Greetings!

As I write this note, preparations are hotting up for the ACENDIO conference on March 19-20 in Venice. We have a very exciting programme, and as usual the conference will be a wonderful opportunity for sharing ideas. The location of the conference is between Padua, a very ancient seat of learning and Venice, which everyone must see at some time - why not now?

Although our main focus during the conference is on Europe, we will be welcoming some participants from other continents, and we have included a session on the USA nursing classification systems presented by the researchers who developed them.

The conference will also, of course, include the meeting of the ACENDIO General Assembly. ACENDIO can be nothing without its members, so please come and make sure that your voice is heard. There will be elections for Board members, officers and committees. For some ideas of how you might become involved in ACENDIO see page 5. Nomination papers are included with this Newsletter, so please use them and get your nominations to our Secretary (Anne Casey) as soon as possible. I am willing to stand for just one more term as President but that should not preclude other nominations. One interesting item will be a proposal from some UK members...
who want to establish a UK branch of ACENDIO. While the core mission of ACENDIO is always to network across Europe, the idea of national branches may help some countries where work on nursing language and classification is still in the early stages of development and enthusiasts need local as well as international support, or where the work is very fragmented among different groups and agencies.

But national groups must not be at the expense of our European identity so I am pleased to know that they propose that any member of a national branch must first be a member of ACENDIO itself. Think about the idea and come prepared to discuss it at the Assembly.

You will see in the pages of this and previous newsletters that there is a great deal of activity in Europe and elsewhere around the development and use of standardised vocabularies in healthcare. I am pleased to see that colleagues in the US are joining ACENDIO and contributing to the newsletter: unless we learn from each other and build on what has already been done there will be a good deal of wasted effort. As never before we need a European network and forum so as to be able to share information about this important work.

See you in Venice!

June Clark
ACENDIO President

Have you booked your place yet?

2nd ACENDIO Conference and General Assembly

Place: Ramada Hotel Venezia, Italy
Dates: 19th and 20th March 1999

Contact: Danielle Rawstrom,
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Report of the PCN meeting:  
ICNP in Europe  
By Ted Kraakman, NU’91 (Dutch NNA)

Sixteen National Nurses’ Associations (NNAs) participated in this meeting which was held in Amsterdam in October 1998. Judith Oulton, Fadwa Affara, Amy Coenen and Cees de Ridder attended the meeting on behalf of the International Council of Nurses. The goal of the meeting, which was organised by the Standing Committee for Nurses in Europe (PCN) and the Dutch NNA (NU’91), was to start an open dialogue between the experts of the European NNAs and the team who are managing the development of the International Classification for Nursing Practice (ICNP). The meeting was very worthwhile and the outcome unconditionally positive. Participants felt that they had established a positive and open dialogue with the development team about many aspects of the ICNP project.

During the morning session three addresses were given. Fadwa Affara and Amy Coenen gave an overview on the development of the Beta-version and described the success of the ICNP project in other parts of the world, especially the developments in the Asia Pacific region, and the ICN-Kellogg-Funded projects in Africa and Latin America. Validation studies and studies to identify and insert primary health care and community-based nursing terms are taking place.

The differences between the alpha- and the beta-version were explained. For example several definitions and titles have been changed and in contrast to the alpha-version the components are classified using a multi-axial approach. They underlined the need to maintain an up to date ICNP content, to ensure that the ICNP is compatible with the current state of nursing science, classification and informatic sciences and other health care developments. They also explained the important role for the NNAs to play in the development and dissemination of the ICNP.

Derek Hoy, researcher at the Glasgow Caledonian University, gave the participants an analysis of the principles of classification in the ICNP. He started with a historical overview of the development of principles of classification in general and the advantages of the multi-axial approach. After this overview, he analysed the existing criteria of the ICNP in relation with two ‘roles’ of the ICNP namely the ICNP as unifying framework and the ICNP as clinical framework. In his opinion it is not possible to come up to the objectives. For example ICNP as unifying framework is possible at some level of abstraction but on the ICNP as clinical vocabulary would require a high level of detail.

William Goossen, lecturer at the Noordelijke Hogeschool Leeuwarden, gave an impression of the problems arising in several countries, in which national initiatives are developing for example the Nursing Terms in UK, VIPS in Sweden etc. These developments will affect the impact of the ICNP in Europe. He believes that the ICN has to choose where to go to in order to fulfil a need in Europe. He gave the ICN several options such as a maximum data set, a small selection of items (as in the Belgian Nursing Minimum Data Set), the continuation of the traditional classification or ‘combinatorial structures’ (as those being developed in the GALEN/CEN work). William described the consequences of each option. He also underlined the fact that a nursing outcome is more than the opposite of the diagnosis and that some outcomes could be related to other factors than the nursing interventions, for example the work of other disciplines.

In the afternoon the participants were divided in three groups to look at the possible role of the NNAs, the process of ICNP development and the content of ICNP in relation to the objectives. The major conclusions/remarks which were made in the workshop were the following:

- The NNAs must play a leading role at national level
- The NNAs must collaborate with experts in the field of informatic, classification, clinicians and academics
- The role of the PCN should be more a facilitating one. For example: by organising meetings, by stimulating dialogue
- ACENDIO could play a role in collaboration with the PCN
- Questions were asked about usability of ICNP in clinical practice
- More research based knowledge must be
used

• Different purposes (objectives) need different tools
• ICNP objectives need to be revised

During the final discussion session it was stated that the ICNP may be a tool for solving some of nursing’s problems. But it is like a Swiss-knife. Only one function can be used at the same time. It was also stated that the impact of the ICNP might differ per country and probably will differ between continents. It was suggested that the ICNP project probably needs a different face in different regions depending on the level of technical progress and the level of nursing development in the different areas: it was clear that participating in the ICNP project was benefiting nurses in some countries because they were getting together to talk about nursing diagnosis, as distinct from testing or using ICNP itself.

It was made clear to the ICNP team that the major issue influencing ICNP development in Europe is the emerging European Standard for clinical terminology (the work of CEN TC251 WG 2). The participants in the discussion group on future development paths for ICNP recommended that a European strategy for ICNP was required and that the team involved in the ‘Short Strategic Study’ on nursing within the European Standard should be asked to report on potential development paths for ICNP within the European Standard context.

The meeting did not explicitly address some strategic issues such as project management, who controls the development and ICN’s commitment to and funding of the long term updating of the ICNP product(s). However a good dialogue was established and the ICNP team were made aware that some NNAs have fundamental concerns about technical issues as well as process issues.

But most of all the ICNP team were made aware that the European NNAs are supporting the idea of the ICNP and are willing to contribute in the development of the ICNP.

ICIDH Revision meetings

*From: RIVM - ICIDH Newsletter.*

**The Netherlands** The WHO Collaborating Centre for the ICIDH (The International Classification of Impairments, Disabilities and Handicaps) in the Netherlands organized a meeting on the revision of the ICIDH in September 1998. About 30 people from various backgrounds - not only from the Netherlands but also from the Dutch speaking half of Belgium - attended the meeting and discussed the Basic Questions of the revision feedback. The meeting started with a short presentation on the progress of the revision, including WHO’s plans for the next months, and a short introduction to the Basic Questions.

Discussions were held in three groups, in which persons from various backgrounds were present. Each group included practitioners in rehabilitation medicine, in allied health and nursing professions, researchers, managers, policy makers, teachers from professional training institutions, and representatives from organizations of disabled persons. Results to date of both the written and the oral answers to the Basic Questions are rather inconclusive. We have collected some very interesting reactions, which we certainly will communicate to WHO.

However, it is striking that people who agree on one question tend to disagree on the next one. We must assume that the set of Basic Questions as a whole has not been conceived from a single viewpoint on which people can agree or disagree. Each question somehow starts anew, making it difficult to interpret the results. A report of the meeting will be made available on request (see address below)

**United States** The North American Collaborating Centre held its fifth ICIDH revision meeting in October 1998. About 35 participants from Canada and the US including representatives from WHO, the United Kingdom and the Netherlands respectively, attended the meeting. Status reports on revision activities were presented by the Canadian and US Field Trial Centres, and by those representing WHO and the two European centres.

The focus of the meeting was on the third dimension, participation, and on the new addition to the classification, the contextual factors. Presentations dealt with:
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- The position in the classification of participation and the contextual factors
- Their interaction with impairments and activities
- Special applications of the ICIDH, and
- The development of instruments to measure participation and the environmental barriers.

WHO A WHO meeting with the heads of Collaborating Centres and Task Forces was held in October 1998. The aim of this meeting was to discuss the results of the interim collection of field trials, the plans for the beta-2 draft, and for the work to be done in 1999.

Europe Also in October, the Dutch Centre organized a European meeting in co-operation with the Collaborating Centres in France, Scandinavia, and the United Kingdom. About 20 ICIDH experts from 12 different European counties attended the meeting. Each country had the opportunity to report on their activities and viewpoints towards the Beta-1 draft and the revision process. WHO presented the results of their meeting and its workplan for 1999. The meeting aimed at developing recommendations for the work on the Beta-2 draft and its field trials. Recommendations related to:
- The domain of the ICIDH-2 versus other international classifications
- The basic concepts and their modelling
- The terms and their translation
- The codes and description of classes, and
- Application rules, the use of measurement instruments, and adaptations to specific fields.

The order in which the five topics are placed is seen as a guideline for the order in which they should be dealt with in classification development.

For further information contact:
Dr. W. Hirs
WHO Collaborating Centre for the ICIDH
RIVM, P.O.Box 1
3720 BA Bilthoven
The Netherlands.

Get involved in ACENDIO

Elections to the Board of Directors and Committees will be held at the General Assembly in Venice during the 2nd ACENDIO conference. Nominations are welcome from any member of ACENDIO.

You can become involved in:
- building the European network for nursing terminology and classification
- contributing to standardisation work
- developing resources to share knowledge and expertise
- participating in meetings and workshops
- planning the next conference

Send your nomination form!
Short Strategic Study
‘System of concepts for nursing: a strategy for progress’

This preliminary study, described in the ACENDIO newsletter No 4 (August 1998) has been carried out under the direction of the CEN/TC251 to develop a strategy for work on concepts for nursing. The specific objectives of the study have been to:

• Provide a basis for further development
• Develop a strategy on how to proceed towards a standard
• Highlight any overlapping work and
• Consider the possibility of performing this work in a wider international arena.

Work has been completed and a draft report has been submitted to WGII. The results of the study will be presented and discussed at a workshop at the ACENDIO conference in March: workshop entitled ‘Standards to support the co-existence, interoperability, development and maintenance of nursing vocabularies’.

Nicholas Hardiker
Manchester University, UK
hardiker@cs.man.ac.uk

The main goal of PROREC is to promote and co-ordinate European wide convergence towards comprehensive, communicable and secure Electronic Healthcare Records (EHR). This is achieved by co-ordinating and supporting the European Commission’s Telematics Applications for Health projects and other initiatives in the area of EHRs, both nationally and internationally. The main objective of this initiative is that in a reasonable time scale a EHR is installed in all member states such that health care data originating from various sources are communicable and understandable.

Managing the convergence is PROREC’s main mission, and this will be realised by undertaking monitoring, assessment and dissemination activities.

On of the intermediate goals of this purposeful strategy is to ensure that bodies such as CEN/TC251 and EC Informatics programmes meet their purpose of providing standards and the highest quality research to enhance the care process for patients and users. But perhaps even more important, PROREC’s aim is to reach all actors in the field, such that even the smallest initiative taken independently by some organisation, company, or user-group, contributes effectively to the common objective.

As a consequence, PROREC follows a workplan by which external areas of waste and inefficiency are minimised, human and financial resources are used effectively, Health Care consequences of given policies and constraints are exposed, and excellence and creative forces are harvested as much as possible. To achieve its mission, PROREC also incorporates in its strategy the following:

• Awareness of the prenormative and precompetitive requirements
• The need to develop and validate standards
• The need for ethical products in the health care marketplace, and
• The need for strategic management of the links.

The success of the Belgian and Spanish national PROREC centres are a major incentive to create PROREC centres in all EU Member States. The Dutch PROREC centre organised its first meeting in January 1999 at the Domus Medica, Utrecht, the Netherlands. Dr. Steve Kay informed the group about the architecture of the EHR.

Steve Kay is the co-founder and co-leader of the Medical Informatics Group in the department of computer science at the university of Manchester. He is also the project leader of the European standardisation initiative of CEN/TC251 producing a communication standard of the Electronic Healthcare Records Architecture. Jesper Theilgaard, general practitioner, Rødding, Denmark, and project leader of CEN/TC251/PT 31 to produce an ENV ‘Messages for the exchange of information on medicine.
prescription’ informed the group about the status of his project. David Markwell, principal consultant of the Clinical Information Consultancy, Reading, UK, informed the group about the status of the TC251/PT29 project on Electronic Health Care Record.

For information contact:
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ICNP NEWS:
The emerging Beta ICNP
(From March 1998 ICNP update)

Similar to the Alpha version, the ICNP Emerging Beta Version continues to have three main components:
- Nursing Phenomena
- Nursing Actions
- Nursing Outcomes

But in contrast to the Alpha version, all three of the components will be using a multi-axial approach in the emerging beta version. The use of a multi-axial approach provides increased robustness and supports the diversity of expression of concepts necessary in an international classification.

Classification of Nursing Phenomena
Phenomena: factors influencing health status, which are concerns of nursing

Classification of nursing actions
Nursing actions: behaviours of nurses in practice.
Nursing interventions: actions taken in response to a nursing diagnosis in order to produce a nursing outcome.

For the ICNP a nursing intervention is composed of concepts contained in the classification of action axes. Changes in the classification of actions include:
- Replacement of the title ‘nursing interventions’ by ‘nursing actions’
- A language-based approach, using linguistic categories, is proposed for further development of this classification.
- Replacement of the term ‘caring’ with ‘attending’ as a top in the action type axis.

Classification of nursing outcomes
Nursing Outcome: the measure of status in a nursing diagnosis at a point of time after a nursing intervention.

Therefore in effect the nursing outcomes classification is a mirror image of the classification of nursing phenomena. In practice the outcome measure is a change (or absence of change) in the nursing diagnosis at a further point along in the time dimension.

ICN web site can be found at http://www.icn.ch.
Swedish National Project on Terminology

Several projects are included in the national Swedish project to develop a health care term data base that is directed by the National Board of Health and Welfare and the Swedish Government. In one part the different professionals around the patient are collaborating to find common terms, as well as different terms when needed, for use in the patient record.

The Swedish Nurses’ Association has national authority to develop and maintain the nursing terms. As a first part of this, a national study has been conducted to find the terms already in use in nursing. The finding showed that the majority of the nurses used the VIPS model or some modification of it. Based on this result, the ongoing terminology work is based on the model. Experiences from the testing of the alpha version of the ICNP will also be considered.

Beside the project group there is a reference network of nurses around the country that will participate by electronic mail, as well as specialist nurses in different areas. The terminology work in nursing has got a research grant for the coming two years.

Margareta Ehnfors, RN PhD
Associate professor at Örebro University, Sweden,
Leader of the Swedish Nursing Terminology Project,
Swedish Nurses’ Association

Project Updates cont...

Zum Projekt ‘Nursing Data’ - Gesundheitsstatistische Daten der Pflege

Ausgangslage


In den vergangenen Jahren ist es gelungen, in der Schweiz wichtige gesundheitsstatistische Instrumente auf- und auszubauen. Diese bezogen sich jedoch primär und schwergewichtig auf den stationären (Spital-) Bereich sowie auf die ärztliche Versorgung (Krankenhausstatistik, Medizinische Statistik der Krankenhäuser, Statistik der sozialmedizinischen Institutionen). Ein grosser Teil der grösste der schweizerischen Gesundheitsversorgung blieb und bleibt dagegen noch ‘im Dunkeln’. Auf gesamtschweizerischer Ebene sind keine einheitlichen, flächendeckenden Daten vorhanden, die Auskunft geben, WAS im Bereich der nicht-ärztlichen Krankenpflege getan wird (Leistungen, Interventionen, etc.) und WARUM dies getan wird (Pflegediagnosen, -phänomene, -bedarf, etc.)

Eine systematische Erfassung drängt sich auf, da der Bereich der nicht-ärztlichen Krankenpflege nicht nur versorgungsmässig ins Gewicht fällt, sondern auch grosse Ressourcen und viele Arbeitsplätze bindet.

Das Projekt ‘Nursing Data’
Diese Informationslücke soll mit dem Projekt ‘Nursing Data’ geschlossen werden. Das Projekt wird von der Schweizerischen Sanitätsdirektorenkonferenz (SDK), vom

The Swedish Nurses’ Association has decided to become an organisational member of


Eine Webb-Seite wird Sie regelmässig unter folgender Adresse informieren:
http://www.hospvd.ch/public/ise/nursingdata/
Für alle weiteren Fragen wenden Sie sich bitte an:
Institut de santé et d’économie
Frau Anne Berthou
Rue du Bugnon 21, 1005 Lausanne.
Email: Anne.Berthou@hospvd.ch.

**NURSING Data CH:**

**A Swiss NMDS**

Switzerland is composed of 26 states (cantons), autonomous in healthcare. Two new laws at national level have deeply affected developments in healthcare reforms: a new insurance law and a new law on statistics. The former modifies the financing system and the relations between healthcare actors, in particular by introducing competition between providers and sickness funds, while the latter introduces new rules for statistics.

Implementation of these two laws evidenced the necessity for nursing data, as a complement to medical and hospital data, through the introduction of a minimum data set. A project is underway, led by a coalition of cantonal and federal authorities with the Nurses Association. A first series of results is planned for early 1999.

Main objectives for the Swiss project are to:

- Recommend by year end 1999 a proven information system to describe nursing needs, activity and services to be implemented nationwide
- Inform and motivate care-givers on the necessity to use a common language

Main challenges are:

- Three national languages with their different cultures (including professional)
- Budgetary constraints in Swiss healthcare
- Developing own system being considered unfeasable, only solution is importing an existing one (adapt it if necessary)
- A link between existing medical (ICD-10) and administrative languages and the proposed new nursing is a prerequisite
- Proposed new system should provide data for statistical and management purposes

The project will start by establishing a method for analysing solutions with regard to the national constraints listed above. The method should facilitate the identification and the choice for systems, languages or solutions best suited for the swiss specificity. Running parallel to the research, an information campaign is planned to keep the nursing professionnals abreast of the latest developments, using the Internet, in order to associate them better to the project and to possibly avoid adverse reactions as identified in former similar venture.

A web site has been open at:
http://www.hospvd.ch/public/ise/nursingdata/
For further information please contact:
Anne Berthou
Institut de santé et d’économie
Bugnon 21, 1005 Lausanne.
Email: Anne.Berthou@hospvd.ch.
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NURSING INFORMATICS
Combining clinical practice guidelines and patient preferences using health informatics

Editors
Margareta Ehnfors, RN, PhD
Susan J. Grobe, RN, PhD, FAAN, FACMI
Marianne Tallberg, RN, PhD

Serie: Omvårdnad No 6, Spri Förlag, Stockholm 1998

The book (200 pages) contains contributions on the topic from experts around the world, based on papers discussed at the post conference with participants from 15 countries.

AN EXAMPLE OF THE CONTENT:
Nursing Informatics: Patient and Clinical Guidelines, the State of our Knowledge and a Vision. Margareta Ehnfors, Marianne Tallberg
Knowing What To Do: International Perspectives on the Roles of Clinical Guidelines and Patient Preferences in Patient Care. A JAMIA Editorial. Patricia Flatley Brennan
Implementing Clinical Guidelines: How Can Informatics Help? Leslie Duff and Anne Casey
Patient Information Needs. Birgitta Engström
The Challenge of Meeting Patients Needs with National Nursing Informatics Agenda. Carole Gassert
Development of Guidelines: Contribution of Patient’s Preferences. Nancy Bergstrom
On-line Practice Guidelines: Issues, Obstacles and Future Prospects. Rita Zielstorff
Patient’s Guidelines: Availability and Use of the Internet to Access Information. Kathleen McCormick
Infrastructure for Reaching Disadvantaged Consumers: Telecommunications in Rural and Remote Nursing in Australia. Evelyn J.S. Hovenga, Joe Hovel, Jeanette Klotz and Patricia Robins
Information Needs of Clients and Providers: Clarity & Confusion in Newly Released HIV Clinical Practice Guidelines Regarding Triple Combination Therapy. William L. Holzemer
Improving Health Care by Understanding Patient Preferences: The Role of Computer Technology. Patricia Flatley Brennan and Indiana Strombom
The Use of Multimedia in the Informed Consent Process. Holly B. Jimison, Paul P. Sher and Yvonne LeVernois
Integrating Patient Preferences in Nurses’ Care Decisions: Clinical Research and Its Implications
Conference Reports

Swedish Symposium on Nursing Diagnoses
*Margareta Ehnfors, Leader of the Swedish Nursing Terminology Project, Swedish Nurses’ Association*

In autumn 1998 a collaboration of the National Nurse Researchers, the Swedish Work Group on Nursing Diagnosis and Interventions and the Swedish Nurses’ Association organized a symposium on the theme “Nursing Diagnosis - the basis for good nursing care?”. The two opposing marks after the label can be seen as significant for the situation just now regarding nursing diagnosis in Sweden: firm statements from some and questions or confusion from others are existing side by side among nurses. The symposium had well-known speakers both from some of the nearby countries, from the US and from Sweden.

Lynda Carpenito from USA emphasized that the medical diagnosis does not give the basis for nursing care. The nurse meets the patient 24 hours a day and the nursing diagnosis, when elaborating on the patient’s individual situation, helps to direct the nursing interventions. Besides the medical and the nursing diagnosis there are also areas where the professionals around the patient need to collaborate. She stressed that nurses need standardized terms for nursing diagnoses to be able to work in a professional way.

Susan J Grobe focused on the profiles of nursing interventions in different phases of a patient’s sickness period. The nursing interventions are the evidence of professional nursing. She also described the close similarities of the categories in the Nursing Intervention Lexicon and Taxonomy (NILT) developed by professor Grobe and collaborates in Texas and the keywords for nursing interventions in the Swedish model for nursing documentation, the VIPS model, despite the different developing strategies used.

Asta Thoroddsen from Iceland shared positive experiences from the use in practice of standardized nursing care plans developed by the nurses.

Cornelia Ruland from Norway described results from her PhD thesis, the good effects on nursing care planning and the patients functioning when nurses had knowledge of the patient’s preferences. Randi Mortensen from Denmark described the current situation of the International Classification for Nursing Practice project. Both the Swedish national efforts to build a common term data base for health care and local work was presented. A main conclusion from the symposium was that we need both nursing research and clinical experience as the basis for nursing development.

2nd International Symposium on Nursing Diagnosis
*Assumpta Rigol, Asociacion Espanola de Nomenclatura Taxonomia y Diagnosticos de Enfermeria (AENTDE), Spain*

The Second International Symposium on Nursing Diagnosis was held in Valladolid in May 1998 for the purpose of analysing and discussing Nursing Diagnosis (ND) as the driving force in the development of Nursing as a profession. The symposium was organized jointly between Asociacion Espanola de Nomenclatura Taxonomia y Diagnosticos de Enfermeria (AENTDE) and Asociacion de Enfermeria de Castilla y Leon.

Before the official opening, two workshop were held:
- ‘Research on Nursing Development’ coordinated by Amy Coenen Phd, RNCS (Technical Advisor for the ICNP), Mercedes Ugalde (President of AENTDE) and Rafael del Pino (Member of the Board of AENTDE)
- ‘Nursing Diagnosis in Pre and Post Nursing Training’ coordinated by Adolf Guirao and Enrique Pacheco (Members of the Board of AENTDE).

After the opening address, Amy Coenen presented a review of the work that has taken place in the ICNP since the publication of the alpha version in 1996. She explained the characteristics of the ICNPproject and that the aim is the completion of the beta version.

Ms Coenan also of the difficulties which can
The state of the art in research on cyber- and telemedicine, as well as applications aiming at securing the patient’s own control in the care situation, were challenging parts of the more than 500 presentations given at the 9th World Congress on Medical Informatics in Seoul, Korea. Of great interest were the possibilities to discuss recent research findings and development and to be inspired by visions for the future use of information technology in the health care sector.

Ms Warren went on to discuss NANDA’s Diagnostic Model viz: how a Nursing Diagnosis is developed; the process of classification; the necessary steps to be taken for the approval of a new ND. She also described the organizational structure of NANDA and its relationships with other Nursing Associations. She also mentioned the problems of cultural adaptation and translation into other languages when trying to apply NANDA’s Taxonomy in other countries.

M. Pax Mompart (Senior Lecturer at the School of Nursing and Physiotherapy, University of Castilla La Mancha) presented her paper entitled ‘Nursing Diagnosis, Interventions and Outcomes to Improve the Quality of Care to the Service User’. In this she talked about the advantages for nurses using ND in their clinical practice as well as the improvement in care delivered to the client. She outlined strategies for facilitating the wider use of ND.

The last speaker at the symposium, Julia Lopez (Senior Lecturer at the School of Nursing, University of Barcelona, and Treasurer of AENTDE) in her paper entitled ‘Proposals for Professional Development’, spoke of the current situation of Nursing in Spain with regard to the status of the profession. At the symposium there were two Panels discussing the following issues: ‘Nursing Diagnosis as Working Instrument in Hospital Care’ and ‘Nursing Diagnosis as a Working Instrument in Community Care’ moderated by nurses from all over Spain.

Thirty-two papers and thirteen posters were presented at the symposium detailing the work and research in Nursing Diagnosis in the fields of nursing training, primary care, hospital care and domiciliary care.

At the General Assembly of members of AENTDE, which took place during the symposium, the Permanent Committee was elected, and the Statutes of the Association were amended. It was also agreed that a prize be given to the best paper. A proposal was put forward for a formal collaboration between NANDA and AENTDE.
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seminars with presentations and discussions of the findings from testing. Among these the Swedish work on the ICNP was presented.

Within IMIA there is a Special Interest Group for Nursing Informatics (SIGNI). This group has subgroups working on e.g. the development of standards, and, from 1997, on evidence based clinical guidelines. During the conference the SIGNI met, and among other things, a working group of experts was established in the area of nursing knowledge representation. This include for instance the development of classifications, terms and concepts in nursing. The Registered Nurse Ulla Gerdin from Sweden was elected as new cashier in IMIA.

Virtual patient record
The electronic patient record had a lot of space in the conference programme. In the future there will probably be no patient record in one place until you - probably via a web page - assembles its separate parts from different care givers.

The development of terminology
Presenters pointed to the development and standardization of specific terms as a basic requisite for safe communication through the patient record. Only if each profession develops its own “language” a common term-data base and classifications can be developed, in order to assure the patients the best care. The work on terms and concepts must be done in multiprofessional co-operation - isolated efforts will have no success. Other foci of the presentations were on how we can assure the patient’s participation, how different decision support systems can be designed and used, and how support systems for nursing practice can function, in for instance the development of individual nursing care plans.

Evidence-based standards
Great efforts are used in order to develop knowledge for use in nursing practice and to develop decision support that can be updated in path with the development of new knowledge. Without computers the pessimistic guess is that it takes about 20 years until new knowledge really reach and come to use in the practical arena. The growth and speed of knowledge today makes this an impossible mission without computer support.

Interaction man - machine
Many presentations concerned the design and theoretical models of information availability and the interaction man- machine. Other areas that got attention were education, evaluation, security, integrity, ethical aspects etc. The need for nurses without any long tradition of computer literacy was discussed.

One conclusion at the conference was: The future will show health care professionals and IT working not only “hand in hand” but “modem to modem”!

Full papers from the entire conference is documented in two proceeding volumes from IOS press. The next Medinfo conference will be held in Edinburgh. Next Nursing Informatics conferences will be held in Auckland, New Zealand year 2000 and in Rio de Janeiro, Brazil year 2003.

For help in putting these memories together, thanks to Gerthrud Ostlinder at the Swedish Nurses Association.

Margareta Ehnfors, RN PhD
Swedish representative in SIGNI
Associate professor at Örebro University, Sweden,
Leader of the Swedish Nursing Terminology Project, Swedish Nurses’ Association.

Please encourage your colleagues to join ACENDIO

THE NETWORK NEEDS TO REACH
ALL NURSES INTERESTED IN TERMINOLOGY AND CLASSIFICATION IN EUROPE AND BEYOND
A letter from Romania

Iona Moisil

As maybe you know, I am one of the vice-presidents of the Romanian medical Informatics Society (member of IMIA and EFMI) and co-ordinator of the Nursing Informatics Special Interest Group of RMIS. Moreover starting with the first of July 1998 I am project manager, on behalf of the Centre for Health Computing, Statistics and Medical Documentation (CCSSDM) of the Romanian Ministry of Health, for the CCSSDM contract with TELENURSE-ID European telematics project. The project is coordinated by Randi Mortensen from the Danish Institute for Health and Nursing Research. In the frame of this project CCSSDM is also the leader of the working package WP02 ‘Promoting Consensus about the use of ICNP in central and Eastern European Countries’ and works closely with PRIMCARE-WHO Collaborating Centre for PMC Nursing in Slovenia (also partner of TELENURSE-ID).

Our intention is to establish a network of nurses interested in nursing informatics and nursing language. As sponsored partners of the former TELENURSE project we have translated in Romanian the alpha version of ICNP and we have developed an Internet tool for evaluation of the Romanian version of ICNP. In order to prepare nurses for the emerging beta version of ICNP we will distribute the alpha version for exercise.

In 1999 the National Health Management Information System will be operational and at least all head nurses from district hospitals and health authorities will have Internet access and then will be able to use the tool we have post-basic Training Centre for Nurses of the Ministry of Health, we have started a program for educating nurses in IT and nursing informatics. We hope to have also the support of the Romanian Nursing Association.

All this long introduction was aimed in fact to demonstrate you why we are so interested in the work developed by ACENDIO. On behalf of the Nursing Informatics Special Interset Group (NISIG) of the Romanian Medical Informatics Society I am asking the Chair of the publication Committee of ACENDIO-Newsletter the permission to translate in Romanian the Newsletter and to publish it in NISIG Newsletter. The first number of our newsletter will appear in October 1998 and if permission guaranteed, it will contain also the translation of no. 4 August 1998 of your newsletter.

Looking forward to hearing from you,

Sincerely yours,

Dr. Ioana Moisil
39, C. Kiritescu St.
RO-73106 Bucuresti, Romania
Tel: 40-1-3205605 (home)
Tel/fax: 40-1-3112998 (office)
Imoisil@sunu.rnc.ro

Note from the ACENDIO: She got permission!

Germany, Austria, and Switzerland

Hanneke van Maanen

During a conference in Freiburg in March 1998 we had a very constructive interchange about the German translation of the ICNP and its concept analysis by the University of Bremen, Department of Nursing Sciences. The meeting was attended by about 120 project leaders and nurses with interest in the development of nursing taxonomies. There was a representation from Austria which was much appreciated whereas this country has not been able to participate in the ICNP development thus far. The Austrian representatives promised to latch on to the German and Swiss activities.

The first day of the conference focused on the professional side of the nursing taxonomy, the second day included also some project activities on part of the users forum and the EDP representatives. The discussion was very thought-provoking whereas it centered around patient’s need to be named (labeled), nurses’ responsibilities in providing all this knowledge into one electronic data system.

One of the representatives told me that in her
entire career she had not witnessed such a powerful professional discussion. The next conference is planned for March 1999. The conference proceedings have been published. In October the National Nurses Association of Austria organized its first congress on Pflegediagnosen.

With regard to the continuation of our coordinating role at the University of Bremen, Department of Nursing Studies, there are at present no resources available to pursue this project.

However, from a point of view of accomplished collaboration it is important to us to continue our support for all who are involved in the development of a nursing taxonomy. We are exploring acceptable alternatives.

Prof. Dr. Hanneke van Maanen
University of Bremen
Germany

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**NANDA NURSING DIAGNOSES: DEFINITIONS & CLASSIFICATION 1999-2000**

In the preface of the new edition of Nursing Diagnoses: Definitions and Classification, 1999-2000 (ISBN: 0-9637042-5-7) Dorothy Jones, president of NANDA, states the following:

*The interest in language development and information systems development has grown internationally. For nurses, the language of nursing diagnosis is a way to represent the patient experience. It is a powerful vehicle that requires critical, analytic, creative and accurate thinking to adequately communicate to others the phenomena of concern for the discipline. Nursing diagnosis is vehicle that will enable professional nursing to move forward in this arena.*

The new edition of Nursing Diagnoses: Definitions and Classification, 1999-2000 contains many features included in previous editions. In addition, it offers new information about the development and classification of nursing diagnoses.

There are 21 new diagnoses included in this classification. These diagnoses reflect the diversity of nursing across populations and settings. They have been classified, staged and incorporated into the existing taxonomy. There are also 37 revised diagnoses. The revisions bring clarity to the existing diagnoses, definitions, defining characteristics and related factors.

At the business meeting of the 13th NANDA conference, the taxonomy committee presented a draft of a new taxonomy structure to conference participants for consideration and comment. The feedback was very positive. The committee is seeking world-wide review of the proposed new taxonomy, which, along with definitions, has been included in this edition.

We ask you to send your feedback to:

NANDA:
1211 Locust street,
Philadelphia, PA 19107, USA.
Fax: ++1 215 545 8107
E-mail NANDA@nursecominc.com.

It is anticipated that the new taxonomy will be formally presented to the membership at the 14th NANDA conference in Orlando in 2000 for adoption as the new Taxonomy II.
Fact Sheet: Center for Nursing Classification

What is it that nurses do? Do the actions of nurses have an impact on the results that are achieved for patients? How can nurses best contribute to the total group caring for the patient? The Center for Nursing Classification at The University of Iowa is helping to answer these questions through the development of two standardized languages which can be used to record and study nursing care.

The Center was established by the University of Iowa Board of Regents in 1995 to facilitate the ongoing research of the Nursing Interventions Classification (NIC) and the Nursing Outcomes Classification (NOC). Such classification research is crucial to the documentation and study of nursing care and to the articulation of nursing care with that of other health care providers. NIC systematically categorizes, standardizes, and describes everything nurses do for patients. These treatments called interventions include everything from suctioning so a person can breathe, to preventing falls, to teaching safe sex.

The second edition of NIC, published in 1996, contains a standardized list of 433 interventions, each with a definition, a set of activities that a nurses performs to carry out the intervention, and a short list of background readings. Both direct and indirect care interventions are included. The interventions are coded and organized in a three-level taxonomic structure that makes it easier to select an intervention and use the classification on a computer. Examples of interventions are Acid–Base Management, Anxiety Reduction, Shock Management, and Exercise Promotion.

NOC systematically names, standardizes, and provides tests used to measure the results of nursing the patients (outcomes). Outcomes include everything from patient comfort and well being, to change in physiological status, to prevention of bedsores. The classification, published in 1997, contains 190 outcomes, each with a label, definition, and a set of indicators and measures to determine achievement of the outcomes. The outcomes are coded and organized in a four level taxonomic structure. Examples of outcomes include: Ambulation, Walking, Caregiver Emotional Support, Mobility Level, and Cognitive Orientation.

The Center staff maintain a web page (http://www.nursing.uiowa.edu/cnc), listserv with approximately 300 individuals from all over the world, and a newsletter (The NIC/NOC Letter) currently sponsored by Mosby Year Book and produced 3 times a year (February, June, and October). Several products related to the ongoing research and implementation of NIC and NOC are also sold and mailed out by Center staff.

The work of the enter is unique; the Classifications have been produced in Iowa but are used all over the US and in many other countries. With the advent of the computerized patient record kept on each patient it is urgent that we have the means to study the contribution of nurses who spend the most time with patients. The two classifications houses in the Center provide the important foundation that makes it possible to build the content of nursing and describe it to the public.

For further information about NIC or NOC, contact:

Center for Nursing Classification
305 Nursing Building
The University of Iowa
Iowa City, IA 52242-1121

Tel/fax: ++ 1 319 335 7051
Email: classification-center@uiowa.edu
WWW: http://www.nursing.uiowa.edu/cnc
Evaluation Methods:
A discussion
Anne Casey, Royal College of Nursing, UK

As more standardized vocabularies become available for use in healthcare, there needs to be more discussion about methods for evaluation. During development of a new vocabulary it is appropriate that there is a focus on evaluating content and structure. My view, however, is that from the outset evaluation should not only address the developer perspective but also user perspectives.

A good overview of current thinking is to be found in the recent paper by Sue Henry and colleagues (Henry et al, 1998) which includes the characteristics required of a vocabulary for implementation in computer systems, as identified by the US Computer-based Patient Record Institute (CPRI). Henry and Mead’s earlier paper (1997) gives an overview of published evaluation criteria, and studies related to coding and classification systems in nursing. They list the characteristics required if a vocabulary is to support clinical nursing practice under the following headings:

- domain completeness
- conceptual clarity and coherence
- data structures and relationships among terms
- clinical concept capture (including expressiveness)
- utility and maintainability (Henry & Mead, 1997).

Within this review only one formal evaluation study of utility is cited. Although there are many reports in the literature of the use of different vocabularies in various settings for a range of purposes, none of these reports take the form of rigorous and systematic evaluations. In Europe the TELENURSE project (Mortenson, 1997) has tested practical applications of the ICNP and hopefully there will be published soon the results of the evaluations of these practical tests. ICN suggested using the SESAME criteria to evaluate the alpha version of ICNP (ICN, 1997). These criteria are: the classification’s purpose, content, structure, nomenclature and whether it has support from the profession. International ‘field trials’ of the beta draft ICDH-2 (International Classification of Impairments, Activities and Participation) are presently underway and reviewers are providing feedback on issues such as:

- coverage and level of detail
- nomenclature
- clarity of concept & definition
- cultural sensitivity
- concept location and other structural issues such as numbering of items
- interaction between concepts
- potential uses of the classification (WHO, 1997).

It is the uses of a vocabulary in practice which I believe should be the main focus of evaluations to ensure that the language tools used by the nursing profession are fit for the purposes for which they wish to use them.

There are 2 perspectives on ‘fitness for purpose’ evaluations in this context - the developer perspective and the user perspective. Evaluations from the developer perspective answer questions like: Does the vocabulary do what it was designed for? Whether the question is answered by the developers or by independent evaluators, it can only be answered if there is a very clear statement of the purpose of the vocabulary. Using ICNP as an example, some of the original purposes are too broad to be used in an evaluation study: whether the ICNP succeeds in its main purpose ‘to describe nursing practice’ is very difficult to evaluate.

You can make an attempt on paper to test the fitness for purpose of a vocabulary but the only real test will be in the real world i.e. from the user perspective: Which is the right vocabulary for my needs? This is the question asked by the researcher, the clinical nurse, the manager or the informatics specialist who is choosing a tool for a particular purpose. This could be for anything from conducting a comparative audit of interventions for mood disorders, or setting up a computer system to support care pathways in intensive care, through to a national data collection of nursing workload for service planning.

Potential users also need answers to a range of
practical questions to help them decide whether the vocabulary is suitable for them to use. For example:

- Is it practical to use the vocabulary in my current (and planned) information context? Can it be used on paper or in our current computer system? Does implementation require an alteration in what we planned to do with our technology and if so, is the extra cost and effort justified?
- Does the vocabulary comply with relevant local or national standards?
- Is any training required so that the nurses understand how to use the vocabulary itself (in addition to using the computer system or other information tool which the vocabulary is supporting)
- What impact (if any) does implementation of the vocabulary (as distinct from the computer system or information tool) have on working practices and patient care? These may be positive impacts, such as better nursing assessment through using NANDA, or negative ones such as using highly formal language in records which might be shared with patients.

Ideally we require systematically obtained, reproducible evidence that a particular clinical vocabulary is safe and suitable for use in particular situations. Alongside this evidence we need a validated statement of the required implementation environment, compliance with standards and other practical considerations which give the potential user the kind of information they need to make an informed judgement about the tool they are considering using. We would not introduce a change in clinical practice with anything less: why are we considering using vocabularies that do not have evidence to support their safety and suitability for use in practice?

References


Mortenson R. (Editor) (1997) *ICNP in Europe: TELENURSE*. Amsterdam, IOS.


ICNP Challenges

*Anne Casey, UK*

At the First European TELENURSE conference in Athens in 1996, Norma Lang, one of the ICNP consultants, discussed the challenges that the ICNP posed for the nursing profession and ICN (Lang, 1997). She drew on work by McCormick and others who had previously published recommendations toward standard classification schemes for nursing language. It might be useful to list the challenges again to help determine how far we have come:

- Rules for ownership
- Responsibility for updates
- Determination of the format to add and delete content
- Critical need to increase the research and science base for language and linkages
- Assurances of resources to develop new content and maintain content
- Determination of use of proprietary content
- Determination of public access and confidentiality
- Institution of educational strategies to teach about the ICNP

Reference

Introduction to the Dutch IVVP: 
Substance and recording of nursing process

Ms.J van Loon RN MNNs
IVVP co-operation alliance
Breda, The Netherlands

IVVP is the Dutch abbreviation of the words: ‘substance and recording of the nursing process’. It is developed at the Cross Association of the city of Breda (the Netherlands) and disseminated to five other organisations for community home-health care. Being a provider of care, and not a research institute, there was no intention to develop a new nursing theory. Nevertheless it was done in a way.

In the seventies topics as nursing theories, professionalization and nursing process emerged. In the early eighties, the cross organisation tried to implement theories and nursing process. In doing so, problems appeared regarding the following aspects:

- Most theories were developed for clinical settings and there was no experience in community home health care.
- Every nursing school at that time adapted their own theory and nurses were not speaking the same nursing language.

In 1983 a steering group for the IVVP started. The aim was to create uniformity and hence strengthen the quality of care. In an inductive way IVVP developed a theoretical model, definitions of three central concepts in this model and a standard language. The model fits in the five phases of the nursing process. The letters of the abbreviation I, V, V and P will be discussed in the next section.

Substance (I from the IVVP)
The model consist of three central concepts covering the domain of (community home-health) care.

A. Fundamental life pattern
‘A physical, psychological or social human activity, that is essential for the promotion or maintenance of health’.

Because health is a combination of physical and social functions 13 fundamental life patterns are distinguished.

<table>
<thead>
<tr>
<th>Fundamental life patterns:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 activity and rest pattern</td>
</tr>
<tr>
<td>2 mobility pattern</td>
</tr>
<tr>
<td>3 eating and drinking pattern</td>
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<tr>
<td>4 elimination pattern</td>
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<tr>
<td>5 breathing pattern</td>
</tr>
<tr>
<td>6 personal hygiene pattern</td>
</tr>
<tr>
<td>7 perception pattern</td>
</tr>
<tr>
<td>8 sexuality pattern</td>
</tr>
<tr>
<td>9 affective pattern</td>
</tr>
<tr>
<td>10 cognitive pattern</td>
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<tr>
<td>11 coping pattern</td>
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<tr>
<td>12 communication pattern</td>
</tr>
<tr>
<td>13 social pattern</td>
</tr>
</tbody>
</table>

B. Environmental condition
‘A factor outside the human being that is essential for the promotion and maintenance of health’.

The second concept is environmental condition (including therapies and adjustments in the house). It influences health as well as fundamental life patterns do. Therefore it is included in the assessment instrument.

<table>
<thead>
<tr>
<th>Environmental conditions:</th>
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</thead>
<tbody>
<tr>
<td>1 family</td>
</tr>
<tr>
<td>2 dependant care</td>
</tr>
<tr>
<td>3 housing conditions</td>
</tr>
<tr>
<td>4 aids</td>
</tr>
<tr>
<td>5 therapies</td>
</tr>
</tbody>
</table>

C. Self care ability
‘That what makes the human being able to grow to his own individual health’.

Self care ability is the third concept. To assess the extent of this ability three questions can be asked:

- what is the client able to do?
- what does the client know?
- what does the client want?

Self care abilities:

<table>
<thead>
<tr>
<th>function</th>
<th>knowledge</th>
<th>motivation</th>
</tr>
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</table>

An example: The fundamental life patterns that have been developed, defined and divided into subcategories (levels):

Recording (V from the IVVP)
The IVVP developed a nursing record that
comprises the central concepts and phases of nursing process. An instruction and training have been developed to apply the system correctly.

**Nursing** (V from the IVVP)
The IVVP uses the definition of nursing of the Dutch national council for public health. The IVVP adopted and developed it as:

> ‘Professional nursing is recognising, analysing, advising and supporting on actual or potential outcomes of physical and/or mental processes of illness, disability and developmental disorders, and their treatment concerning fundamental activities of the life of the individual (according the IVP = life patterns of the individual). Nursing action includes influencing people so that human potentials are used for the maintenance and promotion of health’.

**Process** (P from the IVVP)
The system is based on five phases of the nursing process: assessment, diagnosis, plan (outcomes and interventions), delivering of care, evaluation.
The central concepts are used to construct the assessment list. The life patterns and environmental conditions are positioned vertical, the aspects of self care horizontal:

<table>
<thead>
<tr>
<th>Fundamental life pattern</th>
<th>N</th>
<th>F</th>
</tr>
</thead>
</table>

See Figure 1 for an example. The cross marks are specified on a blank form:

F1 activity: limited, easily tired
F2 walking: stairs, distances
F4 faeces: slow bowel movement
F5 breathing: increasing dyspnoea
F6 bathing: to exhausting
K8 sexuality: afraid of dyspnoea
F9 self esteem: feel worthless
F11 coping: problem solving
F13 relations: losing, changing contacts
K3 House: doesn’t know adjustments
K4 Aids: doesn’t know possibilities

These assessment data will help the nurse to state the nursing diagnosis. It is always hypothetical, if new information is gathered, the diagnosis has to be adjusted. The diagnosis could be formulated as follows:

P activity
E dyspnoea
S walking, bathing, dependency, lack of relations, decreased bowel movement, easily tired, avoids sexual contact.

**Advantages**
The nurses aren’t supposed to use the assessment instrument as an interview protocol. The list
is an aid to assess conditions in the domain of nursing. The advantages of the IVVP method, according to nurses who are using the system are:

- A structured and efficient way to determine existing problems
- More insight in actual and potential problems
- The influence of one pattern on the other can be apparent
- Improved communication because data can be put into words
- The client regains his central place in care

**Critique**

There weren’t only positive reactions. At the start a lot of time was needed to get used to this new method, and time is scarce in nursing. However, just like acquiring you driving license, the implementation of a new system takes time. But it was for us no reason not to invest the time we did.

If you would like more information about our system, please contact:
Ms. Jolande van Loon, RN,MNSc
Kruiswerk Gezinszorg Breda
Postbus 1971
4801 BZ Breda
The Netherlands
Phone: ++ 31 76 526555
Fax: ++ 31 76 520 2366

The impact of nursing interventions and outcomes should be ready apparent, but this not always the case. The revised HFA Strategy for the 21st Century identifies nurses as one of the key players within the healthcare system. It also addresses the need for measuring the quality of nursing in order to improve the care delivered and to increase its effectiveness (WHO, 1997a). Key players should be responsible and accountable. Nurses as a full participant of a restructured health care system need to demonstrate clinical and cost effectiveness.

**Health outcome-oriented management and quality of care**

The way to ensure quality used in the past has been to develop guidelines for the process and the structure. **Structure** refers to the organisational setting of care e.g., the economic conditions, the staff, the facilities. **Process** refers to the activity carried out e.g. interventions, how to do things right.

Donnabedian defines **Outcome** as: ‘what is achieved, an improvement usually in health but also in attitudes, knowledge, and behaviour conducive to future health’. Structure and process are important aspects of patient care, but the most important is a positive outcome for the patient and the community.

Until now attempts to link nursing interventions to patient outcomes prove to be difficult. US reviews on research concerning nursing outcomes have shown that one problem is that so many different outcomes have been identified. The interventions used to achieve certain outcomes are as varied as the outcomes. This fact makes comparative analysis very difficult (Hunt, 1998)

**Continuous Quality Development**

The quality of care model developed by WHO/Europe is known as continuous quality of care development (QCD). It is a dynamic process that identifies and uses the best health outcomes to improve health care. QCD is an ongoing process, based on ‘benchmarking’ and ‘feedback’. Quality indicators are developed to measure

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**WHO European Office Nursing and Midwifery Programme**

**Leading the Way in Quality Indicators**

*Ms Anne Ströbel*

*German Intern with the Nursing and Midwifery Programme*

The world Health Organization, Nursing and Midwifery Programme is currently developing a project for Quality Indicators for Nursing Outcomes in Patient Care. The aim of this article is to give you an idea of the background, the objectives, the difficulties and the progress of the Project. Nurses are the largest group of health professionals in Europe. They constitute up to 80% of the health care workforce.
the results of health care: what happens or does not happen after health care, what makes a difference. The indicators are part of a core quality dataset, which provides the tools / questionnaire for data collection. This approach allows for establishing a comparative database, retrieved from appropriate recording of patient care data and thus identifying ‘best practice’ through standardised benchmarks. QCD should not be mistaken for health research. While research systematically seeks new knowledge, WCD systematically reviews data to ensure the optimal use of new, validated knowledge. Sound scientific principles and methodology is necessary for both (WHO, 1997b).

**Project: Quality indicators for nursing outcomes in patient care**

To demonstrate that nursing care makes a difference in patient outcomes, we selected conditions and situations where there is already research evidence available, which demonstrates the impact of nursing interventions in patient care. The three selected areas are falls, pressure sores and incontinence.

The objectives of the project within the HFA context are to:

- Improve the quality of nursing care
- Assist the nursing profession in demonstrating effectiveness
- To build a body of knowledge for nursing
- To start a network for quality culture in Europe.

The Nursing and Midwifery unit, WHO, Regional Office for Europe has developed the first set of quality indicators for nursing outcomes in preventing falls. The challenge has been to develop indicators for a condition- outcome that is not supposed to happen. Once a fall has occurred it is obvious that the interventions undertaken have not been successful. However if no fall occurs, how would it be possible to demonstrate that this is due to effective nursing interventions?

The first step has been a thorough literature review on falls. Research used included studies describing risk factors, predicting falls, comparative studies falls and not fallen. From this review we retrieved risk factors for patients prone to falling, as well as nursing interventions which had been proven effective in preventing falls. The main problem has been to find a method for establishing a comparative database, which allows the identification of ‘best practice’.

Nursing outcomes and interventions are connected to the patient’s health status. For example collecting data related to falls at a psycho geriatric unit and obstetrical unit would probably show that patients in an obstetrical unit have fewer falls. Does this mean the post delivery unit is using ‘best practice’ in preventing falls? The big challenge nursing is facing is demonstrating outcomes is to use specific measurable terms. Comparing Units and their results without looking at the health status of the patient would not provide any valuable data.

To tackle this task we had to look for an instrument to assess the patient’s health status from a nursing perspective. The medical diagnosis provides only limited information for nursing care. For example, the medical diagnosis diabetes is relevant for nursing care, but what meaning has this condition for the prevention of falls? Conditions to be considered for nursing in respect to falls would be: Is this disease affecting the sensibility or eyesight of the patient?

Presupposition for the profession to use the benchmarking approach is to have a common language for nursing outcomes, the patient’s health status and interventions. The instrument we used to perform this task is the ICNP (ICN, 1997) and nursing Outcomes Classification by Johnson and Maas (1997).

All the terms used in the questionnaire are defined, to make sure that we can derive comparative data. The questionnaire, NURCARE Basic Information Sheet (BIS), developed to collect the data for the project, comprises two parts:

1. Centre/Unit Sheet - this has to be filled in once during the time monitored and will allow us to learn about the structure, tools and nursing interventions used in this Unit.
2. Case Sheet with Nursing Diagnosis - for every patient 70+ years.

The sheet is for the basic patient data, individual interventions for this patient, to learn about the health status of the patient (Nursing Diagnosis). It also has a section,
which has to be completed if a patient had experienced a fall.

The development of this BIS has been a process involving experts from Sweden (Dr. Giggi Uden), Denmark (Gunnar Nielson, Randi Mortensen, Hanne Backe, Kirsten Obelt), the United Kingdom and WHO/EURO.

Through the combination of the data from the two sheets we will be able to identify ‘best practice’. For our project, ‘Quality indicators for nursing outcomes in preventing falls’, it will be the unit with the most patients at risk of falling and the fewest falls. Through the combination of the data we will also be able to identify the nursing interventions used to achieve best practice. Those will be in due course shared with all the participants of the study. The first set of indicators will be tested in a pilot study across Europe to ensure the validity and reliability as well as the feasibility of the questionnaire. The pilot study has now been completed and the results are being analysed.

The benchmarking process applied to nursing offers exciting perspectives. It is a systematic approach to practices and to measure them. If used in the right way, it will allow the profession to demonstrate effectiveness and through a step-by-step process achieving continuous quality improvement.

References

Johnson M, Maas M. (1997) *Nursing Outcomes Classification (NOC): Iowa outcomes project*. St. Louis, Missouri
WHO (1997b) Regional Office for Europe, QualiCare : Quality Management in Health Care in the Information Age, HVR QUALICARE IT.

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**Announcing.........**

**INFORMATICS / CLASSIFICATION SUMMER WORKSHOP**

Plans are underway to hold the first Iowa informatics/classification summer workshop June 15-19, 1999 in Iowa City, LA. The Institute will focus on the design, implementation, and evaluation of state-of-the-art nursing information systems that support evidenced-based professional nursing practice.

Emphasis will be placed on the actual use of these systems to enhance the delivery and management of patient care. The Institute will emphasize in-depth, current information on the classifications of NANDA, NIC, and NOC. Field visits to acute and long-term care implementation sites and dialogue with developers and users will be available. Other topics will examine data repositories, strategies for building knowledge from databases, tele-nursing innovations, legal mandates, ethical issues related to the computer-based patient record and nursing information systems, and image analysis innovations in nursing.

Social occasions interspersed throughout the 5-days will also facilitate networking. The number of participants will be limited to 50. Brochures will be available in February; for more information or for adding your name to the mailing list, call
**Recent Publications**


Forthcoming Events

19-20 March 1999
Second ACENDIO Conference
"Creating our language for the next Millenium"
& General Assembly of ACENDIO
The Ramada Hotel, Venice, Italy
Information: Danielle Rawstrom
c/o RCN, 20 Cavendish Square
London W1M 0AB, England (UK)
Phone: ++ 44 171 647 3576
Fax: ++ 44 171 647 3412
E-mail: danielle.rawstrom@rcn.org.uk

15-17 April 1999
The Second Conference on Nursing Diagnoses, Interventions, and Outcomes: Documenting Nursing Effectiveness
At the Radisson Hotel
New Orleans, Louisiana, USA
Information: NNN Conference Office
1211 Locust Street
Philadelphia, PA 19107, USA
Phone: ++ 1 215 545 1985
Fax: ++ 1 215 545 8107
E-Mail: conference.office@nursecominc.com

20 June - 24 June 1999
AIMDM'99: Joint European Conference on Artificial Intelligence in Medicine and Medical Decision Making.
In Aalborg, Denmark
Information: Steen Andreassen,
Department of Medical Informatics and Image Analysis, Aalborg University
Fredrik Bajers Vej 7D
DK-9000 Aalborg Øst,
Denmark
Phone: ++ 45 9 6358812
Fax: ++ 45 9 8154008

27 June - July 1999

ICN Centennial Conference: "Celebrating Nursing's Past - Claiming the Future"
London, England (UK)
Information: Brian French,
Conference Manager
RCN, 20 Cavendish Square
London W1M 0AB, England (UK)
Phone: ++ 44 171 647 3849
Fax: ++ 44 171 647 3412

22-26 August 1999
International Congress for Medical Informatics - MIE’99
Cankarjev dom
Ljubljana, Slovenia
Information:
E.Mail: mie99@mf.uni-lj.si
Website:
www://animus.mf.uni-lj.si/~mie99

28 April - 3 May 2000
7th International Congress on Nursing Informatics: "One Step beyond: the evolution of technology and nursing"
AOTEA Centre, Auckland, New Zealand
Information: Congress Secretariat/Convention Management
PO box 209, Auckland, New Zealand
Phone: ++ 64 9 529 4114
Fax: ++64 9 520 0718
E-mail: ninz@cmsl.co.nz
Website: http://www.2000plus.co.nz/Nursing.htm

12 May - 14 May
6th Quadrennial Congress European Association of Neuroscience Nurses
In Rome, Italy.
Information: ZIP Congressi
Viale Mazzini, 88
00197 Roma, Italy
Phone: ++39 6 372 5871
Fax: + +39 6 373 2716
E-mail: ziproma@tin.it

25 May - 27 May 2000
10th Biennial Conference of the
ACENDIO NEWSLETTER

Workgroup of European Nurse-Researchers. Challenges for Nurses in the 21st Century: Health Promotion, Prevention and Intervention
At the University of Iceland Conference and Cultural Centre and Hotel saga
Reykjavik, Iceland
Information:
The Icelandic Nurses’ Association
c/o Adalbjorg J. Finnbogadottir,

SECOND NANDA, NIC, NOC CONFERENCE
Documenting Nursing Effectiveness

The second Conference on Nursing diagnoses (NANDA), Interventions (NIC), and Outcomes (NOC) will be held April 15-17, 1999 at the Radisson Hotel, 1500 Canal street, New Orleans, LA.

The conference is being managed by Resource Management plus of Philadelphia with the cooperation of NANDA and the Center for Nursing classification. The planning committee consists of Joe braden, Gloria bulechek, Marion Johnson, Dorothy Jones, and Roy Simpson.

A recent call for abstracts resulted in more than 60 abstracts submitted which are now in the process of being reviewed. Brochures will be available in January. Presentations and posters are expected to focus on the following topics: use of standardized language in informatics; use of NANDA, NIC and NOC; impact of languages on practice; language development and classification; selecting a software vendor; working with physicians; building your database; international perspectives; and risk management.

For more information about the conference contact Resources Management Plus
Phone: ++ 1 215 545 1985
Fax: ++ 1 215 545 8107
Email: conference.office@nursecominc.com.

Conference hotel reservations:
Phone: ++ 1 504 522 4500
Special conference room rates:
$ 149 single and $ 164 double (ask for NANDA/NIC/NOC meeting)

Registration fees:
Early bird - before April 2 $ 345 and for one day registration $ 195
Regular - after April 2 $ 375 and for one day registration $ 210
At the ACENDIO general assembly on 19th March 1999 members will have the opportunity to debate ACENDIO’s role and activities as motions are put to the vote to make changes in the original constitution. There will be a proposal to allow country branches (proposed by UK members) as well as proposals for changes to the terms of office of the directors to ensure continuity.

What do you think the function of ACENDIO should be? At present it is a network but should it become involved in projects, development work and evaluation studies? As a member, your views are important - if you cannot attend the general Assembly yourself you can ask someone who is attending to use your vote for you: all you need to do is give them a letter saying that you have authorised them to vote on your behalf.

Apart from voting on constitutional issues there will be elections for the following positions:

- President
- Vice President
- Secretary
- Board Members (2)
- Standardisation Committee Member (1)
- Publication Committee Member (1)
- Conference Committee Member (1)

Nomination forms have been sent to all members and will also be available up until one hour before the meeting.

If you would like more information about the election process please contact the Secretariat at the Royal College of Nursing (address on the front page of this newsletter) or E-mail: anne.casey@rcn.org.uk

Present Board of Directors and Officers:

June Clark, UK (President)
Cecile Boisvert, France (Vice-president)
Anne Casey, UK (Secretary)
Nico Oud, Netherlands (Treasurer)
Margareta Ehnfors, Sweden
Hanneke van Maanen, Germany
Renzo Zanotti, Italy
Myriam Ovalle (PCN representative)

VOTING

Each member present at the General Assembly has one vote.

Organisational members have 10 votes - the representative of the organisation must register with the election officer at the start of the General Assembly.

Members who cannot be present may nominate another person (in writing) to vote on their behalf.

1997/99 membership is valid until April 1999. If you are unsure of your membership status please check at the ACENDIO desk when you register at the conference.

You can join ACENDIO and participate in the General Assembly by sending a completed registration form and payment to the Secretariat before the conference OR when you register at the conference.
What is ACENDIO?

The Association for common European Nursing Diagnoses, Interventions and Outcomes is a membership organisation established in 1995 to promote the development of nursing’s professional language and provide a network across Europe for nurses interested in the development of a common language to describe the practice of nursing.

What can ACENDIO offer?

ACENDIO supports the development of nursing’s professional language by providing:

- Conferences, publications and presentations to advance understanding and work in this area
- A network for nurses in the different European countries so that they can share knowledge about developments
- Resources such as reference lists and sample methodologies for developing and evaluating nursing vocabularies
- Interpretation of International Standards for terminologies and classifications
- Opportunities to participate in and influence development in nursing terminology and classification in Europe

MEMBERSHIP FEE
for 2 years (1999 - 2001)

Individual £40
Student £20
Institution £400

To join ACENDIO complete the form below and send it with your membership fee to ACENDIO c/o Anne Casey
Royal College of Nursing
20 Cavendish Square
London W1M 0AB, UK

NAME............................................
ADDRESS.......................................
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COUNTRY.......................................
TEL......................FAX...................
E-MAIL........................................

ENCLOSED CHEQUE FOR £.............
OR
VISA / ACCESS / MASTERCARD:
NUMBER........................................
AMOUNT........................................
CARD EXPIRY DATE.....................
SIGNATURE...................................
DATE.........................................