REPORT ON HOSPITAL SCHOOLS OF NURSING
1957

NATIONAL LEAGUE FOR NURSING
Department of Diploma and Associate Degree Programs
1959
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Report on Hospital Schools of Nursing
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Description of the Study

Of the many types of educational programs in nursing, the largest group is comprised of basic professional programs which lead to a diploma and which are under the control of hospitals or of independent, noncollegiate bodies." In January 1957, there were 924 of these programs; their total enrollment, as of the previous October, was 91,553. In 1956, they graduated 25,244 students—86 percent of the total number of all students who were graduated during that year from basic professional programs in nursing.

Any group of schools which makes such an overwhelming contribution to the personnel of a profession constitutes a suitable subject for study not only by the schools themselves and by the profession but by all those who are served by the profession. The educational practices engaged in by these schools cannot help but have a tremendous effect on the quality of nursing care that is provided to the public. Are the concepts of nursing absorbed by the students in line with the kind of nursing care that will be required tomorrow and the day after tomorrow? Are the students given opportunity to develop the abilities and competencies requisite for the realization of these concepts in their nursing practice? The answers to these questions have a very real bearing on the health care, and therefore on the health, of the public.

Aside from this ever-present reason for scrutiny of the educational programs in which the bulk of professional nursing personnel are prepared, the fact that 1957 marked the culmination of an important phase of the School Improvement Program of the National League for Nursing makes the present investigation of their educational practices a timely one.

This program, which was made possible by grants from the Commonwealth Fund, the National Foundation (then the National Foundation for Infantile Paralysis), and the Rockefeller Foundation, was launched in July 1951. The first few years were spent in helping schools of basic professional nursing to examine their purposes, to identify the educational practices and resources through which these purposes could be achieved, and to determine the degree to which they were observing these practices and providing these resources. During this period, some schools found that they could meet the criteria for NLN accreditation and, when their self-evaluation had been confirmed by the NLN’s evaluation, were recognized as being “fully accredited.” Other schools, which were able to meet less exacting criteria, were designated as being “temporarily accredited.”

In the second phase of the School Improvement Program, from 1955 through 1957, the NLN made an intensive effort to help those schools which were not fully accredited to strengthen their educational programs to the point where they could merit the status of full accreditation. Each school with a temporarily accredited or nonaccredited program was offered a one-day consultation visit free of charge. In addition, annual conferences of all schools of nursing within a state were arranged when the schools in the state indicated that they wished such a conference. During this three-year period, 680 consultation visits were provided to hospital schools of nursing and 85 state conferences were held.

Many of the results of these efforts are, of course, not yet fully apparent; it sometimes takes several years to effect major changes in educational practices. Nonetheless, 1957 would seem to be a logical time for hospital schools of nursing to measure the progress made during this period of concentrated effort.

Purposes

This report, then, was designed to help hospital schools of nursing determine where they stand in relation to their goals and, on the basis of this stock-taking, to plan the emphasis and direction of their continuing efforts to improve their programs. The aims of this study also, of course, take into account the data available for the achievement of these aims. In this connection it should be pointed out that no data have been collected for the sole purpose of making this report; all data utilized were intended primarily for some other use. These data will be used in this report for the following purposes:

1. To picture, insofar as possible, the educational practices and resources characteristic of hospital schools of nursing in 1957
2. To show the changes that have taken place in these schools since data were collected in 1949 and 1951—again insofar as this is possible
3. To distinguish, to the extent feasible, between the educational practices and resources of schools of recognized excellence (schools with fully accredited programs) and
those of schools which, in 1957, had not yet achieved such recognition (schools with temporarily accredited and nonaccredited programs)†

4. To identify those areas of educational practice which apparently present problems to a large number of hospital schools.

**Sources and Limitations of Data**

**1957 Questionnaire**

In each of the three years 1955, 1956, and 1957 during which free consultation services were provided to schools which were not fully accredited, these schools were asked to fill out a "Questionnaire on Educational Practices in Basic Professional Schools of Nursing." The primary purpose of this questionnaire was to assist the consultants in their preparation for the consultation visits. The last questionnaire, which was returned in February 1957, was also sent to schools which had been fully accredited at the beginning of 1955. From the information secured on this last questionnaire, it was thought, a fairly good picture could be drawn of educational practices in hospital schools of nursing.

**Number of Schools.** This questionnaire was answered by 798 schools. These 798 schools constitute 86 percent of the hospital schools in the country and account for 90 percent of the enrollments in these schools. From Table 1, which shows their accreditation status, it will be seen that they were well distributed according to levels of recognized educational quality. The educational practices reported by 4. To identify those areas of educational practice which apparently present problems to a large number of hospital schools.

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**TABLE 1**

<table>
<thead>
<tr>
<th>Accreditation Status</th>
<th>Hospital Schools</th>
<th>Hospital School Enrollments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>In Study</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Fully accredited</td>
<td>263</td>
<td>28.5</td>
</tr>
<tr>
<td>*Temporarily accredited</td>
<td>502</td>
<td>54.3</td>
</tr>
<tr>
<td>Other</td>
<td>159</td>
<td>17.2</td>
</tr>
<tr>
<td>Total</td>
<td>924</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Considered as nonaccredited in this report.

them might therefore be expected to be fairly representa-

† In 1957, the NLN was still evaluating educational programs according to criteria for "temporary accreditation" which were less exacting than the standards for "full accreditation." Since January 1958, only one set of accrediting criteria has been used, and the category of "temporary accreditation" has disappeared. In this report, therefore, only two types of accreditation status are recognized—(1) "accredited" (that is, fully accredited) and (2) "other" or "nonaccredited."

The primary purpose of this questionnaire was stated on the first page:

The information submitted by a school will serve to provide information about its program for a consultant of the Department of Diploma and Associate Degree Programs as she prepares to make a consultation visit to the school.

* The questionnaire is reproduced in the Appendix.
Another purpose, corollary to this primary one, might have been stated, namely:

The self-study which a faculty group will undertake in order to answer the questionnaire will help it in identifying the weaknesses in its program and thus be the beginning step in strengthening the program.

Reports from consultants following their visits indicate that the primary purpose was achieved. Not only were the data for each school of use in giving the consultant a fairly concise picture of the school that she was about to visit; a "reading between the lines" sometimes provided clues to the problems that were confronting the faculty. For instance, omission of information or confused reporting about curriculum content might suggest that some of the faculty members who were implementing the curriculum were not participating in planning it.

The extent to which the questionnaire stimulated productive self-study by faculty groups will have to be determined by each faculty group itself. Certainly, there are indications of increasing self-study on the part of hospital schools of nursing throughout the period of the School Improvement Program: More and more articles on "Our Faculty Begins to Study This or That Phase of Our Educational Program" appeared in the professional magazines and the League Exchange; the NLN's Self-Evaluation Guide for Schools of Nursing Offering Programs Leading to a Diploma sold in the thousands; requests for consultant help over and beyond the free one-day visit mounted. It would be impossible to determine, however, the extent to which this trend toward self-study resulted from the questionnaires and the degree to which it was stimulated by other activities connected with the School Improvement Program such as state and regional conferences, activities of the Council of Member Agencies of the Department of Diploma and Associate Degree Programs, and NLN publications.

The questionnaire also listed a secondary purpose:

The information as submitted by all schools will provide data for the study of educational practices in nursing across the country.

This report has been planned to fulfill this secondary purpose.

**Limited Usefulness of Quantitative Data**

At first glance, the questionnaire would appear to be an excellent instrument for collecting data for the study of educational practices in hospital schools of nursing. Certainly, it was far more inclusive than were those which yielded data for the "school portrait" reports of a few years ago—Nursing Schools at the Mid-Century" and the Study of Basic Programs Offered by Schools of Nursing" which was published as Part I of the report on the temporary accreditation program. Also, as has been pointed out, a large and representative group of schools replied to the questionnaire. It might be expected that enough data would be available not only to furnish a current picture of hospital schools of nursing but also to afford a comparison between this 1957 picture with the pictures that were drawn from data collected in 1949 and 1951.

It must be remembered, however, that in the years since 1949 many changes have been effected in schools of nursing and that, as schools improve, numerical data become relatively less important for descriptive purposes. To give an example, in answer to the question: "Is there an organizational chart showing relationships and lines of authority in the school?", 778 of the 798 schools answered "Yes" and only 20 answered "No." Those who were studying the data recognized that practically all schools of nursing have reached the stage where they have an organizational chart; the point for study now is the extent to which the allocation of responsibility and authority is in accordance with sound principles of educational administration and whether this allocation as it exists in actuality is accurately portrayed on the organizational charts. Again, the time has come when those who want to see a picture of schools of nursing are less interested in the amount of experience in various clinical areas than they are in the quality of this experience and in the correlation between classroom and laboratory learning experiences. Nor is there any way of measuring the "educational climate" of a school; yet the enthusiasm of faculty, students, and all other participants in the educational program often counts for more than factors that can be measured quantitatively. In other words, while quantitative data still are of value in describing educational practices in hospital schools of nursing, they are less useful than they were in 1949 and 1951.

**Other Data**

As has been stated, the answers to the 1957 questionnaires often pointed to beneath-the-surface problems that are confronting faculties in hospital schools of nursing. Knowledge about these problems has also been accumulated by the members of the staff of the Department of Diploma and Associate Degree Programs during their visits to schools, at the state conferences held in connection with the School Improvement Program, and at other NLN conferences such as those on curriculum development.

In the opinion of these staff members, information about major problems that has been acquired from various sources would be more useful than a mere summary of the answers to the questions on the 1957 questionnaire. Accordingly, this report includes a discussion of what seem to be the outstanding problems of hospital schools of nursing plus a presentation of those findings from the 1957 questionnaire that might shed light on their underlying causes.

* The four schools that did not reply to this question were counted as not having organizational charts. Throughout this report, "No answer" has been interpreted as "No" or "0" whenever this interpretation has seemed to be logical.
In accordance with the purposes of this report, the data from the 1957 questionnaire were tabulated so as to reveal any differences between (1) hospital schools as they were at the mid-century and hospital schools in 1957 and (2) hospital schools with accredited programs and those whose programs had not become accredited by 1957.

Determination of Typical Practice

To permit comparison with the data on hospital schools collected in 1949 and 1951, extent of practice was determined on the basis of the number or percentage of schools reporting such practice, and "typical practice" was regarded as the practice reported by the median school. This method, it will be noted, gives an equal weighting to every school, large or small. Although the school with 50 students accounts for only one-tenth the volume of nursing education as does the school with 500 students, the two schools are counted as equal in arriving at majority or typical practice.

Another way of determining extent of practice would be in terms of the number or percentage of students affected by each kind of educational practice. Because of the wide range of enrollments in schools of nursing, this method might have yielded quite a different picture of "typical practice." For example, data for the fall of 1956 indicate that there were five times as many small schools with enrollments of under 50 students as there were large schools with 250 or more enrollments—218 small schools as against 44 large schools. According to the method that has been used, the influence of the small schools on majority or typical practice is five times greater than that of the large schools. Yet there were over twice as many students enrolled in the large schools as there were in the small schools—15,028 as against 6,952. Could it not be argued that the educational practices in these large schools would have twice the impact on the preparation of nurses as have the small schools?

As a further illustration of this point, consider a group of five schools which vary with respect to number of enrollments and number of full-time faculty members as follows:

<table>
<thead>
<tr>
<th>School</th>
<th>No. of Students</th>
<th>No. of Full-time Faculty Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>300</td>
<td>14</td>
</tr>
<tr>
<td>B</td>
<td>200</td>
<td>10</td>
</tr>
<tr>
<td>C</td>
<td>125</td>
<td>7</td>
</tr>
<tr>
<td>D</td>
<td>100</td>
<td>6</td>
</tr>
<tr>
<td>E</td>
<td>75</td>
<td>4</td>
</tr>
</tbody>
</table>

In this distribution, the typical (or median) school has 125 students and 7 full-time faculty members, but the typical student is in a school with 10 full-time faculty members, and as many future nurses are being prepared in schools with 10 or more full-time faculty members as are being prepared in schools with 10 or fewer. A faculty body consisting of 10 full-time members might therefore be considered to be more representative of typical educational practice than one with 7.

Grouping of Schools

To permit comparison between accredited and other hospital schools, and to provide a picture of those schools which achieved accreditation during the second phase of the School Improvement Program, the 798 schools in the study were divided into three groups as follows:

GROUP A: The 189 schools whose programs were accredited (fully accredited) by the NLN prior to 1955 when the free consultation visits to the schools were started. These schools were not offered the opportunity for free visits, but they were asked to fill out the 1957 questionnaire.

GROUP B: The 58 schools whose programs became accredited (fully accredited) by the NLN after consultation visits began, that is, between 1955 and February 1957.

GROUP C: The 551 schools whose programs were not yet fully accredited by the NLN at the time the 1957 data were collected, that is, by February 1957. At the time of the study the NLN was still evaluating educational programs according to criteria for "temporary accreditation" which were less exacting than the standards for accreditation (or "full accreditation" as it was then called). Included in Group C are the 447 schools whose programs were then temporarily accredited and the 104 whose programs were not accredited by the NLN at that time.

REFERENCES

The Over-All Picture

The hospital school of nursing of 1957 in most instances has come a long way toward achieving the characteristics of a truly educational institution. Although its students are to some extent still utilized for staffing the nursing services, its major concern is the development of its students. Preparation for nursing practice is, of course, its primary aim (as is true of all schools providing basic programs in nursing), but its offerings extend beyond those required for technical or vocational training into those which provide the type of broad educational background that makes for personal as well as professional development. This is the general impression that emerges from a study of the educational practices reported on by these schools in 1957.

Growth since 1949 and 1951

Comparison of the 1957 data with those collected in 1949 (reported in Nursing Schools at the Mid-Century) and in 1951 (reported in Part I of the Report on the Program of Temporary Accreditation of the National Nursing Accrediting Service) indicate the extent to which the hospital school has "educationalized" itself during the past few years.

Consider, first, the scope and tone of the questionnaires sent out on these three occasions. In neither the 1949 nor the 1951 questionnaire is there any mention of the school's philosophy or purposes; six questions in these areas appeared on the 1957 questionnaire. The 1949 and 1951 questionnaires inquired about the number of weeks students are "on duty" in the evening and at night. The 1957 questionnaire asked not only about the amount of evening and night "experiences" but also about the planning of these experiences and their placement in the curriculum. These are but two examples which demonstrate the "schoolishness" of the 1957 questionnaire in contrast to those issued only a few years earlier.

The point might be made, of course, that the three questionnaires were constructed in offices, not in the places where nursing education takes place. It must be remembered, however, that in all three instances they were drafted by people who had been in scores of schools of nursing and had been conversing with hundreds of teachers of nursing and who, moreover, were anxious to get answers to their questionnaires. It might be assumed, then, that the questionnaire-drafters tended to ask questions that would be recognized as important and to phrase them in the language that would have the most meaning to those to whom they were sent. While such euphemisms as "delving instruments" might be used on other occasions, in questionnaires a spade is called a spade when it is thought of as such by those from whom a reply is sought. It is likely that questions about philosophy were not included in 1949 and 1951 because it was recognized that such questions might be regarded as unimportant to a considerable number of schools. (As a matter of fact, half the 798 schools reporting in 1957 had not developed any statement of philosophy prior to 1949.) Again, the change in terminology from evening or night "duty" to evening or night "experience" probably indicates a growing belief that when assignments for evening and night hours are made, consideration should be given to what the student will learn from these assignments.

This increasing recognition that the student and her development is the main concern of any school has resulted in changes in practice as well as in attitude. To give an illustration, according to the 1949 data, 349, or 30 percent, of all reporting schools, hospital and collegiate, allowed their students fewer than two weeks of sick leave during the entire program, and 204, or 18 percent, of them allowed none.1 In contrast, of the 798 hospital schools reporting in 1957, only 28, or 4 percent, allowed fewer than two weeks of sick leave. Furthermore, during their visits the consultants observed, in many schools, a change in attitudes about the purpose of compensatory time. Formerly, the "make-up" assignment was equivalent to the missed assignment in length of time only and was not necessarily scheduled in the same curriculum area. Now, despite the continued use of terminology that is more suited to a work situation than to an educational one ("sick leave" rather than "absence for sickness"), many schools have developed an educational attitude toward "make-up" time; such time is arranged to provide the student with the learning experiences that she missed.

Other examples of changes since 1949 will be mentioned as the various areas of practice are discussed in this report. These examples have been offered here to show why the general impression of the educational character of the schools gained from the 1957 questionnaire is so different from that gained from earlier ones.
Differences among Schools

The fact that the hospital school of nursing now more truly merits the name of "school" does not mean that all hospital schools are at the same stage of educational development. This fact should be taken into account in plans for future school improvement projects so that schools can be helped to move forward from the point at which they now stand. Accordingly, in the discussion of each area of educational practice, attention will be drawn to the differences exhibited by schools accredited prior to 1955 (Group A schools), those accredited in the 1955-57 period (Group B schools), and those which in 1957 were still working toward the goal of accreditation (Group C schools).

The data from the 1957 questionnaire also revealed certain differences in general characteristics of the A, B, and C schools which might have a bearing on the problems which they face and the way in which these problems are approached. Figures 1 and 2 show that the typical schools

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**FIGURE 1**

Enrollments in Typical Schools in Groups A, B, and C, and Range of Enrollments in Middle Half of the Schools in These Groups

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**FIGURE 2**

Daily Average Adult Censuses in Typical Hospitals Conducting Schools in Groups A, B, and C, and Range of Censuses in Middle Half of These Hospitals

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in these three groups differ from each other considerably with respect to size of student body and patient census of the controlling hospital. The typical school in Group A is twice as large as the typical Group C school and is controlled by a hospital that has about twice as many adult patients as the hospital which conducts the Group C school. The typical Group B school and its hospital stand between the typical Group A and C schools and their hospitals. These differences, of course, do not hold for all schools in each group; there were some small schools in relatively small hospitals in Group A and some large schools in very large hospitals in Group C. In the main, however, large schools controlled by large hospitals have been able to meet the criteria of NLN accreditation sooner than the smaller schools in smaller institutions.

This relationship between caliber of education and size of school and controlling hospital was also apparent in the study based on the 1949 data. As has been stated, it is not a universal relationship and therefore not a necessary one. It is, however, an understandable one. Educational practices are, to a certain extent, dictated by the resources that are available to the school and the educational climate that pervades its setting. Large schools connected with large hospitals are likely to have more resources, or more easily available resources, than do small ones; large hospitals are more inclined to be associated with educational programs for other professional groups and therefore more understanding of educational objectives and problems. Generally speaking, therefore, the small school in the small hospital requires more time to secure or develop necessary resources and to bring about the essential understanding of its needs and purposes.

As has been stated, throughout this report mention will be made of problems that have apparently been solved by most of the Group A and Group B schools but that are still confronting many Group C schools. It might be well for those who are seeking solutions to these problems to think about how they might be approached by the small school of nursing associated with a relatively small hospital.

REFERENCES

2. Ibid., pp. 8-9.
Specific Characteristics of Schools

Philosophy and Purposes

Any group of people who are working together need to be in agreement about the goals toward which they are working and the philosophy on which these purposes are based. In the case of a hospital school of nursing, it is important that all those involved in the educational program—faculty, hospital administration, instructional personnel in cooperating institutions and agencies, service personnel in all the clinical facilities, and students—have a clear understanding, first, of the school's philosophy or basic beliefs about nursing and education, and secondly, of its purposes or the objectives toward which it is aiming. Written statements of the philosophy and purposes of the school are therefore important instruments for helping all participants in the educational program direct their efforts toward the same end.

Apparently, the need for such guidelines is recognized by hospital schools. On the 1957 questionnaire, all but 8 of the 798 schools reported that they had such written statements of philosophy, and all but 7 had statements of purposes. It is also apparent from responses to the questionnaire that many of the schools have recognized this need only recently. Of the 698 schools which were able to report the date when their statements of philosophy were originally formulated, 248, or 36 percent, reported the date of origin to be during or since 1951—the beginning date of the NLN School Improvement Program. In 105 of the 695 schools which reported the date of the first statement of purposes, this statement had been developed in 1951 or thereafter.

The recency with which these statements have been reviewed or revised is also significant owing to the rapidity with which concepts of nursing education are evolving. With the growing emphasis on rehabilitation and promotion of health as goals of health care, the teaching component of nursing is assuming larger and larger proportions. To help patients select and adapt their activities to a "healthful way of life" involves knowledge of human behavior and the way in which people learn to a far greater extent than do administrations directed solely toward the patient's comfort and the cure of his disease. Up-to-date philosophies of nursing education now recognize that the learner (patient) is an active participant in the educational process rather than a passive receptacle for information imparted by the nurse. Objectives of educational programs in nursing therefore stress the development of the student's abilities to communicate, interpret, and secure the cooperation of others—abilities required for doing things with the patient rather than to or for him. This philosophy of education is also reflected in modern teaching methods which give the student a voice in determining her educational objectives and evaluating her progress toward them.

The questionnaire returns show that hospital schools of nursing recognize the rapid obsolescence of statements of philosophy and purposes which, only a few years ago, might have been considered adequate. Eighty-three percent of the 798 schools reported that they had reviewed their statements of philosophy within the past three years, that is, from 1955 to 1957; 84 percent had reviewed or revised their statements of purposes within this period.

Despite the optimistic interpretations that might be made from these findings, the limitations of the questionnaire returns for any real evaluation are readily apparent. While the findings suggest that schools recognize the need to have up-to-date written statements of philosophy and objectives, they do not guarantee that the new statements are consistent with evolving concepts of nursing and education. They do not show whether the ideas in these statements are expressed with sufficient clarity and specificity to provide a real sense of direction in the development of the educational program or whether they are couched in such broad and general terms that they could be subject to a variety of interpretations. Nor is there any way of knowing the extent to which the statements are truly understood and accepted. Have students been given opportunity to learn how to develop relationships with patients so that they can work cooperatively with them, or do they rush from one patient to another with only time to do things for each one? Do the students experience, with their teachers, the kind of teacher-learner experiences that they are expected to develop with patients? Are the beliefs and purposes of agencies and institutions which cooperate in the program in harmony with those of the school? These are important questions which cannot, of course, be answered by the data secured from the 1957 questionnaire.

There is evidence from other sources, however, that hospital schools have formulated new statements of philosophy and purposes for use and not for exhibit purposes only. Within schools, more meetings are held for the discussion of the educational program, including its philosophy, purposes, and objectives, and these meetings include teaching as well as administrative personnel. The behavior of school faculty members during consultation visits and at the NLN curriculum conferences reflects an earnest desire to revise practices as well as statements and to search out the best ways of bringing such revision
Group B schools, and 488 Group C schools, or about 85 per-
both those on the faculties of nursing schools and those
schools of nursing receive instruction—but it also excludes
for the typical hospital school. Moreover, any ratio of
instructors would not reveal the ratio of students to

obtained, there were 8,312 nurse faculty members, 5,228
the total number of students to the total number of
students. Not only does it exclude all non-nurse teachers
with the number of personnel engaged in teaching the
program. This number of 8,312 should not be confused
with the number of personnel engaged in teaching the
students. Not only does it exclude all non-nurse teachers
both those on the faculties of nursing schools and those
in colleges and universities in which students in some
schools of nursing receive instruction—but it also excludes
nurse teachers in other schools of nursing and hospitals
to which students are sent "on affiliation." Therefore, even
if enrollment data were available, it would be difficult,
if not impossible, to calculate a student-instructor ratio
for the typical hospital school. Moreover, any ratio of
the total number of students to the total number of
instructors would not reveal the ratio of students to
instructors in any one curriculum area. What might appear
like an adequate over-all ratio could obscure the fact that
the number of instructors in maternity care, for example,
was grossly insufficient for the number of students.

It is, however, possible to study some of the character-
istics of the groups of nurses who carry full faculty
responsibilities—who, with non-nurse faculty members,
are responsible for establishing the educational and student
welfare policies, for developing the curriculum, for
selecting the clinical and academic learning fields, for
delегating instructional responsibilities to other groups,
and for selecting, promoting, and graduating the students.
Such a faculty group is an important entity in itself as
well as being a segment of a larger group of instructional
personnel.

Among the important characteristics of this nurse
faculty group is the number of nurses who comprise it.
Size alone does not, of course, guarantee that a faculty
group will include people with a variety of skills and
viewpoints. Similarity of background and years of shared
interests may have resulted in a "peas in a pod" faculty.
Again, the benefits of diverse viewpoints may be obliterated
by an authoritarian, director-dominated atmosphere.
Nonetheless, the larger the faculty, the greater the opportunity
it has to encompass the broad range of abilities that the
scope of faculty responsibilities would seem to require.

It is significant, therefore, that between 1951 and 1957
the average number of nurse faculty members in hospital
schools of nursing rose from 8.7 per school to 11.9,
and the average number of full-time nurse faculty mem-
bers from 5.0 to 7.5 (Table 2, page 10). This increase
is probably due in part to the growth in the size of the
schools. It undoubtedly reflects, also, an increasing aware-
ness of the diversity and time-consuming nature of faculty
responsibilities. The trend toward more full-time nurse
faculty members also suggests a growing realization that
faculty activities cannot be "squeezed into" the time left
over from those of nursing service.

Table 3 (page 11) shows the differences between the
Group A, B, and C schools in the average number of nurse
faculty members. As might be expected, these averages
vary in accordance with the size of the school which is
typical of each group; the generally smaller Group C
schools have, on the average, smaller faculties than do the
generally larger Group A schools. It is encouraging to note,
however, that apparently many small schools have been
able to increase their faculties to a size requisite for sound
nursing education. Today, the typical Group C school has
an enrollment of 70 students. In 1951, fully accredited
schools of this size averaged 6 full-time nurse faculty mem-
bers, the same average as the Group C schools showed in
1957. Apparently, the small-faculty obstacle to sound edu-
cational practice is being met and overcome by many Group
C schools.
Academic Preparation of Nurse Faculty Members

The history of nursing education has been marked by the struggle of nurse educators to get the kind of preparation that is usually considered necessary for those who are teaching others. It is recognized, of course, that formal preparation in a university is not the only road toward competency in teaching or educational administration and that some nurses have been able to develop such competence through long years of experience. Even as far back as 1893, however, when the “superintendents of nurse training schools” had their first opportunity to meet and discuss their aims and problems, the hazards of trial-and-error attempts at self-education were recognized.

... the majority [of directors of nursing schools] are forced to assume the charge of training schools with no equipment for the work further than that they have been able to acquire as head-nurses; and the hospital, school, and often the new superintendent herself suffer accordingly while she is gaining the necessary experience. In fact a Normal School for preparing women for such posts is quite as necessary as those established for other kinds of teachers.2

The fact that all nurse educators do not yet have the academic preparation that might be expected of those who are engaged in professional education should not obscure the extent to which progress has been made toward this goal. In 1934, the Committee on the Grading of Nursing Schools reported that “29% of nurse faculty members have never finished high school; 51% have finished high school but have no college education; and only 20% have had as much as one full year of college.”3 By 1951, 68 percent of 7,985 faculty members in hospital and collegiate basic schools of nursing held bachelors or higher degrees, and 16 percent held masters or higher degrees.4

In view of the great progress that was made during the 1930’s and 1940’s in the academic preparation of faculty members, the information in Table 2 might seem disappointing. When data from 1957 are compared with those collected in 1951, the percentage of hospital school faculty members with masters degrees has increased, but there has been no decrease in the percentage with no academic degree. It must be remembered, however, that during this period the schools were increasing the number of their faculty members considerably, and it is encouraging that, in so doing, they did not have to dilute their faculties with an even greater proportion of teachers who were not academically qualified. Moreover, the sharp upward movement in annual graduations from masters degree programs in nursing had not begun when the 1957 data were collected. Hopefully, within a few years the various projects designed to increase the number of prepared leadership personnel in nursing will be reflected in a higher percentage of nurse faculty members with graduate preparation.

Inservice Education

The performance of the faculty as a whole, like the performance of any team, is determined not only by the competence of its members but by the way these members work together, and the group’s ability may be greater

TABLE 2
CHARACTERISTICS OF NURSE FACULTY IN HOSPITAL SCHOOLS, 1951 AND 1957

<table>
<thead>
<tr>
<th></th>
<th>1951 (a)</th>
<th>1957</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of reporting schools</td>
<td>955</td>
<td>697</td>
</tr>
<tr>
<td>Number of nurse faculty members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>4,778</td>
<td>5,228</td>
</tr>
<tr>
<td>Part-time</td>
<td>3,525</td>
<td>3,084</td>
</tr>
<tr>
<td>Total</td>
<td>8,303</td>
<td>8,312</td>
</tr>
<tr>
<td>Percent full-time</td>
<td>57.5%</td>
<td>62.9%</td>
</tr>
<tr>
<td>Average number per school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All nurse faculty members</td>
<td>8.7</td>
<td>11.9</td>
</tr>
<tr>
<td>Full-time nurse faculty members</td>
<td>5.0</td>
<td>7.5</td>
</tr>
<tr>
<td>Academic preparation—all nurse faculty members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters or higher degree</td>
<td>11.8% (b)</td>
<td>14.1%</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>51.9% (b)</td>
<td>49.5%</td>
</tr>
<tr>
<td>No degree</td>
<td>36.3% (b)</td>
<td>36.4%</td>
</tr>
<tr>
<td>Percent of directors with masters degree</td>
<td>28.8% (c)</td>
<td>42.6%</td>
</tr>
</tbody>
</table>

(b) Based on data on 6,601 faculty members only.
(c) Based on data on 798 schools.
TABLE 3
CHARACTERISTICS OF NURSE FACULTY IN GROUP A, B, AND C SCHOOLS, 1957

<table>
<thead>
<tr>
<th></th>
<th>All Schools</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of reporting schools</td>
<td>697</td>
<td>159</td>
<td>50</td>
<td>488</td>
</tr>
<tr>
<td>Percent of nurse faculty members who are full-time</td>
<td>62.9%</td>
<td>70.5%</td>
<td>64.4%</td>
<td>58.8%</td>
</tr>
<tr>
<td>Average number per school</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All nurse faculty members</td>
<td>11.9</td>
<td>16.1</td>
<td>14.1</td>
<td>10.4</td>
</tr>
<tr>
<td>Full-time nurse faculty members</td>
<td>7.5</td>
<td>11.3</td>
<td>9.1</td>
<td>6.1</td>
</tr>
<tr>
<td>Academic preparation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All nurse faculty members—percent with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters or higher degree</td>
<td>14.1%</td>
<td>18.7%</td>
<td>14.4%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>49.5%</td>
<td>56.0%</td>
<td>54.0%</td>
<td>45.6%</td>
</tr>
<tr>
<td>No degree</td>
<td>36.4%</td>
<td>25.3%</td>
<td>31.6%</td>
<td>42.7%</td>
</tr>
<tr>
<td>Full-time nurse faculty members—percent with:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masters or higher degree</td>
<td>13.9%</td>
<td>17.2%</td>
<td>15.0%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Baccalaureate degree</td>
<td>56.4%</td>
<td>59.8%</td>
<td>58.3%</td>
<td>54.0%</td>
</tr>
<tr>
<td>No degree</td>
<td>29.7%</td>
<td>23.0%</td>
<td>26.7%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Percent of directors with masters degree*</td>
<td>42.6%</td>
<td>62.4%</td>
<td>41.4%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Percent of schools with at least one full-time faculty member with a masters degree in nursing education</td>
<td>43.2%</td>
<td>64.2%</td>
<td>74.0%</td>
<td>33.2%</td>
</tr>
<tr>
<td>Percent of schools with faculty inservice education programs*</td>
<td>53.6%</td>
<td>57.7%</td>
<td>81.0%</td>
<td>49.4%</td>
</tr>
</tbody>
</table>

* Based on all 798 schools in the study, since "No answer" has been interpreted as "No."

than might be predicted from the qualifications of the individuals which comprise it. This point is illustrated by the data on the Group B schools. The faculty resources of the Group B schools, it will be noted from Table 3, are, on the whole, more limited than those of the Group A schools. Yet the Group B schools managed to improve so that they were able to become accredited by the NLN in 1957.

One clue to this improvement might be the high percentage of Group B schools which have at least one full-time faculty member with a masters degree in nursing education and the even higher percentage with inservice education programs that are designed especially for their faculty members (exclusive of nursing service personnel). These schools have apparently faced the current situation realistically. While it will undoubtedly be a long time before all, or even a majority, of the faculty members in hospital schools of nursing are prepared at the masters level, the school with at least one faculty member who is well prepared has a "resource person" who can help the entire faculty group in its efforts toward school improvement. Through inservice programs, faculty members, regardless of the educational programs which they have completed, can continue their education which, of course, is never completed.

The Group B schools, then, offer an example of the way limited resources can be developed so as to yield maximum returns. Until higher goals can be established, the goal of at least one well-prepared full-time faculty member plus a good inservice education program might be a realistic one toward which all schools could strive.

**Control of Clinical Resources**

The fact that nursing education utilizes a real-life laboratory has its hazards as well as its advantages. True, the student, when she graduates, does not have to adjust from an ideal to a realistic situation; she already knows that equipment is not always perfect and that personnel shortages exist and has learned to improvise and compromise. On the other hand, there is always the danger that the learner of nursing may be exposed to bad nursing practice or to practice that is based on 20-year-old concepts of nursing. The instructor in nursing is not the student's only model; the head nurses and general duty nurses whose practice she observes are her "indirect" teachers, and the
quality of care that they give cannot help but influence her ideas about what nursing care is and should be.

The quality of nursing service in the hospital or hospitals where students have their nursing care experiences is therefore an important part of any picture of a school of nursing. Unfortunately yet understandably, qualitative information of this kind was not obtainable for this study. The 1957 questionnaire returned by an individual school gave some quantitative information about the “home” hospital which was of help to the consultant who visited the school. For example, the list of the number of nursing personnel in each category, when studied in conjunction with the average daily patient census, gave some indication as to whether the nursing service was adequately staffed with employed nursing personnel. It was not feasible, however, to attempt to secure a composite picture of these nurse-patient ratios for the present study.

The questionnaire data can be used, however, in approaching the question of quality of clinical resources from the point of view of faculty control. Presumably, the faculty which can exert influence on the nursing laboratory will see to it that the kind of nursing care to which the students are witness is consistent with the school’s concepts of what nursing is and should be. Thus, the extent to which the faculty of a school of nursing, like any other faculty group, can control the laboratory facilities which it uses, becomes an important consideration in nursing education.

The faculty of a school of nursing exercises its influence over the school’s laboratory in two ways: (1) through the opportunity which it has to influence the quality of nursing practiced in the hospital which conducts the school and (2) through the power which it has to select other clinical learning fields.

Resources in the “Home” Hospital

In the past, it was taken for granted that the school and the nursing service in the “home” hospital would have similar concepts of nursing since, traditionally, the director of the school of nursing also served as director of the nursing service. Under such circumstances, the beliefs of the school as to what nursing is and should be are presumably mirrored in the kind of nursing care given in the hospital.

It is probable that, in some instances at least, the single director with a dual position is confronted with the problems which face the instructor-supervisor—the pressures of two heavy positions with different objectives and the difficulty of preparing for both educational and service responsibilities. As has been pointed out, there is a trend toward solving this problem of the instructor-supervisor by separating the two positions. Some schools believe that the problems connected with a single director can be solved in another way, that is, through delegation of many administrative responsibilities to associate or assistant directors in each of the areas of the director’s responsibility—service and education. Others, apparently, are experimenting with a separation of the two positions. Of the 731 schools which, on the 1957 questionnaire, indicated the responsibilities carried by the director of the school, 204, or 28 percent, stated that she was not responsible for the administration of the hospital’s nursing service.

The question naturally arises concerning what effect this division of authority has on the school’s relationship to its laboratory. When the director of the school no longer has authority over the hospital nursing service, are the beliefs about nursing held by the school’s faculty and the personnel of the service sufficiently in harmony for the service to provide a suitable laboratory for the school?

It is possible that this question may be answered in different ways by different schools. In some instances, perhaps, ways have been developed for insuring that, although separately administered, the school of nursing and the nursing service will operate according to the same philosophy of nursing. In other instances, however, there is evidence that the separation of administrative authority has created more problems than it has solved. The members of the staff of the Department of Diploma and Associate Degree Programs have noted, in their visits to schools, that some which were experimenting with a two-administrator set-up have returned to the traditional arrangement of one director with a dual position.

Apparently the question has not yet been answered as to whether it is better, as a general rule, to center administrative authority for the school of nursing and the nursing service in one person or to divide this authority between two people. Possibly it is one which merits discussion on the part of schools which have tried out different arrangements. In any discussion of this kind, consideration might well be given to the need for the faculty of a school of nursing, like any faculty group, to have the kind of laboratory that is suitable for teaching purposes.

Resources in Other Institutions

The problems of faculty control of the students’ learning experiences are obviously magnified when some of these experiences are provided through “affiliation.” The term “affiliation” refers to an arrangement by which the faculty of a school delegates one of its major responsibilities—instruction in one field of nursing—to the personnel of a service agency or the faculty of another school of nursing. It does not refer to instances when the instruction is given by faculty members who are selected and employed by the school and who are therefore directly responsible to the school, even though the facilities of an institution other than the “home” hospital are utilized for this instruction.

While, in theory, the faculty of the school has the power to select affiliations which offer suitable learning fields for its students, in practice its choice may be limited. Sometimes the only nearby hospital with the needed clinical facilities provides a kind of nursing care that differs con-
FIGURE 3
Number of Weeks of Clinical Instruction Provided through Affiliation, 1957

780 HOSPITAL SCHOOLS

Median: 20 wks.  
Range: 0–108 wks.

187 GROUP A SCHOOLS
Median: 13 wks.  
Range: 0–45 wks.

56 GROUP B SCHOOLS
Median: 20 wks.  
Range: 0–40 wks.

537 GROUP C SCHOOLS
Median: 21 wks.  
Range: 0–108 wks.

siderably from the concepts of nursing expounded in the school's philosophy. The alternative—sending the students to a distant institution—is not only expensive but poses problems in curriculum development.

The problems of the agency which cooperates with several schools might also be noted here. It is time-consuming for personnel to participate with several faculty groups in the development of their curriculums. Moreover, the schools with which the agency cooperates may differ in their beliefs about what constitutes good nursing care, the preparation of the students when they enter the affiliating course may vary considerably, and so on. All in all, the far-flung extent of the nursing school "campus" offers problems for all concerned.

These problems cannot, of course, be solved by saying: Let there be no affiliations. The schools associated with hospitals which offer clinical resources in all the major fields of nursing could hardly prepare all the nurses needed by society. Nor is the solution which has been found by some schools—having faculty members of the school accompany the students to the cooperating institution and guide their learning experiences there—feasible for all hospital schools at the present time; there just are not enough nurses prepared as instructors.

Total Time on Affiliation. The data derived from the 1957 questionnaire do, however, suggest that in some instances affiliation experiences account for a large part of the nursing curriculum. Figure 3 shows that in no school in Group A or Group B was a student on clinical affiliation for more than 45 weeks. In 16 Group C schools, however, the clinical affiliation periods totaled over 52 weeks—in one instance 108 weeks. In addition to these periods of geographical separation from their school, the students may have been away from it to take courses in colleges.

This situation raises several questions. To what extent can the faculty of a school delegate its responsibility for teaching students and still fulfill the responsibility implied
in certifying them for graduation? How many groups of instructional personnel can be involved in developing a curriculum that is truly coordinated? In short, should a hospital which cannot provide a reasonable proportion of the clinical resources necessary for preparing a nurse attempt to conduct a school of nursing?

In contrast to the situation in psychiatric nursing, fewer than 60,000 hospital beds are allocated to the care of children. Moreover, the occupancy rate of 74 percent in children's hospitals indicates that many of these beds are not occupied throughout the year. These resources would appear to be rather limited for a 12 to 13 weeks' period of study by the 45,000 students who are admitted each year to schools of basic nursing and will be more limited if the admissions figure is stepped up to even the minimum goal of 57,000 students. Certainly, if the traditional practice of providing most or all experiences with children in a hospital setting is continued, a faculty's selection of its laboratory for these experiences will become a matter of Hobson's choice.

To solve this problem, each school might well undertake a thoughtful study of the objectives of that segment of its curriculum which pertains to the nursing care of children, of the learning experiences by which these objectives can be achieved, and of the resources needed for these experiences. In many schools this part of the program is aimed at helping the students to develop an understanding of normal growth and development as well as to learn to care for sick children. Some schools have found that a portion of these "growth and development" objectives can be achieved through a study of well children of various ages or children who are not acutely ill, under the direction

### TABLE 4

<table>
<thead>
<tr>
<th>Type of Affiliation</th>
<th>780 Schools</th>
<th>187 Group A Schools</th>
<th>56 Group B Schools</th>
<th>537 Group C Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Medical and/or surgical</td>
<td>17</td>
<td>2.2</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Obstetric</td>
<td>64</td>
<td>8.2</td>
<td>12</td>
<td>6.4</td>
</tr>
<tr>
<td>Pediatric</td>
<td>329</td>
<td>42.2</td>
<td>44</td>
<td>23.5</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>688</td>
<td>88.2</td>
<td>146</td>
<td>78.1</td>
</tr>
</tbody>
</table>

The Nursing Care of Children. From Table 4 it is apparent that the resources for teaching psychiatric nursing and the nursing care of children constitute the major deficits in the clinical resources of "home" hospitals. Reference to Table 5 indicates that these deficits result from two very different causes. In the case of psychiatric nursing, there is no lack of hospitalized patients for students to study; it is the location of the majority of these patients in specialized institutions that accounts for the large number of affiliation arrangements. The problem in psychiatric nursing, therefore, is not the overuse of cooperating institutions. Rather, there is need for the instructional personnel in the school and cooperating hospital to work together in developing and implementing the students' learning experiences. The great demand for the NLN publication *Psychiatric Nursing Supplement to the Self-Evaluation Guide for Schools of Nursing Offering Educational Programs Leading to a Diploma* indicates that efforts toward such joint planning are being made by many schools of nursing and cooperating hospitals.

### TABLE 5

<table>
<thead>
<tr>
<th>Type of Patients</th>
<th>Number of Beds*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In All Hospitals</td>
</tr>
<tr>
<td></td>
<td>Total Number</td>
</tr>
<tr>
<td>Children</td>
<td>59,819</td>
</tr>
<tr>
<td>Psychiatric patients</td>
<td>730,316</td>
</tr>
</tbody>
</table>

of qualified instructors and other specialists. Resources for such study are available in many community agencies other than hospitals—in nursery schools, kindergartens, and elementary schools; in orphanages; in well-child clinics; and in child guidance clinics and schools for handicapped children.

In its re-examination of the pediatric nursing part of the curriculum, a faculty may also find that the objectives relating to the care of sick children do not require several months’ experience in large pediatric services but can be achieved through intensive study of smaller groups of children in shorter periods of time. A well-directed but relatively small pediatric service in the “home” hospital, or in one that is near by, might be sufficient for learning experiences of this kind if the school can provide instruction by a qualified person.

In other words, from a study of current objectives of pediatric nursing courses and surveys of facilities hitherto considered too limited in size, some of the 329 schools which now rely upon other institutions to give instruction in the nursing care of children may find in their own communities the requisites for this instruction, namely, qualified instructors, groups of well children of various ages, and a group of hospitalized children that is sufficiently large for short-term, intensive study.

Library

Data were collected about the libraries in schools of nursing, but no information was available about other library resources which the schools might be using. The school of nursing which has access to a nearby public library, university library, or medical library may not have to acquire all the holdings needed by its students and faculty. Nonetheless, there is a limit to the extent to which a school can depend on other agencies and institutions for materials that are so closely related to a professional curriculum. Generally speaking, enrichment of an educational program in nursing will be reflected in the growth of its library.

Some idea of the need for growth in this respect can be obtained from the following excerpts from the 1934 report of the Committee on the Grading of Nursing Schools: 7

Few of the Grading studies have cost so much in money, thought, and labor as did the study of training school libraries, and none has yielded such discouraging results. The Committee found not merely many, but that actually most, nursing school text and reference books are not on the approved lists. Many could not even be identified by librarians. Publication dates ran back to days before the Civil War, and a number were dated in the 1880's. . . . Half of the nursing schools in the country have less than 160 reference books in their general school libraries. Seven per cent have no reference books at all. Only 11 per cent have 500 books or more. Yet nursing education should be professional education, and the number of professional books desirable for reference is large.

Table 6 shows the extent to which libraries of schools

<table>
<thead>
<tr>
<th>Resources</th>
<th>1949</th>
<th>1957</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of titles, professional books</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000 or more</td>
<td>23.9</td>
<td>36.5</td>
</tr>
<tr>
<td>500-999</td>
<td>32.2</td>
<td>41.6</td>
</tr>
<tr>
<td>Less than 500</td>
<td>34.7</td>
<td>15.8</td>
</tr>
<tr>
<td>Not reported</td>
<td>9.2</td>
<td>6.1</td>
</tr>
<tr>
<td>Number of professional periodicals subscribed to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 or more</td>
<td>(b)</td>
<td>32.6</td>
</tr>
<tr>
<td>10-19</td>
<td>(b)</td>
<td>39.1</td>
</tr>
<tr>
<td>Less than 10</td>
<td>(b)</td>
<td>26.3</td>
</tr>
<tr>
<td>Not reported</td>
<td>(b)</td>
<td>2.0</td>
</tr>
<tr>
<td>Has a librarian prepared in library science</td>
<td>(b)</td>
<td>46.6</td>
</tr>
</tbody>
</table>

(b) Data not available.
of nursing have grown, in size at least, since the Grading Committee studies. The percentage of libraries with holdings of 500 titles or more increased from 11 percent in 1934 to 56 percent in 1949 and 78 percent in 1957.

Table 6 also indicates that considerable differences exist between the library resources of accredited schools (Group A and Group B) and other schools (Group C). Over half of the accredited schools had 1,000 or more titles in contrast to slightly more than a quarter of the other schools; over 90 percent of the accredited schools subscribed to 10 or more professional periodicals, while one-third of the non-accredited schools subscribed to less than 10; over 60 percent of the accredited schools had a librarian prepared in library science as against less than 40 percent of the non-accredited schools.

These differences among schools are harder to justify than are their differences with respect to faculty and clinical resources. Of two schools which are making equal efforts to offer a good educational program, it is to be expected that the smaller one will have fewer faculty members than the larger, and the school conducted by the smaller hospital will usually have to provide for more clinical learning fields in cooperating agencies. No such inherent limitation exists in the case of library resources; books and periodicals and trained librarians are equally available to any school of nursing. True, the per student cost of maintaining an adequate library may be greater for the small school (although this cost may be equalized by the fact that the larger school will probably need more copies of frequently used books and periodicals). Presumably, however, the institution which conducts a small school has faced the fact that its per student cost is likely to be higher than average. Since it has nonetheless decided to continue operating the school, it has accepted responsibility for meeting the above-average expenses involved in providing the resources essential for sound preparation in nursing.

**Curriculum**

The effectiveness of a program is determined not only by the caliber of its resources but, even more perhaps, by the way in which these resources are used in the curriculum. According to those who have intimate knowledge of a large number of schools of nursing, the curriculum frequently spells the difference between a sound educational program and one of lesser quality. Yet, when the replies to the 1957 questionnaire were analyzed, it was found that the typical Group A, Group B, and Group C schools reported very similar curriculum data—length of time allotted to planned instruction, distribution of time according to content area, and so on.

One reason for this apparent paradox is, of course, the limited usefulness of quantitative data for describing and evaluating curriculums. While the amount and apportionment of learning experiences have some bearing on the effectiveness of a curriculum, these quantitative characteristics are of far less moment than are the way in which the curriculum is organized, the kind of learning experiences that are selected, and the quality of instruction that is given.

A second explanation for these similar findings is the fact that the questionnaire data do not provide even a good quantitative picture of the curriculums in hospital schools. There are many “unknown quantities” which may vary greatly among schools in which the “known quantities” are equivalent.

Despite these limitations, the curriculum data from the 1957 questionnaire are being reported here for three reasons: (1) they give some information about curriculum practices; (2) they may point out areas where curriculum improvement is particularly necessary; and (3) they may be useful as a basis for arriving at more meaningful curriculum measurements.

**Number of Classes**

Of the 798 schools, 766 admitted only one class a year, 25 admitted two classes, and 4 did not reply to the question.

**Length of Program**

The vast majority of the 798 schools—95 percent—reported that their total program was 156 weeks, or three calendar years, in length.

In three-quarters of the schools a week consisted of 40 hours, and in one-sixth it amounted to 44 hours. The remaining schools reported weeks that ranged from 27 to 48 hours. Over 80 percent reported a 4-week vacation period in each year.

**Planned Instruction**

If the length of the typical hospital school program were measured in hours rather than weeks, the 156 weeks would be translated into 6,240 hours. When allowance is made for holidays as well as vacations and for the fact that, during the first part of many hospital school programs, assignments amount to 24 to 32 hours a week instead of 40 hours, the total assigned time during the three years of the typical hospital school program probably amounts to about 5,200 hours. Some of this time is devoted to classroom instruction, group conferences and discussions, and work in the science laboratories. These learning experiences comprise what has traditionally been designated as “planned instruction.”

In statistical studies of nursing curriculums it is customary to collect information on only those learning experiences that come within the definition of “planned instruc-
tion." Although the bulk of the students' time is spent in
learning nursing through giving care to patients, the num-
ber of hours allotted to these nursing care experiences is an
unknown quantity. This fact should be borne in mind as
the data about planned instruction are studied. These data
are important, but they present only a partial picture of
the learning experiences provided in an educational pro-
gram in nursing.

In 1957, the time allotted to planned instruction ranged
from 951 hours to 2,407 hours, with about 75 percent of
the schools reporting between 1,300 and 1,700 hours. The
typical school offered 1,530 hours of planned instruction
—an increase of 300 hours over the planned instruction
time reported by the typical basic program (hospital and
collegiate) in 1949 (Table 7). As will be pointed out later,
however, there is reason for questioning whether this com-
parison has much meaning; it is quite probable that the
real increase in curriculum content and amount of instruc-
tion since 1949 is considerably greater than the data in
Table 7 would indicate.

TABLE 7
HOURS OF PLANNED INSTRUCTION AND PLANNED CLINICAL
INSTRUCTION IN TYPICAL SCHOOL OF NURSING (HOSPITAL
AND COLLEGIATE), 1929 AND 1949,
AND IN TYPICAL HOSPITAL
SCHOOL, 1957

<table>
<thead>
<tr>
<th>Year</th>
<th>Hours of Planned Instruction</th>
<th>Hours of Planned Clinical Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1929</td>
<td>631(a)</td>
<td>(b)</td>
</tr>
<tr>
<td>1949</td>
<td>1,230(a)</td>
<td>150(b)</td>
</tr>
<tr>
<td>1957</td>
<td>1,530</td>
<td>240</td>
</tr>
</tbody>
</table>

(a) Margaret West and Christy Hawkins. *Nursing Schools at the
Mid-Century*. New York, National Committee for the Improvement
of Nursing Services, 1950, p. 28.
(b) Unknown.

Content Areas

Figure 4 (page 18) shows how the planned instruc-
tion time in the typical hospital school of nursing was
distributed according to content area. In this typical school
about 30 hours of planned instruction were allotted to
general education courses, 300 to the biologic and physical
sciences, 90 to the social sciences, 75 to nonclinical nursing
courses, and the remainder to instruction in clinical nursing.

One noteworthy change has occurred in this picture of
curriculum content since the 1949 data were collected.
Although the *Mid-Century* questionnaire inquired into time
allotted for instruction in the humanities, no findings about
this area of instruction were included in the *Mid-Century*
report. In contrast, this report can scarcely ignore the
general education component (English, ethics, speech, re-
ligion, etc.) in the nursing school curriculum; in 1957 it
accounted for 30 or more hours of planned instruction in
half the schools. Many schools apparently believe that
even more time should be devoted to this component; one-
quarter of the schools reported that they allot 90 or more
hours to instruction in the humanities.

This increased emphasis on instruction in the humani-
ties represents an important step in the evolution of the
nurse training program into a program that is more educa-
tional in character. Underlying this trend is the realization
of the broad cultural background that is required to give
the kind of nursing care that society needs today. In pro-
viding the student with opportunities for broadening her
background in the humanities, the school of nursing is not
moving outside the domain of nursing education. It is
recognizing the relationship between the kind of nursing
care that is given and the kind of person who gives it, the
relationship between professional development and personal
growth.

With the exception of the general education area of the
curriculum, the findings of the 1957 questionnaire cannot
be compared with earlier ones which grouped subjects ac-
cording to categories that had been established in the 1937
*Curriculum Guide* and the 1942 *Essentials of a Good
School of Nursing*. Since these guides were developed,
there has been a tendency to combine related content into
larger units of instruction and, in so doing, to change the
way in which the content is grouped.

The trend toward the amalgamation of courses into
broader units of instruction is a natural result of the curric-
ulum studies that so many faculty groups have been engag-
ing in during the past few years. When a faculty studies
its curriculum as a whole, instead of using the piecemeal
approach of reviewing one or two courses at a time, it often
discovers that identical content is being offered in two or
more courses—the chemistry of nutrition in both the chem-
istry and nutrition courses, for example, or the same type
of introductory information in both a professional adjust-
ments course and a course in fundamentals in nursing.
When such duplications have been eliminated, some courses
have disappeared as separate units of instruction, although
the content formerly taught in them is still presented in
connection with other content to which it is directly re-
lated. The net result has been a regrouping of content and
its arrangement into larger units of instruction.

This kind of curriculum revision has had two beneficial
effects: the student can more readily grasp the relationships
that exist between subjects that were once studied as sepa-
rate entities, and instructional time can be used more
economically. For this reason, it might be assumed that
the increase in curriculum content since 1949 is consider-
ably greater than that which is indicated by the increase in
hours of planned instruction (Table 7).

Instruction in Clinical Nursing

The need for economy of instructional time and for
"integration" of knowledge is most apparent, perhaps, in
the clinical nursing courses. The content that must be
Is this distribution reasonable in terms of what is expected of the student? It is difficult, if not impossible, to answer this question from available data. The amount of time needed by the student to prepare for her classroom and laboratory work constitutes an important part of student load. This preparation time presumably varies according to the type of learning experience and therefore cannot be calculated, since classroom instruction, planned clinical instruction, and science laboratory were reported together as planned instruction. There is no way of determining whether the hours allotted for planned instruction are spread evenly over the 48-week year or whether there are more classes in some months than in others. Most important of all, of course, is the fact that the 1,530 hours of planned instruction constitute only a portion of the student’s assigned time; it is not known how many nursing care hours should be added to her load in each year of the program.

One point does stand out clearly in the data reported in Figure 4—the heavy concentration of planned instruction in the first year of the program. Despite the impediments to any precise examination of student load, it would seem advisable to give some attention to this situation. This first-year concentration is probably due, in large part, to the fact that much of the science instruction is provided early in the curriculum. This arrangement is understandable, since knowledge of the biologic, physical, and social sciences is fundamental to the study of nursing. Nonetheless, it must be remembered that science courses scarcely qualify as “snap” courses; they involve a good deal of study outside the classroom. Moreover, they are frequently offered during the first nine months of the year so that what looks like a year’s load of planned instruction may be given almost entirely within a nine-month period.

The first nine months in the typical school would seem to be a difficult period for the student—about 800 hours in the classroom and science laboratory, a considerable amount of time in preparation for classes, and some time in the nursing laboratory; and the situation in the typical school is, of course, better than that in 50 percent of the schools. In over 100 schools the first-year planned instruction time amounts to 1,000 or more hours!

Although it may seem logical to place so much formal classroom instruction early in the program, the resulting “bottom-heavy” curriculum puts a considerable burden on the first-year students. This is possibly a problem for faculties to explore as they study their curriculums. Are there still areas of duplication in the science courses that could be eliminated through a reorganization of content into larger instructional units? Need all the scientific foundations for nursing be laid immediately, or could some of them be provided later in the curriculum when their relationship to nursing will be more obvious to the students? Perhaps, through an investigation of questions like these, faculties may be able to meet the twin needs of their students—solid foundations of knowledge and adequate time to acquire and reflect upon their knowledge.

Are New Definitions Needed?

Total amount of curriculum time—distribution of curriculum content—student load: these constitute important features in the picture of any educational program. Yet in the 1957 portrait of the typical hospital school of nursing, these features are blurred and distorted. Figure 4 should provide a usable profile of the typical school against which each school could measure its own practices, yet it cannot be recommended for this purpose. Two schools might fit every detail of this profile but differ radically with respect to the kind of nursing care experiences which
they offer and which account for 70 percent of their total educational programs.

Consider, for example, two hypothetical schools, A and C, in which the approximately 4,800 hours which the student spends in the clinical nursing area of the curriculum is divided as shown in Figure 5. Neither of these schools is making full educational use of the students' nursing care experiences, but School A has certainly gone considerably farther in this direction than has School C. According to current definitions, however, School A and School C would exhibit the same profile. In evaluating its curriculum, the faculty of School C might come to the conclusion that it has provided a satisfactory amount of guidance in clinical nursing; after all, it offers approximately the amount of planned instruction provided by the typical school and the amount provided by School A, which is recognized as a good school. The faculty in School A may not be aware of how much partially supervised nursing practice is concealed in the term “nursing laboratory experiences” and may therefore not be working to improve this situation to the extent that it should.

More is at stake, however, than program evaluation. Increasingly, the need is being felt for curriculum research that will indicate the kinds of learning experiences that are most effective and most economical, in both time and money, for achieving various curriculum objectives. What understandings are best developed in the classroom? What ones in the nursing laboratory? What should be the instructor-student ratio in the classroom? In the nursing laboratory? Are the time periods that have been traditionally allotted to various segments of the curriculum consistent with the amount of learning required? Is 12 weeks a magic period in which to learn the nursing care of children, of mentally ill patients, of maternity patients? These are among the questions that confront faculty groups in their attempts to evolve more effective curriculums.

Yet how, with the present babel of nomenclature, can schools join forces in curriculum research projects? Present units for scheduling and measuring time are inadequate for the collection of comparable data. School curriculums are divided into different periods of time—semesters, quarters, terms, or, in some cases, merely years—and sometimes these time periods are ignored in curriculum-planning; one course may be scheduled for the last part of one term and the beginning of the next. There is no unit of time, like the credit-hour utilized by most educational institutions, from which student load, including preparation time, can be calculated. Even the week of such-and-such number of hours, which has been adopted from employment rather than educational situations, is an elastic yardstick; in the same school it may sometimes represent 40 hours of classroom and laboratory assignments and, at other times, 24 or 32 hours. There is really no unit for expressing the amount of time spent in nursing care assignments; such time is thought of as the time left over after planned instruction periods, vacations, and holidays have been sub-

| FIGURE 5 |
| Learning Experiences in Clinical Nursing Provided in Two Hypothetical Schools |

<table>
<thead>
<tr>
<th>Hypothetical School A</th>
<th>Hypothetical School C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,000 hours—Classroom instruction and planned clinical instruction</td>
<td>1,000 hours—Classroom instruction and planned clinical instruction</td>
</tr>
<tr>
<td>1,500 hours—Nursing patients who have been selected by the instructor because of specific nursing problems which they illustrate; instructor present for the sole purpose of guiding students</td>
<td>2,400 hours—Nursing patients who are in a particular medical classification, but who have not been selected as illustrations of specific nursing problems; instructor available but not always present; service personnel make assignments to students and supervise and evaluate their experiences</td>
</tr>
<tr>
<td>2,000 hours—Nursing patients who are in a particular medical classification, but who have not been selected as illustrations of specific nursing problems; instructor available but not always present; service personnel make assignments to students and supervise and evaluate their experiences</td>
<td>“Nursing laboratory experiences” (counted in hours rather than the traditional weeks)</td>
</tr>
<tr>
<td>300 hours—Evening and night assignments in 4 periods of 2 weeks each; student and instructor have discussed what student will learn and later evaluate experiences; instructor not present but full service staff on duty</td>
<td>1,400 hours—Evening and night assignments as needed to “fill in”—a few days here, a few days there; no particular learning objectives other than to “see what a ward is like at night”; instructor not present; students replace absent service personnel</td>
</tr>
</tbody>
</table>
tracted from the number of weeks in the total program.

Again, present definitions of the various types of learning experiences put more emphasis on the setting in which the experiences take place than on the kind of objectives toward which they are directed and the student's role and the teacher's role in achieving these objectives. Nursing care experiences range from true laboratory experiences—experiences that are carefully planned to meet the student's educational needs and closely supervised by qualified instructors—to out-and-out work experiences. Yet all these types of experiences are lumped together under the term "nursing laboratory experiences."

Has not the time now come for a redefinition of clinical learning experiences that will more accurately describe them as they exist today? The terms now in use were designed for an era when the provision of an adequate amount of classroom instruction was our major curriculum problem. Since that time, instruction in nursing itself has become the primary target of curriculum study and improvement. For the evaluation and research that will lead to this improvement, schools of nursing need commonly accepted definitions and standardized units of measurement. We need a new language which will enable us to capitalize fully on the greatest opportunity in nursing education—the opportunity to help students learn nursing through giving nursing care to patients.

**Financing**

Evaluation and research are important for pointing the way toward curriculum improvement, but improvement does not follow automatically in their wake. Doubtless many faculty groups are aware of weaknesses in their curricula and of ways in which these weaknesses might be overcome but are prevented from instituting corrective measures because of financial obstacles.

This statement, of course, might be applied to any faculty in any school. All faculties, when developing curriculums, are regulated to a greater or lesser extent by the financial resources available for curriculum implementation. To the faculty of a school of nursing, however, the term "financial obstacles" frequently refers not only to inadequacy of financing but also to poor financial planning and, perhaps most important of all, inappropriateness of sources of income.

It would be an understatement to say that this financial triad—amount of resources, administrative practices, and sources of income—plays a part in curriculum development; more often than not, it claims the leading role. The analysis of data relating to the financing of hospital schools of nursing has therefore been placed in juxtaposition to the section on curriculum data. For any thorough evaluation of curriculum practices in hospital schools of nursing, consideration must be given to three questions: "Is the financing adequate?", "Is the budget properly prepared and administered?", and "Are the sources of income appropriate for an educational program?"

**Cost of Programs**

What constitutes adequate financing for a hospital school of nursing? What does it cost to educate the typical hospital school graduate? These questions, calling as they do for quantitative answers, might, at first glance, seem suitable for investigation in the 1957 questionnaire study. Experience in other studies, however, has demonstrated the futility of seeking answers to them from data that are available at this time. True, hospital schools have made real efforts to determine their costs. According to the 1957 questionnaire, 583 schools, or about three-quarters of those in the study, reported that they had made cost studies since 1950. It would, however, be impossible to derive comparable data from their findings because of the great variety of methods that they have used.

Although no information on costs of hospital schools of nursing can be given in this report, data of this kind are not being labeled "forever unknown." Currently the National League for Nursing, in cooperation with a large number of schools of nursing throughout the country, is engaged in a research project, the Study on Cost of Nursing Education, which is designed to determine the cost of preparation for nursing in various kinds of educational programs.

The findings of this study, which will be available in about five years, will have many uses. Not the least important will be the assistance that the study will provide faculties in schools of nursing in the evaluation of their educational programs. In particular, it may help them track down the causes of many of their problems, particularly those relating to curriculum improvement, to a primary cause: lack of adequate financing.

**Budgetary Practices**

Budgeting is essential to safeguarding the systematic development of a program. Properly conceived and applied a budget...serves as an administrative blueprint for controlling and checking the quality of performance throughout the fiscal period.

In a hospital conducting a nursing school a separate budget should be made for the school and a separate budget for the nursing service. The practice of including both school and nursing service items in one budget does not represent good administration and does not provide the administrative information necessary for the control of either activity.

...a budget becomes a broadly educational as well as an administrative device when each faculty member participates in it to the extent that she is required to consider her special functions and program, to think through and submit for approval her tentative plan of action, and to be informed of the financial implications of the plan.8
TABLE 9
BUDGETARY PRACTICES IN HOSPITAL SCHOOLS OF NURSING
1949 AND 1957

<table>
<thead>
<tr>
<th>Practice</th>
<th>Percent of Schools</th>
<th>1949 (a)</th>
<th>1957</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate budget for school</td>
<td></td>
<td>27</td>
<td>62</td>
</tr>
<tr>
<td>Participation of school personnel in preparing budget</td>
<td></td>
<td>22</td>
<td>55</td>
</tr>
<tr>
<td>Total Schools</td>
<td></td>
<td>76</td>
<td>71</td>
</tr>
<tr>
<td>Group A</td>
<td></td>
<td>74</td>
<td>71</td>
</tr>
<tr>
<td>Group B</td>
<td></td>
<td>56</td>
<td>48</td>
</tr>
</tbody>
</table>

(a) Margaret West and Christy Hawkins. *Nursing Schools at the Mid-Century*. New York, National Committee for the Improvement of Nursing Services, 1950, p. 15.

These statements could scarcely be considered controversial; they would be accepted by any organized group. They appeared in a manual which was looked upon with respect by schools of nursing. The manual appeared in 1942. Yet, reference to Table 9 shows that in 1949 only about a fourth of the hospital schools of nursing had budgets of their own. Apparently, in most instances, the line between the activities of a hospital's school of nursing and those of its nursing services was too indefinite to permit a clear-cut differentiation in the budget.

When, stimulated by the NLN School Improvement Program, faculties began to evaluate their schools as schools and to disentangle educational activities from those of the hospital nursing service, the need for separate budgets became obvious. The great increase in the percentage of hospital schools with separate budgets—from 27 percent in 1949 to 62 percent in 1957—connotes much more than an improvement in fiscal practice. It reflects a change of attitude on the part of hospital administrations and probably hospital school faculties as well; the school is recognized as a separate entity with its own objectives and activities, not as a branch of the hospital nursing service.

Table 9 also shows that in most Group A and Group B schools, and to a lesser extent in Group C schools, faculties have some voice in preparing the school budget, either through the director of the school or the educational assistant or a faculty committee. This, too, might be considered an outgrowth of the recent emphasis on school improvement. As faculties began to develop specific measures for improving their schools, they probably understood more clearly the relationship between educational planning and financial planning. To map out ways of improving an educational program without making financial provision for these improvements is about as productive as a daydream. Thus, the increased extent to which the personnel in the nursing school is participating in budget preparation may well indicate that improvements are being made in all parts of the program—improvements that have not only been planned but have been put into operation.

Sources of Income

To one unacquainted with the customs of nursing education, it would appear that with adequate funds at its disposal and opportunity to plan the use of these funds, a faculty would be free to develop the kind of curriculum it believes its students need. This assumption would be true of most educational programs. While many students in higher education have to earn part of their living and educational expenses, their curriculums are not modified to include their earning activities.

In most schools of nursing, on the other hand, the curriculum is developed as an income-producing as well as a "learning-producing" operation. This deviation from the usual financing practices of educational institutions can be attributed to the fact that many of the expenses of these schools are paid out of funds that are really contributed for the care of patients.

One goal for any improvement program in hospital schools of nursing would therefore seem to be a method of financing that is based on appropriate sources of income—tuition, tax funds, and contributions that have been made by private individuals and groups for educational purposes, not for the care of patients. In 1949, income from these sources was reported as: tuition and fees, 22 percent; tax funds, 3 percent; and contributions, 1 percent plus an unknown but probably small amount of "hospital contributions" that were not derived from funds secured primarily for patient care.9 To raise this proportion of appropriate income from 26 + percent to 100 percent is one of the biggest tasks that faces nursing education.

Income from Students. Figure 6 (page 24) shows that the cost to students in hospital schools of nursing has risen considerably in the last few years. In 1949 the median hospital school charged about $250 for all expenses—educational and maintenance—during the three years of the program; by 1957 this figure had increased to over $400, or by about 60 percent. This is a much greater rise than the 18 percent increase in the cost of living which occurred
FIGURE 6
Percentage Distribution of Hospital Schools of Nursing According to Total Cash Cost to Student, 1949 and 1957

<table>
<thead>
<tr>
<th>Percent of Schools</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$800 and over</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1957-41</td>
</tr>
<tr>
<td>$700-799</td>
<td></td>
<td></td>
<td></td>
<td>1957-45</td>
<td></td>
</tr>
<tr>
<td>$600-699</td>
<td></td>
<td></td>
<td>1957-64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$500-599</td>
<td></td>
<td></td>
<td>1957-99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$400-499</td>
<td></td>
<td>1957-175</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$300-399</td>
<td>1957-232</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$200-299</td>
<td>1957-90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$100-199</td>
<td>1957-36</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $100</td>
<td>1957-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td>1957-0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not reported</td>
<td>1957-13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1949: 2  4  7  21  47  199  324  270  57  49  40
between 1949 and 1957. The costs of educational programs in nursing may, however, have risen much more sharply than have consumer costs, so that, in the absence of data on present per student costs in hospital schools, it is impossible to say whether the student is paying in cash for a larger or smaller share of the expenses of her education and maintenance than the 22 percent that she paid for in 1949.

For the same reasons, Schools A, B, and C cannot be compared with respect to the share of total income received from tuition and fees. Figure 7 shows that the student in the typical Group A and Group B school pays about $100 more than the student in the typical Group C school. This may mean that in the better schools she contributes a greater portion of her expenses in cash and presumably less in service than she does in the weaker schools. Or it may be that the per student cost in the better schools is higher. In either event, the relationship between the amount of tuition charged to the student and quality of education offered her would seem to be more than an accidental one.

While no calculation can be made of the extent to which hospital schools of nursing are supported by cash payments from the students, available data do permit an estimate of the maximum percentage of income derived from this source. On the assumption that the per student costs of hospital schools of nursing have not decreased since 1949, it might be concluded that in the typical hospital school in 1957, income from student fees accounted

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**FIGURE 7**

Cash Cost to Student in Typical Schools in Groups A, B, and C, and Range of Student Costs in Middle Half of the Schools in These Groups
for no more than 35 percent of the total school income (160 percent of the 22 percent reported in 1949). In contrast, in 60 colleges and universities whose income and expenditures were studied in 1953-1954, and in 11 women’s colleges included in this group of 60 institutions, 60 percent of the educational costs and presumably all maintenance costs were covered by student fees.11

These data are useful for indicating the extent to which hospital schools of nursing may have to change their financing practices if they are to match their educational practices to those of other post-high school educational programs. The data do not, however, furnish information about the equally important question of the students’ financial resources. To what extent does the college student meet his expenses from his family’s pocketbook, from loans and scholarships, and from extracurricular employment? Would the student in nursing have equal sources to tap if she were made responsible for paying in cash for her maintenance and for a larger share of her educational costs?

From Figure 6 it might be argued that students in nursing are willing to pay more for a good education than they are for a mediocre one and that, as schools of nursing improve, fees may be raised to a certain point. Although this is undoubtedly true of some of the low-cost schools, there is evidence that the “certain point” has already been reached for many students; 42 percent of the schools reported that they were giving financial help to some students through waiving school fees. In any study of student fees, it must be remembered that most nursing students are girls—a group often given low educational priority in the family budget—and that for the good of society, nursing education cannot be limited to students from high-income families.

The limitations in the student’s own financial resources underscore the need for a well-financed system of scholarship aid in which students in hospital schools of nursing can participate. At first glance, the 1957 questionnaire data on this point seem encouraging. Eighty-six percent of the schools reported loan funds available for their students, and in 91 percent of the schools students had received scholarship aid from civic and philanthropic organizations other than the hospital. In view of the extensiveness of the fee-waiving practice, however, it might be questioned whether these devices are sufficient for present tuition charges, much less for any considerable increase in them.

Because she has a shorter vacation period and more hours of assigned schoolwork, it would seem that the student in nursing has less opportunity to earn money through outside activities than have other students. This is a situation that may be changed if a more suitable system of time-measurement is adopted by hospital schools of nursing. The arrangement of the curriculum into terms and the replacement of the “40-hour” week with a time unit that is more adapted to educational purposes would not only solve some of the problems of curriculum development; it would also result in a more even distribution of the time which the student can plan for extracurricular activities, including extracurricular employment.

Private and Public Contributions. No data were secured on the 1957 questionnaire about the percentage of income derived from governmental funds and private sources; the last available estimate is the figure of 4 percent reported in 1949. This is in sharp contrast to the 40 percent share of income from public and private contributions reported by the 60 colleges and universities in the 1953-1954 study.

Considering the essential service which nursing renders to society, this is an incredible situation. It is a situation, of course, that schools of nursing and the hospitals which conduct them cannot rectify. Nonetheless, they would be in a better position to put their financial needs before the public if there were accurate data to show what their costs are and what their income should be. The results of the NLN Study on Cost of Nursing Education should help all concerned—the school of nursing, the student, and the public—work out better ways for financing the preparation of nurses.

Graduates

The acid test of any educational program in nursing is the extent to which it has helped its students to prepare for their future professional responsibilities and to develop as citizens and as people. To put it another way, the graduates of the groups of schools being studied in this report constitute the most important feature in the composite portraits of these schools.

Performance on the Licensing Examination

The only information now available for describing the graduates of all schools of nursing is their performance on the licensing or State Board Test Pool examination. Data of this kind, presented in Table 10, have been computed for all graduates who took the examination in 1957 and for the graduates of all diploma schools, both hospital controlled and college controlled. Since the 798 schools in the 1957 questionnaire study constituted a fairly large percentage of all diploma schools, the performance of graduates of Group A and B schools might be considered as roughly equivalent to that of the graduates of accredited diploma schools, as shown in Table 10, and the performance of graduates from Group C schools as approximately equal to that of graduates of “other” diploma schools.

From Table 10, then, it might be concluded that the average graduate of the Group A and B diploma schools scored higher on each of the tests in the licensing examination than did the average graduate of all basic programs.
Her performance on each examination was also considerably above that of the average Group C school graduate. Thus, it would appear that, when judged by the nursing abilities that are measured on the licensing examination, the graduates of the Group A and B schools are better prepared to practice nursing than are those of the Group C schools.

The use of this comparison to differentiate between strong and weak schools could, of course, be challenged on the ground that the performance of the graduate of a school does not necessarily reflect the extent to which the school has helped her to develop her potentialities. Not all students have the same capacity for learning nursing. Of necessity there are as many students who are below the average of all nursing students in prenursing abilities as there are above-average ones, and it might be claimed that the school which helps less-than-average students become good nurses is contributing as much to society as is the school which accepts only superior students. Since a student who passes the licensing examination with below-average scores may have progressed during her educational program to the same extent as a student with above-average scores, it might be argued that the schools which have graduated these two students have been equally successful in helping them develop certain abilities.

No such “mitigating circumstances” can be claimed in the case of graduates who fail the licensing examination, for, in accepting a student, a school assumes responsibility for helping her to become licensed as a nurse. The percentage of students who pass the licensing examination might therefore be considered a fundamental criterion for measuring a school’s success. Any comparison of such percentages would, however, be colored by the fact that the passing scores on the licensing examination vary from state to state. Accordingly, the data presented in Table 10 show what percentage of students would pass the licensing examination at different passing scores. When measured against this “passing score” criterion, the Group A and B schools are considerably superior to the Group C schools. For example, if, to pass the licensing examination, a candidate were required to earn a score of 350 on each test in the examination, over 90 percent of the graduates from the Group A and B schools would become licensed as against only about three-quarters of the graduates of the Group C schools.

In using licensing examination results to evaluate schools of nursing, it must be remembered that there are many qualities which the sound educational program helps its students to develop which cannot be tested by the examination. The examination is designed to test professional nursing abilities only and cannot indicate the extent to which an examinee has been helped to lay foundations for her personal development. Moreover, even as a device for measuring nursing abilities, the examination has the limitation inherent in any paper-and-pencil test. It can measure the knowledge, understandings, and judgmental ability which an examinee will bring to a nursing situation, but it cannot evaluate her actual performance; it can show whether she knows what to do but not whether she will do it. Nor can it test an examinee’s alertness in observation, her conscientiousness and industry, her health, her manual dexterity—all important attributes for a nurse. Finally, the examination tests an examinee’s abilities at the time she takes it, not her capacity for future growth.
Need for Evaluative Studies

Any full-scale comparison of the extent to which the schools in Groups A, B, and C have helped their students to develop would therefore require more extensive evaluative data about their graduates, collected over a longer period of time, than the data provided by the licensing examination. Individual schools of nursing are making such evaluative studies of their graduates as a guide for improving their educational programs. Comparable data of this kind, however, cannot be secured because of the lack of commonly accepted specific criteria of good nursing care and reliable tools for measuring the nurse's ability to give this care.

The need for these criteria and measuring devices far transcends the requirements of a comparative study such as this one. They are essential for the establishment of sound objectives for all types of educational programs—not only for those conducted by schools of nursing but for the in-service education programs in agencies in which nurses are employed. They are necessary for any real appraisal of the effectiveness of measures to improve nursing care, whether these measures be related to a reorganization of nursing services or to the development of curriculums in educational programs. Their development, of course, would require massive research in which many people would have to cooperate—not only nurses themselves but patients, the employers of nurses, educators, and evaluation experts—but the results of such research could well be the key for improving nursing care to a point that cannot now be even visualized.

REFERENCES

Uses of This Report

This report, it is hoped, will have many uses for those concerned with the improvement of hospital schools of nursing. In particular, it might be utilized in the charting of self-improvement plans in hospital schools, in the establishment and application of accrediting criteria, and in the mapping of future NLN programs.

A realistic approach to these various activities requires an understanding of the major problems which are confronting all hospital schools of nursing, regardless of their stage of educational development. In addition, knowledge of the problems that are particularly pronounced in non-accredited schools may be helpful. Accordingly, throughout this report an attempt has been made to identify some of the problems to which those concerned with improving nonaccredited schools might wish to direct special attention.

Table 11 summarizes the main differences between accredited and nonaccredited hospital schools that were identified in the 1957 questionnaire data. In presenting this summary, it is important to call attention again to the limitations of the data-collecting instrument. Information secured from a questionnaire that asks for "yes-no" or numerical answers only cannot reveal many of the most important differences that one might expect to find between sound educational programs and those of lesser quality.

### Table 11

**Some Characteristics Which Differentiate the Typical School in Groups A and B from the Typical School in Group C, 1957**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Groups A and B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Range</td>
</tr>
<tr>
<td><strong>Size</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of enrollments</td>
<td>132</td>
<td>27 to 656</td>
</tr>
<tr>
<td><strong>Nurse Faculty</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>15.6(a)</td>
<td></td>
</tr>
<tr>
<td>Percent full-time</td>
<td>69.2(a)</td>
<td></td>
</tr>
<tr>
<td>Percent with academic degree</td>
<td>73.4(a)</td>
<td></td>
</tr>
<tr>
<td>Masters degree held by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>At least one full-time member</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Inservice program</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult patient census in controlling hospital</td>
<td>245</td>
<td>55 to 2,543</td>
</tr>
<tr>
<td>Number of affiliation weeks</td>
<td>18</td>
<td>0 to 45</td>
</tr>
<tr>
<td><strong>Library</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of professional titles</td>
<td>1,167</td>
<td>23 to 8,000</td>
</tr>
<tr>
<td>Number of professional periodicals</td>
<td>20</td>
<td>4 to 420</td>
</tr>
<tr>
<td>Trained librarian</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td><strong>Finances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in budget preparation by school personnel</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Cash cost to student</td>
<td>$482</td>
<td>$33 to $2,418</td>
</tr>
<tr>
<td><strong>Graduates</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent who, on SBTP, achieve scores of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>97(c)</td>
<td></td>
</tr>
<tr>
<td>350</td>
<td>91(c)</td>
<td></td>
</tr>
<tr>
<td>400</td>
<td>78(c)</td>
<td></td>
</tr>
</tbody>
</table>

(a) Average for 209 reporting schools.
(b) Average for 488 reporting schools.
(c) Percent of graduates from all fully accredited diploma programs.
(d) Percent of graduates from all diploma programs not fully accredited.
Most of the differences that were identified relate to resources available to the schools rather than to their educational practices, and, except for some information about faculty qualifications, these resources are described in quantitative terms only.

This lack of descriptive information about educational practices accounts, in part at least, for the overlap of the data in the two groups of schools that is noted when the "range" columns of Table 11 are studied. For example, the total affiliation time in some accredited programs is longer than the median time for nonaccredited schools. It is possible, however, that the accredited school which has had to rely on the cooperation of other agencies for clinical facilities and instruction has taken steps to insure the educational value of the students' experiences in these agencies; only those agencies which maintain high educational standards are utilized, and the instructional personnel of the school and agencies, as well as the nurse administrators, meet frequently to plan the learning experiences and discuss the students' progress. In other words, the questionnaire data can reveal a quantitative deficiency in resources without showing the educational practices which compensate for this deficiency.

The NLN's philosophy of accreditation also accounts for the lack of a clear-cut boundary line between the data recorded for accredited and nonaccredited schools. According to the NLN statement of principles of accreditation, "emphasis is placed upon the evaluation of the total program and its general excellence as well as upon its achievement with regard to particular aspects." Thus, an accredited school may be weak in some areas but, because of strengths in other areas, be recognized as a generally sound program.

This explanation, of course, does not nullify the usefulness of studying the data in Table 11. While quantitative data cannot be used as the sole criteria of educational excellence, Table 11 shows that there is often a relationship between the quantitative information that a school supplies and the quality of education that it provides. All the quantitative data in this report (Tables 1-11 and Figures 1-7) might therefore be studied by the many groups and individuals concerned with improving nursing education.

Making Plans for Self-Improvement

Of all the efforts that are being directed toward the improvement of nursing education, the most important are the efforts which each school makes to strengthen its own educational program. In charting the next phase in its school's self-improvement plan, the faculty group in a hospital school might well explore the data in this report for clues to specific steps that might be taken.

For example, a faculty group might observe: "An inservice program designed for school personnel exclusively seems to be the mark of a good school. Why don't we start such a program?" Or again, "If most good schools, and almost half of all schools, have a trained librarian, why haven't we arranged to provide our students with this kind of assistance?"

It may be more difficult for a small school in a small hospital to institute needed improvements than for a large school in a large hospital. There is no necessary connection between size of school and hospital and the educational excellence of a program. Reference to Table 11 shows that some accredited programs are conducted by small schools in relatively small hospitals. Generally speaking, however, it would appear that small schools have been slower in meeting the criteria of accreditation than have medium-sized and large ones. Of the 233 basic programs in nursing (hospital and collegiate) which in October 1956 reported enrollments of under 50 students, only 15, or 6 percent, were accredited; of the 205 programs with enrollments of over 150 students, 139, or 68 percent, were accredited. Although there is no accreditation criterion concerning the size of a school or its controlling hospital, these characteristics would appear to be directly related to the amount of effort required for a school to meet criteria of general excellence.

A realistic self-evaluation on the part of a small school of nursing must take into account the extra difficulties which confront it. Both the school and the community it serves must answer the question: Is this school of nursing really needed in the community? Some schools and communities will answer: "Yes; there are no other schools of nursing in the vicinity which will serve the purpose that this school serves." In such instances, the school and community should be willing to face and overcome the difficulties that are apparently inherent in operating a good, small school of nursing.

In other cases, the school and community may find a different way of solving the problem. Possibly they will decide that a combination of resources of two or more schools will bring about an improvement in the community's facilities for nursing education without lowering the total student capacity.

From these examples of how this study might be used for purposes of self-evaluation and self-improvement, it can be seen that not all of the questions it will raise can be easily answered. Some of them are truly "tough" and can be expected to provoke an immediate emotional response. In the final analysis, though, those responsible for schools of nursing can be depended upon to approach them objectively and answer them courageously. At least, this would seem to be our "pattern" throughout the history of nursing education.
Establishing and Applying Accrediting Criteria

The findings of this report might also be studied by the members of the NLN Department of Diploma and Associate Degree Programs (about 6,000 individual members and 550 agency members), who establish the criteria for accrediting diploma programs, to determine whether existing criteria are realistic and sufficiently specific, and by the NLN Board of Review for Diploma Programs for guidance in its application of these criteria.

For example, although a masters degree in nursing education might be considered as one requirement for a qualified faculty member, a glance at Table 3 shows that in 1957 fewer than 20 percent of nurse faculty members in hospital schools of nursing could meet this requirement. Obviously, the Board of Review for Diploma Programs has been extremely lenient in its interpretation of criteria about faculty; in 1957, one-third of NLN-accredited hospital schools did not have even one full-time nurse faculty member with a masters degree in nursing education.

On the other hand, when over three-quarters of all hospital schools have libraries of 500 or more books (Table 6), is it being overly lenient to accredit a school whose library contains only 23 professional titles? Should the criteria as to what constitutes “sufficient” library facilities be more specific?

Planning NLN Activities

Those who guide the program and activities of the NLN might also find this study of use. Although, technically speaking, the School Improvement Program in capital letters has come to an end, the provision of services that will help schools improve their programs will always be a major NLN function. The needs of the schools for assistance, of course, far outstrip NLN resources, and it is not always easy to decide which of the many pressing problems should be selected for first attention. A study of the findings of this questionnaire study may help the NLN Board of Directors, committees, councils, and staff identify the problems that are most urgent and the projects that give promise of being most productive.

Preparation of Faculty

An examination of the problems confronting schools of nursing shows that many of them can only be solved by the faculty groups themselves. For example, only the school’s faculty, with its knowledge of the school’s objectives and resources, can develop a good curriculum for the school or prepare a budget consistent with the blueprint of the school’s activities. Many faculty members, however, are not prepared to carry out some of their responsibilities; the “know-hows” of curriculum-building and budget preparation are not learned in the basic school of nursing nor are they easily developed through self-teaching. The League’s efforts to promote the development of graduate education for nursing, which is resulting in the preparation of more qualified faculty members, might be regarded as the most promising program for solving “at one gulp” many of the problems now facing basic schools of nursing.

Pending the achievement of this long-range goal, the League, through consultation services, conferences and workshops, and publications, helps faculty members now “on the job” to prepare themselves better for tackling some of their problems. As has been pointed out, this study may be of use in the selection of the problems which might be approached in this way.

For example, in 1949, when only a fourth of the hospital schools of nursing had budgets of their own, to help all faculty members learn the technicalities of budget-making might have been regarded as somewhat visionary. Now that over three-fifths of these schools have separate budgets (Table 9), assistance of this kind might be one way of moving school plans for improvements from the stage of wishful (and sometimes unrealistic) thinking to that of real action. Again, now that more and more faculty members are able to devote their full time and attention to school activities, it might be timely for the League to assist schools in the development of good faculty inservice programs.
Cooperative Research Projects

The NLN might also give consideration to the problem areas which cannot be completely straightened out by each faculty group in its individual school. These have been identified in this report in a negative way as "missing pieces": the development of the educational potential of nursing care experiences, the cost of educating a nurse, the criteria for evaluating the most important characteristic of any school—its graduate. Each school can study these areas "on its own" and partially solve some of the curriculum and financial problems related to them. A concerted approach by many schools is required, however, for the kind of curriculum research and financial investigation that is needed. As the membership organization for schools of nursing, the NLN would seem to be the appropriate organization to bring about this coordination of effort.

Mention has already been made of the research project through which the League is helping schools to investigate the cost of nursing education. This project cannot really "take off" until a great deal of preliminary "tooling up" has been done. Schedules have been developed that can be used by a large number of schools so that the data collected from these schools will be comparable. These schedules have been tested. Schools are being helped to apply them. Only after all these preliminary steps have been taken can the main part of the project—the collection and analysis of data—be undertaken.

A coordinated approach to curriculum research would involve a much vaster tooling-up process. Data for such research cannot be collected without commonly accepted definitions of the various kinds of learning experiences and standardized units for measuring the time allotted to them. Progress toward the goals of nursing education cannot be appraised without a more specific definition of the primary goal—good nursing care. If these definitions are established, schools will have to be helped to understand them and use them effectively. Then, and only then, can there be research of the scope required for nursing education to fulfill its responsibility to society.

Reporting Progress

Throughout this report, comparisons have been made between the hospital schools of nursing of 1949 and those of 1957. The 1957 schools, in most instances, bear the same names and are conducted by the same institutions as the 1949 schools, but they are not the same schools at all. Compare a statement that was made after an analysis of the data submitted by the 1949 schools (hospital and collegiate) with a statement that might have been made about the 1957 hospital schools.

The 1949 statement:

Schools with scores of 70 or better were those which could be called "good" schools in terms of the criteria of the Essentials [of a Good School of Nursing] .... About one-tenth of the schools had scores of 70 or better.2

The 1957 statement:

Hospital schools which are called "excellent" schools are those which have demonstrated that they meet the NLN criteria for full accreditation as diploma programs. About three-tenths of the hospital schools have demonstrated that they meet these criteria.

In February 1959 the concluding sentence could be changed to:

About one-half of the hospital schools have demonstrated that they meet the NLN accrediting criteria.

To summarize:

1949—good schools—one-tenth
1957—excellent hospital schools—three-tenths
1959—excellent hospital schools—one-half

Most of the credit for this progress belongs to the schools themselves and to the hospitals that control and to a large extent support them. But it is doubtful whether the schools and hospitals could have effected so many changes without the stimulation and assistance provided through the NLN School Improvement Program. The NLN, in turn, could not have undertaken the School Improvement Program without the financial assistance of three foundations—the Commonwealth Fund, the National Foundation, and the Rockefeller Foundation.

All the people and groups who have contributed so much toward the success of the School Improvement Program deserve a rendering of accounts—a statement of the achievements of the program which they can balance against the work and money they have expended on it. In addition to its other uses, it is hoped that this study will serve as a report of the real progress that has taken place in hospital schools of nursing to all those who have made this progress possible.

References

Appendix
QUESTIONNAIRE ON EDUCATIONAL PRACTICES
in
BASIC PROFESSIONAL SCHOOLS OF NURSING

This questionnaire is designed to provide information about schools of nursing which offer diploma programs. The completed questionnaire will serve two purposes: (1) The information submitted by a school will serve to provide information about its program for a consultant of the Department of Diploma and Associate Degree Programs as she prepares to make a consultation visit to the school; (2) The information as submitted by all schools will provide data for the study of educational practices in nursing across the country.

Directions
Please read each question carefully. Fill in the blank to the right of the question or place a check mark to the right of the answer or answers which best describe your program. You will note that many questions are so phrased that more than one answer may be checked. Please disregard the code numbers at the right of each page.

General Information
1. Official title of the educational unit in nursing (school, department, division)

Street and number

City Zone State

2. Which of the following categories best describes your school?
   (Check only one answer)
   a. Hospital school
   b. Junior college offering a nursing program
   c. Independent school
   d. Other (specify)

3. Which of the following programs is offered?
   a. Diploma
   b. Associate degree

4. What is the current status of the school with the state approving authority?
   a. Full approval
   b. Tentative approval
   c. Conditional approval
   d. Not approved

Philosophy and Purposes
5. Is there a statement of the philosophy of the school?
   Yes
   No

6. If so, in what year was this statement of philosophy
   a. Originally formulated?
   b. Most recently reviewed or revised?

7. By whom was the philosophy formulated?
   (Check as many as apply)
   a. Governing board
   b. Advisory committee
   c. Director of the school
   d. Director and educational assistant
   e. Committee of the faculty
   f. Other (specify)

8. Is there a statement of the purpose of the school?
   Yes
   No

9. If so, in what year was that statement of purpose
   a. Originally formulated?
   b. Most recently reviewed or revised?

10. By whom was the purpose formulated?
    (Check as many as apply)
    a. Governing board
    b. Advisory committee
    c. Director of the school
    d. Director and educational assistant
    e. Committee of the faculty
    f. Other (specify)

Administration and Organization
11. Is there an organizational chart which shows the placement of the educational unit in the institution administering the unit?
    Yes
    No
12. Is there an organizational chart showing relationships and lines of authority of the school?  
Yes 701  
No 28-9

13. If the answer to No. 12 is "yes," which of the following are shown?  
(Check as many as apply)  
a. Code for interpretation of the chart 29-1  
b. Advisory groups 2  
c. Direct lines 3  
d. Indirect lines 4  
e. Relationships with other agencies participating in the program 5

14. Is there an advisory committee or council for the school?  
Yes 31-6  
No 7

15. If the answer to No. 14 is "yes," which of the following describes this group?  
(Check as many as apply)  
a. A committee of the board 32-1  
b. Advisory to the faculty 2  
c. Advisory to the board 3  
d. Interpretative to the community 4  
e. Responsible for policy-making for the school 5

16. Which of the following are included in the membership of the advisory group?  
(Chck as many as apply)  
a. Community 33-1  
b. General education 2  
c. Community agencies 3  
d. Counseling and guidance 4  
e. Nursing education (other than faculty of the school) 5  
f. Alumnae 6  
g. Medical profession 7  
h. Administration of the institution 8  
i. Director of the school of nursing 9  
j. Associate, assistant, or educational director of the school (Check only if she is a member by virtue of her position and not as a representative of the alumnae.) 0

17. Are there written regulations governing the faculty organization?  
Yes 34-1  
No 2

18. If the answer to No. 17 is "yes," which of the following do they include?  
(Chck as many as apply)  
a. Purpose 35-3  
b. Functions -4  
c. Membership -5  
d. Provisions for standing committees -6  
e. Provisions for regular meetings of the total group -7  
f. Provisions for regular meetings of the standing committees -8  
g. Other (specify) -9

19. For which of the following are minutes on file?  
a. General faculty meetings 40-1  
b. Committee meetings -2  
c. Advisory committee or council -3

20. Does the administrator of the hospital provide for regular meetings of all department heads?  
Yes 41-4  
No -5

21. If the answer to No. 20 is "yes," is the director of the school of nursing regularly included?  
Yes 42-6  
No -7

22. With which of the following does the director of the educational program meet regularly?  
(Chck all those which apply)  
a. Controlling group 43-1  
b. Hospital administrator -2  
c. Nursing service personnel -3  
d. Faculty -4  
e. Other (specify) -5

23. Who formulates educational policy?  
(Chck all those which apply)  
a. Board of control 44-1  
b. Advisory committee -2  
c. Hospital administrator -3  
d. Director of the school of nursing -4  
e. Director of the school of nursing with educational assistant(s) -5  
f. Executive committee of the faculty -6  
g. Faculty -7  
h. Other (specify) -8

Finance  
24. Is there a separate budget for this school?  
Yes 45-1  
No -2
25. If the answer to No. 24 is "yes," by whom is the budget prepared?  
(Check all that apply)  
a. Director of nursing  
b. Director of nursing and assistant  
c. Director of nursing with assistance of faculty  
d. Budget committee of the faculty  
e. Administrative officers of the institution  
f. Other (specify)  
26. What is the estimated educational deficit for the current year?  
a. The total deficit  
b. Per student  
27. Has a recent (since 1950) study been made of the cost of the  
educational program?  
Yes  
No  
28. Has there been an attempt to determine the value of student services?  
Yes  
No  
29. If the answer to No. 28 is "yes," what percent of graduate staff salary  
was estimated for the service provided by each of the following?  
a. Preclinical students  
b. Students in second half of first year  
c. Second-year students  
d. Third-year students  
30. How much money, exclusive of student fees, did the school receive in the  
last year from the following sources?  
a. Government funds (city, county, or state)  
b. Endowment  
c. College or university funds  
d. Private grants  
e. Hospital funds  
f. Estimated value of student service  
g. Other (specify)  
31. What is the cost to the student for the following?  
(Indicate the cost for only those items for which the student is charged)  
a. Pre-nursing tests  
b. Registration fee  
c. Tuition  
d. Books  
e. Achievement tests  
f. Library fee  
g. Laboratory fee  
h. Breakage fee  
i. Health fee (including hospitalization insurance)  
j. Student activity or recreational fee  
k. Affiliation fee  
l. Transportation  
m. Uniforms and shoes  
a. Room  
o. Board  
p. Laundry  
q. Graduation  
r. Other  
32. What is the cash cost to the student for the total program?  
(Items reported in the above questions should total this sum)  
33. Is there a loan fund available to students?  
Yes  
No  
34. If the answer to No. 33 is "yes," how many students received loans  
during the past school year?  
35. If the answer to No. 33 is "yes," what was the range in the amounts  
of these loans?  
Highest  
Lowest  
36. How many students enrolled on January 1st of this year had received  
scholarship aid from civic and philanthropic organizations other than  
the hospital?  
37. How were the recipients of the foregoing selected?  
a. By the organization awarding the scholarship  
b. By the school  
38. Does the school give financial aid (or grants in aid) through the  
waving of school fees?  
Yes  
No
39. If the answer to No. 38 is "yes," how many students of those enrolled January 1st of this year were given financial aid (or grants in aid) through the waiving of school fees?

40. What obligations do the recipients of the financial aid described in No. 38 assume for repayment?
   a. No provision for repayment
   b. To be repaid (in full or in part) if student does not complete the program
   c. To be repaid (in full or in part) within a stated period following graduation
   d. The recipient agrees to work as a graduate nurse in this institution for a stated period following graduation

41. What other kind of financial aid is provided? (Specify)

Instructional Personnel

Note: In the following question, include the director and her educational assistant as part-time instructors if they have nursing service responsibilities. Do not include head nurses, unless responsible for planning and teaching a formal course or unit of a course.

- a. head nurses, unless responsible for planning and teaching a formal course or unit of a course
- b. physicians who participate as lecturers in the clinical courses
- c. instructors in clinical affiliations
- d. instructors in colleges when the students are regularly enrolled students in the college. Information about these instructors is requested in question No. 43.
- e. If instruction is purchased from a college and students are not registered in the college, the college instructors should be included in the part-time categories listed in question No. 42.

42. How many of each of the following categories of instructors participate in this program?
   a. Full-time nurse
   b. Full-time non-nurse
   c. Part-time nurse
     (1) carry nursing service responsibility
     (2) employed part-time
   d. Part-time non-nurse

Total

43. If the students take some courses as regularly matriculated students at a college or university, how many instructors regularly teach in this program?
   a. Number having a baccalaureate degree
   b. Number having a master's degree
   c. Number having a doctorate degree

44. If the students in this program regularly receive instruction and experience in a clinical area in another institution, what is the number of instructors in those institutions who regularly teach in those clinical areas?
   a. Full-time nurse
   b. Part-time nurse
   c. Full-time non-nurse
   d. Part-time non-nurse

45. What responsibilities does the director of the school of nursing carry?
   a. Administration of the school of nursing only
   b. Administration of nursing service as well as of the school of nursing

46. What responsibilities does the associate or assistant director of the school (educational director) carry?
   a. Administers the educational program primarily
   b. Carries nursing service responsibilities as well as educational
   c. Teaches the sciences
   d. Teaches nursing arts
   e. Teaches in a major clinical area
   f. Other (specify)

47. How many nursing service personnel participate in the teaching program?

48. How many persons in each of the following categories does the answer to question No. 47 include?
   a. Assistant director of nursing service
   b. Supervisors
   c. Head nurses

49. What are the educational qualifications of the full-time instructional staff? Indicate in the blanks below the number in each category listed. Record the highest educational achievement only for each instructor. Therefore, the sum of a through k should equal the sum of a and b in question No. 42.
   a. Number having less than 15 semester credits
   b. Number having more than 15 semester credits
   c. Number having a baccalaureate degree in basic nursing
   d. Number having a baccalaureate degree in nursing education
   e. Number having a B.S. degree with major other than nursing
   f. Number having a B.A. degree with major other than nursing
   g. Number having a master's degree in nursing education
   h. Number having a master's degree in nursing education
   i. Number having a M.A. degree with major other than nursing
   j. Number having a M.S. degree with major other than nursing
   k. Number having advanced work beyond master's level
   l. Number having a Ph.D. degree

Total
50. What are the educational qualifications of the part-time instructional staff? 

Indicate in blanks below the number in each category listed. Record the highest educational achievement only for each instructor. Therefore, the sum of a through k should equal the sum of c and d in question No. 42.

a. Number having less than 15 semester credits
b. Number having more than 15 semester credits
c. Number having a baccalaureate degree in basic nursing
d. Number having a baccalaureate degree in nursing education
e. Number having a B.S. degree with major other than nursing
f. Number having a B.A. degree with major other than nursing
g. Number having a master's degree in nursing education
h. Number having a M.A. degree with major other than nursing
i. Number having a M.S. degree with major other than nursing
j. Number having advanced work beyond master's level
k. Number having a Ph.D. degree

Total

51. How many schools of nursing are represented by the basic nursing preparation of full- and part-time nurse instructors?

52. How many colleges and universities are represented by the degree in nursing education held by full- and part-time nurse instructors?

53. What is the number of instructors (nurse and non-nurse, full- and part-time) in each of the following categories? (The figures should total the same number as the total shown in question No. 42.)

Full-Time Part-Time

a. New appointments (less than one year) 53-58
b. One to three years 59-64
c. Three to five years 65-70
d. More than five years 71-76

Total 707

54. What percent of nurse instructors are members of ANA?

55. What percent of the instructional staff are members of NLN?

56. Have job analyses been made of faculty positions?

Yes 14-1

No 2-2

57. Have job descriptions been prepared for faculty positions?

Yes 15-3

No 4-4

58. Is there an inservice education program designed for instructional personnel which is different from that planned for nursing service personnel?

Yes 13-5

No 6-6

59. Is there a written plan for orientation of new faculty members?

Yes 27-8

No 2-2

60. What is the length of the faculty's work week?

61. How many days vacation are given regular members of the faculty?

62. How many official holidays are granted the faculty?

63. Which of the following are available to the faculty? (Check all of those which apply)

a. Retirement
b. Social Security
c. Hospitalization insurance
(1) paid by the institution
(2) paid by the individual
(3) cost shared by the individual and the institution
d. Employees' health service
(1) without charge
(2) reduced charge
(3) without charge beyond that covered by insurance
(4) at reduced charge beyond that covered by insurance
e. Hospitalization provided
(1) without charge
(2) reduced charge
(3) without charge beyond that covered by insurance
(4) at reduced charge beyond that covered by insurance
f. Other (specify)

64. What was the enrollment in the school as of January 1st of the year in which the questionnaire is completed?

a. Total
b. In the first year of the program
c. In the second year of the program
d. In the third year of the program

65. How many affiliating students were enrolled at that time?

66. What has been the withdrawal rate from the last three classes to graduate?

<table>
<thead>
<tr>
<th>Year of Graduation</th>
<th>Total No. Admitted to the Class</th>
<th>Total No. Withdrawn from the Class</th>
<th>Total No. Graduated in the Class</th>
<th>Attrition Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Any student who dropped back to another class should be included in the admissions of the class with which she graduated and not as an admission in the group with which she began. If more than one class graduates yearly, treat totals as one class.
67. What was the total number of withdrawals from the three classes as shown in the preceding question?

<table>
<thead>
<tr>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>49-51</td>
<td>52-53</td>
<td>54-55</td>
</tr>
</tbody>
</table>

68. Of the number reported in question No. 67, what percent was due to each of the following?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Failure</td>
<td>56-57</td>
</tr>
<tr>
<td>b. Dislike for nursing</td>
<td>58-59</td>
</tr>
<tr>
<td>c. Personality unsuited for nursing</td>
<td>60-61</td>
</tr>
<tr>
<td>d. Personal reasons</td>
<td>62-63</td>
</tr>
<tr>
<td>e. Disregard for regulations</td>
<td>64-X</td>
</tr>
</tbody>
</table>

69. Are applicants to the school required to have a pre-admission physical examination?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-1</td>
<td>-2</td>
</tr>
</tbody>
</table>

70. If the answer to question No. 69 is "yes," who makes this examination?

<table>
<thead>
<tr>
<th>Physician</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>66-3</td>
<td>-4</td>
</tr>
</tbody>
</table>

71. If the examination is given by a physician or physicians designated by the school, who bears the cost?

<table>
<thead>
<tr>
<th>Applicant</th>
<th>School</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>67-5</td>
<td>-6</td>
<td>-7</td>
</tr>
</tbody>
</table>

72. Is hospitalization insurance carried for students who are not covered by policies carried by their parents?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>68-8</td>
<td>-9</td>
</tr>
</tbody>
</table>

73. If the answer to question No. 72 is "yes," who bears the cost?

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Student</th>
<th>Shared by both</th>
</tr>
</thead>
<tbody>
<tr>
<td>69-1</td>
<td>-2</td>
<td>-3</td>
</tr>
</tbody>
</table>

74. Who directs the student health program?

<table>
<thead>
<tr>
<th>Nurse responsible for student health only</th>
<th>Nurse responsible for hospital personnel health program</th>
<th>A nurse instructor</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>70-1</td>
<td>-2</td>
<td>-3</td>
<td>-4</td>
</tr>
</tbody>
</table>

75. Is there a physician appointed to handle student health problems?

<table>
<thead>
<tr>
<th>No physician appointed</th>
<th>Part-time appointment</th>
<th>Full-time physician for hospital personnel health service</th>
</tr>
</thead>
<tbody>
<tr>
<td>71-5</td>
<td>-6</td>
<td>-7</td>
</tr>
</tbody>
</table>

76. If there is an appointed school physician, is he paid for his services?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>72-8</td>
<td>-9</td>
</tr>
</tbody>
</table>

77. How many hours per week do the students' class and clinical assignments total?

<table>
<thead>
<tr>
<th>First year</th>
<th>Second year</th>
<th>Third year</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-12</td>
<td>13-15</td>
<td>16-18</td>
</tr>
</tbody>
</table>

78. How many days vacation are given the students?

<table>
<thead>
<tr>
<th>First year</th>
<th>Second year</th>
<th>Third year</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-28</td>
<td>29-31</td>
<td>32-X</td>
</tr>
</tbody>
</table>

79. What is the total number of days sick leave allowed during the entire program?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>22-1</td>
<td>-2</td>
</tr>
</tbody>
</table>

80. How is this sick leave allocated?

<table>
<thead>
<tr>
<th>Cumulative</th>
<th>Apportioned per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-25</td>
<td>-2</td>
</tr>
</tbody>
</table>

81. How many official holidays are granted the students each year?

<table>
<thead>
<tr>
<th>Full days</th>
<th>Half days</th>
</tr>
</thead>
<tbody>
<tr>
<td>33-X</td>
<td>34-X</td>
</tr>
</tbody>
</table>

82. Which of the following are provided in the residence(s)?

<table>
<thead>
<tr>
<th>Recreation room</th>
<th>Kitchenettes</th>
<th>Beau parlors</th>
<th>Lounges</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-5</td>
<td>-6</td>
<td>-7</td>
<td>-8</td>
<td>-9</td>
</tr>
</tbody>
</table>

83. Are students provided with keys for their rooms?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>36-1</td>
<td>-2</td>
</tr>
</tbody>
</table>

84. Which of the following are provided in students' rooms for each individual student?

<table>
<thead>
<tr>
<th>Desk</th>
<th>Lamp</th>
<th>Dresser or chest</th>
<th>Chair</th>
<th>Closet</th>
</tr>
</thead>
<tbody>
<tr>
<td>37-3</td>
<td>-4</td>
<td>-5</td>
<td>-6</td>
<td>-7</td>
</tr>
</tbody>
</table>
88. Does the residence have 24-hour supervision?  
Yes  
No  

89. How many personnel are employed for this purpose?  

Curriculum

90. How many weeks are there in the total program?  

91. How many classes are admitted annually?  

92. What is the total number of hours of planned instruction?  

93. How many of the hours noted in question No. 92 are devoted to planned clinical instruction?  

94. What is the distribution of hours and percent of total in each time period?

<table>
<thead>
<tr>
<th>Class Hours</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

95. What is the distribution of curriculum hours according to content?

<table>
<thead>
<tr>
<th>Content Description</th>
<th>Class Hours</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. General education</td>
<td>50-53</td>
<td></td>
</tr>
<tr>
<td>b. Biologic and physical sciences</td>
<td>54-57</td>
<td></td>
</tr>
<tr>
<td>c. Social sciences</td>
<td>58-61</td>
<td></td>
</tr>
<tr>
<td>d. Non-clinical nursing courses</td>
<td>62-65</td>
<td></td>
</tr>
<tr>
<td>e. Clinical nursing courses</td>
<td>66-69</td>
<td></td>
</tr>
<tr>
<td>f. Other (specify)</td>
<td>70-72</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>74-77</td>
<td></td>
</tr>
</tbody>
</table>

96. How many weeks of experience are planned for all students in each of the following areas? Record in Column I. In Column II record the daily average census of the resources used. If experience is provided by a hospital other than the one conducting the school, indicate by an asterisk (*) in Column I.

<table>
<thead>
<tr>
<th>Weeks of Experience</th>
<th>Daily Average</th>
<th>I</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Preclinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Gynecology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Urology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Orthopedics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Eye, ear, nose, and throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Diet therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Operating room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Recovery room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Central supply room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Obstetrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Pediatrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Communicable disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o. Tuberculosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Psychiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Neurology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Outpatient department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s. Electives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t. Unassigned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>u. Vacation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>v. Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>74-76</td>
<td></td>
<td>58-61</td>
</tr>
<tr>
<td><strong>This figure should equal that shown in the answer to question No. 92.</strong></td>
<td>78-X</td>
<td>62-X</td>
<td></td>
</tr>
</tbody>
</table>

97. In what services does this school provide instruction and experience for students from other schools? (Do not include services used by collegiate programs which provide their own instruction or those used by "special" students)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Class Hours</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medicine</td>
<td>63-1</td>
<td></td>
</tr>
<tr>
<td>b. Surgery</td>
<td>-2</td>
<td></td>
</tr>
<tr>
<td>c. Pediatrics</td>
<td>-3</td>
<td></td>
</tr>
<tr>
<td>d. Obstetrics</td>
<td>-4</td>
<td></td>
</tr>
<tr>
<td>e. Communicable disease</td>
<td>-5</td>
<td></td>
</tr>
<tr>
<td>f. Tuberculosis</td>
<td>-6</td>
<td></td>
</tr>
<tr>
<td>g. Psychiatry</td>
<td>-7</td>
<td></td>
</tr>
<tr>
<td>h. Diet therapy</td>
<td>-8</td>
<td></td>
</tr>
<tr>
<td>i. Outpatient</td>
<td>-9</td>
<td></td>
</tr>
<tr>
<td>j. Other (specify)</td>
<td>64-1</td>
<td></td>
</tr>
</tbody>
</table>

98. Are NLN achievement tests used?

Yes  
No  

7-X
99. If the answer to question No. 98 is "yes," how are they used?
   a. At the end of a course 66-1
   b. At the end of a year 4
   c. In the senior year exclusively 5
   d. Other (specify) 6

100. What was the school mean in the state licensing examination as compared with the state mean for the last three classes to graduate?

<table>
<thead>
<tr>
<th>State</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-15</td>
<td>16-18</td>
</tr>
<tr>
<td>19-21</td>
<td>22-24</td>
</tr>
<tr>
<td>25-27</td>
<td>28-30</td>
</tr>
<tr>
<td>31-33</td>
<td>34-36</td>
</tr>
<tr>
<td>37-39</td>
<td>40-42</td>
</tr>
<tr>
<td>43-46</td>
<td>46-48</td>
</tr>
<tr>
<td>49-51</td>
<td>52-54</td>
</tr>
</tbody>
</table>

102. Do the outlines for clinical courses show the relationship of formal instruction to clinical instruction and experience?
   Yes 11-3
   No 4

103. Membership of the curriculum committee includes representation from which of the following areas? (Check all those which apply)
   a. General education 12-1
   b. Biologic and physical sciences 2
   c. Social sciences 3
   d. Non-clinical nursing 4
   e. All clinical nursing areas 5
   f. Some clinical nursing areas (specify) 6
   g. Other (specify) 7

104. Which of the following does the faculty make use of in curriculum planning?
   a. Resource persons or consultants 13-1
   b. Other (specify) 2

105. Is there a rotation plan available for the entire program?
   Yes 14-3
   No 4

106. To whom is the rotation plan readily accessible?
   a. Students 15-5
   b. Instructional personnel 6
   c. Administrative and nursing service personnel 7
   d. Other 8

107. Who is responsible for drawing up the rotation plan?
   a. Director of the school 16-1
   b. Assistant or associate director of the school 2
   c. Assistant or associate director of the nursing service 3
   d. Faculty committee 4

108. Are assignments for evening experience scheduled on the rotation plan for the total program?
   Yes 17-5
   No 6

109. If the answer to question No. 108 is "yes," how many weeks of evening experience are planned for the total program?
   18-20

110. Do the students' final records show amount of evening experience?
   Yes 21-1
   No 2

111. Are assignments for night experience scheduled on the rotation plan for the total program?
   Yes 22-3
   No 4

112. If the answer to question No. 111 is "yes," how many weeks of night experience are planned for the total program?
   23-25

113. In the last class to graduate, how many weeks of evening experience were recorded for the student who had the most experience?
   26-28

114. In the same class, how many weeks of evening experience were recorded for the student who had the least experience?
   29-31

115. In the same class, how many weeks of night experience were recorded for the student who had the most experience?
   32-34
116. In the same class, how many weeks of night experience were recorded for the student who had the least experience? 

117. In what month of the program is the first regular evening assignment made? 

118. In what month of the program is the first regular night assignment made? 

119. How are evening assignments made? (Check only one) 
   a. Periods longer than four weeks 
   b. Periods of four weeks 
   c. Periods of two weeks 
   d. Periods of one week 
   e. Irregular assignments of two or three evenings 
   f. Other (specify) 

120. How are assignments to night duty made? (Check only one) 
   a. Periods longer than four weeks 
   b. Periods of four weeks 
   c. Periods of two weeks 
   d. Periods of one week 
   e. Irregular assignments of two or three nights 
   f. Other (specify) 

121. How frequently does the faculty meet with representatives of other agencies which provide instruction and experience for students in this program? 
   a. Annually 
   b. Twice a year 
   c. Never 
   d. Other 

122. In which of the following areas has there been joint planning with the other agencies providing instruction and experience? 
   a. Content 
   b. Experience 
   c. Evaluation of a and b 
   d. Other (specify) 

123. How many of the following are provided for the educational program? 
   a. Classroom 
   b. Laboratories 
   c. Clinical conference room 
   d. Auditorium 
   e. Other 

124. Is there a separate nursing school library? 
   Yes 
   No 

125. If the answer to question No. 124 is “yes,” how many volumes (exclusive of fiction) are included in the collection? 

126. How many dictionaries and encyclopedias are included in the above figure? 

127. How many titles does the answer to question No. 125 include? 

128. How many new titles (exclusive of fiction) were added during the last school year? 

129. How many titles (exclusive of fiction) were withdrawn during the past school year? 

130. How many titles are there in the fiction collection? 

131. How many periodicals are subscribed to in each of the following? 
   a. Professional 
   b. Recreational 
   c. Other (specify) 

132. Is there a system which provides for an up-to-date collection of ephemeral material (pamphlets, reprints, etc.)? 
   Yes 
   No 

133. Is there a librarian? 
   Yes 
   No 

134. If the answer to question No. 133 is “yes,” is she prepared in library science? 
   Yes 
   No 

135. If there is a librarian, what is her appointment? 
   a. Full-time 
   b. Part-time 

136. Is the librarian a voting member of the faculty organization? 
   Yes 
   No 

137. Are library needs provided for in the budget? 
   Yes 
   No 

138. If the answer to question No. 137 is “yes,” what amount exclusive of salaries was budgeted for last year? 

139. How much of the above sum was spent last year? 

140. Which of the following apply to the hospital used for the major portion of the students’ experience? 
   a. Accredited by the joint commission 
   b. A member of the State Hospital Association 
   c. A member of the Catholic Hospital Association 
   d. A member of the Protestant Hospital Association 
   e. Other (specify)
141. What is the bed capacity of the hospital?
   a. Adult
   b. Child
   c. Bassinets for newborn

142. What was the daily average patient census for the last year?
   a. Adults
   b. Children
   c. Newborn

143. If there is an outpatient department, what was the daily average number of visits for the last year?

Nursing Service

144. What are the number of hours of work per week for
   a. Administrative nursing personnel
   b. General duty nurses
   c. Nonprofessional nursing personnel

145. For an average day, how many nursing service personnel are there in each of the following categories for each time period?

<table>
<thead>
<tr>
<th>Category</th>
<th>Days</th>
<th>Evenings</th>
<th>Nights</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Director of nursing service</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Director of nursing service and nursing education</td>
<td></td>
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<tr>
<td>c. Associate director of nursing service</td>
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<tr>
<td>d. Assistant director of nursing service</td>
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<td></td>
<td></td>
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<tr>
<td>e. Supervisors</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>f. Assistant supervisors</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. Head nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Assistant head nurses</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>i. General duty nurses</td>
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<td></td>
<td></td>
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<tr>
<td>j. Licensed practical nurses</td>
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<td></td>
</tr>
<tr>
<td>k. Other nonprofessional (specify)</td>
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</tbody>
</table>

146. What is the average number of private duty nurses on duty in a 24-hour period?

147. Is there a formal program for on-the-job training of aides?
   Yes
   No

Records, Reports and Announcements

149. Which of the following describe the provisions made for record-keeping?
   a. Fire-proof file cabinet
   b. Centrally located place
   c. Up-to-date locked file

150. Are records accessible to:
   a. Administrative officers of the school?
   b. Faculty?
   c. All members of the instructional staff?

151. How many full-time clerical assistants does the school of nursing have?

152. How many full-time clerical assistants does the nursing service have?

153. How is the annual report of the nursing department presented?
   a. Combined report
   b. Separate report for nursing service
   c. Separate report for the school of nursing

154. Does the annual report include recommendations for consideration and action?
   Yes
   No

155. Does the faculty participate in the preparation of the annual report?
   Yes
   No

156. For what group or groups is an annual report prepared?
   a. Hospital administrator
   b. Board of control
   c. School of nursing committee
   d. Other (specify)

157. What purpose does the school bulletin serve?
   a. Agreement with the student
   b. Source of information