Guidelines for libraries serving hospital patients and the elderly and disabled in long-term care facilities

Compiled by a working group chaired by Nancy Mary Panella under the auspices of the Section of Libraries Serving Disadvantaged Persons

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FOREWORD

The designation 'hospital library'

During the course of its preliminary research, the working group was struck with how the concept of a hospital library differs so in different parts of the world. It found, for example, that in some countries, the term 'hospital library' almost always signified a biomedical/health sciences library, while in others, it usually meant a library providing leisure reading materials for patients. In still other countries, 'hospital library' could signify either a biomedical/health sciences library or a patients' library, with the latter providing leisure reading collections *or* health information materials *or* both.

Recognizing the ambiguity of the term, therefore, these guidelines have tried to avoid its use. It was not possible to do so in some instances, for example, in recounting the history of patients' libraries. The reader should thus be aware that where the term **'hospital library'** is used, it means a library for patients, one that routinely provides leisure reading collections, often in combination with health information materials.

PREFACE

1. Rationale For These Guidelines

Prior to developing these guidelines, the working group discussed at length what it thought would be universal changes in the traditional character of patients' libraries and the corresponding problems of trying to identify and capture those in a new publication. A prime concern was how near-global trends in the health care field - for example, attempts at shorter lengths of hospital stays and fiscally constrained hospital environments - might have affected these libraries and how (and whether) the libraries had been able to adjust.

Subsequent to its field research, though, the working group realized that, while the climate of patients' libraries - the user bases, resources, restrictions, and opportunities - was in many cases changing, the missions were remaining fixed, that is, in support of patient care, the libraries were continuing to try to provide as wide a range of library materials as possible.

With that in mind, the working group proceeded with this publication. In so doing, it recognized that, beyond providing direction, current guidelines would also function as a document descriptive of the field and supportive of field practitioners. As such, the group believed that they would ultimately prove useful, not only to those already providing library services to hospital patients, the elderly, and the disabled, but also to those who were seeking to initiate, justify, or expand such services.

2. Preliminary Research

2.1 Initial Inquiries

In organizing material for these guidelines, the working group first assembled as much current field information as was possible. Initially, it isolated and recorded its own experiences and those of its parent committee: in all, the two groups represented public, biomedical, academic, and special librarians working in Bulgaria, Canada, Cuba, Denmark, France, Norway, Russia, Spain, Sweden, the United Kingdom, and the United States.

Following those considerations, the working group conducted a search of the literature. Using a broad range of descriptors, it queried international indexes such as MEDLINE and Library Literature and subsequently retrieved, translated as necessary, and reviewed any article (regardless of publication medium or article size or type) judged relevant to the revision.

Coincidental with the literature review, the working group used the Internet to broadcast requests for information from hospital-based librarians, public librarians, and others who were or might be involved in providing library services to hospital patients, the elderly and the disabled. (Listserv locators and the working groups' own Internet affiliations were used to identify target discussion groups.)

Those requests proved extraordinarily fruitful - librarians from some twenty-five countries responded and, in the aggregate, provided a wealth of current information.

The working group next perused as many current sets of recommendations for hospital patients' libraries as had been located through the literature and Internet searches; they ultimately ranged from guidelines issued by a national library to
standards developed for regional use to basic principles meant for local use.

Hoping to learn the average time that patients - the libraries' primary clients - were actually staying in hospitals, the working group also gathered as much current data on acute care hospital average lengths of stays as was possible. It was not an easy process: information gathering had to be done on a country to country basis, and what data could be retrieved was often not comparable - acute care hospitals worldwide tend to have different patient configurations and thus organize and report their statistics differently. In any case, the working group was at least able to compare data from twelve nations representing four continents. The results are noted below.

Finally, the working group asked a group of practicing librarians - in all, representing six countries and six different areas of expertise - to review and comment on the guidelines. Their willingness to help, their suggestions, and their very positive support contributed much to the final document.

2.2 Selected Results

The background research revealed a wide variety of conditions existing throughout the world in the field. They include: 1) sophisticated freestanding patients' libraries maintaining leisure reading and health information collections and a wide variety of programs and services; 2) newly established freestanding patients' libraries providing leisure reading materials only; 3) existing and emerging programs, primarily the work of external agencies such as public libraries or voluntary organizations, providing hospital patients and the institutionalized elderly or disabled with leisure reading materials and some services; 4) simple book cart services administered by non-library hospital departments; 5) library services near being discontinued due to lack of fiscal support; and 6) local, regional, and national libraries and library networks providing health information to patients in the most technologically advanced ways.

The inquiries further revealed the continued existence of freestanding libraries for patients in several countries' psychiatric and children's hospitals. It was gratifying to learn that, in some countries, public libraries routinely provide both reading materials and certain library-related services to homes for the elderly.

With regard to the continuing need for library services for acute care hospital patients in what are sometimes perceived as shorter lengths of hospital stays, the working group found that there remains country to country vast differences in such stays - they range, for example, from as low as 5.2 days to as high as 33.7 days.

Length of stay data further indicated that hospitals continue to see classes of patients requiring extended stays, including certain pediatric, orthopedic, neurological, psychiatric, and cardiac cases, as well as cases of infection, trauma, and neoplasms.

With regard to library-related treatment trends, the working group was not surprised to find the literature showing a continuing need for and interest in bibliotherapy as an adjunct to patient care[1], it also found that music therapy seems increasingly to be used in patient care[2], for example, for pre- and post-surgical relaxation, for pain, and in palliative medicine.

Finally, what appears to be a multi-national trend towards hospital-based home care as a substitute for lengthy hospital stays also seems to require the support of traditional library materials, in particular, for music therapy provided in the home, for home-based bibliotherapy, and to meet the need for current health information materials.

INTRODUCTION

1. Historical Framework

1.1 The Development of Libraries for Hospital Patients

Both as concept and reality, libraries and library services for patients have enjoyed a long and successful history. And, to a large degree, their successes have been tied to a persistent recognition that books and reading - through an ability to distract, amuse, inspire, support, and uplift - can foster the rehabilitation of sick people.

Providing books and reading as therapeutic aids dates to at least the latter part of the Middle Ages (a time of great hospital growth, particularly in Europe[3]). For example, in an impassioned discourse on the need for patients' libraries as a part of curative medicine, Bruce Bruce-Porter, an English physician, wrote that Caliph Al Mansur's great hospital in Cairo, Egypt (c. 1276 A.D.) provided not only medical and surgical care, but also priests to read the Koran day and night for patients wishing to listen;[4] for patients who could not sleep, music and story-telling were provided.[5] Bruce-Porter saw that as the first idea of a patients' library and its role in the plan of healing.[6]

Psychiatric hospitals, particularly in eighteenth- and nineteenth-century England, France, Germany, and Scotland maintained libraries for patients, since physicians treating the mentally ill in those countries were prescribing reading as therapy.[7] And, in the United States, by the first half of the nineteenth century, reading for the mentally ill was being judged important enough that retreats and asylums there maintained organized patients' libraries. Indeed, during that era, library services were a significant part of therapeutic programs for the mentally ill .[8]

By the second half of the nineteenth century, it was not uncommon to find both psychiatric and general hospitals publishing printed catalogs of their books for patients.[9] And in the late nineteenth- and early twentieth centuries, driven by a

sustained belief in the value of patients' libraries, practitioners began undertaking studies of the field. In Britain, for example, just prior to 1895, Dorothy Tylor conducted a survey of some seventy patients' library services and subsequently reported the results at the Library Association's eighteenth annual conference (Cardiff, 1895). Among its findings, her survey noted that most of the hospital medical staffs queried, believing that books and reading contributed to patient care, urged that library materials be made available to patients.[10]

Studies were also done In Germany, two of the more extensive being Ernst Schultze's (1907) and Irene Chromse's (1913) reviews of hospital library services.[11] And, in 1911, in the United States, Edith Jones published the results of a study she had conducted on library services in some 121 psychiatric hospitals. (The results showed what she felt were less than optimum conditions, thus she subsequently urged state library associations to devote more attention to libraries for the incarcerated mentally ill.)[12]

Despite the efforts of physicians and librarians who so deeply believed in the therapeutic value of books and reading, patients libraries, particularly those in general hospitals, evolved slowly during the early part of the twentieth century. World War I, however, proved to be a major catalyst to their development because, through the successes of several nation's War Service programs, there emerged a clearer and more widespread recognition that books and reading could contribute to well-being and recovery.

The War Service programs consisted of organized, cohesive efforts to provide armed forces personnel - including those who were wounded, sick, or hospitalized - with books and other reading materials. While the literature doesn't permit tracking all of the War Service Programs, two that *are* well-described are those developed in Great Britain and the United States. In Great Britain, the War Service began in 1914 and was organized as a voluntary program, primarily by librarians from the London Library.[13] It operated under the general direction of Helen Mary Gaskel, and it received financial assistance from the Order of St. John and the British Red Cross Society.[14] Initially, the program provided books to the wounded military who were in hospitals and on hospital ships. But, in 1918, civilian hospitals began to be included in the service;[15] that year, the program's astonishing output was two million books, magazines, and newspapers.[16]

In the United States, the War Service began in 1917 and was organized under the direction of the American Library Association (ALA). Initially, ALA supplied reading materials primarily to US armed forces camps and bases throughout the world. But, in 1918, it extended its services to hospitals and transcontinental hospital trains used by US military personnel. ALA arranged for professional librarians to staff libraries in the larger hospitals, while library services in smaller hospitals were to be supervised by staff from local libraries. By the end of its second year, the War Service had provided reading materials to some 3,981 service points; at the peak of the service, more than 170 librarians were working in
the hospital library part of the program.[17]

In both countries, (and in at least Germany[18]), War Service efforts enjoyed enormous success, primarily for the positive effect that reading materials were seen to have had on armed forces personnel. An address to ALA's Hospital Libraries Division perhaps best describes that:

> Not many, if any of us...have personal recollections of the enormous therapeutic value of the patients' libraries that miraculously sprang into existence overnight in the hospitals of the armies of the first World War...most of this heterogeneous group of men bore their hardships more easily by reason of reading matter that either diverted or nourished them in some mysterious way. For perhaps the first time since the days of ancient Thebes there was the realization on a very large scale of the fact that books may indeed be medicine for the soul - and, hence, the body.[19]

Britain's War Library came to an end in 1919, but the Red Cross Society and Order of St. John Hospital Library, realizing the value of reading materials to hospitalized people, continued working with Gaskell to further extend library services to peacetime civilian hospitals.[20] In the United States after the War, ALA turned over its equipment and books to the military but continued to work with Public Health Service reconstruction hospitals. The federal government eventually took control of the libraries in those hospitals: they evolved into the Veteran's
Bureau Facility Libraries,[21] today know as the Veteran's Administration Libraries.

Due largely to such War Service successes, the immediate post World War I era witnessed a dramatic growth in the establishment of patients' libraries, the literature reflecting that that was particularly so in the United States.[22] But, progress in the field was also often reported in Australia, Czechoslovakia, Denmark, France, Germany, Great Britain, New Zealand, Spain, and Sweden.[23]

The widespread interest in libraries for patients soon led to formation of national and international hospital library committees. While a recounting of their work is beyond the scope of this introduction, mention should at least be made of the earliest of them. Dating to 1916, the first committee was organized by ALA and informally called the "Institutions Libraries Committee."[24] Though meant to represent libraries in hospitals and charitable and correctional institutions, by 1923, it had become so overwhelmed with burgeoning hospital library activities, that ALA had to form a second committee - the "Hospital Libraries Committee" - to work solely with those needs. (The "Institutions Libraries Committee" continued working with non-hospital institutional libraries.)[25] The following year, also within ALA but for unknown reasons, an entity called the Hospital Libraries Roundtable surfaced. It quickly became the more productive of the two groups, issuing, for example, comprehensive standards for hospital patients' libraries.[26] For several years, the Hospital Libraries Committee and the Roundtable worked side by side and continued to hold similar goals.[27]

1.2 IFLA and Libraries for Patients

1.2.1 The Genesis of IFLA's Hospital Library Committee

The inspiration for IFLA's earliest hospital library committee dates to the (British) Library Association's fifty-third annual conference in Cambridge, in 1930. At that meeting, the Association's first session on hospital libraries was held, and it witnessed both formal descriptions and informal discussions of patients' libraries as they then existed in Denmark, Germany, Great Britain, Sweden, and the United States.[28] Hoping for cohesion in a field that they saw was developing rapidly, the session's attendees agreed to try to form an international alliance of patients' libraries.[29] They also agreed on the need for an international survey of the field, one that would elicit information on the libraries' goals, methods and successes.

The 'Cambridge suggestion' ultimately led to formation of two subcommittees on patients' libraries, one established under the sponsorship of the International Hospital Association and the second under the auspices of the International Federation of Library Associations (IFLA).[30] It is unclear what constituted the former subcommittee (that committee's fate is also unclear), but it is known that IFLA's subcommittee - proposed and approved at IFLA's annual meeting in Cheltenham (England) in 1931[31] - aimed to draw membership from approximately thirty countries: two people from each country would sit on the subcommittee, one representing the country's libraries and, the second, its hospitals. Work on the subcommittee's design continued until, by 1935, it was finally organized with twelve
countries holding membership.

At its inception, the subcommittee was designated the Subcommittee on Hospital Libraries.[32] However, over the years, as IFLA's rules changed, the subcommittee's status changed - it became a full committee, then a sub-section and, finally, a section. Its essential name - 'hospital libraries' - underwent change as the scope of its coverage changed: most notably, in 1977, it became the Section of Library Services to Hospital Patients and Handicapped Readers, and, in 1984, the Section of Libraries Serving Disadvantaged Persons.

1.2.2 IFLA's Recommendations for Patients' Libraries

From 1960 through 1984, IFLA published four sets of recommendations for patients' libraries.

The first set was published in 1960 in Libri (10 [2]:141-146) as *Mémoire indicateur sur les bibliothèques d'hôpitaux (*Memorandum on hospital libraries); a shorter version appeared in English in Hospital Abstracts, 1961/1963.

A second set of recommendations, *IFLA Standards for Libraries in Hospitals*, was published in UNESCO's Bulletin for Libraries, volume 23, number 2, March/April, 1969, pages 70-75.

IFLA's third recommendations were published as paragraphs 53-61 of IFLA's Public Library Section's *Standards for Public Libraries* (Verlag Dokumentation, 1973). Reflecting an expanded focus, these recommendations

included not only hospital patients, but also: housebound readers; the visually handicapped; day centers, clubs, and residential homes for the elderly; and prisons, remand homes, and detention centers.

Finally, in 1984, IFLA published G*uidelines for Libraries Serving Hospital Patients and Disabled People in the Community*. These guidelines covered services to a number of other groups, including: aphasiacs/dyslexics; people with motor handicaps; the deaf; and, the mentally handicapped/mentally ill.

Noting that it was impossible to draw up universally applicable standards, the 1984 document aimed, instead, to be a set of suggestive guidelines based on the work and experiences of librarians in the field. The Guidelines took into account any work that had already been done by national library associations.

2. Parameters of These Guidelines

2.1 Aim

These guidelines recognize that, due to different needs and resources, and due to cultural, social, and political variations among countries, no one method or plan can be universally recommended. Therefore, while ***they aim to portray levels to which library services for patients should aspire,*** they have been organized so that they can be used simply to identify the essential features of such services. The working group sincerely hopes that they will thus prove helpful in almost any situation, and that each institution will determine for itself the feasibility and appropriateness of the services outlined.

2.2 Objectives

To promote the establishment of libraries / library services for patients
To support an ideal of excellence in those programs already existing
To encourage external agencies to extend library services to people in long-term care facilities

2.3 Scope

The guidelines are meant to apply to libraries and library services for patients
of all ages in every type of health care facility, and to the elderly and the disabled in long-term care residencies, homes and other institutions.

2.4 Assumptions

The guidelines assume the following:

- that books and other library materials have intrinsic value for everyone, regardless of age, educational level, social status, or physical or mental facility.

- that, in a unique and highly personal way, books and other library materials provide the opportunity to be informed, to be entertained, to be inspired, to reflect, and to learn.

- that individuals in any society, including those who are temporarily or permanently confined in health or other care institutions, should have the right of access to books and library materials suited to their individual needs and interests

- that books, reading, and library materials can exert a positive affect on the state or recovery of those who are physically or mentally ill.

2.5 Definition of Terms

- **acute care**: short-term care that is rendered for an immediately treatable injury, illness, or health-related condition.

- **adapted literature**: books and other reading matter whose form or content have been adapted to meet special user needs, for example, large-print books for the visually disabled, Easy-to-Read books for the cognitively disabled

- **assistive devices**: mechanisms that allow the disabled to use standard materials, equipment, and resources, for example, electronic page turners for those who cannot hold a book, braille keyboards for the visually impaired.

- **chronic care**: on-going care for a disease, disorder, or other health-related problem or condition

- **clinic**: in these guidelines, a hospital unit providing outpatient care only

- **collections**: book stock

- **disabled:** see 'The Disabled,' p. 34

- **elderly**: see 'The Elderly,' p. 32

- **hospital:** a licensed institution providing short- or long-term care for any number of health-related problems or conditions; often includes specialty facilities, for example, rehabilitation centers

- **hospital library**: a library based in a hospital and serving a specific user group

- **long-term care facility**: any institution, including hospitals, homes, and group residencies, providing on-going physical, psychological, custodial or other care

- **reading materials:** in these guidelines, the range of library materials made available to patients

LIBRARIES FOR PATIENTS

The following might be considered guides in planing libraries and library services for patients.

Mission

- consistent with the parent institution's mission, to provide patients with as broad a range of library materials and services as is possible

Objectives

- to foster the well being and recovery of patients by:
  - acquiring, organizing, maintaining, and/or providing library materials and services that can, according to each patient's need, offer a means of diversion, therapy, culture and, where appropriate, education and training;
  - as needed, providing information on health and wellness, and on specific illnesses, disorders, or other health-related problems including etiology, diagnosis, prognosis, and treatment;
- to work collaboratively with the institution's other patient care services
- to further the understanding:
  - that library materials are one of the only means patients have of counterbalancing the foreign, for some, frightening hospital environment;
  - that reading is often one of the few - and perhaps most practically sustainable - recreations available to institutionalized people;
- to encourage the recognition that, consistent with the concept of whole patient care, libraries or library services should be a fundamental part of any short- or long-term care facility.

General Recommendations

The following recommendations represent ideal levels of service. ***They can and should be used selectively***, according to each institution's needs and the resources available to meet them.

1. Clients

1.1 Client Base

The library's clients will usually include inpatients or residents and their families: they may also include outpatients; pre- and post admission patients;

patients' receiving home care or care in the community; and hospital staff.

While inpatients and residents will use the library for a variety of reasons, it is likely that families, outpatients, pre- and post admission patients, and those receiving care in the community will mainly seek health information materials. Arrangements for providing those materials, however, vary greatly from country to country, and even within countries. In some cases, the hospital's health sciences library provides health information materials to inpatients, with the local public library filling that need for outpatients and the community; sometimes, health sciences libraries also provide for the latter groups. In other instances, a department or service within the parent institution will be the primary provider of health information materials. In still other cases, that responsibility will rest with the patients' library.

Whatever the arrangements, local trends then will likely determine each library's actual client base.

With regard to hospital staff use of the library, that on-going interaction, even if for personal use, is important in that it allows the staff to see, firsthand, the materials and services available to patients. It also allows the staff and the patients a chance to meet and talk in a non-clinical, quasi-social setting, thus potentially expanding their insights and strengthening their relationships.

1.2 Planning Considerations

Since inpatients or residents will be the library's primary clientele, planning for library services should focus on that group. By and large, they will represent a cross-section of society - their ages will vary greatly, as will their economic, social, cultural, ethnic, and educational backgrounds. Common to all, though, will be an illness or disorder that may cause: diminished concentration; weakness; tiredness; depression; limited physical mobility and coordination; difficulty in gripping and manipulating; limited breathing and thus exertion abilities; visual or hearing impairments; and, with the aged and the chronically ill, possibly strength, alertness, mobility, balance, and seeing and hearing limitations.

Coincidental with patient types, the library's role as therapeutic agent must also be kept in mind, that is, by distracting patients from their illnesses and engaging them in a highly positive way, the library promotes healing. Where care rather than healing is the goal, the library at the very least offers the therapy of new and inspiring outlooks. It can also help eliminate feelings of helplessness and dependency and can teach or otherwise inform.

The German Institute of Librarianship's guidelines for patient libraries notes: "Any hospital stay means a very heavy emotional burden on the patients and influences their psychological state of mind. This is caused by the sudden loss of privacy, one's familiar surroundings, and the social interaction of one's everyday life;"[33] "...by personal intervention, such as the offering of books and

media, [the library helps] relax and unburden the patients, and in the final analysis, expedites
recovery."[34]

2. Organization

Library materials and services can be provided to patients in a number of ways, the most common being through a freestanding facility located within the institution or by means of an externally provided service.

2.1 A Freestanding Library

The following represent some of the ways an on-site facility can be organized.

1 - A library fully supported by the parent institution. In this case, the library is maintained by the parent institution, which pays for its space, staff, equipment, materials, services and programs.

2 - A library jointly supported by the parent institution and an external agency, such as a local or regional public library. Here, costs are shared, for example, the parent institution might provide space, equipment, and voluntary staff with the external agency providing collections, programs, services and professional staff. Regardless of the arrangements, though, the parent institution and the external agency should draw up and sign a binding agreement specifying each other's aims, responsibilities, expectations, and limitations.

3 - A library considered a branch of the local public library

or

4 - A library set up and maintained by a voluntary group.

In both of these cases, other than space and its maintenance, and possibly equipment, the sponsoring agency or group assumes all operating costs.

Regardless of funding source, the library should be established and run as an independent unit of the parent institution. It should be represented in the institution's table of organization, and should have it's own staff and budget. Its space should be committed to it for a mutually agreed upon length of time.

2.2 A Library Service

If maintaining an on-site library is infeasible, arrangements should be sought with a local public library - in some countries it might be a regional or national library - to regularly provide patients with a range of library materials and services. In rare cases where that proves impractical, the parent institution should turn to voluntary groups having the expertise and resources to initiate *and sustain*

such a project. (Sometimes the initial impetus for providing library services to patients will come from an external agency, and in those cases the parent institution should pledge its cooperation and any resources it can make available.)

The parent institution and the external library or agency could cooperate to support a library service: the parent institution might provide staff and the external agency staff training; the parent institution might provide the collections and the external agency staff expertise in weeding and replacing the collections' materials; the parent institution might pay for the more expensive items, such as audiovisual hardware and assistive devices, with the external agency providing the print and non-print collections including specialized items.

In any case, both parties should sign a contractual agreement clearly describing each other's goals, objectives, and commitments. The agreement should specify that the library service will be allowed to continue in the space assigned to it - or in space as adequate - for a mutually agreed upon length of time.

Finally, it is **crucial** that the parent institution assign a senior management staff member as liaison with the library service. Without that high-level contact to monitor and, as necessary, regulate the needed internal support systems, the service may flounder or eventually even fold.

3. Physical Facility

3.1 Location

For the sake of all of its users, the library should be located in a central part of the hospital - an area readily accessible to and from the patient floors and within the flow of outpatient, staff, and visitor traffic. Where that is impractical, the parent institution should provide ample, conspicuous signage throughout the building(s) indicating the library's existence and location.

Where an externally library service is provided, the institution should furnish* and maintain a centrally located, lockable storage area adequate to house a significant deposit collection. To facilitate rotation of the collection, the area should be close to a main or, preferably, delivery entrance and should also provide ready access to the patient floors. Additional secured space should be made available to store equipment - audiovisual hardware and bookcarts, for example - as well as reading aids, office supplies, and oversized and valuable miscellaneous items. According to local need, storage areas for smaller deposit collections might also be useful on selected patient floors.

*The furnishings should include shelving, a desk and/or work table, files, and other necessities.

3.2 Entrance and Environment

The library's entrance should be free of raised thresholds or steps and should be wide enough to permit passage of wheelchairs and bed-stretchers. (See Appendix for average wheelchair and bed-stretcher dimensions.) For ease of recognition, and to invite entry, consideration should be given to equipping the library with full or half glass doors; however, in such instances, the glass should be marked so that visually impaired people will not walk into it.

The entrance doors should be easy to open: push-button, sliding, or automatic doors are good examples. Alternately, the doors could be fitted with a holding device that will keep them open as needed / allowed. A book-return box, a bulletin board for posting notices, and a suggestion box - all located just outside the doorway - will prove useful to both library staff and users.

Every effort should be made to see that the library projects a warm and welcoming environment. While a sensitive, friendly staff will do the most to achieve that, the thoughtful use of plants, flowers, framed pictures and posters, interesting rotating exhibits, seasonal decorations, and displays of materials from the library's
collections will also foster that mood.

3.3 Space

3.3.1 Utilization

The library's space should never be shared with any other department or service. In keeping with their missions, libraries need to provide a quiet, relatively peaceful environment, and that cannot be ensured if part of their space is given over to the work activities of others.

3.3.2 Capacity

The library should be able to seat both individuals and groups; seating for the latter is particularly important in long-term care institutions, where there is a increased need for regularly scheduled group programs.

Libraries in short-stay hospitals should provide seating for 5 percent, preferably 10 percent, of the inpatient population. The seating requirements will be higher if the library is expected to be used by family members, outpatients, and the community.

In long-term care institutions, seating should be provided for 15 percent, preferably 20 percent, of the inpatient population.

In planning the space needs of a patients' library, it is important to remember that semi- and nonambulatory patients require more space than ambulatory patients. (See Appendix for average space requirements.) Those considerations become especially significant in long-term care institutions, which often have a high proportion of physically disabled people.

Ultimately, overall space allowances should be liberal rather than minimal; the result will be a facility that everyone can safely and comfortably use.

3.3.3 Allocation

Space allocation depends on the size and type of the institution, the target clientele, the objectives of the library's operations, and planned programs and services. Within that framework, the following might be considered.

* A reading/study area.

  This should be a quiet area, away from the main entrance, the information/circulation desk, and other areas with distracting noises and activities. It should be comfortable and have natural lighting if possible.

  The minimum space recommended for each reading place is 2.5 sq. metres (27 sq. ft.); the minimum recommended study space is 4 sq. metres (43 sq. ft.) per place.

  As noted above, where the library's clientele is expected to include a significant number of semi- or nonambulatory patients, the minimum space requirement per place will be higher.

* A listening and viewing area.

  In this section, patients can use, with headsets as required, audiovisual materials such as slides, audio and video tapes, and CDs. The area should be planned according to the kinds of audiovisual software in the collection: large, long tables or several large carrels may be needed to accommodate the corresponding hardware. The section should be well-equipped with electrical outlets. Also, a disinfectant medium such as alcohol swabs should be provided so that users can clean the listening part of the headset.

  Four sq. metres (43 sq.ft.) per user place should be allowed.

* A computer section.

  This is best placed in an area where library staff are readily available for assistance. Each computer station should have written use instructions; each should provide peripheral table space for papers or other materials the user might be working with; and, each should be attached to a printer. (See also 3.6, A personal computer.)

* A information/circulation section.

  This section houses the information/circulation desk, which should be placed in a way that allows visual supervision of much of the library, including the entrance. Regardless of the library's size, the desk should accommodate two people.

  A reference area should be set up adjacent to the desk to house the card, book, or computerized catalog and general reference materials, such as encyclopedias, dictionaries, directories, and almanacs.

* A toilet room that accommodates disabled people.

  If possible, this room should be within the library's physical space. Alternately, it should be close to the library's entrance.

* An area for social interaction.

  This area is particularly important in long-term care institutions where

the opportunity for on-going social interaction is higher. Overall, patients' libraries - representing as they do some of the normal resources and activities common in the outside world - have a social function, and that should be recognized and encouraged.

* A children's section.

Part of the library should be set aside for children's needs, not only for those who are patients, but also for siblings of patients and children accompanying visiting families. The size and arrangement of the space will depend on the children likely to be served, the materials that will be provided, and the kinds of activities planned - film shows, puppet theater, story hours, visiting clowns, and the like. In some cases, space within the library might also be useful for children to follow classes, thus providing a link between their hospitalization and their normal school work.

* Office, processing, and storage areas.

Separate office space is required for administrative and managerial activities, and for the privacy that conferences and consultations require.

A processing room with a sink, hot and cold running water, a work table, file cabinets, and suitable shelving should also be available for unpacking, holding, and processing materials.

A third room should be provided to store supplies, technical equipment, reading aids, and book carts.

The number and size of the office, processing, and storage rooms depends on the size of the library, the size of its staff, and the scope of its activities. Generally, for office space, 12 sq. metres (130 sq. ft.) per staff member is recommended.

* Lounge facilities

Libraries relying heavily on volunteer help might consider designating a room adjacent to the office area as a volunteer (or staff/volunteer) lounge. Equipping it with a table, comfortable chairs, and basic kitchen equipment would symbolize a "thank you" and perhaps suggest a caring attitude on the part of the library that attracts others to volunteer.

3.4 Lighting

As much natural lighting as possible should be provided, but care should be taken, especially in the reading / shelving areas, to avoid direct sunlight which, at certain times of day, can cause glare. If direct sunlight can't be avoided in those areas, consideration should be given to fitting the windows with adjustable blinds.

Artificial lighting that is pleasing as well as suitable should be furnished as a supplement to natural light; it should be amply provided when there is limited natural lighting, or where the library has evening hours. (See also 3.5.1, Lamps.)

If freestanding bookcases are used to house the collections, ample lighting should be installed directly over the aisles between the bookcases (as opposed to over the bookcases themselves).

3.5 Furnishings and Shelving

3.5.1 Furnishings

Some of the furnishings chosen for the library will depend on the needs of the clientele served. However, all should conform to the parent institution's specifications for safety, serviceability, and ease of upkeep. Beyond that, the following may provide some direction.

* Tables.

  It is difficult to recommend dimensions for tables that are a uniformly serviceable height, since patients' requirements may differ significantly. For example, for chair clearance, a wheelchair patient needs a table slightly higher than that suitable for a seated ambulatory person. (See Appendix for required table dimensions.) Children, of course, require shorter than average tables.

  Given the strong possibility of diverse user needs, it is best to consult the catalogs of companies specializing in furniture for libraries and/or the disabled for exacting specifications and current styles.

  Dimensions notwithstanding, all tables should be sturdily constructed and heavy enough to bear the weight of a person without tipping.

* Lamps

  Lamps can provide a pleasant, home-like environment, and are often a valuable supplement to overhead lighting. Where table lamps are used for decorative or supplemental lighting, to avoid being knocked over, they should be bolted or otherwise semi-permanently fixed to the surfaces on which they stand. Lamp wires should be carefully arranged and secured against the danger of someone tripping on them. (See also 3.4, Lighting.)

* Chairs

  Chairs should be comfortable, inviting, durable, and safe. They should also be well balanced to accommodate the additional strain that weak or disabled people are likely to put on them. Generally, chairs should have an armrest to allow for ease in rising. They should also be slightly higher than normal so that wheelchair patients can easily transfer into them and weaker or unsteady patients can more easily sit and rise.

  Where feasible, cozy chairs, perhaps set in groupings around small coffee or end tables, should be used in the reading area. Upright chairs with armrests, backs, and padded seats are useful in the study and magazine areas, and a few might also be useful at the main entrance for patients who are awaiting families or friends.

  If upholstered chairs are used, they should be made of a material that is easily wiped down with a disinfectant medium. The hospital's infection control officer (or committee) will usually provide guidance on that.

* Flooring

  A variety of floorings are suitable for the patients' library, including linoleum, composition (sometimes called VAT) tiles, and vinyl tiles. All are washable, a prime consideration in hospitals and other care institutions with infection control requirements.

For fatigue-reduction and overall comfort, linoleum - usually available with a thin cushioning liner set into its base - is a good choice. Further, since its seams are heat sealed, it can be thoroughly washed and disinfected without danger of seepage into the floor. Linoleum also stands up well to repeated mechanical cleaning and buffing.

Consideration might be given to installing decorative rubber matting in the children's area: a glazed, hard rubber, usually available as interlocking sections and in many colors, it is easily disinfected yet offers cushioning for children sitting on the floor.

Carpeting, which can harbor bacteria and allergens, but which is difficult to regularly disinfect, should be avoided

3.5.2 Shelving

If possible, the main collections should be housed on wall shelving, since that provides the easiest access for wheelchair and bedstretcher patients and those using walkers or canes. There should enough space between the wall shelving and any adjacent furniture to permit patients to move about safely.

If freestanding bookcases (ranges) must be used, the isles between them should be 460 cm. (5') wide, thus allowing a nonambulatory and an ambulatory person to pass each other freely. Because the library's clientele will likely have reaching and bending limitations, shelving should be no more than 460 cm (5') high and no less than 20 cm. (9") low, on average, five shelves per bookcase. (See Appendix for sample reaching and bending limitations). To give standing but physically limited patients a place to lay, open, and scan a book, shelves should be no more than three quarters full.

The formats of the library's materials (books, magazines, newspapers, audiovisuals, special items) as well as space and budget allocations will determine the kinds of shelving used. However, the following may provide a useful frame of reference.

For books, sturdy wooden or metal ranges with adjustable shelves are the most practical. Generally, 90 linear cm. (3 linear feet) of shelving will accommodate seven volummes of fiction/nonfiction, six reference texts, and five medical texts **or** thirty fiction/nonfiction books.

Pamphlets and brochures are most easily kept on and retrieved from wall-mounted or table-top racks, or from medium height revolving floor stands. The later also does well for paperback material.

Newspapers can be kept either on low wall-mounted racks with rods designed to hold individual issues, or they might be displayed out over a wide browsing table.

Magazines can be stored in a number of ways; one of the more efficient units has liftable, sloping shelves for vertical display of current issues with storage room for back issues underneath. Oversized and specialized materials such as braille books need their own storage units; here again, manufacturer's or distributors catalogs will provide a great source of

information.

Accommodations for reference materials should also provide for the limitations of the sick and disabled. Card catalogs, for example, should have a horizontal rather than vertical drawer arrangement, be no more than three drawers high, and be seated on an open support no more than 65 cm. (26") high. Alternately, they (and book catalogs where they exist) could simply be
placed on a four legged table high enough for wheelchair clearance.

Computerized catalogs should also be accessible to both wheelchair (seated) and ambulatory (standing) patients, thus they should be on supports 75 to 80 cm. (30 to 31") and 90 cm. (36") high respectively. These, too, could alternately be placed on a regular four legged table high enough for wheelchair clearance. Where possible, computerized catalogs should be be attached to a printer; if not, the area should provide ample peripheral space for patients to jot down notes.

Audiovisual materials require storage that protects them from environmental factors such as dust, heat, and magnetic fields. Ideally, they should also be kept at a constant temperature and humidity. Current manufacturer's or distributor's catalogs are the best guides to the appropriate storage media, while institutions having large audiovisual collections can advise on the most
currently recommended temperature / humidity balance.

3.6 Equipment

Depending on budget, scope of operations, and staff and patron needs, the following equipment should be considered

* Telephones are presumed to be available for staff use, but at least one should also be available for patient use; if need be, it should be adapted for the hearing and speech disabled.
* A photocopy machine is essential, not only to library operations, but also for patients needing to copy parts of books or magazines, perhaps especially for copying health information materials.
* Telefacsimilie (fax) machines have become indispensable office equipment, especially for libraries needing to send and receive interlibrary loans. They also provide a highly efficient alternate method of internal communication.
* Bookcarts should be available in several sizes, including: a small version for shelving and other library maintenance functions; a lightweight large capacity cart for bringing materials to the patient floors (for bedside viewing, these should be upright carts with sloping horizontal shelves); and a large capacity cart for transporting materials to clinics, waiting, and other areas. Where feasible, motorized book carts should be considered, especially for transporting large blocks of materials.
  Where there is an externally provided library service rather than a freestanding library, the parent institution should provide a sufficient number of light weight (or possibly motorized), large capacity bookcarts to transport

materials from the storage area to the patient floors.

* Stools, both rolling and stationary, should be liberally available.

* A personal computer or a typewriter should be available for writing, the choice depending on staff habits and preferences. According to local conditions, though, it might be advisable to have a typewriter available for patient use, at least in long-stay institutions, since experience shows that many adults and elderly people prefer to write that way.

Personal computers connected to the institution's network and the Internet should also be available, especially since reliable health information will likely reside online within the institution and will definitely reside on the broader Internet. At least one computer should be equipped with assistive devices for disabled patients. All should be attached to a printer and have floppy and CD or DVD drives installed.

The parent institution's Information Services Department can help with in-house network and Internet connections; for the sake of network security, that help will be mandatory in some institutions. If at all possible, Information Services should also arrange for patients to have email access on the library's computers, an amenity particularly important for business people or for those whose families and friends live at a distance.

* - Laptop computers, with Internet access, that can be circulated to the floors no doubt would greatly help bedfast patients wishing to write, conduct business, or remain in touch with families and friends.

* Assistive devices should be available where there is a large disabled population; those devices become especially critical to that group when the library's catalog and major resources are available only in electronic format. Distributor's or manufacturer's catalogs, usually available on the Internet, will prove enormously helpful in staying abreast of the assistive devices field as will the home pages of academic and other institutions, organizations, and associations focusing on one or more kinds of disabilities.

* A television with caption decoder, connected to internal and external stations, should be available for patient viewing. TVs will take on additional importance in countries that have begun to provide TV-based email.

* Hardware for using the library's audiovisual materials should be liberally available. Included might be: headsets or other listening devices; talking book machines; book reading machines; audio/video cassette players; CD and DVD players (at this writing, most DVD players will also play CDs); and tape recorders.

4. Staffing

4.1 Size and Type

Local factors that will determine staff size and configuration include: 1) the size and type of the parent institution; 2) the number and kinds of people expected to use the library or library service; and 3) the materials, programs and

services that will be made available. In any case, though, when assessing staffing needs, it is necessary to remember that library work with hospital patients, and particularly with the institutionalized elderly or disabled, is extremely staff intensive:

- there will likely be a large number of non-ambulatory patients requiring regularly scheduled bedside service;
- many of the patients or residents who *are* able to visit the library will be disabled or otherwise limited and will need dedicated assistance;
- a sick or physically limited patient population will usually make heavy demands on the audiovisual and assistive devices collections, both of which require qualified staff at the point of use;
- while rewarding, quality bibliotherapeutic assessment/provision is extremely time consuming.
- as part of the patient care team, library staff will have to take time to maintain a rapport with other patient care departments and services, to attend institution-wide management meetings, and to regularly confer with administrative staff

Keeping in mind that the effectiveness of any library or library service depends in part on having an adequate number of trained personnel, the following staff categories should be considered:

- one or more professional librarians
- one or more paraprofessionals (library associates)
- technical assistants (people with expertise in the use of udiovisuals, assistive devices, and computers)
- clerical staff

Whether a freestanding library or an externally provided service, administrative responsibility should rest with a professional librarian having the

requisite education, training and expertise.

Where employing a full time librarian is infeasible, the parent institution should retain a library consultant (a professional librarian) to provide overall administrative guidance. Ideally, the individual should come from a local public library, where community mix and community reading tastes are well known. The parent institution could also consider sharing a librarian with another institution. Again, the person should be from - or familiar with - the local community.

In any case, the library's ancillary staff - paraprofessionals, technical assistants, clerical staff - will never function effectively without professional guidance.

4.2 Qualifications

The administrative librarian should possess the following competencies :

- a thorough knowledge of librarianship including the elements of administration;
- the ability to organize and plan;
- a strong sense of the ways in which library materials and services can contribute to patient care;
- an awareness of sick, elderly, and disabled people's problems and library-related needs;
- a working knowledge of medical, psychological, and psychiatric terms;
- the ability to speak and write clearly, including the ability to effectively define the library's patient care contributions;
- good judgement; flexibility.

Every library staff member should have a basic knowledge of library methods and the library-related needs of sick, elderly, and disabled people. They should also have some technological expertise, particular if the library provides computer-based programs and access to Internet resources.

Staff who work directly with patients should also have:

- a *thorough* understanding of the problems and needs of those being served, be they children, the mentally or physically ill, the elderly, or the disabled
- an approachable, easy manner
- patience, understanding, and empathy;
- the ability to listen

4.3 Volunteers

Volunteers can prove an enormous source of assistance in nearly every aspect of library operations. According to individual ability, and with careful training, they can: staff the circulation desk; provide basic reference or information services; provide some bedside book cart service; process interlibrary loans; help weed the collection; keep statistics; maintain vertical files; process new materials; and prepare bindery shipments.

Where volunteer help is feasible, recruitment should be done, not just through the hospital's volunteer department, but also through local voluntary agencies that might specialize in library-related work or services to hospitals.

4.4 Position Descriptions

The library should develop and keep job descriptions for all paid and voluntary staff positions (in the case of volunteers, it might be a generic description). In institutions where the library is a freestanding department, developing and retaining job descriptions will probably be mandatory.

The parent institution's policy and procedure manual, which complements position descriptions, should always be available in the library for staff and

volunteers to refer to.

4.5 Continuing Education and Training

Every effort should be made to encourage and enable staff continuing education and, for staff and volunteers, on-going training: the field of library service changes continually, thus there are always new techniques, resources, and methods that must be learned.

Continuing learning is vital for staff who work with children, the elderly, and the disabled, since the methods of meeting those clients needs also constantly evolve.

Sources of on-going education and training might include:

- the parent institution's own in-service programs;
- workshops offered by local libraries or library consortia (networks);
- courses sponsored by professional library associations;
- site visits to other patients' libraries;
- seminars given by various agencies or groups;
- distance learning, often provided by academic library schools, and often available either through electronic or postal mail

Though lacking structure and guidance, much can be learned from regularly perusing professional books and journals and even the catalogs of library-related manufacturers and distributors.

5. Budget

The patients' library should receive adequate funding for: salaries; the collections, including print and non-print materials; assistive devices where needed; other equipment; supplies; technical operations; programs; services such as interlibrary borrowing; network and other membership fees.

Where the library is maintained through a cooperative agreement, those costs will be shared. Overall, though, given the fiscal constraints found in many hospitals, long-term care facilities, and public libraries, it seems prudent to keep the library's operating costs as low as possible. At some point, its continued existence may depend on successful cost conservation; it may also rest in part on the *perception* that library staff are trying to keep expenses down.

As needed, costs could be minimized by: reducing routine tasks; dispensing with paper work that is only marginally necessary; automating selected processes; outsourcing selected operations; entering into cooperative agreements for cataloging, technical services, etc.; using less qualified staff; sharing staff; using staff from other parts of the parent institution.

To achieve long-term cost efficiency, the administrative librarian must remain fiscally aware and be flexible and creative enough to try newer, more efficient methods. He/she should also continually examine the library's programs

and services to see which are important and which might be cut back or eliminated.

In the case of an externally provided service, expenditures will be significantly lower: fewer staff are needed; there are no major equipment costs; space maintenance will be minimal; the range and therefore cost of supplies will be less; and there will be less drain on the institution's infrastructure overall.

However, whether freestanding library or library service, staffing and the collections will remain constant expenses. For those, the following guidelines should be helpful.

- staff salaries should be competitive with those paid for similar positions in public or other libraries

- a collection's **start-up costs** should be based on the number of books needed per bed* times the number of beds times the average cost of a book; **to maintain an existing collection**, the budget should be based on

  an annual new book purchase rate of from 10% to 15% of that collection. For example, at a 10% annual new book purchase rate, a collection of 3,000 books will require 300 new books yearly (thus, annual budget = 300 times the average cost of a book).
  Where there is a high need for audiovisuals and assistive devices, these formulae should be adjusted upward.

***** Usually six to eight books per patient bed, but see Section 6**.**

6. Collections

The rationale for well-rounded collections in patients' libraries was suggested in the German Institute of Librarianship's guidelines for patient libraries. The guidelines noted: "Illness is one of the few societal phenomena that does not have advantages or disadvantages as to income, ownership, education, age, or nationality. Patients...represent a cross-section of society."[35]

As with any library, the patients' library's collections should be planned around the needs and preferences of its target clientele. Central to this planning is a collection development policy that not only defines the target group, but also discusses those needs and preferences. Beyond that, the policy should stipulate the types and formats of materials suitable for accession and should address the issues of gifts and donations and weeding.

Several elements should be common to the materials selected:

- all should be in good condition;
- all should be of high quality;
- where possible, books should be lightweight and easy to handle;
- a percentage should allow for the visual limitations of patients, that is, they should have large print with extra spacing between the lines,

or, as necessary, be available in alternate formats such as tapes, CDs, and braille;
- non-fiction and health information materials should be current and authoritative, with a percentage being available in alternate formats.

Generally, the collections will represent **leisure reading** and **health information** in both print and non-print formats.

- **Printed leisure reading materials** should include: hardcover and paperback books; magazines; local, regional and national newspapers; bilingual or foreign language materials; for the visually impaired, books in braille,[36] as well as hands-on and other touch/read books; Easy-to-Read material[37] geared to the cognitively disabled; for first time or slow readers, doorstep books representing 1st to 2nd to 3rd levels of reading; for children, a wide range of age-appropriate books and magazines, including picture books and multiple copies of favorite stories.[38]

In long-term care facilities, some emphasis should be placed on keeping general interest books and magazines that can encourage and allow residents in group activities to share their knowledge and experiences.

A good fiction / nonfiction balance should be maintained.
Fiction should include: best sellers; classics; light reading; books with 'escapist' themes such as adventure novels, romances, and mysteries.
Nonfiction should include: biographies; literature, especially short stories and poems; special interest books, such as cookbooks, travel, and hobbies; self-teaching books, for example, books on computer skills, art expression, gardening, and carpentry.

- **Printed health information materials** can help patients understand their illness or disorder, perhaps thus enabling them to make informed decisions about the course of their treatment. Health information can also teach patients how to manage chronic diseases or show them how to achieve and maintain good health. Towards those ends, the health information collection should include general reference works such as: dictionaries, encyclopedias, and directories (guides to the health care field, guides to physicians, guides to social service sources); medical terminology, acronyms, and abbreviations texts.; and topic-specific bibliographies. Formats should include: books; magazines; and newsletters, pamphlets, and brochures. Subject representation may depend on whether the hospital provides general or special care. On average, though, a well-rounded health information collection will include: anatomy and physiology; drugs; internal medicine, especially current diagnosis and treatment; nutrition; surgery; orthopedics; psychiatry and general mental health; obstetrics and gynecology; dermatology; disabilities, both physical and developmental; pediatrics; geriatrics; otolaryngology; ophthalmology; dental health; rare

diseases and disorders; men's health; women's health; and, wellness.

While the collection will be geared to patients / consumers, it is likely that the comprehension levels of that group will vary widely, hence materials should be available at both the lay and professional levels.

Professional societies and associations are excellent sources of health information, and patients' libraries should take advantage of them; often, their materials are multi-lingual and either free or relatively inexpensive.

Finally, an internal review panel of health information professionals should be used to screen or otherwise advise on materials for the health information collection. In some institutions, the use of such a panel may e mandatory.

The number of books needed for the collection will vary according to local conditions. While no one formula will fit every situation, the following should be considered general guidelines.

For a hospital with:	
under 300 beds	8 books per bed
300-500 beds	7 books per bed
500 + beds	6 books per bed
For long-term care institutions	8 books per bed

The collections should be weeded on a regular basis, mainly to remove out-of-date reference material, books that are in poor physical condition, and books that have remained unused. Approximately 20 percent of the collection should be replaced each year, although that will vary according to individual patterns of library usage.

Where library materials are provided through a deposit collection, that collection should be 'refreshed' regularly. Here, the Norfolk (UK) Library and Information Service's Patients' Library Standards[39] provide a helpful frame of reference. The standards mandate the following book turnover rate.

Books on the shelves	Minimum % to be changed
1000 +	15%
700-999	20%
450-699	25%
150-449	30%

The standards also require that the collection be refreshed every three months and that the combined age of the books not exceed eight years.

- **Non-print leisure materials** should include: books in alternate formats such as talking books in analogue (cassette tape) or digital (tapes, CDs, DVDs) format[40]; talking newspapers and magazines; video tapes, including tapes of movies, plays and shows, all preferably closed-captioned;
music CDs; portable radios and disc-men (walkmen); games, puzzles, playing cards and other realia; particularly for children and those in long-term care, arts and crafts; particularly for the institutionalized elderly, self-learning audio or video tapes (captioned as needed); for the long-term care
cognitively or emotionally disabled, adaptive toys and dolls for teaching cognitive and social interaction skills; for those in long- term care with general learning impairments, software programs that focus on reading readiness, language development, spelling, vocabulary, grammar, and reading comprehension; where useful, a 'toy library.'

- **Non-print health information materials** will include the same subject categories as those in the print collection. To a large degree, though, non-print health information will probably center on internal and external online databases and other electronic resources, including the Internet. For
the librarian, the Internet has become both a blessing and a burden, since,
while it holds enormous amounts of information, locating and evaluating that information can be extremely time-consuming. For the sake of quality as well as time expediency, one should first look to the Internet sites maintained by local, regional, and national medical associations; they are
sources of high quality health information and usually provide links to other
reliable sources. As available, the emerging Internet subject gateways may
help identify reliable health information sources;[41] the home pages of many
biomedical / health science libraries and library consortia will do the same.
Sources notwithstanding, the library and the hospital might want to consider
requiring patients to sign an agreement of non-responsibility for health information found and used via the library's Internet connection. The library/hospital might also require that patients agree not to misuse the service; alternately, filtering software could be utilized.
For all non-print collections, corresponding hardware should be available and in good physical condition.

Finally, where necessary, **assistive devices** should be available. These may include basic aids such as magnifying and prism glasses, reading racks (book holders), electric page turners, book reading machines, and talking book machines. They may also include the more sophisticated

aids
such as teleTypewriters (TTYs, for the deaf and hard of hearing), telephone
amplifiers; caption decoders; computer touch screens, screen enlarging software, speech synthesizers, braille keyboards and braille printers, and print reading systems with speech output.

The assistive devices field has grown rapidly and, no doubt, will continue to do so. To keep informed of the new technologies, the library should maintain contact with regional or national libraries for the blind and physically disabled. For comprehensive awareness, the catalogs / Internet
home pages of assistive devices manufacturers and distributors will prove extremely helpful. (See also Section 3.6)

7. Programs and Services

Beyond building and circulating a collection of library materials, the patients' library should provide at least some services and programs. While the numbers and kinds will be guided by user needs, implementation will probably depend on the staff and fiscal resources available to administer them.

The following are examples of services and programs commonly provided to those in institutional care. Some are basic and require minimal resources; others are more complex and will be at least staff intensive.

- **Regularly-scheduled book cart service** to patient floors should be a fundamental service in any institution caring for a large number of semi- or non-ambulatory people. Ideally, the service should be provided twice weekly, although local circumstances will ultimately decide that. But, whatever per-week schedule is established (more or less than twice weekly), it should be followed: sick, elderly or disabled people who are institutionalized often suffer when schedules change and expectations are not met.

Beyond bedside service, library materials should always be available to patients on a telephone request basis.

There has been discussion in recent years about the benefit of encouraging the ambulatory elderly and certain psychiatric patients to visit the library rather than receive bedside service, the idea being that library visits foster socialization. Such decisions should be made locally and should *always* be based
on each patient's unique circumstance.

- Where useful, small collections of books and other print materials should be available in **clinics, day rooms, waiting rooms, and special treatment areas** such as dialysis and chemotherapy units**.** Paperback books that need not be returned to the library are ideal, since the chance of book loss in such settings is usually high. Alternately, if accepting some loss is feasible, inexpensive hardcover books might also be provided. Current magazines and daily newspapers are also
ideal, particularly for those with limited time to read.

- An **interlibrary loan program** will provide users with materials unavailable to them through the library's own collections. Interlibrary lending and borrowing is perhaps most effectively done though a library consortium (network): in such cases, the process is centralized, thus affording the library the great advantage of a single route into many different collections.

- **Reference services** are especially important where the library provides health information materials and resources, the sheer wealth of which can easily overwhelm the lay person. Users may need help, for example, not only in answering specific questions, but in sorting through the morass of available information. They may also need help in identifying sources of quality information and, more generally, in learning how to tap the Internet's rich resources.

- **Readers' advisory** (or readers' guidance) is particularly important in long-stay institutions where patients stand to benefit from ongoing, individualized reading programs. Readers' advisory implies a knowledge both of the patient's needs and interests and of the materials available to match them. The goals of reader's advisory can be education, diversion, or therapy.

- Where possible, the patients' library should generate **subject-specific annotated bibliographies,** be they on aspects of disease, health, or wellness, or on leisure interests. Among other benefits, locally produced bibliographies are usually more up-to-date that their externally produced counterparts.

- The patients' library should provide supportive materials for the parent institution's **educational and rehabilitation programs -** school and recreational or occupational therapy programs. Not only will the patients and the staff administering those programs benefit greatly, that cooperative work further reinforces the library's role as a patient care service.

- For long-term care patients, the library should consider providing **appropriate forms of entertainment**. That may be done alone or in conjunction with other departments or services and could include: book discussion groups; arts and crafts programs; film or slide shows; lectures; musical performances; game nights; poetry readings, including readings by patients or residents; debates and discussions; special holiday entertainment; and for children, arts and crafts, flannel board stories, puppet shows, and story hours and reading aloud, including braille and signed programs as needed.

- As noted in the preface to these guidelines, **music therapy** continues to be used in patient care, primarily to stimulate, to calm, to relieve pain, stress and tension, and as a complement to palliative medicine. The settings for music therapy can range from patient rooms to operating rooms to recovery rooms and, in the case of home care patients, to group or individual residences.

Every effort should be made to support music therapy programs: building

and maintaining a collection of musical tapes is neither expensive nor time consuming, yet it will greatly benefit the patients and the staff who care for them.

- Where staffing and staff expertise permit, the patients' library should encourage and support **bibliotherapy** programs. By definition therapeutic, bibliotherapy is more structured and intensive that reader's advisory and, as such, requires a positive, long-term commitment on the part of the library. But, given that this age old tool continues to be considered highly effective, particularly for hospitalized children, for the elderly, and for the depressed, any effort devoted to it would seem worthwhile.

- Finally, as space permits, a quiet, separate part of the library might be made available for **meetings and discussions** among patients, families, and health sciences staff regarding health or other topics of mutual interest. Since the library may be the institution's health information center, that location would be fitting. If private enough, the space could also be used for group bibliotherapy sessions, which also stand to be enhanced by a library setting.

8. A Note on Automation

While a detailed discussion of technical services and other library systems is beyond the scope of these guidelines, brief mention of the advisability of automating such services and systems seems warranted.

Technical services usually encompass the processes involved in adding material to the collection - essentially selecting, acquiring, processing, classifying, and cataloging new holdings. Library systems include circulation, interlibrary loan, serials control, inventory, and purchasing and receiving. While automating some of these procedures will often provide greater operational efficiency, deciding to do so is a highly individual decision and should be set against local factors, especially need, feasibility, and usefulness.

Need questions why the particular operation is being automated. Who will benefit from it and how will they benefit? Will it better serve overall needs and goals? For example, an online catalog will allow remote access to information about the library's holdings, and that may be important where the collections are heavily used by an off-site community. It may not be important, though, if the library's users are limited to on-site patients who prefer to visit the library in person.

Feasibility asks whether of not the library has the resources, not only to automate a particular system, but to maintain it over the long run. Do library staff have the expertise needed to monitor the system and trouble-shoot technical problems that arise? Lacking staff expertise, does the parent institution (or sponsoring public library or other agency) have systems specialists who will manage automation? Will the parent institution or external agency provide the funds needed over time to support system software and hardware upgrades?

Usefulness requires determining whether the automated system will

ultimately prove helpful or have its advantages overridden by drains on staff time and other resources. At the very least, automated systems (and their upgrades) carry with them the burden of a high learning curve, which may be troubling to an already overburdened staff. If it seems that a manual system will prove as time-efficient as its corresponding automated system, and will be as effective overall, that manual
system should probably be retained.

Given adequate staff and fiscal resources, there are advantages to automating at least the library's holdings' records - that is, to installing and maintaining a computer-based catalog. As regards staff, it is more time-efficient than the traditional card catalog: once collection records have been entered, adding new acquisitions requires only the time it takes to key in item information, and that data entry is done more quickly than producing and filing sets of catalog cards. Pulling material from the collections is also less-time consuming, involving just a few deletion keystrokes as compared with manually ferreting out and removing series of cards. Most catalog modules will also generate book and spine labels, thus eliminating the time needed to type or purchase them.

An important administrative consideration, computerized catalogs can generate ancillary reports and summaries, for example, subject bibliographies, collection analysis reports, and lists of new accessions, all of which are time-consuming when done manually.

Finally, a computerized catalog will provide staff and users with near-instantaneous holdings information; when tied to a circulation module, it will also provide immediate information on the availability of a particular item.

Perhaps the greatest <u>disadvantage</u> of a computerized catalog in a library serving a large number of disabled users is the high cost of computer assistive devices that group will need. Also, some of the elderly and those less computer literate may find using that catalog difficult. Again, the decision to automate should
be set against such local considerations

The German Institute of Librarianship's guidelines for patients' libraries note that "circulation/book lending should be the absolute priority in a patient library,"[42] and perhaps that goal is the key to decisions regarding systems automation: if

automating will foster and enhance patient use of the collections, and free staff to help in that use, it should be considered; if, on the other hand, it has the potential to drain staff time and financial resources, and if it runs the risk of becoming a goal in itself, it should be approached with caution.

9. Publicity

Devoting time and energy to publicizing the patients' library is nearly as important as providing the library services themselves. For, if patients, hospital staff, and administration are unaware, or only vaguely aware, of this remarkable

resource, its patient care potential stands to be diminished.

Efforts should be made to advertise, not only the library's existence, but also its materials and services. That includes mentioning audiovisual collections, adaptive materials, assistive devices, and the like. Important also are the library's hours of operation and the ways in which patients can be in touch with it.

As a target publicity group, inpatients are perhaps the easiest to reach. They can be provided information about the library through a section in the hospital's patient information booklet and through in-house television stations. They can also receive promotional information through leaflets and brochures kept on the patient floors and in strategic areas such as pre-admission, admitting, and the clinics. As the parent institution permits, informational brochures should also be available in all diagnostic and therapeutic waiting areas.

Though simple in concept, informational bookmarks are an effective means of publicizing the library, and they should be available throughout the institution. Bookmarks actually enjoy an advantage over other types of print publicity in that they are functional and thus people tend to keep them. They are also relatively inexpensive to produce.

Presentations made at institution-wide meetings are an extremely effective way of reaching the administrative and management staffs. Annual or quarterly reports to those groups will also help. A third way of making administration / management aware of the library's work is through a library committee that meets regularly, and whose members represent patient-focused areas such as nursing, medical services, social services, administration, and home or community care.

Hospital staff can be reminded of the library through columns in the hospital's newsletters and other publications. Institution-wide distribution of a new books / new accessions list will also do much to keep staff aware.

Posters strategically placed around the institution will alert not only staff to the library's existence, but also families and visitors. Posters will take on added interest - probably especially administrative interest - if they can be designed / made by the longer-stay patients, including children. In such cases, producing posters for the library could be a joint project of the library and another therapeutic
department, for example, occupational or recreational therapy. That cooperative effort is in itself a fine means of publicity.

Gift shops - If they are willing to keep and make available informational materials about the library - are an excellent means of reaching patients' families and visitors.

Centrally located exhibit cases featuring the library's collections, programs or services will do much to promote it as a unique resource. Fliers announcing special events such as lectures, poetry-reading, book talks and children's events will almost certainly also generate interest. Where possible, the parent institution's staff should be invited to give library-based lectures or readings - their involvement will further

raise the library's visibility.

Finally, hospital staff should be asked for input in building some of the library's resources: not only would their assistance help tailor the collections and services to the institution's needs, it would also help keep the library on their minds.

Where the patients' library also serves those receiving care in the community, or at home, many of the above publicity tools - in particular, leaflets, brochures, and bookmarks - remain an effective means of alerting potential users to the library's resources. Those informational materials should be regularly deposited in community care centers, and should also be distributed to home care patients, perhaps through the hospital staff responsible for that service. Free or inexpensive advertisements in local newspapers will do much to alert community and home care patients and local public libraries to the library's existence and work.

Library services provided to the elderly and/or disabled in long-term care or residential facilities will benefit from having informational brochures and bookmarks deposited in common public rooms.

Germany's guidelines for patient libraries have suggested that the patients' library host an annual open-house tea for the local library community as one means of advertising the library to colleagues.[43] A fine idea, it might be built upon to include quarterly or semi-annual affairs.

10. External Resources

To the degree possible, patients' librarians should take advantage of the external resources available to them. For, their work encompasses so many areas of specialization, it seems wise to make use of organizations that can help with state-or-the-art information, materials, and support services.

Local public libraries (if they are not already providing the library service) can be very helpful in providing both moral and informational support. Establishing a rapport with local public librarians can, for example, offer the isolated patients' librarian 'professional companionship' and the chance to discuss problems and
exchange ideas. Ongoing rapport with the local public library is also an excellent way of keeping up with new developments in the field. It can be a source of contacts for specialized services and volunteer help, and can prove a link to the leisure interests and health information needs of the community.

Public libraries can often help with collection support, either through gifts of duplicate or unneeded materials or through interlibrary loans. They may also provide help with cooperative purchasing, cataloging, and technical processing.

The benefits of **library consortia** (networks) may overlap some of the help pubic libraries can offer. Nonetheless, they can be an additional source of interlibrary loans and often will coordinate member exchange of unneeded / duplicate materials. Sometimes, consortia that operate on a membership fee

basis will offer Internet access (important where that is unavailable through the parent institution). They will also usually provide continuing education programs, and will alert patients' librarians to the availability of grants and stipends.

Local, national, or international networks can prove enormous support systems, providing members a way to share common problems and solutions.

National libraries might offer assistance with deposit collections or loans of special materials, for example, braille and talking books. They will also often provide consultants for operational or other guidance, and may be a source of grant funding. National libraries will sometimes act as a central point for cooperative efforts, such as acquisitions, cataloging, card production, and union lists.

Professional library associations often have sub-sections relevant to the patients' librarian, for example, sections on library services to hospitals, to the elderly, and to the disabled. While local or regional professional associations may not offer such interest-specific groups, nonetheless they afford camaraderie and are
an excellent link to matters affecting all librarians.

Professional medical and allied health sciences associations are usually more than willing to provide free or inexpensive patient / consumer health information materials, some of which will be multi-lingual. The obvious advantage is that their materials will be among the most authoritative available.

Manufacturer's catalogs should never be underestimated for the state-of-the-art information they provide. Librarians should maintain on-going relationships with relevant specialty manufacturers and should receive their catalogs and other
publications .

Book publishers, which provide comprehensive information on materials in print, also often provide topic-specific, annotated book lists that are helpful acquisitions tools. They are often a source of inexpensive remainder books and sometimes will provide multiple copies of new books as a charitable donation.

Internet discussion groups offer a valuable avenue of information exchange with other patients' librarians and with health sciences and outreach librarians. Every effort should be made to participate in them.

11. Special Considerations for the Elderly and the Disabled

11.1 The Elderly

There appear to be no universally recognized meanings for the

designations 'elderly' or 'older people.' For example, while the World Health Organization (WHO) sometimes categorize those *sixty years* of age and above as 'elderly' or 'older people,' it also uses those terms to mean those *sixty-five* years and above.[44] WHO *is* consistent, though, in it's categorization of the 'oldest old;' they are those *eighty years* of age and above.[45]

On the other hand, the United States' National Library of Medicine, the principal indexer of the international biomedical literature, has for some time used just two categories for the elderly - the aged *sixty-five +*, and the aged *eighty +*.[46]

For consistency's sake, these guidelines will use the term 'elderly' and not 'older' or 'aged' and will use WHO's *sixty-five* + and *eighty* + categories, especially since they are supported by current international bibliographical descriptors.

Categorizations notwithstanding, it seems clear that the elderly population is increasing worldwide. In early 1999, WHO noted:

> In 1955, there were 12 people aged over 65 for every 100 aged under 20. By, 1995, the old/young ratio was 16/100; by 2025 it will be 31/100... reaching 10% of the population.[47]

And:

> Elderly people themselves are growing older, increasing the numbers and proportions of the very old. **The fastest growing population in most countries of the world is of the oldest old, 80 years and above.** In 1993, they constituted 16% of all the older population over 65... These proportions will increase during the next 30 years to over 30% in the "oldest" countries.[48]

These trends have profound implications for the field of librarianship, both in terms of an expanding population with what has been called 'decidedly individual needs'[49], and - for those who have been providing library services to the elderly - a
population that even more, now, warrants dedicated resources.

Basic to providing meaningful library services to the elderly is the realization that, at heart, most will remain the individuals they were throughout their lifetimes. In fact, being freed from the responsibilities of raising families and earning incomes, many of the elderly will have entered a phase of their lives where they can more fully pursue their own interests. For the most part, those pursuits will probably be constant: those who were interested in politics, history or social issues will likely continue to be so; the artistically proficient will want to continue to create; learners
will want to continue learning.

Coincidental with that realization, consideration must be given to the age-related debilities the elderly may suffer. For example, while experience tells us that some will progress though advanced years with mental faculties relatively well intact, experience also shows that others will suffer differing degrees of intellectual debility or dementia. Almost all, though, are likely to experience some kind of *physical* debility,[50] thus planning for the elderly's library services should

consider such possibilities. Generally, mental and physical limitations may encompass: poorer health with a resulting decrease in physical strength and energy; sensory limitations; limited mobility; reduced mental capacity (poorer memory or concentration); and sometimes the problem of loneliness. Also, there is evidence
that some of the elderly suffer from depression more than younger people.[51]

Designs for library services for the elderly should also take into account any therapies that population may be receiving. The structured activities of physical, recreational and occupational therapy, for example, will be enhanced by information on basic anatomy, body movement, arts and crafts, and other skills. Psychotherapy could be complemented by bibliotherapy, or directed reading.

Finally, as is the case with the general population, the elderly's reading abilities and interests will vary: some will be active readers; some will be moderately interested in reading; some may be apathetic or reluctant to read; some will have no interest in reading; and some will lack reading skills.

Effective library services for the elderly, then, should aim to provide reading and other library materials that:

- encourage and support individual interests;
- compensate for physical and mental limitations;
- complement specific therapies or activities;
- provide for differing levels of reading ability

Collections meeting these needs will include some of the materials outlined in
Section 6. The following, though, may be particularly important:

- large print books and magazines; text with extra spacing between lines;
- lightweight books or books that are otherwise easily held;
- a variety of newspapers, especially daily newspapers, that can provide a frame of reference for the passage of time;
- for people with poor concentration, high-interest, low vocabulary books, for example, books of photographs or picture books with limited text;
- travel books, including those with large, color photographs;
- self teaching books (art expression, woodworking, computer skills);
- special interest books (local history; cooking, gardening, and other hobbies);
- cultural materials;
- comics, and cross- and other word puzzles; playing cards; board games;
- a <u>generous</u> supply of audiovisuals - audio and video tapes of music, movies, and shows as well as basic and advanced instructional videos

(captioned for the deaf as needed);

- as needed, books in alternate formats, for example, talking books, newspapers, and magazines, and others listed in Section 6;
- basic health information books, magazines, pamphlets, and brochures;
- information on topic-specific disorders and illnesses;
- medical and allied health sciences dictionaries / encyclopedias
- guides to wellness and healthy living;
- books on relaxation, exercise, gerontology and aging;

As is the case with the younger populations, some of the elderly will require assistive devices, thus consideration should be given to providing at least basic reading aids such as hand-held and mounted magnifiers, magnifying glasses, book stands, and electronic page turners. According to need, some of the more sophisticated devices outlined in Section 6 should also be considered, particularly those that compensate for sensory limitations.

WHO looks towards a universal goal of achieving "active aging," that is, aging that is a natural process continuing throughout one's lifetime.[52] It notes that such aging implies "a continuing participation of older persons *in all facets of social interaction.*"[53] In support of that goal, it seems fitting that library services for the elderly not only foster lifelong continuing education, but also aim to provide access to needed social, cultural, health and other information.

11.2 The Disabled

Unlike the term 'elderly,' the designation 'disabled' has a universal basis: writing for the international community, the United Nations (UN) classifies as disabled those having physical, sensory or mental impairments. The UN further distinguishes between the terms 'disabled' and the closely-related 'impaired' and 'handicapped, ' noting that:

- an **impairment** is an abnormality or loss of physiological, psychological, or anatomical structure or function. Essentially, impairments are disorders at *organ level*, for example, blindness, deafness, paralysis;
- a **disability**, which an impairment causes, is the "restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being." It is a limitation in function *at the level of the person*, thus disabilities include difficulty seeing, hearing, moving about;
- a **handicap** is a "disadvantage resulting from a...disability." It exists *within the context of socioeconomic roles*, placing disabled people at a disadvantaged when compared to the non-disabled. Examples of handicaps include being unable to use public transportation, being socially isolated, being confined to a bed.[54]

The UN estimates that more than half a billion people,[55] or 7 to 10 percent of the world's population[56] are disabled, and that five of the ten leading causes of disability are mental problems.[57] Long concerned with the disabled's rights, it has made recommendations regarding their access to information and culture, including the use of libraries and the availability of adapted literature.[58]

Providing library services to such a diverse group is one of the most challenging endeavors in the field. For not only do the disabled represent a multitude of distinctly different impairments, and different impairment levels, they also represent every age group - from infancy through old age - and both impairments and age groups in and of themselves require of the librarian special expertise.

Given the complexity of the field, a detailed discussion of library services for individual disabilities and for age-specific disabled groups is beyond the scope of these guidelines. However, this section *can* offer general considerations and recommendations. The reader needing more should refer to the published book and journal literature, which covers these areas in greater detail. Also, the conference papers presented at IFLA's annual meetings and accessible through IFLA's home page (currently, www.ifla.org) are an excellent source of information on library materials and services for the disabled.

General considerations.

If there is one key to working with the disabled it may be the realization that, disability aside, they are just the same as anyone else. They have likes and dislikes, perhaps hopes and dreams. Often, they will want to work for a high quality of life, and will have competencies and curiosities that will surprise the uninitiated. Many disabled people will be seekers of information, be it on their disability, rights, or opportunities or, more generally, the world in which they live. Experience shows that some seek that information with great energy and determination.

And, just as with everyone else, the disabled want to live meaningful lives, and they will look for things that keep their minds and spirits active. Reading is certainly high on that list for, through the world of books and multi-media, they are able to dream, plan, and become a part of society.[59]

With those considerations in mind, collections for the disabled should aim to provide materials in appropriate formats. Doing so requires a knowledge, not only of the person and his/her interests, but of the level of disability, the limitations posed by it, and the resources available to compensate for it.

Besides the library materials outlined in Section 6, collections for the disabled should include some of the following:

- for the visually disabled: braille books; talking books and spoken word cassettes; talking newspapers which will provide both current news and a frame of reference for the passage of time; large print books; books with maximum spacing between the lines; tactile books; a Kurtzweiler reading machine (a text-to-voice reading machine with speech output); various kinds of music; braille printer or typewriter; reading aids such as magnifying glasses and video magnifiers;

- for visually impaired children, toys and other items they can touch and feel; braille books accompanied by related three-dimensional objects; braille story hours;
- for the hearing impaired: captioned television, particularly news stations; captioned videos, including group showings of captioned films; signed story hours, lectures, and talks; adaptive telecommunications equipment as as needed;
- for the cognitively disabled: easy-to-read books; specially adapted talking books, for example, for aphasiacs, books that read more slowly; video films with simple plots; picture books; simple games; adapted toys such as disability puppets and dolls for learning social and cognitive skills;
- a variety of games; arts and crafts programs
- where there is an online catalog, print enlargement and speech output
- in general, leisure, educational, and cultural materials that are adapted to meet the patients'/residents' needs.

The Internet/World Wide Web is an increasingly important tool for the disabled, not only as a rich source of practical information, but also for leisure reading. Wherever possible, patients should be provided with access to the 'Web,' but that does imply removing accessibility barriers.

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The "oldest" country by 2020 will be Japan (31%), followed by Italy, Greece, and Switzerland (above 28%). today, the countries with the highest proportion of elderly people are Greece and Italy (both 23% in 1998).

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58. See, for example: "The Standard Rules on the Equalization of Opportunities for Persons with Disabilities." http://www.un.org/esa/socdev/dissre00.htm; "World Programme of Action Concerning Disabled Persons." http://www.un.org/esa/socdev/diswpa00.htm

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APPENDIX

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General note:

Since wheelchair, walker, and bed-stretcher dimensions lack universal standardization, the illustrations represent only average sizes and shapes. However, they should provide a useful frame of reference.