Editorial
Carme Espinosa i Fresnedo
Chair Editorial Board Newsletter of ACENDIO.

Once upon a time...

For the majority of the non-nursing health professionals, and for some nurses also, nursing professional language can be something fashionable that appeared just some years ago for...nobody-knows-why! Some of those professionals, nurses or not nurses, do not understand the meaning or the usefulness of having a professional nursing language. But if we have a look at our past, maybe we could realise that nursing professional language is far from new.

The notion of Nursing Diagnoses probably began with Florence Nightingale. When she arrived to the Crimean Battlefields, Nightingale tried to identify the "conditions" under which the injured soldiers lived, not the diseases: cold, hunger, lack of appropriate clothing, or a place to rest, exhaustion, diarrhoea and fever among many other factors. After diagnosing these conditions, Nightingale observed and identified how they impacted upon health outcomes and finally, she developed the adequate interventions.

Does this story ring a bell?

After Nightingale, a long time passed without any real mention of nursing diagnoses, and was not until the mid 1950’s that Lesnik and Anderson pointed out the legal responsibility of nurses to use professional knowledge to make decisions on which to base the best care. “Although diagnosis has been long regarded as the province of the physician, there is current belief, and support for that belief, that this province warrants clarification insofar as the activities of nursing care are concerned” (Lavin, Meyer & Carlson, 1999)

During the 1950’s and 60’s other theorists worked on the conceptualization of nursing diagnosis, some examples are cited below (Carlson, Carft and McGuire, 1985):

- 1957 - Abdellah: Delimitation of the vast nature of nursing problems suffered by patients or they families who are receiving nursing care;
- 1966 - Durand and Prince: Conclusion made by a nurse after the study of a sample in a research on patients;
- 1975 - Gebbie and Lavin: Judgment or conclusion made by a nurse after assessing a patient;
- 1975 - Bircher: Independent function of nursing... an assessment on individual responses of the patient to human experiences along vital cycle, mental development, incidental crises, disease, or other stressful events;
- 1976 - Aspinall: A clinical deduction process using the observation of physical or psychological changes of the patient; when this process is done correctly and with intelligence, it can bring to the identification of the possible aetiology of the symptomatology;
- 1976 - Gordon: Potential or actual health problems that nurses treat. Nurses, thanks to their education and experience are able and authorised to treat those problems.

In 1973 the most internationally well-known phase of development of nursing diagnoses began. A group of nurses from the Saint Louis University School of Nursing identified the need for more formal work on the development and classification of nursing diagnoses and they organised the first National Conference on Classification of Nursing Diagnoses. After this meeting and those that followed, the American Nurses Diagnoses Association was created in 1982. The North American Association became an International Association in 2002, what we know today as NANDA-I.

NANDA-I Nursing Diagnoses Taxonomy, is probably the most expanded Nursing Diagnoses Taxonomy of our time, but it is not the "perfect nursing diagnoses taxonomy", and it is far from being fashionable.

The international community of nursing is now debating the concept of nursing diagnosis; what is a nursing diagnosis and what it is not? And this debate cannot be understood as whether NANDA-I Nursing Diagnoses Classification is or is not a good taxonomy. The debate is about the nursing profession, and about what sort of concepts must be developed by nurses in order to identify the area of responsibility of nurses that needs to be the subject of nursing diagnoses?

It is not a new question; it is exactly the same thing that Lesnik and Anderson pointed out back in the middle of the 1900s.

References

Alert!!
From the President

Kaija Saranto
President of ACENDIO
Professor, University of Eastern Finland, Kuopio Campus, Finland

The winter 2010 has been exceptionally cold and snowdrifts have been seen occasionally almost all over Europe. Thus, thinking of the past beautiful summer brings us warm memories. The Seventh Biennial European Conference of ACENDIO, held in Helsinki in the summer of 2009, had a different format than the previous ones. The programme consisted of presentations given by invited international speakers under the title: “Documenting the Future of Nursing – The case of Nursing Minimum Data Sets (NMDS)”. The proved to be very timely and the participants highly valued the excellent summaries of the NMDS development made by the experts. You will find the resume of the conference in this newsletter.

The General Assembly elected the new Board for the Association in Helsinki and I am honoured to be re-elected as the President for the Biennium 2009–2011. I appreciate the Board’s strong support and active cooperation during my last period. The renewed Constitution, ratified by the General Assembly, will give good guidance for the Board for the future. Please, have a look on the ACENDIO website you’ll find the updated information there. I also encourage all members to contact us in any matters that will enhance to work of ACENDIO.

Since the founding of ACENDIO in 1995 various initiatives have been undertaken to improve health information management both on national, organizational and individual levels. In many countries, and among their national nursing associations, the use of information and communication technologies started under the term “Tele-nursing”. The ICN Tele-nursing Network has existed since 2000 with the goal of improving the timeliness, quality and access of a broad range of health care services for individuals, their families, communities and countries. In 2004, the European Commission launched its eHealth Action Plan to build up infrastructures and to implement solutions in order to move towards an ICT enabled, collaborative, personalized and more efficient model of healthcare.

For many years eHealth has been used as an umbrella term to cover the broad use of Information and Communication Technologies (ICT) in health care. eHealth is not only an technological improvement but it is a reengineering of health care processes, and is important for the socio-technical aspects of design and development of applications used in health care. For the next ACENDIO conference the board has chosen eHealth as the key theme for the conference. As Eysenbach (2001) highlights in his paper, the ‘e’ in ‘eHealth’ stands not only for “electronic” but also for many other concepts: efficiency; enhancing quality; evidence based; empowerment; encouragement; education; enabling; extending; ethics; and equity (http://www.jmir.org/2001/). I hope all these ‘e’s will be present in Madeira 2010, at our next conference.

8th Biennial European Conference of ACENDIO to be held in Madeira in March 2011
ACENDIO Board Activities

Fintan Sheerin
Secretary of ACENDIO
Trinity College, Dublin

Time has passed very quickly since the conference in Helsinki and the Board have met three times. The first meeting took place immediately after the General Assembly and this gave us an opportunity to get to know each other and to decide on a biennial action plan. This first meeting is always quite informal and does not take much time. The members of the board for 2009-2011 are:

The real business begins at the second meeting of the biennium, which usually takes place in October. And so, we came together in Dublin on 9th and 10th October to address a number of important issues, including membership. It was noted that there were 4 institutional members, 1 honorary member and 69 individual members. This is considerably lower than during the last biennium but is related to the fact that the 2009 conference was a smaller than usual event and did not provide a strong basis for attracting memberships. It was agreed that lapsed members and non-member national nursing associations would be invited to join ACENDIO. The second major issue that was discussed in Dublin was the next ACENDIO conference, which will take place in Madeira on 25th and 26th March 2011. A theme was identified and a conference committee was selected to work on the initial planning. Other topics discussed at the meeting related to the newsletter and the association’s finances. Finally, the board action plan was further developed and will be finalised at the February 2010 meeting.

A further meeting of the board was held on-line in January 2010, using email. This type of ‘meeting’ can be very useful for addressing straight-forward decisions and also for identifying agenda items for further discussion in the face-to-face meetings. The next meeting of the board will take place in Stockholm on 19th and 20th February 2010. Conference planning will again be a central item for discussion and action, but the board is also examining ways to make the work of ACENDIO more visible and meaningful for members and for nurses in practice, education, management and research. I will update you on the outcomes of that meeting in the next Newsletter.

From left to right: Walter Sermeus (Vice President); Asta Thoroddsen (Treasurer); Anna Ehrenberg; Elvio Jesus; Martin Lysser; Kajja Saranto (President); Kathy Moelstad; Carme Espinosa (Editor – ex officio).

Fintan Sheerin (Secretary) – behind the camera!
On the 26th and 27th June 2009, the 7th Biennial Conference of ACENDIO took place in Helsinki, with the title, “Documenting the Future of Nursing – The Case of Nursing Minimum Data Sets (NMDS)”. Suggested by the title, it was an invitational conference on the Nursing Data Bases, and various Electronic Data Base Systems, as they are developed in Europe, were presented.

During the first morning, keynote speakers tried to answer the question of why a NMDS is needed. They explained the European Nursing agenda for the future, and the state of the art in relation to the nursing profession in Europe, based on data from the Organisation for Economic Co-Operation and Development (OECD). The results of a survey, carried out by ACENDIO, on the status of standardisation in Europe were also presented. In relation to the European Agenda, special emphasis was made on the challenges that nurses are facing from different perspectives, during the talk by Ingabritt Rahm-Hallberg from Sweden. A number of issues were clarified:

- On a Macro level, we need to take account of how different financial systems for health care, impact differently on population health in each European Country, depending on which services are offered to the people. This also has an impact on the welfare model as we know it in Europe.
- On a Meso level, the impact of the different mix of health professionals, nursing independence regarding health care provision and the accountability of nurses has to be acknowledged. So too, does the interaction between and among different levels of the health system and its implication for families.
- On a micro level, we need to be aware of the nursing process, from the admission of the patient, through the process, and the implication of social networks in caring, cultural differences in the expected outcomes, and the assessment of those outcomes as well as patient satisfaction with the care received need also to be taken into account.

Gaetan LaFortune, presented OECD data regarding the nursing work-force in Europe. From the beginning of his presentation it was obvious that the system for gathering the necessary information is very complex, and this is due partly to the non-existence of any single definition of what a nurse is in Europe. The references given about the ratio of nurses to patients, by country, the economical remuneration and also the qualification of nurses in different countries provoked an interesting discussion as did his revelations about the complexity of gathering and managing the information.

Asta Thoroddsen, presented a web-based survey carried out across various European Countries, to gather reliable information for ACENDIO about the use of standardized nursing languages, and nursing standards in Europe. The findings of this survey are not conclusive due to the methodology, and also due
to the poor response rate, but it is a good point of departure for further work on this issue.

During the afternoon of the first day of the conference, different examples of NMDS in Europe were shown. Representatives from Belgium, Ireland, Switzerland, Finland, Portugal, Holland, and Germany presented their countries’ experiences. There was also an opportunity to listen to experiences from the USA and Australia.

The second day of the conference, focussed on the practical use of the NMDS. The relationship between nursing data and the proportion of nurses was analysed and Claudia Bartz, from the International Council of Nurses, spoke of the future of standardised nursing languages.

At the end of the conference, the newly-elected members of the ACENDIO board of directors were presented. It was also announced that the location for the next Biennial ACENDIO conference would be the Madeira Islands and that it would be held in April 2011.

Participants received the conferences proceedings and presentations in electronic format. These can also be accessed by members through the ‘members only’ section of the ACENDIO website at http://www.acendio.net.
Synopsis
The Council of State made a decision in principle in 2002 that Finland should have a nationally interoperable electronic health record (EHR) by the end of the year 2007. Furthermore the decree launched in 2007 requires public health care organizations to join the national patient record archive by the end of the year 2011. The Ministry of Social Affairs and Health is in charge of the implementation of this decision and the specification of the EHR solution.

The development process started in 2004 when the core data elements of the national EHR were introduced. The core data means health-related information required for data exchange between health information systems in a standardized format. In Finland, six IT suppliers representing the whole health care industry were initially involved in the national project.

The Nursing Minimum Data Set (NMDS) is a part of the core data elements. The national nursing documentation model and the Finnish Care Classification (FinCC) were developed in the national nursing documentation project 2005-2008. The national NMDS and FinCC were integrated during 2005-2007 into eight health recording systems in 33 health care organizations (piloting in 106 units/wards / three university hospitals, 11 district hospitals, 19 health care centres, one privat hospital). An education model and an eEducation environment were also developed to support the implementation.

Based on the experiences and evaluation results the Finnish Care Classification can be implemented and used among all kinds of wards. Overall, the quality of the nursing documentation has improved. It is more uniform, patient-centered, based on guidelines accepted for care and in interdisciplinary use. The length of oral reports has decreased, giving more time to actual care. The information concerning the wellbeing of the patient during the care episodes until discharge improves the care process and pathway and the data of nursing documentation can be used for managerial and administrative purposes.

After the results of the national project, the nationwide implementation process started in Finland in October 2007 and will end in 2011. The data elements of this model generate the Nursing Minimum Data Set (NMDS) i.e. nursing core data: nursing diagnoses, interventions and outcomes as defined in international co-operation. (www.saba.care.com; www.icn.ch; http://www.nursingworld.org)

FinCC has been also implemented in CDA R2 format by Health Level 7 Finland. The information on nursing diagnoses, nursing intervention, nursing outcomes and the nursing discharge summary can be transformed and stored in the national archive of EHRs. The health care professionals can, by patient consent, search and reuse the same information in all EHR systems.

Introduction
The conclusion was that, in Finland with a population base of 5.3 million inhabitants, the EHR access should be organized at the national level. Nearly all public and private health care providers already deploy patient information systems. These need to be adapted and modified by vendors to be interoperable with the national solution.

The Ministry of Social Affairs and Health has been funding 2005-2009 healthcare providers for IT projects seeking to further collaboration on a regional basis. The development of the electronic health record required consensus about its structure and content.

A national consensus on the data elements was reached at two special consensus seminars and working group meetings of health care professionals and software developers from IT suppliers. The definitions were also publicly available for comments on the internet.
The national systematic nursing documentation model was adopted to describe nursing care in the EHR system. The model is based on the nursing decision making process introduced by the World Health Organization in the late 1970s. This international model comprises mainly four phases: assessment and naming the nursing needs (nursing diagnoses), planning and describing the outcomes of care, description of interventions performed, as well as assessment of nursing outcomes.

The Nursing Minimum Data Set (NMDS) is part of the core data elements. The national nursing documentation model (Figure 1) and the Finnish Care Classification (FinCC) were developed in the national nursing documentation project 2005-2008. FinCC includes the Finnish Classification of Nursing Diagnosis (FiCND), Finnish Classification of Nursing Interventions (FiCNI) and Finnish Classification of Nursing Outcomes (FiCNO).

The nursing core data and FinCC were implemented in electronic health record systems (six IT suppliers) which are used in nursing care planning and for making daily notes.

Piloting was carried out in 34 health care organizations (106 units/wards):
- 3 university hospitals
- 11 district hospitals
- 19 health care centres
- 1 privat hospital

http://www.vsshp.fi/fi/4519

The Finnish Classification of Nursing Diagnosis (FiCND) comprehends 19 care components, 88 main categories and 179 subcategories defining caring needs and it is used to describe needs assessment and expected outcomes of patient care in various health care settings. The Nursing Interventions Classification (FiCNI) comprehends the same 19 care components, 164 main categories and 266 subcategories defining planned and performed nursing actions. The care components represent the functional, health behavioral, physiological and psychological patterns of a patient. Nursing outcomes (FiCNO) can be described using three qualifiers: improved, stabilized, or deteriorated.

When comparing nursing diagnoses and outcomes of patient care it is possible to evaluate the care process and measure the care outcomes.

The FinCC is a translation of the Clinical Care Classification (CCC) (www.sabacare.com) and it was implemented after a cultural validation. The CCC is approved by the American Nurses Association (ANA) and is cross-mapped to the International Classification for Nursing Practice by the International Council of Nursing (ICN) and to the (Unified Medical Language Systems). The CCC is also a part of the international Snomed CT classification and it can be used together with ICD-10. Clinical LOINC (Logical Observations, Identifiers, Names and Codes) has integrated the CCC of Nursing Diagnoses Outcomes in its clinical application. ABC Codes for...
Complimentary and Alternative Medicine (CAM) has adapted selected CCC of Nursing Interventions for billing codes.

Education activities

An education model and an eEducation environment were also developed to support the implementation. Education was first launched to nurses in clinical settings both in primary and specialized care. Education was built primarily on the content of classification and the theoretical assumptions of need theory behind it. Surprisingly, having been in use for almost thirty years as a paper-based system, the nursing process model also needed discussions and repetition.

A national network of mentors supported the adoption of the documentation model by using case studies developed for the implementation. All wards and units named their own mentors who act as tutors during two weeks in the beginning of the implementation. The implementation process started in whole Finland in October 2007 and will end in 2011.

Evaluation of the documentation model

The model for systematic nursing documentation is evaluated by continuous observations, questionnaires (N=975), discussions and by statistics of the classified documentation. Based on the experiences and evaluation results, the Finnish Care Classification can be implemented and used among all kinds of wards. Overall, the quality of the nursing documentation has improved as a result of a unified model to describe nursing activities. They are more uniform, patient-centered and based on guidelines accepted for care. This reflects on the handovers between the shifts. The length of oral reports has decreased during the project, giving more time for actual care. The use of systematic nursing documentation brings up the content of the nursing care more clearly, allowing nurses to read patient information from the electronic records. Generally, the use of EHR was a routine after three months.

Figure 1. The nursing documentation model in Finland

Statistical information concerning use of FiCND and FiCNI were revealed between 2006–2009 in a nursing decision-making process. The statistical reports have been discussed in each ward. The discussion has been very important and meaningful. Statistical reports have also enabled more in depth study of the caring process and the intervention used in care.

Outcomes

The standardized model facilitates the use of databases for managerial and administrative purposes. The main outcomes concerning the quality of care can be concluded:

- The variance in care protocols and nursing interventions in various settings is apparent based on databases analysis
- Discussion concerning the quality issues is easy and activates development of nursing care
- Casemix between different wards enables decision in prioritizing nursing interventions

The main outcomes concerning patient safety

- The information concerning the wellbeing of the patient during the care episodes facilitate the discharge process and co-operation with the next of kin
- Information is more readable based on the use of classification and the amount of free text is minimized to the most important patient centered notes
- The clarification of adverse events and complaints accelerated when the data were available in databases
- As a national system, the documentation model facilitates the interoperability of nursing data throughout the country
The main outcomes concerning cost and resources
- The use of classification system has speeded up the care planning process
- The handover meetings between the shifts have mainly changed in format and speed due to structured documentation, making it easier to find relevant and current patient information
- Nursing intensity is possible to be assessed based on standardized documentation from databases

The main outcomes concerning the developed education model
- The co-operation between health care professionals and students is more focused when the standardized documentation model is used

The main outcomes concerning the software development
- The development work with IT suppliers was done successfully and was coordinated by Ministry of Social and Health Affairs.

Conclusion
There is no desire to return to the old model of recording patient data among nurses. The users have begun to see the benefits of the systematic nursing documentation and use of EHR. The experiences of the systematic model of recording patient data are promising. Statistics and reports of nursing process by systematic documentation benefit nursing management, planning, education, research and quality assessment.

Referenced supporting the project.
Publications of the project:
 Ora-Hyytiainen, Ikonen H, Ahonen O: Developing Competences and Use of the Finnish Model of


Documents

Commission Recommendation (COM/2008/3282 final) of 2nd July 2008 on cross-border interoperability of electronic health record systems (on EurLex in all languages)

http://ec.europa.eu/information_society/newsroom/cf/itemdetail.cfm?item_id=3540
ICNP® Version 2: Representing Nursing Practice and Improving Quality of Patient Care

The vision of ICNP® is to be an integral part of the global information infrastructure informing health care practice and policy to improve patient care worldwide (ICN, 2009). ICNP supports the ICN mission of advancing nursing and health worldwide by providing a unified nursing language for documentation at the point of care (ICN, 2009). ICNP is a dynamic tool to advance nursing practice. As such, ICNP is always evolving. The ICNP Terminology Life Cycle represents three important components of the programme: Research & Development, Maintenance & Operations, and Dissemination & Education (ICN, 2009).

We strongly encourage nurses to consider participating in various ICNP activities. ICN Accredited ICNP Research & Development Centres and ICNP catalogues development and testing provide avenues for participation. Please see http://www.icn.ch/icnp.htm for more information on how you can participate.

ICNP Version 2 was released at the International Council of Nurses Congress in Durban South Africa in June 2009. ICNP now includes over 2800 concepts with over 400 new concepts since the release of Version 1.1. Many of the new concepts are diagnosis and intervention statements developed for use in ICNP catalogues.

A new collaborative workspace, ICNP C-Space, was released with ICNP Version 2. C-Space is a web-based platform that supports the development and distribution of ICNP. See http://icnp.clinicaltemplates.org/ The workspace will provide toolsets for catalogue development, mapping, and other projects that would benefit from worldwide access and participation. In addition, the ICNP browser is on the C-Space. Anyone who downloads the browser is asked to sign a non-commercial use agreement online and the information gathered with this process is added to the ICNP Research & Development database on the ICNP website (http://www.icn.ch/database1.htm).

The Browser and Translation (BaT) tool is accessible from the ICN website and work is progressing to connect the translation tool with ICNP C-Space. The BaT assists distributive work by translation teams. A hierarchy of users can participate in the work of translation, supporting wide participation while maintaining a clear mechanism for decision-making. See http://docu.icnp-bat.de/doku.php

In 2008, the WHO Family of International Classifications (FIC) approved ICNP as a member of FIC. Initial collaborative work with WHO FIC involves examining harmonization of ICNP and the International Classification of Functioning (ICF). ICN is also participating in the WHO FIC Family Development Committee’s development of an International Classification for Health Interventions (ICHI).

In 2009, ICN and IHTSDO established a Harmonization Board to support collaborative efforts in terminology development and application. With the establishment of the new Board, harmonization of ICNP and SNOMED-CT will be examined along with efforts to develop clinically-relevant nursing subsets or Catalogues for use by researchers, vendors, and nurses in multiple care settings.

In summary, the ICNP terminology is used in EHRs for communication and decision-making in support of best practices and quality care.


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Amy Coenen, ICNP Programme Director coenena@uwm.edu
Nursing Informatics in Sweden: a short overview

There are currently a wide interesting variety of initiatives concerning health informatics in Sweden, and accordingly also concerning nursing informatics. This is a short report about this from the Swedish Nursing Informatics Group (SNIG), organized within the Swedish Society of Nursing and also the Swedish Association of Health Professionals. The national IT-strategy has formulated a vision for the future use of information technology in health care. A projected development is planned with activities in six areas: laws; information structure; technical infrastructure; cooperating and practice supporting IT-systems; access to information across organizational borders; and availability for citizens.

It is thought of as a paradigm shift where current documentation practice with chronological notes in the patient record changes to a concept oriented information system where the meaning and usability of the information is secured through semantic interoperability. A prerequisite for this is a common information structure.

The Swedish National Board of Health and Welfare has initiated two major initiatives that are currently on the way: “National information structure” and “National terminology and classification resource with SNOMED-CT”. The Swedish Association of Local authorities and Regions, a national organization for county councils and communities in Sweden, is also an important actor in the process. Development of the information structure is on its way, described in three models: generic concept, process and information models. The national terminology and classification resource is built on standardized terms and codes and classifications already identified and in national use, and SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms). Sweden is one of the member countries in the organization IHTSDO (International Health Terminology Standards Development Organisation) managing SNOMED CT. A vast and rapid effort with translation of all the concepts and their relations is in process. Discussions about implementation and smaller projects with application in clinical practice are performed. Further, an interesting project is addressing the question of central key information about the patient needed to be present wherever he/she is contacting the health care system. An implementation project is now evaluating the initial ideas about what information need to be available and in what format.

The aim of SNIG is to contribute to the development of Nursing Informatics in Sweden. The organization works within four broad areas of interest: IT systems, concepts and standardized terms; decision support; informatics competence development. An annual conference is organized in springtime, and sometimes additional conferences are planned in collaboration with others. The conference themes have moved from documentation practice, standardized care plans to standardized nursing vocabulary and multiprofessional collaboration. The plan for 2010 is to hold a nursing conference with the theme “What’s the use of national IT-initiatives in daily clinical practice?”. The idea is to highlight projects evaluating implementation of standardized vocabulary, preferably as outcomes in patient health condition or experience of care, and not only concerning documentation practice in patient records. Further, the organization’s web site (www.omyvardsnadsinformatik.se) is the center for activity and effort to support a national discussion about informatics among nurses. A profound idea is to contribute to information sharing, discussion and networking of issues related to nursing informatics, e.g. standardized care plans. For further information about SNIG please contact Jan Florin (jfl@du.se).

Jan Florin, Swedish Nursing Informatics Group
eHealth – Everyone’s Responsibility and in Everyone’s Interest

The Norwegian Nurses Organisation’s (NNO) eHealth Strategy is a collaborative effort between the NNO and the special interest group in nursing informatics.

Nurses are the largest group of health personnel in the health care services; they work in all areas of the sector, deliver services close to the patient 24 hours a day, and have an essential coordinating function. There are approximately 110 000 RNs in Norway, of which 89 000 are members of the NNO. This gives the organisation a unique position as a political and professional force. The overall goal is that the eHealth strategy support patient safety, communication, and continuity in patient care, integrated in nursing practice, leadership, through competency and knowledge building (The Norwegian Nurses Organisation’s eHealth Strategy 2008).

The strategies overall goal is: eHealth supports continuity in patient care and is integrated in nursing practice, leadership, and competency and knowledge building. Several strategic goals are highlighted as areas of concern:

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<th>Priority Area</th>
<th>Description of Strategic Goal - Expected Achievements</th>
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<td>1.- Information Security</td>
<td>Required levels of information security, privacy and confidentiality are maintained, and development of reflected and ethically accountable attitudes to eHealth in the nursing service</td>
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<td>2.- Terminologies</td>
<td>Provide relevant and reliable data about nursing processes, and outcomes that contribute to knowledge development and competence building for clinical practice</td>
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<td>3.- Electronic Patient Record (EPR)</td>
<td>Next generation of EPR supports work processes of nurses in more timely manners, healthcare documented according to professional standards and legal requirements. Sufficient access to ICT equipment, and nurses contribute premises for design and development of EPR</td>
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<td>4.- Electronic Interaction - Interoperability</td>
<td>Electronic information exchange and interaction are formalised within the health service and levels of care. User-friendly electronic interaction solutions are developed and available in all care services</td>
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<td>5.- Quality and Staffing Education, Professional development and Research</td>
<td>Knowledge base clinical practice through application of eHealth. Access to electronic professional support and further developed sources of knowledge applied as tools and measures in knowledge and competence building and clinical practice. Knowledge and professional development plans in eHealth for clinical faculty and researchers, are developed and implemented. Bachelor and Master degree programs have a framework and professional study programs contain descriptions of expected knowledge and competence in eHealth after completed education</td>
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<td>6.- Telemedicine Solutions and Patient Participation</td>
<td>Telemedicine solutions are developed and implemented in the nursing service. Electronic tools for interaction with patient and family members are available to accumulate patient’s experiences and reactions regarding symptoms and illness experiences for participation and directly, systematically feedback to health personnel by means of eHealth</td>
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If you want to read more, please download the strategy.

Merete Lyngstad, Norwegian Nurses org., Special Adviser
Anne Kristin Rotegaard VicePresident of the Norwegian Nurses Special Interest Group in ICT and Documentartion
Kathryn Molstad Senior Adviser, Norwegian Nurses Org.
This book is about nursing diagnoses accuracy. Since the beginning of the inception of nursing diagnoses in 1973, nurses have been dealing with the issue of how to use nursing diagnoses, but in general, they have not taken responsibility on diagnostic reasoning and accuracy. The Electronic Health Record will put more pressure on nurses from the point of view of organisation and the use of Standardise Nursing Languages (SNL) to communicate with and to others the problems, risk states and readiness for health promotion states of the persons they are treating. SNL are the languages that will keep track of the effectiveness of nursing practice.

One of the problems that nurses face is that they do not know how to be accurate in selecting the nursing diagnoses to guide nursing care.

In this book a first chapter helps nurses to learn how to apply critical thinking processes for the development of diagnostic reasoning skills with will be further developed in chapter two with actual case studies. There is also the practical use of NOC outcomes and NIC Interventions to fully analyse the proposed case studies.

The book contains case studies from around the world, what makes it very helpful independently of the country in which the reader is practising.

Avery useful book both for registered nurses and also for students. Easy to read even if your first language is not English.
Creative Intelligence & self liberation. Korzybsky non-Aristotelian Thinking and Enlightenment
By Ted Falconar
Crown House Publishing
Albert Einstein thought in an entirely different way from ordinary people, and theorist Alfred Korzybski wanted to know why. Studying Einstein’s unique thought processes in his book Science and Sanity, he explained how genius works, and named this process Non-Aristotelian Thinking. Now "Creative Intelligence" extends Korzybski’s concept by weaving together the Eastern philosophies of Realization and Liberation. Falconar teaches us to ‘unlearn’ the rigid patterns of thought that we are indoctrinated with - and to escape the confines of memory, association and, most importantly, words.
Nurses are now thinking deep about how to explain their world with words, but only if they are able to use creative intelligence and learn to use other ways of thinking other than words, they will be able to describe they world in a creative liberating way.
A very inspiring book about the way of thinking of children and geniuses. It looks quite difficult to read, but is only a matter of enlightenment. Just a taste of the book:

Being myself a remarkably stupid fellow, I have had to unteach myself the difficulties, and now beg to present to my fellow fools the parts that are not hard. Master these thoroughly, and the rest will follow. What one fool can do, another can!

Sylvanus P. Thompson
Calculus Made Easy

The Clan of the Cave Bear
Jean M. Auel
ISBN: 978-0-553-25042-8 (0-553-25042-6)

Just a novel to re-read if you already know it. How can we better explain the importance of language than going back to the time when language was still inexistant? Just for those of you who do not know the novel:
A natural disaster leaves the young girl wandering alone in an unfamiliar and dangerous land until she is found by a woman of the Clan, people very different from her own kind. To them, blond, blue-eyed Ayla looks peculiar and ugly--she is one of the Others, those who have moved into their ancient homeland; but Iza cannot leave the girl to die and takes her with them. Iza and Creb, the old Mog-ur, grow to love her, and as Ayla learns the ways of the Clan and Iza’s way of healing, most come to accept her. But the brutal and proud youth who is destined to become their next leader sees her differences as a threat to his authority. He develops a deep and abiding hatred for the strange girl of the Others who lives in their midst, and is determined to get his revenge.
**Wednesday 12th May**

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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>08.00 - 09.00 h</td>
<td>Registration</td>
</tr>
<tr>
<td>09.00 - 09.45 h</td>
<td>Opening ceremony</td>
</tr>
<tr>
<td>09.45 - 10.45 h</td>
<td>Auditorium&lt;br&gt;Opening Conference: Developing language, sharing knowledge&lt;br&gt;Rosa González Gutiérrez-Solana; Dickon Weir-Hughes</td>
</tr>
<tr>
<td>10.45 - 11.15 h</td>
<td>Auditorium&lt;br&gt;Towards a global future for nursing&lt;br&gt;Máximo A. González Jurado</td>
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<tr>
<td>11.15 - 12.00 h</td>
<td>Coffee Break</td>
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<tr>
<td>12.00 - 13.30 h</td>
<td>Auditorium&lt;br&gt;Master Class: Clinical reasoning&lt;br&gt;Margaret Lunney; Carme Espinosa i Fresnedo; Katrin Bjorvell&lt;br&gt;Chairperson: María Girbés Fontana&lt;br&gt;Discussion</td>
</tr>
<tr>
<td>12.00 - 13.30 h</td>
<td>Simultaneous sessions&lt;br&gt;Oral communications</td>
</tr>
<tr>
<td>13.30 - 15.30 h</td>
<td>Working lunch</td>
</tr>
<tr>
<td>15.30 - 16.30 h</td>
<td>Auditorium&lt;br&gt;Discussion/Colloquium: Nursing diagnoses concept controversy&lt;br&gt;Dorothy A. Jones; Heather Herdman; Mercedes Ugalde Apalategui; Marie Thérèse Celis; Maria Müller Staub&lt;br&gt;Chairperson: Carme Espinosa i Fresnedo</td>
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<tr>
<td>16.30 - 17.30 h</td>
<td>Simultaneous sessions&lt;br&gt;Oral communications</td>
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<tr>
<td>16.30 - 19.00 h</td>
<td>Auditorium&lt;br&gt;Workshop: Committee review of NANDA new diagnoses&lt;br&gt;Geralyn Meyer; DDC Members</td>
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<tr>
<td>17.30 - 19.00 h</td>
<td>Simultaneous sessions&lt;br&gt;Oral communications</td>
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### Thursday 13th May

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<tr>
<th>Time</th>
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<tr>
<td>09.00 - 10.00 h</td>
<td>Simultaneous sessions</td>
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<td>Oral communications</td>
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<tr>
<td>10.00 - 11.30 h</td>
<td>Auditorium</td>
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<td>NOC Outcomes/NIC Interventions</td>
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<td></td>
<td>Sue Moorhead; Howard Butcher</td>
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<td>Chairperson:</td>
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<td>José Luis Aréjula Torres</td>
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<tr>
<td>11.30 - 12.00 h</td>
<td>Coffee Break</td>
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<tr>
<td>11.30 - 13.00 h</td>
<td>Room 8</td>
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<tr>
<td></td>
<td>AENTDE General Assembly</td>
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<tr>
<td>12.00 - 13.30 h</td>
<td>Simultaneous sessions</td>
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<tr>
<td></td>
<td>Oral communications</td>
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<tr>
<td>12.00 - 13.30 h</td>
<td>Auditorium</td>
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<tr>
<td></td>
<td>Student workshop</td>
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<td></td>
<td>Lynda J. Carpenito Moyet</td>
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<tr>
<td>13.30 - 15.30 h</td>
<td>Working lunch</td>
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<tr>
<td>15.30 - 17.00 h</td>
<td>Auditorium</td>
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<tr>
<td></td>
<td>Research in nursing languages</td>
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<td></td>
<td>Dorothy A. Jones</td>
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<td>Chairperson:</td>
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<td>Susana Martín Iglesias</td>
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<tr>
<td>16.30 - 19.00 h</td>
<td>Auditorium</td>
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<tr>
<td></td>
<td>NANDA-I General Assembly</td>
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<tr>
<td>16.30 - 18.00 h</td>
<td>Simultaneous sessions</td>
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<tr>
<td></td>
<td>Oral communications/Poster presentation</td>
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<tr>
<td>18.00 - 19.00 h</td>
<td>Simultaneous sessions</td>
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<tr>
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<td>Oral communications/Poster presentation</td>
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### Friday 14th May

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<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>09.00 - 10.00 h</td>
<td>Simultaneous sessions</td>
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<tr>
<td>10.00 - 11.30 h</td>
<td>Auditorium</td>
<td><strong>Integration of nursing languages for clinical use</strong></td>
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<td></td>
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<td>Carmen Alonso Villar; Gail Keenan; Antonio Arribas Cachá; José Miguel Morales Asencio</td>
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<td><strong>Chairperson:</strong></td>
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<td></td>
<td></td>
<td>Marie Thérèse Celis</td>
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<tr>
<td>11.30 - 12.00 h</td>
<td>Coffee Break</td>
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<tr>
<td>12.00 - 13.30 h</td>
<td>Auditorium</td>
<td><strong>Workshop: Strategies to teach nursing diagnoses and potential complications to students and clinical nurses</strong></td>
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<td></td>
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<td>Lynda J. Carpenito Moyet</td>
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<td><strong>Chairperson:</strong></td>
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<td></td>
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<td>Rosa Mª Rifa i Ros</td>
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<tr>
<td>12.00 - 13.30 h</td>
<td>Simultaneous sessions</td>
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<tr>
<td>13.30 - 15.30 h</td>
<td>Working lunch</td>
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<tr>
<td>15.30 - 16.30 h</td>
<td>Simultaneous sessions</td>
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<tr>
<td>16.30 - 18.30 h</td>
<td>Auditorium</td>
<td><strong>Information systems</strong></td>
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<td>HP; OESIA; STACKS</td>
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<td><strong>Chairperson:</strong></td>
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<td>Rosa González Gutiérrez-Solana</td>
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<tr>
<td>18.30 - 19.00 h</td>
<td>Auditorium</td>
<td><strong>Conclusions</strong></td>
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<td>Aurora Quero Rufián</td>
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<td>Jane Brokel</td>
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<td>19.00 - 19.30 h</td>
<td>Auditorium</td>
<td><strong>Closing ceremony</strong></td>
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<td>Rosa González Gutiérrez-Solana; Dickon Weir-Hughes (NANDA-I); Japanese Society of Nursing Diagnoses (ISND); Kajsa Saranto (ACENDIO); Marie Thérèse Celis (AFEDI).</td>
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</table>
EFIM2010, planned for Stockholm, September 21-24, 2010 is cancelled.

We regret to inform you that we have to discontinue the planning of the Congress for EFIM2010. In spite of a broad and outstanding scientific programme with highly recognized lecturers, the Swedish Society of Internal Medicine has regrettably reached the decision to cancel the Congress. The reason for the cancellation is the financial problems, due mainly to the ongoing financial crisis that we have encountered in the health care sector and within the pharmaceutical industry. The financial situation, with a great economical loss for the Congress, is considered to be a significant threat to the future activities of the Swedish Society of Internal Medicine (SIM).

We deeply regret the problems this creates for the international activities of Internal Medicine and of course particularly for the European Federation of Internal Medicine (EFIM).

However, the Swedish Society of Internal Medicine will in the future be directed towards participation in activities within the EFIM and to be an active member in different areas, as well as in education.

Once again, we are deeply disappointed by the decision that we had to take after exploring all possibilities to save the Congress, and we are very grateful to all of you who have been engaged in the planning of the Congress.

February 8, 2010.

Mikael Köhler         Thomas Kjellström         Stefan Lindgren
President SIM         President EFIM2010         Scientific secretary EFIM2010  Secretary General
EFIM2010              Past President of EFIM

Steering Committee: Thomas Kjellström, Sweden, President thomas.kjellstrom@skane.se Mikael Köhler, Sweden, Secretary General, Werner Bauer, President EFIM, Switzerland, Christopher Davidson, United Kingdom, Jan Willem Elte, Secretary General EFIM, Netherlands, Eugene J. Kucharz, Poland, Stefan Lindgren, Sweden, Eva Nitelius, Sweden

Congress Secretariat: Ann-Catrin Moberg, Congrex Sweden AB ann-catrin.moberg@congrex.com www.congrex.se
OBJECTIVES

- To discuss the implications of sharing the Nursing knowledge globally
- To explore the clinical reasoning process
- To explain the process of development of NANDA-I Nursing Diagnoses
- To participate in the discussion on the controversies related to the classification and development of Nursing Diagnoses
- To explore the utilisation of NANDA-I, NIC & NOC in education, clinical practise and information systems

TECHNICAL SECRETARY: AENTDE-NANDAI2010@ORZANCONGRES.COM
ORZAN CONGRESS

www.aentde-nandai2010.org