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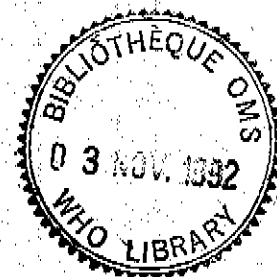
THE DEVELOPMENT OF NURSING CLINICAL CENTRES

Report on a Joint
Project HOPE/WHO Seminar

Zlenice, Czechoslovakia
15-17 May 1992

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EUR/HFA TARGET 27

This activity was organized by the WHO Regional Office for Europe to promote work aimed at achieving the following target in the health for all strategy.^a

TARGET 27

HEALTH SERVICE RESOURCES AND MANAGEMENT

By the year 2000, health service systems in all Member States should be managed cost-effectively, with resources being distributed according to need.

Keywords

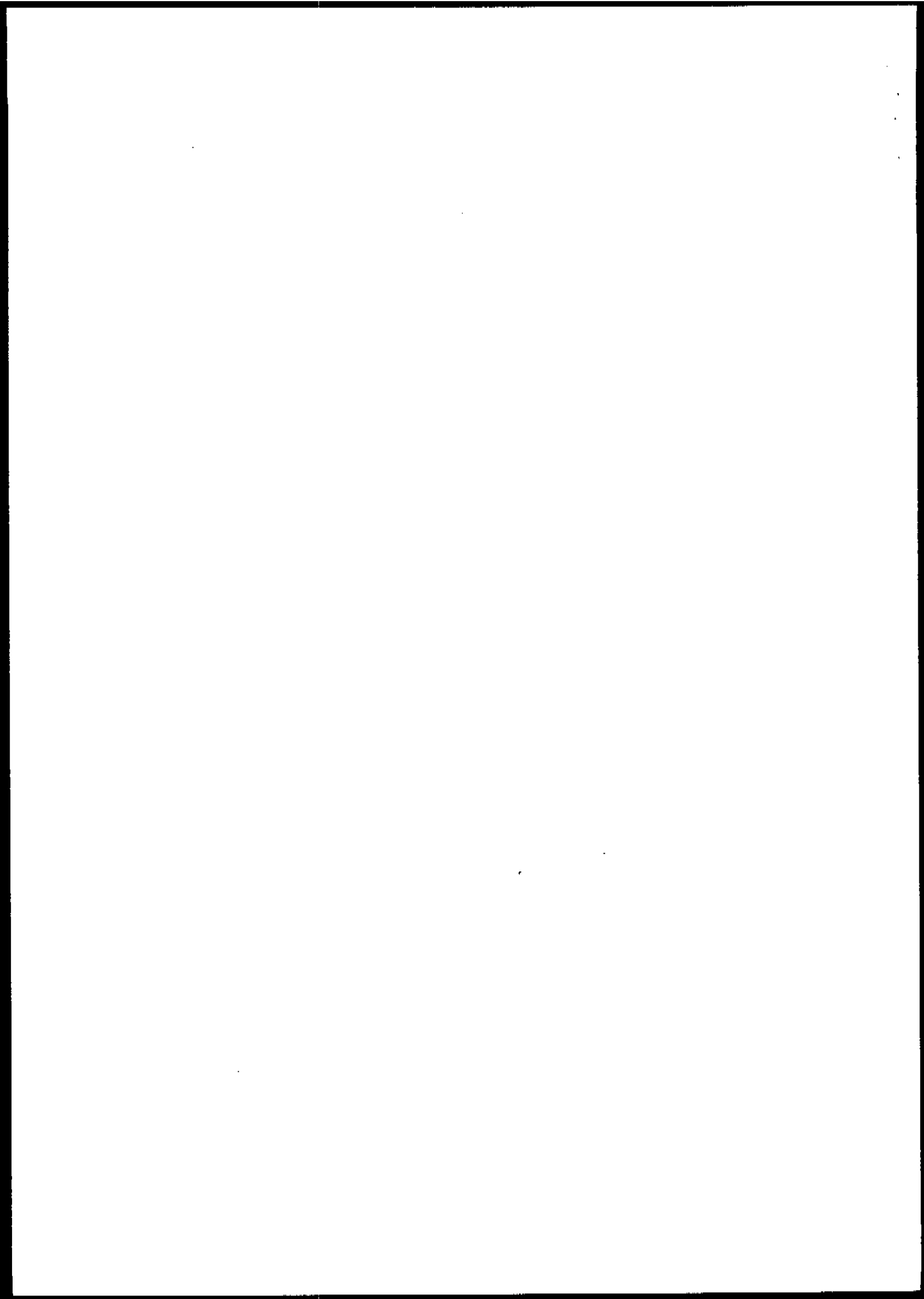
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^a *Updating of the European HFA targets*. Copenhagen, WHO Regional Office Europe, 1991 (document EUR/RC41/Inf.Doc./1 Rev.1).

CONTENTS

	<u>Page</u>
Introduction	1
Principles of nursing clinical centres	1
Experience gained - case studies	2
Changing the care of the elderly - Denmark	3
Clinical demonstration units - Egypt	3
Moscow burn clinical centre - Russian Federation	4
Clinical centres of excellence - Poland	4
Tameside nursing development unit - United Kingdom	5
Other projects	6
Managing change	6
How to start - group exercise	6
How to move on - methods and resources	7
Strategies for change	9
Future action	13
Annex 1. Further reading on nursing development	14
Annex 2. Participants	15



Introduction

Nurses comprise the largest group of health professionals, so good health care demands good nursing care. This is hard to deliver; despite their commitment, nurses must contend with many obstacles. Their workload is often excessive and their responsibilities great, yet they lack autonomy and esteem from other health professionals and society at large. Further, nurses usually have no voice in the current debate on health care reform in Europe, and their role in future systems is unclear. All these problems are particularly severe in the countries of central and eastern Europe.

The WHO Regional Office for Europe and the People-to-People Foundation, Inc. (Project HOPE) are working to help nurses tackle these problems and build a role that will improve both patient care and the nursing profession. The two organizations use a variety of methods in this task, but both promote a special tool: the nursing clinical centre (or nursing development project). These centres aim to improve people's health by developing nursing practice, education, management and research. They encourage practitioners to become agents of change in nursing and to work as the partners of their colleagues and other health professionals. These are important contributions to the achievement of the WHO goal of health for all.

The two organizations - with the support of the Ministry of Health of the Czech Republic - held a Joint Project HOPE/WHO Seminar on the Development of Nursing Clinical Centres in Zlenice, Czechoslovakia from 15 to 17 May 1992. The participants were nursing leaders from 11 countries, mostly in central and eastern Europe. They met to define the principles underlying nursing clinical centres, to discuss the experience gained in widely different projects and to make their own plans for clinical centres or other strategies for change. The participants also hoped to enjoy the Seminar and to gain knowledge and skills to share with colleagues at home.

Dr C. Kruger and Ms J. Salvage chaired the Seminar, and eight people facilitated discussion and group work. Ms M.S. Burgher served as Rapporteur. Documentation on change and nursing and the list of participants comprise Annexes 1 and 2.

Principles of nursing clinical centres

All nursing clinical centres should help nurses develop by developing their practice. Centres can differ widely, but all rest upon eight principles. These were discussed at the Seminar as key words beginning with the letter "e".

1. Nursing clinical centres can be located in any health care setting and serve any type of patient. They can be everywhere.
2. The goal of all centres is excellence. Excellence is always just out of reach because nurses constantly redefine it as they progress.
3. Experiments are the means of working towards the goal. Centres test new or alternative ideas in and approaches to care. The nurses taking part should realize that their experiments will lead to change, which requires careful management.

4. Nursing clinical centres aim at equality - for patients in care, for nurses with their colleagues and other members of the health team, and for all members of the team.

5. The effects of a clinical centre include the expansion of the nursing profession by the development of new roles for nurses and new forms of care.

6. Equity is another effect. Nurses do not hoard but share their new knowledge and skills.

7. Nurses use every means for the export of the knowledge gained, including speeches, publishing, organizing meetings and offering internships.

8. The final result is empowerment. Nurses learn how to identify problems in care and to act on them in ways that are safe and productive for themselves and their patients.

A second description of nursing clinical centres explained their principles and characteristics in a slightly different way. Although centres could have a variety of purposes, all were expected to offer models of good practice to the health care system and to offer opportunities for education. The units selected to become a nursing clinical centre should meet certain criteria. They should have, for example, links with nursing education, support from all the parties involved in the project and a commitment to change to improve nursing practice.

Strategies in the development of the participating units could include setting up an advisory body, asking the participants about their needs and preparing to meet resistance to change with education. Finally, a nursing clinical centre would probably pass through a number of stages, some of which would overlap: negotiation, preparation, implementation and evaluation.

Experience gained - case studies

Nursing clinical centres in five countries were described to the Seminar participants. The descriptions revealed that, despite widely different circumstances, participants and objectives, the centres had some important characteristics and principles in common. In particular, each centre:

- helps the participating nurses to develop by developing their practice;
- attacks a problem in nursing practice that is important to the nurses and patients involved;
- includes nurses acting as agents of change;
- includes in its activities negotiation with a variety of groups, education (often the training of trainers) and evaluation;
- has managers who support and protect nurses in making changes and sharing their work with others; and
- leads to changes that expand the nurse's role and autonomy, usually through membership of a team that gives individual and holistic care.

Changing the care of the elderly - Denmark

Nurses form an important part of a project called "services for the elderly by the year 2000" in the Danish municipality of Helsingør. Begun in 1986, the project addresses important issues in the care of elderly people. Existing services encouraged passivity and isolation in patients and were too inflexible to meet their needs. Home care, for example, was available only in the daytime. Further, although local politicians wanted to cut the funds allocated to services for the elderly, they recognized that the increasing number of elderly people would lead to the doubling of costs if services remained unchanged.

The project involves the health workers of the municipality (about 1200 nurses, nurses' aides, general practitioners, nutritionists and social workers) and representatives of other interest groups: taxpayers, trade unions, politicians and the mass media. Reconciling the interests of these groups and negotiating solutions acceptable to all are important parts of the work.

The participants in the project chose its objectives. These are to enable elderly people:

- to remain in their homes for as long as possible;
- to have the chance to move into sheltered housing when necessary;
- to receive the same kind of care in all environments;
- to make informed decisions about their care.

These changes had to be made without increased resources.

Training and follow-up supervision for all staff have enabled them to practise in new ways. Care has been decentralized into smaller units staffed by multiprofessional teams. The resources of patients and their families have been mobilized to contribute. Care is planned in accordance with the patient's wishes, and promotes and maintains healthy aging. These changes were difficult to make. For example, making care more flexible required health workers to learn how to bridge gaps between different professions and parts of the health care system. Nevertheless, nursing personnel are enjoying and benefitting from their new role.

Clinical demonstration units - Egypt

A three-year project is developing model clinical units to improve patient care and provide high-quality clinical education to nursing students in Egypt. A Project HOPE consultant and the project's executive board set criteria for the selection of units that had certain facilities and taught a large number of students. This meant the choice of general surgical or medical units in hospitals attached to universities with higher institutes of nursing. By early 1992, seven units had been chosen, differing in location, circumstances and stages of development. In addition, the consultant took part in the setting of the first standards for nursing care in Egypt.

The activities of the project include negotiation, the adaptation or renovation of unit facilities, unit management, in-service training, the implementation of new systems and evaluation. The Project HOPE consultant works with the coordinator of each unit, through whom she is linked to the hospital and the institute of nursing.

Each unit has its own plan and schedule for development, made by the participating staff. The project has brought together medical and nursing educators and hospital staff to address issues in the quality of care from the perspective of the health care team. Such teams are taking part in the evaluation of progress so far. Considerable improvements have already been made in the demonstration units. They range from the renovation of old facilities and the construction of new ones to the introduction of a computerized record system and new means of in-service training.

Moscow burn clinical centre - Russian Federation

After a terrible gas explosion in the Ural Mountains in 1989 left many children suffering from burns, Project HOPE signed an agreement with the government of the then USSR on a five-year project to develop a centre for better burn care. The aim was to train health professionals to deliver better care as members of burn teams. The high motivation of the staff led to the selection of Children's Hospital No. 9 in Moscow as the centre.

Patients were to be the centre of care planned and coordinated by doctors and nurses in partnership. Part of the project was the instruction of surgical staff in advanced techniques. Nurses were also to learn new techniques. There was an important obstacle, however. Nurses had no identity as autonomous practitioners; they were seen as doctors' assistants and housekeepers. Further, the idea of teamwork conflicted with the established hierarchical structure of the health services.

A nurse working for Project HOPE came to the Russian Federation to develop and carry out an education programme to expand the role of nurses at Children's Hospital No. 9. The result was an eight-month course of 36 modules, moving from basic skills and techniques to more advanced concepts in burn nursing. The hospital management supported the programme. In addition, Russian doctors and nurses visited the United States to study various techniques and systems of burn care.

The results of the project are good. The nurses at the centre have a new vision of their role in care. Doctors have recognized the change and begun to work with nurses as team members. Nurses are also members of a committee, representing all parties concerned, that makes decisions about care. Both doctors and nurses welcome these changes, which have improved burn care at the hospital. Individual care plans have been introduced in the intensive care unit and mortality in burn patients has dropped by 71%. The infection rate has also dropped and the duration of the stay in hospital has fallen by one third.

Further, the centre has forged links with two nursing education institutions. The next goal is for the centre at Children's Hospital No. 9 to export its experience by becoming a training centre for both doctors and nurses. Here they can learn to form teams whose members work together to give the best possible burn care.

Clinical centres of excellence - Poland

Early in 1992, a primary nursing programme was established, with the help of Project HOPE, in two units of the Paediatric Institute of the Polish-American Children's Hospital in Cracow. The programme was only three months old, but a number of steps had already been taken. The early results were good and nurses' motivation and interest were high.

The first task was to define the difference between primary nursing and the task-oriented model used in the hospital. Next, two units were chosen to participate in the programme. One focused on noncommunicable diseases and the other on rehabilitation, but both have patients of widely different ages, a cooperative relationship between doctors and nurses, and enthusiastic and open-minded nursing personnel.

New documents were developed to take the history of and record the nursing plan for each patient. An advisory group was formed for the programme, with members representing all groups of hospital staff.

Classes were held on the nursing process, communication skills, primary nursing and other clinical and psychosocial topics. The classes were offered twice - for the nurses in the programme and then for nurses from all over the city - and evaluated. Next the nurses in the programme began to test their new technical skills and holistic approach. These exercises also covered dealing with patients' families. Primary nursing for a small group of patients began 10 days before the Seminar opened.

Plans for the future included: biweekly follow-up meetings with the participating nurses, meetings of the advisory committee, a questionnaire on quality assurance and the revision of the new documents. In addition, new fellows and nurses would be admitted to the programme.

Tameside nursing development unit - United Kingdom

The Tameside nursing development unit began with efforts to change the conditions and improve nursing care in one ward for elderly people in what is called a total institution. The ward provided custodial care of low quality. The health of patients was poor and morale low in both patients and staff.

The nurses of the ward gradually conquered these problems by changing their practice, making it more creative and personal, adapting it to patients' needs, and designing it to encourage patients' independence, self-respect and ability to care for themselves. Care plans and new activities were introduced and restrictive rules (on visiting hours and nurses' uniforms, for example) were broken. Nurses involved patients and their families in decision-making.

The changes in practice started small and developed slowly, but a 1984 evaluation revealed dramatic improvements just three years after the project began. The number of complaints from patients fell from 163 to 7 (and to 3 in 1991), the number of accidents to patients fell sharply from the 1981 figure of over 200, and staff turnover fell from 46% to 3% (the national average was 16%). Further, in 1981, many patients died and few were discharged to return home. The 1984 evaluation showed the opposite: a low death rate and high patient turnover. Finally, few nursing students in 1981 would train in the unit or work in it after qualifying. The opposite was true in 1984. These trends have continued.

Four changes created this success. First, a nurse was appointed to work in the ward as an agent of change. The nurse did not advise or lecture the other staff but worked alongside them, first learning the ropes and then suggesting changes by example. Again, the first changes were small ones, such as giving patients cups and saucers from which to drink their tea, rather than plastic beakers with lids. This method allowed the other nurses in the unit to adopt the new practices and to suggest and develop others for themselves.

Second, the managers of the institution were persuaded to develop their management style into a more supportive one that encouraged change. Third, the staff chose an education programme to meet their needs. Fourth, the staff used existing resources more flexibly at first; later, the success of the unit secured increased funding for more ambitious changes.

Other projects

After the planned presentations, participants from countries in central and eastern Europe described projects that they had devised and conducted. Some, for example, had instituted an open visiting policy in a hospital. Other hospital nurses had reduced the costs and duration of hospital care through the early discharge of patients and follow-up care in their homes. Owing to the shortage of funds, they delivered this care in their spare time, receiving no extra pay.

Managing change

How to start - group exercise

Change arouses opposition. Nurses who want change should therefore decide not only exactly what they want but also how to go about getting it. They should make plans to manage change. Agents of change should ask themselves eight questions to secure the information they before they begin:

1. What is the problem or challenge?
2. What difference will the change make to me, to the other people involved and to the overall situation?
3. Who will suffer from the change?
4. Who will benefit from the change?
5. Who will help me?
6. Who will hinder me?
7. What can stop me?
8. What do I need to take the next step?

These questions can be a useful starting point for discussion with colleagues.

Before making their own strategies for change, the Seminar participants formed six groups to address a common issue as an exercise in planning. Most of the groups were formed on the basis of nationality or language; one, however, comprised participants from four countries. Each group included one of the facilitators, but chose its own leader and rapporteur. The groups' task was to apply these questions to the issues of introducing individual nursing care plans in a health care unit. This enabled them to practise using the questions before applying them to their own projects.

The discussion that followed the group session revealed remarkably similar answers. Everyone agreed that the introduction of care plans would encounter certain problems. Nurses lacked time, self-esteem and the knowledge and skills needed to make such plans. They also faced a lack of trust from patients.

Nevertheless, the change would bring a number of benefits. Patients would receive better care and they and their families would build a cooperative relationship with health workers. It would improve nursing

practice, giving the nurse more responsibility, independence in decision-making and job satisfaction. In fact, all the health workers involved would benefit from improved communication and cooperative working methods. These benefits would spread into the rest of the hospital and thence to the whole health care system. Costs would be cut, care improved and better organized, and the hospital and care system more highly regarded. Finally, the benefits of change would reach society at large. Holistic nursing care would enable people to learn health promoting skills in the hospital and pass them on to the community, which would benefit from the improved health of its citizens.

In discussing the victims and beneficiaries of change, and allies and opponents in making it, the groups recognized two important facts. First, the change would ultimately affect a wide variety of people, ranging from health care workers and managers, and patients and their families to health authorities, insurance companies and the public. Second, people would try to help or hinder the change according to their view of its effects on them. As a result, one group stressed the importance of involving all possible allies in the change process as early as possible, and of using networks to win formal and informal support.

Some nurses, for example, would welcome care plans as a chance to give better care in a more independent way, while others would oppose them as an unnecessary extra burden. Doctors might accept a new partner in their work or prefer to keep information and power to themselves. Managers would seize the chance for better care, perhaps at lower cost, or fear demands for additional resources. Patients and their families would want to take part in creating better care or refuse to trust nurses with important personal information. In addition, conservatives in all groups were likely to oppose change and a variety of international organizations were likely to be allies.

In discussing obstacles to change, two groups said that nothing could stop them. The factors they gave as hindrances, however, resembled those listed by the other groups. The problems mentioned included: poor education, a lack of skills, staff and resources, bureaucracy, some hospital routines, tradition and restrictive laws on nursing. Reflecting on these obstacles, the groups listed what they needed to take their next steps: improved education and communication, training in new models of care and evaluation, support and additional resources, and new laws on nursing.

How to move on - methods and resources

The exercise showed that the participants knew how to start change. The next task was to act on their ideas. Nurses could use the same methods to make changes at any level; 12 were discussed, using key words beginning with the letter "p".

Power. Changes can be made in three ways. All involve power and each is based on a different reading of human nature. Two work from the top down, and one from the bottom up. In other words, the driving force for change comes from outside in two methods, and from within in the third.

The first method is telling, or ordering people to adopt a change. The idea of giving such orders to, for example, the nurses of a clinical unit is based on the belief that they will obey in both the short and long terms. The

second method is selling. Based on the belief that people use reason and self-interest to guide their behaviour, this method involves persuading the nurses to change by showing them the benefits to themselves or others. The third method is cooperation, which entails people choosing and implementing change for themselves. It is based on the recognition that people accept and implement the changes that fit into their system of values. This method leads to changes that last.

Possession. Changes made cooperatively are easier to accept and sustain because the nurses involved feel that they own or have a stake in them. Without this sense of possession, change is likely to stop when the driving force is removed.

Pilot testing. Nurses may want to test an innovation for themselves before widely or fully adopting it. This has the benefits of determining the value of the change and allowing for its modification or rejection if necessary - thus giving a sense of ownership. Not all changes are good or can be transplanted.

Passion. In addition to possession, the passion of nurses who believe in their ideas provides an internal driving force for change.

Participants. People respond to change in different ways. In a group of nursing staff, a small number would be innovators, people who envisage change. Some others would accept the new idea right away, while most would do so after some persuasion or initial resistance. The remainder would comprise people who may never accept the change. It is important to remember, however, that resistance may be both justified and useful.

Patients. Patients and their families should be included as participants. Their views on the change can be useful and their support valuable in negotiation.

Pragmatism. Nurses should set pragmatic goals and work towards them persistently and flexibly.

Plotting. A nurse who wants change can increase the chances of success by joining with like-minded colleagues. The members of such a group can share ideas and support, and win others' support for their work.

Planning. Nurses should plan the change they want as thoroughly as possible and give it time for implementation. Because values drive change, the group needs to create a shared vision of its goal.

Purpose. Having formed their purpose, the nurses should put their vision into practice, evaluate its effects and modify it as necessary, continuing this cycle throughout the change process.

Projection. Nurses should share their ideas and results in as many ways as possible. This allows others to test and adopt them.

Protection. Nurses working for change should remember that they are an important resource, and protect themselves. They should give mutual support by such means as praise, the celebration of successes, and opportunities for a rest or further training. The group also needs protection from the wider organization. A steering group could give valuable help, and membership could convert some potential opponents into allies.

The human resources of the clinical unit - the agent of change and the other nurses of the team - are the most important and should be nourished and protected. People are born energetic and creative, but these qualities can be crushed out of them. The countries of central and eastern Europe face particularly severe problems, but nurses everywhere are often tired, under stress and worried about making ends meet. This increases the need for mutual support in the clinical unit. Team members should take time out for talk to sustain the team and its vision. They should care for each other and celebrate each of their successes.

A nursing clinical unit can seek new funding from a variety of sources. On the international level, proposals can be made to the European Community and to United Nations organizations. WHO can act as a broker, helping nurses to formulate proposals and putting them in touch with possible donors. Other nongovernmental organizations, such as the Red Cross, offer funding, and some governments offer fellowships. In addition, many private voluntary organizations offer funds or advice, as do nursing organizations and other professional bodies in western Europe and the United States.

Sources in countries include ministries of health and, at the regional or local levels, community groups and businesses, although money from the latter sometimes comes with strings attached. Finally, clinical units can raise money for themselves. Some form voluntary groups, sometimes including discharged patients and their families, to raise money and provide other assistance such as carpentry or publicity. Others look for ways to raise money for themselves, such as selling their new services.

The discussion of methods concluded with a re-emphasis of the value of evaluation. Every nursing clinical unit should develop a continuing process of review and adjustment, a cycle that fuels change and development. Units should begin by collecting baseline information. Data collected by the health ministry, the health authority or hospital are often available and may be useful, although their correctness should be checked. The next step is to select a few simple indicators to measure progress, such as those used by the Tameside nursing development unit. The constant use of evaluation to guide planning and implementation leads to success.

Strategies for change

The participants used the last day of the Seminar to plan and present their own strategies for change, to be carried out on their return home. The six groups were asked to make their plans and describe in the final plenary session: the changes they would make, the strategies they would use and what they had learned from their group work. Although the members of each group could make as many plans as they liked, the rapporteur would describe only one. In this task the facilitators worked with the groups and consulted with individual participants. To structure their reports, some of the groups used a form prepared by Project HOPE, which asked for the description of:

- the status of a number of factors, including the type of unit, patient and family systems, available staff and facilities, management and systems for communication and networking;
- forces in each factor that facilitated and restrained change; and
- the objectives of the change and the strategies chosen to achieve them.

Czech group. The Czech group planned to improve care in intensive care units by establishing better communication between the members of the health care team and between the nurses and patients. At present, patients were isolated by restrictive rules (including a ban on visitors). Some staff were lazy and had poor attitudes. All suffered from an inadequate education and a lack of communication within the health care team. These problems resulted in rigid and poorly managed care.

Several factors could hinder change. Staff were few in number and lacked communication skills. The roles of staff were stereotyped and the competences of doctors and nurses unclear. Finally, some staff with strong personalities would oppose change.

On the other hand, some factors would facilitate change. The staff included creative people. Support for change could be obtained from the head doctor, the hospital management and professional associations. Cooperation could be established with education and public institutions. The nurses working for change could also benefit from the example of another unit.

The group listed its strategies to improve communication and care. A steering group would be formed, and education workshops held for the unit's nurses. Patients would have more privacy and be allowed to receive visitors. The nurses would work towards giving several levels of care, tailored to the individual. They would cope with the extra work by saving time through improved technology and materials and improving the management of care.

Slovak group. The Slovak group intended to improve patient care in a hospital unit by introducing new documentation. The group members expected this to lead to numerous benefits. Better communication between the nurses and with the patients would improve nursing care. Introducing and using the new documents would increase the nurses' professional skills and responsibilities. Nurses would be more satisfied with their jobs and patients, with care. Ultimately, the hospital would gain a reputation for high-quality care.

The Slovak nurses would use a number of strategies to make the change and cope with problems that could arise. They would begin by informing the unit's nurses and doctors of the proposed change, and setting up a working group (with members of both professions) to prepare the documents. They would also secure the support of the hospital administrators and senior staff. Nurses would be trained in the use of the new documents and new professional skills. The documentation would require a new style of work, so staff meetings would be held to discuss it. The change would increase nurses' workload, so the work would have to be reorganized and additional staff secured, particularly volunteers from the Red Cross. Finally, the project would be evaluated in two ways. A questionnaire would be sent to nurses, doctors, and patients and their families. In addition, two indicators - infection rates and the length of stay in hospital - would be used to measure improvements in care.

Afterwards, the nurses would celebrate their successes and inform others about their work. They would write reports, publish their results and speak at meetings to spread the word to other units, the hospital administration, nurses' organizations and health authorities.

Bulgarian, Italian, Russian and Slovenian group. This group made several plans, but the rapporteur described only that of the participants from the Russian Federation. They planned to establish high-quality care in a surgical

unit with 60 beds. At present, patients suffered from a high rate of post-operative complications and infections and poor nursing care. Patients needed individual care but did not trust the care givers. Everyone involved suffered from poor communication. The unit's equipment was poor and the cost of replacement high. Nursing care needed to be reorganized and given in new ways.

The change agents recognized both restraining and facilitating factors in the environment. In general, conservatism and some cultural habits were likely to raise obstacles, but many potential partners would welcome change. For example, nurse educators lacked materials, clear objectives and a readiness to take on new roles. On the other hand, they would welcome discussion and information, and had begun many new programmes.

There were a lack of nurses and no standards for nursing care. Both nurses and doctors delivered poor-quality care. The nurses were highly motivated, however, and the doctors were willing to cooperate as team members. While hampered by outdated legislation and poor communication, the hospital administrators wanted to cooperate with the health care team.

The health authorities lacked clear policies and strategies and those at the top were unwilling to negotiate. Nevertheless, the authorities also wanted to support change. Finally, the lack of information and communication had led the community to distrust care givers. On the other hand, changing health care was the subject of much debate and a new law allowed greater cooperation between the community and the hospital.

The change agents planned to promote excellent care by reducing post-operative infections and reorienting care to individuals. They would also work to increase the trust between the providers and users of services, cooperation within the health care team and the patients' responsibilities in care. Their strategies included:

- analysing their resources;
- developing objectives, new forms of cooperation and clear communication, and standards of care;
- organizing education activities; and
- applying the principles of quality assurance and honestly evaluating their work.

Finally, they would work for new legislation on nursing, designed by nurses.

Romanian group. The Romanian group planned to improve nursing care in a community health centre by shifting the emphasis to primary health care and using a holistic approach to prevent disease in the community. The change agents would use four strategies to achieve their goal:

- establishing a pilot programme in the clinical centre;
- ensuring proper education for qualified nurses in the centre;
- ensuring proper education for student nurses in the centre;
- delivering care through multidisciplinary teams.

Polish group. The Polish group planned to continue its primary nursing programme in two units in the Paediatric Institute of the Polish-American Children's Hospital in Cracow. The change agents listed five objectives.

The first was to continue the education of nurses. This meant involving doctors and nurses from other units, choosing topics and setting a schedule, translating texts into Polish and buying reference books.

Second, the change agents planned to set up a committee to formulate standards for nursing care, and to work on nursing policies and procedures.

Third, the change agents would increase the dissemination of information about their programme. They planned to publish articles in newspapers and professional journals, give interviews on television and radio, meet with community officials and make contact with the nurses' organization in Poland.

Fourth, the change agents would support the nurses taking part in the programme by holding biweekly staff meetings and maintaining daily contact with the staff at work.

The final objective was to increase the contact between the people in the programme and organizations in other countries that were involved with nursing care.

Hungarian group. The Hungarian group planned to improve the care in a maternity unit by instituting rooming-in through a programme lasting at least two years. In contrast with the usual practice of separating mothers and babies - rooming-in allows women to care for their newborn babies, and thus become confident about their ability. The change agents planned to use several strategies:

- to mobilize the resources of the mothers;
- to upgrade the knowledge of and technical facilities available to nursing staff; and
- to develop a shared concept of nursing, management tools, an information system and indicators for monitoring and evaluation.

The programme would have three steps. The first was preparation. This would be the stage in which to deal with opposition and create consensus. Preparation would mean setting up a steering group, selecting documentation and technical tools, writing a questionnaire and conducting numerous education activities. These activities would include: reorganizing the nursing curriculum, offering study trips, selecting education materials and training the trainers. Many of these tasks would be expensive to accomplish.

The second step would be the implementation of the rooming-in system. The staff would use the new techniques and documents, working as team members, take external and internal education courses, discuss the programme with one another at meetings, and move from quality assurance to quality management. Staff would also inform the community about their work through such means as the local newspapers and forming a mothers' club.

The third step would be research and evaluation, to test four hypotheses: that rooming-in promotes early breastfeeding, that this helps babies to regain their birth weight faster, that breastfeeding is the best feeding method for the first six months of life and that it increases the mother's satisfaction. The researchers would gather data through observation and the use of a questionnaire and indicators. The results would be summarized and used to help the programme develop further.

Conclusion. All the groups reported that their work had been fruitful. Many participants lacked experience with working with others as equals, discussing problems frankly, dealing with opposing views and reaching consensus. They said that the seminar had given them valuable practice in the open discussion of problems that they faced, the sharing of ideas and the need to negotiate and work together as a group. They now had to decide how they would share what they had learned and produced at the seminar with their colleagues at home.

Future action

The staff of Project HOPE and the WHO Regional Office for Europe hoped that the seminar would be an important step towards helping European nurses to develop and improve clinical care. The participants were urged to put what they had learned into practice when they returned to their workplaces, where real change would take place.

Two main options were discussed for continuing the work begun at the seminar; the Project HOPE and WHO staff offered to explore their feasibility and report back to the participants. These options focused on written material and networking.

As to the first, the report on the seminar would be sent to all participants as soon as possible, and the feasibility of publishing a short book on clinical practice development would be considered. Such a book would include the guidelines, case studies and other useful material from the seminar, and other commissioned contributions. It could be translated and circulated widely in Member States. Funding would need to be obtained for such work, however.

Second, the participants were urged to maintain the contacts they had established during the seminar and use them to share news and ideas with a few colleagues. In addition, Project HOPE and WHO would explore the possibility of holding a second seminar in 1993 or 1994. This would enable the participants to review progress, renew contacts and generate new ideas.

Annex 1

FURTHER READING ON NURSING DEVELOPMENT

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