7
2 weeks	9.1	8.3
3 weeks	5.0	5.2
1 month	3.0	5.7
More than 1 month	5.0	11.9
Inappropriate	4.0	
Not answered	16.1	6.7

CARE OF PATIENTS

TABLE 27.—*Public assistance patients in nursing homes by supervisor of nursing care*

Qualification of supervisor:	*Percent of patients*
Total	100.0
Nurses aid	43.9
Registered nurse	31.9
Licensed practical nurse	24.2

TABLE 28.—*Percent of assistance patients in nursing homes by daily amount of time needed for care and daily amount of time received on day prior to interview as estimated by nurse interviewers*

	R.N.		L.P.N.		Nurses aid	
	Received	Estimated requirement	Received	Estimated requirement	Received	Estimated requirement
Total	100.0	100.0	100.0	100.0	100.0	100.0
No nursing care	67.5	21.8	72.5	27.8	2.4	7.1
Supervision of activities only	5.4	7.0	7.7	.7	1.0	1.3
Direct care:						
Less than ½ hour	16.8	41.3	10.7	10.4	.7	.7
½ to 1 hour	8.0	27.9	6.4	36.6	12.4	12.8
1 to 2 hours	.7	2.0	2.4	18.8	24.9	33.2
2 to 3 hours	1.0	0	0	5.7	25.7	20.8
3 to 4 hours	.3	0	0	0	9.7	8.7
More than 4 hours	.3	0	.3	0	23.2	15.4

TABLE 29.—*Public assistance patients in nursing homes by status of selected items of personal care*

	Percent of patients		
	Yes	No	Not specified
Does this patient have evidence of good personal hygiene	93.0	4.4	2.6
Is patient free from decubiti	93.0	6.7	.3
Is there evidence that a regular program is in effect to prevent decubiti	95.0	4.0	1.0

TABLE 30.—*Public assistance patients in nursing homes by time interval since last seen by physician*

Last seen by physician:	Percent of patients
Total	100.0
Within the past 30 days	38.6
1 to 3 months ago	22.8
3 to 6 months ago	14.4
6 to 12 months ago	7.4
1 to 2 years ago	5.7
More than 2 years ago	3.0
Not seen since admission	5.7
Not answered	2.4

TABLE 31.—*Public assistance patients in nursing home by time of last physical examination, change of therapeutic regime, and laboratory work*

Time interval	Percent of patients		
	Physical examination	Therapeutic regime change	Laboratory work
Total	100.0	100.0	100.0
Within past 30 days	24.5	12.5	6.1
1 to 3 months ago	17.8	11.7	4.4
3 to 6 months ago	10.4	8.7	3.7
6 to 12 months ago	4.4	8.1	4.0
1 to 2 years ago	5.7	7.1	5.7
More than 2 years ago	2.0	5.0	8.4
None since admission	5.4	17.8	35.2
Unknown [1]	29.8	29.1	32.5

[1] Includes patients for whom no medical records were available (28.5 percent of patients).

NURSING HOME RECORDS

TABLE 32.—*Public assistance patients in nursing homes by information made available to nursing home at time of admission*

Medical information	Percent of patients		
	Yes	No	Not specified
Administrator considered medical admission data adequate	60.4	38.3	1.3
Information made available at time of admission:			
Medical history	47.9	51.6	.5
Recent physical exam	41.3	58.2	.5
Diagnosis	72.8	26.7	.5
Relevant laboratory findings	20.6	78.9	.5
Medical orders	73.2	26.3	.5
Diet	52.1	47.4	.5

TABLE 33.—*Public assistance patients in nursing homes by nursing information made available to nursing home at time of admission*

Nursing information	Percent of patients		
	Yes	No	Not specific
Administrator considered admission nursing data adequate	44.0	55.0	1.0
Information made available:			
Immediate and long-term prognosis	51.3	47.3	1.4
Specific nursing instructions	61.8	37.2	1.0
Information on patient's limitations which might influence nursing care plans	58.1	40.9	1.0

TABLE 34.—*Public assistance patients in nursing homes by nursing home administrator's opinion of adequacy of admission data and by housing of patients prior to admission*

Housing prior to admission:	*Percent of patients with adequate data*
Total	60.4
General hospital	90.0
Own home or relatives home	48.3
Other	54.3

TABLE 35.—*Public assistance patients in nursing homes by availability of selected medical records in nursing home*

Record	Percent of patients		
	Yes	No	Not specified
Medical record	71.5	28.5	
Provisions to keep progress notes	86.9	11.7	1.4
Provisions to keep medical orders	94.3	4.7	1.0

TABLE 36.—*Public assistance patients in nursing homes by availability of selected data in nursing records in home*

	Percent of patients		
	Yes	No	Not specified
Nursing record maintained	90.9	8.4	0.7
Content of nursing record:			
Medication	94.0	6.0	
Treatments performed	90.3	9.7	
Untoward reactions	84.2	15.8	
Observations of patient's condition	83.2	16.8	
Most recent acute episode of disease	67.9	24.3	7.8
Nursing care directions	73.8	26.2	
Identification of person giving care	66.4	33.6	

TABLE 37.—*Percent of public assistance patients in nursing homes by potential for rehabilitation*

Rehabilitation potential	Team	Social worker	Nurse	Physician
Total	100.0	100.0	100.0	100.0
Could be rehabilitated to care for self completely outside of institution	1.0	2.0	1.0	1.3
Could be rehabilitated to care for self, but needs supervision for feeding and lodging	7.4	6.0	7.0	7.7
Could be rehabilitated to function more adequately, but needs nursing supervision	9.1	11.7	17.1	12.1
Patient has no rehabilitation potential	81.8	79.9	74.5	75.2
Not answered	.7	.4	.4	3.7

TABLE 38.—*Public assistance patients in nursing homes by type of facility most appropriate for care as indicated by social worker-nurse-physician team*

Type of facility	Percent of patients as indicated by—			
	Team	Social worker	Nurse	Physician
Total	100.0	100.0	100.0	100.0
Nursing home	83.9	88.9	79.5	83.9
Boarding home	7.7	6.0	6.7	7.4
Own home	1.7	.3	4.4	.3
Mental hospital		1.4	1.4	1.4
Rehabilitation facility	.3	0	1.3	.3
General hospital	.7	0	.3	1.3
Other	5.0	2.0	5.7	2.0
Not answered	.7	1.4	.7	3.4

SERVICE FOR NURSING-HOME PATIENTS

TABLE 39.—*Public-assistance patients in nursing homes by reason of need for continued nursing home care as indicated by social worker-nurse-physician team*

Reason for need	Percent of patients as indicated by—			
	Team	Social worker	Nurse	Physician
Total	100.0	100.0	100.0	100.0
Do not need continued nursing home care	13.1	7.1	17.4	8.4
Need continued care (total)	86.9	92.9	82.6	91.6
Patient could not be cared for at home because of extent of illness	82.6	87.9	69.2	59.7
Patient could not be cared for at home because of other family problems	.7	0	3.0	3.7
No other place to go	1.3	2.0	5.0	11.7
Terminal care	1.7	1.0	3.7	13.1
Convalescent care	.3	.7	0	3.4
Other reason	0	.7	1.0	0
Not answered	.3	.6	.7	0

TABLE 40.—*Percent of public assistance patients in nursing homes by kinds of community services which might make it possible for patient to live outside nursing home, as indicated by social worker-nurse-physician team*

Service	Essential				Desirable			
	Team	Social worker	Nurse	Physician	Team	Social worker	Nurse	Physician
No service	85.6	88.3	76.2	83.9	85.6	88.3	76.2	83.9
Visiting nurse service	6.7	4.3	11.4	4.4	.7	.3	2.3	2.3
Regular physician visits	6.4	5.0	13.1	3.0	2.3	1.3	3.4	3.0
Homemaker service	2.7	2.3	5.7	5.0	.7	.0	1.3	.7
Social service	2.7	1.3	6.7	1.7	2.3	3.0	1.0	.7

TABLE 41.—*Public assistance patients in nursing homes who could benefit from short period of hospitalization for specified services*

Specified service:	*Percent who might benefit*
Total	100.0
None	89.3
Diagnostic tests	5.0
Intensive treatment	1.7
Intensive rehabilitation	1.0
Not answered	3.0

BIBLIOGRAPHY

State Medical Advisory Committee Activated, Sullivan, George E., Journal of the Maine Medical Association, April 1964.
Factfinding Survey of Massachusetts Nursing Homes, Kelleher, Rita P., Boston College School of Nursing, 1963.
Blue Cross Reports, The Availability and Financing of Nursing Home Care, Blue Cross Association, volume II, No. 2, April–June 1964.
Physicians' Observations in Nursing Homes, Jackler, J., et al., Journal of the Maine Medical Association, volume 54, No. 3, March 1963.
Hospital and Medical Facilities Survey and Construction Plan, State of Maine, annual revisions, 1961–65.
Nursing Homes in Maine, Maine Department of Health and Welfare, December 1956.
Demonstration of Rehabilitation Potential of Patients on Home Care or in Nursing Homes 1959 to 1963, Thayer Hospital, Waterville, Maine.
Medical Care in the State of Maine—1956–62, Smillie, Wilson G., Bingham Associates Fund, 1962.
Nursing Homes and Related Facilities Fact Book, U.S. Department of Health, Education, and Welfare, Public Health Service, Publication No. 930–F–4, February 1963.
Nursing Homes, Consumers Union, Mount Vernon, N.Y., Consumer Reports, January–April 1964.
Improvement of Nursing Care in Adult Care Homes in Kansas; Kansas State Board of Health, August 1962.
Medical Care: Its Social and Organizational Aspects—Nursing Homes and Medical Care, Solon, J., New England Journal of Medicine, volume 269, No. 20, November 14, 1963.
Nursing Home Standards Guide, U.S. Department of Health, Education, and Welfare, Public Health Service, Publication No. 827, 1961.
Guides for Medical Care in Nursing Homes and Related Facilities, American Medical Association Council on Medical Service, Chicago, Ill., June 1959.
Professional Personnel in Nursing Homes, Terry, Luther L., Public Health Report, volume 78, No. 12, December 1963.

APPENDIX B

STATE OF MAINE,
Androscoggin, ss:

OFFICE OF THE ADMINISTRATIVE HEARING COMMISSIONER

DOCKET NO. 4

STATE OF MAINE DEPARTMENT OF HEALTH AND WELFARE OF AUGUSTA, KENNEBEC COUNTY

v.

MEDA A. WESTON D.B.A. SUN REST NURSING HOME OF PORTLAND, CUMBERLAND COUNTY

DECISION

This case came before the commissioner on a complaint filed by the State of Maine Department of Health and Welfare charging the defendant from January 3, 1962, to February 21, 1964, with—

(*a*) Physical abuse and neglect of patients;
(*b*) Inadequate medical records;
(*c*) Use of unsterile equipment;
(*d*) Inadequate diet for both patients and personnel;
(*e*) Improper care of incontinent patients;
(*f*) Use of inadequate and/or improper bedding;
(*g*) Inadequate nursing staff;
(*h*) Dispensing medications without or contrary to doctors' orders; and
(*i*) Resistance to inspection by agent of the department.

A pretrial conference was held on April 1, 1964, at the probate court room, Androscoggin County Building, Auburn, Maine. The hearing was held at the said probate court room on April 9, 1964. Ruth L. Crowley, assistant attorney general, represented the plaintiff, and the defendant was represented by Attorney Sumner J. Goffin.

In response to defendant's motion, plaintiff filed a more definite statement setting forth some 36 violations on specific dates, plus others "on diverse other dates," which allegedly occurred between August 1961 and October 1963. Defendant answered the more definite statement denying in each instance that she had committed any act which constituted a violation.

Findings of fact: This is an administrative hearing wherein the plaintiff must prove the allegations, not beyond a reasonable doubt, but only by a fair preponderance of the evidence.

The transcript in this case is voluminous and the testimony of the several witnesses pertaining to the numerous allegations in the more definite statement follows no particular categorical or chronological order or pattern.

The plaintiff presented only one State official, Miss Martha Robbins, R.N., supervisor, health services department, department of health and welfare, who testified concerning her inspection visits to the defendant's nursing home and her observations of some of the allegations contained in the more definite statement. Numerous other allegations were based solely upon the questionable testimony of one or more of plaintiff's three other witnesses, all former employees at defendant's nursing home, one of whom was employed during the period of only 1 night and 2 days in 1962, the second of whom was employed during a period of 3 days in October or November of 1963, and the third of whom was employed at the nursing home during a total period of approximately 6 months in 1962 and 1963, and who had a drinking problem, felt the affects upon reporting to work on several occasions, and who was dismissed from her job by the defendant.

The testimony of plaintiff's witnesses was rebutted, in addition to the testimony of the defendant, by two reputable physicians who had treated patients in the nursing home during the alleged periods and who are still doing so, by a minister

who resides directly across the street from the defendant's nursing home and who frequently visited patients in the home during the period of the alleged violations, by a former patient of the home and by a former employee who was employed at the nursing home from July 1961 to May or June 1963.

After a painstaking review of the transcript, depositions and exhibits, and having due regard for matters pertaining to the credibility of the individual witnesses, the commissioner finds as follows:

(*a*) The preponderance of the evidence fails to prove that defendant or her agents physically abused or neglected the patients, except that nonambulatory patients were not provided with bells on certain occasions.

One of the more serious charges presented here is the allegation that two patients were observed with black-and-blue marks under the eye and that patients were observed with black-and-blue marks on other areas of their bodies, "for which no satisfactory explanation was given." The inference here, of course, is that said marks and bruises were caused by the abuse of the defendant or her employees, an allegation so serious in nature that were it substantiated by the evidence, then, for this violation alone, the commissioner would revoke the defendant's license. However, the preponderance of the evidence falls very short of substantiating the charge.

Although Miss Martha Robbins, R.N., supervisor, health services department, department of health and welfare, testified that she observed a patient, Mrs. Barnett, show an "expression of fear and cringe back onto her pillow when Mrs. Weston approached her bed." Miss Robbins also testified that the patients never complained to her, that no relative of the patients ever complained to her, and that she never saw anyone strike a patient. Were the foregoing the only evidence available on the matter, the commissioner would not be justified in concluding that Mrs. Weston or her employees had struck or abused the patients. The commissioner cannot inject speculation and conjecture in order to conclude what may or may not have caused the subject patients to sustain bruises.

However, there is considerable evidence pertaining to the cause of the aforesaid black-and-blue marks and which indicates that same did not result from physical abuse or neglect. Several witnesses, including witnesses for both the plaintiff and the defendant, and including a practical nurse and a physician, testified that it is common for elderly people to have an excess of fluids in their bodies whereby they bruise easily merely from the pressure of their bodies against the hands of attendants who are required to lift them. The aforesaid testimony was neither disputed nor rebutted. Moreover, Dr. Thor Miller, of Westbrook, and Dr. Walter Penta, of Portland, both reputable physicians, testified that they have treated patients at defendant's nursing home in the past and will continue to do so in the future. Dr. Penta also stated that from his observations Mrs. Weston has a well-run nursing home and that his patients there are well treated and cared for.

The only explanation for the bruises under the eyes of two patients was the testimony of the defendant and her witnesses that same could have been caused by the patients rolling over in bed and striking against the side of the guardrail or that a patient may possibly have struck the bedrail upon being "rolled over" by defendant or an employee for the purpose of changing the bedding. Defendant testified that same "must have" occurred in the aforesaid manner but that "I really don't know" how it happened. The aforesaid explanation was neither disputed nor rebutted other than by testimony of plaintiff's witness, a former employee of the defendant, who stated that she questioned Mrs. Weston about the matter and was told by her that Mrs. Weston did not see it happen but that the patient "fell" or "struck it on the crib rail." In any event, there is no evidence of any nature of said bruises having been inflicted through the abuse or neglect of the defendant or her employees.

The testimony of Helen Aikens, Marjorie Gardiner, and Sarah Valente, the only witnesses for the plaintiff other than Miss Robbins, pertaining to the group of allegations under discussion at the moment, lacks credibility in many particulars:

Mrs. Helen Aikens is a practical nurse who was employed by the defendant during a period of only 1 night and 2 days in August of 1962. At the pretrial it was indicated that Mrs. Aikens was so disturbed by what she saw at defendant's nursing home during said period that she personally complained to high State and Federal officials. At the hearing, upon testifying that she once saw defendant slap a patient on the shoulder, she stated that same "was minor to the terrible things I saw." Yet, Mrs. Aikens failed to substantiate the aforesaid serious statement with any credible testimony of specific incidents, which, in conjunction

with other elements of her testimony, indicates some prejudice, exaggeration, and inconsistencies which will be discussed under other allegations subsequently.

The testimony of Marjorie Gardiner, a practical nurse employed by the defendant for several months in 1962 and 1963, lacked credibility. Mrs. Gardiner stated that some patients were frightened when Mrs. Weston entered their room, that "they screamed and hollered" and that "at least two begged me to help them get out." Mrs. Gardiner also admitted that she had a drinking problem at the time, that on three or four occasions she felt the affects of drinking when she came on duty but that she didn't have the "d.t.'s—not while I was employed there." Rev. Walter Colby, a minister, testified that on several occasions after Mrs. Gardiner had been drinking, he would help her get into condition to report for work and that he interceded with Mrs. Weston in order to help Mrs. Gardiner retain her job. Moreover, two physicians who treated patients at the nursing home, a former employee of the home, a former patient of the home, and plaintiff's supervisor, Miss Robbins, all testified that no patient or a relative of a patient ever complained to them. Mrs. Weston's testimony that she dismissed Mrs. Gardiner from her employ was not disputed.

Plaintiff's witness, Mrs. Sarah Valente, a nurses aid, who was employed by defendant for 3 days in 1963, also testified that she observed Mrs. Weston strike a patient across the legs with a facecloth when the patient tried to get up while an enema was being administered, that Mrs. Weston called a patient "a thing," and that patients were afraid of the defendant. However, the following inconsistencies in Mrs. Valente's testimony are noted: On direct examination, Mrs. Valente testified: "They were afraid of her. Things they said." On cross-examination, contradicting her direct testimony, she stated: "They didn't say anything. I didn't say they did. Mrs. Weston told me they were afraid of her." Upon being questioned by the commissioner, she again changed her version and testified that Mrs. Weston did not say the patients were afraid of her, that on her first day of duty Mrs. Weston said, "None of the patients like me," that she, Mrs. Valente, could not understand her saying that "as Mrs. Weston had a beautiful home to step into." Further, on direct testimony, Mrs. Valente stated positively that in her presence the defendant called a patient "a thing." Again, on cross-examination, Mrs. Valente changed her testimony and stated that the defendant was not referring to the patient, but to the patient's daughter who was visiting in the patient's room.

Summarily stated, the aforesaid allegations under discussion at the moment rest mainly upon the questionable testimony of two former employees of 3 days' duration and a third former employee who had a serious drinking problem to the extent that her job with the defendant was in jeopardy, who testified, not to recent events, but to alleged incidents of 1962 and 1963. Whereas the plaintiff did not introduce testimony of present employees or credible employees of longer tenure with the defendant, the commissioner cannot justifiably conclude that the testimony of the three aforesaid individuals carries the weight of the evidence as rebutted by the testimony of a clergyman, two reputable physicians, and others.

In view of the aforesaid, the testimony of the aforementioned former short-term employees, standing alone, is also insufficient to carry the weight of the evidence pertaining to the allegations that patients were kept on bedpans for prolonged and unreasonable periods of time, that defendant administered catheterizations and enemas in such rough manner as to constitute physical abuse, or that patients sustained excrement burns and bed sores as the result of defendant's abuse or neglect.

Plaintiff's supervisor did not observe any of the aforesaid other than her testimony that on November 20, 1962, she observed one patient whose buttocks "was discolored, some of it from incontinence" and "had a caked appearance which I believed to be fecal matter and which had been powdered over." However, one individual's testimony of an isolated incident of this nature occurring in 1962 would not justify a finding of a violation for neglect in view of the testimony of said patient's physician, Dr. Thor Miller, who found no abuse or neglect in connection with his said patient. Dr. Miller also testified that old people lying in bed are apt to get excoriation from urine leakage.

Evidence pertaining to rough and abusive administering of enemas was based solely on the questionable and contradictory testimony of said 3-day employee, Sarah Valente. Were the testimony of Mrs. Valente to be accepted without question, the substance of same leaves considerable doubt as to whether the two subject enemas were given in such a manner as to constitute physical abuse. First, there was no medical or other testimony that the physical condition of the two subject patients would render the administering of an enema dangerous or inadvisable, there was no evidence that the enemas were given either in compliance with or against the orders of a physician, except that defendant testified

that she administered one enema upon the instructions of the patient's doctor, and there was no medical testimony that the enemas proved harmful to the patients. Finally, from the description given by Mrs. Valente, there is no evidence that the enemas were improperly administered or that the defendant used other than customary methods of administering a treatment which is ordinarily an unpleasant experience to the patient.

Testimony of said 3-day employee Helen Aikens, that patients were left on commodes for prolonged periods of time, "night and day" and for "24 hours a day", lacks credibility per se. Moreover, said witness was not present 24 hours per day, had no personal knowledge of events over a 24-hour period and offered no explanation concerning the source of her information. It is inconceivable that physicians, relatives, and other visitors would not observe such incidents. However, it was not observed by other witnesses who frequented the nursing home or who were employed there.

With regard to the specification under this allegation that patients were not provided with bells with which to call attendants, plaintiff's supervisor, Miss Robbins, testified that on more than one occasion she observed nonambulatory patients who were not provided with bells. The commissioner has no reason to doubt Miss Robbins' veracity. Although portions of Miss Robbins' testimony pertaining to other allegations consisted of speculation and opinions which, for various reasons, did not carry the weight of the evidence, there is no justifiable reason to doubt her truthfulness and the accuracy of her firsthand observations.

Defendant's explanation was that the hand bells which were provided may have fallen on the floor or have been under the patients' pillows in some instances. However, it is defendant's responsibility to insure that bells or other signaling devices are available and within immediate reach of said patients. Frequent, periodic checks should be made to determine whether patients' bells have fallen to the floor and have become out of reach, if such is the case.

(*b*) The requisite preponderance of the evidence substantiates the allegation that defendant kept inadequate medical records. Although many records were kept by the defendant, her medication report, doctors' order book and narcotics record book were, in some instances, incomplete and not current.

In the way of mitigation, it is apparent that plaintiff is having difficulty in inducing many other nursing homes to establish an adequate record-keeping system and that some confusion has resulted among a number of licensed nursing homes. Defendant's exhibit No. 2, admitted without objection, is a circular letter dated March 16, 1964, from the division of hospital services, department of health and welfare, to licensed nursing homes on the subject of "Record Forms" and is one of several such letters issued pertaining to the problem of recordkeeping. Said letter states in part: "It has been gratifying to know that some homes have made satisfactory arrangements to purchase forms and to have an individual patient record well maintained. However there appears to be failure to have a well-established record system in some homes and possible confusion concerning the most satisfactory forms to be used.

"It is admitted that a uniform system of recordkeeping would be possible only if the department of health and welfare supplied all forms, or if purchase of special forms were to be made from a certain company. This is not considered a possible or desirable method at this time and it is believed that a very acceptable system is possible by purchase of forms on the recommended list. A good system, well established, need not necessarily be more time consuming than a haphazard record system."

Defendant's exhibit No. 1, also a letter from division of hospital services to licensed nursing homes, dated November 4, 1963, states in part: "It is recommended that prompt purchase be made, from the desired firm of the following forms which will meet the requirements of the department." Said communication then lists, among others, 14 types of forms which are in the category of medical records.

From the use of the word "recommended" in said letters and from the testimony of plaintiff's supervisor concerning various record books which she "suggested" the defendant maintain, nursing home proprietors could reasonably be confused in some instances, as to which records are mandatory and which are merely recommended, particularly since part II, sections J.1 and J.3 (on "Reports and Records") of plaintiff's Standards and Requirements for Nursing Homes adopted in October 1956, offered in evidence by the plaintiff, are vague and ambiguous. Moreover, several reports alleged to be inadequate in plaintiff's more definite statement and inadequate reports referred to by a witness for the plaintiff, such as "long-term form books" and "daily census of patients," although apparently recommended or suggested by the plaintiff elsewhere, are not requred or enumer-

ated in plaintiff's aforesaid Standards and Requirements for Nursing Homes—its officially adopted compilation of rules and regulations. And the complaint is based upon the allegation that "all the above irregularities are in violation of the Standards and Requirements for Nursing Homes as adopted in October 1956, with amendments thereto."

(c) Paragraph 3(c) of the complaint alleges "use of unsterile equipment." Plaintiff's more definite statement pertaining to said allegation sets forth the following: "A former employee complained to plaintiff department that pads from incontient patients, as well as waste, were burned in a fireplace in the dining room of said nursing home. In report of inspection on November 20, 1962, inspector reported that at least four mattresses were stained and one badly torn, and that equipment requring sterlization was not being adequately sanitized in the kitchen."

The requisite preponderance of the evidence fails to substantiate the allegation that defendant used unsterile equipment.

Plaintiff presented no evidence concerning equipment requiring sterilization and plaintiff's witnesses made no reference to the subject. Defendant was questioned on the matter, on cross-examination, but no evidence of a violation pertaining to sterilization resulted.

The allegation that pads and waste from incontinent patients were burned in a fireplace in the dining room is based solely on the testimony of said Marjorie Gardiner, as denied by defendant and her witnesses, and is not supported by the preponderance of the evidence. The preponderance of the evidence substantiates the allegation that on November 20, 1962, several stained mattresses and one torn mattress were in use on patients' beds. However, same constitutes a violation under allegation (f): "Use of inadequate and/or improper bedding," infra, and does not constitute use of unsterile equipment within the meaning of plaintiff's official rules and regulations.

(d) The requisite preponderance of the evidence fails to substantiate the allegation that defendant provided an inadequate diet for patients and personnel.

Here, again, the plaintiff's case rests upon the questionable and contradictory testimony of Mrs. Helen Aikens, and is confined to the 1 night and 2 days in August 1962, during which she was employed by the defendant.

Mrs. Aikens testified that she was served inadequate meals during her brief employment with defendant in 1962. She elaborates on the inadequacy of her meals with the following statement: "The last night I was there she gave me two warmed-up biscuits she offered to me. The first night I was told to help myself, there was some chicken. The second night she definitely handed me the two rolls and a cup of tea." However, on cross-examination, upon being asked if Mrs. Weston allowed her to have additional food, Mrs. Aikens answered: "There was nothing said about allowing. She didn't say that is all the food, she said; 'Are you going to have supper before you go?' She didn't restrict me from going to the refrigerator. She really was all right that way."

With regard to the alleged inadequacy of patients' meals, Mrs. Aikens testified: "The ones we had to feed had a very inadequate diet * * * not enough, not hot, and not served until between 2 and 3 o'clock in the afternoon one of the days. The other day it was a little earlier * * *. Once I kept asking for the feeders meal, that she finally got a small dish of cold mashed potatoes mixed up with cold string beans and a cup of jello and a small glass of milk. Another day they had cereal. And the night they had the mashed potato for dinner they had a large eggnog with brandy for supper."

Were the commissioner to accept the foregoing testimony without question, it would not justify a finding that the defendant was in violation for providing an inadequate diet for patients, based solely on three meals served to some of the patients 1½ years prior to the date of the complaint. Moreover, there is no medical or other expert testimony concerning the dietary requirements of the particular patients referred to and no evidence that Mrs. Aikens is a dietary expert or authority qualified to determine whether the subject food was adequate for the requirements of the individual patients to whom Mrs. Aikens stated it was served.

Further, none of the plaintiff's inspectors or other personnel testified that defendant's food was inadequate. No patient or relative or friend of a patient was presented.

On the other hand, Dr. Walter Penta testified that, "We have occasion to order salt-free and diabetic-type diets, so we do watch the patients' food, and I have found that the food is as prescribed and perfectly adequate."

Dr. Thor Miller testified that he enters the nursing home through the kitchen, that he has never tasted the food but that he has observed that it "always looks kind of tasty" and that "they looked as if they were adequate servings".

Defendant testified that patients are given ample and adequate food and that some patients require or accept much less food than others. She further testified that on several occasions plaintiff's officials inspected her food and found it adequate; plaintiff did not dispute the latter statement.

(*e*) The requisite preponderance of the evidence fails to prove that defendant took improper care of incontinent patients. The more definite statement sets forth three alleged incidents under this allegation:

(1) "Inspection report of November 20, 1962, noted evidence of excrement burns due to prolonged use of rubber pants on incontinent patient." However, plaintiff's supervisor, upon giving evidence pertaining to her said inspection of November 20, 1962, testified on direct examination that said patient; i.e., Mrs. Barnett, was not wearing rubber pants, that she had a retention catheter. Said witness testified that defendant was treating Mrs. Barnett for the alleged condition but that she assumed that the medication defendant stated she was using was of a different variety which the witness did not believe to be proper. However, Dr. Thor Miller, Mrs. Barnett's physician, testified that his said patient sustained excoriation around the vulva, rectum, and buttocks resulting from, he assumed, urine leakage which an elderly lady being in bed "is apt to get" and that same would not come from lack of care.

(2) "Employee complaints indicate that defendant ordered that no incontinent patients be changed during the night; that patients are left on bedpan or commode for several hours at a time; that diapered patients are left wet for prolonged periods of time; that incontinent patients lie on bare rubber or plastic sheets without a drawsheet or other covering." The requisite preponderance of the evidence fails to substantiate these statements of said three part-time employees which were rebutted by defendant's witnesses, for the reasons discussed under other allegations, supra.

(*f*) The requisite preponderance of the evidence establishes that defendant used inadequate and improper bedding in some particulars: On November 20, 1962, several stained mattresses and one torn mattress were in use on patients' beds. Defendant contends that mattresses do become stained and worn after which they are replaced. It is evident, here, from the description of the stained and worn condition of said mattresses as related by plaintiff's supervisor and others, that they remained in service beyond the point at which they should reasonably have been replaced.

Testimony that patients were permitted to lie on plastic or rubber sheets without a covering, that blankets were not available for use on all beds and that undersheets were removed after visiting hours, fails to carry the weight of the evidence for the reasons heretofore stated and that plaintiff's witnesses, in some instances here, contradicted each other in their testimony pertaining to said alleged violations.

The preponderance of the evidence proves the allegation that on November 20, 1962, "one patient was found on a cot with two other regulation beds in a room designated for only two beds." Plaintiff's said supervisor testified that on said date she observed a patient, one Mrs. Angie Chapman, on a roll-away cot located in a room with two other bed patients, that only two beds were authorized for said room. Said supervisor also testified that the aforesaid Angie Chapman was lying on a bare plastic sheet with no cloth sheet over the plastic sheet.

Defendent denied that said patient was on a bare plastic sheet. However, there is no justifiable reason to doubt the credibility of the supervisor or her ability to observe the covering upon which the patient was lying.

Defendent testified that said Mrs. Chapman was placed on the cot during the morning of said date because a relative of the patient had advised that she would call at the nursing home and remove said patient to her residence; that the relative was expected "any minute"; that defendant had another patient for Mrs. Chapman's bed and, therefore, placed Mrs. Chapman temporarily on the roll-away cot while waiting for the relative to remove her from the nursing home. Nevertheless, defendant was aware, or ought to have been aware, that the aforesaid act is contrary to plaintiff's rules and regulations and constitutes a violation.

Although the weight of the evidence does not substantiate the allegation, except as regards the isolated incident involving Mrs. Chapman, supra, that defendant permitted patients to lie on bare rubber or plastic sheets without a covering sheet, there is, however, a preponderance of evidence that on November 20, 1962, and on some other occasions during the periods alleged, defendant used pieces of sheeting which did not properly cover a sufficient area of some rubber sheets.

(*g*) Paragraph 3(g) of the complaint alleges that defendant maintained an inadequate nursing staff. Plaintiff's more definite statement pertaining to said allegation sets forth the following: "Inspection report of November 20, 1962, notes that defendant was sole attendant other than the cook in the nursing home with 10 patients. Former employees complained that they frequently had to work 2 or more hours overtime, without extra pay, until attendants on following shift came on duty. All reports indicate a big turnover of personnel with periods of employment for specific employees frequently very brief."

At pretrial, defendant admitted the allegations that an inspection report of November 20, 1962, notes that defendant was the sole attendant, other than the cook, in the nursing home with 10 patients, but denied that same constituted a violation. The commissioner is unable to conclude that said circumstance constitutes a violation of plaintiff's standards and requirements whereas said standards and requirements do not specify that more than one attendant must be present at all times. It is required therein that a nursing home provide a minimum of an average of 2½ hours of nursing staff time per patient per day up to 20 patients. Certainly, if defendant were the sole attendant on duty with 10 patients throughout the entire 24-hour period of the day, it would be impossible for her to have given an average of 2½ hours nursing staff time to each of the 10 patients during said day. However, there is no evidence of the period of time during the alleged day that defendant was the sole attendant on duty.

The allegation that former employees complained that they frequently had to work 2 or more hours overtime, without extra pay, until attendants on following shift came on duty, is not substantiated by the weight of the evidence. Moreover, said allegation, if proved, would not constitute a violation, in any event. The allegation that all reports indicate a big turnover in personnel, with periods of employment for specific employees frequently very brief is not substantiated by a preponderance of the evidence. Of course, plaintiff presented two witnesses who did work during very brief periods for the defendant. However, were the latter allegation supported by the weight of the evidence, it would not constitute a violation, as plaintiff admitted at pretrial.

(*h*) The preponderance of the evidence fails to substantiate the allegation that sleeping pills and not her medication were dispensed either contrary to or without doctors' orders for same, except in one instance: Defendant was in violation for using a posey belt on a patient without the written authorization of the patient's physician. Plaintiff and patient's said physician testified that the physician gave the defendant a verbal order for the use of the posey belt. However, the required written authorization was not given.

(*i*) The preponderance of the evidence fails to prove that defendant was in violation for refusing admission to the nursing home to plaintiff's inspection agent, for keeping said inspection agent waiting for a considerable period of time before proceeding with the inspection or for treating the inspection agent rudely or hurrying her through her inspection as alleged in paragraph (i) of the plaintiff's more definite statement.

The evidence is undisputed that plaintiff's supervisor (said inspection agent) waited outside the door of defendant's nursing home for periods of about 15 to 30 minutes after ringing the doorbell, or several occasions, before the bell was answered and the supervisor admitted. Once inside the nursing home, said supervisor was kept waiting for periods of time on several occasions before making her inspection. However, said supervisor also testified that defendant and her agents would have no means of knowing who was ringing the doorbell before opening the door, whereby it could not be inferred that defendant or her agents knowingly kept said supervisor waiting at the door. Said supervisor also testified that she does not wish to make inspections of nursing homes unless accompanied by the proprietor; that she would not expect the proprietor to interrupt administering to a patient in order to accompany her on an inspection tour; that defendant kept her waiting before making inspections due to the fact that defendant was engaged in tending to patients on said occasions. In view of the foregoing, by the supervisor's own testimony, she voluntarily waited for the defendant to complete her duties with patients before proceeding with the inspection. Also, the supervisor's description of the defendant being busy at times she called to make the subject inspections would not indicate that defendant rushed the supervisor through her inspections nor that the defendant treated her rudely.

During the course of the hearing there was testimony pertaining to 11 and 12 patients in the home on certain occasions in the past and testimony pertaining to the number of hours worked by the defendant in the nursing home during a

given week. Said matters were not alleged in the plaintiff's more definite statement and are, therefore, not subject to review here.

Conclusions of law: Licensee was in violation in the following particulars:

(*b*) Inadequate medical reports in some instances.

(*f*) Use of inadequate and/or improper bedding.

(*h*) Use of posey belt on a patient with only the oral authorization of a physician and without written authorization; defendant was not in violation for dispensing medication without or contrary to doctors' orders.

Defendant was not in violation in the following particulars:

(*a*) Physical abuse and neglect of patients, except that nonambulatory patients were not provided with bells on the alleged dates.

(*c*) Use of unsterile equipment.

(*d*) Inadequate diet for patients and personnel.

(*e*) Improper care of incontinent patients, except that, in one instance, Mrs. Angie Chapman was permitted to lie on a bare rubber sheet while waiting to be removed from the nursing home.

(*g*) Inadequate nursing staff.

(*i*) Resistance to inspection by the agent of the department.

In summary, the Commissioner has a responsibility to the patients of a nursing home to protect them from abuse and neglect by means of closing the nursing home where warranted. Many of the allegations here are most serious. The commission has weighed the evidence most carefully and has devoted an unprecedented amount of time to the decision and disposition of this case, in view of the seriousness of the charges involved.

However, the more serious allegations here were not substantiated by the requisite preponderance of the evidence, but were based solely upon the questionable testimony of three former short-term employees who testified to isolated incidents which allegedly occurred in 1962 and 1963. It would seem that if defendant had abused her patients in the manner alleged, same would have come to the attention of physicans, of relatives, friends or neighbors of the patients, or others; that said allegations could have been supported by more credible evidence without the necessity of relying solely upon the testimony of the three aforesaid individuals. On the other hand, the testimony of said witnesses was rebutted by two physicans and a minister who was a neighbor and frequent visitor to the nursing home, all of whom spoke favorably and impressively of the operation of the home.

Nevertheless, defendant has committed several lesser violations which could have been avoided by the exercise of due diligence and which would justify a 15- to 30-day suspension of license.

At the hearing, in response to the Commissioner's inquiry, it was indicated by both plaintiff and defendant that a short suspension of license, rather than a revocation, would cause a difficult problem which would not be in the best of interest of the patients in that it would be necessary to move the patients to another home during the period of suspension.

Therefore, in this first instance, the commissioner will impose a penalty which shall not take effect at this time:

Defendant's license to operate a nursing home is hereby suspended for a period of 30 days, which said suspension shall not take effect at this time, but may be added to any penalty imposed for any further violations occurring on or before August 1, 1966.

Defendant is warned, however, that she must henceforth operate her nursing home, in all particulars, in compliance with plaintiff's standards and requirements and that her further failure to do so may result in a severe penalty.

In this regard, defendant should clarify with the plaintiff any misunderstanding she may have relative to recordkeeping, required bedding and any other requirements of the plaintiff, and thereafter insure that she is in compliance with same. It would also be in order for defendant to make a more conscientious effort to cooperate with plaintiff's agents regarding inspection tours and other requirements.

In any event, further violations of the instant nature may result in a suspension of license, regardless of the problem of transferring patients.

Dated at Lewiston, Maine, this 17th day of August 1964.

EDWARD M. ROBINSON,
Administrative Hearing Commissioner.

APPENDIX C

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Physicians' Observations in Nursing Homes

(Jacob M. Jackler, M.D., Paul H. Pfeiffer, M.D., Ovid F. Pomerleau, M.D., Vaughn R. Sturtevant, M.D., Lucien F. Veilleux, M.D., and Harold N. Willard, M.D.[1])

INTRODUCTION

There is a growing body of literature on the quality of care in nursing homes. However, no article has been written by practicing physicians on which they express their opinions based on actual experience.

Under a grant from the Office of Vocational Rehabilitation, a program for evaluating patients in nursing homes has been going on at the Thayer Hospital since July of 1959.

This experience has shown that changes are needed, and that the Maine Department of Health and Welfare, and the Maine Association of Nursing Homes are attempting to effect changes. The medical profession has not become interested in this problem, and yet their leadership is vital if effective methods are to be found to improve nursing home care. Every patient in a nursing home in Maine—whether private or financed by a State or community agency—has a physician who is responsible for his care. Bearing this responsibility, the medical profession knows best which of the patient's needs are met or unmet in nursing homes, and can be a valuable source of leadership in planning for improved care.

The problem was discussed with the house of delegates of the Maine Medical Association at their meeting in June of 1961. A resolution was passed approving a 6-month pilot project in the Waterville area.

Dr. Dean H. Fisher, commissioner of health and welfare for the State of Maine was brought in on the planning. He gave enthusiastic support and provided funds for regular doctor's rounds in nursing homes.

THE PURPOSE OF THIS PROJECT

To observe the clinical needs of patients in nursing homes.
To observe problems of nursing home administrators.
To make recommendations for improvement of nursing home care.

METHODS AND MATERIAL

Six nursing homes in the Waterville area agreed to participate in the project. Ten physicians volunteered to carry out the observations and six doctors were finally selected.

At one planning session a lawyer for the Maine Medical Association outlined the medico-legal considerations. To avoid legal entanglements, he suggested that the physician-observer be employed as a consultant to the nursing home administrator. This would clarify the point that the physician-observer had no responsibility for the individual patients, who would remain under the care of their own physicians.

A permission form was developed, to be signed by the patient, and the private physician before any patient was included in the project.

The physician-observer acquainted himself with the clinical problems of all patients in the nursing home assigned to him. He did this by review of records, or interviews, or complete history and physical examination at his own discretion.

Any suggestions for further study or change in therapy were given to the nursing home administrator. It was her responsibility to see that the patient's physician was made aware of these suggestions.

The physician-observer also acquainted himself with the problems faced by the nursing home administrator. About half his time was spent in discussions with the administrator and the personnel.

Visits were scheduled at weekly intervals at first. In homes with 12 or less beds, the physician spent 1 hour each visit. In homes of more than 12 beds, 2 hours were scheduled. The largest home had 29 beds.

Once a month, instead of visiting the nursing home, the physicians would meet for a 1-hour discussion and review of the project.

The final report was presented to the house of delegates of the Maine Medical Association in June 1962.

[1] From Thayer Hospital, Waterville, Maine. This project was supported in part by the Office of Vocational Rehabilitation, grant No. 447 and in part by the Maine Department of Health and Welfare.

The project ran for 6 months—from the middle of November 1961 through the middle of April 1962. After the midpoint of the project, visits were scheduled at 3- and 4-week intervals.

CLINICAL FINDINGS

What can a physician do from a clinical point of view about patients in nursing homes? In planning sessions, it was decided that he could do the following:

Establish or confirm the diagnosis.

Note whether or not treatment being received is appropriate.

Observe the frequency with which significant episodes of illness occur in a nursing home population, and whether they were reported to the physician.

Look for patients who could be benefited by a short period of hospitalization for diagnostic tests, or for intensive treatment, or for intensive rehabilitation.

Evaluate rehabilitation potential of patients.

Table I summarizes these observations. It leaves little doubt that there is a need for more careful clinical supervision of patients in nursing homes.

TABLE I.—*Summary of clinical findings*

	Patients	Percent of total
Number of patients seen	81	100
Change in diagnosis	12	15
Clinical episodes not reported	15	19
Need for hospitalization	21	25
Hospitalization arranged	16	19
Hospitalization not arranged	5	6
Change of treatment	21	25
Unrecognized rehabilitation potential	12	15

A few examples will emphasize the importance of these findings. Change in diagnosis: One of these patients was at the nursing home for terminal care with a diagnosis of cancer of the nose. Biopsy showed only benign nasal polyps. This patient had been in the nursing home 2 years.

TABLE II.—*Comparison of clinical findings in 2 nursing homes*

	Nursing home No. 1	Nursing home No. 2
Number of patients seen	24	30
Change in diagnosis	4	8
Change in treatment	4	11
Clinical episodes not reported	1	13
Need for hospitalization	5	12
Hospitalization arranged	4	8
Hospitalization not arranged	1	4
New rehabilitation potential	1	5

Clinical episodes not reported: A patient developed chest pains and vomiting. The nursing home administrator did not call the doctor but treated her with laxatives. The patient died in 2 days of a coronary occlusion.

Need for hospitalization: A patient was bedbound in a nursing home for 2 years following a stroke. He was hospitalized for intensive rehabilitation and is now ambulatory with a brace.

Change of treatment: A patient with mental confusion was receiving nine different drugs. When all the drugs were canceled except digitalis; the confusion cleared.

The need varies with the nursing home. In table II, two nursing homes of approximately the same size are compared, In nursing home No. 2, there was a larger number of patients with incorrect admission diagnosis, inappropriate therapy, and with need for hospitalization. The number of significant clinical episodes which occurred and were not reported to the responsible physician is strikingly different in the two homes. This table makes it clear that the quality of care in a nursing home depends on both the physician and the nursing home administrator, and when there is lack if interest on the part of one, there is also lack of interest in the other.

OBSERVATIONS OF THE NURSING HOME ITSELF

Each home was observed to do a particular type of care well. One home gave excellent convalescent care and active rehabilitation, but handled patients with emotional problems poorly. Another prided itself in dealing with the mentally confused patients, but did not do active physical rehabilitation. Most were giving adequate care for the bedbound patient, but all had a number of patients who could be in boarding homes.

One physician said the best thing that could be done with the nursing homes to which he was assigned was to close it. However, he admitted his patients to this home in spite of this opinion. The reason given was that there was no alternative for most of them.

OBSERVATIONS MADE BY THE PHYSICIANS CONCERNING THEIR OWN ATTITUDES FOLLOWING THE PROJECT

"I couldn't get interested. All a doctor can do clinically is to postpone death. The main needs are social and economic, and I can't arrange for more attentive families, more money, or more hobbies."

"I can't feel as much responsibility for State patients as I do for private parties."

"It was interesting for the first few visits. Then there was nothing more to contribute. I was glad when the project was over."

"I wasn't bored. Each visit strengthened my previous convictions. However, the problems seem too difficult to solve."

"It is not a pleasant task to work with patients who are so unstimulating and so unresourceful as those who are rejected by their own families."

DISCUSSION

From these observations, we are convinced that improved clinical care would not only be a significant help to individual patients in nursing homes, but would also be a great stimulus to nursing home administrators. The most evident need for improved clinical care is a careful evaluation of patients before they are admitted to the nursing home. Once a patient is admitted to a nursing home, he is liable to remain there. Our observations show that at least 50 percent of patients in nursing homes need neither skilled nursing care or complicated medical procedures. They could have been cared for as well or better in their own homes, if the family wanted them, or in boarding homes.

Reevaluations of patients should be done periodically.

On admission, the physician should prescribe the expected length of stay in the nursing home, just as he prescribes the length of use of any powerful drug. It is also the physician's responsibility to let the nursing home administrator know whether the patient is admitted for convalescence, rehabilitation or long-term custodial care. Without the prescription of "dosage," proper continuity of care cannot be expected.

In addition to evaluations, our observations show an urgent need for more careful clinical supervision of patients in nursing homes. The possibility of having a physician assigned to cover nursing homes in his district was discussed. However, it is difficult to see how such a position could be set up realistically. Even if salary for such a position were provided by the State department of health and welfare, none of the observers could visualize a really good physician taking such a job. Therefore, it can only be recommended that the physician admitting the patient assume the responsibility for close continuity of care.

Totally inadequate charting is presently one of the chief obstacles to good patient care in nursing homes. We collected many examples of patients arriving at the nursing home without any information about their diagnosis and without any orders for medication. In fact, the majority of patients are admitted with only enough information to fill out the form for the undertaker. Rarely does a physician write a progress note when he visits a patient.

In several nursing homes there were no written orders for medication several months after admission and charting of medication given to patients was done poorly.

We believe strongly that a standardized charting procedure should be initiated by the State.

A serious handicap for better care has been very frankly stated. In brief, physicians find little stimulation in the care of the chronically ill and elderly in the nursing home environment. Once the diagnosis and specific treatment have

been accomplished, there seems little else to do except the treatment of clinical episodes as they occur. We have no answer for this. It may be if more training in the care of the chronically ill were included in the curriculum of medical schools, this attitude would be altered in future generations.

SUMMARY

This project was done by physicians to observe the quality of care in nursing homes.

Serious gaps in clinical care were found. Suggestions are made for improvement.

Most doctors are frankly not interested in the care of the chronically ill and elderly in the nursing home environment.

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