



World Health  
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## **Good practices in nursing and midwifery – from expert to expert**

**A manual for creating  
country case studies**



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## Introduction

Demographic trends and patterns of diseases have changed significantly over the last years. Meanwhile, new developments in diagnostic technologies and non-invasive treatments have allowed new means of health service delivery and health care models. In order to manage the trends, the World Health Organization (WHO) Regional Committee for Europe adopted Health 2020 (1), which sets the goal: “To significantly improve health and well-being of populations, to reduce health inequities and to ensure sustainable people-centred health systems” (2). In order to deliver on the goal, Member States of the WHO European Region are now faced with the challenge of providing equal access to health services and improving the quality of services given limited financial and human resources.

Nurses and midwives, the largest health workforce of the Region and one that works closely with patients, are central to the efforts to deliver on the priorities of Health 2020. In the Munich Declaration (3) endorsed by ministers of health of the Region in 2000, Member States recognized nurses and midwives as a real force for public health and effective contributors to health systems. However, in order to realize their potential it is vital that nurses and midwives develop and enhance their roles to meet the challenge.

*WE BELIEVE that nurses and midwives have key and increasingly important roles to play in society's efforts to tackle the public health challenges of our time, as well as in ensuring the provision of high-quality, accessible, equitable, efficient and sensitive health services which ensure continuity of care and address people's rights and changing needs.*

*Munich Declaration, 2000 (3)*

The 2002–2008 Strategic directions for strengthening nursing and midwifery services (4) and the more recently updated Strategic directions for strengthening nursing and midwifery services for 2011–2015 (5) seek to provide policy-makers, practitioners and other stakeholders at every level with a flexible framework for broad-based, collaborative action to enhance the capacity of nurses and midwives. Building on the global strategic directions, the WHO Regional Office for Europe has prepared the Strengthening nursing and midwifery services: European strategic directions towards Health 2020 (6). The shared goal is to strengthen the contribution of nursing and midwifery in improving the health and well-being of populations and reducing health inequalities.

In many Member States, much work has been done in the development of nursing and midwifery education and enhanced professional roles, including the development of nurse and midwife-led services. This has enabled the management of more complex patient care. There still exists, however, large variation between countries and also little documentation of the ways in which nurses and midwives in the Region have changed their roles and expanded services in order to respond to health changes (7). An evidence-based approach to treatment and care is crucial for the development of nursing and midwifery practice and is important to ensure effectiveness, efficiency and equity of care (8). It is recognized that achieving better health outcomes requires substantially strengthening nursing and midwifery. For this reason, the Regional Office has decided to profile country case studies of good practices in nursing and midwifery.

## Aim

The aim of this manual is to gather evidence from Member States on good nursing and midwifery practices and act as a supporting document to Strengthening nursing and midwifery services: European strategic directions towards Health 2020 (6). For this purpose a template is provided to guide collection of this information through country case studies. In this manual good practice is defined as practice that has been proven to work well and produce positive results, thereby deserving the status of a recommendation.

Country case studies are an excellent way to share experiences in new services and expanded roles. Case studies also enable decision-makers to review the benefits of the contribution of nurses and midwives to population health. Above all, country case studies aim to inspire and encourage the development and dissemination of good nursing and midwifery practices. In addition, country case studies can provide technical guidance to individual Member States by identifying ways to improve workforce capacity, professional education, working conditions, health-related regulations and legislation.

Case studies can also demonstrate to policy-makers how nurses and midwives contribute effectively to patient care and service needs. Case studies also demonstrate how nurses provide increased access to care and improve outcomes, while also improving cost-efficiency and continuity of care. Furthermore, new policy recommendations can be formulated on the basis of the evidence gained.

Once collected the country case studies will be compiled into a compendium under the guidance of the Regional Office. The compendium should provide a comprehensive summary of case studies collected from all over Europe and from a variety of health care settings. The focus is on reflecting on the role nurses and midwives play in strengthening and revitalizing health care systems.

*Good practice is based on the best available evidence and appraised as a relevant course of action in its operational environment. Good practice can be characterized as beneficial for the client, supportive of the client's well-being, justifiable, evaluated, effective, efficient, results-oriented, subject to modelling and co-modification, applicable, transferable, widely distributed and ethically sustainable.*

*National Institute for Health and Welfare in Finland [in Finnish] (9)*

## Purpose

The current and emergent public health challenges require intersectoral collaboration and a coordinated approach across the multidisciplinary teams of health professionals (1). Nurses and midwives have key and important skills and expertise, which are essential for population health, in addition to ensuring the provision of quality and equitable services.

As public health and health system challenges change, so do the roles of nurses and midwives. How have nurses and midwives initiated change? What have been the benefits for the patient outcome?



Due to the changes in the health system, efforts to scale up, transform and optimize the capacity of nursing and midwifery are more pressing than ever. Revising roles and expanding the scope of practice of nurses and midwives can result in more effective responses to population health needs. This can respectively lead to higher quality of care and better health outcomes. It can also increase job satisfaction and professional status of nurses and midwives.

Achieving a sustainable and competent health workforce is crucial to the progress and implementation of the Health 2020 policy framework. Nurses and midwives can and do play a key role in implementing Health 2020 by means of:

- promoting health
- promoting behaviour change through life-course approach
- empowering people
- promoting healthy ageing
- managing chronic conditions and long-term care
- applying evidence-based and safe practice.

Within the context of community health nursing, the role of the Family Health Nurse introduced by the Regional Office in 2000 (10), can bring important contributions to public health, primary health care and integrated health care services. The number of countries developing the role of family health nurses has increased and the implementation of this model has been reported to be positive in terms of services provision (6).

One of the latest surveys, conducted by the Registered Nurse Forecasting study, focused on hospital nurses in 12 European countries and the United States of America. Their main conclusions were that improved work environments of nursing care and reduced patient-nurse ratios were associated to improved nurse well-being, nurse-perceived quality of care, patient satisfaction and decreased odds of patient deaths (11). Moreover, nurses and patients agreed on which hospitals provided good care and could be recommended (12). Although, across the Region, numerous examples of nurses and midwives developing new and innovative ways of providing effective, efficient and financially viable health care exist, no single reference resource or standard data collection tool to collate this innovation and good practice is available.

*In primary care, it appears that appropriately nurses can produce as high quality care and achieve as good health outcomes for patients as doctors. However, the research available is still quite limited.*

*Laurant M et al. (13)*

More knowledge, however, is needed about the actual amount of improvement. In addition, more documentation is needed about the added value of innovative good practices in nursing and midwifery.

Building the capacity of nursing and midwifery will help address the two main strategic objectives of Health 2020: working to improve health for all and reducing health inequities, and improving leadership and participatory governance for health.



The Regional Office calls for experts' contributions in creating a European compendium of country case studies to demonstrate evidence on the impact of good nursing and midwifery practices on health outcomes.

## Template guidelines

The template is provided to guide individuals in describing their case studies of good nursing and midwifery practice in the Region (see Annex 1). The manual provides an explanation of each component of the template. Examples of country case studies are provided in Annex 2 to assist with the completion of the template.

Country case studies can focus on any target population, health concern and/or level of health care system including local, regional and national initiatives and innovation. All are relevant as long as the case study maintains a clear focus on the nurses' or midwives' role in contributing to a new service or an expanded role.

Case studies will be compiled for a Regional Office compendium to reflect the diversity of practice in the Region. They should emphasize and highlight the country context where applicable as well as emphasize the ways in which they address the goal of Health 2020 (2).

Government chief nurses, chief midwives and national focal points for nursing and midwifery are invited to coordinate the contribution of national experts in nursing and midwifery to complete the country case studies of good practice. The WHO collaborating centres for nursing and midwifery as well as the European Forum of National Nursing and Midwifery Associations are committed to this collaboration on the basis of their mission.

Information can be collected via interviews with nursing and midwifery experts, such as nurse/midwife managers, researchers, teachers, senior clinicians and practitioners. If possible please include a narrative in English, between 500 and 1000 words and in full sentences. Wherever possible, support the information by available evidence, e.g. expert reviews, reports, research, scientific papers or other suitable references. Contact information should be included in the country case study for further follow-up.

The template can be filled in electronically or manually (and is available for download at <http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/nursing-and-midwifery>). See the section, Submitting case studies, for additional information.

## Creating case studies

Case studies can relate to any one of the following:

- a nursing and/or midwifery contribution to a new or revised patient service, which involves a multidisciplinary team;
- a new service, which is led by a nurse or midwife; and
- an expanded role undertaken by a nurse or midwife within an existing service, for example a nurse prescribing medication as part of an agreed care management plan.

Case studies are divided into three parts reflecting the development stages of the practice. First, the **foundation** stage maps the starting point from which a specific change in role(s) or practice has occurred. Next, the **process** stage refers to the evolution of the practice. For example, how has the practice evolved and what have been the facilitators and the barriers to the change in practice? Finally, the case study identifies the **benefits** of the role or practice change. What have been the benefits for patients, nurses and/or the multidisciplinary team? In addition, authors can include personal reflections on the development of the role/practice change at the end of the template.

Guidelines on the descriptors used in the template are in the next section. Not all elements in the template need to be addressed; however, the more elements that are covered in each stage, the more useful the case study will be for nurses and midwives.

### ***Foundation***

The following characteristics should be provided to describe the foundation stage of the case study.

**Driver for change:** outlines why the change in roles has taken place and identifies the targets to be met by the change. Examples may include changed patient needs, changing population needs or identified gaps in the services.

**Role expansion:** elaborates on what has actually changed and explains the effects on the daily working routine of nurses and midwives, and care delivery.

**Initiator of the service change:** identifies the person or group that has initiated the role change.

**Area of health care:** identifies the sector in which the change has taken place, for example in primary health care, a hospital setting, community care, school, etc.

**Stakeholders:** are those who supported the change, for example hospital management, physicians, senior nurse or midwife managers or professional bodies.

**Evidence-based practice:** refers to the evidence nurses and midwives have consulted to demonstrate improved patient care.

**Other (please define):** is where any other foundational characteristics that are important to emphasize in the case study can be described.

### ***Process***

One or more of the following items can be used to describe the process involved to achieve the change in scope of practice or role.

**Skills and competencies developed:** identify skills and competencies required to realize the change in scope of practice or roles. Examples could include academic, clinical and/or practical training in new skills, relevant higher diplomas, master or doctorate level education or academic and clinical leadership.

**Management support:** indicates whether the nurse or midwife received any clinical or management support in developing and executing their new role.

**Multidisciplinary team support:** describes the support available from different members of the multidisciplinary team.

**Guidelines, legislation and regulatory framework:** identify the guiding logic and principles in which the role expansion was justified. Examples include national regulatory or legislative frameworks, or in-hospital or primary care guidelines at organizational or national levels.

**Other (please define):** is where any other process characteristics that are important to emphasize in the case study can be described.

### ***Benefits***

The following areas are suggestions for how the new role or scope can be of benefit to the patient, team or system.

**Performance outcomes:** describe the outcomes of the role and service change. Examples could include more equitable access to primary health services, increases in nurse-/midwife-led services, decreased hospitalizations, shorter stays in hospitals and reduced costs. Whenever possible, use precise figures to describe benefits. The quality-adjusted life year index is a suitable and well-tested indicator.

**Improved quality of care:** demonstrates improvement in at least one of the six dimensions defined by WHO.<sup>1</sup> Examples could include improvements in patient satisfaction and patient safety, or patient education that has contributed to health behaviour changes and better health outputs, such as lower hospital acquired infection rates.

**Professional climate:** explains how changes have had an impact on the nursing and midwifery professions. Examples could include increased job satisfaction, lower turnover rates, or increased student intakes and enhanced professional status.

**Multidisciplinary team dynamic:** identifies the changes that have occurred within the larger health care team with an emphasis on the relationships and collaborations between nursing and midwifery and other professional groups. Examples could include improved communication that enhances patient safety, increased work satisfaction and better integration of the team.

**Other (please define):** is where any other benefits that are important to emphasize in the case study can be described.

### ***Personal reflection***

Authors of case studies who wish to describe more than is requested in the template can use this section to elaborate, acknowledge or add to the case study. This section is optional.

### ***Contact person***

Each case study should indicate a contact person who can respond to requests for additional information about the case study. Contact information includes the person's full name, job title, institution, city, country and e-mail address.

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<sup>1</sup> In 2006, WHO defined quality of care as having to fulfil six dimensions: effective, efficient, accessible, acceptable, patient-centred, equitable and safe (14).

## Submitting case studies

Completed templates can be submitted by e-mail to: [nmp@euro.who.int](mailto:nmp@euro.who.int) or by regular mail to:

Good practices in nursing and midwifery  
WHO Regional Office for Europe  
UN City, Marmorvej 51  
DK-2100 Copenhagen Ø, Denmark

## Selection process

An expert committee consisting of nursing and midwifery experts from the Regional Office and collaborating centres will be assigned the selection of case studies. The experts will prioritize case studies that are supported by evidence and are representative of the Region and the professions. It is, therefore, important that sufficient details are provided. Greater weight will be given to case studies where the new role or service has been evaluated positively by an external agency or has been published in a periodical; please include relevant document details in the submission, if applicable. Additionally, case studies that link to the priority areas described in the *Strengthening nursing and midwifery services: European strategic directions towards Health 2020 (6)* will also be prioritized.

The Regional Office would like to thank the ministers of health, country representatives, and national and international experts from the Region who submit best practices highlighting the contribution of nurses and midwives in improving population health and transforming health services.

## References<sup>2</sup>

1. *Health 2020. A European policy framework and strategy for the 21st century*. Copenhagen, WHO Regional Office for Europe, 2013  
([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/199532/Health2020-Long.pdf](http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf)).
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([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0014/173300/FINAL-E-Print-version-Agis-Tsouros-Health-2020-An-overview.pdf](http://www.euro.who.int/__data/assets/pdf_file/0014/173300/FINAL-E-Print-version-Agis-Tsouros-Health-2020-An-overview.pdf)).
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([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/53854/E93016.pdf](http://www.euro.who.int/__data/assets/pdf_file/0007/53854/E93016.pdf)).
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([http://whqlibdoc.who.int/hq/2010/WHO\\_HRH\\_HP\\_N\\_10.1\\_eng.pdf](http://whqlibdoc.who.int/hq/2010/WHO_HRH_HP_N_10.1_eng.pdf)).

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<sup>2</sup> All references with web sites were accessed on 17 September 2013.

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8. Banta HD et al. *Handbook for evidence-based working and case study writing*. Copenhagen, WHO Regional Office for Europe, 2006.
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10. *The family health nurse. Context, conceptual framework and curriculum*. Copenhagen, WHO Regional Office for Europe, 2000 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/53860/E92341.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/53860/E92341.pdf)).
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*Annex 1. Country case study template*

<b>Title and country of the case study</b>	
<b>Foundation</b>	<b>Driver for change</b>
	<b>Role expansion</b>
	<b>Initiator of the service change</b>
	<b>Area of health care</b>
	<b>Stakeholders</b>
	<b>Evidence-based practice</b>
	<b>Other (please define): _____</b>
<b>Process</b>	<b>Skills and competencies developed</b>
	<b>Management support</b>
	<b>Multidisciplinary team support</b>
	<b>Guidelines, legislation and regulatory framework</b>
	<b>Other (please define): _____</b>
<b>Benefits</b>	<b>Performance outcomes</b>
	<b>Improved quality of care</b>
	<b>Professional climate</b>
	<b>Multidisciplinary team dynamic</b>
	<b>Other (please define): _____</b>
<b>Personal reflection:</b>	
<b>Contact person: Name, job title, institution, city and country</b>	
<b>E-mail:</b>	

*Annex 2. Sample country case studies*

The case studies are detailed as presented by countries as examples of practice. Evidence for care changes rapidly and countries and health professionals should continuously review new evidence as it emerges. The accuracy, currency and completeness cannot be guaranteed and countries seeking to implement similar practice developments to those presented in the country case studies should examine relevant evidence and adapt practice developments as appropriate.

**Finland**

<b>Nurse consultations for acute health problems and noncommunicable diseases, Finland</b>	
<b>Foundation</b>	<p><b>Driver for change</b></p> <p>Physician shortages in primary health care started to increase at the turn of the millennium, particularly in remote areas. Consequently, access to treatment was declining. Meanwhile, there was a growing interest in improving nursing competencies. In addition, as part of the social and health service reform the work of nurses was reorganized and advanced nursing roles developed.</p>
	<p><b>Role expansion</b></p> <p>Roles of nurses were developed in order to reallocate certain patient groups from a physician’s care to a nurse’s care. Nurses have the authority, knowledge and skills to examine, assess, treat and follow up certain patient groups. In these cases, if nurses, public health nurses or midwives (hereby referred to as nurses) have passed regulated postgraduate education, they can also re-prescribe medication prescribed by a physician and have prescription authority if the medication is from a predefined national list of authorized medicines.</p>
	<p><b>Initiator of the service change</b></p> <p>The Ministry of Social Affairs and Health in collaboration with health care units and polyclinics on the basis of the national social welfare and health policy programme adopted by the Government initiated the change.</p>
	<p><b>Area of health care</b></p> <p>This change of practice affected particularly the area of primary care. Furthermore advanced practice nurses were mobilized to work in outpatient hospital care and emergency care.</p>
	<p><b>Stakeholders</b></p> <p>Stakeholders who supported the change of practice were nurses, public health nurses, midwives and physicians working in health care units; the Ministry of Social Affairs and Health; polytechnics; universities and the Finnish Nurses Association.</p>



<b>Process</b>	<p><b>Skills and competencies developed</b></p> <p>Nurses providing consultations for patients have to be competent in taking a medical history, conducting a physical assessment of the patients' symptoms and treatment needs as well as decision-making around treatment, medication and follow-up. Health promotion, patient education and ensuring patient safety are required competences.</p> <p>Core competencies for prescribing authority are taught at postgraduate level and are based on nationally defined curriculum requirements. It also includes new skills testing to appraise</p>
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**Nurse consultations for acute health problems and noncommunicable diseases,  
Finland contd**

<b>Process</b>	<p>and ensure that core competences have been achieved. Several joint learning opportunities have been organized with medical students.</p>
	<p><b>Management support</b></p> <p>Development of the advanced roles of nurses specializing in noncommunicable diseases and acute health problems has been included in national health policy programmes adopted by the Government since 2002. The Ministry of Social Affairs and Health has assigned state grants for municipal projects on advanced roles of nurses in accordance with these programmes.</p>
	<p><b>Multidisciplinary team support</b></p> <p>As a means to reorganize the primary health care services, nurses provide consultations within the multiprofessional team or work in pairs with physicians in health centres and emergency care units. In some cases physicians are not available in health stations. Particularly, in remote areas, nurses working in nurse-led health stations can also use e-consultation by telephone, e-mail or Internet to contact physicians working in larger health stations.<sup>3</sup></p>
	<p><b>Guidelines, legislation and regulatory framework</b></p> <p>Evidence-based national and local clinical guidelines available through the Internet have been prepared with multidisciplinary collaboration in order to guide appropriate decision-making by the nurse in an advanced role. Legislation on nurse prescribing authority came into force in 2010. Corresponding postgraduate education requirements were legislated at the beginning of 2011. An evaluation report on nurse prescribing will provide evidence for further development in 2015.</p>
	<p><b>Other: support from other stakeholders</b></p> <p>Projects on the advanced roles of nurses have been initiated by the nursing profession in cooperation with practicing health centre physicians since 2003. National policy targets as well as collaboration with the Finnish Nurses Association and international nurse experts have supported the development.</p>

<sup>3</sup> Jaatinen P, Vanhatalo R, Tasanko A. Miten terveysaseman hoitaja toimii, jos terveysasemalle ei ole saatu lääkäriä. Kuvaus Luoteis-Satakunnan terveyskeskuksen lääkärihoitaja-projektin alkuvaiheesta hoitajan tekemän työn näkökulmasta. [How a health station nurse works if the health station has no doctor. Description of the first phase of the nurse-physician project at the northwest Satakunta health centre from the perspective of the nurse's work]. *Suomen Lääkärilehti [Finnish Medical Journal]*, 2002, (25–26):2795–2799.

<b>Benefits</b>	<b>Performance outcomes</b> The number of nurse consultations has increased while the number of physician consultations and the total number of outpatient visits have decreased in health centres since the early 2000s. <sup>4</sup>
	<b>Improved quality of care</b> Some health stations have reported improved productivity. <sup>5</sup> According to several studies, patients have experienced better access to care <sup>6</sup> as well as satisfaction with counselling <sup>7</sup> and support of self-care provided by nurses.

**Nurse consultations for acute health problems and noncommunicable diseases,  
Finland contd**

<b>Benefits</b>	<b>Professional climate</b> Physicians and nurses have reported improved well-being at work. <sup>8</sup>
	<b>Multidisciplinary team dynamic</b> Physicians and nurses have reported improved multiprofessional cooperation. <sup>8</sup>
<b>Contact person:</b> Dr Marjukka Vallimies-Patomäki, Ministerial Adviser, Ministry of Social Affairs and Health, Helsinki, Finland <b>E-mail:</b> marjukka.vallimiespatomaki@stm.fi	

<sup>4</sup> Kauppinen S, ed. *Terveiden ja hyvinvoinnin laitoksen asiantuntijoiden arvioita peruspalvelujen tilasta. Peruspalvelujen tila 2010 -raportin tausta-aineisto. Raportti 9/2010 [Reviews of the experts at the National Institute for Health and Welfare on the state of the basic public services. Background materials of the report on the state of the basic public services 2010].* Helsinki, National Institute for Health and Welfare, 2010.

<sup>5</sup> Koski J, Elonheimo O, Linna M. Työvoimapula perusterveydenhuollon avotoiminnassa – mitä keinoja avuksi? In Mikkola H, Klavus J, eds. *Terveystaloustiede [Health Economics] 2004.* Helsinki, Stakes, Aiheita 3/2004:21–24.

<sup>6</sup> Rajala K-R. *HOLA - Hoitajien toimenkuvan laajentaminen. Terveyskeskusten loppuraportti. [HOLA-Expanding the role of nurses. Reports of the health centres].* Vieskan terveydenhuollon kuntayhtymä [Vieska Joint Municipal Authority of Health Care], 2005.

<sup>7</sup> Härkönen E et al. Hoitajavastaanotot erikoissairaanhoidon polikliinisessä hoitotyössä – potilaiden kuvaus tyytyväisyydestä. [Nurse consultations in outpatient hospital care – patients' description of satisfaction]. *Tutkiva hoitotyö [Researching nursing]*, 2007, 1:5–11.

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## Iceland

<b>Outpatient clinic for children and adolescents with diabetes, Iceland</b>	
<b>Foundation</b>	<p><b>Driver for change</b> A team consisting of a physician and a nurse identified an increased need for health education and support in treating diabetes mellitus (DM) among their clients (children, adolescents and parents). The team developed an enhanced ambulatory nurse service by requiring that nurses develop their own knowledge and skills. The expansion of the nurse's role allowed the nurse to better meet clients' needs.</p>
	<p><b>Role expansion</b> An enhanced nursing service was developed, which prioritized multidisciplinary ambulatory care for youth DM. The nursing service focused particularly on providing information, education and support according to the expressed needs of parents and children.</p>
	<p><b>Initiator of the service change</b> A nurse and a physician working at the University Hospital</p>
	<p><b>Area of health care</b> Primary care and noncommunicable diseases</p>
	<p><b>Stakeholders</b> Patients, physicians, nurses and hospital management</p>
<b>Process</b>	<p><b>Skills and competencies developed</b> Skills and competencies for this new role were developed over time through training and continuing education opportunities including several academic degrees at the Bachelor of Science, Master of Science and Nurse Specialist level. The nurse was able to conduct scientific research and participated in conferences and workshops over a period of at least 15 years. Training focused on increasing competences in understanding and meeting clients' needs. With this training, clients' needs could be observed and measured with scientific methods.</p>
	<p><b>Management support</b> Clinical nurse management provided general support that was very important at all stages. Deeper understanding and support from senior hospital management would be helpful to further develop the expanded role of nurses for the service.</p>
	<p><b>Multidisciplinary team support</b> A very collegial working relationship was secured throughout the expansion of the nurse's role. However, limited support from the multidisciplinary team was available.</p>
	<p><b>Guidelines, legislation and regulatory framework</b> No specific guidelines or framework were available before the nurse-led clinic was initiated. An evidence-based approach was important. Clinical guidelines, including those used by the International Society for Paediatric and Adolescent Diabetes, and the National Institute for Health and Care Excellence, are now being used and specific guidelines and check lists have been developed at the clinic.</p>

### Outpatient clinic for children and adolescents with diabetes, Iceland contd

	<p><b>Other: support from other stakeholders</b> Support from nursing academia was very important in developing the skills to conduct scientific research and writing scientific papers.</p>
<b>Benefits</b>	<p><b>Performance outcomes</b> Benefits for clients included increased satisfaction with education and improved coping mechanisms with the support of the clinic; improvement in DM treatment compliance was measured by blood sugar control (haemoglobin A1c).</p>
	<p><b>Improved quality of care</b> Several improvements were made to service delivery, including improved services to patients, and development of individual and family sessions, motivational interviews and group sessions. Several reports and scientific papers were produced.<sup>9</sup></p>
	<p><b>Professional climate</b> Benefits to the nursing profession included the creation of professional development opportunities and governmental approval of a new nursing role – that of a specialist in paediatric nursing.</p>
<p><b>Personal reflection:</b> The service was developed because of a perceived need for strengthening the client’s ability to enjoy daily life. Throughout the 15 years that it took to develop the programme and the new nursing role, the personal initiative of the nurse specialist was fundamental. The process required continuous learning, strength and patience, as many obstacles were encountered. Initially, medical doctors did not understand the importance of this nurse-led service. A key element in this process was the continuous and very supportive attitude of the first-line nurse manager. Hospital strategy was limited in relation to ambulatory nurse services at the hospital. More organizational support is necessary to develop team-based approaches in health care delivery and nursing services should be recognized as an important element of the multidisciplinary team. A balance should be struck between nurse-led services and active nurse participation in multidisciplinary service. Currently, two nurses (amounting to one full-time position) work at the clinic, providing nursing services to 120–130 clients annually. More nurse-led services have been developed and integrated in the hospitals’ model for health care delivery. Special focus is on psychosocial needs as an important addition to support in treating DM. More collaboration with primary health care and schools is needed. Better health outcomes for clients and the system affirm the importance of nurse role expansions.</p>	
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<sup>9</sup> Konradsdottir E, Svavarsdottir EK. How effective is a short-term educational and support intervention for families of an adolescent with type 1 diabetes? *J Spec Pediatr Nurs*, 2011, 16(4):295–304.

## Ireland

Respiratory Assessment Unit (RAU) is a nurse- and physiotherapist-led service. It provides seamless integrated care for patients with chronic respiratory disease.

<b>Respiratory Assessment Unit, St. James's Hospital, Dublin, Ireland</b>	
<b>Foundation</b>	<p><b>Driver for change</b></p> <p>In response to pressure on hospital beds, an early discharge initiative was set up in 2002 for patients with exacerbations of chronic obstructive pulmonary disease (COPD).</p>
	<p><b>Role expansion</b></p> <p>The initiative was initially comprised of the nurse or physiotherapist visiting the patient at home, but has progressively evolved to deliver three levels of care.</p> <p><b>Level 1: early discharge</b></p> <p>Patients admitted with exacerbations of COPD are discharged early with hospital-in-the-home care. The care requires 2 to 3 home visits and has led to a reduction in hospital length of stay from 10.5 days to 1.5 days.<sup>10</sup></p> <p><b>Level 2: RAU evaluation</b></p> <p>After recovery, patients return to a nurse-/physiotherapist-led clinic for assessment and management of all aspects of their disease. Ongoing telephone support is provided. These measures led to better disease control and to a 75% reduction in readmission rate at year 1.<sup>10</sup></p> <p><b>Level 3: pulmonary rehabilitation</b></p> <p>Once stable, patients are offered entry to a pulmonary rehabilitation programme comprising of education and exercise at two outpatient group sessions per week over eight weeks. Programmes have been shown to improve exercise capacity, reduce symptoms and improve quality of life.<sup>11</sup></p> <p><b>Further expansion</b></p> <p>Funding was secured to expand the unit in 2008, with the addition of two clinical nurse specialists and a larger unit. Expansion provided:</p> <ul style="list-style-type: none"> <li>• outreach programmes for other respiratory conditions including asthma, pneumonia and bronchiectasis;</li> <li>• direct referrals from general practitioners for admission avoidance;</li> <li>• provision of palliative and supportive care visits and referral pathway to hospice and respite services; and</li> <li>• long-term oxygen assessment clinics.</li> </ul>
	<p><b>Initiator of the service change</b></p> <p>The change was initiated by a nurse and physiotherapist with the support of the multidisciplinary team at St. James's Hospital, Dublin, Ireland.</p>

<sup>10</sup> Lawlor et al. Early discharge care with ongoing follow-up support may reduce hospital readmissions in COPD. *Int J Chron Obstruct Pulmon Dis*, 2009, 4:55–60.

<sup>11</sup> Qaseem et al. Diagnosis and management of stable chronic obstructive pulmonary disease: a clinical practice guideline update from the American College of Physicians, American College of Chest Physicians, American Thoracic Society and European Respiratory Society. *Ann Intern Med*, 2011; 155(3):179–191.

### Respiratory Assessment Unit, St. James's Hospital, Dublin, Ireland contd

<b>Foundation</b>	<p><b>Area of health care</b> The area of health care is acute hospital with outreach to primary care.</p>
	<p><b>Stakeholders</b> Stakeholders are patients and their families, nurses, physiotherapists, consultant physician, respiratory registrar, nurse management, multidisciplinary team, hospital management, community, intervention team and general practitioners.</p>
<b>Process</b>	<p><b>Skills and competencies developed</b> Both nurses and physiotherapists expanded their scope of practice supported by continuous professional development education, mentorship and competencies, for example:</p> <ul style="list-style-type: none"> <li>• to take and interpret arterial blood gases</li> <li>• to order and interpret diagnostic imaging.</li> </ul>
	<p><b>Management support</b> Negotiation with corporate management for adequate levels of staff, space, and finances was supported by the consultant, nurse manager and business manager. Financial support was provided to undertake Specialist Master of Science degrees and higher diplomas. Staff were facilitated to attend college, conferences and study days.</p>
	<p><b>Multidisciplinary team support</b> The nurse-/physiotherapist-led service requires the expertise and services of other multidisciplinary teams within the hospital and community, e.g. social workers, respiratory technicians, public health nurses, a community intervention team and Our Lady's Hospice.</p>
	<p><b>Guidelines, legislation and regulatory framework</b> The clinical practice is based on international,<sup>12</sup> national<sup>13</sup> and local guidelines and the nursing practice is underpinned by a scope of practice and a code of ethics for nurses.<sup>14,15</sup></p>
	<p><b>Other: support from other stakeholders</b> The most important support was from patients, their families and the multidisciplinary team.</p>
	<p><b>Performance outcomes</b> This service has benefits for patients by reducing length of stay and hospital admissions.</p>
<b>Benefits</b>	<p><b>Improved quality of care</b> The new service improves patient quality of life as not only is time in hospitals decreased but there is now a central place to refer patients for holistic management.</p>
	<p><b>Other: cost saving</b> The reduction in bed days has a cost-saving benefit for the hospital.</p>

<sup>12</sup> *Global strategy for the diagnosis, management and prevention of chronic obstructive pulmonary disease.* Vancouver, Washington, Global Initiative for Chronic Obstructive Lung Disease, Inc. 2013.

<sup>13</sup> *Global strategy for the diagnosis, management and prevention of chronic obstructive lung disease (updated 2013).* Global Initiative for Chronic Obstructive Lung Disease, 2013 ([http://www.goldcopd.org/uploads/users/files/GOLD\\_Report\\_2013\\_Feb20.pdf](http://www.goldcopd.org/uploads/users/files/GOLD_Report_2013_Feb20.pdf), accessed 5 November 2013).

<sup>14</sup> *Scope of nursing and midwifery practice framework.* Dublin, An Bord Altranais, 2000.

<sup>15</sup> *The code of professional conduct for each nurse and midwife.* Dublin, An Bord Altranais, 2000.

### **Respiratory Assessment Unit, St. James's Hospital, Dublin, Ireland contd**

**Personal reflection:** The service has evolved over time and developed from within the unit. The expansion can be attributed to drive, fearlessness and perseverance in overcoming delays and obstacles. Staff should analyse their practice continuously and respond to service needs. Support from respiratory consultants and the nurse manager allowed the freedom to develop truly nurse-led, autonomous services.

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## United Kingdom

<b>Relaunch of a freestanding birth centre to promote normal birth, England, United Kingdom</b>	
<b>Foundation</b>	<p><b>Driver for change</b></p> <p>The Chorley Birth Centre (freestanding) at Chorley and South Ribble District General Hospital was in a poor state, needing to be rejuvenated. The number of women using the Chorley Birth Centre fell and midwives were beginning to believe that there was no future for it.</p> <p>The consultant midwife used the evidence from the birthplace study<sup>16</sup> and the potential advantages for the Lancashire Teaching Hospitals National Health Service (NHS) Foundation Trust using the new maternity payment structure in the United Kingdom to change current thinking about the Chorley Birth Centre. She led a bid for improving birth environments funded by the Department of Health to refurbish it.</p>
	<p><b>Role expansion</b></p> <p>Chorley Birth Centre reopened in May 2013. A 24-hour stay with partners was initiated, keeping the family together for this special time. This has provided the opportunity for more women and their families to be in a relaxed and comfortable environment and to have good, satisfying birth experiences.</p> <p>This project is increasing well-being as it: promotes normal birth, reduces interventions, includes partners in the birth process, provides a healthier start for newborns and supports women to resume a normal lifestyle quicker.</p>
	<p><b>Initiator of the service change</b></p> <p>Dr Tracey Cooper (see Contact person below)</p>
	<p><b>Area of health care</b></p> <p>Chorley Birth Centre is a freestanding birth centre, located in a local community hospital setting. It is run by Lancashire Teaching Hospitals NHS Foundation Trust, with its main maternity services site at Royal Preston Hospital located 14 miles away.</p>
	<p><b>Stakeholders</b></p> <p>Women and families in the area through local maternity service user groups.</p> <p>NHS Greater Preston, and Chorley and South Ribble Clinical Commissioning Groups</p> <p>Midwifery teams, supervisors of midwives, Obstetric Team, management teams of the Women’s Health Directorate, the Specialist Services Division and the board of directors at Lancashire Teaching Hospitals NHS Foundation Trust</p>

<sup>16</sup> Hollowell J et al. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ*, 2011;343:d7400.

	<p><b>Evidence-based practice</b></p> <p>According to the birthplace study,<sup>16</sup> for planned births in freestanding midwifery units (FMU) and alongside midwifery units (AMU), there were no significant differences in adverse perinatal outcomes compared with planned births in an obstetric unit.</p>
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**Relaunch of a freestanding birth centre to promote normal birth,  
England, United Kingdom contd**

<b>Foundation</b>	<p>Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more normal births than women who planned birth in an obstetric unit.</p> <p>Shroeder et al<sup>17</sup> found midwifery-led care environments for women who have uncomplicated pregnancies are a more cost-effective option for service providers.</p> <p>Kirkham<sup>18</sup> found midwives were more likely to stay with their employer if different choices of how and where to work were given, e.g. working in midwifery-led settings, which increased job satisfaction.</p>
<b>Process</b>	<p><b>Skills and competencies developed</b></p> <p>Midwives' skills in normality have developed, especially in water birth. Good job satisfaction maintains retention of staff and makes the Lancashire Teaching Hospitals NHS Foundation Trust attractive as an employer for recruitment.</p> <p><b>Management support</b></p> <p>Acting head of midwifery, general manager, clinical director, divisional director, director of nursing and midwifery, associate director of nursing and midwifery, chief operating officer and chief executive at Lancashire Teaching Hospitals NHS Foundation Trust</p> <p><b>Multidisciplinary team support</b></p> <p>Obstetric Team, supervisors of midwives and midwifery teams</p> <p><b>Guidelines, legislation and regulatory framework</b></p> <p>Organizational guidelines developed by a multidisciplinary group and guided by the National Institute for Health and Care Excellence are in place. Annual mandatory training supports staff.</p> <p>Maternity services are compliant with Level 2 Clinical Negligence Scheme for Trusts. Evaluation is performed by reviewing all cases, comments from women/families and normal birth rates.</p> <p><b>Other: support from other stakeholders</b></p> <p>University of Central Lancashire; local clinical commissioning teams, including general practitioners; users of the maternity service groups, including the National Childbirth Trust and the Maternity Service Liaison Committees; and the Department of Health capital fund programme</p>

<sup>17</sup> Schroeder E et al. Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study. *BMJ*, 2012;344:e2292.

<sup>18</sup> Kirkham M, Morgan RK, Davies C. *Why Midwives Stay*. London, Department of Health, 2006.

<b>Benefits</b>	<p><b>Performance outcomes</b></p> <p>The Chorley Birth Centre reopened in May 2013 and – with 89 births (in 4 months) – is on target for 200 births in a 12-month period; there were 112 births in 2012. These births equate from 1.07% in December 2012 to 5.53% in August 2013, out of the total birth population for the organization. Normal birth rates, water births and women using water in labour have increased.</p>
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**Relaunch of a freestanding birth centre to promote normal birth,  
England, United Kingdom contd**

<b>Benefits</b>	<p>This development will reduce costs to the organization and increase profit, evidenced by measuring costs from the birthplace study's economic evaluation<sup>17</sup> against the maternity tariff.<sup>19</sup> The financial position for the service has improved and will be monitored to evidence further cost savings.</p>
	<p><b>Improved quality of care</b></p> <p>Of women attending the Chorley Birth Centre, 86% have a normal birth, 68% have a water birth and 92% used water. It promotes normal birth, reduces interventions, includes partners and leads to a healthier start in life for newborns, with a mother who is able to get back to a normal lifestyle quicker.</p>
	<p><b>Professional climate</b></p> <p>Midwives have excellent job satisfaction and work in an integrated model, between the community setting and Chorley Birth Centre, improving continuity. Midwives have been working with service users, local newspapers and radio to promote it and raise the profile of midwifery-led care. The statistics and experiences will provide evidence for the future.</p>
	<p><b>Multidisciplinary team dynamic</b></p> <p>The teams work flexibly. Team leaders and a consultant midwife provide feedback into the directorate and divisional teams to provide seamless communication, resolve problems and share good practice.</p>
<p><b>Personal reflection:</b> Midwives really own the philosophy and inspire women to believe in the normal physiological birth process, take ownership of their birth experience and believe that they can do it. It is truly inspirational to see.</p>	
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<sup>19</sup> *Maternity services pathway payment system: a simple guide 2012 to 2013*. London, Department of Health, 2012.

## **The WHO Regional Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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