Univerza v Mariboru

Fakulteta za zdravstvene vede

Mednarodna konferenca
Z znanjem do razvoja in zdravja

International conference
Knowledge brings development and health

Zbornik predavanj

Conference Proceedings

Maribor, 14. - 16. 5. 2013

ČASTNA POKROVITELJA:

REPUBLIKA SLOVENIJA
MINISTRSTVO ZA IZOBRAŽEVANJE, ZNANOST IN ŠPORT

Zbornica zdravstvene in babiške nege Slovenije - Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije

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PROGRAMME

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Torek, 14. 05. 2013 / Tuesday, May 14th, 2013

PLENARNI DEL / PLENARY SESSION

13:05 - 13:15 **Otvoritev mednarodne konference / Opening of the International conference**

13:15 - 14:00 **Skrb in medosebni odnosi v zdravstveni negi / Caring and interpersonal relations in nursing care**
Izr. prof. dr. Majda Pajnkihar, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

14:00 - 14:45 **Vloga univerze pri razvoju inovacij, izboljšanju in večji varnosti pri zagotavljanju zdravstvenega varstva / The role of the University in developing innovation, improvement and better safety in health care delivery**
Prof. dr. Tony Butterworth, Professor Emeritus, University of Lincoln, UK

14:45 - 15:00 **Razprava / Discussion**

15:00 - 15:15 **Odmor / Break**

15:15 - 16:00 **Na dokazih utemeljena praksa in kompleksnost intervencij v zdravstvu / Evidence-based practice and the complexity of interventions in healthcare**
Prof. dr. Peter Callery, The School of Nursing, Midwifery and Social Work The University of Manchester, UK

16:00 - 16:45 **Status quo v praksi zdravstvene nege in oskrbi starostnika v Walesu / Taking the Temperature: the Status Quo of Nursing Practice and care of the Older Person in Wales**
Lorraine Morgan, MSc, Faculty of Health and Social Care, The Open University Wales, UK

16:45 - 17:00 **Razprava in zaključek / Discussion and conclusion**

Sreda, 15. 05. 2013 / Wednesday, May 15th, 2013

PLENARNI DEL / PLENARY SESSION

09:00 - 09:45 **Priprava prispevkov in objava v mednarodnih revijah / Writing for publication in international journals**
Dr. Verena Tschudin, School of Health and Social Care, University of Surrey, UK

09:45 - 10:30 **Ustanavljanje nove znanstvene revije: ozaveščenost avtorja – primer South Eastern Europe Health Science Journal (SEEHSJ) / Establishing a new scientific journal: authors awareness – an example of South Eastern Europe Health Science Journal (SEEHSJ)**
Prof. dr. Selma Uzunović; Faculty of Health Care and Nursing, University VITEZ, Cantonal Public Health Institute Zenica; BIH

10:30 - 11:15 **Pomen raziskovanja v zdravstveni negi: mednarodno sodelovanje pri raziskovanju / The importance of research in nursing: International collaboration in research**
Prof. dr. Árún K. Sigurðardóttir, Faculty of Health Sciences, University of Akureyri, IS

11:15 - 11:30 **Razprava / Discussion**

11:30 - 12:00 **Odmor / Break**

12:00 - 12:45 **Poročanje o procesu, veljavnosti in rezultatih vsebinske analize: primerjava dveh desetletij / To report content analysis process, validity and results: comparison between two decades**
Dr. Satu Elo, dr. Maria Kääriäinen, dr. Tarja Pölkki, dr. Outi Kanste, prof. dr. Helvi Kyngäs, Institute of Health Sciences, University of Oulu, FI

12:45 - 13:30 **Etični vidiki raziskovanja v zdravstveni negi / Ethical issues in nursing research**
Dr. Beata Dobrowolska, Medical University of Lublin, PL

13:30 - 13:50 **Stigmatiziranje oseb z duševno motnjo med medicinskimi sestrami in babicami / The presence of stigma towards people with mental disorders among nurses and midwives**
Prof. dr. Divna Kekuš, Sanja Stanisavljević, Zvonko Dimoski, Dragana Terzić Marković, Higher education school of professional health studies in Belgrade, RS

13:50 - 14:00 **Razprava / Discussion**

14:00 - 15:00 **Kosilo / Lunch**

15:00 - 15:30 **Projekt ROSE (Zmanjšanje poklicnega stresa zaposlenih) – e-program obvladovanja stresa za zdravstvene delavce / The ROSE project (Reducing Occupational Stress in Employment) – An online stress management programme for health care workers**
Prof. dr. John SG Wells, School of Health Sciences, Waterford Institute of Technology, IE

15:30 - 16:00 **Ocenjevanje psihosocialnega stresa na področju zdravstvenega varstva z uporabo vprašalnika o zadovoljstvu pri delu / Assessing psychosocial stress in the health care sector using the job content questionnaire**
Prof. dr. Margaret Denny, School of Health Sciences, Waterford Institute of Technology, IE

16:00 - 16:20 **Razvijanje socialnih veščin – empirična raziskava poklicne skupine v zdravstveni negi / The development of social skills - An empirical study of the occupational group of nursing**
Monika Rode, University of Applied Sciences Münster, DE

16:20 - 16:40 **Pravni vidiki odgovornosti pri delu medicinskih sester / Legal Responsibilities of Nurses**
Doc. dr. Jadranka Stričević, Fakulteta za zdravstvene vede Univerze v Mariboru, doc. dr. Suzana Kraljič, Pravna fakulteta Univerze v Mariboru, izr. prof. dr. Majda Pajnkihar, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

16:40 - 17:00 **Znanstvena utemeljitev in optimizacija izobraževalnih programov za vodje zdravstvene nege / Scientific substantiation and optimization of the educational programmes for heads of nursing services**
Doc. dr. Natalya N. Kamynina; Faculty of Higher Nursing Training, Psychology and Social Work, I.M. Sechenov First Moscow State Medical University, RU

16:40 - 17:00 **Razprava in zaključek / Discussion and conclusion**

Četrtek, 16. 05. 2013 / Thursday, May 16th, 2013

PLENARNI DEL / PLENARY SESSION

09:15 - 09:45 **Magistrski in doktorski študij v zdravstveni negi: ustvarjanje novega znanja z uporabo znanstvenih metod / Masters and doctoral studies in nursing: Creating new knowledge by using scientific methods**
Izr. prof. dr. Brigita Skela Savič, Visoka šola za zdravstveno nego Jesenice, SI

09:45 – 10:00 **Razvoj raziskovalnih potencialov pri študiju zdravstvene nege / Development of research potential in nursing study**
Prof Dr Radivoje Radić, School of Medicine, J J Strossmayer University Osijek, HR

10:00 - 10:15 **Možnosti razvoja karierne poti na področju raziskovanja v zdravstveni negi / Career development opportunities in nursing research**
Barbara Donik, mag. Mateja Lorber, Barbara Kegl, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

10:15 - 10:30 **Optimiziranje visokošolskega poučevanja in učenja s konstruktivno poravnavo predmetov in študijskih programov / Optimizing higher education teaching and learning through constructive alignment of courses and study programs**
Izr. prof. dr. Slavko Cvetek, Milena Pišlar, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

10:30 - 10:45 **Razprava / Discussion**

10:45 - 11:15 **Odmor / Break**

Sekcija - ZNANJE IN VARNOST V KLINIČNEM OKOLJU - predavalnica 2 / Thematic session - KNOWLEDGE AND SAFETY IN CLINICAL ENVIRONMENT - classroom 2

11:15 - 11:30 **Varno delovno okolje za člane negovalnega tima / Secure working environment for nursing team members**
Doc. dr. Jadranka Stričević, izr. prof. dr. Majda Pajnkihar, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

11:30 - 11:45 **Model prioritetnih kompetenc mentorjev zdravstvene nege / A priority competences model of mentors in nursing**
Petra Kamenšek, Univerzitetni klinični center Maribor, SI

11:45 - 12:00 **Prepoznavanje latentnih napak s simulacijami v kliničnem okolju – in situ simulacije / Identification of latent errors during simulation in clinical settings – in situ simulations**
Doc. dr. Miljenko Križmarić, Medicinska fakulteta in Fakulteta za zdravstvene vede Univerze v Mariboru, Anemarija Smonkar, Univerzitetni klinični center Maribor, SI

12:00 - 12:15 **Uporaba supraglotičnih pripomočkov v oskrbi dihalnih poti / The use of supraglottic devices in respiratory care**
Maja Strauss, Anton Koželj, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:15 - 12:30 **Zdravstvena nega bolnika pri trombolitičnem zdravljenju možganske kapi / Thrombolytic therapy of stroke patient in nursing care**
Jasmina Nerat, mag. Vida Gönc, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:30 - 12:45 **Osveščenost staršev o preventivnih obiskih otrok s strani patronažne medicinske sestre in v dispanzerju za otroke / Parental familiarity with pre-school children's preventive visits by community nurses and dispensary for children**
Barbara Kegl, mag. Milica Lahe, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:45 - 13:00 **Razprava in zaključek / Discussion and conclusion**

Sekcija - JAVNO ZDRAVJE IN KAKOVOST V ZDRAVSTVENI NEGI - predavalnica 3 / Thematic session - PUBLIC HEALTH AND QUALITY IN NURSING - classroom 3

11:15 - 11:30 **Pomen izobraževanja za obvladovanje bolečine / The importance of education in pain management**
Mojca Dobnik, Univerzitetni klinični center Maribor, SI

11:30 - 11:45 **Merjenje z zdravjem povezane kakovosti življenja pri multipli sklerozi / Measuring health-related quality of life in multiple sclerosis**
Dominika Jakl, izr. prof. dr. Majda Pajnkihar, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

11:45 - 12:00 **Kdo v družini sprejme odločitev za odhod starostnika v domsko varstvo? / Who in the family makes the decision about nursing home accommodation?**
Doc. dr. Ana Habjanič, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:00 - 12:15 **Pomen higiene bolnišničnih tekstilij za zdravje / The importance of hospital textiles hygiene for health**
Doc. dr. Sabina Fijan, prof. dr. Sonja Šostar Turk, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:15 - 12:30 **Škodljivost ambrozije za zdravje / Ambrosia, harmful to health**
Urška Vernik, prof. dr. Sonja Šostar Turk, mag. Mateja Lorber, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:30 - 12:45 **Obvladovanje higienskih razmer na bazenskih kopališčih za varovanje zdravja / Hygiene conditions management at swimming pools for health protection**
Vesna Fluher, izr. prof. dr. Majda Pajnkihar, prof. dr. Sonja Šostar Turk, Fakulteta za zdravstvene vede Univerze v Mariboru, SI

12:45 - 13:00 **Razprava in zaključek / Discussion and conclusion**

INTERNATIONAL CONFERENCE
KNOWLEDGE BRINGS DEVELOPMENT AND HEALTH

OB KONFERENCI - Z ZNANJEM DO RAZVOJA IN ZDRAVJA

Pridobivanje novih znanj in posledično razvoj profesije in discipline sta temelj in cilj vsakega izobraževanja. Fakulteta za zdravstvene vede Univerze v Mariboru organizira, z namenom obeleženja 20-letnice delovanja fakultete in razvoja zdravstvene nege, mednarodno konferenco »Z znanjem do razvoja in zdravja.

Raziskovanje, ki predstavlja vez med teorijo in prakso, medicinskim sestram omogoča pridobivanje novih znanstvenih, teoretičnih in praktičnih znanj koristnih in potrebnih pri vsakodnevnem delu. Za razvoj izobraževanja, raziskovanja in prakse smo odgovorni vsi v zdravstveni negi. Vse aktivnosti in rezultati so usmerjeni v dobrobit in zdravje posameznika, družine in družbe kot celote. Znanje je temelj za holistično, humano in na znanstvenih dokazih osnovano prakso zdravstvene nege ter doseganje profesionalne avtonomije medicinskih sester. Hkrati predstavlja osnovo za prevzemanje odgovornosti v učinkovitem in varnem procesu obravnave pacientov, ki od nas pričakujejo veliko mero pomoči, znanje, pogovor, razumevanje in ne nazadnje humane ter enakovredne partnerske odnose.

Konferenca je za fakulteto in zdravstveno nego pomembna zaradi mednarodnega povezovanja, sodelovanja in izmenjave znanja ter izkušenj v izobraževanju in zaradi raziskovanja, ki je temeljnega pomena za razvoj zdravstvene nege. Interakcija izobraževanja, raziskovanja in prakse je ključ do razvoja sodobne paradigme znanja v zdravstveni negi, katera vključuje znanost, etiko, estetiko in osebno profesionalno znanje.

Cilj mednarodne konference »Z znanjem do razvoja in zdravja« je interdisciplinarno povezovanje znanstvenih spoznanj uglednih strokovnjakov doma in v tujini zaradi razvoja kakovostne in varne zdravstvene obravnave in nege pacientov.

Konferenco bogatijo ugledni domači in tuji vabljeni predavatelji iz številnih univerz iz Evrope, Rusije in Zahodnega Balkana, ki bodo predstavili **znanstvene rezultate in spoznanja v zdravstveni negi in zdravstvu** ter ne nazadnje pot do ustvarjanja in širjenja znanja. Na fakulteti si prizadevamo k učinkovitemu povezovanju in sodelovanju s priznanimi tujimi univerzami in institucijami za razvoj specialnih znanj, specialističnih

programov, magistrskih programov in **prvenstveno doktorskega študijskega programa Zdravstvena nega,** za kar je temeljnega pomena mednarodno sodelovanje. Obstoječa mednarodna sodelovanja in partnerstva želimo povečati in razširiti na nova področja. Pri tem so posebej pomembna **mednarodna povezovanja** visokošolskih učiteljev, raziskovalcev in študentov na profesionalni in osebni ravni. Mednarodno sodelovanje in povezovanje nam na fakulteti in širše v zdravstveni negi ponuja možnosti za okrepljeno znanstveno raziskovalno delo in sodelovanje na razvoju podiplomskih študijskih programov. Posledično bomo lahko na fakulteti izobraževali lastne kadre in tako pridobili prepotrebne doktorje znanosti.

Častni pokrovitelj mednarodne konference »Z znanjem do razvoja in zdravja« je Zbornica zdravstvene in babiške nege – Zveza strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije in Ministrstvo za izobraževanje, znanost in šport RS**,** kjer se združujeta skrb za razvoj znanosti in discipline ter razvoj profesije zdravstvene nege.

Ob tej priložnosti se iskreno zahvaljujem Univerzi v Mariboru in Kariernemu centru Univerze v Mariboru za vsa prizadevanja in finančno podporo pri organizaciji konference. Iskrena hvala gre tudi vsem sodelavcem za ves trud, napore, prizadevanja in osebno motivacijo vsakega posameznika za organizacijo dobre in prepoznavne mednarodne konference doma in v tujini.

Udeležencem konference želim izpolnitev osebnih in profesionalnih pričakovanj, veliko strokovnih užitkov, uspešno izmenjavo znanja in izkušenj, in **posebej osebnega povezovanja**, zaradi bodočega uspešnega sodelovanja na izobraževalnem in raziskovalnem področju.

Acquisition of new knowledge and the consequent development of the profession and discipline are the foundation and goal of every education. The Faculty of Health Sciences, University of Maribor, is organising the international conference "Knowledge Brings Development and Health" with a purpose to mark the 20th anniversary of its foundation and the development of nursing care.

Research, which represents a link between theory and practice, makes it possible for nurses to acquire new scientific, theoretical and practical knowledge that is useful and necessary in their daily work. All of us who work in the field of nursing care are responsible for the development of education, research and practice. All our activities and results are focused on the wellbeing and health of individuals, families and society as a whole. Knowledge is the basis for a holistic, humane and scientific evidence-based nursing practice, and for the achievement of professional autonomy of nurses. At the same time, it is the basis for taking responsibility in an effective and safe process of treatment of patients who expect from us a great deal of assistance, knowledge, conversation, understanding and, not lastly, a humane approach in which they are treated as equal partners.

For the Faculty and for nursing care, this Conference is important for developing international connections and cooperation, and for the exchange of knowledge in education and research which is fundamental to the development of nursing. The interaction between education, research and practice is vital for the development of a modern paradigm of knowledge in nursing care which includes science, ethics, aesthetics and personal professional knowledge.

The goal of the international conference "Knowledge Brings Development and Health" is to promote interdisciplinary connection and sharing of scientific knowledge by the renowned experts at home and abroad for the development of high-quality and safe medical treatment and patient care.

The Conference is enriched by the presence of several renowned domestic and foreign invited speakers from a number of universities from Europe, Russia and the Western Balkans who will present scientific results and knowledge in nursing and health care, and, as such, represents the way to knowledge creation and dissemination. The Faculty is making efforts to establish effective cooperation with renowned foreign universities and institutions to develop specialist knowledge, specialized programs, master's programs and, above all, a doctoral study program in Nursing Care where international cooperation is fundamental. We wish to increase the existing international cooperation and partnerships and expand these on new areas. Of particular importance here are international connections of teachers, researchers and students on both professional and personal level. International cooperation and networking provides the Faculty, and nursing in a broader sense, with opportunities for enhanced scientific research and cooperation in the development of postgraduate programs. As a result we will be able to educate our own faculty and staff and thus obtain so much needed doctors of science.

The Honorary sponsor of the international conference "Knowledge Brings Development and Health", the Chamber of Nurses and Midwives - Nurses and Midwives Association of Slovenia, and the Ministry of Education, Science and Sport where the responsibility for the development of science and discipline, and development of the profession of nursing are joined together.

I take this opportunity to sincerely thank the University of Maribor and the Career Center of the University of Maribor for all the efforts and financial support in organizing the conference. My sincere thanks also go to my colleagues, for their effort, work, and the personal motivation of each individual for the organization of a good and recognizable international conference, both at home and abroad.

I wish all conference participants to fulfil their personal and professional expectations, a lot of professional satisfaction, a successful exchange of knowledge and experience, and especially in making personal connections with a purpose of future successful cooperation in teaching and research.

Dekanica Fakultete za zdravstvene vede UM
Dean of the Faculty of Health Sciences UM

Izr. prof. dr. Majda Pajnkihar
Assoc Prof Dr Majda Pajnkihar

THE HONORARY SPONSOR MINISTRY OF EDUCATION, SCIENCE AND SPORT RS

ČASTNI POKROVITELJ MINISTRSTVO ZA IZOBRAŽEVANJE, ZNANOST IN ŠPORT RS

Spoštovane udeleženke in udeleženci mednarodne konference!

Vse razvite države so si danes enotne, da sta izobraževanje in raziskovanje dva izmed ključnih elementov na poti do tistega, kar imenujemo razvita družba. Človeški kapital, ki ga premoremo in njegova razporeditev je predpogoj za to, da bi se naša družba nadalje razvijala. Predpogoj za to je tudi ustrezno vlaganje v sistem izobraževanja in raziskovanja na različnih ravneh.

Na ravni visokošolskih izobraževalnih inštitucij je pri tem ključna njihova kakovost. Univerze morajo namreč predstavljati vrhunske znanstvene ustanove, kjer morata pedagoški in raziskovalni proces potekati v sozvočju. Brez novih znanj, do katerih pridemo skozi raziskovalno delo, in ki jih dnevno prenašamo v pedagoški proces, ne more biti napredka.

V tem duhu tudi naslov konference »Z znanjem do razvoja in zdravja« ni naključen. Konferenca je namreč nastala kot plod potrebe po povezovanju in harmonizaciji nacionalnega in mednarodnega izobraževanja, prakse in raziskovanja, njen namen pa je v povezovanju teorije s prakso na področju zdravstvene nege in zdravstvenih ved.

Ob želim izpostaviti, da seveda tudi razvoja ni brez zdravja. Vsakršno zdravje, fizično, umsko, javno in osebno, je integralni del razvoja vsake družbe. Le s tovrstnim razvojem lahko dosegamo rast. Le rast, ki ne sme biti sama sebi namen in izhaja iz razvoja je namreč dolgoročno vzdržna in v korist družbe.

Zdravstvena nega in zdravstvene vede v slovenskem visokošolskem in raziskovalnem prostoru so soočene s težavami v avtonomnosti odločanja o potrebah in razvoju izobraževanja, raziskovanja ter prakse, zato je povezovanje s tujimi institucijami nujno za razvoj podiplomski študijskih programov, predvsem doktorata zdravstvene nege. Koncentracija potencialov na mednarodni ravni, torej skozi vključevanje v mednarodne raziskovalne in visokošolske mreže ter prenos znanj in dognanj, na koncu prinaša dodano vrednost za uporabnike zdravstvenih storitev.

Raziskavam na področju zdravstvene nege je nedvomno treba zagotoviti vlogo in mesto v slovenskem prostoru, ki ga za lasten razvoj in napredek tudi morajo imeti. Strinjam se, da je potrebno tudi v širši javnosti utrjevati vlogo univerzalnosti zdravstvene nege, saj je slednja v procesu dela udeležena v večino dejavnosti v zdravstvu.

Konferenca »Z znanjem do razvoja in zdravja« bo zagotovo pripomogla k razvoju na raziskovanju temelječega in podprtega izobraževanja ter prakse zdravstvene nege. Dosežek bo izmenjava znanja, ki ga potrebujemo za razvoj študijskih programov in povezovanje teorije s prakso ter osnovanje izobraževanja in prakse na znanstvenih osnovah, za doprinos k zdravju ljudi.

Za zaključek naj še iskreno čestitam Fakulteti za zdravstvene vede Univerze v Mariboru ob 20-letnici delovanja ter vam zaželim še veliko uspehov na konferenci in pri delu po njej.

Dr. Jernej Pikalo,
Minister za izobraževanje, znanost in šport

THE HONORARY SPONSOR NURSES AND MIDWIVES ASSOCIATION OF SLOVENIA

ČASTNI POKROVITELJ ZBORNICA ZDRAVSTVENE IN BABIŠKE NEGE SLOVENIJE - ZVEZI STROKOVNIH DRUŠTEV MEDICINSKIH SESTER, BABIC IN ZDRAVSTVENIH TEHNIKOV SLOVENIJE

Spoštovana gospa dekanica izr. prof. dr. Majda Pajnkihar, cenjeni profesorski zbor, študentke in študenti, vsi, ki slovesno obeležujete dvajsetletnico Fakultete za zdravstvene vede Univerze v Mariboru,

na Zbornici zdravstvene in babiške nege Slovenije – Zvezi strokovnih društev medicinskih sester, babic in zdravstvenih tehnikov Slovenije (Zbornici – Zvezi) smo počaščeni, da smo lahko **častni pokrovitelji lepega praznovanja - okroglih dveh desetletij delovanja vaše fakultete**. V tem slovesnem trenutku vam iskreno čestitamo za ti dve desetletji delovanja pomembne izobraževalne institucije za našo stroko, druge po vrsti v zgodovini izobraževanja za diplomirane medicinske sestre in diplomirane zdravstvenike. Z leti je institucija prerasla v fakulteto in pred kratkim je bila prav tu inavgurirana prva dekanica v zgodovini zdravstvene nege pri nas, ki je po osnovni izobrazbi medicinska sestra. Bodimo ponosni na te dosežke in se jih veselimo.

Te dni se ves svet spominja medicinskih sester (12. maja) in babic (5. maja) ob naših mednarodnih dnevih, ki smo jih dostojno obeležili tudi pri nas. Z dobro udeležbo na 9. kongresu zdravstvene in babiške nege in s slavnostno akademijo na Brdu pri Kranju smo dokazali, da cenimo stroko in tudi skupno organizacijo. Obeležitev takšnih dogodkov je pomembna in potrebna, saj s tem opozarjamo, da smo kot poklicna skupina prisotni - tukaj in zdaj. In da smo bili v zgodovini in bomo tudi v prihodnosti. S tem dokazujemo, da razvoja stroke ni moč ustaviti skozi politične pritiske in katero koli krizo.

Zbornica – Zveza je v svoj ustanovitveni akt, statut, že pred leti zapisala, da »skrbi za razvoj in delovanje stroke zdravstvene in babiške nege ter oskrbe v R Sloveniji, sodeluje pri oblikovanju in usmerjanju zdravstvene politike v R Sloveniji ter se v ta namen povezuje z ustreznimi institucijami, sodeluje z državnimi organi, izobraževalnimi institucijami, … organizira, usklajuje in usmerja strokovna in druga izobraževanja, izpopolnjevanja ter usposabljanja medicinskih sester, babic, zdravstvenih tehnikov in bolničarjev -

negovalcev ter se v ta namen povezuje z ustreznimi strokovnimi institucijami, kamor spada tudi vaša fakulteta.

Naša skupna organizacija je lani (2012) obeležila 85 let delovanja Zveze društev, 20 let zborničnih aktivnosti, 20 let izdajanja glasila Utrip in 45 let izdajanja Obzornika zdravstvene nege; imamo biti na kaj ponosni. Sovpadanje dvajsetletnice in drugi dogodki ter vsebine so stičišča, ki Zbornico – Zvezo in vašo izobraževalno institucijo tesno povezujejo. Gre za spoštljivo dediščino naših predhodnic in v zadnjih letih tudi predhodnikov, ki so verjeli v razvoj, v moč znanja, znanstvenega pristopa k stroki, vseživljenjskega izobraževanja, stanovske solidarnosti, zastopanja skupnih interesov z enim glasom, ob tem pa ne pozabili človečnosti, empatije do sočloveka, pa naj bo pacient ali stanovski kolega/ica. Zahvala gre najprej predhodni generaciji, ki je prepoznala pomen ustanovitve še ene izobraževalne institucije za našo stroko, in tudi sedanji generaciji, ki razvija fakulteto naprej.

Delovanje Zbornice – Zveze je skozi desetletja potekalo bolj ali manj neovirano, le za nekaj časa ga je pretrgala druga svetovna vojna; naše zavesti, organiziranosti in z njim povezane vloge v sistemu zdravstva pa ni moglo nič zaustaviti. Upajmo, da nas tudi obdobje, ki

ga preživljamo, ne prizadene do te mere, da bi morali zaradi gospodarske, finančne in predvsem krize vrednot preveč izgubiti ali preveč upočasniti razvojne trende, ki jim sledimo skozi spremljanje razvoja stroke v sorodno razvitih državah EU oz. sveta, skozi lastno raziskovalno dejavnost, publiciranje strokovnih izsledkov in drugo. In da politični prepih, ki smo mu priča v teh časih (npr. že leto dni stroka ni regulirana, torej Zbornica – Zveza nima javnih pooblastil za vodenje registra izvajalcev, izdajanje licenc, izvajanje strokovnih nadzorov s svetovanjem, stoji razvoj specializacij), ne bodo preveč okrnili naših razvojnih poti, zgrajenih v osmih, skoraj devetih desetletjih. Pogosto menjajoči se resorni ministri ne nudijo vedno tudi pričakujoče podpore, nekateri prej oviro v tem razvoju, žal. Zavedamo se, kaj to pomeni za kakovostno, varno zdravstveno obravnavo pacientov in tudi za varno delo izvajalcev samih.

Strokovno se bogatiti in rasti v preizkušeni obliki civilne družbe, ki jo predstavlja Zveza (strokovnih) društev, ponuja raznolike možnosti ustvarjanja in sobivanja. Govorjenje z enim glasom, številčnost in moč članstva preprosto štejejo. Vsa leta medicinske sestre, zdravstveni tehniki in babice skupaj ustvarjamo vzdušje povezovanja in sodelovanja, kar ni samemu sebi namen. Izobraževanje - večna rdeča nit naših prizadevanj, raziskovanje, še posebej v kliničnih okoljih, iskanje pravih teorij za strokovno delo, postavljanje standardov in normativov, oblikovanje lastnih poklicnih kodeksov, terminoloških slovarjev, merjenje svojega dela, prizadevanja za sooblikovanje zdravstvenih politik so naše skupna torišča delovanja, ki jih moramo skupaj razvijati. To so tudi prioritete nacionalne organizacije, ki združuje skoraj 16.000 kolegic in kolegov iz kliničnih okolij, izobraževalnih institucij, socialno varstvenih zavodov itd.; vsepovsod smo medicinske sestre, zdravstveni tehniki in babice najštevilčnejša in nepogrešljiva poklicna skupina v sistemu zdravstva in ni nas moč spregledati.

Dejavnost strokovnega združenja je bogata in razvejana, kar dokazuje enajst regijskih strokovnih društev; med njimi je Društvo medicinskih sester, babic in zdravstvenih tehnikov Maribor več kot pet desetletij igralo in še igra pomembno vlogo v vaši regiji in je tudi drugo najštevilčnejše v državi. V svoje delovanje lepo vključuje tudi vašo fakulteto. Pod Zbornico – Zvezo deluje tudi 31 strokovnih sekcij, ki po vsej državi »pokrivajo« stroko, poleg njih še stalne in občasne delovne skupine, telesa, posamezniki, zunanji sodelavci, številni drugi. S svojim delovanjem si nenehno prizadevamo za izboljševanje kakovosti, učinkovitosti in varnosti zdravstvene obravnave pacientov. Promoviramo zdravo, varno in prijazno delovno okolje ter spodbujamo kulturo nenasilnega vedenja, v skrbi za kakovostno medpoklicno sodelovanje v zdravstvu in za ugled poklica. Skozi delovanje strokovnih sekcij in regijskih strokovnih društev uresničujemo vizijo učeče se organizacije. Z organizacijo strokovnih izobraževanj in izpopolnjevanj omogočamo članstvu kontinuirano nadgrajevanje znanja in spretnosti. **V znanju in skupnem nastopu so naša moč, napredek in razvoj.** Če kdo, se tega močno zaveda tudi vaša fakulteta in nas pri tem podpira. Hvala za to.

Naša prizadevanja gredo v smeri večje avtonomije poklica. Podpiramo razvoj managementa zdravstvene in babiške nege, izobraževanje medicinskih sester, zdravstvenih tehnikov in babic na vseh treh bolonjskih stopnjah in akademizacijo stroke. Razvijati želimo klinične specializacije, klinično raziskovanje in na dokazih podprte sodobne prakse zdravstvene in babiške nege. Takšno zdravstveno in babiško nego potrebujejo pacienti in njihovi bližnji, to pa smo mi vsi.

Kot zagovornikom pacientov ter varuhom strokovne integritete nam ni vseeno, kakšen bo zdravstveni sistem jutrišnjega dne. Zato si Zbornica Zveza želi v partnerskem sodelovanju s članstvom, z izobraževalnimi zavodi, vsemi drugimi proaktivno in enakopravno sodelovati pri oblikovanju zdravstvene politike in zakonodaje v državi. Zbornica - Zveza si bo tudi še naprej prizadevala za ohranitev regulacije v zdravstveni in babiški negi, kot je v veljavi v razvitem svetu in jo nazadnje predpisujejo številni dokumenti, ki zavezujejo vlado. Regulacijo zahtevajo tudi svetovne in evropske organizacije, sistemi akreditacije bolnišnic in jo, povsem razumljivo, zahtevajo tudi pacienti.

Želeli bi obvarovati zdravstveni sistem pred razstavljanjem tistega, kar se je izkazalo v več desetletjih za dobro, in kjer smo ključno vlogo odigrali na področju zdravstvene in babiške nege (recimo sistem patronažne službe, ki ima zibelko nastanka prav v vaši regiji). In še mnogo je področij, ki bi jih lahko menjali, a praznovanje okrogle obletnice fakultete ni priložnost, da naštevamo težave, je prej priložnost za slavje, zadovoljstvo, ponos, da je uspelo. In velika želja, da bo šel razvoj v tej smeri naprej.

Naj vam ob vašem jubileju zaželimo iskrivega razvoja in dobrih pogojev za vsakdanje delo, ki ga zaznamuje dejstvo, da smo sredi hude ekonomske in politične krize, tudi krize vrednot. V tem trenutku je pomembno, da medicinske sestre, babice in zdravstveni tehniki združimo svoje vrste. Toplo vabljeni vsi diplomanti, ki zaključujete študij, ali se nam že kot študenti pridružite. Skupaj bomo močnejši in prepoznavnejši; lažje se bomo upirali poskusom zniževanja kadrovskih in drugih normativov, prenosu kompetenc na nižje ali priučene profile, že konkretne poskuse degradacije izobrazbe, ki smo jo mukoma dosegli v teh desetletjih. Tudi zaradi vaše fakultete, vaših predhodnic, ki so izjemno zaznamovale slovenski »negovalni« prostor, imamo dobro zastavljeno pot. Naj

omenimo le dve, lansko in letošnjo dobitnico nagrade Zbornice – Zveze za življenjsko delo gospo Majdo Šlajmer Japelj in gospo Silvo Vuga. Vseh drugih ne bomo menjali, da koga ne izpustimo, je pa regija kot taka prispevala zelo veliko dobrih strokovnjakinj in strokovnjakov, ki so povezani tako z razvojem vaše fakultete kot tudi stroke in organizacije na nacionalni ravni.

Hvala vam za vaš doprinos, praznujte prešerno, naprej pa z novimi cilji in pogumom. Čestitamo.

Darinka Klemenc
Predsednica Zbornice – Zveze

CARING AND INTERPERSONAL RELATIONSHIPS IN NURSING CARE

SKRB IN MEDOSEBNI ODNOSI V ZDRAVSTVENI NEGI

MAJDA PAJNKIHAR

Izvleček

Izhodišča: *Skrb za drugega je osnovni koncept na katerem temelji začetek in razvoj nege, je osnova za razvoj humanih, profesionalnih in enakovrednih partnerskih medosebnih odnosov ter predstavlja osrednji element zdravstvene nege v skrbi za pacienta. Možen dejavnik neustreznega vzpostavljanja medosebnih odnosov je lahko posledica pomanjkanja znanja in veščin, zato smo z raziskavo želeli oceniti karativne dejavnike skrbi in ugotoviti ali obstajajo razlike pri oceni teh dejavnikov glede na izobrazbo medicinskih sester.*

Metode: *Uporabljena je bila kvantitativna metodologija. V raziskavo je bilo vključenih 1098 medicinskih sester v 5 zdravstvenih institucijah. Za oceno karativnih dejavnikov skrbstvene zdravstvene nege je bil uporabljen standardiziran vprašalnik merjenja skrbi in medosebnih odnosov avtorice Watson. Za predstavitev rezultatov so bile uporabljene opisne statistične metode, za ugotavljanje statistično pomembnih razlik v oceni karativnih dejavnikov glede na izobrazbo pa je bil uporabljen Pearsonov korelacijski koeficient (p < 0,05).*

Rezultati: *Analiza 603 ustrezno izpolnjenih vprašalnikov je pokazala, da se medicinske sestre zavedajo pomena skrbi, saj so bili vsi karativni dejavniki zelo dobro ocenjeni (PV>4). Menijo, da izvajajo skrbstveno zdravstveno nego, ob tem pa nudijo predvsem pomoč pri zagotavljanju osnovnih človekovih potreb (PV=4,66) ter vzbujanju upanja (PV=4,58). Statistično pomembno razliko v oceni karativnih dejavnikov skrbi glede na izobrazbo smo ugotovili le za dejavnik transpersonalnega učenja (p=0,020).*

Diskusija in zaključek: *Skrb se vzpostavi preko medosebnih odnosov med medicinsko sestro in pacientom. Sprejetje koncepta skrbi in nudenje skrbstvene zdravstvene nege pa je osrednja in temeljna naloga medicinskih sester ne glede na stopnjo izobrazbe. Skrb za pacienta je moralna in profesionalna obveza vsakega zdravstvenega profesionalca in je osnova medsebojnim odnosom.*

Ključne besede: *skrb, karativni dejavniki skrbi, medosebni odnosi, zdravstvena nega*

Abstract

Introduction: *Caring is basic concepts of nursing on which care begins and develops. It is foundation for development of human, professional and equal interpersonal relationships and represents central element of nursing and caring for patients. One of the problems in interpersonal relationships could occur because of a lack of knowledge and skills. That is why we decided to estimate the carative factors and ascertain if there are any differences in estimation regarding education level of nurses.*

Methods: *Quantitative methodology was used. The study included 1098 nurses in 5 health institutions in Slovenia. Watson's Scale of measuring care was used for assessment of carative factors of nursing care. Descriptive statistics were used to describe results and Pearson's correlation coefficient was used to determine statistically significant differences between carative factors and education level (p < 0,05).*

Results: *Analysis of 603 valid questionnaires showed that nurses are aware of the meaning of caring because all carative factor were assessed as very good (M>4). They think they perform caring, especially they assist in the gratification of human needs (M=4,66) and give hope (M=4,58). Education of nurses was statistically connected only to factor of transpersonal teaching (p=0,020).*

Discussion and conclusion: *Caring is established through the nurse–patient relationship. Accepting care as essential concepts in nursing care is one of the important roles of nurses regardless of education level. Caring for patients is moral and professional responsibility of each health care professional and also foundation for interpersonal relationships.*

Keywords: *caring, carative factors, interpersonal relationships, nursing care*

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IZHODIŠČA

Zdravstvena nega je znanost in umetnost, kot umetnost se izraža skozi aktivnost medicinske sestre, vključene v medsebojni človeški kontakt (Watson, 1999). Watsonova opiše skrb za drugega kot moralni imperativ in jo tesno povezuje z ohranitvijo dostojanstva pacienta. Skrb se izkazuje v medsebojnem odnosu, vedenju in pomoči. Dimenzije skrbi so: skrb kot humana lastnost, moralna obveza, čustvo, medosebna interakcija in kot terapevtska intervencija (Morse et al., 1991). Skrb se nanaša v procesu obravnave pacienta in interakcije med medicinsko sestro in pacientom za nudenje tolažbe in pomoči, human medsebojni odnos in izvajanje celostne obravnave pacienta.

Watson (1999) in drugi definirajo različne naloge in znanje medicinskih sester, vendar teoretiki verjamejo, da je prva naloga medicinske sestre, skrb, pomoč in podpora pacientom. V raziskavi, ki jo je izvedla Pajnkihar (2003) sodelujoči poudarjajo skrb, podporo, pomoč, znanje in enakovredne medsebojne partnerske odnose med pacienti in zdravstvenimi profesionalci.

Medosebni odnosi med pacientom in medicinsko sestro predstavljajo osrednji element zdravstvene nege (McKenna, Slevine, 2008; Sieger, Fritz, Them, 2012). Wright in Gros (2012) zdravstveno nego celo opredeljujeta kot medosebni odnos med osebo, ki potrebuje pomoč in osebo, ki je tako pomoč sposobna in zmožna nuditi. Zdravstvene nege tudi ni brez skrbi za pacienta (Sieger, Fritz, Them, 2012). Finfgeld-Connett (2008) opredeljuje skrb kot medosebni odnos, ki je značilen za zdravstveno nego, vključuje pa medosebno občutljivost in zaupne odnose. Watsonova (1999) skrb imenuje karativna skrb. Slednja se vzpostavi preko medosebnih odnosov med medicinsko sestro in pacientom, izraža pa se v načrtovanih negovalnih intervencijah (Granados, Gámez, 2009). Medsebojni odnosi tudi kažejo, kako medicinska sestra vidi in zaznava pacientov globlji pomen njegovega doživljanja bolezni ali zdravljenja (Watson, 2005). Nyström (2007) meni, da ima ta medosebni odnos med obema pozitiven izid za pacienta, Milton (2012) pa dodaja, da mora ta interakcija temeljiti na zanesljivosti in zaupnosti. Vendar se velikokrat žal zgodi, da medicinske sestre iz različnih razlogov pri vzpostavljanju medosebnih odnosov uporabljajo neučinkovito komunikacijo in formalen nastop (Gordon, Ellis-Hill, Ashburn, 2009). Vendar bi le-to moralo temeljiti predvsem na skrbi (Watson, 1999). Eden izmed možnih dejavnikov neustreznega vzpostavljanja medosebnih odnosov je lahko posledica pomanjkanja znanja in veščin (Poggenpoel, Myburgh, Morare, 2011).

Namen

Z raziskavo smo želeli oceniti karativne dejavnike skrbi, ki predstavljajo temelj medosebnih odnosov skrbstvene zdravstvene nege, z uporabo vprašalnika merjenja skrbi in medosebnih odnosov avtorice Watson ter ugotoviti ali obstajajo razlike pri oceni teh dejavnikov glede na izobrazbo medicinskih sester.

METODE

Uporabljena je bila kvantitativna metodologija. Raziskava je potekala v okviru bilateralnega projekta med Slovenijo in Rusijo (2012-2013). V raziskavo so bile vključene medicinske sestre v 5 zdravstvenih institucijah pri nas. Od 1098 vprašalnikov je bilo vrnjenih 655, v samo analizo pa je bilo vključenih 603 ustrezno izpolnjenih vprašalnikov (stopnja odzivnosti 54,9 %). Sodelovalo je 313 (51,42 %) medicinskih sester s poklicno in srednješolsko izobrazbo, 18 (2,9 %) z višješolsko, 220 (36,3 %) z visokošolsko, 40 (6,6 %) z univerzitetno izobrazbo, 11 (1,8 %) z zaključenim magisterijem in 1 (0,3 %) z doktoratom. Za oceno karativnih dejavnikov skrbstvene zdravstvene nege je bil uporabljen standardiziran vprašalnik merjenja skrbi in medosebnega odnosa medicinska sestra – pacient avtorice Watson (Watson's Scale of measuring caring). Za predstavitev rezultatov so bile uporabljene opisne statistične metode. Za ugotavljanje statistično pomembnih razlik v oceni karativnih dejavnikov glede na izobrazbo je bil uporabljen Pearsonov korelacijski koeficient. Meja statistične pomembnosti je bila $p < 0,05$. Za analizo podatkov je bil uporabljen programski paket IBM SPSS verzija 20.0.

Instrument merjenja

Vprašalnik ocene karativnih dejavnikov skrbstvene zdravstvene nege obsega 70 trditev, ki se nanašajo na karativne dejavnike skrbi, pri čemer se strinjanje z merjenim aspektom označuje na 5-stopenjski lestvici (1–nestrinjanje, 5–strinjanje) (Watson, 2009). Deset karativnih dejavnikov skrbi je: načrtovanje in izvajanje humanističnih in altruističnih vrednot (humanizem), vzbujanje upanja (upanje), občutljivost do sebe in drugih (občutljivost), razvijanje odnosa pomoč-zaupanje (pomoč), spodbujanje k izražanju pozitivnih in negativnih občutkov (izražanje), razvijanje procesov kreativnega reševanja problemov (reševanje problemov), spodbujanje medosebnega odnosa poučevati in učiti se (učenje), zagotavljanje in ohranjanje varnega fizičnega, psihičnega, socialnega in duhovnega okolja (okolje), pomoč pri zagotavljanju osnovnih človekovih potreb (potrebe), priznavanje eksistenčnih, fenomenoloških in spiritualnih sil pomembnih za človeka (spiritualnost) (Watson, 1999; Watson, 2005).

REZULTATI

Razpredelnica 1: Karativni dejavniki skrbi v 5 zdravstvenih institucijah

SKRB	A	B	C	D	E
Humanizem	4,41±0,604	4,54±0,459	4,36±0,700	4,50±0,458	4,49±0,459
Upanje	4,49±0,683	4,67±0,432	**4,66±0,720**	**4,65±0,506**	4,61±0,456
Občutljivost	4,02±0,731	4,33±0,598	4,15±0,643	3,88±0,633	4,06±0,570
Pomoč	4,32±0,596	4,53±0,491	4,33±0,571	4,34±0,469	4,48±0,462
Izražanje	4,21±0,665	4,51±0,709	4,,34±0,588	4,19±0,557	4,43±0,462
Reševanje problemov	4,11±0,716	4,49±0,521	4,28±0,629	4,09±0,642	4,24±0,628
Učenje	4,22±0,651	4,48±0,511	4,25±0,729	4,19±0,483	4,12±0,628
Okolje	4,51±0,627	4,62±0,466	4,57±0,615	4,55±0,407	4,43±0,494
Potrebe	**4,62±0,587**	**4,71±0,392**	4,62±0,598	4,61±0,386	**4,57±0,371**
Spiritualnost	4,23±0,748	4,46±0,554	4,28±0,658	4,11±0,719	4,20±0,698

Legenda: A, B, C, D, E – zdravstvene ustanove, vključene v raziskavo

Rezultati raziskave so pokazali, da je bil v treh institucijah najvišje ocenjen karativni dejavnik skrbi pomoč pri zagotavljanju osnovnih človekovih potreb, v dveh institucijah pa vzbujanje upanja-zaupanja. V povprečju je bil najnižje ocenjen karativni dejavnik skrbi občutljivost do sebe in drugih. Podrobnejši rezultati so prikazani v razpredelnici 1.

V vseh institucijah je bil najvišje ocenjen karativni dejavnik skrbi pomoč pri zagotavljanju osnovnih človekovih potreb (PV=4,66), sledilo je vzbujanje upanja (PV=4,58). Preostala opisna statistika posameznih elementov karativnih dejavnikov skrbi je prikazana v razpredelnici 2.

Razpredelnica 2: Opisna statistika karativnih dejavnikov skrbi

SKRB	Min	Max	PV	SD
Humanizem	1	5	4,46	0,565
Upanje	1	5	4,58	0,665
Občutljivost	1	5	4,11	0,683
Pomoč	1	5	4,39	0,558
Izražanje	1	5	4,33	0,708
Reševanje problemov	1	5	4,23	0,671
Učenje	1	5	4,28	0,627
Okolje	1	5	4,56	0,555
Potrebe	1	5	**4,66**	0,505
Spiritualnost	1	5	4,29	0,687
SKRB	1	5	4,39	0,622

Legenda: min – najnižja vrednost, max – najvišja vrednost, PV – povprečna vrednost, SD – standardni odklon

V razpredelnici 3 so predstavljene statistične razlike v oceni karativnih dejavnikov glede na izobrazbo medicinskih sester.

Razpredelnica 3: Karativni dejavniki skrbi v povezavi z izobrazbo medicinskih sester

SKRB	Izobrazba	
Medosebni odnos medicinska sestra - pacient	Pearsonov korelacijski koeficient	p
Humanizem	-0,070	0,097
Upanje	-0,023	0,590
Občutljivost	-0,025	0,547
Pomoč	-0,025	0,152
Izražanje	-0,060	0,926
Reševanje problemov	-0,048	0,261
Učenje	-0,100*	**0,020**
Okolje	-0,023	0,455
Potrebe	-0,022	0,607
Spiritualnost	-0,036	0,396

DISKUSIJA

V prvi vrsti spada v poklic medicinske sestre skrb za in o človeku-pacientu. V zdravstveni obravnavi ni bolj pomembne, vredne in cenjene intervencije, postopka ali obravnave, kot je NEGA, ki je osnovana na spoštljivem, zaupnem in enakovrednem medsebojnem partnerskem odnosu (Pajnkihar, 2003). Osrednja in temeljna naloga medicinskih sester je skrb za človeka, zato mora le-ta biti v središču vseh aktivnosti medicinskih sester (Klemenc, 2003). Rezultati raziskave kažejo, da se medicinske sestre zavedajo pomena skrbi, saj so bili vsi karativni dejavniki zelo dobro ocenjeni (PV>4). Menijo tudi, da izvajajo skrbstveno zdravstveno nego, ob tem pa nudijo predvsem pomoč pri zagotavljanju osnovnih človekovih potreb ter vzbujanju upanja. Razveseljivi rezultati, saj vemo, da so medicinske sestre v zdravstvenih institucijah velikokrat preobremenjene in imajo premalo časa za vzpostavljanje neposrednih in odkritih medosebnih odnosov (McKenna, Slevine, 2008). Izvajanje skrbstvene zdravstvene nege pacientu namreč zagotavlja tako mentalno in fizično

blagostanje, pozitivni učinek pa se kaže tudi kot zadovoljstvo medicinskih sester (Finfgeld-Connett, 2008).

Medicinske sestre morajo biti čustveno izoblikovane, izkušene ter empatične, zato ima pri tem pomembno vlogo izobraževanje (Williams, Stickley, 2010). Nekateri so mnenja, da bi izobraževalne institucije morale posvetiti več časa in virov za oblikovanje skrbstvene zdravstvene nege med študenti zdravstvene nege (Finfgeld-Connett, 2008). Vendar v naši raziskavi statistično pomembnih razlik v oceni karativnih dejavnikov skrbi glede na izobrazbo nismo ugotovili. Izjema je le dejavnik učenje, ki se nanaša na promocijo transpersonalnega učenja - poučevati in učiti se. Kar tudi ni presenetljivo, saj je izobraževanje povezano z obojim. Transpersonalno učenje poteka v okviru vzpostavljanja medosebnega odnosa med dvema človekoma, v katerem obe osebi vplivata druga na drugo, hkrati pa tudi obe v tem odnosu pridobivata (Watson, 1999).

Vse medicinske sestre morajo sprejeti in predstavljati koncept skrbi in nuditi skrbstveno zdravstveno nego ne glede na to ali izhajajo iz akademskih krogov ali delajo v klinični praksi (Wagner, Whaite, 2010). Pri oblikovanju pozitivnih medosebnih odnosov in zmanjševanju negativnih dejavnikov, ki lahko negativno vplivajo na odnose in s tem tudi na skrb, so nam lahko v pomoč tudi teorije medosebnih odnosov v zdravstveni negi. Ne nazadnje lahko rečemo, da vse teorije zdravstvene nege obravnavajo medosebne odnose med medicinskimi sestrami in pacienti, nekatere manj, druge bolj (McKenna, Slevine, 2008). Teorije skrbi pa nam lahko pomagajo pri vključevanju skrbi v proces zdravstvene nege, k razumevanju kako skrb in »neskrb« vplivata na medosebne odnose med medicinsko sestro in pacientom, k razumevanju razmerij med obema nasploh, razumevanju obnašanja in izidov skrbstvene zdravstvene nege za pacienta itd. Za izvajanje skrbstvene zdravstvene nege je potrebna predvsem profesionalna zrelost medicinskih sester in moralna odgovornost, pomemben element pri tem pa je tudi ustrezno in ugodno delovno okolje (Finfgeld-Connett, 2008).

ZAKLJUČEK

Skrb in medosebni odnosi sta tesno povezana koncepta, predstavljata pa temelj zdravstvene nege in s tem pomembno nalogo vseh medicinskih sester ne glede na stopnjo izobrazbe. Medicinske sestre s tem ko nudijo skrbstveno zdravstveno nego pacientu ne predstavljajo le profesionalca in tujca, ampak humano osebo, ki mu poleg nudenja pomoči pri zagotavljanju potreb, lahko tudi zaupa, mu nudi pomoč pri reševanju problemov. Vendar skrb za pacienta ne predstavlja le pozitivnih učinkov za pacienta, medicinski sestri omogoča profesionalno rast.

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THE ROLE OF THE UNIVERSITY IN DEVELOPING INNOVATION, IMPROVEMENT AND BETTER SAFETY IN HEALTH CARE DELIVERY

VLOGA UNIVERZE PRI RAZVOJU INOVACIJ, IZBOLJŠANJU IN VEČJI VARNOSTI PRI ZAGOTAVLJANJU ZDRAVSTVENEGA VARSTVA

TONY BUTTERWORTH

Abstract

It is clear that for at least the next decade, funding for many health systems across the world will be challenged by serious financial uncertainties.

In facing these challenges Universities have to respond positively to innovations in the delivery of care, increases in productivity and the eradication of errors that result in harm to patients.

In committing to supporting this necessary change, quality improvement and innovation programmes are now available from national, not for profit organisations such as the Health Foundation (UK) and the Institute for Health Improvement (USA) that specifically address these important issues. Although the targets for these programmes are often health care systems at the macro level, the role of Universities in understanding and delivering innovative practices at a more micro level is vital. Evidence is now available that demonstrates the outputs of such programmes and the impact from making consequent changes to health care practice. University education programmes and research activity by health professionals can also take advantage of this activity and begin to ask questions that focus on those subject areas as well as adding positive value to people who use health care services.

This paper briefly describes some developments during the last decade, offers examples of University innovation programme content, describes the results of introducing patient safety, quality improvement and innovation into education curricula and suggests potential areas for future research by clinical academic researchers.

INTRODUCTION

As the world economy begins to recover from its present catastrophic financial difficulties, health care systems are asking serious questions about the safety, cost, relevance and usefulness of the services they offer.

There is compelling evidence that some services are unsafe, not evidence based and wasteful of resources (Eaton, Kennedy 2007). There is also some emerging evidence that nurses are being educated in ways that do not prepare them for practice sufficiently well and their capacity to understand and use research is often limited (Jackson et al., 2009).

Several countries have established organisations that are seeking to make a difference both to systems of care delivery and patient safety (Bevan, 2010).

This paper describes a development timeline, a patient safety programme, policy 'high impact action' focus points for nurses in England and considers how this might affect future research activity by nurses.

As nurses make up the greatest part of the health care workforce, their safe practice, innovation and contribution to service improvement are going to be significant. In order to achieve the potential of nurses as 'culture carriers' there must be changes to University education programmes, renewed focus to ways of working in the clinical setting and a response from those who would fund and undertake research.

How did we get to where we are? A timeline of events illustrates a recent story during the last decade.

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Figure 1: A timeline of selected developments in patient safety and service improvement - a UK case study.

2003 – Institute for Health Improvement (USA) introduces a programme - 'Transforming care at the bedside'

2004 – Safer patients initiative (SPI) introduced by the Health Foundation (UK) in tandem with the Institute for Health Improvement

2005 – Luton and Dunstable NHS Trust (UK) introduce an 'Exemplar Ward' to support the Safer Patients' Initiative

2007 – A programme is developed by the NHS Institute for Innovation and Improvement – 'Productive Ward – releasing time to care' a reflective development, building on work from the IHI and The Health Foundation

2007 – Building on the work of the Health Foundation patient safety programme the NHS Institute launches a programme -'Leading Improvements in patient safety' (LIPS)

2008 – A 'Patient Safety First' campaign is established by the National Patient Safety Agency, the Health foundation and the NHS Institute

2010 – The UK Chief Nurse and the NHSI introduce a series of 'High Impact Actions' for nurses through which they can take significant actions on patient well-being and safety (and reduce waste).

2012 – The UK Government introduces a new policy document 'Innovation, health and wealth'

This figure shows a systemic historical progression of developments in approaches to improvements in patient safety in one country. In the UK a health policy think tank - the Institute for Healthcare Improvement (IHI) set the ball rolling with a programme of work to Transform Care at the Bedside (TCAB) this programme encouraged nurses to look again at the way they worked and taught them how to redesign the processes of care in order to ensure safe and reliable care.

The Health Foundation developed the Safer Patients Initiative (SPI) with IHI and set aspirational goals around harm reduction. As part of an SPI programme Luton & Dunstable Hospital developed the 'Exemplar Ward' as a way of helping nursing staff to improve the safety of the care they provided. It evolved into the NHS Institute's Productive Ward programme with the strap line "Releasing Time to Care". The Improvement In Patient Safety (LIPS) programme built on learning from the Health Foundation's SPI and from the work of the IHI. When the Patient Safety First campaign was established, LIPS also helped teams with practical improvement and implementation skills and it was noted that the LIPS teams were particularly successful with their campaign efforts to improve safety.

The United Kingdom Chief Nurse developed work to define 'high impact actions' in which nurses in particular could make positive changes (NHS, 2009). This work identified 8 areas for sustained improvement by nurses. The 8 areas are; - Your skin matters-no avoidable pressure ulcers, staying safe – preventing falls, keeping nourished – getting better, promoting normal birth, important choices – where to die when the time comes, fit and well to care – reducing sickness and absence in nursing, and ready to go – no delays in discharge.

As useful illustrative examples three of these impact actions are listed here with a short observation on each. Although the examples are from acute general care there are significant indicators that community and primary care can offer illustrations that are just as telling, indeed the necessary (but sometimes poor) collaboration between hospital and community care services can significantly affect the high impact action list.

One action is to avoid pressure ulcers in care settings. This well reported problem (Clark, Bours, Defloor, 2004) has been estimated to cost up to £600,00 to £1. Million per year in one average sized acute hospital each year in the UK (Touche 1993).

It has been suggested that if the incidence of pressure ulcers can be reduced by 50% then significant savings (in bed days and remedial treatments) can be made. Action to effect this change clearly relates to the work of nurses.

A second action relates to the prevention of falls. In the United Kingdom there are estimated to be up to an average of 24 falls by patients in acute care hospital each week (National Patient Safety Agency, 2007). The associated mortality and morbidity has significant consequences and up to 10% of falls will result in people dying within one year (Help the Aged, 2008). Safe environments for that care are clearly the business of the nursing profession.

A third action is that of patient discharge from hospital. In all, 'simple discharges' make up 80% of the total of all discharges. (Lees, 2004). Delays to discharge can cost up

to £440 per patient day and there is significant evidence that delays to discharge are often unrelated to clinical need and that it is more likely to be related to organisation competence. It has been estimated that a reduction in length of stay for patients of between two and six days per patient could save a nations health care bill up to £15.5 and £46.5 million per year. (National Audit Office, 2000). Simple solutions led by nurses can dramatically and positively affect patient experiences and contribute significantly to cost economies (Chatterjee, 2004).

These illustrations offer clear evidence that the work of nurses is central to patient safety and their successful recovery but also has cost implications for health care systems.

These three illustrations offer telling insights into clinical situations that are led and overseen by nurses.

Improving our understanding of the safety of patients and the part that health professionals play has become important. Two examples that follow here are examples of programmes designed to change how health care organisations and nurses and doctors think.

Example one – Improving patient safety

In 2004 the Health Foundation commissioned IHI to work in partnership to run the Safer Patients Initiative (SPI). SPI was developed to test practical ways of improving hospital safety and to demonstrate what can be achieved through an organisation-wide approach to patient safety. The programme had ambitious and stretching goals to improve safety. The first phase of the programme, launched in 2004, brought four UK hospitals together to test ways of preventing harm from routine care by making clinical processes more reliable. They introduced a range of interventions in particular clinical areas, with a focus on strengthening the role of executive leaders to create a culture of patient safety. The programme had a significant impact on the care provided in participating hospitals and on their staff. It provided the foundation for subsequent programmes to improve patient safety.

'Leading Improvements in Patient Safety' (LIPS) is such a programme now underway in the UK. It is one example (there are a number of others) of a programme which is designed to try to reduce the 'avoidable harm' so often seen in health care systems. Teams of staff from hospitals and community services have been extensively exposed to safety improvement education with the aim of dramatically reducing harm. A nine month modular LIPS programme works with teams from organisations. This is in recognition of the need for both top down and bottom up approaches to achieve real service transformation. The overall purpose is to raise awareness of the levels of harm, to build a sense of personal commitment to positive action and to develop an organisation that will support improvement efforts in a proactive manner.

In a first module; 'Getting Started' the programme takes a team of doctors and nurses through the principles of measurement for improvement. This focuses on real time measurement to help teams see the impact of their improvement efforts. Teams also learn about case note review and the use of trigger tools to generate a measure of harm for their organisation.

The next module takes the organisations chief executive and team through an Executive Quality and Safety Academy. During this very practical two days the teams set an ambitious system level aim relating to safety improvement, for example to halve rates of harm as measured by a trigger tool in a two year period.

The third, five day core module is attended by the whole clinical team and focuses on improvement science. Teams learn about reliability, human factors, system capability, the model for improvement and how to align their efforts to deliver the system level aim. High impact interventions are considered and include: falls reduction, care of the deteriorating patient, harm from medication, elimination of pressure ulcers and healthcare acquired infections. A proposed action plan is then discussed with their Chief Executive on a final day.

Follow up events support the teams as they experience the challenges of implementing change in the real world of a busy National Health Service. They offer the chance to learn from each other and to receive guidance on how to move forward.

It has been reported that in tandem with other strategic measures, these positive changes save lives and produce dramatic benefits to cost savings. (Leonard, Frankel, Simmonds, 2004)

Example two - developing organisational productivity with nurses

A second example offers a systemic model of organisational change and development led by nurses. In England an organisational development programme called the Productive Ward has seized the imagination of nurses, their employers and Government alike (National Nursing Research Unit, 2009). A USA version

developed by IHI is known as Transforming Care at the Bedside (TCAB). This programme focuses on four themes: Safe and Reliable Care, Vitality and Teamwork, Patient Centered Care, and Value-Added Care Processes. The underpinning belief is that teams need to work on all four streams simultaneously in order to achieve transformation of care.

Using these tried and tested techniques developed in the UK and USA, the 'The Productive Ward' programme was developed. Its evaluation has proved to be both significant and positive. (National Nursing Research Unit, 2009).

In summary this programme allows staff, following suitable training to introduce an improvement programme into wards and departments. There are several targets for action. They include patient hygiene, nursing procedures, ward rounds, patient observations, admissions and planned discharge, shift handover, meals, medicines and common understandings about patient status. Using such techniques as interviews, group discussion, a video 'waste walk' photographs and 'incident timing' has led to the whole sale reorganisation of wards and departments

Examples serve to make useful illustration. In seeking to improve mealtimes for patients productive wards do not allow other activities to interfere with delivering proper nutrition to patients. Doctors are banned from undertaking patient examinations and therapists must schedule treatments so that they are outside meal times. In the delivery of medications, a specific nurse is often identified to be in charge of delivering medication to patients. They often wear brightly coloured tabards saying such things as 'Medication administrator please do not interrupt unless you are a patient'. This prevents unnecessary distractions and demands for information from staff who are feeding patients or administering medicines. In a final example, shift handovers are reorganised so that staff are obliged to attend handover meetings and follow a common process of handing over between staff shifts. They sometimes adopt an SBAR system (Situation, Background, Assessment and Recommendation) so that communications are consistent and clear.

Compelling evidence is beginning to accumulate that the Productive Ward offers significant benefits to patient experiences and to staff. National and local evaluations have shown that demonstrable changes occur. There are reports of a doubling of direct patient contact time, 100% of patients thinking that there are enough staff to care for them, up to 30 minutes saved on the delivery of meals, £3,000 pounds worth of wasted stock and supplies recovered, staff sickness reduced by 1% and up to a 90% reliability score on patient assessment ratings.

Can University programmes respond through curriculum development and research?

The arguments for change and organisational and professional development are compelling. However understanding the evidence and developing the existing workforce is only part of the necessary work. A secondary question remains, can skills of improvement, quality improvement and safety be successfully taught in undergraduate programmes thus preparing a next generation of well prepared nurses? The answer is probably yes.

In a sustained project in the UK service improvement skills have been introduced by the NHS Institute for Innovation and Improvement into the undergraduate education programmes of nurses and doctors in tandem with University education providers. In a series of programmes involving up to 30 plus UK universities, improvement skills modules have been introduced and evaluated. Using clinically based mentors, the modules make a contribution to the overall assessment of students and their eventual ward of a professional qualification. Evaluations over 3 time periods show that students have benefited from their new skills and in all probability made themselves more attractive to prospective employers. There have been reported difficulties in making space for this work within already crowded curriculum but it has not stood in the way of these exciting developments. It has been estimated that up to 10,000 undergraduate and postgraduate students in nursing, medicine and the other health professions in the UK will have been exposed to this educational experience. Many of them will have undertaken a formally assessed piece of work as part of their programme. This has proved to be an attraction to prospective employers as students graduate.

Can any of this translate into research action by nurses?

There are significant advances in developing the capacity and capability of nurses to understand, undertake and lead research. Although very well advanced in some countries, questions remain about disconnections between academic nurses and nurses who lead and manage services (Butterworth, 2009; Kim, 2009). The delicate questions of methodology or nursing models agonised over by academic nurses are often of little interest to people in services who are often hard pressed by issues of service delivery, service improvement and patient safety. In order to answer some of these challenges we are beginning to see the development of

clinical academic careers in which nurses pursue careers that are jointly funded or supported by both hospitals and by universities.

It is clear that some of the subjects addressed in this paper lend themselves particularly well to such clinical academic research.

The Academy of Nursing, Midwifery and Health Visiting Research in the UK is a collaborative venture between 13 'research interested' organisations including the Royal College of Nursing and the Royal College of Midwives and their main aim is to *'be an expert collaborative voice for all aspects of research involving nursing, midwifery and health visiting in the United Kingdom, including policy development, its implementation and evaluation through negotiation and dialogue with other key stakeholders'* (Academy of Nursing, Midwifery and Health Visiting Research, UK). The Academy led a work stream featuring a Delphi survey to establish a commonly agreed short list of research questions that could be agreed by senior nurse leaders in service and in Universities. After a two round survey a priority list was identified and a number of agreed relevant areas are shown at Figure two.

Figure 2: Agreed areas of research interest by senior nurse leaders in service and in Universities

Continue research into relationships between skill mix, patient outcomes and costs as they relate to nursing, midwifery and health visiting activity.

Establish research that explores the work of nurses, midwives and health visitors and its effect on patient safety and acquired infections.

Establish longitudinal studies to examine the work of nurses, midwives and health visitors in the development of 'innovation positive cultures that embrace leadership and transformational change.

Establish longitudinal studies to examine the costs and impact of nurse-led interventions and treatment on long-term conditions.

Cost effectiveness of the work of nurses and midwives undertaking community-based rather than hospital-based interventions and treatments.

Research to develop models of education and its delivery in the light of the implementation of an all-graduate profession.

Source: Academy of Nursing, Midwifery and Health Visiting Research, UK

It is clear from this list that there is common understanding about the importance of innovation and patient safety. Questions remain however. Are these questions suitable for research, how do we properly take on board the views of people who use services, can we further refine the questions and seek funding and what experiences are there of understanding and developing 'uncertainties' in research questions?

Much of this 'unpicking' process has undoubtedly been stimulated by a better understanding of nurses about issues arising from strengthening our capacity and capability in safety, innovation and service improvement.

Universities are now beginning to see value in focussing their research energies on innovation, improvement and improvements in patient safety. There is much to learn within and between countries. This conference is proof that national and international collaboration can develop and share research, practice and education together.

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EVIDENCE-BASED PRACTICE AND THE COMPLEXITY OF INTERVENTIONS IN HEALTHCARE

NA DOKAZIH UTEMELJENA PRAKSA IN KOMPLEKSNOST INTERVENCIJ V ZDRAVSTVU

PETER CALLERY

Abstract

Introduction: *The term "evidence based practice" has wide relevance and importance in nursing and health care more generally. Evidence based practice provides a model for rational decision making.*
Methods*: Narrative review of key texts to identify principles and procedures of evidence based practice and consideration of their application.*
Results: *A key element of evidence based practice is the identification of clinical uncertainty and the formulation of questions using the Patient Intervention Comparison and Outcome framework. This provides a basis for systematic searching and appraisal of research literature in order to identify the best available evidence to guide practice. Much of nursing should be understood as "complex interventions" which comprise multiple, interacting components.*
Discussion and conclusions: *There are challenges for nurses to making the ideals of evidence based practice reality. These include the need for a stronger evidence base, recognizing that much of nursing consists of complex interventions, and implementation into the organization of nursing care.*

INTRODUCTION

Evidence based practice should be central to nursing practice, as stated in the International Council of Nurses code of ethics: "The nurse is active in developing a core of research-based professional knowledge that supports evidence-based practice"(International Council of Nurses, 1953, revised 2012). This paper reviews the definition of evidence based practice and examines issues in implementation, with particular consideration of the issues arising in "complex interventions" which describes much nursing practice. Implications for research to develop and evaluate nursing interventions are considered.

METHODS

The approach adopted is a narrative review of key texts to identify principles and procedures of evidence based practice and consideration of their application. This includes consideration of the definition of evidence based practice and its application in nursing.

RESULTS

Evidence-based practice has been defined as "the application of valid, relevant, research-based information … used alongside our knowledge of our patients (their symptoms, diagnoses and expressed preferences) and the context in which it is made (including the care setting and available resources)" (Cullum, 2008) p.2. The first stage of evidence-based practice is to identify uncertainties which are converted into focused, structured questions, in order to direct a search of the literature to identify relevant research evidence, which is critically appraised for validity and applicability. The best available evidence is used alongside clinical experience, the patient's perspective, and available resources to plan care and the outcomes of care should then be evaluated (Flemming, 2008) p.18. The logic of these principles is widely recognised although it is suggested they often remain an ideal rather than a reality (Heneghan and Godlee, 2013).
Central to evidence based practice is a set of principles and procedures for searching and assessing research literature. The first step is to identify the clinical uncertainty "what is the best evidence about how to care for this person?".

A key step is to formulate a clearly focused question to guide the approach to searching the literature for evidence. Questions can be expressed in terms of four elements, using the PICO framework (Sackett et al., 1997):

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1. Patient
2. Intervention
3. Comparison
4. Outcome

A systematic review can then be designed to search comprehensively for all the relevant research.

This approach is illustrated by an example from the field of communication. Some practitioners have tried to provide patients with recordings of consultations. Patients may listen to these recordings at home, either on their own to remind themselves of what was said and to check their understanding, or perhaps to share with family members. The clinical uncertainty is whether this is helpful to patients: does it help them to recall important information, and to discuss decisions with their relatives? Is this more helpful for some patients than others, and are there any patients for whom it can be harmful? The authors of a systematic review used the Cochrane approach "to examine the effects of providing recordings or summaries of consultations to people with cancer and their families" (Pitkethly et al., 2008). The participants included adult or child patients diagnosed with cancer and their close families. The intervention was giving a video or audio recording to patients to take home so that they could listen again to what was said. The authors wanted to compare this with giving written summaries of consultations, although there were not enough studies to make this comparison. The outcomes included information obtained, recalled and level of understanding and their experience of health care. Data on participants' uses of recordings and summaries, and their perceptions of their usefulness, were also extracted. Systematic methods were used to search for studies and to assess their methodological quality. This was a substantial task, which involved searching PubMed, Medline, CINAHL and others making a total of 40 databases, using 45 searching steps in which individual keywords were searched alone and in combination. Thirty seven studies were considered in detail and from these sixteen met the requirements for inclusion in the review. Of these many were found to have small sample sizes and there were variations, which limits the strength of the evidence. However, the authors concluded that "the use of consultation tapes and written summaries is probably helpful for many patients, but not all." (Pitkethly et al., 2008). The evidence is not yet clear, however, as to which group of patients will benefit most from receiving summaries/recordings. This was a Cochrane review and so the studies selected were Randomised Controlled Trials (RCTs) and quasi-randomised controlled trials. A hierarchy of knowledge about the effectiveness of interventions identified the best types of evidence in turn as: 1. systematic reviews, 2. RCTs, followed by other designs, including cohort studies, case control studies and cross-sectional surveys (Muir Gray, 1997). This may not apply well to all health settings and it may be necessary to consider matching other design to different research questions (Petticrew and Roberts, 2003).

While this example shows how a systematic approach can be taken to identify evidence, it also illustrates some important issues that explain why evidence based practice remains an ideal rather than a reality (Heneghan and Godlee, 2013). The first issue is the limitations of the evidence that the authors were able to retrieve: most studies were small and comparing studies was complicated by their differences. This is a recurring issue which "leaves us with increasingly sophisticated methodological tools but not the raw materials (reliable data) to answer with certainty some common clinical questions" (Heneghan and Godlee, 2013). Although the evidence about giving recordings to patients may not be definitive, it could be considered clear enough to justify a practice that has low costs and risks. While it is conceivable that some people may be upset by listening to a recording, this is within their control because they can choose to stop or not to listen at all. Despite the evidence of benefits, only some centres offer patient recordings of consultations and research is in progress to find out what are the barriers and facilitators to their use (Hack et al., 2011). This is an approach called "implementation science" which is becoming increasingly important in nursing. It is the focus of a forthcoming special issue of the International Journal of Nursing Studies, which includes studies of common nursing problems including: preventing falls, hand hygiene, pressure ulcer prevention, medication adherence and administration, tracheostomy care, pain assessment and oral health, but the editor describes a "critical void in the evidence to support nursing practice and organization" (Sales, 2013). The reference to organisation of care highlights that it can be important to consider the context in which an intervention is to be delivered. Implementation of evidence based practices may require changes to the organisation and delivery of care. The most appropriate research designs for these questions may be case studies to examine the way in which care is delivered and to identify barriers and facilitators to implementation, and organisational issues that need to be addressed in order to change the delivery of care in practice.

One of the key points to recognise is that much nursing and healthcare practice involves "complex interventions" which include "a number of separate elements which

seem essential to the proper functioning of the intervention although the 'active ingredient' of the intervention that is effective is difficult to specify"(MRC Health Services and Public Health Research Board, 2000). The 'active ingredient' of a medicine can be isolated and compared with a placebo in a RCT. Much nursing cannot be reduced to a single ingredient that is given in the same way to all patients. Researching complex interventions can require a programme of research which includes a series of studies to develop and evaluate the intervention (Craig et al., 2008a, b). It is important to identify or develop the appropriate theoretical basis for the intervention. Studies may then be required to establish the feasibility of the intervention in practice and the outcomes that should be used to assess its effectiveness. This provides a basis for studies of the effectiveness of the intervention, perhaps by a RCT. The implementation is also a subject of study: how can the intervention be made to work in practice? Different research designs and methods may be required at different points in the programme. Qualitative methods may be appropriate to explore the perspectives of patients and practitioners about what form of intervention would meet their own needs and goals and be feasible within everyday practice. A combination of quantitative and qualitative methods may be required to identify the 'active ingredients' of an intervention and the most acceptable form of delivery.

DISCUSSION AND CONCLUSIONS

Evidence based practice is a key goal for nurses and is recognized internationally as an expected standard of practice. The principles are clear and compelling: that decisions should be made rationally on the basis of the best evidence available. There are well developed methods for searching the literature and assessing evidence. However, there are important challenges in making the ideals of evidence based practice a reality. These include the need for more research to provide a stronger evidence base for nursing care. In addition, the emerging science of implementation is concerned with how evidence based practice can be applied in organizational settings. It is important to recognise also that much nursing and health care involves does not have a single "active ingredient", and so programmes of research using a combination of methods to develop, evaluate and implement these complex interventions.

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TAKING THE TEMPERATURE: THE STATUS QUO OF NURSING PRACTICE AND CARE OF THE OLDER PERSON IN WALES

STATUS QUO V PRAKSI ZDRAVSTVENE NEGE IN OSKRBI STAROSTNIKOV V WALESU

LORRAINE MORGAN

Abstract

This paper provides a background to the development of a Position Statement on Nursing Practice and Care of the Older Person. It is based on informal research undertaken by the Welsh Nursing Academy (WNA) Council members because of their concerns about UK and Wales reports on the poor quality of nursing care for older people. Also they wanted to inquire further as the current knowledge and models used which underpinned practice. They wished to find evidence of the status quo, then share, debate and research further.

Relevant UK social policy, gerontological nursing research, campaigns and adverse reports on poor practice over 15 years were reviewed in order to establish an idea of the current state of gerontological nursing in Wales. An ethnographic approach (Polit, Beck, Hungler, 2009) was then used to facilitate open participative (Cornwall, Jewkes, 1995) workshop discussion with nurses around Wales. Finally participants and older people were invited to two public seminars to debate with government officers, senior nurses and gerontology academics the first results in 2010 and then the Position Statement in 2012.

The workshops summary showed that there was a concern for the deprofessionalisation of nursing knowledge and skills, a poor understanding of ageing and working with older adults, and a lack of use of evidenced gerontological models. The conversational public seminars indicated a continuing lack of evidence of engagement with the older person or recognition of the principles within the Strategy for Older People (Welsh Government, 2003) or indeed the United Nations (UN) Principles (UN, 1991).

The Position Statement provided 6 key points to address, defined and illustrated how the unique function of the nurse (Clark, 2003) relates to relationship-centred care, and The Senses Framework (Nolan et al., 2006) as the model of good practice to use. It finally requested that nurses address, in their practice, the important principles of the worldwide unique Wales Strategy for Older People.

BACKGROUND

The Welsh Nursing Academy is an independent nursing association in Wales, and is committed to the development and improvement of nursing services (WNA, 2005). It has now merged in order to strengthen its organizational base with Sigma Theta Tau International, the Honor Society of Nursing, as a Special Interest Group concerned with the nursing of older people.

It was originally set up as a result of the 1999 Strategic Framework for Nursing, Midwifery and Health Visiting from the National Assembly for Wales following devolution. In 2004 Health Professions Wales, a government body was given a remit to facilitate and provide support to establish the Academy and in 2005 it was launched.

WNA established some unique Master Classes and in 2010, and after a successful public Master Class in 2008 around Wales on nursing practice and the older person (Morgan, 2008) it was decided by WNA Council to focus for the next two years on scoping nursing practice and the older person further by undertaking some literature review and participant workshops around Wales with National Health Service (NHS) nurses.

Rationale

Gerontological nursing is often viewed as unchallenging and is rarely a positive career choice for student nurses following their qualification as registered nurses (Brown et al., 2008). Issues of recruitment and retention in gerontological nursing is a global phenomenon (Nolan et al., 2011) and according to Professor Nolan's longitudinal

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research begun in 1996 (Brown et al., 2008) students are often exposed to 'impoverished' environments of care in which they witness poor standards of care and negative attitudes towards older people. Nolan goes on to describe what an enriched care environment should contain through his seminal research into the development and use of the 'Senses Framework' and a relationship-centred approach (Nolan et al., 2006). This Framework, which is for care workers, older people and their supporters, has now been researched in the NHS and care homes and is based on the 6 senses of:

- "Security – feeling safe and free from threat.
- Continuity – skilful use of knowledge now and from the past.
- Belonging – meaningful relationships and to feel a 'part' of things.
- Purpose – sense of direction, a feeling of purposeful activity.
- Fulfilment – meeting goals, feeling satisfied and achieving.
- Significance – feeling recognised, valued and that you 'matter.'"

This Framework had already been adopted as the model to use for My Home Life (My Home Life, 2006) and within an action research programme for care homes called My Home Life Cymru funded by Welsh Government from 2008 (My Home Life Cymru, 2008).

However, it should be argued that nursing practice and older people should not now be a specialist area of clinical nursing or indeed only recognised within nursing care homes for older people. This is because it is a clear fact that older people (over 60) are significant users of hospitals in Wales, accounting for 47% of inpatient admissions in 2009 and 2010 (Older People Commissioner Wales, 2011).

Working with older people is a core role and has core skills for all those studying to become registered nurses, as well as continuing to practice and professionally develop in all care environments. It is considered that core knowledge on ageing and working with older people is required for all nurses now. These were the main reasons for the WNA Discussion Event 2010, the others being around the various research and reports (House of Lords, 2010; Nolan et al, 2004; RCN, 2005; SNMAC, 2001) into nursing practice and attitudes towards ageing and older people.

The WNA wanted to identify good practice from nurses around Wales as well as raise awareness of this crucially important subject area. It was vital that the nursing family showed that they are ahead of the demands from older people in Wales about high quality and equitable nursing practice. The announcement from the new Older People Commissioner that her first review was into the care of older people in hospital was significant. UK Parliament had already identified a lack of human rights approach to healthcare in the UK through the House of Lords Report (UK Parliament, 2010). Dr Win Tadd's European research into Dignity (Woolhead et al., 2004) confirmed the necessity and urgency.

METHODS

Four WNA Council members undertook this small research study in a voluntary capacity, 3 were academics and one Nurse Executive. It was therefore recognised as informal research but nonetheless important. They used a participatory research methodology to offer workshops for all NHS Wales regional boards, the nurse population in Wales being just under 22,000 (Welsh Government, 2011). Nurse executives for each region were contacted between June and November 2010 and invited to offer venues and dates and invite nurses working in the NHS and local nursing homes. Out of 7 regions 6 responded, 1 area refused. Eventually 5 open workshops were conducted with participants attending and leaving each workshop during its presentation depending on shift pattern. The invitations included an assurance of anonymity both for individual comments and as a regional group. Content of the workshops was a presentation on the timeline of social policy, UK national campaigns, adverse reports on healthcare practice and professional organisations attempts to change practice for the better. A presentation was also given on managing nursing practice in acute settings.

Finally participants were given three questions to answer and discuss:

1. What do nurses do well when working with the older person?
2. What nursing practice could be improved?
3. What are the barriers to providing good nursing care?

The issues raised from workshop discussions were then presented at a public seminar in December 2010. All eight Nurses Executives and all 5 Deans of Schools of Nursing were invited and a panel including senior and director representation from government, Royal College of Nursing, Gerontology and Ethics Researchers, Older People organisation, and the Older People Commissioner debated the results that were presented.

After the first Seminar in 2011 workshops were also held at a My Home Life Cymru conference with nursing home staff using the same NHS workshop format and the 3 questions were sent out to nurses in the nursing home sector.

The limitations of this study was that it was voluntary and unfunded, and not statistically significant, although the latter point is similar to the Dignity Research undertaken by the RCN in 2009 where there was little response from RCN members.

Finally for the Position Statement and each statement in the summary of issues that nurses raised, some research evidence where available was stated to underpin what the nurses were saying from their own experience.

RESULTS

There is a wealth of information and research on challenging and reporting poor nursing practices and care of the older person. The workshop presentation was based on studying 15 years of evidence and producing a timeline of reports.

In 2001 the Standard Nursing and Midwifery Committee for the UK published a very important report called 'Care of Older People: a Nursing Priority' (SNMAC, 2001) which detailed what should be done to tackle poor nursing practice, particularly in hospital. No evidence was found to suggest that this report was actioned.

In 2001 onwards malnutrition in hospitals and elder abuse was debated at RCN Congress, the RCN Strategy for Nursing Older People written with older people and nurses in 2002/4 (RCN, 2004), and a pan UK report with nurse academics, gerontologists, Age Concern and RCN on nurse education and working with older people published in 2005 (RCN, 2005).

Between 2005 and 2009 there were various critical reports on elder abuse in hospitals and care homes and A Dignified Revolution was set up in Wales by three nurses in 2008 (Dignified Revolution, 2008) but spanning the whole of the UK in its activities. In 2009 the Nursing and Midwifery Council (NMC) the UK Nurses regulatory body was commissioned by a funding benefactor to develop some guidelines on principles for nurses working with older people. These were published in March 2009, but they were not mandatory and were not mapped illustratively against the statutory code of practice. In Wales despite an overarching and unique Strategy for Older People there was no government gerontology nurse to focus solely on policy guidance and support for nursing practice and the older person, as there was at the Department of Health in England, despite a Wales Strategy.

There are only a few NHS Wales Nurse Consultants in Wales specialising in aspects of working with older people and there is no clear evidence that learning about older people nursing practice is an All Wales approach to student nurse education or to the professional updating that is required for all nurses in practice (Care Council for Wales, 2010).

Older People in Wales are knowledgeable, experienced and represent the majority of the population in Wales (Older People Commission, 2012). They are not a homogenous group who should be identified as 'frail' and 'elderly'. As people age they may require support and care to continue with their interests as best they can. Was there anywhere where they and their carers could enquire as to where good nursing practice examples exist when they needed these?

DISCUSSION

The Position Statement is based on WNA discussions with nurses in the NHS and independent sector, as well as older people, during workshop and other focus group sessions 2010-11. UK nursing leadership initiatives had already been produced but the WNA believed that more specific emphasis and action for older adult nursing was required.

In workshops and seminar discussion the nurses seemed very worried about the deprofessionalisation of their knowledge and skills, in particular their lack of knowledge about what the WNA had presented as the evidence based for gerontological nursing in their workshops.

In the workshops a history of key reports of concern, research on practice was offered and attendees were reminded of the key principles and codes already developed. They reflected on 3 key questions using activities to collate and move information around for discussion. Most of the summary statements of their answers below can be supported by research and practice evidence over the past 7 years, so some references were included.

1. What did nurses do well when working with the older person.
    a. Nurses stated generally that they wanted to know about and share good practice. They spoke about using their own professional

organisation's web resources but not necessarily using these. Care home nurses used employers' membership organisation and the My Home Life Cymru networks.

b. There were local NHS initiatives by some nurse leaders that refocused everyone on the core values and implementing into practice, using, for example, the RCN online Dignity Tool (RCN, 2009) and local NHS Wales Dignity information.

c. Nurses who worked in Care Homes felt that nursing care was much more individualised and relationship centred. They felt that there was much more job satisfaction in what they could achieve in practice.

2. What nurses said could be done better.

a. Nurses were very concerned about staffing levels and skill mix which they strongly felt were not appropriate to NHS hospitals that now contain a significant majority of patients over the age of 65, and with multiple and complex acute and chronic conditions. (Tadd et al., 2011)

b. They felt that nurses had been deskilled. One nurse said that 'we now only provide Task and Finish nursing.' They said that local nursing assessment documentation for admission to NHS services (part of the Wales unified assessment process) overrides the use of specific gerontology nursing approaches to care planning, and focuses too much on 'activities of daily living.' Care plans had been reduced to lists of tasks.

c. They felt that all nurse leaders and Universities need to provide core education and post qualifying learning relating to ageing and/or working with and nursing the older person. Mentioned were issues around supporting people with dementia, and specific gerontological nursing practice (RCN, 2005).

d. They felt that there needed to be a stronger recognition that care for the older person is not just patient centred, or indeed person-centred, but relationship centred. Some nurses were clearly aware of evidence-based gerontology nursing models but did not feel empowered to use it consistently.

3. What nurses said were the barriers to good practice.

a. Nurses felt that there was still a low value placed on working with the older person even though the older person was the typical acute NHS patient. (Tadd et al., 2011).

b. Care Home nurses continue to feel excluded from All Wales nursing discussions and leadership. They also felt that NHS and Care Home gerontological nursing practice development lacked leadership and felt unsupported by government, regulation and inspection actively. 'Who do we go to in Wales to support our development of practice and working with the older person?"

c. There were stereotypical attitudes and default language – such as 'dear', 'love' or as a group – 'the elderly' rather than formal address such as Mr, Mrs or Ms or 'older people' - used towards the older person in general, in nursing practice and in medical practice and NHS management. This was not challenged appropriately.

d. They still felt that Nursing had little teeth to actually change practice. Comments included "We just have to go with the flow of the latest flavour of the month." "There seems to be only action for change when it is mandatory to do so - or there is an investigative report."

e. Care Home nurses felt that the objectives of profit driven care, and inaccurate costing of care, overrode any development of nursing practice in some care homes.

THE FINAL POSITION STATEMENT

There were 6 key principles that developed from this secondary literature review; workshop and seminar discussions and these are contained in the actual Position Statement.

1. The typical NHS patient is an older person therefore a workforce based on safe staffing levels and a needs-led skill mix is imperative.
2. A major shift of thinking and culture is needed. Strong effective leadership and challenge is needed at all levels by clinicians, managers and policy makers to achieve this at all times and applies to all nurses, from the most junior nurse to the most senior manager.
3. There should be a strong relationship and regular communication between nurses working in all environments of care, including housing, with a common focus on gerontological practice.
4. A workforce based on safe staffing levels and a needs-led skill mix is imperative.
5. The Wales Strategy for Older People needs to be alive and embedded in nurse education, practice and the monitoring and evaluation of practice, as well as management.
6. The public and policy makers in Wales must recognise the 'unique' function of the nurse, as set

out in Virginia Henderson's accepted definition of the unique function of a nurse utilised in the RCN definition of nursing (Clark, 2003). This function must be valued and nursing knowledge and skills used before these are lost.

This "unique function" of the nurse is the essence of nursing practice and is especially important for the older person. This is included in gerontological models of nursing. It depends fundamentally upon:

a. Knowledge about the older person as a unique individual, their background and history, their relationships and their environment; this is what is meant by Relationship-Centred care.
b. Understanding of the individual's strengths, needs, wishes and preferences, as derived from a full assessment guided by a human rights approach; with kindness, compassion, empathy and respect; this is what is meant by individualized Person-Centred care.
c. Use of a gerontological model of care which supports the individual's autonomy and dignity and includes assessment for personal care as an integral part of health, wellbeing, relationships, biography and nursing care;
d. An individualized care plan (not a task list) developed in partnership with the older person, with specified care outcomes including the promotion of health and independence, and always monitored.
e. The highest quality personal and clinical care as derived from up-to-date knowledge and skills supported by strong values, knowledge, evidence and experience."

The time line of reports presented to nurses seemed to suggest that the status quo of nursing practice and the older person had changed very little since the UK Standing Nursing and Midwifery Committee (SNMAC) report in 2001. However, this is far too simple, a statement and further work needs to be undertaken with older people as partners in terms of finding out where good gerontological nursing research into practice exists in Wales, and who are the leaders and innovators for change.

The next steps to make this Position Statement alive and embedded into nursing education and practice in Wales is to meet regularly with the Older People Commissioner who supports this Statement and has provided further media messages for Wales nurses. Interestingly despite some very important and influential panel members at the first Seminar none of the 8 Nurses Executives or the 5 Deans of Schools of Nursing attended. The Position Statement was also sent out to all the above senior nurses but no comments on its structure or content were received.

The intention also now is to discuss further with the Chief Nursing Officer for Wales how the Senses Framework can be adopted as the evidence based model of choice for nurses working with the older person using NHS services in all environments of care provision.

The Framework is already promoted for use in the care home sector in Wales through the My Home Life Cymru programme of action and strongly supported by the sector's Chief Inspector from Welsh Government as well as Wales' Older People Commissioner. It is therefore an anomaly that this evidence based model, adopted in other nations around the world is not seen to be used in NHS services in Wales.

The Older People's Commissioner said on 20/11/12 about her discussions with older people 'It is the little things that really matter'.

CONCLUSION

The WNA support this further and say that knowledge on ageing and gerontology practice, skills, partnership and compassion and kindness for every older person should be part of every contact between a nurse and an older person. Kindness and compassion always and the WNA is providing the discussion, the means and the key principles to begin a journey which develops and changes the quality of contact that older people have with nurses and nursing practice in Wales.

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WRITING FOR PUBLICATION IN INTERNATIONAL JOURNALS

PISANJE ZA OBJAVO V MEDNARODNIH REVIJAH

VERENA TSCHUDIN

Abstract

This presentation describes the process of publication of articles from the first decision to write to acceptance.

The presentation is written in the form of points to remember, or a checklist for students to use in the process of writing, from the preparation necessary for successful writing, the items to pay attention to while writing, to how to deal with submission, reviews and proofs.

The presentation is envisaged to consist largely of a dialogue with the audience with questions and answers, especially on the topics presented.

WRITING FOR PUBLICATION IN INTERNATIONAL JOURNALS

Preparation

Write about what you know and have experienced.

Decide who your readership will be: students, peers, general readership.

- Is the topic you want to write about relevant to a national/local/international readership?
- Why is your topic/article important and relevant to an international readership?

Chose a working title for your article.

For which journal is the topic suitable?

All journals have a different emphasis; choose which one to use.

If possible, look through some of the relevant journals in hard copy and always read their objectives, mission statements, aims etc. online.

Decide in which journal you would like to publish and why.

Write abstract, avoiding giving geographical details other than country or district.

If necessary, send the working title and abstract to the editor of the preferred journal and ask if your topic is relevant for the chosen journal. Editors are always willing to advise.

Composing your article

Start writing with what is easiest.

Make 1-2 points per article only.

Write the article, keeping to the author guidelines and information.

- As an editor, nothing is more irritating than receiving an article that does not keep to the guidelines (too long/short, wrong reference system, below/above the general level of readership).
- Words/pages (USA pages, ROW words; 300 per A4 page).

Put in page numbers.

Make an outline:

- Remember: all written work should have a beginning, middle and an end.
  Introduction/Background/what prompted the writing.

Research:

- Background.
- Literature review.
- Objective.
- Methodology.
- Results (if quoting examples from recorded interviews, avoid using all the hesitations, (‘hmmm’) and filling words (‘you know’).
- Discussion.
- Conclusion/summary: say something new and avoid repetition.
- Recommendations.

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Keywords (for Google).

Use of headings: short, clear, factual.

- 2-3 main headings
- A-B-C headings.

Short, clear sentences and simple language. Do not use abbreviations ('don't').

Use Tables and Figures only if necessary and useful.

- Make them clear, not complex.

Avoid 'filling' words; 'moreover', 'as mentioned before'.

Approximately 70 Refs (for research articles), 80% from within the last ten years;

- References are vital; must be correct in every detail.
- Do not use Endnotes.

Be aware of plagiarism.

Ask friends to read your text for general comments.

Ask someone to check your text for language. It is the author's duty to submit a text in good English/the language of the publication.

Do not include acknowledgements to people at this stage.

Finally: re-write the title: clear, less than ten words (short articles are read more readily than long ones), avoid using your country name in the title (put this in the abstract).

Re-write the abstract: to be a summary.

Researchers read mainly the abstract, first paragraph and conclusion.

Journals have various clauses for 'Conflict of Interest' disclosure that have to be followed.

Submission and beyond

Submit the article as required (online).

If you do not have an acknowledgement from an editor within six weeks, withdraw your article and tell the editor.

Usually an editor will acknowledge and give indications of the review process.

Dealing with review comments and re-submission:

- Reviews hurt: read them, then put aside for a few days and read again.
- Important: reviews are about the work, not the author. Do not take criticism personally.

Reviewers are chosen for their expertise in your particular field. All reviews are anonymous. Try to avoid giving your identity away in the article (through references). Reviewers can be mistaken. Normally two reviewers are asked. When their comments disagree, a third reviewer is asked by the author.

The author is and remains the expert on the subject.

- Make the required changes and justify why some changes are not made or not necessary. Changes necessary are usually indicated as 'minor' or 'major' on the review.
- Re-submit the article as required by the journal, within the time-scale indicated.

At this stage include any acknowledgements to people and/or funders.

Dealing with rejection:

- Submitting to another journal: adapt the article to the new journal.

Acceptance.

Proofs and proof reading: check for every word, line, punctuation, spelling of names.

- Answer all author queries but make minimal changes only.

Publication and access to your work/journal.

ESTABLISHING A NEW SCIENTIFIC JOURNAL: AUTHORS AWARENESS – AN EXAMPLE OF SOUTH EASTERN EUROPE HEALTH SCIENCE JOURNAL (SEEHSJ)

USTANAVLJANJE NOVE ZNANSTVENE REVIJE: OZAVEŠČENOST AVTORJEV – PRIMER SOUTH EASTERN EUROPE HEALTH SCIENCE JOURNAL (SEEHSJ)

SELMA UZUNOVIĆ

Abstract

A new issue arose with the establishment of new schools—the insufficient and inadequate qualification of professors and assistants for higher level education institutions, which made it difficult to ensure the implementation of high quality education programs. The nurses studying at other undergraduate programs to get their university degree or at post-graduate programs for a master's degree or a doctorate focused their research mainly on management, quality and the perception of nursing, and these programs did not necessarily give them the tools needed for researching nursing from a clinical point of view. A crucial element to be considered by those in charge of accrediting undergraduate and postgraduate programs in nursing is the qualification of professor and assistants at higher education institutions. Publication of research work is essential in order to advance science and to improve health. It is also essential for people pursuing a scientific career. Their recognition as researchers depends on their publications and contributions to scientific progress. Strong adherence to the Instructions (Guidelines) to authors of every particular scientific journal is very important step in the process of succesful submission of scientific work and accordingly it will resulted in avoidance of delying of a conduction of editorial process. Editors of scientific journals should be aware about an importance of strong adherence of all ethical principles declared by International Committee of Medical Journal Editors in order to make nice, good and respectable scientific journal.

Keywords: *nursing, science, research*

INTRODUCTION

The education of nurses at the university level is the basic level of education in nursing and it must be conducted in accordance with the Bologna Process and with other guidelines. Starting from 2005 the qualifications of nurses responsible for general care are regulated according to European directive the European Mutual Recognition of Professional Qualifications Directive which defines European nursing. However, the demands posed by modern society are putting registered nurses under increased pressure for continuous knowledge and skills, which means that the education provided by the EU directive is the basis for further training of nurses to meet the needs of healthy and ill populations (World Health Organization, 2001; European Union EU Parliament and Council, 2005; European federation of nurses, 2007; European Federation of Nurses, 2008).

The development of advanced nursing practice has become a global trend in the last few decades. Bologna Process creates a great opportunity for nursing education at the bachelor's degree level as the entrance level, followed by masters and doctoral academic recognition in all EU countries (Zabalegui et al., 2006).

A Bachelor of Science in Nursing Programme (BSN) is typically either a 3- or 4-year degree program for Registered Nurses. This study programme will provide the knowledge and professional skils required to work as a nurse, as well as provide prerequisites for further academic studies. A registered nurse works with an ethical approach and in agreement with science and experience within many different fields and areas of care with various tasks. The work of nurse can be divided in to three main categories: theory and practice of nursing, research, development and training, and leadership (Cubit and Lopez, 2012; Spoelstra and Robbins, 2010; Wong and Cummings, 2007).

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Nursing science is the major field of study of the nursing programme, and constitutes the knowledge base for the independent practice of the nurse's profession. Nursing as a scientific discipline constitutes a clear patient focus and clinical rooted (Wong and Cummings, 2007). Nursing research provides the practical nursing work with evidence-based knowledge (Park and Cho, 2009). A central part of nursing is the relation between the nurse, the patient and the next of kin. Relations that are characterised by a comprehensive view, an ethical and scientific approach (Park and Cho, 2009; Segrott et al., 2006; Novak et al., 2010).

The graduate of the master degree course deals with the outcomes of reliable research, to participate in research activities and to use scientific working methods and procedures in nursing practice in compliance with ethical principles and patients' rights, putting a particular emphasis on high quality and efficiency (Skela Savič, 2009).

However, a new issue arose with the establishment of new schools—the insufficient and inadequate qualification of professors and assistants for higher level education institutions, which made it difficult to ensure the implementation of high quality education programs. The nurses studying at undergraduate programs to get their university degree or at post-graduate programs for a master's degree or a doctorate focused their research mainly on management, quality and the perception of nursing, because these programs did not necessarily give them the tools needed for researching nursing from a clinical point of view. The professors at higher education institutions must assume responsibility for planning and implementing study programs which will be based on the transfer of knowledge into the clinical environment. A crucial element is the qualification of professor and assistants at higher education institutions (Fulmer et al., 2011).

PUBLISHING IN SCIENTIFIC JOURNALS – IT IS A NEED

A dream of every academic person is probably to create (in her/his local community) a good scientific journal which would present the medical research in the region.

In my case this came true at the 2004. As an active researcher in microbiology at the time, I was accepted an initial idea of the President of Medical Association of Zenica-Doboj Canton to help create a journal and he was promised to take care of the finances. The journal survived all these years and continued its growth with the support and dedication of many colleagues in the country and abroad, as the members of Editoral Board or reviewers.

It was the same happened with the South Eastern Europe Health Scientific Journal (SEEHSJ). The Rektor and Manager of the University ''Vitez'' (the four faculties including the Facluty of Heath Care) talked me into taking the position of Editor-in-Chief of the new journal and promised to take care of the finances. Since our faculty (University) has already established the collaboration with Medical Faculty of University ''Josip Juraj Strosmeyer'' from Osijek, it was happened in the same time a proposal by its vice-dean about an establishing joint scientific journal with me in the function of Editor-in-Chief and a colegue from her faculty as the Assitant Editor-in-Chief.

The main goal of this international, peer reviewed, scientific and professional journal is to present of original basic and applied research from all fields of medicine (general and clinical practice, and basic medical sciences), seeks to promote the development and exchange of knowledge that is directly relevant to all spheres of nursing practice (ambulatory, community and family care, home, hospital, primary and secondary practice, and public health), as well as physiotherapy, sanitary and laboratory engineering, laboratory biotechnology, midwives. Special attention is to invite all undergraduate, master and doctoral students together with their mentors to present their recent works and to share their findings and experiences with others. Moreover, all papers presenting the current situation in high education of nurses in order to define current weekness, as well as future goals, in Bosnia and Herzegovina, as well as in regional and other European countries, based on the experiences of countries in which this process has already implemented very wellcome.

The immediate ambition of the Editorial Team was to make the SEEHSJ the foremost regional journal for all health professionals. However, to achieve this goal, the journal needs continuous support of its readers, including authors and reviewers of submissions that we receive.

Indexing of scientific journals

An inclusion in the abstract and indexing databases increases dissemination of authors' papers because sophisticated linking technologies drive additional traffic to individual articles. This in turn promotes journal brand awareness and subscription sales (Farthing, 1998; Marušić and Marušć, 1999). In order to increase dissemination of authors' papers published in the SEEHSJ I have decided to include it and all its contents free of charge in the Directory of Open Access Journals

from 2005 onwards (DOAJ). This service covers free, full text, quality controlled scientific and scholarly journals. There are now 5021 journals in the directory, and 2063 journals are searchable at the article level.

The SEEHSJ has already been selected for coverage by Elsevier Bibliographic Databases from 2011 (after two first issues published). These include EMBASE (Excerpta Medica), EMNursing, Compendex, GEOBASE, several specialized niche databases and other derivative products such as Mosby Yearbooks as well as Scopus (Elsevier Bibliographic Databases). Launched commercially a few years ago, Scopus, the world's largest abstract and indexing database of scientific and social sciences literature, is already firmly established as the all-science database, with close to 8 million users at more than 500 institutions worldwide.

Since the first issue published in the November 2011 I sent an application for the selection for coverage by Thomson Reuters, which includes Science Citation Index Expanded (SciSearch®) and Journal Citation Reports (JCR)/Science Edition and covers more than 8,000 of the world's most highly cited, peer-reviewed journals from 3,300 publishers in approx. 227 disciplines, from 66 countries (less than 2% journals from developing countries). Journal Citation Reports (JCR)/Science Edition offers a systematic, objective means to critically evaluate the world's leading journals, with quantifiable, statistical information based on citation data and helps to measure research influence and impact at the journal and category levels, and shows the relationship between citing and cited journals. Science Citation Index Expanded (SciSearch®), accssed via Web of Science® provides researches, administrators, faculty, and students with quick, powerful access to the bibliographic and citation information they need to find research data, analyze trends, journals and researches, and share their findings. After three isuues I sent I am expecting the results of the application process (Thomson Reuters, 2013).

WHY SHOULD PUBLISH IN SCIENTIFIC JOURNALS

Publication of research work is essential in order to advance science and to improve health. It is also essential for people pursuing a scientific career (Marušić, 2009). Their recognition as researchers depends on their publications and contributions to scientific progress. Scientists live in a culture of "publish or perish". Researchers should learn not only how to write a scientific paper, but also how to get it published (Marusic et al., 2004). One benefit of publishing an academic paper in a scholarly journal is that someone gets to add new insights to a topic that's currently covered by scholars, and there's a chance that this could lead to advanced career opportunities (Brembs, 2009).

Scientific journals have technical requirements, and authors should make themselves familiar with these requirements. Researchers deserve to have the credit for their work, but only if they have contributed intellectually to it. Ethical standards apply to scientific publication and should be observed by authors, and ensured by editors (Farthing, 1998; International Committee of Medical Journal Editors).

No matter how important scientific discovery is, someone career risks stagnation unless she/he publish. Sharing their findings with the scientific community in peer-reviewed journals for discussion and recognition is key to advancing their career and winning that fellowship or tenured university position (Marušić and Marušć, 1999; Brembs, 2009).

Basic advice

Write the paper, including all key research points and resources. Include these key points: Abstract (an overview of the paper), Introduction (describe what enticed you to the subject, include your thesis statement), Methods (detail the experiment's design and data collection), Results (use charts or tables to simplify collected data), Discussion (list observations that came out of the experiment and what may be changed for further experimentation), and Literature Cited (sources used to explain terms or experts quoted). Consult with a professor or mentor. Have the paper edited. Write a second draft, making needed edits and expanding or simplifying sections as suggested by a professor or mentor.

Write an abstract. Abstracts are a shortened version of the paper that touches on the objectives of the study, how the study was done, what the results were and how the results were significant. Many readers of scientific journals only read the abstracts of articles, choosing to read the full length only of those of specific interest. For this reason, an abstract may very well be the most important part of the scientific paper. While it appears at the beginning of the paper, most scientists write it last (eHow Contributor, 2013).

Gather all of the materials you'll need to prepare the paper. Visit public and campus libraries, bookstores, local historical organizations, hospitals, churches and government agencies' offices. Also choose only materials that pertain to the topic of your research

paper. If you need assistance with seeking materials, meet with your professors or university department dean in your academic specialization and ask if they know of any resources that would be beneficial to you. When you write the final draft, give a clear hypothesis at the beginning of the paper. Also stay away from any subtopics that will move you away from the hypothesis in the paper (Huth, 1990).

Do a literature review and compose an introduction. Organizationally, the introduction moves from the general to the specific.

Create a methods section. This section should provide all of the methodological details required for other scientists to replicate your experiment. It should be in narrative form.

Discuss the results in the discussion section. Refer readers to data that is summarized in the tables and figures that are in the results section. Discuss how data differs from or is similar to previous studies executed on the topic the experiment explores. Suggest future research topics and note any problems encountered (Parks, 2013). Begin your discussion section by reminding your reader of the purpose of your study and what you did to address the issue, and provide a summary of your important results. Although you do not want your paper to be repetitive, it can always be helpful to provide readers with a road map for what they are reading. Tell your readers what you are going to tell them, tell them the information and then tell them what you told them (Huth, 1990; Parks, 2013).

Include a section that addresses any limitations of your study. No study is perfect, and it is important to understand scientific results within their own context. Was there a specific element of the study that could not be controlled for? Do your results not generalize to the entire population in question?

Conclude your paper by reminding your reader of your most important findings and highlighting their most relevant implications.

Cite literature quotes in the reference section. Only include literature you actually used in the paper. References or citations must be made when you use work or ideas that are not your own. There are strict guidelines that must be followed in order to identify and credit the source correctly.

Research the journals you're interested in sending your work to.

Compare your paper with those in the journals you're interested in. If those scholars' papers are of better quality than your paper, make some revisions to your paper or gather more unique research to make your paper stand out to potential publishers.

Write your cover letter and mail your submission along with this letter. In the cover letter, state the nature of your research paper, why it's relevant to the field you specialize in, and the ways in which this research paper is different from other papers that have been published in the journal you're interested in. Also, be sure to review the publisher's mailing guidelines and don't mail your work to more than one journal publisher because it's considered unethical.

Submit your paper to applicable journals (Parks, 2013)

The journal's reviewer may request updates or revisions. Respond quickly and courteously (Grant and Laird, 1999).

The message

The paper must have a message. A good message can be put in one sentence. Some journals now require this one sentence, beneath the title of the paper, in order to put it in the table of contents. A second issue is the “so-what” test: Do the findings have implications? Whether a journal accepts a paper often hinges on whether its message is new, expands on, confirms or rejects a previously published message (Brembs, 2009; eHow Contributor, 2013; Parks, 2013).

Matching the topic and the journal

A decision on which journal to submit the paper to must be made before the paper is finally written. The paper must be written in conformity with the style of the journal. The list of journals indexed in PubMed/MEDLINE of the US National Library of Medicine (PubMed/MEDLINE, 2013) includes over 2600 peer-reviewed journals grouped by subject field. A peer-reviewed journal is one that submits most of its published articles for review by experts who are not part of the editorial staff. It is important to ensure that the topic of the paper falls within the scope of the journal selected. The format of the paper should also be one that is accepted by the journal.

High prestige journals have high rejection rates, sometimes as high as 80%. Rejection does not necessarily mean that the paper is not good. Journals cannot publish all the good papers they receive. For

the authors, rejection means loss of weeks or months before the paper is submitted again to another journal.

A single paper is more likely to be accepted than one in a series. ("salami science") (Huth, 1990; Parks, 2013; Jones, 1999).

EDITOR-IN-CHIEF WORK

How to get your paper published

The editor's decision to accept or reject a paper is generally based on the following: the message of the paper: how clear, important and new is the message? the relevance of the paper to the journal's scope and its audience; the journal's backlog of accepted papers is also a factor in the consideration; scientific validity of the evidence supporting the paper's conclusions; quality of the manuscript.

Uniform requirements for manuscripts submitted to biomedical journals

A group of editors of general medical journals met informally in Vancouver, British Columbia, Canada, in 1978 in order to establish guidelines for the format of manuscripts submitted to their journals. The group became known as the Vancouver Group. Its requirements for manuscripts, including formats for citing bibliographic references, were first published in 1979. The Vancouver Group expanded and evolved into the International Committee of Medical Journal Editors (ICMJE), which meets annually, and has gradually broadened its concerns. The Committee has produced several editions of the Uniform Requirements for Manuscripts Submitted to Biomedical journals: Writing and Editing for Biomedical Publication. Over the years, issues have arisen that go beyond manuscript preparation. Some of these issues have been covered in subsequent editions; others are addressed in separate statements.. The total content of the Uniform Requirements for Manuscripts Submitted to Biomedical Journals may be reproduced for educational, not for-profit purposes without regard for copyright. The Committee encourages distribution of the material (International Committee of Medical Journal Editors, 2013).

The Uniform Requirements are instructions to authors on how to prepare manuscripts. If authors prepare manuscripts in the style specified in these requirements, editors of the participating journals will not return the manuscripts for changes in style before considering them for publication.

Authors must also follow the instructions to authors in the journal as to what topics are suitable for that journal and the types of papers that may be submitted, for example, original articles, reviews or case reports. In addition, the journal's instructions are likely to contain other requirements unique to that journal, such as the number of copies of a manuscript that are required, acceptable languages, length of articles, and approved abbreviations.

Participating journals (over 500 internationally) are expected to state in their instructions to authors that their requirements are in accordance with the Uniform Requirements for Manuscripts Submitted to Biomedical Journals and to cite a published version (International Committee of Medical Journal Editors, 2013).

EDITORIAL PRACTICE

All submissions are peer-reviwed before a decision on publication is reached. Resposibilities and rights of editors (review and publication process) are in accordance with the text: Council of Science Editors (CSE). Editorial Policy Statements (Council of Science Editors, 2013).

After submitting the manuscript

All manuscripts are considered to be confidental. Editor-in-Chief reads every manuscript received and assigns its a general priority level:

a. manuscript sent to reviewers immediately;
b. manuscript returned to authors with suggestions for modification and improvement;
c. rejected manuscripts.

Editor-in-Chief read the revised manuscript. If the manuscript is improved adequately, it is sent to two reviewers (anonimuously) for the review and to statistical review, if warranted. Authors are welcome to suggest up to five potential reviewers for their manuscript, excluding co-authors or collaborators for the last three years, or to ask for the exclusion of reviewer(s) and the reasons for it. The Editor-in-Chief's decision is final.

Acknowledgement of receipt of the manuscript is usually received immedeately. A decision regarding publication is usually made within 6–8 weeks, depending on reviewers'responses.

The reviewers' responses may suggest that that the paper can be made more acceptable by revisions. The investigators do not need to make all the changes

suggested automatically. They should adopt revisions that will satisfy the reviewers' criticisms wherever possible and justify any decision not to do so. It is good to indicate in a separate page the criticism made and how the revised paper responds to them. This will facilitate a decision by the editor.

Authorship in scientific papers

An "author" is generally considered to be someone who has made substantial intellectual contribution to a published study. The ICMJE issued the guidelines about authorship (International Committee of Medical Journal Editors, 2013). Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. Authorship credit should be based on substantial contributions to: conception and design, or acquisition of data or analysis and interpretation of data; and drafting the article or revising it critically for important intellectual content; and final approval of the version to be published. Acquisition of funding, collection of data or general supervision of the research group does not justify authorship. (International Committee of Medical Journal Editors, 2013; Ivaniš et al., 2008).

To provide information on the work done by authors and to resolve the inconsistency between the information provided for those named in the byline versus those listed in the acknowledgements, some journals require authors to indicate the specific contributions of all those involved. Consequently, authors are required to describe their specific contributions as well as the contributions of those acknowledged but not listed in the byline. While many individuals may contribute to the work of an article, the contributors must decide for themselves what their contributions have been, and what level of contribution merits a place on the by-line. It is suggested that those in the by-line should be listed in order of actual contribution made, as decided by the authors. Any contributors who do not meet the criteria for authorship should be listed in the acknowledgement section. Because readers may infer their endorsement of the data and conclusions, all persons listed must give written permission to be acknowledged (Malički et al., 2012).

Ethical Considerations

Any experimental research that is reported in the manuscript has been performed with the approval of an appropriate ethics committee, and should be stated in the Material and methods section. Research carried out on humans must be in compliance with Helsinki Declaration, and any experimental research on animals must follow internationally recognized guidelines. A statement of this effect must appear in the Methods section of the manuscript, including the name of the body which gave approval, with reference number where appropriate. Informed consent must also be documented. Manuscripts may be rejected if editorial office considers that the research has not been carried out within an ethical framework, e.g. if the severity of the experimental procedure is not justified by the value of the knowlegde gained.

To protect the privacy of individuals mentioned in clinical studies, in case histories, do not identify them by their names or initials, do not give hospital unit numbers. For all articles that include information or clinical photographs relating to individual patients, written and signed consent from each patient to publish must also be mailed or faxed to the editorial staff. The manuscript should also include a statement to this effect in the Acknowlegements section, as follows: ''Written consent was obtained from the patient or their relative for publication of study'' (Marusic and Marusic, 2001).

Ethical responsibility of journal editors

Editors should take all reasonable steps to ensure the accuracy of the material they publish. Whenever it is recognized that a significant inaccuracy, misleading statement or distorted report has been published, it must be corrected promptly and with due prominence. Editors should ensure that research material they publish has been approved by an ethics committee. In addition, they should satisfy themselves that the research is ethical as they can be held responsible for publishing "unethical" research even if it has been approved by an ethics committee (Farthing, 1998; Marusic and Marusic, 2001).

In conclusion, strong adherence to the Instructions (Guidelines) to authors of every particular scientific journal is very important step in the process of succesful submission of scientific work and accordingly it will resulted in avoidance of delying of a conduction of editorial process. Editors of scientific journals should be aware about an importance of strong adherence of all ethical principles declared by International Committee of Medical Journal Editors in order to make nice, good and respectable scientific journal.

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THE IMPORTANCE OF RESEARCH IN NURSING: INTERNATIONAL COLLABORATION IN RESEARCH

POMEN RAZISKOVANJA V ZDRAVSTVENI NEGI: MEDNARODNO SODELOVANJE PRI RAZISKOVANJU

ÁRÚN K. SIGURÐARDÓTTIR

Abstract

Nursing research is important as nurses have to base their care on evidence. The promotion of research in nursing is based on availability of competent researchers. Studies at masters and doctoral level gave the nursing profession the chance to develop necessary knowledge in research. To fulfill knowledge gaps in practice, action is needed to build groups of researchers often through international collaboration. Collaboration across countries seems to be necessary due to the global nature of nursing, the common health market of Europe as well as, strategies of universities, EU bodies and other organizations emphasize international collaboration. Assumptions, attributes and consequences of international research collaboration will be discussed. International research has been criticized for bureaucracy which sometimes can be a limiting factor. There is also a need to be aware of differences in philosophies, culture, values and belief systems when data from international research are interpreted. At last, a short example of participation in an international research project will be discussed.

Keywords: *nursing, research, international collaboration*

INTRODUCTION

The importance of research in nursing is more than ever as now nurses are expected to base their care on evidence. Strategies of some universities (UNAK, n.d.) and other educational and health care institutions emphasize the importance of research and also of international research cooperation (UNAK, n.d.). It is now a requirement that nurses in the academia and even in clinical care (Girot, 2010) should have the competence to conduct research. The nursing profession has progressed in developing academic competence, but has also struggled to build a competent mass of researchers (Segrott, McIvor, Green, 2006) and to develop successful research career pathways (Butterworth et al., 2005). The importance of research in health care today is acknowledged and the requirements in clinical practice are that care should be based on evidence.

IMPORTANCE OF RESEARCH IN NURSING

The nursing as a profession has a brief tradition of research, but in the year 1980, Gortner wrote that nursing practice should be based on knowledge and have veracity. The promotion and development of research and academic skills depends on the availability of university-level courses. Opportunities for nurses to attend university courses improved throughout the twentieth century (Råholm et al., 2010). Studies at masters and doctoral level gave the nursing profession the chance to develop necessary knowledge in research (Girot, 2010; Råholm et al., 2010). Now the situation, at least in some countries is different as in some universities in the UK the requirement is doctoral qualification for initial lecturer position (Girot, 2010).

Training and collaboration are key elements in developing nursing research capacity (Segrott, McIvor, Green, 2006), which is essential to promote a research-based culture for practice (Hallberg, 2009). Nursing researchers need to be aware of the knowledge that is obtained through research should also be able to make recommendations for practice. The many descriptive studies, such as qualitative and cross-sectional studies, conducted in recent decades (Mantzoukas, 2009) are essential to create a platform to build on for further research. However, there is a need to move nursing research to interventions studies, or to test the effects of nursing interventions. When testing an intervention it is important that the intervention is applicable in practice. But true randomized controlled studies, preferably blind, are often not feasible in clinical nursing (Burns, Grove, 2009). To establish evidence base on what works in practice, in what ways and under which circumstances, is an urgent need if nursing care is to be based on evidence.

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That brings the discussion to systematic reviews and meta-analyses. Hallberg (2009) claims that the number of scientific journals has increased and so much research has been reported in nursing, that now sounds reviews can be undertaken. A review by Coster and Norman (2009) of Cochrane systematic reviews (n= 30), regarding education and self-management among patient with chronic illnesses, demonstrated the effectiveness of education for special groups of patients and provided a knowledge platform for practice. The results from that review are important in two ways. First, now the profession can see if and how their work affects patients and secondly nurses have some evidence to base their work on. The policy of modern health care is to base the care on clinical guidelines (Habour, Miller, 2001).

To fulfill knowledge gaps in practice, action is needed to build groups of researchers. Research groups have a larger knowledge base than an individual researcher, providing both opportunity and challenges (Suhonen, Saarikoski, Leino-Kilpi, 2009). Therefore nurses and other health care providers need to give attention to the benefits of international collaboration in research.

INTERNATIONAL RESEARCH COLLABORATION

Collaboration across countries seems to be necessary due to the global nature of nursing and the common health market of Europe (Björnberg, 2012). When a research project is moved from a national to an international study it will pursue moving from a small scale project to large-scale, multi-centre, team-led project, which needs well prepared research protocol (Suhonen, Saarikoski, Leino-Kilpi, 2009). In this paper some of the assumptions, attributes and consequences of international research projects will be explored.

Assumptions

The first assumption is better educated nurses. As more nurses are receiving doctoral degrees, the profession is gradually building up a critical mass of competent researchers. This process has though been slow in comparison to other professions (Råholm et al., 2010), with obstacles from the academia and the nurses themselves, as nurses often do not see themselves as academics with autonomy in nursing research (Larsen, Adamsen, 2009). Therefore the role of nurse educators is essential in preparing nursing students with the knowledge, skills and positive attitude towards research (Girot, 2010). As critical mass of competent researchers is required in international collaboration, the nursing profession needs to strengthen their doctoral education in the future. The second assumption is the global nature of nursing care including the common health market of Europe. In the common health market of Europe, patients as health care consumers can literally choose their place and country of health care service (Quigley et al., 2008). As patients expects greater transparency about performance and quality of health care services in each country (Quigley et al., 2008), international projects are needed to improve European evidence based health care and nursing care on international bases (Suhonen, Saarikoski, Leino-Kilpi, 2009). The third assumption is that strategies of universities (UNAK, n.d.), EU bodies and other organizations emphasize international collaboration and some EU funds are based on multinational cooperation (Charlesworth et al., 2009). All those assumptions increase the importance to participate in and pursuing international research projects.

Attributes

The first attribute for international research is the notion that collaborative research partnership should be based on equity, mutual benefits and collaboration. International projects need good cooperation and collaboration where the partners trust each other (Freshwater, Sherwood, Drury, 2006). Collaboration has been described as working together, by pooling talents, resources and sharing time consuming tasks and work intensity to produce a quality product (LeGris et al., 2000). More collaboration promotes understanding and equity among partners. Mutual benefits of international collaboration can be purposes such as presentations at national and international conferences, publishing papers and reports and also to cooperate with people from different countries (Suhonen, Saarikoski, Leino-Kilpi, 2009). Benefits of cooperation also include subjective feelings for each partner, such as satisfaction in relationships, increased self-confidence and increased reputation. If all partners value the research and bring strength to the process the relationships are more likely to be long-term and partners are more willing to use creative problem solving for the benefit of the project (Freshwater, Sherwood, Drury, 2006). The second attribute is commitment. Partners have to have commitment to the research plan and a clearly written research plan is necessary from the initial stage. Members from each country must conduct their own national research as a part of their responsibility within the project, precisely according to the research plan (Suhonen, Saarikoski, Leino-Kilpi, 2009). As the project develops it is important to involve all partners in updating and clarification of the project. The third attribute is

the role of the members. A challenge in international studies is to organize the project in advance where role of each member of the team needs to be clarified (Suhonen, Saarikoski, Leino-Kilpi, 2009). Some members can obtain extra responsibility based on their specific knowledge (Freshwater, Sherwood, Drury, 2006). A characteristic of international projects is that the role of the leader or leadership is highly important. The leader must take the responsibility of the project management, coordination and quality control to ensure success. From the start of the project a management plan regarding implementation of the whole project, including meetings is needed (Suhonen, Saarikoski, Leino-Kilpi, 2009), Regular meetings as face-to-face meetings and meetings over internet are useful and even necessary to ensure the quality of the research project and to keep the partners interests (Freshwater, Sherwood, Drury, 2006). Agreements, plans and other documents should be sent electronically to increase speed (Suhonen, Saarikoski, Leino-Kilpi, 2009). Authorships of papers need to be decided in advance and all authors must react promptly when asked to give comments on publications. The fourth attribute is diversity, often because of different culture, environment and time zones. Although the research process in international research is meant to be as similar as possible some differences can arise. The situation can be different in the participating countries often depending on funding, culture and time, which can be a risk to successful collaboration (Freshwater, Sherwood, Drury, 2006). It is important to acknowledge the differences and try to anticipate what differences are likely to arise and how they can be overcome (Suhonen, Saarikoski, Leino-Kilpi, 2009).

Consequences

International research projects often gain more visibility and even more prestige compared to research confined within a single country (Katsouyanni, 2009). Generally, in international projects there is increased access to expertise, equipment and resources contributing to the development of research capabilities, as experts from different countries are gathered together. Knowledge transfer from one country to another should also be increased due to multinational cooperation which should enable productivity and more speed of knowledge transfer (Suhonen, Saarikoski, Leino-Kilpi, 2009). International projects have often better access to funds and the European Union requires at least some projects to be multinational to be funded (Charlesworth et al., 2009). One important aspect of international research cooperation is benchmarking. Benchmarking can be useful for a country, for one institution or for a single person as benchmarking discovers "best practices". It allows members of the research team to compare performance in care between countries or institutions in order to achieve best-of performance and to identify, understand, and adopt outstanding practices in order to help others (Billings, Connors, Skiba, 2001). Benchmarking provides a forum for sharing and discussing practices that work (Suhonen, Saarikoski, Leino-Kilpi, 2009).

The previous writings about international research have covered some of the issues that are necessary for the research project to succeed. The critique of international research is that the bureaucracy can be a limiting factor (Charlesworth et al., 2009) and Freshwater, Sherwood and Drury (2006) highlight that when data are interpreted, differences in philosophies, culture, values and belief systems can yield varying interpretations. There is a need to measure the effects of international research and Charlesworth et al. (2009) claimed that there is a need to have a more structured outcome reports after the projects have finished demonstrating the effects of the projects and speed up the transfer of knowledge. It has been pointed out that few studies investigate advantages, disadvantages, experiences and lessons learned from research collaboration (Katsouyanni, 2008).

PARTICIPATION IN AN INTERNATIONAL PROJECT

In the year 2009 a European project "Empowering Education of Orthopeatric patients" was started, as a co-operation of seven European countries, four in northern and three in southern Europe. The seven participating countries are bringing together expertise from different clinical fields and research areas, often from universities. The main aims of the projects are to strengthen the theoretical basis of empowering patient education, and to identify and explain the differences in patient education in the various countries. The aims are also to construct practice-oriented patient education models and to obtain valid and reliable instruments in the participating countries (Johansson, 2009). The method was a descriptive, prospective, comparative follow-up study with three data collection points (before surgery, time 1; at hospital discharge, time 2; and 6-7 months after surgery, time 3) (Johansson, 2009).

This project has presented challenges and opportunities. The first challenge was to obtain valid and reliable instruments in the participating countries, but instrument translation is crucial to obtain valid instruments (Tanzer, Sim, 1999). When the instruments were translated from English to the other languages the translation method

was forward-backward translation by two independent translators with cultural validation (Cha, Kim, Erlen, 2007). The second challenge was the organization of time schedule to follow the research protocol and to implement and keep track of the rigorous data collection. The project had to be organized in a punctual way but simultaneously give each country a certain freedom to organize and adjust the project according to their local situation. In this project the protocol was clear with research method and measurement points which made it easy to follow the project. Each country needed to obtain their own ethical approval and permission from various bodies to be able to conduct the study (Johansson, 2009), and each country was also responsible for obtaining funds to support their research part such as data collection. This project has presented challenges in communication, using new technology as SKYPE and the internet. The leadership has also been a challenge (Suhonen, Saarikoski, Leino-Kilpi, 2009) as a new leader had to take over the leadership. For the clinical nursing practice this project is an opportunity for benchmarking (Billings, Connors, Skiba, 2001). This applies to the practice of patient education, which can be compared between hospitals in the same country or between countries. The knowledge obtained from the project regarding orthopaedic patient education should enable development and construction of evidenced based educational model and materials. Preliminary results of the project show that generally the education that the patients receive is adequate but the content of the education needs to be strengthened and improved.

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REPORTING CONTENT ANALYSIS, PROCESS, VALIDITY AND RESULTS: COMPARISON BETWEEN TWO DECADES

POROČANJE O PROCESU, VELJAVNOSTI IN REZULTATIH VSEBINSKE ANALIZE: PRIMERJAVA DVEH DESETLETIJ

SATU ELO, MARIA KÄÄRIÄINEN, TARJA PÖLKKI, OUTI KANSTE, HELVI KYNGÄS

Abstract

Introduction: *Even though content analysis is commonly used in nursing science research its use is not systematically evaluated. Aim was to describe the reporting of content analysis process, validity and results in nursing between two decades 1989-1999 and 2000-2009.*

Methods: *The data were collected from a peer-review journal (n=156) and it were analyzed by content analysis and quantified.*

Results: *The description of content analysis process has been improved during the last years. However, the data analysis was not described in fifth of the articles in 1989-2009. At 21st century it was described already in 80% of articles. The results were reported according to the analyses in 64% of the articles, better in the last decade. The validity of the study was evaluated in 64% and validity of analysis in 51% of the articles.*

Discussion and conclusion: *The results add understanding to how content analysis should be reported to produce a valid and understandable report. In its entirety the description of content analysis process description has been improved during the last years.*

Keywords: *content analysis, research, qualitative, analysis method*

INTRODUCTION

Content analysis is used in qualitative as well as quantitative research to analyze answers to open-ended questions. Even though content analysis is commonly used in nursing science research its use is not systematically evaluated (Elo & Kyngäs, 2008). Content analysis is used to describe the research phenomenon. It can be used to create categories, concepts, a model, conceptual system or conceptual map to describe the research phenomenon (Weber, 1990; Elo & Kyngäs, 2008). A model, conceptual system or conceptual map is a structure where concepts, their hierarchy and possible connections to others are presented. The aim of this study was to describe how content analysis is used in nursing research in two decades: 1989-2009 and 2000-2009. The aim is to seek answers to the following research questions:

1. How is the analysis process described?,
2. How are the results reported? and
3. How is the validity of study and analysis evaluated?

It is challenging to report a study where content analysis is used. Abstraction is the part of the inductive content analysis during which concepts are created. The researcher can describe part of that process, but some of it involves the researcher's insight or intuitive action, which is very difficult to describe to others (Graneheim & Lundman, 2004; Elo & Kyngäs, 2008). However, to indicate the validity of study it should be explained how the concepts are created. In deductive content analysis the structure of analysis consists of concepts, and the results of analysis consist of the content of these concepts (e.g. subconcepts and codes to describe those concepts). Describing these concepts and how they have been created is challenging for the researcher as well; this can often be seen as incompleteness of analysis. The researcher has not abstracted data or she/he has grouped too many different types of things together (Dey, 2003; Hickey & Kipping, 1996, Elo & Kyngäs, 2008).

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The validity of content analysis is evaluated according to the criteria of qualitative study. There are many criteria. A feature the criteria have in common is that they aspire to support the validity by reporting the process of content analysis accurately. Examples of analysis illustrate to readers how the analysis is done. To assure validity, the researcher has to be able to indicate the connection between results and data (Sandelowski, 1995; Sandelowski, 2001). Use of quotations to report the results is seen as a crucial indication of the validity of results (Harwood & Garry, 2003; Guthrie, Yongvanich, Ricceri, 2004; Elo & Kyngäs, 2008). However, they should indicate a connection between the data and results systematically, not occasionally. This may lead to the risk that the report includes too many quotations. In order for quotations to support validity there should be codes as to how the original data can be connected to the quotations. However, the quotations have to be chosen so that their content does not reveal subjects' identity.

METHODS

The mixed method was used. The data was collected by structured form. After that the data were grouped based on principles of inductive content analysis. To present the results the data were quantified. The data were collected from the journal Hoitotiede (Journal of Nursing Science) from 1989 to the end of 2009. The Journal was established in 1989. The journal is a scientific (peer review) journal where 482 peer-review articles were published during that time. Of these articles, all those where authors reported to use content analysis were included in the sample. Sample size was 156 articles (1989-1999: 48 articles, 2000-2009: 108 articles). Content analysis was used in 20% of the articles in quantitative study to analyze answers to open-ended questions. In 90's using content analysis when analyzing questionnaire's open-ended questions has been more common (31 %) than at the beginning of the 21st century (24 %).

For data collection the researchers developed deductively a structured form reflecting the ideal way to report content analysis. Information from the articles was collected on the structured form.

The data were first analyzed using the principles of inductive content analysis by grouping the same content together into categories (Hsieh & Shannon, 2005). Second, the data were quantified by calculating how many times the content of a certain category was found in the data. The results here were reported as a frequencies and percent (Elo & Kyngäs, 2008).

RESULTS

The description of content analysis process

The sample method was not reported in most articles (78%, table 1). It was slightly often reported in 90's (25%) than in 2000 century (21%). The most commonly (13%) mentioned method was purposive sample and the next was random sample (11 %). Over third of articles (39%, n=61) failed to describe how the analysis had been done. Though there were remarkable diffence between decades: as only 19 % (n=9) of 90's articles were a description of analysis process the equivalent percent between years 2000-2009 were 80% (n=86). Analysis was not explained especially when content analysis was used to analyze answers to open-ended questions. This was also true for literature reviews which became general from the beginning of the 21st century. The change between two decades in reporting the analysis can be seen in the number and diversity of concepts used in reporting and describing the analysis. Between 1989-1999 reporting on analysis was poor, and only few concepts were created through analysis and used to describe results. Between 2000 and 2009 more concepts began to be used to report the results. The most common (30%) way to describe the analysis was to refer to with one reference and 28% of the articles had no references. Using one or more references in analyze description increased between 2000-2009 (table 1).

The logic behind use of chosen concepts (e.g. class, category) to describe analysis was also analyzed through the articles. Concepts were logically used in 56% (n=92) of the articles. The articles where the concepts were not used logically had mixed concepts and synonyms, such as theme, class and category, instead of using just one of those concepts in a logical manner. There was a notable difference between decades. In 1989-1999 the use of concepts was logical in 29 % (n=14) of the articles, compared 72% (n=78) in 2000-2009.

Reporting results and the evaluation of validity of study and analysis

In inductive content analysis the idea is to create a structure of classes, categories, concepts or themes and present it as a result. Based on our evaluation, only 43% of authors had a systematically created structure of classes/categories/concepts/themes (table 1). Quite often the reporting of results did not follow the results of analysis; instead, the results were reported using different concepts than those indicated in the analysis section. Also this has happen an improvement

Table 1. Reporting the use of content analysis (f/%) between two decades 1989-1999 (n=48) and 2000-2009 (n=108).

	1989–1999 (n=48) f/%	**2000–2009 (n=108) f /%**	**Total (n=156) f /%**
References where analysis is based			
No reference	27/56	16/15	43/ 28
One reference	11/23	36/33	47/ 30
Two reference	7/15	33/31	49/ 26
Three reference	2/4	16/15	18/ 11
Four or more reference	1/1	7/1	8/ 5
Sample method			
Purposive	6/13	14/13	20/13
Random sample	4/8	7/6	11/7
Random and purposive	2/4	1/1	3/2
Not mentioned	36/75	86/80	122/78
Classes/categories/themes/concepts used in reporting structure			
Systematically	8/17	59/55	67/43
Occasionally	11/23	18/16	29/19
Not mentioned	29/60	31/29	60/38
Expression			
Everyday expression	10/21	10/9	20/13
Repeat subject's words	17/35	10/9	27/17
Scientific expression	21/44	88/82	109/70
Use of quotations			
Systematic	6/12	28/26	34/22
Occasionally	9/19	17/16	26/17
No quatations	33/69	63/58	96/61
Validity of study			
Evaluated	19/40	81/75	100/64
Not evaluated	29/60	27/25	56/36
The evaluation of validity of analysis			
Evaluated	14/29	65/60	79/51

in 21st century when 55% classes/categories/concepts/themes were systematically used in reporting structure compared 17 % in 90's. Reporting of results has changed into a more scientific direction during the last few years. In 2005–2009 almost all (98%) reporting of results was scientific: prior to that, everyday expressions were used in reporting results, repeating respondents' statements and/or their opinions, even though supposedly reporting the results of analysis (table 1).

Use of quotations is argued to be necessary to indicate the validity of results, and it is generally suggested to use quotations when reporting results. Quotations were used systematically in 22% (n=34) of the articles, and while 61 % (n=96) had no quotations. There were slightly increase of systematically use of quotations in 21st century, but at the same time the use of quotations in elucidation had decreased. Only in 10% of articles the code of identification of quotations was reported, so that it was possible to identify the group to which the subject belonged, such as nurse, parent or patient.

The evaluation of validity of study and analysis has been remarkable better in 21st century. The validity of study was evaluated in 64% and validity of analysis in 51% of the articles. However, there was a remarkable difference between decades: in 2000-2009 three quarter (75%) of authors was evaluated the validity of study and in 1989-1999 less than half (39%). In 29% (n=45) of articles the validity was used as a criterion to evaluate validity. The use of criteria has generalized from 9% (n = 4) in 1989-1999 to 38% (n=41) in 2000-2009. Most commonly (40%, n=18) validity was evaluated by the criteria of qualitative study. Lincoln and Cuba (1985) was used as a reference in 23% (n=10) of articles. Even if the use of the criteria was reported, the discussion of validity did not follow the criteria. The problem was that the criteria were rarely followed even though the authors of articles reported using them. Authors rarely (25%, n=39) gave their own opinion about the validity of study and the results.

DISCUSSION AND CONCLUSION

The results are reported so that the identity of authors of the articles that make up the data or their content is not identified. For this reason the results are not reported here per year or by topic, but articles are divided into two periods.

In this study, well-structured data collection provided valid data. For data collection the material was divided into periods, and each of the three researchers collected data from that period (e.g. years 1989–1995). During data analysis each researcher analyzed data covering twenty years, but the data were divided according to topics. For example, one researcher analyzed data concerning the results and validity of study. In this way all researchers had an opportunity to see how the others collected and saved data, comparing it to others. This is supposed to support the validity of this study because this made it possible to assure that data was collected congruently.

To confirm conformability the process of analysis is described in as much detail as possible, as researcher must be able to point out a connection between the results and the data (Weber, 1990; Elo & Kyngäs, 2008). To facilitate transferability, a clear and distinct description of context, selection and characteristics of data, data collection and process of analysis is provided in this study (Graneheim & Lundman, 2004). Consequentiality in this study means that both human variation and changes due to the study design were present.

Content analysis is criticized because it produces results that appear simple. Based on our results this criticism is justified; the method has been used in some articles especially to analyze answers to open-ended questions in a simple way, and its possibilities have not been exploited (Harwood & Garry, 2003; Elo & Kyngäs, 2008). Reduction, grouping and abstraction require rich data. However, the answers to open-ended questions on questionnaires are often so brief that it is difficult to use content analysis. It is possible to group narrow and brief data by using the principles of content analysis, but is that real content analysis where abstraction can be carried out according to the principles of analysis?

According to the present study there were some problems with reporting the results systematically. Problems with reporting result can be consequences of unsuccessful analysis or presentation of results (Dey, 1993; Elo & Kyngäs, 2008). An uncompleted analysis abstraction process is not fully done, and because of this concepts can be presented as results that do not exclude others. Also, when saturation is not achieved it is difficult to group the data and create concepts (Harwood & Garry, 2003; Elo & Kyngäs 2008). The uncompleted analysis looks like simplified result of the study (Weber, 1990; Harwood & Garry, 2003).

In its entirety the description of content analysis process description has been improved during the last years. One reason for that is development is that overall qualitative research approach has been more common. In future more attention should also be paid on how to report the connection between the data and results. The content and structure of concepts created by content analysis is supposed to be clear and understandable for readers. This study produced knowledge that can be taken advantage of in using and developing content analysis. The results are also useful in teaching content analysis. They could also be used to add our understanding on how content analysis should be reported in a valid and understandable manner.

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ETHICAL ISSUES IN NURSING RESEARCH

ETIČNI VIDIKI RAZISKOVANJA V ZDRAVSTVENI NEGI

BEATA DOBROWOLSKA

Abstract

The rising interest in implementing scientific research projects, the fast-progressing technology making it possible to carry out the research, close cooperation between industry and science, the growing competition in the field and the resulting temptation for misconduct in science have sparked a broader discussion on the need for developing the ethics of scientific research.

This type of ethics deals with defining and justifying ethical principles which should be respected by researchers at each stage of the research process: the stage of planning, implementation and dissemination of results. Among the most important rules are obtaining informed consent for participation in research and the right to withdraw any time, confidentiality and data protection, beneficence (the analysis of potential benefits and risks associated with the research).

Obeying these rules in the practice of nursing scientific research is essentially aimed at one major goal - gathering reliable scientific evidence which will benefit science (nursing) and the general public.

Keywords: *nursing research, research ethics, ethical principles*

INTRODUCTION

The main assumption of nursing research is to provide reliable scientific evidence making it possible to improve the nursing practice and the development of nursing as a science. Carrying out research constitutes one of crucial (indirect) professional functions of nurses (Ciechaniewicz, 1999). Furthermore, participating in scientific research is considered by the ICN as part of the moral responsibility of nurses. In the amended Code of Ethics for Nurses there is a statement: "The nurse is active in developing a core of research-based professional knowledge that supports evidence-based practice" (ICN, 2012). Similar message is conveyed by the Polish Professional Code of Ethics for Nurses and Midwives: "Nurses/midwives should participate to the largest extent possible in the development of scientific research in the field of nursing and obstetrics (…)" (KEZPiPRP, 2003).

Carrying out scientific research is usually associated with the work of academics. It should be pointed out that in nursing – similar as in medicine – this practice is very common and is followed by nurses working in different fields of the healthcare system. What is more, nurses often manage their own research projects, and even more frequently are members to research groups managed by other specialists, mainly physicians.

It is also generally known that the results of scientific research not only benefit the development of nursing science and practice, but are also used in political measures for the purpose of increasing the access to nursing care, the quality of care, and, finally, improving the working conditions of nurses themselves (e.g. European Nursing Research Foundation, which is in the process of establishing a link between evidence and policy-making process) (EFN, 2013).

SCIENTIFIC RESEARCH ETHICS

The rising interest in implementing scientific research projects, the fast-progressing technology enabling the research, close cooperation between industry and science; growing competition in the field and the resulting temptation for misconduct in science have sparked a broader discussion on the need for developing the ethics of scientific research.

In order to further specify this discipline, it can be stated after Galewicz (2009) that this is a branch of normative ethics dealing with the ethical aspects of research in science. The major objective of scientific research ethics is to develop and justify ethical principles which should be followed by researchers.

In the last decades numerous ethical and legal documents have been created, establishing the

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directions of scientific research in biomedicine. Among the major ones it is essential to mention: the Declaration of Helsinki by the World Medical Association (1964, reviewed every few years, last review 2008), The Belmont Report (1979), and the Convention on Human Rights and Biomedicine by the Council of Europe (1997). Of course, there are many more.

The ethical rules developed in the aforementioned documents and within the tradition of medical ethics (including nursing ethics) will be presented according to the main three stages of the scientific research process:

A. Planning

B. Implementation

C. Dissemination.

A. The first stage of the research process, i.e. research planning involves the determination of the objective, the hypotheses and research methods, is of primary importance from the ethical perspective. In the document prepared by the Good Academic Practice Group and the Ministry of Science and Higher Education in Poland it is emphasised that beginning academic research cannot be justified by the researcher's scientific career and/or the lack of publications - the basis for taking up research is finding that the knowledge in a given field is insufficient and that the research will be useful in cognitive and/or practical terms. This is particularly important in research involving human subjects - regardless whether this is interventional or observational research (Diligence in scientific research, 2012).

Due to the increasing necessity of protecting research participants, the ethical acceptability of research projects is being formalised. Currently not only invasive research but also observational studies require the consent of an applicable Bioethics Committee. It turns out that also by using the diagnostic survey method and a questionnaire survey, the interest of the surveyed person may be infringed by an improperly asked question. Members of Bioethics Committees take into account not only the ethical aspects of research expressed in a direct way, e.g. the informed consent of probands but also the methodological aspects of research, starting from the justification. Contrary to appearances, this issue also has an ethical dimension, which is associated, *inter alia*, with the question whether there is a point in spending public funds on the given project. How will the project contribute to the development of science? Can we expose the research participants to the risk associated with participating in the project? According to the provisions of Article 2 of the Convention on Human Rights and Biomedicine (1997): "The interests and welfare of the human being shall prevail over the sole interest of society or science."

Of course the issue of the quality of Bioethics Committees' work may be disputed. It is emphasised, for example, that there are no unified criteria for evaluating applications apart from documents regulating the permissibility of biomedical research on a global scale; much depends on the ethical sensitivity and knowledge of members of the group evaluating the application, and therefore an application dismissed by one Committee may be approved by another. Nevertheless, it is difficult to claim that such authorities should not exist.

B. The stage of implementing scientific research includes a broad range of actions which cannot be overlooked from the ethical perspective. As claimed by experts, one of the substantial omissions during carrying out scientific research is negligence and methodological ignorance. This concerns negligence at each stage of the research process: planning, obtaining the participants' consent and informing them about the course of the research, securing the gathered research material, and also respect for co-workers, research participants and natural environment, and the lack of interference in the values represented by research participants (Diligence in scientific research, 2012). Thus we can see that methodological errors may also result in infringing the basic ethical principles of scientific research.

The process of gathering the research material is a strenuous work which does not always bring satisfactory results. Each researcher should consider this before taking up research. Needless to say, data fabrication and falsification is unacceptable (Galewicz, 2009; Diligence in scientific research, 2012). Diligence and fairness in gathering data is an issue of the researcher's moral responsibility. Publishing fabricated research results is harmful in at least two ways: first, it misleads the scientific community and the public opinion, and, second, as a consequence, it may be harmful to patients themselves if such results are put into practice.

In the first and the second stage of the research process, it is necessary to obey the following ethical principles: obtaining informed consent for participation in the research, the right to withdraw, confidentiality and data protection, and beneficence [RCN, 2011; Fry & Johnstone, 2009; Galewicz, 2009; Hartman, 2009].

Obtaining the consent for participation in the research

Respect for the autonomy of the individuals participating in the research primarily involves the necessity to obtain an informed consent for each medical procedure; this is not only an issue of ethics but also a standard required by law (the Convention on Human Rights and Biomedicine, 1997).

Obtaining informed consent consists of supplying the person with sufficient understandable information regarding his or her participation in a research project. The information must be formulated in a comprehensible way, without concealing anything. People having difficulties with granting the consent (e.g. mentally ill, elderly people, persons in dementia or children) should receive information adjusted to their understanding capabilities and, where necessary, the legal guardian must give his/her consent (RCN, 2011). The information should also include a statement that the research participant can withdraw any time without any consequences. Participation in research is purely voluntary. Therefore, the patient cannot be encouraged to participate in research by, e.g., improved access to medical procedures or threatened that the lack of consent will result in the discontinuation of treatment. Treatment and care should always be available for patients through all possible means, also when the patient resigns from participation during the research.

Besides, it is worth referring to the ethical problem appearing in the process of obtaining the consent for participation in phase 1 clinical trials in oncology. A question arises how to provide information to the patient so that his/her consent would be really informed and not motivated by the false hope in the therapeutic effectiveness of medical procedure which is in the experimental phase (Szewczyk, 2009).

The consent for participating in the research should be given in writing, and the consent form should include the most important information about the trial protocol. My experience gained during working in the Bioethics Committee shows that preparing a consent form which is comprehensible for the research participant is a difficult task. What is understandable for the researcher does not necessarily need to be obvious for the research participant.

Confidentiality and data protection

The researcher is obliged to protect all data gathered within the scope of the research project from being divulged to others and to keep individuals anonymous in relation to their participation in that project. Research participants must be ensured that throughout the whole period of data gathering and storing the information provided by them is safe and will not be used against them or for any purpose other than specified in the consent (RCN, 2011).

Beneficence

As stated in the Belmont Report (1979) this ethical principle does not only mean protecting a person from harm, but also acting towards his/her benefit. The researcher must analyse the situation to see whether the undertaken activities will bring any benefits, to whom and of what type, and to what extent they pose risk to the research participants. The risk of harm should be understood in very broad terms – in the physical, mental, spiritual, financial and social aspects, sometimes also involving the legal aspect.

Both physicians and nurses performing research work may be subject to a specific conflict of values involving the patient's welfare and the public interest (Hartman, 2009). It is sufficient to recall the example of oncology patients participating in phase 1 clinical trials, or the use of placebo. However, it is emphasised that, whenever possible, the role of a physician or nurse should take precedence over the role of a researcher.

This issue is particularly crucial in the nursing practice. It is often pointed out that in the historically-established tradition of medical care nurses have concluded a sort of a covenant with society stating that they would protect the moral order in care-providing institutions and always defend the welfare of patients. Nowadays this is expressed in the theory of advocacy in nursing. According to this concept, nurses are obliged not only to protect the rights of their patients but also to look after the observance of those rights by other members of the therapeutic team (Fry, Johnstone, 2009).

C. The third stage of scientific research,

i.e. dissemination of research results, is associated with respecting the principles of conscientiousness and fairness. First, preparing a research report necessitates an accurate presentation of the research results, regardless whether the initial hypothesis was confirmed or not. Sometimes young scientists experience anxiety connected with the fact that the analysis carried out did not confirm the research assumptions. However, if the entire research procedure from planning to implementation had been executed properly, they probably obtained a reflection of the

actual state of affairs. Second, it is important to fairly present the contribution of each person participating in the research project and in preparing the material for publication. Adding persons who did not take part in the research work or failing to mention those who did is a breach of ethics (Galewicz, 2009). Another problem is associated with commissioning a persons who did not participate in any part of the research process to prepare the results and draw up the final report, e.g. in the form of a scientific article. Today, in order to restrict such situations, most scientific journals introduce anti-ghost writing measures. Unfortunately, they do not eliminate this malpractice entirely. The last major issue is the problem of plagiarism. Improper documentation of ideas taken from other authors' work or the lack of references to the quoted publications is one of the most serious infringements of ethics in scientific research.

CONCLUSION

There is no doubt that, as emphasised by the ICN in its standpoint, "nursing research is needed to generate new knowledge and advance nursing science, evaluate existing practice and services, and provide evidence that will inform nursing education, practice, research and management." (ICN, 2007). Most importantly, all these measures in consequence contribute to ensuring the high quality of services, giving satisfaction to nurses and patients. However, it should be borne in mind that the frequently encountered "*publish or vanish*" approach or the growing competition among researchers cannot be used as an excuse for inaccuracies in the implementation of scientific research and the publication of its results.

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THE PRESENCE OF STIGMA TOWARDS PEOPLE WITH MENTAL DISORDERS AMONG NURSES AND MIDWIVES

STIGMATIZIRANJE OSEB Z DUŠEVNO MOTNJO MED MEDICINSKIMI SESTRAMI IN BABICAMI

DIVNA KEKUŠ, SANJA STANISAVLJEVIĆ, ZVONKO DIMOSKI, DRAGANA TERZIĆ MARKOVIĆ

Abstract

Introduction: *Stigmatization of person with mental disorders is a major element of modern scientific research. In order to develop and improve anti-stigma strategy, the focus of researchers' attention moves from the stigmatized people to the ones who stigmatize. The aim of this work was to investigate the presence of stigmatization towards people with mental disorders among future nurses and midwives throughout the analyses of their attitudes, and to investigate the influence of the existing curriculum on those attitudes.*

Methods: *Presented results were obtained from a sample of 573 students, of both sexes, from the department of nurses and midwives. The survey instrument designed for this research is composed of the demographic questionnaire and the modified version of the Scale of attitudes towards the mentally ill. Cronbach alpha coefficient has a value of 0.73. The methods of descriptive statistics- ANOVA and T-test were used. Statistical analysis was done using software SPSS-15.*

Results and discussion: *The analysis of students' attitudes attending the department of nurses showed low levels of stigma towards patients with mental disorders. The existence of high statistical significance in the results of first and third year's students' attitudes in terms of: risk of mental illness ($p<0.050$), relationships with patients ($p<0.012$), their ability to work with children ($p<0.037$) and needs for constant hospitalization ($p<0.002$), supports the fact that teaching contents, combined with practice and work experience, influence the reduction of negative attitudes towards patients. Significantly higher level of negative attitudes was found among students attending the department of midwives. Even 85.2% of them believe that "people with mental illness are more dangerous than others'' ($F=4.74$, $df=4$, $p=0.01$). It was expected result because their curriculum does not provide Psychiatry as a subject.*

Conclusion*: This study provides important information and represents a basis for the introduction of the Health care in Psychiatry as an obligatory subject in the current curriculum for nurses. It also has a positive impact on additional education and application of anti-stigma interventions for students at the department of midwifery, and in other departments.*

Keywords*: Stigma, future nurses and midwives - now students, people with mental disorders, syllabus.*

INTRODUCTION

People with mental disorders are exposed to stigmatization in the social environment due to their specific biological, psychological and social characteristics. Stigma is a social construct including two basic components: recognition of differences based on certain behavioural marks and consequential devaluation of the person holding that mark, based on prejudice, discrimination and ignorance. As a phenomenon, stigma is founded on negative stereotypes and reflects harmful behaviour of the person performing it. Fot the reason, researchers focus their attention from stigmatized people (with mental disorders) to the ones stigmatizing them(people, institutions, media). Determing the stigmatizators' features appears to be the first step towards their correction, as well as towards the decrease of the stigma. (Byrne, 2001; Jovanović et al., 2007).

The aim of this work was to investigate the presence of stigmatization among the students towards people with mental disorders. The work was done by various analyses of students' attitudes and by revision on destigmatizing potential of existing syllabuses.

People with psychiatric stigma perceive the stigma as a new dimension of suffering and describe it as a "silent disease" (Corker, 2001; Milačić-Vidojević et al.,

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2011). The most difficult consequence comes from its permanence. Stigma determines social status and social relations among people, repressing all other features and leading to decrease of some life term perspective, lower self-esteem, discrimination and isolation of the ill person. Some of the frequent reasons making the treatment of primary disorders more difficult are postponing in asking for help and attempts to conceal the disease in order to avoid embarrassment and humiliation (Muniza et al., 2010). According to the authors (Okasha, Stefanis, 2005; Jovanović, 2006) there is a great predominance of negative attitudes towards patients with mental disorders by healt care workers, emphasizing that this attitude is showed by almost 90% of examined nurses.

METHODS

The presented study represents a segment from the Research Project examining the presence of stigma toward psychiatric patients performed by the students that are being prepared for the health care profession. The study has involved 573 students. Of those, 356 students are future nurses (317 female and 39 male) and 217 students of them are future midwives (all female). All students taking part in the research have completed secondary medical school before the university. Health Care in Psychiatry and Clinical psychiatry are elective subjects only for the future nurses. The instrument used for the survey is composed of a demographic questionnaire designed for the purpose of this study and a modified version of Original Questionnaire by Taylord, Dear and Hall (1979). The questionnaire for the assessment of attitudes contains 14 items. The five-level Likert scale was used, ranked from 5 (strongly agree) to 1 (completely disagree). The calculated Cronbach alpha coefficient has a value of 0.73. Statistical analysis was done using SPSS Software 15th. We used factorial analysis of variance (ANOVA) and t-test. The satisfying level of statistical significance was defined as $p<0.05$.

RESULTS AND DISCUSSION

The largest numbers of students come from urban environments and live with their parents. Just 22.9% of them are employed. Through the investigation of the impact of various factors on the formation of students' attitudes (among the students from the department of nurses and midwives) towards psychiatric patients (Table 1), it was noticed a statistically significant difference between the attitudes of students and nurses prior to the contact with psychiatric patients F=3.990, p=0.008 and expressing the wish to work in the psychiatric ward F=0.000. The students - future midwives, have shown a statistically significant difference in attitudes in relation to previous contact with psychiatric patients F=3.29, p=0.022., and a desire to work in the psychiatric ward F=4.229, p=0.006.

Table 1: Analyses of the factors having impact on the attitudes

ANOVA	Nurses			Midwives		
	F	df	p	F	df	p
Previous contact with psychiatric patients	3,990	3	0,008**	3,291	3	0,022*
Had teaching contents in psychiatry	1,832	2	0,162	0,376	2	0,687
Wants to work in psychiatric ward	11,909	3	0,000**	4,229	3	0,006**
Statistically significant ** highly statistically significant						

Table 2: Comparison of the attitudes of the students from different departments (nurses and midwives)

	Nurses		Midwives					
	M	SD	M	SD	**t**	df	Mean difference	**p**
1. People with mental illness are more dangerous than others.	3.01	1.10	3.22	1.04	**-2.280**	571	-0.213	**0.023***
2. People with mental illness can attack anyone.	3.81	0.88	3.93	0.81	**-1.511**	571	-0.112	**0.131**
3. Mental illness is transitive.	1.67	0.83	1.83	0.84	**-2.158**	571	-0.155	**0.031***
4. People with psychiatric illness do not know how to behave.	2.28	0.80	2.61	0.94	**-4.325**	399	-0.333	**0.000****
5. People with psychiatric illness are less capable than others.	2.78	0.80	3.09	1.00	**-3.552**	571	-0.311	**0.000****
6. People with psychiatric illness are responsible for their condition.	2.06	0.72	2.19	0.78	**-2.020**	429	-0.133	**0.044***
7. I'm afraid to live in the neighbourhood next to people with psychiatric illness.	2.40	1.02	2.56	1.07	**-1.702**	571	-0.153	**0.089**
8. If my roommate was suffering from a psychiatric illness I would move.	2.97	1.10	3.31	1.07	**-3.541**	571	-0.334	**0.000****
9. If my boyfriend/girlfriend is suffering from a psychiatric illness I should end the relationship.	3.07	1.13	3.41	1.10	**-3.531**	571	-0.342	**0.000****
10. It is better for society that people with mental illness do not have children.	2.80	0.97	3.33	1.04	**-6.070**	433	-0.531	**0.000****
11. It is better for society that people with mental illness do not work with children and adolescents.	3.53	0.95	3.87	0.96	**-4.140**	455	-0.343	**0.000****
12. I can recognize a person with a psychiatric illness by their look.	3.05	1.11	3.05	1.06	**0.320**	571	0.030	**0.749**
13. If it was up to me I would decide that the people with psychiatric illnesses should remain hospitalized.	2.65	1.03	3.10	1.08	**-4.890**	571	-0.445	**0.000****
14. I would be ashamed if my friends found out that someone in my family has a psychiatric illness.	1.80	0.74	1.80	0.75	**0.024**	571	0.002	**0.981**

As the test results were based on independent samples, there were different attitudes between future nurses and midwives. A high statistic difference has been identified in items 4, 5, 7, 9, 10, 11 and 13.

Table number 3 noticeably shows the presence of high statistical significance in the attitudes of the students attending the first and the third year of studies (attitude in the statement no.1 (p<0,050); no.2 (p<0,012), no. 4 (p<0,037), no.6 (p<0,002)). All those facts clearly illustrate that the syllabus combined with practical and working experience encourage the decrease of negative attitudes towards the people with mental disorders.

Table 3: The differences of the attitudes among the students from the first and the third year (future nurses)

	Nurses I and III year of study			
	t	df	Mean difference	p
People with mental illness are more dangerous than others.	1,974	221	0,287	0,050*
If my boyfriend/girlfriend is suffering from a psychiatric illness I should end the relationship.	-2,537	221	-0,400	0,012*
It is better for society that people with mental illness do not have children.	2,936	221	0,0396	0,004**
It is better for society that people with mental illness do not work with children and adolescents.	2,105	156	0,139	0,037*
I can recognize a person with a psychiatric illness by their look.	2,544	221	0,390	0,012*
If it was up to me, people with psychiatric illnesses should remain hospitalized.	3,108	199	0,440	0,002**
I would be ashamed if my friends found out that someone in my family has a psychiatric illness.	-1,076	221	-0,109	0,283

CONCLUSION

The attitudes of health care workers towards people with mental disorders are important for several reasons: they define the quality of relationship between health care workers and patients, they directly affect the willingness of the patient to seek for professional help timely; they affect the acceptance and the outcome of treatment, they provide rehabilitation and reintegration in society (Strbad et al, 2008; Stojiljkovic et al, 2009). This is the reason why the stigmatization of people with mental disorder has become, in recent years, a significant element of scientific research, in order to find and develop successful anti stigma strategies. Destigmatization of the people with mental disorder becomes professional and ethic imperative.

The analysis of attitudes in our research has shown that students from the nursing program have a lower level of stigma towards people with mental disorders in regard to the students of midwife program, whereas two thirds of examined students have a negative attitude. The hypothesis that a certain student group will have a higher level of stigma due to the lack of curriculum activities is here by proven.

Since health care students make an important link in the chain of the health system, its future quality and perspective, this survey provides us with important information and represents a basis for the introduction of Health Care in Psychiatry into the current curriculum for the nurses program. Also, there are more opportunities for introducing additional education and implementation of anti stigma interventions with the students of midwife program, as well as with other profiles and in the social environment.

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THE ROSE (REDUCING OCCUPATIONAL STRESS IN EMPLOYMENT) PROJECT – AN ONLINE STRESS MANAGEMENT PROGRAMME FOR HEALTH CARE WORKERS

PROJEKT ROSE (ZMANJŠANJE POKLICNEGA STRESA PRI ZAPOSLOVANJU) – E-PROGRAM OBVLADOVANJA STRESA ZA ZDRAVSTVENE DELAVCE

JOHN SG WELLS

Abstract

Introduction: *Work related stress is a significant cause of ill health amongst health care professionals, particularly in mental health services. European Commission guidance on work-related stress states it is "the emotional, cognitive, behavioural and physiological reaction to aversive and noxious aspects of work, work environments and work organizations'. Commonly identified sources of stress are workload, patient care, interpersonal relationships with colleagues, knowledge of nursing and nursing skills, type of nursing, and bureaucratic-political constraints.*

The ROSE project and online programme was developed to support health care workers to self manage their stress and create less stressful working environments.

Methods: *Developmental work involved a review of relevant literature, followed by a 'mapping' exercise involving the survey of legislative requirements and service structures in five major organisations and 25 service centres delivering vocational and support services to people with mental health/ cognitive difficulties in five European countries. The aim of this survey was to assess the degree to which services operated in a stress inducing context and the degree to which they had in place policies and procedures to support their employees in relation to the management of work related stress.*

Results: *It was found that there was wide variation in the operational contexts both at national and local level, with a number of organisations having little or no supportive policies and procedures in place to deal with work related stress whilst at the same time operating within stressful working contexts. These results suggest a need at an organisational level for the development of a person centred and work environment centred online stress management programme. Consequently, the ROSE programme was established (www.leonardorose.eu).*

Discussion and Conclusion: *Interventions that target the organisation as well as the individual are most effective in stress reduction.*

INTRODUCTION

Literature indicates that working with people with mental health problems and intellectual disabilities can be particularly challenging for support staff in terms of occupational stress, emotional exhaustion and „burnout", and can be a significant reason for experienced staff leaving their employment, either through stress related illness or resignation. Loss of such experienced personnel may in turn reduce the ability of services to provide effective care and support to people with mental health problems and intellectual disabilities.

A literature review conducted by Michie and Williams in 2003 on work related psychological ill health and sickness absence in health care settings indicated that key work factors associated with psychological ill health and sickness absence in staff were long hours worked, work overload and pressure, and the effects of these on personal lives; conflicting demands; poor social support at work; unclear management and work roles; interpersonal conflict and conflict between work and family demands.

In a report on Mental Health in Europe, the World Health Organisation (2008) emphasised that "mental health problems and stress-related disorders are the biggest overall cause of early death in Europe". Work place stress is the most commonly reported cause of illness

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by European workers, affecting more than 40 million individuals across the European Union, with studies suggesting between 50% and 60% of all lost working days related to it (European Foundation, 2007; European Agency for Safety and Health at Work, 2009). Estimates indicate that work-related stress costs an estimated €20 billion a year in lost time and health bills; accounting for a loss of 3 to 4% of European Gross National Product (European Agency for Health and Safety at Work, 2009).

Defining work related stress

European Commission guidance on work-related stress states it is "the emotional, cognitive, behavioural and physiological reaction to aversive and noxious aspects of work, work environments and work organizations" (Levi, 2000). The guidance goes on to state that work place stress is characterised by people feeling distressed and unable to cope at work (Levi, 2000). Work place stress can be caused by factors such as work content, work organisation, work environment and poor communication in the workplace (European Social Partners, 2004). Organisational indicators of work related stress include high absenteeism or staff turnover, frequent interpersonal conflicts or complaints by workers. At the individual level, workplace stress can result in various emotional, cognitive, behavioural and physiological reactions (Sarafino, 2005).

Policy on work related stress

The legislative frameworks of all EU countries consider work organisations to be a source of health and safety risks (Levi, 2000). Although the regulatory framework of most EU countries does not refer to stress directly, there are often regulations that refer to the causes of stress. This can be seen in the European Commission's Directive on the Introduction of Measures to Encourage Improvements in the Health and Safety of Workers at Work, 1989.

Transpositions from this EU directive can be seen at national level in the UK-Management of Health and Safety at Work Regulations, 1999 and Health; in Ireland in the Safety, Health and Welfare at Work Act, 2005; in Italy in the Safety at Work Charter, 2000; in Austria in the Health and Safety at Work Act, 1995; and in Romania in the health and safety law under the Romanian Labour Code, 2005. Consequently, all member states, and specifically the ones examined in this study should at an organisational level be compliant with their national legislation with regards work-related stress and be implementing supportive policies on the ground to deal with it.

Rose project

The ROSE project aims to develop a combined person and work-directed stress management programme in order to improve the long-term retention within services of staff in rehabilitation and support services. The project provides an accessible and user friendly online stress management programme which will be available to services and individuals 24 hours a day. The online programme will support centre managers, trainers and care workers to manage personal and organisational stressors. This will contribute to the well-being of an important group of staff who contribute to the social inclusion of people with disabilities.

METHODS

A Qualitative survey instrument was used to gather data through a convenience and purposeful sampling strategy. Both qualitative instruments were designed to gather data on the profile, national and local, of vocational and rehabilitation centres for mental health and/or intellectual disability service users. The questions were based on what the literature identified as significant organisational issues and contributors to work-related stress as these were referenced to current European Union policy.

The questions were divided into sections which sought information on the nature of service provision, service funding, work-related stress policies, staff qualifications and training and career pathways. These questionnaires were sent to senior centres in five service centres in each of five countries (Austria, Ireland, Italy, Romania and the United Kingdom – n=25). The countries were not chosen randomly but were selected on the basis of the location of organisations who had agreed to participate in the research at the time of application for funds to the European Union.

RESULTS

Size of sector

Respondents were asked to report on the size of the sector in terms of number of clients served and the level of provision of occupational services. All countries reported that specific occupational support services to clients who experienced mental health problems and intellectual disabilities were available. However, precise data relating to such services at a national level were unavailable since governments did not collect it. Nevertheless, at local level centres were able to report on their own number of clients served. This revealed interesting variations. For example in Italy there was an

average of 20 service users at centres whilst in Romania 380. Such figures suggest that case loads for individual staff in services in each country vary extremely.

Sources of funding

Respondents were asked to profile their respective countries in terms of principal sources of sector funding. All respondents reported that there were no figures available for the level of national funding for the sector. In all five countries, the sector was funded by a mixture of national and local funding, with in some cases, supplements from a fee for service or extra-national funding. However, in terms of security of funding there was wide variation. Thus in the UK For example, funding is received directly from the Department of Health (for NHS provision) and from local authorities (for other provision). This compared to Romania where funding sources were less certain being drawn from a mix of some state funding, but principally reliant upon grants from the European Union, the World Bank and the European Commission Development Bank.

Policies on work related stress

Centres were asked to comment on the degree to which it had policies in place that specifically dealt with work-related stress. In Austria, all centres reported that there were no local policies on workplace stress, stress risk assessments or anti-bullying. Only one centre reported that there was a policy to deal with absence from work and two centres reported that they had employee assistance programmes and conflict resolution policies.

In Ireland, four centres reported that their organisations had a policy on workplace stress, and all five said they had a policy to deal with absence from work, and an anti-bullying policy. Four centres reported that their organisations had an employee assistance programme and four reported that they had a conflict resolution policy in place.

In Italy, three centres indicated that they had policies that dealt with workplace stress, absence from work and employee assistance programmes. Only one manager reported that they had policies on an anti-bullying policy and conflict resolution. Again, only one manager reported that their centre had a stress risk assessment policy that incorporated workplace stress.

In the UK, four centres had a policy on workplace stress, five had a policy to deal with absence from work, five had an anti-bullying policy, four had an employee assistance programme and four centres had a policy on conflict resolution. Notably, centres in Romania stated that there were no policies in place in any of the above areas.

In terms of the numbers working in the sector, as with the case of numbers using such services, there was no national data available in any of the five countries. Data in this regard are held at the level of individual organisations. For example, in Ireland, the National Federation of Voluntary Bodies (NFVB) employ approximately 15,650 staff. Data from the National Association of Professional Educators (ANEP) and the Ministry of Health in Italy indicate that there are 25,000 educators working in the sector, 70,000 working in the social sector and 1,300,000 working in what is described as the sanitary health field. No data was available from the UK, Austria or Romania.

Staff qualifications

Qualification requirements to work in the sector also varied widely. In Italy it was reported that high levels of qualifications were the norm in the sector, though again based on role. Doctors/psychologists working in centres require a college degree. In the case of nurses particular specialist diplomas are requested. Others in the rehabilitation team (e.g. special educators, physiotherapists, speech therapists, neuropsycho-motility therapists, technicians, educational therapists, occupational therapists) require either a degree or a special diploma. This stands in contrast to Romania where staff are not required to hold any specific qualifications and it is at the discretion of the employer to ask for any proof of formal training before employment. As a result there remain a large number of people without specific or high levels of qualification or training working in the sector.

Career path

Centres were asked to report whether there was a nationally recognised career path for this sector in their respective countries. All reported no specialised career pathway but rather recognised pathways for the different professionals working in the sector, for example nursing, have their own specialised career path, but even with regard to these professions, there was no clearly defined avenue of progression.

DISCUSSION

Perceptions around limited or uncertain resources, the impact of these on structures of organisations

and the actual impact on day-to-day work are known to impact on the experience of work related stress (Edwards and Burnard, 2003; Lenthall et al., 2009). In most countries resourcing appears to have a strong contingent, and therefore unpredictable base – with perhaps the exception of the UK. As a result there is a degree of uncertainty built into the system with regards to level of resource from year to year which is likely to contribute to work-related stress. This may explain variation in both level of service provision and nature of demand in terms of numbers clients served between countries, with services in the poorest country in terms of resource security –Romania – often having to deal with significantly larger case loads than other countries, such as Austria and the UK which receive a significant element of government funding.

Career pathways in the sector do not appear to have a clear progression, with little in the way of systematic approaches to staff development and support. In the context of the evidence for the protective nature of training and career paths helping employees deal with work-related stress this is significant (Golubic et al., 2009; Pitts, 2007).

Finally, bearing in mind the exhortations of European policy and the requirements of national legislation it is clear that at a local organisational level the presence of policies and procedures that address work-related stress vary considerably. The results would seem to indicate that the English speaking countries, Ireland and the UK, have a greater consciousness of work related stress – measured by policies and systems reported in place – than the non-English speaking countries. However, it is notable that no country at a local level appears to have a fully comprehensive set of policies and procedures that address the issue. This variation may be due lack of awareness on the part of these organisations not only of their legal responsibilities but also of the issue of work-related stress itself or the possibility that most of the literature on the issue appears to be in English.

Development of rose (reducing occupational stress in employment) website

Having considered these 'scoping' results two significant issues emerged overall which needed to be considered in terms of development of a supportive intervention to help manage work place stress. The first was affordability and the second was accessibility to a large group of people with various levels of educational attainment (both in terms of ease of access and also language). An important consideration for this project was its financial viability. As a result a web-based simple self management programme and organisational support programme design was proposed that could be provided on the internet with free access for all.

Bearing in mind the results of the centre survey and results from reviews of the literature, it was decided that the intervention programme would concentrate on two levels of support. The first, for centre managers, would provide them with information and tools to help them design working environments that minimised environmental stressors in the work place. The second would provide a series of self help teaching sessions for individuals to help them manage their own work related stress.

To build a platform Moodle, an open source virtual learning environment (VLE) was used. Preliminary feedback from a small sample of potential users (n=100) indicated that the Moodle format was too plain and not graphical or interactive enough for users. Another software package that could provide a more attractive and interactive face called Articulate was then used. The final Programme is now online in four languages (English, German, Italian and Romanian) and is available at www.leonardorose.eu.

CONCLUSION

Using a web-based programme has benefits for users because they can tailor their own SMI to suit their individual needs and preferences, and the intervention can be made widely available for minimal post-development cost.

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ASSESSING PSYCHOSOCIAL STRESS IN THE HEALTH CARE SECTOR USING THE JOB CONTENT QUESTIONNAIRE

OCENJEVANJE PSIHOSOCIALNEGA STRESA NA PODROČJU ZDRAVSTVENEGA VARSTVA Z UPORABO VPRAŠALNIKA O ZADOVOLJSTVU PRI DELU

MARGARET DENNY

Abstract

Introduction: *This paper reports the findings of a small-scale exploratory study on psychosocial job strain amongst health care workers. The objective of this paper is to report on the findings of the Job Content Questionnaire (JCQ) as this relates to psychosocial work place stress. The JCQ, a 12-item scale, evaluates perceived work stress in six dimensions: skill discretion, decision authority, psychological demands, job insecurity, physical exertion and social support from supervisors and co-workers.*

Methods: *A cross-sectional design was used. Data were collected and analyzed from a range of managers and support workers (n=60) in the health care sector from 5 central locations in countries across Europe. Statistical analysis was conducted using SPSS Version 15.*

Results: *The JCQ adequately described perceived job stressors in the two participant groups as it identified 20% of the sample as presenting with symptoms of job strain. In addition, the findings from JCQ suggested that there is wide variation in terms of psychosocial job strain between countries.*

Discussion and conclusion: *The job content questionnaire is a useful tool to improve the working environment for employees. However, measurement techniques of psychosocial stress in the workplace and assessment tools are just a small part of the overall job-improvement process for health care workers. Based on European policy, which emphasises workplace well-being, the results indicate that there is a need to carry out more research that addresses stress management interventions in this sector.*

Keywords: *job content questionnaire, psychosocial stress, heath care, European Union*

INTRODUCTION

It is reported that up to 28% of employees across the European Union experience work related stress (Health & Consumer Protection Directorate-General, 2005). The European Social Partners Framework agreement, European Social Partners (2004) states that work place stress can be caused by factors such as work content, work organisation, work environment and poor communication in the workplace. The psychosocial work environment encompasses a number of factors that impact on the stress levels and well-being of workers, including the first identified job stressors such as job control and job demands (Karasek, 1979), but also more recently recognised stressors such as workplace bullying and sexual harassment (LaMontagne, Keegel, 2010).

Studies on stress and burnout in the workplace have considered individual and contextual work related factors separately rather than incorporating the two (job-person fit) in relation to the assessment of the psychological demands placed on workers and their capacity for autonomy in a busy and demanding working environment (Fernet, Guay, Senecal, 2004; Maslach, Schaufeli, Leiter, 2001). There are a number of job stress models discussed in the literature (Van de Ven, Van den Tooren, Vlerick, 2013), for example, the job demand-control model (JD-C or DCM model) (Karasek, 1979), which is the most widely studied (Karasek, Theorell, 1990). The effort–reward imbalance model (Siegrist, Siegrist, Weber, 1986), the job demands–resources model (Demerouti et al., 2001), and the demand-induced strain compensation model (de Jonge et al., 2001; de Jonge, Dormann, 2003; de Jonge, Dormann 2006; de Jonge et al., 2007; de Jonge et al., 2008; de Jonge, Peeters, 2009). In addition, most authors suggest that there are interactive effects between job demands and job resources, in which job resources are assumed to moderate the relationship between job demands and outcomes (Van de Ven, Van den Tooren,

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Vlerick, 2013) The Effort-Reward Imbalance Model (ERI) is an alternative theoretical model that focuses on the personal coping characteristics of workers and work rewards, as opposed to the control structure in the workplace (Siegrist, Siegrist, Weber, 1986; Siegrist, 1996). According to Van de Ven, Van den Tooren and Vlerick (2013, p. 1):

'The ERI Model claims that lack of reciprocity between `costs' and `gains' (i.e. high effort/low reward conditions) may cause a state of emotional distress which can lead to cardiovascular risks and other strain reactions (like poor subjective health and sickness absence).'

On the contrary, the 'strain' hypothesis formulated by Karasek (1979), Karasek and Theorell (1990) assume that the worst influence on health derives from a high demand, low control type of job JD-C Model (Clumeck et al., 2009). The JD-C model of job strain is one of the most widely used models in research on the relationship between work and health (Ylipaavalniemi et al., 2005). The model was designed to assess the psychological demands upon an employee as these relate to such psychological and social factors as decision latitude, social support, physical demands and job security (Karasek, 1979; Karasek, Theorell, 1990; Karasek et al., 2007). Job demand is conceptualised as the volume of work to be achieved as well as the requirements and time constraints related to the work, such as, physical, social, or organizational aspects of the job that require sustained physical and mental effort, with resultant exhaustion (Demerouti et al., 2001). Job control is conceptualised as the control over work process, or the ability to make decisions and the chance to exercise a degree of control over the work to be accomplished (Fernet, Guay, Senecal, 2004).

The JD-C model proposes that job demands may have two opposing consequences for employees, either job strain development or positive job outcomes (Fernet, Guay, Senecal, 2004). Therefore, the JD-C model predicts, first, stress related risk and, second, active-passive behavioural correlates, which Karasek (1998) describes as feelings of competence, productivity and accomplishment by employees in the workplace. Therefore, the model hypothesises that a combination of high psychological job demands and low job decision latitude or low job control causes high job strain and leads to job related negative health outcomes (Cheng et al., 2000; Van de Ven, Van den Tooren, Vlerick, 2013; Yeh, Cheng, Chen, 2009). These negative health outcomes relate to the physiological manifestations of stress, as identified by JD-C hypothesis, such as a risk factor for coronary heart disease (CHD) (Akiomi et al., 2009; Cheng et al., 2000; Landsbergis et al., 2005; Leroux, Brisson, Montreuil, 2006; Wang, Mittleman, Orth-Gomer, 2006). Other studies have suggested that there is a correlation between job related stressors and insomnia (Cahill, Landsbergis, 1996; Kalimo et al., 2000; Leroux, Brisson, Montreuil, 2006; Murata et al., 2007; Nomura et al., 2009) and job strain (Nomura et al., 2009), whereas insomnia decreases when an employee has a higher degree of job control and social support at work (Nomura et al., 2009). Achat et al. (2000) and Elovainio et al. (2004) have found that job related stressors may increase cancer risk. Karasek and Theorell (1990) suggest that job decision latitude moderates the detrimental effects of psychological work-related stressors on health. Elovainio et al. (2004, p. 1167) conclude their research by suggesting that: 'decision-making procedures and interpersonal treatment routines may be factors worth focusing on when an organization aims to prevent health problems among its employees.'

The JD-C model uses additional scales to measure macro-level decision latitude, psychological strain, job satisfaction, the customer interface, and the human/computer interface. Moreover, the JD-C model reflects a stimulus approach that emphasizes personal cognitive interpretations of the person-environment relationship, suggesting that behaviour is generated by the social environment (Karasek, 1979; Karasek, Theorell, 1990). According to Fernet, Guay and Senecal (2004, p. 40) 'this model suggests that job control protects the individual from the unhealthy effects of the work environment.' Fernet, Guay and Senecal (2004) suggest that m JD-C model proves to be useful for understanding the link that exists between job demands and work adjustment, but they caution that it does not take account of individual differences in explaining such a link.

METHODS

A cross-sectional research design was used.

The objectives of this study were:

- To compare psychosocial stress across countries
- To ascertain if any of the participants in the five countries presented with a combination of high job demands and low job control that signifies higher stress job situations.
- To investigate if the main sub scales of the JCQ: decision latitude (DL), psychological job demands (PJD) were associated with the prevalence of job strain risk behaviours, that is, smoking, high blood pressure, sleep problems that are associated with coronary heart disease.

Sample

An available sample from five rehabilitation centres in five European countries – United Kingdom, Ireland, Italy, Romania and Austria – were accessed using the job content questionnaire (JCQ). Specific parameters of interest to this survey were centre managers (n=30), who coordinated vocational rehabilitation centres in the mental health and intellectual disability occupational support sector across the EU and frontline centre support workers (n=30) who were directly engaged in the provision of such services. Ethical approval was sought from Institute where the research was carried out. The researcher adhered to all the ethical principles and associated guidelines for research, thus ensuring the protection of the welfare and rights of all the participants involved in the research. The researcher obtained informed consent and written assurance of anonymity and confidentiality were given to all participants involved in the research.

Instrumentation - The Job Content Questionnaire

The JCQ is a nationally standardized instrument that provides a scoring system that enables both within and across population comparative analysis of occupational psychosocial stress and is available in several languages (Karasek, 1979; 1998). The theoretical interpretation of the JCQ reflects a sociological focus since it presumes the existence of socially objective environments that systematically affect an individual's well-being and behaviour (Karasek, 1979; 1985). In addition, the JCQ adopts a psychological focus, with a behaviour basis for emotion-driven psychological distress, psychosomatic illness development and changes in micro level behaviour that are related to social situations (Karasek, 1998).

No personality orientation scales or measures of non-job stressors are included. The full JCQ consists of 49 items. Each of these items has a 4-point Likert scale response, ranging from 1 (strongly disagree) to 4 (strongly agree) (Karasek, 1985). All the scales can be used for micro-level, job-characteristic analytical purposes, such as assessing an individual's exposure to particular psychosocial stressors, which is dependent on the person's role in the organisation (for example, manager or support worker) (Karasek, 1985). In addition, it has been used for population and comparative analytical purposes (Karasek, 1985).

The items on the JCQ are grouped under 5 major scales:

1. Decision Latitude (job control) with two subscales (Decision authority and skill discretion) (9 items).
2. Psychological demands and mental workload (5 items).
3. Social support (co-worker and supervisor) (11 items).
4. Physical demands (5 items).
5. Job insecurity (6 items).

Decision latitude, which is the first scale (range 24-96), is defined as the sum of two subscales given equal weight:

- Skill discretion, measured by six items (keep learning new things, can develop skills, job requires skills, task variety, repetitious, and job requires creativity).
- Decision authority, measured by three items (have freedom to make decisions, choose how to perform work, and have a lot of say on the job) (Karasek, 1999).

The second scale, which is psychological job demands (range 24-48), is defined by five items (excessive work, conflicting demands, insufficient time to work, work fast, and work hard) (Karasek, 1998).

Psychometric properties of the JCQ

The reliability of the JCQ scales in a cross-national context has been tested using 10,288 men and 6,313 women from 6 studies conducted in 4 countries (Karasek et al., 1998). Substantial similarity in means, standard deviations, and correlations among the scales, including correlations between scales and demographic variables, was found for both men and women in all studies. Reliability for all scales was good and the results suggest that psychological job characteristics are more similar across national boundaries than across occupations (Karasek et al., 1998; Karasek et al., 2007). Table 1 presents the average Cronbach's alphas of the main JCQ scales.

Table 1: Average Cronbach's alphas of the main JCQ scales from the two studies (Karasek et al., 1998; Karasek et al., 2003)

Main JCQ Scales	Average Cronbach's alphas Study 1 (Karasek et al., 1998)		Average Cronbach's alphas Study 11 (Karasek et al., 2003)	
Skill discretion	**Male**	**Female**	**Male**	**Female**
Decision authority	0.73	0.75	0.73	0.72
Psychological demands (5-items)	0.68	0.68	0.63	0.66
Supervisor support	0.63	0.63	0.59	0.61
Co-worker support	0.84	0.84	0.85	0.86
Physical demands	0.75	0.77	0.79	0.80
Job insecurity	0.86	0.79	0.86	0.84
Skill discretion	0.61 (3-items)	0.58 (3-items)	0.48 (4-items)	0.47 (4-items)
Decision authority	0.73	0.75	0.73	0.72

In addition, detailed information regarding the psychometric properties of the C-JCQ can be found in the research publications of Cheng et al. (2005) and Yeh, Cheng and Chen (2009). In this survey the internal consistency of the JCQ was ascertained using Cronbach's alpha coefficient. Questions that were negatively worded were re-coded before analysis. Cronbach's alpha coefficients of psychological demands, decision latitude and social support of participants were 0.42, 0.66 and 0.85 respectively. Permission was given by Professor Karasek to use the JCQ in this small scale research.

Data analysis

All scores were imported into an industry standard software package – Statistical Package for the Social Sciences (SPSS-version 15) and statistically analysed. Descriptive statistics were used to describe sample characteristics and inferential statistics were used to deduce conclusions about the population based on the sample's characteristics.

RESULTS

The JCQ was distributed to managers (n=30) and support workers (n=30) and a response rate of 90% was achieved. Altogether, fifty four questionnaires were completed by both managers and support workers from the five partner countries. Table 2 presents the demographic details of participants from the five participating countries.

As can be seen from Table 2 the greatest response rate was from Romania (n=14). Italy had the lowest response rate (n=7). In relation to gender the greatest response was from females (n=43) compared to men. Participants were predominantly white with one in the 'other' category. The greatest number of participants were married (n=33) followed by twelve who were single (n=12). The distribution of scores for age shows that participants in Italy (mean=51.0) were slightly older than the other participant groups with the youngest participants coming from Ireland (mean=34.7; SD 7.7).

Table 2: Gender, ethnicity, marital status, mean age by country

Country	Response	Gender		Ethnicity		Marital Status				Age Mean(SD)
	n	F (%)	M (%)	W (%)	O (%)	S (%)	M (%)	D/S (%)	W (%)	
Austria	9	6	3	8	1	3	4	1	0	48.0 (9.2)
Ireland	12	10	2	12	0	5	6	1	0	34. 7 (7.7)
Romania	14	13	1	14	0	1	12	1	0	39.9 (7.1)
Italy	7	5	2	7	0	2	3	2	0	51.0 (9.4)
UK	12	9	3	10	0	1	8	2	1	46.3 (11.2)
Total	54	43	11	51	1	12	33	7	1	

Legend: F=female; M=male; W=white; O=other; S=single M=married; D/S=divorced/separated; W=widowed

Table 3: Decision Latitude; psychological job demands; social support; job insecurity and physical psychosomatic strain, cross-tabulated by country and job type

	Country		Support Workers	Managers
Country	**n (%)**	**Mean (SD)**	**n (%)**	**Mean (SD)**
Decision Latitude				
Austria	4	57.7 (7.1)	5	60.4 (4.9)
Ireland	6	54.6 (5.7)	6	57.5 (4.9)
Romania	8	52.5 (4.2)	6	57.2 (7.5)
Italy	3	60.1 (6.1)	4	61.3 (6.0)
UK	4	58.0 (9.0)	8	56.1 (6.9)
Total	25		29	
Psychological Job Demands				
Austria	4	32.3 (3.9)	5	34.6 (2.9)
Ireland	6	30.3 (3.3)	6	35.8 (6.1)
Romania	8	32.9 (6.2)	6	34.2 (2.2)
Italy	3	29.0 (3.6)	4	28.3 (1.8)
UK	4	31.8 (4.8)	8	34.4 (5.1)
Total	25		29	
Social Support				
Austria	4	20.0 (4.2)	5	32.0 (11.2)
Ireland	6	24.8 (2.6)	6	23.7 (4.2)
Romania	8	20.6 (4.0)	6	21.0 (3.6)
Italy	3	23.3 (2.0)	4	23.0 (1.0)
UK	4	25.3 (6.0)	8	28.6 (9.7)
Total	25		29	
Job Insecurity				
Austria	4	6.8 (3.5)	5	4.6 (0.5)
Ireland	6	4.8 (1.0)	6	5.5 (0.8)
Romania	8	7.0 (2.1)	6	5.5 (1.7)
Italy	3	4.3 (0.6)	4	6.8 (4.1)
UK	4	4.3 (0.6)	8	4.9 (0.8)
Total	25		29	
Physical Psychosomatic Strain				
Austria	4	0.3 (0.3)	5	0.1 (0.0)
Ireland	6	0.1 (0.0)	6	0.3 (0.2)
Romania	8	0.2 (0.1)	6	0.3 (0.1)
Italy	3	0.2 (0.0)	4	0.2 (0.2)
UK	4	0.3 (0.1)	8	0.3 (0.1)
Total	25		29	

Table 3 evidences the demographic distribution of the recommended scales scores (decision latitude, psychological job demands, social support, job insecurity and physical psychosomatic strain).

Scores for decision latitude (skill discretion and decision authority) were greater for managers than support workers in each country other than the UK.

The mean scores for psychological job demands, which is the psychological stressors involved in accomplishing the work load, stressors related to unexpected tasks, and stressors related to job related personal conflict were greater for managers than for support workers. In Italy, psychological job demands scores were slightly higher for support workers (m=29.0, SD=3.6) than for managers (m=28.3, SD=1.8). The greatest score for psychological job demands was for managers in Ireland whilst the lowest score was for managers in Italy.

Social support scores were greater among managers in Austria and the lowest score was for support workers in Austria.

Job insecurity was higher for managers than for support workers. Support workers in Romania scored highest on the job insecurity scale. The lowest score was by support workers in Italy and in the UK. In relation to the scale physical psychosomatic strain, managers scored highest. The highest scores were by managers in Ireland, Romania and Italy and by support workers in Austria and the UK.

Table 4 presents a breakdown of results on workers exposed to both high Psychological Demands and low job Decision latitude (PD+, DL–) referred to as a high-strain group of workers.

Table 4: Job strain (high psychological job demands and low decision job latitude)

Job Strain	Frequency	%
No job strain	44	(81.5)
High job strain	10	(18.5)
Total	54	(100.0)

The findings indicate that 10 (18.5%) participants presented with high job strain. High job strain is defined as scoring above 32 (median score) in Psychological Job Demands and below 56.5 (median score) in Decision Latitude.

Table 5 presents risk behaviours that have been associated with job strain.

Table 5: Risk behaviours associated with job strain

Variable	**Frequency**	%
Smoker		
No	40	74.1
Yes	13	24.1
Missing	1	1.9
Total	54	100.0
Blood Pressure		
Yes	2	3.7
Borderline	4	7.4
No	46	85.2
Don't Know	2	3.7
Total	54	100.0
Often Tired		
Often	11	20.4
Sometimes	29	53.7
Rarely	13	24.1
Never	1	1.9
Total	54	100.0
Trouble Getting to Sleep		
Often	4	7.4
Sometimes	17	31.5
Rarely	19	35.2
Never	14	25.9
Total	54	100.0
Trouble Staying Asleep		
Often	6	11.1
Sometimes	16	29.6
Rarely	11	20.4
Never	20	37.0
Missing	1	1.9
Total	53	100.0

As can be observed from Table 4 approximately one-quarter (24.5%) of the participants stated that they smoke. Less than 4% (3.7%) stated that they had high blood pressure problems. Eighty-four per cent reported that they are sometimes or often tired. Approximately 42% (41.5%) stated that they sometimes or often had trouble staying asleep.

Table 6 presents the results of risk behaviours cross-tabulated with the high strain group.

Table 6: Risk behaviours cross-tabulated with high strain group

Smoker	**No Job Strain** n %	**High Job Strain** n %	**Total** n %
No	30 (69.8)	10 (100.0)	40 (75.5)
Yes	13 (30.2)	0	13 (24.5)
Total	43 (100.0)	10	53 (100.0)
High Blood pressure			
Yes	2 (4.5)	0	2 (3.7)
Borderline	4 (9.1)	0	4 (7.4)
No	36 (81.8)	10 (100.0)	46 (85.2)
Don't Know	2 (4.5)	0	2 (3.7)
Total	44 (100.0)	10 (100.0)	54 (100.0)
Often Tired			
Often	8 (18.2)	3 (30.0)	11 (20.4)
Sometimes	24 (54.5)	5 (50.0)	29 (53.7)
Rarely	11 (25.0)	2 (20.0)	13 (24.1)
Never	1 (2.3)	0	1 (1.9)
Total	44 (100.0)	10 (100.0)	54 (100.0)
Trouble Getting to Sleep			
Often	3 (6.8)	1 (10.0)	4 (7.4)
Sometimes	13 (29.5)	4 (40.0)	17 (31.5)
Rarely	16 (36.4)	3 (30.0)	19 (35.2)
Never	12 (27.3)	2 (20.)	14 (25.9)
Total	44 (100.0)	10 (100.0)	54 (100.0)
Trouble Staying Asleep			
Often	5 (11.6)	1 (10.0)	6 (11.3)
Sometimes	13 (30.2)	3 (30.0)	16 (30.2)
Rarely	9 (20.9)	2 (20.0)	11 (20.8)
Never	16 (37.2)	4 (40.0)	20 (37.7)
Total	43 (100.0)	10 (100.0)	53 (100.0)

Table 6 indicates that none of those in the high strain group smoke. All of those within the high strain group reported that they did not have high blood pressure. Eight of the 10 in this group stated that they are sometimes or often tired and four out of the 10 stated that they had trouble staying asleep.

The items corresponding to depression/life dissatisfaction are given in Table 7 together with the number and percent who reported a score of at most three for each item. This score indicates that the participants described their lives by the words outlined in Table 7.

Table 7: Depression/Life dissatisfaction items

Is your life	**n**	**%**	**Cross-tabulated (High strain group) n**
Boring	1	1.9	0
Enjoyable	47	87.0	6
Worthwhile	50	92.6	6
Friendly	48	88.8	5
Full	50	92.6	7
Hopeful	49	90.6	6
Rewarding	47	87.0	5
Brings out the best in you	46	85.2	3

Less than two per cent of participants described their life as boring. The majority of participants described their lives as worthwhile (92.6%), full (92.6%), hopeful (90.6%), friendly (88.8%) enjoyable (87%), rewarding (87%) and brings out the best in them (85.2%).

Of the 10 participants within the high strain group, boring was not selected by any of them to describe their lives. Seven described their lives as full. Enjoyable, worthwhile and hopeful were each identified by six participants. Friendly and rewarding were each selected by five participants. Three participants described their lives as bringing out the best in them.

DISCUSSION

Findings from the JCQ showed that just under 20% of the sample showed symptoms of job strain, whilst results from the focus groups indicated that the key stressors for workers were uncontrollable/unpredictable events, lack of communication between staff, interpersonal conflict and lack of support in one's work.

Scores for decision latitude (skill discretion and decision authority) psychological demands and social support in the JCQ were consistently positive for managers when compared to support workers in each country. This suggests that managers in centres who have high psychological demands and high control (latitude) do not appear to present with high job strain. This is consistent with the findings of other studies (Akiomi et al., 2009; Leroux, Brisson, Montreuil, 2006). Social support was low for support workers. It has been found that high staff support at work increases staff retention (Brough, Frame, 2004; Houkes et al., 2003). If staff perceive that they are supported in the workplace it improves health outcomes, as it acts as a stress buffer (Gruber, 2008; Wang, Mittleman, Orth-Gomer, 2005).

The finding in the JCQ that 10 participants presented with high job strain is consistent with the results of studies such as Akiomi et al. (2009) and may be an important predictor of future physiological manifestations of job strain, such as cardio vascular disease, for these workers. The results do not support the findings of other studies that have suggested that insomnia increases with job stressors, including job demands/job strain (Nomura et al., 2009).

This JCQ result is also consistent with other research findings as these relate to work demands and participants' dissatisfaction with levels of communication and involvement in decision making. The European Parliament (2008) in their draft report on Mental Health indicate that poor communication at work can contribute to the development of mental disorders or induce workers to take early retirement. In terms of physiological manifestations of stress, the JCQ results indicate that risk behaviours in other research that is associated with job strain, that is, smoking and high blood pressure, were not substantiated by the 10 people in the high strain group. However, higher level symptoms were reported by this group in response to the following questions often feeling tired, trouble getting to sleep and trouble staying asleep. The latter symptoms are associated with health related risk behaviours and support the results of existing research that suggests that there is a connection between the physiological effects of stress and job strain (Inoue et al., 2009; Leroux, Brisson, Montreuil, 2006; Murata et al., 2007; Nomura et al., 2009; Rehman, Rasli, Alharthey, 2011).

Limitations

The non-random selection of participants meant that an available sample had to be used and the sample (n=60), which impacted on the procedures needed to show statistically significant differences between countries. Measurement of job strain, using the JCQ, at only one point in time may have underestimated the effect of job strain in the identified centres and limits causal inferences. In addition, the subjective interpretation of questions by participants due to cultural or translation misunderstandings, may have impacted on the results. Eighty per cent of the target group did not present with high job strain. This may have been due to the Likert scales distorting the results or other extraneous variables. However, it could be due to respondents avoiding extreme category responses or agreeing with responses as presented or trying not to portray themselves or their organisation in an unfavourable light (Hodge, Gillespie, 2003). However, the strength of this small scale assessment highlights the fact that the JCQ rightly identified psychosocial stress in ten of the participants (Denny, Wells, Cunningham, 2011). Future research, should evaluate more intrinsic work characteristics and the use of logistic regression analysis to estimate the odds ratios (ORs) for job strain in health care sector, using a longitudinal design with a similar cohorts (Stephen et al., 2012).

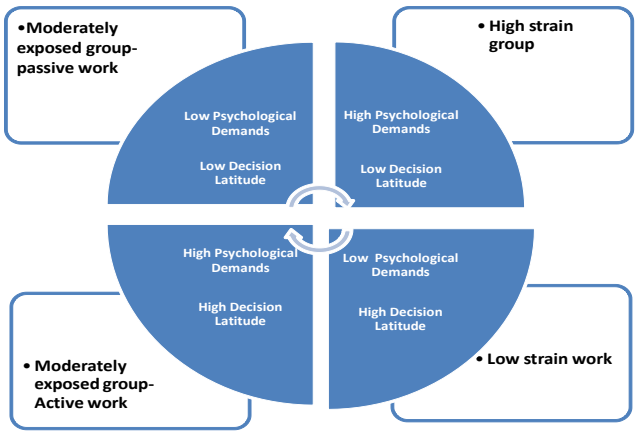
Implications

Some tentative conclusions can be drawn from the finding on psychosocial job characteristics in this survey. Ten participants presented with job strain characteristics or high job strain, which as stated previously is characterised by low job control, high job demands and low job social support (Denny, Wells, Cunningham, 2011). Consequently, there is a probability that participants may have an increased risk of developing cardiovascular disease (CVD) and/or associated negative physiological health outcomes. Landsbergis et al. (2002) posit that even the most refined instruments such as the JCQ are crude tools relative to assessment of other CVD risk factors and suggest that, in addition to such tools, more precise measurement tools should be used (body mass index measures) such that there is no bias in analyses toward underestimating the true effect of job strain (Landsbergis et al., 2002, p. 1045). It is important to understand that the combination of high job demands and low job control precipitates psychological and physical strain (Job strain-Figure 1).

In general, given the available evidence from the literature more proactive measures need to be considered by managers in terms of understanding the trajectory of job strain development in the workplace (Figure 1). As stated previously, the JD-C model presupposes that employees working in an environment that combines high job demands and low job control may develop adverse health outcomes. Whereas, positive psychosocial work conditions, high psychosocial demands jobs combined with high job control, low demands – low control, and low demands – high control conditions do not appear to have as a deleterious effect on the wellbeing of employees (Karasek, Theorell, 1990). The JD-C should be fully incorporated into the assessment of psychosocial stress (Cheng et al., 2000).

Therefore, in terms of job-related risk illness development the results of this cross-sectional study can provide managers/supervisors in health care settings with evaluative tools that assess the factors that contribute to job strain, that is, why some workers have increased work load, conflicting demands, insufficient time to do work tasks, have to work at a fast pace (Denny et al., 2011).

Figure 1: Job strain model



Appraisal of employees work and working environment should aim to facilitate jobs where demands are low and control is high, which leads to feelings of competence, productivity and accomplishment in the workforce (Fernet, Guay, Senecal, 2004; Karasek, 1979; Karasek, Theorell, 1990). Promoting decision making by all workers and fostering interpersonal relationships are key factors that an organisation should aim to promote in order prevent ill health outcomes in an organisation (Elovainio et al., 2004).

CONCLUSION

The findings from this exploratory study indicate that in the health care sector a sense of control over one's work and feeling involved and supported are key variables that impact on a personal sense of occupational stress and organisations need to consider this in relation to how they organise their working environment and structure working relationships. The job content questionnaire, which assesses JD-C in the workplace, focuses on task-level job characteristics and is a good indicator of the perceived stress among workers that arises from the interaction of low control with high demands which, according to the model produces 'job strain' and consequent ill health outcomes.

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THE DEVELOPMENT OF SOCIAL SKILLS - AN EMPIRICAL STUDY OF THE OCCUPATIONAL GROUP OF NURSING

RAZVIJANJE SOCIALNIH VEŠČIN – EMPIRIČNA RAZISKAVA POKLICNE SKUPINE V ZDRAVSTVENI NEGI

MONIKA RODE

Abstract

Introduction*: The interpersonal relation is the midpoint of social occupation as well as a feature of society. In the occupational group of nursing, experience and literary analysis show that social competences are indifferent up to a behaviour that harms patients. The research question: Is there a correlation between the consideration in early childhood with aesthetic subjects, the development of social competences and their personal meaning to nurses?*

Methods*: Selected reference sciences had been looked at with a qualitative content analysis. Semi-structured or focussed interviews have been chosen as a survey method. The interviews have been evaluated on the basis of a developed code and category scheme in terms of the research question.* ***Results****: The concepts, which were developed through the socialisation process of the analysis, the power of imagination, an access, the expressiveness and the developed taste, are defined as elements of the aesthetic competence, which have influenced the individual moral concept and ontogenesis of the social competence. The better the aesthetic competence is promoted in a differentiated way within the socialisation process, the more of the same concepts will be involved and trained. In turn, these portray the main foundation of the social competence. It can be assumed, that an intensive support of the aesthetic competence influences the development and accordingly the extent of the ontogenesis of the social competence.*

Discussion and conclusion*: It has been revealed, that there is a correlation between the aesthetic socialisation and the ontogenesis of the social competence. At the same time, the evaluation shows, that further research is needed to differentiate the correlation for necessary dissociation to other phenomena's and to underpin the assumption.*

Keywords*: research, development, social competence, socialization*

INTRODUCTION

According to an investigation of Dätwyler and Baillod (1995), caregivers claim to look at their patients not as an object of their work, but according to their job description, put welfare of the patients at first. The promotion of the patient's well-being assumes the social competences significantly. However the nursing practise and the research in literature monitor the opposite phenomenon. The social competence of nurses, during a situation when they have to deal with a patient, represents indifferent deeds in sort and area. There are different phenomenons in the nursing practise. On the basis of personal norms there is an imperative for action. Often they are diffuse, irregular and in principle not valid, because they are ethically and individually influenced with regards to an argument of objective. Abresch (1991) demonstrated in a study, that 75% of the nurse trainees treated their patients' worse. They showed a different behaviour: less talking time with the patient, rejection of personal conversations, uninterested towards the patient during the treatment, to neglect the patient, taking back the care intensity, unfriendly behaviour, to treat the patient with contempt and so on. So-called "difficult" patients are to be subjected with the increasing aggressive and generally damaging behaviour of the nurses. Moreover there are studies of Paterson, Turnbull (1993), Oud (1993), Lowe (1993), Steinert (1993), which are indicating that aggressive behaviour of caregivers, evoke the same behaviour in patients (quoted after Elsbernd, Glane, 1996).

The research question: Is there a correlation between the consideration in early childhood with aesthetic subjects, the development of social competences and their personal meaning to nurses?

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METHODS

Selected reference sciences have been looked at by means of a qualitative content analysis. An interdisciplinary research approach has been chosen on the basis of multidimensional concepts of social competence. These concepts are essentially based on the anthropology, psychology and sociology. Moreover it undergoes a removal of boundaries in terms of inter relating additional aspects, as well as multidimensional concepts such as role taking or empathy. Furthermore the interdisciplinary question limits the research approach, in so far that the concept of ontogenesis as well as phylogenesis of evolutionary biology would deliver more aspects, which would not be a midpoint of this thesis. Derived from this follows a synthesis of the interdisciplinary approach as an explanatory model of social competence.

To investigate this, an interview method of the qualitative semi-structured or focussed interviews has been chosen. The question deals with human experiences, therefore qualitative research is suitable for this area. The questions have been developed as an interview scheme, to focus on the main aspects. The scheme should ensure that the interviewer surveys the same information with each individual. This will prevent side information as in a non-structured interview (Holloway, Wheeler, 2000). This way of interviewing admits enquiries to certain aspects and views how to receive distinguished answers.

The interview behaviour is designed with a non-directive method. The interviews have been evaluated according to a developed code- and category scheme in relation to the research question. The question for the investigation retained after the Pre-Test.

The questions are semi-open and divergent. Query regarding the interview and headwords are formulated in the interview manual to determine further information or in-depth aspects. An access to several fields of occupation was given in various nursing care facilities. The total population was selected of 25 three year qualified nurses, which are employed at different institutions or hospitals. A determination of social competence by the Düsseldorfer Scale was considered. The question, if the instruments could be adapted to the specific question, was asked. The scale is exceptionally developed for psychological diagnostic and therefore no adaptation for an interdisciplinary approach is possible. This showed a self-contained complexity, which would have been beyond the scope. 25 caregivers have been selected randomly as a sample by an outside individual (anonymised with numbers). The socialisation research generally concerns itself with the identification of aspects of the ontogenesis of individuals and the relation between the societal impacts on individuals, especially through socialisation. Through a retrospective section on the biography of the questioned, certain aspects of socialisation have been pointed out. Parallel to it, concepts of social competence, which are defined by psychology, were queried. The connection to the anthropological question in particular to the interdependence between the aesthetic and social competence was determined in an indirect way. A qualitative content analysis was used as a basis for a categorization. The social reality is the goal of the survey, in which features of a consisting text will be transferred on features of non-existing context. (Merten, Schmidt, Weischenberg, 1994). It was decided to use a structure in order to be able to assess the interview's content through an organisation pattern. The coding modules represent a super ordinate paraphrasing of content. Here, the attention was paid to keep the format in a describing way.

It followed an adjustment of a unified stylistic level and a short form of grammar. Thereby a reduction high level of abstraction has been set along with a generalisation.

A selection scheme was determined for the divided categories. On this occasion, they used an inductive scheme, with which a generalisation of the material is possible. The credibility of the material was checked through the transcribed interviews of the questioned itself, as well as the interpretation of the facts by member checking. The statements and opinions of the questioned were reflected in codes. The transferability of the data is enabled through the description of the history and context within the explanation framework. Only the reader can facilitate the transferability and the comprehensibility. If the meaning in context changes, values in comparable research in education or in the discussion of nursing science must change. Therefore the dependence of the context and the history is given and the results cannot be static (Prakke, Wurster, 1999).

RESULTS

Social competence is seen as a multidimensional concept. The interdependences of the codes present a multidimensionality of the social competence by appearing during the evaluation of the results of the central question within the investigation and in the generated codes. They have to be understood as ontogenesis in humans and as a context of social action.

The elements indicated in the explanatory frame of the development of the aesthetic competence are confirmed

with all interviewees in the biographic, retrospective consideration. All interviewees have indicated to own imagination. “I must also fancy the things, before I know anyhow where it should go there, so I must consider only how it could look, so figuratively, before I can deal with it.“ To be artistically gifted one, everybody bragged, however, in different dimensions. 80% of them played in or also several instruments like recorder, guitar or percussion, participated in theatre groups or choir. The interviewees stated that this participation has contributed to the imagination. „My brother and I have written ourselves stories at home, also painted, (...) I have myself also composed sometimes a song“. All interviewees have played in the childhood a lot. In the centre stood the role-plays in which behaviour patterns were copied by parents and other attachment figures. Besides, were in the foreground the so-called classical mother and father behaviour. “We have played situations as it could be possible or how one simply fancies in the imagination. We have made this, already with the people whom there are also in the reality”. The takeover of values, norms and moral position is also transferred by the role takeover or is learnt. The interviewees report about the exemplary function of her attachment figures and their influence on her development.

It could be shown, that social competence in a broader sense is an essential feature of individuals. The socialisation in the early childhood and the childhood has an important role to play in the development of this competence. The analysis of the competence of caregivers can be seen as an example, which can be used as a representative for other social occupations. It was establish, that the interaction with patients and the competences necessary for it, have an important role in nurses’ everyday. To interact with other people, to campaign for others, are elements of social competence stated by Kanning (2005). For the discussion with other values, other behaviour patterns and the decisions arising from it for or against single values or images, the penetration of the contents, the examination assumes for a position and capability of expression. The investigation indicated here points to influence of the draughts of the aesthetic competence on the genesis of the social competence. By the development of the social competence it is about basic correspondence of the intrinsic values, the sensitivity, the piercing examination and the good taste in the interaction, in social actions as well as in the communication. Observable behaviour of caregivers during interaction with patients was indicated in the research issue of this thesis.

The following conclusions from the literature analysis are: The applied and promoted competences of the individual ontogenesis had been interrogated in a debate. The concepts developed through the debate of the socialisation process, the power of imagination, an access, the expressiveness and the developed taste, which are defined as elements of the aesthetic competence and which have influenced the individual moral concept and the individual ontogenesis of the social competence. The development of the aesthetic competence is accompanied by the development of the social competence. The aesthetic competence is addressed on different levels of the socialisation process. The promotion of fantasy and their implementation into games supports a role taking and a change of perspective in other people. Reading, playing music and self-contained developed stories and poems promote expressiveness. An interrogation with values of other people stimulates the access and promotes good taste so that it helps to create or support an own value system. In the light of the foregoing, it can be concluded: The differentiated the aesthetic competence, the more supported is the socialisation process and the more concepts of the same kind can be addressed and trained. In turn, social competences provide a solid foundation. It can therefore be taken for granted, that an intensive support of the aesthetic competence influences the development and accordingly the extent of the ontogenesis of the social competence. It can be assumed, that there is a high development of the social competence, if the aesthetic competence is generally strong. A high development of social competence implies mutually respect and esteem to other people, because they understand their situations. This understanding reduces thoughtless actions or words, as they have sensitivity for the individual. Generally damaging behaviour towards patients would be contrary to the internal concept of a distinctive social competence. The damaging behaviour can be attributed to a lacking social competence. However there have to be a distinction of causes between a Burn-Out-phenomenon and lacking social competence, which was not yet discussed in this interrogation.

DISCUSSION AND CONCLUSION

The social competence has a key role within nursing care, which is presented in the study submitted. Correlations between patient damaging behaviour and lacking social competence have not yet been identified. It could be shown that there is a correlation between the aesthetic socialisation and the ontogenesis of the social competence. The results of the discussion show simultaneously, that further research is necessary to differentiate the correlation, demarcate other phenomenon’s and support the assumptions. If further

research confirms the foregoing assumptions, there can be consequences derived for the training of social occupation and the field of education. The development of social competence is as important as the education of society, since the dealings with each other has substantially influenced the social competence. The aesthetic education and socialisation would place the pedagogical endeavours in the foreground, as well as the consideration of the anthropology.

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LEGAL ASPECTS OF THE LIABILITY IN THE WORK OF NURSES

PRAVNI VIDIKI ODGOVORNOSTI PRI DELU MEDICINSKE SESTRE

JADRANKA STRIČEVIĆ, SUZANA KRALJIČ, MAJDA PAJNKIHAR

Povzetek

Avtorice opozarjajo v prispevku na specifičnost vloge medicinske sestre, saj je njena lojalnost posvečena tako zdravniku kakor tudi pacientu. Prikazane so pravne podlage za delo medicinskih sester. Opozarjajo na določena odprta etična vprašanja glede varovanja poklicne skrivnosti in delitve dela med zdravnikom in medicinsko sestro. Posebno pozornost avtorice dajejo vprašanju glede odgovornosti medicinskih sester ter pri tem izpostavljajo zakonsko neurejenost zadevnega področja. Po besedah avtoric bi sodobna medicinska sestra morala biti seznanjena tudi s področjem človekovih pravic ter z osnovami dednega prava.

Ključne besede: *medicinska sestra, zdravstvena nega, odškodninska odgovornost, pojasnilna dolžnost*

Abstract

A nurse has divided loyalties. He or she is responsible to both, the doctor and the patient. In the article are presented legal acts, important for the work of nurses. Authors stress that there are open ethical questions relating to a nurse's obligation of confidentiality and to the division of work between doctor and nurse. Authors are giving special emphasis to the liability of nurses and stress that legal regulation of this is unclear. Authors discus that contemporary nurse should have knowledge of human rights and succession law.

Keywords*: nurse, nursing care, tort liability, explanatory duty*

IZHODIŠČA

Danes sploh ni dvoma, da je tudi na področju medicine in zdravstvene nege potrebno varovati človekove pravice. Človek se namreč pojavlja tukaj v specifični vlogi, saj lahko njegovo zdravstveno stanje povzroči pri njemu spremembe, zaradi katerih je postavljen v položaj določene odvisnosti, tako od zdravnika kakor tudi od medicinskih sester. Pogosto pa je v ospredje postavljeno razmerje med pacientom in zdravnikom - pacient lahko v zdravniku vidi osebo, ki mu bo pomagala, ali osebo, ki mu bo škodovala, kar je podano v primerih, ko je pacient obremenjen z nezaupanjem, ki temelji na preteklih izkušnjah (bodisi lastnih ali tujih). Če izhajamo iz prvega primera, je podana odlična podlaga za pozitivno razmerje med pacientom in zdravnikom, kar pa je bistvenega pomena za postavitev diagnoze, zdravljenje ali poseg. Pacient, ki zdravniku zaupa, mu bo lažje povedal, kje so njegove težave. V drugem primeru pa lahko pride do blokade, saj pacient nima zaupanja v zdravnika. Pacient se tako ne bo popolnoma odprl in bo poskušal prikriti določene informacije (npr. uživanje alkohola, kri v blatu, glavobole), kar lahko povratno pripelje tudi do napačnega ali neuspešnega zdravljenja, kar pa bo še dodatno povečalo pacientovo nezaupanje. Kakšna pa je vloga medicinske sestre? Njena vloga je dvojna, je kot katalizator, ki deluje med dvema poloma, katerima mora biti popolnoma predana. Na eni strani je to zdravnik, na drugi strani pa pacient. Njena vloga je zaradi tega specifična, saj ima svoje odgovornosti in dolžnosti tako nasproti zdravniku kakor tudi pacientu. V literaturi lahko zasledimo veliko zadev napisanih glede razmerja med zdravnikom in pacientom, medtem ko so prispevki, kjer je opredeljeno razmerje med medicinsko sestro in pacientom precej redkejši. Prav tako je malo prispevkov, ki se konkretno ukvarjajo z odnosi med zdravniki in medicinskimi sestrami.

Medicinske sestre: angeli usmiljenja ali angeli smrti?

Zdravniki so se pojavljali že v najstarejših časih (npr. Hipokrat), čeprav njihovo zdravljenje ni vedno možno opredeliti kot zgolj medicinsko, saj so mnogokrat igrali pri zdravljenju pomembno vlogo tudi drugi dejavniki: npr. vera, nadnaravne sile, rituali… Kljub temu pa lahko zasledimo v zgodovini, da so zdravniki že od nekdaj bili zelo cenjeni v družbi in takšen položaj so ohranili do danes.

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Poklic medicinske sestre se je v primerjavi s poklicem zdravnika pojavil znatno kasneje. Začetki dela medicinskih sester so temeljili predvsem na človekoljubnosti, solidarnosti in samaritanstvu. Delo medicinskih sester je bilo pogosto vezano tudi na religijska verovanja. Medtem ko je za zdravnika že od nekdaj veljalo, da mora biti deležen posebnega usposabljanja in kasneje tudi študija medicine, so se medicinske sestre pojavljale zgolj kot neprofesionalna pomoč zdravnikom.

Posebno mestu v razvoju zdravstvene nege zavzema Florence Nightingale, ki jo štejejo za ustanoviteljico sodobnega poklica medicinske sestre. V tedanji družbi medicinske sestre namreč niso imele cenjenega statusa, saj so se za medicinske sestre odločale zgolj revne ženske, ki so velikokrat sledile vojakom kot vojaške branjevke ali prostitutke. Florence Nightingale je prikazala na jasen način, da mora imeti medicinska sestra usmiljenje, da mora biti predana skrbi za pacienta in da mora biti marljiva ter obzirna. Zaslovela je po svojem delu v Krimski vojni (1854 - 1856), kjer je predvsem z delom ponoči, rešila s svojim prizadevanjem življenje več kot 4.000 britanskim vojakom. Znana je bila kot »*Lady with the Lamp*« ali »*Angel of Mercy*« (McDonald, 2001). Po vrnitvi s Krima je v Londonu ustanovila današnjo *Florence Nightingale School of Nursing and Midwifery.* Napisala je tudi *Notes of Nursing.*

Kljub temu, da je Florence Nightingale spremenila pogled na poklic medicinske sestre, pa so se skozi zgodovino zvrstili dogodki, ki so pustili črne packe na poklicu medicinske sestre. Še posebej je glede tega odmeven položaj medicinskih sester v času nacionalsocializma v Nemčiji od 1933. leta naprej. V tem času je sicer poklic medicinske sestre močno pridobil na ugledu, saj so medicinske sestre bile velika podpora in zaupne osebe zdravnikov. Njihov poklic je bil v tem času izpostavljen tudi novim načelom (npr. oblika in obseg podpore medicinske sestre do posameznika je bil odvisen od njegove vrednosti do celotne družbe). Medicinske sestre, ki so bile deležne 1,5 letnega izobraževanja v času nacionalsocializma, naj bi predstavljale elito med medicinskimi sestrami, zato so jih tudi imenovali »rjave sestre« (Lauber, 2012; Hahn, 1994). Po končanem izobraževanju so morale priseči:

> »*Prisegam Adolfu Hitlerju, mojemu voditelju, neomajno zvestobo in poslušnost. Zavezujem se, da bom na vsakem mestu, na katerega bom postavljena, zvesto in vestno v službi svojemu narodu izpolnjevala svoje poklicne naloge kot nacionalsocialistična sestra, kakor mi bo bog pomagal*« (Herholz, 2002).

Med naloge medicinske sestre je spadalo tudi sodelovanje pri evtanaziji in poskusih na ljudeh. Zato so bile po II. svetovni vojni posamezne nacionalsocialistične medicinske sestre spoznane za krive in tudi obsojene na smrt.

Tudi danes lahko zasledimo primere, ko so medicinske sestre vzele pravico odločati o življenju in smrti v svoje roke:

Primer Stephan L. iz Nemčije

»Da bolnega človeka rešiš njegovega trpljenja, je potreben državljanski pogum,« je izjavil strežnik (Krankenpfleger) Stephan L., ki je v različnih bolnišnicah, predvsem pa v bolnišnici Sonthofen, in v domovih za ostarele v Nemčiji, kjer je bil zaposlen, umoril 29 pacientov, starih med 22 in 95 let. Njihovo smrt je videl kot olajšanje njihovega trpljenja (Schlösser, 2006).

Primer Charles Cullen

V svoji 20 letni poklicni poti naj bi ubil več kot 40 pacientov, obsodili so ga v 16 primerih (Blanco, 2012).

Primer Terri Shiavo

Primer Terry Shiavo, ki je bila že 15 let in 34 dni v »budni komi« (Wachkomma) je ameriško javnost razdelil na dvoje, kljub temu, da je v ZDA dovoljena evtanazija, ki lahko temelji na pacientovi želji ali na podlagi odločitve sodišča. V tem primeru je šlo za neusmiljeno bitko med možem in starši. Mož Michael se je celo izučil za strežnika, da bi lahko skrbel za svojo ženo Terry. Boj za prekinitev strojev, ki so Terry ohranjali pri življenju, je potekal več kot sedem let, v katerih je bilo izdano več kot 30 sodnih odločitev (Shiavo, 2012).

PRAVNE PODLAGE ZA DELO MEDICINSKIH SESTER

Kot smo videli, so medicinske sestre že v preteklosti predstavljale nepogrešljivi del v medicini in ta vloga jim zagotovo pripada tudi danes. Že leta 1965 je bil na kongresu *Mednarodnega združenja medicinskih sester* v Frankfurtu sprejet *Mednarodni kodeks etike medicinskih sester (MK) leta* 1965, ki mu je leta 1973 s strani omenjenega združenja sledil *Kodeks za medicinske sestre* (KMS).

MK 1965 zajema 14 členov, v katerih je poudarek na temeljnih nalogah medicinske sestre in smislu njihovega poklica: ohranjati življenje, lajšati trpljenje in pospeševati zdravljenje (Dolenc, 1993). MK 1965 je

posegel s svojimi določbami tudi v odnos medicinske sestre do zdravnika, in sicer določa, da medicinske sestre ne smejo same zdraviti ali priporočati zdravljenja brez zdravnikovih navodil, razen v nujnih primerih. O morebitnem takšnem postopku morajo takoj obvestiti zdravnika. Nadalje je določeno, da mora medicinska sestra razumno in zanesljivo izvrševati zdravnikova navodila ter da mora biti vso njeno ravnanje v skladu z etičnimi načeli. Medicinska sestra mora podpirati zaupanje v zdravnika in v drugo zdravstveno osebje. O nesposobnosti ali neetičnem ravnanju sodelavcev mora poročati edinole odgovornemu organu.

KMS 1973 pa določil MK 1965 ne povzema, ampak določa zgolj, da medicinska sestra vzdržuje splošne delovne odnose s poklicnimi kolegi in drugimi sodelavci ter da je dolžna primerno ukrepati za zavarovanje posameznika, če njegovo zdravljenje ogrozi kakšen sodelavec ali kdorkoli drug.

V Sloveniji še ni sprejet poseben zakon, ki bi celovito in enovito uredil pravni položaj medicinskih sester. Določila, ki se nanašajo na medicinske sestre, predvsem posredno, zasledimo tako v Zakonu o zdravniški službi (ZZdrS-UPB3, 2006), Zakonu o zdravstveni dejavnosti (ZZDej-UPB2, 2005), Zakonu o pacientovih pravicah (ZPacP, 2008) in drugih. Vendar je Zbornica zdravstvene nege Slovenije - Zveza društev medicinskih sester in zdravstvenih tehnikov Slovenije, 25. marca 1994 sprejela Kodeks etike medicinskih sester in zdravstvenih tehnikov Slovenije *(*KEMS, 2002*)*. Problem KEMS je, da gre zgolj za etična pravila, ki pa nimajo *zavezujočega pravnega* učinka, vendar KEMS s svojo vsebino tvori etično podlago za opravljanje dejavnosti medicinskih sester.

Pogledi na posamezna vprašanja odgovornosti medicinskih sester

Zdravstveno dejavnost lahko opravljajo le zdravstveni delavci, ki imajo ustrezno strokovno izobrazbo, so strokovno usposobljeni za samostojno opravljanje v svojem poklicu in imajo ustrezne kvalifikacije (zdravniki, medicinske sestre). Za opravljanje določenih nalog s področja zdravstvenega varstva je potrebno vključiti tudi zdravstvene sodelavce, ki imajo ustrezno strokovno izobrazbo nezdravstvene smeri (prim. 1. in 2. odst. 62. člena ZZdrS). Zdravstveni sodelavci so tako lahko biologi, kemiki, psihologi itd. Razlika nastane pri vprašanju odgovornosti? Praviloma veljajo glede odgovornosti za zdravstvene sodelavce predpisi in standardi njihove stroke. Ker gre za sodelavce, ki nimajo zdravstvene izobrazbe, je neustrezno tudi, da bi se za njih uporabljala t.i. »medicinska skrivnost«. Vendar se tudi ti zdravstveni sodelavci pri svojem delu soočajo s številnimi podatki, ki se lahko nanašajo tako na zdravstveno stanje pacienta kakor tudi na osebne ali družinske zadeve. Zato se ne uporablja več izraza medicinska skrivnost, saj je preozek, ampak se uporablja izraz poklicna skrivnost (Šeparović, 1987), ki tako ni usmerjen zgolj v določen poklic, ampak je vsesplošno uporaben.

Odgovornost medicinskih sester je lahko tako kazenska kakor tudi poklicna, vendar je njihova moralna odgovornost najširša. Obstajajo namreč pravila, ki jih lahko na eni strani predpiše zakon, medtem ko imamo na drugi strani določene osebne lastnosti, ki naj bi jih imela medicinska sestra, a jih ni mogoče predpisati z zakonom. Tu so mišljene predvsem moralne kvalitete (Kravos, 2004). Medicinska sestra mora torej imeti visoka etična načela solidarnosti, pomoči in skrbi za pacienta, ne glede na svoja prepričanja. Njena naloga je, da pomaga drugemu, da mu lajša bolečine, da pri tem potisne v ozadje svoje interese, prepričanja, da je nesebična in požrtvovalna. Poznano je tudi vedenje medicinskih sester v ZDA, ki so igrale ruleto s stavami, kateri pacient bo prej umrl, neustrezno in neetično. Zanimiva je tudi odločitev Zveznega delovnega sodišča Nemčije, ki je odločilo, da je v razmerju do pacienta neprimerno, saj jih lahko iritira, če si strežnik dodatno služi denar kot pogrebnik (Sodna odločba, 2002).

Kako pa je z odgovornostjo medicinske sestre? Odgovornost medicinske sestre je subjektivna in je sorazmerna obsegu dolžnosti. Večji je obseg dolžnosti, ki jih ima medicinska sestra, večja je njena odgovornost. Tako je na primer odgovornost po izobrazbi višje medicinske sestre večja kakor odgovornost srednje medicinske sestre. Višje in nižje izobražena medicinska sestra ne moreta namreč enako odgovarjati, čeprav obe odgovarjata v obsegu svojih dolžnosti, svoje strokovnosti, svojega delokroga in prevzetih dolžnosti. Ameriško sodišče je odločilo, da je podana odgovornost medicinske sestre v sledečem primeru: pacient je bil paraliziran, hkrati pa je bil tudi strasten kadilec pipe. Vžigalice in pipa so bile na njegovi omarici ob njegovi postelji. Medicinska sestra je bila opozorjena, da je bolnik paraliziran ter da ne more ob kajenju sam umakniti pipe iz ust. Kljub temu je medicinska sestra pustila pacienta brez nadzora v sobi s pipo v ustih. Pipa je padla bolniku iz ust in zanetila ogenj v njegovi postelji, zaradi česar je pacient utrpel opekline. Sodišče je odločilo, da ima medicinska sestra dolžnost, da ščiti in varuje svoje paciente pred vsemi znanimi ali razumno predvidljivimi nevarnostmi. Medicinska sestra je bila v tem primeru spoznana za krivo, da je opustila varstvo svojega paraliziranega pacienta pred razumno predvidljivo nevarnostjo ognja (Kraljić, 2006).

Odgovornost ima svoje meje, ki so v človeški naravi. Velja torej načelo, da pravo ne more od nikogar zahtevati več, kot zmore (*ultra posse nemo tenetur).* Nepredvideno, nepričakovano, neznano, vse kar izhaja iz rednega delovnega toka, dosledna strokovnost, kar nihče drug pod istimi okoliščinami, ob isti strokovnosti, ne bi mogel izvesti drugače in če z ničemer ni bilo doprineseno k poslabšanju dejanske situacije, je podana situacija, ko je izključena odgovornost. Poseben problem je pomanjkanje znanja ali sposobnosti. V pravu je malomarnost določena s kriterijem standardne pozornosti povprečnega razumnega človeka, kadar pa oseba opravlja nekaj, kar zahteva posebno znanje ali sposobnost, bo le-ta odgovorna za malomarnost, če zato, ker nima znanja ali sposobnosti, naredi napako, čeprav je storila najbolje, kar je mogla in znala (Kraljić, 2006). Kakšen je standard medicinske sestre je zelo nazorno prikazano v *California Case,* kjer je sodišče opisalo standard oskrbe, ki mu morajo slediti medicinske sestre, s sledečimi besedami: »*Od medicinskih sester se pričakuje, da bodo ravnale profesionalno v skladu s splošno sprejeto razumno prakso zdravstvene nege in njihove storitve se bodo primerjale s storitvami drugih medicinskih sester v enaki specializaciji. V primeru zlorabe ali malomarnega opravljanja poklicnih dolžnosti bo primernost storitev medicinske sestre temeljila na profesionalnem standardu in se bo preizkušala s priporočili drugih medicinskih sester« (*Kraljić, 2006).

Odgovornost je lahko večplastna. Opustitev pričakovane aktivnosti zdravnika oziroma medicinske sestre lahko v določenem primeru zdravnika oziroma v našem primeru medicinsko sestro pripelje na:

- *kazensko sodišče* - 178. člen (KZ-1) se nanaša na *Opustitev zdravstvene pomoči* in določa, da zdravnik ali drug zdravstveni delavec (torej tudi medicinska sestra), ki v nasprotju s svojo poklicno dolžnostjo ne pomaga bolniku ali komu drugemu, ki je v nevarnosti za življenje, se kaznuje z zaporom do enega leta. Omenjeni člen torej nalaga medicinski sestri dolžnost, da pomaga tako bolnikom v bolnišnici kakor tudi vsakomur, ki je v nevarnosti. Ta dolžnost je ustrezna njihovi poklicni dolžnosti, kar pomeni, da se lahko glede na delokrog, sposobnosti, izobrazbo in spretnosti razlikuje. 179. člen KZ-1 (*Malomarno zdravljenje in opravljanje zdravilske dejavnosti*) v svojem 1. odst. posega na področje malomarnega ravnanja zdravnika, v 2. odst. pa enako kazen zapora do enega leta določa tudi za druge zdravstvene delavce, kar vključuje tudi medicinsko sestro, ki pri svoji zdravstveni dejavnosti iz malomarnosti ravna v nasprotju s pravili zdravstvene stroke in tako povzroči, da se komu občutno poslabša zdravje;
- *civilno sodišče* zaradi nadomestila škode;
- ali zgolj pred *disciplinski organ*.

Vsi trije primeri so lahko v konkretnem primeru združeni, lahko pa pride samo do disciplinske odgovornosti.

DELITEV DELA

Za zagotovitev predvidenega dela in njegove uspešnosti, ki se kaže predvsem v zdravljenju pacienta, je neizogibno potrebno, da med vsemi udeleženci, tako med zdravstvenimi delavci kakor tudi zdravstvenimi sodelavci, poteka usklajeno sodelovanje. Uspešnost se lahko zagotovi, če vsak udeleženec natančno ve, kaj so njegove naloge. Da bi se to doseglo, je potrebno organizirati delitev dela in natančno določiti obseg dela. Delitev dela poteka tako horizontalno kot tudi vertikalno. S horizontalno delitvijo dela je podana razmejitev med delavci istega ranga, ki imajo vsaj formalno isto strokovno znanje in enake sposobnosti. Vertikalna delitev pa je podana med delavci, ki so v medsebojnem razmerju nadrejenosti in podrejenosti. Podrejeni delavci so pri tem dolžni slediti navodilom nadrejenih, nadrejeni pa so dolžni nadzorovati delo podrejenih. Poznan je primer, kjer je nemško sodišče odločilo, da je otroška klinika kršila dolžnost nadzora, saj so otroci pacienti lahko neovirano zapustili bolnišnico. Če se otrok poškoduje zunaj bolnišnice, je bolnišnica zavezana k povrnitvi škode. K področju odgovornosti glavnega zdravnika otroške bolnišnice spada, po mnenju Višjega deželnega sodišča v Kölnu, tudi da skrbi za sprejemanje in spoštovanje nujnih ukrepov za varnost in varstvo otrok (Sodna odločba, 1993). Tako je tudi v VI. načelu KEMS določeno, da vodstvena medicinska sestra nosi posebno odgovornost, ki izhaja iz skrbi za sedanje in bodoče varovance.

Zanimivo je, da KMD govori zgolj o odnosih med zdravniki, ne pa o odnosih med zdravniki in drugimi zdravstvenimi delavci, še posebej med tistimi, ki so v odnosu do zdravnikov v podrejenem položaju – torej tudi medicinske sestre. KEMS v svojem VII. načelu ureja razmerja med medicinsko sestro in sodelavci, tako na horizontalni kakor tudi vertikalni ravni. Medicinska sestra tako ne sme odreči strokovne pomoči drugi medicinski sestri in odnosi med medicinskimi sestrami morajo temeljiti na spoštovanju in korektnosti. Medicinske sestre so pri tem dolžne upoštevati življenjske in strokovne izkušnje starejših in nadrejenih ter učiteljev, ki naj bodo mlajšim medicinskim sestram za vzgled in vodilo. Glede vertikalnih odnosov pa KEMS določa, da naj sodelovanje med medicinskimi sestrami in drugimi zdravstvenimi delavci, kamor vsekakor spadajo tudi zdravniki, temelji na odkritosti, poštenosti in kolegijalnih

odnosih. Kljub temu, da tretje poglavje KMD nosi naslov »*Odnosi med zdravniki«,* je možno najti tudi minimalno podlago, ki jo lahko tolmačimo v smeri urejanja odnosov med zdravniki in medicinskimi sestrami. To je podano v:

- - 26. členu KMD, ki se nanaša na solidarnost in tovarištvo med zdravstvenimi delavci, kar se kaže s tem, da zdravnik kolegialno oskrbi obolelega kolega, obolele zdravstvene delavce (kamor vsekakor spadajo tudi medicinske sestre) in študente medicine;
- - 35. členu KMD – zdravnik je dolžan varovati poklicno skrivnost, ki obsega vse, kar zdravnik in zdravstveno osebje (tudi medicinske sestre) pri opravljanju svojega poklica zvedo.

Kot omenjeno, opravljajo medicinske sestre določena dejanja po navodilih in pod nadzorom zdravnikov. Pri tem se postavlja vprašanje odgovornosti medicinskih sester, če napačno izvede navodilo ali če odstopi od navodila? Velja splošno pravilo, da vsak odgovarja sam za svoja dejanja v mejah svoje odgovornosti. Ravnanje po navodilih torej ne izključuje odgovornosti medicinske sestre, če je očitno, da je navodilo, ki ga je dal zdravnik napačno in neprimerno (Šeparović, 1987).

Medicinska sestra in poklicna skrivnost

Že iz KZ-1 izhaja (142. člen - neupravičena izdaja poklicne skrivnosti), da se, kdor neupravičeno izda skrivnost, za katero je zvedel kot zagovornik, odvetnik, zdravnik, duhovnik, socialni delavec, psiholog ali kot kakšna druga oseba pri opravljanju svojega poklica (torej tudi medicinska sestra), kaznuje z denarno kaznijo ali z zaporom do enega leta. Kaznivo dejanje pa ni podano, če se izda skrivnost zaradi splošne koristi ali zaradi koristi koga drugega, če je ta korist večja kakor ohranitev skrivnosti. Pregon se začne samo na zasebno tožbo. Glede na navedeno izhaja, da je tako zdravnik kot tudi medicinska sestra dolžna varovati poklicno skrivnost, ki se nanaša na podatke o zdravstvenem stanju pacienta, o vzrokih, okoliščinah in posledicah tega stanja (1. odst. III. načela KEMS). Pri varovanju poklicne skrivnosti veljajo po 2. odst. III. načela KEMS sledeči standardi:

- za poklicno skrivnost se šteje vse, kar medicinska sestra pri opravljanju svojega poklica zve o pacientu, o njegovih osebnih, družinskih in socialnih razmerah, pa tudi vse informacije v zvezi z ugotavljanjem, zdravljenjem in spremljanjem bolezni. Medicinska sestra je dolžna varovati poklicno skrivnost tudi pred družinskimi člani pacienta in tudi po njegovi smrti;
- dolžnosti varovanja poklicne skrivnosti lahko medicinsko sestro razreši prizadeta oseba sama ali sodišče, za mladoletne osebe in osebe pod skrbništvom pa starši oziroma skrbnik;
- medicinska sestra je pristojna dajati podatke o zdravstvenem stanju pacientov z vidika zdravstvene nege, ki jih opredeljujejo z negovalno diagnozo;
- podatke o zdravstvenem stanju pacienta daje njegovim ožjim svojcem, sorodnikom in skrbniku zdravnik, ki pacienta zdravi;
- dolžnost zdravstvene institucije je, da vzpostavlja in vzdržuje tak informacijski sistem, ki ščiti pacientovo skrivnost, npr. z omejitvijo dostopa do dokumentacije. Posebej se to nanaša na računalniški informativni sistem;
- glede varovanja poklicne dolžnosti pa obstajajo omejitve: medicinska sestra se ni dolžna držati poklicne molčečnosti, če bi bila zaradi pomanjkanja informacij ogrožena varnost pacienta, družine ali skupnosti. Če se medicinska sestra sooča z nujnostjo razkriti skrivnost, naj bo le-ta omejena na tisto število ljudi, ki je nujno potrebno, da se prepreči škodljivo delovanje (Kraljić, 2006).

De Cruz (2002) navaja, da lahko zdravnik razkrije podatke: a) znotraj medicinske ekipe (npr. zdravnik razkrije medicinskim sestram, da je pacient HIV pozitiven; b) razkritje se lahko opravi delodajalcu in zavarovalnici; c) če pacient poda soglasje; d) če ni možno pridobiti pacientovega soglasja (npr. nezrelost, bolezen, duševna nezrelost, nujni primer), ampak je v »pacientovem zdravstvenem interesu«, da se informacije dajo bližnjim sorodnikom; e) če je zdravnik mnenja, da bo razkritje tretji osebi, ki ni sorodnik, v največjem interesu pacienta. Zdravnik si mora v takšnem primeru prizadevati za soglasje pacienta. Če ga ne dobi ali ga pacient ni sposoben podati, zdravnik pa je mnenja, da je to v pacientovo največjo korist, lahko podatke razkrije (npr. če obstaja sum, da je pacient žrtev zanemarjanja, fizične ali spolne zlorabe, lahko podatke razkrije ustrezni instituciji (npr. center za socialno delo, policija); f) če je razkritje podatkov je v korist drugih, kar je v skladu z zdravstvenimi zahtevami (npr. kolera, tifus- primer: Zakon o nalezljivih boleznih); g) razkritje po pacientovi smrti - splošno pravilo je, da se podatki ne razkrijejo niti po smrti - pri tem je odvisno, ali so informacije o smrti že javno znane ter koliko časa je poteklo od smrti; h) če je razkritje podatkov potrebno za namene medicinskih raziskav, ki so odobrene s strani priznane etične komisije.V razmerju medicinske sestre do pacienta je prisotno načelo zaupanja. Gre za razmerje med konkretnim pacientom in konkretno medicinsko sestro. Medicinska sestra je pri svojem delu soočena z množico podatkov o pacientu, ki se nanašajo tako na njegovo zdravstveno stanje kakor tudi na njegovo zasebno življenje. Pacient lahko v zaupanju medicinski sestri razkrije podatke, za katere ne želi, da jih izvedo tretje osebe, ki so lahko bodisi njegovi domači ali

zdravnik. Če medicinska sestra prekrši načelo zaupanja, ima to njeno dejanje lahko različne posledice za pacienta: npr. od rahlega razočaranja do duševnega trpljenja, od izgube službe do obrekovanja, od poslabšanja zdravja do samomora. Kršitev načela zaupanja lahko trajno poseže v življenje pacienta in pusti neizbrisne posledice.

Kako pa je z varovanjem informacij, ki jih je pridobila medicinska sestra, v odnosu do zdravnika? Zaposleni nimajo avtomatično pravice do dostopa informacij pacienta samo zato, ker so zdravniki ali medicinske sestre. Dolžnost medicinske sestre, da varuje poklicno skrivnost, namreč ustreza individualni pravici pacienta, da se informacije, ki jih je pridobila medicinska sestra pri opravljanju svoje dejavnosti, in še posebej iz individualnih pogovorov z pacientom, ne izvejo navzven, torej izven razmerja med njo in pacientom, razen nasproti tretjim upravičenim osebam (npr. zdravnik) (Deutsch, Spickhoff, 2003). Če se torej medicinska sestra sooča z nujnostjo razkriti skrivnost, naj bo le-ta omejena na tisto število ljudi, ki je nujno potrebno, da se prepreči škodljivo delovanje.

Glede na III. načelo KEMSA se za poklicno skrivnost šteje vse, kar medicinska sestra pri opravljanju svojega poklica zve o pacientu o njegovih osebnih, družinskih in socialnih razmerah, pa tudi vse informacije v zvezi z ugotavljanjem, zdravljenjem in spremljanjem bolezni. Vendar so pri tem postavljene omejitve, saj medicinska sestra ni vezana na poklicno molčečnost, če bi zaradi njenega molčanja, torej strogega spoštovanja varovanja poklicne skrivnosti, bila ogrožena varnost varovanca, družine ali skupnosti. V takšnih situacijah se je včasih težko opredeliti, ali gre za primer, ki narekuje izjemo od varovanja poklicne skrivnosti. Na primer:

- medicinska sestra je organizirala patronažno sestro za starejšega pacienta na njegovo prošnjo. Pri tem ji pove vse relevantne informacije o pacientu, brez da bi pridobila izrecno pacientovo soglasje;
- pacient pove medicinski sestri, da je prihranil 50 uspavalnih tablet, ker namerava narediti samomor. Medicinska sestra obvesti zdravnika, da bi preprečila samomor (Kraljić, 2006).

Da bi se osebje zavedalo svojih odgovornosti do spoštovanja informacij pacienta, je potrebno vsakega novega (profesionalnega) člana v timu natančno seznaniti in opomniti glede varovanja poklicne skrivnosti. S tem je potrebno seznaniti tudi študente in volonterje. K varovanju podatkov so vezani vsi zaposleni, ki se soočajo s težavami ohranjanja zaupnih podatkov v razmerju do zdravstvenih informacij o svojih prijateljih, sorodnikih in sosedih.

Položaj MEDICINSKE sestre v nujnih primerih

Nujni primer lahko opraviči medicinsko sestro glede izvajanja določenih dejanj, za katere ni pripravljena in ki niso v njeni pristojnosti. V takšnih primerih namreč medicinska sestra postopa glede na okoliščine - torej glede na to, kaj bi se lahko razumno pričakovalo od nje v takšni situaciji.

Nujni primeri postavljajo zdravnikovo znanje in sposobnost pod veliko preizkušnjo, saj je lahko zdravnik izpostavljen situaciji, ko mora hitro ravnati, kar privede do dviga možnosti, da bo pri svojem delu storil napako. Kako je v takšnih primerih z zdravnikovo odgovornostjo? Kako je v primeru, če se je zdravnik ob nesreči preveč dolgo ukvarjal z enim pacientom in sta zaradi tega umrla druga dva? Ali v takšnem primeru, ko nima vseh aparatov s seboj, ko nima vseh zdravil, ko je ogromno poškodovanih, njegova odgovornost enaka kakor če bi imel enega pacienta v bolnišnici ob prisotnosti vseh zdravil in aparatov? Zdravnik mora v primeru velikega števila poškodovanih opraviti selekcijo. Pri tem ima več metod: a) *kronološka metoda* - po vrstnem redu postavitve zahteve, kar lahko takoj odpove že v primeru, če imamo vsaj dva poškodovana v isti prometni nesreči; *b) loterijska metoda* – se opira na srečo, kar prav tako ni primerno, saj loterijska sreča lahko zadene pacienta z lažjimi poškodbami, medtem ko bi moral pacient s težjimi poškodbami v tem primeru čakati; *c) metoda čakalnega seznama (waiting list system); d) metoda kriterijev (*najpogosteje se uporabljajo medicinski kriteriji). Velja splošno načelo enakosti ljudi ter da ima vsak pravico do rešitve življenja, zato ima tukaj *mornarsko pravilo »najprej otroci in ženske«* zgolj simboličen pomen (Šeparović, 1987; Cotič Anderle, n.d.; Manchester Triage Group, 2006).

Kakšna je zdravnikova dolžnost v nujnih primerih? Zdravnik je tudi v nujnih primerih dolžan ravnati skrbno, kolikor mu je to pač glede na podane okoliščine omogočeno, čeprav so bili v ZDA podani poskusi, da bi se v nujnih primerih izključila odgovornost zdravnikov s ciljem, da bi se spodbudila pomoč zdravnikov v izrednih situacijah (*Good Samaritan Statutes)* (Deutsch, Spickhoff, 2003). Podlago za to najdemo v ZZdrS in ZZDej, vendar pa med obema zakonoma obstajajo razlike:

a. *Ratione materiae* - ZZDej je zelo skromen glede nujne pomoči, saj določa le, da zdravstveni delavec ne sme odkloniti nujne medicinske pomoči (prim. 2. odst. 56. člena). ZZdrS pa v svojem 43. členu določa, da nujna zdravniška pomoč obsega nujne storitve, katerih opustitev

bi v kratkem času vodila v nepopravljivo in hudo okvaro zdravja in smrti. Tako pomoč je dolžan nuditi zdravnik v skladu s kodeksom medicinske deontologije in v skladu z dosežki znanosti in strokovno preverjenimi metodami (prim. 1. odst. 43. člena ZZdrS). ZZdrS torej negativno opredeljuje vsebino nujne storitve, in sicer je nujna storitev tista storitev, katere opustitev lahko v kratkem času vodi v nepopravljivo in hudi okvaro zdravja in smrti. Razlika je podana torej že v sami terminologiji, saj se nanaša ZZDej na nujno medicinsko pomoč, medtem ko je definicija nujne pomoči po ZZdrS precej širša, saj zgolj določa, da gre za nujno storitev;

b. *Ratione personae* – ZZdej je glede osebne vezanosti v primerjavi z ZZdrS širši, saj se slednji nanaša zgolj na nujno pomoč s strani zdravnikov (*nujna zdravniška pomoč),* medtem ko se dolžnost nudenja nujne pomoči po ZZdrS nanaša na vse zdravstvene delavce (*nujna medicinska pomoč).* Pri tem je potrebno prav tako poudariti, da ZZdrS razlikuje med zdravstvenimi delavci in zdravstvenimi sodelavci. Zdravstveno dejavnost lahko namreč opravljajo le zdravstveni delavci, ki imajo ustrezno strokovno izobrazbo, so strokovno usposobljeni za samostojno opravljanje v svojem poklicu in imajo ustrezne kvalifikacije (zdravniki, medicinske sestre). Za opravljanje določenih nalog s področja zdravstvenega varstva je potrebno vključiti tudi zdravstvene sodelavce, ki imajo ustrezno strokovno izobrazbo ne-zdravstvene smeri (prim. 1. in 2. odst. 62. člena ZZdrS).

c. *Vloga KMDS* – kot omenjeno je ZZdrS širši glede določanja *rationae materie,* a ožji pri uporabi *rationae personae* kot ZZDej. Pri tem ZZdrS tudi napotuje na uporabo stanovskega prava, in sicer na KMD, ki je prav tako namenjen zdravnikom in zobozdravnikom, medtem ko imajo medicinske sestre svoj KEMS. KMD natančneje opredeljuje nujno medicinsko pomoč, saj po njegovem 6. členu zdravnik ne sme odkloniti nujne medicinske pomoči, ki je ustrezna njegovi strokovni izobrazbi, ne glede na to, ali je na delovni dolžnosti ali ne in ne glede na to, ali je za pomoč izrecno zaprošen ali ne. Vendar na koncu 6. člen KMD določa, da ima zdravstveno osebje v izrednih razmerah poseben položaj in posebno odgovornost.

Posebnost položaja in odgovornosti v nujnih razmerah je pogojena s specifičnostjo razmerij, saj v teh primerih zdravniki delujejo pod otežujočimi okoliščinami, kar lahko bistveno vpliva na kakovost njihovega dela (npr. število ponesrečenih, pomanjkanje zdravil, slaba opremljenost zdravstvenih institucij, slabe vremenske razmere…). Vendar pa omenjene okoliščine nikakor ne izključujejo zdravnikove odgovornosti.

ŠE NEKATERI POGLEDI NA DELO MEDICINSKIH SESTER

Medicinska sestra in dedovanje

Posebno vlogo lahko ima medicinska sestra, kadar gre za situacijo, ko je medicinska sestra edina in zadnja priča ali oseba, ki je zapisala ali slišala poslednjo voljo bolnika. Zato bi bilo nujno, da se v splošno izobrazbo medicinske sestre vnesejo tudi osnove poznavanja splošnih pravnih zahtev in možnosti v povezavi z dedovanjem, predvsem z oporočnim dedovanjem (npr. stevardesa mora znati dajati pomoč na letalu ob porodu) (Šeparović, 1987).

Medicinska sestra in veroizpoved

Umirajoči bolnik lahko zahteva tudi prisotnost duhovnika zaradi zakramenta, bolniškega maziljenja ali kakšnega drugega obreda. Medicinska sestra bi namreč moralno grešila, če bi namreč iz razloga svojega ateističnega nazora, odklonila posredovati, seveda če to ne gre v škodo drugih njenih profesionalnih dejanj (Šeparović, 1987).

Medicinska sestra kot izvedenec

Izvedenec je oseba, ki ima posebne sposobnosti ali znanje na konkretnem področju, ki jih povprečna oseba nima. V primeru zlorabe ali malomarnosti se lahko medicinska sestra najame kot izvedenec, ki bo pojasnila, kaj je ustrezna zdravstvenega nega ter ali je toženec odstopil od standardne nege.

DISKUSIJA IN ZAKLJUČEK

Predstavljajte si medicinsko sestro ob postelji umirajočega - smrt je lahko krut, hiter dogodek, lahko pa je tudi dolg postopek, pogosto izpolnjen s trpljenjem, ki bolnika, ki je pri zavesti, polni s tesnobo in strahom pred smrtjo. Medicinska sestra je pogosto edina oseba, ki je ob bolniku (npr. nočno dežurstvo). Bolniki se na medicinsko sestro obračajo z različnimi prošnjami - od kozarca vode do lajšanja bolečin do skrajšanja muk in življenja. Delo medicinske sestre je direktno marsikdaj še tesneje povezano z pacientom, kot delo zdravnika, vendar pa je danes posvečeno medicinskim sestram premalo pozornosti, kar izhaja tudi iz literature, ki jo najdemo na opisano tematiko (ob primerjavi z literaturo,

ki se ukvarja z zdravniškim pravom). V Sloveniji trenutno še ni zakona, ki bi celovito urejal področje medicinskih sester, vendar pa bi bilo nujno razmišljati v tej smeri, saj je medicinskih sester v Sloveniji prav gotovo toliko kot zdravnikov oziroma še več. Trenutno imamo le KEMS, vendar bi bilo nujno storiti korake v smeri sprejetja zakona o zdravstveni negi. Številne pravne fakultete v tujini, v Sloveniji žal samo Pravna fakulteta v Ljubljani, že ponujajo fakultativni predmet medicinsko pravo, vendar se tudi v takšnih primerih premalo pozornosti posveča pravnim vprašanjem v zdravstveni negi. S posameznimi pravnimi vprašanji se sicer res srečujejo v času izobraževanja, vendar določena pomembna področja sploh niso ali so premalo zajeta v učnih programih (npr. dedovanje, človekove pravice itd.). Iz navedenega sledi, da je področje dela medicinskih sester eno izmed deficitarno pravno urejenih področij, ki kaže nujnost po čimprejšnji zakonodajni ureditvi.

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SCIENTIFIC SUBSTANTIATION AND OPTIMIZATION OF THE EDUCATIONAL PROGRAMMES FOR HEADS OF NURSING SERVICES

ZNANSTVENA UTEMELJITEV IN OPTIMIZACIJA IZOBRAŽEVALNIH PROGRAMOV ZA VODJE ZDRAVSTVENE NEGE

NATALYA N. KAMYNINA

Abstract

With current study we tried to identify priority issues and in the light of international experience determined modern trends in management training for nursing services in the national health system. In the beginning we carried out a comprehensive analysis of educational programs and then prepared management training for nursing services. The corresponding results of the preparation of professional responsibilities of nursing services managers revealed high potential faculties of higher Sesto maternal education in terms of managerial nursing workforce. We also opened the formal reasons for the low status of the head of the Sesto maternal services in regard to the contents of his professional activities and positions in the management structure of health care. Next we also developed a competence-based model of the head of the nursing service, which includes the main functional areas of work considered in the light of the major functions of management and development of the necessary professional competencies. We substantiated the role of head of nursing in the formation and development of clinical nursing practice through the establishment at uchreage to health systems development and deployment and performed simple medical services. In addition we set out the concept of system management training in higher medical schools of nursing services to health care institutions, which is the basic component of general nursing training that lays the foundation for the further management of specialization. At the end we developed a scientific and organizational model of continuous professional development of nursing services management training that is focused on the needs of managers in the formation of the continuous updating of their professional competence.

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DOCTOR'S DEGREE IN NURSING IN SLOVENIA: EXPECTATIONS AND REALITY?

DOKTORSKI ŠTUDIJ ZDRAVSTVENE NEGE V SLOVENIJI: PRIČAKOVANJA IN REALNOST?

BRIGITA SKELA SAVIČ

Izvleček

Izhodišča*: Za razvoj raziskovanja in dojemanje pomembnosti le tega, ima pomembno vlogo izobrazba medicinskih sester. Bolj ko so medicinske sestre izobražene, boljša je njihova percepcija o potrebnosti raziskovanja.*

Metode*: Uporabili smo metodo pregleda literature v mednarodnih bazah CINAHL in Science Direct. Obdobje pregleda literature je bilo od januarja do aprila 2012. Ključne iskalne besede so bile: »doctorate, nursing, science, research«, uporabili smo operator AND. Iskalno obdobje je bilo od 2002 do 2012. Uporabili smo kvalitativno sintezo spoznanj raziskav.*

Rezultati: *Skupaj smo pregledali 534 izvlečkov. V pregled polnega besedila smo vključili tiste članke, ki so obravnavali doktorski študij zdravstvene nege iz vidika njegovega razvoja in doprinosa k razvoju zdravstvene nege ter kazalnikov kakovosti pri izvajanju doktorskega študija. Skupno število uvrščenih člankov v končno vsebinsko kvalitativno sintezo prispevka je bilo 11, identificirali smo 9 vsebinskih kategorij.*

Diskusija in zaključki: *Pregled literature opozori na slabe dosežke raziskovalcev v zdravstveni negi pri pridobivanju raziskovalnih sredstev, poudari pomen kliničnih in raziskovalnih kompetenc doktorandov, opozori na pomen kazalnikov kakovosti doktorskega študija in na slabo prepoznavnost pomena raziskovanja v zdravstveni negi in širše ter pozno odločanje za doktorski študij iz vidika starosti študentov. Raziskovalci so kritični do izbranih raziskovalnih tem doktorjev zdravstvene nege, ki so premalo klinične, kritični so do plačila za delo doktorandov na visokošolskih zavodih. Izkazane so velike potrebe po razvoju doktorskega študija.*

Ključne besede*: doktorat, študij, zdravstvena nega, raziskovanje, kakovost izobraževanja, razvoj*

Abstract

Introduction*: The education of nurses plays a key role in the development of nursing research and in raising awareness of its importance. Nurses' awareness of the importance of research increases with their level of education.*

Methods*: Literature review methodology was applied for the international databases CINAHL and Science Direct from January to April 2012. Key search words included: "doctorate, nursing, science, research", the operator used was AND. The search period extended from 2002 to 2012. A qualitative synthesis of the research evidence was conducted.*

Results*: A total of 534 abstracts were reviewed. Of these, full-text articles were studied if the topic dealt with doctorate degree in nursing, its development and contribution to the development of nursing, and quality indicators for the doctoral nursing programme. A total of 11 articles were included in the final qualitative synthesis and 9 categories were identified according to different topics.*

Discussion and conclusions*: Literature review underscores the poor outcomes nursing researchers achieve in obtaining research funding, emphasizes the clinical and research competences of nurses holding a doctorate degree, points out the importance of quality*

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indicators for doctoral nursing programmes and poor awareness of the importance of research in nursing and related areas, and, finally, shows that students tend to enroll in nursing doctoral programmes at a relatively late age. Researchers express their dissatisfaction with the topics selected by nursing doctorate students, finding the topics do not relate sufficiently to the clinical environment, and point out that nursing doctorate students do not receive sufficient remuneration for their work at higher education institutions. Overall, a great need for the growth and development of nursing doctoral programmes is expressed.

Keywords*: doctorate degree, study programme, nursing, research, quality of education, development*

IZHODIŠČA

Številne reforme bolnišnične zdravstvene nege in politika zdravstvene nege še vedno kažejo na dvojnost oziroma razcepljenost med znanjem pridobljenim v kliničnem okolju in znanjem teoretične narave (McNamara, 2005). Za razvoj raziskovanja in dojemanje pomembnosti le tega, ima pomembno vlogo izobrazba medicinskih sester. Bolj ko so medicinske sestre izobražene, boljša je njihova percepcija o potrebnosti raziskovanja (Karkos, Peters, 2006; McCleary, Brown, 2003). Raziskava WHO (Büscher, Sivertsen, White, 2009) pokaže, da mnogo evropskih držav nima kritične mase ustrezno izobraženih medicinskih sester, ki bi lahko prevzele nove vloge v zdravstveni obravnavi. Nove vloge v zdravstveni obravnavi ali zahtevnejše oblike dela v zdravstveni negi (advanced practice in nursing) je potrebno razumeti kot višji nivo zahtevnosti izvajanja zdravstvene nege, kar je povezano z izvajanjem zahtevnejših kliničnih intervencij, izvajanjem kliničnih raziskav, nenehnim izobraževanjem in vodenjem/managementom (Atkinson et al., 2010; The Scottish Government, 2008).

Namen prispevka je zbrati znanstvene informacije, mednarodna ekspertize in mednarodne smernice o razvoju doktorskega študija zdravstvene nege v državah razvitega sveta in ta spoznanja prenesti v slovenski visokošolski izobraževalni prostor na področju zdravstvene nege.

METODE

Uporabili smo metodo pregleda literature v mednarodnih bazah. Obdobje trajanja pregleda literature je bilo od januarja do aprila 2012. Uporabili smo mednarodno bazo Cumulative Index to Nursing and Allied Health Literature (CINAHL), kjer smo iskali izvirne in pregledne znanstvene članke, v obdobju 2002 do 2012, v angleškem jeziku in v polnem besedilu. Ključne iskalne besede so bile: »doctorate, master, nursing, science, research, competences«, uporabili smo operator AND. V različnih kombinacijah uporabljenih iskalnih besed smo dobili 91 zadetkov. V mednarodni bazi Science Direct smo na isto kombinacijo besed, z omejitvijo na zadnjih pet iskalnih let dobili 445 zadetkov.

Uporabili smo kvalitativno sintezo spoznanj raziskovalcev v znanstvenih in preglednih člankih. Glede na obravnavano temo smo upoštevali tudi mednarodne ekspertize, ki so temeljile na pregledu literature in mednarodne smernice.

REZULTATI

Skupaj smo pregledali 534 izvlečkov. V pregled polnega besedila smo vključili tiste članke, ki so obravnavali doktorski študij zdravstvene nege iz vidika njegovega razvoja in doprinosa k razvoju zdravstvene nege ter kazalnikov kakovosti pri izvajanju doktorskega in magistrskega študija in povezava obeh iz vidika kompetenc in zahtevnejših oblik dela. Izločili smo članke,

Razpredelnica1: Podatki o uporabljenih člankih v pregledu literature

Avtor (ji), država	Raziskovalni dizajn
Potempa, Redman, Andreson (2008)	Presečna kvantitativna vzročna raziskava
Evans, Stevanson (2010)	Pregled literature
Edwardson (2004)	Mednarodna ekspertiza
Short (2008)	Mednarodna ekspertiza
Scherzer, Stooos, Fontaine (2010)	Kohortna opazovalna kvantitativna raziskava
McDermid et al. (2012)	Pregled literature
Burton et al. (2009)	Pregled literature
Kim, McKenna, Ketefian (2006)	Mednarodna ekspertiza
Büscher, Sivertsen, White (2009)	Kvantitativna opisna raziskava
Kirkman et al. (2007)	Mednarodna ekspertiza
Tuaoi et al. (2012)	Mednarodna ekspertiza

Identificirali smo 9 vsebinskih kategorij, ki jih natančneje razlagamo v poglavju rezultati.

ki so obravnavali zgolj primerjavo med tradicionalnim znanstvenim doktoratom in strokovnim doktorskim študijem. Skupno število uvrščenih člankov v končno vsebinsko kvalitativno sintezo prispevka je bilo 11. Avtorji člankov in uporabljen raziskovalni dizajn pri posameznih člankih je prikazan v razpredelnici 1. Razvidno je, da je raziskav, ki bi imeli visoko vrednost na hierarhiji dokazov po Polit in Beck (2008), malo. Največ člankov je pregled literature, ki najpogosteje nima značilnosti sistematičnega pregleda, zato smo ta dvom izrazili in te članke označili kot mednarodne ekspertize.

Slabi rezultati pri pridobivanju sredstev za raziskovanje

Potempa, Redman, Andreson (2008) so izvedli primerjavo znanstvenega razvoja in akademskih karier v zdravstveni negi v ZDA v primerjavi z medicino in javnim zdravjem. Opazovane spremenljivke so bile pridobljena sredstva za raziskovanje, zaposleni na fakultetah in njihova uspešnost na področju raziskovanja in njihova uspešnost pri publiciranju. Ugotovili so, da javno zdravje in medicina pridobita pomembno več sredstev na razpisih za raziskovanje, kot zdravstvena nega, kljub temu, da je fakultet za zdravstveno nego in s tem raziskovalcev na fakultetah pomembno več, vendar je v populaciji medicinskih sester le 0,9 % tistih, ki imajo doktorat, kar pomeni, da se raziskovalci iz fakultet težko povežejo s kliničnim okoljem zaradi prepada v razumevanju o pomenu raziskovanja za klinično delo. Büscher, Sivertsen, White (2009) prepoznajo slabo vključenost zdravstvene nege v interdisciplinarne raziskave in slabo razpoložljivost raziskovalnih sredstev za področje širše zdravstvene obravnave, kjer bi lahko raziskovalci v zdravstveni negi kandidirali za raziskovalne projekte.

Kompetence doktorantov in klinično delo

Ugotovili so, da trenutni sistem izobraževanja na področju doktorskega študija v zdravstveni negi ne pripravlja dovolj dobro diplomantov za generiranje in uporabo visokih raziskovalnih dosežkov. Prav tako se slaba raziskovalna usposobljenost iz vidika uporabe pri kliničnem delu kaže tudi na nivoju strokovnega magisterija in univerzitetne izobrazbe, kar predstavlja velik izziv za nadaljnje delo v visokošolskem izobraževanju v ZDA (Potempa, Redman, Andreson, 2008). Avtorji (Anibas et al., 2009; Blauvelt, Spath, 2008; Elliott, Wall, 2008; v McDermid et al., 2012) pravijo, da morajo doktorji zdravstvene nege imeti tako klinične kompetence, kot tudi kompetence in odgovornosti za učenje drugih, saj so prenašalci dobre prakse. Tako kot v drugih znanstvenih disciplinah, morajo akademsko izobraženi kadri v zdravstveni negi znati voditi raziskave in zahtevati raziskovalno delo od ljudi, ki jih vodijo, znati publicirati v revijah z recenzijo, znati pripraviti projekte za razpise za raziskovalna sredstva in prispevati k širšim nalogam in obveznostim za razvoj stroke (Suplee, Gardner, 2009; Worrall-Carter, Snell, 2003–2004; Deans et al., 2003; Gormley, 2003; v McDermid et al., 2012). The Research Councils Velike Britanije (2001; v McDermid et al., 2012) je objavil sedem področij kompetenc za doktorski študij zdravstvene nege: raziskovalne kompetence, sodelovanje v raziskovalnih okoljih, management raziskovanja, osebnostna učinkovitost, komuniciranje, povezovanje in timsko delo, management kariere. McKenna (2005; v Evans, Stevanson, 2010) pravi, da zdravstvena nega urgentno potrebuje doktorski študij za usposabljanje bodočih visokošolskih učiteljev za učenje na univerzah in doktorskih programih zdravstvene nege, ki naj bo usmerjen v znanja s področja kakovostnega pedagoškega procesa in znanja s področja raziskovanja. Na drugi strani Edwardson (2004) opozori, da se v ZDA preveč poudarka daje pedagoški usposobljenosti bodočega doktoranda. Ketefian in drugi (2005; v Evans, Stevanson, 2010) opozarjajo na pomen razvoja doktorskih programov v zdravstveni negi, ki bodo izoblikovali voditelje z veščinami raziskovanja, zagovorništva, mentoriranja in vodenja. Predlagajo, da naj doktorski študij ponuja nabor širših kompetenc, ki bodo doktorandu omogočile delo in uveljavitev na strateških področjih.

Evans, Stevanson (2010) ugotavljata, da je v državah, kjer izobraževanje za zahtevnejše oblike dela v zdravstveni negi še ni razvito, najpogostejše mesto zaposlitve doktorandov v visokem šolstvu. Za nadaljnji razvoj doktorskega študija je potrebno ustvariti klinične dokaze na področju kakovosti dosedanjega izobraževanja v zdravstveni negi, zlasti doktorskega študija in prepoznati znanja in veščine za prihodnja dela, naloge in izzive. Edwardson (2004) opozori, da je znanje, ki ga dobijo študenti doktorskega študija, premalo posredovano na način, da bi znanja in veščine uporabili na natančno definiranih raziskovalnih problemih, s katerimi se srečujejo v kliničnih okoljih.

Kazalniki kakovosti doktorskega študija

Hinshaw in Berlin (1997; v Edwardson, 2004) povzemata nacionalne kazalnike v ZDA, po katerih se rangirajo visokošolski zavodi, ki izvajajo doktorski študij: število doktorandov, pridobljeni raziskovalni projekti nacionalnega inštituta za raziskovanje, število publikacij in znanstvenih objav, delovanje raziskovalnega oddelka in centrov odličnosti, število študentov šole, delež

rednih študentov, čas trajanja doktorskega študija idr. Ključna kazalnika, ki sta se izkazala kot najpomembnejša skozi raziskave sta število objav in čas trajanja študija. Potempa, Redman, Andreson (2008) menijo, da je doktorski študij zdravstvene nege lahko le na tistih fakultetah, ki imajo visoko raziskovalno učinkovitost (pridobljena sredstva, publikacije). Ker je takšnih fakultet malo, je opaziti veliko pomanjkanje kadra, ki prvenstveno izvaja vodstvene funkcije na fakultetah in se premalo ukvarja z raziskovalnim delom. Kim, McKenna, Ketefian (2006) raziščejo kriterije kakovosti doktorskega študija v zdravstveni negi preko baze International Network for Doctoral Education in Nursing. Izkaže se, da so to vizija visokošolskega zavoda, kakovost dela na visokošolskem zavodu, izbor študentov na doktorski študij, sestava študijskega programa, administrativna podpora izvedbi programa in viri za delovanje visokošolskega zavoda.

Slaba prepoznavnost pomena raziskovanja za zdravstveno nego in širše

Büscher, Sivertsen, White (2009) opozorijo na pomanjkanje raziskovanja v zdravstveni negi. Močna raziskovalna jedra so prisotna le v državah, ki imajo tradicijo izobraževanja na magistrski in doktorski ravni. V državah, kjer se medicinske sestre uspejo uveljaviti kot raziskovalke, tudi prispevajo na nivoju države in širše k oblikovanju politik in so uspešne pri pridobivanju raziskovalnih sredstev. Znanje medicinskih sester in raziskovalna vključenost sta tudi tesno povezana s spremljanjem in zagotavljanjem kakovosti ter vrednotenjem lastnega dela. Short (2008) opozori na pomen predstavljanja doktorjev iz vrst zdravstvene nege, ki imajo akademsko izobrazbo. Skromnost, da so »samo medicinske sestre z doktoratom« ne sme biti del besednjaka, saj gre v veliki večini za osebe, ki so prehodile dolgo pot izobraževanja od univerzitetne do doktorske ravni in delujejo na področju zdravstva ter so dobri poznavalci razmer, zato morajo predstavljati svoj širok spekter znanj, ker le na ta način lahko delujejo in dajejo širši doprinos svojega dela v družbi. Družba ima še vedno stereotipen pogled na delo medicinskih sester, zato predstavljanje na način, ki ne da vpogleda v akademske dosežke, ni ustrezno in je zapravljena priložnost za uveljavitev v politiki odločanja o zdravstvenem varstvu v državi.

Kritika vsebin raziskovanja doktorjev zdravstvene nege

Potempa, Redman, Andreson (2008) menijo, da se od medicinskih sester pričakujejo raziskave na področju promocije zdravja, zmanjševanje dejavnikov tveganja za bolezni v vseh starostnih obdobjih, izboljšanje izidov že razvitih bolezni, podpora posamezniku in družini pri soočanju z boleznijo in adaptacija na bolezen, reorganizacija nudenja zdravstvene obravnave v zdravstvenem sistemu idr. White (1999; v Edwardson, 2004) izraža kritiko do raziskav v zdravstveni negi. Meni, da se raziskave, ki jih delajo medicinske sestre in babice preveč osredotočajo na razlagalno pozicijo, ki je filozofsko podprta ali pa raziskujejo izkušnje pacientov z zdravljenjem bolezni. Raziskave v zdravstveni negi so v prvi vrsti interpretativne, najpogosteje je uporabljen samo en metodološki raziskovalni pristop, prispevajo sicer k razumevanju zdravstvene nege kot znanstvene discipline, imajo pa malo skupnega z realnostjo in uporabnostjo v vsakodnevni praksi. Short (2008) opozori, da medicinske sestre raziskovalke vse prepogosto objavljajo rezultate svojih raziskav v revijah, ki jih berejo samo one in rezultati njihovi spoznanj ne pridejo do odločevalcev zdravstvene politike. Le malo je širše prepoznanih medicinskih sester, ki so raziskovalke in ima njihovo delo doprinos (avtor navaja: Peter Buerhas, Linda Aiken, Lois Evans, Neville Strumph) in je upoštevano pri oblikovanju zdravstvene in socialne politike države. Pomembno je, da se rezultati raziskav objavljajo v revijah, ki jih berejo odločevalci zdravstvene politike.

Pozna odločitev za doktorski študij

Raziskava Potempa, Redman, Andreson (2008) pokaže, da je odločitev za doktorski študij sprejeta prepozno in da je potrebna zgodna spodbuda za doktorski študij, že v času magistrskega študija. Edwardson (2004) opozori na dejstvo, da se medicinske sestre v ZDA zelo pozno odločajo za doktorski študij in doktorirajo šele v srednjih letih ali poznih srednjih leti, to je takrat, ko strokovnjaki na drugih poklicnih področjih že dosežejo vrhunec kariere iz vidika postdoktorskega raziskovalnega dela. Navaja podatek, da je povprečna starost doktorandov 46 let, 12 % od teh je starejših od 55 let (Berlin, Sechrist, 2002; v Edwardson, 2004). Do podobnih spoznanj pride tudi McDermid s sodelavci (2012), ki opozori na starost učiteljev na doktorskem študiju in premajhen priliv novih doktorjev znanosti na programih zdravstvene nege. Burton s sodelavci (2009) povzema spoznanja The United Kingdom Clinical Research Collaboration iz leta 2007 na področju starosti doktorskih študentov. Samo 8 % študentov je bilo starih manj kot 29 let, 60 % je bilo starih več kot 40 let. Ena od ovir, ki pogojuje odločitev je tudi dolžina trajanja doktorskega študija, ki je v ZDA v povprečju 7 let za zdravstvene vede, študij dokonča največ 50 % vpisanih študentov (Edwardson, 2004).

Več vrst doktorskega študija

Razprave o različnih vrstah doktorskega študija so razvidne iz pregledane literature, najbolj na področju znanstvenega in strokovnega doktorata (Evans, Stevanson, 2010). V ZDA so v 2004 sprejeli odločitev, da se zdravstvena nega akademizira v dveh smereh: v raziskovanje usmerjen doktorat iz filozofije zdravstvene nege (PhD) in v prakso usmerjen doktorat v zdravstveni negi (DNP) (Tuaoi et al., 2012). Odločitev je primerljiva z razvojem doktorskega študija drugih sorodnih profesij v ZDA, kot so medicina, audiologija, psihologija, zobozdravstvo, farmacija, ki imajo doktorate usmerjene v prakso (Brown-Benedict, 2008; v Tuaoi et al., 2012). V razvitem svetu se oblikuje vse večji pritisk, da se visokošolsko izobraževanje bolj približa kliničnemu okolju in to velja tudi za doktorski študij zdravstvene nege (Nixon et al., 2006; v Burton et al., 2009). Neizogiben je razmislek o novi strukturi doktorskega študija in novih načinih podajanja in produkcije znanja (Malfroy, Yates, 2003; v Burton et al., 2009). Park (2007; v Burton et al., 2009) tako omenja nove poti poleg tradicionalnega evropskega doktorskega študija, kot so doktorat dosežen na osnovi publikacij in profesionalni doktorat. V akademskih krogih potekajo resne razprave o razvoju doktorata v zdravstveni negi v prihodnosti iz vidika akademskega doprinosa in doprinosa v praksi (Winter et al., 2000; Ellis, 2005; Fulton, Lyon, 2005; McKenna, 2005; v Burton et al., 2009). Kirkman s sodelavci (2007) navaja pet možnosti pridobitve doktorata v zdravstveni negi: tradicionalni doktorat, doktorat s predavanji, doktorat usmerjen v prakso, doktorat pridobljen s projektnim delom, doktorat pridobljen s publiciranjem.

Plačilo za delo

Edwardson (2004) opozori na to, da diplomant na dodiplomskem programu lahko zasluži več denarja, kot učitelj z doktoratom na dodiplomskem programu, kar močno znižuje interes medicinskih sester z doktorati za delo na visokošolskih zavodih. V ZDA je 61 % doktorjev zdravstvene nege zaposlenih v visokošolskem izobraževanju (Spratley et al., 2000; v Edwardson, 2004). Allan, Aldebron (2008; v McDermid et al., 2012) opozorita, da so se plače medicinskim sestram v kliničnih okoljih povečale na račun njihovega pomanjkanja na trgu, zato plače na visokošolskih zavodih niso več konkurenčne. Ne sme se voditi politika, da bi se razvoj visokošolskega izobraževanja gradil na entuziazmu doktorandov. Kuehn ugotavlja (2007; v McDermid et al., 2012), da plače predstavljajo ključno bariero za okrepitev kadrovske strukture v visokošolskih zavodih na področju zdravstvene nege. Zadovoljstvo z delom se pri visokošolskih učiteljih zdravstvene nege ne črpa iz plačila za delo, temveč iz dobrih odnosov znotraj delovnih timov, kolegialnosti, podpore študentom, avtonomije dela in same vsebine dela (Lane et al., 2010; Gui et al., 2009; Ambrose et al., 2005; Disch et al., 2004; Doughty et al., 2002; v McDermid et al., 2012).

Potrebe po doktorskem študiju

Scherzer, Stooos, Fontaine (2010) opisujejo potrebe po doktorskem študiju v zdravstveni negi, ki presegajo zmožnosti izobraževanja v ZDA. Yordy (2006; v Scherzer, Stooos, Fontaine, 2010) opozarja na pomanjkanje fakultet, ki bi lahko izvajale doktorski študij v zdravstveni negi, Evans (2005; v Scherzer, Stooos, Fontaine, 2010) pa na povprečno starost rednih profesorjev, ki je 56 let, izrednih profesorjev 54 let in docentov 50 let. Scherzer, Stooos, Fontaine (2010) prikažejo primer organiziranega pristopa triletnega rednega doktorskega študija, ki je bil finančno podprt na državni ravni za povečanje števila doktorjev zdravstvene nege v ZDA, Kalifornija. Ključnega pomena je bilo poleg finančne podpore kakovostno mentorstvo študentom pri študiju in doktorski raziskavi. Tuaoi et al. (2012) povzemajo, da se je v ZDA podiplomsko izobraževanje za zahtevnejše oblike dela v zdravstveni negi iz magistrskega izobraževanja prestavilo na višji nivo, to je strokovni doktorski študij od leta 2004 naprej. Proces tranzicije bo zaključen leta 2015, z njim bodo okrepili področje klinične ekspertize in vodenja v zdravstvenem sistemu (Brar et al., 2010; v Tuaoi et al., 2012). Burton s sodelavci (2009) pravi, da mora doktorski študij narediti originalni doprinos k znanju v zdravstveni negi. To je mogoče doseči preko raziskovalnih projektov, katerih mentorstvo izvajajo eksperti na področju raziskovalnega problema in znanjem iz metodoloških pristopov raziskovanja.

DISKUSIJA

Izvedeni pregled literature pokaže, da je malo znanstvenih dokazov o doktorskem študiju zdravstvene nege. Mogoče bi dobili več zadetkov, če bi v ključne besede umestili še klinično delo, vendar je bil naš namen predvsem pridobiti informacije o razvoju doktorskega študija v razvitem svetu, ker se v Sloveniji pričenjamo pogovarjati o potrebnosti razvoja le tega tudi pri nas. Zato je pregled izkušenj drugih držav pomemben pri nacionalni razpravi o tej zahtevni točki nadaljnjega razvoja zdravstvene nege v Sloveniji. Rezultati naše raziskave nas vsebinsko opozorijo, da je razvoj doktorskega študija zdravstvene nege izjemno pomemben iz vidika sledenja zdravstvenih potreb v družbi in razvoja tako imenovanih zahtevnejših oblik dela v zdravstveni negi, kjer mednarodne smernice priporočajo strokovni magisterij (Atkinson et al., 2010; The Scottish Government, 2008), v ZDA se zavzemajo

za uveljavitev strokovnega doktorata (Tuaoi et al., 2012). Ker so zahtevnejše oblike dela v zdravstveni negi opisane kot doseganje visokega nivoja kliničnih veščin in kompetenc, avtonomno klinično odločanje, vrednotenje dela in izvedenih aktivnosti, raziskovalno delo in vodenje (Atkinson et al., 2010; The Scottish Government, 2008), upamo, da bo zdravstvena politika v Sloveniji prepoznala, da je potrebno v kliničnih okoljih spodbujati šolanje na študiju zdravstvene nege na drugi bolonjski stopnji. Ob tem pa je potrebno paziti na količino in kakovost, saj izvedeni pregled literature jasno pokaže, da so potrebe po izobraževanju na drugi in tretji stopnji večje, kot so zmožnosti (Scherzer, Stooos, Fontaine, 2010; Tuaoi et al., 2012; Burton et al., 2009; Kim, McKenna, Ketefian, 2006). Ker vsi opozarjajo na ta moment, moramo v Sloveniji paziti, da ne bi prišlo do prekomernega izobraževanja na drugi stopnji glede na sposobnosti iz vidika visokošolskih učiteljev, ki jih Slovenija ima, ker bo s tem ogrožena kakovost izobraževanja in posledično dejanski doprinos šolanja v kliničnem okolju.

Raziskave pokažejo različne možnosti razvoja doktorskega študija (Kirkman et al., 2007), vendar v Sloveniji glede na nacionalne smernice in zakonodajo lahko razvijamo znanstveni doktorat s predavanji. Prav tako velja v okviru nacionalne strategije razvoja doktorskega študija zdravstvene nege v Sloveniji premisliti o ustreznih spodbudah mladih, uspešnih in zavzetih medicinskih sester v kliničnih okoljih, da pričnejo z magistrskim študijem zdravstvene nege in doktorskim študijem sorodnih znanstvenih disciplin, v kolikor že imajo ustrezno izobrazbo za vstop na doktorski študij. Izvedeni pregled literature pokaže na to, da se medicinske sestre prepozno odločajo za nadaljnji študij (Potempa, Redman, Andreson, 2008; Edwardson, 2004; McDermid et al., 2012; Burton et al., 2009). Pri teh sistemskih spodbudah imajo ključno vlogo management zdravstvene nege v slovenskih zdravstvenih zavodih in nacionalno združenje Zbornica Zveza ter zdravstvena politika. Pomembna je tudi profesionalna zrelost posameznika in kakovostni študijski programi, katerih zahtevnost je mednarodno primerljiva. Potrebno se je zgledovati po kazalnikih, ki so jih navedli nekateri avtorji, predstavljeni v tej raziskavi (Edwardson, 2004; Potempa, Redman, Andreson, 2008; Kim et al., 2006).

Iz vidika navedb nekaterih avtorjev (Büscher, Sivertsenm, White, 2009) je v Sloveniji potrebno vzpostaviti raziskovalno mrežo, raziskovalne centre v povezavi s kliničnim okoljem ter razvijati ustrezno promocijo raziskovalnega dela (Short, 2008). Vzporedno s tem je potrebna še kritična analiza dosedanjega raziskovalnega dela iz vidika raziskanih raziskovalnih problemov ter načrtovati aktivnosti za raziskovanje področij po navedba Potempa, Redman, Andreson (2008), kot so promocije zdravja, zmanjševanje dejavnikov tveganja za bolezni v vseh starostnih obdobjih, izboljšanje izidov že razvitih bolezni, podpora posamezniku in družini pri soočanju z boleznijo in adaptacija na bolezen, reorganizacija nudenja zdravstvene obravnave v zdravstvenem sistemu idr. Raziskovalna dela se naj ne objavljajo samo v Obzorniku zdravstvene nege, temveč se naj raziskovalca ciljno usmerja v objave tam, kjer bodo rezultati raziskave prepoznani iz vidika vpliva na zdravstveno politiko.

Predstavljeni kazalniki za izvajanje doktorskega študija (Edwardson, 2004; Potempa, Redman, Andreson, 2008; Kim, McKenna, Ketefian, 2006) jasno pokažejo, da bo v Sloveniji potrebno medsebojno povezovanje visokošolskih zavodov, ki imajo širše raziskovalne reference in raziskovalno delujejo v povezavi s kliničnimi okolji, ker le na ta način bo mogoče vzpostaviti doktorski študij. Skela Savič (2012) poudarja, da si mora visokošolski zavod zgraditi razvojno in raziskovalno jedro, ki šoli omogoča uresničevanje kazalnikov financiranja, oblikovanje raziskovalne skupine, vpetost v mednarodni prostor, kreiranje kritične misli, sposobnost oblikovanja raziskovalnih problemov in multiprofesionalnega povezovanja. Šola ni samo izvajalec študijskega programa, temveč mora pomembno prispevati k širitvi razvojno raziskovalne perspektive v sodelovanju z domačim in mednarodnim okoljem. Šola se mora povezovati z zdravstvenimi zavodi, inštituti, raziskovalno in razvojno delo mora biti osnova za izboljševanje študijskih programov, pot mednarodnega povezovanja in multiprofesionalnega povezovanja.

Potrebeno bo vzpostaviti tudi jasen dialog s kliničnim okoljem, managementom zdravstvene nege, visokošolskim managenetom in zdravstveno politiko iz vidika širših pričakovanj v zvezi z doktorskim študijem zdravstvene nege ter opredelitvijo potreb in zmožnosti za tovrstno izobraževanje. Pregled literature namreč pokaže, da se od doktorandov zdravstvene nege pričakuje poznavanje kliničnih kompetenc in kompetence in odgovornosti za učenje drugih, kompetence za vodenje raziskav, motivacijo zaposlenih za raziskovanje, publiciranje, prijavo razpisov idr. (McDermid et al., 2012).

Opredelitev vloge zdravstvene nege v slovenskem zdravstvenem sistemu je mogoča le na osnovi izvedenega raziskovalnega dela v kliničnem okolju in predstavitev rezultatov raziskav o pomenu znanja, števila, načina obravnave idr., za izide zdravstvene obravnave pacientov. Iz tega izhaja dejstvo, da mora management zdravstvene nege zagovarjati, omogočati in vzpostavljati kritično maso raziskovalcev v zdravstveni negi. Raziskovanje

in uporaba rezultatov raziskav na osnovi dokazov podprtega dela je edina pot, da zdravstvena nega uspe kot stroka in znanstvena disciplina (Skela Savič, 2012)

ZAKLJUČEK

Ocena, kdaj lahko visokošolski prostor razvije doktorski študij zdravstvene nege, mora biti skrbno pretehtana, saj bi lahko z nepremišljenimi odločitvami škodili umestitvi doktorskega študija v državi. Potrebna izhodišča za vzpostavitev kakovostnega doktorskega študija zdravstvene nege so predmet mednarodnih raziskav, razprav in smernic, zato je potrebno temu slediti in na osnovi teh spoznanj voditi dialog med odgovornimi akterji v državi za dosego cilja. Glavna ovira, ki jo moramo premostiti v Sloveniji za kakovostno razpravo o doktorskem študiju zdravstvene nege so nedefinirane potrebe in zmožnosti za visokošolsko izobraževanje na prvi in drugi bolonjskih stopnji študija zdravstvene nege ter kakovost izobraževanja, ki ga trenutno imamo. Strategija razvoja zdravstvene nege V Sloveniji za obdobje 2011 – 2012 je narejena, sedaj je čas, da jo moramo začeti odgovorno uresničevati. Brez kakovostnega izobraževanja, aktivne podpore raziskovalnemu delu in uvajanja na dokazih temelječega delovanja ne bo šlo. V ospredje morata stopiti družbeni interes in interes razvoja zdravstvene nege.

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DEVELOPMENT OF RESEARCH POTENTIAL IN NURSING STUDY

RAZVOJ RAZISKOVALNIH POTENCIALOV PRI ŠTUDIJU ZDRAVSTVENE NEGE

RADIVOJE RADIĆ

Abstract

Recently nursing in Croatia is going through transition toward full recognition in community. Significant progress have been achieved in nursing education. Croatian Universities accepted nursing study programs (undergraduate and graduate) as an integral part of their curricula. Further, Faculties also accepted that courses in nursing should be provided by teacher they finished nursing education. Unfortunately , this level of progress in nursing education have not been occored in nursing research. Number of papers in croatian nursing community is still insufficient. Although nursing is included in croatian law as a scientific discipline in Biomedicine field, my opinion is that most of nurses do not recognize the scientific component of their own profession. Obviously, we can not expect that all nurses are scientist but only a few percent of them could be useful. Bacause of that, faculties have a major role in promotion of scientific activity.In this task we have noted several difficulties.

First, because of lack of specific knowledge, most of nurses can not choose specific subject for their paper. The main topics in nursing research could be sort in few fields: evaluation of nursing care, nursing education and career eevlopment, nursing theories, health promotion and prevention.

According to recent data in literature, we can see that proportion of specific type of subjects is variable depending on stage of nursing professionalization. For example proportion of subjects about nursing education increases with development of graduate nursing study programs. Second, nurses who finished their research, do not publish their papers in journals. One of main reason for this is indifference of editors in biomedicine journals for nursing research. For this purpose Faculty of Medicine Osijek together with Travnik University launched two years ago a specific journal with the title SothEastEuropeanHealthScience (SEEHS).

Analyzing experiences in european countries with developed nursing research, we can conclude that thay have similar problems at begining. When we put parameters of nurisng research progress (for example number of disertations, number of teachers, number of scientific procejts founded by guverment) on the time, we can see that almost all parameters have a similar trendline. At begining increase is very slow and small but in one moment the trendline start to rise almost exponentialy. We believe that this moment is development of graduate and postgraduate nursing study which leeds to sufficient number of adequate mentors.

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CAREER DEVELOPMENT OPPORTUNITIES IN NURSING RESEARCH

MOŽNOSTI RAZVOJA KARIERNE POTI NA PODROČJU RAZISKOVANJA V ZDRAVSTVENI NEGI

BARBARA DONIK, MATEJA LORBER, BARBARA KEGL

Izvleček

Zdravstvena nega temelji na znanju in na dokazih podprti praksi. Izvajalci zdravstvene nege morajo razvijati strokovno znanje na močnih temeljih, kateri izhajajo iz raziskav v zdravstveni negi. Imajo pomembno odgovornost, da prispevajo k razvoju znanja v stroki zdravstvene nege z raziskovalnim delom. V članku so predstavljena teoretična izhodišča, ki so bila zbrana na podlagi pregleda literature. Možnosti kariernega razvoja na področju raziskovalne prakse so velike in izhajajo tako iz lastne pobude kot s strani organizacije v kateri je posameznik zaposlen. V ospredje prihajajo zahtevnejše oblike dela in specialna znanja, ki bodo odprla možnosti razvoja raziskovalnega področja v zdravstveni negi.

Ključne besede*: raziskovanje, karierni razvoj, zdravstvena nega, možnosti raziskovanja*

Abstract

The care provided by nurses must be based on knowledge and research. Nurses are developing their own professional knowledge base with strong foundations built on researches. Nurses have a responsibility in some way to contribute to the development of the profession's knowledge through research. The paper presents the theoretical bases that have been gathered with literature review. There are a lot career opportunities in nursing research and are resulting from nurses own initiative and also from organization initiative in which the individual is employed. Advanced practice and specialized skills are comming in front and will open the possibilities of development of research in nursing.

Keywords: *research, career development, career aspiration, nursing, clinical research*

IZHODIŠČA

Če smo še nekaj let nazaj v zdravstveni negi govorili o generalizaciji znanj in veščin ter bili mnenja, da potrebujemo izvajalce zdravstvene nege – »generaliste«, smo sedaj priča trendu vedno večje specializacije, ki omogoča tudi nova znanstvena spoznanja. To pa seveda vodi v kakovostno oskrbo zdravstvene nege in v vidnejši in večji razvoj zaposlenih. Izobraževanje in usposabljanje ter raziskovanje na področju zdravstvene nege je nujno, spreminjajo se tudi načini prenosa znanj znotraj organizacij, nedvomno pa se tudi spreminja odnos do lastne kariere. Včasih je veljalo, da ko enkrat stopiš na poklicno pot, na njej vztrajaš do upokojitve. Danes je to težko izvedljivo. Novak (2007) pravi, da v današnjem času vse manj govorimo o »zaposlitvi do konca življenja« in vse več o doživljenjski zaposljivosti, o karieri po upokojitvi in doživljenjskem učenju. S tem se prenaša odgovornost za svojo poklicno pot na posameznika, saj smo za svojo kariero v največji meri odgovorni sami. Tako mora vsak posamezni izvajalec zdravstvene nege prevzeti aktivno vlogo pri oblikovanju svoje kariere.

Klasična delitev karierne poti je delitev na vertikalno in horizontalno karierno pot. Na področju zdravstvene nege to pomeni, da izvajalci zdravstvene nege lahko svojo kariero gradijo na vzpenjanju po hierarhični - vodstveni lestvici ali pa z neformalno specializacijo, ki temelji predvsem na izkušnjah pri delu na ozko specialnem področju. Vertikalno napredovanje je velikokrat v zdravstveni negi povezano z odmikom od strokovnega področja, saj so za višje delovno mesto pomembnejša znanja s področja vodenja, ekonomije, organizacije dela,… Štular (2008, str. 48) navaja, da je horizontalno napredovanje navadno vezano na ožje strokovno področje, ki je pogosto povezano z večjo stopnjo odgovornosti. Na podlagi trenutnih opazovanj v praksi lahko rečemo, da je načrtovanje

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kariere zaposlenih v zdravstveni negi zelo specifično v primerjavi z drugimi poklici, saj ne obstaja neko enotno pravilo kako naj se načrtuje kariera posameznega izvajalca zdravstvene nege. Karierni razvoj izvajalcev zdravstvene nege je predvsem individualen glede na ozko strokovno področje na katerem je posamezni izvajalec zdravstvene nege zaposlen. Pomeni predvsem horizontalno premikanje po lestvici napredovanja, ki se kaže v angažiranosti posameznega izvajalca zdravstvene nege v sami instituciji glede odnosa do pacientov in sodelavcev, strokovnem delu, uvajanju sprememb na področju zdravljenja in zdravstvene nege, strokovne usposobljenosti posameznega izvajalca zdravstvene nege in delom na enotah, kjer se zahteva več znanja in izkušenj. Razvoj kariere izvajalcev zdravstvene nege vertikalno po hierarhični lestvici pa je raznolik glede na različna strokovna področja, vendar pogojen z dodatnim izobraževanjem. Nekateri se odločijo za študij ali nadaljevanje študija na univerzitetnem in podiplomskem programu, kjer si pridobijo različna dodatna znanja, ki so potrebna za opravljanje dela na višjih - vodstvenih delovnih mestih. Nekateri pa se odločajo za aktivno delo na raziskovalnem in izobraževalnem področju, tako, da praktično delo združijo z raziskovalnim, kar je izrednega pomena za stalen razvoj profesije zdravstvene nege. Ramšak Pajk, Bernik in Rajkovič (2003) ugotavljajo, da so problemi, s katerimi se srečujejo izvajalci zdravstvene nege pri načrtovanju karierne poti predvsem naslednji:

- Prepuščanje odgovornosti za načrtovanje osebne kariere drugim, predvsem zavodu in vodilnim v zdravstveni negi.
- Nepoznavanje pojma načrtovanje kariere.
- Nizko samovrednotenje lastnih sposobnosti in interesov, ki so ključni v kariernem razvoju posameznika.
- Nezainteresiranost za dodatno izobraževanje.
- Nezavedanje procesa samoevalvacije, ki posredno povečuje zadovoljstvo na delovnem mestu in vpliva na profesionalno rast zaposlenih v zdravstveni negi.

Tudi Brečko (2006) pravi, da se je pojmovanje kariere v zadnjem času drastično spremenilo in več ne pomeni le poti navzgor, ampak tudi pot vstran ali celo navzdol. Kariera je razumljena kot življenjska in poklicna pot ter zajema vse vidike človeške osebnosti in vlog, v katere posameznik vstopa v življenju.

Karierni razvoj zaposlenih v zdravstveni negi bistveno prispeva k napredku sistemov zdravstvenega varstva in profesije zdravstvene nege, ter je neposredno povezan z vzdrževanjem visoke kakovosti izvajanja storitev zdravstva in zdravstvene nege. Nastajati mora v okviru celotnega sistema zdravstvenega varstva in mora omogočati horizontalno in vertikalno napredovanje. Karierno napredovanje v zdravstveni negi lahko definiramo kot prehajanje medicinskih sester na zahtevnejši nivo delovanja, na različna področja zdravstvene nege ali na položaje, kjer prevladujejo različne funkcije, vključno s podjetništvom v zdravstveni negi in avtonomnimi profesionalnimi vlogami (ICN, 2007).

Skela Savič (2009) pravi, da bodo v prihodnje vedno bolj pomembne zahtevnejše oblike dela, specialna znanja, ki bodo temeljila tudi na z dokazi podprti praksi. To dejstvo jasno dokazuje, da bodo v prihodnje karierne aspiracije in karierne poti izvajalcev zdravstvene nege temeljile predvsem na dodatnih specialnih znanjih, ki bodo temeljila na znanstvenih dokazih. Spodbujanje in zagovarjanje pomena raziskovanja na kliničnem področju zdravstvene nege naj bo vodilo v prihodnosti.

METODE

Prispevek je pripravljen na podlagi pregleda literature in virov, uporabljena je deskriptivna metoda dela z analizo virov. V prvi fazi iskanja virov so nas predvsem zanimali znanstveni in strokovni prispevki, ki so glede na izpostavljene ključne besede dostopni v nacionalni bazi COBIB.SI. V kombinaciji iskalnega niza zdravstvena nega in raziskovanje smo dobili 258 zadetkov, v kombinaciji iskalnega niza ključnih besed raziskovanje in karierni razvoj in zdravstvena nega smo dobili 1 zadetek, pri iskalnem nizu zdravstvena nega in možnosti raziskovanja pa smo dobili 2 zadetka. Iskanje virov je potekalo tudi s pomočjo baz podatkov: PubMed, Medline, ScienceDirect in ProQuest. Pri iskanju smo uporabili ključne besede v slovenskem in angleškem jeziku: raziskovanje, karierni razvoj, zdravstvena nega, možnosti raziskovanja/ research, career development, career aspiration, nursing, clinical research. Upoštevali smo samo vire, ki so bili objavljeni kot polna besedila. Odločili smo se, da časovne objave virov ne bomo omejevali.

REZULTATI

Aktivni pristopi izvajalcev zdravstvene nege pri oblikovanju kariere so vezani na vprašanja, ki si jih mora zastaviti vsak posameznik in s tem na nek način prevzeti odgovornost za svojo kariero. Ta vprašanja se nanašajo na samorazvoj (Kam želim priti in kaj želim doseči?), osebni cilj (osebni dohodek, napredovanje, dobri delovni pogoji) in usklajenost lastnih in organizacijskih ciljev (Merkač Skok, 2005). Kralj (2006) v raziskavi vrednotenja dejavnikov razvoja kariere zdravstvenih delavcev ugotavlja, da ima organiziranost kot dejavnik razvoja kariere izredno slab vpliv na karierni razvoj anketiranih zdravstvenih delavcev, dejavnik zadovoljstvo pri delu pa je v omenjeni raziskavi povprečno ocenjen. Kot eden

najbolje ocenjenih dejavnikov je ocenjena družina v smislu razumevanje celotne družine in njihovo zavedanje pomembnosti razvoja kariere družinskih članov, najbolje ocenjen dejavnik pa je v omenjeni raziskavi iniciativnost in inovativnost, kar potrjuje dejstvo, da morajo biti zaposleni v zdravstveni negi v stalnem stiku z izboljšavami in novostmi v stroki zdravstvene nege ter aktivni na raziskovalnem področju. Medtem, ko Švigelj Rogelj (2009) ugotavlja, da se izvajalci zdravstvene nege zavedajo velike strokovne usposobljenosti in velike odgovornosti do svojega dela, ter se počutijo enakovredni in suvereni člani zdravstvenega tima. Želijo se dodatno izobraževati, na svojih delovnih mestih pa so dokaj zadovoljni, kar posredno vpliva na razvoj in skrb za njihovo poklicno pot. Tudi Brečko (2008) navaja, da je poklicna izbira močno povezana s posameznikovo samopodobo v zvezi z delom. Strokovnjaki ugotavljajo, da ne glede na znanje, ki ga posameznik ima, veščine, ki mu jih je uspelo razviti, je uspešen tisti posameznik, ki je zadovoljen s svojo izbiro poklica, da lahko uresničuje osebne vrednote, ima jasne karierne cilje in oblikovano samopodobo. Na podlagi samopodobe razvije svoje karierno sidro že zgodaj v življenju in vse tiste elemente v človekovi predstavi o sebi, ki se jim ne bo odrekel niti, ko bodo pred njim težavne odločitve. Krogstad s sodelavci (2006) ugotavlja, da je karierni razvoj bolj pomemben za zdravnike, za izvajalce zdravstvene nege pa razumevanje in podpora pri delu ter povratna informacija od neposredne vodje. Pokazalo se je, da so tiste medicinske sestre, ki si želijo razvoja kariere tudi na področju raziskovanja, bolj zadovoljne s svojim delom in izbrano profesijo (Kovner et al., 2006). Tudi Tierney (1998) predstavlja sliko razvoja zdravstvene nege na področju raziskav po vsej Evropi. Ugotavlja, da so se Velika Britanija, Finska in Danska razvijale v podobnih časovnih okvirih, začetki raziskovalnega področja v zdravstveni negi v teh državah segajo 50 in več let nazaj, medtem ko so se Estonija, Litva in Slovenija na raziskovalnem področju pričele razvijati šele v letih 1980 in 1990. Razvidno je, da kljub počasni skupni rasti v Evropskem prostoru, je bila leta hitrejša v razvitih Evropskih državah. Veliko dejavnikov je vplivalo na to rast: kot so pomanjkanje sredstev za podporo raziskavam, počasen razvoj usposabljanja na izobraževalnem in raziskovalnem področju in nizek status medicinskih sester v razmerju do drugih zdravstvenih poklicev, zlasti zdravnikov. Poudaril je tudi tri elemente, ki podpirajo razvoj raziskovalnega področja v zdravstveni negi: pobude »od spodaj navzgor«, ki tako vplivajo na karierno aspiracijo posameznikov; pobude s strani državnih in vladnih institucij in podporo rasti raziskovalne infrastrukture s strani univerz in izobraževalnih institucij s področja zdravstvenih ved. Strojan, Zurc in Skela Savič (2012) v raziskavi o odnosu medicinskih sester do raziskovanja v zdravstveni negi ugotavljajo, da je odnos medicinskih sester do raziskovanja pozitiven. Prav tako rezultati njihove raziskave kažejo, da je raziskovanje potrebno za kontinuirano izboljševanje prakse zdravstvene nege, da bi sodelovanje v raziskovalnem delu moralo biti del nalog medicinskih sester, ter da se medicinske sestre v prihodnosti želijo več posvetiti branju strokovne literature. Yang s sodelavci (2004) navaja, da študentje zdravstvene nege moškega spola v svoji strategiji načrta karierne poti v večjem interesu pospešeno izboljšujejo strokovno zanje, znanje na področju raziskovanja ter veščine, da bodo, ko se bodo zaposlili bolj konkurenčni, bolj agresivno iščejo službo, izbirajo ozko specialna področja, kjer aktivno skrbijo za svojo profesionalno rast in izražajo interes za pogosto menjavo delovnega mesta.

DISKUSIJA

Kljub navidezno enakim možnostim kariernega razvoja v zdravstveni negi in seveda že znanemu dejstvu, da kjerkoli posamezni izvajalec zdravstvene nege deluje, je v veliki meri sam odgovoren za svoj karierni razvoj, ne moremo mimo dejstva, da na karierni razvoj posameznika vpliva tudi organizacija. Glede na organizacijo dela in organiziranost posameznega nivoja zdravstvenega varstva lahko govorimo tudi o različnih možnostih, spodbudah in skrbi za karierni razvoj izvajalcev zdravstvene nege s strani organizacije. Razvoj kadrov v zdravstveni negi mora biti močno povezan s pozitivno kadrovsko selekcijo, ki zagotavlja ustrezno kariero predvsem sposobnim, inovativnim in motiviranim izvajalcem zdravstvene nege, ki si bodo želeli razvijati tudi na področju kliničnega raziskovanja. Glede na ugotovitve (Merkač Skok, 2005; Švigel Rugelj, 2009) se odgovornost za lasten karierni razvoj vse bolj pomika v individualno okrilje. Dogodki v okolju in samorazvoj spodbujajo posameznika, da si občasno postavi vprašanja ali je pri svoji karieri uspešen in kaj bi moral narediti, da bi na tem področju dosegel še več. Doseči moramo, da bodo izvajalci zdravstvene nege s podiplomsko oziroma akademsko izobrazbo ostajali pri pacientu – v kliničnem okolju in želeli razvijati svojo profesionalno in karierno pot s pomočjo vseživljenjskega učenja in raziskovanja v stroki. Pri razvoju kariere izvajalcev zdravstvene nege je pomembno, da management v zdravstveni negi deluje v okviru usmeritev zavedanja, da potrebuje dobre sodelavce. Uresničevati mora politiko timskega dela in pri tem upoštevati vrednote organizacije, interese in želje zaposlenih, ter poudariti odgovornost in povezovanje med sodelavci. Izvajalci zdravstvene nege, ki želijo biti uspešni in imajo željo po kariernem razvoju tudi na področju raziskovanja pa morajo biti inovativni, kreativni, pripravljeni se učiti, vešči timskega dela in imeti pozitivna stališča do sebe, drugih in nenazadnje tudi do vseživljenjskega izobraževanja.

Možnosti raziskovalnih področij v klinični praksi so izredno velike. Potrebna je prava izbira, pristop in način izvedbe raziskave. V zadnjem času lahko spremljamo aktualna klinična raziskovalna področja kot so: management, spremljanja akutne in kronične bolečine, pojavnost, spremljanje in odpravljanje vzrokov za nastanek razjede zaradi pritiska, padcev, hospitalnih infekcij in drugih neželenih dogodkov, različni nivoji obravnave kritično bolnih in njihovih svojcev, preventivna dejavnost in področje raziskovanja pri delu z ranljivimi skupinami prebivalstva (starostniki, otroci, brezdomci, zaporniki, begunci…). Pomembno klinično raziskovalno področje je lahko tudi obravnava pacientov v referenčnih ambulantah, kjer lahko izvajalci zdravstvene nege spremljajo kronične bolezni, dejavnike tveganja, pojavnost in preprečevanje kot tudi zdravljenje kroničnih obolenj. Podobno tudi Polit in Beck (2008) povzemata globalna področja na katerih so velike možnosti in potrebe po raziskovanju v zdravstveni negi: preventivna dejavnost in promocija zdravja, varnost in kakovost v zdravstvu, razvoj na dokazih podprtega raziskovanja, promocija zdravja in dobro počutje starejših, na pacienta usmerjena obravnava, paliativna zdravstvena nega, razvoj zdravstvene nege in delovno okolje medicinskih sester. Prav tako Pick (2011) ugotavlja, da so klinične raziskave ključnega pomena za iskanje novih načinov zdravljenja in izboljšanje zdravstvene nege ter oskrbe pacientov. Prav izvajalci zdravstvene nege, ki so aktivni na raziskovalnem področju so v ospredju tega procesa. Potrebujejo poglobljeno razumevanje raziskovalnega procesa in raziskovalne terminologije. Imajo ključno vlogo zagovornika pacientov in zagotavljajo varnost ter zaščito pacientov v celotnem raziskovalnem procesu. Izvajalci zdravstvene nege, ki želijo aktivno razvijati kariero na raziskovalnem področju potrebujejo širok spekter znanj, vključno z vodstvenimi, organizacijskimi, poučevalnimi, mentorskimi in komunikacijskimi sposobnostmi. Sodelovanje med in z drugimi raziskovalci in člani multidisciplinarnega tima je ključnega pomena za uspešno izvedene raziskave.

ZAKLJUČEK

Karierna pot izvajalcev zdravstvene nege mora biti tako horizontalna kot vertikalna. Inovativnost, kreativnost in profesionalnost morajo biti stalnice, ki spremljajo izvajalce zdravstvene nege na njihovi karierni poti. Raziskovalno področje je potrebno še dodatno razviti in spremljati. Veliko vlogo pri spodbujanju razvoja raziskovanja imajo izobraževalne institucije na področju zdravstvenih ved, stroka zdravstvene nege sama in seveda vsak posameznik, ki se želi aktivno razviti na tem področju.

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OPTIMIZING HIGHER EDUCATION TEACHING AND LEARNING THROUGH CONSTRUCTIVE ALIGNMENT OF COURSES AND STUDY PROGRAMS

OPTIMIZIRANJE VISOKOŠOLSKEGA POUČEVANJA IN UČENJA S KONSTRUKTIVNO PORAVNAVO PREDMETOV IN ŠTUDIJSKIH PROGRAMOV

SLAVKO CVETEK, MILENA PIŠLAR

Izvleček

Izhodišča*: V visokem izobraževanju v svetu se krepi spoznanje, da je najpomembnejša naloga univerz in visokošolskih ustanov na začetku 21. stoletja optimirati učenje študentov in s tem družbe nasploh. Med koncepti oz. modeli oblikovanja visokošolskega kurikuluma, ki izhajajo iz zgornjega spoznanja, je v zadnjem desetletju deležen vse večje pozornosti model 'konstruktivne poravnave'. V prispevku avtorja poročata o (pilotskem) projektu, v katerem sta uporabila model konstruktivne poravnave za namen doseganja notranje skladnosti izbranega predmeta v visokošolskem študijskem programu Zdravstvena nega.*

Metode*: V postopku konstruktivne poravnave predmeta je bil uporabljen Biggsov model konstruktivne poravnave. Postopek je obsegal (1) oblikovanje predvidenih učnih izidov za deklarativno in funkcionalno znanje, (2) opredelitev poučevalnoučnih aktivnosti in (3) izbiro nalog za preverjanje in ocenjevanje znanja.*

Rezultati*: Poravnani učni načrt predmeta vsebuje za vsak predvideni učni izid tipične poučevalnoučne aktivnosti in vrste znanja (deklarativno ali funkcionalno) ter nivo razumevanja oz. izvedbe, ki jih od študentov zahtevajo naloge za preverjanje in ocenjevanje znanja). Takšna opredelitev poučevalnoučnih aktivnosti in nalog za ocenjevanje znanja olajšuje načrtovanje in izvedbo visokošolskega poučevanja in učenja oz. študija.*

Diskusija in zaključki*: Konstruktivna poravnava predstavlja uporabno orodje za doseganje notranje skladnosti (poravnanosti) predmetov in študijskih programov v visokem izobraževanju. Za visokošolsko ustanovo, ki si resnično prizadeva za 'optimiziranje' učenja (študija) študentov to pomeni, med drugim, da bo morala, ne le jasno določiti, česa naj bi bili študenti zmožni ob zaključku predmeta ali študijskega programa, temveč tudi v marsičem spremeniti pristope k poučevanju oziroma učenju, preverjanju in ocenjevanju znanja ter jih uskladiti s cilji in predvidenimi učnimi izidi.*

Ključne besede*: visokošolsko izobraževanje, oblikovanje kurikuluma, teorija konstruktivne poravnave*

Abstract

Introduction*: In higher education in the world, there is a growing awareness that the most important task of universities and higher education institutions at the beginning of the 21st century is to optimize student learning and thus learning of society as such. One of the concepts and models of higher education curriculum design which have in the last decade attracted increased interest of universities and curriculum planners is the 'constructive alignment' model which is today considered as one of the most influential concepts in higher education. In the paper, the authors report about a (pilot) project in which they applied the model of constructive alignment for the purpose of achieving the internal consistency of the selected subject in the higher education study program Nursing Care.*

Methods*: The authors used Biggs' model of constructive alignment. The process consisted of (1) the identification of learning outcomes for declarative and functional knowledge, (2) the definition of poučevalnoučnih activities, and (3) the selection of tasks for assessment of knowledge.*

Results*: The constructively aligned subject contains,*

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for each intended learning outcome, typical teaching and learning activities and types of knowledge (declarative or functional) and level of understanding and/or performance which are required from students through assessment tasks. Such an alignment of learning outcomes, teaching and learning activities and assessment tasks facilitates the planning and implementation of pedagogical activities and individual study.

Discussion and conclusions*: Constructive alignment represents a useful tool to achieve internal consistency (alignment) of courses and study programs in higher education. For a higher education institution which is genuinely committed to 'optimize' students' learning this means, among other things, that it will have not only to clearly define what the students should be able to at the end of the course or study programme, but also to change, in many ways, its approaches to teaching, learning and assessment, and align these with the aims and intended learning outcomes.*

Keywords*: higher education, curriculum design, constructive alignment theory*

IZHODIŠČA

V zadnjih desetletjih se na področju visokošolskega izobraževanja v svetu in tudi v Sloveniji vse pogosteje pojavlja beseda oziroma pojem 'optimiziranje', ki je bilo v preteklosti značilno predvsem za področje ekonomskih in organizacijskih ved. Kot je zapisal Carl Wieman, univerzitetni profesor in Nobelov nagrajenec za fiziko (2001) ter v ZDA univerzitetni profesor leta (2004) »je najpomembnejša naloga univerz in visokošolskih ustanov na začetku 21. stoletja optimirati učenje študentov in s tem družbe nasploh.« (Wieman, 2006, str. 1). Kot pravi avtor, morajo študenti v času študija pridobiti kompleksna znanja in spretnosti, ki zahtevajo razumevanje, česar pa ni mogoče pridobiti s pasivnim poslušanjem predavanj (razlage). Resnično razumevanje pride le na način, da študent aktivno gradi svoje razumevanje skozi proces miselne gradnje (konstrukcije) na osnovi predhodnega znanja in znanja, ki ga pridobi skozi aktivno prizadevanje oz. študij (prav tam, str. 2). Povedano drugače, optimiziranje izobraževanja na visokošolski ustanovi pomeni poiskati in uporabljati takšne načine in oblike izobraževanja in učenja oz. študija, ki ob danih pogojih dajejo najboljše rezultate v smislu doseganja ciljev izobraževanja in pridobljenih kompetenc diplomantov.

Med koncepti oziroma modeli oblikovanja visokošolskega kurikuluma, ki izhajajo iz zgoraj opisanega pojmovanja, je v zadnjem desetletju deležen vse večje pozornosti univerz in načrtovalcev visokošolskih študijskih programov model tako imenovane 'konstruktivne poravnave' (Biggs, 1999; Biggs, Tang, 2007; glej tudi Cvetek, 2012, 2013), ki danes velja za enega najbolj vplivnih konceptov v visokem izobraževanju. V nadaljevanju prispevka so predstavljena osnovna načela (Biggsove) teorije konstruktivne poravnave in postopek poravnave predmeta (učne enote) oziroma študijskega programa. Kot je znano, velja v visokošolskem izobraževanju za osnovni pristop k oblikovanju predmeta ali učne enote v izobraževalnem programu še vedno ta, ki ga je že pred več kot pol stoletja opisal Tyler (1949) in vsebuje štiri elemente: cilji, vsebina, organizacija oz. metode (poučevanja in učenja) ter načini preverjanja in ocenjevanja znanja. Znano pa je tudi, in ugotovitve raziskav potrjujejo (npr. Gibbs, 1992; Biggs, 1999; Ramsden, 2003), da prihaja v učnih načrtih predmetov in študijskih programov pogosto do neskladja med npr. cilji in vsebino ali med cilji oziroma vsebino in načini ocenjevanja. Preseganje tega neskladja je glavni cilj teorije konstruktivne poravnave (ang. constructive alignment theory). Teorija se v osnovi navezuje na predvidene učne izide v učnih načrtih predmetov študijskih programov in na kriterije za ocenjevanje znanja študentov . Konstruktivna poravnava temelji na dveh med seboj povezanih oziroma soodvisnih načelih, in sicer na konstruktivističnem pojmovanju učenja in na poravnavi pri načrtovanju (oblikovanju (dizajniranju) poučevanja in ocenjevanja znanja. 'Konstruktivno' pri tem pomeni, da študenti skozi ustrezne učne aktivnosti gradijo pomen (znanje), 'poravnava' pa se nanaša na situacijo, v kateri so poučevalnoučne aktivnosti ter naloge za ocenjevanje znanja poravnane s predvidenimi učnimi izid na način, da uporabljajo aktivne glagole (npr. opisati, razvrstiti, izvesti, oceniti), ki jih vsebujejo predvideni učni izidi (Biggs, Tang, 2007, str. 81). Proces konstruktivne poravnave predmeta (ali učne enote) v osnovi vsebuje tri korake, in sicer: (1) definiranje predvidenih učnih izidov, (2) določanje poučevalnoučnih aktivnosti in (3) določanje nalog za preverjanje ocenjevanje znanja študentov.

Predvideni učni izidi (PUI) so izjave o tem, kaj naj bi dosegli študenti kot rezultat neke poučevalnoučne izkušnje, bistveni kriterij za dobro napisan PUI pa je, da bo študent, potem ko bo videl zapisani izid, vedel, kaj mora narediti in kako dobro naj to naredi, da bo dosegel izid. Pri drugem koraku v procesu konstruktivne poravnave, izbiranju poučevalnoučnih aktivnosti (PUA) gre v osnovi za to, da izberemo takšne aktivnosti poučevanja oziroma učenja, ki ustrezajo prej definiranim izidom, pri čemer je pomembno, da vemo, ali od študentov pričakujemo zgolj deklarativno (teoretično)

znanje, ali pa tudi funkcionalno (praktično) znanje, ki ga študenti izkazujejo npr. skozi uporabo tehnik, izvajanje postopkov, reševanje problemov ipd. Pri tretjem koraku konstruktivne poravnave, izbiri nalog za ocenjevanje znanja (NOZ), pa je pomembno zagotoviti, da bomo ocenjevali študentovo doseganje učnih izidov, kar v praksi pomeni uporabo kriterijskega načina ocenjevanja, pri katerem rezultate posameznika primerjamo z določenimi standardi uspešnosti. Glede na dejstvo, da z vidika študentov ocenjevanje vselej definira dejanski kurikulum, lahko pričakujemo, da se bodo študenti v tem primeru učili to, kar od njih »zahtevajo« učni izidi.

V osnovi torej velja, da je predmet (ali učna enota) konstruktivno poravnan, (1) ko so jasno opredeljeni predvideni učni izidi, (2) ko so načini ocenjevanja znanja skladni s predvidenimi učnimi izidi (in s tem cilji predmeta ali učne enote) in (3) ko so poučevalnoučne aktivnosti skladne s predvidenimi učnimi izidi (in s tem cilji predmeta ali učne enote). Ne glede na to, da se zdi takšna 'poravnava' po svojem bistvu samoumevna in stvar zdravega razuma, pa Biggs in Tang (2007) kritično ugotavljata, da večina učnih načrtov predmetov visokošolskih programov ni (ali ni dovolj) poravnana. Po mnenju avtorjev je eden glavnih razlogov za to dejstvo, da mnogi visokošolski učitelji poučevanje še zmeraj razumejo kot prenašanje znanja, pri ocenjevanju znanja pa jim je najpomembneje doseči dobro porazdelitev med dobrimi in slabimi študenti, kar najpogosteje dosegajo z uporabo testov izbirnega tipa, ki pa pogosto ne merijo tega, kar naj bi glede na cilje in predvidene učne izide merili. Drug pomemben razlog je v tem, da poizkušajo učitelji predvidene učne izide, ki sodijo v domeno funkcionalnega znanja, pogosto dosegati s poučevalnoučnimi aktivnostmi, ki sodijo v domeno deklarativnega znanja, npr. tako, da za predvideni učni izid 'uporaba' znanja, od študentov zahtevajo, da govorijo o uporabi in ne, da bi znanje v resnici uporabili.

Obstajajo razlogi za trditev, da zgornje ugotovitve veljajo tudi za visokošolsko izobraževanje pri nas v Sloveniji. Pregled 10 naključno izbranih predmetov novo akreditiranih študijskih programov, ki se trenutno izvajajo na visokošolskih ustanovah Univerze v Mariboru (Cvetek, 2013, str. 135), je pokazal, da opisi ciljev predmetov pogosto vsebujejo neustrezne, na poučevanju kot transmisiji utemeljene glagole in besedne zveze, kot npr. seznaniti študente, podati oziroma posredovati študentom znanja ali vsebine, obdelati temo, ipd. Opisi predvidenih učnih izidov pogosto vsebujejo splošne glagole, kot so npr. znati, razumeti, osvojiti ali izkazati znanje, obvladati tehniko ipd, ali pa gre zgolj za naštevanje lastnosti in kvalitet, ki naj bi jih imeli študenti, npr. volja za sodelovanje, čut odgovornosti, empatija in spoštovanje ipd. Če upoštevamo še dejstvo, da gre pri vsebinah v učnih načrtih predmetov, ki se nanašajo na metode poučevanja in učenja ter načine ocenjevanja znanja večinoma zgolj za naštevanje tradicionalnih oblik in načinov, kot so predavanje, seminar, vaje, pisni ali ustni izpit, potem lahko na osnovi zgornjih ugotovitev utemeljeno domnevamo, da učni načrti predmetov visokošolskih študijskih programov ne izpolnjuje dveh ključnih zahtev, s katerimi se danes soočajo načrtovalci predmetov in programov v visokem izobraževanju - namreč da so ti utemeljeni na predvidenih učnih izidih in poravnani, to je, skladni, notranje povezani ipd.

V letih 2011 in 2012 sva avtorja tega prispevka izvedla, kot pilotski projekt, postopek konstruktivne poravnave enega od predmetov visokošolskega strokovnega študijskega programa Zdravstvena nega, ki se izvaja na Fakulteti za zdravstvene vede Univerze v Mariboru, in sicer sva v ta namen izbrala predmet Psihologija v zdravstveni negi in zdravstvu. Cilj je bil doseči 'poravnanost', t.j. skladnost med cilji oziroma predvidenimi učnimi izidi, vsebino in ocenjevanjem znanja pri predmetu. Drug, prav tako pomemben cilj projekta je bil preveriti uporabnost same teorije in modela konstruktivne poravnave. V nadaljevanju prispevka je kratek opis metod oz. postopka poravnave in 'poravnani' učni načrt predmeta (podrobneje o postopkih poravnave v Cvetek, Pišlar, 2012).

METODE

V postopku konstruktivne poravnave izbranega predmeta visokošolskega študijskega programa je bila uporabljen Biggsov model konstruktivne poravnave (Biggs, 1999; Biggs, Tang, 2007; Cvetek, 2013). Postopek je obsegal (1) Oblikovanje predvidenih učnih izidov za deklarativno in funkcionalno znanje, (2) opredelitev poučevalnoučnih aktivnosti in (3) izbiro nalog za preverjanje in ocenjevanje znanja. Posamezni postopki poravnave so opisani v poglavju o rezultatih.

REZULTATI

V tem poglavju so predstavljeni rezultati opravljenih postopkov konstruktivne poravnave predmeta *Psihologija v zdravstveni negi in zdravstvu* v visokošolskem strokovnem študijskem programu Zdravstvena nega, ki se izvaja na Fakulteti za zdravstvene vede Univerze v Mariboru (Visokošolski, b.d.), in sicer so najprej. V nadaljevanju so najprej predstavljeni cilji in predvideni študijski rezultati, vsebina, metode poučevanja in učenja ter načini preverjanja in ocenjevanja znanja, kot jih opredeljuje veljavni učni načrt predmeta.

Cilji: Študenti:

- spoznajo biopsihosocialni model zdravja in bolezni in medsebojno vplivanje bioloških, socioloških in psiholoških dejavnikov v zdravju in bolezni.
- spoznajo področje zdravstvene psihologije.
- spoznajo osnovne razvojne in osebnostne teorije.

Predvideni študijski rezultati:

Znanje in razumevanje:

- Študent bo sposoben prepoznati probleme pri pacientu in potrebo po psihološki pomoči.
- Študent bo poznal različne psihosomatske težave in pristope in jih bo znal opisati. Poznal bo pomen psihologije v zdravstveni negi.

Prenesljive/ključne spretnosti in drugi atributi:

- Študent bo sposoben pridobljena znanja prenesti v prakso zdravstvene nege.

Vsebina (teme): Osnovni teoretski pristop: vedenjske, kognitivne, humanistične, interpersonalne, razvojne teorije in teorije osebnosti. Psihologija in zdravstvena nega. Razlike med klinično in zdravstveno psihologijo. Timsko delo. Pomen terapevtske komunikacije. Psihologija bolnika: stres, anksioznost, emocije, procesi žalovanja, kronični bolnik in kakovost življenja. Potrebe in zadovoljitev potreb. Motivacija in razvoj konfliktov. Empatija. Izgorevanje.

Metode poučevanja in učenja: metoda predavanja, metoda dela z besedili, skupinska oblika dela, metoda študije primera.

Oblike preverjanja in ocenjevanja znanja: pisni izpit (70%) in seminarska naloga (30%).

Kot lahko ugotovimo, so opisi ciljev predmeta precej splošni in brez jasno razvidne povezave s kompetencami, ki jih vsebuje študijski program. Predvideni učni izidi vsebujejo predvsem splošne glagole na nižjih nivojih razumevanja, iz katerih ni mogoče ugotoviti, kaj naj bi študenti znali in bili zmožni ob koncu izvajanja predmeta. Vsebina predmeta (teme) je navedena na razdrobljen in nepovezan način. Opisi metod poučevanja so splošni in pomanjkljivi, nekateri so pomensko nejasni (npr. metoda dela z besedili). Opis oblik preverjanja in ocenjevanja znanja vsebuje le podatke o načinu ocenjevanja. Na pisnem izpitu se ocenjuje predvsem deklarativno znanje, in sicer na način, da študent opiše ali razloži pristop, teorijo, model, proces ipd. Avtorja sva prišla do zaključka, da je predmet *Psihologija v zdravstveni negi in zdravstvu*, kot ga opredeljuje veljavni učni načrt, notranje neskladen oziroma 'neporavnan' glede na načela teorije konstruktivne poravnave.

V postopku konstruktivne poravnave predmeta sva se avtorja omejila na poravnavo treh nosilnih elementov učnega načrta (kurikuluma) predmeta – to je predvidenih učnih izidov, poučevalnoučnih aktivnosti in nalog za ocenjevanje znanja – pri čemer sva uporabila postopek (model), kot ga za konstruktivno poravnavo predlagata Biggs in Tang (2007). V nadaljevanju so na kratko opisani postopki treh korakov poravnave in, kot rezultat poravnave, 'poravnani' učni načrt predmeta ter kratka ocena rezultata poravnave.

a. Oblikovanje predvidenih učnih izidov: Avtorja sva najprej preverila skladnost učnih ciljev predmeta s cilji in kompetencami, kot jih opredeljuje študijski program. Spodaj so navedeni cilji predmeta v 'poravnanem učnem načrtu', in sicer študent:

- pozna osnovne psihološke pojme, teorije in modele v zdravstveni negi
- pozna metode raziskovanja v zdravstveni psihologiji
- pozna značilne psihosomatske težave in njihov vpliv na posameznika
- pozna in razume medsebojno vplivanje bioloških, socialnih in psiholoških dejavnikov v zdravju in bolezni
- razvije osnovne psihološke in komunikacijske spretnosti, potrebne za delo s pacientom (poslušanje, usmerjanje razgovora, reševanje konfliktov ipd.)
- je zmožen refleksije in uravnavanja lastnega razmišljanja, doživljanja in ravnanja v različnih situacijah

Za razliko od veljavnega učnega načrta, kjer se cilji nanašajo zgolj na deklarativno znanje in vključujejo le spoznavno dimenzijo, so cilji v poravnanem UN skladni s kompetencami, kot jih določa študijski program in se nanašajo tako na deklarativno kot tudi funkcionalno znanje ter vključujejo kognitivno, psihomotorično (spretnosti) in afektivno (čustva, vrednote, stališča) razsežnost znanj in usposobljenosti študentov. Opisi ciljev so tudi bolj konkretni in razumljivi študentom, kar je ena temeljnih predpostavk konstruktivne poravnave.

Na osnovi opredeljenih ciljev predmeta sva avtorja zatem določila vrste znanja, ki so predmet poučevanja in učenja, pri čemer sva upoštevala Biggsovo delitev znanja na t.j. deklarativno oziroma funkcionalno znanje (Biggs, Tang, 2007). Skladno z načeli konstruktivne poravnave sva preoblikovala glavne vsebine oziroma teme, ki so predmet poučevanja oziroma učenja in jih opredeljuje veljavni učni načrt. Poravnani UN tako obsega naslednje vsebine oz. teme:

- Vloga psihologije v zdravstveni negi, osnovne psihološke teorije (behavioristična, kognitivna, humanistična, interpersonalna).
- Metode raziskovanja, ki se uporabljajo v zdravstveni psihologiji.
- Psihologija skozi življenjsko dobo: otrok in mladostnik, odrasli in starejši bolnik, kronični bolnik, bolnik v terminalni fazi bolezni.
- Psihologija zdravja: tvegana vedenja, vloga čustev, stres, psihologija bolečine, izguba in žalovanje.
- Komuniciranje in svetovanje v terapevtskem odnosu medicinska sestra-pacient : komunikacijske veščine.

Na koncu sva avtorja za vsak predvideni učni cilj določila nivo razumevanja ali izvedbe, ki naj bi ga dosegli študenti, kar sva dosegla z uporabo ustreznih (aktivnih) glagolov na osnovi Bloomove (1956) taksonomije spoznavnih ciljev (Jenkins, Unwin, n.d.; glej tudi Cvetek, 2012). Predvideni učni izidi v poravnanem UN predmeta so:

1. opisati in razložiti osnovne psihološke pristope (teorije) ter metode raziskovanja, ki se uporabljajo v zdravstveni psihologiji (deklarativno znanje; nivo razumevanja 1, 2)
2. opisati značilna psihična stanja in težave pacientov v kontekstu zdravstvene nege in oskrbe ter načine zagotavljanja podpore pri iskanju rešitev (deklarativno znanje; nivo razumevanja 1-2)
3. opisati biopsihosocialni model zdravja in bolezni (deklarativno znanje; nivo razumevanja: 1-2)
4. uporabljati osnovne spretnosti, potrebne pri zdravstveni obravnavi pacienta, npr. aktivno poslušanje, usmerjanje pogovora ipd. (funkcionalno znanje; nivo razumevanja 3)
5. kritično razmišljati (reflektirati) o svojem izkustvu (dogodkih in situacijah) v procesu izobraževanja in usposabljanja za poklic medicinske sestre (funkcionalno znanje; nivo razumevanja: 6)

Za razliko od veljavnega UN, kjer se predvideni učni izidi nanašajo zgolj na deklarativno znanje in vključujejo le spoznavno dimenzijo (skladno s teorijo konstruktivne poravnave sposobnosti prenašanja pridobljenih znanj v prakso zdravstvene nege ni mogoče šteti za predvideni učni izid), so predvideni učni izidi v poravnanem učnem načrtu skladni s kompetencami, kot jih določa študijski program in se nanašajo tako na deklarativno kot tudi funkcionalno znanje in vključujejo kognitivno, psihomotorično (spretnosti) in afektivno (čustva, vrednote, stališča) razsežnost znanj in usposobljenosti študentov. Opisi izidov vsebujejo aktivne glagole, ki dajejo jasne napotke – tako za učitelja kot študente - glede zahtevanega nivoja razumevanja, metod poučevanja in učenja (študija) ter ocenjevanja znanja.

b. Določanje poučevalnoučnih aktivnosti: Pri tem koraku sva avtorja za vsak predvideni učni izid predmeta, ki se nanaša na deklarativno ali funkcionalno znanje, določila poučevalnoučne situacije oziroma aktivnosti, ki vodijo k študentovemu doseganju tega izida. Na koncu sva pri vsaki poučevalnoučni aktivnosti preverila, ali študenti »izvajajo« glagole, ki jih vsebujejo ustrezni predvideni učni izidi.

Za razliko od veljavnega učnega načrta, ki ne vsebuje poučevalnoučnih aktivnosti, ampak zgolj našteva metode poučevanja (metoda predavanja, metoda dela z besedili, skupinska oblika dela, metoda študije primera), vsebuje poravnani učni načrt za vsak predvideni učni izid tipične aktivnosti tako učitelja kot študentov, skladno z opredelitvijo vrste znanja (deklarativno ali funkcionalno). Takšna opredelitev poučevalnoučnih aktivnosti olajšuje pripravo poučevalnoučnih aktivnosti za posamezno poučevalnoučno situacijo (mikro nivo) v izvedbenem učnem načrtu in pripravo nalog za ocenjevanje znanja.

c. Določanje nalog za ocenjevanje znanja: Avtorja sva za vsakega od PUI, ki se nanaša na deklarativno oziroma funkcionalno znanje, določila nalogo (ali več nalog), s katero bi bilo mogoče preveriti in oceniti študentovo doseganje tega izida. Avtorja sva pri tem izhajala iz Biggsove (1999) opredelitve, po kateri preverjanje in ocenjevanje deklarativnega znanja najpogosteje poteka na način oz. v obliki esejskih nalog in testov izbirnega tipa, preverjanje in ocenjevanje funkcionalnega znanja pa na način oz. v obliki različnih predstavitev dela študentov, kot so

npr. predstavitve primerov oz. projektov, reflektivni dnevniki, opisi kritičnih dogodkov, portfoliji, ipd. Pri tem sva upoštevala načelo konstruktivne poravnave, da mora biti iz naloge jasno razvidno, kaj bi moral študent narediti, da bi nalogo opravil. Na koncu sta avtorja preverila, ali so aktivnosti študentov poravnane z glagolom (oz. glagoli) v ustreznem predvidenem učnem izidu predmeta.

Razpredelnica 1: Poravnava poučevalnoučnih aktivnosti pri predmetu Psihologija v zdravstveni negi in zdravstvu s predvidenimi učnimi cilji

Predvideni učni izid (deklarativno in funkcionalno znanje) Študent bo zmožen:	Poučevalno- učna situacija	Poučevalnoučne aktivnosti	
		Učitelj	Študenti
1. (D) opisati in razložiti osnovne psihološke pristope (teorije) ter metode raziskovanja, ki se uporabljajo v zdravstveni psihologiji	predavanje, seminar, individualno delo	razlaga, navaja primere, preverja razumevanje, zastavlja vprašanja, spodbuja diskusijo	poslušajo, zapisujejo, odgovarjajo na vprašanja, razpravljajo o primerih (pari, skupine)
2. (D) opisati značilna psihološka stanja in težave pacientov ter načine zagotavljanja podpore pri iskanju rešitev	predavanje, seminar, individualno delo	razlaga, navaja primere, spodbuja diskusijo, podaja možne pristope k reševanju problemov ipd.	razpravljajo (pari, skupine) o primeru, ga analizirajo skozi uporabo teorije, oblikujejo rešitve ipd.
3. (D) opisati biopsihosocialni model zdravja in bolezni, razložiti pomen in prednosti biopsihosocialnega modela zdravja in bolezni,	predavanje, seminar, individualno delo	predava, preverja razumevanje, zastavlja vprašanja, spodbuja diskusijo	poslušajo, zapisujejo, izdelajo miselni vzorec, razpravljajo v parih ali manjših skupinah
4. (F) uporabljati osnovne spretnosti, potrebne pri zdravstveni obravnavi pacienta npr. aktivno poslušanje, usmerjanje pogovora ipd.	seminar	razlaga, demonstrira, preverja razumevanje, organizira in vodi aktivnosti za razvijanje spretnosti	prakticirajo uporabo spretnosti skozi simulacijo in igro vlog
5. (F) kritično razmišljati (reflektirati) o svojem izkustvu (dogodkih in situacijah) v procesu izobraževanja in usposabljanja za poklic medicinske sestre	seminar, individualno delo	demonstrira in pojasnjuje pomen refleksije in reflektivne prakse v ZN, daje študentom naloge refl. tipa (npr. refl. dnevnik, analiza kritičnega dogodka)	reflektirajo o izkustvu (npr. na klinični praksi) in pomenu izkustva in kritičnega premisleka za poklic MS, vodijo portfolijo

Razpredelnica 2: Poravnava za ocenjevanje znanja pri predmetu Psihologija v zdravstveni negi in zdravstvu s predvidenimi učnimi cilji

Predvideni učni izid (deklarativno in funkcionalno znanje - študent bo zmožen:	Oblika preverjanja in ocenjevanja znanja	Naloga(-e) za preverjanje in ocenjevanje znanja - študent
1. (D) opisati osnovne psihološke pristope (teorije) ter metode raziskovanja, ki se uporabljajo v zdravstveni psihologiji	pisni izpit	opiše (navede, našteje ipd.) mesto in področja psihologije v ZN in zdravstvu opiše (navede, prepozna, ipd.) osnovne pristope v zdravstveni psihologiji (behavioristični, kognitivni, interpersonalni, humanistični) opiše (navede, našteje ipd.) najpomembnejše metode raziskovanja v zdravstveni psihologiji
2. (D) opisati značilna psihološka stanja in težave pacientov ter načine zagotavljanja podpore pri iskanju rešitev	pisni izpit	prepozna (ugotovi oz. določi na osnovi opisa značilnosti, zgodbe, scenarija ipd.) značilna psihološka stanja in težave pacientov in načine zagotavljanja podpore pacientom v različnih psiholoških stanjih
3. (D) opisati biopsihosocialni model zdravja in bolezni	pisni izpit	opiše (navede, našteje ipd.) ključne značilnosti biopsihosocialnega modela in njegovo uporabo (uporabnost) v zdravstveni negi in zdravstvu
4. (F) uporabljati osnovne spretnosti, potrebne pri zdravstveni obravnavi pacienta npr. aktivno poslušanje, usmerjanje pogovora ipd.	seminar, klinične vaje	uporabi (v realnem ali simuliranem okolju) osnovne komunikacijske spretnosti, npr. pogovor s pacientom v značilnem (problematičnem) psihološkem stanju, pogovor s svojci ali člani negovalnega tima
5. (F) kritično razmišljati (reflektirati) o svojem izkustvu (dogodkih in situacijah) v procesu izobraževanja in usposabljanja za poklic medicinske sestre	seminar, klinične vaje, individualno delo	vodi in predloži v oceno reflektivni dnevnik klinične prakse (portfolijo) analizira kritični dogodek (npr. na klinični praksi, seminarju) vrednoti svoje delo (samoevalvacija) načrtuje alternativne strategije ipd.

Za razliko od veljavnega UN, ki določa le načine ocenjevanja znanja (t.j. pisni izpit in seminarska naloga), vsebuje poravnani UN za vsak predvideni učni izid tudi vrste znanja (deklarativno ali funkcionalno) ter nivo razumevanja oz. izvedbe, ki ga naloga zahteva od študenta (npr. naštevanje, opisovanje, uporaba, vrednotenje). Takšna opredelitev nalog za ocenjevanje znanja olajšuje pripravo izpitnih vprašanj in nalog, ki jih morajo opraviti študenti, da bi izkazali s predvidenimi učnimi cilji opredeljeno znanje oz. usposobljenost.

Iz opredelitev aktivnosti, ki jih opravlja študent, da bi izpolnil nalogo, kot jih vsebuje poravnani UN, je v poravnanem UN bolj jasno razvidno, da lahko učitelj pri določanju nalog za ocenjevanje znanja uporablja različne oblike in načine objektivnega ocenjevanja tudi na višjih stopnjah razumevanja (npr. skozi naloge razvrščanja in dopolnjevanja, skozi opredeljevanje do različnih scenarijev, opise kritičnih dogodkov ipd.) in ne zgolj opisovanje, ki ustreza nižjim nivojem znanja (deklarativno znanje), in velja za neučinkovito in v sodobnem izobraževanju medicinskih sester (in profesionalcev nasploh) preseženo obliko ocenjevanja znanja.

DISKUSIJA IN ZAKLJUČKI

Z zgoraj opisanim postopkom konstruktivne poravnave nosilnih elementov predmeta Psihologija v zdravstveni negi in zdravstvu v visokošolskem strokovnem programu Zdravstvena nega sva avtorja postavila okvir za oblikovanje poučevalnoučnih aktivnosti in nalog za ocenjevanje na nivoju posameznih vsebinskih enot oziroma tem, ki se obravnavajo pri predmetu Psihologija v zdravstveni negi in zdravstvu (za primere poučevalnoučnih aktivnosti in nalog za ocenjevanje znanja za izbrano temo v učni enoti predmeta glej Cvetek, Pišlar, 2012). S preoblikovanjem učnega načrta predmeta *Psihologija v zdravstveni negi in zdravstvu* po načelih konstruktivne poravnave sva, kot sva prepričana, uspela dokazati, da predstavlja konstruktivna poravnava uporabno orodje za doseganje notranje skladnosti (poravnanosti) predmetov in študijskih programov v visokem izobraževanju, kar je pogoj za njihovo kakovost in učinkovitost, ki veljata za temeljni zahtevi, ki ju pred fakulteto in univerzo postavlja družba.

Konstruktivna poravnava predmeta oziroma študijskega programa v visokem izobraževanju je zahteven proces, ki zahteva strateško načrtovanje in sodelovanje vseh visokošolskih učiteljev, kar je mogoče le ob jasno opredeljenih ciljih in podpori visokošolske ustanove oziroma univerze kot celote. Za visokošolsko ustanovo, ki si resnično prizadeva za 'optimiziranje' učenja (študija) študentov to pomeni, med drugim, da bo morala, ne le jasno določiti, česa naj bi bili študenti zmožni ob zaključku predmeta ali študijskega programa, temveč tudi v marsičem spremeniti pristope k poučevanju oziroma učenju, preverjanju in ocenjevanju znanja ter jih uskladiti s cilji in predvidenimi učnimi izidi. Za optimiziranje učenja oziroma študija je tudi potrebno povečati uporabo sodobne tehnologije za poučevanje in učenje (npr. e-učenje, inteligentni tutorski sistemi ipd.), kontaktne ure pa morajo biti namenjene predvsem bolj zahtevnim izobraževalnim nalogam, ki za študente predstavljajo izziv in spodbujajo njihovo prizadevanje za učenje (študij) in profesionalni razvoj. Prav za to pa v izobraževanju medicinskih sester in drugih profesionalcev tudi gre.

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SAFE WORKING ENVIRONMENT FOR NURSING TEAM MEMBERS

VARNO DELOVNO OKOLJE ZA ČLANE NEGOVALNEGA TIMA

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IZVLEČEK

Izhodišča*: Večina delovnih nalog negovalnega tima v zdravstveni negi je kombinacija lažjega in težjega dela. Pri organizaciji dela na kliničnih oddelkih v bolnišnici se poskuša upoštevati razmerje med lažjim in težjim delom, kolikor je to le mogoče in vzpostaviti varno delovno okolje za člane negovalnega tima.*

Namen raziskave je bil, da v bolnišničnem okolju med zaposlenimi v negovalnem timu celovito analiziramo pogoje dela in njihov vpliv na bolniško odsotnost zaradi zdravstvenih težav s hrbtenico. Preučevali smo, kateri dejavniki vplivajo na obolevnost hrbtenice pri zaposlenih in koliko lahko neprilagojeno delovno okolje in ergonomsko tehnični pripomočki zmanjšajo nevarne telesne položaje pri delu in olajšajo premagovanje bremen.

Metode: *Podatke s strukturiranimi vprašalniki smo zbirali v letu 2007/2008 med 900 člani negovalnih timov na oddelkih UKC Maribor. Opazovanje negovalnega osebja pri rednem delu s pomočjo metode OWAS je bilo opravljeno leta 2008. Statistična obdelava podatkov je bila izvedena s statističnim programskim paketom SPSS, različico 15.0.1. SPSS je podpiral vse statistične teste in metode uporabljene v raziskavi. Pri preučevanju problema in pridobivanju podatkov o bolečinah ledvenega in vratnega dela hrbtenice pri delu negovalnega osebja, smo vizualno spremljali negovalno osebje pri rednem delu s pomočjo metode OWAS. Osredotočili smo se na bistvene ergonomske pomanjkljivosti v delovnem okolju negovalnega tima pri izvajanju zdravstvene nege pacienta in prikazali uporabo ergonomsko tehničnih pripomočkov, ki se pri negovanju pacienta ne uporabljajo pogosto.*

Rezultati: *Rezultati raziskave so pokazali, da so delovna doba 19 let in več, dvigovanje bremen nad 10 kg večkrat dnevno in neizvajanje preventivnih vaj za krepitev hrbtenice, statistično pomembni pokazatelji težav s hrbtenico. Z metodo OWAS smo pri 15 kritičnih telesnih legah, z uporabo ergonomsko tehničnih pripomočkov, zabeležili skupno znižanje v višini 12,9 odstotnih točk, iz 20,6 na 7,7 odstotka. Naslednja pomembna ugotovitev je bila, da zaposleni na oddelkih v bolnišnici, kjer imajo urejeno delovno okolje in pogosteje uporabljajo ergonomsko tehnične pripomočke, poročajo o statistično pomembno manj težav s hrbtenico.*

Diskusija in zaključki: *Z raziskavo smo dokazali, da varno delovno okolje in uporaba ergonomsko tehničnih pripomočkov bistveno zmanjšata kritične lege in biomehanične obremenitve hrbtenice negovalnega osebja v zdravstveni negi. Ugotovili smo, da ergonomsko tehnične pripomočke, če so na razpolago, tudi uporabljajo v negovalnem timu na oddelkih v kliničnem okolju. Percepcija, da se osebje v negovalnem timu pripomočkov pri delu izogiba ne drži in ne more veljati kot izgovor, da se organizacija ergonomskega programa ne izpelje.*

Ključne besede: *zdravstvena nega, ergonomija, bolečina, delovno okolje, metoda OWAS*

ABSTRACT

Introduction*: The purpose of this was to analyse hospital work environment and its impact on absence from work due to back pain. In included an analysis which factors contribute to back pain and of the extent ergonomic assistive devices reduce awkward working body postures at work and help to overcome physical burden.*

Methods*: Data through structured questionnaires were collected in 2007/2008 to 900 members of the nursing team at the Department UKC Maribor. Observation of nursing staff in their daily work using the method OWAS was done in 2008. Statistical data analysis was performed with the statistical software package SPSS, version 15.0.1. SPSS was supported by all statistical tests and methods used in the study. The study was conducted were used to collect data on low back and neck pain and involved visual observation body posture during work by using OWAS metod. We evaluated physical barriers in hospital which impede nursing care provision and*

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developed standards for nursing interventions by using ergonomic assistive devices which have been in use rarely or not at all.

Results*: Results have shown that 19 years of work and more, frequent manuel lifting above 10 kg of weighting and avoidance of preventive exercises to strenghten back represent significant factors for back pain. Acording to observation(by OWAS method)of 15 awkward body postures, use of ergonomic assistive devices contributed to overall avarage descrease by 12,9 percentage points, from 20,6% to 7,7%. It was also found that nursing staff in hospital departments with more frequent use of ergonomic assistive devices reported signifacanty less back problems.*

Discussion and conclusion*: Our research indicated that safe working enviroment use of ergonomic assistive devices signifcantly reduces awkward working body postures and biomehanical strain on nurses spine in nursing care provision. We also found that ergonomic assistive devices, if available, are frequently used. A common assumption that nurses avoid use of ergonomic assistive devices was not confrimed and may only serve as a shallow argument in postpone the realisation of ergonomic program.*

Keywords*: nursing care, ergonomic principles, back pain,working environment, OWAS metod*

IZHODIŠČA

Poklicne okvare hrbtenice pri negovalnem timu lahko nastanejo pri delih, ki zahtevajo fleksijo in rotacijo hrbtenice, naglo krčenje paravertebralnih mišic, zviti položaj pri delu ali pri nepravilnem dvigovanju bremen (Berger, Kresal, 2003). Najbolj pogoste poškodbe hrbtenice so oslabljene hrbtne mišice, razrahljane ali oslabele hrbtne vezi, poškodovane medvretenčne ploščice in izrabljeni sklepi. Dolgotrajno sedeče in stoječe delo oz. fleksija in hoja z bremenom vplivajo na pojav deformacije hrbtenice v smislu kifoze, skolioze ali deformantne spondiloze ali spondilartroze (Sušnik, Bizjak, Cestnik, 1995). Okvara medvretenčne ploščice v lumbalnem predelu je najpomembnejše obolenje lokomotornega aparata kot posledica fizičnih obremenitev (Turk, 2005). Obolenja lumbalnega dela hrbtenice in vratne hrbtenice so najznačilnejša pri negovalnem osebju v zdravstveni negi, ki držijo pri delu glavo sklonjeno naprej ali nazaj.

Negovalno osebje opravlja svoje delo najpogosteje v stoječem položaju, kar pomeni večjo obremenitev za spodnje okončine in tudi večjo energetsko porabo v primerjavi s sedečim delovnim položajem. Negovalno osebje se mora v stoječem položaju pogosto pripogniti v ledvenem delu hrbtenice, se skloniti v kolkih in tudi zasukati hrbtenico. Zelo pogosta je prisilna drža glave in vratu. V procesu dela se pojavljajo izometrične mišične obremenitve ramenskega obroča, nadlahti, podlahti in prstov rok, pa tudi spodnjih okončin (Muftić, 2006).

Stoječa telesna lega povzroča statično obremenitev. Pri dolgotrajnem stoječem delu se pojavijo težave z obtokom krvi, saj se kri zadržuje v nogah in tako pride do oteklin in krčnih žil (Sušnik, Bizjak, Cestnik, 1995). Stoječa telesna lega povzroča tudi obremenitev hrbtenice in posturalnega mišičja. Če se stoječemu delu pridruži še fleksija in bremena, se povečajo energetske in hemodinamske obremenitve organizma ter pritisk na medvretenčne ploščice (Muftić, 2006). V začetku ne gre za patološke spremembe, toda dolgotrajna obremenitev lahko takšno stanje spremeni v bolezen.

Večina delovnih nalog negovalnega tima v zdravstveni negi je kombinacija lažjega in težjega dela, zato je zaželena takšna razporeditev dela negovalnega osebja, da ne prihaja do izčrpanja. V normalnih razmerah, ko je dovolj negovalnega osebja, se je mogoče izogniti stalni obremenjenosti in posledični izčrpanosti ter koristno uporabiti rezerve v storilnosti (Aiken, Clarke, Sloane, 2002). Pri organizaciji dela na kliničnih oddelkih v bolnišnici se poskuša upoštevati razmerje med lažjim in težjim delom, kolikor je to le mogoče in vzpostaviti varno delovno okolje za člane negovalnega tima.

Delo medicinske sestre v bolnišnici je vsakodnevno povezano z dvigovanjem in prenašanjem bremen (dvigovanje, spuščanje, potiskanje, vleka, držanje, prenašanje in obračanje pacientov), kar vključuje velike statične in dinamične obremenitve, ki jih lahko klasificiramo kot težko in biomehansko zahtevno telesno delo. Posledica fizičnih obremenitev so povečane obremenjenosti številnih organskih sistemov delavca, od katerih so najbolj izpostavljena gibala in še posebej hrbtenica (Engkvist et al., 1998; Hoogendoorn et al., 1999; Goldman et al., 2000).

Težave s hrbtenico kot so bolečine, zmanjšana gibljivost in nezmožnost obremenjevanja so v urbanem svetu glavni vzroki prezgodnje delovne nesposobnosti. V poklicu medicinske sestre je še posebej prizadeta starostna skupina od 20-40 let, ko se že kažejo težave s hrbtenico, kar pa ima vpliv tudi na delazmožnost (Bilban, 2005). Poškodbe, ki nastanejo pri fizično napornem delu, posebno pri dvigovanju bremen, tvorijo skupno četrtino vseh registriranih profesionalnih poškodb s simptomi v ledvenem delu hrbtenice (Sušnik, Bizjak, Cestnik, 1995).

Zdravstveni delavci se odzivajo na prevelike obremenitve, na zdravstveno škodljivost pri delu, na slabe medsebojne odnose in odtujenost s kazalci negativnega zdravja, kamor sodijo tudi poškodbe, poklicne bolezni, bolniški stalež, invalidnost in prezgodnje upokojevanje. Vsi ti kazalci so več vzročno pogojeni: nanje vpliva objektivna in subjektivna stvarnost. Poklicno delo zdravstvenih delavcev mora potekati v stanju dinamičnega ravnovesja, to je v območju obremenitev, ki omogoča procese homeostaze. Pojem se nanaša na dinamično ravnotežje acidobaznega stanja, ozmotskega tlaka, telesne temperature, kardiovaskularne kapacitete, razmerja med anabolizmom in katabolizmom, a tudi na psihične funkcije. Za psihično homeostazo se smatra umirjenost, občutek udobja, zadovoljstvo in notranja harmonija. Zaradi preobremenitve se homeostaza poruši. Odgovor na preobremenitev je preobremenjenost. Obremenjenost nasprotno lahko traja le kratek čas (Wilson, Corlet, 1993).

Medicinske sestre, ki imajo zdravstvene težave, v večini primerov ne morejo govoriti o nepričakovani bolečini v hrbtenici pri delovni aktivnosti, temveč o problemu, ki se postopoma in počasi razvija. Zahtevnost delovnega mesta in človekova reaktivnost morata biti ves čas v dinamičnem ravnovesju, da lahko adaptacijski mehanizmi v človekovem organizmu vzdržujejo homeostazo in se tudi skozi daljšo delovno dobo preprečujejo poškodbe in okvare (Čelan, Turk, 2005).

Pri pravilnem dvigovanju težjega bremena iz nizkega položaja počepnemo in z zravnanim hrbtom dvignemo breme. Pri tem je pomembno, da napnemo trebušne mišice in ves čas dvigovanja zadržimo fiziološko krivino hrbtenice. S tem se pritisk enakomerno porazdeli na medvretenčne ploščice in na stegna in je tako možnost poškodbe manjša (Ivanuša, Železnik, 2008). Maksimalna teža bremena, ki jo oseba lahko varno dvigne, znaša 35 % njegove telesne teže. Dvigovanje bremen z upognjenim hrbtom je nepravilno, saj se pri tem zelo poveča pritisk na ledvene medvretenčne ploščice. Pri nepravilnem dvigovanju, prenašanju in ročnem prevažanju težkih bremen se tako zaradi preobremenitve struktur hrbtenice lahko povzroči akutna poškodba (diskus hernija) ali pa tudi trajna okvara (degenerativne spremembe struktur hrbtenice).

Težave, ki se pojavijo s hrbtenico, so boleče, zmanjšujejo gibljivost in funkcionalno sposobnost osebe, kar zmanjšuje kvaliteto življenja. Pogosto prihaja do daljših odsotnosti z dela ter prezgodnjih trajnih delovnih nesposobnosti, kar s socialno-medicinskega vidika poleg zdravljenja predstavlja največji strošek. Bolečina v križu je velik zdravstveni problem zaradi negativnih zdravstvenih pokazateljev (visoka incidenca bolezni, bolniški stalež, dolgotrajno zdravljenje, pogosta invalidska upokojitev), hkrati pa tudi socialno-ekonomskih problem zaradi visokih stroškov medicinske obravnave in kritja nadomestil zaradi nezmožnosti za delo (Turk, 2005). Razširjenost težav s hrbtenico nalaga kot obvezo različnim strokovnjakom, da iščejo načine preventive in zmanjševanja preobremenitev na delovnih mestih. V raziskavi smo preučevali, dejavnike, ki vplivajo na obolevnost hrbtenice pri zaposlenih in koliko lahko neprilagojeno delovno okolje in ergonomsko tehnični pripomočki zmanjšajo nevarne telesne položaje pri delu in olajšajo premagovanje bremen.

METODE

S pomočjo metode OWAS, ki predstavlja časovno metodo vzorčenja smo opazovali telesne položaje na podlagi simetričnega časovnega intervala. S pomočjo te metode smo pridobili podatke o pojavu bolečine v ledvenem in vratnem delu hrbtenice.

Izvedli smo epidemiološko študijo pojavljanja negativnih kazalcev zdravja zaradi težav s hrbtenico pri medicinskih sestrah in zdravstvenih tehnikih. Vzorec za raziskavo je predstavljala populacija 900 medicinskih sester (MS) in zdravstvenih tehnikov (ZT), ki so zaposleni na različnih oddelkih Univerzitetnega kliničnega centra Maribor (UKC Maribor). Na raziskavo se je odzvalo 663 medicinskih sester in zdravstvenih tehnikov ali 73,7 % vseh povabljenih. Spolna struktura je predstavljala 84,0 % žensk in 16,0 % moških. Povprečna starost je znašala 37,8 let, skupna delovna doba 17,2 leti in delovna doba na sedanjem delovnem mestu 13,3 leta.

S pomočjo anketnega vprašalnika smo želeli ugotoviti rizične skupine medicinskih sester oziroma kateri dejavniki vplivajo na pojav bolečine v ledvenem delu hrbtenice. Podatki so bili statistično obdelani s pomočjo programskega paketa SPSS.

REZULTATI

Rezultati raziskave so pokazali, da večina preiskovancev delo opravlja stoje, da občasno oziroma vsakodnevno večkrat dvigujejo bremena nad 10 kg. Bremena se dvigujejo s pripomočki le v 7,7 %. Podrobnejši rezultati so prikazani v razpredelnici 1.

Razpredelnica 1: Delovne razmere medicinskih sester v UKC Maribor

Poimenujte naslovno vrstico	%
Delo opravljam	
pretežno sede	1,4
menjajoče	29,1
pretežno stoje	69,5
Dvigovanje bremena nad 10 kg	
ne	5,7
občasno	35,4
vsakodnevno večkrat	58,8
Načini dvigovanja bremena	
sami	19,1
s sodelavci	73,1
s pripomočki	7,7

Poimenujte naslovno vrstico	%
Frekvenca bolečine v hrbtenici	
nikoli	9,3
enkrat	5,3
dvakrat	5,8
večkrat	79,7
Frekvenca bolniškega staleža	
nikoli	75,8
enkrat	10,4
dvakrat	5,2
večkrat	8,7

Hi-kvadrat test je pokazal statistično pomembno povezavo med bolečinami v hrbtenici in vsakodnevnim dvigovanjem težjega bremena (p=0,004). Iz razpredelnice 2 je razvidno, da imajo največ težav preiskovanci, ki dvigujejo bremena nad 10 kg vsakodnevno večkrat.

Razpredelnica 2: Križna tabela za bolečine v ledvenem delu hrbtenice v odstotkih

Poimenujte naslovno vrstico		Bolečine v ledvenem delu hrbtenice			
		nikoli	enkrat	dvakrat	večkrat
Pri delu dvigujem bremena nad 10 kg teže	ne	13,2	13,2	5,3	68,4
	občasno	13,2	6,8	6,8	73,1
	vsakodnevno večkrat	6,5	3,6	5,2	84,8
Skupaj		9,3	5,3	5,8	79,7

Bolečina v hrbtenici največkrat nastopi pri večini preiskovancev ob dvigovanju pacientov (60,3 %), sledi delo ob priklonu z 53,8 %, ostali položaji pa so bili navedeni manj pogosto (razpredelnica 3).

Razpredelnica 3: Položaji pri katerih se pojavi bolečina v ledvenem delu hrbtenice

Položaj	%
ob dvigovanju pacienta	60,3
pri delu ob priklonu	53,8
ob dvigovanju predmetov	37,1
pri delu v stoječem položaju	34,1
po daljšem sedenju	22,2
drugo	7,5

Iz rezultatov v razpredelnici 1 je razvidno tudi, da je frekvenca bolečine hrbtenice pogosta, bolniški stalež pa zelo redek. Ko smo analizirali bolniški stalež po posameznih oddelkih, so rezultati pokazali, da je bilo največ preiskovancev v staležu v centralni sterilizaciji (53,3 %), sledijo oddelki nujne medicinske pomoči, travmatologije in nevrokirurgije s tretjinskim deležem (razpredelnica 4).

Razpredelnica 4 : Bolniški stalež zaradi ledvene hrbtenice (v odstotku vseh MS in ZT po oddelkih)

Oddelek	%
centralna sterilizacija	53,3
nujna medicinska pomoč	34,5
travmatologija	33,3
nevrokirurgija	33,3

DISKUSIJA

Rezultati v naši raziskavi so pokazali, da je pojav bolečine v hrbtenici povezan z večkratnim dvigovanjem bremen mase nad 10 kg. Negovalno osebje se premalo zaveda problematike mišično-skeletnih obolenj in pričenja s preventivnimi ukrepi šele, ko se težave pojavijo. Aktivna športna oz. pogosta rekreativna dejavnost sta se izkazali kot zmanjševalec tveganja za pojav bolečine oz. težav s hrbtenico. Telesna aktivnost je bila tudi v drugih študijah prikazana kot učinkovita preventivna intervencija pred bolečinami v hrbtenici in vratu (Linton, Tulder, 2001; Burton et al., 2005), vendar v znanosti ni priporočil za nobeno vrsto preventive in njeno intenzivnost (Burton et al., 2005). Delovna doba posameznika in dvigovanje bremen pri delu sta bila že mnogokrat zanesljivo potrjena kot negativna dejavnika (Marras et al., 1999; Retsas, Pinikahaba, 2000; Bongers, Kremer, Laak, 2002).

Glede uporabe ergonomsko tehničnih pripomočkov smo ugotovili, da se pripomočki ne uporabljajo, ker niso na razpolago in ne, ker je uporaba časovno in tehnično zahtevna. Ugotovili smo tudi, da je manj težav s hrbtenico na oddelkih, kjer se ergonomsko tehnični pripomočki uporabljajo pogosto, čeprav izračunan faktor vpliva ni bil močan. Z OWAS metodo smo pokazali, da je uporaba ergonomsko tehničnih pripomočkov statistično pomembno znižala skoraj vse za hrbtenico kritične telesne lege. V povprečju je znašal upad, znotraj 7,5 urnega delavnika, za 12,9 odstotnih točk, iz 20,6 na 7,7 %.

Negovalno osebje je bilo v preteklosti večkrat deležno raziskav o telesnih položajih pri delu (Hignett, 2003; Dawson et al., 2007). Pri tem je večina avtorjev raziskave usmerila na intervencijske programe in dvižne tehnike. Hignett (1996) je ugotovila, da je neustreznih telesnih leg pri delu s pacientom statistično pomembno več kot pa pri ostalih aktivnostih. V njeni raziskavi so bili opazovani položaji hrbtenice, zgornje in spodnje okončine ter premagovanje sil. Negovalno osebje se je pri delu s pacientom nahajalo v eni izmed nepravilnih telesnih leg več kot 50 % časa, znotraj merjenega časovnega intervala, z izjemo pri oblačenju na dvigalu za kopalno kad. Čeprav se raziskava ni ukvarjala s vplivom ergonomije, se je v tej raziskavi pokazal pomen pripomočkov pri delu. Kot najbolj zahtevna negovalna intervencija je bila identificirana kopanje pacienta v klasični kopalni kadi, kjer se je negovalno osebje nahajalo v nepravilnem telesnem položaju skoraj ves čas. Med nalogami negovalnega osebja, ki niso bile povezane z delom s pacientom, je bila kot zahtevna identificirana aktivnost postiljanje postelje. Tudi Harrison in Nixon (2002) sta ugotovila statistično povezavo med delom s pacientom in mišično-skeletnimi poškodbami.

Številne raziskave so se osredotočale le na dvigovanje oz. premagovanje bremen in določanjem obremenitev za hrbtenico (Hye-Knudsen, 2004). Zaključki so bili skoraj zmeraj enaki, da pri dvigovanju pacienta prihaja do zelo velikih kratkotrajnih obremenitev, ki presegajo zgornje priporočene meje (Marras et al., 1999; Zhuang et al., 1999; Hoogendoorn et al., 2000). Pri opazovanju aktivnosti dvigovanja pacienta oz. premeščanja pacienta na invalidski voziček gre za časovno zelo kratke aktivnosti, ki v povprečju trajajo od 20-30 sekund (Hye-Knudsen, 2004). Uporaba ergonomsko tehničnih pripomočkov v obliki prostostoječega premičnega dvigala isto aktivnost podaljša okvirno na 10 min. V naši raziskavi nismo beležili frekvence kolikokrat je bil pacient premeščen (dvignjen) iz postelje, na primer, na invalidski voziček, vendar pa ni šlo za pogosto aktivnost. Morda je v povprečju vsak nepomičnih pacient enkrat dnevno premeščen iz postelje in nazaj. Če, na primer, posamezni član negovalnega tima dnevno 20 krat sodeluje pri premeščanju pacienta iz postelje na invalidski voziček in obratno, premaguje maksimalno breme le 10 min ali 2 % delovnega časa. Opazovalna metoda OWAS za merjenje kratkotrajne aktivnosti z velikimi bremeni ni najbolj primerna, saj je aktivnost dvigovanja pacienta znotraj 7,5-urnega delavnika zanemarljiva. Zaradi največje nevarnosti poškodbe za osebje in pacienta pa je to aktivnost prav tako treba humanizirati, kljub temu, da bo uporaba pripomočka zahtevala več časa.

Rezultati v naši raziskavi so pokazali, da se ergonomsko tehnični pripomočki, če so na razpolago, tudi uporabljajo. Percepcija, da se negovalno osebje tehnike pri delu v zdravstveni negi izogiba ne drži in ne more veljati kot izgovor, da organizacija ergonomskega programa ne izpelje (Daynard et al., 2001; Kneafsey, Haigh, 2007; Pettersson, Fahlström, 2009). O sami uporabi prostostoječih premičnih dvigal žal ne moremo veliko povedati, saj smo pri popisu opreme zabeležili le dve dvigali v celotnem UKC Mariboru. V namene naše raziskave se je dvigalo izposojalo med oddelki. Vsi ergonomsko tehnični pripomočki, ki smo jih v namene raziskave uporabljali, niso bistveno podaljšali časa izvajanja negovalnih intervencij, razen uporaba prostostoječega premičnega dvigala. Z organizacijskega stališča koristi in stroška imamo tukaj nehvaležno nalogo, ker je težko oceniti ali zaradi 2 % časa maksimalne obremenitve potrebujemo pripomoček, ki je drag in glede na priporočila uporabljene metode ničesar ne spremeni.

Pri obravnavi pacienta obstajajo aktivnosti, ki jih je težko učinkovito izpeljati z ergonomsko tehničnimi pripomočki. Med temi aktivnostmi bi, na primer, lahko izpostavili obračanje pacienta na postelji in premeščanje pacienta

iz postelje na sredstvo za transfer in obratno. To sta dve aktivnosti, kjer pacienta običajno ni potrebno dvigniti, ampak ga lahko nežno potisnemo ali povlečemo, če le-to njegovo zdravstveno stanje dovoljuje. Aktivnosti sta za razliko od dvigovanja pacienta ali bremen veliko manj tvegani za nepredvidljive dogodke in obremenitev lahko sproti doziramo (Engkvist et al., 1998). Če obračanje pacienta na postelji ne poteka po načrtih, je nevarnost poškodbe za pacienta prav tako zanemarljiva. Pri vsaki aktivnosti, ki jo želimo humanizirati, je potrebno preučiti, kje si lahko pomagamo s strategijo pristopa in kje potrebujemo tehnično pomoč. Rezultat humanizacije dela mora biti realiziran do neke razumne meje med tveganjem, potrebnim časom za izvedbo aktivnosti in samim učinkom, ki ga bomo dosegli.

Finančno smo ovrednotili, da se stroški nabave ergonomsko tehničnih pripomočkov dolgoročno izenačijo s stroški, ki nastanejo zaradi mišično-skeletnih poškodb ali obolenj. Treba pa je upoštevati tudi psihosocialne dejavnike, ki nastanejo kot posledica poškodb, tako za posameznika in delovni kolektiv. Organizacije, ki so uspešno uvedle ergonomske programe ugotavljajo tudi, da je fluktuacija kadra manjša in da se izgublja manj čas za uvajanja novega kadra (Owen, 2000). Običajno se zadovoljstvo z delom poveča. V zdravstvu izvedba ergonomskega programa poveča varnost in prinaša največ koristi delavcu in s tem posredno tudi pacientu, povečanje storilnosti je v zdravstveni stroki za enkrat sorazmerno neopredeljen dejavnik (Owen et al., 2002).

Organizacijo dela z uporabo ergonomsko tehničnih pripomočkov ni treba bistveno spremeniti. Dopolnila so potrebna pri izobraževanju osebja in spremljanju kazalnikov ali ergonomski program prinaša pričakovane učinke. Več nalog čaka predvsem vodstveno osebje na oddelkih bolnišnice, saj je spremljanje kazalnikov in merjenje učinka pretežno vodstvena funkcija. Za učinkovito reorganizacijo dela morajo kadrovski normativi ostati nespremenjeni, saj ne smemo pričakovati, da se bo situacija v zdravstveni negi v prihodnosti izboljšala (dvig razmerja osebje/pacient). Tudi druge gospodarske dejavnosti stremijo bolj k zmanjševanju delovnega osebja kot nasprotno.

V raziskavi smo uporabili samoevalvacijske vprašalnike, zato je potrebno dobljene rezultate obravnavati z določeno mero previdnosti, saj lahko samoevalvacija zajema zanikanje, zmoto ali težavo, da se mnenje ponovno prikliče v spomin (Trinkoff et al., 2003). Za opazovanje negovalnega osebja pri delu smo izbrali metodo OWAS z manualnim opazovanjem, kar je seveda manj natančno in zanesljivo, kot pa če bi uporabili snemalno tehniko. K večji zanesljivosti raziskave smo pripomogli na podlagi upoštevanja priporočil in navodil, kako metodo OWAS učinkovito in pravilno uporabiti (Karhu et al., 1977; Salonen, Heinsalmi, 1981; Bruijn et al., 1998; Mattila, Vilkki, 1999). Slikovno snemanje osebja pri delu v bolnišnici in s tem slikovno snemanje pacientov, obiskovalcev in tretjih oseb bi bilo etično sporno dejanje. Ne glede na pomanjkljivosti, ki jih izbrane metode v raziskavi vsebujejo, smo okvirno zajeli problematiko delovnih nalog medicinskih sester, zdravstvenih tehnikov in podpornih služb.

ZAKLJUČEK

Verjetnost, da okvare gibal pogojujejo tudi poklicno delo medicinskih sester je precejšnja. Bolezni so povezane s vplivom neurejenega delovnega okolja medicinske sestre, ergonomskih dejavnikov, z nefiziološkimi, prisilnimi držami na delovnem mestu in dvigovanjem pacientov oziroma bremen.

Predlog rešitev oziroma prispevek k zmanjšanju delovnih obremenitev pri negovalnem osebju v bolnišnični zdravstveni dejavnosti bi moral predstavljati zmanjšanje delovne obremenitve povezane z naravo dela. S pripomočki kot so ustrezne dvižne postelje, dvigala in drugi pripomočki za lažji transfer je treba humanizirati delovno mesto in vzpostaviti varno delovno okolje za člane negovalnega tima.

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A PRIORITY COMPETENCES MODEL OF MENTORS IN NURSING

MODEL PRIORITETNIH KOMPETENC MENTORJEV ZDRAVSTVENE NEGE

PETRA KAMENŠEK

Izvleček

Izhodišča*: V teoretičnem delu je opredeljen pojem »kompetenca«, izpostavljena je vloga mentorja ter pomen postavitve kompetenčnega modela mentorja v kliničnem okolju. Z raziskavo smo ugotavljali nivo pomembnosti kompetenc za izvajanje mentorstva v kliničnem okolju Univerzitetnega kliničnega centra Maribor v okviru sklopov kompetenc mentorja: delovna fleksibilnost, vodenje, organizacijsko vzdušje in ustvarjalnost.*

Metode*: Uporabljena je kvantitativna metoda raziskovanja. V raziskavi je sodelovalo 107 zaposlenih v zdravstveni negi, ki redno ali občasno izvajajo mentorstvo pripravnikov, študentov in dijakov zdravstvene nege. Kot instrument smo uporabili strukturiran anketni vprašalnik z vprašanji zaprto odprtega tipa.*

Rezultati*: Zaposleni v ZN opredeljujejo kompetence mentorja v kliničnem okolju v okviru delovne fleksibilnosti, vodenja, organizacijskega vzdušja in ustvarjalnosti kot pomembne, zelo pomembne, celo nepogrešljive. Izvajanje mentorstva jim pomeni priznanje strokovnosti dela ter omogoča učenje in osebni razvoj.*

Diskusija in zaključki*: Razvoj modela kompetenc mentorja v kliničnem okolju omogoča umestitev mentorja v proces zdravstvene in babiške nege, mentor ve, kaj se od njega pričakuje, katera so potrebna vedenja za iskanje priložnosti za lasten strokovni in osebni razvoj, razvoj mentoriranca in posledično kliničnega okolja ob zavedanju sedanjih in prihodnjih potreb razvoja stroke.*

Ključne besede*: mentorstvo, kompetence*

Abstract

Introduction*: The theoretical part defines the concept of "competence", exposed the role of the mentor and the importance of setting up competitive model mentor in a clinical setting. The survey was used to determine the level of importance of competencies for the implementation of mentoring in the clinical setting UKC Maribor in the framework of sets of skills tutor: labor flexibility, leadership, organizational climate and creativity.*

Methods*: a quantitative research method. The study involved 107 employees in health care, who regularly or occasionally perform mentoring trainees, students and nursing students. As an instrument, we used a structured questionnaire with closed questions open.*

Results*: Employees of the UKC Maribor define competencies of mentor in a clinical setting within the operating flexibility, leadership, organizational climate and creativity as important, very important, even indispensable. Providing mentoring them an acknowledgment of the work and makes learning and personal development.*

Discussion and conclusions*: Development of a competence model mentor in the clinical setting allows placement mentor in the process of Nursing and Midwifery, mentor knows what is expected of them, what are the necessary behaviors to look for opportunities for their own professional and personal development, and consequently mentorees clinical environment Aware current and future needs of the professional development.*

Keywords: *mentoring, competencies*

IZHODIŠČA

V literaturi zasledimo mnogo konceptov in pristopov k opredelitvi pojma »kompetenca«, ki se nanašajo na umestitev posameznika v delovnem okolju. Behavioristični koncepti opredeljujejo kompetence z vidika delovnih nalog in veščin. Tako Mayer et al. (2005) opredeljuje kompetence kot ravnanje, s katerim posameznik lahko učinkovito opravi določeno delo. Gruban (2005) opredeljuje kompetence kot odgovor na vprašanja, česa mora biti vešč posameznik, kaj mora obvladati, kako se mora vesti, kakšne spretnosti mora imeti, da bi določeno nalogo opravil dobro.

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Mc Mullan et al. (2003) poudari pomen holističnega pristopa h pojmovanju kompetenc v smislu osebnostnih lastnosti posameznika, katere so bistvene za učinkovito izvajanje dela ter predstavljajo temelj obvladovanju veščin. Plazar in Ličen (2013) vidita kompetence kot širok nabor zmožnosti, ki so pojmovno povezane in osredotočene na osnovne splošne lastnosti kot so znanje in kritično mišljenje.

RAZVOJ MODELA KOMPETENC MENTORJA

Ramšak Pajk (2007) ugotavlja, da največ definicij mentorstva izhaja iz podjetniškega modela mentorstva, kjer je bistven odnos med mentorjem in mentoriranim, je načeloma prostovoljen ter usmerjen v karierni razvoj. Mentorstvo razumeva v najširšem pomenu kot vzpostavljanje podpornega medosebnega odnosa, ki se lahko manifestira v obliki vzpodbujanja, treniranja, podpiranja, vodenja in perceptorstva ob sposobnosti mentorja za oblikovanje učnega okolja, iskanja možnosti za aktivno vključevanje mentoriranca v delovni proces ob upoštevanju njegovih potreb in učnih ciljev.

Na osnovi definiranja vloge mentorja identificiramo kompetence mentorja v kliničnem okolju v smislu strokovnih, socialnih in osebnostnih kompetenc.

Po Staretu (2005) se strokovne kompetence nanašajo na poklicno izobrazbo, znanje in sposobnosti ob poznavanju metod dela in izobraževanju, ki vključuje razvoj poklicnih spretnosti in znanja. Nadalje Stare (2005) opredeljuje socialne kompetence kot sposobnost za delovanje v skupini, reševanje konfliktov, vodenje ter sposobnost delovanja v različnih kulturah. Osebnostne kompetence se po Staretu (2005) nanašajo na sposobnost odkritega in pozitivno naravnanega pristopa ob identificiranju lastnih prednosti in deficitov, konstruktivnega sprejemanja kritike, odkrivanju novega, odgovornosti za dejanja in razvoj osebnosti.

Splošno Lucia in Leipsinger (1999) model kompetenc opisujeta kot posebno kombinacijo znanja, sposobnosti in karakteristik, potrebnih za uspešno delovanje v določeni vlogi, ki se uporablja kot orodje na področju človeških virov za selekcijo, usposabljanje, ocenjevanje in napredovanje.

Razvoj modela kompetenc mentorja v kliničnih okoljih nam daje odgovor na vprašanje »kam« (kakšen je cilj mentoriranja študenta, dijaka, pripravnika, novozaposlenega?) in »kako« (pot do želenih rezultatov mentoriranja).

METODE

Predstavljena raziskava je prvi korak v procesu priprave modela kompetenc mentorja v kliničnem okolju s cilji:

- ugotoviti, katere od zahtevanih in želenih kompetenc so najpomembnejše za izvajanje mentorstva pripravnikom, študentom in dijakom ZN;
- ugotoviti raven presoje zaposlenih v ZN o sposobnostih in znanjih za izvajanje mentorstva;
- ugotoviti ali in katere prednosti prinaša mentorstvo zaposlenim v ZN v kliničnem okolju.

Postavili smo štiri hipoteze:

Hipoteza 1: Kompetence mentorja v ZN z vidika delovne prožnosti, ustvarjalnosti, vodenja in organizacijskega vzdušja zaposleni v ZN prepoznavajo kot pomemben dejavnik za izvajanje mentorstva .

Hipoteza 2: Zaposleni v ZN identificirajo svoje sposobnosti za izvajanje mentorstva, jih ocenjujejo kot povprečne ter izvajanje mentorstva prepoznavajo kot priložnost za razvoj.

Hipoteza 3: Obstajajo statistično pomembne razlike med pomembnostjo posamezne kompetence in stopnjo izobrazbe zaposlenih v ZN.

Hipoteza 4: Obstajajo statistično pomembne razlike med številom usposabljanj za izvajanja mentorstva in stopnjo pomembnosti posamezne kompetence.

Za analizo podatkov in preverjanje hipotez smo uporabili kvantitativne metode deskriptivne statistike (povprečna vrednost, standardni odklon, test primerjave povprečij-ANOVA, hi-kvadrat test).

Za tehniko zbiranja podatkov smo uporabili anketni vprašalnik. Anketni vprašalnik je vseboval 11 vprašanj zaprto odprtega tipa, katera so se nanašala na ključne kompetence mentorja v kliničnem okolju po sklopih v okviru:

- delovne fleksibilnosti: obvladovanje področja ZN na osnovi strokovnih znanj, učinkovite prepoznave in izrabe potencialov mentorirancev ter komunikacijskih poti.
- vodenja: vpliv na mentoriranca z namenom doseganja predvidenih ciljev, sprejemanja odgovornosti, ocenjevanja mentoriranca ter vzpostavitve odnosa z mentorirancem, ki omogoča razvoj njegovih kompetenc;
- ustvarjalnosti: pripravljenost za projektno, razvojno in interdisciplinarno delo;
- organizacijskega vzdušja: obvladovanje veščin dela in ravnanja z mentoriranci.

Anketirani so se opredeljevali do trditev po pet stopenjski Likertovi lestvici.

Med zaposlene v ZN UKC Maribor, ki redno ali občasno izvajajo mentorstvo pripravnikom ZN, študentom in dijakom ZN, smo razdelili 130 vprašalnikov. Zaposleni v ZN so anketni vprašalnik izpolnjevali v obdobju od 29.3. do 3.4.2013. Vrnjenih in veljavnih je bilo 107 vprašalnikov, kar predstavlja 82,3% odzivnost. Anketni vprašalnik so izpolnjevali 4 (3,75%) moški in 103 ženske (96, 26%) in sicer 61 (57%) z visokošolsko izobrazbo, 30 (28,3 %) s srednješolsko izobrazbo in 11 (10,28%) z univerzitetno izobrazbo.

REZULTATI

Rezultati analize vprašalnikov so sledeči:

Prikaz sklopov kompetenc po pomembnosti. Razpredelnica št. 1 prikazuje povprečne ocene anketiranih po sklopih kompetenc.

Iz razpredelnice je razvidno, da je najvišjo oceno pomembnosti kompetenc mentorja dobil sklop kompetenc »delovne fleksibilnosti«. Na osnovi analize vprašalnikov najvišjo povprečno oceno sklopa kompetenc »delovne fleksibilnosti« dosega kompetenca »obvladovanje znanj in veščin« in sicer 4.867, najnižjo kompetenca »usposobljenost za nastopanje in pripravo gradiv« (4, 325).
Sklop kompetenc mentorja »vodenje« dosega povprečno oceno 4,423. Izstopa kompetenca »ocenjevanje strokovnega napredka mentoriranca« s povprečno oceno 4,614 ter kompetenca »navduševanje mentorirancev za ustvarjalno delovanje« z najnižjo povprečno oceno 3,897.
V sklopu kompetenc mentorja »organizacijsko vzdušje« je najvišja povprečna ocena podeljena kompetenci »zgleden odnos do mentoriranca in sodelavcev« in sicer 4,364 ter najnižja kompetenci »podpora viziji in poslanstvu mentorstva« (3,841).
Najnižjo povprečno ocena je podana sklopu kompetenc »ustvarjalnost« in sicer 3,996 v okviru katerega so ocenjevane kompetence samoiniciativnost pri pridobivanju novega znanja, spodbujanje interdisciplinarnega in projektnega dela, spodbujanje prenosa dobrih praks v delovno okolje in iniciativno reševanje problemov mentoriranja.
Usposabljanj za izvajanje mentorstva se je 1 krat ali več udeležilo 68 zaposlenih (63,55%), 39 (36,45%) se usposabljanja za izvajanje mentorstva še ni udeležilo.
Na osnovi testiranja hipoteze o statistično pomembnih razlikah med pomembnostjo posameznega sklopa kompetenc in stopnjo izobrazbe zaposlenih v ZN in testiranja hipoteze o statistično pomembnih razlikah med številom usposabljanj za izvajanje mentorstva in stopnjo pomembnosti posameznega sklopa kompetenc z uporabo ANOVA testa pri stopnji pomembnosti testa 0,05 dobimo sledeče rezultate (Razpredelnica št.2).

Iz razpredelnice je razvidno, da obstajajo statistično pomembne razlike med pomembnostjo sklopa kompetenc »vodenje« (5,004>F) in »ustvarjalnost«

Razpredelnica št. 1: Sklopi kompetenc, razvrščeni po povprečnih ocenah

SKLOP KOMPETENC	MEDIANA	N	MIN	MAX	STAN. ODKL.	RANG
DELOVNA FLEKSIBILNOST	4.743	107	2	5	0, 365	1
VODENJE	4,423	107	2	5	0,286	2
ORGANIZACIJSKO VZDUŠJE	4,148	107	2	5	0, 763	3
USTVARJALNOST	3,996	107	2	5	0, 595	4

Razpredelnica št. 2: Prikaz statistično pomembnih razlik med pomembnostjo posameznega sklopa kompetenc in stopnjo izobrazbe anketiranih ter številom usposabljanj za izvajanje mentorstva in stopnjo pomembnosti posameznega sklopa kompetenc

Sklop kompetenc	STOPNJE PROSTOSTI	Vrednost F	REZULTAT TESTA: Kompetence-izobrazba	REZULTAT TESTA Kompetence – št. usposabljanj
DELOVNA FLEKSIBILNOST	0,05;4;12	3,49	2,335	8,045
VODENJE	0,05;12,26	2,148	5,004	4,798
USTVARJALNOST	0,05;4;8	4,066	9,176	7,653
ORGANIZACIJSKO VZDUŠJE	0,05;4,8	4,066	2,864	5,168

(9,176>F) in stopnjo izobrazbe zaposlenih v ZN ter med številom usposabljanj in stopnjo pomembnosti posameznega sklopa kompetenc (8,045, 4,798, 7,653, 5,168 > F).

Zaznana je srednje močna korelacija med oceno pomembnosti kompetenc mentorja po sklopih kompetenc in udeležbo na usposabljanju za izvajanje mentorstva (r=0,328; p<0,001) in je višja pri oceni pomembnosti sklopa kompetenc »vodenje« (r=0,351, p<0,001).

Obvladovanje kompetenc mentorja v sklopih »vodenje« in »ustvarjalnost« sta pomembnejša za zaposlene z visokošolsko in univerzitetno izobrazbo (hi- kvadrat test pri stopnji pomembnosti 0.05= 4,455)

Zaposleni v ZN ocenjujejo svoje znanje in sposobnosti za izvajanje mentorstva s povprečno oceno 4,05 ob variabilnosti 0,64.

Zaposleni v ZN opredeljujejo prednosti izvajanja mentorstva na osebni ravni. Da je izvajanje mentorstva priznanje strokovnosti njihovega dela ocenjujejo s povprečno oceno 4,093; s povprečno oceno 4,229 ocenjujejo trditev, da izvajanje mentorstva omogoča učenje in osebni razvoj. Nekoliko nižje povprečne ocene so dane trditvam »mentorstvo omogoča horizontalno in vertikalno napredovanje« (3,495) in »osebno zadovoljstvo« (3,925).

V odprtem delu vprašalnika anketirani prevzemajo vlogo mentoriranca ter opredelijo vedenja/lastnosti mentorja, ki si jih kot mentoriranci ne želijo: slabše teoretično in strokovno znanje ZN, nezainteresiranost mentorja za mentoriranje, nespoštljiv odnos do mentoriranca.

DISKUSIJA

Na osnovi raziskave so bile identificirane kompetence mentorja v kliničnem okolju UKC Maribor po pomembnosti na osnovi sklopov kompetenc delovne fleksibilnosti, vodenja, ustvarjalnosti in organizacijskega vzdušja. Na osnovi analize 107 veljavnih vprašalnikov, ki so jih izpolnili zaposleni v ZN UKC Maribor, ki redno ali občasno izvajajo mentorstvo pripravnikom ZN, študentom in dijakom ZN ugotavljamo, da so vse kompetence v okviru obravnavanih sklopov pomembne, zelo pomembne, celo temeljne in nepogrešljive. Najvišjo povprečno oceno dosega sklop kompetenc »delovna fleksibilnost« s poudarkom na obvladovanju znanj in veščin mentorja s področja ZN.

Najnižjo povprečno oceno kompetenc mentorja po pomembnosti anketirani namenjajo sklopu kompetenc »ustvarjalnost«. Na osnovi testiranja hipoteze z uporabo ANOVA testa ugotavljamo, da obstajajo statistično pomembne razlike med pomembnostjo sklopov kompetenc »ustvarjalnost« in »vodenje« ter stopnjo izobrazbe anketiranih. Statistično pomembnih razlik pri sklopih kompetenc »delovna fleksibilnost« in »organizacijsko vzdušje« ter stopnjo izobrazbe ne zaznamo.

Ugotavljamo, da obstajajo statistično pomembne razlike med številom usposabljanj in stopnjo pomembnosti posameznega sklopa kompetenc. Menimo, da slednje ni posledica slučajnih dogodkov, kajti kar 39 (36,45%) anketiranih se usposabljanja za mentorstvo ni udeležilo še nikoli.

Anketiranim izvajanje mentorstva pomeni priznanje strokovnosti njihovega dela, jim omogoča učenje in osebni razvoj; nekoliko manj zaznavajo na osnovi mentoriranja možnosti za vertikalno in horizontalno napredovanje.

Kompetenco mentorstva »organizacijsko vzdušje«, ki opredeljuje relacije vedenja med deležniki mentoriranja anketirani zaznavajo v zaprtem delu vprašalnika kot zelo pomembno, vendar ne nepogrešljivo. V odprtem delu vprašalnika anketirani izpostavljajo kot neustrezna vedenja mentorja do mentoriranca prav kompetence iz tega sklopa kompetenc mentorja.

Analiza pomembnosti kompetenc mentorstva je pokazala, da se vsi anketirani zavedajo pomena mentoriranja za lasten napredek, napredek mentoriranca in stroke ZN, svoje znanje in sposobnosti za izvajanje mentorstva ocenjujejo z oceno »prav dobro«.

Ali je razvoj modela kompetenc mentorja v kliničnem okolju zdravstvene in babiške nege smiseln in potreben? Seveda, saj omogoča umestitev mentorja v proces zdravstvene in babiške nege, mentor ve, kaj se od njega pričakuje, katera so potrebna vedenja za iskanje priložnosti za lasten strokovni in osebni razvoj, razvoj mentoriranca in posledično kliničnega okolja ob zavedanju sedanjih in prihodnjih potreb razvoja stroke.

Prihodnost priprave modela kompetenc mentorja v UKC Maribor je osredotočena na iskanje odgovorov na sledeča vprašanja in trditve:

- katere kompetence zaposlenih v ZN so pomembne za izvajanje mentorstva;
- katera vedenja zaposlenih v ZN imajo neposreden vpliv na potek in izvajanje mentorstva;
- kompetence mentorja v kliničnem okolju morajo biti odraz sedanjih in prihodnjih potreb razvoja stroke na ravni posameznika in sistema.

ZAKLJUČEK

Na osnovi opredeljevanja pomembnosti kompetenc prepoznavamo kompetenčni model mentorja v kliničnem okolju. Ugotavljamo, da uspešno mentorstvo temelji na delovni fleksibilnosti, sposobnostih vodenja, vzpostavitvi ustreznega organizacijskega vzdušja in ustvarjalnega odnosa med mentorjem in mentorirancem v kliničnem okolju.

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IDENTIFICATION OF LATENT ERRORS DURING SIMULATION IN THE CLINICAL SETTINGS – IN SITU SIMULATIONS

PREPOZNAVANJE LATENTNIH NAPAK S SIMULACIJAMI V KLINIČNEM OKOLJU – IN SITU SIMULACIJE

MILJENKO KRIŽMARIĆ, ANEMARIJA SMONKAR

Izvleček

Izhodišča*: Simulacije se v današnjem času uporabljajo za pridobivanje veščin ali za izobraževanje na področju zdravstvene nege. So ključno orodje v preverjanju različnih veščin na različnih področjih, brez možnosti, da bi škodovali bolniku. In situ simulacije so posebne simulacije, ki jih izvajamo v kliničnem okolju.*

Metode*: Oktobra leta 2012 smo izvedli pilotsko študijo v katero smo vključili 14 medicinskih sester iz oddelkov za krdiokirurgijo in ortopedijo. Izdelali smo scenarije za izobraževanje v kliničnem okolju, ki so vključevali redke situacije iz oživljanja. Z in situ simulacijami smo preverjali veščine udeležencev v kliničnemokolju.*

Rezultati*: Podatki iz simulacij v kliničnem okolju nam lahko pomagajo pri identifikaciji latentnih napak. Ni bilo opaziti statističnih razlik gklede posameznih aktivnosti med oddelkoma.*

Diskusija in zaključek: *In situ simulacije izvajamo z namenom zagotavljanja varnosti bolnikov in prepoznavanja latentnih napak, ki skrite živijo v sistemu. Tak način usposabljanja nam daje priložnost, da se bolje spoznamo z opremo s katero delamo.*

Ključne besede*: latentne napake, Reasonov varnostni model, In situ simulacije.*

Abstract

Introduction*: Simulations are now in widespread use in nursing training or education and are a key tool for testing performance of a variety of skills under varying conditions without concern for harm to a patient. In situ simulations is a team-based training conducted in actual clinical environment.*

Methods*: The authors conducted pilot trials of in situ simulated emergencies involving 14 nurses (two groups: cardiac surgical ward and orthopaedic ward) in october 2012. We create scenarios that simulate real clinical situations and teach valuable skills for rare clinical situations. In situ methodology was used to study participants performance.*

Results*: Data from clinical in situ simulations can help identify and resolve latent errors in the clinical environment. We do not find any differences between the two groups.*

Discussion and conclusion: *In-situ simulation can be conducted to improve patient safety and can identify latent threats. In situ training gives providers the opportunity for familiarizing themselves with medical instruments and equipment.*

Keywords: latent errors, Reason safety model, in situ simulations.

IZHODIŠČA

Izobraževanje s simulacijami predstavlja priložnost, kjer ne da bi škodovali bolniku, pridobivamo različne veščine, znanja in kompetence (Abe et al., 2013). In situ simulacije so posebne vrste simulacij, ki jih izvajamo v realnem kliničnem okolju. Udeleženci se med tečajem nahajajo v kliničnem okolju kjer so zaposleni in uporabljajo svojo medicinsko opremo (Wheeler et al., 2013). Za razliko od običajnih simulacij v Simulacijskih centrih, tovrstna oblika simulacij omogoča identifikacijo latentnih napak, ki ležijo skrite v sistemu obravnave bolnika (Hamman et al., 2010). Latentni pogoji med oživljanjem lahko vodijo v neželene škodljive učinke, saj intervencije niso optimalne in se izgublja preveč časa v postopkih, ki bi se morali izvajati tekoče, hitro in brez napak.

Neželeni škodljivi učinki v teh primerih ne nastopijo samo zaradi enega posameznega vzroka. Slika 1 predstavlja

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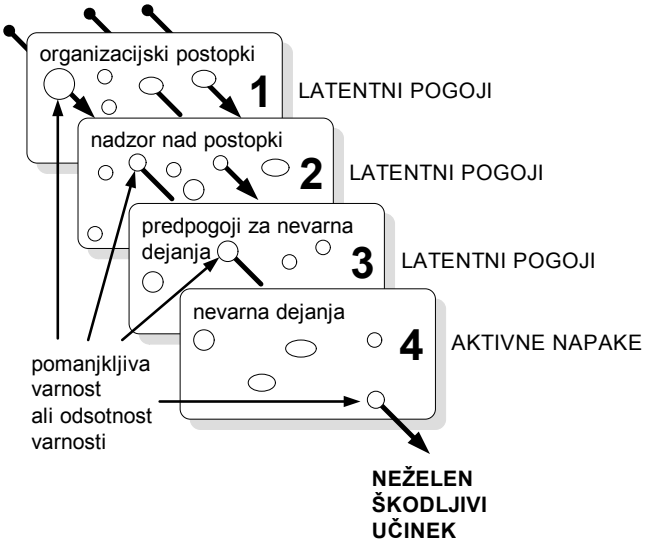
Reasonov sekvenčni model nastanka škodljivega učinka, ki nastane zaradi pomanjkljivosti v različnih varnostnih stopnjah (Reason, 2000). Vsaka plast oziroma stopnja, skrbi za specifično obrambo pred napakami, ki so predstavljene v kontekstu lukenj švicarskega sira. Luknje v rezinah sira nastajajo zaradi aktivnih in latentnih napak (pogojev). Aktivne napake so nevarna dejanja, ki jih povzročijo zdravstveni delavci, ki so v neposrednem stiku z bolnikom (spodrsljaji, zmote, neznanje). Latentne napake je težje odkriti in se jih večkrat niti ne zavedamo, saj živijo v sistemu. Nastajajo iz nepopolne standardizacije postopkov, napak v samem načrtovanju varnostnih protokolov in v managementu. Luknje na posameznih stopnjah predstavljajo pomanjkljivosti, ki se s časom pojavijo ali pa izginejo, se neprestano premikajo, odpirajo in zapirajo ter spreminjajo lokacijo. Neželen dogodek se zgodi, ko se luknje v nekem časovnem trenutku v vseh rezinah med seboj poravnajo.

S simulacijami v kliničnem okolju lahko prepoznamo omenjene latentne skrite napake, določimo vrzeli v znanju in okrepimo timsko delo. Takšne vrste simulacij se v svetu pogosto uporabljajo kot del programa varnosti, za katerega skrbi zdravstvena institucija (Wheeler et al., 2013).

Slika 1: Reasonov model zagotavljanja varnosti



METODE

Pilotski projekt usposabljanja v kliničnem okolju smo izvedli oktobra leta 2012 v Univerzitetnem kliničnem centru Maribor. Vključili smo Oddelek za kardiokirurgijo in Oddelek za ortopedijo. Iz Oddelka za kardiokiruirgijo smo simulacije izvajali s šestimi udeleženci, medtem, ko smo na Oddelku za ortopedijo vključili osem udeležencev. V vsaki posamezni simulaciji so sodelovali trije mentorji, ki so simulirali različne vloge in nalagali udeležencem različne zahteve glede priprave medicinskih pripomočkov in zdravil. Celoten tim med izobraževanjem je prikazan na sliki 2. Vse aktivnosti, ki so jih udeleženci izvajali so bile dokumentirane s strani enega mentorja in pozneje komentirane.

Uporabljali smo realno opremo reanimacijskega vozička, realne postelje, medicinski kisik, zdravila, realne klinične monitorje, defibrilatorje (AED in ročne) in ostale medicinske pripomočke iz kliničnega okolja. Bolnika je predstavljal simulator norveškega proizvajalca Laerdal ALS simulator (slika 2).

Slika 2: Mentorji in udeleženka simulacij v realnem kliničnem okolju (Fotografija: Marina Kodrič)

Udeleženci so dobivali navodila od mentorjev kaj naj izvedejo, sami niso morali sprejemati odločitev (razen za temeljne postopke oživljanja). Med seboj smo primerjali oba oddelka z namenom iskanja razlik v spremenljivkah, ki smo jih opazovali (izvedeni čas, temeljni postopki oživljanja in ravnanje z opremo). Statistično analizo smo izvedli s programskim paketom IBM SPSS 20.0 (IBM Corp., Armonk, NY) Zaradi porazdelitve spremenljivk v vzorcu, ki niso bile normalno porazdeljene, smo uporabili ustrezne neparametrične teste. Izrazito nebalansirani podatki so namesto klasičnih asimptotskih tehnik zahtevali eksaktne statistične teste, zato smo uporabili Monte Carlo aproksimacijo. Vrednosti numeričnih spremenljivk smo prikazali z mediano in medkvartilnim rangom (IQR - InterQuartile Range), vrednosti kategoričnih spremenljivk pa so prikazane z deležih v posamezni skupini. Vrednosti $p<0,05$ smo vzeli za statistično značilne.

REZULTATI

Osnovni podatki o udeležencih so prikazani v tabeli 1. Skupini se statistično nista razlikovali po deležu glede spola in ni bilo razlike v starosti udeležencev, njihovi delovni dobi in času izvedbe simulacij. Čas posamezne simulacije je trajal okoli 20 minut.

Tabela 1: Osnovni podatki udeležencev tečaja in čas izvedbe simulacije

	Oddelek za kardiokirurgijo (n=6)	Oddelek za ortopedijo (n=8)	p
Spol (M/Ž)	1/5	1/7	1,000
Starost v letih: mediana (IQR)	40 (36-46)	32 (23-42)	0,242
Delovna doba v letih: mediana (IQR)	19 (13-24)	12 (1-22)	0,508
Čas izvedbe v min: mediana (IQR)	22 (20-22)	20 (15-22)	0,222

Tabela 2: Primerjava različnih intervencij med oživljanjem

	Oddelek za kardiokirurgijo (n=6)	Oddelek za ortopedijo (n=8)	p
Pravilna namestitev EKG (da/ne)	5/1	7/1	1,000
Poslušal dihanje (da/ne)	4/2	5/3	1,000
Čutil dihanje (da/ne)	4/2	5/3	1,000
Tipanje pulza na a. carotis (da/ne)	5/1	7/1	1,000
Hiter pregled bolnika (da/ne)	1/5	4/4	0,301
Klic na pomoč med oživljanjem (da/ne)	1/5	4/4	0,301
Klic na ustrezno tel. številko (da/ne)	4/2	6/2	1,000
Uporaba deske (da/ne)	0/6	2/6	0,473

Vseh 14 (100%) udeležencev tečaja je preverjalo odzivnost bolnika, bolečinski dražljaj pa so preverili trije udeleženci. Vsi udeleženci so vzpostavili EKG monitoring, vendar je po eden v vsaki skupini EKG elektrode napačno namestil. Vsi so namestili tipalo za merjenje nasičenosti hemoglobina s kisikom v arterijski krvi (S_pO_2). Prav tako so vsi udeleženci spustili vzglavje v vodoravni položaj. Pri spuščanju vzglavja smo ugotovili latentno sistemsko napako, saj nobeden ni uporabil pravilno tehniko hitrega spuščanja vzglavja bolniške postelje. Vsi so sprostili dihalno pot in opazovali dihanje, vendar ga v petih primerih niso poslušali, kot je to zahtevano v smernicah oživljanja. Vsi razen enega udeleženca, so namestili manšeto za merjenje krvnega tlaka.

Pet udeležencev je opravilo hiter pregled bolnika, devet tega ni storilo, enako razmerje je v primeru klica na pomoč med oživljanjem (tabela 2). Štirje udeleženci tečaja niso poznali telefonske številke na katero je treba poklicati v primeru oživljanja bolnika. Še večjo težavo je predstavljala uporaba deske, ki je potrebna za masažo srca in se nahaja na zadnji strani reanimacijskega vozička. 12 udeležencev je pozabilo, da jo je treba namestiti na mehko posteljo. Razlike med oddelki sicer nismo zasledili (p=0,473).

Slika 3 prikazuje primer defibrilacije med izvedbo usposabljanja. Vsi udeleženci so namestili podlogo za defibrilatorske ročke in znali so vklopiti defibrilator.

Slika 3: Defibrilacija med oživljanjem (Fotografija: Marina Kodrič)

Na sliki 3 opazimo nepravilno ravnanje s kisikom, saj je dihalni balon po katerem teče kisik v neposredni bližini defibrilatorskih ročk in tvegamo nastanek požara. Zaradi zagotavljanja varnosti je treba kisik umakniti najmanj en meter. Na sliki 4 je prikazan primer, ko po dveh minutah masaže srca, moramo preveriti pulz bolnika in EKG zapis. Kabli za EKG elektrode niso bili trdno pritrjeni in so se hitro sneli, zato jih je bilo treba ponovno spojiti na aparat. Udeležencem so takšni manjši zapleti z opremo, delali precej težav.

Slika 4: Monitoring po dveh minutah oživljanja (Fotografija: Marina Kodrič)

RAZPRAVA

Glede na podatke iz bibliografskih podatkovnih baz nismo zasledili, da bi se usposabljanje na takšen način izvajalo po Sloveniji. Med reanimacijo zdravstveni kader doživlja visok nivo stresa zato je pomembno, da so na takšne situacije kolikor se da dobro pripravljeni. Še posebej to velja za zelo redke dogodke (Nunnink et al., 2009). In situ simulacije prav gotovo pripomorejo k boljši pripravljenosti zaposlenega osebja za redke in urgentne primere. V našem primeru ni videti razlik med posameznima oddelkoma, kljub temu da je etiologija nastanka zastoja srca bolnikov različna. Udeleženci so imeli težave predvsem s pripravo in aktivacijo različne opreme potrebne med oživljanjem.

Simulacije v kliničnem okolju so nam pokazale, kako pomembno je preverjati napisane klinične protokole v delovnem okolju. Protokole smo namreč razčlenili v posamezne korake z namenom iskanja napak v vsakem posameznem segmentu. S takim načinom usposabljanja je mogoče v določenih časovnih razmikih preverjati znanje in usposobljenost zaposlenih (Miller, Riley, Davis, 2009). Prav tako je mogoče in situ simulacije izkoristiti za preverjanje znanja novo zaposlenih, ki tedaj tudi vidijo ali je to delo za njih ali ne. Delodajalec pa prav tako vidi kakšne veščine obvlada bodoči sodelavec in kakšna je raven njegovega znanja. Pri in situ simulacijah so manjši stroški kot pri klasičnih simulacijah saj uporabljamo prostor v kliničnem okolju z vso logistiko in aparati (Weinstock et al., 2009).

ZAKLJUČEK

Udeleženci izobraževanja so v kratki anketi po usposabljanju, zelo pozitivno ocenili takšen način izobraževanja. Izrazili so navdušenje in željo po ponovnem izobraževanju.

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THE USE OF SUPRAGLOTTIC DEVICES IN RESPIRATORY CARE

UPORABA SUPRAGLOTIČNIH PRIPOMOČKOV V OSKRBI DIHALNIH POTI

MAJA STRAUSS, ANTON KOŽELJ

Izvleček

V smernicah in algoritmih za nudenje nujne medicinske pomoči so jasno opredeljene zahteve za oskrbo dihalne poti in izvedbo umetne ventilacije, v določenih vitalno ogrožajočih stanjih. Po ABCDE pristopu oskrbe, ki predstavlja primarni pristop k poškodovancu oz. nenadno obolelem, predstavlja črka A (airway) prosto dihalno pot, ki jo je nujno potrebno zagotoviti. Obstaja mnogo načinov za zagotovitev le te, vendar nekateri od njih zahtevajo ustrezno izobraženega zdravnika z izkušnjami (npr. endotrahealna intubacija- ET). Kot alternativa slednjim ob neuspelem poskusu izvedbe ET, ali odsotnosti ustrezno educiranega zdravstvenega delavca, imamo na voljo tudi supraglotične pripomočke. Uporaba le teh je dokaj enostavna in zahteva manj znanja in izkušenj. Kljub temu pa nudijo zadovoljivo raven oskrbe dihalni poti. Zato so na voljo tudi zdravstvenem osebju, ki ni vešče izvedbe zahtevnejših postopkov.

Ključne besede*: Prosta dihalna pot, umetna ventilacija, supraglotični pripomočki, I – gel, medicinska sestra.*

Abstract

In the guidelines and algorithms for emergency medical assistance are clearly defined requirements for respiratory care and the implementation of artificial ventilation in certain vital threatening condition. ABCDE approach to care, is primary approach to the injured or. suddenly sick people. The letter A means airway and it is necessary to be provided. There are many ways to ensure airway, but some of them require adequate trained physician with experience (eg, endotracheal intubation, ET). As an alternative after the failure of the attempted ET, or the absence of an appropriate educated health care professional, we can also use supraglottic devices. Use of these devices are quite simple and requires less knowledge and experience. But they still offer the satisfactory level of open airway. Therefore are available for medical staff, which are not trained to perform ET.

Keywords*: open airway, artificial ventilation, supraglottic devices, I – gel, nurse.*

IZHODIŠČA

V oskrbi vitalno ogrožene osebe imata zagotavljanje proste dihalne poti in ustrezna ventilacija primarno vlogo. V primeru, da ta cilj ni dosežen, so vsi ostali nadaljnji postopki brezpredmetni. Brez primerne oskrbe dihalne poti lahko med obravnavo, glede na klinično stanje bolnika oz. poškodovanca, obstaja latentna nevarnost za kompromitacijo dihalne poti (tujki, izbruhane mase, oteklina, spazem mehkega tkiva itd.). Omenjene dogodke je smiselno tudi vnaprej predvideti in izvesti preventivne ukrepe za zavarovanje proste dihalne poti. Vsekakor so preventivni ukrepi učinkovitejši, kot poizkus zagotovitve proste dihalne poti, ko je ta že delno ali v celoti blokirana. V ta namen so opredeljene tudi strokovne smernice in algoritmi odločanja za določena stanja, v katerih se zahteva oskrba dihalne poti že v primarni obravnavi oz. pristopu. Endotrahealna intubacija še vedno predstavlja tako imenovan zlati standard za oskrbo in varovanje proste dihalne poti. Vendar ta poseg v Sloveniji izvajajo le ustrezno usposobljeni zdravniki. Ker pa se v določenih urgentnih situacijah, ko se pojavi potreba po umetni ventilaciji in oskrbi dihalne poti, znajde tudi medicinska sestra /dipl. zdravstvenik (v nadaljevanju MS), brez prisotnosti zdravnika (npr. reševalci na terenu), je njena dolžnost, da stori vse kar je v njeni moči, da vzpostavi ustrezno ventilacijo. V teh trenutkih pa je zelo dragocena uporaba supraglotičnih pripomočkov, ki kljub temu, da niso vstavljeni v sapnično cev, nudijo dobro zaščito dihalne poti in omogočajo ustrezno ventilacijo. Njihova prednost je v tem, da se vstavljajo na slepo. To pomeni, da ni potrebno izvesti laringoskopije. Omenjeno dejstvo in dejstvo, da se oskrbi dihalne poti v določenih urgentnih stanjih ne moremo izogniti, je avtorja prispevka prepričalo, da bi ustrezno educirana MS, v določenih primerih (npr. oživljanje) lahko samostojno uporabila tovrstne pripomočke in s tem morebiti rešila življenje določeni osebi. To pa je tudi

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osnovno poslanstvo medicinske sestre, ki mora skladno s kodeksom etike in zakonodajo, storiti vse kar je v njeni moči, da izboljša kvaliteto življenja in pripomore k izboljšanju zdravstvenega stanja bolnika.

V članku je predstavljen pomen hitre oskrbe dihalnih poti z adekvatno ventilacijo. Zaradi časovne stiske, in posledičnimi ireverzibilnimi okvarami tkiv v primeru neustrezne časovne reakcije, smo v članku želeli opozoriti na dejstvo, da mora biti za nujne postopke v oskrbi dihalne poti, ustrezno izobražena tudi medicinska sestra. Znanje in kompetence bi morale biti sistemsko zahtevane in urejene tako, da bi medicinska sestra določene intervencije lahko izvedla tudi samostojno.

METODE

Za potrebe pisanja članka smo v prvem delu pregledali aktualne strokovne algoritme za oskrbo dihalne poti. Sledila je poenostavljena predstavitev patofiziologije ireverzibilnih okvar ob hipoksiji oz. anoksiji. Nato smo pregledali nabor najaktualnejših pripomočkov za tovrstne posege in izpostavili najustreznejšega.

REZULTATI

Strokovne zahteve za oskrbo dihale poti in ventilacijo

Tako rekoč vsa aktualna strokovna literatura zahteva pristop k vitalno ogroženemu bolniku oz. poškodovancu po ABCDE pristopu. Prva črka A (airway) predstavlja prosto dihalno pot, ki jo moramo zagotoviti, druga črka B (breathing) pa dihanje, ki ga je nemudoma potrebno suportirati oz. umetno nadomestiti v primeru odsotnosti (Nolan et al., 2010).

Prav tako smernice govorijo o reverzibilnih vzrokih, ki jim moramo odpraviti med samim postopkom oživljanja. Predstavljenih je osem odpravljivih vzrokov, ki jih poznamo pod kraticami 4H in 4T; (hipoksija, hipovolemija, hipo/hiper kaliemija, hipotermija, tenzijski pneumotoraks, tamponada srca, toksini in trombembolija). Opisane vzroke je potrebno nujno odpravljati med potekom reanimacije, v nasprotnem primeru le ta ne more biti uspešno zaključena (Grmec, 2008). Kot prvi odpravljivi vzrok zasledimo hipoksijo, ki jo je potrebno korigirati v najkrajšem možnem času. Prav tako osnovne smernice za izvajanje temeljnih postopkov oživljanja govorijo o izvedbi zunanje masaže srca in umetni ventilaciji v razmerju 30:2 (Grmec, 2008; Nolan et al., 2010; Bošan-Kilibarda, Majhen, 2012; Ahčan, Slade, Šutanovac, 2008). Pri tem bi poudarili, da je opustitev umetne ventilacije dopustna izjemoma (nezmožnost ali nepripravljenost izvajanja umetne ventilacije usta na usta itd.), ne pa, da je to novi protokol za oživljanje, kot se je pojavila interpretacija v javnosti. Slednje še posebej velja za laično populacijo. Glede izvajanja dodatnih postopkov oživljanja, ki je namenjeno zdravstvenim delavcem, pa je jasna zahteva za izvajanje neke oblike umetne ventilacije, ki mora biti zagotovljena v najkrajšem času (Nolan et al., 2010). Smernice, ki jih morajo upoštevati zdravstveni delavci tudi zahtevajo zagotovitev ustrezne oksigenacije in ventilacije z namenom doseganja saturacije v vrednosti nad 94 % (razen za bolnike s kronično obstruktivno pljučno boleznijo). Prav tako jasno določajo potrebo po asistirani umetni ventilaciji v primeru, ko je še prisotno spontano dihanje, vendar je frekvenca dihanja manjša kot 10 vdihov na minuto, oz. večja od 30 vdihov na minuto v mirovanju (Bošan-Kilibarda, Majhen, 2012). Takšen način dihanja ne zagotavlja normalne oksigenacije, zato jo je potrebno z določenimi ukrepi zagotoviti. Prav tako je potrebno politravmatiziranim poškodovancem zagotoviti visoke koncentracije kisika (Bošan-Kilibarda, Majhen, 2012), kar pomeni, da je potrebno takšni osebi zagotoviti dodatek kisika iz zunanjega vira (kisikova jeklenka ali centralna napeljava). Ob tem uporabimo pretok kisika 15 litrov na minuto, ali celo več (Gvožđak, Tomljanc, 2011). Še posebno pozornost moramo posvetiti vitalno ogroženim poškodovanim otrokom, ki niso ustrezno oksigenirani, saj bradipneja (v sklopu s bradikardijo, cianozo in hipotenzijo) predstavlja preterminalne znake (Kupnik, 2006).

Zdravstveni delavec, ki se prvi znajde na kraju dogodka, mora nujno prepoznati znake dihalne stiske. Vsekakor to velja tudi za medicinsko sestro, ki se znajde na kraju dogodka, zdravnik pa še ni prisoten. Takoj ocenimo prisotnost dihanja in morebitno frekvenco, ter znake dihalne stiske.

Predstavitev supraglotičnega pripomočka: I-gel

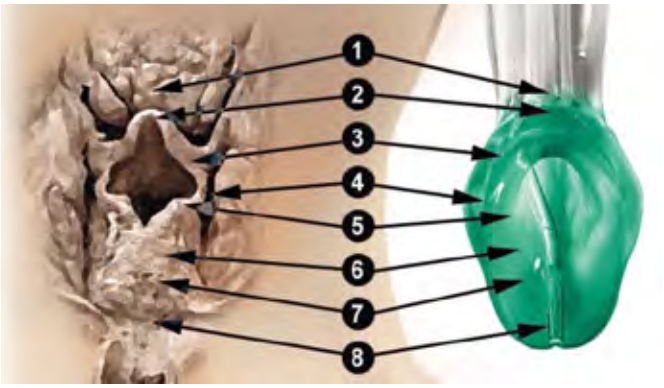
Zgolj hitri pregled osnovnih strokovnih zahtev za oskrbo vitalno ogroženih oseb, poškodovancev in otrok, tako rekoč »dogmatsko« nakazuje zahtevo po takojšnji oskrbi dihalih poti in zagotovitvi ustrezne oksigenacije tkiv. Vsekakor ta zahteva / potreba ostaja enaka, tudi če na kraju dogodka še ni prisoten zdravnik. Prisotna pa je medicinska sestra, ki zagotovo mora enako predstavljati strokovnjaka in profesionalca v zdravstvenem sistemu. Zato mora enako storiti vse kar je v njeni moči, da zadosti strokovnim smernicam. Primarno pa seveda pomaga reševati življenje. Seveda v njene kompetence sodijo postopki čiščenja in vzdrževanja dihalnih poti (ročni manevri, aspiracija, ustno žrelni tubus, itd.), kot tudi umetna ventilacija z ročnim dihalnim balonom.

Vendar v določenih primerih uporaba ročnega dihalnega balona ne omogoča ustrezne umetne ventilacije. Že beseda BOOTS (angl.) nakazuje težave pri ambuiranju oz. težavno prilagajanje maske ambuja: -B: (beards); moški z brado, - O: (obesity); osebe s prekomerno telesno težo, - O: (older patients); starejše osebe,-T: (toothlessness); osebe brez zob, - S: (snores or stridor); smrčanje in dihalni piski (Emory Campbell, 2008). Zato je nujno potrebno poseči po alternativnih možnostih, ki so učinkovite oz. celo boljše kot uporaba samega AMBU-ja. In prav supraglotični pripomoček I- gel predstavlja trenutno enega izmed aktualnejših pripomočkov za tovrstno uporabo.

Indikacije za uporabo I – gela

I-gel sodi med supraglotične pripomočke (lega pripomočka je nad glotisom; najožji del grla) za vzdrževanje dihalne poti. Ob tem pa omogoča tudi umetno ventilacijo. Narejen je iz mehkega želatinastega termoplastičnega elastomera, ki na telesni temperaturi tudi delno spremeni svojo obliko in se s tem prilagodi anatomskim strukturam faringealnih, laringealnih in perilaringealnih predelov. I-gel je oblikovan kot zrcalna slika omenjenih struktur, zato zatesni vhod v del dihalnih poti in s tem omogoči dobro mehansko ventilacijo. S tovrstnim prileganjem pa delno tudi zavaruje dihalne poti (blokada jezika, delno prepreči aspiracijo izbruhanih mas, krvi, omogoča aspiracijo iz prebavne cevi in tudi iz traheje itd.). Ne vsebuje napihljivega mešička, kar zmanjša možnost nezaželene kompresije. Ne vsebuje lateksa. Njegova prednost pred npr. klasično endotrahelano intubacijo je v tem, da se vstavlja na slepo. Laringoskopija zato ni potrebna. Načeloma tudi ni potrebno dobro poznavanje anatomije tovrstnega predela. Za uporabo pripomočka je potrebno poznati tehniko vstavljanja, ter indikacije in kontraindikacije za njegovo uporabo. Osnovne indikacije zagotavljanja proste dihalne poti in umetne ventilacije pa tako ali tako izhajajo iz strokovnih smernic.

Slika 1: Pogled na mešiček pripomočka i-gel v primerjavi z laringealnimi strukturami.



1) jezik, 2) koren jezika, 3) epiglotis, 4) ariepiglotične gube,
5) piriformna vdolbina, 6) posteriorni hrustanci,
7) tiroidni hrustanec, 8) krikoidni hrustanec
Vir: Intersurgical (2012)

Uporaba pripomočka i-gel je indicirana pri: zavarovanju in ohranjanju dihalne poti bolnika pri rutinski in nujni anesteziji za kirurške posege teščih bolnikov med spontano ali intermitentno ventilacijo s pozitivnim tlakom (intermittent positive pressure ventilation – IPPV).

Uporaben pa je tudi v sledečih primerih:

1. Vzpostavljanje čiste dihalne poti pri bolnikih s kardiorespiratornim zastojem tako v predbolnišničnih kot bolnišničnih ustanovah, kadar druge tehnike intubacije niso bile uspešne ali kadar osebje za intubacijo ni usposobljeno. Slednje velja za medicinske sestre.
2. Vzpostavljanje in vzdrževanje dihalne poti pri težavnih ali nepričakovano težavnih intubacijah v reševalnih vozilih.
3. Zagotavljanje dihalne poti pri težavnih ali nepričakovano težavnih intubacijah pri bolnikih v operacijski dvorani.
4. Pri elektivni, težavni ali nepričakovano težavni intubaciji bolnika, pri kateri se skozi napravo vstavi endotrahealni tubus z mešičkom (cuffed endotracheal tube – CETT).
5. Pri težavnih ali nepričakovano težavnih intubacijah za slepo, a nežno vstavljanje gumijastih elastičnih tubusov skozi pripomoček in-situ v trahejo, in za vodenje pripomočka CETT skozi njo.
6. Pri znanih težavnih ali nepričakovano težavnih intubacijah za vstavljanje fibero-optičnih naprav (bronhoskop) skozi i-gel za vizualizacijo glotične odprtine kot pomoč pri intubaciji.
7. Pri bolnikih v enoti intenzivne medicine, ki slabo prenašajo endotrahealni tubus.

8. V situacijah kjer imajo bolniki težave pri odpiranju ust se lahko i-gel vstavi z neposrednim prikazom s pomočjo laringoskopa (Intersurgical, b.d.).

Kontraindikacije za uporabo i –gela

1. Bolniki, ki niso tešči, za rutinske in nujne anesteziološke postopke.
2. Bolniki s točkovanjem po ASA ali Mallampati III ali več.
3. Pri bolnikih s trizmom, omejenim odpiranjem ust ali faringo-perilaringealnim abscesom.
4. Kadar bi za umetno predihavanje morali preseči najvišji tlak v dihalni poti 40 cm H_2O.
5. Kadar bi pri vstavljanju i-gel-a ali nazogastrične sonde morali uporabiti preveliko silo.
6. Kadar pri bolniku ne moremo zagotoviti ustrezne stopnje anestezije, kar lahko povzroči kašelj, premikanje, pretirano salivacijo, bljuvanje, laringospazem ali zadrževanje diha in s tem zaplete anestezije.
7. Kadar bi i-gel pripomoček morali pustiti in situ več kot 4 ure.
8. Uporabljenega pripomočka i-gel ne smemo ponovno uporabiti.
9. Bolniki s kakršno koli boleznijo, ki lahko povzroči polnost želodca, npr. s hiatusno hernijo, sepso, sladkorno boleznijo, z močno prekomerno telesno maso, nosečnostjo ali kirurškim posegom na zgornjih prebavilih v anamnezi, itd. (Intersurgical, b.d.).

Seveda se za rutinsko elektivno uporabo upoštevajo navedene kontraindikacije za uporabo. Vendar se v primerih življenjsko ogrožajočih stanj, določene kontraindikacije lahko zanemarijo in se vseeno poskusi uporabiti pripomoček. Če je dobro vstavljen in omogoča ustrezno ventilacijo, je njegova uporaba upravičena. To pa predvidevajo tudi njegove indikacije.

Postopek vstavitve i – gel-a

Izkušen uporabnik lahko pripomoček i-gel vstavi v manj kot 5 sekundah.

1. Pripomoček i-gel trdno primemo vzdolž integralne zapore ugriza. Pripomoček postavimo tako, da je odprtina mešička i-gela obrnjena proti bradi bolnika.
2. Bolnik mora biti v položaju »prvega jutranjega vdiha«, glavo mora imeti iztegnjeno, vrat pa upognjen. Pred vstavljanjem pripomočka i-gel moramo brado bolnika nežno potisniti navzdol.
3. Vodilno mehko konico vstavimo v bolnikova usta v smeri proti trdem nebu.
4. Pripomoček potisnemo navzdol in nazaj vzdolž trdega neba. Potiskamo neprekinjeno, vendar nežno, dokler ne začutimo upora.
5. Pripomočka med vstavljanjem ne potiskamo premočno. Med postopkom vstavljanja pripomočka ni treba vstaviti prstov v bolnikova usta. Če med vstavljanjem pripomočka prezgodaj začutimo upor, je priporočeno izvesti »potisk čeljusti navzdol« ali »vstavljanje z globokim vrtenjem«. V tem trenutku bi morala biti konica dihalnega dela pripomočka vstavljena v zgornjo ezofagealno odprtino, mešiček pa naslonjen ob laringealni predel. Sekalci morajo biti v nivoju vodoravne linije, ki je na integralni zapori ugriza.
6. Praviloma pripomoček i-gel ostane na mestu, po potrebi pa ga lahko pritrdimo s samolepilnim trakom ali ga privežemo (Intersurgical, b.d.)

Slika 2 in 3: Začeten pristop pri vstavitvi in končna lega I – gela: RTG posnetek

Sliki prikazujeta začetni pristop pri vstavitvi I – gela, ki je enostaven in brez vseh dodatnih pripomočkov, in končno lego gela, ki supraglotično zatesni vhod v grlo.

Vir: Postopek vstavitve I – gela (b.d.)

DISKUSIJA

Oskrba in zagotovitev proste dihalne poti sodi med prioritetno nalogo, ki jo morajo izvesti zdravstveni delavci v nujnih stanjih (Nolan, 2010; Kupnik, 2006). Endotrahealna intubacija še vedno predstavlja zlati standard oskrbe dihalne poti, vendar zanjo medicinske sestre v Sloveniji niso usposobljene. Imamo pa na voljo sodobne alternativne supraglotične pripomočke, ki zagotavljajo učinkovito uporabo (Hastings, Page, 2008). Vstavljajo se na slepo (brez laringoskopije), v zelo kratkem času, in so minimalno invazivni. Omogočajo kvalitetno oskrbo dihalne poti in izboljšajo učinkovitost umetne ventilacije (npr. pri oživljanju). ABCDE pristop je temelj vseh »Advanced Life Support « tečajev, ker je logičen in ima svojo osnovo v patofiziologiji. Primerna ventilacija pljuč ni možna brez proste dihalne poti. Brez ustrezne ventilacije pljuč pa ni možna izmenjava plinov v tkivih. Vse to preprečuje smrt celice (Prosen, 2009). Strokovna literatura navaja potrebo po takojšnji oskrbi dihalih poti in ustrezni ventilaciji, z namenom preprečitve reverzibilnih okvar tkiv (Nolan, 2010, Prosen, 2009, Hastings, Page, 2008, Kupnik, 2006). Razen v primeru endotrahealne intubacije, pa praviloma ne navaja nivo dodiplomske izobrazbe zdravstvenih delavcev. Predvsem je poudarek na ustrezno izobraženem in verziranem zdravstvenem delavcu, ki je v urgentni situaciji usposobljen v najkrajšem času oskrbeti dihalno pot in zagotoviti ustrezno ventilacijo. Supraglotični pripomočki pa so v teh primerih zelo uporabni. Zahtevo, da jih lahko uporablja le zdravnik, pa nismo zasledili nikjer v svetovni literaturi.

ZAKLJUČEK

Zaradi omenjenega sva avtorja prispevka prepričana, da bi medicinska sestra morala biti ustrezno educirana za uporabo tovrstnih pripomočkov. Uporaba v najnujnejših stanjih (npr. pri oživljanju) bi morala soditi v njen delokrog (kompetence), saj v teh stanjih s kvalitetno in strokovno oskrbo dejansko rešujemo življenja. To pa zagotovo sodi delo in poslanstvo medicinske sestre.

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THROMBOLYTIC THERAPY OF STROKE PATIENT AND NURSING CARE

ZDRAVSTVENA NEGA BOLNIKA PRI TROMBOLITIČNEM ZDRAVLJENJU MOŽGANSKE KAPI

JASMINA NERAT, VIDA GÖNC

Izvleček

Izhodišča*: Trombolitično zdravljenje oz. razgradnja krvnega strdka z rekombinantnim aktivatorjem tkivnega plazminogena (rtPA) je po sodobnih evropskih smernicah najbolj ustrezen način zdravljenja akutne ishemične možganske kapi. Z raziskavo smo želeli spoznati najpogostejše negovalne probleme, ki se lahko pojavijo pri bolniku po možganski kapi, zdravljenim s trombolizo in vlogo medicinske sestre v okviru zdravstvene obravnave teh bolnikov.*

Metode*: Raziskava je temeljila na kvalitativni metodi deskriptivnega raziskovanja. Kot raziskovalna tehnika je bil uporabljen intervju z vodenimi vprašanji odprtega tipa. Izvedli smo študijo primera bolnika po ishemični možganski kapi, ki je bil zdravljen s trombolizo.*

Rezultati*: Rezultati študije primera kažejo, da moramo biti ob in po trombolizi pozorni na naslednje možne negovalne probleme: odstopanja v vrednostih krvnega tlaka in srčnega utripa, spremembe zavesti in različne krvavitve. Omenjeni negovalni problemi lahko predstavljajo veliko grožnjo bolnikovemu življenju.*

Diskusija in zaključki: *Trombolitično zdravljenje pripomore k izboljšanju zdravstvenega stanja bolnika, zmanjšanju stopnje prizadetosti ter preprečitvi sekundarnih zapletov po ishemični možganski kapi. Za dosego teh ciljev je potrebno intenzivno spremljanje bolnikovega zdravstvenega stanja po protokolu NIHSS in takojšnje ukrepanje v primeru spremembe zdravstvenega stanja.*

Ključne besede: *akutna možganska kap, trombolitično zdravljenje, zdravstvena nega*

Abstract

Introduction*: Thrombolytic treatment or blood clot decomposition with the use of recombinant tissue plasminogen activator (rtPA) is by contemporary european standards the most effective way of treatment in the case of an acute ischemic stroke. With research we tried to explore the most common nursing problems when dealing with a stroke patients treated with thrombolytic therapy and the role of nursing staff in the mainframe of medical treatment of the patients.*

Methods*: The research was based on qualitative methods of descriptive research. As a research technique we used an interview with guided questions of an open type. We conducted a study case of an acute ischemic stroke patient treated with thrombolytic therapy.*

Results*: Results of the study case show that we have to pay special attention when dealing with thrombolysis, during and after the threatment, to: deviations in blood pressure and heart rate, changes in consciousness and various bleeding. The mentioned nursing problems can present a grave threat to the patients life.*

Discussion and conclusions*: Thrombolytic therapy helps to improve the health status of the patient, reducing the degree of disability and prevention against secondary complications after ischemic stroke. To achieve these goals intensive monitoring of the patients health status according to the NIHSS protocol is required and immediate actions in the event of changes in the health status.*

Keywords*: acute stroke, thrombolytic therapy, nursing care*

IZHODIŠČA

Možganska kap je klinični sindrom nevroloških simptomov in znakov, ki so posledica primarne ishemije možganovine ali krvavitve v možganovino (Bajrović, 2006). Prognoza bolezni je odvisna od vrste cerebrovaskularne bolezni in je slabša pri možganskih krvavitvah kot pri ishemični možganski kapi. Akutna

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možganska kap (AMK) je po svetu med najpogostejšimi nevrološkimi boleznimi, od katerih je njena najpogostejša oblika, v nekaterih državah več kot v 85 %, ishemična možganska kap (IMK) (Vujasinovič, Žvan, 2012). Ishemično možgansko kap klinično razvrščamo glede na časovno opredelitev (izboljšanje, poslabšanje, stabilno stanje), mehanizem nastanka (trombotični, embolični, hemodinamski), klinično kategorijo (aterotrombotični, kardioembolični, lakunarni ali drugi) in distribucijo nevroloških znakov (karotidni sistem, vertebrobazilarni sistem) (Grad, 2003).

Ishemična možganska kap je posledica perfuzijskih motenj pri stenozantnih ali okluzivnih procesih na ekstrakranialnem in intrakranialnem možganskem ožilju. Osnovni vzrok za nastanek je najpogosteje ateroskleroza s trombozo možganskega ožilja ali trombembolija možganskih arterij kardialnega izvora (Tetičkovič, 1997).

Z raziskavo smo želeli spoznati najpogostejše negovalne probleme, ki se lahko pojavijo pri bolniku po možganski kapi zdravljenim s trombolizo in vlogo medicinske sestre v okviru zdravstvene obravnave teh bolnikov. Z izvedbo raziskave smo želeli odgovoriti na naslednje raziskovalno vprašanje: Na katere negovalne probleme morajo biti medicinske sestre pri bolnikih po možganski kapi zdravljenih s trombolizo, posebej pozorne?

TROMBOLITIČNO ZDRAVLJENJE MOŽGANSKE KAPI

Uspešno zdravljenje možganske kapi se začne s prepoznavo simptomov in znakov bolezni ter predstavlja nujno medicinsko stanje. Pogoj za uspešno zdravljenje ishemične možganske kapi je hitro ukrepanje. Dokazano je, da je trombolitično zdravljenje akutne ishemične možganske kapi (AIMK) z rekombinantnim aktivatorjem tkivnega plazminogena (rtPA) edino učinkovito in dovoljeno, vendar se uporablja le pri bolnikih, ki ustrezajo določenim pogojem (Švigelj, 2012). Intravensko zdravljenje AIMK z rtPA ne zmanjša umrljivosti, vendar pomembno omeji invalidnost, ocenjeno tri mesece po nastanku možganske kapi (Hacke, Donnan, Fieschi, 2004). Urad za zdravila Evropske unije je leta 2002 dovolil začasno uporabo zdravila rtPA pri zdravljenju AIMK, po letu 2007 pa ga odobril kot edino izbirno zdravilo za zdravljenje te kapi pri bolnikih, ki ustrezajo pogojem. Ena od zahtev tega urada je natančno vodenje registra zdravljenja. Namen registra Safe Implementation of Treatment in Stroke (SITS) je spremljanje pozitivnih in stranskih učinkov trombolitičnega zdravljenja z rtPA ter s tem varnost uporabe. Slovenija se je priključila temu projektu 1. 1. 2003. Baza podatkov je tako osnova za oceno uspešnosti zdravljenja v posamezni državi in za primerjavo z drugimi državami (Švigelj, 2012).

S trombolitičnim zdravljenjem akutne ishemične možganske kapi so v Sloveniji prvi pričeli v Univerzitetnem kliničnem centru Ljubljana leta 1997, leta 2003 pa se je začelo zdravljenje v drugih bolnišnicah (Švigelj, 2008). V Univerzitetnem kliničnem centru Maribor (v nadaljevanju UKC Maribor) so od oktobra 2003 do oktobra 2011 zdravili 120 bolnikov. 112 bolnikov je bilo vključenih v mednarodni register SITS – ISTR (Safe Implementation of Thrombolysis in Stroke – International Stroke Thrombolysis Register). Povprečna starost obravnavanih bolnikov je bila 64 let, 54 % bolnikov je bilo moškega spola in 46 % ženskega spola, za arterijsko hipertenzijo je obolevalo 58 % bolnikov, sladkorno bolezen jih je imelo 14 %, povišane lipide 19 %, atrijsko fibrilacijo 19 % in 19 % bolnikov je bilo kadilcev. Povprečna ocena bolnikov po NIHSS (The National Institutes of Health Stroke Scale) je bila 17, od tega je bilo 34 % bolnikov ocenjeno po NIHSS med 8 do 14 in 61 % nad 15. Najpogostejši vzrok IMK so bile druge bolezni velikih žil (v 56 %), v 24 % je bila IMK posledica srčnega vzroka (embulus) in v 10 % pomembna zožitev karotidne arterije (Menih, 2011).

Čas je najpomembnejši dejavnik za dober izhod pri zdravljenju s trombolizo. Raziskava ECASS (European Cooperative Acute Stroke Study) je pokazala, da so bolniki, ki so prejeli rtPA znotraj 90 minut po nastanku simptomov možganske kapi, imeli najboljši izhod zdravljenja (Menih, 2011). Vendar pa so v najnovejših evropskih smernicah za zdravljenje AIMK na osnovi raziskave $ECASS_3$ čas intervencijske trombolize podaljšali iz 3 na 4,5 ur (Hacke, Kaste, Bluhmki, 2008). V razpredelnici 1 so prikazane časovne zakasnitve od nastanka IMK do zdravljenja pri bolnikih v UKC Maribor v primerjavi z ostalimi bolniki iz SITS registra.

Razpredelnica 1: Časovne zakasnitve pri zdravljenju v UKC Maribor v primerjavi z ostalimi bolniki iz SITS registra (Menih, 2011)

Povprečen čas v minutah	UKC Maribor	Vsi SITS centri
Od nastanka IMK do prihoda v bolnišnico	75	70
Od prihoda v UKC do slikovne diagnostike	31	25
Od prihoda v UKC do zdravljenja	70	66
Od začetka simptomov IMK do zdravljenja	160	148

Na osnovi podatkov v razpredelnici 1 ugotovimo, da je:

- čas od nastanka IMK pri bolnikih pa do prihoda v UKC Maribor povprečno za pet minut daljši kot v vseh SITS centrih,
- čas od prihoda bolnika v UKC Maribor do računalniške tomografije (CT) možganov povprečno za šest minut daljši kot v vseh SITS centrih,
- čas od prihoda bolnika v UKC Maribor do zdravljenja s trombolizo povprečno za štiri minute daljši kot v vseh SITS centrih,
- čas od začetka simptomov IMK do zdravljenja v UKC Maribor povprečno za dvanajst minut daljši kot v vseh SITS centrih.

Uspešnost trombolitičnega zdravljenja se po treh mesecih ocenjuje z modificirano Rankinovo lestvico (mRl) (Šeruga, 2013). Pri ocenjevanju uspešnosti trombolitičnega zdravljenja v UKC Maribor v primerjavi z ostalimi centri opažajo slabši izhod zdravljenja, kar je verjetno posledica vključevanja v trombolitično zdravljenje tistih bolnikov, ki so imeli izhodiščno vrednost po NIHSS visoko, povprečno 17 in so bili ob vključitvi nevrološko zelo prizadeti, izsledki raziskav pa kažejo na manjšo verjetnost izboljšanja pri bolnikih z oceno višjo od 12 (Menih, 2011).

Potek trombolitičnega zdravljenja možganske kapi

Ob prihodu bolnika s sumom na svežo ishemično možgansko kap v zdravstveno ustanovo, se najprej na osnovi vprašalnika za ugotovitev primernosti za zdravljenje ishemične možganske kapi z rtPA oceni primernost bolnika za zdravljenje z rtPA.

Zdravnik bolniku oz. svojcem razloži prednosti in tveganja trombolitičnega zdravljenja ter poskrbi za njihov pristanek. V primeru, da bolnik ni sposoben odločanja in ni prisotnih svojcev, je odločitev za poseg v rokah dežurnega nevrologa oz. konzilija.

Protokol (SITS) zahteva natančno dokumentiranje:

- začetek nevroloških simptomov,
- čas sprejema v zdravstveno ustanovo,
- čas izvedenega CT možganov in prejetega izvida,
- čas pričetka trombolize,
- odmerjanja in aplikacije trombolitične terapije, v katero sodi: ocena telesne mase, količina zdravila v bolusu in kontinuirani infuziji,
- podpis zdravnika.

V protokolu je opisan tudi postopek aplikacije zdravila. Odmerek obsega 0,9 mg/kg telesne mase, maksimalno 90 mg/kg telesne mase rtPA (Actilyse), 10 % v bolusu v 1 minuti in 90 % v kontinuirani infuziji v 1 uri s pomočjo črpalke.

Zdravnik opravi ocenitev stanja bolnika po skali za oceno prizadetosti pri možganski kapi (NIH-NINDS STROKE SCALE) pred trombolizo, neposredno po trombolizi, 24 ur po trombolizi in 7 dni po trombolizi. V sklopu protokola se beleži krvni tlak in srčna frekvenca ter spremembe terapije glede na vrednosti krvnega tlaka ali pulza. Zdravnik v protokol pribeleži eventuelne komplikacije med in po trombolizi.

UGOTAVLJANJE POTREB PO ZDRAVSTVENI NEGI BOLNIKA PO AMK

Potrebe po zdravstveni negi bolnika po AMK ugotavljamo na osnovi pogovora z bolnikom ali njegovimi spremljevalci, opazovanja bolnika, merjenja vitalnih funkcij, zdravstvene dokumentacije in pogovora z nevrologom oz. drugimi člani zdravstvenega tima. Negovalna anamneza naj bo kratka. Najprej ugotovimo podatke, ki jih potrebujemo takoj (osnovne podatke o bolniku, podatke o sedanji in ostalih boleznih, podatke o zdravilih, ki jih uživa, alergijah), ostale podatke lahko ugotavljamo kasneje. V okviru podatkov o sedanji bolezni nas predvsem zanima, kateri simptomi so se pri bolniku pojavili in kdaj. Zanimajo nas predvsem podatki glede:

- motnje zavesti,
- motnje gibanja, nerodnost ali izguba nadzora nad izvajanjem finih gibov, ohromitev ene strani telesa (hemipareza, hemiplegia), motena ali odsotna mimika obraza, pojav visečega ustnega kota, iztekanje sline ter nezapiranje očesa, če je prizadet obrazni živec, motnje požiranja, če je prizadeta mišica jezika,
- težave pri govoru (nerazločen govor, oteženo razumevanje in težave z izražanjem) ali nezmožnost govora, če je prizadeta dominantna hemisfera,
- izpad čutil in vidnega polja,
- bruhanje, omotica, motnje ravnotežja,
- delna ali popolna inkontinenca,
- motena orientacija v prostoru, zanemarjanje prizadete strani, nezmožnost prepoznavanja prizadete okončine,
- motnje spomina, slabša koncentracija itd.

Ob navedenih podatkih pa nas zanimajo tudi podatki o socialnih in družinskih razmerah bolnika, družinska

anamneza, podatki o uživanju alkohola, kajenju oz. drugih razvadah, prehrana oz. dieta, sposobnost samooskrbe, ortopedski pripomočki, ki jih uporablja itd.

Pri bolniku z AIMK, kjer je zdravnik na osnovi vprašalnika odredil trombolitično terapijo, upoštevamo zahteve protokola (SITS) in zdravnikova navodila ter glede na negovalne probleme oblikujemo cilje zdravstvene nege.

METODE

Za sistematično analizo primera smo uporabili raziskovalni pristop – študija primera kot metodo kvalitativne, analitične in induktivne narave. Predmet raziskave je bil bolnik po ishemični možganski kapi, zdravljen s trombolizo. Za analizo podatkov smo uporabili dokumentirane vire (medicinska dokumentacija bolnika), podatke, ki smo jih zbrali s pomočjo intervjuja z vodenimi vprašanji odprtega tipa ter podatke zbrane z opazovanjem bolnika. Raziskavo smo izvedli januarja 2013, v bolnikovem domačem okolju. Preiskovanec je v raziskavi sodeloval prostovoljno, zagotovljena mu je bila anonimnost in možnost odklonitve sodelovanja v raziskavi. Raziskava je bila opravljena skladno z načeli Kodeksa etike medicinskih sester in zdravstvenih tehnikov Slovenije in Helsinške deklaracije.

REZULTATI

Bolnica, stara 66 let, je bila sprejeta v bolnišnico zaradi nenadne oslabelosti levih okončin in govornih motenj. Težave so se pojavile 1,5 ure pred sprejemom, okrog 22. ure zvečer, ko je že ležala v postelji. Najprej je občutila oslabelost leve roke, kasneje se je pojavila še oslabelost leve noge. Sin, ki jo je spremljal, je povedal, da bolnica težje govori. Bolnica ni bila v nezavesti, ni imela glavobola in ni bruhala, prav tako ni imela epileptičnega napada. Aprila 2012 se je zdravila v bolnišnici zaradi paroksizmalne atrijske fibrilacije in je obravnavana pri kardiologu. Pred sprejemom v bolnišnico je bolnica redno jemala naslednja zdravila: Enap 2x20 mg, Biol 2,5 mg zvečer, Atoris 20 mg zvečer, Edemid 40 mg 1x dnevno in Fosavance 1 tbl. 1x tedensko. Alkohola ni uživala, kadila je okrog 10 cigaret dnevno. Mama ji je umrla zaradi možganske kapi, oče pa zaradi raka pankreasa.

Krvni tlak ob sprejemu je bil 180/70 mmHg, pulz 86 utripov/minuto, aritmičen. Bolnica je bila ob sprejemu pri zavesti, orientirana, zenici sta bili okrogli, simetrični, centralno ležeči, na osvetlitev sta primerno reagirali, bulbomotorika je bila primerna, nistagmus ni bil prisoten, izpad vidnega polja ni bilo opaziti. Levi ustni kot je bil povešen in je pri mimičnih kretnjah zaostajal, jezik je rahlo deviiral v levo, gibljivost jezika je bila rahlo upočasnjena. Mišični tonus v levi zgornji okončini je bil nekoliko nižji kot v desni, refleksni status je bil dobro izziven, simetričen, dvignjena levica je omahnila, desnico je obdržala. Levo nogo je poskuša nekoliko dvigniti, jo flektirala v kolenu z drsenjem pete za cca 20 stopinj, ostale gibljivosti ni bilo, patelarni in Ahilov refleks sta bila levo nekoliko bolje izzivna kot desno, plantarni odgovor je bil levo v fleksiji. Meningealni znaki so bili negativni. Telesna teža pacientke je bila 70 kg, telesna višina 157 cm, ITM 28,4.

Diagnoze ob sprejemu: ICV, Hemiparesis sin., Arterijska hipertenzija, Hiperlipidemija, Paroksizmi atrijske fibrilacije, Osteoporza.

Ker je zdravnik na podlagi kliničnega pregleda, vprašalnika za ugotovitev primernosti za zdravljenje ishemične možganske kapi z rtPA, ocene po NIHSS, ki je bila 10, laboratorijskih izvidov in izvida CT možganov ugotovil, da je obravnavana bolnica primeren kandidat za trombolitično zdravljenje, ji je predpisal 63 g zdravila Actylise, in sicer 6,3 g v bolusu in 56,7 g v trajni infuziji v eni uri s pomočjo črpalke. Bolnica je bila nameščena v intenzivno enoto zaradi kontinuiranega intenzivnega spremljanja zdravstvenega stanja.

Čeprav je pri bolniku po možganski kapi lahko prisotnih veliko negovalnih problemov, kot so motnje zavesti, spremembe v vitalnih funkcijah, motnje spomina, ovire v komunikaciji zaradi težav z govorom in razumevanjem, motorična prizadetost, motnje vida, deficit v samonegi, strah itd., moramo biti ob in po trombolizi pozorni na naslednje možne negovalne probleme:

- odstopanja v vrednostih krvnega tlaka in srčnega utripa,
- spremembe zavesti,
- različne krvavitve.

Cilji zdravstvene nege pri bolniku z AIMK, zdravljenim s trombolitično terapijo so:

- v skladu s protokolom na trombolitično terapijo pripravljen bolnik,
- poučen o potrebnih negovalnih postopkih in posegih,
- aplicirana trombolitična terapija,
- preprečitev zapletov tokom aplikacije trombolitične terapije in po njej.

Po predhodnem preverjanju že ugotovljenih potreb po zdravstveni negi in oceni, da so deficiti pri bolniku nespremenjeni, prične medicinska sestra za doseganje ciljev z načrtovanjem in izvajanjem intervencij zdravstvene nege po protokolu. Načrtovane aktivnosti

zdravstvene nege pri bolniku z AIMK, zdravljenim s trombolitično terapijo so:

- psihofizična priprava bolnika na tombolizo: poučitev o potrebnih intervencijah, nastavitev periferne intravenske kanile (ne sme se izvršiti punkcija velike žile ali nastaviti flebokatetra, prav tako je kontraincidirana lumbalna punkcija), odvzem krvi za elektrolite, hemogram, belo krvno sliko, trombocite, CRP, PČ, INR, PTTK, fibrinogen,
- posneti EKG,
- transport bolnika na CT možganov,
- kontinuirano spremljanje krvnega tlaka in srčnega utripa preko monitorja (neposredno pred aplikacijo trombolitične terapije v bolusu, nato 1 uro na 15 minut, dalje do 6 ur po trombolizi na pol ure in do 24 ur po trombolizi na 1 uro) in dokumentiranje v protokol,
- aplikacija trombolitične terapije (Actilyse) po predpisani shemi,
- spremljanje stanja zavesti in učinkov zdravila (izboljšanje motoričnih funkcij, govora itd.),
- spremljanje dihanja in telesne temperature,
- opazovanje bolnika zaradi morebitne krvavitve,
- aplikacija predpisanih infuzijskih tekočin,
- dokumentiranje dane terapije, meritev in stanja bolnika,
- poročanje zdravniku,
- ocena bolnikovega stanja po Glasgow koma skali (GCS) po naročilu zdravnika,
- 24 ur po trombolizi aplicirati nizkomolekularni heparin po naročilu zdravnika,
- v času 24 - 48 ur po trombolizi poskrbeti, da bo bolnik opravil kontrolni CT možganov.

Pri obravnavani bolnici so bile vse načrtovane intervencije zdravstvene nege izvedene v skladu s protokolom in načrtom zdravstvene nege. Ob vrednotenju zdravstvene nege je bilo ugotovljeno, da se je zdravstveno stanje obravnavane bolnice izboljšalo. Med samo aplikacijo trombolitične terapije ni prišlo do zapletov. Takoj po trombolizi je bila ocena po NIHSS 6. Kontrolno CT slikanje možganov 24 ur po trombolizi je pokazalo ishemični cerebrovaskularni inzult v področju bazalnih ganglijev desno. 24 ur po trombolizi je bolnica dobila Fraksiparin 0,4 ml subkutano in Cardiopirin 100 mg 1 tbl. Omenjeno terapijo, je ob svoji stalni terapiji, prejemala 1 krat dnevno ves čas hospitalizacije. V času hospitalizacije so bile pri bolnici opravljene še naslednje preiskave: Rtg pljuč in srca, UZ karotidnih debel in vertebralnih arterij ter UZ srca. Bolnica je bila po štirih dneh premeščena iz intenzivne enote na oddelek, kjer je začela z rehabilitacijo. Klinično stanje se je postopno začelo izboljševati. Ves čas hospitalizacije je bila kardiorespiratorno kompenzirana, normotenzivna. Ob odpustu je bila ocena po NIHSS 2, predvsem zaradi prizadetosti centralnega facialisa na levi strani. Prav tako je bila prisotna še blaga pareza levih okončin in slabša groba mišična moč levih okončin. Pri hoji jo je rahlo zanašalo v levo, sicer je hodila brez pripomočkov. Ob odpustu v domače okolje je bolnica prejela pisna in ustna navodila glede načina življenja in nadaljnje rehabilitacije. Ob odpustu so ji predpisali naslednjo terapijo: Enap 20 mg 2x1 tbl., Biol 2,5 mg 1 tbl. zvečer, Atoris 20 mg 1 tbl. zvečer, Edemid 40 mg 1 tbl. zjutraj, Nillar 20 mg 1 tbl. zjutraj, Predaxa 2x150 mg, Lexaurin 3 mg po potrebi, Fosavance 1 tbl. na teden ob nedeljah, Lekadol 500 mg 1 tbl. po potrebi ob bolečinah. Čez mesec dni je potrebna kontrola v ambulanti za koagulopatije. Po priporočilu nevrologa je bila predlagana nadaljnja rehabilitacija v zdravilišču.

DISKUSIJA

Zdravljenje z aktivatorjem tkivnega plazminogena pri akutni možganski kapi zahteva intenzivno zdravstveno nego bolnika. Ker je uspešnost trombolitičnega zdravljenja AIMK pogojena s časom (Hacke, Kaste, Bluhmki, 2008), v katerem je lahko tromboliza izvedena, je pomembno, da so znaki možganske kapi čim hitreje spoznani in zdravstvena oskrba čim hitrejša. Medicinske sestre, ki sodelujejo pri trombolizi, morajo biti seznanjene z varno uporabo in aplikacijo rtPA, saj se aplikacija rtPA in obravnava bolnika po ishemični možganski kapi razlikuje od aplikacije rtPA in obravnave bolnika po miokardnem infarktu. Pri trombolitičnem zdravljenju AIMK je pomembno intenzivno spremljanje nevrološkega stanja in prepoznavanje morebitnih zapletov. Braimah, Kongable, Rapp et al. (1997) prav tako poudarjajo pomembnost intenzivnega spremljanja nevrološkega stanja ter kontinuirano merjenje krvega tlaka in pulza. Pomembno pa je tudi upoštevati standarde zdravstvene nege kritično bolnega bolnika.

Čeprav je zdravljenje z rtPA učinkovito, pa okrog 50 % bolnikov po preboleli IMK kljub zdravljenju s trombolizo ostane težje nevrološko prizadetih (Bhatia, Hill, Shobha, 2010). Zato je potrebno pri bolniku z IMK, ne glede na način zdravljenja, poskrbeti tudi za zadovoljevanje osnovnih življenjskih potreb, kar pomeni, da načrt zdravstvene nege prilagodimo stanju in sposobnostim posameznega bolnika. V okviru rehabilitacije bolnika po IMK je pomembno poučiti bolnika o dejavnikih tveganja za nastanek možganske kapi (Tetičkovič, 2007). Obravnavana bolnica je imela več dejavnikov tveganja, na katere ni mogoče vplivati (starost, spol,

genski dejavnik) ter dejavnik tveganja, na katerega je mogoče vplivati (kajenje). Prisotna so bila tudi bolezenska stanja kot dejavnik tveganja (arterijska hipertenzija, hiperlipidemija, atrijska fibrilacija, ateroskleroza in zadebeljena intima medije desne in leve skupne karotidne arterije, ki sta bili ugotovljeni z UZ karotidnih debel in vertebralnih arterij). Evropska iniciativa za možganskožilne bolezni ter slovenske smernice za preprečevanje IMK in slovenske smernice za preprečevanje arterijske hipertenzije priporočajo odstranjevanje in zdravljenje dejavnikov tveganja za možganskožilne bolezni, v prvi vrsti pa zdravljenje arterijske hipertenzije (Žvan, 2006). Poudariti je potrebno pomen zdrave uravnotežene prehrane, ustrezne telesne teže, redne telesne aktivnosti, izogibanje slabim razvadam ter pomen rednega jemanja predpisane terapije. Ob zdravstveno vzgojnem delu pa je pomembna zgodnja rehabilitacija, ki je usmerjena v zmanjšanje funkcionalne stopnje prizadetosti bolnika, spodbujanje bolnikove samostojnosti pri dnevnih aktivnostih ter gibanju in povrnitev bolnikove samozavesti, ki je potrebna za ponovno vključevanje v družbo. Barnes (2003) navaja, da je eden od ciljev zgodnje rehabilitacije tudi priprava svojcev na življenje z bolnikom po možganski kapi.

ZAKLJUČEK

Možganska kap je tretji najpogostejši vzrok smrti na svetu (za koronarno boleznijo in rakom). Ker je izid prebolele možganske kapi v veliki meri odvisen od hitrosti ukrepanja, je treba čim prej prepoznati simptome in znake, ki kažejo na to stanje, ob tem pa čim prej zagotoviti ustrezno zdravniško pomoč ter ob čakanju nanjo bolniku zagotoviti čim večjo varnost in udobje. Zato je ob sodobnem zdravljenju in rehabilitaciji bolnikov po možganski kapi pomembna tudi osveščenost populacije o zdravem načinu življenja ter njihovem ravnanju v primeru pojava simptomov možganske kapi pri osebi. Naloge medicinskih sester torej ne obsegajo le skrb za bolnike po možganski kapi, ampak tudi poučevanje populacije o preprečevanju možganske kapi, simptomih možganske kapi in pravilnem ukrepanju v primeru simptomov. Pri tem nam je v pomoč kratica GROM (govor, roka, obraz, minuta), s pomočjo katere širšo populacijo lažje naučimo, kaj naj pri prizadeti osebi opazuje.

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PARENTAL FAMILIARITY WITH PRE-SCHOOL CHILDREN'S PREVENTIVE VISITS BY COMMUNITY NURSES AND DISPENSARY FOR CHILDREN

OSVEŠČENOST STARŠEV O PREVENTIVNIH OBISKIH OTROK S STRANI PATRONAŽNE MEDICINSKE SESTRE IN V DISPANZERJU ZA OTROKE

BARBARA KEGL, MILICA LAHE

Izvleček

Izhodišča*: V okviru obveznega zdravstvenega zavarovanja imajo otroci v Sloveniji zagotovljene različne preventivne dejavnosti, ki so zapisane v Pravilniku za izvajanje preventivnega zdravstvenega varstva na primarni ravni. Starši se morajo zavedati odgovornosti za otrokovo rast in razvoj ter biti hkrati informirani o pomenu preventivnih pregledov. Osveščanje staršev o pomenu preventivnih obiskov otrok je pomembna naloga patronažnih medicinskih sester in medicinskih sester v dispanzerjih za otroke. Z raziskavo smo želeli ugotoviti razlike v informiranosti staršev o pomenu preventivnih pregledih otrok.*

Metode*: Uporabili smo kvantitativni raziskovalni pristop z metodo anketiranja. Raziskavo smo izvedli med starši predšolskih otrok. Podatke smo statistično obdelani z računalniškim programom SPSS 20.0. Za ugotavljanje statistično pomembnih razlik med posameznimi spremenljivkami smo uporabili opisno statistiko in x^2 test. Statistično značilnost smo preverjali na ravni 5 % tveganja ($p \leq 0,05$).*

Rezultati*: Ugotovili smo, da obstajajo statistično pomembne razlike v informiranosti staršev o pomenu preventivnih pregledih otrok glede na starost staršev ($p = 0,021$ in $p < 0,001$) ter glede na izobrazbo ($p = 0,045$ in $p = 0,005$) le pri dveh od desetih trditev. Hkrati smo ugotovili, da so starši v povprečju dobro informirani o pomenu preventivnih pregledih otrok.*

Diskusija in zaključek: *Varovanje zdravja otrok je najpomembnejše področje na primarni ravni in prednostna naloga vsake sodobne družbe. Pri skrbi za zdravo rast in razvoj otrok imajo pomembno vlogo starši, ki pa morajo biti osveščeni, pri tem pa odigrajo pomembno vlogo patronažne medicinske sestre in medicinske sestre v dispanzerjih za otroke.*

Ključne besede: *medicinska sestra, starši otrok, otrok, dispanzer, preventivni obiski, patronažno varstvo*

Abstract

Introduction*: In the framework of compulsory health insurance, children in Slovenia have access to different preventive activities as stipulated in the Rules for the Implementation of Preventive Health Care at the Primary Level. Parents must be aware of their responsibility for the child's growth and development and at the same time parents need to be informed about preventive check-ups. Community nurses and nurses in dispensaries for pre-school children have a very important role. The aim of the survey was to identify differences in parental familiarity with importance of children´s preventive visits.*

Methods*: We used a quantitative research approach and questionnaire as the method of collecting data. The survey was conducted among parents of preschool children. The obtained data were statistically analysed by using SPSS 20.0. To determine statistically significant differences between variables, we used descriptive statistics and the x2 test. Statistical significance was checked at 5% risk ($p \leq 0,05$).*

Results*: We discovered that there are statistically significant differences in informing parents about importance of preventive examinations of children by the age of the parents ($p = 0.021$ and $p < 0.001$) and level of education ($p = 0.045$ and $p = 0.005$), only two of the ten claims. At the same time, we found out that parents are, on average, well-informed on screening children.*

Discussion and conclusions: Protecting children's health is the most important area at the primary level and a priority of any modern society. Care for the healthy growth and development of children play an important role parents should be informed, at the same time play

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an important role community nurses and nurses in dispensaries for pre-school children.

Keywords*: nurse, dispensary, children, parents of children, preventive visit, community nursing*

IZHODIŠČA

Otroci so naše največje bogastvo. Vsi starši si najbolj od vsega želijo, da bi se njihov otrok razvijal čim bolj zdravo. Informacije o zdravi rasti in razvoju otroka dobijo starši velikokrat s strani patronažne medicinske sestre ter medicinske sestre zaposlene v dispanzerju za otroke. Zdravje otrok je splošna vrednota in bistveni vir za produktivno in kakovostno življenje slehernega posameznika, družine in skupnosti kot celote. V okvirju obveznega zdravstvenega zavarovanja imajo otroci pravico do sistematičnih in namenskih pregledov otrok, posvetov in medicinsko timskega sodelovanja, zdravstveno-vzgojnega dela, patronažnega zdravstvenega varstva in tudi zobozdravstvenega varstva. Medicinska sestra v dispanzerju za otroke mora starše o pomenu preventivnih programov informirati, saj so le ti pomembni za ohranjanje zdravja in ustvarjanje pogojev za zdravo življenje otrok in mladostnikov. Dela in naloge medicinske sestre v dispanzerju za otroke so specifične, zahtevajo psihofizične sposobnosti in osebnostne lastnosti, ki omogočajo human, odgovoren, celosten in skrben odnos do obravnavanega otroka ter njegovih staršev. Z omenjenimi preventivnimi dejavnostmi si medicinske sestre na primarni ravni in tudi drugi strokovnjaki prizadevajo k ohranitvi, krepitvi ali vrnitvi zdravja otrok.

Namen raziskave je bil ugotoviti razlike v informiranosti staršev o preventivnih pregledih otrok.

PREVENTIVNI PREGLEDI OTROK

Zdravstveno varstvo na primarni ravni je organizirano v zdravstvenih domovih in zasebnih otroških ordinacijah po celi Sloveniji. Zdravstveno varstvo izvaja tim pediatra, medicinske sestre, ki je dodatno usposobljena za izvajanje preventivne dejavnosti, predvsem zdravstveno-vzgojne dejavnosti in tehnik zdravstvene nege. Zdravstveno varstvo otrok na primarni ravni vključuje: odkrivanje in zdravljenje bolezni in poškodb otrok; preiskave, ki se lahko opravljajo v okviru zdravstvenega doma; preventivne preglede, svetovanje in cepljenje, ki je predpisano z nacionalnim preventivnim programom (Brcar et al., 2004, str. 139).

Brcar (2008) navaja, da k preventivnim zdravstvenim programom sodijo obiski patronažne medicinske sestre, sistematični pregledi v posameznih starostnih obdobjih, preventivni pregledi z določenim namenom, zdravstveno-vzgojne vsebine za informiranje otrok, mladostnikov in staršev ter pedagoškega osebja, cepljenje po programu in različne oblike svetovanja.

Najprej se v domačem okolju sreča otročnica in novorojenček s preventivnimi obiski patronažne medicinske sestre, ki ju mora prvič obiskati v roku 24 ur po odpustu iz porodnišnice. Dojenček je nato obravnavan v 1. letu starosti šest krat ter enkrat v drugem in tretjem letu otrokove starosti. Dojenčki in predšolski otroci imajo pravico do naslednjih preventivnih pregledov v dispanzerju za otroke: sistematični pregled v starosti enega, treh, šestih, devetih, dvanajstih in osemnajstih mesecev ter v starosti treh in petih let; namenski pregled v primeru, da je bila pri sistematičnem pregledu najdena sprememba, ki potrebuje sledenje; izvedbe obveznega cepljenja predpisanega s programom cepljenja in izvedbe programirane zdravstvene vzgoje in individualnega svetovanja. Sistematičnem pregledu otroka v starosti treh let je pridružen tudi pregled pri psihologu, v starosti petih let pa pregled pri logopedu (Preventivni pregledi novorojenčkov, predšolskih in šolskih otrok, mladine in študentov, 2013; Pravilnik za izvajanje preventivnega zdravstvenega varstva na primarni ravni, 19/98).

Namen sistematičnih preventivnih pregledov otrok je poznavanje zdravstvenega stanja otrok, aktiven zdravstveni nadzor, odkrivanje zdravstvene problematike in svetovanje staršem oziroma skrbnikom in otrokom. Obsega oceno telesne rasti in razvoja, ugotavljanje telesnega in duševnega zdravja, ukrepe za ohranitev in krepitev zdravja in omogočanje optimalnega telesnega in duševnega razvoja ter odkrivanje negativnih socialnih dejavnikov in nezdravih življenjskih navad v družini. Prav tako mora biti pri vseh sistematičnih pregledih otrok narejen Denverski razvojni presejalni test (DRPT) (Pravilnik za izvajanje preventivnega zdravstvenega varstva na primarni ravni, 19/98).

Sistematični preventivni pregledi dojenčkov, otrok in mladine se vsebinsko nekoliko razlikujejo glede na starost otroka, okvirno pa vključujejo pregled zdravstvene dokumentacije, anamnezo, pregled otroka in presejalne teste, razgovor z otrokom, zdravstveno-vzgojne aktivnosti, po potrebi cepljenje otroka. Zdravstveno-vzgojne aktivnosti potekajo v začetku individualno in so usmerjene k staršem, vzgojiteljem in učiteljem, kasneje, z odraščanjem otroka, pa potekajo tudi skupinsko v vrtcih in šolah. Razvojno in vedenjsko moteni otroci imajo vsako leto preventivne zdravstvene preglede v identičnem obsegu, prilagojene njihovi prizadetosti. Vsi otroci imajo tudi redne letne preventivne sistematične

preglede pri zobozdravniku ter zobozdravstveno vzgojo (Preventivni pregledi novorojenčkov, predšolskih in šolskih otrok, mladine in študentov, 2013). Torej sistematični preventivni pregledi otrok so način, s katerim lahko starše seznanijo z zdravstvenim stanjem njihovih otrok.

ZDRAVSTVENA VZGOJA STARŠEV IN OTROK

Zdravje je ključnega pomena od rojstva otroka in vse do šestega leta starosti, saj zdravje v otroštvu pomeni tudi zdravje v celotnem življenju posameznika (Svetiči Marinko, 2007, str. 288). Zdravstvena vzgoja je del splošne vzgoje in pomemben dejavnik napredka posameznika in skupnosti. Je odraz splošne izobrazbe in kulture posameznika ter celotnega naroda (Hoyer, 2005, str. 1). Kodeks etike medicinskih sester in zdravstvenih tehnikov Slovenije (2006) določa, da je zdravstvena vzgoja ena temeljnih nalog medicinske sestre.

Programirano zdravstveno-vzgojno delo poteka v posvetovalnicah za starše in otroke, v jaslih, v vrtcih in socialno varstvenih zavodih. K temu sodijo tudi različni posveti s starši, vzgojitelji in svetovalnimi delavci o zdravstveni in vedenjski problematiki otrok. Namen tega dela je odstraniti oziroma zmanjšati škodljive vplive na zdravje otrok, ki izhajajo iz njihovega bivalnega okolja (Zaletel-Kragelj et al., 2008).

Temeljna naloga, ki jo ima medicinska sestra pri preventivnih pregledih v dispanzerjih za otroke je pomoč otrokom in družinam, da izkoristijo svoje fizične, psihične in socialne zmogljivosti. Medicinska sestra mora opravljati naloge, ki pospešujejo in ohranjajo zdravje, kakor tudi naloge, ki preprečujejo ogrožanje zdravja. Skrbeti mora za krepitev zdravja, učiti zdrav slog življenja in motivirati starše za pravočasen prihod v dispanzer, če opazijo kakršnekoli spremembe v zdravju otroka. Izredno pomembna je komunikacija, vzpostavitev zaupljiv medosebnih odnosov in zdravstveno-vzgojno delovanje. Zdravstveno-vzgojno delovanje medicinske sestre je eden od temeljnih vsebin preventivnega dela, izvaja se individualno v času preventivnih in kurativnih pregledih otroka (Verlak in Frankič, 2006, str. 49).

Namen zdravstveno-vzgojnega delovanja medicinske sestre v dispanzerju za otroke je informirati in motivirati starše in otroka, da lahko aktivno skrbijo za svoje zdravje in zdravje otroka. Staršem in otroku tako pomaga oblikovati znanja, stališča in vedenjske vzorce za zdrav slog življenja ter izogibanje razvadam. Zdravstvena vzgoja v predšolskem obdobju predstavlja začetek vseživljenjskega izobraževanja. Namen takšnega izobraževanja je vzpostavitev dobrih temeljev za doseganja zdravja otrok in družin.

METODE

V okviru raziskovalnega procesa smo uporabili kvantitativni pristop raziskovanja, za metodo zbiranja podatkov smo uporabili anketni vprašalnik. Anketni vprašalnik je vseboval 8 trditev in 7 zaprtih in polodprtih vprašanj. Zastavili smo 1 raziskovalno vprašanje: Ali obstajajo statistično pomembne razlike glede informiranosti staršev o pomenu preventivnih pregledih otrok med proučevanima skupinama staršev? Raziskavo smo izvedli v dispanzerju za otroke Zdravstvenega doma dr. Adolfa Drolca Maribor. Razdelili smo 100 anketnih vprašalnikov staršem, ki so s svojim predšolskim otrokom obiskali enega izmed preventivnih pregledov v času od 2. 1. 2013 do 1. 2. 2013. Vrnjenih in popolno izpolnjenih je bilo 72 anketnih vprašalnikov, kar predstavlja 72 % odziv. Pred izvedbo raziskave smo si pridobili pisno soglasje vodstva Zdravstvenega doma dr. Adolfa Drolca Maribor. Anketirance smo seznanili z namenom in cilji raziskave. Zagotovljena je bila anonimnost in imeli so možnost odklonitve sodelovanja v raziskavi. Podatke smo statistično obdelali z računalniškim programom SPSS 20.0. Za ugotavljanje statistično pomembnih razlik med posameznimi spremenljivkami smo uporabili opisno statistiko in x^2 test. Z njimi smo ugotavljali razlike v informiranost staršev o preventivnih obiskih otrok. Statistično značilnost smo preverjali na ravni 5 % tveganja ($p \leq 0,05$).

REZULTATI

V raziskavi je sodelovalo 72 staršev predšolskih otrok, od tega je bilo 52 (72,2) žensk in 20 (27,3 %) moških. 24 (33,3 %) anketirancev je bilo starih med 18 in 25 let. 38 anketirancev je bilo starih med 26 in 35 let ter 10 anketirancev je bilo starih med 36 in 45 let. Od tega imajo 3 (4,2 %) anketiranci zaključeno osnovno šolo, 21 (29,2 %) srednjo šolo, 29 (40,3 %) visoko šolo ter 19 (26,4 %) fakulteto. V 38 (52,8 %) anketiranih družinah imajo enega otroka, v 23 (31,9 %) imajo dva otroka in v 11 (15,3 %) imajo tri otroke ali več. 56 (77,8 %) otrok anketiranih staršev je bilo starih od 0 – 2 leti, 15 (20,8 %) otrok je starih od 3 - 5 let in 1 (1, 4 %) je bil star od 5 - 6 let.

V razpredelnici 1 so predstavljene trditve ter rezultati x^2 testa s katerim smo ugotavljali povezanost med starostjo ter izobrazbo staršev predšolskih otrok glede na navedene trditve.

Z raziskavo smo ugotovili, da obstajajo statistično

Razpredelnica št. 1: Rezultati x2 testa o pomenu preventivnih obiskov otrok glede na starost in izobrazbo staršev

	X^2 (starost)	X^2 (izobrazba)
Informiranost staršev o preventivnih pregledih otrok.	p = 0,069	p = 0,065
PMS pride prvič na dom prvi dan po odpustu novorojenčka iz porodnišnice.	p = 0,387	p = 0,230
Dojenčka obišče PMS med 4.-5. mesecem otrokove starosti.	p = 0,487	**p = 0,045**
Dojenčka obišče PMS med 7.-8. mesecem otrokove starosti.	p = 0,365	p = 0,601
Dojenčka obišče PMS med 10.-11. mesecem otrokove starosti.	p = 0,997	p = 0,356
Novorojenček in dojenček je 6x obravnavan s strani PMS v 1. letu starosti.	**p = 0,021**	p = 0,120
Otrok je 1x obravnavan s strani PMS v 2. letu starosti.	p = 0,271	p = 0,120
Otrok je 1x obravnavan s strani PMS v 3. letu starosti.	p = 0,106	**p = 0,005**
Dojenček gre prvič v OP pri 1. mesecu starosti.	p = 0,497	p = 0,311
Sistematični in namenski pregledi otrok v dispanzerju za otroke.	**p < 0,001**	p = 0,102

pomembne razlike v informiranosti staršev o pomenu preventivnih pregledih otrok glede na starost staršev (p = 0,021 in p < 0,001) ter glede na izobrazbo (p = 0,045 in p = 0,005) le pri dveh od desetih trditev.

Zanimalo nas je kdo napoti starše v otroško posvetovalnico. Ugotovili smo, da se je 30 (41,6 %) staršev samih naročilo v otroško posvetovalnico. 26 (36,1 %) staršem je obisk svetovala patronažna medicinska sestra. 11 (15,2 %) staršem je to informacijo posredovala medicinska sestra ob odpustu otroka iz porodnišnice in 1 (1,4 %) staršu je to pisalo na odpustnem listu iz porodnišnice.

Prav tako smo želeli izvedeti od koga starši izvedo največ o samih preventivnih obiskih otrok in tudi o njihovem pomenu. Na voljo so anketiranci imeli več odgovorov. Največ informacij o tem dobijo starši od medicinskih sester v dispanzerjih za otroke. Te informacije je dobilo 31 (43,05 %) anketirancev. 20 (27,7 %) anketirancev je dobilo to informacijo od patronažnih medicinskih sester, 9 (12,5 %) anketirancev v šoli za bodoče starše, 7 (9,72 %) od prijateljev in sorodnikov ter 6 (8,3 %) na internetu in ostali iz zloženk ali knjig.

DISKUSIJA

Otrok se rodi kot nepopisan list, s pomočjo patronažnih medicinskih sester in medicinskih sester v dispanzerjih za otroke pa dajemo staršem eno od možnosti, da držijo pisalo in pišejo. S preventivnimi pregledi tako omogočamo otroku ugodne pogoje za zdravo rast in razvoj otroka ter dovolj hitro ugotavljamo odstopanja od le tega. Krajnc (2012) opredeljuje, da med najpomembnejše naloge patronažne zdravstvene nege sodi izvajanje preventivnega programa, namenjenega ohranjanju, krepitvi in varovanju zdravja celotne populacije, torej tudi otroku. S promocijo zdravja skuša tako patronažna medicinska sestra kot medicinska sestra v dispanzerju doseči, da starši prevzamejo skrb in odgovornost za svoje zdravje in zdravje svojih otrok. V raziskavi smo ugotovili, da se patronažne medicinske sestre in medicinske sestre v dispanzerju za otroke zavedajo pomena osveščenosti staršev o preventivnih pregledih otrok. Ugotovili smo, da jih je bilo s strani medicinske sestre v dispanzerju informiranih manj kot polovica anketiranih staršev in manj kot tretjina s strani patronažnih medicinskih sester. Menimo, da bi medicinske sestre morale še intenzivneje opravljati svojo temeljno poslanstvo; zdravstveno – vzgajati in ozaveščati starše predšolskih otrok o pomenu preventivnih obiskov. Tudi Bigec, Frankič, Šrok (2010) navajajo, da je ena temeljnih nalog medicinskih sester v okviru patronažnega varstva in v sklopu otroških posvetovalnic zdravstveno – vzgojno delo in prenos informacij o pomenu preventivnih obiskov otrok. Rautio (2012) navaja, da je zelo pomembno vzpostaviti zgodnjo podporo in osveščanje staršem predšolskih otrok, predvsem s strani patronažnih medicinskih sester, saj so starši s tem zelo zadovoljni.

Glede na dobljene rezultate sklepamo, da so starši sorazmerno dobro poučeni o preventivnih obiskih otrok in njihovem pomenu. Le pri 2 trditvah »novorojenček in dojenček je 6x obravnavan s strani PMS v 1. letu starosti« in »sistematični in namenski pregledi otrok v dispanzerju za otroke« sta statistično pomembno povezani s starostjo anketiranih staršev. Torej starši stari med 26 in 45 let bolje poznajo kolikokrat je otrok obravnavan v 1. Letu s strani patronažnih medicinskih sester in prav tako bolje vedo kdaj so sistematični in kdaj namenski pregledi otrok v dispanzerju za otroke kot mlajši starši. Prav tako vidimo, da sta 2 trditvi »dojenčka obišče PMS med 4.-5. mesecem otrokove starosti« in »otrok je 1x obravnavan s strani PMS v 2. letu starosti« statistično pomembno povezani z izobrazbo anketiranih staršev. Starši, ki imajo visokošolsko in univerzitetno izobrazbo, so bolje informirani o tem, da patronažna medicinska sestra obišče dojenčka med 4.-5. mesecem ter v 2. letu otrokove starosti. Z raziskavo smo tako ugotovili, da ne

obstajajo statistično pomembne razlike v informiranosti staršev o preventivnih pregledih otrok glede na starost in izobrazbo anketiranih staršev. Halfon et al. (2005) navajajo, da je zelo pomembno izvajanje preventivnih ukrepov v primarnem zdravstvenem varstvu otrok ter osveščanje staršev o teh ukrepih in ne samo zgolj o zdravi rast in razvoju otroka. Ne navaja statistično pomembnih razlik glede na starost in izobrazbo staršev temveč glede na dohodke družine in etično pripadnost. V Letnemu programu javne službe javnega zdravja Zavoda za zdravstveno varstvo Ljubljana za leto 2013 (2012) je opredeljeno, da so otroci in mladostniki ranljiva skupina prebivalcev in zato potrebujejo posebno pozornost. Iz tega razloga je zanje organizirano preventivno zdravstveno varstvo. Sistematične preglede izvajajo predvsem pediatri in šolski zdravniki, vzgojo za zdravje pa pretežno medicinske sestre. Vse to je seveda opredeljeno v Pravilniku za izvajanje preventivnega zdravstvenega varstva na primarni ravni (1998).

ZAKLJUČEK

Medicinska sestra mora starše v domačem okolju ali v dispanzerju osveščati o pomenu izvajanja preventivnih pregledov otrok. Informirati jih mora, da so preventivni pregledi otrok pomembni zaradi ohranjanja in krepitve zdravja slehernega otroka ter bistveno pripomorejo k pravočasnem odkrivanju nepravilnosti. Starši se morajo zavedati odgovornosti, ki jo imajo do svojih otrok. Vedeti morajo tudi to, da se lahko s preventivnimi pregledi pravočasno odkrijejo in odstranjujejo škodljivi vplivi na zdravje otrok kar jim zagotavlja višjo raven zdravja.

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THE IMPORTANCE OF EDUCATION IN PAIN MANAGEMENT

POMEN IZOBRAŽEVANJA ZA OBVLADOVANJE BOLEČINE

MOJCA DOBNIK

Izvleček

Izhodišča*: Vseživljenjsko izobraževanje zaposlenih v kliničnem okolju je zelo pomembno. Glede na težave pacientov z bolečino, je še posebej izpostavljeno izobraževanje o obvladovanju bolečine. Izobraževalni programi za obvladovanje bolečine prispevajo k povečevanju znanja, medtem ko je klinično okolje tisto, ki pripomore k razvoju in uporabi znanj o obvladovanju bolečine. Pomanjkanje znanja in usposabljanja zaposlenih v zdravstvu lahko omeji izvajanje storitev za uspešno obvladovanje bolečine. Namen raziskave je s hipotezama ugotoviti ali zaposleni menijo, da se zadostno izobražujejo s področja ocenjevanja in spremljanja bolečine za kakovostno obravnavo pacienta in ali ocenjujejo bolečino pred in po aplikaciji analgetične terapije po VAS lestvici.*

Metode*: Raziskava temelji na kvantitativni metodologiji. Uporabljena je opisna raziskovalna metoda, za metodo zbiranja podatkov je uporabljen anketni vprašalnik. V raziskavo so vključeni zaposleni v zdravstveni negi Klinike za interno medicino Univerzitetnega kliničnega centra Maribor. Podatke smo statistično obdelali z računalniškim programom SPSS 20.0. Za ugotavljanje statistično pomembnih razlik med posameznimi spremenljivkami bomo uporabili ANOVA test.*

Rezultati*: Ugotovili smo, da se proučevane spremenljivke, kot so izobraževanje zaposlenih (r=0,314; p<0,001), in samoocena aktivnosti s področja lajšanja bolečine (r=0,245; p<0,001) se statistično pomembno pozitivno povezujeta s kakovostjo v zdravstveni negi. Ugotovili smo, da glede na leta delovne dobe (izkušnje) ne prihaja do statistično pomembnih razlik pri proučevanih spremenljivkah, kot so izobraževanje, samoocenjevanje delovanja na področju ocenjevanja bolečine in kakovosti. Hkrati smo ugotovili, da glede na izobrazbo prihaja do statistično pomembnih razlik le pri spremenljivki izobraževanje in samoocenjevanje.*

Diskusija in zaključki*: Izobraževalni programi s področja upravljanja bolečine lahko pripomorejo k izboljšanju znanja medicinskih sester na področju obvladovanja bolečine. Tudi mednarodne raziskave kažejo, da je potrebno dati prednost upravljanju kronične bolečine v kliničnem okolju. Rezultati te študije bi lahko bili vodilo pri razvoju in izvajanju stalnih izobraževalnih programov za zaposlene, ki bi temeljili na zagotavljanju z dokazi podprtega zdravljenja bolečine. Znano je, da medicinske sestre potrebujemo ustrezna znanja, spretnosti, odnos in timsko sodelovanje pri obvladovanju bolečine, da lahko učinkovito prispevamo k udobju pacientov.*

Ključne besede: *izobraževanje, znanje, bolečina.*

Abstract

Introduction*: Lifelong education of employees in the clinical setting is very important. Given the difficulties of patients with pain, with particular focus on education about pain management. Educational programs for pain management helps to increase knowledge, while the clinical environment is one that contributes to the development and application of knowledge about pain management. Lack of knowledge and training of health care may limit the provision of services to cope with the pain. The purpose of the research is to determine whether employees are aware of the importance of education for the control of pain and or attend sufficient training.*

Methods*: The study is based on quantitative methodology. Used the descriptive research method, the method of data collection, we used questionnaires. The study involved employees in health care clinics UKC Maribor. Data will be statistically analyzed with the software SPSS 20.0. To determine statistically significant differences between variables we used t-test.*

Results*: We found that the studied variables such as employee training (r = 0.314, p <0.001), and self-assessment activities in the field of pain (r = 0.245, p <0.001) and statistically significant positive correlation with the quality of health care . We found that depending on the seniority (experience) there are no statistically*

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significant differences in the studied variables such as education, self-operation in the field of evaluation of pain and quality. At the same time however, we find that the level of education leads to statistically significant differences only for the variable education and self-assessment.

Discussion and Conclusions*: Educational programs in the field of pain management can help to improve the knowledge of nurses in the field of pain management. The international studies show that it is necessary to give priority to the management of chronic pain in a clinical setting. The results of this study could lead to the development and implementation of ongoing training programs for employees, based on the provision of evidence-based treatment of pain. It is well known that nurses need appropriate knowledge, skills, attitudes and team cooperation in the management of pain that can effectively contribute to the comfort of the patient.*

Keywords: *education, knowledge, pain.*

IZHODIŠČA

Bolečina in kakovost življenja so kompleksne zadeve in kakovost življenja je morda lahko občutljiv kazalec uspešnosti izobraževanja o bolečini. Naloga medicinske sestre je, da bolečino prepozna in ustrezno ukrepa. Lajšanje bolečine je ključnega pomena za zagotavljanje kakovostne zdravstvene nege. Ustrezno obvladovanje bolečine lahko vpliva na zadovoljstvo pacientov, skrajša bivanje v bolnišnici in zmanjša stroške oskrbe. V obravnavi bolečine je pomembno sodelovanje med medicinsko sestro, zdravnikom in pacientom. Medicinska sestra ima aktivno in ključno vlogo v obravnavi bolečine. Ustrezna znanja medicinske sestre, pozitivna stališča v skrbi za upravljanje bolečine ter moralna, etična in nenazadnje poklicna obveznost medicinski sestri narekuje, da ustrezno oceni bolečino in ukrepa. Obvladovanje bolečine in ocenjevanje bolečine je nepogrešljiv del zdravstvene nege pacientov. Z nenehnimi izobraževalni programi lahko vodstvo dokazano izboljša znanja medicinskih sester o bolečini. Rezultati raziskave McNamara, Harmon, Saunders (2012) dokazujejo, da nenehni izobraževalni programi dokazano izboljšujejo znanja medicinskih sester o bolečini. Različna literatura navaja, da imajo medicinske sestre pomanjkanje znanj o bolečini, zato se pojavlja determinantno slabo upravljanja bolečine v praksi. Corrigan et al. (2011) so v raziskavi ugotovil dvoje, najprej, da študenti medicine opredeljujejo bolečino kot »veliko skrb«, v svojih zgodnjih kliničnih izkušenjah. Drugič pa, da večina interakcij s pacienti, ki imajo bolečino, zlasti tistimi, ki imajo kronično bolečino, le to dojemajo kot negativno.

METODE

V okviru raziskave smo zastavili dve hipotezi:

H1: Zaposleni menijo, da se zadostno izobražujejo s področja ocenjevanja in spremljanja bolečine za kakovostno obravnavo pacienta.

H2: Zaposleni ocenjujejo bolečino pred in po aplikaciji analgetične terapije po VAS lestvici.

V okviru raziskovalnega procesa smo uporabili kvantitativno metodologijo raziskovanja, kot metodo raziskovanja smo uporabili poizvedovanje, za metodo zbiranja podatkov pa vprašalnik, ki je vseboval vprašanja zaprtega tipa, ter analizo dokumentov.

Opis inštrumentarija

V raziskavi smo uporabili anketni vprašalnik, ki je vseboval 17 trditev. Anketiranci so se v vseh 17 trditvah opredelili po Likertovi lestvici, kjer je 1 pomenilo »sploh ne drži« in 5 »popolnoma drži«. Prvi del anketnega vprašalnika se je nanašal na demografske podatke, drugi del pa na izobraževanje zaposlenih o bolečini ter samooceno izvajanja le te. Stopnja zanesljivosti je znašala 0,818.

Raziskovalni vzorec

V raziskavo so bili vključeni zaposleni v zdravstveni negi Klinike za interno medicino Univerzitetnega kliničnega centra Maribor. Razdelili smo 100 anketnih vprašalnikov, kar je predstavljalo 67 % vzorec med 150 zaposlenimi v zdravstveni negi. Vrnjenih in pravilno izpolnjenih je bilo 82 vprašalnikov, kar je predstavljalo 82 % odziv. Pred izvedbo raziskave smo pridobili pisno soglasje bolnišnice.

Potek raziskave in obdelava podatkov

V sodelujoči kliniki smo v aprilu 2013 sodelovali pri razdelitvi vprašalnikov. Vsakemu vprašalniku je bil priložen spremni dopis z namenom raziskave in prošnjo za sodelovanje. Anketiranci so imeli 7 dni časa za izpolnitev vprašalnikov. Uporabili smo različne statistične metode s pomočjo računalniškega programa SPSS 20.0. Uporabili smo opisno statistiko ter z ANOVA testom ugotavljali statistično pomembne razlike med posameznima proučevanimi spremenljivkami.

REZULTATI

Povprečna starost sodelujočih zaposlenih je 35 let (najmanj 21 in največ 55). V raziskavi je sodelovalo 17

moških in 65 žensk. Od zaposlenih, ki so sodelovali v raziskavi je bilo 53 zaposleni zdravstvenih tehnikov, 27 diplomiranih medicinskih sester in 2 z končano izobrazbo magisterij. V razpredelnici 1 so predstavljene povprečne vrednosti in standardna deviacija za posamezne proučevane trditve.

Razpredelnica 1: Rezultati proučevanih spremenljiv

Spremenljivke	N	Min	Max	Standardni odklon
Izobraževanje	82	1,02	4,55	0,61
Samoocenjevanje	82	1,83	4,13	0,511
Kakovost	82	2,36	4,84	0,489

V nadaljevanju smo uporabili korelacijski koeficient za ugotavljanje korelacije med proučevanimi spremenljivkami. Ugotovili smo**,** da se proučevane spremenljivke, kot izobraževanje zaposlenih (r=0,314; p<0,001) in samoocena aktivnosti s področja lajšanja bolečine (r=0,245; p<0,001) statistično pomembno pozitivno povezujeta s kakovostjo v zdravstveni negi.

V nadaljevanju smo z ANOVO ugotavljali statistično pomembne razlike v proučevanju izobraževanja, samoocene in kakovosti glede na delovno dobo in stopnjo izobrazbe. Rezultati so prikazani v razpredelnici 2.

Razpredelnica 2: Rezultati ANOVE za proučevane spremenljivke

Spremenljivke	Izobrazba		Delovna doba	
	F	**p**	**F**	**p**
Izobraževanje	8,558	<0,001	1,328	0,245
Samoocenjevanje	10,192	<0,001	1,423	0,143
Kakovost	1,173	0,393	1,042	0,342

p=statistična pomembnost

Ugotovili smo, da glede na leta delovne dobe (izkušnje) ne prihaja do statistično pomembnih razlik pri proučevanih spremenljivkah kot so izobraževanje, samoocenjevanje delovanja na področju ocenjevanja bolečine in kakovost. Hkrati smo ugotovili, da glede na izobrazbo prihaja do statistično pomembnih razlik le pri spremenljivki izobraževanje in samoocenjevanje.

DISKUSIJA

Rezultati naše raziskave so pokazali**,** da se izobraževanje zaposlenih in samoocena aktivnosti zaposlenih s področja lajšanja bolečine pomembno pozitivno povezujeta s kakovostjo v zdravstveni negi. Pomen kontinuiranega izobraževanja za izboljšanje razumevanja bolečine medicinskih sester in vključevanje ocene bolečine v dnevno »rutino« medicinskih sester, vpliva na zadovoljstvo pacientov in je ključnega pomena pri obvladovanju bolečine, je pokazala tudi študija Innis et al. (2004). Prav tako je študija Rahimi-Madiseh, Tavakol in Dennick (2010) skušala oceniti znanje in stališča študentov zdravstvene nege v Iranu o obvladovanju bolečine. Izvedli so presečno študijo, katere rezultati so pokazali, da je med študenti hudo pomanjkanje znanj o bolečini in upravljanju le te. Pokazalo se je, da obstaja potreba po izboljšanju učnega načrta, ki bi vseboval vsebine bolečine in njenem upravljanju, da bi v bodoče lahko izboljšali zagotavljanje optimalne zdravstvene nege pacientov. Horbury, Henderson in Bromley (2005) so opravili raziskavo, zaradi slabe udeležbe medicinskih sester na srečanjih, kjer so razpravljali o oceni bolečine in upravljanju. Znanje obstoječe prakse zdravstvene nege in spremljevalna prepričanja in odnosi v zvezi z bolečino so ključnega pomena pri razvoju ustreznih nadaljnjih izobraževanj diplomiranih medicinskih sester. Rezultati kažejo primanjkljaje v znanju glede optimalnega lajšanja bolečine. Cheuk-chi, Lui in Winnie (2012) so v študiji ugotovili, da se po izobraževanju intenzivnost bolečine znatno zmanjša, vendar statistično spremembe na kakovosti življenja ni bilo mogoče dokazati. Namen članka je poudariti potrebo po inovativnih učnih strategijah in pristopih v klinične okvire za povečanje osveščenosti medicinskih sester o pomanjkanju znanj o oceni in obvladovanju bolečine. Prav tako je študija Guardini et al. (2008) pokazala pomen izobraževanja v okviru 18. mesečnega izobraževanja sestavljenega iz predavanj, razprav in igranja vlog v tečaju »Bolnišnica brez bolečine«. Zaključek raziskave je bil, da se znanje postopoma izgubi, če ne potekajo izpopolnjevanja. Tsai et al. (2007) so v študiji ugotovili, da je največja ovira medicinskih sester upravljanje bolečine pri akutnih pacientih. Znanje o bolečini in upravljanje ima pozitiven odnos z obsegom klinične oskrbe in izkušnjami ter skupnim številom ur predhodnega izobraževanja za upravljanje bolečine. Rezultati kažejo, da je nujno potrebno okrepiti izobraževanje o bolečini.

ZAKLJUČEK

Če želimo izboljšati kakovost življenja in zmanjšati resnost bolečine pri pacientih, moramo pristopat individualno, pacientom priznavati razlike v izkušnjah z bolečino in pri tem ne zanemariti multidisciplinarnega pristopa. Nadaljnje raziskave je morda priporočljivo usmeriti v izobraževalne intervencije in v obstoječe programe izobraževanj ter strokovnih znanj zdravstvenih delavcev.

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MEASURING HEALTH-RELATED QUALITY OF LIFE IN MULTIPLE SCLEROSIS

MERJENJE Z ZDRAVJEM POVEZANE KAKOVOSTI ŽIVLJENJA PRI MULTIPLI SKLEROZI

DOMINIKA JAKL, MAJDA PAJNKIHAR

Izvleček

Izhodišča*: Merjenje z zdravjem povezane kakovosti življenja je pomemben element obravnave kroničnih bolezni kot je multipla skleroza. Merimo jo s splošnimi in specifičnimi vprašalniki. Slednji podajo bolj edinstvene in koristne informacije o posameznikovem dojemanju bolezni in zdravljenja, zato smo s pregledom literature želeli dobiti vpogled v njihov namen in uporabnost.*

Metode*: Pregled literature je bil izveden z deskriptivno metodo. Iskanje je potekalo marca 2013 v iskalnem sistemu PubMed in podatkovni zbirki EBSCOhost s pomočjo ključnih besed: quality of life, health-related quality of life, measurement, instruments, scale, multiple sclerosis. Iskanje je bilo omejeno na objave člankov v angleškem jeziku.*

Rezultati*: Pri pregledu literature je bilo najdenih 31 specifičnih vprašalnikov na temo z zdravjem povezane kakovosti življenja pri multipli sklerozi, namenjenih raziskovanju in praksi, obolelim in njihovim negovalcem.*

Diskusija in zaključek*: Vprašalniki se med seboj razlikujejo po obsegu, dimenzijah posameznikovega življenja, času izpolnjevanja, razlike so tudi v veljavnosti in zanesljivosti teh instrumentov. Zaradi nekaterih slabosti je njihova uporaba v praksi manjša, vseeno pa gre razmisliti o njihovi uporabi, saj lahko služijo tudi kot evalvacijsko orodje. Pred uporabo je vprašalnike potrebno ustrezno lokalizirati, opredeliti pa moramo tudi njihovo uporabno vrednost.*

Ključne besede*: merjenje, specifični vprašalniki, kronična bolezen*

Abstract

Introduction*: Measuring of health-related quality of life is an important component in chronic diseases treatment such as multiple sclerosis. There are generic and disease-specific measures. Disease-specific measures provide more unique, relevant and comprehensive information about impact of disease and treatment on the individual. With a literature review we try to examine their purpose and use.*

Methods*: We conducted a literature review using descriptive method. Data collection was carried out in March 2013 in PubMed and EBSCOhost using the search terms: quality of life, health-related quality of life, measurement, instruments, scale, and multiple sclerosis. The search was limited to relevant English articles.*

Results*: We identified 31 measures to assess health-related quality of life in people with multiple sclerosis and caregivers addressed either for research or use in practice.*

Discussion and conclusion*: Questionnaires differ in several ways, including different domains of life, the extent and time required for completion, reliability, and validity. The actual adoption of measures remains low in clinical practice due to their deficiencies. But still the use should be considered because instruments can also be used as evaluation tools. Questionnaires require adaptation called localization and determination of their value.*

Keywords*: measurement, disease-specific measures, chronic disease*

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IZHODIŠČA

Zdravje in bolezen pomembno vplivata na posameznikovo kakovost življenja, sam koncept pa opredeljujemo z zdravjem povezano kakovostjo življenja (health-related quality of life – HRQoL) (Masaaki, 2008). Zagotavljanje in s tem tudi merjenje HRQoL je pomembno predvsem pri obravnavi kroničnih boleznih (Drulović et al., 2007) kot na primer pri multipli sklerozi (MS). Pacientovo poročanje o kakovosti življenja nam prinaša bolj obširne informacije o tem, kako MS vpliva na posameznika, kot o tem pove število poslabšanj in stopnja telesne nezmogljivosti (Pluta-Fuerst et al., 2010).

Vendar je to subjektivno dojemanje različnih vplivov bolezni na življenje težko meriti, zato si pomagamo s standardizirani vprašalniki. Delimo jih na splošne in specifične. Splošni vprašalniki se nanašajo na kakovost življenja pacientov različnih kroničnih bolezni, medtem ko so specifični vprašalniki razviti za obravnavo določene kronične bolezni in zagotavljajo dodatne informacije (Kargiotis et al., 2010).

S pregledom literature smo želeli pregledati specifične vprašalnike HRQoL, ki jih je možno uporabiti pri obravnavi pacientov z MS. Članek bo medicinski sestri posredoval novo znanje in vpogled v njihov namen in uporabnost.

METODE

Pregled literature temelji na deskriptivni metodi. V iskalnem sistemu PubMed in podatkovni zbirki EBSCOhost je bilo izvedeno iskanje s ključnimi besedami

Tabela 1: Specifični vprašalniki merjenja z zdravjem povezane kakovosti življenja pri multipli sklerozi

Instrument	N	Čas	Dimenzije oziroma področja	Notranja konsistentnost	Zanesljivost pri prvem in ponovnem testiranju	Avtor
MSIS-29	29	15	fizična in psihološka dimenzija	0,91	0,87	Hobart et al., 2001
MSQoL-54	54	11-18	vpliv bolezni, splošno zadovoljstvo z življenjem, kognitivne funkcije, utrujenost, bolečina, spolna funkcija in socialna situacija	0,75-0,96	0,66-0,96	Vickrey et al., 1995
MSQLI	138	40	splošna vprašanja (SF-36), utrujenost, bolečina, spolna funkcija, delovanje mehurja, črevesja in vida, kognitivna, emocionalna in socialna funkcija	0,77-0,97	0,69; 0,90	Fischer et al., 1999
FAMS	59	20	simptomi, mobilnost, splošno zadovoljstvo, razmišljanje/ utrujenost, družinsko, emocionalno in socialno blagostanje	0,82-0,96	0,85-0,91	Cella et al., 1996
FILMS	25	12	utrujenost, bolečina, telesno delovanje, čustvena stiska, kognitivna funkcija	0,80-0,90	0,91	Wesson et al., 2009
MS HRQoL measurement for RMP	10	2-3	fizična in mentalna dimenzija ter dimenzija energije	0,70-0,83	0,82-0,91	Devy et al., 2013
PRIMUS	22	7-20	simptomatika, omejite pri aktivnostih in kakovost življenja	ni točnega podatka (visoka)	0,80	Doward et al., 2009

Legenda: N – število vprašanj, Čas – čas izpolnjevanja v minutah, MSIS-29 – Multiple Sclerosis Impact Scale (Lestvica vpliva posledic MS), MSQoL-54 – Multiple Sclerosis Quality of Life-54 Instrument (Vprašalnik kakovosti življenja pri MS), MSQLO – Multiple Sclerosis Quality of Life Inventory (Inventar kakovosti življenja pri MS), SF-36 – 36-Item Short Form Health Survey (Kratka oblika vprašalnika o zdravju s 36 postavkami) FAMS – Functional Assessment of Multiple Sclerosis (Instrument ocenjevanja funkcionalnih sposobnosti pri MS); FILMS – Functional Index for Living With Mutliple Sclerosis (Funkcionalni kazalnik življenja z MS); MS HRQoL measurement for RMP – Multiple sclerosis-specific health-related quality of life measurement for routine medical practice (Specifični vprašalnik HRQoL pri MS namenjen rutinski praksi), PRIMUS - Patient-Reported Outcome Indices for Multiple Sclerosis (Pacientovo poročanje izidov kazalcev MS)

v angleškem jeziku: quality of life, health-related quality of life, measurement, instruments, scale, multiple sclerosis in Booilovim logičnim operatorjem »AND«. Pregled literature je potekal marca 2013. Kriterij pri izboru literature je bila objava članka v angleškem jeziku, časovne omejitve nismo podali. Članki vključeni v podrobnejši pregled in analizo so se nanašali na merjenje HRQoL pri MS s specifičnim vprašalnikom.

REZULTATI

Pri pregledu literature je bilo najdenih 27 specifičnih vprašalnikov merjenja HRQoL pri MS za obolele in 4 za negovalce obolelih. V razpredelnici 1 so našteti le nekateri specifični vprašalniki HRQoL namenjeni obolelim za MS.

Najpogosteje uporabljen instrument za obolele je vprašalnik kakovosti življenja pri MS – Multiple Sclerosis Quality of Life Instrument (MSQoL-54). Sestavljen je iz splošnega vprašalnika SF-36 (36-Item Short Form Health Survey SF-36 – Kratka oblika vprašalnika o zdravju s 36 postavkami) in 18 specifičnih vprašanj, ki se nanašajo na MS. 54 vprašanj je razdeljenih v 12 lestvic (Vickrey et al., 1995). Vprašalnik je splošno sprejet in relativno zanesljiv, uporablja pa se pogosteje v raziskovalne namene (Bandari et al., 2010). Za izpolnitev vprašalnika naj bi oboleli za MS potrebovali slabih 20 minut (Vickrey et al., 1995), po nekaterih drugih podatkih pa kar 32 minut, kar je ena izmed slabosti vprašalnika, saj ga je v praksi težko uporabljati (Bandari et al., 2010).

Bolj rutinski uporabi v praksi sta namenjena Funkcionalni kazalnik življenja z MS – Functional Index for Living with Multiple Sclerosis (FILMS) (Wesson et al., 2009) in novejši specifični vprašalnik HRQoL pri MS (Devy et al., 2013). Čas izpolnjevanja obeh je zaradi manjšega obsega zelo kratek.
Specifični instrumenti namenjeni negovalcem pa so namenjeni merjenju HRQoL negovalcev (CAREQOL-MS) (Benito-Leon et al., 2011), nalog negovalcev (CTiMSS) (Pakenham, 2007), spoprijemanja negovalcev z MS (CMSCI) (Pakenham, 2002) in koristi negovanja obolelih za MS (BFiMSCare) (Pakenham, Cox, 2008).

DISKUSIJA

Multipla skleroza in njeno zdravljenje vplivata na različne vidike posameznikovega življenja. Različnih vplivov pa ni možno oceniti brez instrumentov HRQoL (Miller, Allen, 2010). Poznavanje HRQoL nam pomaga pri ocenjevanju poslabšanja stanja obolelih (Baumstarck et al., 2013), pri izbiri intervencij za izboljšanje kakovosti življenja (Heiskanen, Pietilä, 2009) in pri evalvaciji terapevtskih pristopov ter zdravljenja (Bandari et al., 2010; Baumstarck et al., 2013; Pluta-Fuerst et al., 2010).

Pregled literature je podal širok nabor obstoječih specifičnih vprašalnikov za merjenje HRQoL pri MS. Velika večina vprašalnikov je namenjena obolelim, nekaj pa tudi njihovim negovalcem, kar je razveseljivo, saj je znano, da ima lahko negovanje obolelih za MS negativne posledice za družino oziroma za tiste, ki skrbijo zanje (Alshubaili et al., 2008). Negovanje pa lahko tudi pozitivno učinkuje in na primer pripomore k bogatenju medsebojnih odnosov (Pakenham, Cox, 2008). Vprašalniki namenjeni obolelim za MS se med seboj razlikujejo po obsegu oziroma številu vprašanj, ki se nanašajo na različne dimenzije posameznikovega življenja, času, ki je potreben za izpolnjevanje, razlike so tudi v veljavnosti in zanesljivosti teh instrumentov ter nenazadnje tudi v namenu. Nekatere od teh razlik so prikazane v razpredelnici 1.

Vse zgoraj naštete elemente je potrebno upoštevati preden izberemo vprašalnik, ne glede na to ali ga bomo uporabili v raziskovalne namene ali ga želimo uporabljati v praksi. Vprašalnike je pred samo uporabo potrebno ustrezno prevesti ter raziskati njihovo uporabnost v različnih okoljih (Benito-Leon et al., 2003). Toda potrebna priredba ni zgolj prevod, temveč je pri tem potrebno upoštevati določena navodila. Lokalizacija vprašalnika po mnenju Lajovica (2008) zajema prevod, sintezo in prilagoditev v ciljnem jeziku, vzvratni prevod, primerjavo različic v izvirnem jeziku in prilagoditev v ciljnem jeziku, preverjanje razumljivosti, preverjanje zanesljivosti. Ne smemo pa pozabiti, da so vprašalniki zaščiteni tudi z avtorskimi pravicami, zato je za njegovo uporabo potrebno dovoljenje avtorjev.

Vendar je kljub zavedanju o pomembnosti merjenja HRQoL uporaba teh instrumentov v praksi majhna (Baumstarck et al., 2013; Miller, Allen, 2010; Wesson et al., 2009). Problem se pojavi predvsem pri izbiri ustreznega vprašalnika ter njegovi vpeljavi v prakso (Baumstarck et al., 2013; Benito-Leon et al., 2003). Vprašalniki imajo različne pomanjkljivosti: obdelava dobljenih podatkov zahteva čas in znanje, vprašalniki so večinoma namenjeni primerjavi kakovosti življenja in ne spremljanju skozi čas, tu so še stroški izvedbe, vprašanje koristnosti dobljenih podatkov za zdravljenje ter obseg vprašalnikov (Baumstarck et al., 2013; Wesson et al., 2009). Pri tem je potrebno upoštevati, da so obsežnejši vprašalniki uporabnejši za raziskovalce, med tem ko zdravstveni delavci v praksi potrebujejo krajše vprašalnike, ki so enostavnejši tudi za interpretacijo (Benito-Leon et al., 2003). Dolžina vprašalnika pa vsekakor vpliva tudi na odzivnost obolelih, ko gre za izpolnjevanje vprašalnika. Ko spremljamo spremembe HRQoL skozi čas je potrebno

upoštevati, ali so razlike posledica dejanskih sprememb ali pa gre le za prilagoditev novemu spremenjenemu načinu življenja (Baumstarck et al., 2013). Večina vprašalnikov je namenjena samoizpolnjevanju. Zato je pri vprašalnikih potrebno upoštevati morebitne funkcionalne, vizualne in kognitivne težave, ki lahko nastopijo pri izpolnjevanju. Baumstarck et al. (2013) ugotavljajo, da je pri kognitivnih motnjah še posebej pomembno, da izberemo vprašalnik, ki bo zagotavljal primeren pristop. Vsi pa tudi niso sposobni samostojno izpolniti vprašalnikov. Velika večina vprašalnikov je po mnenju Gruenewald et al. (2004) namenjenih manj prizadetim posameznikom.

Zelo verjetno je tudi, da z uporabo enega samega vprašalnika ne bomo dobili vseh potrebnih odgovorov o dejavnikih oziroma dimenzijah, ki vplivajo na HRQoL (Benito-Leon et al., 2003; Jesenšek-Papež, 2012). Ocenjevanju HRQoL v praksi bi morale slediti tudi intervencije za izboljšanje stanja, kar pa žal ni vedno tako (Baumstarck et al., 2013), zato bodo po mnenju Bandari et al. (2010) potrebne nadaljnje izboljšave obstoječih vprašalnikov ter razvoj poenostavljenih vprašalnikov.

Ne glede na nekatere pomanjkljivosti pa so vprašalniki zelo uporabni na področju rehabilitacije (Miller, Allen, 2010), merjenje HRQoL pri MS pa je pomembno tudi pri ugotavljanju vplivov in učinkov zdravil na posameznika (Rudick, Miller, 2008).

ZAKLJUČEK

HRQoL pri MS lahko merimo z različnimi vprašalniki. Pred uporabo je potrebno izbrati ustrezen vprašalnik glede na naš namen in ga ustrezno prirediti in prilagoditi. Pri tem se moramo zavedati njihovih prednostih in slabostih ter oboje tudi upoštevati pri interpretaciji rezultatov. Ko jih uporabimo v praksi, je potrebno razmisliti, kako bi HRQoL obolelega izboljšali. Vsekakor pa bi tudi pri nas bilo smiselno preizkusiti uporabnost vsaj nekaterih obstoječih vprašalnikov bodisi v raziskovalne namene ali za uporabo v praksi.

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WHO IN THE FAMILY MAKES THE DECISION ABOUT NURSING HOME ACCOMMODATION?

KDO V DRUŽINI SPREJME ODLOČITEV ZA ODHOD STAROSTNIKA V DOMSKO VARSTVO?

ANA HABJANIČ

Izvleček

Izhodišča*: Odhod starostnika v domsko varstvo predstavlja za celotno družino veliko preizkušnjo. Cilj raziskave je predstavljal ugotoviti kdo v družinskem krogu sprejme odločitev za odhod starostnika v domsko varstvo.*

Metode*: Leta 2010 so bili izvedeni nestrukturirani intervjuji. V raziskavi so sodelovali stanovalci v domu starejšim občanov in družinski člani, ki svojce v domu starejšim občanov obiskujejo. Podatki so bili predstavljeni opisno po temah in s statistično analizo.*

Rezultati*: Pokazalo se je, da za odhod starostnika v domsko varstvo pretežno odločijo družinski člani (v 51 %), tudi stanovalci so v številnih primerih sprejeli odločitev sami zase (v 31 %). Sporazumna odločitev med vsemi deležniki je bila sprejeta le v 11 %.*

Diskusija in zaključek: *Obstoječa raziskava je pokazala, da odhod v domsko varstvo ne pomeni izobčenja starostnika iz družinskega kroga s strani preostalih družinskih članov, pogosto je bila odločitev dobro načrtovana in premišljena kar s strani starostnikov.*

Ključne besede*: starejši, oskrba starostnika, družinski člani*

Abstract

Introduction*: Decision about nursing home accommodation represents in majority of cases difficult decision for both, the frail older people and their family members. The aim of this research was to investigate who in the family made the decision about nursing home accommodation of frail older people.*

Methods*: A qualitative research design that involved individual unstructured interviews was used in 2010. Participants were fifty nursing home residents and fifty family members. Data was presented by thematic and statistical analysis.*

Results*: Majority of respondents reported that family members decided about nursing home placement individually (51%). Residents made this decision on their own in 31% of cases. Mutual agreement was reported less (11%).*

Discussion and conclusion*: Present research provided insight that decision about nursing home accommodation does not represent banishment of older people by their family members. Older people had on many occasions carefully considered all options and decided on their own.*

Keywords*: older people, elder care, family members*

INTRODUCTION

Decision about nursing home accommodation represents in majority of cases difficult decision for both, the frail older people and their family members. Much of the literature to date acknowledges that persons moving into nursing home experience a major life change which highlights the physical and psychosocial problems they experience during this process (Huppert et al., 2000). Literature discussing the decisions about nursing home accommodation is very scarce; literature search provided no reference. Past research primarily exposed reasons why nursing home accommodation was not perceived as welcomed in the family; for example due negative health outcomes such as depression, malnutrition and also precipitated mortality (Schur, Whitlatch, 2003; Sherwood et al., 2005). On the other hand, frail older people who live in home environment are in bigger danger to harm themselves (e.g. falls, improper medication use) and therefore contribute to negative health outcomes on

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their own (Buhr, Kuchibhatla, Clipp, 2006; Lord, Menz, Sherrington, 2006).

Frail older people and their families are also insecure about nursing home accommodation as past research provided some negative aspects about quality of life and quality of care in nursing homes. For example, Tuckett (2007) described nursing home placement as waiting to go up to St. Peter, nursing staff was found overloaded with tasks, starved of time with little engagement with the residents. Additional research involved twenty-seven residents of a nursing home facility who were observed for 13h each. At 5-min intervals, location, position, mood, and activity were recorded. Residents spent 65% of their time doing little or nothing, and 12% of their time in social activities. They spent the majority of their time in their rooms, sitting and alone. Although nursing home involved had a high standard of care and a creative activities department, residents still spent a great portion of their days inactive, immobile, and alone (Harper Ice, 2002).

A main objective of nursing homes is to make the residents' lives as good as possible in spite of their health problems, reduced level of functioning and extensive dependency (Bergland, Kirkevold, 2006). The expected level of quality, as defined by general policy, has not been always been met due staff shortage, prescribed health care routines and regulations, negative stereotypes of older people etc. (Teeri et al., 2007). Conditions in Slovenia were reported similar, nursing staff is overwhelmed by care activities and is always in a hurry; time for conversation and leisure activities is scarce (Mali, 2006). Owing to the lack of staff and according to unofficial data, the duration of care provision in the morning is set at 3–10 minutes per resident.

To research who in the family made decision about nursing home accommodation of frail older people. The strategy was twofold, first residents were asked to describe who was responsible for their accommodation, in the second part close family members were asked the same question.

METHODS

A qualitative research design that involved individual unstructured interviews was used in 2010. Participants were fifty nursing home residents and fifty family members. Close family member was defined as wife, husband, daughter, son or other important person.

Residents were asked: "Who was responsible for your accommodation to nursing home?" and family members "Who was responsible for nursing home accommodation of your older family member."

Five Slovenian nursing homes were included in the study. Nursing homes residents were selected randomly, resident living in dementia department were excluded from random sampling. In each nursing home 10 residents were included in the research. Approval for the study was obtained locally from the ethics committee of each nursing home. Family members were also selected 10 from each nursing home. Nursing staff identified a pool of frequent visitors and frequent visitors from this pool who made the first visit starting from Monday, 7th of June 2010, between noon and 3:00 PM, were selected for the interview. Since interview theme was not very delicate all participants agreed to cooperate in the research. Residents and family members were not related or were related only by coincidence. Participation in the research was anonymous and we did not collect any names.

RESULTS

The sample of family members included 32 (64%) women and 18 (36%) men. In relationship to the resident, the majority were daughters (36%), followed by sons (20%) and wives (8%). Their mean age was 59.1 (SD 13.8) years. The sample of residents included 35 (70%) of women and 15 (30%) men. Their mean age was 79.3 (SD 7.6) years.

Results in table 1 show that majority of respondents in both groups described that family members decided about nursing home placement on their own. Residents

Table 1: Decision about nursing home accommodation from residents and family members' point of view

	Residents (n=50)	Family members (n=50)	Total (n=100)
Resident	17 (34.0%)	14 (28.0%)	31 (31.0%)
Family consent	4 (8.0%)	7 (14.0%)	11 (11.0%)
Family members	26 (52.0%)	25 (50.0%)	51 (51.0%)
Medical doctor	3 (6.0%)	4 (8.0%)	7 (7.0%)

Chi-square=1.271 p=0.736

made this decision in approximately 30 % of cases. Statistical comparison provided no difference in description between groups of respondents (residents vs. family members).

Majority of respondents also described the reasons that led to nursing home accommodation. Surprisingly, this was not always acute or sudden illness. For example, a male resident described that he lived alone and when he realized that he has difficulties in household he decided to move to nursing home. A female resident described that as she had some health problems before retirement she started to visit and inspect nursing homes in vicinity of her home. When she found suitable location she immediately applied for accommodation; her application was prolonged a couple of times, before she decided to move in. Another female resident described that she lived alone in her house; she had a daughter with children who meanwhile also started to build own families. Therefore she decided to move to nursing home and provided living place for her younger family members. When the decision about nursing home accommodation was made by family members, residents in majority described, that their health worsened and family members could not look after them and decided for admission.

Family members who described that their loved ones made the decision on their own were seldom able to described exact motivation behind this decision. A son explained that because family house had stairs, father got afraid of falls and made decision about nursing home accommodation. A daughter described that because her mother felt unsafe at home and had suitable pension she decided to move to nursing home. Some family members described that they do not know exact reasons, but they presumed that some of their loved ones made this decision due loneliness, as they got widowed. Family members who decided on their own described that decision had to be made due sudden illness, falls or state of advanced dementia. They also explained that eventually their loved ones got used to life in nursing home; prolonged problems were described in two cases. A daughter described that her mother fled a couple of times and returned to home. Another daughter described that her father could not accept his dependence in activities of daily living and was very depressed for a long period of time.

DISCUSSION

The present study showed that in majority of cases family members decided about nursing accommodation of frail older people. In many cases frail older people decided on their own. The research strategy to include both views was to improve reliability of the results. I was of opinion that residents may took some responsibility from their family members about nursing home accommodation, while on the other hand, family members may have reduce their responsibility towards the family consent or towards medical doctor. Since results of present study provided only minor insignificant differences in descriptions between both groups of respondents, above stated concerns were not addressed.

Results of present study showed that several older people made consideration how they will cope in advanced age. They made their own inquiries about nursing home life and quality of care, by making visits to location and surroundings, by talking to residents and even by inspecting the restaurant's meals etc. This group of older people was of opinion that it is better to move to nursing home early, in reasonable health condition, to get used to life in nursing home and find ways how to contribute to an experience of thriving, as was also suggested by Bergland and Kirkevold (2006). Yet majority of the residents were accommodated to nursing home after emerged health problems, family members got afraid and immediately decided that their loved ones are not safe in home environment any more. If the move did not result from their own choice and decision it is important that the institutionalized elder must be able to make sense of and give meaning to this major life change (Lagacé et al., 2012).

Family consent was reported very seldom, in approximately 10% of cases. This may suggest that nursing home accommodation remains a theme difficult to approach to. Results in present research show quite obvious picture where family members are waiting what their loved ones will do and are afraid to talk about this issue in a sense that loved ones may misunderstood their intensions. It seems that historic perceptions about nursing home remain persistent which was also reported in the literature (Bauer, Nay, 2003). Due rising costs of nursing home operations and lower pensions nursing home accommodation started to represent a financial burden too, this will presumably force many families to discuss what is best for their loved ones, entire family and how to finance elder care.

CONCLUSION

The present research provided overview on decision about nursing home accommodation, which was primarily made by family members. Their decision depended upon health problems (e.g. stroke, advanced dementia) and falls in home environment. In nearly

a third of the cases, the decision was made by older people on their own. We also found that both groups of respondents (residents and family members) provided similar picture about accommodation responsibility, which makes present results more reliable. Current results also provided insight that decision about nursing home accommodation does not represent banishment of older people by their family members. Older people had on many occasions carefully considered all options and decided on their own.

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THE IMPORTANCE OF HOSPITAL TEXTILES HYGIENE FOR HEALTH

POMEN HIGIENE BOLNIŠNIČNIH TEKSTILIJ ZA ZDRAVJE

SABINA FIJAN, SONJA ŠOSTAR TURK

Izvleček

Izhodišča: *Bolnišnične tekstilije lahko vsebujejo različne mikroorganizme, od fekalnih mikroorganizmov iz posteljnine do različnih vrst patogenih in potencialno bakterij, gliv in virusov na tekstilijah iz različnih oddelkov bolnišnic. Zato se v bolnišničnih pralnicah ne moremo izogniti obstoju mikroorganizmov v nečistem delu. Ker so uporabniki bolnišničnih tekstilij običajno bolniki s šibkim imunskim sistemom, jih moramo zaščititi pred okužbami iz slabo opranih tekstilij, zato oprane bolnišnične tekstilij ne smejo vsebovati povzročiteljev bolezni.*

Metode: *V raziskavi smo v treh pralnicah bolnišničnih tekstilij izvedli sanitarno-mikrobiološko preiskavo na različnih kontrolnih točkah v čistem delu pralnice in rezultate primerjali s tolerančnimi vrednostmi za bolnišnične tekstilije, ki jih je izdal RAL, nemški inštitut za zagotavljanje kakovosti in izdajanje certifikatov, in temeljijo na predpisih Robert-Koch inštituta iz Nemčije. Pri tem smo določili razkuževalni učinek postopkov pranja z uporabo standardnih bioindikatorjev in vzeli odtise zlikanih in zloženih bolnišničnih tekstilij z RODAC agar ploščami.*

Rezultati: *Kemijsko-termični razkuževalni učinek postopkov pranja smo potrdili le v eni pralnici. Na odtisih zlikanih in zloženih bolnišničnih tekstilij smo našli naslednje microorganizme: Enterococcus spp., Bacillus spp., Corynebacterium spp., koagulazno negativne stafilokoke, saprofitne Gram negativne bacile, plesni.*

Diskusija in zaključki: *Iz rezultatov je razvidno, da je le ena bolnišnična pralnica dosegla zahtevano stopnjo higiene tekstilij. Doseganje primerne stopnje higiene bolnišničnih tekstilij odvisno od razkuževalnega učinka postopka pranja in od rednih ukrepov čiščenja in razkuževanja vseh površin, prostorov in tehnične opreme v bolnišnični pralnici, ki pridejo v stik z opranimi tekstilijami in rednega izobraževanja osebja o pravilni higieni rok pri vzdrževanju higiene v bolnišnični pralnici.*

Ključne besede: *zagotavljanje higiene, pralnice, razkuževanje, tekstilije*

Abstract

Introduction: *Hospital textiles may contain various microorganisms, from faecal microorganisms on bedding textiles to various pathogenic and potentially pathogenic bacteria, fungi or viruses on textiles from various hospital departments. Therefore we cannot avoid the presence of microorganisms in the unclean area of hospital laundries. Since the users of hospital textiles are usually patients with weak immune system, they must be protected from infections from poorly laundered hospital textiles; therefore laundered hospital textiles must not contain pathogens.*

Methods: *In this research we conducted a sanitary-microbiological research on various control points in the clean area of three hospital laundries and compared the results to the tolerance values for hospital textiles published by RAL the German Institute for quality assurance and quality marks. The disinfection effect of the laundering procedures was determined using standard bioindicators and surface sampling of ironed and folded hospital textiles was conducted using RODAC agar plates.*

Results: *The chemo-thermal disinfection effect of the laundering procedures was confirmed in only one laundry. Surface sampling of ironed and folded hospital textiles yielded the following microorganisms: Enterococcus spp., Bacillus spp., Corynebacterium spp., coagulase negative staphylococci, saprophytic Gram negative bacilli, fungi.*

Discussion and conclusion: *From the results it is obvious that only one hospital laundry reached the required level of textile hygiene. Achieving the appropriate hygiene level of hospital textiles depends on the disinfection effect of the laundering procedure and on regular cleaning and disinfection measures of all surfaces, areas and technical equipment in the clean area of the hospital laundry that come into contact with laundered textiles as well as regular education of personnel on proper hand hygiene in maintain hygiene in the hospital laundry.*

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Keywords: *hygiene assurance, laundry, disinfection, textiles*

IZHODIŠČA

Za bolnišnične tekstilije je pomembno, da ima postopek pranja razkuževalni učinek, predvsem pri pranju bolnišničnih tekstilij, saj lahko vsebujejo veliko vrst patogenih bakterij, gliv in virusov (Fijan, 2003). Prav tako je v bolnišnični pralnici pomembna splošna higiena, da ne pride do rekontaminacije opranih tekstilij z mikroorganizmi pri procesu nadaljnje obdelave tekstilij, ki vključuje sortiranje, likanje, zlaganje in pakiranje tekstilij. Uporabniki bolnišničnih tekstilij so običajno bolniki s šibkim imunskim sistemom in jih moramo zaščititi pred okužbami iz slabo opranih tekstilij, zato oprane bolnišnične ne smejo vsebovati povzročiteljev bolezni (Fijan, Šostar Turk, Cencič, 2006). Večina ljudi predvideva, da so oprane tekstilije čiste in zato varne. Čeprav je morda res umazanija odstranjena, ni nujno, da so tekstilije razkužene. Vedno več je tudi izsledkov, da v bolnišnicah prihaja do izbruhov okužbe brez očitnega vzroka (Orr et al., 2002) in v takšnih primerih, je pomembno ovrednotiti pravilnost postopka nege tekstilij. Za zagotavljanje ustrezne stopnje higiene opranih bolnišničnih tekstilij je RAL, nemški inštitut za zagotavljanje kakovosti in izdajanje Certifikatov izdal Navodila za zagotavljanje kakovostne nege tekstilij RAL-GZ 992 (Sachgemäße Wäschpflege, Gütesicherung RAL-GZ 992, 2004), ki veljajo v državah evropske unije kot pomembna priporočila (Šostar Turk, Fijan, 2003). V okviru teh priporočil so pomembne redne eksterne kontrole v bolnišničnih pralnicah, pri čemer se preveri razkuževalni učinek postopkov pranja bolnišničnih tekstilij in splošna higiene v pralnicah na različnih izbranih kontrolnih točkah podanih (tabela 1).

Pri tem so:

- mejne vrednosti po uradnih uredbah definirane vrednosti (Robert Koch Inštitut (RKI), Nemčija),
- priporočene vrednosti pomembne vrednosti, ki niso uradno določene,
- orientacijske vrednosti namenjene kot informacija vodstvu pralnice.

Najpomembnejša kontrolna točka je kemijsko-termična razkuževalna učinkovitost postopka pranja. Doseganje ustreznega razkuževalnega učinka pranja je zelo kompleksen proces, ki vključuje primerno sestavo in doziranje pralnih sredstev, razkuževalnih sredstev, neoporečno tehnično vodo, zadostno temperaturo kopeli, ustrezno mehaniko pranja, kopelno razmerje, polnilno razmerje in čas trajanja procesa. Posledica ekonomizacije postopkov pranja je znižanje temperature, časa, energije, količine pralnih in razkuževalnih sredstev in vode, kar povečuje tveganje, da mikroorganizmi, ki vstopajo v postopek pranja na umazanih tekstilijah, preživijo. Ostale kontrolne točke v bolnišnični pralnici so površine, ki pridejo s stik z opranimi tekstilijami pri nadaljnji obdelavi tekstilij (sortiranje, likanje, zlaganje, pakiranje) in jih je zato treba nadzorovati ter redno čistiti in razkuževati. V tej raziskavi smo v treh izbranih pralnicah bolnišničnih tekstilij ovrednotili sanitarno-mikrobiološke preiskave opranih tekstilij na nekaterih izbranih kontrolnih točkah in rezultate primerjali s priporočili RAL-GZ 992. Pri tem smo najprej ovrednotili razkuževalni učinek pranja, saj je le-ta osnovni pogoj za razkužene oprane tekstilije in nato ovrednotili sanitarno-mikrobiološko preiskavo tekstilij pred in po ožemanju, vlažnih tekstilij in zlikanih, zloženih tekstilij.

Tabela 1. Tolerančne meje kontrole higiene tekstilij po RAL-GZ 992/2 na kritičnih kontrolnih točkah

MEJNE VREDNOSTI		PRIPOROČENE VREDNOSTI	
Odtisi zlikanih in zloženih tekstilij**	9 od 10 vzorcev ne sme vsebovati več kot 20 cfu/dm^2	Vlažne tekstilije	< 30 cfu/dm^2
Razkuževalni učinek postopka pranja	Indikatorski mikroorganizmi ne smejo preživeti	Voda za pranje pred mehčanjem	< 100 cfu/mL
ORIENTACIJSKE VREDNOSTI		Voda po mehčanju	< 100 cfu/mL
Tehnična oprema	< 100 cfu/dm^2	Voda po predpranju	< 1000 cfu/mL
Higiena rok	< 100 cfu/dm^2	Voda po izpiranju	< 100 cfu/mL

* cfu (colony forming units) je število vseh nastalih kolonij mikroorganizmov (bakterije, glive).
** Na odtisih zlikanih, zloženih tekstilij ne smejo biti prisotni patogeni in potencialno patogeni mikroorganizmi, kot so: Escherichia coli, Enterobacter cloaque itd.

METODE

Postopki pranja

V treh bolnišničnih pralnicah smo izbrali po en postopek pranja za ugotavljanje razkuževalnega učinka pranja (tabela 2). Vsi postopki pranja so potekali v industrijskih pralnih linijah.

Določanje razkuževalnega učinka pranja

Za določanje razkuževalnega učinka izbranih postopkov pranja smo kot standardne bioindikatorske mikroorganizme izbrali *Enterococcus faecium* (ATCC 6057) in *Staphylococcus aureus* ATCC 6538 inokuliranih z defibrinogenirano ovčjo krvjo (Borneff-Lipp et al., 1998; Liste der von Robert-Koch-Institut geprüften und anerkannten Desinfektions-mittel und- verfahren Chemotermische Wäschedesinfektion, 2007). Glede na predpise Robert-Koch Inštituta je za baktericidni učinek razkuževanja potrebno zmanjšanje za 7 logaritemskih stopenj. Bioindikatorje v suspenziji ovčje krvi smo inokulirali na tekstilne krpice s površino 1 cm^2 s koncentracijo mikroorganizmov 10^7 cfu/mL in jih vstavili v postopek pranja. Nato smo ugotavljali njihovo preživetje po standardnih metodah (Fijan, Šostar Turk, Cencič, 2005).

Sanitarno-mikrobiološka preiskava higiene opranih tekstilij

Za ugotavljanje sanitarno-mikrobiološke preiskave higiene opranih tekstilij smo odvzeli odtise s ploščicami z RODAC agarjem (BioMérieux, 43501). Po inkubacijski dobi 48 h pri 37°C smo prešteli število nastalih kolonij (cfu) in izvedli njihovo identifikacijo po standardnih mikrobioloških metodah (Terpstra et al., 2003).

REZULTATI

Razkuževalni učinek izbranih postopkov pranja

Rezultati razkuževalnega učinka izbranih postopkov pranja v treh pralnicah po podani v tabeli 3. Rezultati kažejo, da ni bilo rasti bioindikatorjev po postopkih pranja le v pralnici B. V pralnici C je preživel *Enterococcus faecium*, v pralnici A pa celo oba izbrana bioindikatorja.

Tabela 3: Ugotavljanje razkuževalnega učinka postopkov pranja

Postopek pranja	Rast bioindikatorjev	
	S. aureus, ATCC 6538	*E. faecium*, ATCC 6057
A	+	+
B	–	–
C	–	+

Odtisi zlikanih in zloženih tekstilij

Tabela 4 prikazuje rezultate vzorčenja odtisi zlikanih in zloženih tekstilij. Razvidno je, da je bilo število mikroorganizmov na odtisih zlikanih in zloženih tekstilijah v dovoljenem območju mejnih vrednosti po RAL-GZ 992/2 samo v pralnici B. V pralnicah A in C pa je bila mejna vrednost presežena na dveh od desetih vzorcev. V pralnici A smo našli tudi predstavnika rodu *Enterococcus* spp., ki je pokazatelj fekalne kontaminacije, saj spada med del normalne črevesne flore vretenčarjev, in plesni.

Tabela 2: Postopki pranja s pogoji razkuževanja

Pralnica	Program	Postopek razkuževanja		
		Čas	Temperatura	Razkuževalno sredstvo
A	Bolnišnično posteljno perilo	3,33 min	70 °C	6,5 mL# / kg vode
B	Bolnišnično posteljno perilo	8,40 min	60 °C	2,5 mL# / kg vode
C	Bolnišnično posteljno perilo	4 min	70 °C	4,0 mL# / kg vode

* Razkuževalno sredstvo vsebuje približno 30 % raztopino vodikovega peroksida in peroksiocetne kisline (komercialna imena smo izpustili zaradi ohranitve tajnosti pralnic in zagotavljanja nepristranskosti raziskave),
# Razkuževalno sredstvo vsebuje približno 30 % raztopino vodikovega peroksida.

Tabela 4: Sanitarno mikrobiološke preiskave zlikanih, zloženih tekstilij

Pralnica	Mesto odvzema		cfu/dm^2	Prisotni mikroorganizmi
A	1	Valjčna likalna naprava	0	0
	2	Valjčna likalna naprava	8	*Corynebacterium* spp.
	3	Valjčna likalna naprava	16	*Corynebacterium* spp.
	4	Valjčna likalna naprava	28	*Bacillus spp*.
	5	Likalna preša ali finišer	24	*Corynebacterium* spp.
	6	Likalna preša ali finišer	4	Saprofitni Gram neg. bacili
	7	Likalna preša ali finišer	4	Saprofitni Gram neg. bacili
	8	Likalna preša ali finišer	4	Saprofitni Gram neg. bacili
	9	Spodnja stran frotirke	12	Saprofitni Gram neg. bacili, *Enterococcus* spp.
	10	Zgornja stran frotirke	4	plesni
B	1	Valjčna likalna naprava	0	0
	2	Valjčna likalna naprava	0	0
	3	Valjčna likalna naprava	24	*Corynebacterium* spp.
	4	Valjčna likalna naprava	0	0
	5	Likalna preša ali finišer	0	0
	6	Likalna preša ali finišer	0	0
	7	Likalna preša ali finišer	4	Koagulazno neg. stafilokoki
	8	Likalna preša ali finišer	0	0
	9	Spodnja stran frotirke	0	0
	10	Zgornja stran frotirke	0	0
C	1	Valjčna likalna naprava	0	0
	2	Valjčna likalna naprava	12	Koagulazno neg. stafilokoki
	3	Valjčna likalna naprava	8	Koagulazno neg. stafilokoki
	4	Valjčna likalna naprava	40	*Bacillus* spp.
	5	Likalna preša ali finišer	88	Koagulazno neg. stafilokoki
	6	Likalna preša ali finišer	0	0
	7	Likalna preša ali finišer	0	0
	8	Likalna preša ali finišer	4	*Bacillus* spp.
	9	Spodnja stran frotirke	4	*Corynebacterium* spp.
	10	Zgornja stran frotirke	16	*Corynebacterium* spp.

DISKUSIJA

Razkuževalni učinek pranja predstavlja mejno vrednost po RAL-GZ 992 za bolnišnične tekstilije pri čemer se mora znižati število mikroorganizmov za vsaj 7 logaritemskih stopenj. Ker smo pripravili bioindikatorje s koncentracijo 10^7 cfu/mL, ni smelo biti po postopku pranja nobene rasti bakterij. Glede na podatke o postopkih pranja bolnišničnih tekstilij in rezultatih preverjanja razkuževalnega učinka teh postopkov pranja (tab. 2in 3.) je razvidno, da je le postopek pranja v pralnici B imel ustrezen kemijsko-termični razkuževalni učinek zaradi kombinacije temperature in uporabe belilnih in razkuževalnih sredstev (vodikov peroksid, peroksiocetna kislina). Po drugi strani pa je razvidno, da je bioindikatorska bakterija *Enterococcus faecium*, ki je očitno bolj termična in kemijsko tolerantna od obeh izbranih bioindikatorjev, preživela preverjena postopka pranja v pralnicah A in C. Bioindikatorska bakterija *Staphylococcus aureus,* temperaturno občutljiva mezofilna bakterija, ki jo najdemo na koži in v mukoznih membranah toplokrvnih sesalcev, pa je preživela preverjen postopek pranja v pralnici A. Čeprav je bila temperatura pranja 70 °C, je očitno, da je bil čas razkuževanja prekratek oziroma je bila uporabljena premajhna količina razkuževalnih sredstev za učinkovito razkuževanje.

Tudi odtisi zlikanih in zloženih tekstilij predstavljajo mejno vrednost po RAL-GZ 992. Po kriterijih RAL-GZ 992/2 za tekstilije iz bolnišnic ne sme biti na devetih od

desetih odtisov več kot 20 cfu/dm^2. Pri tem ne smejo biti prisotni nobeni patogeni ali potencialno patogeni mikroorganizmi. 2/3 odtisov odvzamemo pri živih, kjer je večja vlažnost in večja verjetnost, da bodo nastali mikroorganizmi. Tabela 4 prikazuje rezultate vzorčenja odtisi zlikanih in zloženih tekstilij. Razvidno je, da je bilo število mikroorganizmov na odtisih zlikanih in zloženih tekstilijah v dovoljenem območju mejnih vrednosti po RAL-GZ 992/2 samo v pralnici B. V pralnicah A in C pa je bila mejna vrednost presežena na dveh od desetih vzorcev. Na teh odtisih smo našli naslednje vrste nepatogenih mikroorganizmov: saprofitne Gram negativne bacile, koagulazno negativne stafilokoke (tipični mikroorganizmi kože), *Corynebacterium spp*. (tipični mikroorganizmi kože), *Bacillus* spp. (ubikvitarni mikroorganizem, ki je kot sporogeni Gram pozitivni bacil prvi indikator neustrezne higiene v pralnici). Podobne zaključke so podali tudi drugi avtorji (Neely et al., 2000; Neely, 2000; Nordstrom et al., 2012). Vsi ti mikroorganizmi so bolj ali manj neškodljivi za človeka, vendar je zaradi higieničnih zahtev pralnice nujno, da pralnice zmanjšajo njihovo število. V pralnici A smo našli tudi predstavnika rodu *Enterococcus* spp., ki je pokazatelj fekalne kontaminacije, saj spada med del normalne črevesne flore vretenčarjev in plesni. Iz rezultatov v pralnici B pa je razvidno, da je mogoče doseči mejno vrednost po RAL-GZ 992 na zlikanih in zloženih tekstilijah v vseh pralnicah z rednim čiščenjem in razkuževanjem površin ter s primerno ločitvijo med čistim in nečistim delom.

ZAKLJUČEK

Doseganje ustrezne higiene tekstilij v bolnišnični pralnici je v prvi vrsti odvisno od razkuževalnega učinka postopka pranja, saj se v primeru neustreznega razkuževalnega učinka pranja mikroorganizmi razširijo v čisti del pralnice. V pralnicah smo našli tipične mikroorganizme kože ter saprofitne Gram negativne bacile. Njihova prisotnost v velikem številu kaže na pomanjkanje higiene rok delavcev, visoko kontaminacijo zraka, neprimerno prostorsko ločitev med nečistim in čistim delom itd. Našli smo tudi potencialno patogene bakterije iz rodu *Enterococcus* spp. Pravilni sanacijski ukrepi v pralnicah obsegajo redno čiščenje in razkuževanje vseh površin, prostorov, tehnične opreme, skladiščnih polic itd., redno izobraževanje osebja o pravilni higieni rok pri vzdrževanju higiene v pralnici, omejitev stika delavcev z opranimi tekstilijami na potreben minimalni in skrajšanje časa čakanja med zlaganjem in pakiranjem zlikanih tekstilij, da ne pride do posedanja mikroorganizmov iz zraka.

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AMBROSIA, HARMFUL TO HEALTH

ŠKODLJIVOST AMBROZIJE ZA ZDRAVJE

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Izvleček

Izhodišča*: Ambrozija se je v zadnjih letih zelo razširila tako v svetu, kot tudi v Sloveniji, prav tako se je povečalo število ljudi alergičnih na ambrozijo. Namen raziskave je bil ugotoviti osveščenost lastnikov kmetijskih zemljišč o ambroziji in ali se je povečalo število ljudi alergičnih na ambrozijo na območju Ptuja.*

Metode*: Podatke smo zbrali s pomočjo strukturiranega anketnega vprašalnika, ki je bil sestavljen iz 12 vprašanj zaprtega tipa in 4 vprašanj odprtega tipa. Raziskovalni vzorec je zajemal 30 lastnikov kmetijskih zemljišč na območju Ptuja. Prav tako smo pridobili podatke od Službe zdravstvenega varstva pljučnih bolnikov Ptuj.*

Rezultati*: Ugotovili smo, da se je število alergikov na ambrozijo na območju Ptuja od leta 2009 do 2012 povečevalo in v letu 2012 doseglo največje število. Prav tako smo ugotovili, da lastniki kmetijskih zemljišč prepoznajo ambrozijo in jo tudi zatirajo, kljub temu, da večina ne ve, da je le-to tudi zakonsko predpisano.*

Diskusija in zaključki*: Čeprav se vedno več govori o ambroziji tudi v medijih, ljudje naredimo zelo malo oziroma skoraj nič za njeno pravilno zatiranje. Verjetno tudi vsi niso dovolj poučeni o tem, kako ambrozija zgleda in kako jo pravilno in varno zatirati. Tako kot se širi ambrozija na območju Ptuja, se povečuje tudi število ljudi alergičnih nanjo.*

Ključne besede*: ambrozija, alergija, okolje, zdravje, zakonodaja*

Abstract

Background*: Ambrosia has in recent years greatly expanded in the world, as well as in Slovenia. Everywhere also increased the number of people allergic to ragweed. The purpose of this study was to determine the awareness of owners of agricultural land of ambrosia: and whether the number of people allergic to ragweed in the area of Ptuj.*

Methods*: Data were collected by using a structured questionnaire, which consisted of 12 closed type questions and four open-ended questions. The research sample consisted of 30 owners of agricultural land in the area of Ptuj. We also obtained information from the Health Service Pulmonary patients Ptuj.*

Results*: We found that the number of people with allergies to ragweed in the Ptuj area from 2009 to 2012 increased and in 2012 reached the maximum number. We also found that the owners of agricultural land identified ragweed and even suppressed, despite the fact that most do not know that it is also required by law.*

Discussion and conclusions*: Although more and more talk about ragweed in the media, people make very little or almost nothing for the proper control. Probably all of them not taught enough about how ragweed looks like and how too properly and safely controlled. Like the spread of ragweed Ptuj area is also increasing numbers of people are allergic to it.*

Keywords*: ambrosia, allergy, environment, health, legislation*

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IZHODIŠČA

Ambrozija je v grški mitologiji »hrana, ki daje bogovom mladost in nesmrtnost« (SSKJ, 1994, str. 12). Mnoga stoletja kasneje pa velja ambrozija za eno izmed največjih škodljivk za okolje in zdravje ljudi. Rod Ambrosia šteje okrog 40 vrst, ki večinoma prihajajo iz Severne Amerike, le ena vrsta bi naj izhajala iz Evrope. Najpogostejša vrsta ambrozije je *Ambrosia artemisiifolia* ali pelinolistna ambrozija. Pelinolistna ambrozija je tujerodna invazivna rastlina, ki je vse bolj razširjena v Evropi in tudi v Sloveniji. Škodljiva je zaradi tega, ker pri ljudeh povzroča alergijo, na kmetijskih zemljiščih pa vpliva na zmanjšanje pridelka. Vsaka rastlina ambrozije lahko tvori 30.000 do 100.000 semen, ki so lahko kaliva tudi do 20 let (Škerbot, 2011). V Evropo je prišla iz Severne Amerike in sicer predvsem s človeško pomočjo. Prenesla se je z uvozom različnih semen žitaric in drugih poljščin, prav tako pa je ambrozija prisotna v vseh ptičjih hranah, ki vsebujejo sončnično seme (Alberternst et al., 2006). Intenzivno širjenje ambrozije kot invazivne rastline po Evropi, pa se je začelo nekje 20 do 25 let nazaj. Pelinolistna ambrozija je predvsem razširjena v Vzhodni in Srednji Evropi. V nekaterih državah, kot je na primer Madžarska je že skoraj 80 % obdelovalne zemlje zapleveljene z ambrozijo in je tudi najbolj pogosti plevel v zadnjih 20 letih na kmetijskih površinah (Euphresco, 2008, str. 7-9). Ambrozija se namreč v zadnjih letih v večji meri iz naših sosednjih držav širi v notranjost Slovenije. V Sloveniji se ta rastlinska vrsta najhitreje širi predvsem na nekmetijskih slabo vzdrževanih zemljiščih, od koder se nato širi na kmetijska zemljišča. Natančnejših, zlasti pa sistematičnih popisov območij, kjer se pojavlja, pri nas še ni narejenih (Kofol Seliger, 2001). V Sloveniji je bila leta 2010 izdana Odredba o ukrepih za zatiranje škodljivih rastlin iz rodu Ambrosia (Odredba o ukrepih za zatiranje, 2010).

Zrnca cvetnega prahu ambrozije imajo na površini majhne tope koničaste izrastke, ki zaidejo v dihalne poti in povzročajo alergično reakcijo (Taramarcaz et al., 2005). Cvetni prah ambrozije povzroča alergijski rinitis in tudi hude simptome podobne astmi. Pelinolistna ambrozija vsebuje tudi eterična olja, ki lahko povzročajo urtikarije. Simptomi alergične reakcije so vodeni izcedek iz nosu, ščemenje v nosu, kihanje, otečene veke, ščemenje v očeh in oteženo dihanje (Škerbot, 2011). Da dokažemo alergijo so potrebni določeni postopki in preiskave. Pri diagnostiki, zdravljenju in spremljanju alergij je najpomembnejši pogovor z bolnikom - alergikom. Medicinska sestra si mora vzeti dovolj časa, da se pogovori z bolnikom. Bolnika sprašuje o osrednjih simptomih oz. največjih težavah, o tem ali so motnje sezonske, stalne ali le občasne. Anamnezi sledijo kožni vbodni testi alergije, ki pa jih alergolog izbere glede na podatke, ki si jih pridobi med pogovorom (Mušič, 2006, str. 15). Alergije lahko preverjamo tudi s krvnimi testi. Vzorec krvi analiziramo s specifičnimi protitelesi IgE. Omenjeni testi imajo slabost, saj so zelo dragi in manj občutljivi, prav tako rezultati niso vidni takoj (Howarth, Reid, 2001). Načini zdravljenja alergije na ambrozijo so: izogibanje alergenu, zdravila, specifična imunoterapija, informiranje, vzgoja ter izobraževanje. Izmed vseh teh načinov zdravljenja zdravnik izbere enega ali pa jih kombinira. Odločitev je odvisna od intenzivnosti pojavljanja alergijskih simptomov (Mušič, 2006, str. 121).

Nasveti za odstranjevanje, zatiranje ambrozije in kako se ji izogibati:

- Če rastlino opazite na svojem zemljišču, jo čim prej odstranite. V Euphresco (2008) je zapisano, da je najbolj učinkovito seveda puljenje, vendar to žal na velikih površinah ni mogoče. Herbicide pa ni dovoljeno uporabljati predvsem na površinah, kjer se izvaja ekološka pridelava. Košnja je priporočljiva za velike površine oz. tam kjer je zatiranje s herbicidi prepovedano, vendar s košnjo preprečujemo samo nadaljnjo tvorjenje semen.
- Če ambrozijo odstranjujemo ročno, priporočamo uporabo zaščitnih sredstev (rokavice, primerna oblačila, zaščitna očala in dihalno masko). Ambrozijo naj odstranjujejo ljudje, ki nimajo alergije na ambrozijo. Priporočamo, da jo odstranjujemo v popoldanskem času, saj je takrat najmanj cvetnega prahu v zraku. Pomembno je, da odstranjene rastline, še posebej cvetoče, spravimo v vreče in nato odvržemo med mešane odpadke (Kofol-Seliger, 2013).
- Za tiste, ki so alergični na ambrozijo je pomembno, da pregledajo koledar cvetenja, da vedo kdaj je največ cvetnega prahu v zraku, to si lahko pogledajo na spletni strani Inštituta za varovanje zdravja, saj je tam objavljena predvidena koncentracija cvetnega prahu v zraku za vsak dan. V tem času je najbolje za bolnika, da se izogiba alergenu. Mušič (2006) svetuje, da se tisti, ki so alergični na cvetni prah v obdobju cvetenja ne zadržujejo in delajo v lepem, suhem vremenu na poljih, travnikih, gozdovih in parkih, da zaprejo okna (predvsem zjutraj in opoldan), da so sprehodi priporočljivi, kadar dežuje oz. neposredno po dežju, da ne uporabljajo klimatskih naprav ter če imajo možnost, naj obdobje cvetenja preživijo v višjih legah ali ob morju, saj je tam manj peloda.

METODE

V okviru raziskovalnega procesa smo uporabili kvantitativni pristop. Kot raziskovalni instrument smo uporabili anketni vprašalnik, ki je bil namenjen lastnikom kmetijskih zemljišč na območju Ptuja in je obsegal 16 vprašanj zaprtega tipa in 4 vprašanja odprtega tipa. Skupno smo razdelili 30 vprašalnikov in vsi so bili vsi tudi vrnjeni (100 % odziv). Statistične podatke o številu alergičnih ljudi na ambrozijo smo pridobili pri Službi zdravstvenega varstva pljučnih bolnikov Ptuj. Vsi udeleženci v raziskavi so bili pisno obveščeni o namenu in ciljih raziskave. Vsem anketirancem je bila zagotovljena anonimnost in možnost odklonitve sodelovanja. Pri izvedbi raziskave smo upoštevali načela Kodeksa etike medicinskih sester in zdravstvenih tehnikov Slovenije. Raziskovalni vprašanji, ki smo si ju zastavili sta bili: Ali lastniki kmetijskih zemljišč prepoznajo ambrozijo in poznajo njeno škodljivost na zdravje ljudi? in Ali se je v zadnjih letih povečalo število ljudi alergičnih na ambrozijo na območju Ptuja?

REZULTATI

V raziskavo je bilo vključenih 30 lastnikov kmetijskih zemljišč na območju Ptuja. Anketne vprašalnike je izpolnilo 8 (26,7 %) žensk in 22 (73,3 %) moških. Največ (26,7 %) anketiranih je starih od 31 do 40 let in nad 61 let. 6,7 % anketiranih je starih od 20 do 30 let.

Kar 28 (93,4 %) anketiranih je odgovorilo, da pozna ambrozijo, en (3,3 %) anketirani ambrozije ne pozna in en (3,3 %) ne ve ali ambrozijo pozna. Ugotovili smo, da je ambrozijo po sliki resnično spoznalo 25 (83,4 %) anketiranih, en (3,3 %) jo je zamenjal za belo metliko, trije (10 %) za navadno lobodo, en (3,3 %) pa se ni odločil za nobeno sliko.

Večina anketiranih in sicer 23 (76,7 %) ve, da je ambrozija škodljiva za zdravje ljudi in da povzroča alergijo, medtem ko jih 7 (23,3 %) ni vedelo, katero bolezen povzroča ambrozija. Kar 19 (63,3 %) anketiranih je odgovorilo, da ambrozija cveti od avgusta do septembra oz. je takrat najbolj škodljiva, 6 (29 %) jih je odgovorilo, da ambrozija cveti v juniju in juliju, 2 (6,7 %) sta mnenja, da cveti od junija pa vse tja do septembra.

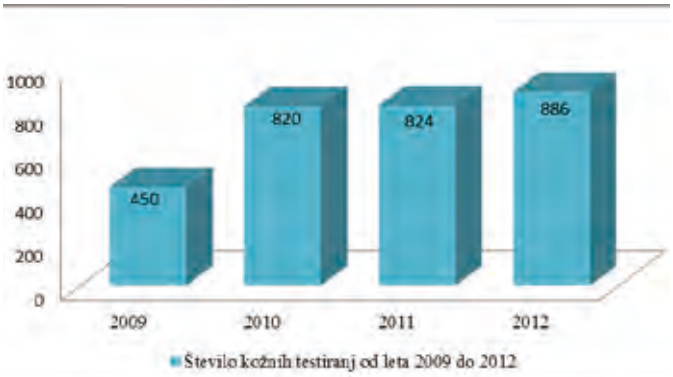
Da je zakonsko urejeno zatiranje ambrozije je vedelo 15 (50 %) anketiranih, 2 (6,7 %) sta odgovorila, da zatiranje ni zakonsko urejeno in kar 13 (43,3 %) anketiranih ni vedelo ali je zatiranje ambrozije zakonsko urejeno. 44 (80 %) anketiranih je menilo, da nadzira zatiranje ambrozije kmetijski inšpektor, 6 (20 %) jih pa meni, da nihče ne nadzoruje zatiranja ambrozije. 9 (30 %) anketiranih je bilo opozorjenih na obvezno zatiranje ambrozije, medtem ko jih kar 21 (70 %) ni bilo opozorjenih o obveznem zatiranju ambrozije.

23 (76,7 %) anketiranih je potrdilo prisotnost ambrozije na svojih zemljiščih, medtem, ko jih 7 (23,3 %) anketiranih še ni zaznalo ambrozije na svojih zemljiščih. Vsi (100 %) anketirani, ki so ambrozijo zaznali na svojih zemljiščih, so jo tudi zatirali. 7 (30,4 %) jih je zatiralo ambrozijo s košnjo, 5 (21,7 %) s herbicidi, 5 (21,7 %) anketiranih jo kosi in škropi s herbicidi, 4 (17,4 %) jo zatirajo s košnjo in puljenjem, 1 (4,4) anketiran škropi s herbicidi in puli in 1 (4,4 %) jo zatira s košnjo, herbicidi in puljenjem.

V 9 (30 %) družinah anketiranih ima nekdo težave z alergijo na cvetni prah, pri ostalih 21-ih (70 %) družinah pa nihče nima težav z alergijo na cvetni prah. Od tistih, ki imajo alergijo na cvetni prah, ima 1 (11,1 %) težave v mesecu februarju in marcu, 3 (33,3), 2 (22,2 %) v juniju in juliju in 3 (33,3 %) v mesecu avgustu in septembru.

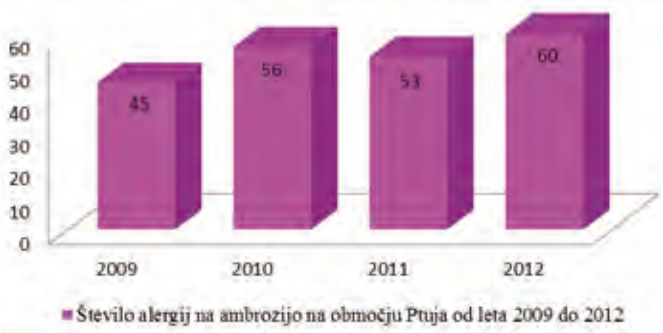
Iz podatkov Službe zdravstvenega varstva pljučnih bolnikov smo pridobili podatke o številu testiranj (Graf 1) in številu alergij na ambrozijo (Graf 2) na območju Ptuja.

Graf 1: Število kožnih testiranj od leta 2009 do 2012



Iz grafa 1 je razvidno, da je bilo leta 2009 450 kožnih testiranj na območju Ptuja, leta 2010 je bilo 820 kožnih testiranj, leta 2011 je bilo 824 kožnih testiranj in leta 2012 je bilo že 886 kožnih testiranj.

Graf 2: Število alergij na ambrozijo na območju Ptuja od leta 2009 do 2012



Iz grafa 2 lahko razberemo, da je bilo leta 2009 na območju Ptuja 45 alergij na ambrozijo na območju Ptuja, leta 2010 je bilo 56 alergij na ambrozijo, 2011 jih je bilo 53 in leta 2012 je bilo že 60 alergij na ambrozijo.

DISKUSIJA

V raziskavi, v kateri je sodelovalo 30 lastnikov kmetijskih zemljišč na območju Ptuja, smo ugotovili, da večina lastnikov kmetijskih zemljišč na območju Ptuja prepozna ambrozijo in da je ta rastlina že zelo prisotna na kmetijskih zemljiščih na tem območju. Večina anketirancev je seznanjena, da ambrozija povzroča alergijo, vendar pa jih polovica ne ve, da je zatiranje zakonsko predpisano z Odredbo o ukrepih za zatiranje škodljivih rastlin iz rodu Ambrosia iz leta 2010. Ugotovili smo, da kar 70 % anketiranih ni bilo opozorjenih, da je ambrozijo potrebno zatirati.

Glede na dobljene rezultate lahko podamo odgovore na zastavljeni raziskovalni vprašanji. Na prvo raziskovalno vprašanje »Ali lastniki kmetijskih zemljišč prepoznajo ambrozijo in poznajo njeno škodljivost na zdravje ljudi?« lahko odgovorimo, da več kot ¾ anketirancev prepozna ambrozijo. Ugotovili smo tudi, da se lastniki kmetijskih zemljišč zavedajo njene razširjenosti, saj so jo vsi, ki so jo na svojih zemljiščih prepoznali, tudi zatirali. Zelo velik odstotek, oziroma tri četrtine anketiranih ve, da ambrozija povzroča alergijo. Ugotovili smo tudi, da kar tretjina anketiranih zatira ambrozijo s košnjo in četrtina s herbicidi, kljub temu, da je v Euphresco (2008) napisano, da je najbolj učinkovito puljenje, kar pa žal na velikih površinah ni mogoče, prav tako ni dovoljeno uporabljati herbicidov na površinah, kjer se izvaja ekološka pridelava.

V nadaljevanju podajamo še odgovor na drugo zastavljeno raziskovalno vprašanje, ki se je glasilo »Ali se je v zadnjih letih povečalo število alergij na ambrozijo na območju Ptuja?«. Ugotovili smo, da je v letu 2009 bilo narejenih 450 kožnih testov, od tega je bilo alergičnih na ambrozijo 45 testiranih. V letu 2010 se je povečalo tako število kožnih testov kot število alergikov, in sicer je bilo narejenih 820 kožnih testiranj, od tega je bilo alergičnih na ambrozijo kar 56 testirancev. V letu 2011 so naredili 824 kožnih testov, pozitivnih testirancev na ambrozijo je bilo 53, kar je sicer nekoliko manj kot leta 2011. Leta 2012 pa se je povečalo število opravljenih kožnih testov na 889, pozitivnih na ambrozijo pa je bilo kar 60 testirancev, kar je največje število alergičnih ljudi na ambrozijo v zadnjih letih. Prav tako se povečuje število alergikov na območju Murske Sobote, saj Lopert (2010) ugotavlja, da je bilo v Pulmološki in alergološki ambulanti Murska Sobota pred desetimi leti preobčutljivih na pelod ambrozije deset odstotkov ljudi, zdaj jih je že skoraj tretjina. Samo v njihovo alergološko ambulanto je v zadnjih petih letih prišlo okrog dvesto novih bolnikov. Kofol-Seliger (2001) ugotavlja, da natančnih podatkov za celotno Slovenijo nimamo, vendar se stanje zaradi širjenja ambrozije iz sosednjih držav kot tudi njenega širjenja znotraj Slovenije iz leta v leto slabša. Še pred 10 leti naj bi bilo v Sloveniji le okrog 10 % alergij povezanih z ambrozijo, medtem ko se je v zadnjih letih ta odstotek po oceni alergologov povečal že na blizu 30 %.

Pomembno in trenutno zelo pozitivno je tudi, da na Inštitutu za varovanje zdravja spremljajo vsebnost cvetnega prahu ambrozije v zraku in s tem opozarjajo alergike, kdaj in kje naj se izogibajo gibanju na zraku.

ZAKLJUČEK

Vsi bi se morali zavedati, da se ambrozija v Sloveniji močno in hitro širi. V medijih se veliko govori o tem od kod je ambrozija prišla, kako hitro se širi, da je alergena in da je bila sprejeta Odredba o ukrepih za zatiranje škodljivih rastlin iz rodu Ambrosia. Nihče pa ne opiše ambrozije, ne svetuje o tem kako in kdaj jo je potrebno zatirati, tudi nihče tega ne nadzoruje in spodbuja lastnike zemljišč, da bi jo zatirali. Vzrok je verjetno, ker država sama ne poskrbi za zemljišča katerih lastnik je in se na njenih površinah (predvsem ob avtocestah, železniških progah, parkirišči itd.) zadržuje in razrašča ambrozija. Če ne bomo zatirali ambrozije oz. je vsaj pravočasno prepoznali na zemljiščih, se bo še naprej širila, to pa ni dobro ne za okolje in tudi ne za zdravje ljudi. Število alergikov se z leti viša, to je razvidno iz podatkov Službe zdravstvenega varstva pljučnih bolnikov Ptuj, ki so bili eni redkih, ki so bili pripravljeni sodelovati v okviru raziskave. Verjetno se na ravni države še ne zavedamo, da bi bili preventivni ukrepi veliko cenejši, kot kasnejši vedno večji stroški za zdravljenje alergij.

Predlagani preventivni ukrepi, ki bi jih lahko sprejeli na državni ravni, so: ozaveščanje ljudi o ambroziji in

njenih negativnih posledicah preko različnih medijev, lahko bi tudi vsakemu gospodinjstvu poslali letak o njenih značilnostih in možnostih zatiranja. Veliko bi naredili, če bi na lokalni ravni organizirali kakšna srečanja oz. seminarje, na katerih bi strokovnjaki predavali o škodljivostih ambrozije in pomagali ljudem z nasveti, kako prepoznati ambrozijo in jo učinkovito ter na najbolj naraven način zatirati. Uvedli bi lahko tudi večji nadzor nad zatiranjem s strani pristojnih služb. Če se ti preventivni ukrepi ne bodo začeli izvajati, se bo ambrozija razširila tako močno, da je ne bo mogoče več izkoreniniti, kar pa povečuje možnost razširjenja in tudi večje stroške.

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HYGIENE CONDITIONS MANAGEMENT AT SWIMMING POOLS FOR HEALTH PROTECTION

OBVLADOVANJE HIGIENSKIH RAZMER NA BAZENSKIH KOPALIŠČIH ZA VAROVANJE ZDRAVJA

VESNA FLUHER, MAJDA PAJNKIHAR, SONJA ŠOSTAR TURK

Izvleček

Obvladovanje higienskih razmer ima v kopaliških kompleksih poseben pomen, saj se tukaj nahaja veliko število ljudi, ki imajo različne higienske navade in zdravstvena stanja. Namen naše raziskave je prikazati mikrobiološko in kemijsko onesnaženost kopalne vode, ozaveščenost samih kopalcev o higieni na kopališču in obvladovanje higienskih razmer na bazenskih kopališčih. Cilj raziskave je s pomočjo koncepta HACCP, ki ga bomo vpeljali v kopališče, sistematično reševati težave in ozaveščati kopalce o pomenu upoštevanja kopališkega reda in vzdrževanju higiene. Obdelani so bili podatki fizikalnih, mikrobioloških in kemijskih analiz bazenskega kopališča Term 3000 v obdobju 5 let. Rezultati analize vzorcev bazenske vode so pokazali, da se je število mikrobiološko neskladnih vzorcev v obdobju od leta 2005 do 2010 zmanjšalo. Za izboljšanje stanja je bilo največ izvedeno na področju higienskih režimov saj se je s stalnim usposabljanjem sodelavcev in kontrolnimi postopki zmanjšuje število neskladnosti vzorcev bazenskih vod. Trihalometani (THM) v kopalni vodi pa presegajo mejne vrednosti v času največje obremenitve poletne kopalne sezone. Izvedena je bila tudi raziskava o higienski ozaveščenosti obiskovalcev na podlagi anketnega vprašalnika v katerem je sodelovalo 76 kopalcev. Rezultati anketnega vprašalnika so pokazali, da je ozaveščenost kopalcev slaba. V vodi se zadržujejo več kot 20 minut, kot je priporočeno. Kopalno vodo koristijo predvsem za sprostitev in v terapevtske namene. Eden izmed ključnih faktorjev v kopališču je higiena, ki je predvsem odvisna od vedenja samih kopalcev, zato je v okviru raziskave bil uveden koncepta HACCP.

Ključne besede*: higiena, javno zdravje, kopališče, kopalna voda, promocija zdravja*

Abstract

The management of hygiene in swimming pools is of particular importance due to the large number of people who have different hygiene habits and medical conditions. The purpose of this research was to show the management of hygiene in swimming pools and the microbiological and chemical pollution of bathing waters, and determine the awareness of swimmers with regard to hygiene in bathing spas. Goals of the research are to implement HACCP concepts in the spas, systematically solve problems and educate bathers on the importance of considering bathing orders and maintaining hygiene. A five - year period data on microbiological and chemical analysis of the Terme 3000 swimming pools were collected and processed. A survey on hygiene awareness of swimmers, based on a questionnaire distributed among 76 participants, was carried out. The results of the analysis of the pool water samples showed that the number of microbiologically non-compliant samples decreased from 20% to 10% during the 5 - year period. The trihalomethanes concentration in the pool water is above the thresholds during the peak summer bathing season. The results of the questionnaire survey showed poor hygiene awareness of swimmers. It was found that most of the respondents stay in the pool longer than recommended (20 min). Maintaining order in the bathing complex consists of expert qualification and technology as well as awareness of swimmers with regard to hygiene based on HACCP concepts.

Keywords*: Hygiene, public health, swimming, pool water, health promotion*

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IZHODIŠČA

Bazen je opredeljen kot vodna površina v bazenskem kopališču. Vodo v bazenskih kopališčih lahko uporabljamo v terapevtske in rekreativne namene (Kapus et al., 2004). Pri tem pa se zahteva stalen nadzor nad kakovostjo kopalne vode (Šink in Šolar, 1997). Športno in rekreativno kopanje v termalno-mineralnih vodah, kakor tudi terapevtsko kopanje, predstavlja sodoben način vzdrževanja in ohranjanja primerne fizične in psihološke kondicije človeka v vseh starostnih obdobjih (WHO, 2006). Zato velja prepričanje, da voda v bazenskih kopališčih in njene termalno-mineralne značilnosti zelo ugodno vplivajo na rehabilitacijo predvsem gibalnega in živčnega sistema, to še ne pomeni, da zdravju škodljivih vplivov ni. Dejavniki tveganja na bazenskih kopališčih so kemijski, mikrobiološki in fizikalni. V bazenskih kopališčih je kopališki gost primarni izvor okužbe (Gale, 1999). Zdravstvena tveganja so posledica neustreznih tehnologij čiščenja bazenskih vod, neprimerne organiziranosti čistih in umazanih poti, neustreznega prezračevanja, ter drugih tehnoloških značilnosti bazenskih kopališč. Zelo pomembne pa so tudi higienske navade upravljavcev in uporabnikov bazenskih kopališč (WHO, 2000).

Med ključne dejavnike tveganja se uvrščajo vsa kemijska dezinfekcijska sredstva in njihovi stranski produkti, posebno v primeru prekomerne uporabe in neustreznih tehnologij vzdrževanja bazenske vode. Dezinfekcija bazenske vode se izvaja fizikalno ali kemično, da bi iz vode odstranili žive organizme (bakterije, glivice, viruse, spore in praživali) oziroma onemogočili njihov obstoj in razvoj (WHO, 2000). Kot najbolj razširjeno dezinfekcijsko sredstvo za pripravo bazenske vode se uporablja predvsem klor in spojine na osnovi klora. Tako kot je klor najbolj pogosto uporabljeno dezinfekcijsko sredstvo, so trihalometani (THM) običajno najbolj razširjena stranski proizvodi kloriranja (Villanueva et al., 2007). Klor namreč reagira z organskimi snovmi v vodi in tako nastanejo stranski produkti dezinfekcije, to so THM, ki neugodno vplivajo na zdravje ter dražijo dihala, kožo in sluznice (Department of health, 2011).

Mikrobiološki dejavniki tveganj so nedvomno ključni dejavniki kroničnih in tudi akutnih tveganj, saj se mikroorganizmi splakujejo v kopalno vodo s površine kože in telesnih votlin. Zato se lahko pojavijo razni dermatitisi, konjuktivitisi, enteritisi in draženja dihal. Nasploh najpogostejše okužbe na kopališčih, ki se prenašajo s stikom bosih stopal s površinami so glivične okužbe in virusne bradavice. Možne so številne nalezljive bolezni zaradi pomanjkljive higiene v kopališčih. Zato je izjemnega pomena v bazenskih kopališčih tuširanje pred in po uporabi bazena. Pomembno je, da si zamenjamo mokre kopalke in osušimo predele med prsti, saj s tem preprečimo rast in razmnoževanje mikroorganizmov (Gale, 1999).

Upravljavci bazenov se morajo zavedati bremena prevelikega števila kopalcev. Potrebno bi bilo zagotoviti število kopalcev, ki ne presega zmogljivosti kopališča. Vsi bazeni morajo imeti točno opredeljeno in realno razmerje med številom kopalcev in zmogljivostjo čistilne naprave. Zato je treba za nov bazen kopalno obremenitev oceniti v fazi projektiranja. S tem lahko že na primarnem nivoju prispevamo k izboljšanju kakovosti vode. Z vpeljavo HACCP koncepta v kopališče pa lahko opredelimo kje se nahajajo velika tveganja v času obratovanja kopališča, ter določimo kontrolne kritične točke (KKT). Potrebno je opredeliti katere so kritične mejne vrednosti, kakšen je način nadzora, merjenja in spremljanja KKT. Prav tako se vpeljejo korektivni ukrepi, odgovornost za spremljanje posameznih KKT, zapisi in mesta, kjer se beležijo rezultati meritev (Arzenšek-Pinter et al., 2003).

METODE

Raziskava temelji na mikrobioloških, fizikalnih in kemijskih parametrih bazenskega kopališča Term 3000. Vzorce kopalne vode v Termah 3000 analizira Zavod za zdravstveno varstvo Maribor po Pravilniku o minimalnih higienskih in drugih zahtevah za kopalne vode (2011). V raziskavi smo tudi uporabili kvantitativno metodologijo raziskovanja z uporabo vprašalnika. Vključeni sta bili dve ciljni skupini ljudi, domači in tuji obiskovalci kopališča Term 3000 v Moravskih toplicah. Anketiranih je bilo 40 tujih obiskovalec in 36 domačih starih od 23 do 80 let, ki so odgovarjali na 26 vprašanj pol odprtega in zaprtega tipa.

REZULTATI IN DISKUSIJA

Mikrobiološki parametri, ki jih spremljamo, so indikatorski parametri, ki predstavljajo onesnaženost bazenske kopalne vode in uspešnost njene priprave. Skupno število mikroorganizmov pri temperaturi 37^0C pa ne sme presegati 100 v 1 ml. Kvaliteta vod iz bazenov se je v zadnjih letih bistveno izboljšala. V letu 2005 je bilo okrog 20 % vzorcev neskladnih do leta 2010 pa se je odstotek neskladnih vzorcev kopalnih vod znižal pod 10 %. Za izboljšanje stanja je bilo največ izvedeno na področju higienskih režimov saj se s stalnim usposabljanjem delavcev in kontrolnimi postopki zmanjšuje število neskladnosti vzorcev bazenskih vod. Izboljšanje kvalitete bazenske vode pa so dosegli s pravilnimi postopki izvajanja čiščenja in zagotovitvijo dobre higienske prakse.

Poleg mikrobioloških so zelo pomembni tudi kemijski in fizikalni parametri kopalne vode. Na podlagi kemičnih analiz bazenskih vod smo ugotovili predvsem odstopanja oz. neskladnosti pri parametru THM. Po Pravilniku o minimalnih higienskih zahtevah, ki jih morajo izpolnjevati kopališča in kopalna voda v bazenih (2011) je voda neprimerna za kopanje, kadar je koncentracija THM > 20 µg/l (0,02 mg/l). Analiza kopalne vode v Termah 3000 je pokazala, da je koncentracija THM v času kopalne sezone od junija do avgusta višja. Temu lahko pripisujemo tudi večjo obremenitev kopalne vode, saj število kopalcev presega zmogljivost bazena in posledično s tem tudi zmogljivost čiščenja in dezinfekcije vode s kopalci. Največja je obremenitev s THM v bazenu s toboganom, sledita mu skakalni bazen in otroški bazen. Nekateri raziskovalci trdijo, da je glavni vnos THM v telo preko kože, saj je v vodi THM izpostavljena celotna površina kože, višja temperatura vode pa pospeši krvni obtok, razširi kapilare v koži, ki tako postanejo bolj prepustne za prehajanje THM v kri (Gordon et al., 1998). Pri tem ne smemo pozabiti, da daljša izpostavljenost v kopalni vodi vpliva neugodno na zdravje kopalca (Villanueva et al., 2007). Zaradi tega bi bile potrebne manjše količine dodajanj dezinfekcijskega sredstva in s tem posredno nastanka trihalometanov (WHO, 2006). Njihovo količino zmanjšamo z zmanjšanjem količine nečistoč v bazenski vodi, z dodajanjem polnilne vode in/ali omejitvijo števila obiskovalcev (Gale,1999).

Iz analize anketnih vprašalnikov domačih in tujih gostov smo ugotovili, da pomembne razlike med gosti ni. Raziskava je pokazala, da se kopalci v kopalni vodi zadržujejo več kot 20 minut, koliko je priporočeno. Takšnih kopalcev je 84 %, le 16 % jih po 20 min kopanja bazen zapusti. Kopalno vodo kopalci koristijo predvsem zaradi njenih termalno mineralnih značilnosti (32 %), za sprostitev (29 %) in v terapevtske namene (21 %), manj pa v športno rekreativne namene. Kopalna voda še zlati termalnomineralna voda lahko ima tudi ugodne terapevtske značilnosti, zato nas je zanimalo s kakšnimi bolezenskimi stanji pridejo kopalci v kopališče. Velika večina je takih z boleznimi kosti, sklepov ali živcev in sicer kar 54 % in z boleznimi prebavil in kože 13 %. Manj je takih z boleznimi dihal 10 %, z boleznimi sečil in ušesnimi obolenji 4 %, samo 2 % pa jih je navedlo da ima težave z očmi. Po obisku kopališča so kopalci navajali bolečine v mišicah kar je navedlo 32,5 % anketiranih, kar je lahko tudi posledica aktivnosti v vodi. 17 % kopalcev je imelo rdeče oči, kar je lahko posledica neugodnega vpliva klora v vodi in zraku, kakor tudi glavodol, ki ga navaja 15 % kopalcev (Department of health, 2011). Manj je bilo navedenih drisk, kožnih izpuščajev, bruhanja in raznih vnetij.

Higiena na kopališčih je predvsem odvisna tudi od vedenja samih kopalcev. Zelo pomembno vlogo ima tuširanje in vzdrževanje osebne higiene (WHO, 2000). Kopalec bi se moral stuširati takoj ko vstopi v kopališče, kar naredi 53 % kopalcev. 54 % kopalcev se stušira tudi po končanem kopanju in odhodu domov. Pred vstopom v bazen se stušira 38%, prav tolikšen procent ko zapustijo bazen. Prhanje pred plavanjem namreč pomaga odstraniti sledi znoja, urina, fekalnih snovi, kozmetike, olj za sončenje in drugih potencialnih vodnih onesanževal (WHO, 2006). Manjši je odstotek tistih, ki se stuširajo po uporabi sanitarij (13 %). Zanimivo pa je da se 2 % tujih gostov sploh ne tuširajo na kopališču. Glede na zastavljena vprašanja v anketnem vprašalniku se je ugotovilo, da je sama ozaveščenost kopalcev slaba, prav tako poznavanje kopališkega reda. Kopalci se v povprečju zadržujejo predolgo v kopalni vodi.

Pomembna je tudi osušitev kože po kopanju. Predvsem je to pomembno v kožnih gubah in med prsti (Gale, 1999). Zaradi mokrega področja in gub je namreč to ugodno okolje za razvoj glivic in mikroorganizmov, ki lahko povzročajo najrazličnejša bolezenska stanja (Hudson et al., 1985). Velika večina in sicer 62 % si vedno dobro osuši kožo, 30 % si včasih osuši kožo in samo 8 % si nikoli ne osuši kože. Anketirance smo tudi vprašali, kateri dejavniki so za njih na kopališču najpomembnejši. Gostom kopališča je najpomembnejša higiena sanitarij (20 %), bazenov (19%), garderob (18 %), obbazenskih površin (16 %). Šele nato prijazno osebje (11 %), učinki termalne vode (8 %), dostop do bazenov (5 %) in gostinska ponudba (3 %). Zaščitne kreme in vsa kozmetična sredstva, ki jih kopalci vnašajo v bazen obremenjujejo kopalno vodo (WHO, 2000). V naši anketi je velika večina (63 %) anketirancev navedla, da krem sicer ne uporabljajo, nekaj (28 %) jih uporablja včasih. Samo 9 % pa je takih, ki jih uporabljajo zmeraj.

Z telesnimi izločki in uriniranjem kvaliteta kopalne vode zmanjša pri tem pa nastane tudi več stranskih produktov dezinfekcije bazenske vode (Department of healt, 2011). Kopalce smo vprašali, ali so kdaj namerno ali po nesreči urinirali v kopalno vodo. Kar 70 % je bilo takšnih, ki je navedlo da niso nikoli urinirali v kopalno vodo, 14 % jih je po nesreči, namerno pa 3 %. Klorirana voda ima značilen vonj po kloru. Ko smo o vzroku za vonj po kloru v kopališču vprašali anketirance, nam je le 30 % odgovorilo, da je to posledica prevelike količine klora v vodi.

Pomembno vlogo za urejenost kopališča in kakovost kopalne vode pa ima samo vedenje kopalcev. Anketiranci so bili vprašani ali so potrebe po večjem nadzoru na kopališču. 67 % jih je mnenja, da je potrebno, 20 % da ni

potrebno in 13 % je odgovorilo, da ne ve ali so potrebe po večjem nadzoru na kopališču. Z kopališkim redom se seznani 71 % , medtem ko se 29 jih % ne seznani. Največ in sicer 68 % se z kopališkim redom seznani pred vstopom v kopališče. 17 % preko katalogov in prospektov in 15 % preko interneta. Za vzdrževanje ugodnih higienskih razmer je potrebno vplivati na ozaveščenost in vedenje kopalcev (WHO, 2006). 33 % anketirancev je mnenja, da je potrebno kopalce obveščati o kopališkem redu preko obvestila, s katerim se 68 % kopalcev tudi seznani. 20 % anketirancev kot možnost za ozaveščanje navaja plakate, zloženke, letake, 18 % jih je mnenja, da jih mora ozaveščati receptor na kopališču, 14 % reševalec in 10 % mediji.

Na osnovi pregleda problematike kopališča in analize anketnega vprašalnika glede samega vedenja kopalcev in pregleda kritičnih točk se je prvič v našem prostoru uvedel HACCP koncept v kopališki sistem, z namenom sistematičnega reševanja higienskih problemov. Za izdelavo koncepta so upoštevane smernice HACCP iz prehrambene industrije, kjer so le te že uveljavljene. Najprej so se določili člani tima, ki so za uspešno vodenje in delovanje sistema potrebni. Izdelal se je HACCP koncept za 33 kritičnih točk v kopališkem kompleksu Term 3000 in s tem pripomogel k sistematičnemu reševanju higienske problematike in razbremenitev tehnologije čiščenja kopalne vode.

Za vsako KKT v kopališču Term 3000 so zapisane HACCP smernice. Na osnovi HACCP načrtov so obdelani bazeni (otroški, skakalni, natur, rekreativni letni, whirpool, termalni, bazen ob savni, bazeni s toboganom), prelivne rešetke, ploščad (zunanja, notranja), manjše poškodbe na pohodnih poteh (zunaje, notranje), sanitarje, tuši (zunaji, notranji), previjalnica, garderobne omarice, slačilnice, prehod v kopališče, prehod v prehranjevalni del, bazenčki za dezinfekcijo nog (zunanji, notranji), držala za roke ob stopnišču v in iz bazena, protidrsne podloge, ležalniki, sušilniki za lase. Poleg materialnih stvari, ki se nahajajo v kopališču so pomembni še nekateri drugi dejavniki, ki vplivajo na higieno v kopališču in sicer: kozmetična sredstva, masažne šobe, raven dezinfekcijskega sredstva (prenizka, previsoka), preobemenjenost filtrirnih naprav in plast zraka tik nad kopalno vodo.

ZAKLJUČEK

Kopališča predstavljajo za ljudi obliko sprostitve in rekreacije. Veliko pa je takšnih, ki koristijo termalno mineralne učinke kopalne vode. V kopališča prihajajo ljudje z najrazličnejšimi bolezenskimi stanji, predvsem z obolenji sklepov, mišic in živcev. Ljudje z najrazličnejšimi navadami, lahko z načinom vedenja v samem kopališču pomembno vplivajo na kakovost tako kopalne vode, kakor tudi higiene na samem kopališču. Zato moramo biti reševanje higienske problematike usmerjeno na kopalca, ki lahko zaradi slabih higienskih navad in slabe kopalne prakse onesnažuje kopalno vodo. Kopalci lahko z načinom vedenja na kopališču ter vzdrževanjem higiene pomembno vplivajo na zmanjšan vnos organskih snovi kar je ugotovljeno tudi v raziskavi. Zavedati se je potrebno, da je vedenje kopalca in upoštevanje kopališkega reda pri reševanju te problematike ključnega pomena. Zato bi bilo smiselno da se v prihodnje izdela tudi načrt za izobraževanje kopalcev z zdravstveno vzgojnim gradivom, ki bi jih motiviral za upoštevanje pravil in priporočil na kopališču.

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