INTRODUCTION

Throughout the development of modern health care, there has been the recognition that information is necessary for the planning, development and delivery of adequate, appropriate and affordable health care. This recognition has lead to the development of many systems for the collection, abstraction and summarization of health related information (Werley & Grier, 1989). The need to standardize and formalize this health related information has been demonstrated in a number of arenas, from the organized patient record to the system of reports and statistics gathered for governmental purposes. Nursing has been involved in the collection and abstraction of health related information from the beginning. However, nursing has historically focused its supportive role and gathered information which was of use to other professionals, whether physicians or health planners.

More recently nursing has begun to focus on the needs of nursing. Patient records have begun to focus on the nursing needs of the patients. The gathering of patient related information has focused on the areas where nurses can intervene independently as well as in cooperative practice with other professionals. Thus patient records have begun to have a clear focus on functional assessments, the needs of the patient and the supportive structures which can assist in the meeting of those needs, whether by the family, or by informal or formal organizations. This perspective on information gathering and organization is very different than just supporting the needs of other health care providers.

The development of a Community Nursing Minimum Data Set for Australia (CNMDS-A) is another example of nursing's need to gather and structure information which will meet the needs of nursing. This paper will present a short history of the goals, the background and development of the CNMDS-A, the items which have been selected and the work which has yet to be done for the continued development of the CNMDS-A.
GOALS

Community nurses recognized that there was no common language to organize and describe the varieties of community nursing practice in Australia. Without a common language it was difficult, if not impossible, to describe succinctly what community nurses did and how they did it (Gliddon, 1990). Nursing has historically focused on the process of doing nursing rather than on the outcomes which resulted from the process of nursing. One result of this process oriented focus has been that nurses have had difficulty explaining what nurses do to people who are not initiated into the profession and who do not speak the language of nursing. Another aspect of being process oriented, is that nurses recognize the uniqueness of each client and each client situation. This focus on uniqueness has meant that nurses have been reluctant to adopt any standardized language which would inhibit the description of the unique client situation.

These aspects have made nursing language difficult to translate from one nursing arena to another, from one nursing organization to another and more importantly from nursing to a non-nursing organization. From this perspective, it was clear that a set of working goals had to be established in order to have a framework for discussing the development of the CNMDS-A. While nursing has focused on the uniqueness of clients, there has been evolving a growing need to demonstrate accountability based on the outcomes and cost effectiveness of nursing activities. This has mean that nursing must rethink the relation between its historical process orientated focus and the outcome based demands of funding agencies and accountability.

A series of discussions were established with community nurses across the country. This included making home visits with field nurses. During the home visits, they were asked to describe what they were doing, what information they were using, what records and reports they had to present, what information they found useful and what information they needed that was not easily available. Visits were made with community nursing managers, ranging from clinical coordinators to directors of nursing organization. They were asked to describe what information they needed from their staff, and what information they had to report upward to governmental and other organizations. They were asked to describe the information that they felt which they needed that they did not have immediate access to. In addition copies of forms and reports were collected. Also, meetings were held with state and commonwealth organizations who contracted with community nurses for the delivery of care. Again they were asked what information they required and what had to be reported onward, copies of forms were obtained when available. They were also asked what information they would ideally like to have available to them.