REPORT

OF THE

COMMITTEE TO STUDY VISITING NURSING

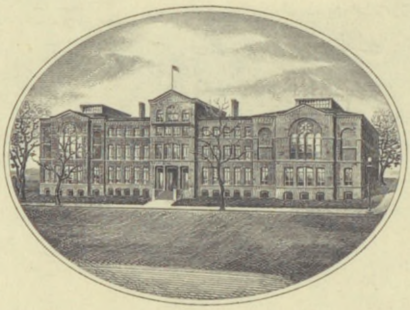
INSTITUTED BY THE

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

AT THE REQUEST OF THE

METROPOLITAN LIFE INSURANCE COMPANY

NEW YORK
1924



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Nursing

N.O. organization...

RESOLUTION

passed by the National Organization for Public Health Nursing at its third Biennial Convention, Detroit, Mich., June 16 to 21, 1924.

WHEREAS, the report of the Committee to Study Visiting Nursing has given us information long sought, and which promises to be a vital contribution to the solution of many problems in connection with administration and budgeting of visiting nurse associations;

BE IT RESOLVED, that the National Organization for Public Health Nursing in Convention assembled expresses a very genuine appreciation to the members of the Committee for this valuable report, and to the Metropolitan Life Insurance Company for their financial assistance which made this piece of research possible, and for their generous provision for printing this report.

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INTRODUCTION

When visiting nursing was introduced into this country less than half a century ago, the primary interest was in bedside care for the sick poor. Thus in 1877 we find the Woman's Board of the New York City Mission employing a "Missionary Nurse," to give home nursing service to the sick poor for whom the Mission cared. *As other visiting nurse services were organized, many were developed for this same group, though a few outstanding organizations were started for the purpose of giving service to "people of moderate means, who could pay something for the care received, as well as for the poor to whom the service would be given free of cost."† In all of these organizations, however, we still find that a large part of their accepted programs is the home care of those who are ill, in need of and unable to pay for the services of a nurse.

Coincident, however, with the maintenance of the early purposes of the first visiting nurse societies, we find a slow but steadily developing realization of larger possibilities in successfully carrying out the older ideals of visiting nursing. The visit of the public health nurse today means not only the bedside nursing care of the individual who is ill. It also involves an intelligent understanding of the social situation in which that individual and the other members of his family group live. And in all cases it involves an educational function in that the sick individual and the members of his family are instructed in personal hygiene. Thus not only care in acute illness is given, but also instruction in right living to prevent other illness.

The report of the Committee for the Study of Nursing Education has so clearly brought out the facts of this development, this inter-relationship of bedside care and home teaching, that further discussion at this place is superfluous. The following quotation from this report is in point.

> Our inquiry leads us to conclude that the distinguishing functions of the public health nurse which should determine her training are to teach habits of healthful living in the home, to see to it that the physician's instructions are intelligently carried out, to be on the alert for all that is suspicious or divergent from health. These functions differentiate the public health nurse from all the other workers—social workers and vocational workers, dietitians, clinic assistants, etc.—who also share in the manifold variations of public health work.‡

Hence, as the emphasis has swung from bedside nursing in its narrow sense to family health work with education as its basis, so has the group

*The Evolution of Public Health Nursing, Annie M. Brainard, W. B. Saunders Co. 1922. Page 195.
†Op. cit. Page 220.
‡Nursing and Nursing Education in the United States. Report of the Committee for the Study of Nursing Education. The Macmillan Co., New York. 1923. Page 51.

coming under the care of the visiting nurse societies grown from that of the sick poor to an ever increasing group of independent, self-supporting members of society, in search of nursing care for which they can pay. The figures of most large public health nursing organizations will show a small but constant increase in the direction of a clientele of patients who are paying a part or all of the cost of their nursing service.

As visiting nurse organizations constantly reach a larger and more representative community group, so it becomes more and more important that they consider the true *cost* of their nursing service in relation to the quality of service that is given, and what is a fair charge to those who are able and want to pay for it.

Few studies of cost have been made though various more or less uniform methods of arriving at cost have been attempted. One of the most important and carefully organized analyses of cost available today is that made by the Visiting Nurse Service of the Henry Street Settlement for a period of six months in 1921. This analysis is based on the actual expenditures, number of visits and hours of service, for each district in the organization.*

A number of industrial and business concerns have also tried at different times to apply some uniform method of computing cost in the public health nursing organizations which are giving service to their clients. Though these methods have been satisfactory in some instances, it has been difficult to apply to a number of centers with entire success, a plan which was, perhaps, particularly fitted to a few of the agencies.

Among these business organizations the Metropolitan Life Insurance Company stands as a pioneer in the field of providing visiting nurse service for its industrial policyholders. An organization which has working agreements with 650 visiting nurse associations in addition to having a large nursing staff of its own, constantly encounters the problem of a proper cost for given types of nursing service.

Since a number of questions had arisen as to the adequacy of the present method, the Metropolitan Life Insurance Company referred the problem to the National Organization for Public Health Nursing in the following letter of December 23, 1921.

> Some years ago, we took up with the National Organization the problem of preparing a standardized financial statement, under which costs would be distributed and segregated so that the disbursements of one association might be compared with those of another. I had meetings at various times with a committee of this organization having this matter in charge. So far as I am aware, no final report of this committee has been presented. At the time we instituted nursing service, we stated our willingness to meet the full cost of service. Certain reports which have reached us indicate the existence of a belief on the part of some

*Visiting Nurse Service administered by Henry Street Settlement. Analysis of the per Visit Cost, January 1, 1921 to June 30, 1921.

associations that this is not being done. If this is the case, we should know it.

To this end, I am suggesting to the National Organization for Public Health Nursing that an impartial and unbiased study be made of the work of visiting nurse associations. This study should be made preferably by an independent committee. The study should cover both the quality and quantity of work done. It should include a careful analysis of disbursements, the ratio of overhead expense to total expenditure, salary, rentals, etc. In particular, the study should be directed toward the type of service given, number of visits per day per nurse, length of time spent in actual nursing and in going from home to home, the amount of time required for office duties, vacations, etc., and the time given to outside activities not directly concerned with bedside care.

I shall appreciate it if you will lay this matter before the Executive Committee at its next meeting.*

Following the suggestion outlined in the above letter, the National Organization for Public Health Nursing appointed a Committee to Study Visiting Nursing in the spring of 1922. This Committee included representative public health nursing administrators, physicians, social workers and, laymen, and its members were chosen from the various sections of the United States. At the biennial convention of the National Organization for Public Health Nursing in Seattle in June, 1922, the organization of the Committee and the plan and purpose of the study were discussed and agreed upon by a large and representative group of the members of this organization. The plan, as formulated at that time, was to study the visiting nurse services in a number of different types of agencies in order: (1) to evaluate the present quality of visiting nursing work; (2) to determine the "per visit" cost. From this study it was hoped that the Committee not only could recommend a basis for determining cost and a uniform system of accounting, but could also discuss the most economical operating machinery necessary for carrying on effective public health nursing.

The selection of the fourteen communities to be studied took into consideration the following factors in an attempt to obtain a cross section of typical public health nursing organizations throughout the country.

[1] *Geographical location.* The communities selected represent various sections of the country, from New England and the extreme South to the Pacific Coast.

[2] *Size of community.* The range of communities covered runs from a small New England village to one of the largest cities in the United States. In addition there are two rural communities.

[3] *Scope of work.* This includes both generalized and specialized service in either one or more or all types of work carried on by public health nursing organizations.

*Extract of a letter dated December 23, 1921 from Dr. Lee K. Frankel, Third Vice-President of the Metropolitan Life Insurance Company to Miss Elizabeth Fox, President, National Organization for Public Health Nursing.

[4] *Form of organization.* The communities selected include two public organizations, nine private organizations and three semi-public organizations.

The general method approved by the Committee for gathering the necessary information from the agencies was as follows: Two graduate nurses, with wide public health nursing experience and special training, visited the various agencies and were responsible for the immediate contact with each visiting nurse association, and the study of the organization, its administration and the content of its nursing work. A trained accountant visited each agency and collected from its various cost statements a complete picture of the cost situation and the agency's method of handling it. A trained research worker directed the details of planning the study and was responsible for assembling and organizing the material obtained. Each section of this assembled material was then discussed by the Executive Committee of the Committee to Study Visiting Nursing. From this discussion the Committee formulated its conclusions and recommendations.

The following study includes in detail the findings of the Committee, thus affording a cross section picture of the organization and administration of the various agencies, as well as an analysis of the cost statements related to a description of the quantity and quality of services rendered, all of which serves as a basis for recommendations of a uniform system of cost accounting.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

The following recommendations have been selected from the report for the convenience of the reader since they represent the factors which have been considered most fully. For additional detail on each of these points and on related factors of public health nursing, the reader is referred to the complete text which follows:

A. ORGANIZATION AND ADMINISTRATION

[1] *Training New Staff Nurses.* That every agency should have an established routine for introducing new nurses into the work of the agency. This introduction in the small agency and training period in the larger agency should aim to prepare the new staff nurse for the work which she is to do in that particular agency and to give any additional point of view of the public health nursing field as a whole that is essential in the carrying out of her work.

[2] *Staff Education* That in addition to the initial period there should be a more or less continuous staff educational program. This is particularly important because of the newness of the field of public health nursing, its rapid and continuing evolution and the impossibility of getting a supply of adequately prepared nurses in any other way.

[3] *Staff Participation* That there are advantages in the development of standards if there is active participation of staff membership in the formation of all policies governing the service. Without such a policy it is difficult for real leadership to develop.

[4] *Supervision.* That adequate supervision is essential to the efficient administration of every public health nursing agency. There should be a sufficient number of supervisors so that the work of each nurse is observed with regularity and so that there may be continuous training and teaching. From this study it would appear that it is difficult to carry on such a program, including the reading of records, conferences and visiting with the nurses if there are more than 10 nurses to a supervisor and we recommend less than this number of nurses. In many instances there is an advantage in having more intensive supervision than the minimum supervision previously discussed. It is not wise to make an arbitrary statement of the number of nurses whom one supervisor can assist and advise carefully, since the types of work in agencies vary so radically.

Since the quality of nursing work is likely to deteriorate where a nurse is working alone in a community with no supervision, it is desirable that some plan of regional supervision should be arranged, whereby such nurses may have the benefit of occasional but regular contacts with a supervisor.

In general, specialized supervisors on a large staff are essential as continuous teachers along specialized lines, keeping the staff nurse in touch with the latest developments and knowledge in a particular field, working out special techniques and trying out the methods developed by specialized agencies.

[5] *Record Writing.* That in agencies where the nurse has the entire responsibility for all the details of the finished record there should be additional clerical help provided to release the nurse from this work. We would recommend that more emphasis be placed on writing notes directly on the permanent clinical record, if possible at the bedside of the patient, thereby saving much of the nurse's time now spent in transcribing or dictating notes. Thoughtful attention should be given to the duplication of detail and writing in many of the record systems in use today. Careful instructions regarding the interpretation of each item on each record form should be given to every new nurse, and referred to at intervals by all staff nurses. Nurses should be interested through lectures, analyses of records, etc., in the great value of the material they are gathering.

[6] *Visit Classification.* That because of the loose terminology and the confusion in classifying visits, a uniform classification should be developed. The following classification of visits is suggested:

I. *Visits to the Patient.*
This will include all visits where the patient is seen. Since effective public health nursing must include necessary instruction, it is very difficult to try to separate "nursing" and "instructive" visits. This grouping, therefore, includes all visits where the patient is seen, whether the visits are mainly nursing or mainly educational.

II. *Visits to the Patient in Which the Patient was not Seen.*
Visits where patient was out, had moved, etc.

III. *Visits in Behalf of the Patient.*
Visits to social agencies, hospitals, doctors, relatives, etc., where the purpose of the visit is in behalf of some patient.

[7] *Analysis of Work.* That it is necessary for every agency to know at least the simple facts of what constitutes the nursing program, the frequency of care to the various types of cases, and the outstanding results of such care, in order to plan intelligently for future development. This assembling and critical analysis of the work of a public health nursing agency, through adequate statistical presentation, should be as much a part of its administration as any other administrative function now commonly employed, and should be done periodically, at least quarterly.

[8] *Health Examination.* That health examination before appointment and regular re-examinations are necessary for visiting nurses.

B. CONTENT OF THE VISIT

The cardinal principle of visiting nursing which must permeate all consideration of the essentials of visit content is that family health work is the basis upon which all other factors rest. This means that the nurse who goes into a home must take responsibility for the health of all members of the family. She should not only give necessary nursing care and teach health and the correction of defects, but also carry out a constructive health plan for the family as advised by the physician in charge. With this to build upon, it is important that every visit should contain various other factors.

First among these is a good nursing technique and procedure in the actual care given the patient, and in the use of the nursing bag and its contents.

Second, each visit should make use of every opportunity to teach. This teaching should include health teaching as well as instructions through demonstration to the family or friends regarding the home nursing of those who are ill.

Third, there should be an ability to detect serious problems, other than sickness, in the home situation and to take advantage of other resources in the community for handling and treating these difficulties. That is, there should be a nice balance between insight into difficult social situations and an understanding of how to care for them, when to refer them to other agencies, and to which agencies they should be referred.

Fourth, the spirit of the visit, which affects each factor, should include such qualities as the nurse's ability to make a good contact, sympathy, courtesy, adaptability to all individuals and situations.

Fifth, each visit should reflect the general policy of the organization in its acceptance of certain cases for care, and in the general procedure in relation to these cases, after acceptance.

C. COMPUTATION OF COST

From a study of the methods already in operation in 14 agencies, and from a discussion of other methods not found in any of these communities, this Committee has reached the following conclusions:

[1] That because of the extreme variation in the present methods of computing the cost of visiting nursing, it is not possible to compare the cost of the various agencies from the available material.

[2] That while the cost of the nursing service can be calculated with reasonable accuracy from the records now kept by a number of organizations, it will be impossible to determine the actual cost of visiting nursing of many agencies by a uniform method until a method of computing cost has been adopted and put into effect for a sufficient period of time to give representative data.

[3] That even if a uniform method of computing cost should be adopted by all agencies, costs would still vary markedly between communities, because of the differences in type of work, territory covered, travel facilities, cost of living which affects salaries, etc.

[4] That the basis for computing the cost of a nursing service should be the cost of a visit. This visit cost will be determined by dividing the total cost of the visiting nurse service, minus expenditures for activities not strictly within the field of visiting nursing,* by the total number of visits to the patient, and visits in behalf of the patient.

That for the purpose of analyzing the unit cost of any particular service, however, or for determining the relative costs of various

*See "Salaries" page 114 and "Relief" and "Other Nursing Activities." Page 116.

services, the Committee recommends that data should be used showing the amount of time spent on these various services.

[5] That the cost of visiting nursing should be interpreted as the true cost of conducting the work of visiting patients. The true cost will include two aspects of cost, the direct and indirect,* both of which are essential in carrying on visiting nursing. This will not necessarily be the same as the actual cash cost which may be reduced in some instances by special conditions. The Committee is agreed that gifts of necessary equipment, supplies, services or other items essential in the administration of a visiting nurse agency represent actual cost to the community and should, therefore, be interpreted as gifts given in lieu of money and should be charged to the true cost of the organization.

That this expense, however, must relate to visiting nurse work, as generally recognized and previously described, and not to the allied nursing work including the development of clinics, occupational therapy, etc., which are known to many public health nursing agencies. This shall include all expenses of administration, all field or nursing expense, all general running expenses and a pro-rated share on unusual expenses which are not entirely applicable to the current year.

*Direct cost includes expenses directly related to visiting nursing work while indirect cost includes the expenses of administration.

PART I

ORGANIZATION AND ADMINISTRATION OF FOURTEEN PUBLIC HEALTH NURSING AGENCIES

IN discussing comparative methods of cost computation in various types of visiting nurse organizations it is necessary to consider not only such quantitative measures as the amount of money that has been expended and the amount of work that has been done, but also the quality of the service rendered. We may assume, for example, that in two cities with approximately the same annual expenditures there is a marked difference in the total number of visits made. This difference in output may be due to several things. The association in the city of X, let us say, may have produced a smaller number of visits because of the form of its organization which may have put upon the nurses heavy clerical burdens or means of travel that were time consuming. Or the nurses in the city of X may have made fewer visits because of the more thorough care given in the home which, of course, necessitated a longer visit and therefore fewer visits during the day. In either case a comparative study of cost would be of little significance if it failed to recognize the form of organization and administration of the nursing service.

For this reason, this study will attempt to discuss in some detail the underlying plans of organization and methods of administration in a group of 14 selected public health nursing agencies.

TYPE OF ORGANIZATION

In considering form of organization we find that two out of the fourteen agencies are public; that is, their entire funds are given by the city. In nine instances the agencies are private and have no public funds. In three agencies an appreciable amount of the budget is received from public funds, while the control of the organization still remains as in a private agency. These three agencies are designated as semi-public agencies.

DESCRIPTION OF PUBLIC AGENCIES

If we return to the public agencies we find that in one instance the nursing work was organized as a Bureau of Nursing in the Department of Health in 1913 through an ordinance passed by the City Council. At the same time the ordinance included the creation of a Nursing Commission to serve in an advisory capacity to the Health Commissioner in administering the Nursing Bureau. This Commission is appointed by the Mayor to serve for a period of four years. It is a group serving without salary and carries with it no authority. In its duties it is analagous to the average nursing committee of the visiting nurse board differing from them only in that no decision can be made regarding nursing policies without the approval of the Health Commissioner.

At present this Commission is made up of the following community representatives: chairman, an Episcopal minister of high standing; a woman physician (not practicing); a man physician (practicing); a graduate nurse (not practicing); a business man (member of the Rotary Club and active in civic affairs).

This commission must always be made up of five members, not more than three of one sex, and not more than three physicians or nurses.

The superintendent of nurses is present at all the meetings and remains for the full time. She takes up with the Commission all questions regarding nursing and medical policies, plans for new work, new stations, the appointment of new nurses, the dismissal of unsatisfactory probationers—in fact all the matters that usually come before the nursing committee. These matters are thoroughly discussed and are then followed by definite recommendations to the Health Commissioner. Only in rare instances has the Health Commissioner failed to act favorably on the recommendations of the Nursing Commission.

The Nursing Commission is an effective medium in interpreting to the community the city's public health nursing problems and needs. The members go before their various clubs and societies and enlist their aid in new projects. Last summer they were especially effective in gaining a salary increase for the nurses in the face of city retrenchment in all other lines. Public opinion had been so thoroughly aroused that the Finance Committee did not oppose it. Quite recently this Commission was instrumental in obtaining the consent of the Civil Service Commission to appoint a physician to examine all applicants for nursing positions before they take the written examinations.

In the other public agency studied the form of organization is also of interest. In 1921 the various organizations doing social and health work in this city held a joint meeting at which they decided to pool their funds and place all the nursing work under one head. This group cooperation was called forth by a consciousness of much overlapping in work. The group was represented by such agencies as a Tuberculosis Committee, a Relief Society, the Red Cross, the School Board, the Welfare Board and others. A nursing director was appointed and had charge of the nursing work formerly carried on by these separate agencies. Shortly after this cooperative enterprise the city passed an ordinance appropriating funds for a public health nursing association whose function should be, "first—the prevention of disease, and second, to give nursing care to the sick in their homes." It was stipulated, moreover, that the Board of Managers was to be non-political and to consist of representatives of the various agencies that had previously employed nurses, the city being represented by the Finance Commissioner. This arrangement of administering city funds with an independent and non-political Board has been as successful as it is unique. The Board is made up of nine members, eight of whom are men. Three of the members are physicians. A monthly meeting is held which all of the members usually attend.

BOARD ORGANIZATION

In Table I we find the number of board members varying from 11 to 50 in the 9 strictly private agencies. In all but 3 of these agencies the majority of the members are women. In fact, in 3 of the agencies—as it happens, the oldest ones—there are no men on the boards of managers, but there are separate advisory committees of men called in for advice on medical and financial problems.

In the 3 semi-public agencies the number of board members is less than 10 in one agency, but between 30 and 40 in the other two. In one of these agencies there is no representation of men on the board but there is a separate advisory board of men.

From this it appears that the tendency is for the private agencies to have larger boards than the public agencies. The obvious reason for this is, of course, that the private agency dependent upon contributions from individuals is more readily assured of a necessary budget if there is a large board of influential persons to back it.

TABLE I.—*Size of Board of Managers.*

TYPE OF AGENCY	NUMBER OF MEMBERS					
	1 to 10	11 to 20	21 to 30	31 to 40	41 to 50	TOTAL
Private	..	1	4	3	1	9
Public	2	..	..	..	..	2
Semi-public	1	..	..	2	..	3
TOTAL	3	1	4	5	1	14

In this connection it is worthy of note that in six of the cities studied there is an active community chest from which the public health nursing agency draws a large part of its budget. The success of this method of raising money is apparent in each of these communities, since it releases a considerable part of the time of executives and board members from the task of raising money for their individual agencies. In only one city is there a community chest in which the public health nursing agency does not participate.

Since the success of public health nursing is largely dependent upon the interest and cooperation of physicians, their representation on the managing boards is of significance. In six of the fourteen agencies we find that there are no doctors on the boards of managers. In four of these six agencies there are additional medical advisory boards or committees whose recommendations, however, must be passed upon by the board of managers. In one city there is no representation of physicians either on the board or committees, and in the remaining agency there is no direct medical representation but consultation as necessary with a local Public Health Committee of the Academy of Medicine. In the other eight agencies there is a direct representation of physicians on the boards of managers, ranging from one to six physicians for each board. In all but one of these, however, there is also an additional medical advisory committee.

REPRESENTATION OF MEDICAL GROUP

In general, the public health nursing agencies have appreciated the advantage of having a strong medical group to back their policies, and to work out plans of cooperation with other physicians. Theoretically it would seem ideal for each agency to have a medical advisory committee whose chairman sits on the board of managers This form of organization is too elaborate, however, for many small organizations where it is usually found more practicable for a few physicians to serve on the board of managers instead of acting as a separate medical advisory committee. There are also situations where a separate medical advisory committee with no representation on the board of managers is preferable. This is particularly true where the board meets very frequently, takes responsibility for all phases of the work of the agency, and discusses medical matters only as the need arises. Whatever form of relationship to the medical group is worked out for the needs of individual agencies, there is agreement that there should be active participation by the medical group.

STAFF PARTICIPATION

In studying staff participation in general administration it was found that in every agency the nurse superintendent meets with the board of managers, though in two instances she stays only to give her report. The importance and necessity of this form of participation of the executive is obvious. The participation of the rest of the staff varies widely in the different types of communities. One satisfactory plan of staff participation was found in an agency where all matters of nursing procedure and content of the nursing visit are first discussed with the supervisors who, in turn, discuss them with the staff at branch conferences before being presented to the nursing committee and board for final action. Matters relating to methods of work, uniforms, hours—all matters directly concerning the nurses are taken up by a staff committee composed of a nurse elected from each branch and meeting once a month. In another agency the staff nurse is asked to express herself only on rare occasions when such a question as that of uniforms has come up.

In general, it seems fair to say that in these 14 organizations there seems to be a marked tendency for those agencies encouraging participation in the discussion and formulation of policies to do an all round more intelligent and far seeing type of public health nursing. We are agreed that there are advantages in service rendered if there is active participation of staff membership in the formation of all policies governing the service. Without such a policy it is difficult for real leadership to develop.

BOARD AND COMMITTEE ADMINISTRATION

The organization of boards into committees is again of significance in showing the board de-centralization of the private agencies as compared with the public. In the two public agencies in which, to repeat, the number of board members are five and nine respectively, we find that there are no committees of the board but that all matters relating to detail and policy of the agency are brought directly to the board for consideration. In all the other organizations there are committees ranging from four to twelve in number. In eight of the organizations there are eight or more committees. In each case the most important and active committee is the executive or nursing committee which shapes the general nursing policy to be recommended to the board for final action. Other committees are those organized to take care of finance, budget, supplies, publicity, records, social service, volunteers, transportation, telephone, etc.

From this discussion it might appear that the board of managers in the private agencies acts only as a ratifying group. This is not the case, however. In every instance, except one of the semi-public groups,* the board is very active and in addition to discussing and ratifying the reports of committees, initiates the discussion of general policies not taken up by any committee.

It was felt by a number of the superintendents of visiting nurse agencies that the active and interested board was a means to a greater community understanding of the necessity of progressive health movements and to a greater appreciation of the direction in which public health nursing must develop. This is possible through a large, well organized and interested board representing a diversity of interests in a community. In this respect the public agency with a small administering group may suffer. There is not the same stimulus for publicity, the drive for funds and the attention from the general public that is found in the private agency which depends for its very existence upon community approval and understanding. There are, however, assets in the organization of public agencies to be discussed later which may outweigh the advantages of a more representative group control.

*This organization needs a few words of explanation. It is a County Public Health Service in a rural community. The staff consists of a director, who is the county health officer, paid by the U. S. Public Health Service, and three nurses, each of whom has a separate territory composed of several villages and a rural area. While the county health officer and the three county commissioners are responsible for any general change in plan or policy, each nurse has her own committee which meets on call and more or less ratifies the suggestions of the nurse. The committee is informal, non-official and the members are used largely in an advisory capacity or for the purpose of backing up the nurse in an emergency.

Scope of Work

It is difficult to apply an arbitrary cost finding system to a number of visiting nurse agencies and obtain uniform results because of the extreme variations in the nursing programs which these organizations are carrying. The present study intentionally covers a large number of nursing activities in order to ascertain the important relationships between cost and various kinds of nursing work.

The following table shows the types of nursing which are being done by the 14 agencies and whether they are being carried on largely by a specialized or by a generalized group of nurses. For example, delivery nursing service in one agency may be done by nurses who carry no other type of nursing work. In another agency, however, the general district nurse may attend not only delivery cases, but also any other type of case reported in her district. In some instances, a special type of nursing work has been taken on only in an emergency, or is for some other reason a minor function of the organization. In such cases the agency has been recorded in the third column of the following table:

Table II.—*Type of Nursing Work Carried in 14 Visiting Nurse Associations.*

TYPE OF NURSING WORK	NUMBER OF AGENCIES			
	Work Being Carried On			Work Not Being Done
	Through Generalized Service	Through Specialized Service	Only in Emergency or as Minor Function	
Maternity Nursing				
Pre-natal	12	2	..	..
Delivery	4	2	1	7
Post-partum	14	..	..	..
Infant Welfare	9	3	..	2
Child Welfare (Pre-school)				
Orthopedic	1	1	7	5
Nutrition	4	1	6	3
School Nursing	2	3	..	9
General Medical and Surgical Nursing	14	..	..	..
Acute Communicable Disease Nursing	6	2	1	5
Tuberculosis Nursing	10	3	1	..
Venereal Disease Nursing	3	1	8	2
Health Education	14	..	..	..
Industrial Nursing	3	1	1	9
Nursing of Chronics	14	..	..	..
Mental Hygiene	2	..	2	10
Hourly Service	5	..	..	9

From this table it is evident that most of the agencies are doing prenatal, postpartum, infant welfare, general medical, tuberculosis nursing and the nursing of chronics while throughout health education is being carried on.

In fact, all of the agencies selected have a pretty general program, differing in point of view on only a few types of work such as venereal disease, mental hygiene, delivery and acute communicable disease nursing.

Where there are no other nursing resources developed in the community to care for any of these types of cases, there are advantages in having the visiting nurse agency cover as many of these services as possible. Each service is important as it represents the care of a community sickness problem, and the agency which concentrates its care in one direction, without attempting to meet a large need for which no other nursing service has been developed, is just so far failing to adapt itself to the most urgent community needs. There are, it is true, difficulties of administration which will make it impossible for some agencies to develop in certain directions, because of limited funds, few nurses or other limitations of service. We shall try to note some of the difficulties of administration in the discussion of the various types of service.

PRENATAL NURSING

In the prenatal nursing there are great differences in the plan and scope of the work. In one of the agencies where the work is most intensive, there is a definite effort made to visit each patient once a month for the first five months, twice a month for the next two months and weekly during the last two months of pregnancy. At each visit the nurse does a urinalysis in the home of the patient. In this agency the nurses are also beginning to take the blood pressure of the patient, having been taught by physicians. The following illustration will indicate the extent of the nurse's instructions in one visit.

The nurse was visiting an old patient when a relative of the patient came to call. When she learned that the nurse was able to give prenatal advice, she said that she was six months pregnant and would be very glad to have the nurse visit her. The nurse went with her to her home nearby and remained for an hour. During that time the nurse obtained a specimen of urine, examined it and found that it was negative. She explained the need for regular urinalysis. The nurse then made careful inquiries regarding the expected date of delivery, arrangements for care, history of pregnancy to date, varicosities, "life," appetite, exercise, supplies, layette. She examined the patient's breasts and gave instructions for their care. The legs and feet were also examined for varicose veins and for swelling. The supplies and layette were examined. The nurse urged careful attention to daily evacuation and diet. She gave out some literature, lists of supplies, layette patterns, and the main office 'phone number. She asked the patient to call the visiting nurse whenever anything troubled her and urged her to consult a physician immediately.

Since this was the first visit the nurse intentionally did not cover some other points such as the need for loose clothing, measuring amount of urine, kind of exercise, etc. The nurse investigator's comment was that the care was complete for a first visit and that it would be followed up in later visits by the rest of the necessary prenatal instruction.

As Table II shows, prenatal service is generalized in twelve of the communities and specialized in two. In one of the two specialized centers there is a hospital clinic; in the other is a conference conducted by the nurse to which the patients come for instruction. There are special nurses who visit the patient in the home between the clinic or conference visits. In neither of these cities do the prenatal nurses attend the patient in delivery or for postpartum care. In fact, in both of these cities the prenatal service is specialized while the postpartum care is given by the general nurses. This means that the nurse giving prenatal care never sees through to completion the patient with whom she has worked for a number of months. The patient, also, who has accustomed herself to one nurse must have different nurses for delivery and postpartum care. Out of the 14 agencies it is found that urinalysis is done as a matter of routine in only 2 of the cities. In one of these cities it is done in the home of the patient for the most part, though in the station if necessary, and in the other city it is done in the branch station. Blood pressure is being taken by the nurses in only one agency out of the fourteen. In some centers where there is too much work for the small number of nurses, it is obvious that intensive prenatal work suffers in favor of the nursing of sick patients. In the better organized and larger agencies where the work is districted, the prenatal work is more adequately developed. There we find an effort to have the same nurse continue with a case and with some regularity. The best standard of regularity developed in the agencies studied is in the agency previously mentioned where there is a plan to have each prenatal patient seen once a month for the first five months, twice a month for the next two months and weekly during the last two months of pregnancy.

Since the administration difficulty of arranging for night work is not involved in prenatal nursing, there would seem to be marked advantages in having the same nurse continue with the care of the patient whom she has known through the prenatal period. If there is a specialized nursing service for deliveries, the general nurse who has given prenatal care can, however, continue with the postpartum nursing. This insures for the nurse a continuity of service that is invaluable. She sees the advantages and failures in her prenatal care as she can not if her care of a patient is terminated before delivery.

DELIVERY NURSING SERVICE

The delivery service, it will be noted, is not available in seven communities, and is provided only in emergency in another community. In four agencies the regular nursing staff answers all delivery calls, though in one of the larger cities the delivery service is carried on in only four out of seven branches. In these agencies the plan of administration is to have nurses on the general staff rotate for delivery service and take time off the day following a night delivery. This is one of the most difficult administrative problems since the delivery time cannot be anticipated, and if there are a number of deliveries occurring at approximately the same time the routine work for the next day may suffer. In one organization this difficulty has been partially met by the employment of a "floater" nurse who goes to one district after another as she is needed. This is of course an impractical plan for an extremely small agency whose funds would not permit of having an extra nurse, and whose daily work would be too frequently upset if one of the few regular nurses should have a number of days off duty because of night deliveries. In the agencies studied, however, the plan has been successfully handled, through various adjustments as emergencies have arisen. It was felt in general, that this plan played little hardship on the nurse if reasonable precautions for making up over-time were taken. The great advantage of the plan lies in the increased interest of the nurse through seeing to completion the patient with whom she has been working. Though it is not always true that the nurse attends the delivery of the patient to whom she has given prenatal care and to whom she will give postpartum care, this is generally arranged unless the delivery is at night.

The one divergence from a strictly generalized delivery service in the agencies just noted occurs in an agency which has developed a maternity centre in one district. All training for maternity work is in this district, and the supervisor of the district acts in the capacity of a specialized supervisor of the staff nurses who are doing delivery work along with their other general nursing.

In the two remaining cities where delivery is conducted on a specialized basis we find in one city with a total staff of 26, two delivery nurses. In the other city with a staff of 36, there are 4 delivery nurses and occasionally a regular staff nurse called in for emergencies. Both of these cities feel that the generalized plan would not work out for their delivery work, though neither city has tried it.

In the two public agencies no delivery service is carried on, though in both of these agencies, the prenatal work has been fairly well developed and in one city there is daily home visiting for postpartum care. In the other public agency postpartum care is given only to indigents.

POSTPARTUM NURSING

It is interesting that the postpartum nursing in every one of the cities studied is done by the general nursing staff. The length of time that the case is carried differs widely in the communities. The most frequent policy is for daily care until the patient is out of bed and the baby's cord is off (usually 10 days), occasional visits as necessary to make sure the mother knows how to care for the baby, and a fifth week follow-up visit before the case is closed.

In the two public agencies postpartum care is given though in one of these cities only the indigent are nursed until the patient is out of bed and there are no later follow-up visits. In the other public agency there is a daily visit for ten days on every case referred and the case is carried for six weeks.

From the point of view of community need the inclusion of this service in a visiting nurse program is very important. The administration of this service through a generalized staff probably presents no more difficulties than the administration of general medical nursing which every public health nursing organization carries.

INFANT WELFARE

Infant welfare has been interpreted in this study as the well baby supervision after dismissal from postnatal care and up to two years of age. The two agencies which do little or no infant welfare work are in large cities where the bulk of the work with infants up to two years of age is done by public agencies. In one instance the visiting nurse agency does the infant welfare work in a home as long as she is visiting in the family for any other reason. This same agency does the nursing work with sick babies.

The three agencies in which the infant welfare work is specialized are conducted largely by clinics and conferences with occasional home visits by a specialized nurse until the child is two years old. In one of these agencies only those who attend the clinic are carried, and if the mother fails to attend with some regularity the case is dropped.

In the nine generalized services the most frequent plan is to visit once a month until the child is two years old. In five of these nine agencies there are either clinics or conferences in addition to home visiting. In only one of the generalized services is there a specialized supervisor for infant welfare work.

The results achieved by infant welfare work in the past have well demonstrated the necessity for the inclusion of this program in every community. If no other agency is doing it and it falls to the lot of the visiting nurse agency there may be a tendency to let this well baby supervision suffer when there is a pressure of acute illness to be handled. Herein lies the advantage of having a specialized group of nurses carry this service, insuring regularity of care. There is, however, a great advantage in having the general nurse who is supervising the baby, also care for the other illness and health supervision in the family. The care of the baby then becomes a part of the family health program rather than an isolated unit in itself.

CHILD WELFARE

In the child welfare or pre-school program there is a wide divergence in practice. The work in the agencies studied seems to fall, for the most part, into orthopedic and nutrition, though the general supervision of the pre-school child is carried on in a number of agencies where the nurse is visiting in the family for any other reason. The only two agencies in which orthopedic work with children is more than an incidental thing, is one specialized and one generalized orthopedic service. The specialized service has one nurse who does only orthopedic work. She assists the doctor in two clinics weekly and does a great deal of home visiting. In the generalized service, which is public, the most of the orthopedic work is done in clinics with no systematic plan for home follow-up.

Nutrition work for children we find in four agencies being carried on by the generalized nurse, and in one agency by a special group of dietitians. Special nutrition work for children is not being done or is only an incidental thing in nine out of the fourteen agencies. In two of the generalized and in the specialized service there are special nutrition classes or conferences either for mothers or their children.

SCHOOL NURSING

In nine of the agencies studied no school nursing is carried on because there are school nurses in the community under the supervision of the Board of Education. In seven out of these nine agencies, the visiting nurse associations are asked, however, to do the home follow-up, for children in need of nursing care. In each of the three agencies doing school nursing with specialized nurses we find three nurses. In two of the agencies the school nurses do the follow-up for children they see in the school. In the other agency the school nurses do the work in the school only, and refer to other nurses on the staff any home follow-up of school children.

In the two agencies where school nursing is done by the regular staff nurse we find that one is rural, and the other a public urban agency with school nursing in 20 parochial schools, the public school nursing being done under the Department of Education. In the rural community the school work is a large part of the nurse's program. In both agencies the nurse who visits the school follows up with home visiting, as necessary.

GENERAL MEDICAL AND SURGICAL, NURSING

In each agency studied, general medical and surgical nursing form a large part of the nursing load. In each organization this is done on a generalized basis, one nurse carrying many types of cases.

CHRONICS

Although the patients are usually general medical and surgical cases. the care of chronics is listed separately in Table II because it presents special problems of long time care, family teaching and encouragement. It will be noted that every agency includes the care of chronics as a part of its nursing work, though some agencies have a much more liberal policy than others. A fast developing tendency seems to be to carry all cases as long as necessary, but to stress the teaching and instruction to the family and to drop out as steadily as possible from actual nursing. One of the cities with a most liberal policy toward the care of chronics, and doing exquisite nursing work has an average load of 50 to 60 chronics for a staff of 41 nurses.

A plan which has been tried out with varying degrees of success in various communities is the employment of assistants on the staff of the nursing organization, to work under the supervision of the trained nurses on the staff. There is certain routine work in the care of chronics which a nursing organization is unable to delegate to members of the family. An assistant on the nursing staff, however, with an occasional visit from the nurse can take over this care and thereby save the time of the person with more training for other duties.* At best this is a complicated system to incorporate into the work of a visiting nurse organization, but where the nursing of chronics is an appreciable part of an agency's program, it is a resource worthy of consideration.

ACUTE COMMUNICABLE DISEASE, NURSING

Acute communicable disease nursing was found in eight out of the fourteen cities, though in some of these cities we find one or more contagious diseases which nurses are requested by the Board of Health not to visit. In one other city doorstep instructive visits are allowed, and in the other five cities the agency is requested by the Department of Health to do no contagious disease nursing. Since the question of whether a public health nurse can safely go from a contagion case to a patient with some other illness without infecting the second patient, has been a moot question with public health nursing agencies for a number of years, it is of interest to find that out of the eight cities doing acute communicable disease nursing, only two employ a specialized nurse for this service. One of these two agencies is public and has two specialized nurses who, for the most part, give instruction, placard, take cultures, but do comparatively little bedside nursing. The other agency, which is semi-public, has one nurse paid by the city who does all city culture work and all of the contagious disease nursing, which, however, includes little real bedside care.

In the six agencies where the general nurse carries acute communicable disease along with the rest of her nursing load, general satisfaction with the plan was expressed by the various executives and public health officials in the communities. As far as could be ascertained there was no real criticism of this procedure. On the other hand, very warm praise was found of the work of the nurses who took over during an epidemic, the most pressing community sickness problem.

To carry such a program effectively requires, of course, the practice of a very thorough asepsis and persistent instruction to other members of the family group. It also requires the use of extra articles to be carried in the nurse's bag and left in the patient's room. Aside from constant emphasis and insistence on asepsis, which of course should be employed in every type of nursing care, no marked administrative difficulty was found.

*The Saskatchewan Registered Nurses' Association has successfully utilized the services of the "nursing housekeeper." For a discussion of the regulations and recommendations see "The Saskatchewan Nursing Housekeeper" and "Regulations and Recommendations concerning the Nursing Housekeeper," published by the University of Saskatchewan in cooperation with the Provincial Red Cross.

TUBERCULOSIS NURSING

The tuberculosis program differs radically in different communities, according to the development of independent tuberculosis societies in these communities. In seven of the communities studied there are no separate tuberculosis associations. In these communities, therefore, we find the public health nursing association carrying both the bedside and educational work for the tuberculous. In the other seven communities there are separate tuberculosis associations of which three are public, two private and two both public and private. In each of these tuberculosis agencies the stress of the work is on education and supervision and all bedside nursing is referred to the Visiting Nurse Association.

The three specialized tuberculosis departments in visiting nurse associations are found in the communities where there are no tuberculosis associations. In each of these three specialized departments and in one other agency of the seven which are doing the community tuberculosis work we find a great deal of emphasis laid on the clinic development with physicians regularly in charge. In one instance the clinics are supported by the City Health department; in one instance by a local medical school; in one instance by a hospital; and in one instance by the visiting nurse association. Among the seven communities with other tuberculosis agencies, only one of the associations studied has developed any clinics for tuberculous patients, and this is a public agency. The reason for this, of course, is that the tuberculosis agency in the community takes the responsibility for the educational and supervisory part of the work referring only cases for bedside care to the visiting nurse association.

For the most effective tuberculosis work a combination of clinic work and home visiting would seem important. In a number of the agencies studied the nursing care, the educational work in the home and the emphasis on contact cases was carefully and thoughtfully given by the visiting nurse. Through the clinic where examination is made by the physician, or through occasional office conference or class, in addition to the home visits of the nurse, the same result may be accomplished by somewhat less effort on the part of the nurse. This plan will be more fully discussed in a following section.

VENEREAL DISEASE

The care of patients with venereal disease is a minor function in eight of the agencies, and is not carried on in two because other public agencies are doing the work. In the most of these ten communities the care is limited to clinic visits with inadequate follow up. The one specialized service is in a southern community where one nurse assists in the venereal disease clinic for men and women and does the most of the follow-up. She is allowed to call on the staff nurses, however, when she is unable to do all of the home follow-up. In another southern community the general staff nurse assists in the clinic and does the necessary follow-up. In general, this is a small service, and with a few exceptions confined to the venereally diseased patients who must have bedside care.

With the stress of recent years on this phase of public health work, its importance in the community cannot be ignored. While in a large number of communities, hospitals or other public agencies are taking over the clinic work and some follow up work for the venereally diseased, the resources lying within the visiting nurse group have been for the most part, untapped. The plan of utilizing visiting nurses not only for occasional bedside care but for home instruction has many possibilities for the community which is inadequately dealing with this phase of public health work.

HEALTH EDUCATION

Health education which appears next in Table II is carried on with varying degrees of adequacy along with the routine work in every community. In no agency was there found a nurse who did only instructive nursing. There seems to be a general agreement among the nurse superintendents interviewed that the soundest way of teaching a patient and his family is through actual demonstration during the period of bedside nursing. When there is no need for bedside care the general district nurse has an entreé which is invaluable. In some communities the training for teaching patients has been well organized so that a nursing visit means not only immediate care or demonstration and instructions showing how care could be given while the nurse is away, but also teaching in home and personal hygiene and stimulation in the development of health habits for all members of the family. Two cases visited in different communities by the nurse investigator will illustrate two varying approaches.

When the nurse in a small western city visited an old colored woman over two years ago she found her paralyzed, bed-ridden, dirty and wet, with large bedsores. The family had not been willingly neglectful but did not know how to give care. The nurse has been making daily visits, except on Sunday, since that time and on the day in question made her 621st visit. At that time all the bedsores had cleared up, the back was in good condition, and the family had been taught enough about her care so that she is always clean. The nurse each day gives general care, rubs the patient's back and with the aid of the patient's daughter gets her up in a chair for two or three hours daily. While the visits of the nurse have contributed much to the comfort of the patient, the nurse observer raised the question as to whether the family should not have been taught to assume more of the nursing responsibility. The care is simple and the only time that aid is needed is in lifting the patient from the bed to the chair. The comment was made that the neighbors who were often visiting would be glad to assist in lifting, thereby releasing the time of the nurse for 30 to 40 minutes a day several days a week.

Another illustration is the case of a child of seven years whom the nurse was treating for a third degree burn. After finishing the dressing, which was very painful, the visiting nurse remarked to the nurse investigator that she had known this child a year ago when she had impetigo. After leaving the house the investigator commented on the fact that in a home of such extreme cleanliness it was unusual to find impetigo. The nurse then explained that the year before the house had been very dirty and the child was undernourished and neglected. During the treatment for impetigo the nurse discussed with the mother at various times the importance of personal and home hygiene and interested her in proper health habits for each member of the family. The mother began to improve immediately and there has been a constant effort since that time to keep the house clean and to carry out the nurse's instructions. The instruction in this case was most effective and made the mother a warm friend of the visiting nurse. When the nurse entered the house the mother turned to the nurse observer and said, "When she come, it is just like the mother come."

INDUSTRIAL NURSING

Industrial nursing interpreted as "nursing care and instruction of industrial workers, in connection with their employment, at or centering at their places of employment,"* was found in connection with only one of the agencies studied. In this agency the industry pays a special industrial nurse to do all the nursing connected with the industry and necessary home visiting of employees, but at the request of the industry this nurse is under the entire supervision of the visiting nurse association.

In three other agencies, included in Table II under generalized service, we find a situation which is not strictly industrial nursing as defined above. These agencies have been included, however, because of the nurse's contact with the industry. Here we find that the district nurse visits the industry and does any necessary home visiting in the course of her other district work.

A somewhat different development which has not been included in Table II under industrial nursing is the home visiting of employees for certain industries on a contract basis. This is found in three of the agencies studied. The nursing technique, consideration of social problems, and reports are no different from that involved in the nursing of any patient referred to the agency, since the nurse has no direct contact with the industry. The names of sick employees are referred directly to the office for assignment, and bills to the industry are based on a definite cost per visit, and are sent directly from the office of the agency. There are many advantages in this method of having the general district nurse do this visiting for industries, with possibly a first aid or accident room nurse within the industry where this is necessary.

*Nursing and Nursing Education in the United States. Op. cit. Page 149.

MENTAL HYGIENE

Emphasis on mental hygiene in the nursing of sick patients is found in only two agencies. In both of these agencies there is direct contact with a nervous and mental clinic and a habit clinic. In one of these cities the nurses are being instructed by the psychiatrist in charge of the clinic to detect mental symptoms and behavior problems in children who should be brought to the habit clinic. In two other cities the nurses are attempting to do mental nursing only if it enters directly into the general physical care of the patient.

This lack of the nurse's equipment for observing and dealing with the mental mechanisms of patients is recognized by all agencies. Its importance is granted by all. As the principles of mental hygiene more and more explain the basis for physical illness, so it becomes imperative for the nurse to understand those principles. The nurse with the entreé of dealing with sickness is often in a better position than the social or psychiatric worker to interpret to the patient and his family his behavior in terms of mental illness. It is necessary, therefore, that she have adequate knowledge of mental processes, of behavior which suggests abnormal mental states, of community resources for examining and caring for mental cases, and that she incorporate this knowledge into her general district nursing where behavior problems and maladjustments of all kinds will be found to exist.

HOURLY NURSING SERVICE

Hourly service has been added to Table II because it is a constantly growing development and bears closely on the question of cost through its form of organization. Hourly nursing service is designed primarily for persons requiring skilled care, able to pay, but not needing full time of a private nurse. As nearly as possible the visiting nurse arrives at the time designated by the patient and stays as long as she is needed. Because of this time adjustment which causes greater expense to the agency a larger fee is charged than for the regular pay patient whom the nurse visits in the course of her other duties. Because of the time basis it is clear that hourly nursing service demands careful administration to make sure that the specification of certain hours is not encroaching upon the other work of the organization.

Only five of the agencies studied have developed hourly nursing service but several others are considering it. In four instances the charge is a dollar for the first hour and a fraction of that for subsequent hours or a portion of an hour. In the remaining agency the fee for the first hour is $1.25. This charge, in each case, is based on the cost of a visit as computed in these agencies plus a somewhat arbitrary sum which allows for the rearrangement of the nurse's time. Whether the total charge actually meets the full cost is an accounting problem which needs close analysis, but for which there is little organized material.

The inclusion of this service in a general visiting nurse program is one more step in the direction of meeting the community needs. The need for it is apparent. The agency, however, must constantly recognize the possibility of this service over-developing in proportion to the other services needed in the community.

SPECIALIZED OR GENERALIZED NURSING

Since the question of whether a generalized or specialized nursing staff can be more effectively administered has long been a subject of controversy among public health nursing agencies, it may be of interest to consider the form of organization of the fourteen agencies studied. We find that in five of the fourteen organizations the nursing and supervisory staff is completely generalized. That is, any nurse may be called upon to do any of the nursing undertaken in the agency. The specialized nursing staffs in the remaining nine communities vary radically in the degree of their specialization. In four agencies, for instance, the specialization is in one field only. In three agencies we find specialization in two fields, in one agency there is specialization in three out of ten fields and in another agency in five out of nine fields. Out of these nine agencies only two consider themselves specialized or partly specialized. In several of the agencies with some specialization there has been a gradual breaking away from specialized service over a period of years. It has been necessary to go slowly in changing the plan of organization because there were in several instances not only board members but older staff nurses who felt that a generalized plan would be destructive to the work of the organization. It has been the experience of each of the agencies that have changed from a specialized to a generalized basis that their work is now more easily and effectively done, avoiding duplication of travel and records, as well as saving the patient the necessity of contacts with a number of nurses.

As public health nursing has progressed, the whole question of generalization and specialization has become somewhat of a quibble on words so far as care to the patient is concerned. There is poor work under both names, but good work in either service comprises practically the same nursing service to the individual and the family, the chief difference being in the initial contact and in the division of work among the staff members. A well done specialized service ignores no health need of the individual or the family. Attention to one need and neglect of others probably occurs no more often in a specialized than in a generalized service and where it does occur is not due to an inherent defect in the plan of either service but is the result of poor preparation, teaching and supervision.

One of the fundamental principles of our present day methods of social and health work is to keep as small as possible the number of agencies and individual workers who visit a family or an individual. If this number can be reduced to one worker there is more likelihood of an all 'round and far-seeing treatment. In the field of public health nursing, also, there are advantages in limiting the number of nurses who visit the same family to as few as possible, preferably one. One of the assets of the generalized service is the human relationship that comes from the one-nurse contact in the home, which also stimulates that nurse to see the situation as a whole. There is also a very distinct advantage in the prevention of travel duplication which is inherent in the specialized service when more than one nurse is in the district though not necessarily working with the same family at the same time. The added advantage of having one nurse know her families over a long period of time is of great importance if a long time family health job is to be successfully accomplished. This advantage, it must be stated, is very often only a theoretical one because of the large turnover of staff nurses. Its value in particular instances observed in this study, however, is too great to escape comment.

On the other hand there are certain accomplishments which can perhaps be brought about more successfully by the use of a specialized staff. The demonstration of certain types of nursing, the making of standards to carry on that nursing, the education of the community to accept a new type of nursing work, the teaching of the rest of the nursing staff can often be best accomplished through nurses who have had special training in a given field and who are concentrating all of their nursing work upon this field.

The question of specialization of supervisory staffs is quite a different one. In five of the agencies there are one or more specialized supervisors. In one of the western agencies which has no specialized staff nurses there are two specialized supervisors who are responsible primarily for educating and training the staff nurses in infant welfare and tuberculosis respectively. They also have the responsibility for building up the work in the community so that it will become recognized as an essential part of nursing work. In another large agency, not included in the five, while there are no specialist supervisors, strictly speaking a number of the branch supervisors have had special training in different fields, and act in an advisory or teaching capacity to the staff as a whole, as occasion demands.

In general, we are agreed that specialized supervisors in a large staff are essential as continuous teachers along specialized lines, keeping the staff nurse in touch with the latest developments and knowledge in a particular field, working out special techniques and trying out the methods developed by specialized agencies. In small staffs where it is usually not possible to have specialized supervisors much help can be gained by employing as staff nurses, nurses who have had experience in various types of nursing work. The expense of specialized supervision may also be met temporarily by having the generalized supervisor get special training. More and more, also, we may hope for help for the small agency from state departments of nursing, from specialized agencies in the community and through obtaining specialists to head up staff conferences at regular intervals.

The difficulties involved in the administration of specialized supervision lie, for the most part, in the relationships of specialized supervisors to each other, to the staff nurses and to the district supervisors of a large staff. Many of the difficulties can be avoided if the fundamental principle is kept in mind that specialized supervisors are teachers and advisers, and not administrators. Nursing technique common to more than one type of service should be agreed upon by the specialist supervisors in conference with the staff and director. Special nursing technique, however, is in the province of the specialist. The district supervisors, on the other hand, are administrators or executives as well as teachers. The organization of the day's work belongs to the district supervisor, but special problems in relation to any individual case, that deviate from policies already decided on, belong to the specialized supervisor. Conflicts can always be settled by conference if there is mutual respect and understanding. The details of these relationships are in a state of evolution and the number of specialized supervisors needed is still to be worked out. But in spite of the real difficulties of administration that are involved, we are agreed that specialized supervisors in a large agency are needed and that their primary function is to teach.

DEVELOPMENT OF OFFICE VISITS

A development in public health nursing which is of extreme interest from the point of view of cost is the constantly growing use of conferences, classes or office visits with the patient, in combination with home visiting. The home visit is essential in giving the nurse a background of the patient's environment so that her teaching can be adapted to the needs of each family. The combination of home and office visits, however, can be handled satisfactorily for many types of cases such as prenatal, infant welfare, child welfare, tuberculosis and some convalescent surgical cases. While it is the policy of many corporations who are paying for the nursing care to those connected with their corporation, to pay only for the home visit, there is still a great deal to be said on the other side. If the pregnant mother is willing to come to the office occasionally for nursing care and advice, is it not quite as satisfactory for her to do this as for the nurse always to make a special visit to her home? By this method a nurse can see a number of people in a short time that otherwise might take her a half day or more because of the additional travel time involved. This plan makes group instruction with the attendant stimulation possible and emphasizes the health teaching side of care. It develops responsibility in the mother and is, therefore, of distinct educational advantage. Incidentally it reduces the number of "out" or "patient not seen" visits. The practice in the agencies studied is quite varied in relation to office visits and classes, but where it has been tried, it has proved successful and is being constantly developed.

It is again worthy of note that in the two public agencies studied we find one with no specialization except in the school work, and specialization in the other only for contagion and special inspections of boarding homes, day nurseries, hospitals, etc. In both of these public agencies, however, there have been a number of clinics developed and this, of course, has reduced home visiting. It is significant that in both of these agencies the work with sick patients has not markedly decreased in favor of educational work. Dr. CHAMPION* believing that educational service, not bedside nursing should be the function of the board of health, would be critical of the development in these cities, especially where the amalgamation of all the private visiting nursing agencies was taken over by the city so that there is now no other nursing agency to do bedside nursing. Moreover the experience of both of these agencies shows that a large part of the effective educational work in the community has come through the care of sick patients in clinics and the follow up of this care in their homes.

OTHER PUBLIC HEALTH NURSING COMMUNITY RESOURCES

In connection with the nursing work of any visiting nurse organization, it is important to know what other public health nursing agencies are active in the community and whether there is duplication or overlapping of work. In Table II we have seen that there are a number of types of work which a number of agencies are not doing. This is due in many cases to the presence of another nursing agency in the community, either public or private, equipped to handle that particular kind of nursing. Table III shows the number of additional nursing agencies in the communities studied classified by the type of nursing which they are doing.

TABLE III—*Other Public Health Nursing Agencies in the Communities Studied.*

TYPE OF NURSING	NUMBER OF AGENCIES		
	PUBLIC	PRIVATE	TOTAL
General Visiting Nurse Program	1†	3‡	4
Maternity Nursing			
Pre-natal	1	4	5
Delivery	1	2	3
Post-partum	..	2	2
Infant Welfare	1	5	6
School Nursing	10	..	10
Acute Communicable Disease Nursing	5	..	5
Tuberculosis Nursing	3	4	7
Venereal Disease Nursing	2	2	4
Industrial Nursing	..	3	3
Metropolitan Life Insurance Co. Nursing	..	3	3

†One county nurse in a large city.
‡Small private agencies with 1 to 3 nurses.

In this table it is seen that the public agencies are, for the most part, school, contagious disease and tuberculosis nursing. In the school nursing

*Again, What of the Public Health Nurse? MERRILL CHAMPION, M.D., Director, Division of Hygiene, Massachusetts State Health Department. The Public Health Nurse, February, 1923. Page 67.

there is no overlapping with the agencies we have studied, for as seen in Table II, nine of these agencies are doing no school nursing and one other has work in only one school not touched by the public agencies. In the acute communicable disease nursing, again, there is no duplication for the private agencies studied do no contagious disease nursing in the five communities where the public agencies are organized to handle it. In the tuberculosis work the public agencies for the most part do supervision and follow up. To avoid duplication where bedside nursing is necessary, one agency has worked out the following plan of relationship with the State Department of Health tuberculosis nurses.

Relation of the Visiting Nurse Society to the State Department of Health Nurses

[1] When a visiting nurse is on a case first and refers the contact to the State Dispensary, the supervision of the whole family will rest with the visiting nurse, who will render monthly reports to the clinic physician as to the present status of the patient reporting to the Dispensary.

[2] If the patient is going to a sanatorium, the State nurse will make one visit to get the necessary data. The remainder of the responsibility of getting the patient to the sanatorium—in regard to equipment, etc.,—will rest with the visiting nurse.

[3] In referring cases to the Dispensary the visiting nurse should state definitely whether she wishes to keep on or to transfer them entirely to the Dispensary and its nursing staff.

[4] In the case of children going to the sanatorium, the visiting nurse will visit the day before they go in order to be sure that they have not been exposed to communicable disease and that there are no pediculi. If there still are nits, the sanatorium should be notified to this effect.

[5] It is understood that all cases requiring frequent nursing care—oftener than twice a week—will be referred to the Visiting Nurse Society.

[6] If the visiting nurse is caring for a case in a family where there is also a patient suffering from tuberculosis, known to the State tuberculosis nurses, the procedure will be as follows: The visiting nurse will notify the tuberculosis clinic that she is giving care in the home. The tuberculosis nurse will withdraw during the period of activity of the visiting nurse who will assume during that time the responsibility for the tuberculosis problem. When the visiting nurse withdraws from the case, the original problem for which she entered being cleared up, she will notify the State Clinic and the State tuberculosis nurse will again assume responsibility.

[7] The nurses doing tuberculosis work prefer to give the prenatal instructions to their patients, the visiting nurse to do the actual postnatal bedside care. They will cease visiting any patient where there is a complication requiring nursing care, the visiting nurse to assume the responsibility and notify the tuberculosis nurse upon withdrawal from the case.

Similar plans of relationship have been attempted in a number of communities and are very necessary where there is likely to be joint responsibility for the same cases. The same agency has worked out the following relationship to social service departments of hospitals.

Relationship of the Visiting Nurse Society to Hospital Social Service Departments

The relationship between the Visiting Nurse Society and social service departments will be made on the basis of the principle that it is desirable if possible to have but one health agency visiting in a family at one time. Therefore, when the Visiting Nurse Society must of necessity continue visiting in a family because nursing care is needed, the social service department, if it is doing only health follow-up work, will turn over to the Visiting Nurse Society the health responsibility both for the patient and for the family. In such an instance, the Visiting Nurse Society will automatically transfer this case back to the social service department when the visiting nursing work is done. If, in the previous treatment of the case by the social service department, there has been intensive case work on either the health or the social side, the Visiting Nurse Society will give nursing care only.

The reverse of this would be that when the Visiting Nurse Society is on the case first the social service departments will handle only the individual from the clinic angle and not visit in the home. In either of these instances the Visiting Nurse Society will be prepared to follow the directions of the clinic doctor and render such reports as are desired.

When medical appliances are needed and the patient is not able to pay for them, theoretically the hospital should supply these, as part of its treatment, like free service or free medicine. Practically, however, for the present, this is not feasible and, therefore, the basis of relationships will be as follows:

[1] When the Visiting Nurse Society is on the case first, it will pay for medical and surgical appliances if the patient cannot afford them.

[2] If the social service department is on the case first it will pay for them.

[3] Where both the Visiting Nurse Society and social service department are jointly interested and both have a sense of responsibility, after conference they may decide to share the financial burden in a given instance.

With the private agencies in Table III there is some duplication of the program of the agencies studied in Table II, but for the most part this is not a serious matter and in several instances it has been overcome by frequent joint conferences. It is clear that in every community studied there are far from enough nurses to meet the day to day demands. The problem of duplication, therefore, becomes less serious than the tendency to draw out of a nursing field which another agency will handle.

OTHER SOCIAL AGENCIES

The problem of relationship to other social agencies is a more involved and intricate one. In the rural districts and the small town studied there are no other agencies so that the nursing organization is obliged to take some responsibility for the social conditions found in day to day visiting. In the urban nursing agencies there are varying degrees of insight into social situations and cooperation with agencies equipped to handle these conditions. In one of the largest agencies the nurse is instructed to observe but refer all serious social conditions involving long continued social treatment to the proper agency. In a somewhat smaller agency which is one of the strongest agencies in the community, the nurse is taught to take a much more active responsibility for social conditions. Several times in this agency the nurse has worked under the supervision of the Associated Charities when the patient did not like the Associated Charities visitor as well as the nurse. Again the nurse has taken children to court, has investigated social conditions and given relief when it was agreed by the interested agencies that her contact with the individual was better and treatment would be more effective. This was the only agency studied where such active participation in social treatment was found, and it was discouraged by most of the organizations. We are agreed that it is more satisfactory for public health nursing and social agencies to cooperate, each giving its services in accordance with its special functions and equipment. It is important, however, that this be arranged through conference and consultation so that the number of workers in a home should be limited to as few as possible at any one time.

There will be a further discussion of contacts with agencies in connection with the section on record writing.

Personnel

SIZE OF STAFF

The largest item affecting the cost of a nursing visit is the amount paid out in salaries for the various members of the staff. It is important, therefore, to analyze the makeup and the qualifications of the staff and to discuss the proportion of staff nurses to other staff members. Table IV gives a picture of the entire staff in each of the 14 agencies at the time this study was made. The agencies are arranged in order of their size, the largest agency represented by I.

NUMBER OF NURSES

From examination of Table IV we see that the staffs vary from 2 to 103 members. The staff nurses, however, vary from 1 to 70 in number and it will be noted that the differences in the number of staff nurses are not always proportionate to the differences in the number of the total staff. If we compare the percentages of staff nurses we find that they comprise:

40 to 50 per cent. of the staff in 1 agency
60 to 70 per cent. of the staff in 4 agencies

70 to 80 per cent. of the staff in 8 agencies
80 to 90 per cent. of the staff in 1 agency

That is, in 12 out of the 14 agencies the staff nurses make up from 60 to 80 per cent. of the total staff.

NUMBER OF SUPERVISORS

There is more significance, however, in comparing the number of supervisors with the number of staff nurses. We must also add to the staff nurses the students both undergraduate and graduate, since the supervision of students is a large factor to be considered. If we include all assistant supervisors and disregard the fact that some supervisors work part time we find that the number of staff nurses and students to a supervisor runs from 3 in Agency IV to 27 in Agency V which has only one supervisor for the entire staff. In the 14 organizations;

2 have no supervisor
1 has less than 5 nurses to a supervisor
5 have from 5 to 10 nurses to a supervisor
1 has from 10 to 15 nurses to a supervisor
1 has from 15 to 20 nurses to a supervisor
2 have from 20 to 25 nurses to a supervisor
1 has from 25 to 30 nurses to a supervisor
(1 has only 2 nurses with part time of
1 nurse as supervisor)

From the point of view of cost it is important to determine a minimum and if possible a maximum for what seems to be a necessary and adequate amount of supervision. Here we find two extremes. Agency XIII, a rural community, has three nurses but no supervision, the County Health Officer in charge believing that supervision is unnecessary for well trained nurses and that no small community would accept a person whose primary function was to supervise. On the other hand is the extent of supervision in Agency IV justifiable? Here we find in addition to the superintendent who takes the responsibility for general supervisory work, and for reading many records, two field supervisors who cover three districts each. In each of the districts there is in turn a supervisor who does some nursing as she finds time, and the number of staff nurses and students is only 24. The result of this may lead to a divided responsibility tending to make a loose form of organization and a poorer quality of supervision. In addition, of course, it is costly. In fact as it happens, the cost per visit in this agency is higher than in any other agency. In Agency I, which has a little over five nurses to a supervisor, we must note that there is, however, a teaching district which gives intensive training to all new staff nurses, to postgraduate students in the School for Public Health Nursing and to pupil nurses in the local hospitals. In this teaching district there are a supervisor and four assistant supervisors which help to keep the ratio of nurses to supervisors small.

From a study of the bedside nursing in each agency it seems probable that the best nursing work is being done in the agencies which have less than ten nurses to a supervisor, and in one agency which has just over ten nurses to a supervisor. In this latter instance, however, the nurse investigator's chief criticism of the nursing work involved the lack of sufficient supervision. This problem is more fully discussed in the section dealing with supervision.

TABLE IV—*Size of Staff*

(Agencies arranged in order of size of staff.)

STAFF MEMBERS	AGENCIES													
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV
Superintendent....	1	1	1	1	1	1	1	1	1	1	1	1	1	1§
Asst. Supts........	2†	1	1	..	..	1	1	1	1§	..	1	..	..	..
Supervisors........	7	4	3	8§	1	3§	1	1	..	2§	2§	..	..	..
Asst. Supervisors...	9§	..	3§	..	..	..	..	..	..	..	..	..	..	..
Staff Nurses........	70	41	32	18	27	24	21	17	14	12	10	12	3	1
Dietitians..........	..	..	..	2	..	..	..	..	..	..	..	..	..	..
Occupational Therapists......	2	..	..	..	..	..	..	..	..	..	..	..	..	..
Clerical:														
Nurses..........	1	..	..	..	2	..	1	1	..	..	..	..	..	..
Not Nurses:														
Full Time......	6	5	4	5	3	3	..	1	1	1	1	1	1	..
Part Time....	1	..	..	1	..	..	..	..	..	..	..	..	..	..
Bookkeepers.......	..	1	..	1	1	1	1	..	..	..	1	..	..	..
Accountants.......	1‡	..	..	..	..	..	..	1‡	..	..	..	..	..	..
Janitors,Maids,etc.	3	1*	3	2	1	..	1*	1*	1	..	..	..	..	..
Students (not included in total):														
Graduate..........	..	..	..	..	..	..	..	..	..	..	6	..	..	..
Undergraduate....	14	..	..	6	..	..	2	4	1	..	1	..	..	..
TOTAL..........	103	54	47	38	36	33	27	24	18	16	16	14	5	2

*Part time.

†One of these is an educational director who for the present purposes may be grouped as an assistant superintendent.

‡Volunteer.

§Does some nursing work. In Agency IV, 6 of the 8 do some nursing work.

NUMBER OF CLERKS

If we turn to the clerical force we find that the proportion here also varies markedly. In Agency I with a staff of 103 we find 8 clerical persons. In Agency IV with somewhat more than a third as large a staff we find 6 clerks. In Agency II with a staff of 54 or close to one-half the size of the staff in Agency I we find 5 clerks. Obviously the proportions in these three cities are very unequal. If we exclude janitors and maids from the total staff and include as clerical all bookkeeping and accounting service we find that the number of clerks to all non-clerical members of the staff including students is;

1 clerk for less than 5 staff members in 2 agencies
1 clerk for 5 to 10 staff members in 4 agencies
1 clerk for 10 to 15 staff members in 5 agencies
1 clerk for 15 to 20 staff members in 2 agencies

What then is an adequate measure of the amount of clerical assistance necessary in this form of organization? We cannot answer this fully at this point but we may observe that in Agency II where there are about seven staff members to a clerk and where the nurses dictate their records, the mean length of the nurse's time spent daily on records outside of the home is 30 minutes less than in Agency I where there are approximately 12 staff members to a clerk and where the nurses write their own records. That is, for the whole staff Agency II saves about 20 hours of the nurses' time daily which would seem to more than compensate for the additional clerical help. This problem is also discussed at greater length in the section dealing with record writing.

DESCRIPTION OF STAFF

In examining the qualifications of the staff members two methods were used; first, general information was obtained from the executives of the agencies on their policies regarding the age, educational background, professional training and previous experience of applicants for the position of staff nurse. The second method was the use of a personnel schedule which was filled in by each staff member. The general policies of the agencies will be presented first for each section.

AGE

In the 14 agencies 7 state that they have no requirements regarding a minimum or maximum age at which staff nurses are accepted. In the remaining seven agencies the range of ages preferred varies from 21 to 50 years. In four of the agencies the range is from 23 to 40, and in one agency 27 to 30 years are given as the preferred limits. In only one of the agencies, however, is there a *fixed* age limit. This is found in a public agency where all appointees are civil service and must be within the ages of 21 and 50. While each organization feels that it is desirable to have staff nurses who are not too young, and yet wishes to guard against older nurses who may be fixed and inflexible in their attitude toward public health nursing, this, of course, depends in each case on the previous background and experience of the applicant. Where an older nurse has had long and valuable public health nursing experience she is of more value to the organization than a younger nurse who may have had no experience.

Table V and the following tables are based on 366 personnel schedules from the 14 agencies. From Table IV we find that the total personnel in the agencies is 433. That is, about 85 per cent. of the staff members filled in schedules. So far as can be determined this is not a selected group, for those who did not fill in the schedules were, for the most part, out of town, on vacations, or ill.

Table V shows that for the total group the range of ages runs from below 25 years to over 50 years, with a considerable number in each of the five year age groupings indicated. It is evident from inspection of the table that the ages for the executive and supervisory staff are appreciably higher than for the nursing staff since the only ages under 25 occur in the nursing staff whose most frequent age is between 25 and 30 years, while in the executive staff the largest number of cases occurs in the 30 to 34-year age group. If we use the mean as a measure of central tendency we find the mean age for the nursing staff to be 32 years; for the executive and supervisory staff 36 years and for the total staff 33 years. At first thought the ages throughout seem older than we might expect, and it seems difficult to explain it accurately. We might assume that the age at which women go into nurses' training is older than in other professions. But Table XII shows that a small number, only 7.1 per cent. of the staff, came to the agency with no previous experience, which would indicate that the nurses did not come directly to the agency from training schools. Since in the same table almost 60 per cent. of the nurses have done only private or institutional nursing it seems possible that the higher age for public health nurses is due to a number of other factors.

As nurses in private duty continue with their work over a number of years, many become interested in public health nursing because of the appeal of service to many instead of one, or because of their interest in the field of teaching health and preventing illness rather than curing it. It is also probably true that a number of nurses with long experience in the irregular hours of private duty nursing are influenced to enter public health nursing because of the more regular hours with little night work.

EDUCATIONAL BACKGROUND

Perhaps one of the most flexible requirements encountered is in the standards of educational background. Four of the 14 agencies state that they have no educational requirements. Seven other agencies state that they prefer some high school work but very often accept a nurse without this because of her excellent professional record. In only three agencies is high school work required.

The public health nursing agency finds itself in a difficult situation when it attempts to set up educational standards that are not required for admission to the hospital training schools. A nurse may have had the minimum education necessary to enter a training school and may in her nursing course, in her whole experience, and in her contact with patients show such unusual ability as a nurse that this consideration overbalances the lack of formal education. Herein lies the explanation of the need for definite staff educational work by public health nursing agencies. The product of the training school must be used. Her general education is often limited and her nursing education has prepared her primarily for caring for the sick. It is important, therefore, that she get through the public health nursing agency, her ideal and technique of health teaching, community relations and a concept of the family as a unit for care rather than the individual sick person.

In Table VI we find that 17.8 per cent. of the nurses have only a grammar school education, while 72.1 per cent. have either attended or finished high school. Less than half of those who were in high school, however, finished.

TABLE V—*Present Position in Agency Related to Present Age*
(Based on 366 personnel schedules from 14 agencies.)

POSITION IN AGENCY	Total	Mean Specified Age in Years	AGE IN YEARS							
			Under 25	25-29	30-34	35-39	40-44	45-49	50 and over	Age Not Specified
Total	366	33	26	103	90	72	38	14	7	16
Total Nursing Staff	305	32	26	96	69	54	30	11	6	13
Staff Nurse	299	..	26	95	67	53	30	11	6	11
Substitute Nurse	6	..	..	1	2	1	..	..	..	2
Total Executive and Supervisory Staff	61	36	..	7	21	18	8	3	1	3
Asst. Supervisor	9	..	..	1	5	3	..	..	..	..
Supervisor	35	..	..	4	11	11	4	2	1	2
Registrar	3	..	..	1	1	1	..	..	..	..
Asst. Supt.	7	..	..	1	2	1	2	1	..	..
Superintendent	7	..	..	..	2	2	2	..	..	1

The percentage of nurses attending college, 9.8 per cent., is very small while only 14 nurses or 3.8 per cent. graduated from college. It is clear that there is a tendency for those with more educational background to have the more responsible positions, since among the staff nurses we find only 7 per cent. who have been in college, while there are 23 per cent. among the executive and supervisory staff. As will be explained later in connection with Table VII nursing training rather than general education may account largely for

TABLE VI—*General Education Related to Present Position*

GENERAL EDUCATION	TOTAL		PRESENT POSITION						
			NURSING STAFF		SUPERVISORY AND EXECUTIVE STAFF				
	Number	Per cent.	Staff Nurse	Substitute Nurse	Asst. Supervisor	Supervisor	Registrar	Asst. Supt.	Supt.
TOTAL	366	100.0	299	6	9	35	3	7	7
Grammar School only	65	17.8	58	1	2	4	...	...	...
Attended	11	3.0	11	...	...	...	...	...	...
Graduated	54	14.8	47	1	2	4	...	...	...
High School only	264	72.1	219	4	5	22	3	6	5
Attended	142	38.8	126	2	2	8	2	1	1
Graduated*	122	33.3	93	2	3	14	1	5	4
College*	36	9.8	21	1	2	9	...	1	2
Attended	22	6.0	16	1	1	3	...	...	1
Graduated	14	3.8	5	...	1	6	...	1	1
Not Specified	1	.3	1	...	...	...	...	...	...

*There are 24 nurses who have attended but not finished normal school and 9 who have finished normal school. This was interpreted as professional training rather than general education and was not included in this table.

the difference in position though education and advanced nursing training are, of course, closely related.

A study of the relationship between general education and present salary, again, indicates a tendency for those with more educational background to receive a higher salary. This we should expect from an examination of Table VI, since there is a direct relationship between position and salary in each agency. We find, for example, that the mean monthly salary for nurses who have attended grammar school only is $119. For nurses who have attended or graduated from high school the mean monthly salary is $124 while for nurses who have had college training the mean monthly salary is $140.*

PROFESSIONAL TRAINING The following requirements for professional training are given by the 14 agencies:

Graduate nurse	1
Graduate nurse eligible for registration	1
Registered nurse	3
Registered nurse eligible for membership in the N.O.P.H.N.	7
Registered nurse, member of the alumnae association and N.O.P.H.N	1
Registered nurse, higher standards than required for admission to N.O.P.H.N	1

From this table it is evident that the standards of professional training vary to a considerable extent. While the largest number of agencies require registration and eligibility to membership in the National Organization for Public Health Nursing, five agencies have less than this standard. The agency which asks only that the worker should be a graduate nurse is a public agency with civil service requirements. Registration in the state is, however, required of the superintendent.

TABLE VII—*Nursing Training Related to Present Position*

NURSING TRAINING	TOTAL		PRESENT POSITION			
			NURSING STAFF		Supervisory and Executive Staff	
	Number	Percent.	Number	Percent.	Number	Percent.
TOTAL	366	100.0	305	100.0	61	100.0
Graduated nurses' training school (No other training)	241	65.8	225	73.8	16	26.2
Graduated nurses' training school plus gradate courses in hospital. (No public health nursing training.)	32	8.7	30	9.8	2	3.3
Graduated nurses' training school plus following public health nursing training:	93	25.4	50	16.4	43	70.5
Separate classes or summer course	27	7.4	17	5.6	10	16.4
4 months' course	35	9.6	23	7.5	12	19.7
9 months' course	31	8.5	10	3.3	21	34.4

*This form of average is affected by the extreme item of one salary over $300. Exclusive of this item, however, the mean salary is appreciably higher than for the other two groups.

At the other extreme the agency which demands a higher standard than that of the National Organization for Public Health Nursing is a western agency which requires of each new staff nurse that she should have had a high school education and a public health nursing course. The standards of personnel in this city are throughout higher than in any other city studied.

In considering nursing training as related to position in the agency we must turn back to Table VI which indicates that the nurse with more educational background is more likely to hold an executive or supervisory position than the nurse with less education. There is another factor to be included here which makes this conclusion seem less obvious, however. In Table VII where it is shown that 25.4 per cent. of the nurses have professional training in public health nursing, we find by analysis of this percentage into nursing and executive staff, that 16.4 per cent. of the nursing staff have had such training while 70.5 per cent. of the executive and supervisory staff have had public health nursing training. Since the 9 months training courses require high school graduation for admission we have immediately injected into our problem of relationship between education and position or salary, the joint problem of professional training dependent on education. It seems reasonable to expect that agencies pay better salaries for nurses with the most training to do that particular job. If a certain type of education is necessary to take the training, the relationship then becomes—position and salary to education and training, rather than to either one exclusively.

TABLE VIII—*Nursing Training Related to Present Salary*

			MONTHLY SALARY										
NURSING TRAINING	Total	Mean Monthly Salary	Under $100	$100 to $124	$125 to $149	$150 to $174	$175 to $199	$200 to $224	$225 to $249	$250 to $274	$275 to $299	$300 and over	Not specified
TOTAL	366	$124	14	184	123	29	7	1	2	3	1	1	1
Graduated nurses' training school (No other training)	241	$119	13	139	73	13	1	..	1	1	..	..	..
Graduated nurses' training school plus graduate courses in hospital. (No public health nursing training)	32	$119	..	19	12	1	..	..	..	..	..	..	..
Graduated nurses' training school plus following public health nursing training	93	$140	1	26	38	15	6	1	1	2	1	1	1
Separate classes or summer course	27	$139	1	5	15	3	1	..	..	..	..	1	1
4 months' course	35	129	...	11	20	3	..	..	..	1	..	..	..
9 months' course	31	153	..	10	3	9	5	1	1	1	1	..	..

In Table VII it is shown that the largest percentage, 65.8 have had no professional training after finishing the course in nurses' training school. A percentage of 8.7 have taken graduate courses in the hospital, such as obstetrics or pediatrics or mental and nervous disease nursing. About a fourth of the group, 25.4 per cent. have taken some work in public health nursing training though only 18.1 per cent. have taken the regular 4 or 9 months courses.

Table VIII bears out the figures shown in Table VII, namely, that the nurses with special training have the more responsible positions and therefore the larger salaries, with the nurses who have taken the 9 months public health nursing course receiving the highest mean salary.

In observing the registration of nurses we find that of the total group, 97.8 per cent. are registered. Of the executive and supervisory staff alone

REGISTRATION

100.0 per cent. are registered while for staff nurses the per cent. of registration is 97.4. This consistently high percentage of registration we should expect, especially since 12 out of the 14 agencies require registration of nurses before appointment in the agency.

We find, however, a smaller percentage than we might expect who are members of the National Organization for Public Health Nursing. For the

MEMBERSHIP IN NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

nursing staff the percentage of members is only 47.2 while for the supervisory and executive staff it is 91.8. There are probably a number of nurses who are not eligible for full nurse membership* but very few who are not eligible for associate nurse membership.

In 10 out of the 14 agencies no previous public health nursing experience is required. The four agencies which require experience are: the western

PREVIOUS PUBLIC HEALTH NURSING EXPERIENCE

city discussed under "Professional Training"; a rural community where a nurse must immediately take responsibility for initiating her own work; a public agency which has no facilities for training; and an agency in an eastern city which will, however, accept in lieu of previous experience the four months training course with the agency. It was stated by a number of superintendents that they preferred, of course, to have experienced workers, but that they were entirely unsuccessful in finding enough experienced public health nurses who would come for the salary they were able to pay.

In Table IX we may see what the actual practice of the agencies is regarding the previous experience of the nurses they employ. Almost 60 per cent. of the nurses had only private or institutional nursing experience at the time they came to these agencies for employment. Almost 25 per cent. had public health nursing experience and about 9 per cent. had no

*"The requirements for individual nurse membership in the National Organization for Public Health Nursing embody the minimum standard for fundamental technical training of nurses—as endorsed by the three National Nursing Organizations."

"Graduation from a training school for nurses connected with a general hospital having a daily average of thirty patients or more and a continuous training in the hospital of not less than two years. Training shall include practical experience in caring for men, women and children, together with theoretical and practical instruction in medical, surgical, obstetrical and children's nursing. Training may be secured in one or more hospitals."

"In those states where nurse practice laws have been secured, registration shall be an additional qualification."

TABLE IX—*Previous Experience Related to Present Position*

PREVIOUS EXPERIENCE	TOTAL		PRESENT POSITION						
			NURSING STAFF		SUPERVISORY AND EXECUTIVE STAFF				
	Number	Percent.	Staff Nurse	Substitute Nurse	Asst. Supervisor	Supervisor	Registrar	Asst. Supt.	Supt.
TOTAL	366	100.0	299	6	9	35	3	7	7
No experience	26	7.1	21	..	1	4	..	..	..
No nursing experience, but:									
Social work	1	.3	1	..	..	..	..	..	..
Teaching	7	1.9	4	..	..	3	..	..	..
Private or institutional nursing only	217	59.3	189	4	6	12	2	3	1
Private or institutional nursing and:									
Social work	1	.3	1	..	..	..	..	..	..
Teaching	20	5.5	17	..	2	1	..	..	..
Public health nursing only	6	1.6	5	..	..	..	..	..	1
Public health and private nursing	76	20.8	54	2	..	12	1	4	3
Public health nursing and:									
Social work	2	.5	..	..	..	...	..	..	2
Teaching	7	1.9	4	..	..	3	..	..	..
Experience not specified	3	.8	3	..	..	..	..	..	..

experience in nursing since graduation but 2.2 per cent. had other experience. It is interesting to note that in the whole group only 1.1 per cent. had done any social work, and only 9.3 per cent. had held teaching positions.

In comparison with Table VII we find that while there is a slight tendency for those with public health nursing experience to hold more responsible positions in the agency—43 per cent. of the executives as against 21 per cent. of the staff nurses having had public health nursing experience—this difference is not so great as the difference between executives and nurses in regard to training.

TURNOVER OF STAFF

Turnover of workers in any organization is an expensive and time-consuming item. This is particularly true where training within the organization is necessary, as with public health nursing. If we consider in the 14 agencies studied the turnover of staff nurses from October 1, 1921 to October 1, 1922, we find that out of 302 staff nurses, 108 or 35.7 per cent. left the agency. Of this number, 4.6 per cent. were discharged as incompetent or insubordinate. There is a wide variation, however, in the amount of turnover among the individual agencies. This is summarized as follows:

No turnover in 2 agencies (the 2 rural communities)
Turnover less than 10 per cent. in 2 agencies (the 2 public agencies)
Turnover from 10 to 20 per cent. in 2 agencies

Turnover from 20 to 30 per cent. in 2 agencies
Turnover from 30 to 40 per cent. in 2 agencies (includes the largest agency)
Turnover from 40 to 50 per cent. in 1 agency
Turnover from 60 to 70 per cent. in 1 agency
Turnover from 70 to 80 per cent. in 2 agencies

From this it is clear that the turnover is very low in a number of agencies but so high in three or four instances that its effect is readily discernible in the quality and quantity of work accomplished. One of the agencies with a turnover of over 70 was in a period of radical reorganization and because of the unwillingness of several older staff members to accept the new organization, they resigned. This was not a normal situation in the agency, however. A somewhat similar difficulty was found in the other agency with a turnover of 75 per cent.

In the agency with a turnover of 44 per cent. we find the longest training period, 4 months with pay, and likewise the highest cost of a visit. This high turnover of persons with such intensive training during a period when they are paid by the agency but accomplishing less than half the work of a regular staff nurse must, of course, be reflected in cost. This raises several questions regarding the intensive training of new workers, which will be discussed at length under that section.

While a high turnover is to be expected in a comparatively new field of work, such as public health nursing, where the opportunities for employment exceed the available number of workers, there should be some methods of attracting workers to stay longer on the job. Perhaps this can be accomplished through training opportunities in the agency, through a carefully planned change of work as one type becomes irksome, through a more regular salary increase plan, or through other devices. It is necessary, however, that this expensive element in public health nursing agencies be considered and that more thoughtful attention be given to meeting it.

Methods of Administration of Nursing Work

The crux of both the cost problem and the problem of evaluating the nursing work of any public health nursing organization lies in the methods by which the agency is administered. A very satisfactory form of organization may be so unsatisfactorily administered that it is both costly and inferior in its nursing quality. We shall discuss from the point of view of both cost and content of a nursing visit, some of the most important factors in public health nursing administration.

TRAINING OF NEW NURSES

How is the new staff nurse with no previous public health nursing experience to be fitted into the organization so that she gets the soundest training in this field? Will the thoroughness of this preliminary training affect the need for later supervision? Can a complete system of training new nurses pay for itself by better work and less supervision? The 14 agencies studied have answered these questions in various ways. The following statement shows briefly the different methods employed:

A. Agencies requiring no public health nursing experience of new staff nurses	11 agencies
Methods of Training:	
1. No teaching district in agency	9 agencies
a. Individual instruction and observation	6 agencies
b. Occasional formal classes and observation	3 agencies
2. Teaching district in agency	2 agencies
a. Formal 2 months' training course	1 agency
b. Formal 4 months' training course	1 agency
B. Agencies requiring public health nursing experience of new staff nurses	3 agencies
Methods of Training:	
1. No teaching district in agency	3 agencies
a. Very little individual instruction	1 agency
b. Individual instruction and observation	2 agencies
TOTAL	14 agencies

Since the problem is quite different where public health nursing experience is required of staff nurses, we may begin first with the group of 11 agencies where nurses without such experience are accepted. In 9 of the agencies there are no teaching districts, that is, special districts organized especially for training and teaching purposes. This means that when the nurse first comes to the agency one of two things happens. She is either placed immediately in the district in which she is to work, or she is sent to a number of districts for a day or more of observation. The most frequent method is for the nurse to go directly to her own district and there to receive individual instruction from the supervisor and perhaps observe the supervisor or an older staff nurse for a few days in the field.

Agency II (Table IV) is fairly typical of the six agencies where there is no teaching district and where the nurses receive only individual instruction. In Agency II the new nurse goes immediately to the district where she is to work permanently. She receives a book of instructions covering the aim and policies of the agency, first visits, etc., and also goes over standing medical orders under the guidance of the supervisor. The supervisor takes every new nurse out in the district on the first day, the supervisor doing the work while the new nurse observes. The next day the new nurse does the work while the supervisor observes. New patients are avoided at first. The nurse does not dictate her records but writes out her reports for some time, the supervisor correcting each report and instructing the nurse in record writing. For the first few weeks the supervisor tries to visit with the nurse frequently. The supervisors have some latitude in their routine in teaching the new nurse, each supervisor putting into practice the method she has found most satisfactory and best adapted to the temperament of the new nurse.

For so large an agency with so many nurses to a supervisor—about 10—this seems like a somewhat inadequate method of introducing a new nurse into an entirely new field. The result of this, so our investigator felt, was for the supervisor to emphasize a perfect nursing technique which was formally presented in a nursing manual, at the expense of some of the fundamental principles of public health nursing.

In the three agencies with no teaching district where there is an attempt to formalize training to a certain extent by group classes, we find varying degrees of success. In Agency VII every new staff nurse takes a course of 22 lectures, given 3 times weekly by the superintendent. In this course the principles of public health nursing are stated and the work of other agencies in the community explained. The course is given every two months, so that each nurse is assured of having such training within two months after she starts her work. Since the total staff of this agency is only 27 the class is usually very small. In addition to the class work the new nurse is introduced into field work by the supervisor in the district where she is to work. Responsibility is given to her slowly and she has a variety of cases assigned to her at first.

In Agency VI which also has no training district we find individual instruction and observation for about five half days, and in addition courses given by the local School of Public Health Nursing in Public Health Nursing two hours a week, in Prenatal Nursing and Infant Welfare approximately one hour a week.

In Agency VIII, which is in the process of organizing a teaching district, we find that the change in personnel, both supervisory and staff, has been so constant that no regular system of training has been possible. The following plan has just been put into operation, however. The new nurse is at first under the supervision of a senior nurse with occasional supervisory visits from the supervisor. Only selected cases are given in the beginning, the senior nurse first demonstrating and then observing. During the first month the senior nurse assigns the work and the new nurse does not accept the responsibility of the district for this time. There are required classes in public health nursing given by the assistant superintendent two hours a week for two months. For six weeks, one morning weekly is spent with the infant welfare supervisor.

In two agencies which have a teaching district the organization of training is much more adequately developed. We shall discuss first Agency I, which has a full two months' training course for every new nurse accepted on the staff, for all post-graduate students and for pupil nurses. The theoretical training is the same training as that given to students in the School of Public Health Nursing in this city. In the teaching district there is a supervisor, 4 assistant supervisors, and enough of a permanent nursing staff to insure continuity of work. The plan of instructive work is observation for the first two mornings; lectures three afternoons a week for $1\frac{1}{2}$ hours; conference, one afternoon weekly for two hours; demonstration one afternoon weekly. The case conference is conducted by a student nurse. Family problems are discussed, recommendations are made and reported on one week later. The educational director conducts the formal conference.

In the field the new nurse accompanies an experienced staff nurse or the assistant supervisor for observation the first two mornings. The first two afternoons there is bag demonstration and explanation of the morning work. Following this the nurse begins actual work with one case, and in going over this with the supervisor is shown how to keep records. The new nurses are then assigned to staff nurses for regular morning work, which is planned so that there is continuity in the work. The new nurses carry the work to conclusion if possible. They are given responsibility regarding the social problems encountered and must make their own contacts with social agencies. Throughout this time the assistant supervisor visits with the new nurse at least once in two weeks and oftener if necessary. She also visits every very sick case, every case of gonorrheal eyes and all complicated social problems.

In this agency, which gives excellent training, it is estimated that the services of the new nurse during the two months' training period are about one-half of the services of the regular staff nurse. In the opinion of the nurse investigators this time is equalized later by the high quality of nursing work which does not require such persistent supervision and teaching as that necessary for the untrained worker. During the first three months the nurse is paid $100 a month, and if at the end of that probation period she is accepted on the staff her salary is raised to $110 a month.

In the second agency with a teaching district, Agency IV, the plan of training is quite different. In many ways the course is comparable to the four months' course given in Schools of Public Health Nursing except that during this four months the new staff nurse in Agency IV is paid $75 a month. The plan of the course is as follows:

The four months' course is divided into four distinct types of work. One month is in the Teaching Center, where the nurse is given general bedside work, excluding maternity and prenatal care. The following month is spent in the Maternity Center where the work is entirely prenatal, delivery or post-partum nursing. While in the Teaching and Maternity Centers the nurses are directly under the supervision of the special supervisors and do not go out with the staff nurse. The groups are small enough to permit this. The third month is spent in the Children's Clinic in the General Hospital, where the nurse attends well baby, nutrition and children's clinics and does the follow up work for these clinics. While here she is under the supervision of the nurse in charge of the clinic and the dietitian engaged by the Visiting Nurse Association, who assists in the home teaching of dietetics. The fourth month is spent with the Associated Charities, where the nurse receives actual case work experience.

For class work and demonstrations the nurses return daily to the Teaching Center so that the supervisor of this center is able to keep in touch with the work that all new nurses are doing. There are 8½ hours a week for classes, one hour a week for demonstrations and 34½ hours a week in the field. In addition to this, one afternoon weekly is devoted to visiting other agencies and institutions.

If we examine the cost per visit in this agency we find that the only cost computation—dividing total expenditures by the total number of visits—is $1.21 a visit for the fiscal year 1921-22. This high cost may be partly affected by the long training period with pay, by the organization of the staff as discussed in Table IV, and by other factors which will be discussed later.

If we turn to the three agencies which require public health nursing experience of their new staff nurses we find that none of them has a teaching district in the agency. In one agency there is almost no individual instruction, the new nurse merely going over details, when she finds it necessary, with the county health officer who is in charge of the nursing work. In the other two agencies there is some introduction to the work by the supervisors, the amount of initial supervision depending altogether on the character of the nurse's previous experience. The introduction to the work is probably less extensive in those agencies which employ only experienced public health nurses, but it is necessary that there should be some flexible arrangement whereby additional supervision and training can be given to those nurses whose experience has been less comprehensive than others.

What then, from the angle of cost accounting, would seem to be the minimum amount of training necessary to insure good nursing technique and a public health nursing point of view? Can this be obtained through the type of individual instruction outlined in Agency II, or is it necessary to have a four-months' course such as that outlined under Agency IV? There would seem to be a medium position. For the large agency the two-months' training course in Agency I is adequate from the nursing point of view and probably not to be criticized in terms of cost, since the thoroughness of the training insures more even and excellent work and somewhat less constant supervision than would otherwise be necessary to keep up the same standard of public health nursing. For the small agency with few new nurses added at any one time, and where there is no training of graduate or pupil nurses, a teaching district with the organization of classes outlined in Agency I is impracticable. In such instances a short series of lectures by the superintendent, supervisors or specialized workers may be organized to give a point of view of the field as a whole, and the technique involved in specialized fields. Through required reading lists, through daily detailed case conferences, through visits to other agencies in the community, a point of view may be developed which does not involve an elaborate organization of training. The details of nursing within the district can then be given through an adequately supervised introduction into the work in the district. It does not seem justifiable to charge to the cost of administering an agency the cost of training new nurses on salary as thoroughly as they could be trained in organized Schools of Public Health Nursing The training of the new staff nurse should aim to prepare for the work which she is to do in that particular agency and to give any additional point of view of the public health nursing field as a whole that is essential in the carrying out of her work.

Conferences and Other Educational Methods

In addition to the initial training period what provision is made to keep up the continued interest and education of the staff nurse? Does the agency assume any responsibility for this educational process, and if so, what are the plans for working it out? Is time allowed off during the day for lectures or other forms of education, and is this time excluded from cost or counted as a part of the nurse's routine? There are many questions relating to educational policies of an organization which affect cost indirectly through absorbing a greater or lesser part of the nurse's day which would otherwise go into nursing care.

Through the 14 agencies it is evident that there is an earnest effort on the part of the executives to provide every opportunity for staff nurses to go to lectures and courses on social and health subjects and in many instances to organize courses or to obtain lecturers where there are no such facilities in the community. The eagerness of the nurses themselves to obtain more specific information and a more general understanding of what is being done in the social and health fields was noted throughout the study. In one agency it was found that every nurse on the staff was taking an extension course in the School of Public Health Nursing. Since the methods used for staff education vary from the regular staff meeting to the formally organized course we will consider briefly the various types of conferences and educational methods that are employed.

A usual device to permit self-expression and cultivate discussion of professional work in an organization is the general staff meeting. In the 14 agencies studied staff meetings are held as follows:

STAFF MEETINGS

Weekly in 6 agencies
Semi-monthly in 1 agency
Monthly in 2 agencies
Irregularly in 3 agencies
No meetings in 2 agencies

In all but two of the agencies where staff meetings are held the superintendent or her assistant plans the program. In the other two agencies the Staff Committee or Staff Council made up of representatives from each branch plans the material to be discussed at staff meetings. In each agency the superintendent presides at the meeting.* The matters discussed in general

*In one city where the superintendent is not a nurse the supervisor of nurse s presides.

staff meetings are for the most part subjects related to social and health work which are instructive to the nurses in their work in the agency. In one agency, however, one meeting a month is given over to current topics not necessarily social or health, and at this time an effort is made to get a good speaker from another field. In only one agency does the staff meeting include a detailed discussion of questions of technique and procedure and this is in a smaller agency where the whole group can easily get together. The staff participation at these meetings varies of course with the size of staff and the type of meetings. In general free staff participation was noted by the nurse observers wherever there was a chance for staff discussion. It is gratifying to observe that the regular staff meeting is in so many places being turned into a lecture or conference period which will yield something of practical benefit to the staff, rather than being used to "scold" or check up on daily routine which can be handled more satisfactorily by another method.

SUPERVISORS' MEETINGS

The meeting of supervisors in large agencies is limited to so much smaller a group that it can more advantageously discuss questions of administratin which it would be difficult to present to the entire staff. In the eight agencies where there is more than one supervisor we find that regular weekly supervisors' meetings are held in all the agencies but two. With no exceptions administrative detail, nursing policies and all new problems are discussed with the supervisors. It is interesting to see how much the supervisors determine the general policies in an agency. One nurse superintendent remarked when asked whether she thought a certain plan involving a change in records would be practicable—"I frankly don't know until I have talked with the supervisors who are so much closer to the work that they know what such a change involves." The supervisors also act as interpreters to the staff in their districts carrying the supervisors' discussions back to the nurses and the nurses' reactions to the supervisors' conference.

CASE CONFERENCES

The case conference is so necessary a tool to the nurse in the care of her patient that it is important to note the constantly increasing use of conference on difficult problems as a means to more effective treatment. In only two agencies were no case conferences held while in the other twelve agencies we find frequent use of the case conference within the agency, but in several instances a much less frequent use of conference with outside agencies working at the same time with the same difficult case. In practically all of the 12 agencies the nurse who is working on the case and the supervisor attend these outside conferences. The rapidly growing use of the second type of case conference is one more indication of the greater pulling together of social and health agencies. Social and health problems are so closely interwoven that it is not possible to have effective treatment where workers from different agencies are not informed of the whole situation. The value of this method can hardly be over-stated. Its effects are shown in all of the nurse's work, for it brings a greater realization of the social situation in which her patient lives, and tends to improve the quality of nursing service.

LECTURES OR CLASSES

The question of allowing nurses or social workers time off during the day to attend courses or lectures outside of the agency has been the subject of much controversy among boards of managers and executives. It is found that in 12 of these agencies it is the practice to allow staff members time to take courses directly related to their work during the working day provided there are not too many nurses who want to take such work at the same time. This is limited in the most of the agencies to one course. In the two remaining agencies there are no possible facilities for regular lecture periods so that the question has never been raised. In two out of the twelve agencies noted above the agencies occasionally pay the tuition of nurses for special courses when they feel that this would be of particular value in the nurse's work. In six agencies it is found that the agency has paid at various times for special training of a nurse in another city. For instance, one agency sent a supervisor to Teacher's College for 9 months and paid all of her expenses. Other nurses have been sent to the Maternity Center Association in New York for a number of weeks; to the School of Public Health Nursing in Western Reserve University, Cleveland, for a summer course; to Boston for work with Dr. LOVETT and to various other schools and agencies for varying periods of time. In all but one instance it was felt that the nurse's added contribution to the agency when she returned with specialized training more than made up for the expense to the agency.

LIBRARY FACILITIES

In all but two instances the agency either has a small library of nursing books and magazines or has made cooperative arrangements with local libraries. In one of the largest agencies a traveling library has been planned in which books are sent from one branch to another so that the nurses do not need to come to the central office. In one of the rural agencies the State Division of Public Health Nursing loans books so that nurses can have access to any new publications. It was noted several times in the course of this study that the library facilities are not used as freely by the nurses as the opportunities for more formal education.

Again the question arises as to how much of these educational facilities should be included in the program of the nursing agency and how much should be charged to the cost of nursing service. These two problems are very different and should not be decided on the same basis. Certainly the special course which is essential to insure the satisfactory work of the nurse in her particular position in the agency is clearly a justifiable part of the work of the agency and is therefore rightly chargeable to cost. This is particularly important because of the newness of the field, its rapid evolution and the impossibility of getting a supply of adequately trained nurses in any other way. The additional courses which give a point of view on the social and health field and which are of general rather than specific educational value enter into a more disputed field. Since public health nursing agencies are in a formative stage and are still feeling their way on many matters, the use of a reasonable amount of leeway in regard to educational courses would seem to be entirely within their functions. The cost of such educational opportunities, however, since they are not directly a part of the nursing work of the agency, but of more general and perhaps future value should not be charged up to the cost of a nursing service.

Supervision

The quality of public health nursing in any agency is very largely dependent upon the amount and type of supervision. Through thoughtful supervision responsibility is fixed, standards are set up and maintained and changing standards are adopted. Through adequate supervision the work of nurses is equalized, insuring better nursing service; records are kept up to date; necessary outside contacts are followed up and the whole is tempered by a wise regard for the importance of each phase of public health nursing. Without such a centralized and impartial referee as the supervisor the nursing work becomes decentralized, each nurse following out her own individual preferences and idiosyncracies; the quality of work becomes uneven and we may find instead of public health nursing as it is generally understood, merely exquisite nursing technique or essentially social service visits.

In addition to this, supervision involves a more subtle function in the relationship between supervisor and staff worker. The supervisor is the teacher, the adviser on special problems, and the leader in stimulating interest and enthusiasum. Without these qualities, supervision becomes a dead level of "checking up" on the work of nurses.

Supervision may be organized in various ways. Since we have previously discussed supervision in terms of specialized and generalized supervisors, we will again classify these agencies in this way. In the 14 agencies studied the following situation was found:

Generalized supervision.......................... 6 agencies
1. One supervisor responsible for all nursing work in the entire agency. No branch supervisors. (Found in 2 agencies with 14 and 27 staff nurses, respectively)................................ 2 agencies
2. Branch supervisors responsible for the work in only one branch of the agency................ 4 agencies

Generalized and specialized supervision..............5 agencies
In each of these agencies there are either 1 or 2 specialized supervisors, and 1 generalized supervisor.

No supervisors................................ 3 agencies
(Includes 1 agency of 2 nurses with part time of one nurse as supervisor. This agency is grouped here because the time for supervision is limited, informal in character, and necessarily unlike supervision as discussed above.)

Under the generalized supervision it was found to be generally unsatisfactory for one supervisor to take the responsibility for all the nursing work of an agency where that agency has a number of staff nurses. In a previous discussion of personnel the number of nurses to a supervisor was noted and on the basis of the agencies studied, it was stated that the best nursing work was done in the cities where there were less than ten nurses to a supervisor. If there is only one supervisor in an agency of approximately ten nurses, however, her duties are proportionately greater than those of the branch supervisor with ten nurses in the branch. She probably has a larger territory to cover, she undoubtedly has an amount of general administrative detail which does not fall to the branch supervisor, and she may be expected to spend a larger proportion of her time in teaching if the agency has made no other provision for teaching. It would seem to be important, therefore, for the agency with one supervisor only, to provide one or more supervisory assistants, depending on the size of the agency, in order to secure adequate staff supervision.

The plan of branch supervision was found to be generally satisfactory, though here, also, too many staff nurses to a branch supervisor was noted in some of the agencies.

The advantages and disadvantages of specialized supervision have been previously discussed, so there will be no repetition at this point. In the five agencies where specialization occurs we find two with very good supervision with a carefully worked out relationship between the two types of supervisors. In the three remaining agencies this relationship has not been worked through and the result therefore is less satisfactory.

TRAINING AND EXPERIENCE OF SUPERVISORS

Since supervision is so necessary a function of a public health nursing agency, the type of training of the supervisor is of first importance. Through interviews with the executives of these 14 agencies it is found that the policy of the agency regarding nursing training of supervisors is as follows:

Graduate nurse only	1 agency
Graduate registered nurse	4 agencies
Graduate registered nurse with public health nursing training	6 agencies
(only 2 require the 9 months' course)	
No supervisors	3 agencies

The agency which requires only a graduate nurse is public, and the civil service requirement is that the supervisor must be appointed from the staff so that the training requirements for the two positions are the same. The two agencies which require the full public health nursing course are conspicuous for the very good work that is being done and for the excellent plan of supervision. As it happens, one of these two agencies has generalized supervisors and the other has one generalized and two specialized supervisors.

If we turn to the experience required of supervisors, we find that eight of the eleven agencies employing supervisors require experience in public health nursing. These requirements are very elastic, however, and in several instances the field work in a public health nursing course was interpreted as experience. Only one agency requires experience on the staff and that is the public agency noted above. In fact several agencies prefer nurses who have been trained in other organizations.

From a study of personnel schedules in these 14 agencies it was found that 88.6 per cent. of the supervisors have had public health nursing training, and that 37.1 per cent. have finished the full nine months' course. It should be noted, however, that approximately half of the supervisors with a nine months' course are in Agency I which requires that all supervisors should have had such training.*

The qualities which it was stated, determine the selection of supervisors include leadership, administrative ability, teaching ability, ability to work with groups, an ability to critically analyze situations and an effective personality. Only two agencies ever consider seniority on the staff as a prerequisite for a supervisor. Two agencies consider excellent nursing technique only incidentally among other qualifications. Since the supervisor's position is not unlike that of the superintendent, for a smaller group, a number of executives have expressed themselves as looking for the same inherent qualities in a supervisor that they would expect to find in any successful administrator in the field of public health nursing.

The methods of supervision fall into the following types, some of which are used in every agency that has a plan for supervision:

METHODS OF SUPERVISION

Supervisors' conferences with nurses
Supervisors' visits to the clinics or home with the nurse
Supervisors' visits to the home without the nurse
Reviewing records, daily report sheets and day books
Reviewing records, just before or after the case is closed
Inspection of bags
Efficiency reports

For the present discussion we shall eliminate agencies XII, XIII and XIV because there is little or no supervision. Agency XII has 12 nurses and a nursing director who is responsible for administrative nursing details and who also carries a nursing load, so that any real supervision of nursing work is impossible. Agency XIII has three nurses in a rural county, each nurse with a separate district and working independently. There is no supervision of the nursing work other than a nominal contact with the county health officer in charge of the Public Health Service. Agency XIV has two nurses, one of whom is in charge of the work, but who carries her own nursing load.

*There is one exception on the staff, of a supervisor who has had only the equivalent of the 4 months' course. All future appointments will require the 9 months' course.

In the remaining 11 agencies we find that conference with the individual nurse as a means of supervision is used throughout. In some instances these conferences are daily as a matter of routine; in other agencies they occur as necessary. In every case this individual contact with the nurse was felt to be one of the most important methods of supervision. Conference which is based on a study of the nurse's records and occasional visits in the home with her is indispensable in teaching the nurse through her own experience.

CONFERENCES

The number of informal contacts between nurse and supervisor is dependent upon the frequency with which the nurse reports at the office. In the 14 agencies we find that the nurse reports at the district office in person:

Once daily in 7 agencies
Twice daily in 4 agencies
Three times daily in 2 agencies
Irregularly in 1 agency

In checking over a sample of nurses' daily report sheets it seems obvious from the point of view of cost that in many instances it would be better for the nurse to telephone to the office for emergency calls rather than to return at a scheduled time.

In 9 of the 11 agencies the supervisor visits the home with the nurse as frequently as possible. Anything approximating a statement of actual frequency is difficult to obtain since the practice varies with supervisors in the same agency. Through this method the supervisor can actually see what the nurse's technique and procedure are. In two agencies this method is almost never used. One of these agencies has a very large proportion of supervisors to nurses, but the supervisors say that it is difficult to get time for this method of supervision. It is a policy of the other agency not to have two nurses in the same home at the same time for fear of the community criticism that the nurses are "doubling up." In this connection the nurse investigator who has had experience in supervising rural public health nursing comments that it is the function of the superintendent to install an adequate system of supervision and to see that the community understands the necessity for it. As a result of the inadequate supervision in these two agencies it was found in a number of visits with staff nurses that the nursing technique was often very poor and in some cases shockingly inadequate. The contagious disease nurse who takes no precautions, contaminating other members of the family and her own nursing bag; the district nurse who examines a syphilitic baby without washing her hands before or after the examination and then puts her hands into her nursing bag and goes on to another patient; these and other instances show the laxness which creeps into a technique if there is not regular supervision with emphasis on good nursing technique. Observation of a nurse's work in a home pre-supposes that there will be discussion of this observation either im-

VISITING WITH NURSE

mediately following the visit or at the regular conference period. In other words, the method of observation should not be used to "check up" on the nurse, but to furnish concrete teaching material which will have a more general application.

VISITING WITHOUT THE NURSE

The method of going to a home after the nurse has made her regular visit to check up on the nurse's work is discouraged in each agency and is never used in seven of the agencies. In the four others this method is very rarely used, perhaps on problem cases or in an unusually difficult situation with a nurse. Since we are interested in avoiding unnecessary duplication of contacts, this would seem to be a wise precaution. Also it smacks too much of the spy system in the opinion of several supervisors, and does not permit observation of the steps in technique which can be noted in a visit with the nurse.

In every agency, however, the supervisor often takes the nurse's patients on the nurse's day off. This is often a matter of necessity as well as supervision and is understood by the patient as a substitute for the nurse. It is generally accepted as an excellent method of supervision if the case is later thoroughly discussed with the nurse.

REVIEWING RECORDS, DAILY REPORTS AND DAY BOOKS

The method of reviewing current records, of checking up on daily report sheets and day books if they are used is found in each agency. The thoroughness of this method, however, varies markedly in different communities. It is the opinion of those who have been close to this study that not enough use is made of reading records as a method of supervision. In one city where records are summarized weekly as a family record rather than giving daily entries with a description of the condition of each patient, the superintendent said that she felt the supervisors were so close to each case in their districts that this detail on a record would not be helpful. In this agency it was clear that there was a direct relationship between much poor nursing work and inadequate supervision. It is impossible, of course, for each supervisor to remember the daily details of all the cases carried by each nurse in her branch. Unless she is able to review this detail in a record she cannot intelligently discuss with the nurse the technique of caring for her patients. In fact, reading the nurse's recorded material should form the critical basis for conference with her and for careful observation of her nursing work in the district.

REVIEWING RECORDS BEFORE OR AFTER CASE IS CLOSED

The plan of having the supervisor review a record before each case is closed is used in only three agencies. In three other agencies the supervisor goes over each closed case. In the remaining five agencies as many closed records as possible are reviewed, but this is not a current or routine procedure. Reviewing the nurse's completed treatment is very satisfactory and offers advantages which can be obtained by no other method. More use might be made of this method by having selected closed cases discussed by the staff in branch conferences.

FINAL VISIT TO THE PATIENT BEFORE CASE IS CLOSED

The method of having the supervisor visit the patient before the nurse closes the case is used in at least one well known and highly specialized agency not in this study where conditions are such that they allow the development of perfect method and technique. In none of the visiting nurse agencies studied, however, was this method found to be practicable since there are so many short cases. It would certainly seem to be unprofitable and probably an unnecessary plan for the majority of the routine cases which pass through a general visiting nurse agency. In extremely difficult or long drawn out problems such a final check might occasionally be of value.

INSPECTION OF BAGS

The clean bag, the well equipped bag is one of the most important tools in bedside nursing. Unless there is some method by which the patient can be assured of such uniform bag cleanliness the public health nursing agency has failed in one of its very necessary functions. In each of the agencies there is bag inspection, but in only five instances is it regular and routine. In one agency inspection is daily, in two weekly, and in two monthly. In all of the agencies where the supervisor visits with the nurse it is felt that the contents and condition of the bag are fairly satisfactorily determined at that time and that additional routine inspection is not necessary. If adequate training is carried on, the nurse will constantly appreciate the importance of this detail of her nursing technique. It is probably significant of a fundamental lack of teaching if a nurse needs routinely current inspection of the content and condition of her bag.

EFFICIENCY REPORTS

The use of the report which checks up on certain assets and limitations of each nurse at given intervals is coming to be more and more frequent. Miss Hunter has well described the efficiency report:*

> In order to determine the progress of the nurse in adapting herself to her duties and also to provide information regarding the efficiency of the supervisor, several organizations have adopted efficiency records which are made out by the supervisor following each visit of observation with a nurse. These records call for few items, but they are planned to show whether helpful supervision has been attempted and to justify the action taken in cases of promotion, demotion or discharge. Emphasis is placed upon the fact that general remarks have no value unless supported by specific instances.

Such reports are used in six agencies and in two others similar reports are given orally to the superintendent. In the remaining five agencies each nurse's work is discussed informally as her probation period expires. In order to make

*U. S. Department of Labor, Children's Bureau. Publication No. 101, 1922. Office Administration for Organizations Supervising the Health of Mothers, Infants and Children of Pre-school Age. By Estelle B. Hunter. Page 30.

this report of the greatest possible use, it is important that the nurse be allowed to see it at intervals or that its content be discussed with her.

While the number of methods of supervision may offend the reader as indicative of a red-tape and "checking system," there is on the other hand very little tendency in this direction. The spirit of helpful supervision is to advise, to suggest new and better methods of accomplishing results and to carry on a continuous teaching program. This spirit was rather generally found in the agencies studied.

This description of supervision raises the question of just what the duties of the supervisor are. In the district plan of supervision we find that her duties are somewhat analagous to the duties of the superintendent of a small visiting nurse society. She is an administrative officer and responsible for the detail that comes within her jurisdiction. She is responsible for the district records, clerical detail and reports to the office. She carries a bag and assists in the nursing work in an emergency or on the nurse's day off. In some agencies she covers a small nursing district of her own in addition to her supervisory functions, though this plan is, in general, discouraged. She trains the new nurse in those agencies where there is no teaching district, and is continually in a teaching relationship to all of her nurses. Above all, she keeps in touch with and supervises the work of all the nurses in her district. While in all but two agencies the nurse plans her day, the supervisor is responsbile for seeing that this plan is carried out. In agencies which have developed clinics she is often responsible for clinic administration and detail.

In one of the two agencies with assistant supervisors we find that they assist with all of the duties of the supervisor outlined above and also usually serve a small nursing district, when necessity arises. They take the place of the supervisor when she is away. In the other agency the assistant supervisor takes over especially the routine clerical administrative duties, leaving the supervisor free for teaching and supervision.

The supervision in these 14 agencies covers such a wide range from none to excellent supervision, and is so differently organized that it is difficult to state definitely what cost should be legitimately charged to supervision. We are agreed, however, that adequate supervision is essential to the efficient administration of a public health nursing agency in every community; that there should be a sufficient number of supervisors so that the work of each nurse is observed with regularity and so that there may be continuous training and teaching. From this study it would appear that it is difficult to carry on such a program, including the reading of records, conferences and visiting with the nurses, if there are more than ten nurses to a supervisor and we recommend less than this number of nurses. In many instances there is an advantage in having more intensive supervision than this. It is not wise to make an arbitrary statement of the number of nurses whom one supervisor can assist and advise carefully, since the types of work in agencies vary so radically. Where there are student nurses the problem becomes more complex, especially with pupil nurses who require more supervision. Our recommendation will be discussed in another section that the cost of student supervision, which is additional to the supervision of the regular staff nurse, should not be included in the cost of a nursing visit.

Since the quality of nursing work is likely to deteriorate where a nurse is working alone in a community with no supervision, it is desirable that some plan of regional supervision should be arranged whereby such nurses may have the benefit of occasional, but regular contacts with a supervisor.

Record Writing

The importance and uses of records have been so ably discussed by Dr. Louis I. Dublin* that no further discussion is necessary at this point. We are agreed that adequate records are essential first of all for the use of the nurse in the effective treatment of the patient and secondly for the use of the supervisor and executive in the effective supervision and administration of the nursing work. Since public health nursing is still somewhat in a state of flux, so that facts are essential in determining progress, it is also to be desired that records should make some contribution in the field of research. One of the most important contributions would be to make available, morbidity statistics which would furnish some index of the extent of community sickness.

In this study our primary interest lies in relating cost to the quality and content of the nursing work. We have attempted to determine the various methods of record keeping used by these 14 agencies, and also to obtain uniform and specific information on a number of significant points in the record writing for each organization. We shall not attempt to describe the routine course of the record system in each agency, since this is a separate problem in itself.

TYPE OF RECORD

First of all we want to know whether a complete separate record is kept for each patient or whether there is a family folder with one social history record for the family, but with a separate medical card for each patient. We find that in eight agencies the individual record system is used while in six instances there is a family folder with social information recorded only once for the whole family.

In one of these six agencies, however, a family record is made with no individual medical records. The sick patient is treated in the record only as one member of a unit, and at the end of the week each nurse dictates a general statement of the status of each member of the family. There are no daily entries in the permanent record of the condition of even the most acutely sick patients. These details the director feels, interfere with the nurse's getting the family point of view and are of no permanent value. In this agency the

*Records of Public Health Nursing and their Service in Case Work Administration and Research. By Louis I. Dublin, Ph.D., Statistician, Metropolitan Life Insurance Company, New York, 1922. (Reprinted from the Public Health Nurse.)

only way to trace the course of an illness and the nurse's treatment is to refer to the daily report sheets which are not, of course, filed with the records.

The use of family folders for information common to all in the family group is a device which is coming to be used more and more as family health work is increasingly emphasized, with health for all, as well as care of the sick member of the family, as a goal.

PLACE OF WRITING RECORDS

It is found that in only two agencies does the nurse as a matter of routine make her daily entries on the permanent record in the home of the patient. Notations on the bedside notes are, of course, made in the home in each agency. In many instances the nurses carry small note books in which they jot down significant facts, either in the home or on the street after leaving. This means that the permanent record must be written later either in the nurse's own home or in the office. In one small agency the nurse writes her record wherever she likes. In another agency in addition to a regular time in the office in the morning and at noon, nurses are allowed a half hour at the end of the day for record work, and this may be done in the office or in their own homes. The reason for this is that nurses may go home directly from the field and avoid the travel duplication back to the office. In the rest of the agencies the bulk of record work is done as a routine in the office.

We would recommend that more emphasis be placed on the writing of notes directly on the permanent clinical record. This should be done, if possible, in the home of the patient. In those extreme cases where the patient is mentally disturbed or is antagonized by the presence of a record, it is possible to make the entry on the record immediately after leaving the home. This may be in the hallway, in the corner drug store or in the nurse's automobile if she uses one. There will, of course, occasionally be instances where this procedure is impossible. As a matter of routine, however, the writing of the record in the home of the patient insures accuracy and saves duplication of writing.

TYPEWRITTEN OR LONGHAND RECORDS

The present administration of records in public health nursing agencies puts a heavy load of clerical and record work on the shoulders of the nurse. That is, the nurse herself is usually responsible for all of the detail that goes into records and reports. She writes her permanent records in longhand, fills in her own face cards and is responsible for all final detail of the completed record. While in many social agencies most of this work has been delegated to stenographers, a number of public health nursing executives feel that this plan is not practicable in their agencies. They see the advantages in having all nurses in the office at the same time once or twice daily and they realize that to follow a dictation schedule would mean losing the daily joint meeting of nurses. Others feel that it would take less time for the nurse to write out her comments, since she carries a heavy load and has so many short entries that dictation is difficult and time-consuming.

All this has a bearing on cost. Does it cost more to the agency either in nurse's time or in money to have the nurse write out entries on the permanent record rather than dictating them to a stenographer or is there a saving over both of these methods in turning in slips, written in the home, which are typed in the central office on the permanent record? In this study it was found that three methods are used. First of all the nurse writes out daily entries on her final record in longhand and has the entire responsibility for keeping it up to date. Second, daily entries are dictated to a stenographer by the nurse at regular dictation hours during the week. Third, weekly summaries are dictated to a stenographer for each family visited during that week. The first method is found in twelve of the cities, the second in one and the third in one.

We may first eliminate the third method as one which is not adequate for meeting the three primary functions of a record as outlined above. First of all if the record contains no details of daily visits it cannot be used in the effective treatment of the patient. The nurse is not able to check back on the patient's condition from Friday to Monday, for instance; she is not able to observe details of progress or retrogression. For the purposes of medical research the material is so incomplete that no comparable and uniform data can be obtained.

The second method of having the nurse dictate daily entries has been worked out with a degree of satisfaction in Agency II. In this agency there are 41 nurses and five stenographers; that is, about one stenographer to eight nurses. The total annual cost of this stenographic force, including summer substitutes, is $3,795. If we turn to Table X we find that the average time of the nurse spent daily on record writing is 38 minutes in Agency II. Contrast this with 68 minutes daily for Agency I, and we find a saving of 30 minutes per day per nurse on record writing. Expressed in terms of nurses, this releases the time of practically two and one-half nurses per day. Interpreted in terms of yearly cost, this saving of nurse time, figured at the minimum salary of $130 a month in Agency II, would amount to $3,900 a year, or more than the entire cost of the clerical force. Of course, it is not possible to carry this comparison too far for the general scheme of record writing is quite different in the two cities. There are slightly longer record forms in Agency I and there is also somewhat more material included on the record regarding the family health problem, the social situation, etc. Also, there is some duplication of writing in Agency I, which means that the nurse writes certain information three times for each visit; on the bedside notes, daily report sheets and on the permanent records. Agency II on the other hand, uses no daily report sheet. But even allowing for these differences the plan in Agency II, of having the final record typed, would seem to save more of the nurse's time than in any of the other agencies where this information is available.*

*See footnote at bottom of Table X which suggests that the last three agencies have too few reports for consideration.

The plan of record writing which Dr. DUBLIN† suggests would seem to be less time-consuming and more accurate than that in Agency II, for the nurse merely sends to the record office daily her notations made in the home for each visit. In the office they are transcribed to the permanent record and returned to the nurse in the district. This plan insures a well organized final record, up to date; saves the time of the nurse from dictation or from writing her final record in longhand and is arranged so that she has her own record with her in the district all of the time.

TABLE X—*Mean Number of Minutes Spent on Divisions of the Nursing Day*

(Agencies arranged in order of size of staff)

DIVISION OF NURSING DAY	MEAN NUMBER OF MINUTES BY AGENCIES														
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	Total
Whole Day..........	478	458	485	437	479	483	458	490	485	452	493	463*†	644†	503†	476
In office.............	86	52	118	103	98	109	81	97	75	98	116	34	70	77	91
Records...........	68	38	64	61	57	89	...	...	...	...	...	...	47	34	64
Other Clerical......	18	14	54	42	41	20	...	...	...	...	...	...	23	43	27
In Field.............	378	394	349	313	370	353	351	366	403	319	363	422	531	347	367
Travel.............	111	116	114	122	106	128	118	147	132	113	160	213	75	106	120
Home Visits.......	258	272	108	175	201	188	194	169	192	173	163	26	358	233	207
Other Visits.......	4	3	...	1	1	8	5	2	1	1	2	...	7	8	3
Clinics, Classes, etc.	5	3	127	15	63	28	34	48	77	32	38	183	91	...	38
Miscellaneous........	14	12	18	21	11	21	27	28	7	35	13	7	43	79	18
Total full time Daily Reports.......	332	163	147	80	97	162	90	75	62	44	47	9	18	8	1,334

*Daily report sheets were obtained from only the two rural nurses in this organization, though the rest of the report discusses the organization as a whole.

†The number of nurses in these agencies is so small that the sample of nursing days obtained is probably not adequate to represent a true picture of the organization's work.

It is not our function to suggest forms of records in this study, but to determine the amount of time and the cost of record writing. We are interested, therefore, to observe the time spent on records and other clerical work ranging from an hour and a quarter in one of the small agencies where the records are very simple and quite inadequate, to an hour and 58 minutes or practically two hours a day in Agency III, which has a large clinic development taking a considerable portion of a nurse's record time. If we express this time in per cent. of the nursing day (Table XI) we find that for all of the agencies the per cent. of the nurse's day that is spent on records is 13.4 while her total office time is 19.1 per cent. In individual agencies the record time varies from 8.4 per cent. of the day in Agency II to 18.5 per cent. in Agency VI. Throughout, the amount of time that is spent on records and other clerical work is high in relation to the time spent in the field. Since the staff nurse is the most important person in the organization and since her time in the field is the work for which the organization primarily exists, it would be cost saving for the agency to increase the amount of the nursing time by any economic device

†Ibid. Lecture II.

which would decrease her clerical duties and which would at the same time insure accuracy and completeness of records. We would recommend, therefore, that in agencies where the nurse has the entire responsibility for all the details of the finished record there should be additional clerical help provided to release the nurse from this work. Making entries directly on the permanent record at the time of the visit, where this is possible, would save much nursing time now spent in transcribing or dictating notes. The summarizing and tabulation of record and report material by the clerk rather than the nurse would also save the nurse's time to an appreciable extent. And finally the duplication of record and report forms could be eliminated in many instances where the nurse is responsible for recording in three or more places, the details of her day's work.

TABLE XI*—*Per Cent. of Average Day Spent on Divisions of the Nursing Day*
(Agencies arranged in order of size of staff.)

DIVISION OF NURSING DAY	PER CENT. OF AVERAGE DAY BY AGENCIES														
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	Total
Whole Day	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
In Office	18.0	11.5	24.3	23.6	20.4	22.7	17.7	19.7	15.5	21.6	23.6	7.4	10.9	15.3	19.1
Records	14.1	8.4	13.2	14.0	11.9	18.5	...	...	...	...	...	...	7.2	6.7	13.4
Other Clerical	3.9	3.1	11.0	9.5	8.5	4.2	...	...	...	...	...	...	3.6	8.6	5.8
In Field	79.1	85.8	72.0	71.6	77.3	73.0	76.5	74.7	83.1	70.6	73.7	91.1	82.5	69.0	77.2
Travel	23.2	25.3	23.6	28.0	22.0	26.6	25.6	30.0	27.2	25.0	32.5	46.1	11.6	21.1	25.1
Home Visits	54.1	59.2	22.2	40.1	41.9	39.0	42.4	34.5	39.7	38.3	33.1	5.5	55.6	46.3	43.4
Other Visits	.8	.6	...	.2	.3	1.6	1.0	.4	.2	.3	.3	...	1.1	1.6	.6
Clinics, Classes, etc.	1.1	.7	26.1	3.4	13.1	5.9	7.4	9.7	16.0	7.1	7.8	39.5	14.1	...	8.0
Miscellaneous	2.9	2.7	3.8	4.8	2.3	4.3	5.8	5.6	1.4	7.8	2.6	1.4	6.7	15.7	3.8
Total Full Time Daily Reports	332	163	147	80	97	162	90	75	62	44	47	9	18	8	1,334

*See foot notes to Table X.

STUDY OF SELECTED RECORDS

In each of the agencies studied a representative group of records was selected, including the main types of cases carried by the agency, closed and open records, and cases worked on during given periods of the year. For each record read a schedule* was filled in covering certain points. The analysis of these schedules follows:

USE OF CONFIDENTIAL EXCHANGE

First of all, in the 568 records read we are interested in knowing whether the patient was registered with the Confidential Exchange† or any other form of clearing house for the cases cared for by social and health agencies. In only nine of the communities studied has a Confidential Exchange been established, so our figures apply only to these communities. It is true, of course, that as nurses are more and more going into homes of economic independence there will be a smaller

*For schedule used and instruction regarding selection of cases, see Appendix.
†For some communities the Confidential Exchange is known as the Registration Bureau or Social Service Exchange.

percentage of cases known to other social or health agencies, and this may result in an increasingly smaller registration of cases. It is important to bear in mind, however, that registration may be as necessary in families where economic independence, but a serious social problem is found, as in families unable to pay for their services.

In Table XII it is shown that less than half of the patients are registered, and while there is a slight tendency to register fewer of the cases where the patient pays the fee, such as in hourly service, there is no great difference between this percentage and the percentage of free patients who are registered.

From interviews with the executives of these nine agencies it is found that the general policy is to register:

All patients in 5 agencies.

Free patients and serious social problems found among other patients, in 3 agencies.

No patients in 1 agency.

Since social and health problems are inter-related and since each worker needs to know of the plans of all other workers concerned with the same situation, it would seem important that in every community where more than one agency is working on social and health problems the policy be established of

TABLE XII—*Registration with Confidential Exchange Related to Paid or Free Treatment*

(Based on 9 communities where there is a Confidential Exchange.)

REGISTRATION WITH CONFIDENTIAL EXCHANGE	FEES				TOTAL	
	PAID BY		Free	Unknown	Number	Per Cent.
	Patient	M. L. I.*				
Registered........	27	51	110	13	201	47.6
Not Registered....	40	51	111	1	203	48.1
Unknown.........	5	2	8	3	16	4.3
TOTAL.........	72	104	229	17	422	100.0

*The Metropolitan Life Insurance Company pays the per visit cost for nursing of certain of their policy-holders.

registering all cases with a confidential exchange and of learning as soon as possible after the case is taken up, all that any other agency knows about, or is planning for that family, so that intelligent joint work may be done and duplication of effort prevented. Otherwise much of the nurse's energy may go into making a plan which, perhaps, another agency is working on for the same family. Miss MARGARET BYINGTON† has well described the inter-play that is necessary between nurse and social worker through the information that can be obtained from the Confidential Exchange.

†The inter-Dependence of the Nurse and the Social Worker. By MARGARET S. BYINGTON. (Reprinted from the Public Health Nurse.)

If we turn to the time of registration for the 201 registered cases, we find that it was made as follows:

Before the first visit	19 records
After the first visit	133 records
Same day (Unknown whether before or after)	17 records
Unknown	32 records

In one agency it was stated that it is their policy to register every case, but not until the case is completed, unless the problem is acute and serious. A number of agencies state that they prefer to register their cases before the first visit, but that the information sent into them is often too meagre for identification.

Since registration with a Confidential Exchange is often significant only if other registered agencies are consulted, this policy was observed in the records read. Out of 201 registered cases, consultation with other registered agencies was as follows:

Consulted in	122 records
Not consulted in	35 records
Unknown in	157 records

Every completed record should cover the following points: a description of the patient's condition at the time of each visit; a description of service rendered at each visit; contacts with the physician in charge of the case; some picture of the social situation and social treatment if this was given; contacts with other agencies; the reason for closing the case and a description of the patient's condition at the time of closing.

DESCRIPTION OF GENERAL PHYSICAL CONDITION

In studying 568 records, it was found that the plan of daily entries is used in every agency but the one previously described which is on the basis of a weekly summary. In these daily entries a description of the patient's general physical condition is given for each visit in 301 records and not given for each visit in 267 records. That is, in 47 per cent. of the records, entries of general physical condition are not made as a matter of routine after each visit. Where descriptions of general condition are given, however infrequently it may be, it was found that for the most part these descriptions were:

Adequate in	105 records
Fair in	272 records
Poor in	191 records

The following basis was used for determining whether a statement is adequate:

> The use of the term "adequate" on the schedule means sufficient for the purpose of supervision or later follow up, rather than adequate for the purpose of research. In determining what is an adequate statement of general physical condition, the following will be considered:

> *On the first visit* a complete but concise picture of the patient's condition, degree or stage of illness, whether seriously or moderately ill, outstanding and significant symptoms and if possible, a brief history of the present illness.
>
> *On subsequent visits,* if the condition is *acute,* daily temperature, care or advice given, response to previous treatment or advice, any change in condition either for better or worse and comments on the situation reported in the first visit. For chronic and non-acute cases, a statement at intervals depending on type of case, regarding progress or retrogression.
>
> *At the close of all cases,* a complete, concise statement regarding the patient's condition, noting improvement or lack of improvement of situation reported in first visit.

For specific types of illness special standards of adequacy were set up by the nurse observers.

DESCRIPTION OF SERVICE RENDERED

A description of the nursing care given by the nurse was recorded for each visit in 296 cases and not recorded for each visit in 273 cases. Where the description of care was given, it was:

Adequate in	128 records
Fair in	269 records
Poor in	79 records
Unable to determine in	92 records

Instructions recorded for each visit were found in only 78 out of 568 records. In 327 records, however, there were occasional statements of the instructions given, though not for every visit. In these 327 cases the records of instructions given were:

Adequate in	24 records
Fair in	171 records
Poor in	132 records

It is the opinion of the nurse observers that the records as a whole make too little use of recording the instructions given to the patient or family. This, it is felt, is essential for supervision if thorough family health work is to be done.

CONTACTS WITH DOCTOR

It was found that the name of the doctor was on the record in 519 instances, or 91 per cent. of the cases. The doctor's orders, however, were recorded in only 44 per cent. of the cases. In the 568 records, only 166 records, or 29 per cent., showed that at any time throughout the course of the record was a notation made of sending the nurse's findings to the doctor. The methods of sending these findings were recorded as follows:

Telephone	87 records
Telephone and mail	4 records
Mail	2 records
Personal interview	7 records
Method unknown	66 records

For the purpose of supervision, this situation is difficult since the supervisor has no way of telling to what extent the nurse is cooperating with the doctor.

At some point in the records read, a description of the social situation was recorded in 527 or 93 per cent. of the records. This description of the social situation was recorded:

DESCRIPTION OF SOCIAL SITUATION

Day of the first visit in	298 records
Day after first visit in	37 records
Following day to 1 week after first visit	5 records
1 week to 1 month after first visit	7 records
1 month to 1 year after first visit	5 records
Date of recording unknown in	175 records

In only 48 records, or 9 per cent., was any statement of social treatment recorded, but since the number of cases involving social treatment is unknown, we are unable to determine how representative this is of the tendency to record social treatment.

LENGTH OF TIME SINCE LAST VISIT

In the 568 records, 424 were closed records and 144 open. In the open cases there is some interest in observing the length of time since the last visit on the case:

Length of Time Since Last Visit

(Based on 144 open records.)

Less than 1 week	72
1 week to 2 weeks	19
2 weeks to 3 weeks	13
3 weeks to 4 weeks	8
1 month to 2 months	1
2 months to 3 months	2
3 months to 4 months	3
5 months to 6 months	1
7 months to 8 months	1
Unknown	24
Total	144

From this table it appears that of the known cases only 7 per cent. had not been visited in over a month, the bulk of the cases having been seen within a week.

TIME BETWEEN LAST VISIT AND CLOSING OF THE CASE

If we examine the length of time between the last visit and the closing of the case, however, we find that 16 per cent. of the cases are not closed until from one to six months after the last visit. Since there was no way to determine from the record whether the condition of the patient had changed during that time, we must assume that many records are kept open either because of lack of time for clerical work or because the nurse hopes to make another visit, but is unable to until she knows the need for it has passed.

Length of Time Between Last Visit and Closing of Case

(Based on 424 closed records.)

Same day	130
Less than 1 week after day of visit	93
1 week to 2 weeks after day of visit	52
2 weeks to 3 weeks after day of visit	34
3 weeks to 4 weeks after day of visit	40
1 month to 2 months after day of visit	50
2 months to 3 months after day of visit	9
3 months to 4 months after day of visit	1
4 months to 5 months after day of visit	2
5 months to 6 months after day of visit	3
Unknown	10
TOTAL	424

In the closing entries the general physical condition of the patient was noted in 331 cases, or 78 per cent., while in 93 cases, or 22 per cent., there was no statement regarding the final condition.

REASONS FOR CLOSING

The reasons for closing the cases are to be noted for their diversity. Throughout the study it was observed that the same terminology meant different things not only in different agencies, but among the workers in the same agency. That is, an "improved" patient might be recovered to one nurse, more comfortable but incurable to another, and so on. The need for a standard and generally accepted terminology is very apparent.

REASON FOR CLOSING

Recovered	165 records
Improved	77 records
Moved away	45 records
Death	39 records
To hospital	16 records
Can't locate	16 records
Nurse not needed	12 records
Other care	12 records
Non-attendance at conferences	7 records
Uncooperative	4 records
Care refused	3 records
Dismissed to private nurse	2 records
Dismissed to private physician	1 record
Dismissed to chiropractor	1 record
Able to provide own care	1 record
Contagious disease—cannot handle	1 record
Baby over age	1 record
Unknown	21 records
TOTAL	424 records

In observing the use of the record forms that have been developed for various types of cases it was found that all of the forms that have been developed for each agency were used to some extent in 530, or 93 per cent., of the cases. The number of items that are filled in on record forms, however, does not make such a good showing. The following was found regarding the number of items used:

USE OF FORMS

	No. of Records	Per Cent.
All items were filled in	77	13.6
1 to 5 items blank	295	51.9
6 to 10 items blank	118	20.8
11 to 15 items blank	45	7.9
16 to 20 items blank	17	3.0
Over 20 items blank	16	2.8
Total	568	100.0

In considering what constituted a blank item the nurse observer did not count as blank an item which was inapplicable to that particular case. For instance in hourly service, where there was obviously no financial problem, facts regarding income left blank were not counted as blank, but as inapplicable.

From studying these records it is apparent that there are many gaps and many unsatisfactory spots in the records of each agency. Yet throughout, the record keeping takes an appreciable part of the nursing day. It is evident that the routine clerical work of the records slips up all too often, such as the failure to register with the Confidential Exchange and failure to fill in on the record form items which are covered under daily entries on the back of the form. The nurse observers feel that in nearly every agency the records do not do justice to the excellent nursing work which is often being done. That is, a nurse will exert her best energies in the field and hurry through the record work with unsatisfactory entries which do not reveal in any way the thoroughness of her nursing.

Is this situation not primarily due to a fault in administration? Are records necessarily the bugaboo of public health nursing and here to stay in that role? Or is the difficulty one which can be cleared away by more concentrated effort to make the record simple and clear, to throw the responsibility for its final detail on the clerk instead of the nurse, and to interest the nurse and supervisor in the greater uses that can be made of accurate and thorough nursing records? We are agreed that effort should be expended in that direction. The nurse's time should be released from as much clerical work as possible and more clerks should be employed for this purpose. Thoughtful attention should be given to the duplication of detail and writing in many of the record systems in use to-day. Careful instructions* regarding the

*Agency V has excellent typewritten instructions for the use of each record form with a statement of how each item on these forms should be interpreted. Such a plan insures greater precision in recording as well as greater uniformity.

interpretation of each item on each record form should be given to every new nurse and referred to at intervals by all staff nurses. Nurses should be interested through lectures, analysis of records, etc., in the great value of the material they are gathering. Instead of having records one of the most costly and one of the least satisfactory phases of nursing work, they should be developed into a much more useful part of the administration of public health nursing.

Travel

Too often the nurse's day is thought of as the number of hours spent in actual nursing or record work, with no consideration of the time that is involved in getting from patient to patient and back to the office. The amount of time that the nurse spends in travel is a large factor in the cost of a visit and more time-saving arrangements for travel should therefore receive greater consideration by many agencies.

In Table XI it was found that for the 14 agencies studied, 25.1 per cent. of the nurse's total time is spent in travel within her district. This time varies from 11.6 per cent. in one of the rural communities to 46.1 per cent. in another rural community. The reason for the small percentage of travel time, 11.6 per cent. is that during the six days chosen as a sample, and for which daily report sheets were made, the nurses were working largely within their respective villages, and did little nursing in the rural area surrounding the villages. This was probably not a typical week's work. In the other rural community the nurses were visiting rural schools with the county health officer. This meant a high percentage of travel time for the relatively less amount of time that was spent in homes and classes.

In the city agencies the time consumed in travel varies from 22 to 32 per cent., depending upon the size of the city, the street car facilities, whether or not the agency has automobiles for the staff, etc. In order to relate the differences in travel time to the differences in organization of methods of travel, we will consider the plans for transportation in the various centers.

TRANSPORTATION FURNISHED

First of all, it was found that in each agency the nurse's transportation for district work is paid by the agency. In nine agencies, also, the nurse's transportation is paid from her home to the office and return. In the remaining five agencies the nurse pays her own transportation to and from the field.

METHOD OF TRANSPORTATION

Automobiles for nurses are supplied in all but two agencies. These two agencies are in cities and have staffs of 36 and 38 respectively. In the other agencies the number of automobiles owned by the association are as follows:

Table XIII—*Number of Cars Owned by Agency with Number on Staff*

Number of Cars	Number on Staff							
	Less than 10	10 to 19	20 to 29	30 to 39	40 to 49	50 to 59	60 and over	Total
None	..	..	..	2	..	..	..	2
1	1	1	..	..	..	1	..	3
2	..	..	..	1	..	..	..	1
3	1	2	..	..	1	..	..	4
4	..	..	1	..	..	..	..	1
5	..	..	1	..	..	..	..	1
6	..	..	..	..	..	..	1	1
8	..	1	..	..	..	..	..	1
Total	2	4	2	3	1	1	1	14

From this table it is seen that there is little relationship between the number of cars and the size of the agency, one of the three smallest agencies having the largest number of cars, and next to the largest agency having only one car. In this larger agency, however, as in two other agencies, two nurses who own their own cars are paid mileage by the association for time in the field. It is interesting to note that in Table XI the two city agencies showing the highest percentage of travel time have in one instance three cars for a staff of 10 to 20, and in the other instance four cars for a staff of 20 to 30. In the latter city, however, the street car lines are so arranged that in order to get from one part of the city to another, it is necessary to return to the center of the city and take a different car line from that point. In this agency, which takes approximately 30 minutes a day more per nurse for travel (Table X) than most of the city agencies, additional automobile service would probably be advisable, even though the ratio of cars to staff is greater than in Agency I. Agency I, which has a larger number of cars than any of the city agencies considered, has next to the smallest number of minutes a day for travel. This is due, probably, also to the branch and district form of organization with nurses working exclusively in their own districts, thus avoiding duplication of travel.

From the facts obtained in this study it is difficult to make a conclusive statement showing whether there is any saving of money in the use of automobiles in the district. In order to substantiate this statement it would be necessary to have data showing for the same locality the amount of time spent in travel with and without automobile transportation, the relative expense of street car fares and automobile up-keep and depreciation, and other items which it was not possible to obtain. There are various other facts which must also be considered, such as the density of population, the street car facilities and the districting of the agency as related to population needs. Thus, at first glance, when we observe that Agency V with a staff of 36, spends 22.0 per cent. of the day in travel, without automobiles, while Agency VII with a staff of 27 and 5 cars, spends 25.6 per cent. of the day in travel, we might assume that the automobile was not a time-saving device for public health nurses. Upon examination, however, we find that while Agency V is in a city with a population twice that of the city in which Agency VII is located, it concentrates the bulk of its work upon a farily central and accessible area. Agency VII, on the other hand, spreads out over an area of 37 square miles in which the street car system is entirely inadequate for the needs of the nurses. In fact, there is only one car line that has a continuous route across the city. Nurses desiring to transfer to other lines frequently must go down town for this purpose. Experience in this agency has shown that the automobile is essential if the nurse is to cover anything like a reasonable number of patients in a day, and though there has been no careful cost accounting, it is agreed by those in charge that the great saving in the time of the nurse for nursing work has more than made up for the additional cost of automobiles.

USE OF AUTOMOBILES IN DISTRICTS

It was found that in one instance, Agency II, where the agency owns only one car, it is used almost exclusively by the superintendent and her assistant for visiting the districts. In the remaining 11 agencies owning cars, they are used as follows:

In all districts	5 agencies
In outlying or large districts	3 agencies
Where needed most	3 agencies

It was found that cars are used for the following purposes:

For transportation of executive staff only	1 agency
For transportation of nurses	5 agencies
For transportation of executive staff, nurses and patients in emergency	5 agencies

In general, the transportation of patients is discouraged except in emergency, an effort being made to have the patient arrange and pay for his own transportation to clinics, hospitals, etc., wherever possible. The types of patients to whom transportation is furnished are for the most part, orthopedic or arthritic patients who attend special clinics, certain types of tuberculosis cases, a few prenatal cases, occasionally a mother with small children or some form of emergency case.

NIGHT TAXI SERVICE

In four agencies it was found that nurses are allowed to charge to the association, night taxi service when they are called out in an emergency. In three of these agencies such calls are allowed for delivery nursing service; in the other agency for any emergency service, but for the most part delivery. In general, an effort is made to have the patient pay this bill, but this is not always possible.

If we turn back to Table XI and analyze the time in the field we find that roughly speaking, for the total group, one-third of the time in the field is spent in travel. This proportion varies among the different agencies, but is from one-third to one-fourth of the time in the field for most of the city agencies. We would recommend that in considering the reduction of travel time, agencies should review not only the facilities for transportation, but the districting of the organization, the actual time spent in travel in the various districts, the plans for organization of the day's work, and the general organization of the staff to prevent travel duplication.

Hours of Work

The hours of work daily, including time spent in record keeping, were found to be as follows in the 14 agencies:

HOURS OF WORK DAILY

7 hours daily in 1 agency
7½ hours daily in 5 agencies
8 hours daily in 8 agencies

The hour at starting work in the morning is:

HOUR STARTING WORK

8 o'clock in 7 agencies
8.30 o'clock in 6 agencies
9 o'clock in 1 agency

The hours of work weekly are:

HOURS OF WORK WEEKLY

38 hours in 1 agency
41½ hours in 2 agencies
42 hours in 1 agency
44 hours in 7 agencies
44½ hours in 1 agency
45 hours in 2 agencies

This includes Sunday work only in emergency in seven agencies and on certain specified Sundays in seven agencies.

In seven agencies night work is expected when an emergency arises or when there is a delivery to be attended. In the remaining seven agencies there is practically no night work allowed. In each agency where night work is done, time is allowed off either the next day or as soon after as can conveniently be arranged.

OVERTIME WORK

Overtime work in general is allowed in all but one agency, but discouraged in every agency except for emergencies. That overtime work as a matter of routine is unnecessary if work is well planned was the opinion of nearly every executive interviewed in this study. In large rural districts this is not always true, for there are often emergencies which the nurse alone can meet, since there are usually no other resources available for nursing care.

In every agency there is a provision for each nurse to have one whole day of rest a week and a weekly half-holiday in addition, though these are not consecutive in many instances where a nurse works on Sunday.

It is of interest to compare the hours of work of the public health nursing group with the usual working hours of the social worker. We find the hours of nine to five and a 39-hour week customary in the majority of social agencies throughout the country, while as short a week as this was found in only one of the nursing agencies studied. Though the conditions of work for the social worker are somewhat different, we would recommend that consideration be given to the shortening of the nursing day in those agencies where the organization of the work makes this possible. The hard physical work involved in giving nursing care, the tedious travel time and the frequent emotional strain cannot be carried over too long a day if the nurse is to do her best work. It is also important that routine overtime work should be discouraged. Where the nurse is asked to do night work in an emergency, this time should be made up. This is essential for the physical welfare of the nurse, and also for her effectiveness on the job.

VACATIONS

If we turn to the vacation time allowed supervisors, we find that the 11 agencies having supervisors, one month of vacation with pay is given yearly in ten of the agencies and two weeks in the other, which is a public agency. The staff nurses are also allowed one month of vacation with pay in all but two of the organizations, one public and one private, where they are allowed two weeks. The clerical force, in the 13 agencies where there is at least one clerk is allowed two weeks with pay in nine agencies, one month in two agencies, and either two weeks or one month, dependent upon the position, in two agencies.

In the matter of vacations, also, it is important that the nurse should have enough time away from her work each year so that she may retain her good health and an interested attitude toward her work. In order to accomplish this a month's vacation is necessary.

Physical Condition

HEALTH EXAMINATION

In approaching the whole question of physical condition it is important to know what facilities the agency has for ascertaining the physical condition of its staff members, what provisions there are for maintaining health and what provision is made for the nurse who becomes sick. From a study of individual staff members, we find that of the nursing staff, 49.8 per cent. had received a health examination before appointment, while 41.0 per cent. of the supervisory and executive staff had been examined. This represents different policies in different agencies, of course, and varying policies in the same agencies over a period of time, since some of the workers were appointed before the agency made a practice of examination.

The practice of having all new staff nurses examined as a matter of routine was found in only four agencies. In three of these four agencies the nurse's own physician makes the examination; in the other agency the staff physician makes it. In the other ten agencies a nurse may be requested to have an examination if this seems desirable.

The general requirement is outstanding good health, with no organic disease. In several instances flat foot was mentioned as a particularly serious defect to be looked for. In one agency arrested tuberculosis cases are accepted with the understanding that whenever they are below par they must be re-examined.

Re-examination is compulsory in only one of the 14 agencies, and this is yearly as a routine and oftener if necessary. In the other agencies there is re-examination only when necessary.

RE-EXAMINATION

We are agreed that health examination before appointment and regular re-examinations are necessary for the public health nurse who is going into all types of homes. This preventive measure may in many instances cut down the amount of sickness and the consequent ineffectiveness which often precedes and follows sickness.

In all but one of the agencies the agency* assumes some definite responsibility for promoting the health of the staff. In each of these organizations an effort is made to prevent routine overtime work, to see that any necessary overtime is made up and in several instances, to adjust work to the capacity of the individual nurse. In one agency each nurse receives the Schick test and typhoid vaccine. In another agency an extra day is given in every month with no legal holiday. In the largest agency studied the number of days of sick leave has been reduced by one-half through allowing occasional preventive sick leave, through insisting on no routine overtime work without making this time up, by taking time off each week, by guarding against exposure, etc. There is no way to measure the advantage that was also gained in more efficient nursing work due to better physical condition.

PROMOTION OF HEALTH

The amount of time given for sick leave is as follows:

SICK LEAVE

Individual adjustment	2 agencies
1 week a year	2 agencies
12 days a year	1 agency
12 days first year and 1 month thereafter	1 agency
2 weeks a year	6 agencies
2 weeks a year on 75 per cent. of salary or 4 weeks on 50 per cent. of salary	1 agency
6 weeks a year	1 agency

In no instance is sick leave deducted from vacation period as a matter of routine, though in one agency this may be done, depending upon the length of time the nurse has been off duty. Unused sick leave, on the other hand, is never added to the vacation period except in two agencies where it may be done if the nurse needs extra rest. It then becomes in the nature of preventive sick leave.

Throughout, a growing consciousness was evident of a direct relationship between the physical condition of the nurse and the general effectiveness of

*A rural agency with no supervisors.

her work. One might expect that a nursing organization would be the first to appreciate this relationship, but in the past this has not been the case. Financial pressure, too few nurses, overwhelming community needs, have meant long hours of overtime, overwork and lowered physical resistance of the nurses. In the rural community to-day there is the same overtime problem that the city agency has faced and in some instances, is still facing.

The following picture of a day's work was recorded in a rural nurse's daily report sheet. The nurse's day was 13½ hours. Of this time, 1 hour was spent in the office on records, reports and telephone calls. Two hours and 20 minutes were spent in district travel, 30 minutes were spent in giving 3 ten minute talks in rural schools, and 9 hours and 40 minutes were spent in home visits. These visits included 4 new influenza patients, 1 case of pneumonia, 1 case of tuberculosis, 1 prenatal patient, the care of a mother and her 3-day old baby, and assisting for 5 hours on a difficult delivery. That this was not an unusual day's work is shown by the rest of this nurse's daily report sheets for the week, which included one 24-hour day, part of which was spent on a meningitis case, and one 16-hour day which included a delivery.

That such a continuous program is not possible in the interests of good work is well known to all public health nursing administrators. Yet it is bound to occur unless the agency takes a definite stand on the question of overtime, of more equal districting in the agency, and assumes responsibility for the health of the staff. May we look forward to the time when the week of no public health nursing agency will be more than 44 hours, when there will be no less than 1 month of vacation with pay and when there will be preventive sick leave as occasion arises? As in other fields, increased effectiveness on the job will occur when there is less fatigue and stress. As noted above in the reduction of days of sick leave by half through preventive sick leave, the cost of the nursing work will be lower. Sickness of staff workers is expensive for every agency. From the angle of cost alone, it involves the payment of salary for a period when no services are given in return. After that period has expired, if the nurse is still unable to work, it involves the employment of substitutes or new staff nurses who may need training. It is important, therefore, in considering both the quality of nursing work and the cost of that work, that the physical welfare of the nurse be emphasized.

Salaries

The largest item in the expenditures of all public health nursing organizations is the amount expended for the salaries of the nursing staff. The salary alone, however, is not indicative of the general calibre of the work done, since a number of agencies pay smaller salaries but give more training than others. Also the general cost of living and the demand and supply in a given locality must be considered in making any comparative study of salaries in a number of widely separated communities.

Our first interest centers on the range of salaries paid in the agencies studied. Table XIV gives the executive's statement in each agency regarding the minimum and maximum monthly salaries paid to staff nurses and supervisors. Except for the four agencies listed in the footnote, the increase from the minimum to the maximum is either based on merit or on a yearly increase. In the four agencies indicated the initial salary covers the training period, with an increase for the remainder of the first year. If we eliminate the training period salaries, we find that the minimum salaries for white staff nurses vary from $100 to $150 monthly. The latter salary is paid in only one community in a rural area, where each nurse is responsible for a definite part of the county and has the combined duties of nurse and administrator. The maximum salary varies from $115 to $150 a month for white nurses, $125 occuring most frequently.

RANGE OF SALARIES

It is interesting to note that in two Southern communities the colored nurse has a lower salary schedule than the white nurse for the same work, and that in one agency the maximum for the colored nurse is lower than the minimum for the white nurse after her training period in any of the agencies studied. In commenting on this, it must be remembered that the private agency dependent on community funds must reflect to a large extent, the well accepted community traditions. In one of these communities it is generally believed that

TABLE XIV—*Salary Schedules of Staff Nurses and Supervisors**

(Agencies arranged in order of size of staff.)

AGENCIES	STAFF NURSES' MONTHLY SALARIES		SUPERVISORS' MONTHLY SALARIES	
	Minimum	Maximum	Minimum	Maximum
I	$100§	$115	$125‡	$150‡
II	130	150	165	175
III	110	130	135	145
IV	75§	125	125	150
V White	100	125	135	150
Colored	80	90	...	...
VI	90§	115	...	125
VII	112	125	...	150
VIII	100§	125	135	150
IX	115	125	...	140
X	130	130†	...	150
XI	115	125	140	150
XII White	100	125†	...	No Supervisor
Colored	85	115	...	...
XIII	150	150	...	No Supervisor
XIV	108	125	...	No Supervisor

*Only Agencies I and III employ assistant supervisors. In Agency I, 8 of the 9 assistant supervisors are paid $118 a month. In Agency III, the assistant supervisors have the same salary range as the staff nurses.

†One exception—a school nurse earning $150 a month.

‡$125 is the minimum salary for only one supervisor out of 7.
$150 is the minimum salary for the 6 supervisors with the 9 months' course in public health nursing.

§Agency I—$100 monthly, first 3 months; $110 following 9 months; $115 the second year.
Agency IV—$75 monthly, first 4 months; $100 for following 6 months.
Agency VI—$90 monthly, first 2 months; $100 following 10 months; $110 the second year.
Agency VIII—$100 monthly, first 3 months; $105 following 9 months; $115 the second year.

the colored nurse can live on a smaller salary than the white nurse. Here again the law of demand and supply, and few opportunities for colored women control the situation. In the other agencies employing colored nurses, no salary distinction is made between the colored and white nurse.

Agencies IV, X, XI and XIII require nurses with previous public health nursing experience. This accounts, therefore, for the higher maximum salary in Agencies X and XIII. Agency II stands alone in the high maximum salary of $150 paid to nurses in a city agency. This salary is disproportionately high when we consider that no previous public health nursing is required.

If we turn to the supervisors' salaries we find that the minimum runs from $125 to $165 monthly, while the maximum varies from $125 to $175 with $150 occurring in seven out of eleven instances.

SALARIES BY AGENCIES

In Table XV we have the statement of actual salaries paid to the staff nurses who returned the personnel schedules from the various agencies. From this table we are able to compare the salaries being paid to nurses, with the salary range given by the agency in Table XIV. We may note that the number of nurses who were receiving less than $100 monthly at the time of our study is very small, as, also, is the number receiving $150 or over, while the bulk of the cases fall in the $100 to $150 group.

In this table, the mean salaries are given in column two to express the central salary tendency in each agency, and to facilitate comparison between agencies. Agency II shows an outstanding higher mean salary than any of

TABLE XV—*Present Monthly Salary of Staff Nurses by Agencies*
(Agencies arranged in order of size of staff.)

AGENCIES	TOTAL	Mean Monthly Salary	Monthly Salary					
			Under $100	$100 to $124			$125-$149	$150-$174
				Total	$100-$114	$115-$124		
TOTAL	304*	$118	14	173	86	87	101	16
I	79	112	1†	78	30	48	..	..
II	38	140	..	..	..	..	27	11
III	33	123	..	13	9	4	20	..
IV	18	113	1	9	5	4	8	..
V	25	113	3	11	11	..	11	..
VI	23	98	8	15	14	1	..	..
VII	21	123	..	7	5	2	14	..
VIII	16	108	..	15	9	6	1	..
IX	13	120	..	10	..	10	3	..
X	12	132	..	..	..	..	11	1
XI	10	114	..	10	1	9	..	..
XII	12	118	1	4	2	2	6	1
XIII	3	..	..	..	..	..	..	3
XIV	1	..	..	1	..	1	..	..

*One salary not specified in Agency V.
†Part time worker. Minimum full time salary is $100.

the other city agencies, though an analysis of the nursing training, experience and skill in the work shows little, if any, variation from several other agencies with a markedly lower salary range. In this agency the cost of the nursing work is not as high as we might expect because the training facilities are limited. Few supervisors are employed and the general overhead expense is lower.

If we compare the present monthly salaries of the nursing organizations studied with the positions in the agencies for which those salaries are paid, we find, as we should expect, that the mean monthly salary for the nursing group is $118 while the mean monthly salary for the supervisory and executive group is $155. If we analyze the latter group, however, we find that the marked differences from the nursing staff occur among the supervisors, assistant superintendents and superintendents, each group, in turn, receiving a somewhat higher mean salary.

LENGTH OF NURSING EXPERIENCE

Closely related to the salaries just mentioned for nursing and supervisory positions is the length of experience, both in the nursing field and in the agency in question. In Table XVI we find that while the range of years with the agency is the same for the nursing and supervisory staff, the mean number of years with the agency is 3.8 for the executive staff and 2.4 for the nursing staff. From the point of view of cost, it is important to note the relatively short length of nursing service in each agency. While there are a few nurses who have been with five of the agencies for five years or more, the bulk of the nurses have been with the agencies under three years. The mean number of years with the agency is, in fact, under three years in each agency but III, a public agency where nurses are under the civil service commission. It is interesting to see that in Agency II with a high salary scale, the length of nursing service is less than in a number of other agencies. As previously stated, in considering turn-over, short nursing service means much additional cost due to the length of the training period.

ITEMS IN LIEU OF SALARY

In connection with the question of salaries it is important to ascertain whether there are items provided in lieu of salary. The following items were studied for each agency to see whether they were furnished in addition to salary.

1. *Uniforms*—Not furnished in 11 agencies. Partially furnished in 3 agencies.
2. *Board*—Not furnished in any agency.
3. *Lodging*—Not furnished in any agency.
4. *Transportation*—Furnished for district work in all agencies. Furnished for *all* travel in 9 agencies.
5. *Nursing Bags*—Furnished in 13 agencies. Not furnished in 1 agency.

6. *Supplies*—Furnished in all agencies, with exception of certain instruments in 4 agencies.*
7. *Laundry*—Bag laundry including aprons and towels used in district, and in 2 instances communicable disease gowns and caps, furnished in 12 agencies.
   Two agencies furnish no laundry.

TABLE XVI—*Length of Service in Present Organization*
(By agencies and present position)

POSITION AND AGENCY	TOTAL	Mean Number of Years	NUMBER OF YEARS							
			LESS THAN 5 YEARS					5 to 9 Years	10 Yrs. and Over	Not Specified
			Total	Less Than 1 Year	1 to 2 Years	2 to 3 Years	3 to 5 Years			
TOTAL	366	2.6	310	107	84	55	64	42	7	7
Executives and Supervisors	61	3.8	42	7	16	7	12	16	3	..
Supervisors	47	3.5	35	5	14	6	10	10	2	..
Executives	14	4.9	7	2	2	1	2	6	1	..
Nursing Staff	305	2.4	268	100	68	48	52	26	4	7
AGENCY										
I	79	2.7	68	26	20	8	14	8	3	..
II	38	2.4	34	12	9	7	6	4	..	..
III	33	3.5	24	8	5	5	6	8	1	..
IV	18	1.7	18	6	4	6	2	..	..	..
V	26	1.4	25	6	6	7	6	..	..	1
VI	23	2.6	18	9	4	3	2	5	..	..
VII	21	2.1	20	7	1	8	4	..	..	1
VIII	16	1.0	13	9	3	..	1	..	..	3
IX	13	2.8	12	2	3	2	5	1	..	..
X	12	1.1	11	5	6	..	..	..	..	1
XI	10	1.9	10	3	4	..	3	..	..	..
XII	12	1.5	12	6	2	2	2	..	..	..
XIII	3	2.0	2	1	..	..	1	..	..	1
XIV	1	..	1	..	1	..	..	..	..	..

Since the nurse carries on a more or less hazardous occupation, it is also important to know whether, in general, she has any form of organized protection. The following was found:

1. *Sickness insurance.* None in any of the 14 agencies.
2. *Group life insurance.* None in any of the 14 agencies.
3. *Workmen's compensation.* None in 9 agencies. In 5 agencies where state laws are operative, such protection was found.
4. *Pensions.* None in any of the 14 agencies.
5. *Loan fund.* None in 10 agencies. In 4 agencies there was an available loan fund for sick nurses or for other difficult personal situations.

*Agency I—Nurse furnishes scissors, forceps, hypodermic syringe, probe, 2 thermometers and watch.
Agency IV—Nurse furnishes instruments.
Agency VIII—Nurse furnishes hypodermic syringe.
Agency IX—Nurse furnishes bandage scissors, hypodermic syringe, thermometer.

From this discussion it is evident that for the most part, the nurse has few items in lieu of salary, and in several instances, is responsible for certain cost related to her job, such as bags, instruments, laundry.

Other Than Paid Staff

In addition to the paid staff, which we have been considering, there are two unpaid groups of considerable importance in a number of agencies. There are the student group, both graduate and in training, and the large group of volunteers.

If we turn back to Table IV, we find that at the time of this study only one agency was training graduate students and six agencies had under-graduate nurses for a number of hours a week. Since the problem of relating student training and work to cost is one of the most difficult, it is important for us to consider the working arrangements of these agencies carefully.

GRADUATE STUDENTS

The one agency which at the time of this study, was training graduate students, had six students. They give to the Visiting Nurse Society 15 hours a week for 20 weeks from January to June. This includes two consecutive full days of work and one evening clinic. The plan of starting each student is to assign her to a supervisor and then change supervisors after six weeks. That is, the infant welfare supervisor will keep two students for six weeks, two days weekly. Then the student will go to the tuberculosis supervisor, etc. At the end of the field work period there wlll be a few days with the industrial nurse. Each supervisor begins by taking the student into the district, giving her only selected cases. Some effort is made to have the student follow up two new tuberculosis families during the period of field work, but aside from this they must be given cases for each separate day of service, since they are not working full time. This, of course, increases the work of the supervisor. In addition to this, the superintendent teaches the students twice weekly at the university, but this is not deducted from the field work time. The only cash expense to the organization is the carfare of the students for district work. Since there are two students to a supervisor, however, there is the additional large expense of the supervisor's time.

In one other agency, Agency I, while there were no graduate students for the one term during which this study was made, there have been an average of 10 students each year for a number of years. Since this agency is very closely allied to the public health nursing course in this community, and it was only a coincidence that there were no students at this particular time, it will be well to give the salient features of their training problem. For two months (8½ weeks) each student carries 30 hours a week of field work. This amount of time in the field enables her to take responsibility for a small district and to carry a consecutive piece of work. The student nurse starts out under the supervision of the teaching district where there is an average of six nurses to a supervisor. The general plan of training and supervising the student is the same as that for the new nurse, outlined earlier in this report. The only cash expenditure of the agency is for carfare in the district.

PUPIL NURSE STUDENTS

If we turn to the undergraduate students in this agency we find that there are 14 students giving 24 hours of field work a week for 2 months, or, with one hospital group, 3 months. In addition to this, each student has 4 to 5 hours of classes weekly. These nurses also go into the teaching district and receive the same training as the new staff nurse, assuming responsibility for a small district under supervision. The only payment by the agency is carfare to and from the hospitals and within the district, lunches when the pupil nurse does not return to the hospital, and her outdoor uniform. At the time of the study there were pupil nurses from five of the best hospitals in the city.

Since the plan of training student nurses for the remaining five agencies is essentially like that in the agency just described, only the points essentially unlike this plan will be mentioned. In one of the agencies pupil nurses are taken in their senior year for a period of four months. The public health nursing course is elective and given as a scholarship for merit. The plan of training is the same as that outlined for Agency IV under "Training of New Nurses." In another agency an arrangement is made to take one nurse at a time for a month. This arrangement is so unsatisfactory to the agency that it is to be changed soon. In the other three agencies the training period is two months. In one of these agencies the student is never in charge of a district, but is assigned to a staff nurse who plans her work.

The computation of student nurse cost has been so variously dealt with in different communities that it is important for us to consider the most satisfactory way of handling it. Does the time given by students, carefully supervised, make up for the additional time of the supervisor; or does the agency gain by having this additional service for which they are paying no salary cost? The problem is different in every community, of course, depending upon the amount of supervision, whether compensation in money or kind is given to the student, what the replacement by new staff nurses would be, etc.

The following method has been agreed upon by this Committee as applicable to all agencies where enough supervision is given to the student to insure satisfactory work. Whenever students, graduate or undergraduate, participate in the work of the organization, an estimate should be made of the number of staff nurses it would take to replace the services given by such students. An item equal to two-thirds of the salary of the staff nurses necessary to replace such students, minus the cost of student supervision which is additional to the supervision of the regular staff nurse should then be included in the cost. It is recommended that one-third of the replacement cost be deducted because of the large turnover of students, necessitating continued training and supervision; and also because of the additional indirect administrative expense.

Every visiting nurse society is able to obtain volunteer service for certain types of work. In the most of the agencies this includes motor service, making dressings and other supplies, assisting in health stations, clinics, etc. In a few agencies service requiring more specialized technique is given by volunteers. This includes, in three agencies, book-keeping and accounting service and in one agency, part time of a research worker. In one agency members of the Association of University Women are teaching several crippled children in the children's homes, under the care of the Visiting Nurse Society. In one agency, four physicians give their services weekly for four different clinics. In one agency half time of an occupational therapist is volunteered, and in the same agency the equivalent of four part time clerks and one part time stenographer is volunteered.

VOLUNTEERS

In the agencies where volunteer service has been most successful it has been accepted by the agency as a serious part of its working program. In one agency the superintendent interviews each applicant for volunteer service. She makes clear to her the necessity for willingness to accept any kind of task, according to the needs that develop. Each volunteer has impressed upon her a sense of responsibility, and is expected to do some real piece of work. In addition, volunteers are kept closely in touch with the work of the organization.

Some of these services have an established market value to the organization. Others, while a distinct advantage to the agency in its development of community response, in its service to patients and in a certain lessening of detail for the staff, have no market value and are not entirely essential to the furtherance of the agency's program.

In considering whether volunteer service should be included in cost, these two factors must be distinguished. All volunteer service requires a certain amount of time on the part of the administrative staff in organizing and supervising volunteers. Also, the service of volunteers is irregular, for the most part. It is the recommendation of this Committee, therefore, that wherever volunteer service has a market value to the organization, it is a part of the cost to the community and should be charged in part to cost in the agency. For the reasons given above, this replacement cost should not be entire, but should be estimated at not more than two-thirds of the replacement cost.

Methods of Analysis of Nursing Work

In attempting to determine cost it was necessary to obtain from each agency studied some quantitative statement of the amount and type of work done during a given period. These statements have included, wherever possible, the total number of patients under care, the number of new patients, patients brought forward and discharged. The classification of visits for each agency was obtained and any other quantitative statements of the nurse's activities, and the general accomplishments of the organization.

It was found that one agency with three nurses keeps no record of the number of patients cared for, while 12 agencies keep a record of the total number of patients under care, the number of new patients in a given period, the number of patients brought forward and the number of patients discharged. The remaining agency keeps no record of any kind of the number of individual patients, but counts only the *families* taken under care. This is the agency, mentioned before, which to a marked degree, is attempting to do a piece of family health work with emphasis on the preventive side. Only family records are kept with no individual medical history card.

YEARLY INTAKE

If we examine the number of new patients yearly in these 12 agencies, we find that while the range is from 280 in Agency XIV, to 23,649 in Agency I, the distribution is as follows:

Less then 2,500 new patients yearly in	2 agencies
2,500 to 5,000 new patients yearly in	6 agencies
5,000 to 7,500 new patients yearly in	1 agency
7,500 to 10,000 new patients yearly in	1 agency
Over 10,000 new patients yearly in	2 agencies

A comparison of the total number of patients is of little significance, since the policy of closing cases varies so markedly among the different agencies. In Agency IV, just described as keeping family records, for instance, the policy is not to close cases unless the patients move or die, refuse service or for some other special reason. This means that health supervision cases become cumulative year after year, while new cases are constantly being added. In Agency V, also, the number of discharged cases is very small, so that the load becomes cumulative. In Agency II, however, with a total of 10,836 cases during the year studied, 9,783, or 90.3 per cent., of these were discharged during the year. In general, the percentage of cases discharged during a given period varies in the other agencies from 70 to 90 per cent. of the total load.

DIAGNOSIS OF PATIENTS

In six agencies there was no tabulated record of the diagnoses of the discharged patients, or of the total group of patients. One of these agencies was starting to keep such a tabulation at the time of our study, but figures were available for only a two-months' period. That is, these agencies are unable to tell to what extent one part of their case load is overbalancing another, or to measure their intake with the community sickness problem.

In the remaining eight agencies, annual tabulations of diagnoses of patients cared for are made, but with varying degrees of accuracy. In some instances a patient with three distinct diseases, for example, may be counted as three patients. In other agencies only one of the diseases is counted, but the selection of which one is left to the discretion of the registrar, with no consistent plan to follow. In all of these agencies the outstanding observation is that maternity cases, including prenatal, delivery or post-partum, are in each instance larger in number than any other group. The percentage of maternity cases in these eight agencies is as follows:

30 to 40 per cent. of total cases in	2 agencies
40 to 50 per cent. of total cases in	4 agencies
50 to 60 per cent. of total cases in	2 agencies

The other types of cases handled vary too much for any significant general observation, since in the agency with any given form of specialization, that type of case often predominates. In each agency a great variety of cases is reported, with maternity cases contributing more than any other one type. As discussed earlier in this report, some agencies do no contagious nursing, while others, such as Agency I, report a considerable percentage of patients with contagious disease. Any general picture of the predominance of certain types of work, therefore, is more accurately obtained by referring to the previous discussion of scope of work, and Table II.

VISITS CLASSIFIED BY DIAGNOSIS

In no agency studied was it possible to obtain a statement of the number of visits to patients, classified by diagnosis. Such data should be of considerable value to an agency in determining development, since they show the time involved and the approximate cost of the various types of cases that are being carried.

VISIT CLASSIFICATION

Since the unit of measuring the amount of visiting nursing has been the visit, an effort was made in each agency to obtain the total number of visits made during the period of a year and the classification of those visits with a definition of each class. The following types of visits were reported:

Nursing	Visits of patients to the stations	Not found
Working		Nurse not needed
Instructive	Moved	No illness
Advisory	Unable to locate	Business
Social Service	Change of address	Miscellaneous
Consulting	Out	Other
Referred	Absent	Incidental
Visits to the home		

It is evident from this list that there is little uniformity in evaluation of types of visits and that there is generalized and slip-shod thinking in the use of terms. In one agency a social service visit means every visit not classified as nursing or instructive; in another agency social service means only a visit to a social agency or a relative in behalf of a patient. In other agencies these visits are counted as "miscellaneous" or "other." Frequently a "consulting" visit is interpreted as a social service visit, but it is also used to describe a business visit. Because of the variety of usage, it is impossible to group the visits for the total number of agencies.

Back of the classification, moreover, lies a more fundamental difficulty in determining what shall be counted as a visit under each of these headings. In one agency a telephone call is counted a visit. In three agencies the visit of a supervisor when she is with a nurse, is counted as a separate visit. In one agency a student's visit is not counted as a full visit, while in the other agencies the opposite is the practice. In one agency a visit to a home where nursing care is given to a number of sick patients is still counted as one visit. So long as the basic determination of what shall be called a visit varies so widely, comparative figures of number of visits are of little significance.

In discussing what shall be called a visit, so far as cost computation is concerned, this Committee is agreed on the following procedure:

1. A student's visit should be counted as a visit.
2. A supervisor's visit to a home with a nurse should not be counted as a visit when the nurse's visit is counted.
3. When nursing care is given to more than one in a family, each patient cared for should be counted as one visit.
4. Telephone calls should not be counted as visits.
5. Delivery nursing service should be counted in number of visits according to the average length of visit in that agency. That is, if the average length of visit in an agency is 45 minutes and the average delivery service is 3 hours, that service should be counted as the equivalent of 4 visits.

In reviewing the classification and definition of visits, this Committee would recommend that a more uniform terminology and method of classification be used so that comparative statements of the work of public health nursing agencies may be of value. The following general classification of visits is suggested:

I. Visits to the patient.
   This will include all visits where the patient is seen. Since effective public health nursing work must include necessary instruction, it seems futile to try to separate "nursing" and "instructive" visits. Every nursing visit should be instructive and many instructive visits, so called, necessitate the use of a certain amount of nursing technique. This grouping, therefore, would include all visits where the patient was seen whether mainly nursing or mainly educational.

II. Visits to the patient in which the patient was not seen.
   This will include every visit where the patient was out, had changed his address, had moved out of town, etc.

III. Visits in behalf of the patient.
   This will include visits to social agencies, hospitals, doctors, relatives, etc., where the purpose of the visit is in behalf of some patient.

Since this does not account for various other activities of the nurse, such as telephone calls, group classes with patients, etc., all of which are sometimess counted as visits by certain agencies, the following rough grouping of time is suggested for the time consumed in activities not mentioned above as visits:

I. Time spent on group meetings with patients.
This will include conferences, or classes with patients or the mothers of patients.

II. Time spent on other services in behalf of patients.
This will include telephone calls, office interviews, letter writing, records, etc.

III. Time spent in travel.

IV. Time spent on assigned duties of indirect value to patients.
This will include staff conferences, district meetings, committee meetings, reports, speeches, etc. While these duties are not directly related to the care of any one patient, they are of indirect value to the patient in that they give the nurse a more general understanding of public health nursing and its relationship to the community in which she is working.

SOURCES OF PATIENTS

In six of the fourteen agencies it was found that no record is kept of the sources from which the patient is referred. In the remaining eight agencies these figures are of interest in showing whether the agency is getting cooperation from physicians and from social agencies. It shows whether patients are coming on their own initiative to consult the nurse. It shows how often the nurse finds new patients in the district in which she is working. An intake which is exclusively from a few sources, may indicate that community resources have not been tapped, and is of significance in planning future contacts.

FREE OR PAY PATIENTS

An effective method of finding out to what extent certain groups in the community are being served is to examine for each year the number of patients who have paid full cost or part cost for this service, the number of free patients and the number referred and paid for by corporations. In these 14 agencies it was found that four keep no record of this. The two public agencies have no patients other than free, except for a small number of corporation patients in one agency. In the remaining eight agencies three groups stand out. First we may note Agency IV, stressing family health with 97 per cent. of the patients free and 3 per cent. paying part cost. In the next group of four agencies the largest percentage of patients are free and the next largest percentage are referred by corporations who pay for the service. In the two remaining agencies, I and II, the largest percentage of patients is that referred by corporations, the next largest percentage is free, but there is a considerable percentage, namely 25 and 23 per cent. respectively, who pay full or part cost for their services.

Since public health nurses are constantly trying to reach more groups in the community it is essential that they know whether it is exclusively the very poor with whom they are working or whether they are gradually adding a greater proportion of patients who are able to pay a part or all of the cost. Unless an account and tabulation is made of such payments there is no accurate way to determine this fact.

This study of the meagre amount of material available in public health nursing agencies again brings out the need of research as a part of the program in each organization. Until we know the simple facts of what constitutes the nursing load, the frequency of care to the various types of cases, and the outstanding results of such care, we can not plan intelligently for future development. Until some uniform method of interpreting and tabulating such results has been established we can not compare the work of any two organizations. Because the field of public health nursing is not crystallized and is feeling its way to newer developments, it is more important that its progress should be based on the facts of past and present experience.

It is true that research is expensive and that most organizations are unable to add any large item for such an expenditure. In fact, in none of the organizations studied is there a statistician or a registrar with adequate statistical training. In small organizations where it is impossible to employ a full time trained person for this purpose, a study of closed records may be made at intervals of two years or more. To prepare for this study, many of the outstanding facts from closed records can be routinely recorded by clerks. The possibility of saving unnecessary expenditure for the organization, of establishing new and time-saving devices as a result of study, of developing in a sound direction is often overlooked in considering this expense. The assembling and critical analysis of the work of a public health nursing agency should be as much a part of its administration as any other administrative function now commonly employed, and should be done periodically, at least quarterly.

The Content of the Visit

The discussion of any phase of public health nursing should center around the nursing visit. The main objective in visiting nursing is the family unit receiving nursing care and health instruction. To make the nursing visit of maximum value to the families visited is the purpose, therefore, for which visiting nurse organizations exist. The soundness of an agency's administration is evidenced in a study of the essentials of its visit content. Its cost, also, should be in proportion to the effectiveness with which the visiting nurse work is accomplished.

ESSENTIALS OF NURSES' TRAINING

In order to produce satisfactory public health nursing visits it is necessary that the nurse with a well organized agency should have adequate educational background; that she should be a graduate of a hospital training school of recognized standing, meeting at least the National Organization for Public Health Nursing standards*; that she should receive a careful introduction into the work of the

*These standards for membership were adopted by the National Organization as a minimum.

public health nursing organization in which she is to be employed, and if possible, that she should also have preliminary training in the agency or public health nursing courses outside of the agency; and that in her work in the agency she should have adequate supervision to insure uniformly good work.

ESSENTIALS OF VISIT CONTENT

The cardinal principle of visiting nursing which must permeate all consideration of the essentials of visit content is that family health work is the basis upon which all other factors rest. This means that the nurse who goes into a home must take responsibility for the health of all members of the family. She should not only give necessary nursing care and teach health and the correction of defects, but also carry out a constructive health plan for the family as advised by the physician in charge. With this to build upon, it is important that every visit should contain various other factors.

First among these is a good nursing technique and procedure in the actual care given the patient and in the use of the nursing bag and its contents.

Second, each visit should make use of every opportunity to teach. This teaching should include health teaching as well as instructions through demonstration to the family or friends regarding the home nursing of those who are ill.

Third, there should be an ability to detect serious problems, other than sickness, in the home situation and to take advantage of other resources in the community for handling and treating these difficulties. That is, there should be a nice balance between insight into difficult social situations and an understanding of how to care for them, when to refer them to other agencies, and to which agencies they should be referred.

Fourth, the spirit of the visit, which affects each factor, should include such qualities as the nurse's ability to make a good contact, sympathy, courtesy, adaptability to all individuals and situations.

Fifth, each visit should reflect the general policy of the organization in its acceptance of certain cases for care, and in the general procedure in relation to those cases, after acceptance.

It is to be expected, of course, that all of these factors cannot occur with uniformity of excellence in every community. The community which has many resources, for instance, will offer much more scope to the nurse in her referring of social problems than the locality which has no resources and in which the nurse herself must be responsible for many of the social adjustments of her patients. We must differentiate, therefore, between the community that has many social and health resources and the community which is doing the best it can with no resources. While an agency may be working toward a more or less standardized ideal, the real criterion of its effectiveness, other things being equal, is whether it is doing the thing that is essential and that counts, in that community.

HOW VISITS WERE STUDIED

In order to study what was actually being done in a number of centers, the two nurse investigators for the Committee to Study Visiting Nursing went into the district with several nurses in the organization which each investigator visited. For each visit with a nurse the investigator recorded on a schedule* exactly what the nurse did and how she did it. In addition, the schedule contained other important factors such as the number of previous visits, the diagnosis, the length of the visit, the nurse's approach to the patient, a comparison of what was done in a visit with the nurse's entry of the visit on the record, etc. Finally the investigator recorded what in her opinion, the nurse should have done that she did not do, and the additional time that would have been involved for this. From the study of these individual schedules it was hoped that the essentials of visit content as in actual practice might be determined.

So that there might be a uniform basis for determining what constituted good public health nursing, the two nurse investigators prepared a tentative nursing manual to serve as a guide. This manual was made up of sections from various well known manuals in use by a number of good public health nursing organizations. The manual was discussed and its use for this purpose agreed upon by a representative committee of nurses before the investigators started their work.

When the study was completed, an evaluation of these individual nursing schedules was made by a special committee of nurses, including the two nurse investigators. This evaluation was made in as uniform a way as possible, so that all of the schedules could be used in a complete picture of the nursing work being done in these 14 agencies. In evaluating these schedules the five factors previously mentioned were considered and each factor graded as good, fair or poor.

SPIRIT OF THE VISIT

It is of first importance to observe the relationship between these various factors. The factor which is outstanding for its excellence is the spirit of the visit. This might be illustrated by the bulk of the cases analyzed, for the uniformly good contacts, interest, adaptability, courtesy and loyalty in personal and professional relationships. It is interesting that in the two agencies where the spirit was poorest, the supervision also lacked the quality of leadership and vision which was found in certain other agencies.

In one instance the investigator commented on the hurried, rather abrupt approach of the nurse when she was visiting a foreign family. She was making arrangements with the husband to take his wife to a clinic, and was herself anxious to get back to the clinic. Because of her hurried manner, and her failure to explain carefully and simply just how to get there, the man failed to understand and did not bring his wife to the clinic. In another home the same nurse found a sick baby with a temperature of 104 degrees. In her haste to

*For nursing schedule, see Appendix.

return to the clinic, she first sent the father for castor oil to give the child, and as soon as he had left, realized that she should not have done this and hurriedly told the mother not to give the castor oil, but to get a physician. In her instructions to the parents she did not attempt to use simple, direct language, repeating her instructions. As a result, the parents felt dazed, did not understand, and the visit accomplished nothing.

Such instances as these were rare, however, and in general the nurse got hold of the home situation and adapted herself to it quickly, usually introducing the nurse investigator as a friend, a nurse from another city who wanted to find out what the visiting nurses were doing in another community, and then proceeding as if the investigator were not there. The nurse who did not ask to see the sick baby, because it had just gone to sleep after crying all night; the nurse who reassured and quieted the pregnant mother whose labor had been interrupted four days before; the nurse who entered a home for the first time after the patient had died and yet made the family feel grateful for her coming, rather than that the visit was an intrusion; all these are typical of the approach, the adaptability, the generally good spirit of the visit, which was found in most agencies.

NURSING TECHNIQUE

The factor which ranked next best to the spirit was the nursing technique, including the use of the bag and its contents, the actual care given the patient, demonstrations, etc. In all but four of the agencies, the bulk of the visits showed good or fair nursing technique with only occasional poor technique. It is probably true that nursing technique is on the whole, more satisfactory than the instructive side of a nursing visit or the general policy which controls the type of visit being made, because nursing technique is well standardized and the nurse who has completed her training in a good hospital has received a routine and satisfactory training in the methods of asepsis, the care of the patient, etc., which with proper introductory teaching, can be adapted to public health nursing.

Among the exceptions to good nursing technique were found a number of cases of communicable disease nursing which is, on the whole, less standardized than various other types of work in the field of public health nursing. It is interesting, however, that the poorest communicable disease technique occurred in an agency where this nursing is specialized, and unfortunately without anything more than the most nominal supervision. A typical example of the type of communicable disease nursing done in this community is shown by a visit to a five-year-old child with scarlet fever and diphtheria. There were 13 people living in four small rooms. The nurse had made six previous visits. On entering the home the nurse removed her hat and coat and put on her gown which was hanging on the door. The child was on a cot in a front room which one enters directly from the street. The nurse asked for a basin, towel and wash cloth which the mother brought in from the kitchen where the members of the family were constantly living. The nurse stripped the bed, bathed the child without changing the water, prepared a mouth wash and gave the child the bath basin to use in cleansing her mouth. When the patient's gown was changed, the mother took it and threw it into the kitchen behind the door. The investigator's comment on this visit was that no communicable disease routine was followed by the nurse except that she put on another gown. The whole house was contaminated, and the nurse's bag also was contaminated, for she put back in the bag a box of partially used cotton which had been lying on the table in the patient's room.

An illustration of very good nursing technique, on the other hand, was found in the visit to a Polish family where the mother had tuberculosis. Though for many months the family had an indifferent attitude toward the work of the visiting nurse, the mother now welcomes her and on the day of this visit greeted the nurse pleasantly in response to her sympathetic and friendly approach. The mother was bedridden and growing weaker, yet she had almost no care from the family. Once a week the nurse went into the home and made the mother comfortable, trying to instil in the family an interest in personal hygiene and proper care of the mother. On the day in question the nurse gave very thorough care including a complete bath and change of clothing. The bed was rearranged and changed; the bedside table was cleaned up and neatly arranged; piles of sweaters and coats found in the bed, as cushions, were taken out to air; the cuspidor was emptied and a paper bag and napkins substituted; half eaten particles of food were disposed of; the ventilation was attended to. The nurse was very careful to wash her hands thoroughly before handling the bag contents which were in no way contaminated. The nurse had orders from the doctor, and left a report for him on the bedside notes. In addition to the nursing care, the nurse instructed a daughter again in the proper disposal of sputum and in keeping the bedside table clean and in good order. When she removed the sweaters and coats from the patient's bed she showed the daughter how to air them. She again demonstrated how to make the bed comfortable without using personal clothing for pillows. Throughout the nurse showed an interest in good nursing technique under difficult circumstances and had a fine regard for the patient even though her patience and hard work for a long period of time was yielding only a grudging response from the rest of the family.

It would be misleading to give the impression that all acute communicable disease nursing was conducted in the same manner as the first illustration given above, for this is not the case. In a number of communities this type of nursing was done with the greatest skill and with great credit to the organization. In the communities where this phase of nursing is less good than the other nursing of the agency, it is probably due largely to the lack of additional standardization which is required for a satisfactory communicable disease routine, and back of this, of course, to inadequate supervision which should be responsible for setting up and maintaining such standards. It is also important to consider the lack of adequate teaching and experience in this type of work in many schools of nursing.

TEACHING IN EVERY VISIT

The instructive side of the nursing work, including health teaching, as well as instruction in home nursing and care of the sick, is much less satisfactory than the nursing procedure previously discussed. This is very largely due to the fact that there is little standardization of technique in teaching people how to protect their own health, the health of others and how to keep well. There is need of a definitely established technique in the instruction of the mother in the essentials of baby care, how to keep the pre-school child well, how to teach the tuberculous to protect themselves and others, etc. Until there is some method of giving nurses the facts which should be reviewed with the patient on every nursing visit, and additional facts for special types of visits, there will always be the wide variation which now exists in the effectiveness of instruction.

Here again, of course, the lack of supervision is also responsible for much of the poor teaching done in the home. In the following case, for instance, a supervisor visiting with the nurse, could have shown her a number of specific instances in which she failed to make use of an opportunity to teach. This nurse, who had been with the agency over two years, visited a home in which the two-year-old child had an old empyema and was under the doctor's care for possible tuberculosis. The home was clean, but very hot and stuffy, with no windows open. A nursing bottle partly filled with coffee was on the floor. The child had a slight temperature, but was running around the room, scarcely able to be up. Her abdomen was also very much distended. The nurse and the mother discussed the child's diet briefly, the nurse suggesting green vegetables and milk. The most important observation here would have been the connection between the possible tuberculous condition of the child and her distended abdomen. Then a careful survey with the mother of the child's health habits, including diet, would have brought out, among other things, the use of coffee. The investigator's comment was that the visit was superficial, the nurse missing an opportunity to emphasize the need of ventilation, the necessity for conserving the child's strength by keeping her in bed when her temperature was elevated, and most of all the importance of the child's diet.

Contrast this with a visit in another city where the nurse was interested in a baby a month old, being carried as an infant welfare case. The child's mother, unmarried, insisted upon going to work to support the family, and it was necessary, therefore, that the child's grandmother, a Spanish woman, be taught milk modification. On the day in question the grandmother had everything in readiness and prepared the formula with the nurse standing by to review it. The spoons, bottle, etc., were all being boiled in a big pan on the stove. The kitchen table had been scrubbed and covered with a clean, white cloth. The grandmother did not dry the utensils with a cloth, but allowed them to dry by heat. She measured out the materials and prepared the formula quickly and accurately. When the funnel dropped on the floor she re-boiled it before further use. The formula was placed in a quart bottle, and the nurse taught the grandmother how to keep it cool without ice, to shake the quart bottle well before filling the nursing bottle, and to heat the milk before feeding. While the work was quickly done, the nurse remained long enough to be sure the grandmother understood all the details. She was careful to praise her for her accurate and neat work, with the result that the grandmother was very proud of her accomplishment, and was eager to carry out every suggestion the nurse made.

Here the nurse had a very concrete piece of teaching based on a definite, standard plan of milk modification. If there were equally definite standards for instructing the mother in the general care of a child, for instance, the nurse would have a more tangible program to take hold of, and would make the instructive part of her work more effective.

GENERAL POLICY

The general policies of the organizations showed marked variations, and were, on the whole, the least satisfactory of the five factors considered. The actual care given on any case might have been excellent, but the judgment in accepting that case for care might have been poor, according to the best public health nursing policies, which were practicable in that community. It may have been that the nurse was continuing to make supervisory visits to a family when the illness was past, and when the family needed to be under the supervision of the family case work agency in the community. Again, in rare instances, we found a nurse caring for a patient without doctor's orders, or possibly when there was no doctor on the case. And most important of all, perhaps the nurse was nursing one sick patient in the family and ignoring a big family health problem.

An example of excellent nursing care, but poor policy, was shown in a visit to a woman of 77 years, bedridden with paralysis and old age. There had been 620 previous visits on this case. When the nurse first went to the home she found the patient dirty and wet, with large bedsores. The family had not been willingly neglectful, but did not know how to give care. The nurse has been going in daily, except Sundays, ever since. The bedsores are all healed and the patient's back is in good condition. The family were taught how to care for the patient and she is now always clean and dry. Nevertheless, the nurse goes in every day, giving a general or partial bath, rubbing her back, and with the aid of the patient's daughter, getting her up in a chair for 2 or 3 hours daily to relieve her back pressure. The investigator's comment on this case was that while the daily visits of the nurse had contributed much to the comfort of the patient and to the education of the family, the daily visit did not seem necessary. The care was so simple that the daughter could have done it easily, except to get the patient out of the bed into a chair, and a neighbor would have helped in doing this. If the nurse came in once a week to give thorough care it would seem to be sufficient, both to make the patient entirely comfortable and to oversee the type of care the daughter was giving. The policy of the agency in continuing with daily visits to chronic patients when there is available assistance within the family group, is poor both because of its effect on the family and because the nurse has other more urgent demands which she must neglect.

Examples of good procedure, developed as part of carefully thought-out policies, were numerous. For example, the nurse who used good, sound nursing technique in a maternity case, encouraging the mother to gradually care for herself after a few days of rest, and having the mother from the first observe the care of the baby, taking this over as soon as possible; the visit to a communicable disease case, which showed the excellent technique adopted by the agency and put into effect through good supervision; the prenatal visit which showed that regular visits had been made at stated intervals, that urinalysis and blood pressure, among other things, had been followed up, that careful instructions regarding diet, exercise, physical symptoms, plans for delivery, plans for the baby's supplies, etc., had been given; all these are typical of many of the good public health nursing procedures which were found to be in practice.

On the whole, it is apparent from this study that a number of agencies have not adopted definite policies regarding their methods of procedure in various types of cases. This less satisfactory phase of visiting nursing will undoubtedly be developed as greater attention is given to the necessity of having more uniform procedures in agencies, and of incorporating into the nurse's introduction to the field a demonstration of the procedures in all types of service.

The final essential of visit content which we shall note is that of the consideration given by the nurse to any social problem where that was evident.

SOCIAL PROBLEMS

From a study of the schedules, such a large percentage of cases was found where there was no evident social problem, that the results are not as representative as we should desire. In those cases, however, where there was an opportunity for the nurse investigator to observe the nurse's reaction to an obvious social situation, the results make a very satisfactory showing. That is, where there is an *obvious* social maladjustment, the nurse, in general, is shown to have handled it with a certain degree of skill. Where the social difficulty is not so obvious, however, the results might not have made so good a showing had there been a sufficient number of schedules in which to observe this. In those cases where the attention to the social problem is poor, the difficulty seems to be that there is no nice balance in the insight into and the handling of such a problem. The nurse was prone either to overlook a crying social need or to attempt to carry it alone without reference to other social resources. In order to correct this tendency which was found among a comparatively small group of cases, it is necessary that more training be given to nurses in the use of social resources, in standards of cooperation, and above all, in developing an interest in and an ability to detect and understand difficult social situations.

The following illustration is an example of how the nurse may fail to recognize the social significance of the situation with which she is working. This family had received 29 previous visits. The father had tuberculosis, the four children were being taken to the tuberculosis dispensary for a complete examination, the mother was not strong, but supported the family by sewing on coats at home. The mother was very cooperative and wished to carry out every suggestion the nurse made. At the time of this visit the mother was found sewing on coats in a room that was very warm and poorly ventilated. She said she was tired and had a headache. The nurse told her that it was necessary that she change her work, since this work was too strenuous and would cause her to break down. There was no further discussion of her employment. The nurse investigator commented that this eight-minute visit had left the mother looking helpless and hopeless. She was trained to do no other kind of work and she certainly could not give up what she was now doing until she had some very definite plan for other employment. A nurse who was more aware of the social implications involved in her advice would not have left a situation like this without discussing other plans for work or suggesting other individuals or agencies who could give advice and definite help in regard to work. As it was, she left the whole home situation in a worse state than she found it and accomplished little but to upset the tired mother and the tuberculous father.

A visit in another city, however, gives a very different picture of a similar situation. In this case, the mother of four small children was again pregnant and recovering from a seriously infected arm. A few days before, she had fallen from a ladder and since then had been in constant pain. The doctor had ordered complete rest in bed until all the pain had subsided. As a result of this the husband had been forced to stay at home and, of course, his wages stopped during this time. If he went to work it would mean that his wife would get up to look after the children. They finally decided to call in the visiting nurse whom they had known previously, and discuss the whole situation with her. Together, the man and wife and the nurse went over the man's earnings, the possibility of sending for relatives, the cost of a practical nurse in relation to the man's earnings, the possibility of hospital care involving placement of the children, etc. As a result of this discussion, which was skilfully handled by the nurse, the man decided to apply at the Nurse's Registry for one of two practical nurses whom both the family and the nurse knew. This visit was interesting as an evidence of the nurse's previous understanding of the home situation and her ability to help the family work out their problems. If she had been less skilful the man might have continued to stay at home, thereby losing his job and causing the family financial embarrassment, or he might have gone to work without making any other plan for his wife, and so jeopardized her health.

Again, we would urge the importance of having this phase of public health nursing emphasized in the training and supervision of nurses. The public health nurse's function is not only to care for the sick person and to plan a health program for all of his family group, but also to relate the teaching which goes into such a program, to the family situation as it exists. To make her work of practical value, therefore, the nurse must have insight into the situation with which she is working and adapt her plan to it. This involves a knowledge of other community resources, when to use them and which ones to use. It involves, also, an ability to detect and analyze the factors, other than health, in a home in order to determine how health instruction may be made most effective.

In summarizing the evaluation of visit content as observed in these 14 agencies, it is clear that the spirit of the visit, the contact and rapport between nurse and patient is excellent. The actual nursing technique, such as the care of the patient, the use of the nursing bag, or demonstrations of care to the other members of the families is also among the best of the factors involved in visit content. Somewhat less good than the nursing care is the health teaching which is an equally important phase of visit content, but one which has been less standardized, and is therefore less routinely a part of the nurse's training. The general policies which determine the acceptance and conduct of visits make the least good showing among the essentials of visit content, and this again, is due to the lack of formulation of policies in many agencies, the lack of adequate supervision and a resulting lack of discrimination and selection on the part of the nurse. The attention to social problems, while the number of cases is inadequate for definite conclusions, is suggestive as pointing to a need for more thorough training in the ability to detect social difficulties and in the knowledge of and technique involved in using other resourses. Throughout, in considering each of these factors, the need for better supervision is apparent. At this point we should also emphasize the need for cooperation between the nursing service and the physician. This is a basic relationship upon which the work of the nurse must rest, and every effort should be made to develop mutual understanding and cooperation.

RECORDS OF SERVICE RENDERED

It is particularly important to stress the fact that the nurse's recorded entry of the patient's condition and the nursing care given did not do justice to the actual accomplishment of the visit in the great bulk of the cases. As previously mentioned in an earlier section of the report, the nurse may give in one visit excellent nursing care, including careful instruction and demonstration; she may have an understanding of the social situation and help the family to make adjustments other than those related to health; and yet her entry on the record for that visit may be "June 17th. Patient about the same. Gave general care." The nurse investigators had an unusual opportunity to observe this situation, since in the 225 visits which they made with nurses in the various cities, they also obtained the entry made on the record by the nurse for each of those visits. Throughout, the same difficulty was found of recording inadequately the substance of what was accomplished during a visit. "General care" or "partial care" was used frequently to cover a variety of types of care. Usually no mention or very brief mention, was made of the careful instructions which had been given. Rarely was there any indication on the record that the nurse had been doing a piece of family health work, though the investigator had observed that this very fundamental part of public health nursing was being done. We have earlier discussed the necessity of greater emphasis on more accurate and thorough record writing, for the use of the nurse in the effective treatment of the patient and for the use of the supervisor in the effective supervision of the nursing work. We would again urge the importance of this in order that visiting nurse organizations may also know the actual content of their nursing work from the recorded observations of their nurses.

This does not mean to imply that an elaborate analysis of services rendered ought to go on record cards. There should be some provision, however, to cover the factors found in the patient's condition and in the care given, and the outstanding factors in the home situation, if these affect the health of the family. A very satisfactory check, or check and dash method is in use in many places for certain types of cases. Some such device which specifies for each visit the items which should be noted, and allows a space for checking each of these items takes very little of the nurse's time, insures a uniform recorded observation for each visit and furnishes comparable material for supervision and study of records.

NUMBER OF VISITS PER DAY

In connection with a discussion of the content of the nursing visit, it is important that the number of visits a day in the various agencies be considered. Whether there are few or many home visits in a day may depend upon the type of case under care, whether it requires educational health work or bedside nursing, the form of organization, the amount of travel time, outside activities, etc., or it may be determined by the thoroughness of care given at each visit. In Table XVII we find that, with the exception of Agency XII, the mean number of home visits a day* varies from 7.4 in Agency XI to 13.0 in Agency V. The number of visits, such as visits to the doctor, to relatives or to social agencies is very small, averaging only a small fraction of a visit per day, except in Agency XIV, a small village and rural area where many problems other than nursing are bound to occur in the day's routine.

*The information on which this is based was obtained from the daily report sheets kept by the nurses in each organization for a period of a week.

If we turn to the mean number of clinics, group conferences or classes for patients, per day, we find again that the number is small. In Table XVIII, however, the reason for this is obvious since the mean number of minutes per clinic for the total group of agencies is nearly two hours. That is, in the agency which spends approximately two hours and a half on a clinic, as with Agency III, and averages a little less than five clinics a week for each nurse, or about two hours per nurse per day, the number of home visits is bound to be small. Notice in Agency III, for example, that the mean number of daily home visits per nurse is 7.8, but that the mean number of minutes per visit is only 13.8. If we turn back to Table XI we find that the portion of the average day spent on home visits in Agency III is 22.2 per cent. as contrasted with a much higher percentage in practically all other agencies. That is, though the mean number of visits is almost eight per day, the character of the visits is largely supervisory, with little bedside nursing, resulting in a uniformly shorter visit.

DURATION OF VISITS

A similar situation is found in several of the other agencies where the duration of the nursing visit is very short. In Table XI the three agencies spending the largest percentage of the day on home visits, namely Agencies I, II and XIII, are found to spend the longest time on the home visits, with the exception of Agency XII. That is, it would appear that the agencies which concentrate on the home nursing part of their program, tend to increase the length of the home nursing visit. As the public health functions of visiting nurse organizations are increasingly developed, the nursing visit will also increase in length up to a certain point. There is a point above which a nurse cannot make more than a certain number of visits a day, each of these visits taking sufficient time to approach the family health situation with an eye alert to all health and obvious social problems. The number of visits a day will depend, of course, upon the community in which the nurse is working, the transportation facilities, the social and health resources available for

TABLE XVII—*Mean Number of Visits and Clinics per Day.*

(Agencies arranged in order of size of staff.)

TYPE OF VISIT	MEAN NUMBER OF VISITS AND CLINICS PER DAY BY AGENCIES														
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	Total
Home Visits	9.1	8.9	7.8	8.8	13.0	9.9	8.8	9.0	10.7	12.7	7.4	.9*	8.6	9.6	9.3
Other Visits	.2	...†	...	.1	...†	.4	.2	.1	.1	.1	.2	...	.2	.9	.1
Clinics, Group Conferences, etc.	...†	.1	.8	.1	.4	.2	.3	.4	.8	.2	.2	2.2	1.7	...	.3
Total Number of Visits	3,096	1,468	1,266	713	1,303	1,696	819	717	718	573	366	28	189	84	13036
Number of Full Time Daily Reports	332	163	147	80	97	162	90	75	62	44	47	9	18	8	1,334

*Agency XII will be eliminated from any discussion of this table, since during the week in which the 2 nurses filled in the daily report sheets, they were chiefly engaged in doing school nursing.

†Less than .05.

reference, etc. It is no more possible to prescribe the quantity of visits which nurses in different communities can make, than it is to determine what the cost of those visits should be, without studying each community. It is important, however, that those who are responsible for the work of a visiting nurse organization should appreciate that there is a limit to the number of thorough public health nursing visits a nurse can make in a day, and that a large number of visits a day is not necessarily a credit or a discredit to any nurse.

TABLE XVIII—*Mean Number of Minutes per Visit and Clinic.*

Agencies arranged in order of size of staff.

TYPE OF VISIT	MEAN NUMBER OF MINUTES PER VISIT AND CLINIC BY AGENCIES														
	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	XIII	XIV	Total
Home Visits	28.3	30.6	13.8	19.9	15.5	19.0	22.5	18.7	18.0	13.7	22.1	28.8	41.6	24.2	22.1
Other Visits	23.9	56.3	...	17.5	46.7	20.3	29.3	25.8	17.5	8.3	8.7	...	41.7	9.3	23.1
Clinics, Group Conferences, etc.	120.1	42.5	155.3	171.4	144.8	163.9	117.9	108.3	239.9	141.5	180.0	82.3	52.8	...	125.6
Total Number of Visits	3,096	1,468	1,266	713	1,303	1,696	819	717	718	573	366	28	189	84	13036
Number of Full Time Daily Reports	332	163	147	80	97	162	90	75	62	44	47	9	18	8	1,334

"BUDGETING" A NURSE'S DAY

In this connection, an interesting suggestion has been raised of "budgetting" a nurse's time through a study of the number of visits and length of time that goes into the various services. Through such a study it would be possible to determine what portion of a nurse's day goes into morbidity service, prenatal service, etc., and with this information to determine how the time of the organization should be distributed in relation to its intake. Is a nurse, for instance, who is carrying prenatal cases as one-fifth of her load, giving the proper proportion of her time to this part of her load, or do these cases always receive the time that is left over after the morbidity service is completed? Though such an application of proportionate time would need to be very flexible to meet such situations as epidemics or undue prevalence of sickness, it would, nevertheless, be well for every agency to so study its intake and the expenditure of time for these various services, that it would be possible to set up a tentative "budget" of the nurse's time.

From a survey of the nursing work being done in the 14 agencies studied, we would like to urge, again, greater emphasis on the public health aspect of the work with concentration on the family health problems and with particular emphasis on the need for more adequate supervision in order to accomplish this. The nursing technique, while it varies in different agencies, is uniformly satisfactory as compared with the less standardized processes involved in determining the family health situation, in the teaching of certain routine home nursing, in teaching all members of the family how to keep well, and in recognizing other situations than sickness which may, however, affect the health and well being of the whole group. Since this emphasis in visiting nursing is of recent development as compared with the emphasis on good nursing technique in the care of the sick, such a lack of balance is inevitable. It shows the goal, however, toward which public health nursing should aim in the future.

PART II

COMPUTATION OF COST

In the earlier part of this report it was brought out that coincident with the rapid development of public health nursing there are ever increasing difficulties involved in determining the cost of visiting nursing. As new functions are added to the organizations, as new methods of approaching old services are devised, the simple problem of computing the cost of a visit becomes more and more complex. Because of the variation in the methods of cost computation in the different agencies it is difficult to compare the cost of any two agencies.

At this point it is, again, important to stress the fact that in this report we are primarily interested in the cost of visiting nursing and not in the cost of the nurse's other activities such as the clinic, where a physician is in charge, giving medical diagnosis, treatment or advice. Visiting nursing will for the most part include the visit of the nurse to the patient's home, but it may also include the nurse's conference or class where she meets patients in groups or individually, for the purpose of giving the same kind of nursing advice or teaching that she would give in the homes. The value of a well balanced combination of the nurse's visits to the home and the occasional visit of the patient to the nurse's office either for individual or group conference has previously been stressed. At the outset, then, our problem becomes more complicated, for visiting nursing, strictly speaking, is no longer the *only* function of many public health nursing agencies.

This means that in order to study the factors involved in the cost of visiting nursing it is also necessary to survey the cost of other activities of public health nursing organizations so that the actual expenditures for visiting nursing may be separated from the expenditures for those activities not strictly within the field of visiting nursing.

Under the supervision of the Committee, a trained accountant examined the accounting methods in each of the 14 agencies. In some of these agencies there is little interest in cost, for the service to practically all patients is free. Other agencies are public and the interest centers on the total amount allowed for nursing service in the city's expenditures rather than on the cost of a unit of that service. In each instance, however, all available figures on the yearly expenditures and yearly output of work in terms of visits, hours, etc., were obtained.

A brief analysis of the outstanding methods of determining the cost of nursing time falls into three groups. In addition to this there are two agencies where no attempt is made to compute the cost of a unit of nursing time, for there are no patients who pay either full or part cost to the agencies.

METHODS OF COST COMPUTATION

In 10 of the 14 agencies studied some attempt is made to arrive at the cost of a nursing visit. The method varies considerably in the different agencies.

1. COST PER VISIT

In some instances the total expenditures of the agency for a year are divided by the total number of visits. In other agencies certain items are deducted from the total number of visits. Or possibly deductions from both factors are made for the same agency. This method of charging for the cost of a visit is probably the one most commonly employed by public health nursing agencies throughout the country. It offers the advantage of a simple concise measure of cost applicable to all types of visits, of varying lengths of time.

The second method of computing cost was found in only one center. The method is employed not only for the public health nursing agency studied, but

2. UNIT COST FOR EACH ITEM OF HEALTH WORK

for all public health work in the state in which this agency is located. This method is, briefly, to determine the unit cost for each item of health work, and to charge the cost equivalent of the various items monthly. The method of computing the cost per item was worked out in one of two ways:

(1) Based upon actual records. Where the State Board of Health had statements of the exact amount of money spent throughout the state for a sufficient period of time, for given items, the total expenditures were divided by the total items, resulting in the cost per item for that period. (2) Where no such classified figures were available, the nurses and doctors who were engaged in the work discussed what was the average time spent in doing a certain piece of work and then figured the cost of doing that piece of work by taking a proportionate share of that doctor's or nurse's salary. For instance, if it was estimated that it took 30 minutes to complete a certain type of visit and the nurse received 56 cents per hour, reducing her salary to an hourly basis, the unit cost for that type of visit was 28 cents. This computation was used only where there were no available records by which the cost of the items could be determined.

The third method found in one agency is the per capita cost, obtained by dividing the total expenditures by the total number of patients. From this

3. COST PER CAPITA

the average per capita cost is computed for the maternity service, service with children and service for adults other than maternity. Actually only one of these costs, that of maternity service, is used. That is, a fee is charged for maternity service as a whole, including prenatal care, care at delivery and ten days for postpartum care. In all other cases there is a sliding scale of fees for each visit based on the verified income of the head of the family. While the cost per patient, if this were divided into the various types of patients with consideration of the average number of visits and the average length of visit for each type, would be very helpful in analyzing the work of the agency, it can never be applied practically in charging cost to the patient. The obvious reason, of course, is the extreme deviation from the average, in the course and duration of various illnesses and the impossibility of charging, for instance, the same average cost of care to a pneumonia patient who may have died after two vists and to a pneumonia patient to whom many more than the average number of visits was made.

After a careful examination of the various methods of cost computation, this Committee recommends the use of the *visit* as the most satisfactory unit of cost at this time. The visit has the advantage of being the measure most commonly employed by visiting nurse agencies. It is readily accepted by all and is understood because of its conciseness and its common usage. In charging the patient, also, it is the most practicable method, and most easily administered. Furthermore, if accurately computed, it gives a true picture of cost to the organization.

COMMITTEE RECOMMENDATION OF UNIT OF COST

However, the present methods of computing the cost of a visit are quite different in each one of the agencies studied. This is due, partially, to the exclusion of certain items of expenditure in some centers and partially to the difference in interpretation of what constitutes a visit in the various agencies. That is, Agency X may include telephone calls, the supervisor's visit with the nurse, and other types of visits, thereby reducing the cost of a visit to a smaller amount than Agency Y, which may have the same expenditures, but interprets the visit only as a visit of the nurse to the patient's home or a visit in behalf of the patient.

For computing the cost of a visit, this Committee recommends that the procedure be to divide the total agency cost for visiting nursing as previously discussed, minus the expenditures later described under "Salaries," "Relief" and "Other Nursing Activities."* by the total number of visits made, including all visits to the patient or visits in behalf of the patient. In connection with the interpretation of what is a visit, it is important that we should review the previous discussion on this point which was based on the differences in interpreting a "visit" in the 14 agencies studied.

"In discussing what shall be called a visit, so far as cost computation is concerned, this Committee is agreed on the following procedure:

[1] A student's visit should be counted as a visit.

[2] A supervisor's visit to a home with a nurse should not be counted as a visit when the nurse's visit is counted.

[3] When nursing care is given to more than one in a family, each patient cared for should be counted as one visit.

[4] Telephone calls should not be counted as visits.

[5] Delivery nursing service should be counted in number of visits according to the average length of visit in that agency. That is, if the average length of visit in an agency is 45 minutes and the average delivery service is 3 hours, that service should be counted as the equivalent of 4 visits.†

*Pages 114 and 116 of this report.
†See page 112 of this report.

It should be mentioned at this point that before recommending the visit as the unit of cost, this Committee considered the advantages and disadvantages of the nursing hour as the unit of cost. The advantages of this method in accuracy and theoretical fairness to the patient, through equalizing the time distribution in cost, are unassailable. Its disadvantages as a practicable method at this time, however, seem to outweigh the one outstanding advantage of greater accuracy. From the patient's point of view, charging on the time basis puts a premium on quick work, and quick work easily degenerates into poor work. This danger applies more to educational work than to bedside nursing, because in educational work there are two factors involved, both of which imply a personal equation, *i.e.*, the nurse's ability and the receptivity of the patient. The experienced nurse learns to teach quickly. Younger nurses must learn this lesson. Shall the patient be charged more for the instruction of the younger nurse who is really less valuable to her? Shall the dull patient, who cannot grasp readily, be charged more than the quick patient on whom little time need be spent? Because of these personal differences in both nurses and patients it was felt that the application of this method to charging the patient would be a serious handicap in the present development of the fundamental principles of public health nursing. The greater expense of installing and operating such a system of determining and charging cost is also a factor of grave importance to most visiting nurse organizations.

CONSIDERATION OF HOME NURSING HOUR AS UNIT OF COST

The Committee is agreed, however, that it is desirable, wherever possible, for visiting nurse organizations to compute the cost of various services on the basis of the time consumed in rendering those services. This will be particularly important in adding new services, or in studying the unit cost of any particular service, such as delivery. That is, the most accurate way for an agency to determine the relative cost of various services, is to find out how much time is being spent on each service and apportion all expense accordingly.

From a study of the methods already in operation in 14 agencies and from discussion of other methods not found in any of these communities, this Committee has reached the following conclusions:

CONCLUSIONS RELATING TO COST

[1] Because of the extreme variation in the present methods of computing the cost of visiting nursing, it is not possible to compare the cost of the various agencies from the available material.

[2] Furthermore, it is impossible to actually determine the cost of visiting nursing of most of these agencies by a uniform method, until a method of computing cost has been adopted and put into effect for a sufficient period of time to give representative data.*

[3] Even if a uniform method of computing cost should be adopted by all agencies, costs would still vary markedly between communities,

*This is not true of a few of the agencies which could give, in a comparatively short period of time, cost figures based on the method recommended by this Committee.

because of the differences in type of work, territory covered, travel facilities, cost of living, which affects salaries, etc.

[4] The basis for computing the cost of a nursing service which this Committee recommends is the cost of a visit. This visit cost will be determined by dividing the total cost of the visiting nurse service, minus expenditures for activities not strictly within the field of visiting nursing,* by the total number of visits to the patient, and visits in behalf of the patient.

For the purpose of analyzing the unit cost of any particular service, however, or for determining the relative costs of various services, the Committee recommends that data should be used showing the amount of time spent on these various services.

Expenditures

It is necessary for each agency to examine its expenditures carefully before attempting to apply any method of cost computation. As previously indicated a number of public health nursing agencies do not confine their activities to strictly visiting nursing work, and this makes an analysis of expenditures essential in order to separate the expense which should be charged to this work. With the study of 14 public health nursing agencies as a basis, the Committee to Study Visiting Nursing recommends that the cost of visiting nursing should be interpreted as the true cost of conducting the work of visiting patients. The true cost will include two aspects of cost, the direct and indirect,† both of which are essential in carrying on visiting nursing. This will not necessarily be the same as the actual cash cost which may be reduced in some instances by special conditions. The Committee is agreed that gifts of necessary equipment, supplies, services or other items essential in the administration of a visiting nurse agency represent actual cost to the community and should, therefore, be interpreted as gifts given in lieu of money and should be charged to the true cost of the organization.

This expense, however, must relate to visiting nurse work, as generally recognized and previously described, and not to the allied nursing work, including the development of clinics, occupational therapy, etc., which are known to many public health nursing agencies. This shall include all expenses of administration, all field or nursing expense, all general running expenses and a pro-rated share on unusual expenses which are not entirely applicable to the current year.

Since, in analyzing methods of computing cost in these 14 agencies, it was found that a number of different methods are used which confuse cost finding, the Committee makes the following recommendations regarding expenditures which are handled differently in the different organizations. These recommendations are made with the full understanding that they do not begin to

*See "Salaries," page 114, and "Relief" and "Other Nursing Activities," page 116.

†Direct cost includes expenses directly related to field work, while indirect cost includes the expenses of administration.

cover all questions of detail which will arise, since so small a group of agencies was studied.

SALARIES

All salaries should be included in cost when the services for which the salaries are paid are essential to the nursing care and teaching of the patient and his family group. When the salary of a nurse or any other necessary staff member is paid by the city or by any public or private agency, that salary should be included in computing cost. If, however, all or a part of the nurse's time is given to some work not a part of visiting nursing as generally recognized, such as assisting a doctor in a clinic, that proportion of her salary, plus the proper pro rata of supervision and administration costs, should be excluded from the cost of visiting nursing.

VOLUNTEER SERVICE

When volunteer services are given, if these services are essential, have an established market value, and would have to be replaced by paid service, an item not to exceed two-thirds of their replacement cost should be included. It is recommended that one-third of the replacement cost be deducted because of the irregularity of service, and the time consumed in organizing and supervising such service.

Thus in Agency I, all of the bookkeeping and accounting is done by volunteer board members who have had the necessary training to do this work. Without this volunteer service the agency would be obliged to employ a full time bookkeeper at a current salary. The Committee is agreed that in such an instance two-thirds of the necessary salary should be included in cost.

STUDENTS

Whenever students, graduate or undergraduate, participate in the work of the organization, an estimate should be made of the number of staff nurses it would take to replace the services given by such students. An item equal to two-thirds of the salary of the staff nurses necessary to replace such students, minus the cost of student supervision, which is additional to the supervision of the regular staff nurse, should then be included in the cost. It is recommended that one-third of the replacement cost be deducted because of the large turnover of students, necessitating continued training and supervision; and also because of the additional indirect administrative expense.

TRAINING

The necessary preliminary training of new staff nurses for the positions they will fill in the agency should be included as a part of the legitimate cost of visiting nursing.

EDUCATION OF STAFF

As previously stated, the special classes which are essential to insure the satisfactory work of the nurse in her particular position in the agency are clearly a justifiable part of the work of the agency, and are, therefore, rightly chargeable to cost. This would include not only the special class in the introductory training period for new nurses on the staff, but also the special classes in the continuous staff educational program.

The additional courses which give a point of view on the social and health field and which are of general rather than specific educational value, should not be charged to the cost of a nursing service, since they do not contribute directly to the nursing work of the agency.

RENT

When quarters for visiting nurse work are given by the city or by an individual, an item which would cover the actual rent of those quarters should be included in cost when it is possible to determine that rent. If the quarters are not rentable, such as space given in public buildings, a rent item should be included for adequate space to house the work of the organization.

When the quarters occupied are owned by the organization, an item for rent should be included in the cost figures. This item should include interest on the original investment, interest on other capital expenditures which are additional to the cost of the building, cost of repairs, insurance premiums and taxes, pro rated according to usual accounting methods. From this total should be subtracted income derived from renting any portion of the building either for living quarters for nurses or office space for other activities. A useful check on this method would be to obtain a carefully appraised rental value from a real estate authority.

TRANSPORTATION

When carfare is donated to staff nurses by a street car company, for use in visiting nursing work, an item should be included under expenditures based on the actual amount such carfare would have cost in that community.

When an automobile is used for transportation, an item for yearly depreciation based on the life of the car, should be included. The actual expenditures for insurance, repairs and general running expenses should be included, and if any of these expenses are donated an item based on their cost value should be estimated and included in cost.

TELEPHONE

When telephone service is donated, or when the telephone contract allows a discount because of the nature of the organization, an item covering the current rate for telephone service should be included.

EQUIPMENT AND SUPPLIES

When necessary equipment* and furniture are purchased, an item should be included for depreciation on the purchase price. If these articles are donated, they should be properly valued and an item should be included for depreciation on the value set up. Insurance on equipment and furniture should be pro rated and included in cost.

Supplies† purchased for direct daily use should be included at cost price. When necessary, supplies for direct use are donated an item equal to their

*Articles of a fairly long life which do not need to be replaced for two years or more are considered equipment, such as furniture, typewriters, stethoscopes, etc.

†Supplies are those articles regularly used up and replaced within a short period of time, such as supplies for nurses' bags, gauze, dressings, etc., and all small accessories ordinarily called office supplies.

replacement value should be included. Supplies purchased for re-sale to either patients or nurses, however, should be excluded from cost, since the agency will be reimbursed for this expenditure by re-sale. But if refunds should be received for supplies not specifically purchased for re-sale, those refunds should be deducted from the actual cost of the supplies. That is, a patient may pay for certain supplies which the agency ordinarily expects to contribute. Where this is the case, the amount the patient has paid should be deducted from the original cost of the supplies.

RELIEF

All expenditures for material or medical relief to patients should be excluded. This should cover any contributions in money or kind to the regular family budget, and in addition any medical equipment such as braces, artificial limbs, etc.

UNIFORMS

When nurses' uniforms are supplied by the organization they should be considered as in lieu of nurses' salary and included in cost.

OTHER NURSING ACTIVITIES

Whenever medical clinics or other special nursing work not strictly within the field of visiting nursing are carried on by the agency, the entire cost of such work, including the proper pro rata of supervision and administration should be excluded from the cost of visiting nursing.

The same principle of exclusion should apply where milk stations for the sale of milk are conducted, or where formulæ are made and dispensed.

ANNUAL AUDIT

This Committee recommends that an annual audit of the books and accounts of every agency should be made by competent accountants, not so much for the detection or prevention of fraud or errors, as for the suggestions and advice to be expected from such a source, based upon a careful study of actual conditions.

Accounting for Public Health Nursing Organizations

Accounting for Public Health Nursing should be based on the principles governing accounting in general. Originally, one book was all that was used to record the transcations occurring in the operation of an enterprise. Subsequently, as business expanded and transactions increased, for convenience, this one book was split into a journal of original entry and a ledger wherein summaries of items of a similar nature appearing in the journal were grouped. These summaries are known as accounts. The journal, when required, may be further subdivided as described later in this system. The left-hand side of an account is called the debit side and the right is known as the credit side, and the items entered thereon are called debits or credits as the case may be. The total figures on the left or debit side, representing the aggregate of all the items must be exactly equal to the total figures representing the aggregate of all the figures appearing on the right or credit side. This fundamental idea is called the law of double entry. The introduction or transcribing of figures on the debit or credit side of an account or summary in the ledger from the journal, is called posting or making entries.

One of the rules of modern bookkeeping is that no ledger account entries shall be made, unless posted from a record performing the function of a journal. The Journal is known as a record of "original entry," and classifies all transactions into debits and credits and from it the debit and credit postings are made to the specified ledger accounts. The number of the Ledger page is shown on the Journal and the number of the Journal page is also shown on the Ledger, thus facilitating cross references.

During an accounting period, there will be a great many transactions to be recorded which are similar in nature, although not in amount. Even in a small organization there will be a great many debits and credits to the Cash Account during any one accounting period as there would also be many entries to various expense or income accounts. If there were forty debit and credit entries to cash scattered through the Journal, it would require that number of ledger postings.

To reduce the labor involved in posting, the Journal for convenience, is split into separate books of "original entry," each book recording one class of facts. A class which may readily be segregated are those transactions which refer to cash. In an organization of sufficient size it is desirable to have separate journals for cash receipts and cash disbursements, respectively. The books are known as a "Cash Receipt Book" and a "Cash Disbursement Book." In a small organization, it is satisfactory to combine the two into one journal known as a "Cash Book." There are other separate book developments of the Journal, one of which is known as the "Voucher Register." This book is a medium for the distribution of charges for the purchase of supplies, expenses and other items which are to be paid for at some future time.

"Assets" are defined as "the entire property of all sorts of a person, association or corporation applicable or subject to the payment of debts." "Liabilities" are the association's "pecuniary obligations or debts." The terms "Income" and "Expenses" are self explanatory. In the case of a Public Health Nursing organization assets would include: cash, supplies on hand, accounts receivable, securities owned, buildings and land, automobiles, furniture and equipment or any other tangible property. Liabilities would include: loans payable, accounts payable and fund liability accounts. There would also be accounts for "Reserve for Depreciation of Fixed Assets," excluding land, and "General Fund." The latter account represents the measure of the excess of assets over liabilities. The assets are debits or charges, and are entered on the left-hand side of the ledger account. The liabilities are credits and are entered on the right-hand side of the ledger account. Similarly expenses are debits and are entered on the left-hand side of the ledger account, while income items are credits and are entered on the right-hand side. These ledger accounts are defined as a "record of one or more items, relating to the same person or thing kept under an appropriate heading or title."

In the preceding paragraph we outlined the development of the "account" and the standard form of two-column, or debit and credit, ruling for a ledger account. This form is the one most frequently used for the General Ledger. The accounts receive many of their entries in lump sum totals representing monthly items of a similar nature, which have been grouped by a columnar development of the book of original entry. There are other accounts carried in the General Ledger which are not entered in special columns in the books of original entry. Accounts of this nature generally are not active, i.e. they receive very few postings throughout the entire year. The postings to the General Ledger accounts are made at the end of each month and involve a small percentage of the bookkeeper's time.

As previously pointed out, "in this report we are primarily interested in the cost of visiting nursing and not in the cost of nurses' other activities." The best possible system for any organization is one which furnishes the information required with the least possible effort and should be of sufficient flexibility to eliminate or add to wherever it is found necessary. Outlined in the following paragraphs, we present two systems of accounts based on the same principles. One is for the larger type of Public Health Nursing Organization and the other for the smaller type. The system to be used and the amount of detail will depend on the size of the organization. The income and expense accounts have been adopted from the classifications of the fourteen organizations examined as well as recommendations made by this Committee. In a preceding paragraph we spoke of a standard form of ruling for a ledger account most frequently used. It will be noticed that in the system for the larger organizations we have deviated from this standard ruling, and in order to effect a considerable saving of time in posting, have suggested columnar ruled ledger pages for the income and expense accounts.

When an organization has more than one station and wishes to know the cost of operating each station, this cost can be obtained by providing an account for each of the stations with column captions similar to those provided for "Visiting Nursing Expense Account." Similarly, if it is desired to know the cost of a nursing visit at each of the stations separate summaries (Forms 1 and 2) of nurses' and supervisors' visits and time can be compiled for each station. The distribution of nurses' and supervisors' salaries, as well as administrative expense, applicable to nursing, clinic, milk station or other activities will be on the basis of the nurses' and supervisors' time at each station directly applicable to each of the activities. The method for obtaining the cost per visit will be the same as explained for finding the cost per visit of the organization as a whole.

Provision has been made in the major accounting system for a distribution of expenses direct from the Cash Disbursement Book, as it was felt that this involved less work than the distribution from a Voucher Register and was the method used by the majority of the organizations examined. If, however, a Voucher Register is desired, it may be installed and a column added to the Cash Disbursement Book headed "Accounts Payable."

As the best system of accounts for any organization is one which furnishes the information required with the least effort, we have outlined in a subsequent section of this report, under the caption "System Suitable for a Small Organization," a one-book system of accounting.

It has been stated that one of the rules of modern bookkeeping is that no ledger entries shall be made, unless posted from a record, performing the function of a journal. We have also outlined the standard form of ruling most frequently used for ledger accounts, as well as a columnar ledger account form. In the one book system, we have combined in one, a record functioning as a book of original entry and a ledger, at the same time retaining all the necessary principles of double entry bookkeeping and reverting to the original method of keeping records outline in the first paragraph. For organizations with financial transactions of limited scope a one-book system is a time and labor saver and frequently answers every purpose.

The following systems, as outlined, are not devised to meet the requirements of any individual case, but are sufficiently flexible to meet any changes that are found necessary to bring out certain financial facts or information which might be required.

Description of Accounting Forms:

VISIT AND TIME RECORD. Form 1

The information recorded on this form will be obtained from the nurses' "Daily Report."

A separate sheet will be used to record the visits and time of each nurse. The number of visits to patients as shown by the daily reports will be posted in the respective distribution columns of the Visit and Time Record. (Form 1.) The total number of visits will be extended to the column "Total Visits." The sum total of the visits posted to the distribution columns should equal the total number of visits posted in the "Total Visits" column. The total hours consumed in visiting patients will be posted in the "Total Visiting Hours" column. The distribution of time spent for "Group Meetings with Patients," "Other Services for Patients," "Travel," "Assigned Duties of Indirect Value to Patients," and "Visiting Nursing Supervision" will be posted to the columns provided. The sum total of the time entered in the last mentioned columns plus the time entered in the "Visiting Hours" column will be posted to the "Visiting Nursing Hours" column. Nurses' time spent at Clinics, and Milk Stations will be posted to the columns provided. The sum of the "Visiting Nursing Hours," "Clinics Hours" and "Milk Station Hours" columns should equal the total time entered in the "Total Hours" column. The number of calls made by patients at the clinics and the number of persons calling at milk stations should be entered in the columns provided for that purpose.

At the close of the month, all the columns will be totaled. A proof of the accuracy of the work will be secured by following the procedure of proving the daily entries as described in the preceding paragraph.

When Form 2 is used for recording supervisors' time, Form 1 will be prepared to record the visits of each supervisor. In addition to recording the time spent by the supervisors in actual nursing, this form will be used in place of Form 2, whenever it is practicable to do so, for recording of all the time of the supervisors. Form 2 is merely suggested as an expedient for those who consider Form 1 too elaborate for recording of supervisors' activities. The total time spent in the field for supervision will be posted to the column under the caption, "Visiting Nursing Supervision." The method of posting, totaling and proving will be the same as described for the recording of staff nurses' visits and time.

When student nurses participate in the work of the organization a separate sheet will be made for each student nurse of the number of visits made and the total time consumed thereon during the month. After all postings are made, the various columns will be totaled and balanced as aforementioned.

At the close of the month, this form will also be used to compile separate summaries to arrive at the monthly totals of visits and time of all supervisors, nurses and student nurses. The names of the nurses and supervisors will be written in the wide column following the date column. The totals as shown by the various distribution and total columns of the supervisors' and nurses' sheets, will be posted to the respective columns of the summary sheets opposite the nurses' or supervisors' names. Upon the completion of the posting, the sheets will be totaled and proved as described for the proving of the daily postings to the individual records.

The respective summaries of supervisors' and nurses' time charged to "Visiting Nursing Hours," "Special Activities—Clinics, Milk Stations and Others," columns will be the basis for the distribution of the respective total amounts of the nurses' and supervisors' salaries, charged to "Visiting Nursing Expense Account."

Explanation of Columns:

1. Visits to Patients.

In this classification will be included all visits where the patient is actually seen and the purpose of the visit attempted, whether the purpose of that visit be to give actual nursing care, instruction, or advice essential to the adequate care of that type of patient. These visits will be further classified as

(a) **Acute Medical Nursing.**

This will include such patients as those with typhoid, acute rheumatism, acute cardiac or nephritic condition, pneumonia, cerebral hemorrhage, etc.

(b) **Acute Communicable Disease Nursing.**

This will include care of patients with measles, scarlet fever, diphtheria, whooping-cough, etc.

(c) **Acute Surgical Nursing.**

This would include care of post-operative patients, as well as assistance at minor surgical operations and care of accidents and injuries.

(d) **Chronic Nursing.**

Form 1

VISIT AND TIME RECORD

Station ____________________
Name ____________________
Month ____________________

DATE	VISITS TO PATIENTS — ACUTE — MEDICAL	ACUTE — COMMUNICABLE	ACUTE — SURGICAL	CHRONIC	MATERNITY — PRENATAL	MATERNITY — DELIVERY	MATERNITY — POST PARTUM	MATERNITY — NEW BORN	WELFARE — INFANT	WELFARE — CHILD	WELFARE — SCHOOL	VENEREAL	T.B.	PATIENTS NOT SEEN	VISITS ON BEHALF OF PATIENTS	TOTAL VISITS	VISITING HOURS	GROUP MEETINGS WITH PATIENTS — HOURS	GROUP MEETINGS WITH PATIENTS — PATIENTS	OTHER SERVICES ~~FOR~~ PATIENTS on behalf of — HOURS	OTHER SERVICES ~~FOR~~ PATIENTS on behalf of — PATIENTS	TRAVEL — HOURS	ASSIGNED DUTIES — HOURS	VISITING NURSING SUPERVIS. — HOURS	VISITING NURSING — HOURS	SPECIAL ACTIVITIES — CLINICS — HOURS	CLINICS — PATIENTS	MILK STATIONS — HOURS	MILK STATIONS — PATIENTS	OTHER — HOURS	OTHER — PATIENTS					TOTAL HOURS
1																																				
2																																				
3																																				
4																																				
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TOTALS																																				

(e) **Maternity Nursing.**

This would have to be further divided into pre-natal nursing, assistance at delivery, post-partum nursing, newborn care (which means the care of the baby for the first month.)

(f) **Infant Welfare Nursing.**

(g) **Child Welfare Nursing.**

(h) **School Nursing.**

(i) **Venereal Disease Nursing.**

(j) **Tuberculosis Nursing.**

2. **Visits in Which the Patient is Not Seen.**

Under this heading are included all visits where the patient is not seen, whether because the patient was not found at the address given, had moved, was out, or refused care.

3. **Visits in Behalf of Patients.**

In this classification are included all visits which the nurse may make in behalf of an individual patient, whether those visits be to a doctor's office, a hospital, an employer, a social agency, or other organization.

4. **Group Meetings With Patients.**

In this classification would be included conferences or classes with patients or the mothers of patients.

5. **Other Services in Behalf of Patients.**

Records, telephone calls, correspondence, etc.

6. **Time Spent in Travel.**

7. **Assigned Duties of Indirect Value to Patients.**

Under this heading would be included all time spent in preparing reports and speeches; also time spent in staff conferences, district meetings and other staff education.

8. **Special Activities.**

Under this would come:

(a) **Clinics.**

(b) **Milk Stations.**

(c) **Other Miscellaneous Activities.**

Whenever it is *not practicable* to use Form 1 for recording all of the Supervisors' time, Form 2 will be used. A separate sheet will be used for each supervisor. The distribution of time on duty as shown by the Supervisors' Daily Reports will be posted to the respective distribution columns of Form 2. The total time will be entered in the total column. The sum total of the time posted to the following distribution columns will be entered in the "Total Visiting Nursing Hours" column, "Visiting Nursing," "Group Meetings with Patients," "Other Services for Patients," "Travel," "Assigned Duties," and "Visiting Nursing Supervision." The total time for the month posted to "Visiting Nursing Hours" should be in agreement with the time entered on Form 1 under the caption "Visiting Hours" for the respective

SUPERVISORS' MONTHLY TIME RECORD.
Form 2

supervisors. The sum total of the time posted to "Total Visiting Nursing Hours" "Supervision—Clinics and Milk Station" columns should equal the total time entered in the total hours column.

At the close of the month all the columns will be totaled. A proof of the accuracy of the work will be secured by following the procedure of proving the daily entries as described in the previous paragraph.

At the close of the month, this form will be used to summarize the totals as shown by the individual monthly records to arrive at the total monthly time of all supervisors. The procedure of totaling and balancing will be the same as described for the supervisors' individual monthly records.

The summary of supervisors' time as charged to "Total Visiting Nursing Hours," "Supervision—Clinics and Milk Stations" columns will be the basis for the distribution of the total amount of supervisors' salaries charged to "Visiting Nursing Expense Account."

DISBURSEMENT VOUCHER. Form 3

This form will be attached to all purchase and expense invoices. The form provides for recording the number of the voucher, name of creditor, date, amount and classification of the items contained in the invoices attached and also for information as to payment—date, check number, approval, etc.

The total of the amount paid will be entered in the total cash disbursement column of the Cash Disbursement Book and the detail entered in the proper distribution column or columns as shown by the "Account To Be Charged" column on the voucher.

The voucher will be numbered at time of entry in the Cash Disbursement book, and initialed in the space provided. The invoice will be examined as to its correctness and so marked and will also be approved by the proper authority.

PETTY CASH EXPENSE VOUCHER. Form 4

This form will be used as an authorization for disbursements made from Petty Cash, and at the close of the week will be entered on the Petty Cash Disbursement Summary—Form 5.

PETTY CASH DISBURSEMENT SUMMARY. Form 5

This form will be made up by the departments and stations weekly, or any part thereof necessary to complete a month. The Petty Cash Expense Vouchers (Form 4) will be entered on Form 5 and at the close of the week, the columns will be totaled. The sum total of the distribution columns should equal the sum total of the total column. Upon being approved, the supporting vouchers will be attached and forwarded to the Administrative Department for reimbursement. The cash on hand, plus the total amount disbursed, as shown by Form 5, should equal the required amount of the fund provided.

PAY ROLL. Form 6

This form can be made up to cover all of the departments and stations or a separate form made for each department and station.

Form (7)

CASH DISBURSEMENTS BOOK

					ADMINISTRATIVE EXPENSE								VISITING NURSING EXPENSE											SPECIAL ACTIVITIES									GENERAL								
DATE	NAME AND DESCRIPTION	VOUCHER NO.	CHECK NO.	TOTAL DISBURSEMENTS	SALARIES		TELEPHONE & TELEGRAPH	OFF. SUPPL. AND STATIONARY	GENERAL EXPENSE	BUILDING OPERATING EXPENSE	SUNDRY		SALARIES				AUTO OPERATING EXPENSE	CARFARE & AUTO HIRE	RENT OF STATION	LAUNDRY	TELEPHONE	SUNDRY		CLINIC			MILK STATIONS				OTHER		INVENTORY	SUPPLIES ACCTS.		SUNDRY					
					SUPT. & ASST. SUP.	SECRETARIAL & CLERICAL					NAME OF ACCOUNT	AMOUNT	SUPERVISORS	STAFF NURSES	NURSE ASSTS.							NAME OF ACCT.	AMOUNT.	SALARIES	SUNDRY		SALARIES	MILK ICE	SUNDRY		NAME OF ACCOUNT	AMOUNT	MEDICAL ETC.	OTHER SUPPLIES		NAME OF ACCT.	AMOUNT				
																									NAME OF ACCOUNT	AMOUNT			NAME OF ACCOUNT	AMOUNT				ACCOUNT	AMOUNT						

Form (8)

STATION CASH RECEIPT RECORD

*STATION*____________

TOTAL AMOUNTS $________ *NAME OF BANK OR RECIPIENT*____________ *SIGNED*____________

DATE	NURSE	TOTAL	FEES				SALES					
							MILK	SUPPLIES				
	TOTAL											

Form (9)

CASH RECEIPT BOOK

DATE	NAME & DESCRIPTION	TOTAL RECEIPTS	BANK DEPOSITS	ACCT'S REC.	FEES				CONTRIBUTIONS		MEMBER DUES		APPROPRIATIONS	REFUNDS			INCOME FROM INVESTMENTS	SUNDRY	
					GENERAL	CORP.			GEN'L.	ASSOC.				SUPPLIES MEDICAL	SUNDRY			ACCOUNT	AMT.
															ACCOUNT	AMOUNT			

Explanation of columns:

The "Name," "Title of Position" and "Rate" columns are self explanatory.

"Check" number and "Amount." These columns provide for the numbers and amounts of the checks drawn for each name on the payroll.

"Account To Be Charged." In entering the names on the payroll they will be grouped to arrive at the totals to be charged to the various salary accounts. That is, all secretarial and clerical salaries should be grouped and the total carried to the last column. The totals of the two amount columns should be in agreement.

Disbursement Voucher (Form 3) will be made up and attached. The amount of the voucher will be the total amount of the payroll.

CASH DISBURSEMENT BOOK
Form 7

All disbursements will be made by check and entered consecutively as to voucher number and check number. When a voucher covers more than one check, such as payroll vouchers, the check numbers will be entered showing the first and last numbers; *viz.* 1 to 25. The total amount will be entered in the total disbursement column and extended to the distribution column or columns affected. At the close of the month, the columns will be totaled. The sum total of the distribution columns should equal the sum total of the "Total Disbursement" column.

The totals of the various columns will be posted to the respective accounts in the general ledger. The various sundry columns should be summarized and posted to the general ledger accounts affected.

ADMINISTRATIVE EXPENSE

Disbursements pertaining to the Administrative Department will be entered in these columns.

A sundry column is provided to record disbursements for which there would be only a few entries per month. The items in this column will be summarized at the close of the month as to the accounts affected, to facilitate the posting of same.

VISITING NURSING EXPENSE

Disbursements pertaining to visiting nursing will be entered in these columns.

SPECIAL ACTIVITIES—CLINICS, MILK STATIONS

All expenses which can be directly allocated to this class of work will be entered in these columns. The "Salaries" column is provided to record salaries of special workers which can be directly applied.

GENERAL

Enter in these columns disbursements made for the purchase of equipment, supplies to be inventoried, prepaid insurance, or other expenses to be prorated and miscellaneous items, not otherwise provided for.

CASH DISBURSEMENT BOOK.
Form 7

When payments are made in total and are chargeable to more than one department the pro-rating should be made to the expense distribution columns of the respective departments through the Cash Disbursement Book whenever it is possible to do so. One item of this nature would be rent, which would be prorated on floor space.

STATION CASH RECEIPTS
Form 8

This form will be made up weekly or any part thereof necessary to complete a month. It will record cash receipts at the stations and will be made up in duplicate. The original will be forwarded to the Administrative Office and the duplicate filed at the station. As the cash is received, it will be entered in the total column and extended to the distribution columns affected. At the close of the week, or part thereof, necessary to complete a month, all of the columns will be totaled. The sum total of the distribution columns should equal the sum total of the total column. After being signed, the original and duplicate will be forwarded with the cash to the administrative office, where the duplicate will be signed as a receipt for the cash received and returned to the station to be filed. The cash received will be entered in the Administrative Office cash receipt book, the total being entered in the total receipt column and distributed to the various columns affected.

CASH RECEIPTS BOOK.
Form 9

All cash received will be entered in the Cash Receipts' Book and all receipts deposited in the bank. The total amount received will be entered in the "Total Receipts" column and extended to the distribution columns affected. Whenever a deposit is made the amount deposited will be entered in the column under the caption "Bank Deposits." At the close of the month, the columns will be totaled. The sum total of the distribution columns should be in agreement with the sum total of the "Total Receipts" column. The total amount deposited in the bank should equal the total receipts for the month.

The totals of the various columns will be posted to the respective accounts in the general ledger. The "Sundry Refunds" and "Sundry Accounts" columns will be summarized and posted to the accounts affected in the General Ledger.

COLUMNAR LEDGER ACCOUNT
Form 10

This form will be used as a ledger account and will be the same size as ledger Form 11. By using short sheets, any number of distribution columns can be provided. For the method of posting and operation of these forms, see the explanations appended to the accounts for which this form will be used.

LEDGER ACCOUNT.
Form 11

This form will be used when it is not practicable to use Form 10. The sizes of Form 10 and Form 11 will be the same and both should be filed in one binder.

RECORD OF SUPPLIES.
Form 12

This will be a card record and will show the detail of the various supplies on hand. A separate card will be used for each article. The cards will be grouped as to the kind of supplies, *i.e.*, medical, etc., uniform material or any other group for which a separate control account is kept in the General Ledger.

"*Receipts.*" Upon receipt of the supplies, the date and quantity will be entered. When the invoices are received, the unit prices and total values will

LEDGER ACCOUNT

Form 10

BUILDING OPERATING EXPENSE

DATE	REF.	WAGES	LIGHT & HEAT	INSURANCE	REPAIRS	HOUSE SUPPLIES	WATER RATES	INTEREST ON CAPITAL INVESTED	DEPRECIATION					REFUNDS RENT CR.					TOTAL	
																			DR. EXPENSE	CR. REFUNDS

LEDGER ACCOUNT

Form 10

ADMINISTRATIVE EXPENSE

DATE	REF.	SALARIES					RENT	TELEPHONE	OFFICE SUP. & STATIONERY	POSTAGE	CARFARE & TRANSPORTATION	INSURANCE	GENERAL EXPENSE	PUBLICITY	DEPRECIATION OFFICE FURN AND EQUIPMENT	REPAIRS REPLACEMENTS LOAN CLOSET SUP'S.	MEDICAL AND MATERIAL RELIEF		TOTAL	
		SUPT. AND ASST. SUP'T.	SECRETARIAL CLERICAL																DR. EXPENSE	CR. REFUNDS

LEDGER ACCOUNT

Form 10

VISITING NURSING EXPENSE ACCOUNT

DATE	REF.	SALARIES					RENT	TELEPHONE	OFFICE SUP. & STATIONARY	AUTO OPER. EXPENSE	CARFARE AUTO HIRE	LAUNDRY	SUPPLIES CHEM.-DRUG MED. SURG.	REPAIRS REPLACEMENT UNIFORMS & EQUIPMENT	DEPRECIATION				TOTAL	
		SUPER-VISORS	STAFF NURSES	STUDENT NURSES															DR. EXPENSE	CR. REFUNDS

LEDGER ACCO

BUILDING OPERATING

REPAIRS	HOUSE SUPPLIES	WATER RATES	INTEREST ON CAPITAL INVESTED	DEPRECIATION

LEDGER ACCO

ADMINISTRATIVE

SALARIES		RENT	TELEPHONE	OFFICE SUP & STATIONERY	FU
SECRETARIAL CLERICAL	SUPT. AND ASST. SUPT.				

LEDGER ACCO

VISITING NURSING EXP

STUD NURS	STAFF NURSES	SUPER-VISORS	RENT	TELEPHONE	OFFICE SUP & STATIONARY	AUTO EXP

Form 10

LEDGER ACCOUNT

SPECIAL ACTIVITIES – CLINICS EXPENSE ACCOUNT

DATE		REF.	SALARIES					RENT	TELEPHONE	OFF. SUP. AND STATIONERY	LAUNDRY	MEDICAL SUPPLIES	REPAIRS REPLACEMENTS UNIFORMS & EQUIP.	DEPRECIATION.						TOTAL	
			SUPERVISORS	STAFF NURSES	NURSE ASSTS.															DR. EXPENSE	CR. REFUNDS

Form 10

LEDGER ACCOUNT

SPECIAL ACTIVITIES – MILK STATION EXPENSE

DATE		REF.	SALARIES					RENT	TELEPHONE	OFF. SUP. AND STATIONERY	LAUNDRY	SUPPLIES	MILK	ICE	REPAIRS REPLACEMENTS UNIFORMS & EQUIP.	DEPRECIATION				TOTAL	
			SUPERVISORS	STAFF NURSES	NURSE ASSTS															DR. EXPENSE	CR. REFUNDS

Form 10

LEDGER ACCOUNT

INCOME ACCOUNT

DATE		REF.	FEES				CONTRIBUTIONS						APPROPRIATIONS				INCOME FROM INVESTMENTS	INTEREST ON BANK DEPOSITS	DUES MEMBERSHIP	TOTAL	
			GENERAL	CORPORATION			GENERAL	ASSOCIATION	SERVICES	EQUIPMENT	SUPPLIES		CITY	COUNTY	STATE					DR. REFUNDS	CR. REVENUE

Form E20

SPECIAL ACTIVITIES

SALARIES		REF.		RENT	DATE
STA... NURS...	SUPERVISORS				

Form E20

SPECIAL ACTIVITIE...

SALARIES		REF.		RENT	DATE
STA... NURS...	SUPERVISORS				

Form E20

INCO...

FEES		REF.			CONTRIB...
CORPOR...	GENERAL		GENERAL	ASSOCIATION	DATE SERVIC...

Form 14

SUMMARY OF REQUISITIONS OF SUPPLIES

Month ____________
Station ____________
Activity ____________

ARTICLE & QUANTITY	ARTICLE & QUANTITY	ARTICLE & QUANTITY	ARTICLE & QUANTITY	ARTICLE & QUANTITY	ARTICLE & QUANTITY	ARTICLE & QUANTITY	ARTICLE & QUANTITY	RECAPITULATION			
								ARTICLE	QUANTITY	PRICE	AMOUNT

Form 15

SECURITY RECORD AND INTEREST TICKLER

Name of Fund ____________ Security ____________	PAR VALUE	BOOK VALUE	REMARKS	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL INT.

Form 16

BUDGET COMPARISON FOR YEAR ENDED ____________

ITEM	BUDGET ESTIMATE		ACTUAL																						COMPARISON OF ACTUAL WITH BUDGET ESTIMATE	
	12 MONTHS	1 MONTH	JAN.	FEB.	2 MONTHS ACCUMULATED	MAR.	3 MONTHS ACCUMULATED	APR.	4 MONTHS ACCUMULATED	MAY	5 MONTHS ACCUMULATED	JUNE	6 MONTHS ACCUMULATED	JULY	7 MONTHS ACCUMULATED	AUG.	8 MONTHS ACCUMULATED	SEPT.	9 MONTHS ACCUMULATED	OCT.	10 MONTHS ACCUMULATED	NOV.	11 MONTHS ACCUMULATED	DEC.	OVER	UNDER
TOTALS																										

be entered. Freight and cartage, if any, will be charged against the articles affected, and entered on the respective cards.

"*Issued.*" At the close of the month, the total issues for each article, as shown by the grand "Summary of Requisitions for Supplies," will be posted to the respective cards. The unit price to be used in valuing materials issued will be found by dividing the quantity into the invoice value, plus freight and cartage.

"*Balances.*" The difference between the quantity receipts and quantity issues should be in agreement with the actual count of the articles on hand. The sum total of the values as shown by the cards for each group should be in agreement with the respective control accounts in the General Ledger.

REQUISITION FOR SUPPLIES. Form 13

This form will be made out to record supplies taken from the storeroom for use. Upon the delivery of the supplies, the requisition will be signed by the recipient. The requisition will then be filed according to the activity expense account for which the supplies are to be used, *i.e.*, "Visiting Nursing Expense," "Clinic Expense," and "Milk Stations," awaiting the close of the month to be entered on the Summary of Requisitions for Supplies (Form 14).

SUMMARY OF REQUISITIONS FOR SUPPLIES. Form 14

At the close of the month, the requisitions will be summarized on this form as to quantity. A separate summary will be made for each activity. The captions of the columns will show the name of the articles. The supplies taken from stores during the month as shown by the requisitions, will be entered in the columns affected, *viz.:*

Gauze	Cotton, etc.
5	6
10	3

When the requisitions are entered on the summary, a check mark will be made in the block provided—"Entered Summary." When all the requisitions are entered, the columns will be totaled and entered in the "Recapitulation," "Quantity" column. The unit prices will be obtained from the "Record of Supplies" cards (Form 12) and inserted in the price column opposite the respective articles. The amounts of the various articles will be extended. When all extensions are made, the amount column will be totaled. These sheets will show the value of the supplies used by the respective activities and will be the basis for a journal entry to be made each month charging "Supplies Used" in the following accounts: "Visiting Nursing Expense," "Clinic Expense," "Milk Station Expense," etc. A credit will be made for the total amount to the "Supplies' Inventory" ledger control accounts. The total issues for each article as shown by the grand summary will be posted to the respective record cards of Supplies, Form 12.

An alternative method for charging supplies would be the plan suggested for Replacements and Repairs of Nurses' Uniforms and Equipment, *i.e.*, *charge* an inventory account for the purchases of supplies and *credit* with an estimated amount monthly and *charge* the expense accounts affected.

This book will show the detail of securities held in safekeeping for the respective endowment or special funds, and the amount of interest receivable by months on bonds. The name of the fund will be shown in the first column and directly under will be listed the names of securities held for the fund. The par values and book values will be shown in the respective columns. The total book values for all the securities of each fund should be in agreement with the respective balances of the various fund investment accounts as shown by the General Ledger.

SECURITY RECORD AND INTEREST INCOME TICKLER
Form 15

BUDGET COMPARISON.
Form 16

This form will be used for comparison of actual expenses with estimated budget expenses.

The captions of the items of expense will be listed down the extreme left-hand column. At the beginning of the year, the total estimated amount for each item will be entered under the caption "Budget Estimate 12 Months." Each one of these amounts divided by twelve, will give the estimated expense applicable to one month. The actual expenses applicable to each month will be entered in the column of the month affected. The expenses will be accumulated by months and the accumulated amounts entered in the columns of the months affected. To compare the accumulated actual expenses for a certain number of months with the accumulated estimate applicable to the corresponding period, the figures for the latter will be computed by multiplying the amounts shown in the one month estimate column by the accumulated number of months to be compared. The final three columns are self explanatory.

MEMBERSHIP DUES RECORD.
Forms 17, 17A

When one of the sources of revenue of an organization is membership dues, a card form similar to either of Forms 17 or 17-A should be used to record the necessary information for the collection of dues.

JOURNAL.
Form 18

This form of ruled journal will be used for adjusting entries, distribution of expense entries, and closing entries. Detailed explanations should be given for all entries.

At the close of each month, the total amounts of the various columns as shown by the "Administrative Expense Account" will be entered opposite the respective items on this form. (In another section of this report the Committee has recommended that medical and material relief and certain other items shall be excluded from expenses in determining the cost per visit.) These items will be deducted before distributing the total administrative expense to the various activities.

STATEMENT OF ADMINISTRATIVE EXPENSES AND DISTRIBUTION TO ORGANIZATION ACTIVITIES.
Form 19

Form (19)

STATEMENT OF ADMINISTRATIVE EXPENSES AND DISTRIBUTION TO ORGANIZATION ACTIVITIES

ADMINISTRATIVE EXPENSE ITEM.	JANUARY	FEBRUARY	TWO MONTHS ACCUMULATED	MARCH	THREE MONTHS ACCUMULATED	APRIL	FOUR MONTHS ACCUMULATED	MAY	FIVE MONTHS ACCUMULATED	JUNE	SIX MONTHS ACCUMULATED	JULY	SEVEN MONTHS ACCUMULATED
TOTAL ADM. EXPENSE													
LESS ITEMS NOT APPLICABLE													
TO ORGANIZATION ACTIVITIES													
REPAIRS AND REPLACEMENTS													
LOAN CLOSET SUPPLIES													
MATERIAL-MEDICAL RELIEF													
Total Deductions													
TOTAL OF ADM. EXPENSE													
APPLICABLE TO ORG. ACTIVITIES													

DISTRIBUTION:	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT	HOURS	AMOUNT
VISITING NURSING																												
CLINICS																												
MILK STATIONS																												
OTHER																												
TOTALS																												

The basis for distribution will be direct working hours devoted to the various activities. The source of the direct working hours for each activity will be as follows:

VISITING NURSING This time will be the sum total of the respective number of hours for supervisors' and nurses' time directly devoted to visiting nursing as shown by the "Visiting Nursing Hours" column of the summaries of Form 1.

CLINICS This time will be the sum total of the total hours spent at Clinics by Supervisors and Nurses as shown by Forms 1 and 2.

MILK STATIONS This time will be the sum total of the total hours spent at Milk Stations by Supervisors and Nurses, as shown by Forms 1 and 2.

The total direct working hours for each of the activities will be entered on Form 19 under the caption of "Hours" and the "Hours" column totaled. The total amount of Administrative expense applicable to Organization Activities will be divided by the total "Hours." The result will be an Administrative cost per hour. This cost per hour, multiplied by the total number of hours for each of the activities will be the amount of Administrative expense applicable to said activities.

Financial Statement—Form 20.
Condensed Statement of Income and Expense—Form 21.
Statement of Visiting Nursing Expenses and Cost per Visit—Form 22.

These are outlines respectively of a Financial Statement, a Condensed Statement of Income and Expenses, and a statement to show the detail of Visiting Nursing Expenses and the Unit Cost per Visit. To compute the Unit Cost per Visit, divide the Total Visiting Nursing Expense by the total number of visits made. Statements similar to the last named may be prepared to show the detail of Clinics and Milk Stations Expenses. The proportions of Administrative Expense to be added to Visiting Nursing Expense, Clinics Expense, and Milk Stations, Expense Statements will be obtained from Form 19.

In preparing the Condensed Statement of Income and Expenses, the expenses may be taken direct from the ledger, *i.e.*, the balances in the "Administrative," "Visiting Nursing," "Clinics" and "Milk Stations" accounts.

Form 2

SUPERVISOR'S MONTHLY TIME RECORD

Supervisor..................................

Station..................................

Month..................................

Date		Visiting Hours	Group Meetings With Patients	Other Services For Patients	Travel	Assigned Duties	Visiting Nursing Supervision	Total Visiting Nursing Hours	Supervision		Total
									Clinics	Milk Stations	
1											
2											
3											
4											
29											
30											
31											
Total											

Form 3

DISBURSEMENT VOUCHER

No..........................

Date..........................

To.................................... Check No.................... Total Amount $..........

Attach Original Bills to this Form.

Date	ITEM	Amount	Distribution to Activity	Account Column	Amount
		$			$

Entered: .... Examined and Found Correct: .... Approved: ....

Form 4

PETTY CASH EXPENSE VOUCHER

Department or
Station.. Date..

Received from .... $..........................

.... Dollars

For..

Charge Account.. Entered on Summary..

Signed...

Approved..

Form 5

PETTY CASH DISBURSEMENT SUMMARY

Department or
Station...

Expenses Week Ending............................ Total Amount $............................

Reimbursement Voucher No.................... Approved...

DATE	NAME OR ITEM	CAR FARE		TELEPHONE		MISCELLANEOUS		TOTAL	
	TOTAL...............								

Form 6

PAYROLL FOR PERIOD........................

Department or
Station..

Disbursement Voucher No.................

NAME	Title or Position	Rate		Check No.	Amount		NAME OF ACCOUNT TO BE CHARGED	Amount

Form 11

LEDGER

DATE	ITEMS	REF.		DEBITS		DATE		ITEMS	REF.		CREDITS	

Form 12

RECORD OF SUPPLIES

ARTICLE

RECEIPTS					ISSUED					BALANCE			
Date	Invoice Refer.	Quantity	Unit Price	Amt. of Invoice	Date	Ref.	Quantity	Unit Price	Amt.	Date	Quantity	Unit Price	Amt.

Form 13

REQUISITION FOR SUPPLIES

Date................................ Station................................

Nurse................................

Approved................................

QUANTITY	DESCRIPTION

Department or Activity to be Charged................................

Signed: ....

Entered on Summary: ....

Form 17

Name.................................... Initial Payment........................

Address..

Date Payment	Paid To	Amount	Date Payment	Paid To	Amount	REMARKS

Form 17a

Address..

Town.. State........................

SUBSCRIPTION ACCOUNT						
Began	Amount	Date Paid	Expires	Bill Sent	Letter	

Form 18

JOURNAL

Form 20

FINANCIAL STATEMENT

ASSETS		
Current Assets:		
Cash	--------	
Petty Cash	--------	
Accounts Receivable	--------	
Accrued Interest Receivable	--------	
Inventories:		
Building Supplies	--------	
Uniforms and Uniform Material Purchased for Resale	--------	
Supplies—Chemicals and Drugs, Medical and Surgical	--------	
TOTAL CURRENT ASSETS		--------
Funds:		
Endowment Fund—Principal Cash	--------	
Endowment Fund—Investments	--------	
Special Fund—Principal Cash	--------	
Special Fund—Investments	--------	
Special Fund—Loans	--------	
TOTAL ASSETS OF FUNDS		--------
Fixed Assets:		
Land	--------	
Buildings	--------	
Automobiles	--------	
Office Furniture and Equipment	--------	
Equipment at Stations	--------	
Less Reserve for Depreciation	--------	--------
TOTAL FIXED ASSETS		--------
Deferred Charges:		
Repairs and Replacements—Nurses' Uniforms and Equipment	--------	
Insurance Prepaid	--------	
Water Rates	--------	
TOTAL DEFERRED CHARGES		--------
TOTAL ASSETS		--------
LIABILITIES		
Accounts Payable		--------
Endowment Fund		--------
Special Fund		--------
General Fund		--------
TOTAL LIABILITIES		--------

Form 21

CONDENSED STATEMENT OF INCOME AND EXPENSES

INCOME			
Fees:			
General	--------		
Corporation	--------	--------	
Contributions:			
General	--------		
Association	--------		
Services	--------		
Equipment	--------		
Supplies	--------	--------	
Appropriations:			
City	--------		
County	--------		
State	--------	--------	
Income from Investments		--------	
Interest on Bank Deposits		--------	
TOTAL INCOME			--------
Expenses:			
Administrative		--------	
Visiting Nursing		--------	
Clinics		--------	
Milk Stations		--------	

Less Interest on Capital Invested in Land and Building—Contra		--------	
TOTAL EXPENSES			--------
EXCESS OF INCOME OR EXPENSES			--------

Form 22

STATEMENT OF VISITING NURSING EXPENSES AND COST PER VISIT

SALARIES:	January	February	2 Months Accumulated
Supervisors	--------	--------	--------
Staff Nurses	--------	--------	--------
Student Nurses	--------	--------	--------
Rent	--------	--------	--------
Telephone	--------	--------	--------
Office Supplies and Stationery	--------	--------	--------
Automobile Operating Expense	--------	--------	--------
Carfare and Auto Hire	--------	--------	--------
Laundry	--------	--------	--------
Supplies, Chemical and Drugs, Medical and Surgical	--------	--------	--------
Repairs and Replacements, Nurses' Uniforms and Equipment	--------	--------	--------
Depreciation	--------	--------	--------
TOTAL DIRECT VISITING NURSING EXPENSE	--------	--------	--------
Add—Administration Expense, applicable to Visiting Nursing	--------	--------	--------
TOTAL VISITING NURSING EXPENSE	--------	--------	--------
TOTAL VISITS	--------	--------	--------
UNIT COST PER VISIT	--------	--------	--------

NOTE.—As in the case of Form 19, Administrative Expense, this exhibit may be made comparative for as many months as may be desired, by simply adding March and three months accumulated; April and four months accumulated, and so on.

CLASSIFICATION OF LEDGER ACCOUNTS AND PROCEDURE FOR POSTING.

REAL ESTATE
Form 11

When the association owns the building which it occupies, separate accounts will be carried showing the value of the land and building respectively.

AUTOMOBILES.
Form 11

Charge this account through the Cash Disbursement Book with payments made for the purchase of automobiles.

Charge this account through the Journal with adjustments to be made to the purchase price of automobiles for allowances made by the vendor for used automobiles traded as part payment.

When automobiles are donated to the organization, charge this account through the Journal with an amount equal to the replacement cost value and *credit* "Income Account"—"Contributions of Equipment." *Credit* this account with the cost value of automobiles sold, traded or scrapped.

OFFICE FURNITURE AND EQUIPMENT.
Form 11

Charge this account through the Cash Disbursement Book with the value of office furniture and equipment purchased.

When office furniture or office equipment are donated to the organization, *charge* this account through the Journal with an amount equal to the cost value and *credit* "Income Account"—"Contributions of Equipment."

Credit this account through the Journal with the cost value of office furniture and equipment—sold, traded or scrapped.

Charge this account through the Journal with adjustments to be made to the purchase prices for allowances made on used furniture and equipment traded as part payment.

EQUIPMENT AT STATIONS.
Form 11

There will be a separate account for each station to record the value of equipment at the respective stations.

Charge these accounts through the Cash Disbursement Book for station equipment purchased.

Charge these accounts through the Journal with adjustments to be made to the purchase price for allowances made on used equipment traded as part payment.

When station equipment is donated to the organization, *charge* the respective station equipment accounts through the Journal with the replacement cost values and *credit* "Income Account"—"Contributions of Equipment."

CASH.
Form 11

Charge this account at the close of each month with the total amount of cash receipts for the month as shown by the total column of the Cash Receipt Book.

Credit this account at the close of each month with the total amount of cash disbursements for the month as shown by the Cash Disbursement Book. The balance of this account, after reconciliation, should be in agreement with the cash balance in the bank.

Reconciliation will be made by deducting from the balance as stated by the bank, the amount of the checks not returned by the bank as having been paid, and adding to this result cash entered in the cash book, which had been received too late to be deposited on the last day of the month. The final result should agree with the cash balance as shown by the cash book and the ledger account.

PETTY CASH FUNDS.
Form 10

Petty cash disbursements will be operated on the "Imprest System." Each station and department will be provided with a fund estimated to cover all petty cash disbursements for a period of one week. At the close of the week, Form 5 Petty Cash Disbursement Summary with the supporting expense vouchers attached, will be forwarded to the Administrative Department. A Disbursement Voucher, Form 3, will be made up and attached to each Petty Cash Disbursement Summary.

Checks will be drawn reimbursing the various station funds for the total amounts disbursed as shown by the respective Petty Cash Summaries. The various expense accounts affected as shown by the Petty Cash Summaries will be charged through the Cash Disbursement Book.

A columnar ledger account, Form 10, will be used to record the amounts of cash advanced. The distribution columns will be used to show the amounts advanced to the respective stations and the administrative department. The total amount will be extended to the "Total" column.

ACCOUNTS RECEIVABLE.
Form 11

When the association agrees to render nursing service to policyholders of an insurance corporation or to the employees of an industrial corporation, the fees to be paid by the corporations, separate accounts will be carried in the name of each corporation. At the close of the month, *charge* these accounts through the Journal with the amounts due from the respective corporations and credit "Income Account"—"Fees—Corporations."

Credit the respective corporation accounts through the Cash Receipt Book for payments received. The balances of the respective accounts will show the amounts due from each of the corporations.

INVENTORY ACCOUNT—BUILDING SUPPLIES.
Form 11

When the Association owns the building which it occupies, charge this account through the Cash Disbursement Book with supplies purchased in quantity to be used in the operation of the building, such as coal, wood, electrical supplies, etc.

When supplies are donated, charge this account through the Journal with the replacement cost value and credit "Income Account—Supplies Donated."

Credit this account through the Journal monthly with an amount equal to one-twelfth of the estimated annual cost of supplies, and charge "Building Operating Expense Account." This amount will be based on the previous year's experience for cost of building supplies. At the end of the year a physical inventory will be made of the supplies on hand. This account should be adjusted to bring the balance into agreement with the total value of the physical inventory.

INVENTORY ACCOUNT. REPAIRS AND REPLACEMENT OF NURSES' UNIFORMS AND EQUIPMENT. Form 11

Charge this account through the Cash Disbursement Book with the value of repairs to uniforms and the cost of new uniforms and equipment purchased. *Credit* this account through the Journal monthly with an amount equal to one-twelfth of the total estimated annual expense for repairs and replacements of uniforms and equipment. At the end of the year a physical inventory will be made of uniforms and equipment which will be costed at a depreciated value. This account should be adjusted to bring the balance into agreement with the total value of the physical inventory.

INVENTORY ACCOUNT. SUPPLIES OF CHEMICAL, DRUGS, MEDICAL, SURGICAL, ETC. Form 11

Charge this account through the Cash Disbursement Book for the cost of supplies purchased.

When supplies are donated, *charge* this account through the Journal with an amount equal to the cost value and *credit* "Income Account"—"Contributions of Supplies."

Credit this account through the Journal with the value of supplies requisitioned from stock for use during the month.

Alternative method, *credit* this account monthly through the Journal with an estimated amount and *charge* the supplies columns of the respective expense accounts affected.

INVENTORY ACCOUNT. UNIFORMS AND UNIFORM MATERIAL PURCHASED FOR RESALE. Form 11

Charge this account through the Cash Disbursement Book for the cost of uniforms and uniform material purchased to be sold at cost to members of the staff. *Credit* this account through the Cash Receipt Book with receipts from sales. The balance in this account should equal the inventory value of the uniforms and material on hand.

INSURANCE PREPAID. Form 11

Charge this account through the Cash Disbursement Book with insurance premiums prepaid.

Credit this account through the Journal and charge the expense accounts affected with the monthly proportion of premiums expired.

WATER RATES PAID ACCOUNT. Form 11

Charge this account through the Cash Disbursement Book with payments made for water rates.

Credit this account through the Journal monthly with one-twelfth of the annual expense for water rates and *charge* "Building Operating Expense Account."

To show the true amount of income from investments for the accounting period, the accrued interest on the various bonds at the end of the period will be figured. This account will be *charged* through the Journal for the total amount accrued and "Income Account—Interest from Investments" will be *credited*. When the accrued interest is received in the subsequent accounting period, the accrued Interest Receivable account will be credited through the Cash Receipt book.

ACCRUED INTEREST RECEIVABLE. Form 11

At the close of an accounting period, if there are any unpaid expense bills, the total amount of same will be *credited* to this account through the Journal and the expense accounts affected will be *charged*. When these bills are paid in the subsequent accounting period, this account will be charged through the Cash Disbursement book.

ACCOUNTS PAYABLE. Form 11

When the association owns the building which it occupies, *credit* this account monthly through the Journal with an amount to equal one-twelfth of the total estimated annual depreciation. The estimated annual amount will be a percentage of the cost value of the building, exclusive of land value. The percentage will be based on the estimated life of the building. In commercial practice, the percentage varies, but is usually from two to three per cent.

RESERVES FOR DEPRECIATION OF BUILDING. Form 11

Credit this account monthly through the Journal with one-twelfth of the total estimated annual amount of depreciation on automobiles owned by the organization. The estimated annual amount will be a percentage of the cost value. The percentage will be based on the estimated life of the automobiles. In commercial practice the percentage used varies, but is usually from 20 to 33 1-3 per cent.

RESERVE FOR DEPRECIATION OF AUTOMOBILES. Form 11

Credit this account monthly through the Journal with one-twelfth of the total estimated annual amount of depreciation on office furniture and equipment. The estimated annual amount will be a percentage of the cost value. The percentage will be based on the life of the furniture and equipment. From eight to twelve per cent. is usually used in commercial practice.

RESERVE FOR DEPRECIATION OF OFFICE FURNITURE AND EQUIPMENT. Form 11

RESERVE FOR DEPRECIATION OF NURSING STATIONS' EQUIPMENT. Form 11
RESERVE FOR DEPRECIATION OF MILK STATIONS' EQUIPMENT. Form 11

Credit these accounts monthly through the Journal with one-twelfth of the total estimated annual amounts of depreciation on the above equipment. The estimated annual amounts will be a percentage of the cost values. The percentage will be based on the life of the equipment.

NOTE—When equipment is sold, traded or scrapped, the various reserve accounts affected will be adjusted by a *charge* for the amount of depreciation on the equipment disposed of, which had been previously credited to the aforementioned accounts.

GENERAL FUND. Form 11

The balance of this account will reflect the net value of the assets of the association, exclusive of the assets held for endowment and special funds. At the close of the accounting period, *credit* this account with the excess of revenue over expenses, or *debit* it with the excess of expenses over revenue.

ENDOWMENT AND SPECIAL FUNDS. ENDOWMENT FUND—PRINCIPAL CASH. Form 11

SPECIAL FUND—PRINCIPAL CASH. Form 11

A separate cash account will be carried to record the uninvested cash balance of each fund. *Charge* the cash accounts for cash additions to the funds or the proceeds from sales of securities. *Credit* the cash accounts with disbursements made for the purchase of securities. If loans are made from Special Fund—"Principal Cash," credit the cash account for the amount of the loan. When the loan is repaid, charge the cash account for the repayment.

SPECIAL FUND LOANS. Form 11

When loans are made from Special Fund—"Principal Cash," *charge* this account—"Special Fund Loans"—through the Cash Disbursement Book for the amount of the loan. When the loan is repaid, *credit* this account through the Cash Receipt Book.

ENDOWMENT FUND—INVESTMENTS. Form 11

SPECIAL FUND—INVESTMENTS. Form 11

A separate account will be carried to record the value of securities held for each of the respective funds. *Charge* the accounts with the value of securities acquired or purchased. Credit the accounts with the book value of securities sold.

ENDOWMENT FUND—LIABILITY. Form 11

SPECIAL FUND—LIABILITY. Form 11

Separate accounts will be carried in the name of each fund. The balances of these accounts will represent the total value of the assets in the respective funds.

INTEREST ON CAPITAL INVESTED IN LAND AND BUILDING—CONTRA ACCOUNT. Form 11

Credit this account monthly through the Journal with one-twelfth of a total annual interest charge to be computed on the amount invested in the building. At the close of the accounting period, this account will be closed to "Profit and Loss" or "General Fund" accounts.

BUILDING OPERATING EXPENSE ACCOUNT—Form 10

When the organization owns the building which it occupies for either nursing or administrative purposes, a columnar form of ledger account will be used to record the various classes of expenses. All expenses incurred in operating the building will be *charged* to this account.

At the close of the month, after all postings have been made, the columns will be totaled. The sum total of the distribution columns should equal the net total of the "Total Debit and Credit" columns.

This account will be *credited* through the Journal monthly for the total amount of expenses incurred less refunds and charged to "Administrative Expense" and "Visiting Nursing Expense" Accounts, prorated on the basis of floor space occupied by the respective departments.

The captions of the distribution columns of this account and the procedure for posting will be as follows:

WAGES *Charge* this column through the Cash Disbursement Book with wages paid to janitors and other help for the operation of the building.

LIGHT AND HEAT *Charge* this column through the Cash Disbursement Book with payments made for electric light, electrical supplies, gas, coal, wood, removal of ashes, etc. Purchases made in large quantities for coal, wood and electrical supplies will be charged to "Inventory Account—Building Supplies." A *credit* will be made to the latter mentioned account through the Journal monthly, for one-twelfth of the estimated annual cost of supplies, and a corresponding *charge* made to this account.

INSURANCE *Charge* this column through the Journal with the monthly proportion of premiums expired for insurance applicable to the building.

REPAIRS *Charge* this column through the Cash Disbursement Book with repairs made to the building, such as painting, plumbing, etc. If repairs are made by the organization's employees, their wages for the time used in making the repairs should be charged to this account.

HOUSE SUPPLIES Charge this column through the Cash Disbursement Book with supplies purchased for the operation of the building.

WATER RATES Charge this column through the Journal with the prorata amount of water rent chargeable to each month.

INTEREST ON CAPITAL INVESTED *Charge* this column monthly through the Journal with one-twelfth of a total annual interest charge to be computed on the total amount invested in the building.

DEPRECIATION *Charge* this column monthly through the Journal with one-twelfth of the total estimated annual depreciation on the building. For basis of charge see "Reserve for Depreciation—Building."

REFUNDS—RENT *Credit* this column through the Cash Receipt Book with revenue received through the renting of any portion of the building for either living quarters for nurses or office space for other activities.

ADMINISTRATIVE EXPENSE ACCOUNT—Form 10 A columnar form of ledger account (Form 10) will be used to record the various classes of expenses applicable to the operations of the administrative office. At the close of the month, the various columns in the Cash Disbursement Book under the caption of "Administrative Expense" will be posted to the respective "Administrative Expense Account" columns and the total of all the postings from the Cash Disbursement Book for the month extended to the "Total Debit" column. "Refunds" on expenses will be posted from the Cash Receipt Book in red to the distribution columns affected and the total extended to the "Total Credit" column. After all postings have been made for the month from the Cash Receipt Book, Cash Disbursement Book and Journal, the columns will be totaled. The sum total of the distribution columns should equal the net total of the "Debit and Credit Total" columns.

The captions of the distribution columns of this account and the procedure for posting will be as follows:

SALARIES—SUPERINTENDENT AND ASSISTANT SUPERINTENDENT

Charge this column through the Cash Disbursement Book with the total amount of salaries paid to the Superintendent and Assistant Superintendent.

SALARIES—SECRETARIAL AND CLERICAL

Charge this column through the Cash Disbursement Book with salaries paid to office secretaries, registrars, bookkeepers, clerks, stenographers and other office assistants. When volunteer services are given, a *charge* will be made through the Journal for an amount to equal two-thirds of the replacement cost, and a *credit* made to "Income Account—Contributions of Services." When there are salaries paid by the City or any public or private agency a *charge* will be made through the Journal for the amount of the salaries paid and a *credit* made to "Income Account"—"Appropriations, City," or "Contributions."

RENT

Charge this column through the Cash Disbursement Book with payments made for rent, light, heat and janitor service. When the quarters occupied are given by a city, an individual or another organization, a *charge* will be made to this column through the Journal for an amount which would cover the actual rent of the quarters and a *credit* made to "Income Account—Contributions." When quarters are occupied jointly by the administrative office and a field station, total payment made for rent, light, heat and janitor service will be prorated through the Cash Disbursement Book between the departments and will be based on the floor space occupied respectively by the field station and the administrative office.

Credit this column through the Cash Receipt Book with refunds of expense.

When the quarters occupied are owned, a *charge* will be made to this column through the Journal for the prorata proportion of the total monthly Building Operating Expense. This prorata charge will be based on floor space occupied by the administrative office and field station.

TELEPHONE AND TELEGRAPH

Charge this column through the Cash Disbursement Book with disbursements made for telephone and telegraph services. When telephone service is donated or when the telephone contract allows a discount, a *charge* will be made through the Journal for an amount covering the current rate of telephone service, or the discount allowed and a *credit* made to "Income Account—Contributions of Services."

Credit this account through the Cash Receipt Book with refund.

OFFICE SUPPLIES, STATIONERY AND PRINTING

Charge this column through the Cash Disbursement Book with purchases of miscellaneous office supplies such as bookkeeping and statistical records, letterheads, ink, drinking cups, drinking water, etc. When supplies are donated, a *charge* equal to the replacement value will be made through the Journal and a *credit* made to "Income Account—Contributions of Supplies."

Credit this column through the Cash Receipt Book with refunds.

POSTAGE

Charge this column through the Cash Disbursement Book with postage expense.

CARFARE AND TRANSPORTATION

Charge this column through the Cash Disbursement Book with carfare and transportation applicable to the administrative office.

INSURANCE

Charge this column through the Journal with the expired monthly proportions of premiums paid to cover insurance against losses, such as fire insurance on office furniture and other equipment, and compensation insurance on salaries. Do not charge this account with premiums on automobile insurance or building insurance, as these are to be charged to "Automobile" and "Building Operating Expense" Accounts, respectively.

GENERAL OFFICE EXPENSE

Charge this column through the Cash Disbursement Book with miscellaneous office expenses, such as dues paid to other organizations, interest on borrowed money, auditing fees, etc.

Credit through the Cash Receipt Book with refunds.

PUBLICITY

Charge this column through the Cash Disbursement Book with advertising and other publicity material and expenses.

Credit through the Cash Receipt Book with refunds.

DEPRECIATION EXPENSE

Charge this column monthly through the Journal with one-twelfth of the total estimated annual depreciation on Office Furniture and Equipment.

REPAIRS AND REPLACEMENT—LOAN CLOSET SUPPLIES

Charge this column through the Cash Disbursement Book for disbursements made for repairs and replacements of loan closet supplies.

Credit this column through the Cash Receipt Book with amounts received for rental of loan closet supplies.

MEDICAL AND MATERIAL RELIEF

Charge this column through the Cash Disbursement Book with aid extended to needy cases, such as food subsistence, medical relief, etc.

Credit through the Cash Receipt Book with refunds.

VISITING NURSING EXPENSE ACCOUNT
Form 10

A columnar form of ledger account will be used to record the various classes of expenses. At the close of the month, the columns in the Cash Disbursement Book under the caption of Visiting Nursing Expense will be posted to the respective expense columns. The sum total of all the postings from the Cash Disbursement Book to the columns for the month will be extended to the "Total Debit" column.

This account will be credited through the Cash Receipt Book with refunds of expenses. The credit postings to the distribution columns will be made with red ink and the sum total of the credits carried to the "Total Refunds" column. After all postings have been made to this account for the month from the Cash Receipt Book, Cash Disbursement Book and Journal, the distribution columns will be totaled. The sum total of the distribution column totals should equal the net total of the "Debit and Credit Total" columns.

The balance of this account will show the total Visiting Nursing Expense applicable to visiting nursing after all credits have been made for the prorata amounts applicable to "Clinics" and "Milk Stations Expense" accounts.

The captions for the distribution columns of this account and the procedure for posting will be as follows:

SALARIES—SUPERVISORS

Charge this column through the Cash Disbursement Book for salaries paid to nurse supervisors.

When the salary of a supervisor is paid by a City or by any public or private agency, a *charge* will be made through the Journal for the amount of the salary and a *credit*, made to "Income Account"—"Appropriations, City" or "Contributions."

At the close of the month, *credit* this column through the Journal with the total amount of supervisors' salaries chargeable to other accounts and columns. The total credit to be based on the distribution of supervisors' time as shown by Forms 1 and 2. The offsetting charges for this credit will be to the following accounts and distribution columns:

"Special Activities—Clinic Operating Expense Account," *charge* "Salaries—Supervisors' column" with the prorata value of supervisors' salaries for time spent at clinics.

"Special Activities—Milk Stations Operating Expense Account," *charge* "Salaries—Supervisors' column" with the prorata value of supervisor's salaries for time spent at milk stations.

SALARIES—STAFF NURSES

Charge this column through the Cash Disbursement Book for salaries paid to Staff Nurses. When the salary of a nurse is paid by a city or by any public or private agency, a charge will be made through the Journal for the amount of the salary paid and a credit made to "Income Account"—"Appropriations, City" or "Contributions."

At the close of the month, *credit* this column through the Journal with the total amount of nurses' salaries chargeable to other accounts and columns. The total credit to be based on the distribution of nurses' time as shown by Form 1.

The offsetting charges will be the following accounts and distribution columns:

Special Activities—Clinic Operating Expense Account, *charge* "Salaries—Nurses' column" with the prorata value of nurses' salaries for time spent at clinics.

Special Activities—Milk Stations Operating Expense Account, *charge* "Salaries—Nurses' column" with the prorata value of nurses' salaries for time spent at milk stations.

When student nurses participate in the work of the organization, *charge* this account through the Journal with an amount equal to two-thirds of the salary of the staff nurses necessary to replace such students less the cost of student supervision which is additional to the supervision of the regular staff nurse. A *credit* will be made to "Income Account"—"Contribution of Services"—for the amount charged to this account. The charge made to this account will be based on the actual time spent by the student on nursing work as shown by Form 1.

SALARIES—STUDENT NURSES

Charge this column through the Cash Disbursement Book with the total amount for station rental applicable to Visiting Nursing Expense. When quarters are occupied jointly by the administrative office and a field station, this column will be *charged* through the Cash Disbursement Book with a prorata amount of the total rent expense based on the floor space occupied respectively by the field station and the administrative office. When the quarters occupied are owned, a *charge* will be made to this column through the Journal for the prorata proportion of the total monthly building expense. This prorata charge will be based on the floor space occupied by the administrative office and the field station. When the quarters occupied are given by a city, an individual or another organization, a *charge* will be made to this column through the Journal for an amount which would cover the actual rent of the quarters, and a credit made to "Income Account"—"Contributions."

RENT

When clinics are held at the nursing stations, *credit* this column through the Journal with an amount to cover the prorata percentage of the total rent expense applicable to clinics expense and *charge* "Clinics Expense Account"—"Rent." The percentage will be based on the total time consumed during the month for clinics. For example, if there were 5 stations operated 8 hours per day, this would total 1,200 hours for a 30-day month; and if there were 10 clinics, each of 3 hours duration, held at each of the 5 stations, there would be a total of 150 clinic hours for the month. The percentage the total clinic hours bears to the total station hours would be 150–1200, which equals one-eighth or 12½ per cent.

When quarters are occupied by a field station and a milk station, *credit* this column through the Journal with a prorata amount of the rent applicable to the milk station, based on the floor space occupied and *charge* "Milk Stations Expense Account"—"Rent."

TELEPHONE—STATIONS

Charge this column through the Cash Disbursement Book with the total cost of service at the stations. When the service is donated or when the telephone contract allows a discount, a *charge* will be made through the Journal for an amount covering the current rate of telephone service, or discount allowed, and a *credit* made to "Income Account"—"Contributions of Services."

When clinics are held at nursing stations, *credit* this column monthly through the Journal with an amount to cover the prorata percentage of telephone expense applicable to clinics expense, and *charge* "Clinics Expense Account"—"Telephone." The percentage will be the same as that used for the distribution of rent.

Credit this column through the Cash Receipt Book with refunds.

OFFICE SUPPLIES, STATIONERY AND PRINTING

Charge this column through the Cash Disbursement Book with the cost of all record forms of patients used by nurses in connection with visiting nursing work. When stationery and printing supplies are donated, a *charge* equal to the replacement value will be made through the Journal and a *credit* made to "Income Account"—"Contributions of Supplies."

Credit this column through the Cash Receipt Book with refunds.

AUTOMOBILE OPERATING EXPENSE

Charge this column through the Cash Disbursement Book with all expenses for the operation and maintenance of automobiles, such as repairs, gas, oil, etc.

Charge this column through the Journal with the expired monthly proportion of prepaid premiums on automobile insurance. When any of the above expenses are donated, a *charge* will be made to this column through the Journal for the cost value of the donation and a *credit* made to "Income Account"—"Contributions of Services."

A monthly *charge* to cover one-twelfth of the estimated annual amount for depreciation of automobiles will be made to this column through the Journal.

CARFARE AND AUTOMOBILE HIRE

Charge this column through the Cash Disbursement Book with street carfares and automobile hire. When car tickets are donated by a street car company, a *charge* will be made to this column through the Journal for an amount equal to what such carfare would have cost, and a *credit* made to "Income Account"—"Contributions of Services."

LAUNDRY

Charge this column through the Cash Disbursement Book with all expenses for laundry applicable to "Visiting Nursing Expense."

Whenever possible, distribute laundry expense through the

Cash Disbursement Book direct to "Visiting Nursing" and "Clinics" accounts. When direct distribution is not possible, use the following method:

At the close of the month, *credit* this column through the Journal with an amount to cover the prorata percentage of total laundry applicable to Clinics Expense and *charge* "Clinics Expense Account"—"Laundry." The percentage will be based on the total time consumed by clinics and will be the same as that used for the distribution of rent.

SUPPLIES—CHEMICALS, DRUGS, MEDICAL AND SURGICAL

Charge this column through the Journal with the total value of supplies used during the month as shown by the Summary of Requisitions for Supplies—Form 14.

Credit this column with refunds for sale of supplies.

Alternative method—*Charge* this column monthly through the Journal with an estimated amount for supplies consumed and *credit* "Inventory Account—Supplies—Chemicals, Drugs, Medical and Surgical."

REPAIRS AND REPLACEMENTS OF NURSES' UNIFORMS AND EQUIPMENT

Charge this column monthly through the Journal with an amount equal to one-twelfth of the estimated annual repairs and replacements of nurses' uniforms and equipment. *Credit* this column monthly through the Journal with an amount to cover the prorata percentages of the total charges to this account applicable to "Clinics" and "Milk Stations Expense" accounts. These percentages will be based on the relative per cent. which the total of Nurses' and Supervisors' time spent at milk stations and clinics respectively, as shown by Forms 1 and 2, bears to the grand totals of Supervisors' and Nurses' time for the month.

DEPRECIATION

Charge this column through the Journal with an amount to cover one-twelfth of the total estimated annual depreciation of equipment at field stations.

When clinics are held at nursing stations, *credit* this column through the Journal with an amount to cover the prorata percentage of the total depreciation applicable to clinics expense, and *charge* "Clinics Expense Account"—"Depreciation." The percentage will be based on the total time consumed during the month by clinics in the use of nursing station equipment. This percentage will be the same as that used for the distribution of rent.

SPECIAL ACTIVITIES CLINICS EXPENSE
Form 10

A columnar form of ledger account will be used to record the various classes of expense.

At the close of the month, the items entered in the Cash Disbursement Book under the caption "Special Activities—Clinics Expense" will be posted to this account. The total expense for the month will be posted to the "Total Expense" column and the distribution made to the columns affected.

Distribution of expenses directly applicable to clinics will be made through the Cash Disbursement Book when making the entries covering payments for such expenses.

This account will be credited through the Cash Receipt Book with refunds of expenses. The credit postings to the distribution columns will be made in red ink, and the sum total carried to the "Total Refunds" column.

After all postings have been made to this account for the month from the Cash Receipt Book, Cash Disbursement Book and Journal, the distribution columns will be totaled. The sum total of the distribution columns should equal the net total of the "Debt and Credit Total" columns.

The captions for the distribution columns of this account and the procedure for posting will be as follows:

SALARIES—SUPERVISORS

Charge this column through the Journal with the prorata value of supervisors' salaries for time spent at clinics. (For the basis of this charge, see explanation of "Visiting Nursing Expense Account"—"Salaries—Supervisors.")

SALARIES—NURSES

Charge this column through the Journal with the prorata value of nurses' salaries for time spent at clinics. (For the basis of this charge, see explanation of "Visiting Nursing Expense Account"—"Salaries—Nurses.")

SALARIES—NURSE ASSISTANTS

Charge this column through the Cash Disbursement Book with salaries paid persons assisting nurses at clinics.

RENT

When quarters are rented only for the purpose of holding clinics, *charge* this column through the Cash Disbursement Book for the amount of rent paid. When clinics are held at the nursing stations, *charge* this column through the Journal with an amount figured to cover the prorata proportion of total station rent applicable to "Clinics Expense." (For the basis of this charge see "Visiting Nursing Expense Account"—"Rent.")

TELEPHONE—CLINICS

Charge this column through the Cash Disbursement Book with the cost of service at clinics. When the service is donated or when the telephone contract allows a discount, a *charge* will be made through the Journal for an amount covering the current rate of telephone service, or the discount allowed, and a *credit* made to "Income Account"—"Contributions of Services."

When clinics are held at nursing stations, *charge* this column through the Journal with the prorata proportion of the telephone service applicable to clinics expense. (For the basis of this charge, see "Visiting Nursing Expense Account"—"Rent.")

Credit this column through the Cash Receipt Book with refunds.

Charge this column through the Cash Disbursement Book with all record forms of patients used by nurses in connection with work at clinics. When

OFFICE SUPPLIES, STATIONERY AND PRINTING

stationery and printing supplies are donated, a *charge* equal to the replacement value will be made through the Journal, and a *credit* made to "Income Account"—"Contributions of Supplies."

Credit this column through the Cash Receipt Book with refunds.

Whenever possible, distribute laundry expense through the Cash Disbursement Book direct to "Visiting Nursing and Clinics Expense Accounts"—

LAUNDRY

"Laundry." When direct distribution is not possible, use the following method:

Charge this column through the Journal with the prorata amount of laundry expense applicable to clinics expense. This amount will be a percentage of the total amount of laundry expense charged to "Visiting Nursing Expense Account." The percentage will be based on the total time consumed for clinics and will be the same as that used for the distribution of rent.

Charge this column through the Journal with supplies requisitioned from

MEDICAL SUPPLIES

Storeroom Supplies during the month and used at the clinics.

Alternative Method—*Charge* this column monthly through the Journal with an estimated amount for supplies consumed, and credit "Inventory Account"—"Supplies—Chemicals, Drugs—Medical and Surgical."

Charge this column monthly through the Journal with an amount to cover the prorata percentage of the total charge for the month to "Visiting

REPAIRS AND REPLACEMENT OF NURSES' UNIFORMS AND EQUIPMENT

Nursing Expense Account." This percentage will be based on the relative per cent. the total hours of nurses' and supervisors' time spent at clinics, as shown by Forms 1 and 2 bears to the grand total of nurses' and supervisors' time for the month.

When clinics are held at the nursing stations, *charge* this account monthly through the Journal with an amount figured to cover the prorata percentage

DEPRECIATION

of the total depreciation applicable to clinics expense. The percentage will be based on the total time consumed during the month by clinics in the use of the nursing station equipment. This percentage will be the same as that used for the distribution of rent.

A columnar form of ledger account will be used to record the various classes of expense. At the close of the month, the items entered in the Cash

SPECIAL ACTIVITIES—MILK STATIONS EXPENSE—Form 10

Disbursement Book under the caption "Special Activities—Milk Stations Expense" will be posted to this account. The total expense for the month will be entered in the "Total Expense" column and the distribution made to the expense columns affected.

Distribution of expenses directly applicable to Milk Stations will be made through the Cash Disbursement Book when making the entries covering payments for such expenses.

This account will be credited through the Cash Receipt Book with refunds of expenses. The credit postings to the distribution columns for refunds will be made with red ink, and the sum total of the credits extended to the "Total Refunds" column.

After all postings have been made to this account for the month, through the Cash Receipt Book, Cash Disbursement Book, and Journal, the distribution columns will be totaled. The sum total of the distribution columns should equal the net total of the "Debit and Credit Total" columns.

The captions for the distribution columns of this account and procedure for posting will be as follows:

SALARIES—SUPERVISORS

Charge this column through the Journal with the prorata value of supervisors' salaries for time spent at milk stations. (For the basis of this charge, see explanation—"Visiting Nursing Expense Account"—"Salaries—Supervisors.")

SALARIES—NURSES

Charge this column through the Journal with the prorata value of nurses' salaries for time spent at milk stations. (For the basis of this charge, see explanation—"Visiting Nursing Account"—"Salaries—Nurses.")

SALARIES—OTHERS

Charge this column through the Cash Disbursement Book with salaries paid for other services at the milk stations.

RENT

When quarters are rented only for use of milk stations, *charge* this column through the Cash Disbursement Book with the total amount of rent paid.

When quarters are occupied jointly by a nursing station and a milk station, this column will be *charged* through the Cash Disbursement Book with a prorata amount of the rent based on floor space occupied.

TELEPHONE

Charge this column through the Cash Disbursement Book for payments made for service directly applicable to milk stations. When the service is donated, or when the telephone contract allows a discount, a *charge* will be made through the Journal for an amount covering the current rate of telephone service, or the discount allowed; and a credit made to "Income Account"—"Contributions of Services."

Credit this column through the Cash Receipt Book with refunds.

Charge this column through the Cash Disbursement Book with all forms used in connection with milk station expense. When stationery and printing

OFFICE SUPPLIES, STATIONERY AND PRINTING supplies are donated, a charge equal to the replacement value will be made through the Journal, and a *credit* made to "Income Account"—"Contributions of Supplies."

Credit this column through the Cash Receipt Book with refunds.

LAUNDRY *Charge* this column through the Cash Disbursement Book with laundry expense applicable to milk stations.

Charge this column through the Journal with supplies requisitioned from

SUPPLIES Storeroom Supplies, during the month and used at the milk stations.

Alternative method—*Charge* this column monthly through the Journal with an estimated amount for supplies consumed, and *credit* "Inventory Account"—"Supplies, Chemicals, Drugs, Medical, Surgical."

MILK, ICE *Charge* these columns through the Cash Disbursement Book with the cost of milk and ice.

Credit "Milk" column with refunds from sales of milk.

Charge this column monthly through the Journal with an amount to cover the prorata percentage of the total charge to "Visiting Nursing Expense

REPAIRS AND REPLACEMENT OF NURSES' UNIFORMS AND EQUIPMENT Account," which should be borne by the "Milk Station Account." This percentage will be based on the relative percentage that the total hours of nurses' and supervisors' time spent at milk stations, as shown by Forms 1 and 2, bears to the grand total of supervisors' and nurses' time for the month.

DEPRECIATION *Charge* this column through the Journal monthly with one-twelfth of the total estimated annual depreciation of equipment at milk stations.

A columnar form of ledger account will be used to record the various classes of income. At the close of the month, the totals of the various columns

INCOME ACCOUNT. Form 10 in the Cash Receipt Book will be posted to the respective "Income Account" columns affected. The total of all the postings to the distribution columns will be extended to the total column. This account will be *charged* through the Cash Disbursement Book with refunds. The charges to the distribution columns will be made with red ink and the sum total of the charges carried to the "Total Refunds" column. After all postings from the books of original entry have been made to this account for the month, the columns will be totaled. The sum total of the distribution column totals should equal the net total of the "Debit and Credits Total" columns.

The captions of the distribution columns of this account and the procedure for posting will be as follows:

FEES—GENERAL	*Credit* this column through the Cash Receipt Book with fees received from patients.
FEES—CORPORATION	*Credit* this column through the Journal with fees received from corporations.
CONTRIBUTIONS—GENERAL	*Credit* this column through the Cash Receipt Book with contributions from individuals.
CONTRIBUTIONS—ASSOCIATIONS	*Credit* this column through the Cash Receipt Book with contributions from chest funds.
CONTRIBUTIONS—SERVICES, EQUIPMENT, SUPPLIES	*Credit* these columns through the Journal with the replacement cost values of donations of services, equipment and supplies.
APPROPRIATIONS—CITY, COUNTY, STATE	*Credit* these columns through the Cash Receipt Book for funds appropriated from City, County or State funds toward the operating expenses of the organization.
INCOME FROM INVESTMENTS	*Credit* this column through the Cash Receipt Book with interest on bonds and dividends on stocks. At the close of the accounting period, *credit* this column through the Journal with the total amount of accrued interest receivable on bonds.
INTEREST FROM BANK DEPOSITS	*Credit* this column through the Cash Receipt Book with interest on bank deposits.
DUES—MEMBERSHIP	*Credit* this column through the Cash Receipt Book with income from membership dues.

Forms for System Suitable for Small Organization

JOURNAL AND CASH BOOK

DATE 19—	ITEM	CHECK NO.	CASH RECEIPTS DR.	CASH DISBMNTS CR.	JOURNAL DR.	JOURNAL CR.	INCOME FEES CR.	INCOME DUES CR.	INCOME CONTRIBUTIONS CR.	INCOME APPROPRIATIONS CR.	INCOME MISCELLANEOUS CR.	EXPENSES NURSE SALARIES DR.	EXPENSES CAR FARES & AUTO EXP. DR.	EXPENSES MED & SUR SUPPLIES DR.	EXPENSES LAUNDRY DR.	EXPENSES REPAIRS REPLACEMTS UNIFORMS DR.	EXPENSES RENT DR.	EXPENSES TELEPHONE DR.	EXPENSES ADMINISTRA. SALARIES DR.	EXPENSES STATIONERY OFF. SUP. DR.	EXPENSES MISCEL. EXPENSE DR.	EXPENSES MEDICAL RELIEF DR.	ASSETS AND LIABILITIES AUTO DR.	ASSETS AND LIABILITIES FURNITURE EQUIP. DR.	ASSETS AND LIABILITIES PETTY CASH DR.	ASSETS AND LIABILITIES GENERAL FUND CR.		
	Forward																											

VISIT AND TIME RECORD

Name

Month

DATE	VISITS TO PATIENTS ACUTE MEDICAL	ACUTE COMMUNICABLE	ACUTE SURGICAL	CHRONIC	MATERNITY PRENATAL	MATERNITY DELIVERY	MATERNITY POST PARTUM	MATERNITY NEWBORN	WELFARE INFANT	WELFARE CHILD	WELFARE SCHOOL	VENEREAL	T.B.	PATIENTS NOT SEEN	VISITS ON BEHALF OF PATIENTS	TOTAL VISITS	VISITING HOURS	GROUP MEETINGS WITH PATIENTS HOURS	GROUP MEETINGS WITH PATIENTS PATIENTS	OTHER SERVICES ~~FOR~~ PATIENTS on behalf of HOURS	OTHER SERVICES PATIENTS	TRAVEL HOURS	ASSIGNED DUTIES HOURS	STAFF EDUCATION HOURS omit			NON VISITING HOURS	TOTAL HOURS
1																												
2																												
3																												
4																												
5																												
6																												
7																												
8																												
31																												
TOTALS																												

SYSTEM SUITABLE FOR A SMALL ORGANIZATION.

For small organizations, the financial transactions will be recorded in a combined Journal-Cash Book. This will be of the columnar type. The system calls for a book having twenty-four (24) columns in addition to the date, item and check number columns. It would be well to use a book with more columns to provide for additional distributions should they be required by local conditions.

In addition to the "Cash Receipt" and "Cash Distribution" columns, "Journal" columns are provided to record donations of materials, supplies and services, expenses not paid out in cash, such as depreciation, which should be considered in computing the cost of visits, and any other entries not arising through cash.

The book will be operated on the double entry system in that every entry in the "Cash Receipt" column (debit) will have a similar entry in an income or liability distribution column (credit), and every entry in the "Cash Disbursement" column (credit) will have an equivalent entry in an expense or asset distribution column, (debit). Each entry in the debit "Journal" column will have a similar entry in an expense or asset distribution column, (debit) and each entry in the credit "Journal" column will have an equivalent entry in an income or liability distribution column (credit).

Credit posting in a debit column will be made in red ink and debit postings in a credit column will be made in red ink. For instance the entry for depreciation on an automobile will be

Journal, (debit)	$50.00	
To Journal, (credit)		$50.00

On the line on which the "Journal" debit entry is written, $50.00 will be entered in black ink in the Miscellaneous Expense distribution column, while on the line on which the "Journal" credit entry is written, $50.00 will be entered in red ink in the Asset distribution column, headed "Automobiles."

JOURNAL—CASH BOOK All cash received will be entered in the Cash Book and deposited in the bank.

All disbursements, with the exception of those made out of the petty cash fund, will be made by check.

RECEIPTS The total amount received will be entered in the "Cash Receipt" column and extended to the income and other columns affected.

All disbursements will be entered consecutively as to check number. The

DISBURSEMENTS total amount will be entered in the "Cash Disbursement" column and extended to the expense and asset columns affected.

At the end of the month, the cash book balance will be reconciled with the bank blance as stated by the bank, by deducting from the bank balance

RECONCILIATION

the total of the checks which have not been returned by the bank as having been paid, and adding to this result items appearing in the cash receipts which had been received too late for deposit in the bank on the last day of the month. The final result should agree with the cash book balance.

Bills should be numbered with the check numbers by which they are paid, marked with the columns to which they are to be charged, and after payment, filed alphabetically in a different file from that in which correspondence is filed.

INCOME COLUMNS—FEES

Credit this column through the "Cash Receipt" column with fees received from patients and corporations.

MEMBERSHIP DUES

Credit this column through the "Cash Receipt" column with income received from membership dues.

CONTRIBUTIONS

Credit this column through the "Cash Receipt" column with contributions.

Credit this column through the "Journal" columns with the replacement cost values of donations of services, equipment and supplies.

APPROPRIATIONS

Credit this column through the "Cash Receipt" column with funds received from appropriations by the City, County or State toward the operating expenses of the organization.

MISCELLANEOUS INCOME

Credit this column through the "Cash Receipt" column with interest on bank balances and income received from sources not otherwise provided for.

EXPENSES: NURSES' SALARIES

Charge this column through the "Cash Disbursement" column with salaries paid to the nurse. When the salary of a nurse is paid by the city or any public or private agency, a *charge* will be made through the "Journal" columns for the amount of the salary paid and a *credit* made to "Income", "Appropriations" or "Contributions" columns.

CARFARE, AUTOMOBILE HIRE AND AUTOMOBILE EXPENSE

Charge this column through the "Cash Disbursement" column with street carfares, automobile hire and automobile expense. When carfare is donated by a street car company, a *charge* will be made to this column through the "Journal" columns for an amount equal to that which the rides would have cost, and a *credit* made to Income, "Contributions" column. *Charge* this column through the "Journal" columns with the amount of depreciation on automobiles for the period.

SUPPLIES—CHEMICALS AND DRUGS MEDICAL AND SURGICAL

Charge this column through the "Cash Disbursement" column with the cost of medical and surgical supplies purchased. When such supplies are donated, *charge* this column through the "Journal" columns with the value of the supplies and *credit* Income "Contributions" column.

LAUNDRY

Charge this column through the "Cash Disbursement" column with all laundry expenses.

REPAIRS AND REPLACEMENT OF NURSES' UNIFORMS AND EQUIPMENT

Charge this column through the "Cash Disbursement" column with the cost of repairing and replacing nurses' uniforms and equipment. When repairs and replacements are donated, *charge* this column through the "Journal" columns with the value of the donations and *credit* Income "Contributions" column.

RENT

Charge this column through the "Cash Disbursement" column with rent paid. When the quarters occupied are supplied free, *charge* this column through the "Journal" columns with the rental value of the space used, and *credit* Income "Appropriations," or "Contributions" columns.

TELEPHONE

Charge this column through the "Cash Disbursement" column with the total disbursements made for telephone services. When telephone service is donated, or when the telephone company allows a discount, a *charge* will be made through the "Journal" columns for an amount covering the current rate of telephone service or the discount allowed, and a *credit* made to Income "Contributions" column.

ADMINISTRATIVE SALARIES

When volunteer services are given, a *charge* will be made to this column through the "Journal" columns for an amount equal to two-thirds of the replacement cost and a *credit* made to Income "Contributions" column. This column is only to be used for services in connection with administrative work such as writing up the books of account or preparing statistics.

STATIONERY AND OFFICE SUPPLIES

Charge this column through the "Cash Disbursement" column with the cost of miscellaneous office supplies, such as records, letterheads, ink, drinking cups, drinking water, postage, etc. When supplies are donated, a *charge* equal to the replacement value will be made through the "Journal" columns, and a *credit* made to Income "Contributions" column. *Credit* this column through the "Cash Receipt" column with refunds.

MISCELLANEOUS EXPENSES

Charge this column through the "Cash Disbursement" column with lighting bills, station cleaning, etc.

Charge this column through the "Journal" columns with the estimated amount of depreciation on office furniture and equipment for the period.

MATERIAL AND MEDICAL RELIEF *Charge* this column through the "Cash Disbursement" column with aid extended to needy cases in the form of food subsistence, medical relief, etc.

Credit this column through the "Cash Receipt" column with refunds.

ASSET AND LIABILITY COLUMNS:

AUTOMOBILES *Charge* this column through the "Cash Disbursement" column with payments made for the purchase of automobiles.

When automobiles are donated to the organization, *charge* this column through the "Journal" columns with an amount equal to the replacement cost value and credit Income "Contributions" column.

Credit this column with the estimated amount of depreciation for the period and charge "Automobile Expense."

Credit this column with the depreciated value of automobiles disposed of.

OFFICE FURNITURE AND EQUIPMENT *Charge* this column through the "Cash Disbursement" column with the cost of office furniture and equipment purchased.

When office furniture and equipment are donated to the organization, *charge* this column through the "Journal" columns with an amount equal to the cost value, and *credit* Income "Contributions" column.

Credit this column through the "Journal" columns with the estimated amount of depreciation for the period and charge the "Miscellaneous Expense" column.

Credit this column through the "Journal" columns with the depreciated value of office furniture and equipment disposed of.

PETTY CASH A fund will be provided to pay for small items such as carfare, telephone messages, taxi fares, etc. It will be reimbursed from time to time by check, and the amount of the reimbursement will be distributed to the expense columns affected. Vouchers for these petty cash expenditures will consist of receipts or slips signed by the nurse. The amount of the fund will be entered in this column.

GENERAL FUND The balance of this column will reflect the net value of the assets of the organization. At the close of the year, the accumulated totals of the "Income" and "Expense" distribution columns will be closed to the "General Fund column." This operation will be carried out as follows:

Debit (in red ink) the "Income Distribution" columns for the respective total amounts and *credit* (in black ink) the "General Fund" column with the sum total of all the "Income Distribution columns."

Credit (in red ink) the "Expense Distribution" columns for the respective total amounts and *debit* (in red ink) the "General Fund" column with the sum total of all the "Expense Distribution" column totals.

The book will then be ruled off and the balances in the following columns will be brought down: "Cash," "Automobiles," "Furniture and Equipment," "Petty Cash" and "General Fund." These balances will be the opening entries for the ensuing year.

The book will be opened in the first instance by *debiting* the "Cash Receipt" column with the total amount of cash on hand and *crediting* the "General Fund" with the same amount.

The columns of the book should be totaled at the bottom of each page and at the end of each month, and the respective totals should be carried forward, so that at the end of the year, the totals of the columns will show the entire transactions for the year. In totaling the columns, the red ink entries should be deducted from the black ink entries. The accuracy of the work may be proved by adding the totals of the columns as follows:

Debits	*Credits*
1. Cash Receipt.	1. Cash Disbursement.
2. Journal Debit.	2. Journal Credit.
3. All Expense columns.	3. All Income columns.
4. All Asset columns.	4. General Fund.

The totals of the Debits and the Credits should be equal to each other.

VISIT AND TIME RECORD

The information recorded on this form will be obtained from the Nurses' "Daily Report."

The number of visits to patients as shown by the Daily Reports will be posted to the respective distribution columns of the Visit and Time Record. The sum total of the visits posted to the distribution columns should equal the number of visits posted in the "Total Visit" column. The total hours consumed in visiting patients will be entered in the "Total Visiting Hours" column. The distribution of the time spent for "Group Meetings with Patients," "Other Services for Patients," "Travel" and "Assigned Duties of Indirect Value to Patients," will be posted in the columns provided. The total time devoted to this class of work should be posted to the column "Non-Visiting Hours." The sum total of the time entered in these distribution columns should equal the time posted in "Non-Visiting Hours" column. The sum of the "Total Visiting Hours" column and of the "Non-Visiting Hours" column should equal the total time on duty entered in the "Total Hours" column. At the close of the month, all the columns will be totaled. A proof of the accuracy of the work will be secured by following the procedure of proving the daily entries as already described.

Where there is more than one nurse, a separate sheet will be used to record the time of each nurse. At the close of the month, after totaling the sheets, a summary of the work of the various nurses will be made on another sheet. The same method of posting will be followed with the exception that the totals of columns on the respective nurses' sheets will be entered in the respective columns opposite the name of each nurse as written in the wide column after the date column.

This form will also be used to summarize the monthly totals of all nurses' visits and time, in order to compute the yearly totals. The method of proving the postings to the columns on this summary will be the same as that explained for the posting of the work of each individual nurse.

An income and expense statement will be made from the columns of the Journal Cash Book as follows:

INCOME:		
Fees	--------	
Dues	--------	
Contributions	--------	
Appropriations	--------	
Miscellaneous	--------	
TOTAL INCOME		-------
EXPENSES:		
Nurse Salaries	--------	
Carfare, Automobile Hire and Autombile Expense	--------	
Supplies—Chemical and Drugs—Medical and Surgical	--------	
Laundry	--------	
Repairs and Replacements, Nurses' Uniforms and Equipment	--------	
Rent	--------	
Telephone	--------	
Administrative Salaries	--------	
Administrative Supplies	--------	
Miscellaneous Expense	--------	
Medical and Material Relief	--------	
TOTAL EXPENSES		--------
EXCESS OF INCOME OR EXPENSES		--------

The cost per visit may be calculated by the following method:

(In another section of this report, the Committee has recommended that medical and material relief and certain other items shall be excluded from expenses in determining the cost per visit.)

Deduct the cost of "Medical and Material Relief," and these other items from the total expenses; and divide the result by the total number of visits. The quotient will be the cost per visit.

APPENDIX.

Copies of the five schedules used in this study are attached to this report in numerical order:

Schedule I. This schedule was filled in by the nurse investigator for each agency she studied. The material was obtained by interviews with the superintendent of the agency, branch supervisors, registrars, etc.; through information obtained at staff or supervisors' meetings; through observation of work in the districts; through reading reports, etc.

Schedule II. This schedule was filled in by the accountant who visited each agency studied. The material was obtained by interviews with the superintendent of the agency, the registrar or office secretary; by inspection of books, forms, and all detail which showed the *method* of bookkeeping and accounting.

Schedule III. This schedule was filled in by the nurse investigator for each visit she made with a nurse. For the most part, the nurse investigator made home visits in each agency with an average of 3 different nurses for an average of 3 days. In general, the agency was asked to select one satisfactory and one average nurse, the investigator usually selecting the third nurse after conferring with the superintendent, reading records or looking over personnel sheets. In selecting nurses care was taken to select nurses who had been with the agency for different lengths of time, in different branches and carrying different types of work.

In filling in this schedule the investigator used as a reference, a nursing manual compiled by the two nurse investigators from the nursing manuals of a number of good public health nursing organizations.

Schedule IV. This schedule was filled in by each staff member of each organization. This included the clerical staff and specialists on the staff as well as nurses.

Schedule V. This schedule was filled in for each of 50 records read in each agency by the nurse investigator. This sample of records included approximately the first 20 cases worked on by the agency in January, 1922, the first 20 cases worked on in March, 1922, and 10 cases active at the time the nurse was visiting the agency. In selecting these records care was taken to secure records of a representative number of nurses in a representative number of branches, and various types of cases, always including at least 10 maternity cases, 5 acute communicable disease cases and 5 chronic disease cases.

SCHEDULES.

SCHEDULE I

Investigator

Date

City State

1. Total population 1920 census
   Male Female
   Native white
   Foreign-born white
   Negro
   All others
2. Give country of birth of foreign-born white and numbers for the 8 countries having the largest representation:

COUNTRY	NUMBER

3. Area of city in acres
4. Area covered by association
5. Obtain the following for the city for the last fiscal year:
   Infant mortality rate
   Tuberculosis death rate (all forms) (Pulmonary)
   Crude death rate
6. Classification of causes of death, Bureau of Vital Statistics, last fiscal year (*attach*)

A. ORGANIZATION

Name of Association

Address Year Incorporated

7. Is agency private or public?
8. Financed by: (*check*)
   Public funds: State County City
   Community chest
   Private contributions solicited by association
   Other means
9. Number of members on Board of Managers: Men Women
10. Number of doctors on Board
11. Frequency of Board meetings
12. Length of Board meeting 13. Average Attendance
14. General program of Board meetings
15. What are the functions of the Board as a whole?

A. ORGANIZATION—*Continued*

16. Does the nurse superintendent meet with the Board? "Yes"………… "No"…………

17. Is there any other staff representation?…………

18. What is the relationship of the staff to the general administration? (Participation in determining questions of policy etc.)…………

…………

…………

…………

19. List Advisory Boards giving for each Board:

a. Number of members men and women

b. Frequency of meetings

c. Function

…………

…………

…………

…………

20. Into what Committees is the Board divided?…………

…………

…………

…………

NAME OF COMMITTEE	NUMBER OF MEMBERS		FREQUENCY OF MEETINGS
	Men	Women	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

21. Describe the functions of each of these committees:

1.…………
2.…………
3.…………
4.…………
5.…………
6.…………
7.…………
8.…………
9.…………
10.…………
11.…………
12.…………
13.…………

A. ORGANIZATION—*Continued*

22. What committees determine policies?..

....

23. What committee controls the budget?..

....

B. PERSONNEL

OBTAIN 2 COPIES OF ALL APPLICATION BLANKS

Size of Paid Staff:

PAID STAFF	PRESENT NUMBER	Number of Workers Who Left Agency from Oct. 1, 1921, to Oct. 1, 1922	REASON FOR LEAVING
1. Superintendent—Name and title...			
2. Assistant superintendents........			
3. Supervisors....................			
4. Assistant supervisors............			
5. Staff nurses....................			
6. Student nurses (graduate)........			
7. Student nurses (Undergraduate)..			
8. Attendants or practical nurses....			
9. Dietitians......................			
10. Occupational therapists..........			
11. Clerical workers (nurses)..........			
12. Clerical workers (not nurses).....			
13. Bookkeepers....................			
14. Auditors........................			
15. Accountants....................			
16. Housekeepers..................			
17. Maids..........................			
18. Janitors........................			
19. Other workers (specify)..........			
20. TOTAL NUMBER OF WORKERS...			

21. Make an organization chart showing the plan of organization, including type, number and distribution of workers, number of districts, relationships, etc.

Qualifications for staff nurses and special workers:

22. Age on appointment: Minimum........................ Maximum........................

23. Minimum general education (Give exceptions)..

....

24. Minimum professional training (Give exceptions)..

....

25. Is any experience in Public Health Nursing required? "Yes"............ "No"..........
If so, how much and what type?..

26. Is a personal interview with applicant required? "Yes"............ "No"..............

27. Are references looked up? "Yes".................... "No"..............................

B. PERSONNEL—*Continued.*

Physical Condition:

27. Is there provision for routine physical examination of applicants? "Yes"............... "No"....................

28. By whom is physical examination made?....................

29. What, in general, is the physical standard required of new workers?....................

30. What provision is made for re-examination of workers?....................

31. Where is record of physical re-examination kept?....................

32. What responsibility does the agency assume for promoting the health of the staff?....................

33. What responsibility do supervisors take for the physical condition of the staff?....................

34. Is preventive sick leave allowed?....................

35. How much yearly sick leave is allowed?.......... **36.** Is this uniform? "Yes".......... "No"..........

37. Is sick leave ever deducted from vacation period? "Yes".......... "No"..........

38. How much?.................... **39.** Under what conditions?....................

40. Is unused sick leave ever added to vacations?....................

41. Under what conditions?....................

Salaries (Monthly) See Schedule IV on Personnel for present salaries.

42. SALARY	Staff Nurses	Supervisors	Assistant Supervisors	Clerical Workers
Minimum.............				
Maximum.............				
Automatic Increase.....				
Rate of Increase.......				

43. Are the following furnished in addition to salary?

a. Uniforms?.................... Laundry?....................

b. Board?....................

c. Lodging?....................

d. Transportation?....................

e. Bags?....................

f. Supplies?....................

g. Other allowance?....................

Specify general or special funds for the following:

h. Sickness insurance....................

i. Workmen's Compensation....................

j. Group life insurance....................

k. Pension....................

l. Loan fund....................

B. PERSONNEL—*Continued*

Other than regular staff. List additional occasional salaries, such as:

44. Doctors: Fees for clinics, health centers, etc.

45. Auditors

46. Accountants

47. Others

Other than regular staff
Students

48. STUDENTS	POST-GRADUATE	IN TRAINING
a. Number		
b. Time given:		
Hours in week		
Weeks in a year		
c. Paid ("yes" or "no")		
d. If so, monthly rate		
e. Paid by whom?		
f. Uniforms provided: ("yes" or "no")		
g. Other items provided—housing, lunches, etc.		
h. Type of work assigned:		
Observation		
Selected cases		
In charge of district		
i. Visit counted same as staff nurses' visit		
j. Number of students to supervisor		
k. Describe plan of supervision		
l. Length of course		

49. Describe agency's affiliations with hospitals in regard to the training of students:

Substitutes:

50. Number from October 1, 1921, to October 1, 1922

51. How many of these were later taken on regular staff?

52. Under what circumstances are substitute nurses employed?
Vacation Epidemic Sickness Other

B. PERSONNEL—*Continued*

Other than regular staff—Continued

53. Prevailing salary

54. Describe standards for substitute nurses (cover age, education, professional training, experience)

55. Type of work assigned to substitutes

56. Describe plan of supervision of substitutes

57. *Volunteers.* Cover the following points for each type of volunteer such as clerical, motor, dressings, health stations, etc.:

a. Number of volunteers.
b. Hours a week volunteered.
c. Plan for training volunteers.
d. Type of work given to volunteers.
e. Plan of supervision.

C. ADMINISTRATION

Obtain 2 copies of standing medical orders and two copies of instructions for nursing technique and procedure in homes.

Training:

1. Describe plan of training new nurses, covering the following:

Use of training center..........

Conferences..........

Classes..........

Visiting with supervisor or staff nurse. (Specify whether in training or other district.)..........

Printed instructions:..........

Are standing medical orders used? "Yes".......... "No"..........

Are printed instructions for nursing technique and procedure used? "Yes".......... "No"..........

Other plans..........

2. Probation:

Length of probation period..........

On what is acceptance based?..........

3. Additional information on training:..........

Conferences and other educational methods:

4. Frequency of general staff meetings..........
5. Who plans program?..........

C. ADMINISTRATION—*Continued*

6. Who presides?
7. Extent of participation of staff in program
8. Type of subjects discussed in staff meeting
9. Frequency of supervisors' meetings
10. Type of material discussed
11. Frequency of case conferences. (*a*) between supervisor and staff; (*b*) local social or health conferences
12. Who attends?
13. What opportunities are there for the staff to go to lectures or classes related to their work?
14. Is this ever allowed during the working day? "Yes" "No"
15. Does the agency ever pay the tuition for this training? "Yes" "No"
16. What provision is made for nurses to use a technical or public library?

Remarks:

C. ADMINISTRATION—*Continued*

Supervision:

17. Schedule IV on Personnel will give number of supervisors and their training. On the back of each of these schedules add the number of nurses each supervisor has.

18. What is the minimum professional training required of supervisors?

19. What is the minimum experience in P.H.N. required of supervisors?

20. What determines the selection of the supervisor? Seniority
Leadership .... Good work as nurse .... Other

21. Who plans the nurse's day?

22. How often do nurses report to the supervisors in the main or branch office?
By 'phone or in person?

23. How does the supervisor check up on the nurse's daily work?

24. Outline the duties of the supervisor. (Include administration, clerical work, actual nursing, etc.)

25. What are the supervisor's contacts with the superintendent?

26. Outline the duties of the assistant supervisor

27. Attach to this sheet as much information as you can obtain from supervisors as to their ideas of what constitutes supervision.

C. ADMINISTRATION—*Continued*

Supervision—Continued

28. Describe the frequency and kind of supervision given, covering the following:

Frequency and length of conferences............

Visiting in home or clinic with nurse............

Visiting in home without nurse............

Reviewing records and day book............

Reviewing record before case is closed............

Final visit to patient before case is closed............

Inspection of bags............

Efficiency reports............

29. Remarks:............

C. ADMINISTRATION—*Continued*

Obtain 2 copies of all record forms and description of their use.

Record Writing:

30. Are individual or family records kept?..........

31. Are the same records kept for all patients, short and long service, pay or free?..........

If not, specify difference..........

32. Where does the nurse write her record? In home of patient..........
In her own home.......... Office..........
Other..........

33. If in the home of patient, are notes made on permanent record? "Yes"..........
"No"..........

34. Are these records copied? "Yes"...... "No"...... Typed? "Yes"...... "No"......

35. If typed, by whom?..........

36. What material is the nurse instructed to put in the record?..........
Entries for every visit..........

Condition of patient..........

Treatment given..........

Instructions given..........

Social situation..........

Report to doctor..........

Reports of conferences..........

Other..........

37. How many hours weekly are spent in recording for all cases?	For M.L.I. cases?
a. By supervisor..........	....
b. By assistant supervisor..........	....
c. By staff nurse..........	....

38. What patients are registered with Confidential Exchange? Pay.......... Free..........
Social problems..........
Other..........

39. Is registration made before the first visit? "Yes".......... "No"..........

40. If not, when is registration made?..........

41. Are copies of letters written by nurse filed with record? "Yes".......... "No"..........

C. ADMINISTRATION—*Continued*

42. What use is made of closed records and monthly reports with respect to:
Administration..

....

....

Development of new objectives..

....

....

Research...

....

....

Publicity...

....

....

43. Write on the back of this page a description of the course of a record from the time the case is reported until it is closed. Include assignment slips, day sheets, temporary records, etc.

Hours of Work:

44. What are the hours of work daily?...
Sunday?... Weekly?.......................................

....

45. Is night work expected? "Yes"................ "No"................ For what cases?

....

....

46. Is overtime work allowed? "Yes"........... "No"........... Under what circumstances?

....

....

....

47. Is time allowed off for night work? "Yes"............... "No"...............................

....

48. When nurses go on delivery service at night, how is time made up?.......................

....

....

49. Is there one whole day of rest a week? "Yes"............... "No"...............

50. Is there a weekly half-holiday in addition? "Yes"............... "No"...............

51. Is time spent in record keeping included in working day? "Yes"........... "No"...........

52. What is the vacation period yearly for:

a. Supervisors...

b. Staff nurses...

c. Clerical workers..

Uniforms:

53. By whom are uniforms furnished?...

....

54. By whom are uniforms chosen and passed upon?..

....

....

55. Describe uniforms...

....

....

....

C. ADMINISTRATION—*Continued*

Transportation:

56. Is transportation furnished to nurses for all district work? "Yes"........ "No"..........

57. Is transportation paid from home to office and return? "Yes".......... "No"..........

58. Are automobiles furnished? "Yes".................... "No"....................

59. How many? ....

60. Used in which districts?..........

61. Used for what purposes?..........

62. Used by supervisors only?..........

63. Is transportation furnished to patients? "Yes".................. "No"................

64. For what type of cases?..........

65. Is taxi service furnished to nurses for night work? (Specify when)..........

66. Is any suburban work done by association? (Describe)..........

Publicity: (Obtain 2 copies of all publicity material for last 2 years):

67. Who takes the responsibility for publicity?..........

68. Describe publicity methods of past year..........

Employment:

69. By whom are the following engaged and dismissed?
 - *a.* Supervisors..........
 - *b.* Staff nurses..........
 - *c.* Clerical workers..........

C. ADMINISTRATION—*Continued*

Quarters:

70. How is association housed? Specify whether building is (*a*) owned free; (*b*) owned with encumbrances; (*c*) rented; (stating rent); for:
Headquarters ....
District offices ....

71. Is there any provision for housing of nurses? "Yes" .... "No" .... If so, describe, stating amount paid by nurses ....

Policy regarding relief:

72. Financial relief. Is it ever given? ....
If so, under what circumstances? ....

73. Medical relief. Under what circumstances and how much is given? ....

Policy regarding continuance of cases:

74. What is the policy of the agency regarding closing of cases? (Give full particulars)

75. What is the technique of closing cases? (Summary, etc.) ....

76. What is the policy regarding the transfer of cases to other health or social agencies?

77. What is the policy regarding the refer of cases to other health or social agencies for specialized care? ....

D. TYPE OF WORK OF ASSOCIATION

TYPE OF CASE	GENERAL VISITING NURSING Give Reason Where Cases Refused. Otherwise Check.	SPECIALIZED SERVICE (Specify Whether Clinics, Bedside Care, Health Centers, etc.)	Frequency of Visits	Length of Time Carried	General Policy and Type of Service
Prenatal					
Delivery					
Postpartum					
Infant Welfare					
Child Welfare:					
Poliomyelitis					
Orthopedic					
Nutrition					
Other					
School					
Gen'l Medical and Surgical					
Contagious Diseases					
Tuberculosis					
Venereal Disease					
Health Education					
Industrial					
Chronics					
Mental Hygiene					
Social Service					
Hourly Service					

D. TYPE OF WORK OF ASSOCIATION—*Continued*

Analysis of cases for last fiscal year:

1. Dates of fiscal year..
2. Total number of patients........................ (*a*) Number of new patients..................
   (*b*) Number of patients brought forward from year before..........................
3. Number of patients discharged..
4. Give diagnoses of discharged patients (Complete table on form attached).
5. Number of visits for year:

KIND OF VISITS	NUMBER	COUNTED IN ESTIMATING COST	DEFINE
TOTAL....................			

6. Average number of visits per day per nurse for (*a*) nursing visits; (*b*) non-nursing visits. How computed?..
7. Number of visits on discharged patients classified by diagnosis (Add to table in No. 4 where figures are available.)
8. Cost of a visit (Define visit.)...
9. Fee for delivery service.............................. How computed?........................
10. Hourly service fee..

D. TYPE OF WORK OF ASSOCIATION—*Continued*

11. Sources of new patients. (Attach table)

12. Number of patients paying:

a. Full cost..........

b. Part cost..........

c. Nothing..........

d. M. L. I. patients..........

13. How is it determined whether a patient shall pay?..........

14. When the agency is unable to accept all patients referred to it, is the selection of patients accepted based on the ability to pay?..........

15. Does the agency try to meet the community sickness problem? How? (Determine whether there is selection of cases according to prevalence of disease groups in community.)..........

D. TYPE OF WORK OF ASSOCIATION—*Continued*

City........................

Table Showing (*a*) Diagnoses of Discharged Patients and Number of Visits by Diagnosis for Last Fiscal Year; (*b*) Causes of Death for City for Last Fiscal Year

Code No.	DIAGNOSIS (For City, Cause of Death)	No. of Cases % of Total		No. of Visits Average Visit		Mortality for City
		No.	%	No.	Avge.	
	Grand Totals					
	I—General Diseases (a. Epidemic Diseases):					
1	Typhoid Fever					
4	Malarial Fever					
6	Measles					
7	Scarlet Fever					
8	Whooping-cough					
9	Diphtheria and croup					
9a	Diphtheria					
9b	Croup (membranous)					
10	Influenza (grippe)					
14	Dysentery					
18	Erysipelas					
19a	Epidemic cerebrospinal meningitis					
19b	Chicken-pox					
	(B. Other General Diseases):					
20	Septicemia					
22	Anthrax					
23	Rabies					
24	Tetanus					
28	Tuberculosis of lungs					
29	Tuberculosis, acute miliary					
30	Tuberculous meningitis					
31	Abdominal tuberculosis					
32	Pott's disease					
33	White swelling					
34	Tuberculosis of other organs					
35	Tuberculosis, disseminated					
36	Rickets					
37	Syphilis					
38	Gonococcus infection					
39	Cancer of mouth					
40	Cancer of stomach and liver					
41	Cancer of intestines and peritoneum					
42	Cancer of genital organs (female)					
43	Cancer of breast					
44	Cancer of skin					
45	Cancer of other or unspecified organs					
46	Tumor (non-cancerous)					
47	Acute articular rheumatism					
48	Chronic rheumatism and gout					
49	Scurvy					
50	Diabetes					
51	Exophthalmic goiter					
52	Addison's disease					
53	Leukemia					
54	Anemic chlorosis					
55	Other general diseases					
56	Alcoholism					
57	Lead poisoning					
58	Other occupational poisonings					
59	Other chronic poisonings					

D. TYPE OF WORK OF ASSOCIATION—*Continued*

City........................

Table Showing (*a*) Diagnoses of Discharged Patients and Number of Visits by Diagnosis for Last Fiscal Year; (*b*) Causes of Death for City for Last Fiscal Year—*Continued*

Code No.	DIAGNOSIS (For City, Cause of Death)	No. of Cases % of Total		No. of Visits Average Visit		Mortality for City
		No.	%	No.	Avge.	
	II—Diseases of the Nervous System and Organs of Special Sense:					
60	Encephalitis					
61	Meningitis					
62	Locomotor ataxia					
63	Other diseases of spinal cord					
63a	Anterior poliomyelitis					
64	Apoplexy					
65	Softening of brain					
66	Paralysis					
67	General paralysis of insane					
68	Other forms of mental disease					
68a	Other diseases of brain					
69	Epilepsy					
70	Convulsions (non-puerperal)					
71	Convulsions of infants					
72	Chorea					
73	Neuralgia and neuritis					
74	Other diseases of nervous system					
75	Diseases of the eye and its adnexa					
76	Diseases of the ear					
	III—Diseases of Circulatory System:					
77	Pericarditis					
78	Endocarditis					
79	Heart disease					
80	Angina pectoris					
81	Diseases of arteries					
82	Embolism and thrombosis					
83	Diseases of veins					
84	Diseases of lymphatics					
85	Hemorrhages (except of lungs)					
	IV—Diseases of Respiratory System:					
86	Diseases of nasal fossa					
87	Laryngitis					
88	Diseases of the thyroid body					
89	Acute bronchitis					
90	Chronic bronchitis					
91	Broncho-pneumonia					
92	Pneumonia					
93	Pleurisy					
94	Congestion and apoplexy of lungs					
95	Gangrene of lungs					
96	Asthma					
97	Emphysema					
98	Other diseases of respiratory system					
	V—Diseases of Digestive System:					
99	Diseases of mouth					
99a	Dentition					
100	Diseases of pharynx					
100a	Tonsilitis					
101	Diseases of esophagus					

D. TYPE OF WORK OF ASSOCIATION—*Continued*

City..

Table Showing (*a*) Diagnoses of Discharged Patients and Number of Visits by Diagnosis for Last Fiscal Year; (*b*) Causes of Death for City for Last Fiscal Year—*Continued*

Code No.	DIAGNOSIS (For City, Cause of Death)	No. of Cases % of Total		No. of Visits Average Visit		Mortality for City
		No.	%	No.	Avge.	
102	Ulcer of stomach					
103	Other diseases of stomach					
104	Diarrhoea and enteritis (under 1 year)					
104a	Diarrhoea and enteritis (1 to 2 years)					
105	Diarrhoea and enteritis (2 years and over)					
106	Ankylostomiasis					
108	Appendicitis and typhlitis					
109	Hernia					
109a	Other obstructions of intestines					
110	Other diseases of intestines					
111	Acute yellow atrophy of liver					
113	Cirrhosis of liver					
114	Biliary calculi					
115	Other diseases of liver					
116	Diseases of spleen					
117	Peritonitis (non-puerperal)					
118	Other diseases of digestive system					
	VI—Non-venereal Diseases of the Genito-Urinary System and Anexa					
119	Acute nephritis					
120	Bright's disease					
122	Other diseases of kidneys					
123	Calculi of urinary tract					
124	Diseases of bladder					
125	Diseases of urethra, urinary abscess, etc.					
126	Diseases of prostate					
128	Uterine hemorrhage (non-puerperal)					
129	Uterine tumor (non-cancerous)					
130	Other diseases of uterus					
131	Ovarian tumors					
132	Diseases of tubes					
133	Non-puerperal diseases of the breast (cancer excepted)					
	VII—The Puerperal State					
134	Accidents of pregnancy					
135	Puerperal hemorrhage					
136	Other accidents of labor					
137	Puerperal septicemia					
138	Puerperal convulsions					
139	Puerperal phlegmasia alba dolens					
140	Other puerperal accidents					
For P.	H. N. Figures Only:					
	Pregnancy—total					
	Pregnancy—prenatal only					
	Pregnancy—delivery only					
	Pregnancy—postnatal only					
	Pregnancy—prenatal and delivery					
	Pregnancy—prenatal and postnatal					
	Pregnancy—delivery and postnatal					
	Care of newborn					
	Well babies					

D. TYPE OF WORK OF ASSOCIATION—*Continued*

City........................

Table Showing (*a*) Diagnoses of Discharged Patients and Number of Visits by Diagnosis for Last Fiscal Year; (*b*) Causes of Death for City for Last Fiscal Year—*Continued*

Code No.	DIAGNOSIS (FOR CITY, CAUSE OF DEATH)	No. of Cases % of Total		No. of Visits Average Visit		Mortality for City
		No.	%	No.	Avge.	
	VIII—DISEASES OF THE SKIN AND CELLULAR TISSUES:					
142	Gangrene					
143	Furuncle					
144	Abscess					
145	Other diseases of skin					
	IX—DISEASES OF BONES AND ORGANS OF LOCOMOTION:					
146	Diseases of bones					
147	Diseases of joints					
149	Other diseases of organs of locomotion					
	X—MALFORMATIONS:					
150	Hydrocephalus					
150a	Other congenital malformations					
	XI—DISEASES OF EARLY INFANCY:					
151	Premature birth					
151a	Congenital debility					
152	Other diseases of early infancy					
153	Lack of care					
	XII—DISEASES OF OLD AGE:					
154	Senility					
	XIII—AFFECTIONS PRODUCED BY EXTERNAL CAUSES:					
155-163	Suicide					
164	Poisoning by food					
165	Other acute poisonings					
166	Conflagration					
167	Burns					
168	Absorption of gases					
169	Drowning					
170-176	Injuries					
178	Cold and freezing					
179	Effects of heat					
180	Lightning					
181	Electricity					
182-184	Homicides					
185	Fractures					
185b	Injuries at birth					
186	Other external violence					
	XIV—ILL-DEFINED DISEASES:					
187	Ill-defined organic diseases					
189	Other ill-defined diseases					
189a	Unknown					
	Malnutrition					
	Not Found or Not Requiring Nursing Care					
	Health Instruction Only					

E. OTHER AGENCIES

Other Public Health Nursing Agencies:

1. For each public health nursing agency in the city give the following information:

NAME	Number of Nurses	Private or Public	Type of Work	Cooperation with Association Studied	Overlapping of Service in Area Covered by Association Studied

2. List any type of service which is lacking or meagerly developed................................

Other Social Agencies:

3. Describe the policy of the agency with regard to taking on special work with their patients, which other agencies are equipped to handle, such as relief, child placing, special case work problems, convalescents, etc.:

4. List agencies which are particularly useful to the association studied:

II ACCOUNTING

Accountant..................................

Date..................................

Name of Association.................................... City..................................

1. *a.* Has the Association a budget?..................................

   b. By whom initiated?..................................

   c. By whom considered?..................................

   d. When adopted?..................................

   e. Yearly Budget or reviewed monthly?..................................

2. If they have a budget, is it made a part of their Accounting System?..................................

3. Obtain copy of budget, showing detail of classification. (Attach to this page.)..........

4. Obtain descriptive circular as to items chargeable to various budget captions. (Attach)

5. If descriptive circular is not obtainable, carefully go over the budget items with the person in charge and prepare such a description, in sufficient detail to enable yourself and the committee to determine, for example; whether such items as office salaries are charged into office expense, general expense, or salaries in order that the value of comparison of the different organizations' reports may be established. (Attach)..............

6. Obtain copy of annual report for last fiscal year which must include all financial statements, showing classified expenses and cost per visit, if Association has such figures..................................

7. Cost of a visit?..................................

8. Reconcile figures used in arriving at cost per visit with figures shown in last annual report. (Describe in detail, giving figures for last year.)..................................

9. Does Association own any of the property used for nursing or administrative purposes?

a. Do they compute an interest charge on capital invested in this property in lieu of rent?

If so, how much?

If not, obtain such an interest charge. (State method of computing.)

b. If interest is charged, is it subject to a deduction for taxes, repairs to building, etc.?

If so, how much?

If not, obtain figures for taxes, repairs to building, etc.

c. Is any portion of the property revenue producing?

d. If so, state amount of revenue

10. What items in the statement of income and expenditures occasion your comment as being allocated in such a way as to confuse cost finding. Give details

11. Are there any services donated to the Association? (If so, number and list nature of services donated.)

Number consecutively the above services and after each number give the following information:

a. Is there a monetary value placed on such services?

b. If so, how much?

c. Is this figure included in the calculation of the cost per visit?

d. If no monetary value has been placed on volunteer services obtain an estimated value

12. Are there any supplies donated to the Association? (If so, number and list kind of supplies donated.)

Number consecutively the above supplies and after each number give the following information:

a. Is there a monetary value placed on such supplies?

b. If so, how much?

c. Is this figure included in the calculation of the cost per visit?

d. If no monetary value has been placed on these supplies, obtain an estimated value

13. Are there any other donations or contributions, excepting cash, on which a monetary value should be placed? (If so number and list.)

Number consecutively the above items and after *each* number give the following information:

a. Is there a monetary value placed on such contributions?
b. If so, how much?
c. Is this figure included in the calculation of the cost per visit?
d. If no monetary value has been placed on these contributions, obtain an estimated value

14. Does the Association have occupational therapy or other activities not coming directly within the scope of bedside care? (If, so itemize.)

For each of these activities, number consecutively and give the following detail:

a. Total annual cost
b. Number of visits per annum
c. Included in calculation of cost per visit?
d. If so, how?

15. Obtain form of case record card

16. Is provision for fees made on record card?

17. Are fees taken into General Cash as receipts of the organization?
Gross
Net

18. *a*. List total amount of fees divided into (*a*) payments in full, and (*b*) partial payments. (Give per cent. paying one-half, one-third, etc.)

b. List total amount of fees by type of service (such as "hourly," "Delivery," "Operations," etc.)

19. *a*. List sources of income

b. State method of acknowledging income

20. Does the Association keep a statistical record, showing when monthly donations fall due?

21. Does the Association keep a Member's Dues Ledger or Record arranged to show the month dues expire, for the follow-up of renewals?

22. Does the Association have investments?

a. Who is charged with the custody of these investments?

b. Are they carried as part of their accounting system?

c. Is an income "tickler" kept?

23. How many districts, branches or centers are there?

24. Is there a pension fund for nurses?

a. If funded by a charge to operations, state amount of such charge per year

25. Is there a nurses' sick benefit fund?

a. If funded by a charge to operations, state amount

26. *a.* Are accounts audited?

b. By whom?

27. *a.* Had Association a comprehensive accounting system?

b. By whom kept?

c. Is anything lacking?

28. Is accounting system on a cash or accrual basis?

29. Obtain list of books used with brief description of style and their use

30. Obtain copy of all loose leaf forms and description of use

31. Make a rough pencil draft of forms of bound books and give description of their use

32. What is counted as a visit?

1. *Patients "Out"*

a. Included in total number of visits for year?

b. Included in computing cost per visit?

c. If included, how? (Fractional or full?)

2. *Patients "Un-cooperative."*
   a. Included in total number of visits per year?
   b. Included in computing cost per visit?
   c. If included, how? (Fractional or full)

3. *Social Service visit.* (Visit to social agency, relatives, friends, etc.).
   a. Included in total number of visits for year?
   b. Included in computing cost per visit?
   c. If included, how? (Fractional or full?)

4. *Case Conferences.*
   a. Included in total number of visits for year
   b. Included in computing cost per visit?
   c. If included, how? (Fractional or full?)

5. *Visits to doctor on case.*
   a. Included in total number of visits for year?
   b. Included in computing cost per visit?
   c. If included, how? (Fractional or full?)

6. *Educational or instructive visits.*
   a. Included in total number of visits for year?
   b. Included in computing cost per visit?
   c. If included, how? (Fractional or full?)

7. *Examination of children in boarding homes.*

a. Included in total number of visits for year?

b. If more than one child is boarded by the family, is the visit counted as one or more?

c. Included in computing cost per visit?

d. If included, how? (Fractional or full?)

8. *Examination of day nursery children.*

a. Included in total number of visits for year?

b. Is each visit to the day nursery counted as one visit, counted as on an hourly basis, or estimated in terms of number of children? Describe

c. Included in computing cost per visit?

d. If included, how?

9. *Student's visit.*

a. Counted as equivalent of staff nurses' visit?

b. Included in total number of visits for year?

c. Included in computing cost per visit?

d. If included, how? (Fractional or full?)

e. Obtain complete data as to salary paid, equipment furnished, expenses paid for account or anything else given or paid for in lieu of cash

10. *Supervisors' visits in conjunction with nurse.*
a. Included in total number of visits for year?
b. Included in computing cost per visit?
c. If included, how? (Fractional or full?)

11. *Industrial.*
(Within the Industry.)
a. Included in total number of visits for year?
b. Is each visit to the industry counted as one visit, counted on an hourly basis or estimated in terms of employees seen? Describe
c. Included in computing cost per visit?
d. If included, how?

12. *Delivery Service.*
a. Counted as one visit?
b. Counted on hourly basis?
c. Estimated as a number of visits based on average number of hours for delivery?
d. What is delivery fee?
e. Do you think this pays for itself?
f. How treated in computing cost per visit?

13. How is delivery service treated in terms of visits when billing any organization which pays for services on a per visit basis?
a. Counted as one visit?
b. Counted on hourly basis?
c. Estimated as a number of visits based on average number of hours?

14. *Hourly Service.*
a. One hour or fraction thereof counted as one visit?
b. When a visit consumes more than an hour, how is it counted in terms of visits?
c. Hourly service fee
d. What is fee for fractional part of an hour?
e. How treated in computing cost per visit?

15. *Clinics and Health Centers.* How estimated in terms of visits?
a. Counted as one visit?
b. Counted on an hourly basis?
c. Estimated in terms of number of patients handled?
d. How treated in computing cost per visit?

16. *Overtime work.*
a Are nurses paid an additional amount for routine overtime work?
b. If not, how recompensed?

17. *Home visit to more than one member of family.*
a. If several members in home are cared for during the same call, is this counted as one or more visits?
b. How treated in computing cost per visit?

18. Where other types of visits, not nursing, are included in the analysis of the total number of visits for the year, give for each of these types of visit the following information:
a. Included in total number of visits for year?
b. Included in computing cost per visit?
c. If included, how? (Fractional or full?)

III—NURSING TECHNIQUE

Investigator..

Nurse..

Name of Association.......................................City.................. Date............

How long has nurse been with Association?...

Name of patient... Address..............................

1. Diagnosis of patient...
2. Source (by whom referred)?...
3. Date of first visit on case.................. 4. Number of previous visits.....................
5. Give the strong and weak points in the approach to the patient...........................
....
....
6. List what nurse did and methods employed. (What nursing care was given, advice given, questions asked, information obtained, etc.)...
....
....
....
....
7. Length of visit..
8. What should nurse have done that she did not do?..
....
....
....
....
9. How much additional time would this have taken?..
10. Did nurse have orders from doctor? "Yes"........................ "No"....................
11. What did nurse report to the doctor?...
....
12. When did she report to the doctor?...................... 13. How?.......................
14. Where did she leave report to doctor?..
....
15. Did nurse contaminate contents of bag? .... How?..........................
....
16. Did nurse contaminate patient or surroundings?.................... How?..................
....
17. How was visit organized?..
....
....
18. What use was made of opportunities to teach?..
....
....
19. Were the principles taught, demonstrated or merely stated?................................
....
20. Describe family's reaction to visit..
....
....
21. When did nurse make entries on the record?...
22. Where was nurse when she made entries?...
23. (Attach a copy of the nurse's entry.)

IV—PERSONNEL

Name of Association.............................. City........................ Date................

Name or Number......................... 1. Date appointed......................... 2. Age........

3. Position to which appointed.......................... 4. Initial monthly salary..............

General Education:

TYPE OF SCHOOL	Name of School, City and State	Number of Years Attended	Graduate ("Yes" or "No")
5. Grammar or Parochial School...	....	....	....
6. High School..................	....	....	....
7. College......................	....	....	....
8. Other Schools not Nurses'...... Training Schools............	....	....	....

Professional Training:

Nursing (Undergraduate)

9. Name and address of nurses' training school..

....

10. Graduate: "Yes"...... "No"...... Year of graduation........ Length of course..........

11. Registered nurse: "Yes"...... "No"...... If so, state and year..........................

12. Member of N.O.P.H.N.: "Yes"............... "No" ....

Postgraduate Courses in Nursing:

13. SCHOOL, CITY AND STATE	Length of Time Attended	Year	Subjects Studied
....	....	....	....
....	....	....	....

Other Professional Training, such as School for Social Work, Normal, etc.:

14. SCHOOL, CITY AND STATE	Length of Time Attended	Finished ("Yes" or "No")
....	....	....
....	....	....

Previous Experience (Include volunteer work):

Nursing—Give in chronological order:

15. Kind of nursing Dates

....

....

Other professions:

16. Kind of work Dates

....

....

Physical Condition:

17. Was physical examination given before appointment: "Yes"........... "No".........

18. Did examiner consider applicant physically fit to carry on her work with agency: "Yes"............... "No"...............

Present Status:

19. Present position..

20. Present salary..

V—RECORDS

Pay..........................
M. L. I.......................
Free.......................... Investigator..
Name of Association.................................. City......................... Date..................
Record Number.................. 1. Date of first visit...

2. Is there a record of case being registered with Confidential Exchange? "Yes"............ "No"....................
3. If so, date of registration...................... 4. Before or after first visit.....................
5. List diagnosis involved in case...

Record Forms:

6. List, by number, the record forms the agency has developed for such diagnosis..........
....
7. List, by number, the record forms actually used in this case..................................
8. List, by number, the items left blank on each record form..................................
9. List, by number, the items partially filled in, but unsatisfactory..............................
10. List, by number, the items which are not applicable in this case...............................

Current History:

11. Are Entries kept for each visit? "Yes"......... "No"......... 12. If not, how often is information summarized?...
13. If not, is each visit recorded on daily report sheet? "Yes"................ "No"............
14. Is description of patient's physical condition given for each visit? "Yes"...... "No"....
15. Where given, is it adequate.................. fair.................. poor...........................
16. Is description of physical care given by nurse recorded for each visit? "Yes"........... "No"................
17. Where given, is description adequate.................. fair.................. poor..............
18. Is description of instructions given by nurse recorded for each visit? "Yes"............ "No"....................
19. Where given, is description adequate.................. fair.................. poor..............
20. Is there a record of the nurse's findings being sent to the doctor? "Yes"....... "No"......
21. By telephone......... By mail......... 22. How often are reports sent?..................
23. Is description of social situation recorded? "Yes"......... "No"......... 24. Where given, is description adequate .... fair.................. poor....................
25. How long after the first visit was the social situation recorded?...............................
26. Is description of the social treatment recorded? "Yes"............ "No"..................
27. Where given, is description adequate.................. fair.................. poor..............
28. Is there a record of any letters having been written? "Yes"........... "No"................
29. Are copies of letters filed with record? "Yes"...................... "No"..................
30. Are agencies registered with Confidential Exchange consulted? "Yes"....... "No"........
31. If so, is the information recorded, adequate............. fair.............. poor..............
32. Are contacts with other agencies noted in the record? "Yes"........... "No"............
33. If so, is the description of this contact adequate............. fair............. poor............
34. Is the name of the doctor recorded? "Yes"........... "No"........... 35. Are the doctor's orders recorded? "Yes"................. "No"....................
36. Is case closed or open?.......................... 37. If closed, how long after last visit before closed?..................... 38. If open, how long since last visit?.........................
39. Was nurse's observation of patient's physical condition recorded when case was closed? "Yes"........... "No"........... 40. On whose decision was case closed? .... 41. Reason for closing..
42. If case was closed, but further care needed, such as hospital or clinic, was definite arrangement for such care made?..
43. Length of time covered by record...................... 44. Total number of visits............