



EUROPEAN COMMISSION
EUROSTAT

Directorate D: Single market, employment and social statistics
Unit D-6: Health and Food safety

Doc ESTAT/D6/04/HEA/09
Original: EN

WORKING GROUP ON ‘**PUBLIC HEALTH STATISTICS**’

Luxembourg – 24/25 November 2004

Item 6.2 of the agenda

European Data on Nurses

Final Report of the ad-hoc Task Force

Prepared by: Gunter Brückner, Eurostat D/6

FINAL REPORT

of the

ad-hoc Task Force

“European data on nurses”

To be delivered to the Technical Group CARE
and the Working Group “Public Health Statistics”

The Technical Group Care in its 2003 Meeting mandated an ad-hoc Task Force to explore the potentials for improving the quality and comparability of statistical data on nurses in Europe and to recommend ways for changing the European data collection accordingly. The mandate specified,

- To consider the requirements derived from the System of Health Account’s (SHA) framework,
- to take on board the experiences made during the previous efforts on improving the quality of European data on doctors, and
- to sufficiently reflect the new information needs as e.g. specified in European health indicators lists such as the one of the “European Union Health Indicators” (ECHI) framework.

The following countries participated in the TF:

- Czech Republic,
- Germany,
- Luxembourg
- Norway,
- Sweden
- United Kingdom (first meeting only).

Furthermore, representatives of the following organisations and institutions were present:

- Organization for Economic Co-ordination and Development, Health Policy Unit,
- World Health Organization, Headquarters,
- European Commission, DG Health and Consumer Protection.

The first meeting took place on 29-30 April and was chaired by Raymond Wagener (L), the second was held on 23-24 September and was chaired by Marleen de Smedt, Eurostat, and Raymond Wagener (L).

The discussion covered the following subjects and provided the following results:

1. The need for statistical data on health professionals is continuously growing in Europe. Health professionals are the most important part within the labour force active in the health care sector, both by relative numbers and by qualifications. Nursing professionals are the largest group within health professionals, followed by physicians and other health professionals. Health Care is commonly known as one of the business sectors with the most labour-intensive ‘production’, and it is also known that highly qualified labour is more prominent here than in other economic sectors.

2. In most European countries, there were or still are political debates on whether or not the health care sector employs ‘sufficient’ qualified manpower. These debates are influenced by waiting lists for selective medical procedures in some countries and by making public the information that many posts for health professionals are unfilled in other countries. These national debates often quote ‘density rates’ (number of health professionals by type per 100.000 inhabitants) for countries across Europe to support the arguments on whether or not a given country provides sufficient health professionals.
3. Experts have repeatedly stated that the work sharing between groups of health professionals is both changing over time and differs substantially from region to region, not only between countries but also between regions within countries. The work sharing between physicians and qualified nurses seems to be influenced among other things by population density. In areas with high population density, physicians are often exclusively entitled to perform specific medical functions (such as taking blood or tissue samples), which in areas of low population density (and fewer physicians available) nurses also qualify to perform.
4. On the other side, the work sharing between fully qualified nurses and nursing assistants also influences the meaningfulness of respective density rates, as less qualified nursing staff may allow qualified nurses to focus more or exclusively on highly qualified work, whereas under other circumstances they would have to dedicate substantial working time to lower qualified activities such as bedding or feeding patients or supporting them with their other activities of daily living (ADL).
5. At international level, the migration of nursing professionals increasingly becomes subject of political debate, as more and more also European countries have come to employ nurses from foreign countries, using the respective wage differentials as arguments. At the end of this trickle-down-process, the least developed countries in the world will remain those with insufficient nursing capacity despite them often undertaking huge efforts of qualifying nurses nationally.
6. New elements of European health policy may create information needs adding to the ones currently on the agenda already – migration of health professionals. The European Statistical System will have to flexibly respond to such requests.
7. The data on health professionals, among them nurses, which countries provide to Eurostat and international organisations, have a long national tradition, but are not particularly qualified to support international comparisons. With respect to the various health care professionals, most countries use purely nationally defined professions and occupational classification systems. Internationally comparable classification systems for occupations such as ISCO-88 are widely used for manpower statistics in all Member States referring to all economic sectors but health care.
8. In addition, the actual routine data collection suffers from data using different methodological concepts:
 - Trained nurses (equivalent to doctors ‘entitled to practise’),
 - nurses working within the health sector, but including e.g. head nurses or directors of nursing departments, and
 - nurses in direct contact with patientsprovide different perspectives and are designed to answer different questions. As the respective numbers differ substantially the preferred concept has to be agreed on.

9. When countries provide data on health professionals to Eurostat or international organisation they are required to map the nationally defined categories of health professionals into one of the classes provided for international use. They do this to the best of their knowledge but without explicit guidance, and often this mapping is not explicitly documented. Then is it not possible to verify what countries did, and whether the resulting data are by any means comparable.
10. Health Care is one of the few booming economic sectors in most countries. Labour force statistics show that the sector N of NACE (Health and Social Care) employs an ever-growing number of different professions, which the level of work-sharing among these different occupations likely to change continuously. As a consequence, it may become necessary to regularly revise the explicit list of professions to be included into the data collection of health care professionals.
11. Changes in work-sharing will not only refer to nursing professionals, but will influence the degree of cooperation of nursing professionals with other professions, in particular with physicians and with lower qualified staff providing supportive nursing functions. Without a solid understanding of the 'agreed role play' among the various professions, the comparison across countries of absolute numbers or density rates of health professionals is likely to monitor statistical artefacts and may thus induce wrong conclusions.
12. The Task Force was confronted with professions dealing with both core nursing functions and activities absolutely different from nursing. Such 'mixed' responsibilities may be carried out by professional nurses in some countries and by completely different professions in others. When dealing with professions partially performing nursing functions, the Task Force had to decide whether to give preference to a wide definition (include anyone who does nursing, even if only in a small share of his working time) or a narrow one (include only those that exclusively do nursing). With respect to fully qualified nurses they had to decide how to deal with nurses, who no longer see patients but perform administrative or managerial functions.
13. Based on those problems the Task Force discussed the feasibility of grouping the various professions active in different Members States into common groups of 'nursing professionals' by using the information of whether or not specific well-defined medical functions are performed 'on own responsibility', 'upon prescription' or with a 'supporting role' only – either with respect to 'a legally defined responsibility' or what the 'tend to do' during their daily routine, whereby the latter was seen as a non-acceptable way, as it may leave the impression that some professions are entitled to perform functions, which they are not allowed to do by the rules and regulations explicitly installed for the underlying by qualification.
14. The countries represented in the Task Force tested a questionnaire containing these well-defined functions (see Annex 5 for details). They considered it a very useful tool, which provided much in-depth information, in particular relevant for describing the work sharing process among different groups of health professionals. However, that questionnaire was seen as probably too big a tool for the job to be accomplished. The Task Force suggested to explore, whether the objective could be reached with less efforts, i.e. with a smaller questionnaire, so that countries need not be bothered with more questions than necessary.
15. For this purpose the Task Force agreed on a second questionnaire and tested again its feasibility for the countries represented in the Task Force. The questionnaire is described

in Annex 1. All members of the Task Force consider this questionnaire the best instrument for solving the problem at hand.

16. The Members of the Task Force stated repeatedly that the most important prerequisite for using that questionnaire in a meaningful way is to include as many professions into the evaluation process as possible. Countries may be tempted to limit the professions to those, which they consider relevant for a potential inclusion into classes of nursing professionals. Such ‘unintentional’ or ‘well-meant’ censorship can create substantial damage. Countries should rather include all professions active in the health care sector, as long as they are expected to perform at least one of the functions described in Annex 5. It is always possible to exclude a profession later on, based upon the questionnaire contents, but it is not possible to compare countries in a meaningful way if the professions are incompletely covered in the questionnaire.
17. The Task Force discussed different options on agreeing on ‘common groups’ of professionals to retain at international level. They found the international classifications of professions in the version implemented in Europe (ISCO-88) as the best alternative, because ISCO uses educational attainment as one of the criteria to categorize professions, and because the Task Force itself considered educational attainment as the most important discriminatory factor among groups of nursing staff groups. Using existing ISCO categories where available and applicable would furthermore ease the comparison with data collections on health professionals performed outside Europe.
18. It was noted, however, that ISCO could not be used unconditionally. In the last 25 years, the European Union has issued directives regulating the “equivalence” of national professions (more precisely their respective qualifications) for the purpose of professional migration in Europe (nursing staff settling for work in countries other than the ones in which they acquired their training and qualification). The directive on nurses describes explicitly as equivalent nursing professionals from different countries, which – using the educational attainment criteria of ISCO-88 – could never belong to the same group. Such European directives are published for midwives (see Annex 3) and for fully qualified nurses in general care (see Annex 2). For the new Member States there are similar lists of professions considered ‘equivalent’, although there is not yet a directive as such. The Task Force agreed that, whenever classifying by European regulations yielded different result than classifying by ISCO-88, classifying by European regulations should supersede classifying by ISCO-88.
19. Nursing staff should be clearly separated from physicians on one side and from “other health professionals” on the other. There may always be cases of proximity or potential overlap, which asked for more detail or for special treatment. The Task Force, however, agreed not to focus too much on ‘small’ problems, i.e. on dealing with subjects, which only refer to a small number of persons. The Task Force considers it necessary that comparable data collections for health care manpower exist on at least on
 - physicians,
 - nursing professionals (described here),
 - other health professionals (e.g. physiotherapists, psychotherapists, speech therapists etc.), and
 - other staff.

20. Within the category ‘Nursing professionals’, sub-categories should primarily reflect different educational attainment, i.e. level of qualification, as expressed by the degree and the respective issuing institution.
21. Data on health care manpower as described in 17 and 18 above need to be provided for the health care sector altogether and by provider categories as defined in SHA (1: hospitals, 2: nursing homes, 3: ambulatory care institutions, 4. other providers). As SHA includes occupational health care provided in other economic sectors, it was seen desirable to include under ‘4. other providers’ nurses active in occupational health outside the health care sector.
22. Data should be provided by countries in the maximum national detail level available, if such detailed data can be handled by Eurostat, and if such delivery does not add to the workload in countries. Statistical data should be provided for each the professions included in the mapping exercise, if not immediately then in medium-term perspective. Providing such data in national categories allows a flexible adaptation of classifications. The classification of the source professions into the target groups (see annex 3) should be built in the data collection tool. So countries can input the readily available national data, and Eurostat has available the national input data in addition to the reclassified result.
23. It may be needed to further detail data on nursing staff cross-classifying professional categories by socio-demographic variables such as age, gender, country of birth or country in which the nursing certificate was received. Such information may be needed for specific purposes such as the age strata of the nursing staff or monitoring the international migration of professionals. The Task Force did not deal with these subjects, and there are no recommendations as to which additional variables should be collected on nursing staff.

Recommendations

The countries are invited to discuss and approve the following suggestions:

1. Raising the quality and comparability of data on nursing staff requires different criteria to be fulfilled:
 - Data must not mix different methodological concepts. *Nurses ever educated*, irrespective of whether active, retired, working abroad, or active in a different profession provide information of a different kind than *nurses economically active in their profession*. This again differs from what data on *nurses active in the health care sector* or *nurses in direct patient treatment* tell.
 - The Task Force considers *nurses in direct patient treatment* to be the best concept for the purpose here, if it includes nurses active in health programmes. The TF admits, however, that *nurses active in the health care sector* may be the only available concept, and that the data collections will have to settle with that.
 - Data must refer to all professions providing nursing care in non-negligible amounts and quality.
2. Making data comparable requires that the national classifications used for the professions active in health care are mapped into a common classification.
3. The Task Force recommends to use ISCO-88 as this common classification. The underlying framework of ISCO refers to educational attainment as the primary criterion for classification, which is considered suitable for the nursing staff.
4. In some cases, the European Directives on equivalence of professional qualification in the framework of professional migration differ from the ideas of ISCO-88. In these cases, the Task Force recommends to follow the European Directives rather the ISCO.
5. The mapping of professions uses a set of well-defined and easy to measure criteria. This allows third parties to evaluate and verify the country's suggestion for the result of the mapping exercise. It also provides useful information both for data providers and users. The Task Force recommends to use the questionnaire described in Annex 1 for this purpose. Countries should answer the questions for each nationally defined profession active with providing nursing care-related activities in the health care system of the country. Based on the results, Eurostat will agree with each country individually on how to deal with data for the individual professions.
6. The Task Force recommends the collections of data following the national classifications used in the respective country. This way of proceeding provides maximum flexibility when classifying or re-classifying data, and it reduces the work-load and the error risk in countries, as it uses the commonly known national framework.
7. The Task Force recommends to design the data collection tool in a way that it incorporates the approved results of the mapping exercise. By doing this, the work load and error risk would be reduces both at the sending and the receiving end. Countries provide the data in their nationally known framework, and Eurostat and the international organisations receive it classified in internationally agreed common categories.

8. The Task Force recommends to retain the categories of nursing staff as described in Annex 4, and to use the labels described their for the categories and their respective subtotals.
9. The Task Force recommends to again explore the feasibility of the meta data on nursing care functions for defining common categories for professions active in health care provision. The TF suggests to start with list of nursing care functions tested in 2004, and to possibly extend its functional list, so that physicians or other health professionals can be included. This study could be organised in the framework of a project. The results are expected to raise the interest of different user groups in Europe.

Annex 1: Questionnaire recommended for mapping.

#	Subject
A	Local name: Please provide the name/title for the professions in your national language
B	English name: Please provide a rough translation of the profession's name/title in English
C	Description: You may describe the functions and responsibilities performed by the profession in greater detail, using free-text elements, when considered necessary (not required element)
D	Work place: Please enumerate the work places, in which the these jobholders are found. (Only needed, if profession is found in few health care institutions only)
General Criteria for mapping	
E1	Is the profession compliant to a recognised midwife in the sense of the European Directive 80/154/EEC and 2001/19/EEC? <i>See annex 1 for description.*</i> ==> Answer: YES or NO
E2	Is the profession compliant to a recognised nurse for general care in the sense of the European Directive 77/482/EEC and 2001/19/EEC? <i>See annex 2 for description.**</i> ==> Answer: YES or NO
E3	Is the profession registered in the country? ==> Answer: YES or NO
E4	Does the training for the profession include a specialised nursing qualification? ==> Answer: YES or NO
Educational attainment	
F	Alternative 1 for enquiring educational attainment
To qualify for the profession, a person from the age of 15 onwards, needs to have completed: (<i>please only specify the number of years needed above the age of 15</i>)	
F1	Number of years in secondary education
F2	Number of years in tertiary education
F3	Number of years in an apprenticeship or likewise
F4	Number of years in training on the job
G	Alternative 2 for enquiring educational attainment
To qualify for the profession, a person from the age of 15 onwards, needs to have completed: (<i>please only specify the number of years needed above the age of 15</i>)	
G1	number of years in general education , i.e. education that does not explicitly or exclusively qualify for the specific profession or class of professions in question
G2	number of years in specific education , i.e. education that does explicitly or exclusively qualify for the specific profession or class of professions in question
Quantitative importance of the profession	
H	Please give a rough estimate for the number of persons in your country in this profession – absolute number – (<i>Not based on a data collection, can rather be any form of estimate</i>)
Suggested comparable category	
Z	Which of the categories described in the table A1 in sheet target do you believe the profession should be classified into?

The Task Force members tested alternatives F and G for quantifying the educational attainment. There is a slight preference for alternative 2 (G).

* See Annexes 2 and 2a;

** See Annexes 3 and 3a

Annex 2: Council Directive of 21 January 1980 concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in midwifery and including measures to facilitate the effective exercise of the right of establishment and freedom to provide services (80/154/EEC) as quoted in E1 in Annex 1 above).

THE COUNCIL OF THE EUROPEAN COMMUNITIES,

...

HAS ADOPTED THIS DIRECTIVE:

CHAPTER I SCOPE

Article 1

1. This Directive shall apply to the activities of midwives as defined by each Member State, without prejudice to Article 4 of Directive 80/155/EEC, and pursued under the following professional titles:

in the Federal Republic of Germany:

- “Hebamme” oder “Entbindungspfleger”;

in Belgium:

- “accoucheuse/vroedvrouw”;

in Denmark:

- “jordemoder”;

in France:

- “sage-femme”;

in Ireland:

- midwife;

in Italy:

- “ostetrica”;

in Luxembourg:

- “sage-femme”;

in the Netherlands

- “verloskundige”;

in the United Kingdom:

- midwife.

...

Annex 2a: Directive 2001/19/EEC of the European Parliament and of the Council of 14 May 2001 amending Council Directives 89/48/EEC and 92/51/EEC on the general system for the recognition of professional qualifications and Council Directives 80/154/EEC, ... concerning the professions of ... midwife, ...

**ANNEX IV:
Titles of diplomas, certificates and other evidence of formal qualifications
in midwifery**

Country	Title of qualification
Belgique/België/Belgien	<ul style="list-style-type: none"> • Diploma van vroedvrouw/ • Diplôme d'accoucheuse
Danmark	Bevis for bestået jordemodereksamen
Deutschland	Zeugnis über die staatliche Prüfung für Hebammen und Entbindungspfleger
Ελλάς	<ol style="list-style-type: none"> 1. Πτυχίο ... 2. Πτυχίο ... 3. Πτυχίο ...
España	Título de matrona / asistente obstétrico (matrona) /enfermería obstétrica-ginecológica
France	Diplôme de sage-femme
Ireland	Certificate in Midwifery
Italia	Diploma d'ostetrica
Luxembourg	Diplôme de sage-femme
Nederland	Diploma van verloskundige
Österreich	Hebammen-Diplom
Portugal	<ol style="list-style-type: none"> 1. Diploma de enfermeiro especialista em enfermagem de saúde materna e obstétrica 2. Diploma/carta de curso de estudos superiores especializados em enfermagem de saúde materna e obstétrica 3. Diploma (do curso de pós-licenciatura) de especialização em enfermagem de saúde materna e obstétrica
Suomi/Finland	<ol style="list-style-type: none"> 1. Kätilön tutkinto / barnmorskeexamen 2. Sosiaali- ja terveystieteiden ammattikorkeakoulututkinto, kätilö (AMK) / yrkeshögskoleexamen inom hälsovård och det sociala området, barnmorska (YH)
Sverige	Barnmorskeexamen
United Kingdom	Statement of registration as a Midwife on part 10 of the register kept by the United Kingdom Central Council for Nursing, Midwifery and Health visiting

Annex 3: Council Directive of 27 June 1977 concerning the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of nurses responsible for general care, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services (77/452/EEC) as quoted in E2 in Annex 1 above).

THE COUNCIL OF THE EUROPEAN COMMUNITIES,

...

HAS ADOPTED THIS DIRECTIVE:

CHAPTER I SCOPE

Article 1

1. This Directive shall apply to the activities of nurses responsible for general care.
2. For the purposes of this Directive “activities of nurses responsible for general care” shall mean activities pursued by persons holding the following titles:

in Germany:

“Krankenschwester”, “Krankenpfleger”;

in Belgium:

“hospitalier(ère)/verpleegassistent(e)”, “infirmier(ère) hospitalier(ère)/ziekenhuisverpleger (-verpleegster)”;

in Denmark:

“sygeplejerske”;

in France:

“infirmier(ère)”;

in Ireland:

Registered General Nurse; (1)OJ No L 257, 19.10.1968, p. 2.

in Italy:

“infermiere professionale”;

in Luxembourg:

“infirmier”;

in the Netherlands:

“verpleegkundige”;

in the United Kingdom:

England, Wales and Northern Ireland:

State Registered Nurse;

Scotland:

Registered General Nurse.

...

Annex 3a: Directive 2001/19/EEC of the European Parliament and of the Council of 14 May 2001 amending Council Directives 89/48/EEC and 92/51/EEC on the general system for the recognition of professional qualifications and Council Directives 77/452/EEC, ... concerning the professions of nurse responsible for general care, ...

**ANNEX:
Titles of diplomas, certificates and other evidence of formal qualifications
in nursing (general care)**

Country	Title of qualification
Belgique/België/Belgien	<ol style="list-style-type: none"> 1. Diploma gegraduateerde verpleger/verpleegster <ul style="list-style-type: none"> • Diplôme d'infirmier(ère) gradué(e) • Diplom eines (einer) graduierten Krankenpflegers (-pflegerin) 2. Diploma in de ziekenhuisverpleegkunde <ul style="list-style-type: none"> • Brevet d'infirmier(ère) hospitalier(ère) • Brevet eines (einer) Krankenpflegers (-pflegerin) 3. Brevet van verpleegassistent(e) <ul style="list-style-type: none"> • . Brevet d'hospitalier(ère) • . Brevet einer Pflegeassistentin
Danmark	Eksamensbevis efter gennemført sygeplejerskeuddannelse
Deutschland	Zeugnis über die staatliche Prüfung in der Krankenpflege
Ελλάς	<ol style="list-style-type: none"> 1. Πτυχίο ... 2. Πτυχίο ... 3. Πτυχίο ... 4. Πτυχίο ... 5. Πτυχίο ... 6. Πτυχίο ...
España	Titulo de Diplomado universitario en Enfermería
France	<ol style="list-style-type: none"> 1. Diplôme d'Etat d'infirmier(ère) 2. Diplôme d'Etat d'infirmier(ère) délivré en vertu du décret no 99-1147 du 29 décembre 1999
Ireland	Certificate of Registered General Nurse
Italia	Diploma di infermiere professionale
Luxembourg	<ol style="list-style-type: none"> 1. Diplôme d'Etat d'infirmier 2. Diplôme d'Etat d'infirmier hospitalier gradué
Nederland	<ol style="list-style-type: none"> 1. diploma's verpleger A, verpleegster A, verpleegkundige A 2. diploma verpleegkundige MBOV (Middelbare Beroepsopleiding Verpleegkundige) 3. diploma verpleegkundige HBOV (Hogere Beroepsopleiding Verpleegkundige) 4. diploma beroepsopleiding verpleegkundige . Kwalificatieniveau 4 5. diploma hogere beroepsopleiding verpleegkundige . Kwalificatieniveau 5

Österreich	<ol style="list-style-type: none"> 1. Diplom als .Diplomierte Gesundheits- und Krankenschwester/Diplomierter Gesundheits- und Krankenpfleger. 2. Diplom als .Diplomierte Krankenschwester/Diplomierter Krankenpfleger.
Portugal	<ol style="list-style-type: none"> 1. Diploma do curso de enfermagem geral 2. Diploma/carta de curso de bacharelato em enfermagem 3. Carta de curso de licenciatura em enfermagem
Suomi/Finland	<ol style="list-style-type: none"> 1. Sairaanhoitajan tutkinto / sjukskötarexamen 2. Sosiaali- ja terveystieteiden ammattikorkeakoulututkinto, sairaanhoitaja (AMK) / yrkeshögskoleexamen inom hälsovård och det sociala området, sjukskötare (YH)
Sverige	Sjuksköterskeexamen
United Kingdom	Statement of Registration as a Registered General Nurse in part 1 or part 12 of the register kept by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Annex 4: Groups of nursing care staff to be retained for international use.

Category	Name/Description
1	Midwives
2	Qualified nurses
2 A	• Qualified nurses for general care
2 B	• Qualified nurses for specialised care (branch nurses)
<i>1+2</i>	Total number of qualified nurses and midwives
3	Associate nurses
<i>1+2+3</i>	Total number of nursing professionals
4	Caring personal (e.g. nursing aids, assistants)
<i>1+2+3+4</i>	Total number of nursing and caring professionals

Annex 5: Nursing care functions evaluated for its use to categorise nursing staff.

#	Description	
A	Profession's name in national language	
B	Profession's name in English (rough translation)	
C	Required educational attainment for profession	
D	– follow-up education based on other profession (indicate underlying profession by referring to respective column or leave blank if there are no prerequisites)	
E	+ # of years in primary education (=years 0–7 following national definitions)	
F	+ # of years in secondary education (=years 8–12 following national definitions)	
G	+ # of years in tertiary education (=years 13+ following national definitions)	
H	+ # of years in apprenticeship or likewise	
I	+ # of years in training on the job	

Own initiative *	Upon prescription	Support **
------------------	-------------------	------------

GENERAL CARE functions				
<i>Activities related to patient's ADL</i> (e.g. alimentation & hydration, rest & sleep, body care & hygiene, locomotion, communication, well-being & autonomy,)				
1	Support activities of daily living: feeding, washing, bedding, bowel movement, urination			
2	Care related to traction/immobilization			
3	Care for patients confined to bed (also in nursing homes)			
4	Patients care during visits to a physician e.g. in a policlinic			
5	Home care as prescribed by doctors			
6	Preparing food for newborns, infants and toddlers			
7	Provision of diet control			
8	Change of a feeding tube/gastric probe			
<i>Activities related to the patient's need of surveillance and security</i>				
9	Patient environment surveillance			
<i>Activities related to medical supervision/investigation (for preparing diagnostics)</i>				
10	Use of medical technologies: radio-diagnostics, biological and medical analyses in laboratories (incl. entering parameters into haemo-calculator)			
11	Measuring blood pressure, temperature, pulse			
12	Taking samples e.g. blood, urine, etc.			
13	Specimen collection			
14	Performing arterial puncture			
15	Phlebotomy: vein blood extraction			

		Own initiative *	Upon prescription	Support **:*
Activities related to emergency care				
16	Receiving, registering and assessment of emergency calls			
17	Transmitting instruction for lay first aid by telephone			
18	Initiating life-saving measures			
19	Performing tracheal intubation			
20	Gastrolavage			
21	Heart defibrillation			
22	Activation of crisis traumatology programmes (for mass disasters, catastrophes)			
Activities related to medical treatment				
23	Giving selected injections under authority (e.g. immunisation)			
24	Placing probes (e.g. gastric, urinary)			
25	Cleaning and dressing wounds			
26	Provision of parenteral medicine			
27	Provision of oral medicine			
28	Provision of intravenous therapy			
29	Provision of fluid control			
30	Provision of analgesics			
31	Provision of colds			
32	Provision of intravenous functions			
33	Applying anticoagulants and other therapeutic solutions			
34	Activities relating to provision and transfusion of blood			
35	Performing haemo-dialysis/peritoneal dialysis			
36	Care related to tracheal intubation or tracheostomy			
37	Surveillance of special treatments: oxygen or serum therapy, parenteral nourishment ...			
Activities related to surgery (before, during, after)				
38	Pre-operation coordination			
39	Operation preparation			
40	Periodic surveillance of vital signs			
41	Surgical precautions			
42	Anaesthetic support			
43	Providing special nursing care before, during and after serious surgery			
44	Infection control during operation			
45	Applying surgical mask towels			
46	Instrumentation during surgeries			
47	Post-anaesthesia care			

		Own initiative *	Upon prescription	Support **
Activities related to radio-/chemotherapy				
48	Monitoring the patient's health before, during and after radio-therapy or -examination			
49	Participating in radio-diagnostics or therapy by open irradiators			
50	Assistance in specialised radiology procedures			
51	Activities relating to radiation protection			
52	Applying radiopharmaceuticals			
Activities related to palliative care				
53	Psychic support of dying patients and their relatives			
54	activities related to death			
Activities related to psychologically difficult situations / mental problems				
55	Support of patients and relatives in difficult psychological situations			
56	Performing psychological preparation of children			
57	Participating in psychological support to families			
58	Participating in crisis interventions			
59	Consulting in prevention of mental health defects and in re-socialisation			
60	Participation in (group-)psychotherapy			
Activities related to patient information and documentation				
61	Documentation (patient records, other documents, ward-related or otherwise)			
62	Patient rights protection			
63	Informing blood donors or patients about adverse effects of blood sampling			
64	Pre-surgery information and education			
65	Informing patients about radiology procedures and their risk			
66	Health education: Family planning			
67	Mother and new-born health education (counselling of women before and during pregnancy, nutritional and personal care for the first year)			
68	Health education for chronic conditions (high blood pressure, diabetes, overweight, arthritis, obstructive chronic pulmonary disease)			
69	Health education: Home injury prevention			
70	Drug-related health education (drug/alcohol abuse prevention, auto medication, inadequate drug-use)			
71	Executing health programmes: smoke cessation, risk group identification, screening ...			
72	Health education: Dental hygiene			
Activities related to provision and maintenance of medical equipment				
73	Preparation without repairing of medical devices and instruments			

		Own initiative *	Upon prescription	Support **
SPECIFIC CARE functions: midwifery				
74	Normal delivery assistance			
75	Registration function of newborns (length/weight)			
76	Surveillance of newborns			
77	Surveillance of post delivery (=placenta)			
78	Maternal education			
79	Provision of treatments to pregnant women			
80	Provision of treatments to the newborns			
SPECIFIC CARE functions: rehabilitation				
81	Setting up a treatment plan			
82	Monitoring and executing the treatment plan			
SPECIFIC CARE functions: dental care				
83	Supporting dentist			
TEACHING functions				
84	Teaching, if in health care institution and not performed exclusively			
RESEARCH functions				
85	Medical or likewise research, if in health care institution and not performed exclusively			
86	Organising of the patient admission and discharge process			
87	Organising patient care/treatment schedule; nursing care program planning			
88	Management of manpower resources/Work flow planning			
89	Task control and assessment			
90	Quality control			
91	Co-ordination of nursing care departments			
92	New nurse orientation.			
93	Patient rights protection			