Care Work and Nursing at Hospitals and Health Centres in Germany

Content

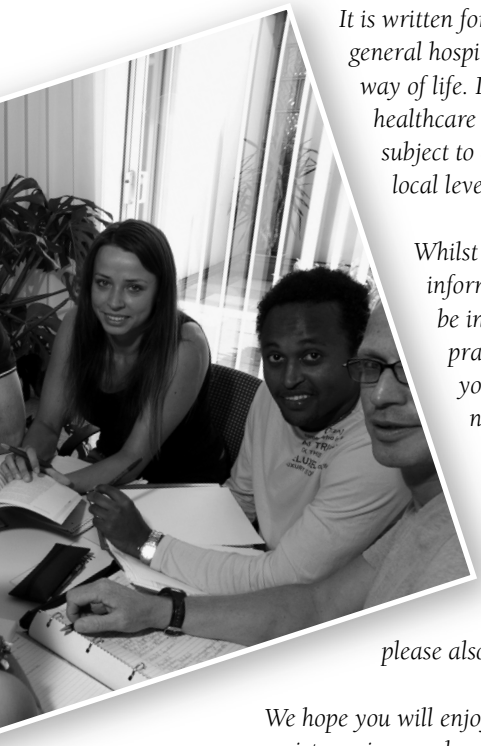
Introduction

Dear Student

◆ *Welcome to Germany!*

We are very pleased that you have chosen Germany for your practical study placement! We really hope your time here will completely fulfil or even surpass your expectations.

The handbook you are about to read is a result of co-operation between institutes for vocational education in six different countries: Finland, Estonia, the Netherlands, Scotland, Sweden and Germany.



It is written for students who want a practical study placement in a general hospital in Germany, to help them understand the German way of life. It explains what it is like to study and/or work in the healthcare system in Germany which, as in other countries, is subject to continual change at the national and thus also at the local level.

Whilst every effort has been made to reflect up-to-date information at the time of writing this handbook, you may be introduced to new initiatives whilst undertaking your practical study placement with us in Germany. Staff in your placement area will be happy to advise you on any new relevant information.

We advise you to read this manual before you start your practical study placement in a general hospital.

When you read "he", "his" or "him" in this manual please also interpret this as also covering "she", "hers" or "her".

We hope you will enjoy your time with us and trust that this handbook will assist you in your learning experience!

1. A Typical Day for Healthcare and Nursing Staff in Germany

◆ During your time with us in Germany you will gain many new insights and impressions.
During your entire time in a hospital in Germany a mentor will be available to assist you.

The mentor will show you around the hospital, explain the work of nursing staff in a hospital and will be available to answer your questions.

In an attempt to prepare you for this placement experience we have identified two specific healthcare settings and have developed some sample case studies for you to think about. We hope that by reading these case studies you will gain some idea of the types of conditions which may be experienced by patients within these settings and an initial understanding of the patient's journey within the German healthcare system.

In an attempt to give you a "nurse's view" of a typical working day we asked some nurses to keep a daily diary during their time in an assessment and rehabilitation ward and an orthopaedic speciality ward. We hope that their account of the working day will help you gain an insight into what you can expect. The nurses' diaries are provided following each of the case studies. Happy reading!!!

1.1. Case Study 1 – An Assessment and Rehabilitation Ward

Patient History:
Peter Störning is 67 and has been retired for 2 years. He lives with his 64-year-old wife Mathilde on the outskirts of Mönchengladbach in the German state of North Rhine-Westphalia (NRW) where they have their own house.
They both live an active and busy life. They maintain intensive contact with their three grandchildren, they cycle a lot and due to their friendly and helpful nature they are a popular and respected couple in the neighbourhood.
In his spare time Peter Störning's favourite pastime is what he did when he worked: gardening.

When his daughter Karin arrives to visit on the morning of Monday the 15th of August she finds her father lying unconscious on the floor. Peter Störning is taken to the local "Maria-Hilf" hospital and is admitted to the Stroke Unit there. A CT is carried out immediately, resulting in diagnosis of a cerebral media infarction.
Peter's circulation is slightly hypertonic. The doctors decide on lysis therapy. Unfortunately this therapy is not particularly successful. An atonic hemiparesis remains on the left side with motor aphasia. After 4 days in the Stroke Unit, on Friday the 19th of August he is transferred in a stable but not significantly improved condition to the peripheral neurological ward 2H3.

In addition to the stroke, Peter is suffering from arterial hypertension and arrhythmia which have been treated with a beta blocker since he entered hospital.
Every 6 hours first his vital functions had to be checked. His breathing currently shows no abnormalities and his skin condition is intact. Since the stroke Peter can not control his urination or defecation.
Peter Störning's nutritional condition is good; his BMI is 26. At home he makes a point of eating whole foods and mainly eats produce from his own garden. Despite his movement restriction Peter Störning is able to alter his position in bed without assistance. Up to now he has not been able to sit or stand. Movements are extremely limited due to sensibility dysfunctions in his legs.

Peter Störning cries a lot and doesn't want to talk much. The motor aphasia drives him to despair. It is clear that he is understanding everything being said to him but he has serious difficulties in speaking himself. His wife has real problems in coping with this situation. Often she can only guess what her husband is trying to say.

Nurse's diary:

Hallo, my name is Juliane. I am 29 years old and I've been working as a nurse in the Maria-Hilf hospital for 6 years now. I completed my nursing exams in 1999.
For the first two years following my training I worked in the Stroke Unit here and then moved to the peripheral neurological ward 2H3 where I still am today.

A total of 28 healthcare and nursing staff work on this ward; 6 of these have full-time posts and the rest are part-time. We all have the same training, i.e. we are all trained nurses. Together we look after up to 30 patients.
The most common medical conditions on our ward are strokes, epilepsy, sleep apnoea, dementia and multiple sclerosis.
We work in accordance with the integrated unit care system with 2 members of staff at any one time looking after a group of 10 to 15 patients, usually supplemented by one or two trainee nurses. The full-time staff have a five and a half day week and mainly work days. The early shift starts at 6:00 in the morning and finishes at 1:30 in the afternoon; the late shift starts at 1:00 p.m. and finishes at 9:00 in the evening. The night shift works from 8:45 in the evening until 6:15 the next morning. Some of the staff work mainly night shifts.

Monday, 22 August

6:00 a.m.: The early shift starts with the handover from the night shift.
Our colleague from the night shift reports on any significant occurrences, new information or developments, tests or examinations due that day and the condition of our patients, including Peter Störning. Then we discuss the specific work assignments for our shift.

6.30 a.m.: All of the nursing staff assist and support the patients in their group in their day-to-day activities. Our work on each shift covers planned patient support, documentation, instructing and advising the patients, preparation and administration of medication, carrying out and monitoring the therapy, checking for and reacting to changes to the patients' conditions and planning the patients' appointments.
In the mornings the emphasis is on assisting the patients with their personal hygiene and getting dressed, integrating any necessary instructions, exercises and prophylactic measures. Where appropriate the necessary preparations are also made for any tests or examinations which may be due that day. In all of these activities we attach significant importance to self-determined and activating care.
The 1st year nursing student assigned to me is called Sabine and she and I are responsible for Peter Störning. In his first few days with us we had to assist him with his personal hygiene while he was still in bed. While doing this we attempted to put emphasis on and where possible integrate the affected side of his body. With the aid of consistent application of the Bobath approach we were able to achieve a significant improvement in his general condition.
Despite this, Peter Störning appears to us to be increasingly resigned and it is difficult to motivate him to cooperate in his daily exercises. Sabine checks and documents his vital signs (pulse, blood pressure etc.) and also documents with my assistance the nursing actions taken.

7:30 a.m.: We distribute the breakfast trays to the patients and assist them with eating if necessary.
Peter Störning needs particular assistance with his breakfast; on the one hand he should as much as possible regain his independence but on the other hand there's always a risk of dysphagia.

9.00 a.m.: Once we've dealt with the patients' breakfast we also have a short breakfast break.

10.00 a.m.: It's time for the ward round. The nursing staff, the trainee nurses, the ward doctors and medical students all take part in the ward round. When addressing Peter Störning's case during the ward round today we had to collectively find a solution for one of his problems: As far as Sabine and I were concerned the fact that Peter isn't prepared to open up and talk and that he's increasingly resigned and often aborts nursing treatment was becoming more and more of a problem. In particularly he is not willing to do movement exercises. We urgently had to find a way of motivating him. Together with Peter and his wife we decided to put a patient whom we know well, who had also had a stroke but who in the meantime has almost no restrictions, in the bed next to Peter's. We hope that this will change his mood and give him hope.

10.30 a.m.: Together with Peter Störning and his wife we develop a new care plan, discuss realistic objectives and consider measures to be taken.

11.00 a.m.: Peter Störning is mobilised in cooperation with the Physiotherapy department. Unfortunately this mobilisation puts such a strain on him that his blood pressure rises steeply so we have to end the mobilisation prematurely. Once he has been given medication for his hypertension we initially have to check and document his blood pressure every 30 minutes. While we're doing this we have a talk with his wife about possibly discharging him and allowing him to go home but we make it clear to her what she will have to do at home before he is discharged.

12.00 noon: It's lunchtime already and once again we assist the patients where necessary and when they've all had their lunch we clear away the trays.

1.00 p.m.: The late shift has arrived and we have the handover meeting. For the first time, with my assistance Sabine is allowed to do the handover for our patient Peter Störning and to report on what was agreed during the ward round to the late shift.

1.30 p.m.: That's it for me for today! I'm off to enjoy my afternoon!

1.2. Case Study 2 - An Orthopaedic Clinic

Patient History:

Hubertine Anton is 85 and lives on her own in a small house. Her husband died of cancer 25 years ago. Her only daughter Doris who is 50 has been divorced for several years and has two children, one 17 and one 15. She has hardly any time to look after her mother.

Each lunchtime Hubertine Anton goes to an old people's home only 300 metres from her house for her lunch. She doesn't like the taste of "meals on wheels".

Hubertine's brother who is 76 lives next door to her with his wife. Both are healthy and very active.

Hubertine Anton has suffered from serious osteoporosis for several years now. A Durogesic® plaster provides good relief against the pain. She can't, however, manage long distances on her own. For short distances she uses her wheeled walker. The electric wheelchair which her daughter bought for her is sitting in a corner following an accident.

On Tuesday the 14th of September Hubertine Anton was coming the stairs from the WC on the 1st floor. She had been a bit dizzy all day and had put it down to the weather. And then it came again. When she came to her senses again she was lying on the floor at the bottom of the stairs.

Her right shoulder and right forearm were extremely painful but her right hip was even worse! She could hardly bear the pain.

In the hospital a fracture of her right femoral neck was diagnosed. Her shoulder and forearm are "only" badly bruised. A hip TEP is arranged for the next day.

After spending a day in intensive care Hubertine Anton is moved to the surgical ward 1A3. Early mobilisation was carried out on the first day after the operation. Hubertine Anton sat on the edge of the bed for 5 minutes without any circulation problems. She has a lot of pain in the area operated on and this restricts her with every attempt at movement. She is, however, extremely motivated to do everything that will help to give her back her independence. Hubertine Anton is scared that she will have to go into an old people's home. She says only old people live there and she's not old!

Nurse's diary:

Hi, my name is Mario; I'm 28 and have been working on the accident surgery ward 1A3 in the Maria-Hilf hospital for the last two years. I took my nursing exams in 2003 and since then I've worked on various wards, for example an internal medicine ward and a urology ward.

Where I am now we have 40 beds. On the early shift we normally have four nursing staff plus two trainee nurses. On the late shift we usually also have four nursing staff and one trainee nurse.

On the two day shifts we work in accordance with the unit or group care principle, i.e. one nurse is responsible for approx. 10 patients and may also be assigned a trainee.
On the night shift we work alone and share a second nurse with another ward.

Saturday, 18 September

1.00 p.m.: The late shift starts with a handover from the early shift.
The main activities during the late shift are preparing and following up on tests, examinations and operations and preparing schedules. But today is Saturday so it will be quieter since no routine operations are performed at the weekend.
The group of patients which I have been assigned to includes Hubertine Anton.

1.30 p.m.: I set up an infusion of 1000 ml NaCl 0.9% for Hubertine Anton.

1.45 p.m.: Together with Hubertine Anton I fill in her pain log to determine whether the medication against her pain is sufficient. It turns out that Hubertine Anton is still in pain so I check her position, the operation wound and her vital signs and give her the prescribed pain medication.

2.00 p.m.: We serve our patients coffee or tea.

3.00 p.m.: We have time to revise Hubertine Anton's nursing plan with her since she will soon be moved to a rehabilitation centre and so it's a good time to discuss the transfer. Her brother is also visiting her today and he has agreed to take care of the necessary formalities.
We discuss a nursing plan with her. We want to achieve realistic objectives with the ultimate aim of her being able to return to her own home. She should practice transferring to the toilet seat on her own and the first standing and walking exercises are planned for the next few days.

4.00 p.m.: I check and document her pain levels again and am pleased to see that Hubertine is now almost completely free of pain. This means that we can now implement prophylactic measures again pneumonia. I once again explain to her how to use the breathing trainer on her own which forms part of her personal nursing plan.

4.30 p.m.: Time for a short break.

5.00 p.m.: The evening meal trays are distributed to the patients. The patients who need assistance demand a lot of attention but Hubertine Anton manages to cope well on her own.

6.00 p.m.: Once we've cleared away the meal trays we start the regular evening rounds.
Patients are once again helped into bed and if necessary we help them again with their personal hygiene. Some patients like to have to have their teeth cleaned; other require intimate personal hygiene again.
We arrange everything such that our patients are prepared for the night.

8.00 p.m.: We administer medication, set up new infusions and prepare patient charts for the next day. The paperwork takes up a lot of time.

8.45 p.m.: The night shift has arrived! Now we do the handover and then I'm off home. After all I'll be back here in the morning!

2. Nursing and Healthcare in Germany

◆ Independent determination, planning and implementation of care requirements, provision of advice, instructions and support to patients and relatives in all aspects of the patients' lives, assistance with ultramodern medical treatment, and computer-supported administrative tasks: the work associated with modern healthcare and nursing is wide-ranging.
The interaction of high-tech medicine in the widest range of different specialist departments, the determination and documentation of personal needs and promotion of the patients' health require considerable sensitivity, attention to detail, organisational talent and creativity on the part of the nursing staff.
The nursing staff are thus an important link in the multidisciplinary patient care team consisting of doctors, physiotherapists, social workers, chaplains etc.

2.1. How is the Federal Republic of Germany Structured?

◆ To be able to understand the health service and the organisation of nursing training in Germany, a basic understanding of the structure of the Federal Republic of Germany is first necessary.

Germany is a federal republic, i.e. an alliance of several independent federal states. These states together form a federation: the Federal Republic of Germany. This principle of an alliance of several states with equal rights is also referred to as federalism.
Since its reunification in October 1990 the Federal Republic of Germany consists of 16 independent federal states, all with equal rights (see Table No. 1).
With the federalist concept the independence of the individual states with their specific cultural, linguistic and regional characteristics is maintained. The individual federal states are thus also able to recognise, solve and finance state-specific problems (e.g. the coastal region in the north of Germany, mining in the west and the alpine region in the south).
Each federal state has its own state government, its own head of government (referred to as the minister-president) and its own state parliament. Each federal state thus has its own federal territory, its own capital city and seat of government and its own state borders.

The federal states have relinquished certain responsibilities from the state governments to the federal government. The allocation of responsibilities between the federal government and the state governments is regulated by the Federal Republic of Germany's

constitution. In accordance with the constitution the federal government is responsible for political issues (internal politics and foreign affairs). Basically the responsibilities are shared as follows:

- ADMINISTRATION: Fundamentally a task of the federal states
- LEGISLATION: Legislation is handled partly by the federal government and partly by the state governments. This naturally also means that different laws can exist in the different federal states. And this is one of the reasons why healthcare and nursing training in Germany is not standardised on a national basis and can vary from state to state (see Section 4).
- JURISDICTION: Jurisdiction is administered via the laws of the federal states. Consistent jurisdiction at the highest level, however, is ensured by federal government courts (e.g. the German Federal Court of Justice or the German Federal Labour Court).

Fig 3: Map of Germany, showing the Federal States

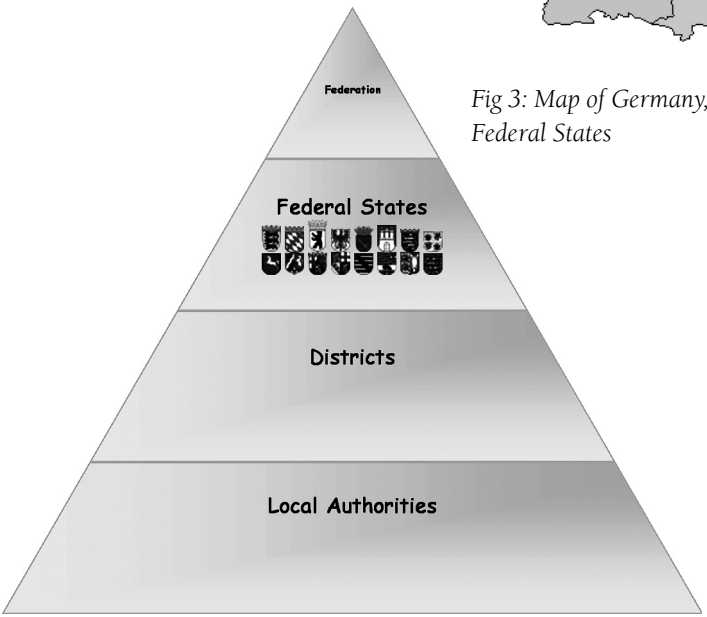


Fig. 1: The structure of Federal Republic of Germany and its federal state system

	State Capital	Residents (million)	Size in km²
Baden-Württemberg	Stuttgart	10.7	35,752
Bavaria	Munich	12.5	70,552
Berlin	Berlin	3.4	892
Brandenburg	Potsdam	2.6	29,479
Bremen	Bremen	0.7	404
Hamburg	Hamburg	1.7	755
Hesse	Wiesbaden	6.1	21,115
Mecklenburg-West Pomerania	Schwerin	1.7	23,180
Lower Saxony	Hanover	8.0	47,624
North Rhine-Westphalia	Düsseldorf	18.0	34,085
The Rhineland Palatinate	Mainz	4.1	19,853
Saarland	Saarbrücken	1.0	2,569
Saxony	Dresden	4.3	18,416
Saxony-Anhalt	Magdeburg	2.5	20,446
Schleswig-Holstein	Kiel	2.8	15,799
Thuringia	Erfurt	2.3	16,172
GERMANY		**82,438,000**	**357,114**

Fig 2: The 16 federal states of the Federal Republic of Germany

The most important political bodies in Germany

The form of government practised in Germany is **democracy**. The populace elects its representatives at the state government and federal government level and thus has the final say in controlling the country's most important bodies, the five constitutional institutions. These are the Lower and Upper Houses of the German Parliament with their *legislative* tasks, the German Federal Constitutional Court which is the highest *judiciary* body in Germany and the German Federal President and the German Federal Government who assume *executive* tasks on behalf of the populace.

The Federal Government looks after political and national issues but also has the right to initiate legislation and changes to legislation.

The most important political institutions in Germany are the Lower and Upper Houses of the German Parliament, The Federal Government and the Federal President. The Federal Chancellor together with the Federal Ministers constitute the Federal Government (also referred to as the 'Cabinet'). The ministers manage the departments (the 'portfolio') assigned to them, independently and on their own responsibility, in accordance with guidelines and directives issued by the Chancellor. Important ministers are the Foreign Minister, the Minister of Finance and the Defence Minister. The **Lower House of the German Parliament** (the 'Bundestag') represents the German populace and is elected every four years by the populace. Its most important tasks are legislation, election of the Chancellor (who is proposed by the Federal President) and monitoring and control of the government.

The head of state is the **German Federal President**. He or she is elected by the Federal Assembly for five years and may be re-elected once. The Federal Assembly only meets for the purpose of electing the Federal President. It consists of the members of the Lower House of Parliament and an equivalent number of delegates elected to the assembly by the state parliaments. A simple majority vote is sufficient for election of the Federal President. The tasks of the Federal President include representing Germany at an international level and appointment and dismissal of the Chancellor, federal ministers, federal judges, federal civil servants and officers of the armed forces. New legislation only comes into effect when the Federal President has signed it. The Federal President has a non-party role; his scope of political involvement is defined in the constitution.

The **Chancellor** lays down the guidelines for government policy and forms the federal government, i.e. decides on the number of ministers, defines their areas of responsibility, selects the ministers and proposes them to the Federal President for appointment (or dismissal). The Chancellor's proposals are binding for the Federal President.

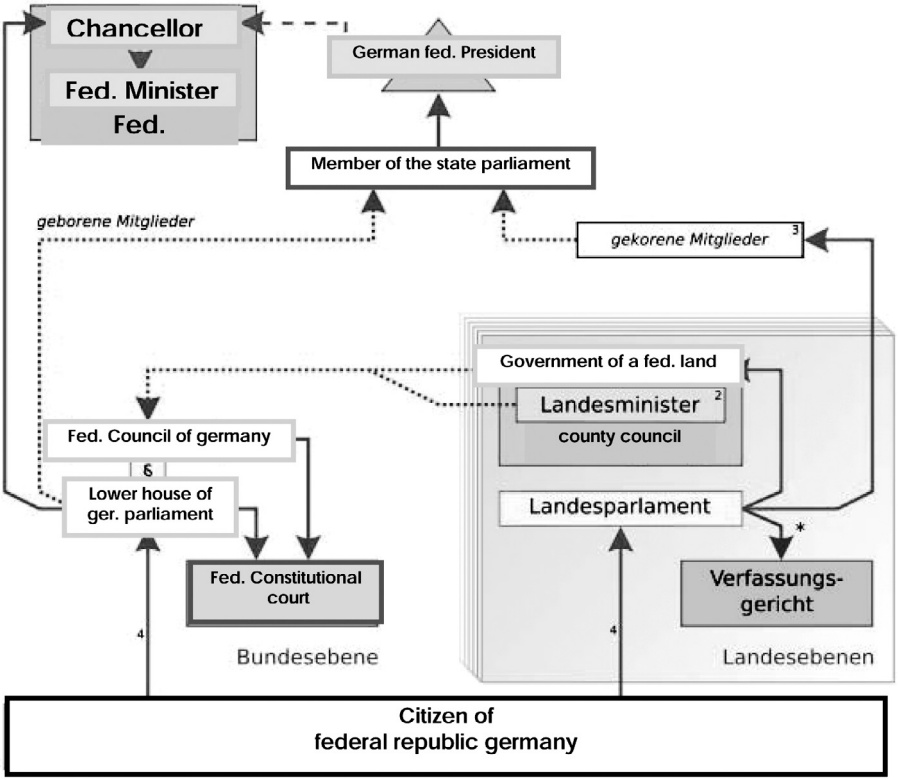


Fig 4: Voting system in Germany

2.2. Definitions of Nursing

◆ Although it's extremely difficult to define the term nursing, and nursing as a profession, some organisations have adopted specific definitions.
Nursing covers all activities which assist people, regardless of whether they are ill or in good health, with measures which contribute to their health or to restoration of good health or to a peaceful death, and which they would implement without assistance if they had the necessary strength, motivation or knowledge.
The objective of nursing is to achieve and/or maintain individual quality of life via recognition and fulfilment of needs based on care concepts and new scientific knowledge.
The definitions below are the most commonly used definitions in Germany.

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, whether sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles (Source: International Council of Nurses, ICN).

The social task of nursing is to assist individuals, families and entire groups of people in the definition and achievement of their physical, psychological and social potential in the demanding context of their living and working environment. Nursing staff must therefore establish and implement measures which promote and maintain good health and prevent illnesses. Nursing also covers planning and support in the case of illness and during rehabilitation and also involves the physical, psychological and social aspects of life to the extent that they affect health, illness, disablement and dying. Nursing staff ensure that the individual and the family, their friends, their social peer group and the community where necessary become involved in all aspects of medical care, and thus promote self-confidence and self-determination. Nursing staff also work in close cooperation with other groups involved in the provision of medical, healthcare and similar services (WHO, 1993).

2.3. Nursing Models

◆ The various nursing models are patient-oriented, regardless of their main focus, be it needs, interaction or results. Needs models primarily highlight what life demands in terms of satisfaction of a person's basic needs. The fulfilment of these basic needs in turn determines the level of well-being, and in extreme cases the will to live. Each healthy person can satisfy their own basic needs; for the sick and disabled this is not so easy.
The most widely-known needs models are those from scientists such as Virginia Henderson, Nancy Roper and Monika Krohwinkel. Krohwinkel's model is strongly based on the Roper's Life Activities (LA) model.

Here's a brief overview of the Life Activities model:

Nancy Roper developed a needs-oriented nursing model whose objective is to assist people undergoing nursing care to promote, maintain or restore maximum independence in the activities of their daily life and to solve the associated problems or learn to cope with remaining dependencies.
The nursing staff should as much as possible minimise disruption of the patient's established way of life. In accordance with the Roper model all life activities can be influenced by biological, psychological, socio-cultural, environment-related or economic factors.

The 12 life activities in the Roper model are:

- Ensuring a secure environment
- Communication
- Respiration
- Eating and drinking
- Excretion
- Keeping oneself clean and getting dressed
- Regulating body temperature
- Moving / getting exercise
- Working and playing
- Feeling and behaving as a man or a woman
- Sleeping
- Dying.

Monika Krohwinkel's nursing model

The "Activities and Existential Experiences of Daily Living" (AEDL) model developed by Krohwinkel is a needs model. With this model the basic needs and abilities of each individual are classified into 13 AEDLs:

The activities and experiences of daily living (AEDLs) in the Krohwinkel model are:

1. Communicating
2. Moving / getting exercise
3. Maintaining the vital functions of life
4. Keeping oneself clean and tidy
5. Eating and drinking
6. Excretion
7. Getting dressed
8. Resting and sleeping
9. Keeping oneself busy
10. Feeling and behaving as a man or a woman
11. Ensuring a secure environment
12. Protecting the social aspects of one's life
13. Coping with existential experiences in life.

The first eleven AEDLs are identical to Roper's "Activities of Daily Life" [1]. The twelfth AEDL, "Protecting the social aspects of one's life", is particularly important when preparing patients for their discharge from hospital. Krohwinkel divides the thirteenth AEDL, "Coping with existential experiences in life" into three areas:

- experiences endangering one's daily living (dependency, worry, angst, pain, dying),
- experience promoting one's daily living (achieving independency, confidence, trust, security),
- experiences which promote or endanger one's daily living (culture / biography).

2.4. The Nursing Process

◆ Nowadays the preparation of nursing plans in Germany varies from hospital to hospital. In addition to care diagnoses and ICNP, in Germany primarily the nursing process forms the basis for the planning of nursing care.

- Appraisal / medical history
- Recognition of problems and resources

- Planning
- Definition of objectives
- Implementation
- Evaluation

The diagram below illustrates the nursing process in the form of a control loop.

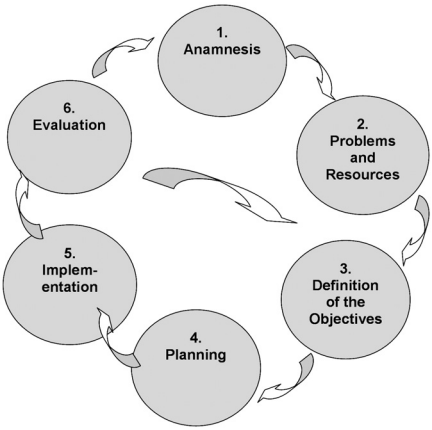


Fig 5: The nursing process as a control loop

Treatment always starts with the gathering of information. In a comprehensive medical history discussion with the patient and his or her relatives or other close contacts the nursing staff collects important data (e.g. via physical examination, medical documentation, observation, living habits, assessments, etc.) which later plays a part in the individually coordinated nursing planning for the patient. The nursing staff structure this individual planning together with the patient to ensure that both resources and the need for patient advice or instruction are taken into account. The patient's relatives are also often integrated into this process.

The planning includes formulation of specific patient care problems, often relating to aspects of life in which the patient's independence is restricted. Taking established care theories into account, problems which require support or where self-care deficits exist, and the associated resources, are in this way determined and documented together with the patient. Resource-oriented planning, however, also means not just focusing care measures on factors aggravating the illness or condition but also specifically including health conservation measures. Patient-oriented therapeutic care measures are formulated for all care problems to assist the nursing team in implementation of structured individual care together with the patient.

The work routines in a nursing care unit depend on the institution and the needs of the patients. Germany is highly geared to patient-oriented nursing systems, i.e. patients always have the same healthcare or nursing staff on each shift as their personal points of contact. Patient-oriented nursing includes group nursing, primary nursing and individual nursing.

Day-to-day work and contact with the patients often highlights any deviations from the planned nursing care, for example whether current care problems have already been solved or if new problems have arisen which the nursing staff then takes into account in subsequent care planning.

Nursing care is thus regarded as a continuous process.

3. Nursing and Healthcare Training in Germany

◆ Socio-demographic developments (not only) in Germany and the changing spectrum of illnesses are leading to professional nursing staff having to care for an ever increasing number of older, multi-morbid people and people with chronic degenerative illnesses. These people in need of nursing care, including the close relatives, need a self-concept of nursing oriented to support and monitoring, assistance in coping with the problems of day-to-day life, encouragement, advice and instruction, in strong contrast to the traditional orientation to somatic treatment and the curing of acute illnesses.

Since the 1990's, the care and health sciences in Germany have been developing into a knowledge base aligned to health promotion. They are prerequisites for the relevant activities of practical nursing care. Significantly more attention must be given during training to the nursing staff's communication and empathy skills to enable them to promote the self-determination and personal responsibility of their patients and activate and support their self-care potentials and individual resources, while at the same time not overburdening them.

The changing structures of the health and welfare systems are also leading to additional demands on nursing staff. In the context of the long-term care insurance in Germany (see Section 6) and the principle of "outpatients rather than inpatients", increased requirements are being placed on the one hand for independent, self-reliant nursing and on the other hand for coordinating, cooperative interdisciplinary nursing and quality control and assurance in respect of the nursing care provided. Last but not least the increasing diversity of treatment systems (see Section 5) in the in-patient, day care and out-patient areas requires the nursing staff to be able to cope with even more specialist fields of medical care, cooperate with the staff there and coordinate the nursing care for patients who "pass through" these various departments.

Educational and didactical aspects place additional requirements on training of the nursing and healthcare professions. In a society in which new knowledge continues to be produced at ever shorter intervals, with existing knowledge quickly becoming out of date, providing the students with as much detailed knowledge as possible is no longer appropriate. What is required is training oriented to providing the students with qualifications directly related to their profession, and also the necessary cross-professional

qualifications, which enable them to master the various, ever changing professional demands placed on them and to actively contribute to the structuring of how these demands are fulfilled. In view of this objective and in furtherance of general education objectives, significant importance must be given to personality development.

In 2004 a Healthcare Act (with the German abbreviation KrPflG) and new education and examination regulations for the nursing professions (abbreviated as KrPflAPrV) came into force in Germany.

The training objective formulated in § 3 of the Healthcare Act is particularly significant. It requires that the training of future healthcare and nursing staff shall include the development and furtherance of specialist, personal, social and methodical skills to prepare them for responsible collaboration in the detection, curing and prevention of illnesses. In particular the training shall enable the nursing and healthcare staff:

1. to carry out the following tasks on their own responsibility:
a) Determination and documentation of the nursing care requirements and planning, organisation, implementation and documentation of the nursing care
b) Evaluation of the nursing care and ensuring and developing the quality of the care
c) Provision of advice, instruction and support to care patients and their relatives and/or close friends during their individual confrontation with health and illness
d) Initiation of immediate life-sustaining measures prior to arrival of a doctor.

2. to carry out the following tasks within the scope of their collaborative responsibilities:
a) Independent implementation of measures prescribed by a doctor
b) Implementation of medical diagnosis, therapeutic or rehabilitation measures
c) Implementation of measures in crisis and disaster situations.

3. to cooperate with the staff of other professional disciplines in the development of multidisciplinary and interdisciplinary solutions to health problems.

In addition to curative measures the focus is on preventive, rehabilitative and palliative aspects of nursing. Comprehensive nursing care is oriented to independence and self-determination in different nursing care and daily life situations. Nursing science knowledge, medical knowledge and other relational science knowledge form the basis for process-oriented nursing care and future developments in this area. The development of a nursing care profession is significantly supported by the explicit reference to tasks to be performed independently and on one's own responsibility.

Nursing care staff carry out their tasks collaboratively in the interdisciplinary therapeutic team.

Nursing covers the sustainment and restoration of health and provision of activating assistance, advice and support during illness, disablement, in old age and in dying, both to the patient and his relatives or close friends. In terms of prevention an important task of nursing staff is to support a health-promoting attitude and behaviour and to highlight and emphasise the effects of factors which are damaging to health. With rehabilitative nursing the emphasis is on restoring quality of life and structuring a sensible and meaningful daily life, despite possible restrictions, together with the care patients and his relatives or close friends.

Dying, death and mourning are intrinsic aspects of life. The acceptance of one's own ultimate death is a prerequisite for being able to cope with the dying, their relatives and for acceptance of dying and death in society.

This all demands a new way of thinking The traditional medical and illness-oriented understanding of nursing has to be replaced by a concept of nursing which with an objective of achieving independence and self-determination on the part of the care patients, in addition to focussing on curative measures also involves health-promoting, preventive, rehabilitative and palliative aspects. This new focus is also embedded in the new occupational title "Healthcare Nurse" which has been in use in Germany since 2004.

This objective also covers the advisory, instructional and support tasks for people in need of nursing care and their relatives or close friends in a different way to that practised up to now. This necessarily includes appropriate promotion of communicative skills.

The development of nursing expertise is significantly supported by the explicit reference to tasks to be performed independently and on one's own responsibility, the requirement for process-oriented nursing care and by an extension of the nursing and health-related knowledge bases for the training.

Intradisciplinary and interdisciplinary collaboration are becoming increasingly important in view of the increasing complexity of healthcare and the development of networks, and are emphasised appropriately in the legislative regulations.

The importance of out-patient treatment taking into account preventive, curative, rehabilitative and palliative aspects has been covered by a significant increase in the number of hours (now 500) devoted to it during the practical training. This allows the attainment of skills in the different treatment systems during the training.

In addition to the training of professional skills the training objective and the objectives assigned to the different subject areas promote personal and thus at the same time interdisciplinary skills. This skills orientation is also reflected in the examination requirements.

As a result of the interdisciplinary structure, the training focuses on professional and interdisciplinary qualifications; the concept of primarily teaching and reproducing specialist details is no longer practised.

Special features of training in North Rhine-Westphalia

In NRW the theoretical training is divided into four subject areas of which three apply to the same extent to the nursing of people of all ages, i.e. children, adolescents, adults and old and sick people; only the fourth area specially addresses the nursing of adults or children and adolescents. This approach has been chosen to accommodate the requirement for standardisation of training in the nursing and healthcare professions. The selection of the subjects on the one hand fulfils the new requirements in terms of health promotion, prevention of illnesses, rehabilitation and palliation and also the requirement for advice and instruction of people of all ages and for intradisciplinary and interdisciplinary collaboration. And on the other hand it takes into account the requirements on nursing care staff in different types of treatment institutions. The differentiation between "people in need of care" on the one hand and "patients" on the other hand" should also be understood against this background. The subject selection is also intended to ensure that not only the nursing and healthcare clientele and their social environment are at the focus of the training but to an equal extent also the nursing and healthcare staff, i.e. the trainees themselves.

The training directive is divided into four interdisciplinary subject areas whose prime contents differ as follows:

- Subject Area I, "The Key Tasks of Nursing": This subject area focuses on comprehensive skills attainment for nursing, covering activating and/or compensating nursing; assisting in medical diagnosis and therapy and taking action in emergencies; conducting discussions and advising and instructing; organising, planning and documenting; looking after people in special living situations or people with specific problems.

- Subject Area II, "The Training and Professional Situation of Nursing Staff": This subject area focuses on the professional and personal situation of the trainee nurses. Firstly it addresses their role "as a student and trainee", covering aspects which range from "social education" via the "introduction to the practical training" through to "maintaining personal health". It then covers the

role of the students as "members of the nursing profession", addressing subjects such as "The Basic Elements and Models of Professional Nursing", "Ethical Challenges to Nursing Staff" and "Nursing as a Science". Thirdly, selected topics are used to address the situation of the students as "employees". A fourth element explicitly addresses the situation of the students as "suffering in difficult social situations", e.g. in terms of "power and hierarchy", "helping and being helpless", "fear and anger" and "revulsion and shame".

- Subject Area III, "The Target Groups, Institutions and Conditions & Constraints of Nursing": The sub-area "Target groups of Nursing" focuses on the confrontation with the mental, welfare, cultural and social and economic situation of young and old, sick and disabled people. The "Institutions and Conditions & Constraints of Nursing" sub-area addresses the handling of structural and political issues, not only in relation to the health and welfare system but also with regard to the public and ecological environment.

- Subject Area IVa), "Healthcare and Nursing for Specific Groups of Patients": This study area primarily uses selected types of patients as an example to address the qualifications provided in Subject Area I in more detail and expand on what was covered there, i.e. the "key tasks of nursing" are addressed again here from a new perspective and are supplemented by special healthcare and nursing aspects.

Subject Areas I to III apply to the same extent for training in healthcare and nursing and in healthcare and child nursing; only subject area IV has separate content for a) healthcare and nursing and b) healthcare and child nursing.

The concept of key qualifications

Interdisciplinary training is oriented to the concept of key qualifications with training being provided in both specialist and socio-communicative, methodical and personal skills. Specialist skills in this context cover all insights, proficiencies and abilities necessary for the application

of nursing concepts in a manner appropriate to the respective situation of the care patient, his recovery and independence, activation or convalescence, his fragility or his imminent death. In more detailed terms this also includes the students attaining insights and proficiencies in terms of orienting nursing measures to the issue of "What keeps people healthy?" and no longer to "What makes people ill?". The students should also learn to critically question traditional asymmetric structures of the helping relationship, to view care patients in their specific social situations and in particular in individual cases to determine and strengthen the (self-care) resources available to the care patients, both directly and via their respective social and/or welfare network. The students should also be provided with knowledge, proficiencies and abilities which enable them to advise and instruct their clientele and to purposefully intervene in illness or age-specific crisis situations and where possible to prevent the occurrence of such situations via preventive measures.

Development of socio-communicative skills means strengthening the students' ability to establish, maintain and ultimately end relationships with other people (interactive skills). An additional objective is that the students learn to understand the world of people in need of care and patients from **their** perspective, i.e. that they develop their empathic skills. The development of social skills also includes strengthening the students' ability to handle conflicts, (self-)criticism and frustration in terms of their clientele and their collaboration with other staff. With communicative skills the primary objective is to develop the students' ability to articulate and argumentatively defend their points of view, to express thoughts and observations precisely, both verbally and in writing, and to purposefully initiate, moderate and end discussions.

Methodical skills are necessary in order to be able to plan, implement and evaluate nursing as a process, ensure the quality of the nursing and to be able to fulfil coordination and cooperative tasks involving other organisations, institutions or professions. This means that the students, once again in the context of their clientele and collaboration with other staff, have to learn how to obtain, assimilate and process information, make decisions, set priorities and purposefully and systematically deal with problems. In this respect the development of cognitive skills such as analytical, proactive and abstractive thinking and the ability to assess and solve problems becomes particularly important. And last but not least the students must be taught appropriate strategies for or at least insights into "lifelong learning about learning".

The (further) development of personal skills involves strengthening the students' personal ability to cope with the pressures which will be placed on

them. Nursing always involves close and direct contact with someone else's body, with their physical, mental and social suffering. It involves close contact to becoming old, to being terminally ill, to being disabled, to dying. This close contact represents a significant stress potential. Becoming involved and at the same time being able to protect oneself from the pressure and the strain of it all without letting the patient become a "routine object", i.e. finding the right balance between being closely involved and keeping one's distance, plays a central role in personal skills. Personal skills also covers the need for the students to clarify or at least reflect on their personal attitude to existential and ethical issues. They should also have the opportunity to learn how to appraise and take into account the impression and impact which they themselves create in their nursing work and in contacts with their colleagues. And their insights and abilities in terms of joint responsibility and co-termination in the structuring of their professional and social environment as it is now and as it will be in the future, or to put it more simply their political awareness, must also be strengthened. And last but not least, independent of specific professional requirements they should develop trust in themselves.

Teaching methods

Attaining these types of skills demands special teaching methods. These include social and problem-oriented, experience-oriented and action-oriented learning.

Social learning means that the entire course of training is viewed and used as a realm of social experience. This includes ensuring that interpersonal conflicts and conflicts of interest lead to joint reflection at an early stage, with all involved participants making an effort to find ways of solving the problem while at the same time learning to tolerate and cope with tension. Social learning also involves providing the students with an opportunity to themselves play an active part in structuring their training. They should also learn how to appraise and evaluate their own performance and that of others. In this respect, and during the entire training, they have the basic right of freedom of speech and also the right to complain. In the context of social learning the teaching staff in particular have initiating, organising, moderating, advisory and supporting roles.

Problem-oriented learning means that the students are presented with a problem which they have to deal with without assistance from the teaching staff. This includes defining and analysing the problem they are faced with in small groups, independently obtaining new information in respect of questions which arise, analysing this information in the context of the problem and thus coming closer to a solution. Problem-oriented learning is at the same time learning by example. This involves the use of examples which clarify general principles by addressing specific aspects of them to provide

the students with both insights into overall principles and relationships and also new methods of approaching and dealing with problems. Problem-oriented learning requires examples from the day-to-way work of the profession which either are already available in the form of training materials or which have to be developed by the teaching staff themselves.

Experience-oriented learning or learning from experience is based on the subjective experience of the students. Experience-oriented learning focuses on the reaction of people in social situations. The term "reaction" in this respect covers both "internal" feelings, fantasies and attitudes (internal reactions) and "external" physical and verbal forms of expression (external reactions). Learning with and from reactions means that one's own body and also one's feelings are included in the learning process. An additional feature of experience-oriented learning is that all of the students (not just a few particularly active ones) can and should contribute their own experience. This method of learning based on mutual responses and reflection on the one hand makes the students more aware of their own reactions and on the other hand enables them to better empathise with the reactions of others.

Characteristic features of action-oriented learning are that the students are motivated into taking independent action, that they learn with their "head, heart and hands" and that this learning process can also take place outside the training centre or hospital. A typical example for action-oriented learning is the "project work" in which the objectives, planning, implementation and assessment of projects are decisively characterised by proactive decisions and actions on the part of the students themselves. Other approaches and methods for action-oriented learning are games (e.g. planning and role games), practising and assessing sequences of actions (e.g. with video) or the production of specific action-related products (e.g. brochures, newspapers, exhibitions).

Checking and measuring learning progress

The decision as to how often and in what way progress checks and performance assessments are carried out is a matter for the individual training centres. The interdisciplinary principle must also be reflected in the measurement of learning progress, and in the context of social learning the group performance and the students' opinion of their own performance are also assessed. In the context of action-oriented learning not just the written and oral work but also other independently performed actions are assessed and in terms of problem-oriented learning the analysis and solution of a problem is more important than memorising facts.

The link between theory and practice

Teachers in the school and training staff during the practical training have a common task. The contributions to the overall training made by the teachers in the school on the one hand and on the other hand by the training staff during the practical training, however, are different. While the primary task in the school is to impart general rules and regulations, principles, overall concepts and models with no instruction being provided on specific nursing practices, the main task of the training staff during the practical training is to enable the students to apply these rules and regulations, principles, concepts and models appropriately and flexibly in practical nursing, taking into account the special aspects of the specific situation, the individuality of the people in need of care and the respective institutional conditions and constraints, and thus also to provide instruction on special nursing practices. Finding the right compromise in individual situations between rules and regulations on the one hand and special patient-related and/or situation and institution-specific aspects on the other hand demands both a high level of nursing and teaching competence and intensive coordination between the teachers and the training staff.

Training exercises

This link between theory and practice can be ensured via practical training exercises related to the respective study units. The general tasks are specified by the school on the basis of their overall responsibility for the training and must be then be tailored to match the specific curriculum and any special aspects of the respective practical training locations. This requires appropriate training planning and coordination and collaboration with the staff in the practical training units. The training exercises include a specification of the prerequisites fulfilled by the school, on which the practical trainers, whose task in respect of the training exercise must also be clear, can build in the practical training environment. It can also be useful to jointly evaluate the training exercises carried out during the practical training together with all of the students during the subsequent theory phase.

Entry requirements for the training

A prerequisite for participation in healthcare and nursing training in Germany is a school leaving certificate which qualifies for entry to a vocational college.

This leaving certificate can be gained in several different ways in Germany. Following primary school, which normally lasts for 4 years, the pupils can continue their education in different types of schools. The Hauptschule (secondary modern school), Realschule (intermediate secondary school), Gesamtschule (comprehensive school) and Gymnasium (grammar school) offer different levels of school leaving certificate. A school leaving certificate

which qualifies for entry to a vocational college can be gained at the end of the 5th form at all of these schools.
Normally the students who decide on healthcare or nursing training are between 16 and 19, depending on the type of school they attended.
The training lasts for 3 years.

Scope and content of the training

The students are taught by instructors who in addition to a university qualification in education have usually all also undergone healthcare or nursing training.
The theoretical training covers at least 2100 hours of instruction in the following areas:

- Recognising, documenting and assessing nursing care situations with people of all age groups
- Deciding on, implementing and assessing nursing care measures
- Ensuring competent support, advice and instruction on health and care issues
- Active participation in the development and implementation of rehabilitation concepts and integration of these concepts into the nursing care
- Aligning the nursing care to the needs of the individual
- Provision of nursing care in accordance with the latest developments in nursing science
- Applying nursing care in accordance with the applicable quality criteria, legal stipulations and economic and ecological principles
- Active participation in medical diagnosis and therapy
- Initiation of life-sustaining measures prior to the arrival of a doctor
- Development of a self-concept of the nursing profession and learning how to cope with the challenges of the profession
- Actively influencing the development of the nursing profession in a social context
- Collaboration and cooperation in groups and teams

These subject areas stem from the following knowledge bases:

Healthcare and nursing, healthcare and child nursing and healthcare and nursing sciences	950 hours
Care and nursing-related aspects of natural sciences and medicine	500 hours
Care and nursing-relevant aspects of humanities and social sciences	300 hours
Care and nursing-relevant aspects of law, politics and economics	150 hours
Available for specific allocation	200 hours
	2100 hours

The practical training covers at least 2500 hours and mainly takes place in the specialist departments of the respective training hospital.

The first two years of training cover the general area.

The time allocation to the different subject areas is as follows:

Healthcare and nursing of in-patients of all age groups undergoing curative treatment in the internal medicine, geriatrics, neurology, surgery, gynaecology, paediatrics and one-week-old and newborn baby care departments and of in-patients undergoing rehabilitative and palliative treatment in at least two of these departments	800 hours
Healthcare and nursing of out-patients of all age groups undergoing preventive, curative, rehabilitative and palliative treatment	500 hours

The third year covers the specialist area.

The time allocation to the different subject areas is as follows:

Healthcare and nursing of in-patients in the internal medicine, surgery and psychiatry departments	700 hours
Available for allocation to the general and/or specialist areas	500 hours
	2500 hours

During the practical training the students are trained by practical instructors with proven educational qualifications gained in the form of further education.

A look ahead to the future

Prior to the start of the training the trainees currently have to decide whether they wish to gain a qualification in child care, nursing care or care of the elderly. The possibility of delaying this decision until the end of the 2nd year of training is currently under discussion, thus enabling common basic training.

So-called *general training* without any specialisation within the training is also being discussed. This would then require further training to gain a separate qualification for one of the specialist areas.

For some time now there have also been moves to combine the training in the healthcare and nursing professions with Bachelor degree studies.

In NRW it will soon be possible to sign up for a dual nursing care course; this is currently planned to start in the autumn of 2009. With this approach the students will complete a course of vocational studies and at the same time undergo professional training in a nursing school.

One year after completion of the professional training, i.e. after a total of four years of training, these students will then have gained a Bachelor of Nursing degree. This dual nursing course is not intended to replace the proven system of nursing training establishments in Germany but to enhance it.

The discussions in Germany, however, are going even further.

At the initiation of the German Advisory Council for Education and Training in the Nursing Care Professions a further restructuring of nursing care training is currently under discussion. In addition to providing for nursing care assistants and professionally trained nurses the concept being discussed also envisages the option of gaining a Bachelor of Nursing degree exclusively via academic studies and, if desired, of following this up with a Masters course.

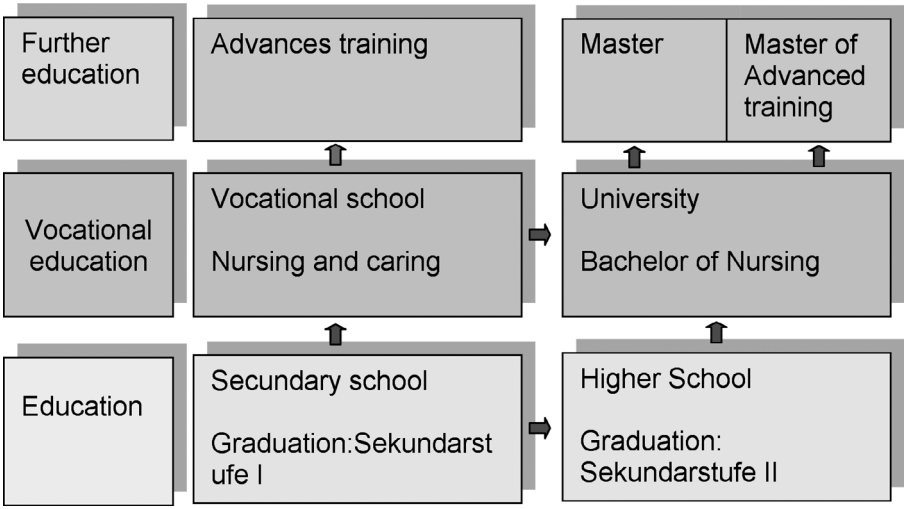


Fig 6: educational concept Deutscher Bildungsrat für Pflegeberufe

As you can see, there's a lot going on in Germany!

4. The Organisation of the Healthcare Service in Germany

Hospitals

Depending on its function, size and location the hospital is divided into various specialist departments (e.g. surgery, internal medicine, etc.). These departments usually consist of different wards; some hospitals however also have interdisciplinary wards. Specialist work areas for healthcare and nursing staff in hospitals are e.g. intensive care, oncology, psychiatric and paediatric wards and outpatient departments.

On the general wards healthcare and nursing staff are normally responsible for the following care-related tasks:

- Ensuring basic care including patient monitoring and provision of advice to patients
- Cooperation with and provision of advice to relatives and other close contacts
- Terminal care
- Assistance with diagnostic and therapeutic measures
- Administrative activities (e.g. in conjunction with the admission, transfer and discharge of patients)
- Coordination of appointments for the patients.

Nursing and medical care is ensured day and night; there are however also day clinics.

Home care

Home care services primarily cover:

- Assistance in basic care
- Treatment care (e.g. insulin injections, applying/changing bandages, etc.)
- Provision of advice and training to those in care and untrained persons looking after them
- Arranging for and providing additional services/assistance (e.g. meals on wheels).

Special demands are placed on healthcare and nursing staff who look after patients at home. Since the patients' domestic situations vary considerably, healthcare and nursing staff must be extremely flexible in order to be able to make best use of the specific conditions, constraints and resources for each patient. Close cooperation with the relatives is not only desirable but essential. Healthcare and nursing staff providing home care are normally left to their own resources during their daily work. This requires a high level of specialist knowledge, sensitivity and organisational talent.

Rehabilitation and recuperation clinics

The focus of all measures here is on prevention and rehabilitation.
In recuperation clinics the healthcare and nursing staff primarily have a supporting and advisory role, e.g. in the

context of dietary measures and regular condition training. Treatment measures are also continued and supported.

In rehabilitation clinics the prime objective is to maintain and promote the patent's abilities. In this case too, significant importance is attached to the provision of advice (e.g. the use of mobility aids is explained and practised).

Nursing homes and homes for the elderly

The healthcare and nursing staff ensure:

- provision of assistance in normal day-to-day activities (with the objective of achieving maximum active and self-determined participation in everyday life in the home)
- monitoring of the general health of the patients and provision of support and assistance in the case of illness
- where necessary meaningful structuring of the patients' daily activities.

The benchmarks for the care and assistance are the needs of the elderly residents and their habits. Accepting and respecting habits also means enforcing as few rules as possible to allow the elderly persons to extensively decide themselves how to live their lives, despite the fact that they are living in an institution.

In contrast to hospital care, diagnostic and therapeutic care is not provided by employed doctors but by private practice doctors (GPs). Since the residents normally remain in the home for a long time, for the most part close ties develop between the residents and the staff. Professional development of this relationship represents a particular challenge to the healthcare and nursing staff.

Hospices

In this case the focus of the care is the dying patient and his or her needs. All efforts are aimed towards providing the best possible quality of life in this final phase of the patient's life. Comprehensive care and support measures within the scope of palliative medicine are provided by a multidisciplinary team consisting not only of doctors and nurses but also social workers, psychologists, chaplains and various therapists. The nursing tasks in this case are primarily:

- Provision of assistance during normal day-to-day activities
- Treatment measures and
- Ensuring the provision of medication, particularly in conjunction with pain therapy.

Homes for the disabled

The tasks of health care and nursing staff in homes for the disabled are similar to those in homes for the elderly. In this case the care is primarily focused on promoting development in a wide range of different areas.

Companies

Some companies, particularly in the industrial sector (chemical companies), have their own ambulance service and medical centre in which healthcare and nursing staff can be employed.

Healthcare and nursing staff can also be employed in e.g. **public authorities, institutes or advisory organisations**, where they are responsible for various different tasks depending on the nature and purpose of the establishment. For example, healthcare and nursing staff are employed in the medical service of health insurance companies to assign patients to different care categories in accordance with the type and intensity of care required. This is necessary to ensure financial support from the nursing care funds.

5. The National Characteristics of the Healthcare Service

5.1. The Health System in Germany

The social security system

The health system in Germany is based on the social security system. Its task is to provide full or partial compensation for specific risks, expenditure and loss of job-related income, taking into account social objectives. The social security system in Germany is compulsory for all salaried employees and covers 5 main categories: unemployment insurance, accident insurance, pension insurance, health insurance and nursing care insurance.

The insured persons pay contributions into an insurance scheme which provides compensation payments when situations covered by the insurance arise. The health system is primarily financed by the health insurance and nursing care insurance contributions.

The majority of the population is compulsorily insured under the health insurance system. It is also possible to take out private health insurance to cover specific additional services (such as treatment by a consultant or a single room in a hospital).

Health system legislation

German politics is based on a democratic party system.
The elected parties form the lower house of the German Parliament (the Bundestag).
The Bundestag decides on all issues related to the German health system which are or have to be regulated by federal legislation in order to ensure standardised living conditions in Germany. The Bundestag also decides on the framework conditions for

- hospital treatment and financing (e.g. the Hospital Remuneration Act, the Hospital Financing Act),
- the provision of medicines (the Pharmacies Act, the Medication Act) and medical and blood products,
- the Nursing Act etc.

Many political decisions in Germany are then specified in more detail at the federal state level which means that certain issues are regulated differently from state to state.

The health insurance system in Germany

The statutory health insurance system in Germany offers, among other things, the following medical services to everyone with effect from their first day of membership:

- Measures for prevention and early recognition of specific illnesses

- Active immunization as a preventive medical service
- Orthodontic treatment for insured persons, normally up to the age of 18
- Medical and dental treatment with a free choice of medical practitioner and dentist among those approved by the statutory health insurance system
- Medication, dressings and therapeutic products, and medical aids such as hearing aids and wheelchairs
- Medically necessary dental prostheses and crowns
- Hospital treatment
- Assumption of the costs or provision of allowances for necessary preventive and rehabilitative measures
- Sick pay: Employees continue to be paid by their employer for 6 weeks if they become ill and if they are still unfit to work after these 6 weeks the health insurance then pays them a percentage of their gross wage or salary.
- Home care if this can avoid or reduce the need for hospital treatment or if it provides the necessary medical treatment
- Maternity pay and maternity assistance during pregnancy and childbirth.

Based on the joint responsibility of the insured persons they pay up to a maximum of 2% of their gross annual income towards the costs of specific services from the heath system. A lower maximum level of 1% of the gross annual income applies for people who are chronically ill.

The distribution of the money within the health system is complicated and is not easy to summarise. An overview of the German health system is provided in the diagram below.

The hospitals settle the costs of in-patient treatment with the health insurance funds via the DRG system. The DRG (Diagnosis Related Groups) system is a patient classification system

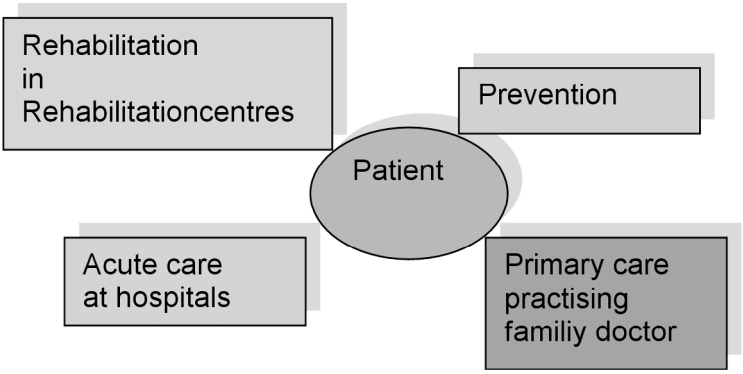


Fig 7: Overview of German health system

which enables clear-cut assignment of all acute in-patient cases to financially homogeneous and at the same time medically logical case groups. This means that the costs are not calculated based on the time spent in hospital but on the diagnosis and the treatment method. Secondary diagnoses carried out during the hospital treatment (e.g. a decubital ulcer, urine incontinence etc.) are taken into account in this classification process.

Nursing care insurance

Nursing care insurance is an element of the German social security system. Its purpose is to be able to take measures which serve to sustain or restore physical, mental and emotional well-being. Its most important benefits are the maintenance of human dignity, of extensive independence despite being in need for care, and the fulfilment of religious needs.

- "In need of care" is defined in this context as follows:
- A person is in need of care if
- due to physical, mental or emotional illness or disablement
- they require significant or additional assistance
- on a long-term basis to perform the normal and recurring tasks of everyday life
- for an anticipated period of at least six months.

Persons in need of care must apply for assistance under the nursing care scheme; the degree of assistance they receive then depends on which of the three care levels they are assigned to. Assistance can be provided in the form of:

- Material care
- Financial allowances
- In-patient or day clinic care
- Training for caring relatives
- Building alterations or conversions.

5.2. Quality Policy in Germany

The quality policy in the German health system is reflected in health promotion and prevention, the foremost objective being optimisation of the population's health.

The legislation requires the health system in Germany to implement and practise quality assurance and quality management.

The objective of quality assurance in the German health system is to actually achieve, ensure and improve the theoretically achievable quality of medical and nursing services. Quality assurance and quality management are also intended to reduce the costs of the health system and the time spent by patients in hospitals.

5.3. The Most Common Medical Conditions of Hospital Patients

The numbers of patients treated in hospital in 2005 show that cardiovascular conditions, lung cancer, breast cancer, arthroses and cerebral infarcts are particularly prevalent in Germany. The quality policy in the German health system is consequently to attempt to counter this situation with preventive measures and to develop concepts for preventive education and combating of these conditions.

In-patients discharged from hospital (incl. deaths and patients not kept in overnight) **The 10 most common diagnoses with male patients in 2005**			
Pos.	**ICD-10 code**	**Diagnosis Category** --- **Reason for Treatment**	**Numbers**
1	F10	Mental and behavioural dysfunctions resulting from alcohol	223,333
2	I20	Angina pectoris	196,029
3	K40	Hernia inguinalis	153,448
4	I25	Chronic ischemic cardiac disorder	147,240
5	I50	Cardiac insufficiency	141,212
6	C34	Malignant growth(s) in the bronchia and lungs	129,245
7	I21	Acute myocardial infarct	128,852
8	J18	Pneumonia, pathogen not specified	121,359
9	G47	Sleep disorders	120,289
10	S06	Intracranial injury	114,772
Source: German Federal Statistical Office, hospital statistics			

Fig 8: most common diagnosis with mal patients in 2005 in Germany

In-patients discharged from hospital (incl. deaths and patients not kept in overnight) The 10 most common diagnoses with female patients in 2005			
Pos.	**ICD-10 code**	**Diagnosis Category** --- **Reason for Treatment**	**Numbers**
1	I50	Cardiac insufficiency	165,523
2	C50	Malignant growth(s) in the mammary glands	153,053
3	K80	Cholelithiasis	140,113
4	M17	Gonarthrosis (arthrosis of the knee joint)	121,635
5	I20	Angina pectoris	119,523
6	S72	Femoral fracture	110,601
7	O70	Perineal laceration during childbirth	110,459
8	I10	Essential (primary) hypertension	103,578
9	J18	Pneumonia, pathogen not specified	102,771
10	I63	Cerebral infarct	96,352
Source: German Federal Statistical Office, hospital statistics.			

Fig 9: Most common diagnosis with femal patients in 2005 in Germany

6. What is European Health Policy Like?

6.1. Background

◆ **European Union's recent general health policy lines** were set out in 2002 with the concept of a **Europe of Health** in 2002. Work was undertaken on addressing health threats, including the creation of a **European Centre for Disease Prevention and Control** (**ECDC**) (2004), developing cross-border co-operation between health systems and tackling health determinants. The Community's **health information system** provides a key mechanism underpinning the development of health policy. This development work has already resulted for example in European health insurance card.

Naturally work and efforts in promotion of health had taken place during previous years. One significant effort being programme of **Community health monitoring programme (1997-2002)**. The aim of the programme was to produce a health monitoring system to monitor the health status in the Community, facilitate the planning, monitoring and evaluation of Community programmes and to provide member states with information to make comparisons and to support their national policies.

Before existing Programme of Community Action in the Field of Public Health was drawn lot of previous work and programmes had been carried out. Development of health indicators (Programme of Community action on health monitoring) has resulted in European Community Health Indicators (ECHI). Other programmes have been e.g. pollution related diseases programme, the cancer programme, the drugs prevention programme and rare diseases programme. Previously carried out work has resulted in following programme.

Aim has been on prevention and finding joint indicators and monitoring systems to facilitate comparison of health status and determinants effecting it.

6.2. Present situation

Programme of Community action in the field of public health (2003-2008)

The Council and Parliament set in 2002 as overall aim "**to protect human health and improve public health**" and as **general objectives**:

A. to improve information and knowledge for the development of public health; that is to be reached by e.g. following measures:

- developing and operating a sustainable **health monitoring system to establish comparable**

quantitative and qualitative indicators at Community level … concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health;

- developing an **information system for the early warning, detection and surveillance of health threats**, both on communicable diseases, including with regard to the danger of cross-border spread of diseases (including resistant pathogens), and on non-communicable diseases;
- improving the **system for the transfer and sharing of information and health data** including public access and by improving analysis of **health policy developments** and of other Community policies and activities.

B. to enhance the capability of responding rapidly and in a coordinated fashion to threats to health; that is to be reached by following types of measures:

- enhancing the capacity to **tackle communicable diseases** by supporting the further implementation of Decision No 2119/98/EC on the ***Community network* on the epidemiological surveillance and control of communicable diseases**;
- supporting the network's operation in relation to common investigations, training, continuous assessment, quality assurance
- developing strategies and mechanisms for preventing, exchanging information on and responding to non-communicable **disease threats, including gender-specific health threats and rare diseases**
- exchanging information concerning strategies in order to **counter health threats from physical, chemical or biological sources in emergency situations**
- exchanging information on **vaccination and immunisation strategies**;
- enhancing the **safety and quality of organs and substances of human origin, including blood, blood components and blood precursors**
- implementing vigilance networks for human products, such **as blood, blood components and blood precursors**;
- developing strategies for **reducing antibiotic resistance**.

C. to promote health and prevent disease through addressing health determinants **across all policies and activities**; that is to be reached by following types of measures:

- preparing and implementing strategies and measures, including those related to public awareness, on **life-style related health**

determinants, such as nutrition, physical activity, tobacco, alcohol, drugs and other substances and on mental health, including measures to take in all Community policies and age- and gender-specific strategies;
- analysing the situation and **developing strategies on social and economic health determinants**, in order to identify and **combat inequalities in health and to assess the impact of social and economic factors on health**;
- analysing the situation and developing strategies on **health determinants related to the environment**
- analysing the situation and exchange information **on genetic determinants and the use of genetic screening**;
- developing methods to evaluate quality and efficiency of health promotion strategies and measures;
- encouraging relevant training activities related to the above measures.

6.3. Future

Programme for Community Action in the Field of Health 2007-2013

The new Community Action in the field of Health sets three broad objectives. These objectives align future health action with the overall Community objectives of prosperity, solidarity and security. This will help to create synergies with other Community programmes and policies – which is inevitable as health issues and their origins derive from existing environment, society and economy. It is to form a continuum for predecessing programme 2003-3008. The objectives of new programme are to:

1. Improve citizens' health security
- to protect citizens against health threats including working to develop EU and Member State capacity to respond to threats
- to cover actions such as those in the field of patient safety, injuries and accidents, and community legislation on blood, tissues and cells and in relation to the International Health Regulation.

2. Promote health for prosperity and solidarity
- to foster healthy active ageing and to help bridge inequalities, with a particular emphasis on the newer Member States.
- to incorporate action to foster cooperation between health systems on cross-border issues such as patient mobility and health professionals.
- to cover action on health determinants such as nutrition, alcohol, tobacco and drug consumption as well as the quality of social and physical environments.

3. Generate and disseminate health knowledge

- to exchange knowledge and best practice in areas where the Community can provide genuine added-value in bringing together expertise from different countries, e.g. rare diseases and cross-border issues related to cooperation between health systems
- to cover key issues of common interest to all Member States such as mental health.
- to expand EU health monitoring and develop indicators and tools as well as ways of disseminating information to citizens in a user-friendly manner, such as the health portal.

Despite being reduced in scope compared to the original proposal, the modified Programme proposal is broad enough to be able to accommodate key health issues as well as those which may arise unexpectedly and need urgent attention.

7. Appendix
Study Unit I.1: Skin and Body Hygiene

Objective
On the one hand the students should address the subject of "body contact" not just in terms of skin and body hygiene but as a central element of nursing care as a whole. And secondly they should learn how to monitor the patients' skin and how to use skin and body lotions, including in the context of preventing skin damage. This demands appropriate scientific knowledge which is also required to subsequently, in the third stage, be able to understand the individual steps involved in skin and body hygiene. In this context, as with "Assisting in getting dressed and undressed" the students should not just learn the "technical aspects" of the nursing care but should also be encouraged to consider the mental state of people in need of this kind of assistance.

Contents of the healthcare and nursing, healthcare and child nursing and healthcare and nursing sciences element:
- Empathy/reflection: Touching someone else's body/skin and allowing oneself to be touched by someone else
- Body contact and body hygiene by healthcare and nursing staff: Stress and relief for those involved
- Skin and body hygiene: Individual needs, the socio-cultural context, special aspects depending on the age of the patient or person in need of care
- Monitoring the skin
- The use of skin and body lotions
- Washing the entire body, showering, bathing, eye /nose / ear hygiene, intimate hygiene, washing hair, nail care and other age-related measures, e.g. navel hygiene, shaving.
- Cognition promotion principles, e.g. basal stimulation, Bobath, kinaesthesia / infant handling
- Empathy/reflection: Getting dressed or undressed with only restricted movement in one limb
- Assisting the person in need of care in dressing and undressing

Care-relevant contents of the natural sciences and medicine element:

- The cell (structure, energy and material transfer)
- The structure and characteristics of the basic types of tissue, the skin (incl. the secretion of sweat), the skin adnexa, the sexual organs, the nervous system
- The physiological flora of mucous membranes and the skin and pathological changes relevant to nursing care
- pH values and the acid-base balance; the composition and characteristics of care products (e.g. soap, paste, emulsion)

Recommended time for this unit:	46 hours
1. Nursing care:	38 hours
2. Natural sciences:	8 hours

The associated subject definition in the education and examination regulations for the nursing professions:
Recognising, documenting and assessing the need for care on the part of people of all age groups.

7. List of figures

Notes

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