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THE CONSULTANT'S ROLE IN QUALITY ASSURANCE
IN NURSING PRACTICE

A report from the programme on Nursing



WORLD HEALTH ORGANIZATION
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TARGET 31

Ensuring the quality of services

By 1990, all Member States should have built effective mechanisms for ensuring quality of patient care within their health care systems.

Index:

QUALITY ASSURANCE, HEALTH CARE

NURSING PROCESS - standards

CONSULTANTS

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THE CONSULTANT'S ROLE IN QUALITY ASSURANCE
IN NURSING PRACTICE

Report on the Second Meeting

The Hague, Netherlands
12-14 April 1989

Note

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Introduction

The Second Meeting on the Consultant's Role in Quality Assurance in Nursing Practice was convened in The Hague from 12 to 14 April 1989 by the WHO Regional Office for Europe in collaboration with the Government of the Netherlands.

The Meeting was attended by 19 nurses from 10 European countries. Dr J. Verhoeff, Deputy Director-General of Health of the Netherlands Ministry of Welfare, Health and Cultural Affairs, welcomed the participants on behalf of the Ministry. Ms E. Stussi, Nursing Officer, opened the Meeting on behalf of the WHO Regional Director for Europe.

The Meeting was the fifth in a series on the topic of quality assurance in nursing practice.^a The list of participants is given in Annex 3.

The overall purpose of the Meeting was to build on a sequence by which trained experts passed on knowledge gained and shared experience with newcomers. Subgroup 1, composed of the experts who had been involved in the first four meetings on standards of practice, and who had already worked on standards with subgroups in their own countries, were to act as consultants to subgroup 2 with whom they would have the possibility of sharing their experiences, as well as providing information on the opportunities and risks of introducing standards of practice.

Other objectives of the Meeting were to:

- review the changes that had taken place in the Region on quality assurance in nursing practice;

^a For further information see background document ICP/HSR 323 (Annex 2).

- analyse the effects of the Regional Office's training efforts on the implementation of standards of nursing in selected settings in the Region;
- establish plans for steps towards the implementation of quality assurance in nursing practice at local level;
- examine possible approaches and agree on strategies for action at regional and national levels;
- review and edit the manual for trainers on quality assurance in nursing practice, based on the table of contents agreed on by participants at the meeting in December 1987.

Changes in quality assurance in nursing practice in the European Region

The participants from each of the ten countries represented reported on the changes that had occurred in their respective countries.

Belgium

A national quality assurance programme has not yet been established, although there is support through new legislation for nursing. For example, documentation of nursing care based on the nursing process is required in all hospitals, as is patient allocation for nursing care; there is a requirement for 24-hour cover of all wards by first-level nurses; the unit head nurse must have specific postgraduate training in management; and postgraduate training is similarly specified for nurse-managers of hospitals.

The hospital financing system in Belgium is being reoriented, with the Ministry of Public Health trying to

change the basis of financing to diagnosis-related groups. Nurses reacted against this, not wishing to be merely part of these groups but requesting a separate and complementary approach. Since 1988, all nursing services in hospitals have had to register certain activities in connection with all patients for a two-week period four times a year. The activities registered should equate to the nursing records of the patients, and this is improving the development of nursing records. The activities to be registered consist of 23 items, selected from a list of over 100, and include bathing, nutrition and observation. The presence or frequency of each activity in a 24-hour period has to be recorded. Data are collected by the hospital and made available to the Ministry of Public Health, where they are processed. The purpose of registering these activities is to identify the activity profile of the wards and then to group wards with similar profiles, which should receive similar finance once the new system has been established.

Following the meeting of the French working group for the development of standards of nursing practice in Lyon in September 1988, the Belgian participants held discussions with the Ministry of Public Health. Support was given at national level for the introduction and coordination of quality assurance activities within the country, where a number of hospitals are working in various ways on quality assurance or standard setting in nursing practice.

Czechoslovakia

In 1986, the Ministry of Health and Social Affairs of the Czech Socialist Republic initiated a five-year programme for the systematic monitoring of the quality of care given to elderly people on admission to hospital. The study is being carried out in collaboration with the Regional Office and is coordinated by the head gerontologist and administrative officers from the

Ministry. Coordinating groups are chaired by regional experts of community health centres and the regional nursing officer.

Twenty health communities from the North Moravian region are involved, with community teams of professional workers including physicians, community and geriatric nurses and other direct-care staff. These teams have contact with specialists and nurses and social workers from hospitals. Evaluation shows improved care for patients aged over 70 years and reduced admission and readmission to hospital, especially for certain diseases. Problems of caring for the disabled were identified, as was the need for two nurses to be available at each health centre. Nurses' working conditions still need some improvement.

Data gathered for the study covered realistic activities. Special seminars and courses have been provided for the participants. Evaluation suggests that improved quality of care has been achieved in both preventive and curative care. Follow-up programmes are being set up. The project is now in its third year, and evidence of improved care and reduced hospitalization is already available. The information obtained and experience gained during the programme should contribute to the health both of the elderly and of future health workers.

Denmark

During the past 10 years, a number of initiatives have been taken to improve the documentation of clinical activities and the quality of nursing services.

In 1980, the Danish Institute of Health and Nursing Research was established. This was a key factor in Denmark's participation in the Regional Office's multinational study on people's needs for nursing care,

in which over 100 nurses took part in data collection after having been trained to provide care using the nursing process.

The relationships between nursing care, quality assurance and the use and allocation of personnel became increasingly obvious, and the Danish Nurses' Organization (DNO) started two major projects to test the effectiveness of various American quality assurance systems and workload management/patient classification systems. The Rush Medicus tool was first adapted for use in Danish settings, and the project was reported in DNO publications. It was found to be reasonably valid for measuring care in a small number of Danish medical and surgical units, but Danish nurses saw the need to move beyond the use of such tools and set up a full quality assurance programme, including the development of standards of nursing care.

A five-year plan was proposed at a meeting of the Northern Nurses' Federation in September 1987. The DNO accepted the plan and appointed a project coordinator and team. In 1988, Dr Alison Kitson of the United Kingdom was invited to discuss the role of professional organizations in a quality assurance programme and the dynamic standard-setting approach as devised by the Royal College of Nursing in the United Kingdom. After the project team's visit to the Royal College of Nursing the dynamic approach was used as a basis to start a small project in Denmark. Following the positive experience of the Regional Office's medium-term programme, a "bottom-up" approach was used to build up a national network of volunteer nurses.

The most urgent need was to establish an agreed terminology for quality assurance and written standards in meaningful and understandable Danish. Six to eight groups were to be set up to write, test and demonstrate various phases of the quality cycle. Currently, three

have been set up and one is ready to demonstrate the validity of one written standard. Highly motivated nurses are keen to participate, but time for supervising them is a serious limitation.

Planned future activities include:

- 1989 to early 1990, the publication of a teaching manual;
- end of 1990, a workshop for all nurses participating in the pilot project, the creation of an expert group to support the development of national standards and ensure the quality of the programme, and the planning and implementation of facilitator courses; and
- 1991-1992, the development of national standards.

In 1988, the steering committee of the Northern Nurses' Federation decided to establish a working group. Two meetings have been held, and the group has drawn up a draft set of definitions of the concepts related to quality assurance. Each of the Nordic countries will develop the programme in a way that is relevant to its own situation and in its own language, but there is common agreement on the basic principles.

Finland

There is a considerable and increasing level of activity and interest, the cause of which is professional rather than economic. Some nurses are now at the stage of rewriting standards. With the experience of 10 years of work, nursing is taking the lead in quality assurance in relation to other health disciplines. Changes are taking place in both health care and the educational system as well as in the nursing structure.

The national level of the health care system gives support, in the way of policies and priorities, rather than action. The five-year health programmes contain a statement that quality assurance programmes should be implemented, but this is not mandatory.

At regional level 5 out of 12 provinces, each with its own department of health and social welfare, are now in a position to promote quality assurance activities effectively in their regions.

Most quality assurance activities take place at local level, especially in the five university hospitals and in other hospitals, but not too much in the health centres as yet.

Quality assurance is being taught in six university nursing programmes. There is also more research into quality assurance, such as importance/ performance-type studies or studies dealing with the interrelationship of structure, process and outcome. Some tools have been validated and will be used in the university programmes. Many continuing education programmes include quality assurance, but all are different. More educators are now competent to teach quality assurance.

The Finnish Federation of Nurses is reviewing an action plan for health for all, with various goals and strategies, which will include a quality assurance programme. It intends to employ a key facilitator. The Federation is organizing several seminars (and has invited Dr Kitson of the United Kingdom) for 1990.

A great deal of information and written material is now available in Finnish. The Lang model^a or a variation of it is used. Most of the projects use the

^a Lang, A. Issues in quality assurance in nursing. ANA issues in evaluative research. Kansas City, MO, American Nurses' Association, 1976.

dynamic standard-setting system adopted by the Royal College of Nursing. It was easy to relate to this approach and build on it. In Karelia, guidelines have been written in Finnish for the dynamic system. Various local groups have developed standards, e.g. for relatives of psychiatric patients, for elderly patients in home care suffering from urinary incontinency, or for mothers who have just had a baby. In community care, developments are in the field of child health. Only some institutes have gone on to the measurement phase.

There are many dynamic changes but some difficult issues persist, such as identifying the best time to start projects, a lack of coordination, and the need for more systematic training of facilitators and clearer organization for quality assurance.

Netherlands

The second project of the National Organization for Quality Assurance has begun. Some 30 institutions are participating, including mental health and community care, involving 9-10 thousand nurses. Three professional nursing organizations were involved from the start and took the lead for the first three years, but now the Government has restructured the financing and has become a single focal point. Although the profession is still involved, the structure of the project has changed. With the increased workload, the two nurses working with the National Organization for Quality Assurance as project coordinators cannot continue to visit the participating institutions to teach and assist with the organization of projects. Thus the National Organization for Quality Assurance is starting to train local facilitators on their premises on a ten-month programme of one day a month. The facilitators each take two wards for training and have a videotape for use on the wards. They are specially trained in the teaching of nurses and how to

deal with problems, and also how to differentiate between the roles of managers and ward nurses in quality assurance. It is the nurse-manager, not the National Organization for Quality Assurance, who takes responsibility for the project. Some hospitals have created full-time posts for facilitators. This training is to be evaluated. Consensus meetings are to be held, the first being on nursing records, and consensus has to be reached before a standard can be established. Other topics are chosen on which to write guidelines for nursing care.

More schools include teaching on quality assurance in both basic and postbasic training. A facilitators' course for nurses in primary health care is to be held in 1989. Members of other disciplines, such as physiotherapists, are being assisted in starting projects. The nursing scientific council of the Organization is planning to include an inventory research on all existing programmes so as to establish where programmes are being carried out and by whom. In March 1988, a large conference was held for all kinds of worker and participant in health care, including consumers, to identify and close the gap in the quality of care, which is mainly at hospital level.

The National Organization for Quality Assurance has prepared clear plans for the future.

Norway

Seminars on quality assurance begun three years ago have been continued and are extremely well attended. Interest is great and there is a large demand for knowledge, apparently for two reasons. The first is economic because of the pressures on the service; the second is the patient classification system carried out in hospitals and home care services. While all this work demonstrates the amount of care given, nurses are trying

to establish the quality of the content of that care. Three articles have been published in professional journals, and nurses will write more as work progresses.

A major initiative has been the establishment of a steering group within the Norwegian Nurses' Association and the appointment of a coordinator. Until now, this role has been shared by two people with other heavy responsibilities. The Department of Health is represented on the steering group, which will support and advise the coordinator as well as coordinate the existing projects and develop the programme of quality assurance.

Various activities have been started, of which five are known nationally. One is the development of standards on senile dementia at a major hospital connected to the University of Oslo. This includes a description of the process by means of a weekly logbook. Another project, on AIDS, is linked to the Association. A third, on paediatrics, had started independently but is now loosely linked to the Association. Nurses working in two specialty care groups on oncology and rheumatology have translated existing American definitions and standards, but the usefulness of this will only be seen in the activity that will follow, because it bypasses the learning and development process.

The main problem is one of coordination of existing projects, and although it is not possible to speak about a national programme as yet, this should be remedied in another six months.

Poland

Polish nurses are convinced that the implementation of standards of nursing care is the only way to quality assurance.

Three years ago, standards of nursing practice for community nurses in primary health care were developed and published by the Ministry of Health and Social Welfare as a new act. This established general standards for community nursing practice at national and local levels. National standards include the qualification required to work as a community nurse and the three types of community nurse: those who care for individuals and families in the home, those who care for children at school, and those responsible for care in the working environment. Other standards include priorities in preventive activities and the workload of a community nurse.

At local level, statements describe activities for community nurses, such as data collection, evaluation of living conditions, use of appropriate interventions, and care of sick people at home.

The chief nurse holds meetings with representatives of nurse-teachers, head nurses and research nurses to consider existing standards and their implementation. There is considerable variation in the way standards are defined, and a critical evaluation is being made of the present situation. Preparatory work should be finished this year, and a pilot implementation project is planned for 1990.

Poland has adopted the Regional Office's target 31, and a programme is being worked out to meet its requirements by 1995. Changes are needed in the health service, such as decentralization of management, planning and financing of the services, and organization of health care. These in turn require changes in legislation, and a new act is being prepared.

There is specific planning to broaden the scope of nurses' activities, their professional responsibilities and independence. These legislative changes can

influence work on the development and implementation of standards in nursing care.

Spain

In 1988, a project was put forward to the Andalusian School of Public Health, but agreement with the health services is required before implementation can be commenced. There are groups in various hospitals working on quality assurance, but with many different philosophies.

In Andalusia, as in Denmark, the WHO medium-term programme and the implementation of the nursing process had given nurses the necessary skills to participate in a quality assurance programme. The latter is now being evaluated, and nurse-researchers are preparing the project. Eighty-three standards have been developed; these are currently being implemented in two health centres, and activities are being measured. A conference is to be held in 1989. One or two studies have been carried out on quality assurance projects, such as on chronically ill patients. In a hospital where the director is a nurse, a project is in progress on the care of diabetic patients.

A national quality assurance programme has existed since 1986, but it is not sufficiently coordinated. There are projects in hospitals in Madrid, Barcelona and Valencia and in other places. There are also many activities, across the country, in primary health care concerned with the evaluation of professional practice in health programmes.

Sweden

Unlike Denmark, Sweden did not participate in the WHO medium-term programme and the implementation of the nursing process. National activity and interest in a

quality assurance programme has only occurred over the last two years. This surge of interest is due to increasing emphasis on the economics of health care, with nurses asking whether nursing care measures up to the legislation laid down for health care, and a growing awareness of the need for professional development.

In 1988, the Nurses' Association began a project entitled "Productivity - efficiency - quality in nursing care". The aims of the study were the clear documentation of nursing care, participation in the debate on the efficiency of health care, raising the professional consciousness of nurses, and contributing to quality assurance as set out in target 31. In November of the same year, Dr Kitson initiated a workshop on quality assurance for selected members of the Nurses' Association and nurse-researchers. The first national congress took place in February 1989, with one of the themes being the quality of nursing care.

An informal network has been built up on the initiative of the Nurses' Association with national government representatives and the Swedish Planning and Rationalization Institute. This institute began a three-year programme on quality assurance with an expert group in 1987 and held a seminar in 1988. The National Congress of Physicians included one theme on quality assurance. The informal group with the national government compiled a ten-point programme on quality assurance in nursing care, which was presented at the European Conference on Nursing in Vienna in June 1988.

In spite of all these initiatives, there is a need to build and strengthen a national strategy and appoint a project coordinator.

Various activities are emerging at local level. Dr Kitson held a course on quality assurance in Malmö in 1988 for a collaborating group covering southern Sweden,

and has lectured on a number of occasions on the Royal College of Nursing's dynamic standard-setting system. In Falun, an 18-month project to implement a unit-based approach covers oncology, infectious diseases and neonatal intensive care wards. This is to be evaluated in January 1990.

Sweden is a member of the Northern Nurses' Federation and needs to be able to participate in a network across the Nordic countries as well as a national network.

United Kingdom

This report was given by a participant who works as a facilitator in Fife, which is one of the 15 health boards in Scotland and is a rural area with 15 hospitals and a college of nursing and midwifery. The quality assurance project is two years old and has been based on the dynamic standard-setting approach of the Royal College of Nursing. For the first 18 months, it was an informal project carried out by two clinical teachers after attending a study day conducted by Dr Kitson. Eight months ago, the project was formalized with the appointment of a senior nurse for quality assurance.

A large educational programme for staff has been carried out and is well developed (at national level) in Scotland. There are 40 local facilitators in Fife, prepared by a two-day workshop, and continuing monthly meetings. To date, 100 standards have been developed from all specialties, and a centralized index has been set up to share standards. Management support is strong - not just from nursing management - and facilitators are also engaged in assisting the paramedical professions. A conference is to be held in the near future with the private sector, and facilitators speak at various events in both Scotland and England on the practical application of standards.

In Scotland, there is great commitment from the chief nursing officer, who has recently written a strategy for nursing. Scotland is about to appoint a national coordinator for a two-year project to further the work already begun. This post is supported by the chief nurses in Scotland, Edinburgh University and the general managers' group. The Scottish health boards have ongoing collaboration; there is much exchange of standards to be worked on and adopted. A facilitator in Fife has a three-year part-time government fellowship to help to evaluate the project. There is contact with the Royal College of Nursing's project and the National Organization for Quality Assurance in the Netherlands. Nursing has been able to make many changes because of quality assurance activities and has sometimes helped to free money, and the project has become a priority with the health board.

Much of the work in the United Kingdom is included in the draft publication under discussion (WHO training manual for facilitators on nursing quality assurance and standard setting), and a leaflet is available on the standards of care project of the Royal College of Nursing. Quality assurance is a major topic in the United Kingdom, and the dynamic standard-setting system of the College is only one of a number of tools, such as "Qualpac" or "monitor", that are being used. National guidelines for good practice have been published, and many local groups are working. An evaluation has just been completed. Dr Kitson is now involved in a three-year evaluation project to see if the quality assurance programme really affects patient care. Her base has now moved to Oxford, where there is contact with the University.

General

When the presentations were concluded and discussion had taken place, the overall impression was that a considerable amount of progress had been made. To obtain

a clearer picture of the overall situation in some of the countries, reference should be made to the report of the First Meeting on the Consultant's Role in Quality Assurance in Nursing Practice,² as the presentations at the current meeting refer to changes and progress and do not repeat information already given.

Identification of major themes in implementing programmes on quality assurance

Dr Kitson summarized the seven key issues that had emerged during the presentations.

- Socioeconomic and cultural issues. These manifest themselves in various ways, such as government strategy in setting priorities and budgets or the position of women in society.
- Tension between legal requirements for the delivery of care and professional requirements. Legislation may require documentation that places extra demands on nurses who are already overworked.
- The power and autonomy of the nursing profession. This varies among countries; quality assurance can be used to raise the consciousness of the profession, but it can also produce negative reactions that need time and help to work through.
- The accountability and autonomy of nursing practice. This also varies among countries and can affect the outcome of work on quality assurance in nursing practice.

² The consultant's role in quality assurance in nursing practice. Copenhagen, WHO Regional Office for Europe, 1988 (document ICP/HSR 324).

- Quality assurance techniques. These can be listed as knowledge, teaching and communication of information.
- Methodology. Knowledge is required to make decisions, which must be based on practicalities. For example, is a national group needed or is the dynamic approach best? How is evaluation to be built into the method chosen?
- Organization and coordination of activities. These include networking, support, political strategies, multidisciplinary activity, financing, and research and evaluation.

The participants divided into three groups to address the major issues presented. Three questions were posed for the groups, but each was free to discuss the question of preference and prepare the answer. The questions were as follows.

- When is a country (or a group of nurses in a country) ready to take on a dynamic approach to nursing quality assurance?
- What strategies would you advise for setting up a networking system in a country that has a fragmented health service and a weak professional organization?
- What should be the framework for standards in nursing?

Groups 1 and 2 addressed themselves to the third question and group 3 to the first question.

What should be the framework for standards on nursing?

There was agreement that the framework for nursing standards should be nursing, because this is the area for which nurses are accountable. It should be a broad framework, and it could be helpful to list the possibilities such as care groups, nursing diagnosis or human needs. Medical diagnosis should not be the basis, but although nursing diagnosis would be the preferred option, a client group would also be acceptable.

The framework should equate to the statements made at the European Conference on Nursing in Vienna in 1988. It should also relate to the definition of nursing used by WHO. A common framework is desirable but may not be possible. In this respect, the standards of care topic list developed by the West Berkshire Health Authority, United Kingdom may be useful (see Annex 1).

A "bottom-up" approach should be used, by starting at local level and moving up to the more general or national level.

When is a country (or a group of nurses in a country) ready to take a dynamic approach to nursing quality assurance?

Group 3 agreed that it was not a question of waiting until people were ready, whatever that might mean. It may be more helpful to make various interventions that help nurses to feel dissatisfied with the current situation or to start them asking questions about quality issues. Nurses tend to feel threatened under change and need help to examine the reasons and to move forward.

Group 3 suggested that economic stringencies may well provide impetus for change, and relative affluence in resources could make for inertia.

The skills required were discussed, and it was queried whether these were needed before a group was ready for quality assurance work. Problem-solving skills were identified as useful, but using the dynamic standard-setting system will help participants to develop those skills. Research awareness is another essential, and there is a need to raise awareness, but this will also come with quality assurance activities.

The group then discussed who should make decisions regarding the target group. It was agreed that the nurses who come forward tend to be dynamic and professionally confident. Usually, the group coming forward tends to comprise head nurses of wards, but the drive can also come from different levels and the particular group identified is the one to choose. Once formed, the group needs to have authority to experiment, to have the necessary information for support and, above all, the authority to continue.

Finally, in returning to the question and asking who should decide when a group was ready, there was consensus that it should be the responsibility of the group itself.

Draft WHO training manual for facilitators on nursing quality assurance and standard setting, prepared by Alison Kitson and Johanna Giebing

The first draft of this training manual for facilitators has been prepared by Dr Kitson and Ms Giebing in response to the conclusions/recommendations of the previous meeting in The Hague in 1987.

Two groups were formed to review the draft of the training manual. The more experienced participants, i.e. those who had worked in the WHO Standard Group since 1982, formed group 1 and the less experienced, i.e. those

who had joined the English-speaking group in 1987, formed group 2. The task was first to identify what may be missing in content or unclear in the text, and second to say if the participants felt they could work with the manual.

Group 1 identified major areas for discussion rather than formulated precise questions or comments on the draft manual. They welcomed the work and looked forward to its publication. The areas for discussion were:

- the philosophical values;
- the identification of nursing;
- the focus on patient/client orientation;
- the connection between standards and nursing research;
- content versus methodology.

As standard setting is a part of quality assurance and not a separate topic, the group suggested that the title should be amended to "WHO training manual for facilitators on standard setting in quality assurance". The comments made under each of the five issues as well as the responses of both group 1 and group 2 were carefully noted, and the synthesis made available for internal use by the group members and authors only.

The status of the manual was classified as a three-organizational project (WHO, the National Organization for Quality Assurance and the Royal College of Nursing) and the protocol for publication was explained. The manual is to be published commercially and will be available for sale. It will contain a list of the participants in the WHO programme, who can be contacted if the reader requires further information. The publication will carry the names of the three

organizations. Translation rights have still to be discussed, but the participants felt strongly that translation should be made in the individual countries, as the language used for definitions and terms must be meaningful.

Review of the programme and future work

WHO will not be funding further meetings of the group, although it will be bringing the French-speaking group to a similar stage of development. The participants reviewed the five meetings held since 1982 and the reports and other material that had been prepared. There had been considerable development in both the knowledge and experience of the core members who had been involved since the first meeting, and also in the changing thinking of the group and the way it had been able to absorb and assist newcomers.

The report of the meeting in Sundvollen in 1982 provides useful general statements, especially those on philosophy and values, which are still applicable. It also shows the situation as it was in the beginning. The two meetings in Brussels in 1984 and 1986 developed material that is now probably at the end of its useful life, as the thinking of the group has developed rapidly. The meeting in The Hague in 1987 was described as a watershed, moving into examining the role of consultants. The current meeting has continued that examination, and an important piece of work has been produced with the draft WHO training manual for facilitators.

The question of future meetings was discussed. It was felt to be essential to continue the work to provide a network and support for individual consultants and to allow them to include others not yet involved in the programme. Individual consultants are already assisting each other by workshops and individual visits and exchange of information.

Conclusions

1. The aim of the programme on quality assurance in nursing practice is to promote professional nursing in Europe through quality assurance.
2. The five meetings between 1982 and 1989 show a continuous development of the programme, and the reports will be most useful if sent to nurses as one package.
3. The network and support given by individual consultants to each other by exchange of information, visits and assistance with seminars and workshops has been successful and should be continued and developed further.
4. Direct contact between the French- and English-speaking groups would be valuable.
5. The meetings are vital to the continuing development of quality assurance in nursing practice in Europe. Dr Kitson and Ms Giebing will liaise with the Nursing unit of the Regional Office to discuss ways and means.

Annex 1

EXTRACT FROM THE WEST BERKSHIRE HEALTH AUTHORITY STANDARDS OF CARE TOPIC LIST

PATIENT/CLIENT

Safety	Eliminating hazards Theatre standards Control of infection standards
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INDIVIDUALIZED CARE

Nursing process	Systematic approach
Activities of living	Maintaining a safe environment Communicating
(a) "Physical"	Breathing
(b) "Psychological"	Eating and drinking Eliminating Personal cleansing and dressing Controlling body temperature Mobilizing Working and playing Expressing sexuality Sleeping Dying

CONTINUITY OF CARE	Reception/admission of patient/client Communication - nursing records/reports Deployment and organization of team Discharge/transfer plans/arrangements/liaison
INDEPENDENCE AND INVOLVEMENT	Promotion of self-care - decisions/choices - ability to care for self Rehabilitation Family/carer participation
PRIVACY AND CONFIDENTIALITY	Privacy - environment and attitudes to privacy Records - access to records
HEALTH MAINTENANCE AND EDUCATION	Surveillance and monitoring Teaching intervention Prevention of disease Availability of information
STAFF/OTHER	
PERSONNEL	Selection/interviewing, etc.
BASIC AND CONTINUING EDUCATION/APPRaisal	Competency of nurses/keeping up to date Orientation Professional development
RESEARCH	Research-based practice
PROFESSIONAL ACCOUNTABILITY	Responsibility for decisions
ENVIRONMENT	Environment to enhance effectiveness of therapy

Annex 2

BACKGROUND DOCUMENTS^a

- ICP/SPM 048 Development of standards of nursing practice: report on a WHO Meeting, Sundvollen, Norway, 6-9 December 1982. Copenhagen, WHO Regional Office for Europe, 1983.
- ICP/HSR 302/m01 Preparation of guidelines for standards of nursing practice: report on a WHO Working Group, Brussels, 22-25 October 1984. Copenhagen, WHO Regional Office for Europe, 1985
- ICP/HSR 323 The development of standards of nursing practice: report on a WHO meeting, Brussels, 10-13 June 1986. Copenhagen WHO Regional Office for Europe, 1987 (EUR/HFA target 31).
- ICP/HSR 324 The consultant's role in quality assurance in nursing practice: report on a WHO Meeting, The Hague, 2-4 December 1987. Copenhagen, WHO Regional Office for Europe 1988 (EUR/HFA target 31).

^a These may be obtained from the Nursing unit, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen O.

Nursing standards: towards better care -
guidelines for standards of nursing
practice. Copenhagen, WHO Regional
Office for Europe, 1984.

Nursing standards: towards better care.
Copenhagen, WHO Regional Office for
Europe, 1984.

EUR/RC38/Tech.
Disc./1

Quality assurance of health services.
Background paper for technical
discussions at the thirty-eighth session
of the WHO Regional Committee for
Europe, September 1988.

Annex 3

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