The important thing is not to stop questioning. Curiosity has its own reason for existing. One cannot help but be in awe when he contemplates the mysteries of eternity, of life, of the marvelous structure of reality. It is enough if one tries merely to comprehend a little of this mystery every day. Never lose a holy curiosity.

Albert Einstein

Merry Christmas and a very Happy New Year!!!
From the President
Kaija Saranto
President of ACENDIO
Professor, University of Kuopio, Finland

I am writing this greeting just before Christmas. This is often the time of the year when you look back assessing things which have happened during the ending year and forward planning for the year to come. This year has been very demanding in many countries also from a nursing point of view. A huge shortage in nursing personnel has greatly affected many developmental activities in nursing practice. Among others nursing terminology has been one of those initiatives which has been forced to step aside for clinical duties. Luckily those units who have started the use of electronic patient records have been good examples to convince of the importance of nursing language. With the help of nursing data they have been able to show how structured nursing documentation can benefit also the measuring of nursing workload.

The year 2009 will be the 14\textsuperscript{th} in Acendio’s history. Since 1995 Acendio has served as a platform for networking in nursing language. From the beginning it was evident that many kinds of support would be needed to guide the development of describing nursing diagnosis, interventions and outcomes in nursing practice. Over the years a lot of advances have taken place and it has been a pleasure to share these results during our conferences. In 2009 the 7\textsuperscript{th} Acendio biannual conference has a different format. Acendio as an organization itself will network with the International Medical Informatics Association Special Interest Group for Nursing Informatics (IMIA – SIGNI). It will be a great possibility to strengthen international cooperation with colleagues from all over the world. A special Acendio pre-conference in Helsinki, Finland, on June 26 to 27, 2009 aside with tutorials will start the 10\textsuperscript{th} International Nursing Informatics Congress on June 28 to July 1, 2009.

The theme for the pre-conference is “Documenting the future of nursing – the case of nursing minimum data sets (NMDS)”. The conference will give an overview of the existing developments in NMDS, discuss how a NMDS can contribute to these forthcoming agendas and discuss the role of ACENDIO in developing a strategy on systematic documentation and the use of standardized terminologies in relation to a NMDS. There will be around 20 presentations by invited guest speakers from different countries. I also have the pleasure to invite all Acendio members and other colleagues to submit an abstract to be presented as a poster in the pre-conference. The instructions for the submissions are available on our website \url{www.acendio.net} in early January 2009. I hope to see you all in Helsinki!

Seasons greetings to all readers of this Newsletter,
Nursing vocabularies have been established for a significant period of time. The necessity to quantify nursing costs, the development of the electronic patient record (Europe Information Society, 2003), and the growth of evidence-based practice have been some of the determinants for the greatest development of these languages.

“If you can’t name it, you can’t control it, finance it, teach it, research it, or put it into public policy”

The above quotation is part of the dedication in Clark’s book (2003) “Naming Nursing”. It was stated by Norma Lang, and summarizes what standardized vocabularies mean for Nurses and the nursing profession.

Nursing vocabularies and terminological work has been going on for a long time, but the last fifteen years have seen the greatest development as pointed out by Hardiker (2000).

From the various terminologies currently in place for Nursing, the NANDA Nursing Diagnoses Classification is one of the most well known across the world. Since the late 1970’s when the NANDA classification was published for the first time, the taxonomy has evolved and changed in order to accommodate the evolving needs of Nursing to describe “phenomena of concern to Nursing”, which are those problems that nurses treat and which cannot be described using medical vocabulary.

More than thirty years after the first publication of NANDA Nursing diagnoses, neither this terminology nor any other terminology regarding Nursing phenomena has been generally adopted by nursing professionals. That fact alone begs the question: is a specific Nursing Terminology needed?

Professional terminology: Need to have vs Nice to have

Terminology as general concept is built upon a vocabulary which can be defined as a set of words that are part of a specific language and which are known by people who speak it. Vocabulary can be passive (the person understand the words but is not able to use them) or active (the person both understands and is able to use the words).

When speaking about technical terminology, reference is made to a specialized vocabulary which is used by a profession and, to the development of which, a number of professionals dedicate a significant amount of their time. Technical terminology evolves because professionals need a way to communicate in a precise specific manner without having to explain each concept that is being used. Professionals who cannot use the language will be excluded.

Professional terminology gives professional identity, and identity is the capacity to make decisions and act without the participation of parental figures. This implies the accountability over own actions and the necessity to acknowledge them. As Lunardi, Peter and Gastaldo (2002) point out, in order that nurses could act following their ethical values, it will be necessary that they develop a sense of professional identity and pride.

Looking at the necessity of having one’s own language from a post-structuralist point of view, Foucault (1980) ascertained that empowerment creates new knowledge, objects
and information systems, whilst knowledge has its own effect on empowerment:

No knowledge can be created without a communication, register, and distribution system which constitutes power in itself, and which is in its own existence and function linked to other power forces. Contrary, any power can be executed without the appropriate extraction, appropriation or retention of knowledge.

Akinsanya (1989) pointed out that every science has its own peculiar terms, concepts and principles which are essential for the development of its knowledge base. In nursing as in other sciences, an understanding of these is a prerequisite to a critical examination of their contribution to the development of knowledge and its application to practice.

All over the world nursing is a relatively invisible profession within the healthcare system. Whilst being the most numerous professionals, their contribution is still not disclosed. Watson (1997) states that the attention to language is especially critical to an evolving discipline, in that during this post-modern era, one survival depends upon having language; Writers in this area remind us “if you do not have your own language you don’t exist”.

In conclusion, based upon the reviewed authors, it appears that a specific Nursing Terminology is not only needed but essential both for the development of nursing science and for the survival of the profession.

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Carme Espinosa i Fresno

Board Member

Spain
Implementing NANDA-I Diagnoses into Swiss Nursing Practice and Nursing Education

Implementing standardized language is common in many Swiss institutions in these days, and a conference organized by M. Müller-Staub, Pflege PBS, gained great attention. More than 150 participants felt honored to meet Marylinn Doenges, Mary F. Moorhouse and Alice C. Murr, our keynote speakers from the USA. M. Doenges and her colleagues are the authors of the “Nurses Pocket Guide”, a book that was translated into seven languages including German. The book was first published in 1985. Implementing nursing diagnoses into clinical practice by fostering nurses’ clinical reasoning skills using NANDA-I diagnoses, linked with desired outcomes and nursing interventions (Doenges et.al, 2003+2008) was the main topic of the conference. The participants got insight in the history of “Nurses Pocket Guide” and the authors shared their experiences in writing, teaching and implementing nursing diagnoses, interventions and outcomes. Currently, the 11th edition of the “Nurses Pocket Guide” is in press in English, and the 4th German edition will follow very soon. Marilynn Doenges shared her great teaching expertise at the conference “Implementing standardized language”, and Alice Murr presented research and use of standardized language in the electronic health record. Mary Moorhouse led a workshop about educational strategies to implement diagnoses, interventions and outcomes by using the “Nurses Pocket Guide”. Swiss nurse educators felt assured (for their own teaching) through this workshop and were encouraged to further develop their educational methods.

C. Vaterhaus-Buser gave a workshop to a similar topic in German language. She enthusiastically presented implementation and teaching methods in Higher Swiss Nursing Education and shared her expertise with the audience.

M. Odenbreit presented a recent survey, including 50 Swiss hospitals with total 12’000 beds (Odenbreit, in review). The results of this survey demonstrated that 62 % use NANDA-I as embedded in the care plan by Doenges et al. Results also indicated that several hospitals did start the implementation of NANDA-I diagnoses. When adding actual and planned implementations, NANDA-I will be used by 88 % of the participating hospitals. Study results have shown “Nurses Pocket Guide” being the most often used book to apply NANDA-I diagnoses in Swiss hospitals.

Evaluation studies of the implementation of nursing diagnoses, interventions and outcomes were presented by I. Needham and M. Müller-Staub, who presented highly significant enhancements in documenting specific nursing diagnoses, effective interventions and patients outcomes. These studies were part of Müller-Staub’s doctoral research at the Radboud University Nijmegen, a sought-after thesis that was distributed in more than 250 exemplars since last summer.

A study evaluating the nursing process documentation in the State of Wallis was presented.
country report

From Europe

by S. Delic. In this state, NANDA-I diagnoses were taught since many years. S. Delic gave insight into an electronically developed measurement instrument to evaluate care plans. Results: 93 % of 152 care plans did include nursing diagnoses. However, 24 % did not contain correct defining characteristics or etiological factors.

This conference reflected the “Swiss state of the Art” in applying standardized language. Participants showed a great interest not in merely introducing nursing diagnoses, interventions and outcomes into electronic programs (EHR), but teaching and fostering nurses clinical decision making skills and critical thinking, aiming to state accurate diagnoses based on patient’s cues (defining characteristics/ etiological factors) and based on knowledge about the NANDA-taxonomy embedded into the nursing process.

References


Maria Müller-Staub, PhD, RN

Pflege PBS, Selzach, Switzerland

author contact: muellerstaub@me.com
conference report
From NANDA Conference

NANDA-International definition for Nursing Diagnoses does not change

From the 13th to 15th November 2008 in the Hyatt Regency Hotel of Miami (USA) the Biennial NANDA-I Conference was held. The theme of the Conference was “Capturing the expert knowledge of Nursing”.

I was there as ACENDIO representative, and these are my report after the NANDA conference.

More than 250 nurses from around the world met in this City to discuss the definition of Nursing Diagnoses and to share their experiences on the use of Standardised Nursing Languages.

The central focus of this conference was the discussion about the changes that NANDA-I were proposing for the definition of nursing diagnoses.

On the 14th, there was an open discussion for all the participants in the conference. Lynda Juall Carpenito-Moyet, gave a presentation explaining NANDA-I’s position on the subject. There are two options: To add the collaborative problems as Nursing diagnoses into the NANDA-I Taxonomy, or to identify Collaborative problems as surveillance nursing diagnoses and then add them into the NANDA-I Taxonomy in a new domain.

Intense and passionate debate followed the presentations, in which two different ideas came up: In the USA nurses want to incorporate Collaborative problems as Nursing diagnoses due to their need for legal support, while internationally, nurses were more in favour of supporting and enhancing the independent role of nurses and consequently maintaining the collaborative problems as something different to Nursing diagnoses.

During the General Assembly of NANDA-I, a change in the definition of Syndrome was approved, while the definitions for Nursing Diagnosis, including the different kinds of Nursing diagnosis, could not be approved due to a formal problem during the voting process.

The General Assembly returned the Nursing Diagnoses definition to the board, and asked the board to incorporate the conclusions from the different discussions into something new to be presented during the next NANDA-I Conference to members.

NANDA-I celebrated its award luncheon in which different awards were given to nurses who were particularly active with their contribution to the dissemination and use of NANDA Diagnoses.

Marjorie Gordon was given an award for her work in mentoring other nurses to facilitate their work, this was a very celebrated and special award, as was Dorothy Jones. Two members of the Spanish Association AENTDE were given two awards for their unique contribution to the development and implementation of NANDA nursing diagnoses, Rosa Gonzalez Gutierrez-Solana (President of AENTDE) and Mercedes Ugalde Apalategui (former President of AENTDE).

Other awards were given and a new award, in the name of Heather Herdman, was introduced.

At the end of the meeting the new president of NANDA-I Dickon Weir-Hughes and the President of
conference report

From NANDA Conference

AENTDE Rosa Gonzalez Gutierrez-Solana presented the next NANDA-I Conference, which will be held in Madrid (Spain) from May 19th to 21st in 2010. This will be a shared Congress between the Spanish Association and NANDA-I and is considered a historical opportunity, not only for Spanish nursing, but also for European nursing, because for the first time in the history of NANDA-I, the association has a President who is not American (he is European) and the conference will be held in a Country outside the USA.

No European nurse can miss the opportunity to attend such an event.

Carme Espinosa i Fresnedo
ACENDIO Board Member
Talking with: Margaret Lunney (1)

This is the first chapter of an Interview made by Maria Müller to Professor Margaret Lunney. In the next ACENDIO Newsletter issues you will find the following chapters.

Margaret Lunney
Professor Margaret Lunney, RN,
PhD, CS
Program Coordinator, Masters in
Adult Health Nursing
College of Staten Island

Organizations
Dr. Lunney has had a long involvement with NANDA. NANDA-
International’s Committee Structure - Committee membership: She
currently serves on the Bylaws and Research Committee’s.

Professional Interests:
Community health nursing, Accuracy of nurses diagnoses, critical thinking,
use of standardized nursing languages, implementation of electronic health records, and nursing theory
and research.

Primary Teaching Areas (at the GC):
Information Technology in Healthcare and Nursing

Honors (2007):
Fulbright Award for a two-week trip to Japan for research consultation and lectures.

Selected Publications:

Electronic Health Record with Elementary School Children. The Journal of School Nursing (April
2006).
JONA, 36 (3), 1-8.
Philadelphia: NANDA International.

Works in Progress:
1. An Appeal for Nurses’ to Address Accuracy of Nurses’ Diagnoses
2. Participant Action Research with Nurses to Identify NANDA, NIC and NOC Categories
3. Facilitating Critical Thinking through Online Courses
4. Interrater reliability of a Grading Tool for Students’ Online Participation in Coursework.

Education:
- BS
- MS
- PhD
Chapter 1:
Nursing Diagnoses Accuracy

1. Nursing diagnoses, diagnostic reasoning, and accuracy of nursing diagnoses are central themes in your career. When did you start with working them, and why did you decide these are my subjects.

I first became interested in accuracy of nurses’ diagnoses while I was working as a home care nurse. I had a regular group of patients that I saw weekly or monthly but sometimes other nurses would visit them when I had a day off or when I was assigned to visit patients in another district. When I returned to the homes of some patients and families, they commented that the “other” nurse did things differently, e.g., taught them something that they thought they knew already, or said things that conflicted with their own ideas of what they needed. This led to an awareness that nurses interpret data differently and they provide interventions based on their interpretations. This was in the early 1970’s. Later in the 1970’s, while I was studying for my bachelor’s degree in nursing, I became aware of the concept of nursing diagnosis. I integrated these two experiences to decide that I wanted to study accuracy of nurses’ diagnoses. I noticed that, even though nurses were talking about diagnoses, they were not referring to accuracy as an issue or a problem.

In the 1980’s, while attending New York University for a doctorate in nursing, I had significant opportunities to support my interest in accuracy. Two well-known experts in psychometrics, Carol Noll Hoskins, a nurse researcher, and Philip Merryfield, an educational psychologist who was a protégée of J.P. Guilford, agreed to help me with concept and tool development associated with measuring accuracy. At the same time, my Dean at Hunter College, recommended me for a two-year continuing education program on measurement being offered by the American Nurses Association and the University of Maryland. These opportunities provided me with the knowledge and scholarly support that I needed to do this work.

The emphasis on diagnostic reasoning and critical thinking was a natural outgrowth of the initial interest in accuracy. Also, Philip Merryfield, my mentor, had conducted extensive studies on thinking as it relates to Guilford’s Structure of Intellect (SOI) Model. I used the SOI model for my dissertation research. Knowledge of this model continues to influence my thinking, even though it is not as popular today was it was in the 1980’s.

2. What are the advantages of applying nursing diagnoses in contrast to state patients’ problems in a free text format?

The advantages of applying standardized nursing diagnoses, in contrast to using a free text format, is that others will know what we mean because the concept has been defined, described, and agreed upon by many nurses. In contrast, every single term that would be used in a free text format has the potential to be defined in multiple ways. This makes it impossible to make sense of nursing data.

Every science, including nursing science, must have standardized classifications of terms that are accepted by consensus so that the meanings of terms will be known across individuals, settings and localities. This was described in detail by the well-known linguist, S.I. Hayakawa, in his 1990 book, Language in Thought and Action.

Sciences, such as nursing, need terms that are defined and described so members of the science can communicate and collaborate with one another to solve problems. Humans cannot think about problems without having the words with which to think about them and they cannot work with others to solve problems unless they agree on the meanings of these words. Hayakawa referred to classification systems such as NANDA International’s approved list of nursing diagnoses as “maps” to the territory, i.e., maps to the territory of nursing. These maps will never be perfect but we must continuously work on them to make them as comprehensive and useful as possible.

3. What are human response patterns and what are the reasons/advantages for using them in the diagnostic process?

When nurses first started to name the phenomena of their concern as nursing diagnoses, the term “human responses” was being used in many states of the U.S. to distinguish the focus of nursing in State Nurse Practice Acts. The term seemed to resonate with many nurses and people from other disciplines who were trying to understand what differentiated the focus of nurses from the focus of physicians. It is based on the belief that nurses focus on the
individual, family or community responses to health problems and life processes. An example of a response to a health problem is a woman with breast cancer who has a mastectomy; one of the nurse’s roles is to help the woman cope with the loss of the breast and the changes in her daily living. An example of responses to life processes is a family who is dealing with an elderly parent with Alzheimer’s disease; one of the nurses’ roles is to help the family to manage the complexity of caregiving.

The term, human responses, has been controversial because, to some, it seems too limiting. No other term, however, has yet been proposed that has received broad consensus, so, for now, that is the term being used by NANDA International.

The word pattern was added to human responses in recognition that nurses address responses when they are patterns of the individual, family or community that becomes problems, risk states, or potential for enhanced health.

4. **You have great expertise in the concept of “accuracy”. What is meant by accuracy and why is accuracy of nursing diagnoses and stating accurate diagnoses important?**

When I first started studied accuracy, I realized that, in the early 1980’s, nurses were viewing accuracy the same as physicians did, i.e., accuracy was viewed as a dichotomous or either-or variable. This approach works for medicine but does not work for nursing because there is too much overlap of human response concepts, e.g., the concept of coping overlaps with the concepts of powerlessness, hopelessness, anxiety and other responses.

Many human responses that nurses diagnose and treat are related to one another and are not mutually exclusive like medical diagnoses. If the best diagnosis is powerlessness, a nurse who diagnoses the patient as hopeless is closer to high accuracy than a nurse who diagnoses the patients as altered nutrition.

To resolve this problem, I developed the concept of accuracy of nursing diagnoses as a continuous variable, instead of a dichotomous one. An associated seven-point scale with specific criteria for each point on the scale is available for measuring accuracy. The studies done to date of using this scale have supported the validity of accuracy as a continuous variable. The scale and the scoring method are described in the book, Critical thinking and nursing diagnosis: Case studies and analyses.

5. **What factors are associated with accuracy?**

The factors associated with accuracy were identified by two nurse theorists, Doris Carnevali and Marjory Gordon. They identified three major categories of factors: the diagnostic task, the situational context, and the diagnostician. Factors within each category were shown to influence accuracy, e.g., in the category of diagnostic task, if there are a lot of low relevance data, it increases the complexity of the diagnostic task and decreases accuracy.

6. **Which cognitive skills are important for nurses to state accurate nursing diagnoses?**

The cognitive skills that were considered important for nursing were named in a Delphi study of nurse experts conducted by Scheffer and Rubenfeld (2000). They identified the seven cognitive skills of analyzing, applying standards, discriminating, information seeking, logical reasoning, predicting, and transforming knowledge.

With the complexity of diagnosis in nursing, probably all of these cognitive skills are important for diagnosing. From the research to date, we do not yet know of any specific cognitive skills that we can say are more important than others. Using the SOI model, I studied divergent productive thinking because I thought it would be important to accuracy to be able to generate multiple possibilities from the data. The findings with written case studies were inconclusive but this is an important area for further study, especially since my study showed that nurses vary widely in this basic ability.

7. **How can critical thinking be fostered in nurses?**

The first step of fostering critical thinking in nurses is to explain the meaning of critical thinking and how to improve thinking processes. The meaning of critical thinking differs, depending on the theoretical perspective that is used. I like using the Scheffer and Rubenfeld model of thinking because it is evidence-based and relates directly to nursing. They were the only researchers who identified the critical thinking terms that apply to nursing.

Current perspectives on intelligence support the fact that humans can improve their thinking abilities through both knowledge and effort. Increased effort
to improve thinking can be supported by teachers and clinical managers through many different strategies, e.g., helping nurses to be more aware of their thinking processes, and helping them to accept possible flaws in thinking. Among other characteristics, tolerance for ambiguity needs to be fostered so nurses can recognize the possibility that they could be wrong in their interpretation of data. Low accuracy diagnoses will only be identified when nurses accept that they can occur.

8. What are the patients’ benefits of accurate nursing diagnoses, and what are the dangers of non accurate diagnoses?

It is important to point out that whether nurses formally name their diagnoses or not, they are always at risk of low accuracy. All nurses must interpret patient data in order to intervene. The advantage of naming interpretations as diagnoses is that they can be thought about, discussed, and even challenged by others if indicated.

The benefits of accurate diagnoses are that the most appropriate interventions can be selected. The dangers of low accuracy diagnoses are (a) harm to patients, (b) wasted time and energy, (c) absence of positive outcomes because the best diagnoses are not being addressed, and (d) patient and family dissatisfaction.

9. Which steps within the diagnostic process are important to get accurate nursing diagnoses?

We have insufficient research data at this point in time to be able to answer this question. At this point, we should consider all steps of the diagnostic process as important. Obtaining knowledge of nursing diagnosis concepts is necessary, but not sufficient. During the process of collecting data, nurses need to be able to see the relationships of data to possible diagnoses, which requires both knowledge and experience, assign relevance to cues as they relate to various diagnoses, take note of conflicting cues to rule out diagnoses, keep an open mind until there are sufficient data to decide on one or more diagnoses, be able to consider multiple diagnoses as explanations for cue clusters, and decide on a diagnoses when there are sufficient data to support the diagnosis.

10. How can patients’ individual needs be assessed in good quality, despite using standardized nursing diagnoses?

The use of these standardized nursing diagnoses does not hinder the individualization of nursing care any more than using the narrative format does. The experience of nurses caring for patients is always richer and more complex than can be represented in nurses’ documentation. These standard terms are intended to represent aspects of patients’ experiences that can be named and are similar to other patients’ experiences. Naming these phenomena of concern enables nurses to address them individually with each patient, in accordance with the specific patients’ needs.

11. How should a nurse go on in the diagnostic process if a patient shows a diagnosis, which is not found in NANDA’s taxonomy?

Nurses should not try to force fit patients’ experiences into categories that are available through NANDA International (I). This classification is incomplete so, if the phenomena of concern is not available through NANDA I, the nurse should name it and consider submitting this term to NANDA I for consideration as an approved diagnoses. For example, I have used a diagnosis, Stress Overload, which is not on the NANDA I list. I have not submitted it yet to NANDA I but plan to submit it this year. In Brazil, I saw that the nurses were using the diagnoses of Bleeding and Risk of Bleeding. They also plan to submit these diagnoses to NANDA I.

Nurse managers should not require nurses to only use the NANDA I list. If nurses identify diagnoses that are not on the NANDA I list, nurse managers can keep records of such diagnoses, and evaluate the records to see whether approved diagnoses should have been used instead or if these new diagnoses should be submitted to NANDA I. If the diagnoses the nurses used are appropriate for submission to NANDA I, nurses in the organization can develop the new diagnoses for inclusion on the NANDA I list or refer the names to NANDA I so that nurse researchers might be commissioned to study these new diagnoses.

12. How can nurse managers support nurses in accurately stating nursing diagnoses?

Nurse managers can provide an environment that supports nurses as professionals and advocate for nurses at the organizational level. Accurate diagnosing requires respect for nurses’ abilities as well as ongoing education and assistance for nurses to use and further develop their abilities. Intellectual,
interpersonal, and technical abilities are needed to achieve accurate diagnoses. Nurse managers can encourage nurses to develop reflective practices, in which nurses think about accuracy, work in partnership with patients and families to achieve accuracy, and collaborate with each other to achieve accuracy.

Policies regarding nursing diagnosis should be centered around identifying the most accurate diagnoses, not identifying a certain number of diagnoses or requiring nurses to only use problem diagnoses. Studies have shown that, even when patients are hospitalized, there may not be a problem response that needs nursing interventions.

13. What are the benefits for nurse managers, if nursing diagnoses are implemented in a hospital?

If nursing diagnoses are implemented with the intention of achieving accuracy, nurse managers and other hospital-based leaders will be able to use patients’ health records to identify the human responses that frequently occur with specific patient populations. This will provide information that can be used to develop nursing knowledge.

The diagnoses nurses treat can be communicated to the public so that others will know how nurses’ contribute to health care services. Without use of nursing diagnoses, the ability of nurses to diagnose and treat human responses is not valued because it is invisible.

14. Where should a hospital/institution start when implementing nursing diagnoses?

If an institution or hospital is just starting to implement nursing diagnosis, this project should be considered as a change in practice, so an evaluation plan should be set up before starting. The institution should consider how the success of this change in practice will be evaluated. For whatever positive effects are expected, e.g., improved professionalism of nurses, attitudes toward nursing diagnosis, or patient satisfaction, baseline data should be identified before starting the project so these data can be compared to data in post implementation phases.

Everett Rogers (2003), in his theory of diffusion of innovations, purports that an innovation, such as implementation of nursing diagnoses, will succeed if the following perceptions are fostered: relative advantage, compatibility with other important ideas, manageable complexity, trials can demonstrate success, and the positive effects are observable. He also suggests that it is important to reach opinion leaders and create a critical mass of supporters so that the innovation is sustainable. For this, he suggests to identify charismatic individuals who can champion the innovation. He said that we should expect that change is slow but entirely possible and can be speeded up. If the system adopts the innovation, it facilitates individual adoption.

The first step is to educate nurses on why it is important to name the focus of care, what are nursing diagnoses and accuracy of diagnoses, how to conduct diagnostic reasoning to achieve accuracy (including the importance of working in partnership with patients and families), how and where to record nurses’ diagnoses in the existing health record, and when to name diagnoses. Case study examples should be used throughout the education process to help nurses to connect these abstract concepts to the real world of nursing.

The next step is to implement a nursing diagnosis model of care on one or more units and to keep ongoing records regarding the processes and outcomes of this change in practice. It is important that the organization be prepared to describe the positive effects of changing to this model of care as well as any problems. The generation of useful data and information related to this process will support ongoing efforts by nurses, educators and managers.

15. Or what is important in a project to implement nursing diagnoses into practice?

Changes in practice are always challenging and difficult, requiring increased effort and attention to detail. It is important to recognize nurses’ efforts in a positive way and to use this change to promote high levels of professionalism.

16. Which tools support clinicians to document nursing diagnoses accurately and patient specific?

The most important type of tool to support clinicians documentation of nursing diagnoses is one that measures the quality of documentation, e.g., the tool developed by Muller-Staub. This tool was shown to be a valid and reliable measure of documentation quality which is an important measure of implementation success.
Other tools that can be used as pretest and posttest measures of the effects of implementation are a tool to measure attitudes toward nursing diagnosis (Lunney & Krenz, 1994), knowledge of nursing diagnosis, the sense of professionalism of nurses, or the effects of program implementation on nurses' power to participate knowingly (Barrett, 1990; Barrett & Caroselli, 1998; Caroselli & Barrett, 1998).

17. From your point of view, what is the connection between the use of nursing diagnoses and the electronic health record (i.e. electronic nursing documentation)?

With electronic health records (EHR), the next big change in health care worldwide, the use of nursing diagnoses and other standardized nursing languages, will be absolutely essential for the survival of nursing as a discipline and a profession. Use of electronic records requires health providers to record their data using file names. If nurses do not use the file names that represent nursing care elements, i.e., standardized nursing languages, their data will be recorded under medical and other diagnoses. This means that nursing data will not be retrievable and there will be no way to describe the contributions of nurses to patient care outcomes. If nursing is not represented in the computer, we can expect the eventual demise of nursing as a distinct profession. There will be no data to sustain growth and survival.

18. What are the advantages of using NANDA, NIC and NOC as standardized nursing terminology in today’s healthcare systems?

The advantages of using all three systems, NANDA International diagnoses, NIC interventions and NOC outcomes, are that: (a) the connections between diagnoses, interventions and outcomes can be clearly delineated, (b) the effects of nursing care on patient outcomes can be described, explained and predicted, (c) specific diagnoses, interventions and outcomes that are important for each patient population can be identified to reduce the complexity of these systems, (d) nurses who use these systems will be ready for implementation of an EHR.

19. Diagnoses Related Groups (DRGs) are more and more often used for cost reimbursement in health care systems in German speaking countries. Are nursing diagnoses a useful tool in dealing with DRGs?

Studies by Welton and Halloran (2000) have shown that nursing diagnoses are more predictive of length of stay and cost than DRGs. If DRGs are considered important, perhaps German speaking countries could consider using both DRGs and nursing diagnoses for cost reimbursement.

20. How do nursing diagnoses and critical pathways fit together? Are nursing diagnoses included and nurses involved in developing critical pathways?

Often critical pathways are developed with nursing diagnoses included but they are not designed to give nurses the opportunity to rule in or rule out diagnoses. The ones that I have seen require nurses to intervene for nursing diagnoses, such as ineffective coping, whether they exist in individual patients or not. This is counterproductive to creating an environment in which the focus is accuracy of nurses’ diagnoses. To achieve accuracy, critical pathways need to be set up so that nurse conduct diagnostic reasoning and rule diagnoses in or out, in accordance with patient data. Interventions are only implemented if the diagnoses are judged as accurate for individual patients.

One problem is that critical pathways are usually based on medical diagnoses. All people with a medical diagnosis do not respond the same way to medical problems. Critical pathways can be based on nursing diagnoses and these pathways would only be used after the nursing diagnosis was judged as accurate.

To be continued...
Klinische Entscheidungsfindung und kritisches Denken im pflegediagnostischen Prozess

Zusammenfassung


Summary
Clinical decision making and critical thinking in the nursing diagnostic process

The daily routine requires complex thinking processes of nurses, but clinical decision making and critical thinking are underestimated in nursing. A great demand for educational measures in clinical judgement related with the diagnostic process was found in nurses. The German literature hardly describes nursing diagnoses as clinical judgements about human reactions on health problems / life processes. Critical thinking is described as an intellectual, disciplined process of active conceptualisation, application and synthesis of information. It is gained through observation, experience, reflection and communication and leads thinking and action. Critical thinking influences the aspects of clinical decision making a) diagnostic judgement, b) therapeutic reasoning and c) ethical decision making. Human reactions are complex processes and in their course, human behavior is interpreted in the focus of health. Therefore, more attention should be given to the nursing diagnostic process.

This article presents the theoretical framework of the paper „Clinical decision making: Fostering critical thinking in the nursing diagnostic process through case studies”.

Reference:

Maria Müller-Staub,
Berufsschullehrerin Pflege,
Supervisorin BSO,
Pflegewissenschafterin MNS, PhD.
Short Articles

Nursing diagnoses, interventions and outcomes - application and impact on nursing practice: Systematic literature review

Abstract

Aim. This paper reports a systematic literature review on the outcomes of nursing diagnostics. Specifically, it examines effects on documentation of assessment quality; frequency, accuracy and completeness of nursing diagnoses; and on coherence between nursing diagnoses, interventions and outcomes.

Background. Escalating health care costs demand the measurement of nursing’s contribution to care. Use of standardized terminologies facilitates this measurement. Although several studies have evaluated nursing diagnosis documentation and their relationship with interventions and outcomes, a systematic review has not been carried out.

Method. A Medline, CINAHL, and Cochrane Database search (1982-2004) was conducted and enhanced by the addition of primary source and conference proceeding articles. Inclusion criteria were established and applied. Thirty-six articles were selected and subjected to thematic content analysis; each study was then assessed, and a level of evidence and grades of recommendations assigned.

Findings. Nursing diagnosis use improved the quality of documented patient assessments (n=14 studies), identification of commonly occurring diagnoses within similar settings (n=10), and coherence among nursing diagnoses, interventions, and outcomes (N=8). Four studies employed a continuing education intervention and found statistically significant improvements in the documentation of diagnoses, interventions and outcomes. However, limitations in diagnostic accuracy, reporting of signs/symptoms, and etiology were also reported (14 studies). One meta-analysis of eight trials including 1497 patients showed no evidence that standardized electronic documentation of nursing diagnosis and related interventions led to better nursing outcomes.

Conclusion. Despite variable results, the trend indicated that nursing diagnostics improved assessment documentation, the quality of interventions reported, and outcomes attained. The study reveals deficits in reporting of signs/symptoms and etiology. Consequently, staff educational measures to enhance diagnostic accuracy are recommended. The relationships among diagnoses, interventions and outcomes require further evaluation. Studies are needed to determine the relationship between the quality of documentation and practice.

Keywords

Nursing diagnoses; interventions; outcomes; evaluation; documentation; systematic literature review.

Reference


Maria Müller-Staub, Mary Ann Lavin, Ian Needham & Theo van Achterberg

Corresponding author: muellerstaub@bluewin.ch
Klinische Entscheidungsfindung: Förderung des kritischen Denkens im pflegediagnostischen Prozess durch Fallbesprechungen

Zusammenfassung

Pflegediagnostische Fallbesprechungen, die sich auf reale Patientensituationen beziehen, sind eine Form klinischer Entscheidungsfindung, welche kritisches Denken von Pflegenden fördern.

Der Artikel beschreibt Methode und Verlauf von Fallbesprechungen in der Weiterbildung von Pflegenden. Diese Methode der Fallbesprechung basiert auf der Fallsupervision nach Balint, wurde weiterentwickelt und mit dem pflegediagnostischen Prozess verbunden. Die Fallbesprechung weist verschiedene Arbeitsphasen auf: Vorphase, Aushandlung, Fallschilderung und Fallbearbeitung. Die Falleinbringerin schildert die Patientensituation durch freies Erzählen, was der Gruppe ermöglicht, Hinweise und Zeichen zu analysieren, thematisch zu bündeln, Pflegediagnosen zu stellen und Pflegeinterventionen abzuleiten. Durch Theoriebezug und kritische Stellungnahme der Falleinbringerin werden die Resultate der Fallbesprechung validiert.


Die theoretischen Grundlagen sind im Artikel „Klinische Entscheidungsfindung und kritisches Denken im pflegediagnostischen Prozess“ beschrieben.

Summary

Case studies, based on actual patients’ situations, provide a method of clinical decision making to foster critical thinking in nurses.

This paper describes the method and process of group case studies applied in continuous education settings. This method bases on Balint’s case supervision and was further developed and combined with the nursing diagnostic process. A case study contains different phases: Pre-phase, selection phase, case delineation and case work. The case provider narratively tells the situation of a patient. This allows the group to analyze and cluster signs and symptoms, to state nursing diagnoses and to derive nursing interventions. Results of the case study are validated by applying the theoretical background and critical appraisal of the case provider.

Learning effects of the case studies were evaluated by means of qualitative questionnaires and analyzed according to Mayring. Findings revealed the following categories: a) Patients’ problems are perceived in a patient centred way, accurate nursing diagnoses are stated and effective nursing interventions implemented. b) Professional nursing tasks are more purposefully perceived and named more precise. c) Professional nursing relationship, communication and respectful behaviour with patients were perceived in differentiated ways.

The theoretical framework is described in the paper „Clinical decision making and critical thinking in the nursing diagnostic process“.


Maria Müller-Staub, Diplomierte Pflegefachfrau, Berufsschullehrerin Pflege, Supervisorin BSO, Pflegewissenschaftlerin MNS, PhD.

Ursula Stuker-Studer, Diplomierte Pflegefachfrau, Berufsschullehrerin Pflege, Supervisorin BSO.
Short Articles

Enhancing patient safety with the use of a standardized nursing terminology

Medication information management is an important tool for improving patient safety in the hospital environment. Previous studies have shown that medication documentation is prone to errors as a result of organisational failures and human errors. The use of electronic patient records (EPR) has been widely introduced in Finland. Electronic medication documentation enables information exchange between health care professionals and the use of patient-specific data where such data are required. Nevertheless, medication information can be stored in different parts of an EPR system due to the architecture of the system. This has meant that health care professionals have had to make several entries in order to document patients’ medication information. From this point of view, the development of medication information management is crucial if safe medication documentation protocols are to be achieved.

The Finnish Classification of Nursing Interventions (FiCNI) is based on the Clinical Care Classification developed in the USA. A cultural validation process was conducted before the classifications were introduced in Finland. However, the structure of Finnish version is for the most part the same as that of the original. The classification is implemented in the EPRs and is used for describing nursing diagnoses and interventions. FiCNI version 1.1 contains 17 main components; these are divided into a number of main categories and further into sub categories.

In a recent study, the focus was on the use of the Medication component of the intervention classification. This component is divided into three different main categories, i.e. Medication Administration, Medication Side Effects and Medication Counselling. In addition, Medication Administration contains of 18 different subcategories. The Medication component - together with its categories/subcategories is used either with or without narrative text. The aim of this study was to find out how the Finnish Classification of Nursing Interventions (version 1.1) is used in medication documentation. In this study the analysed data were taken from the EPRs of one central hospital in Finland during the period 2004-2005. The data included structured documented patient data on 16 762 patients from 14 wards.

The results of this study confirmed earlier results and indicated broad acceptance of the new documentation system supported by a standardised terminology. This was demonstrated by the decrease in narrative documentation without use of the classification, with a concurrent increase in the number of categories used. The results of this study demonstrated that the use of the classification had increased in the daily practise and that the classification had been complemented with narrative text. In the surgical and medical wards, almost half of the items where the classification was used were complemented with narrative text. On the basis of the results it appears that the use of the classification probably saves time in documentation.

In 2003 the FiCNI had just been brought into use; and this affected the results of the earlier study. As regards the present study, the explanation for the huge increase in the use of the Medication component between 2004 and 2005 might be
learning. Generally speaking it takes time before changes are accepted and carried out in daily practise. However, the process has advanced, and the decrease in documentation without use of the Medication component supports this conclusion. In this study, the Finnish Classification of Nursing Interventions version 1.1 was used. Version 1.2 was introduced in 2005, with one new component being added to the classification. In addition, the classification was revalidated in 2007; at this point it was named after the original CCC, and given the title of the Finnish Care Classification (FinCC)

In the near future an analysis of the Medication Side Effects category will be carried out, looking at adverse drug events. It will be interesting to find out how the main category is complemented by narrative text, and to discover why the use of this category has not increased when the number of data items has increased. It will be particularly useful to compare medical and surgical wards in this regard, since there appears to be a significant difference in the use of the Medication Side Effects category.

In Finland more research on the documentation of medication information and its effect on patient safety are needed. The analysis of the use of the Medication component in documentation presented in this paper is part of the research project related to safe medication information management. This project began in 2007 at the Department of Health Policy and Management of the University of Kuopio.

Virpi Jylhä, MHSc  
Kaija Saranto, PhD, Professor  
University of Kuopio  
Department of Health Policy and Management  

virpi.jylha@uku.fi
7th Conference ACENDIO

ACENDIO
ASSOCIATION FOR COMMON NURSING DIAGNOSES, INTERVENTIONS AND OUTCOMES

7th Conference ACENDIO
Pre-conference of NURSING INFORMATICS 2009
HELSEINKI
Friday 26th – Saturday 27th June 2009
Theme: “Documenting the future of nursing – the case of nursing minimum data sets (NMDS)”
NEW!!
Because of many requests from ACENDIO members, we will open a poster session on ACENDIO themes such as nursing terminologies, standardization, classification, documentation, decision making, minimum datasets. Applications for the poster session (1 page A4 abstract) can be sent to the organizing committee before January 31, 2009 (secretariat@acendio.net).

Nursing minimum datasets (NMDS) have been developed since the mid eighties in various countries, for a variety of reasons such as professional recognition, documentation, research and reimbursement. The global shortage of nurses and patient safety issues that are emerging on the international scene will require the systematic collection of nursing data and will give NMDS a new perspective.

The conference will give an overview of the existing developments in NMDS, discuss how a NMDS can contribute to these forthcoming agendas and discuss the role of ACENDIO in developing a strategy on systematic documentation and the use of standardized terminologies in relation to a NMDS.

As the ACENDIO conference is organized in combination with NI2009, we hope that you will consider coming to Helsinki a few days earlier to meet with colleagues and discuss and debate this interesting topic at the ACENDIO conference.

Simultaneous translation from English to German will be provided for the plenary sessions

Preliminary Programme

Friday 26th June
Morning
Theme: Why do we need nursing data and NMDS?
09.00-9.30
Official opening of 7th ACENDIO Conference
Kaija Saranto, President ACENDIO
Katrina Laaksonen, President Finnish Nursing Association
09.30-10.00
Nursing in Europe: Is there a common agenda?
Ada Spitzer (Switzerland)(to be confirmed)
10.00-10.45
Why do we need nursing data and NMDS?
John Welton (USA)
10.45-11.15
Coffee break
11.15-12.00
Collecting data on nurses across European and non-European countries: Past and current experience at the OECD
G. Lafortune (OECD)
12.00-13.00
Lunch
Afternoon
Theme: Examples of NMDS – state of the developments
13.00-14:30
Travelling through European NMDS:
Belgium, Ireland, Switzerland, Finland, Portugal, Germany (cont.)
(cont.)

Sabine Bartholomeczik (Germany), Anneli Ensio (Finland), Elvio Jesus (Portugal), Alain Junger (Switzerland), Kristina Junttila (Finland), Walter Sermeus (Belgium), further speakers to be confirmed

14.30-15.00
Coffee break

15.00-16.30
Travelling through International NMDS:
North-America, Asia, Australia, International

Connie Delaney (USA), William Goossen (The Netherlands), Evelyn Hovenga (Australia), further speakers to be confirmed

16.30-17.00
Questions and discussion

17.15
ACENDIO General Assembly

Saturday 27th June

Morning
Theme: The application of NMDS – Bringing them into practice

Two parallel sessions

09.00-12.00
Session 1:
Linking NMDS to DRG’s and costs – financing - workforce planning

Sabine Bartholomeczik (Germany), Anneli Ensio (Finland), Evelyn Hovenga (Australia), Alain Junger (Switzerland), John Welton (USA)

Session 2:
Linking NMDS to clinical decision making-quality and safety

Hanna Aschan (Finland), Koen Van den Heede (Belgium), Elvio Jesus (Portugal), Kristina Junttila (Finland),

12.00-13.00
Lunch

Afternoon
NMDS and the future of nursing

13.00-13.45
Standardized terminologies: what will it bring for the future of nursing?
Claudia Barz (ICN)

13.45-14.30
Forecasting the number and qualification of nurses in Europe

Walter Sermeus (coordinator RN4CAST)

14.30-15.00
ACENDIO perspective on documenting nursing care

Asta Thoroddsen (chair of standardization committee ACENDIO)

15.00-15.30
Closing ceremony

Kaija Saranto

15.30
Farewell Coffee
Practical Information

VENUE
The Helsinki Exhibition and Convention Centre
Messezukk 1, Helsinki, FINLAND

FEES
360 Euro (until March 31, 2009)
420 Euro (from April 1, 2009)
250 Euro (student fee)

REGISTRATION
Www.mi2009.org
handled by Congrex
mi2009@congresx.fi

DATES
June 26-27, 2008

SOCIAL PROGRAMME
Boat trip and stay in Tallinn, Estonia, June 27-28, 2009

TRANSLATION
Simultaneous translation from English to German

Conference Programme

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Friday 26th June (9-17h)

What are the major priorities for nursing in Europe? Speaker to be confirmed

Why do we need nursing data and NMDS? John Wetton (USA)

Collecting data on nurses across European and non-European countries: Past and current experience at the OECD, C. Lafortuna (OECD)

Travelling through European NMDS:
Belgium, Ireland, Switzerland, Finland, Portugal, Germany, Satine Bartholomew (Belgium), Annemiek Elsen (Belgium), Elisa Jesus (Portugal), Alijan Juenger (Switzerland), John Wetton (USA)

Travelling through International NMDS:
North America, Asia, Australia, International, Conops Delaney (USA), Willem Gooszen (The Netherlands), Evelyn Howenga (Australia), further speakers to be confirmed

Saturday 27th June (9-15:30h)

Linking NMDS to ORGs and costs – financing, workforce planning, Satine Bartholomew (Belgium), Annemiek Elsen (Belgium), Evelyn Howenga (Australia), Alijan Juenger (Switzerland), John Wetton (USA)

Linking NMDS to clinical decision making – quality and safety, Honna Aasen (Norway), Koos Van den Heede (Belgium), Elisa Jesus (Portugal), Kristina Jonhilsa (Finland)

Standardized terminologies: what is it about the future of nursing? , Claudia Bartz (CH)

Forecasting the number and qualification of nurses in Europe, Walter Sommese (coordinator RNCAST)

ACENDIO perspective on documenting nursing care, Asta Thomassone (Chair of standardization committee ACENDIO)

ACENDIO General Assembly at 17:15h

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HELSINKI

Conference Theme:
Documenting the future of nursing – the case of nursing minimum data sets (NMDS)

More info:
Www.acendo.net

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