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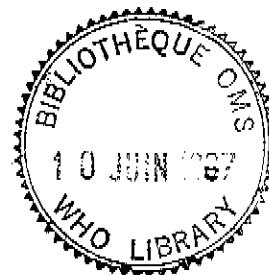
ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

DOCUMENTATION OF THE NURSING PROCESS

DNISMS records

Report on a Working Group

Berne
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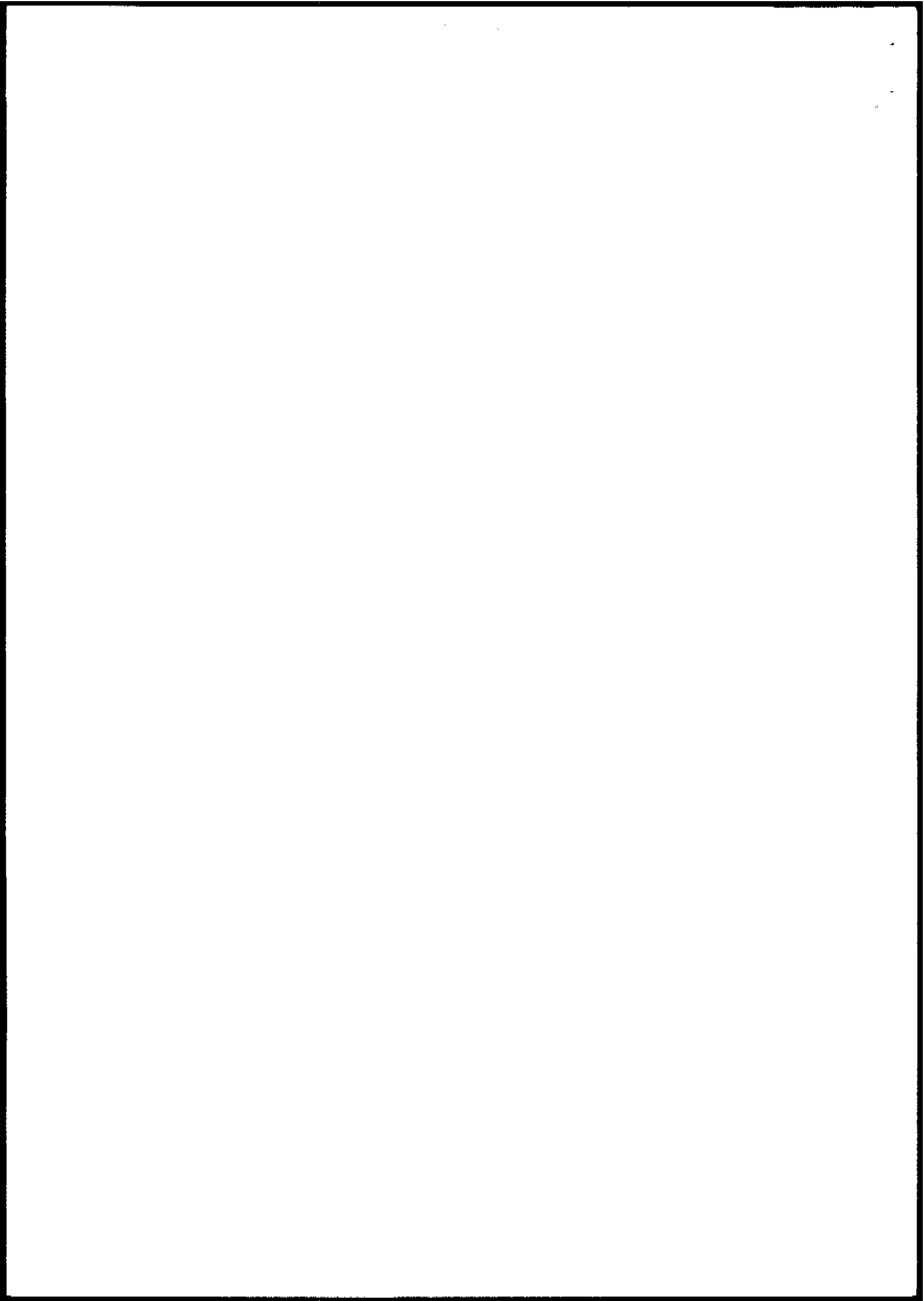
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1. Introduction

The Working Group, convened by the WHO Regional Office for Europe in collaboration with the Federal Office of Public Health, Switzerland, was attended by 33 temporary advisers and two staff members of the Regional Office (see Annex 1).

The aims were:

- to review and discuss the present situation as regards the keeping and use of nursing care records in selected countries of the Region;
- to discuss the role of records in the provision and development of nursing care, using the nursing process method;
- to prepare guidelines on the development of records which, as an integral part of the nursing process, should be kept by every practitioner;
- to provide an opportunity for the programme managers and selected contact persons from type I participating centres to discuss and further develop the records to be used in the multinational "Study of needs for nursing care, planning, implementation and evaluation of care provided by nurses", using two selected groups of people in the European Region.

Dr Frey, Director of the Federal Office of Public Health, welcomed the participants and expressed great interest in the development of the medium-term programme in nursing/midwifery, which he considered to be of prime importance for the improvement of nursing services.

The meeting was opened by Miss E. Stussi on behalf of the Regional Director. The meeting was one of several^{a,b,c} convened within the framework of the nursing process component of the medium-term programme in nursing/midwifery in Europe, one of the major parts of the three-point programme: organization and management, education and resource planning.

The nursing process is a deliberate problem-solving approach which incorporates the principles of scientific methods for meeting the nursing needs of people. It consists of four sequential steps: assessment of needs, planning, implementation of nursing care, and evaluation of the outcome. Records are made at each stage, and this system underlines the importance of a well-developed and well-maintained nursing care record system.

It has become apparent that nurses in the European Region had hoped to improve the quality of the nursing service by introducing the nursing process, but such efforts were often hampered by the rudimentary state of development of the record systems and lack of available opportunities to study the keeping and use of records in order to systematize and/or improve nursing care.

Miss N. Exchaquet was elected Chairman and Dr P. Proffit, short-term consultant to the Regional Office, acted as resource person.

2. Review and discussion of the current situation as regards the keeping and use of nursing care records in selected countries of the European Region

2.1 Country presentations

Representatives from selected Member States described the current state of nursing documentation in their own countries. It became evident that nurses had now developed a keen interest in keeping accurate records identifying the needs of patients and nursing intervention, both planned and made to meet those needs.

^a The nursing process: report on the First Meeting of the Technical Advisory Group. Copenhagen, WHO Regional Office for Europe, 1977 (ICP/HMD 049(1)).

^b Development of designs in, and the documentation of, the nursing process: report on a Technical Advisory Group. Copenhagen, WHO Regional Office for Europe, 1978 (ICP/HMD 049(2)).

^c Evaluation of inpatient nursing practice: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies, No. 4).

Among the reasons given for such increased interest were:

- (a) dissemination of information on and study of the nursing process;
- (b) encouragement received (including that from WHO) to develop the discipline of nursing; and
- (c) awareness that the number of forms relating to one patient/client is rapidly increasing, because:
 - new medical technology demands more comprehensive information and records;
 - physicians and other health professionals request additional observations, sometimes for research purposes or for their own interest;
 - changes are frequently being made in administrative practice;
 - a specific crisis occurs in a ward/unit or department resulting in new "safeguards" that must be documented.

Regarding the last point, it was reported that a new form was frequently introduced when "something went wrong". Examples included failure of a member of the nursing staff either to implement a prescribed intervention, to discontinue a former treatment or to perform some vital observation or test. These ad hoc decisions to increase recordings ignored the obvious need to ascertain why "something went wrong". Usually, no critical analysis was made of either the methods of documentation already in use or of the work procedure that had led to the omission in the first place. It was the resulting plethora of papers, forms, leaflets, charts, boards, notices and handouts that had increased the awareness among nurses that a reorganization of record-keeping and documentation systems was urgently required.

As a result, they had begun to think more logically about patients' needs and the nursing action and care required to meet those needs. This, as well as revisions of nursing curricula in several countries of the Region, had led to widespread study of "the nursing process" and in some instances the introduction of new nursing documentation systems, either locally or nationally.

Where a system had been introduced locally, the ward or hospital concerned had often been used as a model or source of reference for other wards or hospitals in the area (e.g. Leuven, Belgium). Sometimes more than one hospital in the same area had simultaneously planned and introduced a new system so that a national trend developed (e.g. France, UK).

2.1.1 Belgium

Since 1973/1974, the documentation system of nursing care in Belgium has been gradually reoriented from a task-centred to a patient-centred approach. At the present time, the majority of hospitals use:

- seven-day physical care sheets, which are medical prescription cards as well as nursing worksheets;
- nurses' note sheets which consist of (a) individual information or remarks concerning the patient, including specific problems or difficulties; (b) interventions carried out by health professionals other than nursing staff; and (c) chronological reports of nursing care given and observations made.

These two documents are filed together so that all information concerning the patient can be shared by all staff members. The use of the large physical care sheets, covering all care planned and given over a one-week period, has resulted in a decrease in transcription errors and an improvement in teamwork between doctors and nurses. Additional documentation includes recordings of fluid balance, pre-operative checklist, coma-scales, etc., and task-oriented collective recordings (e.g. booklets for recordings of pulse rates and temperatures of all patients) which have later to be transcribed to individual charts. Adaptations are made for special units such as baby care and intensive care.

In the university hospitals, all nursing documentation systems are reviewed regularly and amended as necessary. Advances in medical diagnosis and treatment have rendered traditional systems of recording obsolete. The general trend is towards more individualized care, and more responsibility is being given to qualified nurses.

The aim is to change both the documentation system and the approach to patient care; patients' notes are being revised to produce an attractive format, one which can be easily handled and be available in the patients' rooms. Patients are being assigned to individual nurses who are primarily responsible for the planning and implementation of all nursing care, from admission to discharge (primary nursing), all steps of the nursing process being used.

Both formal and informal networks of communication between professionals are being used for sharing information on the development of nursing documentation and initiating changes. In some instances such developments are supported by continuing education sessions and/or courses of several weeks' duration to provide preparation of appropriate change agents (from both service and educational programmes) to help them to introduce patient-centred nursing care in their hospitals by using the nursing process approach.

2.1.2 Denmark

In Denmark, the use of care plans as a means of teaching the nursing process was first introduced in schools of nursing 12 years ago. Various frameworks have been introduced over the years and, because some have been highly complex, in practice their use has met with opposition.

More recently, the Danish national health service produced papers suggesting desirable developments of community nursing plans, but as yet their value is recognized by only a few nurses.

In hospitals, the most widely used is the Kardex system, which gives mainly retrospective information on patients, but these records are not always kept in the archives when the patient is discharged from hospital.

Nurses have kept medical records for so many years that they have grown accustomed to seeing their patients' needs in terms of medical rather than nursing problems. Some nurses, however, are becoming aware of the need to develop individual nursing care plans for their patients and a few have succeeded in doing so.

2.1.3 Finland

The findings of a national survey in Finland have revealed a need to develop nursing documentation. It is now hoped that the WHO multinational research project will result in the production of guidelines to assist Finnish nurses in this task. Meanwhile, two main medical/nursing recording systems are in use throughout the Finnish health service. These are:

- the continuing patient record system used in general hospitals since 1974, and
- the patient record used in the psychiatric field (for both inpatients and outpatients) since 1979.

A third health record, for introduction in primary health care centres, has been in preparation since 1974.

Patients' records used in the psychiatric field comprise 15 different forms, which were listed in a circular letter issued by the National Board of Health in 1979. The Hospital League prepared both the guidelines for the use of such records and the suggested design of forms, three of which are particularly relevant for recording nursing interventions.

(1) The "care plan" with the following headings:

- problems expressed by the patient;
- problems assessed by the health worker and/or team;
- planned examinations and other data;
- objectives of care;
- methods of care (= interventions);
- evaluation of patients' condition;
- plan for the continuity of care.

This care plan is used by the whole psychiatric team, including the nurses.

(2) A daily progress note sheet.

(3) A follow-up form which serves three purposes, i.e. documentation of patient's situation at the beginning of his/her hospital stay, summary of progress, and the writing-up of a final statement.

The last two are for the use of nursing staff only.

A uniform record system, for use in primary health care centres, is at present being developed by the National Board of Health. The function of the system is to serve planning, implementation and monitoring of guidance and care given to the client. The main principles are the same as in the record systems described above. Primary health care records should include adequate information on health status, on objectives of care, on means for attaining the goals including guidance given, on monitoring implementation, and on the evaluation of outcomes and continuity of care.

The records for maternity care, child health and school health to be used by midwives and public health nurses are stringently structured and will facilitate the monitoring of normal development of pregnancy, infants, schoolchildren, etc.

2.1.4 France

A study undertaken by the WHO collaborating centre at Lyon endeavoured to accumulate information on documentation systems and the ways in which nursing records were being used in France. One hundred and twenty questionnaires had been sent to directors of nursing services in all regions of the country and 40 replies had been received, some accompanied by copies of documents being used.

It was found that many had been introduced as a result of the new definition of the nurse and the functions of the nurse, which had been legally adopted for the country. As a working tool, nursing reports not only collated information on patients, but also helped in the organization of the nursing service. With young children, especially when many categories of health workers were involved, precise and detailed written information was essential. Long-term effects included the improvement of teamwork through broader communication and improved collaboration. Thus, services were more easily coordinated.

In some instances, the opening of a new hospital or the development of a new service meant greater motivation on the part of the nursing staff and the will to improve the nursing service. This created a good climate for the introduction of new documentation systems.

In many cases, various health professionals used the same documentation, but many entries were left unsigned. This practice could lead to difficulties. The larger part of the majority of nursing records was given over to medical prescriptions and technical procedures. Information on the patient - his eating and elimination habits, lifestyle, sociocultural situation and mental health, was documented less often, as was the evaluation of the outcome of the care provided. Of the respondents, 26% reported that they were using the nursing process approach in their practice.

2.1.5 Poland

In Poland, ward reports include information on acutely ill patients, patients who have commenced new drug therapy, patients who have been subjected to diagnostic or therapeutic procedures, and patients who have specifically expressed discomfort. A brief description of all patients admitted or discharged is also made daily.

In intensive care units, 24-hour observation cards are used by all team members and, although some recordings may relate to nursing interventions, they tend to contain medically oriented information rather than comprehensive information required by the nursing process approach.

While nursing recordings made in the community service consist only of data required for statistical purposes, they do provide some kind of record standardization and ensure that the nurses write about the care they give.

The importance of nursing documentation has been realized, and the subject is the main area of research of at least one nursing faculty in Poland.

2.1.6 Sweden

In the past, systems and methods for keeping nursing records in Sweden have formed part of the patient-report administrative system for registering medical prescriptions and treatments. More detailed nursing records have been introduced in recent years because of the high turnover rate of patients, the increased numbers of nursing personnel due to shorter working weeks and part-time employment, and in order to facilitate the appropriate replacement of personnel.

Two systems of Kardex are in use: one similar to that used by Denmark and another, prepared by the Swedish Planning and Rationalization Institute, which is used by the entire care team. These records are kept in the nurses' station. Separate forms are used to record nurses' notes on discussions with relatives and social workers.

2.1.7 Switzerland

Data collected from patients in Switzerland relate mainly to their physical condition. Although the Kardex system has been introduced on a national scale, several institutions have developed their own "politique (or conception) de soins infirmiers" - a kind of declaration of belief of what nurses wish to accomplish in their practice and, therefore, what they see "nursing" to be.

2.1.8 United Kingdom

The keeping of nursing records has received considerable attention in the United Kingdom over the past decade or so. This has been partly due to the publication of a national report on the standardization of hospital medical records (the Tunbridge Report, 1965). While clinical areas of acute care have reasonably efficient documentation systems for specific procedures, such as drug administration, in the majority of instances records of nursing care remain scattered, intermittent or generally inadequate.

Studies undertaken of both hospital and community nursing services have shown little evidence of planned nursing care; usually nursing appeared as "a haphazard series of events" (1).

A disturbing fact that emerged from McIntosh's study (2) on the records kept by district nurses was that the identification of a problem or difficulty by the nurse did not necessarily mean that action was taken to deal with it. For example, 43% of problems relating to diet and 47% relating to incontinence had not been followed up. Hospital studies (3,4) had revealed that the only recordings made by nurses related to physician-directed treatments or to preparation for operations.

The use of, and documentation related to, the nursing process was helping to change this situation, and it was gradually being accepted that recordings should include nursing care planned, nursing care given, and the effects of the care given on the general wellbeing of the patient - with special emphasis on any difficulties or worries they might have. In an open letter from the Department of Health and Social Security in 1979, the Chief Nursing Officer said, "It is impossible to over-emphasize the importance of the nursing record. It is a prerequisite to any attempt to establish, assess and improve standards of care" (1).

It was stressed that adequate preparation had to be made for the introduction of any new forms; without it, they were either not used or were completed and filed without further reference. While a convenient size and format of documentation, e.g. A4 Kardex, may assist in its adoption, acceptance of new record keeping can only be achieved when it is seen as an essential part of nursing care and not just another task of doubtful value.

2.2 Discussion

The Working Group discussed some of the nursing documentation available to it. In many of the reports examined, information was either vague (e.g. "the patient is up and about"), nonspecific (e.g. "dressing renewed", without comment on the condition of the wound), related to the reactions of staff members (e.g. "nice old lady - very cooperative", which said more about the nurse and how the patient fitted into the system than about the latter's condition) or descriptive of medical procedures (e.g. of investigations carried out or medication given and without evaluation of their effects).

It was recognized that, in the past, nurses have collected a good deal of the information needed by doctors to make medical decisions. Where doctors and nurses have worked in partnership, the sharing of information has become a two-way process in which workers from each discipline identified and recorded information that would then be shared for the benefit of the patient and of the practice of both disciplines. Nursing is the only profession which, in the institutional setting, has round-the-clock contact with patients and, in public health settings, has the closest and longest contact with patients. Thus, there is an obvious need for nurses to be able and willing to record and share relevant information with related health workers. They should not, however, allow themselves to become merely data collectors for others.

Clearly, information on patients relating to their lifestyle, habits and sociocultural background should be collected and the new concept of nursing (including patient assignment and patient-centred care) will influence the development of appropriate documentation. The Group emphasized that the collection of data is not a means in itself. Rather, it must be the means to an end, i.e. to optimize the system of care. The steps of the nursing process were in accord with and facilitated this aim.

It was suggested that the fact that nurses have not reported on their nursing practice was indicative of the current reality of the profession, of the present-day philosophy of nursing and - when only medical data are recorded - of the position nursing is accorded in a country.

Reporting was seen as a means of communication between team members regarding patients' needs, and that sharing such information could:

- improve standards of care;
- ensure continuity of care;
- enable nurses to learn more about health needs and how these are "presented" by patients;
- lead to team conferences, thus improving coordination of services.

The Group also saw reporting as necessitating nurse-patient interaction and thus helping to overcome nurses' fear of communicating. Often, this fear was not recognized, and the onus for lack of conversation devolved on the patient, who was often described as not wishing to talk or talking only about his disease.

The need for confidentiality was also sometimes used as an excuse for the lack of documentation, and the Group discussed at length this ethical dimension of the subject. It was agreed that it is essential, when introducing written documentation systems, to preserve confidentiality. This need should be included in the teaching and preparation of staff before introducing the change.

While standardization of documentation for the collection of patient data or for patient preparation before an investigation or treatment (e.g. cholecystogram or a course of chemotherapy) was permissible, participants saw a danger that this could lead to standardization of care. They emphasized that data must be analysed and interpreted for each patient individually. Nursing activities might be computerized, but nursing plans must be developed on a personal basis.

2.3 Summary

It was evident from the presentations of each country and the subsequent discussion that existing nursing records can be divided into two groups:

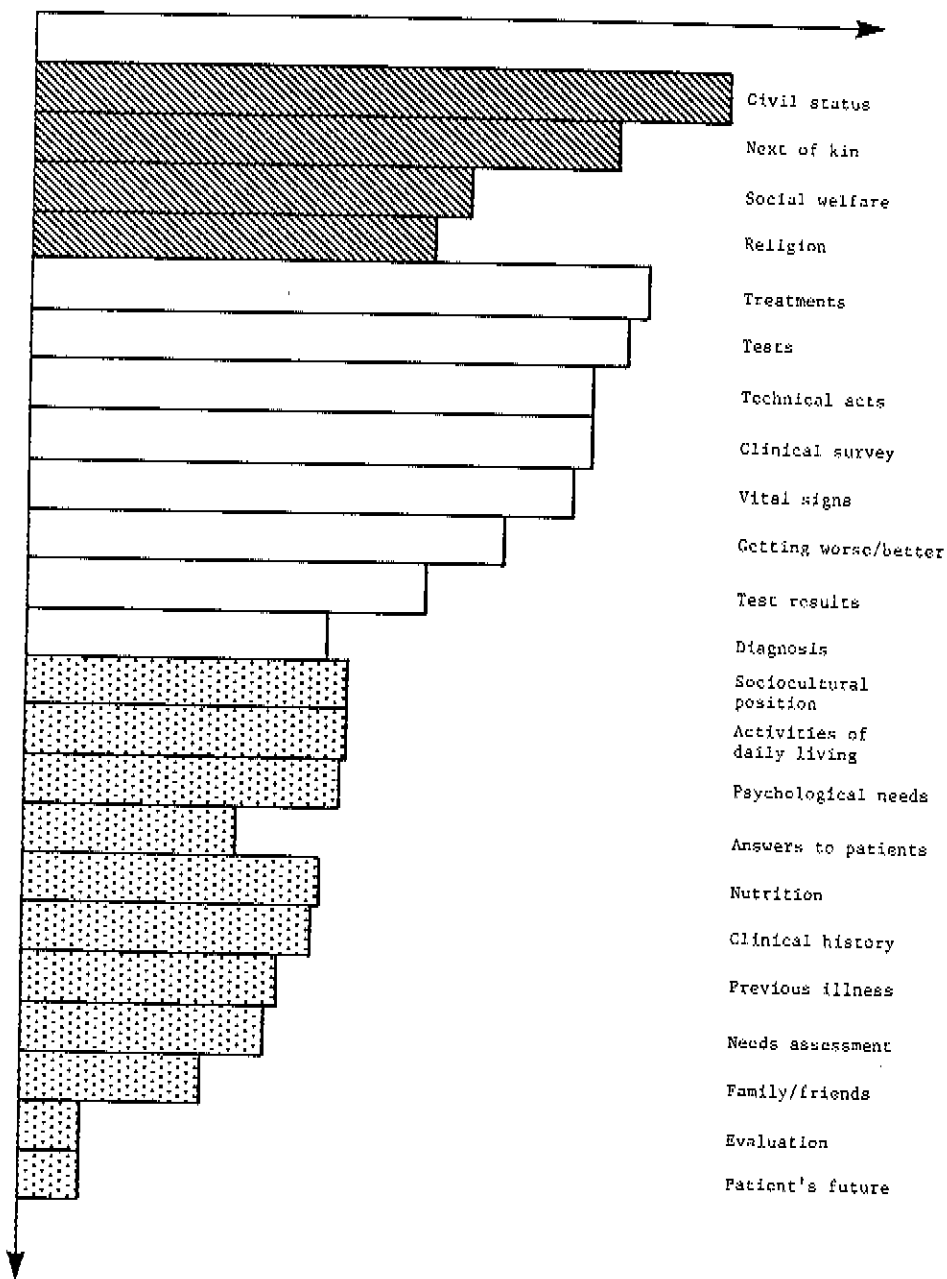
- (a) unstructured treatment sheets for recording observations and procedures unsystematically (very often this type of documentation relates to traditional, job-oriented nursing practice);
- (b) care plans and progress notes which either have been introduced or are being used experimentally; these either:
 - include the elements of systematic nursing; or
 - guide nursing staff to use the nursing process; usually included are such headings as "problems", "objectives", "plan", "implementation", "progress notes" and "evaluation".

Experimental formats are:

- (a) Kardex: introduced at the national level in a number of countries, including Switzerland and those of Scandinavia, in the 1960s and 1970s;
- (b) observation sheets, prescription sheet, working-cards for implementing care, and forms for collecting general data on patients.

Some participants had analysed the content of various documents in use in their own hospitals or countries. Interpretation of such critical analysis was presented in the form of a histogram by the delegate from France (Fig. 1). Such an analysis can be helpful in determining the changes required in existing documentation and demonstrating areas in which educational programmes require greater emphasis (objectives of care, evaluation, etc.).

Fig. 1. Analysis of existing documentation in France



3. Discussion of the place of records in the provision and development of nursing care, using the nursing process method

It became obvious during discussions that there is a gradual reorientation of nursing care in many Member States; the performance of a series of isolated tasks is giving way to comprehensive planning and implementation of total patient care on an individual basis according to the needs of the patient/client or family.

The documentation of the nursing process is a sine qua non for the improvement of nursing care. Without accurate recording, there is no way in which information essential to the development of new knowledge in nursing can be systematically obtained. Each nurse has a responsibility to work in partnership with other nurses in the collection, analysis and assessment of relevant information regarding care. This increases initiative and creativity and also develops a sense of responsibility.

In some countries of the Region, however, nurses are still hampered in their efforts to improve the quality of nursing care and/or to provide continuity of care, by a lack of an appropriate documentation system relating to the four steps of the nursing process. Some existing documentation systems also need further development in order to achieve better collaboration between team members and coordination of the care being given to each patient/client/family.

It was agreed that nursing records should relate to the four major steps of the nursing process, i.e. an assessment of the needs for nursing care, planning to meet those needs, implementation of the plans made, and an evaluation of the results.

First, it is essential to identify the information required to make an accurate nursing assessment, but because it is also important to limit data collection, data not required in certain situations also have to be recognized. Nurses, therefore, should begin to develop knowledge regarding what information is required on the physical, psychological and social aspects of each patient/client and what specific information is required for particular groups or types of patient/client (e.g. elderly patients). Only when the use of the data is determined will nurses know what information they require.

It was agreed that this would only come about as a result of experimentation and experience. For this reason, the Group welcomed the multinational study of needs for nursing care, planning, implementation and evaluation of care provided by nurses being undertaken in the European Region.

Participants saw the documentation of nursing care as providing one basis for nursing research. Findings from such studies could provide governments with information on which the reorientation of nursing education and the reorganization of nursing services (where needed) could be based. It was to be hoped that research on nursing documentation such as that being undertaken in Poland would be initiated in other countries.

The Group reconfirmed that nursing today is a discrete health discipline, whose primary responsibility is to assist individuals and groups (families or communities) to optimize function within various states of health (5). An essential method whereby the profession can fulfil this responsibility is through the nursing process: a deliberate problem-solving approach which incorporates the principle of scientific methods for meeting the nursing needs of people. It is a method which enables nurses to provide more individualized care to people and to maintain continuity and an appropriate consistency of care. This requires a well-structured system of documentation of the process without which the aim of nursing cannot be achieved. In the past, many nurses saw the care of patients and the recording of that care as separate functions of nursing personnel. Today, it is increasingly recognized that the recording of care given is part of that care.

3.1 Effects of "documentation of the nursing process"

The etymological derivations of the major concepts discussed provide meaning to their vital associative linkages (Fig. 2). The basic terms "discipline", "doctrine" and "document" suggest the essential dependence of one on the other, i.e. a discipline relies on the theory and principles that comprise that branch of knowledge, and the documentation of that discipline furnishes the requisite evidence.

The nursing process involves the specialized use of the scientific method, an alternative to ritual, random, chance, traditional methods of thinking and acting. This is the method used in discovery and is the most effective, efficient and creative means for the development of a dynamic science. Whether one speaks of perfecting the science, problem solving, research or the nursing process, the method is consistent; underlying the method is the process of critical reflective thought (Table 1). The nursing process uses a scientific method by which a more complete, systematic and methodical approach is used and which enables the nurse to provide more individual care. The realization of the nursing process, therefore, requires not just reorganization of work, but a reorientation of thought and action. Through this method, nursing is moving from the reactive to the scientific, from the institutional to the individual, from the routine to the creative, and from the dependent to the accountable.

Fig. 2. Interrelationship of etymological derivations

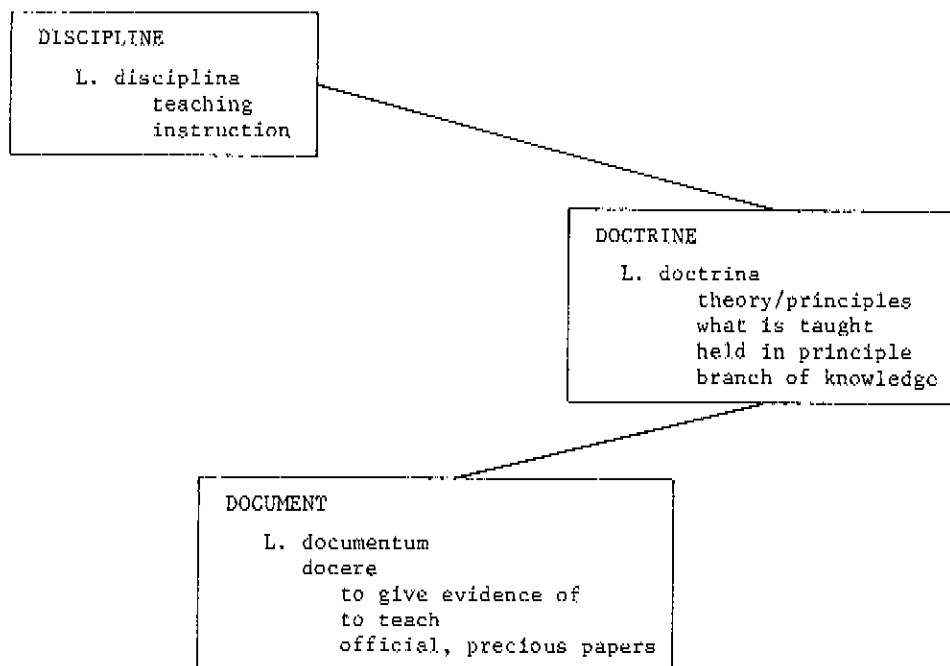


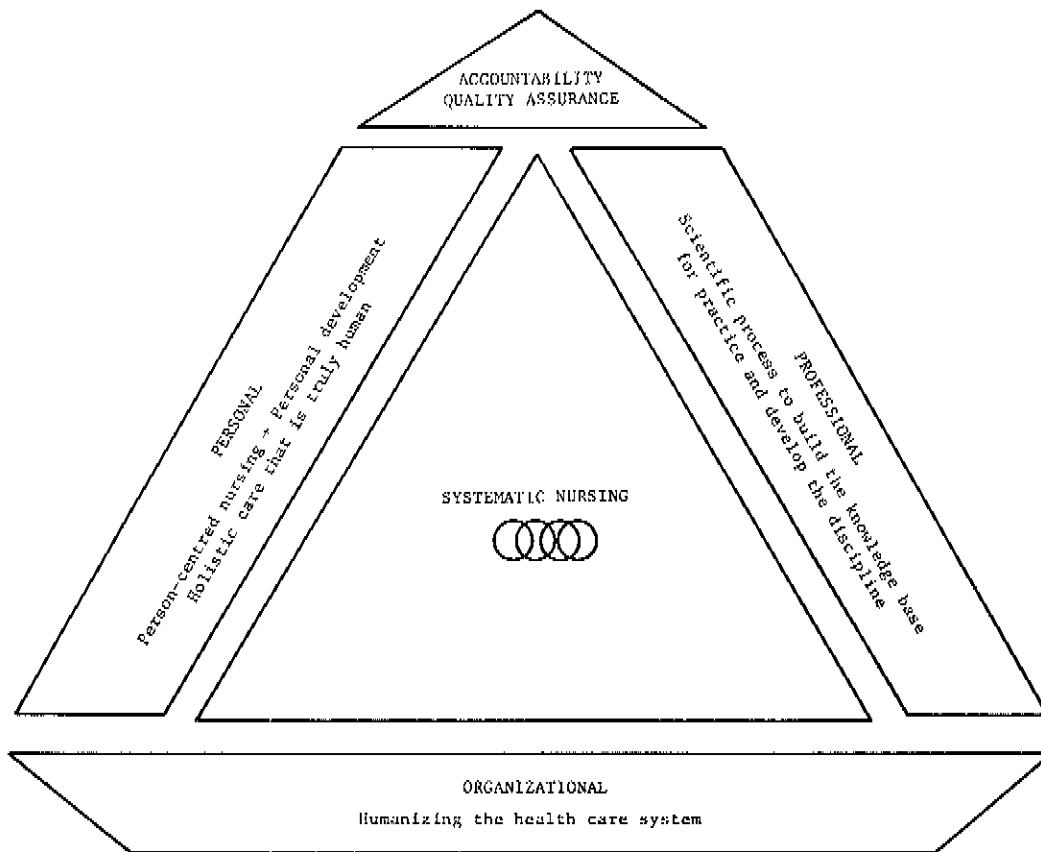
Table 1. The process of reflective thought exemplified consistently through the dynamic method of discovery

Scientific method	Systematic nursing/problem-solving	Research
1. Awareness of a general problem area	1. Recognition of general problem area or patient/client need for nursing	1. Unanswered question, concern curiosity, confusion, patterns
2. Operations to specify more precisely the problem (a) survey pertinent information (literature) (b) develop "hunches" concerning possible solutions to problem	(a) survey pertinent information - assess patient/client status - review other pertinent information - through communication with patient/client, develop impressions - reflective thought and conceptualization process - descriptive definition of the need for nursing (Assessment)	2. Specification and narrowing of the research problem (a) preliminary survey of the literature for pertinent information related to the problem (b) observations of the phenomenon to be investigated
3. Formulate and propose hypotheses to resolve	2. Propose a plan for nursing care (a) goals/objectives (b) interventions/actions (Planning)	3. Statement of the research problem and related subproblems in clear and specific terms
4. Test hypotheses (a) establish baseline data (b) state criteria for acceptance or rejection (c) collect data (d) analyse data	3. Implement the interventions (Implementation)	4. Formulation of hypotheses (a) state criteria for accepting or rejecting hypotheses (b) identify theoretical/ conceptual framework guiding investigation and suggesting predictions
5. Evaluate and interpret results	4. Observe, analyse, interpret results or outcomes of interventions (Evaluation)	5. Test hypotheses (a) collect and analyse data
		6. Evaluate outcomes and formulate conclusions

Systematic nursing through documentation:

- provides a means to improve clinical consistency, validity and reliability of nursing actions and brings to the profession a dynamism and spirit of creativity;
- provides the foundation and spirit for organizational change, personal development and professional growth, as well as a means for accountability and quality assurance (Fig. 3);
- has, through its emphasis on the individual patient, the reciprocal effect of humanizing the treatment, rejuvenating and reinjecting meaning into the lives of the recipients, as well as the providers (6).

Fig. 3. The effects of documentation of the nursing process:
personal, professional, organizational

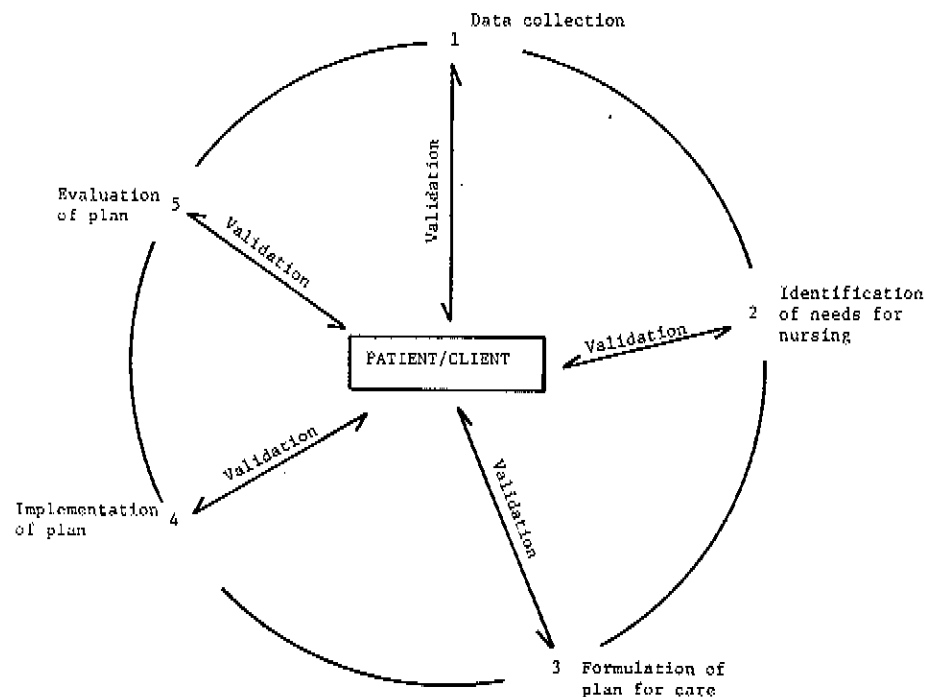


Professional improvement is an obvious consequence of systematic, validated and documented provision of effective care. Utilization of the scientific method enhances the science of the nursing discipline.

Systematic nursing involves several components that are inherent and vital to the accomplishment of nursing as a specific discipline. The essential goal is to perceive accurately the needs and to understand the patient through an organized and precise method for collecting, validating, analysing and interpreting information. The sympathy that guides the nurse must include respect for the unique identity of the individual.

Likewise, the nursing process itself requires that the patient or client be viewed as valuable and, therefore, as the focus of nursing concern. The person is valued through his/her participation throughout the nursing process and the establishment of the nurse-patient relationship. Also, evaluation of the outcome hinges on an appreciation of the patient-client perception. A representation of this process is presented in Fig. 4.

Fig. 4. Nursing process as valuing: patient/client as valuable
person-centred nursing care focus as a value
basis for evaluation is the validation with the person



3.2 Aims of documentation

The components of systematic nursing all provide substantial reasons for documentation (Table 2) and also indicate areas requiring further development of personal and professional dimensions.

The acquisition of raw data and the subsequent intellectual conclusions suggested that clinical practice is neither art nor science; there is no clear distinction nor any precise division between them. Every function contains and incorporates elements of both. Of all human endeavours, clinical practice in health care is the most scientific art and the most humanistic science. The art and the science must be integrated, symbiotic and inseparable. Without the art, there can be no scientific data; without the science, the art can achieve little or nothing.

The management of health care information invokes a significant dimension, relating to people. Every health care system involves human beings and depends for its ultimate success on their performance and behaviour towards each other. Seen from this vantage point, records are an absolute practical necessity; documentation is a fundamental of all responsible health care.

There are many reasons for documenting the nursing process, not least the invaluable uses to which such recordings can be put.

(1) As a means of communication:

- by presenting relevant information via a common, explicit form, in which the thinking process is made available;
- by providing a source of self-knowledge, initiative and creativity;
- by providing a source of available, usable data, especially valuable in an era of increased complexity because of the increasing numbers and categories of health care personnel;
- by offering support for, and support by, others in the health care system.

Table 2. Components of systematic nursing: partial processes

Components	Related goals	Challenges/Tasks
COMMUNICATION for relationship building	To perceive accurately To understand	To learn the other from the other's frame of reference To recognize the possible discrepancy between the subjective and objective frames of reference To include perceptions of others regarding the person's strengths, needs and goals for care
NORMING/STANDARD SETTING for the identification of the need for intervention	To identify existing norms and to establish norms where lacking To formulate decisions regarding how much deviation from health and what kinds constitute a pattern requiring intervention To make decisions concerning appropriateness of behaviour with regard to health/illness dimensions	To develop awareness and appreciation of the interrelated dynamic: which norms, set by whom and in what setting To develop knowledge concerning an awareness of the shifting and overlapping ranges of "normal" within the dynamics of the developing person To avoid psychological "shoulds" which are unrelated to the qualities and capacities of the person
FRAMEWORK for focused observations and/or focal questions	To increase precision in observation and interaction To focus cognitive actions for specific, sequential areas for understanding and for relationship building To focus the perspective of nursing on health and strength building To raise levels of consciousness and intentional operations, such as experiencing, understanding, judging and deciding	To develop a repertoire of questions or situational challenges which reflect status To identify mechanisms to support and enhance the wellbeing/strengths dimensions of human behaviour To develop skills and comfort in the use of questions to elicit responses which reflect patient/client perceptions

(2) As a mechanism for accountability:

- by making use of available knowledge to assign responsibilities and for being answerable for decisions (even where nurses cannot assume complete responsibility);
- assessing quality.

(3) As a method for data collection:

- by providing chronology and assessment, observing patterns, retrospective analyses, anticipation of the unexpected;
- by providing data of patient progress that is reliable and objective;
- by providing data for the detection of trends.

- (4) As a means of individualizing care:
 - by taking into account and documenting individual needs, strengths and individual traits, thus making discriminating nursing judgements based on knowledge of the person;
 - by making accessible data which reflect the individual responses;
 - by using explicit elements in order to plan care programmes.
- (5) To integrate various aspects of the patient:
 - through complete documentation, patterns of behavioural responses, patient or client background may be analysed as significant;
 - through clarification of the interrelated systems affecting the subject;
 - by increasing awareness of the reciprocal effects of mind/body/spirit in health care and the multidimensional aspect of health itself, as well as of illness and its effect on the human system as a whole.
- (6) As a method to assure continuity of care and direction of care:
 - by providing a common, unfragmented documented planning of care;
 - by identifying patient needs to all members of the health team;
 - by providing a base for explicit instructions to communicate and cooperate in direct planned care based on accurate and comprehensive data.
- (7) As a means of evaluation:
 - by providing a means to review, study and determine outcomes of care in the effort to ensure quality;
 - by providing data for structure/process/outcome determinations.
- (8) To maximize interdisciplinary cooperation:
 - by providing a common planning method;
 - by providing multiple inputs from various health disciplines derived from their areas of expertise, superior competence and basic knowledge.
- (9) To provide legal coverage:
 - by providing evidence of, or information on, care provided;
 - by explaining patient/client problems, an awareness of possible complications and facilitating the implementation of planned care based on that knowledge.
- (10) As a means of increasing efficiency of care and establishing a foundation for effective care planning:
 - as an indirect outcome of documented data collection and observations;
 - as an indirect outcome of the means whereby health professionals can communicate.
- (11) As a means to further the education of professionals:
 - by providing source materials for clinical teaching;
 - by furnishing data for case analyses of student performance and effectiveness;
 - by providing source material for peer review.
- (12) As a method of expanding the science of nursing:

- by providing explicit data and evidence regarding the outcome of nursing interventions for systematic studies in nursing research;
- by providing descriptive data concerning the practice of nursing in which concepts may be analysed and the research - theory - practice cycle may be fully utilized.

As with any innovation, the institution of a system of documentation is likely to reduce resistance to the change. The Group went on to consider some of the more common objections of which they had had personal experience.

In relation to the time documentation employs, they agreed that while it is true that time is consumed in the early stages, in introducing any new skill, scientific evidence suggests that time is ultimately saved. A complete and accurate data base for planning avoids costly errors, helps to provide more relevant care and maximizes the use of appropriate staff, their assignment being based on their individual strengths, experience, capacities and qualifications.

Contrary to the belief that the paper work involved detracts from nurses' contact with their patients, the entire process involves nurse and patient (or client) in reciprocal sharing and mutual understanding. Time has to be spent with the patient and communication is always a two-way process.

Some nurses maintain that the nursing process is "done without actually writing it all down", but the difficulties health care professionals experience when trying to conceptualize problems or needs, and when attempting to formulate objectives for care, strongly support the theory that it has not always been "done". In this context, it was suggested that "if you can't write it, you don't know it". Documentation is an essential professionally, legally and ethically.

Substantial evidence suggests that systematic methods are more valid and reliable, more efficient and effective than mere chance, intuition, tradition, trial-and-error and the more random forms of practice. Without documentation there can be no evidence to support either method.

It has been demonstrated that this method saves money and time (which is money) and though early efforts to build a documentation system may involve initial outlays, the method, by increasing accuracy and reducing error, is cost-effective. Documentation also provides for the sharing of information and for communication among all health professionals. This can reduce duplication of effort. The Group welcomed the increasing trend towards joint records, called "patient/client records" instead of either "medical records" or "nursing records".

3.3 The nursing process and documentation

The nursing process involves rationalization which assumes a conscious and deliberate progression towards a goal. It is defined in terms of the following steps which are cyclical and recurring.

(1) Assessment:

- systematic collection of subjective and objective data;
- definition of the need for nursing.

(2) Planning - with the patient/client/family:

- establishing priorities of care;
- identifying goals or anticipated results;
- determining nursing actions to meet goals by a projected time span; planning for care.

(3) Implementation:

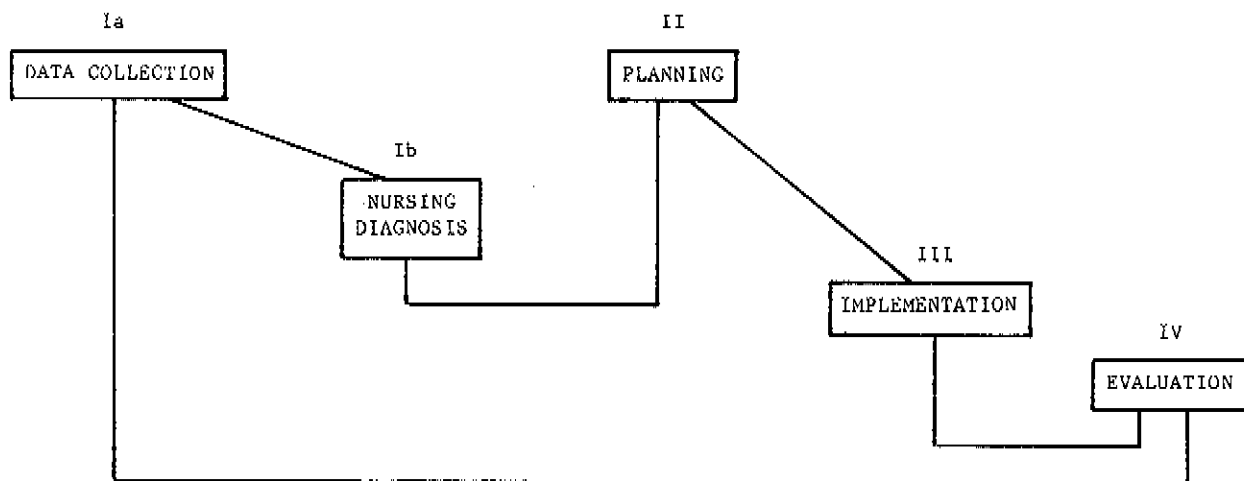
- carrying out the planned nursing;
- carrying out other recommended interventions.

(4) Evaluation:

- determining, through the use of the identified goals or outcomes, the results of nursing efforts on the patient or client.

While the content - as always in nursing - may be complex, the process is simple (Fig. 5).

Fig. 5. Nursing process and standards of practice



Ia. The collection of data about the health status of the patient/client is systematic and continuous. The data are accessible, communicated and recorded

Ib. Nursing diagnosis is derived from health status data

IVb. The patient/client's progress or lack of progress towards goal achievement directs reassessment, reordering of priorities, new goal setting and revision of the plan of nursing care

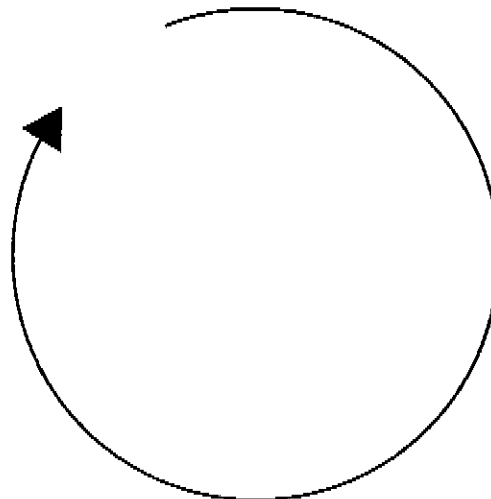
IIa. The plan of nursing care includes goals derived from nursing diagnosis

IVa. The patient/client's progress or lack of progress towards goal achievement is determined by the patient/client and the nurse

IIb. The plan of nursing care includes the priorities and the prescribed nursing approaches or measures to achieve the goals derived from the nursing diagnosis

IIIb. Nursing actions assist the patient/client to maximize his health capabilities

IIIa. Nursing actions provide for patient/client participation and health promotion, maintenance and restoration



The Working Group summarized their discussions by reaffirming that the main aims of the nursing process (or systematic nursing) were to improve the quality of care and to provide continuity. At all stages of the nursing process, the patient/client/family is the focus; documentation in relation to him/her was an essential component of care.

Accurate documentation of the nursing process could assist in the development of the science and enlargement of specialist nursing knowledge. The latter could result in a strengthening of the consultative - and a weakening of the hierarchical - nursing role. Inevitably, this change would necessitate the reorganization of nursing services. As nurses develop their own professional competence and accountability, it seemed obvious that some of the causes of job dissatisfaction and the high mobility rate among nursing personnel would disappear. It was, therefore, considered crucial that leaders of the profession should work with their colleagues to facilitate the teaching and practice of the nursing process.

4. Guidelines for the development of records as an integral part of the nursing process

4.1 Reasons for developing a documentation system

There was growing awareness among many nurses in Member States that, in the past, there had been no systematic or accurate recording of either what was expected of nursing practice, what the ultimate aim was or in what way patients benefited. From the earliest times, medical practitioners have assiduously documented the condition of each patient and the outcome of medical interventions - at least in terms of the disease treated. Eventually, this had led to a classification system stressing the study and improvement of medical care.

Since nurses have not documented their practice systematically, there is little evidence to show why, in a given situation, a particular nursing practice was selected or what resulted from such an endeavour. Consequently, much of the experience gained from nursing practice has simply been handed down from one generation of nurses to another. This failure to develop an adequate reporting system has rendered the use of techniques, such as the audit method currently employed to evaluate medical interventions, largely ineffective.

All systematic work is based upon adequate records, and the nursing process loses most of its value without such documentation. Where communication relies upon verbal reporting and is related to routine tasks, less written information about patients will be available. This does not mean that written records detract from the importance of verbal reporting, but information transmitted verbally (e.g. between shifts) may become distorted by interpretation and by the acceptance of varying criteria relating to priorities. Where there is no common method and no comprehensive recording, information also becomes fragmented, scattered or lost.

It was agreed that methods of documentation were required for all four phases of the nursing process, as well as for the accumulation of information on the entire process. Observations of the patient and what he can do were accepted as objective data, while descriptions by the patient of how he feels were considered to be subjective data. Nurses in clinical practice should also be able to utilize observations provided by other disciplines (e.g. physiotherapy, laboratory and radiology reports) in order to improve nursing care. Data collection forms should, therefore, include such findings and the use to which they are put.

4.2 Underlying principles for documentation

Consistent, appropriate, continuous and coordinated care requires that relevant written information be available to everyone involved; adequate verbal communication among all health workers throughout the working period is simply not feasible.

Nursing therefore requires a well-structured record system available to all members of the team and in which the thinking is clear, logical and explicit.

Among the many reasons given by the Group for documentation of nursing care were the following:

- to make available, to everyone involved, information on the patient's, client's or family's needs, the care planned and given, and its results;
- to state objectives, priorities and goals;
- to provide continuity of care;

- to provide a chronological review of care given and its outcome;
- to make available reference to previous records;
- to facilitate the transfer of responsibility for care;
- to provide firm data contributing to the body of knowledge and technology of nursing;
- to provide reliable information for legal purposes, if necessary.

It was agreed that documentation must cover two levels: the recording of individual patient or client nursing interventions, and in order to establish a reliable data base, the selection, collation and dissemination of a recurring condition.

The need to develop nursing care records of a high quality was repeatedly emphasized, as was the need to educate nurses and other nursing personnel in the importance of maintaining and using those records to improve patient care. Doctors, hospital administrators and others also should be better informed as to the value of nursing care records and the ways in which they can be used to improve services.

The development of multidisciplinary records, the sharing of information (particularly among nurses and doctors) and the need to keep data collection and paper work to a minimum were also discussed. It was recognized that a common source of information is required by the majority of health and social workers, but that each discipline requires supplementary data specific to its own area. It was agreed that it would be most beneficial to patients and health personnel alike if joint patient/client records were developed. Meanwhile, it was suggested that information should not be duplicated or copied, but that representatives of each discipline should be able to make use of the records of other health professionals. Confidentiality must also be assured and respect for the individual and his right to privacy should be an overriding factor in the development and use of any documentation system. The general principles of documentation can be applied in many settings and to every specialty.

4.3 Expected outcome

Implementation of the nursing process necessitates major reassessment of nursing practice. In collaboration with patients, nurses, other members of the medical team and workers from other health service disciplines must have the responsibility and the authority to plan, organize, provide and evaluate nursing services. Since "assisting the patient or client to implement regimes, treatments, etc., prescribed by the physician and/or other appropriately qualified professionals is only one of the activities in which nursing personnel are engaged, this task should not be allowed to compromise relationships with patient, family and community in other contexts (5). Nursing personnel have a crucial responsibility to record the nursing process, to communicate with colleagues regarding care, to involve patients and families in planning, implementing and evaluating care, to experiment with and improve methods, techniques, facilities and equipment used in nursing care, and to participate in evaluating other nursing personnel in, inter alia, their ability to provide care using the nursing process.

The beneficial outcomes of documentation relate to (1) the patient or client; (2) the nurse; (3) the discipline of nursing; and include the following.

(a) Patient or client:

- personal, individual care based on accurate, validated information relating to specific needs;
- comprehensive care with concern for the whole person;
- relationship (involving self-participation in care) with one nurse having overall responsibility for planning, implementing and evaluating care from admission to discharge;
- continuity of care with goals communicated to and shared by the entire health team and at all levels of the health service, as appears appropriate.

(b) Professional nurse:

- working relationship with patient or client participating in own care plans, implementation and evaluation;

- providing care based on people's needs (especially important at primary health care level);
- identifying self with the experience of others, thereby enlarging knowledge of self as a human being and increasing self-knowledge;
- reciprocal growth for care-provider and care-receiver.

(c) Discipline of nursing:

- among its practitioners, increased job satisfaction and higher morale, less absenteeism, sick leave and attrition;
- collation of data for research, theory-building and development of the science of nursing.

4.4 Introducing change: awareness of the need for change

It was unanimously agreed that desirable change was possible only if practitioners themselves saw both the need for it and were motivated to initiate it. The first objective, therefore, was to develop awareness among nurses of their responsibilities to meet the needs of patients and clients - the main aim of the social goal set by WHO and its Member States in achieving health for all by the year 2000 - and awareness that the physical needs were often being met only in a piecemeal fashion.

Within the existing and medicine-dominated health services of the majority of countries, nurses to date have followed medical specialties in both education and practice and in recent years have willingly taken over some routine tasks from doctors. Many nurses consider these jobs to be more prestigious than giving assistance to patients and clients to meet basic physical, social and psychological health needs. Diverse traditional nursing activities have also been delegated to auxiliaries and ancillary staff, because they appeared to be "unscientific" or "too simple" for qualified personnel. The result has been that plans for care are usually based on medical diagnosis, inadequate information and without taking into account the views and normal lifestyle of the patient.

The Declaration of Alma-Ata identified the primary health care approach as the key to achieving health for all; similarly, the nursing approach is the key to dealing efficiently and effectively with all the patients' nursing needs, both the approach and demand, as well as reorientation of nursing education programmes.

The Group identified many obstacles confronting the implementation of the nursing process. Many practitioners found the underlying principles difficult to understand; their very education had developed a high regard only for medicine, medical technology and pharmaceuticals; socioeconomic information and related problems were considered to be the responsibility of others, of less interest and slight importance to nurses.

Nurses in training required learning experiences related to data collection, assessment of needs, objectives and interventions and evaluation of results. Epidemiology and community diagnoses should also be included in evaluation programmes.

The organization of hospital work and satellite programmes was also seen as an obstacle; some participants said that even the architecture of some buildings militated against the nursing process.

Many people saw the proposed method of patient care as costly both in time and staff, a common excuse for failing to implement change.

The Group suggested that nurses should be encouraged:

(a) to undertake a simple exercise to estimate:

- the cost of all paper used in the present documentation system;
- the cost in time of transcribing the same information to the various books, forms and charts currently in use;

(b) to learn how to present the findings of such a study and discuss with administrators how to introduce any necessary changes in the documentation system.

It was recognized that it was not only nursing colleagues who remained unconvinced regarding the value of the nursing process; physicians in particular had to be "won over", their cooperation being vital.

Some members of the Group felt that it was necessary first to enhance current nursing practice and to build up the confidence of practitioners by demonstrating that resources were already available; perhaps the most difficult step was to do consciously what one had been doing automatically and without documentation. Close cooperation between all levels, categories, disciplines and services was necessary if everyone was to become familiar with the nursing process, how one goes about it and also how to compare the results with those of more traditional methods.

From presentations and discussions, it appeared that the majority of units or countries had introduced new systems or modified existing methods of documentation following a critical analysis of the current situation. This had often been undertaken because of dissatisfaction expressed by patients and staff with the way nursing care was being provided. The most successful results were seen in settings where the change had been associated with:

- an educational programme (usually inservice education) which included learning experience in the nursing process, communication skills and organization and management skills;
- the active involvement of nurses in the process of change; participating in the preparation and experimentation of new documentation systems;
- the eager support of health service administrators and senior nursing managers;
- ongoing evaluation and amendment, and continuous support and education (especially important when new nursing personnel joined the ward/unit or public health setting).

It was suggested that it was sometimes useful to begin with one patient or one unit in order to explain the process to the team and enable them to see the results for themselves. This kind of "case study" usually convinced people of the need for increased resources if high quality nursing care on a one-to-one basis was to be practised.

It was agreed that the most important principle in documentation was to centre all information around the patient/client/family. He/she should feel understood; there should be no value judgements and the objective documentation could - and would - be read by the patient/family.

Nursing should be based on a definition of man in society, the health-disease approach in society in general, and the fact that nursing is an interaction between individuals. Thus, the nurse should accept and know herself as a person with resources and needs as she discovers the needs and personality of his/her patient. Nurse-leaders should be the motivators, and documentation systems should be developed not in their offices but with their practitioners. Only by their involvement from the very beginning could the necessary change be brought about.

4.5 Principles of documentation

- (1) Always document your initial assessment as soon as possible after you have interviewed, observed and interacted with the patient or client.
- (2) Always, where possible, directly quote the patient or client or family member who provides the information.
- (3) Take time to review data before writing it up and always go back to the patient or client to clarify or validate information which appears to be incomplete.
- (4) Take care to differentiate between objective information and interpretations.
- (5) Always read the notes written by other health team professionals before you write your own.
- (6) Always document when you observe:
 - a change in condition or the addition of a new problem;
 - a lack of change in condition;
 - a patient/client response to an intervention;
 - a patient/client response to teaching.

- (7) Do not standardize; this defeats the whole aim of the process. There is no standard care plan. No problem can be exactly the same for each patient/client because each person is individual and unique.
- (8) Avoid using "basket" or vague terms (e.g. patient is "up and about").
- (9) Never let long periods of time go by without recording.
- (10) Always write legibly in ink.
- (11) Never change your documentation in order to cover up mistakes.
- (12) Be concise, precise, clear, descriptive and complete.
- (13) Always sign your name after each entry.

Finally, it was agreed that the thinking behind the use of the scientific method applied within a framework was crucial. If the thinking is clear, nurses will be encouraged to document their efforts and, in effect, documentation will evolve from changing ideas.

Systematic documentation, implicit within the nursing process method, is the vehicle for individualized nursing care. Patient data, systematically gathered and documented, is not only instantly accessible for epidemiological purposes, but also stimulates research-mindedness. It forces nurses to ask "what", "why", "when", "how", "where" and "who" in relation to nursing practice. This has subsequent implications for nursing education and for the organization and management of nursing services.

5. Conclusions and recommendations

- (1) Effective nursing care can best be achieved through a commitment to and use of the nursing process, which is the application of the systematic and scientific problem-solving method to patient/client/family care.
- (2) One of the most essential components of responsible, accountable and effective nursing practice is the existence and continuous use of a sound system for the documentation of nursing care.
- (3) Documentation of nursing care should be carried out at each of the four stages of the nursing process: assessment of needs, planning for care, implementation of care and evaluation of outcome.
- (4) Every effort should be made to introduce the systematic documentation of nursing care as an integral part of current nursing practice and the education of nursing personnel.
- (5) The keeping of records as a part of nursing practice should not be considered an end in itself. It presupposes an understanding of the underlying purpose of the nursing process method, serving equally as a means of communication and of data collection. Good records facilitate the individualization of care, underlining the accountability of the nurse-practitioner. If correctly used, they can enhance the efficiency and continuity of the care provided. They can serve as a means of interdisciplinary cooperation and as a basis for evaluating the care given. They can also help to develop new knowledge in the discipline and validate existing beliefs and practices. Finally, they serve as a source of legal protection, both for the public and for the practitioner.
- (6) The introduction of the nursing process and its documentation represents a major shift in nursing practice, whereby patient/client-centred care will supplant task-oriented or functional nursing, and nurses will become managers of direct patient/client care.
- (7) The process of change inherent in the above-mentioned shift should be prepared carefully. Educational programmes, covering various aspects of the philosophy (or concept) of professional nursing, the nursing process and its documentation, and ethical issues such as confidentiality related to documentation, would be most effective if they were based on the analysis of the existing documentation system. This system is usually based on tasks performed by the various categories of health worker rather than on the individual patients/clients requiring a global care/cure approach to their interrelated physical, psychological and social needs. Better understanding should be developed among nursing personnel and other health professionals concerning the value of the documentation of nursing care as a discrete contribution to the overall care provided to patients/clients.

(8) Nurse managers and teachers should be adequately prepared to assume their responsibilities as leaders and agents of change. They should be facilitators or "animators" capable of working closely together with patients, nursing staff and other related health professionals and administrators. They should be prepared to give support to the nursing personnel so as to enable them to become more closely involved in direct patient/client care.

(9) The development of multinational exchanges related to the documentation of nursing care and the reorientation of nursing services aimed at improving the quality of nursing care should be facilitated and encouraged.

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Annex 1

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