Editorial

Dr. Fintan Sheerin, ACENDIO Vice-President and Chair of the eHealth Working Group.

Dear colleagues and friends,

I am very happy to present to you the first theme-based issue of the ACENDIO Newsletter. At the last meeting of the ACENDIO Board, in Helsinki, last February, our editor, Carme Espinosa Fresnedo, and I presented a proposal for the development of the Newsletter. This proposal was stimulated by the repeated difficulties that we had experienced in obtaining information for the publication and the desire for some form of coherence in the planning of the Newsletter both for the biennium and for each issue. We also wanted to provide a sustainable structure and plan for the Newsletter. The proposal, which was agreed at Board level, links the initial Newsletter of the biennium with the previous conference. Thereafter, the remaining three Newsletters of the biennium will be linked with a specific priority of the Association as identified in the Board’s Action Plan. It was agreed that, whilst the editor retains overall editorial responsibility, the responsibility for sourcing material for each issue will be taken on by the Board member who is leading work on the priority area.

If the experience of the past few months is anything to go on, I am very hopeful for the future development of the Newsletter as we have received many contributions from ACENDIO members and collaborators across the region of Europe and beyond. We are grateful to you all for these contributions, many of which are directly related to eHealth.

In this issue of the Newsletter you will find information on eHealth which spans history, education and research. Other information will be found within the re-vamped ACENDIO News and Country Update section which sees contributions from Finland, Norway, Ireland and Italy. You will also be interested to read the current draft of the ACENDIO eHealth Strategy work which is ongoing and which will be further developed at a meeting of the eHealth Working Group in Zurich, in May 2014.

Finally, we are delighted to announce the First Call for Abstracts for the 2015 ACENDIO Conference, which will be held in Bern, Switzerland, in April 2015.
From the President

Walter Serneus
President of ACENDIO
Professor in Healthcare Management, Catholic University Leuven, Belgium

Europe is going digital

The future of healthcare is digital as shown by two recent initiatives of Europe in this domain (https://ec.europa.eu/digital-agenda). The first initiative comes from the eHealth Stakeholder Group, a European Commission advisory body. In April 2014, they presented four reports describing major areas for action: ensuring that patients have access to their electronic health records; a wider use of telemedicine services; increasing the interoperability among eHealth solutions and health systems; and a series of good practices across Europe in which they show how ICT can help to get better access to healthcare.

A second initiative is the green paper on mHealth launched by the European Commission in April 2014 (https://ec.europa.eu/digital-agenda/en/node/69592). The paper is highlighting the importance of mHealth for the future of healthcare. At this moment, 97000 mHealth apps are available. 70% of them target consumers, 30% of them target health professionals. As it is a public consultation, they expect comments and recommendations until July 3.

These two initiatives show clearly that the European eHealth agenda is important for ACENDIO. The four priorities for actions are well in line with our eHealth and nursing strategy. We would like to invite you to send us your comments on the mHealth green paper so that we can prepare a reaction to the consultation. And we expect to see you at the 10th ACENDIO conference from April 16-18, 2015 in Bern, Switzerland. We expect you send in many abstracts for sharing as many experiences as possible.

I am very proud to present to you this issue of the Newsletter in which the ACENDIO strategy on eHealth and nursing is presented and how this strategy is implemented in several countries. Enjoy reading the Newsletter.
News from ACENDIO

Prof. Kaija Saranto is elected as an Honorary Member of ACENDIO

Name: Kaija Saranto
Title: PhD, RN, FACMI, FAAN, Professor in Health and Human Services Informatics
Affiliation: Department of Health and Social Management, University of Eastern Finland, Kuopio Campus
Membership Country: Finland
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As stated in the ACENDIO Constitution (2.5) ‘Honorary membership is a lifetime award of free individual membership which the Board of Directors will award each biennium to an individual who has made an outstanding contribution to the development of nursing terminology within Europe. Any member can nominate such individuals for consideration by the Board which will decide on the award at the Board meeting prior to the General Assembly.’

During the 2013 ACENDIO Conference in Dublin, Prof. Kaija Saranto was elected as an Honorary Member of ACENDIO following her nomination by Asta Thoroddsen and Anna Ehrenberg. Dr. Kaija Saranto joined ACENDIO in 1999. She was a board member from 2001 and was nominated as the president in 2007, in Amsterdam, serving the association as Vice-President and President for two biennia each. She completed her term in 2011. Under her leadership the association continued to develop its administration and strengthen its role in supporting European nurses, as ACENDIO members, to participate in and discuss important initiatives including eHealth. In 2008 Dr Saranto led the first ACENDIO survey about terminology use in Europe. During her leadership ACENDIO conferences established their biennial preparation and format for knowledge sharing.

As an academic, Dr Saranto became the first Nursing Informatics Specialist in Finland to develop educational curricula for the nursing informatics specialty; courses and programs which are now widely used. She also published the first doctoral thesis the field nursing informatics in Finland in 1997. As the leading nursing informatics (NI) expert in Finland she has introduced major NI educational materials including electronic nursing documentation, and the development and implementation of the electronic health record (EHR) for Finland and in Finnish, Dr Saranto and her colleagues have repeatedly shared in conferences and workshops their experience and results about the validation and adoption of the Finnish Care Classification for electronic nursing documentation.

Since 2000, Dr Saranto has been a faculty member in the Department of Health and Social Management. In 2012 the University of Eastern Finland’s master’s degree programme in health and human services informatics, led by her, became the first master degree programme in the world to be certified by the International Medical Informatics Association. Professor Saranto became the first Finn to be elected as a Fellow in the American College of Medical Informatics in 2012 as well as the first Finnish nurse to be elected as a Fellow of the American Academy of Nursing in 2013. The books and articles edited by Dr. Saranto are widely used for Finnish university (master’s and doctoral degree) programs. Also, they are being used for the University of Applied Sciences (baccalaureate degree) level for the health informatics program. The books and book chapters by Saranto serves as the basis for several major courses such as: Introduction to Health Informatics, Implementation of Health Information Systems, Data Security and Privacy Protection as well as Evidence-based Practice.

In May 2010 the Finnish Centre for Evidence-Based Health Care, an Affiliated Centre of the Joanna Briggs Institute which Dr. Saranto co-directors, was established as the first centre in Scandinavia. The aim of the centre is to prepare systematic reviews and publish guidelines for clinical and primary care nursing usage under the international umbrella of the Institute. Her team’s flexible application is the Nursing Thesaurus Hoidokki which was launched in March 2010 (http://www.hoidokki.fi). It was developed over a ten year period by the Finnish Nursing Terminology Group which she chairs and which was funded by the Finnish Nursing Education Foundation. The main purpose of the Online Electronic Finnish Nursing Thesaurus is to develop a controlled vocabulary in Finnish to promote the implementation of evidence-based clinical nursing practice. The Hoidokki not only assists librarians to index nursing literature into database but also assists the nurses to design and develop their search strategies using the controlled vocabulary keywords in Finnish, Swedish or English.
Standardized nursing documentation has been used internationally since 1990’s, and its usage is expanding in different health care settings. Previous descriptive research has showed incomplete and inaccurate documentation, lack of time and administrative support for documenting nursing care. The effects of standardized nursing documentation have only been studied to a limited extent. The findings of these studies are inconclusive both regarding the effects on patient outcomes and nursing practice. This is a topic of concern to healthcare professionals and to administrators (Urquhart et al. 2009). According to a very new review (Hyppönen et. al 2014) more high quality reviews of structuring the electronic health record are needed.

The objective of the theme “Documentation linked to patient outcomes” was to explore available evidence between nursing standards and patient outcomes. The actions for achieving the aims were an inventory of existing literature and a problem statement to give input on research projects.

A workshop was organized at the ACENDIO conference in Dublin 2013 on this subject. The aim of this workshop was to describe and discuss the research of nursing documentation and its effects on patient outcomes, and to identify priorities and future directions for research within this field.

The workshop started with a presentation concerning previous reviews of standardized nursing documentation published during 2006-2011. The findings of the studies are inconclusive both regarding the effects on patient outcomes and nursing practice. About 25 participants from various European countries joined the discussions. To summarize the results of the workshop, more research is needed, for example, of the day-to-day interactions between nurses and electronic nursing documentation, and the relationship between practice and information use in designing and testing nursing information systems. Also randomized controlled trials to produce evidence for practice are needed. It is also important to audit the quality of information entered into electronic patient record systems by different health care professionals.

A systematic review (Saranto et al. 2013) has been completed by a multiprofessional research team including members from the National Institute of Health and Welfare, Finland and the University of Eastern Finland, Department of Health and Social Management. The findings of the review have been summarized into impacts associated with different nursing data structures. The positive and unexpected impacts have been grouped into three categories: effects on healthcare inputs, effects on processes, and effects on outcomes. The results emphasize e.g. that standardized nursing documentation supports the delivery of daily nursing care in various ways. In nursing records, nursing interventions are more accurately described and outcomes of care defined. Perhaps the most important result is what the use of a nursing classification provides for patient care; data reuse which facilitates the continuity of care contributing to patient safety. It also facilitates the research of patient care processes.
The European Commission’s Directorate for Connectivity is backing nurses and social carers’ ambitions to establish a thematic network harnessing the potential of eHealth systems to make effective guidance available in accessible formats through multi-stakeholder collaboration.

The 2-year project “ENS4Care” kicked off in December 2013 and is led by EFN (European Federation of Nurses Associations) with 24 partner organisations representing health professionals, social workers, informal carers, patients, citizens and industry.

The outputs of the project will be the creation of eHealth guidelines in four core areas: prevention, clinical practice, advanced roles and nurse ePrescribing.

One of the first deliverables of ENS4Care will be the production of guidelines. As such, in a first step, the ENS4Care questionnaire (https://www.surveymonkey.com/s/G8837QJ) was launched in the first half of March 2014 with the objective of collecting key information on examples of good practices (e.g. online platforms, services, products, protocols, guidance, clinical guidelines, education and training programs) in the EU and EEA countries regarding, nurses and/or social workers use of eHealth tools/systems in one of the four core areas of investigation. Almost 200 replies with good practice examples were submitted.

Furthermore, the project aims to foster continuity and quality of care as well as patient safety for all citizens across EU Member States through the establishment of a thematic network which will act as a sustainable mechanism to support nursing and social care research in the field of eHealth enabled prevention and integrated care.

As this is an open thematic network, the ENS4Care team encourages nurses to get in touch and join the Linkedin Group ENS4Care and follow them on Twitter as well as proactively contacting the Secretariat to see how you can join the thematic network as they progress.

Further Information: www.ens4care.eu or Ens4care@ens4care.eu.
What the e- stands for?

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Abstract (catalan)

La revolució científica i tecnològica en les últimes dècades, juntament amb l’aparició de noves vies de comunicació i socialització, ha transformat no solament el nostre entorn, sinó també nostres maneres de treballar.

Avui en dia estem bombardejats amb nous conceptes que ens predisponen a pensar que la informatització de les cures és la propera revolució en salut. Térmens com e-salut, m-salut, telemedicina, enfermeria 2.0, salut social, etc. se van haciendo més habituales en nuestro dia a dia y a menudo nos asaltan las dudas del porqué necesitamos la e- en sanidad. ¿Pero es todo esto tan nuevo? ¿Realmente estamos frente a una revolución o no nos hemos querido dar cuenta y esta realidad ha sido siempre parte de la sanidad? ¿La e- es parte de la sanidad tal y como lo es de la sociedad?

Abstract (Spanish)

La revolución científica y tecnológica en estas últimas décadas, sumada a la aparición de nuevas vías de comunicación y socialización, no solo han transformado nuestro entorno sino también nuestras formas de trabajo.

Hoy en día estamos bombardeados con nuevos conceptos que nos predisponen a pensar que la informatización de los cuidados es la próxima revolución en salud. Términos como e-salud, m-salud, telemedicina, enfermería 2.0, salud social, etc. se van haciendo más habituales en nuestro día a día y a menudo nos asaltan las dudas del porqué necesitamos la e- en sanidad. ¿Pero es todo esto tan nuevo? ¿Realmente estamos frente a una revolución o no nos hemos querido dar cuenta y esta realidad ha sido siempre parte de la sanidad? ¿La e- es parte de la sanidad tal y como lo es de la sociedad?

Abstract (English)

During the past decades, scientific and technological developments, together with new ways of communicating and socializing, have not only transformed our world, but also our way of working. Today we are continually faced with new concepts which lead us to expect that nursing care ‘informatisation’ will be the next revolution in the health arena. Terminology like eHealth, mHealth, telemedicine, Nursing 2.0, and social health are becoming more common in our daily work and quite often we ask ourselves why we need an ‘e’ in health care at all! Is this all so new? Are we actually facing a revolution, or has this all around for a while - part of health systems - and just we have not noticed until now? Is ’e’ as much a part of health as it is of society?

IN THE BEGINNING

The Health Care System

Some people may feel that this is all very new, but electronic information systems (EIS), such as Electronic Patient Records (EPR), have been in use since the 1950s. We are not talking about the same health applications that we had 15, 30 or 60 years ago, but rather the evolution of these applications in the development of new technology.

At the same time that software, hardware and, telecommunications evolved, health electronic applications were developed and adapted to the evolving necessities of the health care systems.
The first computer, ENIAC (Electronic Numerical Integrator and Computer), was invented around the 1940s. It had nothing to do with present computers; among other differences ENIAC occupied an area of 167m2. But what is irrefutable is that it was the beginning of informatics development and, from that point forward, it never stopped developing.

Around 1958–59, Diebold conducted an exhaustive study in computerized hospitals, and he identified two main groups of activities that were in need of using computers. These two groups of activities were as follows:
✦ Financial, economic and business application.
✦ Health applications requiring terminals in nursing posts and hospital departments.

In 1964, Charlotte Hospital, in North Carolina, installed one of the first health information systems. A little bit later, El Camino Hospital (Mountain View, CA) began working together with Lockheed Corporation to create an electronic hospital information system.

All those trials demonstrated the advantages of using informatics in health care settings, but neither industry nor government agreed on the need for implementing those sorts of electronic systems in hospitals.

Time passed and health organizations began to acknowledge the usefulness of electronic systems in health care, such that even the Department of Health and Social affairs in USA decided that nurses should input data in an electronic care document.

This was followed by a rapid period of growth in the development of health care systems and informatics. Some examples of these developments are set out below:
✦ 1965. The first standardised medical language was created by the American College of Pathology, SNOP (Systematized Nomenclature Of Pathology). This language evolved to SNOMED which today is known as SNOMED-CT.
✦ 1968. Dr. Lawrence Leed, together with the University Medical Centre in Burlington, developed PROMIS (Problem Oriented Medical System). This was an integrated information system for all health care professionals including laboratory and accounts.
✦ 1969. The UMHD5 (Uniform Minimum Health Data Set) was created with the aim of establishing health guidelines and standards.

The 1960s brought about a great revolution in health informatics, but during the decade of the 1970s the developments reduced, only to regain momentum during the 1980s, alongside the huge advances in informatics that were then taking place. In 1982, IBM produced the first personal computer (PC), and Microsoft released Windows 1.0 for the first time in 1985. In 1989 Macintosh released their first portable computer (Macintosh Portable).

This was the first portable computer to go on the web and to send e-mail in 1991. From that point, computers became increasingly faster, smaller and easier to use.

By 1968, and based upon the concepts of Paul Baran, Donald Davies and Lawrence Roberts, the Advanced Research Project Agency Network (ARPANET) was released. It was one of the world’s first operational packet switching networks, and the first to implement TCP/IP. ARPANET together with TCP/IP would form the backbone of how the internet works today.
By the end of 1970s, all the elements needed for the foundation of the eConnections were in place, and the kick-off for ICT began.

The beginning of 1990s brought about huge developments in health care software, with the aim of developing systems that could facilitate control, prediction and cost containment related to caring, rather than that of developing standards and software to improve caring. Fortunately, this aim changed around the mid 1990s when, not abandoning the need for controlling and decreasing costs, the aim refocused on development of applications that aided the establishment of care standards whilst also capturing the important data.

**What about Nursing?**

The 21st century offers the opportunity of developing platforms for nursing health care unknown until now. Nurses are an essential group in the Health Care System and the developments in information and communication technologies (ICT) have had a positive effect in their daily work.

The ICN considers that “Nurses have to participate in informatics advances and influence them, in order to help world populations to achieve higher levels of health and wellbeing”.

Some of the key historic developments in the development of electronic nursing applications are identified below.

✦ 1911. Creation of the ANA (American Nursing Association). The Association is in charge, among others, of promoting the development of nursing science in all fields.

✦ 1965. The USA Department of Health and Social Services asked nurses to provide data on nursing care to contribute to an official report. The report fostered the development of the Nursing Electronic Care System.

✦ 1973. NLN (National League Nursing) hosted a conference where the usefulness of informatics systems on statistics, cost analysis and management was shown. This same year, the first NANDA (at that time, North American Nursing Diagnoses Association) conference was held with the aim of classifying nursing diagnoses.

✦ 1977-1980. Different approaches to create informatics standards for nursing care were explored.

✦ 1982. London held the first International Medical Informatics Association Working Conference on the impact of computers on nursing. This conference is still held every three years.

✦ 1985. Virginia Saba, together with Georgetown University, developed the HHCC (Home Health Care Classification System). The system classified the resource requirements and outcomes for patients in home health care. Today the system is still in place under the name of CCC (Clinical Care Classification System).

✦ 1986-1991. ANA promoted the use of informatics systems in nursing. Care guidelines and care standards were developed. A research team in the Centre for Nursing Classification and Clinical Standards in the University of Iowa developed NIC (Nursing Interventions Classification).

✦ 1992. ANA established a new speciality in Nursing: Nursing Informatics. A research team in the Centre for Nursing Classification and Clinical Standards in the University of Iowa developed NOC (Nursing Outcomes Classification).

✦ From that point on, nursing institutions all over the world worked towards the development of a standardized classification system that could facilitate the use of ICT in clinical environments.
WHAT THE “e” STANDS FOR FROM A NURSING POINT OF VIEW

The evolution of nursing thinking has, of course, influenced nursing clinical practice. But nursing clinical practice has also been influenced by the changes in informatics technology and science.

Sometimes, and in some systems, nursing is rendered invisible within the EHR because such systems are mainly driven by medical care and economical issues. When nurses assume roles that make their contribution to people’s health ambiguous and indistinct, their message about the need of good care for people is often lost. At the same time, though, the use of computers nowadays is unavoidable as it brings advantages and disadvantages to nursing work.

In a way computers may produce a sense of control, because all the information is there and is generally accessible without much effort, but the implementation of ICT also brings with it an added sense of work stress. Sometimes, depending on how the systems are built, there is inadequate nursing content, rigidity in the way they work and, inadequacy in the space for nursing they provide.

Informatics in nursing must aim to improve quality of care, both within and outside health institutions. The use of a standardized language in an electronic system fosters the development of nursing science and allows the use of standards of care, not only at local level, but at international level, while maintaining individualized personal care for patients.

Standardized nursing language facilitates the gathering, processing and management of a huge quantity of data and information contributing to the improvement of clinical practice, research, education and the dissemination of nursing knowledge (ANA, 2002).

For the ‘e’ in eHealth to have any sense for nurses and nursing care, systems must be designed in a way in which nursing care is visible. Electronic systems are a means to achieve such a goal, but they are not the goal in themselves.

Technology has advanced amazingly in the last few years, or even months! We just need to take a look at the mobile world congress celebrated recently in Barcelona, Spain. We are now able to see not only what is already available, but also what will quite shortly be there: tactile surfaces; intelligent devices that can advise when and wherever an incident occurs; flexible phones. You name it!

Health care professionals, including nurses, must be attentive at the effects that such technology may have on their relationships with patients. A study by Montague and Asan (2014) outlines the effect of using electronic systems on patient and physician eye gaze, to explore the effects of using electronic systems in doctor-patient communication and attention. The study concludes that there are different patterns in patient-physician communication when using electronic systems and paper based systems, and that such knowledge should be used to develop electronic systems that facilitate communication between physician and patient.
In this era where people are completely surrounded by eThings, health cannot stand apart and ignore what electronic systems can bring about to improve nursing care and nursing standards of caring. But health professionals in general, and nurses in particular, should be well aware of the consequences, issues and advantages of using eSystems in eHealth; to be able to discern between what is nice to have and what is needed. With all these technologies within and around health care, nurses and other health professionals run the risk of “phubbing” (phone and snubbing) patients, that is, snubbing someone in favour of a mobile phone or other electronic device.

In conclusion, it may be considered that the ‘e’ in eHealth stands for all those resources that helps nursing improving nursing care, nursing science and communication within the health care team and with other professionals and the population.

REFERENCES


EHealth and Nursing: Developing an ACENDIO Strategy Document

Dr. Fintan Sheerin
ACENDIO Vice-President,
Trinity College Dublin, Ireland

Introduction

eHealth is a rapidly developing area which is creating a new and exciting context for the provision of health services and for the practice of nursing. The European Union has been actively working on eHealth initiatives since 2004 and this has filtered through to policy development in member states and is also evident in that of states in the wider EFTA region. These initiatives are widely characterized as being mediators of better healthcare for citizens.

It has been suggested by some ACENDIO members that, whereas many nurses have been active in the development, application and support of eHealth initiatives, nursing has not been very evident in the development of eHealth strategy. Accordingly, ACENDIO has been engaging with its membership, many of whom are eHealth experts and/or users, in order to produce a coherent and clear voice for nursing on this important work.

The initial work was undertaken by the 2009-2011 Board of ACENDIO, and led to the hosting of a meeting at the 8th Biennial Conference of ACENDIO, in Madeira which was attended by nearly 40 people. The main themes that emerged from the meeting were:

1. Continuation of Ongoing Work
   a. The ACENDIO survey of standards must be further developed. In addition we need to progress the European Observatory containing information about what is happening and where. This information will promote collaboration;
   b. The ACENDIO website must be developed, with the aim of creating a repository for eHealth initiatives, nursing has not been very evident in the development of eHealth strategy. Accordingly, ACENDIO has been engaging with its membership, many of whom are eHealth experts and/or users, in order to produce a coherent and clear voice for nursing on this important work.

2. Dissemination
   It is vital that the outcome of ACENDIO surveys and work be disseminated. This may be achieved in a number of ways:
   a. Publications in ACENDIO and professional journals as well as on the ACENDIO website;
   b. Development of a document which can bring together the results of the standards survey along with examples of good practice and work on standards, drawing together the current divergent approaches;
   c. Disseminate our finds and strategies to the European Commission.

3. Networking and Communication
   There is a need to access and bring together those who are involved in eHealth. The European Observatory may provide a platform for this but it is likely that we will need to support further collaboration and discussion on the ACENDIO website.

4. Research
   We need people who can do research in nursing and eHealth. Few nurses are taking part in large EU projects. There is a need to focus on nursing research and the application of technology. Develop a plan for obtaining resources and dissemination of findings. As many of the leaders in this regard attend conferences across Europe, post-conference workshops could be planned with researchers and experts. We could invite people to speak on different subjects with a resultant publication (link to number 2).

5. Nursing Content
   Any eHealth strategy must have nursing content. Develop a document that describes requirements for the electronic health care record which must include the nursing process. Develop a plan for dissemination (link to number 2).

6. Education
   There is a need for education about eHealth. We need trained faculty/academics who can teach about eHealth. We must lobby for increasing expertise in each nursing educational facility. We could create a curriculum with necessary content. Develop a document that describes areas in eHealth for nursing that should be taught in education. Develop a strategic plan for promotion (link to number 2).

7. eHealth Strategies
   Make all the eHealth strategies available on our website with links to standards. Describe the work about standards, bring them together, there is a lot going on.

8. Resources
   Obtain and allocate financial resources for the various projects.

Following on from this meeting, the new Board of ACENDIO asked Dr. Fintan Sheerin (Vice-President) and Ms. Kathy Mølstad (Secretary) to coordinate a consultation with members with an aim of formulating an ACENDIO contribution to the eHealth strategy for Europe. Dr. Claudio de Pieri was also invited to assist.
Method

The aim of this work was to produce a coherent and clear voice for nursing in relation to the European eHealth Strategy. It was decided that this work would be undertaken using a loose research approach and that a quantitative-qualitative, mixed-methods (modified Delphi and Focus Workgroup), design would be employed. This involved the development of sequential on-line surveys, which sought to ascertain members’ perspectives on key thematic areas, followed by group work on particular themes. Whereas, all ACENDIO members were invited to take part in the on-line work, a cohort of members expressed an interest in being part of an actual working group and it was this group that was facilitated to meet at designated European locations for the second stages of the project.

Stage 1

The initial survey was essentially a brain-storming questionnaire incorporated an open questioning approach and was presented through Google Form. It focused on the following headings: patient; nursing; ethics; system requirements; governance; education; and research. In particular, members were asked to identify what they considered to be the main issues or themes pertinent to each heading. The text-based responses were analysed thematically and these themes formed the content of the next online survey, which Seventeen textual responses were received and following analysis, twelve main themes were identified. These are presented, along with their sub-themes, in Table 1.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-Themes</th>
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<tr>
<td>1. Individuality of Patient Data</td>
<td>Patient access to own data (home and healthcare setting).</td>
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<td>Patient validation of who data can be shared with.</td>
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<td></td>
<td>Contribution of nursing to the patient record and patient summary.</td>
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<td>Potential for people to remain at home using devices to compensate for impaired function and for health monitoring and evaluation.</td>
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<td>Patient education requirements to support use of devices.</td>
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<td>Patient involvement in self-assessment.</td>
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<td>Data collection and documentation.</td>
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<td>Remote consultations.</td>
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<td>Potential for distancing person from health personnel.</td>
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<td>Patient education requirements to support use of devices.</td>
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<td>4. Usability from a Nurse’s Perspective</td>
<td>Human interfaces.</td>
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<td>Nursing information model.</td>
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<td>Open documentation process across health care professionals.</td>
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<td>Continuity of care.</td>
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<td>Decision-support tools.</td>
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<td>Taxonomic nursing framework.</td>
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<td>Standard for flexibility in different settings.</td>
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<td></td>
<td>Nursing education requirements to support use of devices.</td>
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<td>5. Safety and Quality of Care through eHealth Technologies</td>
<td>Standards for security (privacy).</td>
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<td>Standards to avoid data loss.</td>
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<td>Legal requirements.</td>
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<td>Accountability.</td>
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<td>Workload and monitoring of results.</td>
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<td>Avoidance of mistakes/risk management.</td>
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These twelve thematic areas were re-presented to members via an online survey to ascertain which areas were considered of most importance and so were priorities for work. Forty-eight members completed this survey and the themes were ranked in order of importance (Table 2).

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<th>Themes</th>
<th>Sub-Themes</th>
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<td>6. European Nursing Minimum Data Set</td>
<td>International NMDS.</td>
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<td></td>
<td>Indicators of nursing problems (diagnosis, epidemiology).</td>
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<td>Indicators of nursing interventions (management of personnel and material resources).</td>
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<td>Interventions of nursing outcomes (effectiveness).</td>
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<td>Benchmarking between different countries.</td>
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<td>Political use of nursing indicators.</td>
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<td>European NMDS.</td>
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<td>7. Education/Training on Information Technologies</td>
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Stage 2

For the second part of this project, members of the ACENDIO eHealth Working Group were invited to take part in eHealth Seminars and Workshops in Dublin, Ireland on 10th February 2012, Reykjavík, Iceland on 5th June 2012 and Torino, Italy on 20th November 2012. A small amount of financial support was offered to all Working Group members who were able to attend these meetings.

For the Dublin meeting, eighteen ACENDIO eHealth Working Group members were joined by seven other nursing and informatics experts. In all, eleven different European countries were represented. The Reykjavík meeting was attended by 30 people, three of them from ACENDIO eHealth Working Group and the remaining were members of the Icelandic Nurses Association. The final meeting in Torino brought together eighteen ACENDIO members and local nurses. Each of the meetings worked on four of themes that had emerged from the previous work and which had been ranked highly therein. Thus, four workgroups were set up with the following aims:

- To develop the meaning/content of the theme or subtheme;
- To populate the theme or subtheme with concepts considered to be relevant to nursing’s role in/contribution to eHealth.

Findings

1. Safety and Quality of Care through eHealth Technologies

Safety and quality have always been at the forefront of nursing and, in keeping with medical colleagues, nurses have shared the aim of doing the patient no harm. It is clear, though, that both issues have been significantly challenged in recent years and that there is a need to develop systems for quality and safety in health care and to drive change in behavior. It is important, however, that such systems and tools are designed according to practice needs and that the design does not precede consultation with practitioners. The management of information for facilitating continuity of care through good communication is particularly significant here, as excellence in patient documentation can prevent fragmentation of care and lead to the recording of evidence-based knowledge, leading potentially to better decisions and better outcomes.

Any technological developments to supporting nursing practice must, however, be patient-centred; empowering the patient. ACENDIO considers that more technology is required that can support nursing to continue to provide patient centred care.

2. Usability from a Nurse’s Perspective

The focus of usability, from a nurse’s perspective, should be on electronic health record (EHR). There are many factors which have an influence on the successful implementation of EHRs and these should be taken into account. Key amongst these factors are:

- a. The Perception of Usefulness and Ease of Use.
- These have been found to be the most important factors for user acceptance of information technology and in obtaining nurses’ acceptance of EHRs. It is vital that clinicians, as end-users, be involved in the implementation projects.

Usefulness includes:

- ability of EHR to monitor complexity of the patient’s condition and intensiveness of nursing in different situations
- capability to give relevant information and alert in real time;
- quick access to patient history;
- capability to offer relevant reports;
- capability to act as an expert system in promoting evidence-based practice, harmonizing and standardizing practice, preventing errors and implementing health information technology.
Ease of use regards:

- good graphics;
- possibility to have a clear synthetic snapshot of a single patient condition, and of the workflow related to patient care;
- traceability;
- decision support: employment of the nursing process in nursing documentation demands critical thinking and reasoning on the part of the nurse, but it must be remembered that nursing is not just doing. Effective nursing interventions and activities are grounded in appropriate and expert assessment of patient needs driven by evaluation of patient outcomes. Thus, appropriate patient interventions cannot be carried out unless the patient’s needs are correctly and accurately diagnosed. This has, at times, been to some degree misunderstood. Correct diagnosis, prognosis, intervention and evaluation are aided by the decision support systems in EHR.

b. Competency in Informatics

It is a prerequisite for nurses to be able to record, update, store and retrieve data. It is also vital to facilitate the use of information and knowledge in nursing practice, as well as in practice development and management activities. The need for expert decision making challenges nursing educators to include components in informatics knowledge and competence. It is necessary that, for this to be achieved, such content should form part of nursing curriculum in all European nursing schools.

c. Architecture of Software:

It is considered that open software decision support systems where users can add items, as opposed to closed software systems, are preferable for assisting nursing in this regard. Furthermore, it is proposed that there is a need EHRs to have the ability to be individualized according to nursing specialization and to be able to produce lists, selected and tailored for relevance in order to enhance speed of decision-making.

d. Environmental factors

These include, for example, resources, infrastructure and staff. Lack of personnel makes implementation of the EHR difficult. Moreover, attention must be focused on infrastructures such as the wireless network. Tools must be examined and analyzed with respect to viability and efficient use with patients (workstation, laptop, tablet, smart phones).

ACENDIO’s recommendations for usability from a nurse’s perspective are that there must be:

1. A clear European Nursing Position;
2. A decision to use standard nursing language and NMDS;
3. Work undertaken on an interface language to include nursing perspective and nursing knowledge;
4. An emphasis on the nursing process, as an interactive conceptual, yet flexible, process;
5. Involvement of nurses themselves. Nurses need to be at the table where decisions are made and must be involved in implementation;
6. A bringing together of problem lists and definitions;
7. A point of contact when recording;
8. Some structuring for secondary use, for example, data-mining.

3. Remote Patient Support Devices

There are many examples of how remote patient support devices can be employed in healthcare. There are possibilities of patients engaging in self assessment or in health promotional/educational endeavour. The assessment may be also be undertaken by the clinic from a distance through health monitoring technologies. These approaches may support patients to make their own decisions regarding health management. eHealth can also take the form of eSupport allowing people to move beyond their limited abilities and maintain as much independence as possible through the use of SMART technologies with sensors in the home. This can also be facilitated through the employment of remote consultation devices allowing communications to take place in real-time. There is the potential for therapies, such as cognitive behavior therapy, to be provided distally. Information is vital to independence and to informed decision making. The provision of accessible health information through accessible media may help to ensure that patients can take control of their own health.

Nursing has traditionally associated itself with particular values and ideals. One of the most commonly-cited is that of person-centeredness. The use of individually-determined remote patient support devices is in keeping with that ideal as it recognises the individuality and uniqueness of the person and, furthermore, promotes another important concept, self-care. In doing so, it again allows individuals to take control of their health. There are, however, risks and challenges associated with remote eHealth devices. From a purely professional perspective, it questions the usefulness and power of professionals such as nurses. If the concept is misused by governments, it may be used to argue for a reduction in staffing numbers where levels need to be maintained. The community nurse is not just a health clinician. S/he is also a mediator of community and is a source of social interaction for people, especially those living alone. S/he is part of the community. The removal of such contact may increase the experience of isolation among some parts of the population. The lack of the personal relationship may also lead to a loss of ‘holism’ through distancing.
4. Remote Patient Monitoring Devices

eHealth also increases the potential for people to remain at home using devices to compensate for impaired function and for health monitoring and education. This may be particularly pertinent in respect of older people as well as those with disabilities. The movement of the ‘patient’ or ‘service user’ away from the human interface with the clinician poses a challenge to healthcare providers, but particularly to nurses who have traditionally valued the role of interpersonal contact and face-to-face communication in the development of the trust that is central to the delivery of quality nursing. Remote patient monitoring may be seen to create a chasm between the nurse and the recipient of the nurse’s service.

There are a number of approaches which need to be considered. The maintenance of the person in their home may be facilitated through telemonitoring and remote electronic monitoring. Such approaches may be supported by a nurse, in a similar way to that in which nurses provide advice and support to individuals in health insurance companies and health promoting charities. Thus, the nurse can be central to interacting with people as they live at home, offering advice or information and ensuring that there is a human link to other services that might be required (telenursing). It is acknowledged, though, that nurses are often not involved in the decision to employ remote support devices and that this is often a function of social services. In acknowledgement of the invaluable role that community nurses have played since the inception of community care, it is vital that telenursing role be developed and defined so as to ensure that the holistic approach to care, that is embedded in nursing, is not lost. Thus, nurses must be an integral part of the team that liaises with patients in the development of their remote electronic supports.

It is proposed that, within the context of a facilitated health and social network of eSupport, the nurse could take on the role of link/coordinator with the social care worker as his/her assistant. Such a reality would require nurses to develop their expertise in this domain with the creation of appropriate clinical nurse specialisms, drawing together knowledge and expertise in technology, health and nursing.

Examples of such nursing developments have been seen in the distal monitoring of pain, in preventing hospitalisation in the Basque region, and in providing community living units for older people and those with disabilities.

eHealth is not just about supporting people in respect of health and social care. It also has an educational role for patients and can provide accurate information on primary and secondary health perspectives, including information on society, education and rights. Often, for those living in the community, the focus becomes on “wellness” rather than “illness” with the latter a sub-component of the person’s life (rather than the central component it may become in hospital). eHealth may be seen to encapsulate not just a health perspective, but rather a life perspective. It is from this that the concept of eLiving and eLife emerge, providing a single life record from birth to death which may be standardized to allow transfer of “total” information – knowledge and understanding. In this, the focus is on “wellness’ not ‘illness”.

5. Education/Training on Information Technologies

[REQUIRES DEVELOPMENT]

Education/training for nurses in informatics
Education/training for educators and head nurses
Best practices and strategies for the implementation of electronic information systems in nursing
Role of information in decision making and skills required
Blended learning and communities of practice, for basic and continuous education of nurses

6. European Nursing Minimum Data Set (NMDS)

ACENDIO members considered it vital that a European NMDS be central in identifying the nursing contribution within an eHealth Strategy. In some countries, it is a legal requirement for a systematised approach to the identification of nursing problems, interventions and outcomes. Thus, in Spain, the NMDS includes NANDA-I, NIC and NOC (NNN), whereas in Italy nursing problems must be clearly stated, along with an integrated history, whether in electronic or written formats. Embedded in such approaches is an explication of nursing reasoning and decision-making. This is incorporated in some e-systems. Despite this, nurses have expressed a concern that such systems are not always properly employed by them and that this leads to fragmentation of information, particularly relating to history, and to data shared by other health professionals. In light of this, it is considered crucial that integration of the health record be properly developed and maintained.

It is concerning that such variance occurs across Europe regarding the requirement for and application of a European NMDS. Such non-standardisation has implications for the communication of health information across health care institutions across the region, particularly as there is increasing ‘health tourism’ occurring. It is recommended that general regulations regarding a European NMDS be developed across the wider European region and that there be within this a possibility for each country to adapt their application locally within defined parameters. Furthermore, and more specifically, it is recommended that such a NMDS should collect information on the following parameters:
Demographics;
- Medical diagnostic information;
- Assessment criteria, defining characteristics and risk factors;
- Patient outcomes;
- Nursing interventions (including information on the patient status).

7. Information Technology and Diagnostic Reasoning
ACENDIO considers this to include the background mapping of different classifications, inter-operationality with other parts of the patient/health records for multi-professional communication. The main issues that were raised by members in this regard were that:
- It will be useful to have systems that help with the prioritisation of nursing diagnoses;
- The systems should propose a number of nursing diagnoses taking into account the assessment;
- The systems should be flexible and theoretically neutral;
- They should use nursing, methodology, but be flexible, and with the possibility of customizing interfaces depending on the speciality, the field, the type of patients, etc;
- There should be taxonomy standards that all taxonomies used must accomplish;
- There are many different taxonomies today, and the tendency should be towards harmonization. SNOMED-CT could be a way of unifying the taxonomies and the nurses able to use different taxonomies at the interface. The best solution, though, should be to have a unique taxonomy;
- Interoperability is crucial, and the systems should comply with all the communication standards in order to be able to communicate with the other systems in the community and finally in Europe, across Countries. That way, it will not be necessary to copy information from one system to the other and security for the patient will be enhanced;
- The principal issue is to identify the different levels of accessibility and a unique way of addressing personal identification, both for patients and professionals.

8. Data Management, Storage and Access [REQUIRES DEVELOPMENT]
On Risk to data security
- Procedures for permitting access
- Adherence to ISO and CEN standards
- Centrally archiving health-data
- Life-span perspective on storage of data

Patient access to own data (home and health care setting)
Role of patients in Electronic Patient Records

9. Research and eHealth
When considering research in this area, it is important to identify what the overarching focus of the research is, for some research can be looking at eHealth itself whereas other research may be exploring and testing the use, or application, of eHealth technologies. Much of the eHealth research to date has been on eHealth, that is, the technical aspects, and this has often preceded consideration of health or nursing foci. Thus, for example, ePrescription, a great idea, has excluded nursing, as it was not seen to be relevant. Instead, the system was developed. Despite this, nursing must explore ways to re-enter the discussion and to become active contributors to research in this regard. Using the ePrescription exemplar, nursing could explore their role in administration and advice leading to a redesignation or expansion of ePrescription to eMedication Management. It would be vital, though, to ensure that nursing’s core concept would be retained, that is, keeping the patient as the primary focus.

The development of a nursing epidemiology may become a research priority for the profession. Such an endeavour would have implications, not only for nursing, but also for patients and health care systems as the identification of prevalent nursing problems can lead to better service planning, resourcing and education.

Some of the areas which could be developed further are:
- Creation of evidence from nursing data to produce better care;
- Quality of nursing documentation;
- Workload measurement;
- Best practices and strategies for the implementation of electronic information systems in nursing;
- Multicentre studies about specific experiences with eHealth;
- Documentation models;
- User perspectives on eHealth;
- User perspectives on the nursing contribution;
- eHealth for patient empowerment;
- Risk factors associated with outcomes.

ACENDIO considers that there must be careful thought given to the consequences, if any, of collecting and using data in the research and that all legal and practical requirements/practices regarding access to patient data for research are stringently adhered to.
Plan for Completion of the ACENDIO eHealth Strategy Document

The ACENDIO eHealth document has been updated but a number of aspects still need to be worked on, particularly education and individuality of patient data. Furthermore, there is a lack of detailed consideration throughout and this must to be addressed. It was agreed at ACENDIO Board that a three-part approach be implemented to address these issues:

1. **eHealth Meeting**

   The initial work on developing the eHealth document will be completed through the conduct of two more meetings to be held in 2014. The aim of these meetings will be to address the remaining two components and to initialise a deeper consideration of the themes.

   **Meeting: Zurich - 9 May 2014**

   A Working Group meeting will be held in Bern, Switzerland and will replicate the workshop format used in previous such meetings.

2. **International Expert Working Group**

   At the ACENDIO Board meeting it was agreed that an international team of up to 10 experts (professional and non-professional) will be assembled to participate in the ongoing development of the strategy and, particularly in relation to addressing the lack of detail. Identification of the membership is now underway with each being chosen because of their expertise in relation to one of the following specific thematic foci:

   The expert group will be invited to participate in a two-day event in November/December 2014, aimed at producing a consensus document on eHealth. This final draft will be presented back, for ratification, to the eHealth Working Group at the Bern Conference.

3. **Community of Practice**

   An internet community of ACENDIO and non-ACENDIO members will be set up, using the platform being developed by Claudio de Pieri. This will be developed to parallel and engage with the online work of the expert panel to respond to recommendations and ideas being formulated by that panel. It is envisaged that the eHealth Strategy will be completed in time for the 2015 Conference and will be presented to participants at that conference.

### Thematic Focus Possible Experts

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<td>4. Individuality of Patient Data.</td>
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<td>2. European Nursing Minimum Data Set (NMDS)</td>
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<td>2. Foci for Research.</td>
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<th>European Context Focus</th>
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<tr>
<td>eHealth Strategies (<a href="http://www.ehealth-strategies.eu/">http://www.ehealth-strategies.eu/</a>).</td>
<td>This team was responsible for producing a report on eHealth policies and strategies across Europe</td>
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<tr>
<td>2. Representative of EU Directorate for General Health and Consumers</td>
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Introduction

Our society, based upon knowledge and information, is strongly influenced by the use of information and communication technologies.

Present societies are characterized by the tremendous quantity of information generated daily. Regarding medical information, around 1850 all the medical knowledge in the western world could be gathered in a couple of large volumes. Nowadays, if a nurse reads 2 professional articles everyday, by the end of the first year, she will be 800 years behind in her reading. This amazing volume of information can only be processed by the use of electronic systems.

Relationships among and between people are determined by the capacity of using electronic systems, and this is not different in relation to the health care system. The speed at which a person or a company is able to adapt to the new technologies is the key factor for the success of their development.

Nurses are working in an environment that requires competence in the use of electronic systems, but most of the time the competencies required are not acquired during their basic education. Nursing education in Europe has been recently modified and re-designed in several countries to fulfill the recommendations of the harmonized European high education strategy.

Being the largest professional group in health care systems and the ones who maintain closest contact with population, nurses need to acquire important competencies in the use and implementation of eHealth.

eHealth is a broad term that describes a series of tools based upon information and communication technology, that are used to help and promote disease prevention, diagnosis and treatment, health monitoring and management, and life styles (http://ec.europa.eu/health-eu/care_for_me/e-health/index_en.htm).

E-Health in Basic Education

In today’s environment, at an absolute minimum, the nurses need to have knowledge of word processing, spreadsheets, and e-mail applications, as well as knowledge on how to obtain information online. They should also have an understanding of legal and ethical considerations for general computing and specifically for patient information.

To reach for the sky, the ideal person would understand how databases function (helpful in grasping concepts on how clinical applications work) and how to work in a networked environment.

The Department of Nursing in the Faculty of Health Sciences Blanquerna in Ramon Llull University (Barcelona, Spain) has developed a program in eHealth for basic nursing education. The subject analyses the relationships established among and between citizens and health providers, specially nurses, transmission of data between different institutions, communication among and between professionals and professionals and citizens, as well as the role of social networks in health, the electronic health records, tele-health services or mobile devices that facilitate the development of all the above mentioned services.

The knowledge and abilities that the subject aims to develop in pre-graduated students are as follows:

1. Acknowledge the need of using information and communication technologies within the health system.
2. Identify electronic tools that facilitate the development of eHealth services.
3. Identify the components of the electronic health record.
4. Acknowledge the minimum standards required for an electronic clinical information system.
5. Identify the usefulness of social networks and other electronic health resources.
6. Prepare an eHealth project.
7. Practice with ethical compromise, respecting information confidentiality.

(.../...)
Education in e-Health

eHealth in Basic Education (.../…)

Taking into account these outcomes, the eHealth subject contributes to the achievement of the following competences:

1. Development of basic information management abilities and use of computers;
2. Ability to cope with new situations;
3. Ability for decision making and team working;
4. Ability to communicate with non expert in health people;
5. Ability to develop autonomous work;
6. Ability to practice with ethical compromise;
7. Information and communication theories application to nursing health care;

Evaluation of the subject by the students

At the end of every academic year, the students fulfill an evaluation on the subject. The evaluation assesses four different areas and the results achieved during the two academic years in which eHealth had been implemented are identified below:

✦ Planning: In general students evaluate this section quite well. Some of the students during the second year of implementation found that the workload was high, and that they would like to have more practice and less theory.

✦ Development: They evaluate this section very well, specially during the second year of implementation, where some different activities were included and some guest professionals were invited. Students evaluated particularly well the participation of Dr. Fintan Sheerin, Vice-President of ACENDIO. There were also a round table where different professionals in clinical settings were invited, and that was very helpful from the point of view of the students.

✦ Outcomes: The majority of the students recognize that they have fulfilled their objectives for this subject. Only a small number were not happy with the results, and this could be related in some cases with difficulties in mastering the language.

✦ Update and innovation: The students feel attracted by technology, as this has been part of their whole lives. They are very curious and would like to know more mobile apps that are related to health.

Lessons learned

This subject was introduced for the first time in the Academic year 2012-2013. It is not compulsory, which means that students decide whether or not to take this content. The subject is given during the fourth year of education, and in the first semester. The official language used is English.

One of the first handicaps is the level of English of the University Students in Catalunya. A recent newspaper article points out that between 30% (in the most optimistic statistics) and 70% (in the most pessimistic assessments) of the sophomore students at Catalan Universities have a level of English below First Certificate. In spite of these figures, the number of students who choose eHealth as an elective subject has increased during the academic year 2013-2014.

The reasons the students give to follow this subject are quite diverse, but the most common are that they are attracted by the content and that they want to experience following a subject in a foreign language.

Students are quite familiar with ICT. They use all sort of devices, smartphones, tablets and, laptops in their daily living, but they are not so familiar with the usefulness of those devices in health care.

The subject is still quite new, and probably it needs some improvements related to the use of mobile apps related to health care. One of the innovations that students value most is the participation of different professionals who give them a real perspective of the real world outside the security of the University.
Introduction

The International Council of Nurses (ICN) believes that information and communication technology must be used, even exploited, in health care to bring scientific knowledge and well-informed practice to individuals, families and communities with health related needs. ICN uses the WHO definition of eHealth: the use of information and communication technologies (ICT) for health. Examples of use include treating patients, conducting research, educating the health workforce, tracking diseases and monitoring public health.

The goals of the ICN eHealth Programme are: to support eHealth practice; to be recognized as an authority on eHealth; and to be positioned centrally in the eHealth community. With policies and strategies applicable throughout the work of ICN as well as external partnerships, the ICN eHealth program seeks to advance nurses’ knowledge of and involvement in eHealth worldwide. ICN eHealth is active through formal partnerships with WHO-FIC, IMIA-NI, IHTSDO, ISfTeH and ISO. ICN eHealth is currently represented on the Scientific Program Committee of a number of conferences, including NI 2014, Med-e-Tel 2014 and ACENDIO 2015.

The ICN eHealth Programme encompasses:

- the International Classification for Nursing Practice (ICNP®), which provides an international standard to facilitate the description and comparison of nursing practice locally, regionally, nationally and internationally,
- the ICN Telednursing Network which aims to involve and support nurses in the development and application of telehealth technologies, and
- the Connecting Nurses initiative which provides an online forum for nurses worldwide to share ideas, advice and innovations.

International Classification for Nursing Practice (ICNP)

2014 is the 25th anniversary of ICNP. Work on the standard terminology was first approved at the 1989 ICN Congress in Seoul Korea. Version 1.0 of ICNP was released in 2005. ICNP is released every two years. The 2013 release of ICNP, a terminology for nursing that supports improved quality of care and standardized nursing documentation worldwide, includes nearly 4,000 concepts relevant for the support of nursing communication and practice. The 2015 release of ICNP will be at ICN Congress in Seoul Korea, June 2015.

ICNP Catalogues make the terminology easy to use. They include specially selected ICNP concepts that may be useful in a particular context such as adherence to treatment or nursing outcomes, or care settings such as palliative care. All of the catalogues are available for download, along with ICNP itself via the ICN website.

ICNP concepts are now integrated into the U.S. Unified Medical Language System (UMLS). Work also continues on mapping between ICNP and both the Clinical Care Classification (CCG) and SNOMED CT (Systematized Nomenclature of Medicine - Clinical Terms).

In 2013 a public good agreement was established with the International Health Terminology Standards Development Organization (the organization responsible for SNOMED CT) to support the dissemination of the ICNP-SNOMED CT mappings. An equivalency table with ICNP diagnosis and outcome concepts and SNOMED CT concepts is also available for download via the ICN website.

As part of this work, ICN eHealth collaborated with the US National Library of Medicine to have ICNP accurately represented in UMLS.

ICNP is a Related Classification within the WHO Family of International Classifications (WHO-FIC), and ICN eHealth is actively collaborating with the WHO-FIC Network, for example in the development of the International Classification of Health Interventions (ICHI).
Telehealth nursing, or telenursing, extends the capability of nurses with the aims of improving access and quality, and managing costs. From its establishment in June 2009 to December 2013, about 300 members representing 64 countries have joined the ICN Telenursing Network. The membership represents nurses interested in or working directly in many different capacities.

The principal goals of ICN’s Telenursing Network are: [1] to serve as a global resource for nurses working or interested in telenursing practice, technology development, policy, standards, education and research; [2] to promote effective networking and linkages, and [3] to enable the sharing of telenursing knowledge and expertise and stimulate reflection on the changing nature of nursing care delivery systems across the globe. The Network Advisory Group is working on an ICN Position Statement for Telehealth Nursing. The next Network meeting will be at ICN Congress in Seoul Korea, June 2015.

Connecting Nurses
ICN continues to partner with other international nursing organisations in Connecting Nurses, an international initiative, supported by Sanofi, to share nursing knowledge and to champion the extraordinary accomplishments of nurses around the world. Care Challenge is an online recognition programme that invites nurses to submit their innovative patient care ideas and projects. In 2013, twenty award recipients were selected by an independent jury. ICN has been contributing to Information Shareapy, also part of Connecting Nurses, that facilitates the sharing of resources through an online community.

eHealth Publications
Recent eHealth team publications include:


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“In our various areas of practice, we know that new technologies will be a constant and our ability to adapt them and apply them will determine our success or failure as practitioners and as a profession. “

Rosemary Bryant
ICN President 2009-2013
Research Projects

The development of patient care through data mining of nursing records

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Structured wound care documentation enables nurses to use evidence-based methods and provide high-quality multi-professional care contributing positively to patient safety. Structured data also helps to: plan, deliver and evaluate care; manage care and make decisions; and develop and research care. The aim of this study was to compare the structured wound care documentation to previously developed wound care documentation. Finally, it sought to evidence the advantage of structured data, which is a requirement for data mining.

In this writer’s doctoral dissertation she developed a wound care documentation model and evaluated the appropriateness of this model to clinical nursing. The wound care documentation model is based on the Finnish Care Classification’s Skin Integrity component. In the development of the model, Finnish wound care experts, Finnish Current Care Guidelines and evidence-based clinical practice guidelines were utilized.

The data used in the study included structured documentation of nursing interventions of wound care (n=58,060) of different surgical wards (n=10) from one university hospital (2010-2011). Data and text mining were used as research methods. SAS (SAS® Deployment Wizard 9.3) Text analytics software was utilized. Almost half (n=20,763) of the documents included information on wound dressings. Quite often there were also notes on wound redness and swelling, peri-wound, wound edges and position limits in, for example, plastic surgery patients. Terms concerning wound size (depth, width and length) were very seldomly found in the data. Many different terms were used, for example, devices for reduction or elimination of tissue focusing pressure.

According to results of earlier studies, wound care documentation is inadequate and inaccurate hindering quality of wound care, continuity of care and patient safety. This study demonstrated that applying structured wound care documentation entails several positive effects. Nurses document a lot, but more than quantity, quality of the records needs to be taken into account. Data and text mining offer excellent research methods for analyzing structured data. In fact, data mining and knowledge discovery in databases demand structured data.

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References


Research Projects

Developing an eHealth intervention to prepare and support young people (with long-term illnesses) for transition to adult healthcare services

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Background

This project emerged from a current research study (called TRYCIS and funded by the Health Research Board Ireland) which investigates young people (with long-term conditions), parents’ and healthcare professionals’ experiences of the transition process. We found that the transition from child to adult services can be very difficult, and young people want advice, information, support and signposting in relation to transition and currently encounter obstacles to having these needs met. Many young people receive inadequate information and preparation and the move from child to adult services was generally experienced as an abrupt transfer rather than a gradual smooth transition. Hence we co-developed this intervention with young people, as an innovative way of providing relevant information and better preparation for the transition process.

Methods

The research was conducted in two phases.

Phase 1

Firstly we needed to identify young peoples’ preferences for eHealth technologies and information provision. Ethical approval was obtained from the relevant ethics committees. Using a mixed methods design, we conducted a survey (n= 207) and focus group interviews to elicit young people’s preferences. The young people were 14 to 25 years old and were from three disease groups: diabetes, cystic fibrosis and congenital heart disease. The survey data revealed that almost 6 in 10 young people (57.1%) believed that a website would be quite or very useful in receiving information about their illness. Mobile phones/apps were deemed most useful (76.9%) while technologies such as Skype (15.7%), social networks (50.8%) and chat rooms (25.2%) were viewed as not very useful. Email (34.5%) and web pages (33%) were the preferred options for the exchange of information about the disease and for receiving advice/support and information on healthcare facilities. The interview data indicated that young people would value a website that contained information about key hospital personnel, differences between child and adult services, location and configuration of services, transition stories, FAQs and illness management.

Phase 2

Our second aim was to develop an appropriate e-health intervention using a participatory approach underpinned by four key principles: consultation and cooperation with relevant stakeholders, experimentation with alternative designs, contextualisation (testing with users & providers), and iterative development (modification in response to evaluation) (Waller et al. 2006). Using this approach we set up a co-design group consisting of young people with long-term conditions from the three disease groups. We also set up two additional advisory groups consisting of stakeholders from the voluntary organizations, disease support groups, healthcare professionals, parents, young people, web designer, web developer, and a digital technology expert. Using the data from phase one, we worked with young people to co-design and co-develop website and information material. This was an iterative process as we (researchers, young people, web designer) experimented with different designs via participatory workshops. The website design and materials were tested and modified in response to evaluations by young people primarily and latterly by all other stakeholders. In this way, young people’ voices preferences and stakeholders’ views were incorporated into the design of the intervention that is called www.SteppingUp.ie.

Conclusion

SteppingUp.ie is the first of its kind in Ireland and is an innovative online resource that offers video testimonials, downloadable stories and tips and information on managing the transition, becoming more independent, knowing about medications and the differences between child and adult services. During transition, some patients disengage from healthcare services and may experience deterioration in their medical condition. This intervention is one means of providing young people with resources to prepare them for transition to adult healthcare services. In our hectic healthcare environment, we need to develop interventions which enhance information sharing and promote patient empowerment.

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Reference

Comparing nursing diagnoses and collaborative diagnoses by using two diagnostic reasoning methods.

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Tumanggor, R, D, School of Nursing University of North Sumatera, Indonesia
Dewi, E, School of Nursing Muhammadiyah University, Surakarta, Indonesia

Aims
This study aimed to identify the differences between ‘possible diagnoses’ and ‘differential diagnoses (DDx)’ by using the 4 and 6 step diagnostic reasoning methods.

Background
To date several methods of diagnostic reasoning have been established but no research has yet compared one method of diagnostic reasoning to another.

Methods
Indonesian nurse practitioners, academics and students (n=86) participated in this quasi-experimental, post-test only research design in 2012. Participants were taught two methods of diagnostic reasoning (4 step – Wilkinson method and 6 step – Nurjannah method) and after that they chose and worked only on one scenario (from 3 scenarios – C, D, E - provided) using these two methods of diagnostic reasoning. Intan’s Screening Diagnoses Assessment (ISDA) and The Map of Nursing Diagnoses were tools used in the 6 step method. The results of diagnoses identified by participants using two different methods were categorised into a “possible diagnosis” and a “possible differential diagnoses (DDx)”. These two methods were then compared.

Results
A greater number of ‘possible diagnoses’ in all scenarios can be identified by using 6 step rather than 4 step. With reference to the DDx, the results varied. The number of DDx identified using 6 step is greater than that in 4 step in scenario C and D but not in scenario E.

Conclusions
The 6-step diagnostic reasoning method was more accurate for identifying possible diagnoses than the 4-step method.

Recommendation
The 6-step method of diagnostic reasoning can be applied in clinical settings for further testing.

To be presented at the 1st Saudi Nursing Research Conference 6-8 May 2014

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TeleNRsCare-Telenursing network to integrate care for the elderly and chronically ill people

Dr. Dorota Kilańska, Project Coordinator. Faculty of Health Sciences, Medical University of Lodz, Poland

Project Description

A. Identified objectives and planned activities,

Main objective: To create a cross-border telenursing reference center, in cooperation with an Iceland-based institution, in order to exchange expertise, technology, experience and best practices aiming to improve the quality of nursing care, increase access to nursing services with the use of computer information tools, developing telenursing in Poland.

Specific objectives of the project:
1. Improving nurses’ skills in caring for the elderly and chronically ill, with the use of telenursing;
2. Establishing cooperation with Iceland in order to:
   - exchange of experience, expertise and skills in telenursing,
   - establish a network of telenursing for the creation of a reference center in accordance with the Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare, as well as the transfer of expertise in caring for the elderly and chronically ill;
3. The development of care plans and guides with the use of telenursing in the field of caring for the elderly and chronically ill using a dictionary of International Classification for Nursing Practice (ICNP®).

Planned activities:

The project assumes organization of conferences, trainings, workshops and further strengthening established partnership by the organization of teleconferences. The partner in Iceland will be involved in each and every of these activities and, furthermore, each of these activities will be attended by foreign experts.

1. Conference on Telecare for the elderly and chronically ill
2. Trainings on the care for the elderly and chronically ill for the 15 Polish leader areas of nursing involved in the following specializations:
   - primary health care
   - long-term care
   - palliative care
   - surgical nursing
   - geriatric nursing
   - healthy aging promotion
   Training will last 10 days, 8 hours a day.
3. Workshops for 15 nurses in Poland in order to exploit care plans for the elderly and chronically ill based on the dictionary of International Classification for Nursing Practice (ICNP®)
   - validation of the dictionary, directory of nursing diagnoses and interventions built on ICNP®
   - preparing care plans
   Workshops will last for 10 days, 8 hours a day.
4. Establishing a network of telenursing for the creation of a reference center in accordance with the Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare and development of care indicators for elder and chronically ill patients. As part this activity, together with our partner we will carry out:
   - the development of strategies for network’s functioning,
   - the development of standards and procedures for network’s operation (including patients’ service),
   - the development, together with the network members, of the network’s annual action plans, the pursuit of actions leading to further development of the network.

As a coordinator, UM will be responsible for: ensuring the appropriate cooperation mechanisms between all members of the network; effects of the above mentioned activities; and for organizing informational and promotional activities. The structure of the network as well as the tasks carried out will be based on the guidelines laid out by the Norwegian Financial Mechanism for the period of 2009-2014.

5. Training for 15 leaders of telecare to be carried out in Iceland

B. Effects of activities

1. Development of care guides for the elderly and chronically ill as a result of health plans creation.
2. Preparation of a telenursing network set up plan in Poland for the establishment of a reference center in accordance with the Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare and development of care indicators for elder and chronically ill patients.
3. Creation of opportunities for the care of Norwegian elder patients in Poland and contact points that will enable nurse advocacy.
4. Qualified personnel in Poland in the field of telenursing; care for the elderly.

(…/…)
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Acquisition of knowledge on the work of nurses in Poland by the Iceland representatives, in order to support the development of good practice in Polish telecare.

C. Indication of why the project realization is needed

1. The phenomenon of “aging population”
In the aging society of Europe, the demand for medical services will continue to increase. According to European Job Mobility Portal (EURES) the most sought-after professions in Europe are carers and nurses (personal care); these professions came 4th in the ranking, being among the top five most wanted. Another incentive to pursue studies in the nursing profession is the typing for it to be the profession of the future. CSO projections indicate that the number of people in retirement age may increase to 9.6 million by the end of 2030, therefore, the health care system may suffer from insufficient number of nursing personnel, which could meet the challenge of care provision to an aging society.

2. Directive
The EU Directive on the application of patients’ rights in cross-border healthcare (2011/24/EU of 9 March 2011) specifying principles facilitating the access to safe, high-level healthcare, which calls on member states to develop a cooperation between the healthcare entities and responsible for them institutions of all levels (national, regional, local) to ensure a safe, high quality and efficient cross-border healthcare system by the collective planning, defining standards for the introduction of the interoperable ICT system and practical mechanisms ensuring the continuity of health care and the creation of reference centers also for nurses. The starting point for cooperation in cross-border healthcare must be the organization and promotion of health care continuity assurance within the national and regional systems of individual countries. Therefore, it is important to put into effect the procedure obligations and administrative solutions concerning health care, which are being used within organizational units and enabling taking of cross-border actions. Nurses play an important role in ensuring the continuity of care since nursing is a key element uniting sectors of hospital care, primary care and social care and constitutes a bridge leading to the assurance of health care continuity and promoting greater dynamism within health care systems. Nurses are on the front line in the contact between patients and the health care system. Nurses provide care in the form of: health promotion, health education for healthy individuals, or care for the ill (including chronic diseases, specific for the aging population). Many sources claim that nurses constitute the largest group of professional health care in the world, and it is estimated to be over 12 million of the total number of health care workers. Therefore, they require suitable working conditions and technical resources to enable them focusing on what is most important. According to studies, 75% of the time nurses spend on various types of documentation, which may facilitate the use of IT tools using the international dictionary. Nowadays, in order to become a nurse or a midwife, one must have a higher education, and to stay in the profession one must regularly update their state of knowledge - continues education is listed in this occupation as mandatory. This is explained by the situation in Polish health care, where more qualified staff has a better chance of staying employed in restructured care institutions under the Act of 15 April 2005 on public aid and restructuring of public health care institutions.

3. According to the “Rynek Usług Medycznych” (Market of Medical Services) report prepared by “Raport” – Polish Journalist Agency, the sector of medical services is seen as one of the fastest growing segments of the Polish service sector. However, in order for it to evolve in the Lodz region a patient needs to be sure that he will be attended in a professional manner. Treatment of foreign patients requires an introduction of a new quality in the area of patient care, hence the staff of medical units in the region should be prepared professionally for the requirements of potential customers. In terms of the quality of patient care and his satisfaction with the performance of medical services, a crucial role alongside medical equipment and housing conditions is played by a command of foreign languages, the ability to communicate with the patient and his family as well as the use of modern communication tools and techniques at the level of medical staff having secondary education, which generally constitutes the first and continuous contact with a patient using services of a medical unit. For this purpose, nurses must have appropriate language and computer skills enabling them to work with patients and will allow patients to continue using that care in the country of origin. (…/…)
TeleNRsCare-Telenursing network to integrate care for the elderly and chronically ill people (…/…)

This objective will be possible to achieve after implementing an international standard, meaning the International Classification for Nursing Practice (ICNP ®) (ISO 18104:2003), widely accepted by nurses all over the world for cross-border communication. The dictionary is now available in 17 languages (including English and German), is embodied in the Classification of the World Health Organization (WHO) and supported by the Ministry of Health and the Minister of Digitization for introduction for documenting of nursing practice in the electronic health record (EHR). Moreover, on the 1st of August, an electronic medical record is expected to be introduced for the common use, in which the documentation of care will be based on widely accepted ICNP® standards in Poland. Through the use of the dictionary, nurses will be able to improve their IT skills while using the dictionary in creating care plans and nursing procedures – purpose to be achieved by the application.

4. Telenursing

According to the International Council of Nurses (ICN) telenursing helps patients and their families in the active participation in care planning and self-care management, especially when concerning chronic diseases. This method of communication enables to provide information in a timely manner with the use of support e.g. on-line support. The continuation of care is made possible by being in a regular contact with a nurse and it is a necessary condition resulting from the Directive 2011/24/EU. Telenursing is essentially inexpensive and does not require large expenditures for the equipment of practice. According to the ICN, the introduction of such services shortens the hospital stay of patients, increases the availability of medical services for the population, which is often very scattered, and leads to expansion of access to high-quality services in home care. Nurse telephone consultation support mothers by helping them solve the problems with care and health of young children. This has led to a reduction of the burden of children care (Iceland - low density of employment).

According to the ICN efficiency of telenursing service is measured in:
- providing patients and their families with up-to-date information,
- reduction of low-cost health services (doctors’ offices, hospitals, first aid units, visiting nurses),
- limitation of the physical effort – health care can be provided even across borders and mobility of patients is not an obstacle in the access to the services supplied.
- limitation of the length of patients’ hospital stay and increase in their safety in the home environment,
- the use of available technologies by chronically ill patients who require monitoring, and does not meet the criteria of home care, or those who cannot afford it – due to telenursing it is possible to significantly reduce the costs and increase the access to health care services.

In December 2011, the British Department of Health announced that services have a significant effect on the decrease of mortality index by 45%, the need to contact the emergency departments by 20%, the reportability of these branches by 15%, the planned admission to hospitals by 14%, the period of patient’s hospital stay by 14% and up to 8% reduction in the cost of a patient’s hospital stay.

5. The project is in accordance with the European Parliament resolution of 9 September 2010 on long-term care for older people. This resolution draws attention to the importance of further development of the “e-health” program, aimed to enhance the efficiency and effectiveness of care services, as well as to support of informal carers and the older people themselves. It calls for the exchange of information, political strategies and best practices between Member States, using the open method of coordination, concerning the long-term care for the elderly.

6. In 2011, the number of nurses registered in the Polish Central Registry of Nurses and Midwives (CRPiP) of the Supreme Council of Nurses and Midwives having up to 60 years of age amounted to 251,315, and the average of age was 45.5. Among 244,350 registered nurses, who have the license to practice the profession, as much as 171,340 is aged between 40 to 60 years. The high age average of nurses signifies that most of them were not educated in accordance with the Directive 2005/36/EC, with which the education at higher universities was introduced and which regulates the way of education, curricula, and teacher qualifications. The education programs of the time did not take into account the demands of the modern market. In 2010, from the number of 185,893 nurses employed, according to CSO only 9,480 nurses possessed a Master Degree in nursing.
TeleNRsCare-Telenursing network to integrate care for the elderly and chronically ill people (…/…)

7. As of 31.12.2011 in the Lodz province region the total number of employed (with secondary or higher education) nurses was 12,252, of which only 2,706 completed higher education (Rocznik Statystyczny, 2011). Nursing profession is a profession where the majority of employees are women. The multitude of traditionally performed tasks by women also provokes the greater interest in the opportunity to work in part-time manner or to take a break from the nursing profession.

Data from the Polish Central Registry of Nurses and Midwives: altogether in Poland: female nurses – 246,948, male nurses – 46,200; altogether in the Lodz province: female nurses – 15,206, male nurses – 270. The worst indicators were recorded by a group between 19 and 25 years of age - only 4.2% of the staff. Among group of nurses leaving the country, there is a prevalence of young people - in the range of 35 years of age or less.

D. Information on how the planned activities are related to the area of program and objectives of the Programs PL07 and PL13,

The realization of this project in partnership with the center in Iceland, and collaboration with experts from other countries, will be followed by the creation of a network of bilateral exchange of expertise, technology, experience and best practices, aiming to improve the nursing care, especially telenursing, being in compliance with the objective of the Bilateral Fund. Project activities will result in the creation of teams which in the further stage will be involved in development and implementation of knowledge gained from the established international networks of exchange.

The project refers to the main objective of PL07 program on “Development and better adaptation of health care to demographic and epidemiological trends”, by strengthening the international cooperation, enabling the replication of best practices in nursing care, especially telenursing and implementing it into the Polish health service. By introducing new standards of patient care, it will be possible to achieve a significant improvement in public health and to reduce the social inequalities in health. Modern telenursing centers essentially provide the continuity of health care, which in the case of many types of diseases plays a crucial role in the success of their treatment and significantly improves the prognosis for the future health of the patient. Also in case of a sudden deterioration of health a number of actions taken by the patient or the person taking care of the patient, before giving a professional medical assistance, can significantly reduce the health complications and improve the effectiveness of treatment. Another important factor is the availability of health benefits independently of the place of patient’s residence, as well as patient’s mobility, which contributes to the reduction of social inequalities in the access to health protection.

One of the obstacles in the creation of a modern telenursing reference center is the lack of know-how as well as the lack of drawing experience from countries that have already implemented the corresponding centers. Thanks to this cooperation established under the Project it will be possible to overcome this barrier and to introduce modern standards of nursing care in Poland, as well as the improvement of practices in Donor States.

E. Added value in relation to the main objective, which may arise from the FWD project

The added value will be the increase in the throughput of nursing services in the Lodz region, owing to the introduction of telenursing and transfer of a large number of personal nursing consultations to telephone and on-line consultations, and hence, the improvement of the overall health care system, which can lead to the faster development of medical services sector in the region; and further encouragement of other Member States to establish cooperation between medical institutions and entities.

F. Indication of the institution (applicant / partner), and how the planned activities will serve to establishing / strengthening relationships with donors, including how to continue cooperation between the beneficiary and the institutions of the Donor at the end of the project.

Further Information: http://www.telenrscare.umed.pl/en/ or dorota.kilanska@umed.lodz.pl
International Society for Telemedicine and eHealth elects Pirkko Kouri as a new board member (2014-2016).

Name: Pirkko Kouri
Title: PhD, RN, Principal Lecturer in Healthcare Technology
Affiliation: Savonia University of Applied Sciences
Country: Finland

Dr. Pirkko Kouri from the Finnish Society of Telemedicine and eHealth (FSfTeH) works as Principal Lecturer in Healthcare Technology at Savonia University of Applied Sciences. Dr. Kouri has extensive experience both in eHealth education and projects that focus on the use of ICT in the field of mother-child healthcare. She is known for her PhD work title ‘Development of Maternity Clinic on the Net service–views of pregnant families and professionals’. She is the first ISfTeH board member who has nursing background and, furthermore, she is the first European woman on the board. Dr. Kouri is secretary for the FSfTeH.

Dr. Pirkko Kouri joins an international Board of ten other members: Dr. Andy Fischer (Switzerland), Steve Normandin (USA), Fank Lievens (Belgium), Professor Rupert Gerzer (Germany), Professor Rifat Latifi (U.S.A.), Dr. Moretlo Molefi (South Africa), Dr. André Petitet (France), Dr. Adolfo Sparenberg (Brazil), and Professor Yunkap Kwankam (Switzerland) and Prof. Anthony Mader (Australia).

The International Society for Telemedicine & eHealth (ISfTeH), is a nongovernmental and not-for-profit society that services primarily as the umbrella association for national Telemedicine and eHealth organization. ISfTeH exists to facilitate the international dissemination of knowledge in Telemedicine and eHealth and to provide access to recognized experts in the field worldwide. The main activities of the society are promotion and support of Telemedicine and eHealth activities worldwide, assisting the start-up of new national organizations and supporting developing countries in the fields of Telemedicine and eHealth.

For more information: [http://www.isfteh.org](http://www.isfteh.org).
Confirming Knowledge of Nursing Documentation – a workshop in the annual conference of Finnish Nursing Association

Kinnunen Ulla-Mari, University of Eastern Finland (ACENDIO board member),
Liljamo Pia, Oulu University Hospital (ACENDIO member),
Ahonen Outi, Laurea University of Applied Sciences (ACENDIO member),
Sirpa Koivukoski, The Finnish Nurses Association of Uusimaa region

Finland.

The Finnish Nursing Association held its annual conference in Helsinki, Expo and Convention Centre from the 27th to the 28th March 2014. The aim of the workshop “Confirming Knowledge of Nursing Documentation” was to add understanding and knowledge of the national nursing documentation model. A further aim was to know how to prioritize patient’s needs, to set aims, to plan proper nursing interventions, to implement them, and finally, to document and evaluate the interventions according to aims.

Carrying out good quality nursing depends on what kind of data is available. Nursing documentation is a very important part of the whole nursing process. Data exchange and transfer are one of the most significant daily nursing tasks. According to Finnish law, to achieve, increase and/or improve multi-professional co-operation and safe and appropriate patient care, the patient data must be documented and saved into patient records accurately, uniformly, and without any delays.

The structure of the Finnish nursing documentation model is based on the decision-making process and a standardized nursing terminology: Finnish Care Classification (FinCC). Nursing diagnoses, interventions and outcomes are documented in a structured way using the FinCC. It consists of the Finnish classification of nursing diagnoses (FiCND), the Finnish classification of nursing interventions (FiCNI) and the Finnish classification of nursing outcomes (FiCNO). The latest version, 3.0, was launched at the beginning of 2012. Both the FiCND and the FiCNI have 17 components each, with the FiCNO having 27 components.

Both the FiCND and the FiCNI have 17 components each, with the FiCNO having 27 components. The Finnish nursing documentation model is based on the decision-making process and a standardized nursing terminology: Finnish Care Classification (FinCC). Nursing diagnoses, interventions and outcomes are documented in a structured way using the FinCC. It consists of the Finnish classification of nursing diagnoses (FiCND), the Finnish classification of nursing interventions (FiCNI) and the Finnish classification of nursing outcomes (FiCNO). The latest version, 3.0, was launched at the beginning of 2012. Both the FiCND and the FiCNI have 17 components each, with the FiCNO having 27 components.

In each group there were nurses who had or had not used the Finnish nursing documentation model. In spite of that, nurses worked eagerly and effectively. The final nursing process including several patient needs, aims, planned nursing interventions, implemented interventions, and finally, the evaluated outcomes, were reviewed together by all participants. We hope we achieved our aims: for participants to get new thoughts and support to daily work and nursing documentation.

References


Standard Care Plans for Nursing Homes and Homecare Nursing

Kathy Mølstad
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Norway.
The Norwegian Nurses Organisation (NNO) has initiated a project that focuses on the development of standard nursing care plans for nursing homes and homecare nursing. These plans will enable nurses to document and communicate nursing, enhancing patient safety, and ensuring knowledge based practice. Many hospitals in Norway use standard care plans but this method for documentation has not been widely used in nursing homes and homecare nursing.

In order to improve quality and patient safety it is essential to standardize nursing documentation and integration a standard language. Unambiguous terminology and mutual understanding between health professionals will help improve continuity and increase patient safety. The International Classification for Nursing Practice (ICNP) will be the basis for these plans.

Structured and standardized information will lead to more reuse and promote efficiency in the documentation and information processes. This will make it possible to aggregate data for management purposes, quality improvement and research. The plans should be integrated into municipal electronic health records (EHR) and will help to secure quality information on national quality indicators. The goal of the project is to develop plans for documentation of nursing care in the health care services in municipalities. Efforts will be made to implement the plans in the individual EHR system.

NNO started the process of developing these plans in January 2014. They invited 45 nurses from the health care services in communities who have an interest in documentation and standardization.

The following areas are being focused on:
- Risk for Fall
- Risk for Malnutrition
- Risk for Urine Infection
- Risk for Decubitus
- Risk Related to Medication Administration

These plans will be further developed during the coming year.

Kjernejournal (Core Record):
The inhabitants of Trondheim area are the first in Norway testing our new ‘Kjernejournal’ Core Record. Core Records is a new online solution that collects important health information in one source. When a patient needs acute treatment, health professionals do not always have access to updated health information about the patient, according to Anne-Lise Hart, Deputy Director of Health in charge of “Kjernejournal”. The main purpose is to provide health professionals with fast and secure access to patients’ health information. With access to vital health information in one source, the health professionals are able to provide the patient safer health care. The Core Record does not replace other electronic health records, but is an important supplement.

For more information: [https://helsenorge.no/Helsetjenester/Documents/63911_Brosjyre%20engelsk-GODKJENT.pdf](https://helsenorge.no/Helsetjenester/Documents/63911_Brosjyre%20engelsk-GODKJENT.pdf).
Healthcare Informatics Society of Ireland – Nursing and Midwifery Group

Dr Pamela Hussey HISINM

Ireland.

The Health Informatics of Ireland Nursing and Midwifery Group (HISINM) in January 2013 revised their action plan and developed a more focused and cohesive approach to nursing and midwifery informatics in Ireland. This approach included re-defining the scope of the group activity and outlining short and medium term strategic goals. The purpose of this report is to update ACENDIO on the HISINM’s revised mission and strategic goals. It also outlines some of the recent developments on eHealth and ICT in Ireland offering examples of programmes which nurses in Ireland are engaging with.

HISINM Mission is to establish and promote the national profile for nursing and midwifery informatics and through a process of restructuring, strategically position HISINM as an emerging national association for nursing and midwifery informatics in Ireland.

HISINM Goals include the widening of HISINM membership to include nurses and midwives who may not consider themselves to be experts in the domain of informatics. Acting as an advisory hub HISINM wishes to provide a professional network (both formal and informal) for nursing and midwifery practice development in areas that are looking to an active health informatics agenda.

In December 2013 the eHealth Strategy (www.dohc.ie/publications/eHealth_Strategy_2013.html) for Ireland was published, linked to this launch was the first step in the delivery of the Individual Health Identifier (IHI). The legislative framework for the IHI is now in process and will provide the legal basis for Individual Health Identifiers for not only health service users but also health service providers across the health service in both public and private institutions. Additional information is available from the Department of Health and Children website (http://www.dohc.ie/press/releases/2013/20131213.html). In addition to the launch of the above initiatives the Health Service Executive in Ireland is preparing a new ICT Strategy and Integrated Services Framework (ISF) (http://hisi.ie/pdfs/15.15%20HISI%20Report%20Peter%20Connolly.pdf). This process has involved a number of stakeholder engagement sessions in which nursing has been actively involved. HISINM is working with the Office of the Nursing and Midwifery Director to promote the nursing informatics agenda in Ireland. Current initiatives include the deployment of a national programme for nursing metrics in Ireland.

Other recent initiatives are the second National Nurse Midwifery Medicinal Prescribing Conference which included the launch of the revised Guiding Framework Document further information is available at: http://www.hse.ie/go/nurseprescribing. HISINM projects this year include ENS4Care. This project funded by ICT PSP Seventh Call is led by Dr. Paul De Raeye of European Nursing Federation and is entitled Evidence Based Guidelines for Nursing and Social Care on eHealth Services. The Irish Nurses Midwifery Organisation (INMO) leads on Work package 5 ePrescribing. The objective of Work Package 5 is to share information experiences and best practices across Europe with regard to nurse ePrescribing.

Further Information: www.hisinm.ie
Taxonomies and Software for Nursing are Born

Dr. Claudio de Pieri and the Working Group TeSI-IPASVI

Italy.

In the last year, as a result of the ACENDIO workshop on eHealth in Torino (20th November 2012), Claudio De Pieri asked to the Italian National Federation of Nursing Colleges (IPASVI), an organization that represents more than 419,000 Italian nurses, to constitute a national working group on the topics related to nursing language standardization. IPASVI accepted the proposal and decided to finance it. The resultant Working Group, entitled, TeSI–IPASVI (Tassonomie e Standard per l’Infermieristica), was constituted on 23rd November 2013, in Vercelli.

At the first meeting a preliminary program was established, to be submitted to IPASVI. This aimed to contribute to the choices of the Italian Nursing College with respect to standards, languages, classification, computerization, information systems and curricula on information technology subjects for nurses.

It was decided that the group would also act to develop international collaboration on the topics of classification and nursing informatics. Furthermore, it was decided that the work would focus mainly on online instruments. The Working Group agreed to meet several times each year.

As the Working Group is promoted and supported by the IPASVI Federation, it will submit its programs and the decisions to the Comitato Centrale of IPASVI and it will act in coherence with IPASVI Federation Lines.

The objectives of the Working Group are as follows:

1. To develop a position paper for the Federation - IPASVI - regarding the use of nursing standards classifications.
2. To establish guidelines on the introduction and development of computer systems for training and teaching students, management and organization, clinical activities, research and consultancy.
3. To define guidelines concerning the development of an information system for nursing care on national and local basis.
4. To contribute to defining curricula relating to the standard languages classification and computer skills, in basic and post-basic nursing training.
5. To develop partnerships with international organizations that work on classification and standardization of nursing language and on information systems.

The next meeting is in Desenzano del Garda on 29th March 2014. In this meeting work will be undertaken to operationalise a site based on the open source eLearning platform, Moodle, on which to establish the community of practice TeSI and facilitate work online. A national survey on the use of nursing taxonomies is also underway.

It is hoped that the launch of this Working Group of highly motivated and experienced nurses may lead to positive national developments and to greater Italian participation in European and international developments in nursing and, in this way, to contribute also to the work of ACENDIO.
ACENDIO 2015

10th Biennial Conference of the Association for Common European Nursing Diagnoses, Interventions and Outcomes

16-18 April 2015
Bern, Switzerland

First Announcement/Call for Abstracts
CALL FOR ABSTRACTS

10th European Conference of ACENDIO

16 - 18 April 2015

eHEALTH AND NURSING

Knowledge for Patient Care

Inselspital, University Hospital Berne

Freiburgstrasse 254, 3000 Bern

http://www.insel.ch

‘eHealth’ is defined by the European Commission as “The interaction between patients and health-service providers, institution-to-institution transmission of data, or peer-to-peer communication between patients and/or health professionals. Examples include health information networks, electronic health records, telemedicine services, wearable and portable systems which communicate, health portals, and many other ICT based tools assisting disease prevention, diagnosis, treatment, health monitoring and lifestyle management.”

Conference Theme

The 10th European Conference of ACENDIO aims to disseminate knowledge on eHealth in order to improve patient care. Core concepts of nursing represented in nursing classifications and standardized nursing languages will be presented, along with Nursing Informatics standards to ensure global consistency in conceptual work to inform clinical practice, health informatics and health policy.

Conference Subthemes

1. Impact of and evidence for these new technologies in relation to: Patient Safety, Patient Outcomes and Quality of Care through eHealth Technologies; Patient participation; Ethics and eHealth; Electronic Health Records to support nurses in clinical decision-making; Clinical decision support systems; Usability from Nurse’s and Patient’s Perspectives; European Nursing Minimum Data Set; Documentation Standards; Education in Nursing Classifications and Informatics; Virtual Patient Education; Data exchange enhancing care continuity across settings; Data Storage and Access, Data Warehouse based Research.

2. Regular ACENDIO themes such as: Documenting nursing care; use of nursing diagnoses, interventions and outcomes; nursing terminologies and languages; nursing minimum data sets (NMDS) within e-Health.

The official language of the conference is English. Abstracts must be submitted in English.

Submission of abstracts

We invite you to submit abstracts for the conference according the following guidelines:

1. Abstracts must be submitted electronically by 12.00 CET on September 12, 2014 via the ACENDIO abstracts link (http://abstracts.webges.com/acendio2015).

2. Abstracts must be submitted in English and the following formatting guidelines must be adhered to:
   - Font: Arial, Times New Roman or equivalent, size 12 point with single line spacing;
   - Title of presentation in should be typed in CAPITAL LETTERS;
   - The preferred form of presentation must be indicated, for example, oral presentation, poster presentation, workshop or seminar;
   - The name(s) of author(s), preceded by initials, to be types below title of presentation. Professional titles, degrees, etc. should not be included;
   - The name of the main presenter should be underlined;
   - Private postal address, e-mail address, and phone/fax number of main presenter to be included;

(.../...)

30 Summer 2014

www.acendio.net
3. The content of the submission should include:
   • A summary and keywords of the abstract content in English (not more than 50 words);
   • The abstract, which should not exceed 500 words.
   • The specific object of study or project should be stated, including methods and results. Tables, diagrams and footnotes should be avoided if possible.
   • Submissions may report original research, project development/evaluation, practice applications or position papers, but should always relate to the conference theme/subtheme.
   • All submissions will be acknowledged upon receipt.

4. The scientific committee will consider all abstracts and recommend those for acceptance either as oral/poster presentation, workshop or seminar to the board of ACENDIO. Authors will be notified by email, on or before November 20, 2014 of the outcome of their submission. Authors, whose abstracts have been selected for presentation, will also be notified of the time, date, method and allocation of presentation. Submission of an abstract implies registration for the conference, and acceptance of the final decision regarding method and allocation of presentation by the board of ACENDIO. No further correspondence will be entered into in this regard. Successful authors are required to register before February 10, 2015 at the full registration early bird fee.

5. If an abstract is accepted for an oral presentation the author(s) will be required to send in a full version of the paper presentation, with adequate reference to the literature, by 30 January 2015 for inclusion in the proceedings of the conference. The full paper should not exceed 6 pages (A4 page format; font Arial, size 12 point with 1.5 line spacing, including tables, diagrams, footnotes as appropriate and literature references).

6. Schedule:
   • Submission deadline
     September 12, 2014
   • Notification of acceptance
     November 20, 2014
   • Submission full paper for conference proceedings
     December 31, 2014
   • Registration for conference
     February 10, 2015

More information on conference programme and practical information will be available in due course on the ACENDIO website: www.acendio.net.