WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

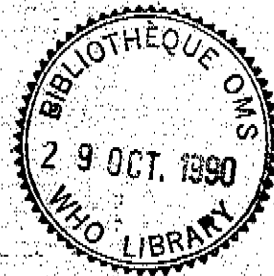
53174

EUR/ICP/HSR 338(1)
6058r
ENGLISH ONLY
UNEDITED

THE DEVELOPMENT OF THE GENERALIST NURSE

Report on a WHO Meeting

Copenhagen
6-9 February 1990



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EUR/HFA target 27

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TARGET 27

Rational and preferential distribution of resources according to need

By 1990, in all Member States, the infrastructures of the delivery systems should be organized so that resources are distributed according to need, and so that services ensure physical and economic accessibility and cultural acceptability to the population.

Index:

NURSING PROCESS - trends
NURSES - trends

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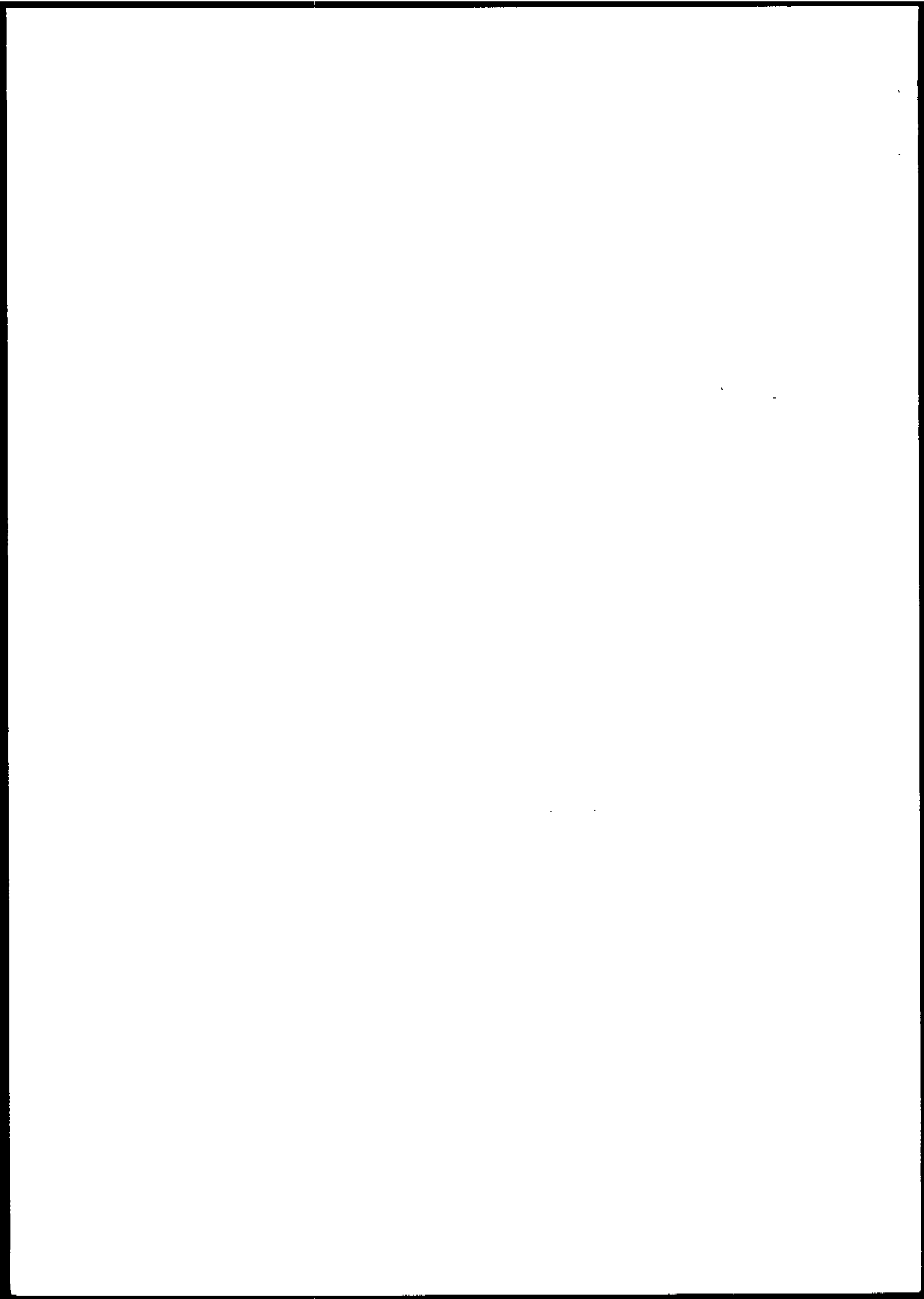

1. Introduction

The Steering Committee on Development of the Generalist Nurse met for the first time in the WHO Regional Office for Europe, Copenhagen, 6-9 February 1990. It was composed of 20 members: 13 representatives of 13 Member States, representatives of the Permanent Committee of Nurses of the European Economic Community (EEC) and International Council of Nurses (ICN) and the Danish/Canadian PHC Nursing Project and two members of WHO/EURO staff. (A full list of participants is given as Annex I).

The terms of reference for the Steering Committee, were as follows:

(1) to provide content for the development of the first draft of a discussion paper on the profile of the Generalist Nurse, (based on existing WHO and other relevant material, e.g. produced by the International Council of Nurses, Council of Europe, the European Economic Community and International Labour Office);

(2) to identify projects in Europe in which generalist nurses (or similar) have been or are being, developed;

(3) to identify existing practice instruments and teaching modules for development of the Generalist Nurse;

(4) to receive information on the Danish/Newfoundland (CANADA) project on Primary Health Care - A Nursing Model;

(5) to advise on the planning of similar experimental projects in four other European countries, including criteria for selection of (i) practice areas; (ii) basic, post-basic and university schools of nursing;

(6) to identify appropriate preparation for nurse teachers and managers to implement experimental curricula and practice programmes;

(7) to suggest membership of WHO consultation groups for (i) the implementation of demonstration projects; and (ii) the development of curricula;

(8) to advise on strategies for ensuring (i) changes in national legislation and regulatory mechanisms where necessary; and (ii) collaboration of health professionals and decision- and policy-makers.

In opening the meeting Dr J.E. Asvall, Regional Director, welcomed participants and described their task as the vital first step towards an entirely new development in Europe. The demographic, epidemiological and social changes occurring in the Region, he said, had resulted in new nursing needs, which could not be met by nurses prepared only for practice in hospital settings. Recommendations from the first WHO Conference on Nursing, held in Vienna in 1988, had emphasised the need for development of a generalist nurse - one who was able to function in both hospital and community: concerned not only with the disease and illness of hospital patients, but also with the promotion and maintenance of health of individuals, families and communities (1) (Annex II). This proposal had been endorsed by Governmental

Chief Nursing Officers at a meeting in Linköping in October 1989. Inevitably, the changes in nursing education and practice involved would meet with resistance and even opposition from some quarters, and appropriate strategies would need to be developed and deployed. Dr Asvall wished the Committee members success in providing advice and guidance to the EURO Nursing Unit in developing the proposed generalist nurse project and looked forward to learning the outcome of their deliberations.

Ms Elisabeth Stussi, Regional Nursing Officer, also welcomed the Committee members and gave a brief account of the recent WHO Nursing programme in the European Region. The proposed schedule for the project under discussion had been drafted as follows:

– Development of the generalist nurse profile and Consultations on i) demonstration practices ii) curricula structure, length and content (basic and continuing)	1990
– Development of the basic curriculum with experimental implementation at pilot sites	1990–1995
– Development of nursing practice demonstration projects including continuing education modules and their implementation	1991–1995
Progress Report to Second WHO European Nursing Conference	1995

Finally, Ms Stussi urged the Committee members to "think globally and act locally"!

2. Background to the meeting

It is well recognized that one of the most important thrusts for achieving health for all is the effective education and use of nursing/midwifery personnel. Yet, to date, the potential contribution which this group of health workers could provide is not being fully realised. Indeed, recruitment, education, appropriate use and retention of nurses pose serious problems for the majority of WHO Member States. It is evident that one of the reasons for this is that the role of the discipline of nursing in society has not been well-defined. Both the education and effective deployment of nursing personnel have suffered as a consequence.

The continued preparation of hospital-trained nurses no longer produces workers who can meet the changing needs of people for care of a nursing nature. It is a practice which ensures that the full potential of nursing and of nurses will never be brought to bear on helping to achieve health for all.

"A genuine commitment to health for all (HFA) in the European Region of WHO implies (among other essentials) a re-orientation in the planning, training and utilization of health professionals" (2). One of the most important of these professionals is the nurse. For the past decade and more, WHO/EURO, in concert with its member countries, has sought to identify and describe the nurse who, through appropriate preparation and deployment, would be able to contribute effectively to the achievement of HFA. For this final phase of the search the Regional Office convened a Steering Committee consisting of nurse educators, practitioners, administrators, and researchers for the purpose of providing advice to the secretariat on desirable characteristics and education of this kind of nurse.

This publication is a record of that advice.

3. The current situation

Members of the Steering Committee began their work by exchanging information on current educational programmes in their own countries. From these descriptions it was apparent that the majority of programmes of countries represented in the group are based on twelve years of general education and have university entrance requirements. The average length of the basic nursing educational programmes represented is approximately three to four years. Most of the programmes were reported as involving, in varying degrees, theory and practical experience related to both community and hospital situations. A few already emphasise health rather than disease. It was reported however, that approximately one-quarter of the 32 Member States in the Region recruit nurse students after only eight years of general education.

In relation to the numbers of various levels and categories of nursing personnel, it was found that these vary widely from country to country. During a brief discussion on nursing auxiliaries, it was re-affirmed that the International Council of Nurses regards the Registered nurse as capable of, and legally responsible for, supervising auxiliaries at primary, secondary and tertiary[a] levels and in all settings.

The lack of data relevant to existing nursing education and to practice projects currently being developed in the Region was a matter of concern, and the group recommended that a situation analysis be undertaken, possibly by one of the Nursing Collaborating Centres. This, they suggested, could be the first stage in establishing a European nursing data bank.

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[a] Within the programme, the WHO definition of tertiary care should be adhered to (ref. Glossary of Health Care Terminology. Hogarth, J. Public Health in Europe no. 4. WHO Copenhagen, 1978). Other WHO definitions shall also be used wherever possible.

These are as follows:

4. Current definitions

The ICN Definition of 'the Nurse' as stated in the Nursing Regulation Project Document (3) and the definitions of 'nursing' as presented by ICN and contained in certain background documentation (4) made available to the Committee, were adopted provisionally.

4.1 The nurse

The 'nurse' is a person who has completed a programme of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country. Basic nursing education is a formally recognized programme of study providing a broad and sound foundation in the behavioural-, life-, and nursing-sciences for the general practice of nursing, for a leadership role, and for post-basic education for speciality or advanced nursing practice. The nurse is prepared and authorized (i) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (ii) to carry out health care teaching; (iii) to participate fully as a member of the health care team; (iv) to supervise and train nursing and health care auxiliaries; and (iv) to be involved in research (5).

The International Labour Organization (ILO, June 1977) defined the professional nurse as "having the education and training recognized as necessary for assuming highly complex and responsible functions, and authorized to perform them" (Recommendation 157) (6).

4.2 Nursing auxiliaries

"In countries with more than one level of nursing personnel, those who assist in the practice of nursing under the standards and the direct or indirect supervision of nurses are referred to in a general sense as auxiliaries or assistants. Specific titles, preparation, and authorization are in accordance with the scope and level of practice, with national custom, and with regulatory policies and practices for auxiliaries in other fields" (7). The ILO Conference mentioned above identified two categories of auxiliaries, a) the 'auxiliary nurses,' having at least the education and training recognized as necessary for assuming less complex functions, under the supervision of a professional nurse as appropriate and authorized to perform them; b) the "nursing aids" having prior education and /or on-the-job training enabling them to perform specified tasks under the supervision of a professional or auxiliary nurse' (8).

4.3 Nurse specialist

"The nurse specialist" is a nurse prepared beyond the level of a State registered nurse and authorised to practise as a specialist with advanced expertise in a branch of the nursing field. Speciality practice includes clinical, teaching, administrative, research and consultant roles. Post-basic nursing education for speciality practice is a formally recognised programme of study built upon the general education for the nurse and providing the content and experience to ensure competency in the speciality practice. Preparation and authorisation are in accordance with scope of practice and with the education and regulatory policies and practices for post-basic specialists in other professions. Titles for nurse specialists include the designation <u>nurse specialist</u> modified by the name of "specialty" (9).

4.4 Nursing

"Nursing, as an integral part of the health care system, encompasses the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages, in all health care and community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual, family and group responses to actual or potential health problems" (10). These human responses range broadly from health restoring reactions to an individual episode of illness, to the development of policy in promoting the long-term health of a population.

"The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death, that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full or partial independence as rapidly as possible" (11). 'Within the total health care environment, nurses share with other health professionals and those in other sectors of public service, the functions of planning, implementation, and evaluation, to ensure the adequacy of the health system for promoting health, preventing illness, and caring for ill and disabled people' (12).

5. The role and functions of the nurse

Discussions on these definitions and also on material contained in other background documentation, led to the following statements being agreed by the group:

5.1 The role of nursing in society

The role of nursing in society is to assist individuals, families and groups to optimize and integrate physical, mental, and social functions as these are significantly affected by changing states of health. This involves nursing personnel in caring functions which relate to health as well as illness and pertain to the total lifespan, from conception to death.

Nursing is concerned with maintaining, promoting, and protecting health, caring for the sick (the infirm and the injured), and providing rehabilitation. It deals with the psychomatic and psychosocial aspects of life as these affect health, illness and dying. Nursing requires the application of understandings, knowledge and skills specific to the discipline. It is both an art and a science and it uses knowledge and techniques from the physical, social, medical and biological sciences, and from the humanities.

Nursing personnel work on a partnership basis with workers from other professions and occupations involved in providing health and related services. When several disciplines are involved in providing health services, their functions should be complementary. Services should be jointly planned and given as an integrated whole rather than as a series of isolated activities. The individual and where appropriate his/her family should be involved in all aspects of health care and nursing personnel should encourage a spirit of self-reliance and self-determination with regard to the establishment and maintenance of good health (13).

5.2 Functions of the nurse

The functions of the nurse derive directly from the role of nursing in society. These functions are universal and remain constant, regardless of the place (home, hospital, factory, school, primary health care clinic, etc.), or the time in or which the nursing care is given, the health status of the individual or group served or the resources available in the situation.

These functions are:

(1) Assessing the needs of the individual, the family or the community for nursing care and identifying and managing the resources available to meet these needs.

(2) Prioritizing the needs and planning and providing the nursing care required.

(3) Evaluating the outcomes of the nursing interventions in terms of the client(s), the nursing personnel involved and the system within which the care is given.

(4) Documenting all aspects of the client-nurse interaction and using the information thus provided to evaluate and improve nursing care, nursing education and the administration of nursing services.

(5) Helping to define and being responsible for applying the ethical and professional standards which guide the education of nursing personnel, the practice of nursing, the administration of nursing services, and research in nursing.

(6) Involving the client and, where appropriate, his/her family in all aspects of care, encouraging community participation, self-care and self-reliance in all matters related to health.

(7) Identifying areas for research or special study designed to increase knowledge and develop skills and technology in health care, nursing practice, education and/or administration and in carrying out the nursing research/studies required.

(8) Educating nursing personnel and contributing to the education of other health and related personnel.

(9) Health education of the public.

(10) Assessing personal needs for refresher and/or advanced professional education and meeting these needs.

(11) Administering (planning, organizing, managing and evaluating) nursing services as an integral component of overall health services.

(12) Collaborating with others in planning, managing, developing, and evaluating health services as a whole.

(13) Delegating nursing activities and tasks to auxiliary personnel and supporting them in their work.

(14) Monitoring and controlling the environment so as to ensure a safe, harmonious and productive therapeutic and work milieu.

The activities and tasks which put into operation the above functions are a product of the knowledge and skills of the practitioners in the discipline and are influenced by the health status of the individual or group served, the self-care abilities of the client(s), the values, laws, policies and customs of the society in which the nurse practises, the availability of other health professionals and ancilliaries and the material resources present in the situation.

Within the limits imposed by the role of nursing in society, the functions of the Nurse, the laws and policies established by the jurisdiction(s) in which the nurse practises, and the resources present in the situation, the activities and tasks involved in nursing comprise an open-ended system (13).

6. Danish/Newfoundland (Canada) project on primary health care: a nursing model (13).

Participants were given a description of the Danish/Newfoundland (Canada) Primary Health Care Project: A Nursing Model, currently being developed in Newfoundland (Canada) and Faxe (Denmark). The overall purpose of this project is to effect a measurable improvement in the health of selected communities in Denmark and Newfoundland through the provision of primary health care services managed and largely provided by nurses.

The project aims at:

(1) effecting a measurable improvement in the health status of individuals and families served by the project;

(2) effecting a measurable improvement in health directed lifestyles;

(3) identifying environmental health hazards and working with the community to reduce and/or eliminate them;

(4) demonstrating a cost-effective way of using resources to provide promotive, preventive, curative, rehabilitative, and supportive services to meet the basic health needs of the population;

(5) giving special attention to meeting the health care needs of high risk groups within such populations as the elderly, the disabled, mothers and children, the chronically ill and persons in high risk occupations;

(6) demonstrating the fact that nurses can provide safe and effective primary health care srvices in an affordable and cost-effective manner;

(7) involving the community in programme planning, implementation and evaluation;

(8) providing around-the-clock services, 365 days of the year in the home, school, workplace, and/or clinic;

(9) developing a prototype of primary health care services which could be usefully modelled, not only in other communities in Denmark and Newfoundland, but throughout the world;

(10) conducting relevant studies and/or research as needed to improve care;

(11) collaborating with other health care providers in order to ensure that the most appropriate care is provided to the client and that good collegial working relationships are operative in the community and between primary health care workers and those in other levels of the health care system;

(12) placing emphasis on assisting individuals and groups to acquire knowledge and to develop skills in self, family and community health care.

These objectives will be achieved by providing selected communities in Denmark and Newfoundland with the kind of primary health care services envisaged in the Alma Ata Declaration. Although these services will be managed and largely provided by nurses, their administration, planning, implementation and evaluation will be carried out in close collaboration and cooperation with the people of the community served and with members of other health disciplines working in the community.

The protocol for the project includes instruments designed for assessing the health needs of individuals, families and communities. In developing the individual assessment tools, Gordon's Eleven Functional Health Patterns and Carpenito's approach to nursing diagnosis have been used. It is anticipated that the assessments will give evidence of needs, (both met and unmet), enable the setting of priorities and highlight any duplications which exist. Cohorts of patients and clients will be followed up and evaluation of the nurses' practice will relate to outcomes of care and audits.

It was reported that the project is strongly supported at both State and Federal governmental levels and that the mass media has shown great interest.

The conceptual framework of the Danish/Newfoundland project was accepted in principle for the European generalist nurse project. The Committee members recognized, however, that it would require considerable development in order to embrace all necessary aspects, including education, legislation (e.g. drug prescribing), manpower issues and research. The group was also aware that the framework and protocol relate only to nursing practice at primary level and that others would need to be developed for nursing practice at secondary and tertiary levels. They emphasized, however, that the primary health care approach must apply to all.

7. Profile of the generalist nurse

It was agreed that the role and functions of the generalist nurse are in accord with those of all nurses. Specifically, however, he/she:

(1) is the lynch pin of the nursing personnel system in every country and thus the single most numerous nurse prepared at the basic, professional level;

(2) is an autonomous practitioner of nursing accountable for the care he/she provides;

(3) accepts responsibility and exercises requisite authority in the provision of nursing care direct to individuals and groups;

(4) employs the primary nursing method in providing care to individuals and groups;

(5) is qualified to:
 (a) assess the health needs of individuals and groups;
 (b) identify which of the foregoing needs can be met most appropriately by nursing care and which should be referred to a worker outside of nursing,
 (c) identify and deploy resources needed to meet the health needs which can be met through nursing,
 (d) plan for, provide and evaluate the care given,

(6) is knowledgeable about and skilled in providing nursing care in all aspects of comprehensive health services (promotion, prevention, cure, rehabilitation and support);

(7) is prepared and willing to provide skilled nursing care to persons in the place where his/her health care needs can be met most appropriately (i.e., homes, hospitals, chronic care institutions, schools, community health clinics, work places, etc.);

(8) applies accepted and appropriate cultural, ethical and professional standards to all aspects of his/her work;

(9) is qualified to act as leader of a nursing care team which may include other nurses as well as a variety of auxiliary nursing personnel;

(10) can effectively administer all aspects of the nursing care of individuals and groups;

(11) is able to contribute effectively to multidisciplinary and/or multisectorial planning for, and evaluation of, health services;

(12) is able to identify needs for, and to participate in, nursing research;

(13) applies the findings of nursing and health care research as appropriate, to meet the needs of individuals or groups under his/her care;

(14) is qualified to teach patients/clients about health, its restoration and maintenance and to participate effectively in the provision of clinical experience for nursing students;

(15) works collaboratively and cooperatively with patients/clients and other health and related workers to foster and establish a working partnership of equals;

(16) has well developed communications skills;

(17) is able to identify personal needs for continuing education and to find ways of meeting these needs;

(18) is qualified for admission to advanced (post-basic) studies in nursing.

8. Nursing auxiliaries in relation to the generalist nurse

The Committee members recognized the importance of clarifying the role of the nursing auxiliary in relation to that of the generalist nurse.

They expressed concern regarding the recent separation in some Member States of this cadre of personnel from the supervision of nurses. It was reported that in European countries where there is an oversupply of physicians, auxiliaries are used as 'cheap labour' and as assistants to doctors. Often they have little or no supervision, especially when caring for old people. In other situations, their need for close supervision was said to take nurses away from nursing patients themselves. In Denmark, it had been shown that having a large proportion of auxiliaries in the workforce was actually expensive, as the patients' stay was protracted and their self-care ability diminished.

Throughout the Region, there is a proliferation of various grades of 'helpers' and aides: the removal of the prefix 'nursing' from their title also means the removal of nursing influence. Often such personnel do not feature in official statistics but when they do, they frequently outnumber nurses.

In addition to acceptance of the definition presented by ICN the group agreed the following:

The nursing auxiliary is an ancillary worker in nursing. She carries out her functions with the support, and under the supervision, of the nurse.

The functions of the nursing auxiliary are:

(1) to assist the nurse in the collection of data essential to assessing the nursing needs of an individual or group to evaluating the outcomes of nursing care or to carrying out nursing research/studies,

(2) to contribute to the nursing care plan and to the collection, preparation and care of supplies/equipment essential to the implementation of the plan;

(3) to provide direct nursing care as delegated by the nurse;

(4) to record, on the appropriate nursing record, the care provided and any important observations and/or results of care;

(5) to assess personal needs for refresher and/or other nursing education and meeting these needs;

(6) to collaborate and cooperate with other workers to help ensure a harmonious and productive therapeutic and working environment;

(7) to help to define and be responsible for applying the ethical and professional standards which guide the education of nursing personnel, the practice of nursing, the administration of nursing services and research in nursing (13).

9. Planning experimental projects for developing the generalist nurse in Member States

9.1 Philosophy of the educational programmes

Having defined the profile of a professional nurse able to adapt her practice to the changing needs of society, the group agreed that her newly-defined (recently-expanded) functions should be tested out in a few selected demonstration projects supported by a carefully prepared research based continuing education programme. In turn the teaching modules (or educational material) developed in such a programme could be used in demonstrating educational projects in selected basic, post-basic/university schools of nursing, willing to reorient their curricula on an experimental basis.

Group discussions further emphasized that a key element of the preparation of this professional ('generalist') nurse was the philosophy underlying the pedagogical approach used in the implementation of the programme at any of the educational levels (basic, postbasic/university). Indeed there was consensus that the role of the educator is that of a facilitator, encouraging positive attitudes towards life-long learning and multidisciplinary and intersectoral cooperation It was obvious to the Committee members therefore, that the philosophy relates not only to students and teachers, but also to managers and nurses in clinical practice. Relationships within the teaching/learning process involve partnership, participation, accountability, self-direction and self-reliance.

It was agreed that because it would take at least five years to develop and test a curriculum and produce nurses suitably prepared at basic level the practice demonstration projects, including the continuing education component, should be initiated to run concurrently with the experimental basic and post-basic/university educational projects.

The group identified a few specific publications which they believed would be useful in planning a curriculum for a generalist nurse programme, but was aware that much more work was needed to produce a comprehensive list. Proposed material would also require evaluation before being recommended.

9.2 Basic criteria for selection of demonstration areas

Discussions concentrated on criteria for the selection of demonstration practice projects; those for the selection of educational projects would have to be developed at a later date.

It was proposed and agreed that the basic criteria used for the Danish/Canadian project for selection of demonstration areas could be used also for the European practice projects.

These were given as follows:

(1) Support of a significant number of individuals/groups in the community to be served;

(2) Geographically manageable area within an already defined jurisdiction; approximately 5000 - 10,000 inhabitants desirable;

(3) Availability of second and third (tertiary) level health services within or closely adjacent to the community to be served;

(4) Confirmed possibilities for interdisciplinary collaboration with workers from other health and related disciplines;

(5) No similar service in the community;

(6) The community is composed of a balanced cross-section of age groups, males, females, lower, middle and upper income groups;

(7) Availability of suitable physical facilities at an affordable cost for the establishment of a primary health care centre;

(8) A reasonable public transport system serves the community;

(9) Understanding and acceptance on the part of all directly concerned of the concepts and principles which guide the project, and a willingness to participate actively in the achievement of Project aims;

10) Support of regional/provincial/federal authorities as appropriate (13).

9.3 Developing a protocol for use at secondary and tertiary levels

The group adopted, provisionally, the protocol for practice projects at primary level as set out in the Danish/Newfoundland project description. Protocols for demonstration areas at secondary and tertiary levels will need to be written. It was agreed that these should include pre- and post-implementation evaluation, background, purpose, rationale, designation criteria, implementation and expected outcomes. A timeframe and budget were obviously essential preparation items.

It was agreed that conditions for admission of Member States to the project should be as follows:

(1) Acceptance of the conceptual framework of the project and the principles of primary nursing.

(2) Acceptance of the aims of the project.

(3) A commitment to:

- remain within the practice project until its completion;
- undertake research projects jointly agreed; and
- carry out regular evaluations of the project.

(4) An undertaking to finance the project. (WHO will provide seed money, technical advice and resource materials only).

(5) The implementation (or development) of a national/regional health policy based on the HFA strategy.

(6) Acceptance that management and control of the project will be carried out by nurses.

(7) An undertaking to continue the services developed during the period of the project, and integrate them within the health care system after completion of the demonstration practice project. (Integration from the time of initiation of the project would facilitate this).

9.4 Evaluation of the project and of the practice

The Steering Committee agreed that evaluation was a vital component of the project and accepted, provisionally, the 'arms-length' approach of the Danish/Canadian project. This involves both a process evaluation and an impact assessment. Information for each is collected from interviews and archival sources. Interviews are conducted with the nurses who are running the project, the population served by the project, key informants in the community and other health care providers on whom the project impinges (e.g., local public health nurse, hospital doctors). Archival sources include medical and nursing records and appointment schedules.

Demonstrating that nurses in a primary health care mode can effect a cost-effective way of providing safe, promotive, preventive, curative, rehabilitative and supportive services to meet the basic health needs of the population, was recognized by the group as being a very difficult exercise. A current task of the Danish/Canadian evaluation group is the development of methods for measuring net benefits. A necessary prerequisite is baseline data relating to the community to be served.

Regarding evaluation of the nursing practice, all nursing personnel involved in the project will be required to use standard assessment tools and recording systems. Primary nurses will be held accountable for the outcomes of care for all clients farming their caseload. Concurrent and retro-active record audits will be carried out by nursing staff. It was anticipated that over a period of time the application of audit methods and the comparison of their results relating to acceptable standards of care and to desirable outcomes (jointly determined by the primary nurse and the client), will provide an accurate evaluation of the effectiveness of the interventions (13). The International Project Coordinator of the Danish/Newfoundland Project reported that this kind of evaluation is relatively new in nursing and it is hoped it will contribute to the small but growing body of knowledge in nursing diagnosis and treatment.

10. Recommendations on strategies for implementation of the EURO/NUR project: Development of the generalist nurse

(1) There was unanimous agreement that an overwhelming priority was to increase support for the EURO/NUR six-year programme, in terms of funding and manpower resources. One suggestion was that a European Nursing Foundation be established to attract donations from individuals, corporate organizations and governments. Meanwhile, Committee members undertook to lobby their governments and appropriate nongovernmental organizations on their return home in an effort to solicit financial and temporary manpower assistance.

(2) At regional level:

- organizations and agencies such as the International Labour Office (ILO), Council of Europe (CE), European Economic Community (EEC), and Nordic Council, should be approached to support the programme and to collaborate in its implementation;

- links with nursing organizations and federations (e.g, International Council of Nursing and International Confederation of Midwives) should be strengthened by collaborative efforts in both educational and practice projects;

- links should be forged with information groups and organizations representing clients/patients;

- representatives of the mass media should be involved at an early stage.

(3) At national level, participating Member States should:

- disseminate information on the generalist nurse project throughout the profession;

- encourage the support of all nurses for the project through influential individuals and nursing organizations;

- appoint one key person to:
  coordinate a publicity campaign and also ensure the integration of the programme into national health care policy; and

- appoint a steering group for the project to i) set up an organizational framework, ii) define specific responsibilities according to local health care needs and culture, and iii) appoint a nurse coordinator who possesses specific desirable qualities, such as flexibility and inter-personal and negotiating skills. He/she would need to have had a broad education.

It was the consensus of opinion that the title 'generalist nurse' has a degrading connotation and that thought should be given to an alternative name and also to designing a suitable logo for the project.

Finally, the Steering Committee members expressed a hope that this component of the EURO/NUR programme would help to address some of the urgent health manpower issues now facing the majority of Member States, as it could present an attractive career structure in clinical nursing practice.

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Annex 1

DEFINITION OF THE FUNCTIONS OF GENERAL TRAINED NURSES

Council of Europe
Strasbourg, 25 October 1967
(revised June 1978)

CHAPTER I

DEFINITION OF THE FUNCTIONS OF GENERAL TRAINED NURSES

1. The general trained nurse exercises, in conformity with the national legislation, the following essential functions:

   (a) giving skilled nursing care to persons as required in accordance with the physical, emotional and spiritual needs of the patient, whether that care is given in health institutions, homes, schools, places of work;

   (b) observing physical and emotional situations and conditions which have significant bearing on health and communicating those observations to other members of the health team;

   (c) training and giving guidance to auxiliary personnel who are required to fulfil the nursing service needs of all health agencies.

2. This also involves an evaluation of the nursing needs of a particular patient and assigning personnel in accordance with the needs of that patient at a particular time.

Annex 2

RECOMMENDATIONS FROM THE VIENNA CONFERENCE ON NURSING
June 1988

1. All nurses, their professional associations, nongovernmental organizations and volunteer groups should be strong advocates for policies and programmes for health for all at national, regional and local levels.

2. Innovative nursing services should be developed that focus on health rather than disease; patterns of work should be appropriate, efficient and conducive to primary health care. Governments, health authorities and nurses' professional organizations should take urgent steps to remove factors that inhibit this process and should draw up or modify legislation and regulations to ensure that nurses are able to meet their responsibilities as front-line workers in primary health care.

3. In keeping with European policies for health for all, the nurse's practice should be based mainly on the principles inherent in the primary health care approach. The focus should be on:

- promoting and maintaining health, and preventing disease;
- involving individuals, families and communities in care and making it possible for them to take more responsibility for their health;
- working actively to reduce inequities in access to health care services and to satisfy the needs of whole populations, especially the underserved;
- multidisciplinary and multisectoral collaboration; and
- assurance of the quality of care and the appropriate use of technology.

4. All basic programmes of nursing education should be restructured, reoriented and strengthened, in order to produce generalist nurses, able to function in both hospital and community. All specialist knowledge and skills subsequently acquired should be built on this foundation. Nursing education should include ample experience outside the hospital. Candidates for nursing education should have completed a full secondary education (which may vary from country to country) and have qualifications for admission that are equivalent to those required by a university or other institute of higher education. The directors of schools of nursing or departments of nursing education, and teachers and supervisors of nursing programmes must all be nurses.

5. Nurses managing care and services must base care on the health needs and participation of the population, in accordance with the regional strategy for health for all, and must take account of:

- demographic and epidemiological trends
- the social and physical environment
- lifestyle issues
- cultural values and beliefs and ethical considerations
- economic choices and alternatives
- the qualified personnel available.

Nurse managers must have professional autonomy, so that they can allocate resources in accordance with the principles of the health for all strategy.

6. To ensure the full cooperation of the nursing community, nurse researchers should be appointed to all national research councils dealing with health or related research, including bodies such as the European Advisory Committee on Health Research.

WHO should urge nurses to start community care demonstration projects that produce measurable improvements in care and promote the efficient use of resources in selected communities.

To permit the development of community-oriented nursing practice, education and leadership, nursing research must be a part of all fields of practice.

An equitable share of existing funds should be made available for nursing research projects.

7. WHO, its collaborating centres, intergovernmental and nongovernmental organizations, and national nurses' associations should set up information systems and increase communication and the dissemination of information and research results through national, regional and international networks. Modern technology should be used to strengthen links between consumer and other groups, organizations and institutes.

8. Nursing should be included as one of the essential elements of national health plans now being developed, based on the regional strategy for health for all, and nurses should take part in the debate on health policy.

Legislation on nursing practice should recognize the nurse's contribution to the organization, development and delivery of health care. It should be formulated in a way that promotes nurses' ability to meet the health needs of the population.

9. In the light of demographic trends and their implications for the development of primary health care, health manpower policies should be based on health for all and should include:

- a plan to recruit nursing personnel, drawn up in collaboration with nurses, administrators and politicians and using current manpower data bases;

- terms and conditions of service that attract and retain qualified nurses, ensure the appropriate use of nursing personnel, and recognize continuing education as part of career development;

- a programme of continuing education accessible to all nurses; and

- counselling programmes for personal and career development.

10. In view of nurses' strong influence as role models for the population, individual nurses and nurses' organizations have a special responsibility to exemplify a healthy lifestyle, and, more specifically, to support the concerted European action against tobacco by promoting smoke-free working environments. Cessation counselling should be made available to all nurses who smoke.

Annex 3

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