This is the last time I shall write the President’s introduction for our Newsletter. As you already know, after four years as President, my term of office comes to an end at the end of the General Assembly in Berlin in March.

It has been a very exciting time. When Randi Mortensen, the first President of ACENDIO, proposed in 1993 at the first European Conference on Nursing Diagnosis, that European nurses needed a “platform” to take forward the work of developing a terminology and classification system for describing nursing practice, none of us knew what the future would hold. That conference set up a steering group with a double brief: to plan another conference to be held in 1995, and to establish the formal membership organisation which has become ACENDIO. In 1995 the second conference was duly held, and ACENDIO was launched.

One of the first issues for the Steering Group was to define the structure and constitution for the new organisation – what kind of organisation should ACENDIO be?

Everyone was clear that it must be a democratic membership organisation in which all interested individuals could participate – but should it be based on individual membership, or should it be an organisation of organisations – in particular what should its relationship be to the National Nurses Associations? We wanted to work closely with the NNAs, but how? The Working Group of European Nurses Researchers (WENR) offered one model, but at that time it too was experiencing organisational problems.
Another problem was the exponential increase in the number of countries arising from the break-up of the former Soviet Union. Perhaps the biggest problem at the time however, was the lack of knowledge and experience of most NNAs in classification and standardised language; and the great imbalance between them; the expertise was vested in individuals who were not necessarily active in NNAs. After a great deal of discussion a compromise was reached: membership would include both individuals and organisations (it was hoped that NNA’s would join as Institutional Members), all Board members would be required to be “members of good standing” in their NNAs, and one place on the Board was specifically reserved for a representative of the European grouping of NNA’s – the PCN.

Myriam Ovalle, who has represented PCN on the ACENDIO Board from the beginning, has worked unceasingly to provide information and encourage collaboration, but only a few NNA’s have joined ACENDIO as Institutional members. Expertise in language and classification is still very unevenly spread. The aspiration of an office in Brussels which could act as a co-ordinating and administrative centre for all the pan-European specialist nursing organisations has yet to be realised. But the acceleration of developments in language and classification in many countries requires us to develop and change too, and at this year’s General Assembly the Board will propose that our membership structure, and in particular our relationship with NNAs should be reviewed.

From the beginning we were clear about our mission, but the early expression of our goals was too idealistic. Another early controversy was the relationship of ACENDIO to the International council of Nurses’ ICNP project. In the early 1990’s some of us naively hoped that the ICNP would be the single unified language for nursing and a specific commitment to supporting ICNP was included in the ACENDIO constitution. One of the members of the initial steering group, Professor George Evers of Belgium, argued against this position: time has proved him right, and ACENDIO’s constitution now has a more pluralistic approach.

During the past six years work in Europe in language and classification has expanded dramatically. ACENDIO members have been at the forefront of these developments and ACENDIO has provided the organisational framework to support these activities. Our reputation and influence as the source of specialist expertise in Europe on language and classification is growing. There is a huge amount of work to do, and still not enough people or money to do it. We need more members, more money, and stronger organisational links with governments, national and European institutions and NNAs. Healthy debate is the mark of a vibrant and dynamic organisation and I hope that ACENDIO will continue to develop and change in response to changing needs. The new President and Board will face many exciting challenges. But they will be building on the foundation of the vision and commitment of a great many people.

May I take this opportunity to express my thanks to all of them, and offer the new President and Board every good wish for the future.

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APOLOGY

Some Membership Renewal forms were sent to the wrong people: please write your own details in place of the wrong ones.

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JUNE CLARK

2
CEN PreStandard Approved

The technical committee of the European Standards organisation responsible for health informatics (CEN TC251) approved the revised final draft of ‘Health Informatics - System of Concepts to Support Nursing’ (NURSYS) as a PreStandard at its meeting in Brussels in December 2000. This work has involved nurses and terminology experts throughout Europe and represents a significant step towards standards for nursing and other healthcare terminologies.

As noted in the last ACENDIO newsletter, the PreStandard is not a terminology for use by nurses but a standard for those developing and implementing terminologies to promote interoperability between the many terminologies available. The agreement between European standards developers at CEN and international developers at ISO means that further work towards standards for nursing terminology will be conducted jointly. Testing of NURSYS will form part of the background to ISO nursing activity. Copies of the PreStandard can be downloaded from http://www.centc251.org/ and anyone can contribute to testing the Prestandard.

La Conférence des directeurs cantonaux des affaires sanitaires (CDS) soutient la réalisation de NURSING data

Sous la devise "un langage pour les soins" a été lancé, en 1998, le projet NURSING data. Il a pour but d'unifier et de standardiser les informations dans le domaine des soins infirmiers. Cela permettra aussi bien aux professionnels de la santé, aux décideurs et au public de se concerter sur le thème complexe des soins à l'intérieur de notre pays et au-delà de nos frontières. L'aptitude à communiquer est la condition première pour parvenir à résoudre en commun et de manière constructive les problèmes qui se posent actuellement dans le domaine de la santé, à commencer par la pénurie de personnel qualifié. La CDS en est consciente et soutient, par conséquent, le projet NURSINGdata avec un montant de 250'000 francs.

Un concept a été élaboré durant les années 1998 à 2000 sous la conduite de la CDS, de l'Office fédéral de la statistique (OFS), de l'Association suisse des infirmières et infirmiers (ASI) et de l'Association suisse des directrices et directeurs des services infirmiers (ASDSI). D'après ce concept, le projet NURSINGdata devrait être réalisé dans les cinq ans et coûter environ 1,2 million de francs. L'exécution du projet intervient en sept modules placés sous la responsabilité de l'Institut de santé et d'économie (ISE).

Il est prévu d'y associer dans une large mesure les spécialistes des professions soignantes ainsi que d'autres acteurs du domaine de la santé. S'agissant d'un projet de portée nationale, il requiert la collaboration de diverses organisations au niveau national, telles que les associations professionnelles, les employeurs, les fournisseurs de prestations et les assureurs. Cela implique une organisation de projet complexe. Les responsables n'en sont pas moins convaincus d'avoir trouvé une solution porteuse et ont sollicité le soutien de la Confédération et des cantons.

Le comité directeur de la CDS a donc décidé le 26.10.2000 de participer à raison de 250'000 francs au projet. Du côté de la Confédération, une participation de l'ordre de plusieurs centaines de milliers de francs est également assurée. Par la mise en œuvre de ces moyens, la Confédération et les
cantons espèrent donner une impulsion afin de faire participer les autres partenaires. L'un des initiateurs du projet, l'ASI, a déjà décidé de sa participation au financement. Il s'agit à présent de récolter les fonds résiduels afin de pouvoir débuter les travaux.

Pour tous renseignements:

Annamaria Müller Imboden, présidente de NURSINGdata, cheffe du Domaine Economie et information de la santé de la CDS, tél. 031 356 20 20
Anne Berthou, directrice du projet NURSING data, Institut de santé et d'économie Sàrl, tél. 021 314 73 95

Le rapport sur la conception peut être commandé à: Institut de santé et d'économie Rue du Bugnon 21 1005 Lausanne
Tél.: +41 21 314 74 00,
Fax: +41 21 314 74 04,
E-Mail: Nursing.Data@hospvd.ch

Translators’ workshop marks end of Telenurse ID project

Delegates from countries as far afield as Korea and Estonia attended the 5th Telenurse ID conference and translators workshop in Coimbra, Portugal in November 2000. It provided an excellent opportunity for those working with ICNP to share experiences and discuss issues. There were presentations of work to incorporate the International Classification for Nursing Practice (ICNP) in electronic patient records and to re-use ICNP data.

The TeleNurse ID project was a continuation of the TELENURSE project that promoted the use of ICNP in Europe. Its aim was to strengthen and enlarge the European consensus on the use of the ICNP as a standard computerised nursing language. Project activity included promoting and disseminating the

Nursing Diagnoses: Definitions and Classification, 2001-2002
(ISBN # 0-9637942-7-3)

Newly revised and expanded - a must for students, authors, instructors, clinicians and language developers!
This edition lists all 155 NANDA-approved diagnoses with their definitions, defining characteristics and related factors according to Taxonomy II.

4th edition of NANDA’s classic book contains:
- 155 NANDA-approved nursing diagnoses with definitions, defining characteristics, risk factors and/or related factors
- 7 new nursing diagnoses
- Taxonomy II
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- New information on nursing diagnoses development

For ordering information see NANDA's web site http://www.nanda.org/

Or write to NANDA at 1211 Locust Street
Philadelphia PA 19107, US
Email: nanda@rmpinc.com
classification in CEE countries, including translation of ICNP in Central and Eastern European languages and by carrying through demonstration phase the software tools that were designed and built to integrate nursing modules in the shared electronic patient record.

At the workshop there were reports on translation of ICNP and/or reviews of the translations were provided by the following countries:

- Austria   Italy
- Belgium   Latvia
- Bosnia    Lithuania
- Bulgaria  Netherlands
- Croatia   Poland
- Czech Republic  Portugal
- Denmark   Romania
- Estonia   Russia
- Finland   Switzerland
- France    Slovakia
- Germany   Slovenia
- Greece    Spain
- Hungary   Sweden
- Iceland   Turkey
- Ireland   United Kingdom

The following non-European countries also participated:

- Brazil    Korea
- Columbia  Thailand
- Japan     Taiwan

The meeting concluded with a proposal for continued work through a network of ICNP.

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**The 3rd Institute on Nursing Informatics & Classification**

This event will be held in Iowa City June 24-27, 2001, with a pre-conference for those who need an introduction to the nursing classifications NANDA, NIC and NOC on June 23rd. The Institute is intended for all those interested in designing, implementing and evaluating nursing information systems and those who wish to know more about standardized nursing language. Registration is limited to 50 participants.

Charles Mead, co-chair of HL7 Patient Care Technical Committee and Chief Technology Officer & Chief Scientist with the Simione Corporation in Atlanta, will be the keynote speaker.

This year’s program will again feature updates on the work of the classification research teams at Iowa: 1) the Nursing Diagnosis Extension Classification (NDEC) -- further developing the North American Nursing Diagnosis Association (NANDA) Diagnoses & Classification; 2) the Nursing Interventions Classification (NIC) ; and 3) the Nursing Outcomes Classification (NOC). Participants will have a chance to present their own plans and ideas in an informal setting for feedback by the group. A special session on working with information systems professionals and other tips for building useful nursing information systems will extend the implementation focus.

Genesis Medical Center in Davenport, Iowa and University of Iowa Hospitals & Clinics, Iowa City, Iowa will host site visits to demonstrate clinical information systems that has successfully incorporated NANDA, NIC and NOC.

If you would like more information, contact Jen Clougherty by e-mail: jennifer-clougherty@uiowa.edu.

A brochure is available for printing/downloading at: [http://www.nursing.uiowa.edu/orgsyscom/cont_ed.htm](http://www.nursing.uiowa.edu/orgsyscom/cont_ed.htm)
Approximately half of the papers were presented by nurses, and covered subjects as diverse as the use of information technology in staff scheduling, absenteeism and theatre management systems, as well as one paper on identifying nursing diagnoses.

ACENDIO was represented at the conference by Irish Board member Fintan Sheerin, who manned an ACENDIO poster presentation. Attendees from both nursing and medical fields expressed much interest in the work of our association.

A local nursing informatics initiative is in the early stages of development at the Mater Misericordiae Hospital, Dublin (http://www.mater.ie), under the leadership of Rosaleen Murname (rmurname@mater.ie) and the informatics nurses in the computer centre. Initial work is focused on patient dependency measurement. A seminar was provided by

European Summer School of Nursing Informatics 2001

will be held at Swansea, UK from 18th to 25th August 2001.

Provisional Tracks for 2001...

1. Effective education on the iNet
2. Quality into Practice
3. Implementing Systems
4. Language and Terminology

We are also planning "masterclass plenaries" by the principle tutors.
Invited faculty includes (to be confirmed) - Diane Skiba (USA), Nick Hardiker (UK), Judy Murphy (USA), Mary Chambers (UK), Aart Aliens (Netherlands) and others

The fee will be 475 UK pounds for registration before the end of June 2001. This fee is inclusive of all tuition, accommodation, meals and main social events.

Further details are available via our website www.come.to/essoni
We have continued to develop nursing diagnosis on the unit. Recent documentation audits have highlighted that only one of these five original diagnoses can be identified – altered family processes. This has raised the following questions:

- are patients receiving the necessary psychological and psychosocial care if this is not documented?
- has the use of nursing diagnosis reduced patient-centred care?

While nursing documentation is seen as a crucial part of the caring process by professional bodies such as the UKCC (1988), there is considerable amount of literature that highlights the disparity that exists between what is documented and what actually happens (Ford and Walshe, 1994; Barnes 1990).

These questions will be explored using an action research approach. The presentation will outline the preliminary findings and provide an overview of the first part of the study. These findings will help identify where we are now in relation to nursing diagnosis and its relationship with patient-centred nursing.

References

Barnes, B. (1990) When will we get it right? Nursing Times 86 (4): 64


ACENDIO Conference

Several abstracts from the forthcoming ACENDIO Conference are presented here to give a flavour of the range and scope of papers and posters. The Publication Committee hopes that extra copies of the proceedings will be available for sale after the conference - the next newsletter will inform you of availability.

DOES NURSING DIAGNOSIS FACILITATE A PATIENT–CENTRED APPROACH TO NURSING CARE WITHIN A GENERAL INTENSIVE CARE UNIT?

Deirdre Miller
Chelsea & Westminster Hospital
United Kingdom

The Chelsea and Westminster Hospital Intensive care unit is a six-bedded general unit with a high dependency unit of two beds. The unit has a well-developed philosophy, common values and beliefs held by the nursing team about the purpose and nature of critical care nursing. As its organisational approach to care, the unit practices primary nursing within a non-hierarchical management style.

Nursing diagnosis is an operational nursing concept, which incorporates the process of data analysis concerning information about the patient and their family gathered through assessment, and the pulling together of data to make a diagnosis. A nursing diagnosis is both a structure and a process (Carpenito, 1989). Nursing diagnosis was introduced in 1995 through piloting five specific diagnoses within two primary nursing teams: anticipatory grieving; sleep pattern disturbance; altered family processes; powerless and impaired verbal communication. These were chosen as it was felt they represented areas where nurses were autonomous in their role and were relevant to our patient population.
APPLICABILITY OF THE NURSING INTERVENTION CLASSIFICATION (NIC) AFTER TRANSLATION TO ANOTHER CULTURE AND LANGUAGE

Asta Thoroddsen
University of Iceland

Standardised nursing language is one of the critical elements for effective use of nursing information systems. The history of taxonomies in nursing is still young but for the past 25 years nursing languages have been developed. Translation of nursing languages from English to another language can create difficulties as many concepts and meanings do not translate well. Language developed in one culture cannot automatically be used in another culture. A survey was performed to test the applicability of the Nursing Intervention Classification (NIC) for use in a nursing information system for documenting nursing in an electronic health care record in Iceland.

NIC includes 433 interventions, each of which is composed of a label, a definition, and a set of activities that a nurse does to carry out the intervention. The purpose of the survey was to ask Icelandic nurses if they recognised the interventions within NIC and to use the results for refinement of a translation of the interventions from English to Icelandic.

Methodology: Nurses enrolled in a course in a RN/BS programme on nursing classifications (N=150) were asked to answer a questionnaire which included all the labels and definitions of the interventions in NIC. All the nurses replied.

Results: Sixty percent of the nurses were working or had their background from hospitals, and 10 % from community health. The biggest nursing specialties represented by the sample were general medical nursing (12%), surgical (10%), geriatric nursing, obstetric and gynecology nursing (8%) each.

Nursing interventions can be grouped into direct and indirect interventions. Of 30 most frequently used interventions used by nurses in this sample nine were indirect. The indirect interventions vary between specialties as well as direct interventions. Nursing specialties are well reflected by NIC.

The translators of NIC tried to work according to general principles and guidelines as put forward by the principal investigators of NIC but were faced with many problems. Many were due to difference in grammatical structure of English and Icelandic. Noun phrases (statements) are not common in Icelandic, instead verbs and adjectives are used. Management is a frequently used word in NIC labels but does not translate well. After the survey 70 labels (16 %) were changed.

Conclusions: The results indicated that nurses recognised the interventions in NIC. Nursed spend a lot of time doing work that is not direct nursing care, i.e. care that is done away from the patient. These interventions are, however, not suitable for the computerised record. Only two interventions of the 433 were not used or recognised by the nurses, Medication Administration: Intraosseous and Amnioinfusion.

So far it seems a feasible choice for nurses in Iceland to use NIC for daily documentation. The results have been used for revising the Icelandic translation and in prioritising ongoing translation of the activities. NIC is now used by nurses to document nursing care electronically.
INTERNATIONAL CLASSIFICATION FOR NURSING PRACTICE (ICNP®) PROGRAMME: RESEARCH AND DEVELOPMENT ACTIVITIES

Amy Coenen
Director, ICNP® Programme
USA

The International Council of Nurses (ICN) formally established the International Classification for Nursing Practice (ICNP®) Programme in January 2000. Three activity clusters were identified in the ICNP® Programme Plan. The three activity clusters are (a) communication and marketing, (b) research and development, and (c) programme management. This presentation will provide an update on the ICNP® Programme, focusing on the research and development activities.

The first priority of the ICNP® Programme research and development activities is the establishment a formal ICNP® evaluation plan. The evaluation plan will aim to provide a systematic review of the ICNP® Beta Version and recommendations for further refinement. During 2000, a review process for the ICNP® was piloted. Clinical experts provided review of recommendations, submitted to ICN, for adding new terms and for revising existing terms and definitions. ICN has received many recommendations from country projects and individual researchers that were submitted to the pilot review process.

Both clinical and informatics experts are needed for the review and evaluation process. A bank of informatics experts is being developed by ICN. Informatics experts will be requested to provide consultation and recommendation to ICN on select issues related to the evaluation and revision of the ICNP®.

A newly created ICNP® Evaluation Committee has been established to serve as an advisory committee, with an emphasis on overseeing the evaluation plan. Terms of reference for the committee include:

- Assist ICN in establishing and overseeing the ICNP® Evaluation Program, including processes for ongoing development and maintenance.
- Provide formal and periodic review of the ICNP®.
- Provide consultation and recommendations for the purpose of revising the ICNP® using reviews, feedback, critique, and research on the Beta Version.

A summary of the first meeting of the ICNP® Evaluation Committee, scheduled for December 2000, will be presented.

Finally, ICN is creating a database to include all the ICNP® research and evaluation projects underway around the world. The database will include information to direct evaluation, as well as facilitate networking and collaboration among researchers. Plans include having the database accessible via the ICN website. Examples of current ICNP® research and evaluation projects will be presented.

The ICNP® Programme processes must be broadly participatory and undertaken in partnership with ICN member countries. Participation is required by scholars and clinicians in the global nursing community to meet the goals of having a clinically relevant, valid and useful tool, which is sensitive to cultural variation and local circumstance. The use of partnerships and projects within the ICNP® Programme, is intended to encourage and support mechanisms for participation of many. These processes are needed to ensure that the best available scientific evidence informs the continual refinement of the ICNP®.
A FRAMEWORK IN PRIMARY HEALTH CARE TO FACILITATE DOCUMENTATION OF NURSING DIAGNOSIS FOR PATIENT WITH LEG ULCER PROBLEMS IN THE PATIENT RECORD.

Inger Rising, Karin Wikell & Inger Johansson
Sweden

Background
Nursing records with well documented assessments, diagnoses, interventions and outcomes are prerequisites for effective nursing care and quality assurance. The Swedish Medical Record Act of 1986 obliged all registered medical staff to document patient care according to the care process: assessments, diagnoses and interventions.

A Swedish model for nursing documentation, the VIPS-model, has been introduced by health-care researchers (1). The VIPS-model which is based on the nursing process model, aims to facilitate a nursing record system(2). The VIPS-model has been very well received by Swedish nurses and has also attracted international attention(2). In order to assist the district nurses documentation’s work to encompass the total field, the VIPS model has been extended with further essential areas of district nursing, called the Primärvårds-VIPS model (from Primary Health Care-VIPS)(4). The use of the PrimärvårdsVIPS-model had improve district nurses documentation work in the patient record. Nevertheless the district nurses had still difficulties to express and describe the nursing diagnosis.

Aim
The ultimate aim of the study is to introduce to Swedish district nurses a uniform documentation model for nursing diagnosis and nursing goals, according to the assessment area in the Primärvårds-VIPS-model.

Method
A study has been conducted by district nurses in working groups to explore accurate description of nursing diagnosis for patient with leg ulcer or wound on leg.

The first step of the study was to form a review over the research results in the field of leg ulcer oriented problems(3). The next step was to explore expressions of nursing diagnosis used in patient records documented by district nurses. The result that emerged from these two steps with descriptions for patient needs, problem and risk, has in the third step, been formed in groups according to the VIPS-model keywords for assessment.

Results
A following questionnaire has given the result that the use of these types of ready formulated descriptions based on results of research could improve districts nurses to not only formulate nursing diagnosis but also facilitate expression of making measurable goal for the treatment of the patient.

References
(3) Svensk författningssamling.SFS Lag om patientjournal ( Swedish Medical Record Act ) 1985:562:
USING ICIDH-2 IN NURSING: FIRST RESULTS FROM AN EVALUATION STUDY.

Gabriël Roodbol, M. Heinen, G. Holleman & Theo van Achterberg
The Netherlands

This paper addresses an evaluation of ICIDH-2 in nursing practice. The use of ICIDH-2 in nursing practice is currently studied at the University Medical Centre St. Radboud (UMC St Radboud, Nijmegen, The Netherlands). This study is part of a larger study at three academic hospitals. Within a period of two years, the overall project will look at the usefulness and applicability of ICIDH-2 in several areas of nursing practice.

Aims

The study at the UMC St Radboud is exploratory in nature and aims at:

1. Evaluating the possibilities of translating written nursing diagnostic statements to ICIDH-2 terminology.
2. Implementing and evaluating the use of an ICIDH-2 specific nursing assessment and diagnostic process.

Methods

The two aims refer to two different study phases. In the first phase of the study, 50 previously collected written diagnostic statements will be re-formulated, using ICIDH-2 terms. For each diagnosis, three independent raters will provide a translation. Furthermore, 30 diagnoses of patients currently admitted to three different hospital wards, are translated by two nurses who are familiar with the patients.

A major purpose of this first phase is an exploration of the compatibility of ICIDH and current nursing diagnoses. Ease of classifying, inter-rater agreement and completeness will be evaluated.

The second phase of the study is the implementation of an ICIDH-specific nursing assessment and a nursing diagnostic process. Four hospital wards will participate in this study phase. Assessment forms, with different versions for different hospital wards, will be developed for this purpose. The processes of implementation, as well as factors hindering or facilitating the implementation are monitored.

Nurses' knowledge and opinions will be assessed during and after the implementation phase. Furthermore, effects on the quality and quantity of assessment data and nursing diagnoses are evaluated. For this purpose, data on assessment and diagnoses at baseline are compared to data after an implementation period of six months.

Results

The study started out in August 2000. Therefore results cannot be mentioned in this abstract. The first results of phase one of the study will be available in March 2001. During the conference, results from this first phase will be presented.

Summary

The use of ICIDH-2 is studied at the UMC St Radboud, The Netherlands. The project focuses on translating nursing diagnoses from non-standardised language to ICIDH-2 terminology. Furthermore, the ICIDH-2 is implemented in the assessment and diagnostic process at four hospital wards. First results from the study will be presented at the conference.
Poster
LEITFADEN ZUR ANWENDUNG DESPFLEGEDIAGNOSEORIENTIER TEN ANAMNESEBOGENS (PDO AB)

Ursula Geissler
Austria

Im Rahmen von Fortbildung und Selbstschulung machen sich Pflegende vertraut mit den Inhalten des pdo AB, seiner Struktur, den Fragestellungen; setzen sich mit den Fragen auseinander, wozu die erhobenen Informationen dienen, was Pflegediagnosen und Klassifikationssysteme leisten, wie Pflegediagnosen richtig erstellt werden, welche Informationen Pflegediagnosen beinhalten und welche Pflegediagnosen an ihrer Station häufig vorkommen.

Nötige Fertigkeiten müssen entwickelt werden: Kommunikationsfähigkeit, Beobachtungsgabe, Hintergrundwissen zu physischen, psychischen, kulturellen und sozialen Pflegeproblemen, fundierte Kenntnisse zum Pflegeprozess und Objektivität.

Die Pflegeanamnese wird bei allen Patienten innerhalb eines definierten Zeitraumes erstellt. Sie dokumentiert den pflegerelevanten Aufnahmzustand des Patienten und dient dazu, den Patienten kennen zu lernen, seine Bedürfnisse, Probleme und Ressourcen zu erkennen und um nachfolgend Pflegeziele und Pflegemaßnahmen zu vereinbaren.

Die Pflegeanamnese wird mit dem Patienten oder seiner Bezugs-/Vertrauensperson oder aufgrund von Beobachtungen der Pflegenden erstellt.

Mit dem Patienten/der Bezugsperson wird Zeit und Ort für das Anamnesegespräch vereinbart und sie werden informiert wozu die erhobenen Daten dienen: Erhebung des Pflegebedarffes, der Ressourcen; um die Planung der Pflege zu optimieren und um anderen betreuenden Berufsgruppen Informationen zur Verfügung zu stellen. Wichtig ist die Information, dass der Patient entscheidet, ob er persönliche Fragen beantworten möchte!

Pflegende lernen Hilfen für die Fragestellungen kennen, verwenden das Akut- oder Leitsymptom zum Einstieg in das Anamnesegespräch und halten sich nicht zwanghaft an die vorgegebene Reihenfolge im pdo AB.

Nicht die Wertvorstellungen der Pflegenden sind maßgebend dafür, ob persönliche Bereiche angesprochen werden (z. B.: Tabuthema Sexualität), sondern der Patient entscheidet, ob er sich zu diesem Themenbereich äußert.

Bereiche des pdo AB, die für den Patienten nicht relevant oder bei einem Patienten nicht erhebbar sind, werden gekennzeichnet. Damit ist dokumentiert, dass sie in die Anamnese einbezogen wurden.

Bestehende Pflegeprobleme und Ressourcen werden kurz und prägnant, aus der Sicht des Patienten (subjektiv) und aufgrund der eigenen Beobachtung (objektiv) beschrieben, um die richtigen Pflegediagnosen ableiten zu können. Widersprüche zwischen den Angaben des Patienten und den Beobachtungen der Pflegenden werden entsprechend dokumentiert.

Nach Beendigung der Pflegeanamnese wird im pdo AB nichts mehr geändert. Neue Informationen und Beobachtungen werden im Pflegebericht vermerkt.

Im Anschluss an die Anamnese erfolgt der “diagnostische Prozess”. Es werden die Informationen analysiert und geordnet, diagnostische Hypothesen gebildet und diese anhand der Definitionen der NANDA-Pflegediagnosen, den jeweiligen möglichen Ursachen, den möglichen Risikofaktoren und den möglichen Symptomen überprüft.

Im Zweifelsfall werden weitere Informationen eingeholt. Nicht zutreffende Pflegediagnosen werden ausgeschieden und eine sorgfältige Liste der zutreffenden Pflegediagnosen mit Titel, Taxonomienummer, Schweregrad/Stufe/Lokalisation, Ursachen, Risikofaktoren und Symptomen wird erstellt.
Short Article

Preliminary review of the ICNP® Beta version: extract from a report to the 5th Telenurse ID conference

Anne Casey, UK
Paul Wainwright, Wales

The original (untranslated) ICNP Beta version was reviewed to identify linguistic issues for users in the United Kingdom (UK). Random sections of the beta version were reviewed and example terms with their definitions were grouped and coded as issues were identified. The goal was to identify types of issues or errors and to estimate the extent of these, not to review the complete work.

During this review significant errors were identified which were not primarily concerned with use of English but more with the structure and content of the beta version. These are summarised below.

Implied / defined meanings
Some terms or term phrases in ICNP would commonly be understood and used in a particular way which is at variance with the ICNP definition. That definition, while not necessarily wrong, is not the meaning generally applied. For example: the definition of infant sucking extends beyond what nurses would expect as it covers aspects of fixing, normal feeding patterns and ending the feed. A different example is beneficiary - the entity to whose advantage a nursing action is performed. We can only assert that there was a beneficiary if we can show some benefit, to the person concerned, as a result of the action. A better term would be recipient, or subject.

Hierarchy errors
There are numerous errors in the application of the ‘type of’ principle of division. Some of these are caused by placing altered phenomena in a hierarchy of ‘normal’ phenomena e.g. illiteracy is not a type of learning. Some of these are linked to errors in definition of the concept, the parent or grandparent – see below. For example: hematomal is not a type of bleeding - it is a collection of blood in the tissues as a result of bleeding; cardiac function is not a type of circulation.

• Breakdown of hierarchy e.g. 2A.1.3 says that surveying is a type of monitoring, but 2A1.3.1 says that monitoring is a type of observing. So monitoring, at 2A1.3.1, is at a lower level than surveying, at 2A1.3, although surveying is said to be a type of monitoring.

• Sibling errors are also common e.g. meal is a sibling of meals on wheels; solution is a sibling of dialysis solution.

Definitions: Issues and examples
Many definitions are self-referential
Nursing Phenomenon: Aspect of health of relevance to nursing practice.
Nursing Diagnosis: Label given by a nurse to the decision about a phenomenon which is the focus of nursing interventions. A nursing diagnosis is composed of concepts contained in the Classification of Phenomenon axes.

A basic requirement of a definition would be that it does not use the term to be defined in the definition. To say that a nursing phenomenon is an aspect of health of relevance to nursing practice tells one very little about what such a phenomenon might be. This may, of course, be deliberate, given cultural and legislative differences between different countries, but that would seem to defeat the object.
Nursing Action

Nursing Action is a type of Actions with the specific characteristics: Behaviour of nurses in practice
This is self-referential and very non-specific. There would be many behaviours of nurses that might not be thought to be nursing actions.

Inappropriate exemplars in definitions
Likelihood - the probability or chance of occurrence of a nursing phenomenon. Examples include risk, chance.
The exemplars here do not make sense. Risk and chance are nearer to similes for likelihood than examples of the kind of descriptors of likelihood. Better examples might be "unlikely", "probable", "very likely", "high risk", "little chance", "significant" etc.

Some definitions are inadequate for discrimination. For example: "A nursing diagnosis is a label given by a nurse to the decision about a phenomenon, which is the focus of nursing interventions" – this seems an inadequate definition of a diagnosis. It is true, but very limited. A diagnosis is not just any decision, but a judgement that has some necessary elements, such as that it must be drawn from some agreed, limited, range of options, and amounts to a statement of a particular kind, about the nature or cause or origin of a problem, rather than just any phenomenon. “I’ll wash his hands” is a decision (I’m going to wash them) about a phenomenon of interest (his hands) but it is hardly a diagnosis.

Some definitions include constraints / dangers for clinical use. For example: family composition - recorded in a patient record, this concept is about who are the members of the family, nothing to do with legitimate makeup by custom and law; urinary elimination – a extended definition which applies only to adults. Normal values and other clinical knowledge which may change over time or between patient groups must not be included in definitions in a terminology.

Errors in definitions, for example:
1A.1.1.1.1 Respiration
Respiration is a type of Function with the specific characteristics: Continuous process of molecular exchange of oxygen and carbon dioxide.....
1A.1.1.1.1.1 Ventilation
Ventilation is a type of Respiration with the specific characteristics: Moving air into and out of the lungs......
If Respiration has “the specific characteristics” of the continuous process of molecular exchange” how can Ventilation (moving air into and out of the lungs) be a type of respiration? Ventilation is the mechanical process of shifting the gas, but does not involve molecular exchange.

1A.1.1.1.1.3.1 Hypoxia
Hypoxia is a type of Gas Exchange with the specific characteristics: Reduced tension of cellular oxygen associated with cyanosis, tachycardia, peripheral vasoconstriction, decreased breathe sounds, dizziness and mental confusion
Hypoxia is the result of a failure of gas exchange, or respiration, or ventilation, rather than a type of...

CONCLUSIONS

Even in this limited review it was possible to identify significant errors in hierarchy placement and concept definition which appear to be extensive. These require systematic review and correction as part of the planned refinement of ICNP. Such review should be undertaken by native English speakers. The findings of all translators and reviewers of ICNP need to be widely disseminated so that other reviewers are aware of the types of errors to consider.
HURRY - Last Chance to attend
Third European Conference of the Association for Common European Nursing Diagnoses, Interventions and Outcomes

“Naming nursing - Developing and communicating nursing’s professional language” 22-25 March 2001
Estrel Konferenz Zentrum / Hotel, Berlin – Germany

Information: Acendio Conference Management - Berlin 2001, c/o Synopsis, Postbus 93, 2000 AB Haarlem, The Netherlands. Tel: ++ 31 23 551 8631, Fax: ++ 31 23 532 5063, E-mail: info@synopsis.nl or oudnico@netscape.net
Web: http://www.acendio.net

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ACENDIO
Association for Common European Nursing Diagnoses, Interventions and Outcomes

NOTICE OF MEETING OF THE GENERAL ASSEMBLY

The fourth meeting of the General Assembly of ACENDIO will be held on Friday March 23rd 2001, at 1715 hours at the Estrel Konferenz Zentrum / Hotel, Berlin.

All members are welcome to attend.

A vote will be held at the General Assembly on whether to increase the ACENDIO membership fee.

Renew your membership now in case the rate increases
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22-25 March 2001
Third European Conference of the Association for Common European Nursing Diagnoses, Interventions and Outcomes (ACENDIO)
Theme: Naming nursing, developing and communicating nursing’s professional language
Tel: ++ 31 23 551 8631, E-mail: info@synopsis.nl
Web: http://www.acendio.net

3-7 April 2001
The Royal College of Nursing Research Society Triennial International Nursing Research Conference
Thistle Hotel, Glasgow, Scotland
RCN Events, 20 Cavendish Square, London, W1G 0RN
Tel: 020 7647 3585, E-mail: research2001@rcn.org.uk

4-6 April 2001
eHealth: a Futurescope Third International Conference in Advances in Delivery of Care
City University London, UK
www.city.ac.uk/ehealth2001

8-10 April 2001
e-Health Europe 2001 Conference
Maastricht, The Netherlands
CAEHR Limited
www.e-health-europe.com

8-12 May 2001
TEPR 2001
The Hynes Convention, Boston, USA
www.tepr.com

15-17 May 2001

AMIA 2001 Spring Congress
Location: Hilton Atlanta and Towers, Atlanta, Georgia USA
American Medical Informatics Association
Tel: ++ 1 301 657 1291
Information: http://www.amia.org

10-15 June 2001
ICN 22nd Quadrennial Congress
Theme: Nursing: A new era for action
Location: Copenhagen, Denmark
Information: DIS Congress Service
Copenhagen A/S, Herlev Ringvej 2C
DK-2730 Herlev, Copenhagen Denmark
Tel: ++ 45 4492 4492
Fax: ++ 45 4492 5050
E-mail: icn@discongress.com
Web: http://www.icn.ch

18-21 June 2001
6th International Conference on the Medical Aspects of Telemedicine
Uppsala, Sweden
email: telemedicine2001@slu.se
www.service.slu.se/conference/telemedicine

24-27 June 2001
Institute on Nursing Informatics and Classification
Location: University of Iowa – USA
Information: Jennifer Clougherty
Organizations, Systems & Community
The University of Iowa College of Nursing
Iowa City, IA 42242, USA
Tel: ++ 1 319 335 7119
Fax: ++ 1 319 335 7129
E-mail: jennifer-clougherty@uiowa.edu
Web: http://www.nursing.uiowa.edu/orgsyscom/index.htm

5-7 August
New Shores: New Horizons
Inaugural conference of the International Network of Nurse Practitioners and Advanced Practice Nurses
Hosted by the RCN UK and the Irish Nurses Organisation (INO)
Grand Hotel, Malahide, Co. Dublin
RCN Events, 20 Cavendish Square, London, W1G 0RN
Tel: 020 7647 3585
E-mail: nurse.practitioner@rcn.org.uk

18-25 August 2001
European Summer School of Nursing Informatics
Swansea, UK
See information on page 5

2-5 September 2001
Medinfo 2001
International Medical Informatics Association (AMIA)
Location: London, United Kingdom
Information: Secretariat Medinfo 2001
PO BOX 94, Malvern,
Worcs WR13 5YB,
United Kingdom
E-mail: jmroberts@fcg.com

9-14 September 2001
2nd International Congress on Pediatric Nursing (and 23rd International Congress of Pediatrics)
Beijing, China
International Pediatrics Association
www.chinamed.com.cn/pediatrics

4-7 November 2001
4th Biennial International Nursing and Midwifery Conference: Contesting Conversations in Practice, Education, Research and Policy
Adelaide Convention Centre, Adelaide, South Australia.
Contact details and information regarding abstract submission, travel and tourism are available at: www.sapmea.asn.au/Conventions/CCERP/ccerp.htm

3-7 November 2001

AMIA 2001 Annual Symposium: A Medical Informatics Odyssey
Marriott Wardman Park, Washington DC
American Medical Informatics Association
Tel: ++1 301 657 1291
Information: http://www.amia.org

10-14 April 2002
15th NANDA Biennial Conference on Nursing Diagnosis
Location: Las Vegas
Information: NANDA office
1211 Locust Street
Philadelphia, PA 19107, USA
Tel: ++1 215 545 8105
Fax: ++1 215 545 8107
E-mail: nanda@nursecominc.com
Web: http://www.nanda.org

2-4 September 2002
11th Biennial Conference of the Workgroup of European Nurse Researchers (WENR)
Theme: Praxis & Research: a joint adventure
Location: Geneva – Switzerland
Languages: English – Deutsch – Francais
Information: SBK / ASI office
PO BOX 8124, CH-3001 – Bern
Switzerland
Tel: ++41 31 388 3636
Fax: ++41 31 388 3635
E-mail: kongress.sbk@bleuwin.ch

20-25 June 2003
8th International Congress in Nursing Informatics
Theme: e-Health for all: designing nursing agenda for the future
Location: Rio de Janeiro – Brazil
Information: IMIA-NI / NIEEN/UNIFESP
Web: http://www.ni2003.com
**Recent Publications**

Many articles listed are from the Journal of the American American Medical Informatics Association. Abstracts can be viewed at www.jamia.org


Ginman M (2000) Health Information and Quality of Life. Health Informatics Journal. 6, 4, 181-188


Collection, Knowledge Organization, and Reasoning. Journal of the American Medical Informatics Association. 7, 6, 569-585


Classifications in Routine Use: Lessons from ICD-9 and ICPM in Surgical Practice. Journal of the American Medical Informatics Association. 8, 1, 92-100


INVITATION


Dear Colleague,

Since its inception in 1995, the International Connecting Conversations Conference series has become one of the most stimulating, interactive, enjoyable and valuable events in the nursing and midwifery calendar.

This year’s conference in Adelaide, Australia will be no exception. We once again bring together internationally renowned keynote presenters, and recognised expert pre and post conference workshop presenters, with nurses, midwives and other health care professionals to debate and discuss vital issues, to share new initiatives and exciting innovations in research, education and practice and to network with leading national and international colleagues.

On behalf of the Conference Organising Committee, I invite you to join us for this important event. This is the ideal forum to present and discuss your research, showcase your practice initiative or clinical advance, highlight your educational innovation, or add your critique of a current health or professional issue. The deadline for submission of abstracts is 5.00 pm, March 30th, 2001. We look forward very much to welcoming you to Adelaide in November.

[www.sapmea.asn.au/Conventions/CCERP/ccerp.htm](http://www.sapmea.asn.au/Conventions/CCERP/ccerp.htm)
**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.

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