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Action Research: From Concept to Model of Forming Autopoietic Building Blocks as Life Circle

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Abstract:

Research question (RQ): How - with the concept of forming autopoietic building blocks - to develop a model of organization of future which will be able of self-/co-organization and self-/co-production in life circle? We are studying human potential as a natural circular process, which is characteristic of action research. Autopoiesis is a complete intertwinement of fields of continuous movement, which is consequently shown in creativity and holistic culture of a person.

Purpose: To develop a concept of forming autopoietic building blocks as life circle and a model of organization as a model of organization of future. We are interested in a human in organization, in interpersonal co-dependence and self-/co-dependence on micro and macro level. Inside this more and more virtual organization we are studying a human, humanity and human potential as a creative potential of humane organization.

Method: Direction in action research, which is supported with mixed methods for comprehensive study of autopoiesis in organization. For qualitative research we used Atlas.ti software. This research can be classified as case study.

Results: For designing autopoietic building blocks as life circle we developed a concept in 5 steps. With results of qualitative and quantitative analysis, comparison of autopoietic, modern and 4.0 organization, we developed a »Model of forming autopoietic building blocks in organization – MOGAO«. The model can be a comparative tool for perceiving processes in an organization. With results we claim that 4.0 organization is oriented mostly towards action and is getting stronger in improved communication. However, it decreases in emotions and thinking of a human.

Organization: Results can serve as a guideline and challenge to humane organizations. We present the challenge how – by knowing horizontal and vertical laws of a human – we can »control« 4.0 organization. The research contributes to awareness of a human and to transformation of allopoeitic to more and more autopoietic organizations in direction of: »Autopoietic 4.0 Human (r)evolution«.

Society: Accepting autopoiesis on all levels of society and consequently emerging organizations, as well as society as a whole. The final result is to influence by autopoiesis the cultural development of society in the sense of connecting science, art, high technologies and spirituality.

Originality: Interlacement of horizontal and vertical scientific areas by connecting natural and social sciences. Recording of autopoietic principles (building blocks of processes) from point of view of an observer and a creator as »self-/co-« principles. Completeness of studying with the developed concept and model »MOGAO«.

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Limitations/Future resesarch:We have no relevant data for a comparison of case study. Studying autopoietic organization in the direction of: »Autopoietic 4.0 Human (r)evolution«.Founding an institute for studying autopoiesis on all levels of society.

Key words:action research, autopoiesis, autopoietic organization, 4.0 organization, autopoietic building blocks, concept and model of formingautopoietic building blocks.

1 Introduction

For humans the activity according to natural life cycle is characteristic: birth, growth, maturation and death, since they are a part of nature, therefore natural laws and principles of activity apply to them. A human influences natural laws too often, but they are not successful at this since they cannot change the laws despite having modern technology, however they can be mentally active. Technological progress is in a »spasm«, it spins in the absence of a human as a conscious creator of an organization and society. Here we see the future of human activity so that they by their thinking process create organization which will be able to produce high technology in concepts of 4.0 (r)evolution. The role model of open and natural action is the great mind Tesla who equated physical work with mental work and devoted his alert life to thinking (Tesla, 2013, p. 7). Lauc (2000) establishes that through philosophy, thinking of freeing a human develops and that only then we can speak about free thinking, which is a whole in a circle of circles. In the research we are studying autopoiesis from its discovery to nowadays attempts of its use in the most complex environments. We look at it through philosophical and biological frame, all with the intention to find the principles in the multifaceted phenomena, named by Maturana and Varela (1980), the pioneers of this discovery, as »autopoiesis«. They reveal it as a natural circular organization with self-organizational characteristics, and by this establish a theory about activity of living organism. We wish to present autopoiesis as a (co)evolution of life circle, which realises itself in self-organization. The process begins in a cell of autopoietic people and it somehow continues in an autopoietic organization, society and civilisation.

We found out that we cannot speak about the progress of society if it does not allow humans their natural activity. We need to be aware that in nature there is an overall connection of everything, as well as mutual dependence, mutual activity and co-operation in natural processes on micro and macro level (Ećimović, 2016, pp. 3-4). The existing organization does not have complete understanding of human capital, which starts in justice and trust in the comprehensive chain of a metabolic process as a (r)evolutionary process in the cosmic sense (Jantsch, 1980). We learned about organic autopoietic organization and its negation which is being shown in allopoietic organizations. Therefore with autopoietic organization we try to implement into practice self-/co-organization of a human as creative potential. We are looking into a human in organization from organic-humane point of view, since they self-/co-work in the existent allopoietic environment. This environment becomes a challenge and motivator for us.

In a modern individual we can detect the prevalence of unconscious activity and lack of reflection which, we suppose, is one of the central problems of research. We came across reflection as conscious thinking in the model »Sine curve« (Ovsenik, 1999, p. 30). We can say that a human is able to control their activity by feedback, named reflection or thinking, and realize it up to concepts, which are in accordance with human and nature. Already Kant (1999, p. 32) was aware of this: »...an individual can consciously use mind in every moment, which enables them mental process, but unfortunately not nature.« Current overloading of networks can be felt everywhere, the consequences are shown as unsuccessful organizations and bad health of individuals who create them. We recognize that it is necessary to change the base which is built from the building blocks. Since this is a living system, it is even more significant that such changes are carried out with feeling for self-/co-person. For a human senses and is a self-/co-passionate being and at this point we will set the demanding problematics of organization. As a basis we take the fact that a man is not a »machine« as treated by the mechanistic paradigm. Therefore we can detect concepts of Industry 4.0 as concepts which in the future will be equalized with a robot or even more, the artificial intelligence will prevail. Thus it is important that organization self-/co-preserves in its autonomy and connection in the networks of action.

Our research challenge was: Can we use the method of action research (AR) through all the phases of research and in the concept and model of forming autopoietic building blocks? This means in theoretical as well as practical aspect or to use AR to intertwine the theory and practical part in the sense of self-/co-organization of an individual, and consequently re-processing and re-structuring of organizations. Mesec (1998) explains that the feature of such studies is curiosity to know the whole and rich understanding that directs us towards practical part, which we cannot substantiate immediately. Our intention is to recognize and research the principles of autopoiesis, form them and set the building blocks of autopoiesis and with them recognize modern and developing 4.0 organization. The key purpose is to present the gained building blocks of autopoiesis in modern and 4.0 organization. We show the connections and comprehensiveness in the life circle of self-/co-organization, self-/co-actualization in the way of self-/co-realization.

2 Theoretical background

2.1 Autopoiesis as life circle and living network of human action

If biologists Maturana and Varela (1980) as pioneers defined autopoiesis as a natural circular process. Železnikar (2016, p. 10) uniquely defines it in cybernetic informational system as an including whole materiality and spirituality, with oscillation between growth and dying out. Kordeš (2004, pp. 91-92) is aware of his part in the creative circle, where there is constant exchange of creation and stability. He determined that all living beings are affected by creative circle, named by Maturana and Varela (1980) as »autopoiesis«. Dalai Lama XIV (2000, p. 48) adds that inner peace is the way to genuine happiness, which includes a great deal of compassion and develops conscious care for co-people. Lasan gives a short but

meaningful definition (Lasan, 2005, p. 7): »Life is breathing, moving and thinking.« Pavuna (2017) self-confidently interprets his scientific supposition: »Life is love in action.« Self-organization is about a certain mentally determined, planned self-lawfulness which does not endure exact observation (Hlebš, 2017, pp. 10-11). Disturbances are detected in a human which show themselves as blockades or as unworking programmes because a human simply does not allow certain programmes to be activated, notes Djurdica (2011, p. 98). Are we actually not prepared for modern thinking? Feyerabend (2008, p. 132) asks himself why a person does not allow and recognize the most important motives for peace, love, compassion, sense for the holiness of nature and natural life.

Theory about action of a living organism - autopoiesis Chilean biologists Maturana and Varela (1980) define and reveal to scientific public in their pioneer work. They see the source of living in the cell as a basic unit which produces live matter. They realized that it is a generally closed structure of self-production and self-organization and that the order of connections between elements and processes is established, which are essential for their action on the ground of priority relations (p. x). Maturana and Varela (1980) present autopoiesis as a natural circular organization of living systems and its consequences. The authors have discovered a suitable term for this new phenomena, which unambiguously describes dynamics and autonomy of living systems. This negation of negation points out Kordeš (2004) as well, who says that the essence of autopoietic systems is not in relations between the system components but in the processes. The essence of autopoietic system is continuous production of abilities of producing oneself and thus maintaining your own organization (p. 176). Luhmann (1995) defines living or autopoietic systems as a specific type of systems. He establishes that they are a depiction of a life's abstraction, in which the principle of self-referencing is built; this is important in materialisation of life and in circulation of self-reproduction (pp. 1-2). Whereas Capra and Luigi determine that in last thirty years there is a tendency to introduce a new view on the concept of life as a new understanding of creating life (2014, p. xi).

Maturana and Varela (1980, p. 5) explain the autopoiesis theory by going into the cognitive process, which is of key importance so that a human knows and is aware that their ability to know depends on biologic integrity. Also Capra (1997, p. 44) points out that seeing is a basis of process of cognition which is founded on self-knowing, followed by real knowledge. This is what Lauc emphasizes as a basis of autopoietic organization that a human is the one who alone sets themselves personal goals on the way of personal development. He stresses that they have to be rational, natural, efficient and humane (Lauc, 2000, p. 133). Ovsenik sees a man as an observer and actor which are natural roles of an individual as a subject and not as an object that is equalized and treated as a machine in mechanistic paradigm. He emphasizes that it is important that each of us qualifies themselves and develops into a full-blooded and all-around personality. In the new doctrine he develops and shows a new view of organization where the phenomena of social and natural organization are equally considered (Ovsenik,

1999, pp. 25-27). Social systems are not only observed but also paradoxical systems, says Luhmann (1995).

In them self-referential activities are not carried out as a part of autopoietic process (pp. 7-9). Maturana and Varela (1998) speak about mutual harmony so that we see a co-person and live in co-existence as accepting fellow men which includes giving love. They add that without love, as accepting others, no social processes and humanity exist (pp. 205-206). Also Lauc (2000) devoted himself to aspects of love and as a driving power of progress pointed out harmonisation of processes in free action, with presence of the highest aspect of love Agape; he adds that Eros is still an enigma for many people, in theory as well as in practice (p. 54). Jantsch (1980) defines novelties and confirmation of information, explains that paradigm includes material as well as mental structures. He adds that this is information that creates new information and this is also the motive of conscious self-organization (pp. 50-51). Capra (2002, p. 13) explains from his point of view that autopoiesis is a continuous production of oneself and that cells have two important characteristics: membrane as a limit and network/web of metabolism as a process. Quantum physicist Pavuna (2016) reveals his findings that a holistic coherence is an un-local method of energetic resonance which is a support to unique person. Jantsch (1980) observes self-organization from another point of view as continuous micro and macro natural dynamics of processes which in their continuous movement create co-evolution, where the absolute and ultimate goal is humane aspect. He adds that a new concept of ecosystem is needed as a non-reductionist perspective of evolution's self-organization (pp. xiii- xv).

Biologists define evolution of living systems as evolution of interaction units, which are defined by self-referencing circular organization, which they call evolution of knowledge areas (Maturana & Varela, 1980, pp. 12-14). Ovsenik (1999) mentions an important category, not included in the theory of organization, which is a circular process, rotating again and again in circular-spiral process (pp. 123-125). Capra (1986) defines the transformation as unique in history of humankind as this is happening with extreme speed and broadness of changes which include the entire Earth hemisphere. With such a thorough transformation of spiritual organizing of Western culture, significant changes of social relations and organization forms are required (pp. 33-34). Also Capra and Luigi Luisi (2014) are in their work aware of all the aspects of human existence which represent a problem of today's human. They see the solution in fundamental changes of perception, thinking and view on world in science as well as in the entire social community. They suggest the change of existing paradigm as a vision of systematic view on life, which they see as a solution for life of further generations, so that the change is carried out on all levels in the web of co-natural living (pp. xi).

2.2 Action research of autopoietic human as new creation

Feyerabend (2007) says that experience is the one which directs a person and thinks that thinking in us is the base of human thinking and consequently activity. Basically, there are

three important factors: we live, learn and follow (pp. 196-197). Lauc (2000) is convinced that the modern issues of humanity are approached in an allopoietic and not in autopoietic way. Morgan (2004) confirms that it is necessary to use the mental process, when we recognize that a human is the one who creates our world. Anthropologist Trstenjak (1985) would agree with this - he suggests that we should not forget to create the world. We perceive this as a characteristic of autopoiesis that we are dependent on self-organization.

Ambrož and Colarič Jakše (2015) say that post-modernism has balanced the relationship between qualitative and quantitative methods. Mesec (1998) points out that with a holistic view on a human not only the entirety of human is studied but also practical problems of people from life, whereas with action research (AR) we reduce distances of involved levels. Železnikar (2011) emphasizes that the development of technology with exponent growth and entirely new concepts is inevitable. Already Tesla (2013) tried to stress this with unthinkable technological visions of the third millennium. As a connection of science, art, high technologies and spirituality, we see today a big scope of unexplored; we can say that these are unimagined possibilities of research in AR spiral as eternal research. The definition of organization of new era is put forward by Vila (2000) who says that this will be an organization without limits, internal as well as external, with limited hierarchy. As mentioned by numerous authors, interdisciplinarity will be upgraded into transdisciplinarity (Detela, 2006, Cerovec, 2013, Kukić, 2015 et al.). In the research we did a circular study and tried to close a circle of circles in the sense of AR spiral of planning, action and reflection.

2.3 Industry 4.0 as 4.0 (r)evolution in 4.0 self-organization

4.0 organization as a challenge of 4.0 (r)evolution, for which we do not find a comprehensive concept of 4.0 Industry. Bokranz et al. (2017) carefully put forward a scenario for 4.0 Industry in the year 2030 and expect specific changes in organization of production which will be marked by extensive solutions of future production. Dombrowski and Wagner (2014) say that industrial revolution will change society with key technologies. They mention relations between 4.0 revolution and mental needs which are not sufficient and further actions will be needed before the final implementation of 4.0 industrial revolution. Schwab (2016) sees the new technological revolution as a challenge of humankind. It is a new understanding and directing, because transformation will include the entire humankind. He estimates that the fourth industrial revolution will include change in dimension, expansion and complexity as never before in human history. Oin, Liu and Grosvenor (2016) take as the base the fact that in this time numerous concepts about 4.0 Industry occur but it is necessary to look at the new industrial revolution from the higher perspective. They are trying to set the frame of the basic concept of 4.0 Industry, which stems from the existing production system. Veža et al. (2015) research control of innovative production networks. They focus on smart factories which employ smart people, talk about smart products and services, which are integrated on the highest level of co-operation in production network. Albers et al. (2016) define 4.0 Industry and predict that it will be an intelligent, connected and decentralised production which connects a human, machines, products in cybernetic physical production system. 4.0 Industry

will enable integration of intelligent quality system in development directly with production as a part of a chain of added value.

Roblek, Meško and Kordež (2015) introduce a question: How important is 4.0 industry and what are the influences for creating added value of organizations and society? They also stress the positive aspects 4.0 as an effect of value efficiency, whereas technological changes will have positive as well as negative influence on employees. Salminen, Nylund and Andersson (2012) focus on evolution efficiency as an autonomous self-organizing system of production. Co-natural production is measured according to social, economical and environmental aspect. Salminen and Kovač (2012) give solutions from the perspective of life cycle. The authors ask themselves how to adjust global and local production by taking into account the system of life cycle. Neugebauer et al. (2016) describe the concept of 4.0 Industry as a technological change, formed on the »bottom up« model, based on »Fraunhofer« technologies. Cybernetic-physical system is described as an infrastructure of: interactions, reflections, transactions, internal operations, rules and communications. Waibel et al. (2017) decisively predict that the next generation of production system will act as a self-organization, included in cyber-physical network.

In the research we present the research question (RQ): How - with concept of forming autopoietic building blocks - to develop a model of organization of future, which will be able of self-/co-organization and self-/co-production in life circle?

3 Method

3.1 Qualitative methods as action research

In the centre of research we put scientific theories of fields of autopoiesis, modern organization and 4.0 industrial revolution with modern 4.0 organization. The research of autopoiesis in organizations is based on interdisciplinarity of abstract phenomena and mutual intertwinement. From the researched literature of authors Mesec (1998), Mali (2006) and Ambrož and Colarič-Jakše (2015) we establish that for research of abstract phenomena it is necessary to follow ontologic process of research, whereas for scientific validation and confirmation it is necessary to use mainly qualitative research method. Mesec (1998, pp. 27-35) says that we use qualitative research if we are interested in purpose, process and relation between research and theory. He points out that holistic perspective on human is not only studying organism as a whole but also practical problems of people in life. In this way define methodological suitability also Ambrož and Colarič-Jakše (2015, p. 50), and at the same time suggest the use of both methods (qualitative and quantitative), if possible so that the results are more comprehensive.

For research process Mesec (1998) directs us into sequential analysis which we repeat several times inside research and by making circles we strengthen and broaden knowledge on phenomena we are researching (pp. 36-39). We see this method as an autopoietic method as it in abstract meaning illustrates a model of autopoietic organization, working according to the

principle of re-processing and re-structuring of the given problem, and closing of circles (Lauc, 2000, p. 9). An organization Ovsenik (1999, p. 14) stresses: "...as self-recognizing, self-observing, self-aware observer with abstract thinking." From similar point of view Mesec (1994) explains that the roles of "researcher" and "user" can be in two holders, whereas if there is one holder, we talk about "self-research". If research is exchanged with validation, this is a special case of action research (AR). The author says that self-research is a legitimate sort of AR, where as a limitation he sees self-reflection, which usually is not broad enough frame with of research in an individual (p. 133).

Our research is about observing and connecting complex theoretical backgrounds, resulting in the base of organization, that is a human as a mentally active "machine", as an observer and at the same time actor of the processes. We suppose that on this human primal action also autopoietic organization is based. With this purpose we examined theories to find similarities and differences of autopoietic building blocks in modern and 4.0 organization. We used methods of observation, cognition, finding relations, triangulation, gaining qualitative and quantitative data, results, deduction and synthesis, which will be used to interpret BRQ, regardless if being confirmed or rejected. The main approach and course of activities coincides with findings of Ambrož and Colarič-Jakše (2015, p. 65), who claim that this is a repetitive process of: observing, rationalization and validation.

Mesec (2009, pp. 14-22) writes that by process of cognition and changing we add to personal and common growth. He describes the course of AR as a model of spirale of processes: observation, thinking, planning and activity. Ambrož and Colarič-Jakše (2015) state the method of data mining, when we want original approaches and insight into depth of a certain phenomena (pp. 94-95). Brcar (2016) emphasizes that we should be aware that qualitative analysis is more demanding, particularly for gaining data. Even more demanding is the processing of data, and all results, as well as interpretation are subjective and the reserchers need to have more experience. He states that the most demanding is the combination of more methods and points out that the use of untested methods does not bring results, therefore he recommends method testing prior to research (pp. 8-9).

3.2 Methodology of forming autopoietic building blocks as concept of life circle

Our research question is directed towards recognizing of similarities and differences of autopoietic building blocks in modern and 4.0 organization. Before that we needed to study the principles of autopoiesis and get an entire insight. All with the purpose to recognize building blocks, find similarities and differences, and that we can present the results of differences in modern and 4.0 organization. The intention of studying natural principles is to learn and pass on the activity by the analogy method into an organization. Our supposition is that if a system works in nature, it also works in a human and organization, which are a part of it.

We considered how to arrange the autopoiesis principles and again authors show us the way how to deal with sistematization. Maturana and Varela (1998) say that a human has the ability

of: observing, thinking, recognizing and understanding. Mesec (2009, pp. 14-22) states that with the process of recognizing and changing we contribute to personal and group growth. He describes the course of AR as a model of spiral of processes: observing, thinking, planning and acting. Lauc (2000) presents as a transformation process of human decision: feeling, thinking, speaking and acting. This directs us to consideration how to set the strategy of autopoietic building blocks. If we follow the authors, we can summarize that if we observe something, we feel it, create emotions, think about it, consider it, recognize it, speak about it, try to understand it and thus act. When we self-/co-operate, we can self-/co-observe ourselves, become self-/co-aware and we try to act more consciously in the spiral of actions. Kordeš (2004) describes creative circle, in which there is a circular exchange of creation and stability. Ivanko (2015) explains dialectic method as a base of organization theory with creation and changing. Železnikar (2017) says that inside cybernetic informational circle there is growth and dying. Lauc (2016) suggests that AR researcher should recognize, gain, develop and change. He mentions that this is a recognition circle, where a wave as well as particle is observed, and explains that these are quantum particles and their intertwinement. Lauc's suppositions correspond to our philosophy since we recognize with feelings, gain knowledge with self-/co-thinking and self-/co-considering, we develop in such a way that we self/co-observe, self-/co-direct and self-/co-change, so that we self-/co-operate.

We studied theoretical background where authors use life circle as a supposition of part as a whole. We look for some models of life circles as examples from nature, already established terms in work processes and science, which serve as a base for forming the concept of autopoietic building blocks. On the ground of comparison of models and self-/co-reflection we formed autopoietic building blocks as life circle. Each model was defined with four parts of one whole. Why is a human included in a circle? Lasan (2005, p. 7) answers this question: »Laws in a body are determined, but a human has to awaken them himself/herself. Without their own activity nothing happens.« On the other side an individual who works over his ability for a longer time, does not have time for thinking (Ambrož and Lotrič, 2009, p. 64). Humans can become a kind of automatism who due to external influences of environment forget that they are self-responsible for their dynamics. We are talking about dynamics that activates self-/co-feelings and continues into thinking, speaking and activity. When forming autopoietic building blocks sequence is important, as present in AR spiral.

4 Results

4.1 Focusing on autopoietic building blocks in three types of organizations

Perceiving, studying, forming autopoietic building blocks (BB) with qualitative and quantitative research of autopoietic (AO), modern (MO) and 4.0 organization (4.OO) was presented in the article: »Fundamental Autopoietic Building Blocks in 4.0 Organization as a Challenge to Humane Organization« (Balažic Peček, Bracar & Bukovec, 2017). Our thinking continued in the creative circle of autopoiesis with sequences: emotions, thinking, directing and activity. We are focused on our conceptual model, where we pointed out human as an

observer and actor. After self-/co-reflection of the observer, researcher and co-researchers, and based on the previous research and co-operation, we formed a conceptual group of four directional building blocks: BB1-Emotions, BB2-Thinking, BB3-Directing, BB4-Activity.

Table 1. Autopoietic building blocks in AO, MO and 4.00

| Cover group of directional BB | AO | | MO | | 4.00 (frequency of BB) | |
|-------------------------------|-------------------|---------------|-------------------|---------------|------------------------|-------------|
| | (frequency of BB) | % (frequency) | (frequency of BB) | % (frequency) | | % frequency |
| BB1-Emotions | 346 | 29,1 | 127 | 10,1 | 67 | 4,8 |
| BB2-Thinking | 244 | 20,5 | 190 | 15,1 | 170 | 12,2 |
| BB3-Directing | 55 | 4,6 | 379 | 30,0 | 313 | 22,4 |
| BB4-Activity | 544 | 45,8 | 566 | 44,8 | 846 | 60,6 |
| Total | 1189 | 100,0 | 1262 | 100,0 | 1396 | 100,0 |

4.2 Forming concept and model of autopoietic building blocks as life circle

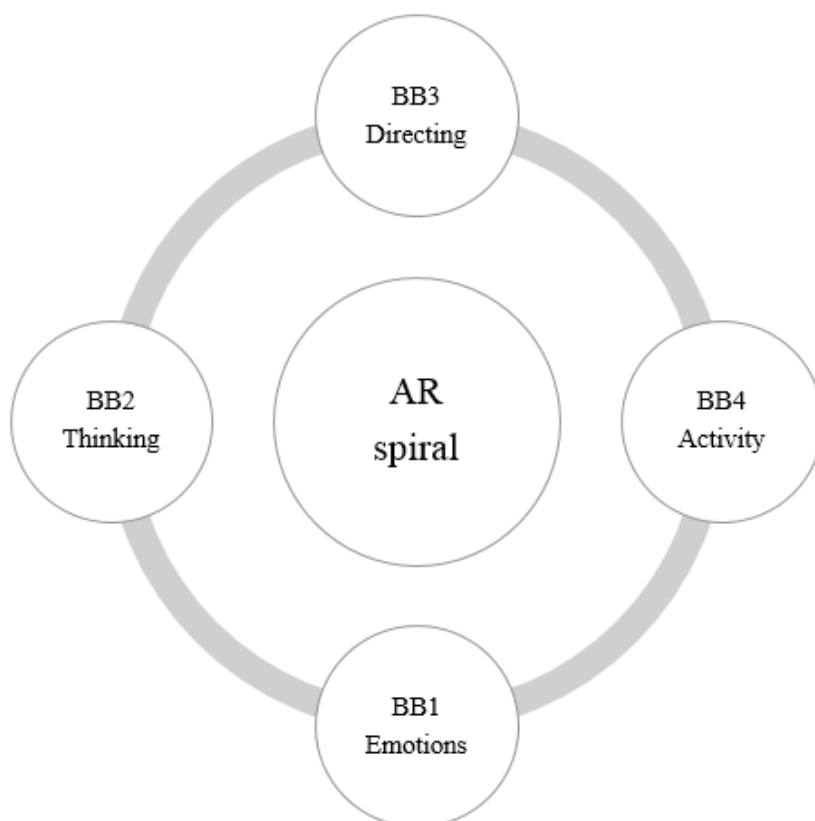
The research concept of forming autopoietic building blocks as life circle was developed as a deductive-inductive model, according to guidelines of Ambrož and Colarič-Jakše (2015), in which we inserted research with AR spiral (Mesec, 2009). Most attention in qualitative analysis was given to process building blocks; we can say that this is a demanding analysis which requires from a researcher to have a lot of experience and knowledge in the research area. Various authors point that out: Mesec (1998) stresses the courage of such research, Ambrož and Colarič-Jakše (2015) demanding systematics and depth, whereas Brcar (2016) emphasizes difficulty itself. Phases of research process are based mainly on qualitative analyses in 5 steps:

1st step: After studying theoretical background on self-/co-principles in autopoiesis, as described by Maturana and Varela (1980, 1998), Capra (1986 and 2002), Jantsch (1980), Ovsenik (1999) and Lauc (2000). We designed »Informational graph of autopoiesis - (IGA)« with A. P. Železnikar. The purpose of »IGA« is to present the comprehensive, systematic and informational view of autopoietic building blocks, as referred to in the continuation. »IGA« is the base and the research tool for central research of autopoietic building blocks in 4.0 organization, thoroughly described in the article Balažic Peček, Brcar and Bukovec (2017).

2nd step: We developed methodology for a concept of autopoietic building blocks as life circle so that we refer to Maturana and Varela (1998), who say that a man has the ability of: observing, thinking, recognizing and understanding. Lauc (2000) included in the process of decision making the transformation process of: feeling, thinking, speaking and acting. With their findings and with findings of others (Mesec, 2009 and Ambrož & Traudi Mihelič, 1998) we develop a concept. In the nature we look for models of natural laws in life circle and recognize in them that the activity of a whole is conditioned by four parts. Theoretical background is taken into account when making the concept of methodology of forming

autopoietic building blocks and validation. Kordeš (2004) helps us conclude the development of the concept as creative life circle with findings of creative circle, and Mesec (2009) with AR spiral (Picture 1).

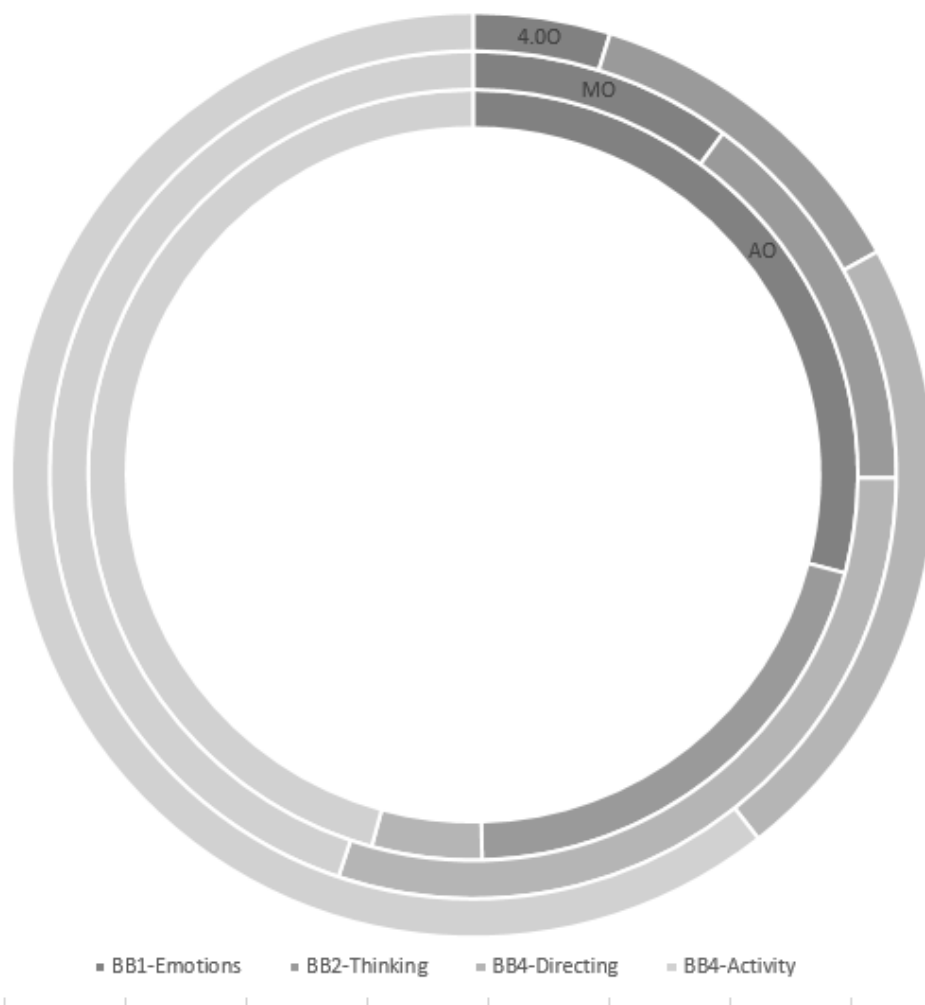
3rd step: The concept of forming autopoietic building blocks as life circle was developed with four building blocks: BB1-Emotions, BB2-Thinking, BB3-Directing, BB4-Activity, with the AR spiral in the centre, as a characteristic of autopoiesis (continuous interaction). Researching according to the concept of forming autopoietic building blocks as life circle is connected with natural laws and in such a way some natural models are set, so that we can say that the research itself is autopoietic. The originality of the concept of forming autopoietic building blocks is shown as life circle, a circle of emerging and decay. AR spiral in the centre means that we are researching, acting and developing groups and thus an individual self-/co-develops as an observer and actor in internal and external world. This duality of self-/co-operation of human was put into the basic concept of the research and served as a starting point practically in all parts of the research. We can say that with continuous self-/co-operation autopoietic activity is being implemented, which starts with self-/co-relationship, thus triggering the processes of feeling, thinking, directing and activity, as presented with directional building blocks from BB1 to BB4.



Picture 1. Concept of forming autopoietic building blocks as life circle

4th step: On the base of »IGA« and the concept of methodology of forming autopoietic building blocks as life circle we design autopoietic building blocks on two levels: cover group of four directional building blocks and 36 process building blocks in line with »IGA«. On the level of directional building blocks: BB1-Emotions, BB2-Thinking, BB3-Directing, BB4-Activity we present the results, on the level of process building blocks we carry out qualitative analyses.

5th step: Suitability of set autopoietic building blocks is validated with triangulation, which is made »as particle and wave«, on the level of particle with static and on the level of wave with dynamic view of triangulation. The result of triangulation is confirmation of suitability of set autopoietic building blocks. Triangulation is made also to confirm identification of autopoietic processes in the organization foundations. The starting points for performing triangulations are summaries of theoretical backgrounds of authors. The central research was carried out with mixed methods. As informational tool we used Atlas.ti. We prepared pdf forms of articles to be processed in Atlas.ti, which transformed data into excel and thus we prepared data for qualitative analysis. Qualitative analysis included an overview of texts (articles) on autopoietic, modern and 4.0 organization, where we searched for set autopoietic building blocks on the level of process building blocks. Results were presented with quantitative data, gained from qualitative data of article texts analysis in AO, MO and 4.00. In final triangulation between AO, MO and 4.00 we establish that all four directional building blocks are present in AO, MO and 4.00, whereas the differences are on the level of process building blocks. With the results we design a model of forming autopoietic building blocks in organization, named: »Model of forming autopoietic building blocks in organization – MOGAO« (Picture 2). In the inner circle results of AO are presented, in the central MO and in the external 4.00. In the »MOGAO« model one can immediately notice a significantly smaller share of building blocks BB1 and BB2 in MO and 4.00 in comparison with AO. In 4.00 we see the increase in BB4 compared to AO and MO. With BB3 we can point out that in MO there exists the greatest effort, which is in 4.00 eliminated with information technology and so the share of BB3 is getting smaller if compared with MO and not with AO. We sense a paradox that the share of BB3 in AO is extremely small. We set a question: can the processes of BB1 in AO be replaced with processes of BB3, which are strongly present in 4.00 and even more in MO. We suppose that in BB1 and BB2 there is internal or vertical activity present, while in BB3 and BB4 there are mainly external processes or horizontal activity.



Legend: external circle presents 4.00, middle circle MO and inner circle AO
Picture 2.»Model of forming autopoietic building blocks in organization-MOGAO«

5 Discussion

With results we can substantiate that process building blocks inside the »MOGAO« model form a structure of AO, MO and 4.00. Autopoietic building blocks can be interpreted so that they bring vivacity in an organization with self-/co-principles. An individual wants to realise himself/herself in an organization as a sensory being, who feels, senses, thinks, directs himself/herself and co-workers in interdisciplinary teams and acts in the direction of self-/co-referencing (Lauc, 2000). Thus we can state that an individual is a creative potential of organization who with self-/co-organization contributes to personal and organizational power. With this we do not mean the power of prevalence and competition but we want to emphasize that human self-/co-operation is important (in the sense of self-/co-education, self-/co-culture and self-/co-organization), with which they ensure the autonomy of the environment. This does not represent isolation because without a human relationship and self-/co-operation there is no organization, proven by the authors (Ovsenik, 1999, Lauc, 2000 and others). We realized that the creative relationship shows itself in respect, trust, awareness, responsibility towards oneself and everything else. With such culture a human can be active self-/co-

operating subject, who uses emotions and thinks therefore he/she is an operator and potential of an organization. The organization of future should not allow the treatment of a human as a matter, as treated in the mechanistic paradigm. We learn that treatment of a human as an object hinders »flow of movement« and self-/co-operation in an organization, pointed out by many authors (Jantsch, 1980, Lauc, 2000 and others). Autopoiesis is »alive« and gives vivacity to a human as well as organization. Modern and 4.0 organization suppress originality of life and when a life is dying, organization is dying as well. With this we can confirm the research question that with establishing vivacity in an organization we create conditions for operation of self-/co-organization, in which a comprehensive complex interdisciplinary intertwinement of different principles and scientific fields is present.

By intertwinement of theoretical starting points we stressed the complexity and interdisciplinarity of human life and action, in studying a human, his biological, physical (quantum physics) and philosophical level, as well as sociological, organizational, economical, including also law in the wider model of autopoietic organization, which presents a research for central study (Balažic Peček, Bracar & Bukovec 2017). We discover a significant difference between autopoietic building blocks in MO and 4.0O, since 4.0O does not have three process building blocks present. As already supposed considering the total value of BB1-Emotions in MO and 4.0, since there's a significant difference. We also determine that in 4.0O the directional building block BB4-Activity is getting stronger, while BB3-Directing is getting weaker, which is a consequence of good communication established by 4.0 organization. Results show that BB4-Activity is getting stronger, which in comparison with MO gained on the account of BB3-Directing, which in 4.0 is a goal so that relations machine-machine, machine-human and human-human are connected. Results prove that 4.0O excellently connects in the connection machine-machine and human-machine, but for connection human-human, seen from BB1-Emotions, this cannot be claimed made - we can relate this to a mechanistic paradigm and allopoietic activity, which is not in line with a human. It seems like a battle for survival of entrenched paradigm which does not see that constant growth of the same building blocks eliminates and thus ruins building blocks that are important for harmony and complementarity of building blocks. We suppose that creative harmony of an organization can be "awakened" with autopoiesis on all levels.

We suppose that an individual is a subject in mutual co-dependence with self-organization where people develop organization as a self-regulating process. Results confirm that the aspect of communication in 4.0 organization is improving compared to modern organization. However, in the results we see a lack of emotional aspect and self-/co-referencing in the sense of self-/co-activity so we can perceive that communication machine-machine and man-machine is improving. Primary relations human-human seem to be forgotten and we see this as a gap of 4.0 (r)evolution and consequently 4.0 organization. In 4.0 Industry and 4.0 organization we do not detect an entire concept but only announcement of extensive changes in future production solutions. We understand that the creators of 4.0 Industry focus on efficiency as an autonomous self-organizing system of production and are aware of

bureaucratic organizations on all levels of society. We do not sense development of organization as a development of organizational thought in the concept of 4.0 (r)evolution, so we can say that according to the known concepts it is more the continuation of mechanistic paradigm. For society a 4.0 (r)evolution is a challenge so that 4.0 organization surpasses allopoietic organization and is becoming more and more autopoietic where relations are important, as well as inner balance and self-respect, creating a harmony between employees. That a base of organization is harmonic co-operation can be seen also with Ovsenik (1999), and competitiveness is a principle of allopoietic organizations, which are becoming more dependent on external world and do not develop self-organization. It is necessary to use mental process, as confirmed by Morgan (2004), when we see that a human is the one who creates our world. Also anthropologist Trstenjak (1985) would agree with this; he suggests that we must not forget to create the world. We recognize this as an autopoietic characteristic, we are dependent on self-organization. From the biological point of view we can assume that mental process is the base of creating and independence of a human in organization.

Our vision is a moral society so that we self-/co-motivate and co-create the needs of a free Human. Schwab (2016) believes that a new technological revolution is a challenge for humanity. This is a new understanding and directing since a transformation will include the entire humankind. From this point of view the transformation of society in the direction of science, art, high technologies and spirituality is of great importance. Tesla also learned directly from nature and knew well the existing scientific theories of that time but that did not stop him. He opened all basic gained things into a surplus space, where science, art and spirituality do not have boundaries (Tesla, 2013, p. 121).

We assume that in BB1 and BB2 internal and vertical activity is present, whereas for BB3 and BB4 we suppose that there are mainly external processes or horizontal activity present. In the organization of future the emphasis should be put on the establishment of internal processes, which are based on moral values and human activity on all levels. This is what ensures the organization the ability of self-/co-operation in the sense of processes' vivacity. Modern and 4.0 organization suppress the originality of life and when a life is dying, organization is dying. Thus we can confirm the research question that by implementing vivacity in an organization, we create conditions for operation of self-/co-organization. We can say that this is a complete complex intertwining of different principles, which need to be studied interdisciplinarily, whereas in the future transdisciplinary aspect of researching should be achieved.

6 Conclusion

We performed research mainly in qualitative way and we decided according to action research what is good practice of studying autopoiesis. We carried out horizontal research of autopoiesis and connected it with anthropology of a human, ethics, philosophy, modern organization, 4.0 organization and aspects of humane society. We did vertical research of autopoiesis and connected it with biology, quantum physics and philosophy of life, and

researched individual building blocks from the point of view of process activity inside autopoiesis and allopoiesis.

We established that with AR method we can form a concept of autopoietic building blocks. The concept is given balance of activity by building blocks: BB1-Emotions, BB2-Thinking, BB3-Directing, BB4-Activity, which are cover autopoietic building blocks, whereas inside there is activity of process autopoietic building blocks, which continuously re-process and re-structure organization on all levels. The result is a concept of forming autopoietic building blocks in which AR spiral is inserted, which gives self-/co-organizational abilities to organization of future as 4.0 organization. From the concept we develop by qualitative and quantitative methods a model »MOGAO«, from which it can be seen that a modern and even more 4.0 organization has moved away from autopoietic organization. We suppose that with the »MOGAO« model we can develop a model of future organization (4.0 organization) which will be able of self-/co-organization in life circle. In future organization the emphasis must be put on the establishment of processes, based on moral values and healthy human activity on all levels. And exactly this ensures that an organization has the ability of self-/co-operation in the sense of processes' vivacity. Modern and 4.0 organization suppress originality of life and when a life is dying, organization is dying, or as Želznikar (2017) says, this is growth and dying. With this we can confirm the research question that with the establishment of vivacity in organizations we create the conditions for operation of self-/co-organization. We assume that this comprehensive harmonic intertwinement of autopoietic building blocks in continuous movement ensures healthy, creative and complete activity of human and organizations. We can conclude that a human and organization are losing their vivacity of natural activity, which in an organization and society show in humane relations and actions. In addition, the originality of life is being repressed in a human, and when life is dying, organization is dying as well. Now a human has a chance to consciously side with a human and civilisation with autopoietic principles as: »Autopoietic 4.0 Human (R)Evolution«.

We did not come across similar approaches of studying organization, and this is stressed as a limitation since we do not have enough data to compare results of different studies. Moreover, in our environment there is no institution which would develop such methods in the sense of creative development of a human, his/her culture on conscious level of an organization and society as a whole. The continuation of researching autopoiesis is to develop - from the set concept and model - practical models which will self-/co-confront with everyday challenges of a human and organization. In order to achieve this our purpose is to establish an institution for autopoietic organization which will be able to study and connect: science, art, high technologies and spirituality.

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Povzetek:

Akcijsko raziskovanje: od koncepta do modela oblikovanja gradnikov avtopoieze kot življenjski krog

Raziskovalno vprašanje (RV): Kako s konceptom oblikovanja gradnikov avtopoieze razviti model organizacije bodočnosti, ki bo zmožna samo-/so-organizacije in samo-/so-produkcije v življenjskem krogu? Človekov potencial raziskujemo kot naravni krožni proces, kar je značilnost akcijskega raziskovanja. Avtopoieza je celovit preplet področij neprestanega gibanja, ki se posledično kaže v ustvarjalni celostni kulturi človeka.

Namen: Razviti koncept za oblikovanje gradnikov avtopoieze kot življenjski in model organizacije kot model organizacije bodočnosti. Zanima nas človek v organizaciji, v medsebojni samo-/so-odvisnosti na mikro in makro ravni. Znotraj te čedalje bolj virtualne organizacije raziskujemo človeka, človečnost in človeški potencial kot ustvarjalni potencial humane organizacije.

Metoda: Usmeritev v akcijsko raziskovanje, ki jo podkrepimo mešanimi metodami, za celovitejšo raziskovanje avtopoieze v organizaciji. Za kvalitativno raziskovanje uporabimo programsko orodje Atlas.ti. Raziskavo lahko umestimo kot študijo primera.

Rezultati: Razvili smo koncept v 5. korakih, za oblikovanje gradnikov avtopoieze kot življenjski krog. Z rezultati kvalitativne in kvantitativne analize, primerjav avtopoietске, sodobne in 4.0 organizacije, smo razvili model »Model oblikovanja gradnikov avtopoieze v organizaciji – MOGAO«. Model je lahko primerjalno orodje za zaznavanje procesov v organizaciji. Z rezultati utemeljujemo, da se 4.0 organizacija usmerja predvsem v delovanje in pridobiva na deležu izboljšanih komunikacij. Izgublja pa v občutenju in razmišljanju človeka v organizaciji.

Organizacija: Rezultati so lahko vodilo in izziv humanim organizacijam. Podajamo izziv, kako s poznavanjem horizontalnih in vertikalnih zakonitosti človeka »obvladovati« 4.0 organizacije. Raziskava prispeva k zavedanju človeka in preobrazbi alopoietskih k vedno bolj avtopoietским organizacijam, za kar uporabimo vodilo »Avtopoietska 4.0 (r)evolucija človeka«.

Družba: Sprejemanje avtopoieze na vseh ravneh družbe in posledično prebujajočih se organizacij, ter družbe kot celote. Končni rezultat je, z avtopoiezo vplivati na kulturni razvoj družbe v smislu povezovanja znanosti, umetnosti, visokih tehnologij in duhovnosti.

Originalnost: Preplet horizontalnih in vertikalnih znanostvenih področij, s povezovanjem naravoslovja in družboslovja. Zapisovanje avtopoietских principov (gradnikov/procesov) iz vidika opazovalca in akterja kot samo-/so- principi. Celovitost proučevanja z razvitim konceptom in postavitev modela »MOGAO«.

Omejitve/nadaljnje raziskovanje: Ni relevantnih podatkov za primerjavo študije primera. Proučevanje avtopoietске organizacije v smeri »Avtopoietska 4.0 (r)evolucija človeka«. Ustanovitev inštituta za proučevanje avtopoieze na vseh ravneh družbe.

Ključne besede: akcijsko raziskovanje, avtopoieza, avtopoietška organizacija, 4.0 organizacija, gradniki avtopoieze, koncept in model oblikovanja gradnikov avtopoieze.

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Sistemi vodenja kakovosti v primarni zdravstveni dejavnosti

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Povzetek:

Namen in originalnost: Namen raziskovanja je pojasniti izvor, razvoj in stanje sistemov vodenja kakovosti v primarni zdravstveni dejavnosti.

Metoda: Uporabili smo metodo sistematični pregled obstoječe literature kakovosti v zdravstvu.

Rezultati: Raziskava je pokazala izhodišča za razvoj in vzroke za uvajanje sistemov vodenja kakovosti ter predloge za nadaljnji razvoj kakovosti v primarnem zdravstvenem varstvu.

Organizacija: Organizacije iz primarne zdravstvene dejavnosti bodo dobile vpogled v stanje kakovosti v primarnem zdravstvenem varstvu v ostalih Evropskih državah in Sloveniji.

Omejitve/nadaljnje raziskovanje: Raziskava je omejena z manjšim številom obstoječih virov, ki so uporabljeni. V prihodnosti bi bilo smiselno raziskati, katere kazalnike kakovosti bi bilo smiselno meriti v primarni zdravstveni dejavnosti in na podlagi tega oblikovati nov model spremljanih ali obveznih kazalnikov kakovosti v primarni zdravstveni dejavnosti.

Ključne besede: kakovost, sistemi vodenja kakovosti, primarna zdravstvena dejavnost, zdravstvena oskrba, varnost pacientov.

1 Uvod

Dostopnost zdravstvenih storitev in spremljanje ter izboljševanje kakovosti le-teh je prednostna naloga vseh držav. Tudi Slovenija je sprejela Nacionalno strategijo za kakovost in varnost v zdravstvu (2010), ki izhaja iz Nacionalnih usmeritev za razvoj kakovosti v zdravstvu (2006), in s tem tudi ukrepe za zagotavljanje kakovostne in varne zdravstvene oskrbe uporabnikov zdravstvenih storitev.

Predvsem vodstvo zdravstvenih ustanov iz različnih nivojev zdravstvene dejavnosti nosi odgovornost do pacienta, zaposlenih, ustanoviteljev in plačnikov. Zato vodje teh ustanov nosijo tudi odgovornost za uvajanje metod in orodij kakovosti in varnosti v zdravstvu. Kakovost ne bi smela biti ločena in posebna dejavnost zdravstvenih ustanov, ampak bi morala biti prepletena z vsakodnevnim delom in procesi.

Kakovosti v zdravstvu primanjkujejo predvsem kazalniki strukture (primernost opreme, izobraževanje zaposlenih, zadovoljstvo zaposlenih...) in procesa (kako je storitev dostavljena uporabniku, zadovoljstvo pacientov...), preveč pa je poudarka na kazalnikih izidov zdravljenja. Izidi zdravljenja niso odvisni samo od postopkov zdravljenja, ampak od številnih dejavnikov, na katere zdravstveni sistem nima vpliva (starost pacienta, resnost obolenja, socialno ekonomski status...), zato je pomen izidov zdravljenja za oceno storitev kakovosti in uspešnost ter učinkovitost organizacije manjši. V številnih virih najdemo dokaze, da samoocenjevanje, strokovna presoja, merjenje kazalnikov kakovosti in javna objava le-teh vodi v izboljševanje kakovosti in varnosti zdravstvene oskrbe.

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V zdravstvu pa je razvoj kakovosti zaenkrat še prepuščen posameznikom in ustanovam, ki se zavedajo pomena izboljševanja kakovosti. Tako so poskusi izboljšav bolj predmet samoiniciativnosti kot pa posledica sistemskih sprememb.

V središču pozornosti je v zdravstvu pacient. Zanj je pomembno, da lahko izvajalce med sabo primerja tako na področju preventive, diagnostike, zdravljenja kot tudi rehabilitacije. Če so ti podatki javno dostopni, lahko zdravnik in pacient izbirata med izvajalci zdravstvenih storitev, ki imajo dobre kazalnike izidov zdravljenja, zato morajo biti kazalniki krajevno in časovno primerljivi. Primarna zdravstvena dejavnost bi morala biti za pacienta, skupnost in Vlado še veliko pomembnejša, ker že od leta 1980 poleg kurative kroničnih obolenj nudi tudi preventivo. Na primarni ravni se torej že lahko ustvarijo odlični izidi zdravljenja oziroma se določene bolezni lahko preprečijo, kar pa pomembno vpliva na kasnejše stroške zdravstvene oskrbe. Pred stroški oskrbe pa je na prvem mestu predvsem kakovost življenja posameznika. (Ministrstvo za zdravje, 2006, str. 39 – 40)

V kolikor bolezen pravočasno preprečimo ali zmanjšamo tveganja za nastanek, bo nivo kakovosti načina njegovega življenja prav gotovo višji. Poleg tega se prebivalstvo vedno bolj stara, veliko je soobolevnosti, pacienti pa so vedno bolj informirani, zato bi moral biti razvoj kakovosti storitev primarnega nivoja zdravstvene dejavnosti prednostna naloga Vlade. Zaenkrat je problem ta, da ni nobenih finančnih spodbud za kakovostno delo v zdravstvu. Predvidene so le sankcije (finančne kazni) – npr.: če izvajalec na primarni ravni zdravstvene dejavnosti ne doseže plana preventivnih pregledov, prekorači povprečje napotitev, predpisuje zdravila tako, da ni v skladu s pravili ZZS itd.

Kakovost dela v zdravstvu lahko ocenimo na različne načine, najpogosteje pa s kazalniki kakovosti (Quality indicators). Kazalniki kakovosti so pomembni tako za izvajalca zdravstvenih storitev kot tudi za uporabnika (pacienta/varovanca). Organizacije najpogosteje merijo kazalnike kakovosti zato, da ugotovijo in spremljajo uspešnost in učinkovitost doseganja zastavljenih ciljev v planih. Na podlagi tega imajo nadzor, kontrolo in možnost pravočasnega ukrepanja ob odstopanjih. Uporabnik zdravstvene storitve pa s pomočjo kazalnikov kakovosti dobi informacijo, v katerih zdravstvenih ustanovah so zdravstvene storitve najbolj kakovostne in varne. Zato je pomembno, da so postavljeni kazalniki kakovosti merljivi, prikazani z absolutnimi vrednostmi in primerljivi v času in med ustanovami. (Kiauta et al., 2010)

Veliko izvajalcev zdravstvenih storitev gleda na kakovost v zdravstvu kot na dodatno birokratsko delo. Zato morajo biti kazalniki kakovosti postavljeni tako, da ni potrebno dodatno delo za njihovo meritev, ampak jih lahko izračunamo iz že obstoječih podatkov.

Načrtovan je bil razvoj kazalnikov kakovosti za vse ključne točke zdravstvene obravnave pacienta, saj bi le tako prikazali tudi gibanje pacienta skozi zdravstveni sistem.

Kljub vsemu so bili leta 2010 oblikovani le kazalniki kakovosti, ki jih je možno uporabiti, meriti in spremljati le v sekundarni zdravstveni dejavnosti. Zato je treba nujno raziskati, kateri

so kazalniki, ki jih merijo in spremljajo organizacije v primarni zdravstveni dejavnosti. Na podlagi zbranih podatkov bi bilo dobro oblikovati in določiti nabor kazalnikov kakovosti za primarno zdravstveno dejavnost, ki bi jih bilo za organizacije iz primarne zdravstvene dejavnosti priporočljivo meriti in spremljati.

V primarni zdravstveni dejavnosti je zelo malo raziskav o finančnih prihrankih in izboljševanju zdravstvenega stanja prebivalstva na račun kakovosti v zdravstvu (Kersnik, 2001). Veliko zaposlenih je preobremenjenih, da bi dajali prednost kakovosti ali da bi se z njo ukvarjali. Večina je slabo seznanjena s procesom obvladovanja kakovosti, zato velikokrat v zdravstvenih ustanovah še naletimo na odklonilni odnos do kakovosti, saj predvsem zdravniki kakovost dojemajo kot nadzor ali kontrolo. Vzrok pa je predvsem neznanje o kakovosti v zdravstvu. S tem velikokrat utrpita škodo tako pacient kot tudi zaposleni. Za sistemske napake se velikokrat kaže s prstom na posameznika, zato bi morali biti prednostni cilji vodstva v primarni zdravstveni dejavnosti predvsem zadovoljstvo pacientov, učinkovitost in izidi zdravljenja, zadovoljstvo zaposlenih, izboljšanje sodelovanja med zaposlenimi in dvig ugleda zavoda.

Namen preglednega članka je, da raziščemo razvoj sistemov vodenja kakovosti v zdravstvu. Na podlagi tega si lahko zastavimo cilj raziskave, ki je ugotoviti, kam segajo začetki razvoja kakovosti v Evropi, kako se je razvijala kakovost v zdravstvu v Sloveniji, kakšni so nadaljnji cilji razvoja kakovosti v primarni zdravstveni dejavnosti.

Raziskovalno vprašanje na katerega poskušamo odgovoriti je, katera so temeljna izhodišča za razvoj kakovosti in sistemov vodenja kakovosti v zdravstvu v Evropi in Sloveniji.

2 Teoretična izhodišča

2.1 Mednarodna izhodišča razvoja kakovosti v zdravstvu

Odbor ministrov Sveta Evrope je 30. septembra 1997 sprejel Priporočilo št. R (97) 17, Razvoj in izvajanje sistemov izboljševanja kakovosti v zdravstvenem varstvu, ki ga je pripravil Strokovni odbor za zagotavljanje kakovosti v zdravstvenem varstvu z namenom:

- večje enotnosti med članicami in zato skupne ukrepe na področju zdravstva,
- da je zdravstveno varstvo je temeljna pravica vsakega posameznika in skupnosti,
- da je treba upoštevati 11. člen Evropske socialne listine o pravici do varovanja zdravja,
- da 3. člen Konvencije o človekovih pravicah zahteva pravično dostopnost zdravstvenega varstva ustrezne kakovosti,
- da je nenehno izboljševanje kakovosti oskrbe prednostna naloga vsake članice, predvsem zaradi gospodarskih omejitev in zmanjšanih proračunov v zdravstvu,
- da zdravstvena oskrba obsega: strukturne in organizacijske vidike (dostopnost), vidike procesa (strokovno odličnost in gospodarno uporabo virov) ter dober izid oskrbe,
- da so zlasti pomembni vsi izidi v smislu zdravja, dobrega počutja in zadovoljstva bolnikov,

- da je za uporabnike nujno, da sodelujejo v lastnem zdravstvenem varstvu in ob spoznanju, da jim zdravstveni delavci morajo nuditi popolne in jasne informacije,
- da mora vsaka država članica podpirati splošno izobraževanje o zdravstvenih problemih, promociji zdravja in načinih preprečevanja in obvladovanja bolezni,
- da je zagotavljanje kakovostnega zdravstvenega varstva dolžnost vseh članic,
- da je pomemben vpliv tveganj v zdravstvu,
- da je izboljševanje kakovosti v zdravstvenem varstvu sorazmerno novo področje.

Odbor ministrov Sveta Evrope priporoča, da vse države članice pripravijo politične smernice in strukture, ki bodo podpirale razvoj in izvajanje sistemov izboljševanja kakovosti zdravstvenega varstva na vseh ravneh. (Svet Evrope, 2001, str. 7–8)

Države članice Svetovne zdravstvene organizacije so sprejele dokument Zdravje 21 – zdravje za vse v 21. stoletju. Navedenih je 21 ciljev. 16. cilj zdravstvene oskrbe se osredotoča na zdravstvene izide kot končno merilo kakovosti zdravstvene oskrbe. (World Health Organization, 1999, str. 174)

Leta 2002 se je začel projekt OECD za kakovost zdravstvenega varstva, katerega cilj je bil meriti in primerjati kakovost zagotavljanja zdravstvenih storitev v različnih državah. V okviru projekta so razvili niz kazalnikov na ravni zdravstvenih sistemov, ki omogočajo oceno vpliva posameznega dejavnika na kakovost zdravstvenih storitev. (www.oecd.org/els/health-systems/health-care.quality-indicators.htm)

Projekt kazalnikov kakovosti zdravstvene oskrbe je vodila strokovna skupina, sestavljena iz predstavnikov držav OECD. Sodelujoče države v letu 2006 so bile: Avstralija, Avstrija, Kanada, Češka, Danska, Finska, Francija, Nemčija, Islandija, Irska, Italija, Japonska, Mehika, Nizozemska, Nova Zelandija, Norveška, Portugalska, Slovaška, Španija, Švedska, Švica, Združeno kraljestvo in Združene države. Cilj projekta je bil razviti niz kazalnikov, ki bi izražali stanje zdravstvenega sistema. (Kelley & Hurst, 2006, str. 1–3)

Do leta 2010 so morale države članice OECD zagotoviti, da se zdravstveno varstvo osredotoči na izide zdravljenja na vseh ravneh.

Glavne usmeritve so bile:

- Uspešnost strategij javnega zdravja naj se ugotovi z zdravstvenimi izidi. Poleg tega naj se primerjajo s stroškovno učinkovitostjo.
- Vse države naj bi imele nacionalne mehanizme za nenehno spremljanje in oblikovanje kakovosti zdravstvene oskrbe za najmanj 10 zdravstvenih stanj, vključno z merjenjem vpliva zdravja, stroškovne učinkovitosti in zadovoljstva pacientov.
- Izidi zdravljenja v najmanj petih od desetih zdravstvenih stanj morajo pokazati pomembno izboljšanje, ankete med uporabniki pa morajo pokazati večje zadovoljstvo pacientov (izboljšanje izkustev pacientov s kakovostjo zdravstvenih storitev, spoštovanje njihovih pravic). (Ministrstvo za zdravje, 2006, str. 19)

Evropska komisija na podlagi ugotovitev, da zdravstvene napake povzročajo človeško trpljenje in visoke stroške v zdravstvu, opominja članice OECD, naj:

- posvetijo veliko pozornost vprašanju varnosti pacientov;
- oblikujejo sisteme za izboljšanje varnosti pacientov, ki temeljijo na raziskavah. (Commission of the European communities, 2008, str. 8–9)

Svet Evrope je leta 1997 sprejel priporočila zdravstvenih ministrov. Na podlagi teh je svet Evrope objavil priporočila o varnosti pacientov. Glavni razlog za oblikovanje sistema kakovosti v zdravstvenem varstvu v posameznih državah Evropske unije so:

- nesprejemljiva raven odklonov zdravljenja;
- nesprejemljiva raven uspešnosti delovanja;
- neuspešna ali neučinkovita uporaba zdravstvenih tehnologij (premajhna uporaba, prevelika poraba, nepravilna uporaba);
- visoka cena slabe kakovosti;
- nezadovoljstvo uporabnikov;
- neenak dostop do zdravstvenih storitev;
- čakalne dobe;
- cena zdravstvenih storitev, ki si jih družba ne more privoščiti. (Svet Evrope, 1997, str. 22–46)

Zaradi mobilnosti pacientov je namen EU zagotoviti kakovostno zdravstveno obravnavo za državljane EU. Zaradi tega morajo izvajalci zdravstvene dejavnosti in države dokazati, da imajo:

- vzpostavljene organe za kakovost (agencije in centre ali inštitute za kakovost v zdravstvu na ravni države, oddelke ali komisije za kakovost na ravni bolnišnic);
- delujočo notranjo presojo – samoocenjevanje;
- delujočo zunanjo presojo – certifikacijo/akreditacijo;
- urejeno nenehno izboljševanje kakovosti (klinične smernice, klinične poti, merjenje in poročanje kazalnikov izidov in drugih kazalnikov kakovosti, urejeno poročanje o zdravstvenih napakah, urejeno upravljanje varnosti pacientov);
- uvedeno izobraževanje za kakovost. (Ministrstvo za zdravje, 2006, str. 22)

2.2 Kakovost v sistemu zdravstvenega varstva v Republiki Sloveniji

Leta 2001 je bil pripravljen dokument Kakovost v sistemu zdravstvenega varstva v Republiki Sloveniji, ki opisuje stanje v državi in nekatere mehanizme, ki so na voljo za zagotavljanje vsaj najnujnejših standardov. (Kersnik, 2001)

Pozneje je bil oblikovan Nacionalni program zdravstvenega varstva Republike Slovenije – zdravje za vse do leta 2004, kjer je v 5. točki zapisano, da je treba spodbujati razvoj stroke in izboljšanje kakovosti dela zdravstvene dejavnosti v smeri, da se bo na vseh ravneh zdravstvene dejavnosti uveljavil sistem celovite kakovosti dela s ciljem, da bo zmogljiv

zdravstveni sistem ustrezal željam in potrebam pacientov in vsega prebivalstva ob smotrni uporabi sredstev. (Ministrstvo za zdravje, 2006, str. 32)

31. maja 2003 so se zbrali predstavniki zainteresiranih skupin: Zdravniška zbornica Slovenije, Zbornica zdravstvene nega, Onkološki inštitut, Klinični center, Projekt razvoja upravljanja sistema zdravstvenega varstva, Združenje zdravstvenih zavodov Slovenije, Splošna bolnišnica Maribor, Splošna bolnišnica Jesenice, Ministrstvo za zdravje, Zavod za pokojninsko in invalidsko zavarovanje, zavarovalnici Adriatic in Vzajemna, Zavod za zdravstveno zavarovanje Slovenije, da bi ustanovili mreže in organizacije za kakovost v zdravstvu na državni ravni. Zaradi nezmožnosti dogovora nacionalna institucija za kakovost v zdravstvu ni bila ustanovljena. Leta 2003 je bil izdelan osnutek zdravstvene reforme, kjer so opisane usmeritve za sistematično vpeljavo kakovosti v zdravstvu v RS. Četrti cilj je posvečen kakovosti. Tu so postavljene zahteve za upravljanje celovite kakovosti/nenehnega izboljševanja kakovosti in zaveze vseh ravni zdravstvenega varstva za vzpostavitev struktur in vsebin kakovosti. Ker ni bilo ustanovljenega nacionalnega telesa za kakovost v zdravstvu, je bil leta 2004 ustanovljen Oddelek za kakovost pri Ministrstvu za zdravje. (Ministrstvo za zdravje, 2006, str. 32)

- Vsi udeleženci v zdravstvenem varstvu (izvajalci, pacienti, plačniki, poslovodni delavci in organi oblasti) morajo sodelovati pri vzpostavitvi in vzdrževanju sistemov nenehnega izboljševanja kakovosti. Vodilni delavci na vseh ravneh pa morajo zagotoviti razmere za vzpostavitev, vpeljavo in vzdrževanje nenehnega izboljševanja kakovosti, in sicer z:
 - jasno oblikovano politiko kakovosti na ravni ustanove,
 - jasnimi organizacijskimi pristojnostmi in strukturami za kakovost,
 - ustreznimi viri (osebje, čas, denar, izobraževanja, strokovna pomoč pri vpeljavi sistema za izboljševanje kakovosti, računalnike, kazalnike kakovosti ...),
 - časovno opredeljenimi cilji za celotno organizacijo,
 - vključitvijo zahtev za kakovost in varnost pacientov v pogodbe z vodilnimi delavci.
- (Ministrstvo za zdravje, 2006, str. 37)

Tabela 1. Pot prizadevanj za kakovost v zdravstvu v Sloveniji od 2006–2016

| | |
|-----------|--|
| 2006–2009 | Nacionalne usmeritve za razvoj kakovosti v zdravstvu (2006), uvajanje izboljševanja kakovosti v bolnišnice (2006), obveza o uvedbi 2 kliničnih poti in poročanju o ocenjevanju kakovosti na podlagi 6 kazalnikov kakovosti v Splošnem dogovoru (2006), Metodološka priporočila za oblikovanje in uvajanje kliničnih poti (2006), Nacionalna anketa o izkušnjah odraslih pacientov v akutni bolnišnični obravnavi in v psihiatričnih bolnišnicah (2008), Zakon o pacientovih pravicah (2008), priročnik Pot do odlične zdravstvene prakse (2009), Priročnik za oblikovanje kliničnih poti (2009), niz dogodkov po vseh regijah na temo opozorilnih nevarnih dogodkov (2009). |
| 2010–2013 | Konceptualni okvir za mednarodno klasifikacijo za varnost pacientov (2010), Pravilnik o najdaljših dopustnih čakalnih dobah za posamezne zdravstvene storitve in o načinu vodenja čakalnih seznamov (2010), Strategija kakovosti in varnosti v osnovni zdravstveni dejavnosti v Sloveniji (2010), Nacionalna strategija kakovosti in varnosti v zdravstvu (2010–2015), ustanovitev Sektorja za kakovost in varnost sistema zdravstvenega varstva (2011), model vzpostavitve sistema akreditacije v Sloveniji (2011), imenovanje posvetovalnega telesa ministra na področju kakovosti in varnosti (2011), mednarodna konferenca Odličnost v zdravstvu – primerljivost kakovosti, varnost pacientov, kompetenc in mednarodna akreditacija (2011), Priročnik o kazalnikih kakovosti (Aneks 2 k Splošnemu dogovoru) (2011), Prevod standardov JCI in pisni dogovori z nekaterimi akreditacijskimi hišami za prevod in objavo standardov v slovenskem jeziku (2011), priročnik Vodenje kakovosti v slovenskih bolnišnicah (2011), dogodki, posvet, konference (2012, 2013), preimenovanje sektorja v Sektor za kakovost in organizacijo zdravstvenega varstva (2013). |
| 2014–2016 | 2014 – Terminološki slovar izrazov v sistemu zdravstvenega varstva 2015 – Analiza realizacije strateških ciljev Strategije KV, imenovanje projektne skupine za organizacijo sistema kakovosti in varnosti v zdravstvu (2016), imenovanje projektne skupine za prenovo kazalnikov kakovosti, vključno z metodologijo (2006), imenovanje Sveta za kakovost in varnost v zdravstvu (2016), Poročilo raziskave o sistemu zdravstvenega varstva v Sloveniji (2016), imenovanje delovne skupine za pripravo predloga Zakona o kakovosti in varnosti vzdravstvu, HSPA-seminar (2016). |

Povzeto po »10 let vodenja kakovosti v slovenskem zdravstvu, izkušnje, dobre prakse, ovire«, Ministrstvo za zdravje, 9. dnevi Angele Boškin, Zbornik prispevkov, 2016, str. 14

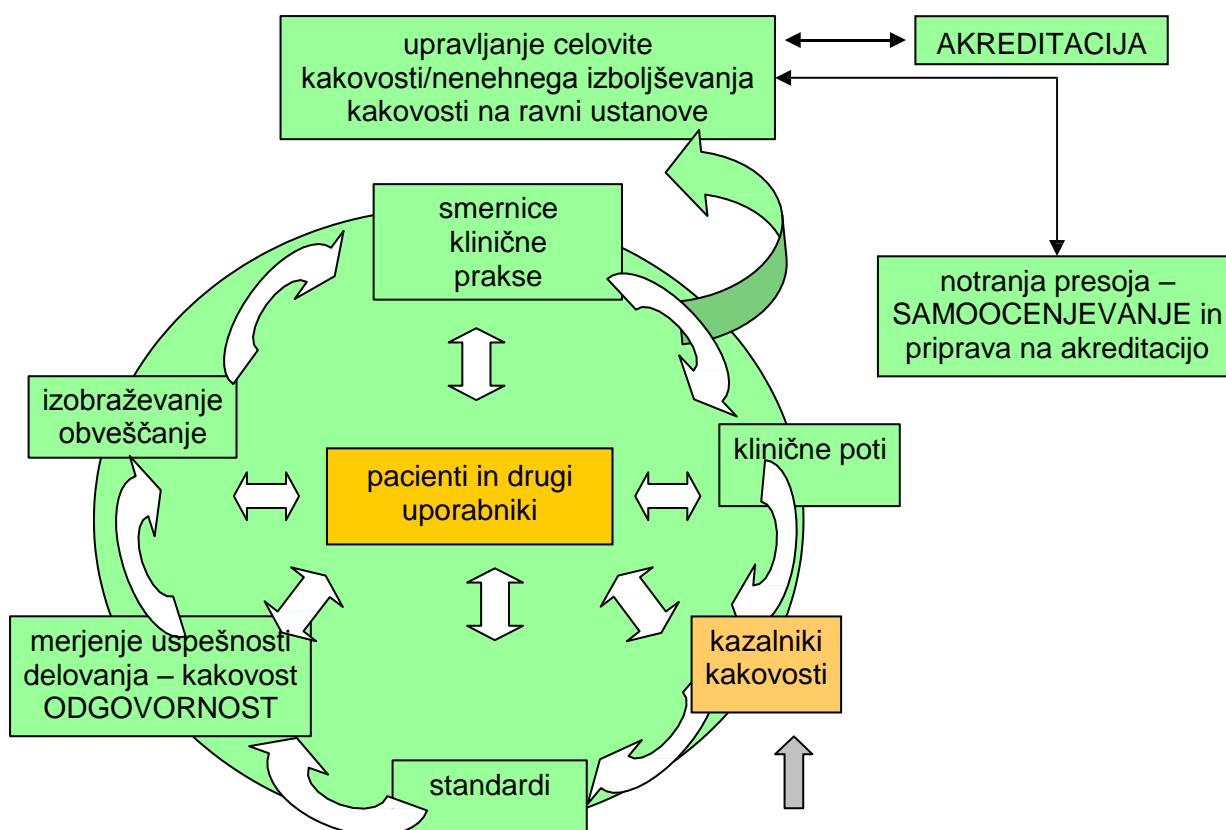
V okviru nenehnega izboljševanja kakovosti uporabimo nenehni krog izboljšav – ugotovimo problem v kakovosti zdravstvene obravnave, zberemo podatke, načrtujemo spremembe na

podlagi analize podatkov, izvedemo spremembo, preverimo, ali sprememba pripelje do izboljšave. Če je sprememba pozitivna, jo uvedemo v proces. To je krog NIPU: načrtuj – izvedi – preveri – uvedi (angleško: Plan – Do – Check – Act = PDCA). To pomeni, da neprestano ugotavljamo, ali je obravnava pacienta skladna s standardi zdravstvene obravnave, kliničnimi potmi, kazalniki kakovosti. Kajti odločitve temeljijo na podatkih in ne na predpostavkah ali mnenju vodstvenih delavcev ali drugih posameznikov in poklicnih skupin. (Ministrstvo za zdravje, 2006, str. 40)



Slika 1. Model procesnega vodenja, Prirejeno iz »Nacionalne usmeritve za razvoj kakovosti v zdravstvu«, Ministrstvo za zdravje, 2006, str. 38

»Ena od nalog nacionalnega telesa za kakovost je spremljanje uspešnosti delovanja izvajalcev zdravstvene dejavnosti na letni ravni na podlagi poročil o samoocenjevanju in poročil o doseganju nacionalnih kazalnikov kakovosti, opozorilnih nevarnih dogodkih in drugih varnostnih zapletih pri pacientih ter obdobja zunanja presoja – akreditacija.« (Ministrstvo za zdravje, 2006, str. 53)



Slika 2. Nenehno izboljševanje kakovosti v zdravstvu, Prirejeno iz »Nacionalne usmeritve za razvoj kakovosti v zdravstvu«, Ministrstvo za zdravje, 2006, str. 39

»V središču dogajanja so pacienti in drugi uporabniki. Za paciente je najpomembnejši dober izid zdravljenja, o čemer govorijo kazalniki izidov in drugi kazalniki kakovosti. Kazalnike izidov in kakovosti prikazujemo za posamezne specifične bolezni, stanja, postopke in podobno. Da bi dosegli dobre izide zdravljenja, moramo imeti urejene sisteme s strukturami in procesi, ki jih tudi merimo s kazalniki – kazalniki struktur in kazalniki procesov. Metode in orodja kakovosti se uporabljajo za doseganje dobrih kazalnikov izidov in drugih kazalnikov kakovosti. Te metode in orodja se med seboj povezani, kot je prikazano na sliki, npr. če hočemo doseči dober kazalnik izidov za neko bolezen, se primerjamo s standardom, ki temelji na dokazih podprti medicini. Ti dokazi so vključeni v klinične smernice in klinične poti. Na podlagi kazalnikov izidov in drugih kazalnikov gradimo uspešnost delovanja in odgovornost posameznika, oddelka in zdravstvene organizacije v celoti. Če želimo izpeljati krog kakovosti, je potrebno tudi izobraževanje. Samoocenjevanje in akreditacija na podlagi vnaprej znanih standardov in vnaprej določenih kazalnikov zdravstvene obravnave se uporabljata za spodbujanje nenehnega izboljševanja kakovosti/ upravljanja celovite kakovosti.« (Ministrstvo za zdravje, 2006, str. 39)

»Akreditacija je formalen proces zunanje presoje zdravstvenih zavodov in drugih izvajalcev zdravstvene dejavnosti, ki niso organizirani kot zdravstveni zavod, pri čemer se presodi, ali zavod ali drugi izvajalci zdravstvene dejavnosti izpolnjujejo vnaprej pripravljene in objavljene standarde kakovosti.« (Ministrstvo za zdravje, 2006, str. 24)

SIST EN ISO/IEC 1702-1 (Slovenski inštitut za standardizacijo, 2015, str. 11) pa navaja, da je certificiranje sistemov vodenja aktivnosti ugotavljanja skladnosti, ki jo izvajajo tretje stranke. Organi, ki to aktivnost izvajajo, so torej organi za ugotavljanje skladnosti kot tretja stranka.

Ker do ustanovitev nacionalnega telesa zaradi nezmožnosti dogovora med zainteresiranimi ni prišlo, je bil leta 2004 ustanovljen Oddelek za kakovost in varnost v okviru Ministrstva za zdravje. Ta bi zato moral prevzeti navedene naloge nacionalnega telesa.

Izvajalci pa so med drugim odgovorni tudi za sodelovanje v nacionalnem programu kazalnikov kakovosti in v programu Kakovost v zdravstvu ter za uporabo kazalnikov kakovosti za izboljševanje sistemov, kliničnih poti in procesov. Zato bi ti izvajalci morali postopoma uvesti metodo uravnoveženih kazalnikov, in pri tem upoštevati vse razsežnosti delovanja (kazalnike poslovanja, varnosti pacientov, klinične kazalnike, kazalnike izkušenj in zadovoljstva pacientov in drugih uporabnikov ter zaposlenih). (Ministrstvo za zdravje, 2006, str. 54)

V podpisani splošni dogovor med izvajalci zdravstvenih storitev, Zavodom za zdravstveno zavarovanje Slovenije in Ministrstvom za zdravje je bilo leta 2006 prvič vključeno določilo o spremljanju nabora manjšega števila kazalnikov kakovosti zdravstvene obravnave. Omenjeni kazalniki so bili namenjeni predvsem spodbujanju kulture spremljanja kakovosti zdravstvene obravnave. Projekt Kakovost v zdravstvu, katerega naročnik je Ministrstvo za zdravje s soudeležbo Zavoda za zdravstveno zavarovanje Slovenije, vodi Zdravniška zbornica in teče že vrsto let. (Kiauta et al., 2010, str. 9)

Ciljna področja vodenja kakovosti bi naj bila:

- vsaka organizacijska enota na vseh ravneh (Vlada Republike Slovenije, Ministrstvo za zdravje, Zavod za zdravstveno zavarovanje Slovenije, javni zdravstveni zavodi, domovi za starejše občane, zdravilišča in zasebne zdravstvene dejavnosti) naj določi prednostna področja vidikov kakovosti, na katere se bo sistematično osredotočala (politika kakovosti);
- na vsakem področju politike kakovosti se nato uvedejo kazalniki, ki na osnovi dejstev pokažejo stanje kakovosti na izbranih področjih;
- uvede se poročanje o spremembah na podlagi odklonov kazalnikov. (Kiauta et al., 2010, str. 13)

Novembra 2010 je izšel Priročnik o kazalnikih kakovosti, ki ga je izdelala delovna skupina. Delo je koordiniral Oddelek za kakovost pri Ministrstvu za zdravje.

Kazalniki kakovosti predstavljajo mero kakovosti zdravstvenega varstva, ki jih izvajalci izračunavajo zato, da imajo sami pregled in nadzor nad kakovostjo zdravstvenih obravnav v lastnih ustanovah. Merjenje kakovosti v zdravstvu s pomočjo kazalnikov je namenjeno široki skupini uporabnikov. Izvajalec zdravstvenih storitev rezultate uporabi za spremljanje in izboljšanje kakovosti storitev, plačnik potrebuje informacije o učinkoviti porabi sredstev, pacienti želijo podatke, ki jim lahko pomagajo pri izbiri izvajalca, prebivalstvo zahteva

zagotovilo o primernosti zdravstvenega sistema, Vlada spremlja zdravstveno stanje prebivalcev in določa prioritete za ukrepanje. Trenutno ne obstaja splošni konsenz o seznamu kazalnikov, ki bi omogočal celovito presojo kakovosti zdravstvenega sistema in elementov v njem. (Pribaković et al., 2010, str. 8–10)

Nabor kazalnikov v Priročniku o kazalnikih kakovosti vključuje predvsem sekundarno in terciarno raven zdravstvene dejavnosti. V njem je zelo malo kazalnikov, uporabnih za primarno zdravstveno dejavnost.

Primarna zdravstvena dejavnost je definirana kot tista, ki je v bližini doma pacienta in je prva raven dostopa do zdravstvene oskrbe. Vključuje pa preventivo z zdravstveno vzgojo in kurativo. (Schäfer et al., 2013, str. 4)

Pomemben gonilnik razvoja primarnega zdravstvenega varstva je večja odzivnost na potrebe prebivalstva in večja stroškovna učinkovitost. Sistem zdravstvenega varstva bi namreč moral izboljšati zdravje ljudi. Primarno zdravstveno varstvo pomembno vpliva na delovanje vseh zdravstvenih sistemov, saj bi morala biti v primarnem zdravstvenem varstvu zadovoljena večina potreb po kurativnih in preventivnih zdravstvenih storitvah. Primerjalna študija v 31 Evropskih državah je pokazala, da je močna primarna oskrba tista, ki ima naslednjih sedem dimenzij:

- upravljanje primarnega zdravstvenega varstva,
- ekonomske razmere primarnega zdravstvenega varstva,
- razvoj delovne sile v primarnem zdravstvenem varstvu,
- dostopnost primarne zdravstvene oskrbe,
- celovitost primarne zdravstvene oskrbe,
- kontinuiteta primarne zdravstvene oskrbe,
- usklajevanje primarne zdravstvene oskrbe.

To pomeni, da močna primarna zdravstvena oskrba zagotavlja dostopno, celovito oskrbo v ambulantni s kontinuirano in usklajeno oskrbo, ki jo podpira ustrezno upravljanje zdravstvenega varstva in dovolj razvita delovna sila v primarnem zdravstvenem varstvu. Obstaja pa jasna razlika v primarni zdravstveni oskrbi med državami vzhodne in zahodne Evrope. Dohodek izvajalcev je v vzhodni Evropi pogosto dosti nižji. Na splošno pa je največji nabor zdravstvenih storitev primarne zdravstvene oskrbe v Belgiji, Franciji, Bolgariji, Finski, Litvi, Norveški, Portugalski, Španiji, Švedski in v Združenem kraljestvu. Države srednje in vzhodne Evrope so namreč primarno zdravstveno varstvo izboljšale v začetku devetdesetih let, ko so preoblikovale svoje zdravstvene sisteme. Odprto ostaja vprašanje razvoja primarnega zdravstvenega varstva v prihodnosti, saj gre za velike razlike v dostopnosti do zdravstvenih storitev primarnega zdravstvenega varstva (decentralizacija zdravstvenih domov), financiranju in kakovosti oskrbe. (Kringos et al., 2013, str. 742–750)

Med leti 2011 in 2013 je bila izvedena raziskava o možnostih izboljšanja primarnega zdravstvenega varstva. Anketirani so bili pacienti v 34 evropskih državah, ki so pravkar

obiskali osebnega zdravnika. Ocenjevali so 5 značilnosti primarne zdravstvene oskrbe: dostopnost/ razpoložljivost, kontinuiteto, celovitost, vključenost bolnika in komunikacijo med pacientom in zdravnikom. 26 držav ima srednje ali visoke potenciale za izboljšanje primarne zdravstvene oskrbe. Najnižji potencial za izboljšanje v vseh državah ima komunikacija med zdravnikom in pacientom, prav tako kontinuiteta in dostopnost zdravstvene oskrbe. Najvišji potencial za izboljšavo pa se kaže na področju vključenosti bolnika pri zdravstveni oskrbi in celovitosti zdravstvene oskrbe. Celovita zdravstvena oskrba je tista, pri kateri zdravnik pacienta povpraša še o drugih težavah in tudi o psihosocialnem stanju. (Schäfer et al., 2015, str. 161–168)

Rotar Pavlič et al. (2015, str. 1–11) v svoji raziskavi ugotavljajo, da je primarno zdravstveno varstvo temelj sistemov zdravstvenega varstva v mnogih delih sveta, družinski zdravniki pa ključni pri zagotavljanju nacionalnega zdravja s pomočjo primarne zdravstvene oskrbe. Kakovost družinske medicine so merili v 34 državah (31 evropskih in 3 neevropskih: Avstraliji, Kanadi in Novi Zelandiji), in sicer z vidika štirih dimenzij: kontinuitete, usklajevanja, usmerjenosti v skupnost in celovitosti oskrbe. Predvsem neprekinjenost zdravstvene oskrbe so zdravniki zaznali kot najpomembnejšo dimenzijo kakovosti. Kot najšibkejši člen kakovosti pa je bilo zaznано usklajevanje oskrbe. Ta pa je pomembna predvsem pri bolnikih s kroničnimi boleznimi, saj so izidi zdravljenja v državah z dobro usklajeno zdravstveno oskrbo pri takih bolnikih dosti boljši, in to predvsem pri odpustu iz bolnišnic ali pri prehajanju med različnimi nivoji zdravstvenega varstva, saj so zdravniki med seboj dosti bolj usklajeni.

Predvsem na Danskem, Finskem, Litvi, Islandiji in Švedski so zelo pozitivne izkušnje prenosa diagnoz med zdravniki med različnimi nivoji zdravstvenega varstva. Edino na Danskem lahko majhne zasebne prakse ovirajo usklajevanje zdravstvene oskrbe in vodijo v kulturo individualizma. Tako si Danska že nekaj časa prizadeva izboljšati usklajevanje med primarnim in sekundarnim nivojem zdravstvenega varstva. Neprekinjenost zdravstvene oskrbe je močno povezana z organiziranostjo primarnega zdravstvenega varstva, ki ne bi smelo biti razdrobljeno. Najboljše rezultate za vse štiri dimenzije kakovosti beležijo na Nizozemskem, predvsem za kontinuiteto in celovitost oskrbe, slabše pa je usklajevanje in usmerjenost v skupnost. Nasploh se je kot najslabša dimenzija kakovosti povsod pokazala usmerjenost v skupnost, kar bi bilo koristno upoštevati pri oblikovanju priporočil za zdravstvena politika. (Rotar Pavlič et al., 2015, str. 1–11)

2. 3 Kakovost v sistemu zdravstvenega varstva v državah članicah EU in ostalih državah

»Evropska komisija je 4. aprila 2014 predstavila priporočila zasnovana kot pomoč nacionalnim zdravstvenim sistemom pri spopadanju z izzivi in pritiski, da bi lahko zagotovili visokokakovostno zdravstveno varstvo. V priporočilih opredeljujejo dejavnike za krepitev splošne vzdržnosti sistemov zdravstvenega varstva. Ti dejavniki so nujnost spopadanja s posledicami finančne in gospodarske krize ter naraščajoče povpraševanje po njihovih

sredstvih. Priporočila so namenjena državam Evropske unije, ki imajo glavno odgovornost za zdravstveno varstvo. Sporočilo vsebuje naslednja priporočila:

- krepitev učinkovitosti storitev s pomočjo rezultatov ocenjevanja uspešnosti, razvojem celovitega pristopa, da zdravljenje ne bi bilo samo bolnišnično in zagotavljanja varnosti pacientov in kakovosti oskrbe,
- večja dostopnost, da bi zdravstveno varstvo bilo dostopno celotnemu prebivalstvu,
- večja prilagodljivost, da bi se zdravstveni sistemi prilagodili spremenjenim okoliščinam, opredeliti inovativne rešitve ter omogočila širša in učinkovitejša uporaba informacij in drugih novih tehnologij.« (http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:2901_2&from=EN)

V sporočilu komisije o učinkovitih, dostopnih in prožnih zdravstvenih sistemih (<http://eur-lex.europa.eu/legal-content/SL/TXT/?uri=celex:52014DC0215>) je zapisano, da morajo zdravstveni sistemi biti sposobni dodati več let življenja in tudi več življenja v letih. Poudarjeno je, da mora zdravstveni sistem temeljiti na naslednjih vrednotah: dostopnost do kakovostne oskrbe, pravičnost in solidarnost. V zadnjem desetletju so se namreč zdravstveni sistemi soočali z vedno večjimi skupnimi izzivi: naraščajočimi stroški zdravstvenega varstva, staranje prebivalstva povezano s kroničnimi boleznimi in večjo obolevnostjo, ki vodi k naraščajočemu povpraševanju po zdravstvenem varstvu, pomanjkanju in neenakomerni porazdelitvi zdravstvenih delavcev, neenakosti na področju zdravja in neenakosti pri dostopu do zdravstvenega varstva. Pri razvoju pristopov se to sporočilo osredotoča na ukrepe za okrepitev učinkovitosti zdravstvenih sistemov, povečanje dostopnosti zdravstvenega varstva in izboljševanje odpornosti zdravstvenih sistemov.

»Namen sklepov Sveta o varnosti in kakovosti oskrbe, vključno s preprečevanjem in obvladovanjem okužb, povezanih z zdravstveno oskrbo in protimikrobne odpornosti je, da nacionalne organe EU pozivajo da:

- v celoti izvedejo Priporočilo Sveta 2009/C 151/01 o varnosti pacientov, vključno s preprečevanjem in obvladovanjem okužb, povezanih z zdravstveno oskrbo,
- izvajajo smernice, priporočila in dobre prakse o varnosti pacientov,
- spodbujajo izobraževanje in usposabljanje zdravstvenega osebja o varnosti pacientov in okužbah, povezanih z zdravstveno oskrbo,
- spodbujajo zdravstvene organizacije k pospeševanju kulture varnosti pacientov,
- pripravijo ukrepe, ki bi zdravstvenim delavcem ali pacientom omogočali korektno poročanje, ki ne temelji na obtoževanju,
- krepijo sodelovanje ter večjo vlogo in vpliv pacientov, družin in nepoklicnih negovalcev,
- utrdijo ukrepe za preprečevanje in obvladovanje okužb,
- oblikujejo strokovne smernice o preudarni rabi antibiotikov,
- namenjajo pozornost protimikrobni odpornosti (dejstvo je, da so mikroorganizmi, ki povzročajo okužbe, razvili odpornost zaradi prevelike uporabe ali zlorabe

antibiotikov).«

(http://eur-lex.europa.eu/legal-content/SL/TXT/?uri=LEGISSUM:2901_5)

»Priporočilo Sveta 2009/C 151/01 o varnosti pacientov, vključno s preprečevanjem in obvladovanjem okužb, povezanih z zdravstveno oskrbo poziva k uvedbi okvira za izboljševanje varnosti pacientov in preprečevanje varnostnih zapletov, zlasti okužb povezanih z zdravstveno oskrbo do katerih lahko pride v zdravstvenih ustanovah. (<http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:sp0009&from=SL>)

V priporočilu o varnosti pacientov je med drugim poudarjeno tudi, da je potrebno razviti učinkovitejše sisteme, procese in orodja na področju varne zdravstvene oskrbe in uvesti poseben pristop za spodbujanje varnih praks, da se preprečijo najpogostejši zapleti povezani z zdravljenjem, okužbe povezane z zdravstveno oskrbo in zapleti v zvezi s kirurškimi posegi. Pacientom mora biti omogočeno, da pridobijo osnovno znanje o varnosti pacientov. Potrebno bi bilo načrtovati takšne sisteme, ki bi spodbujali zdravstvene delavce, da bi poročali o vseh varnostnih zapletih. Ker pa so zdravstveni delavci tisti, ki imajo pomembno vlogo pri izboljševanju varnosti pacientov, morajo imeti usposabljanja in izobraževanja na to temo. Varnost pacientov mora biti vključena v dodiplomske in podiplomske programe za zdravstvene delavce in v stalno strokovno usposabljanje in izpopolnjevanje na delovnem mestu. Prav tako morajo biti zdravstveni delavci seznanjeni o obstoječih tveganjih in varnostnih ukrepih. Dobro bi bilo razviti tudi razvrščanje in ocenjevanje varnosti pacientov, za kar potrebujemo opredeljene in primerljive kazalnike. (<http://eur-lex.europa.eu/legal-content/SL/TXT/HTML/?uri=LEGISSUM:sp0009&from=SL>)

Brubakk et al. (2015, str. 2–8) poročajo o pozitivnih učinkih akreditacij in certifikacij, saj so take organizacije spremljale kazalnike kakovosti. Izpostavili so 7 najpogosteje spremljanih kazalnikov kakovosti: zadovoljstvo pacientov, število pacientov, zdravljenih z zdravljenjem, dostopnost do zdravstvenih podatkov, urejenost (popolnost) zdravstvenih kartotek, popolnost perioperativnih opomb, označevanje bolniških staležev in ocena sanitarij v bolnišnicah. Štiri najpogostejše kazalnike zaradi izzivov Evrope niso več spremljali. To so: kirurška okužba rane, čakalna doba na operacijo, stopnja umrljivosti novorojenčkov in finančna solventnost organizacije. Avtorji študije so prišli do ugotovitve, da so akreditirane in certificirane organizacije veliko bolj uspešne kot neakreditirane in necertificirane. Akreditirane in certificirane organizacije so namreč izvedle ankete med zaposlenimi in pacienti o vplivu akreditacije in certifikacije, ki so pokazale veliko pozitivnih sprememb v organizacijah. Nekoliko bolj skeptični so bili zdravniki, saj jim je primanjkovalo znanja o akreditacijah in certifikacijah, kar so v anketi jasno izrazili. Avtorji so prišli do zaključka, da se učinek akreditacije in certifikacije na organizacije najlažje izmeri s primerjavo med akreditiranimi in certificiranimi organizacijami ter tistimi, ki se niso akreditirale ali certificirale, saj je drugo merjenje kakovosti v velikih zdravstvenih organizacijah izjemno težko. Gre namreč za zelo kompleksne organizacije.

Shaw et al. (2010, str. 445–451) so izvedli analizo spremljanja kakovosti in varnosti v 89 bolnišnicah v 7 državah: Belgiji, Češki, Franciji, Irski, Poljski, Španiji, Nizozemski in v Združenem kraljestvu. Poskušali so določiti sistematične razlike med akreditiranimi ali ISO-certificiranimi bolnišnicami in med tistimi, ki niso ne eno ne drugo. Zakaj sploh bolnišnice v Evropi pristopijo k ISO-certifikaciji ali akreditaciji? V prvi vrsti predvsem zaradi evropskega okvira upravljanja kakovosti in varnosti, večinoma pa bolnišnice prostovoljno pristopijo zaradi usmerjenosti v razvoj, samoregulacijo in trženje.

Od 89 bolnišnic je bilo 34 akreditiranih (brez ISO-certifikata), 10 ISO-certificiranih (brez akreditacije), 27 pa jih ni imelo nobenega od teh nazivov.

Tabela 3. Število akreditiranih ali ISO-certificiranih bolnišnic

| | skupaj | št. akreditacij | št. ISO-certifikacij | nič od tega | drugo |
|---------------------|--------|-----------------|----------------------|-------------|-------|
| Belgija | 1 | 0 | 0 | 1 | 0 |
| Češka | 15 | 2 | 4 | 7 | 2 |
| Francija | 18 | 16 | 0 | 0 | 2 |
| Irska | 6 | 3 | 0 | 1 | 2 |
| Poljska | 15 | 0 | 3 | 6 | 6 |
| Španija | 29 | 10 | 3 | 11 | 5 |
| Združeno kraljestvo | 5 | 3 | 0 | 1 | 1 |
| skupaj | 89 | 34 | 10 | 27 | 18 |

Povzeto po »Accreditation and ISO certification: do they explain differences in quality management in European hospitals?«, po Shaw, C. et al, 2010, International Journal for Quality in Health Care, 6, str. 447

Analiza primerjave med akreditiranimi/ISO-certificiranimi in neakreditiranimi/necertificiranimi bolnišnicami je privedla do ugotovitve, da imajo akreditirane ali certificirane bolnišnice dosti večjo vrednost doseganja kazalnikov kakovosti in so veliko varnejše kot bolnišnice brez akreditacije ali certifikacije. (Schaw et al. , 2010, str. 447)

Shaw et al. (2013, str. 222–231) navajajo akreditacijo kot sredstvo za organizacijski razvoj na eni strani in kot sredstvo za ureditev zdravstvenega sistema na drugi strani. Številni programi zdravstvenih reform, zlasti v državah s srednjim in nižjim dohodkom, vključujejo uvedbo ali okrepitev akreditacij ali certifikacij zdravstvenih organizacij. Razlogi za uvedbo le-teh bi naj bili štirje:

- 1) Etični: izboljšanje kakovosti in organizacijski razvoj, kar je lahko povezano tudi s poklicnim razvojem, kliničnim usposabljanjem in javnim zdravjem.
- 2) Poslovni: dostop do javnega financiranja, zdravstvenega zavarovanja in konkurenčna prednost na trgu.
- 3) Regulativni: v skladu z veljavno zakonodajo in predpisi v nekaterih državah.
- 4) Mednarodni: »medicinski turizem« ustvarja trg za akreditacije in ISO-certifikacije zdravstvenega varstva, kjer soustanovitelji financirajo tehnično pomoč.

Shaw et al. (2014, str. 100–107) v eni od naslednjih raziskav navajajo, da je zelo malo dokazov o vplivu certifikacije in akreditacije na bolnišnice, da te lahko upravičijo čas in denar, uporabljen v ta namen. V študiji navajajo, da pa imata tako certifikacija kot akreditacija tudi koristne lastnosti za zdravstvene organizacije, in to ne glede na to, kateri način zunanjsega ocenjevanja organizacija izbere. Oba sistema vzpodbujata strukture in procese, ki podpirajo varnost bolnikov in tako dosegajo višjo stopnjo kakovosti kot organizacije, ki nimajo nobenega zunanjsega ocenjevanja.

Saut et al. (2017, str. 1–9) v študiji ocenjevanja vpliva akreditacij v zdravstvenih organizacijah v Braziliji ugotavljajo, da so glavni razlogi, ki so zdravstvene organizacije vzpodbudili k izvajanju programov izboljševanja kakovosti, predvsem stroški zdravstvenega varstva, neželeni dogodki, zapletenost novih tehnologij, staranje prebivalstva in hitro širjenje prenosljivih bolezni po svetu. V navedeni študiji primanjkuje dokazov o korelaciji med varnostjo pacientov in akreditacijo. Varnost predpisujejo predvsem brazilski zakonodaji, po kateri je obvezno mesečno poročanje o neželenih dogodkih. Prav tako ni bil potrjen kot ustrezen učinek akreditacij na finančne rezultate zdravstvenih organizacij, zato bi bilo smiselno, da se zdravstvene organizacije usmerijo na spremljanje in merjenje kazalnikov kakovosti, vrednotenje in ukrepe iz le-teh. Dokazano pa je bilo, da akreditacije vplivajo predvsem na notranje procese, kulturo, konkurenčno diferenciacijo organizacij in da je najpomembnejše v zdravstvenih ustanovah načrtovanje programov za izboljšanje kakovosti, saj lahko priprava na akreditacijo v zdravstveni ustanovi poteka do 2 leti.

Od leta 2010 do 2013 je potekala večdržavna študija, ki ocenjuje kakovost, pravičnost in stroške primarne oskrbe v Evropi. Vključenih je bilo 31 držav (od tega 27 članic EU). Namenjena je bila predvsem ugotavljanju učinkovitosti primarne oskrbe in je dobro povezana s projektom »Zdravje 2020«. Demografske spremembe, tehnološki razvoj in naraščajoča pričakovanja prebivalstva so namreč največji izziv za zdravstvene sisteme v prihodnosti. Študija je pokazala, da v Evropi kot rešitev za izboljšanje odzivnosti zdravstvenega sistema na potrebe prebivalstva vidijo uvedbo osebnih računalnikov za zaposlene v zdravstvenih sistemih. (Schäfer et al., 2011, str. 1–9)

Zdravstvene ustanove na Portugalskem so zaradi socialne in gospodarske krize ogrožene, zato so morale sprejeti strategije za ustvarjanje vrednosti zdravstvenega varstva s kakovostnimi zdravstvenimi storitvami. Leta 2003 so začeli z zdravstveno reformo, ki je vse enote zdravstvenega varstva povezovala v mrežo zdravstvenih ustanov, usmerjeno v pričakovanja prebivalstva. V letu 2007 je z reformo nadaljevala in ustanovila tako imenovane družinske zdravstvene enote (FHU – Family Health Units), da bi zagotovila večjo dostopnost do zdravstvenega varstva, krajše čakalne dobe in višjo kakovost zdravstvenih storitev. Ker so raziskave pokazale, da se pogled strokovnjaka na kakovost bistveno razlikuje od pogleda pacienta, so se odločili, da kakovost zdravstvenih storitev spremljajo z vidika treh dimenzij:

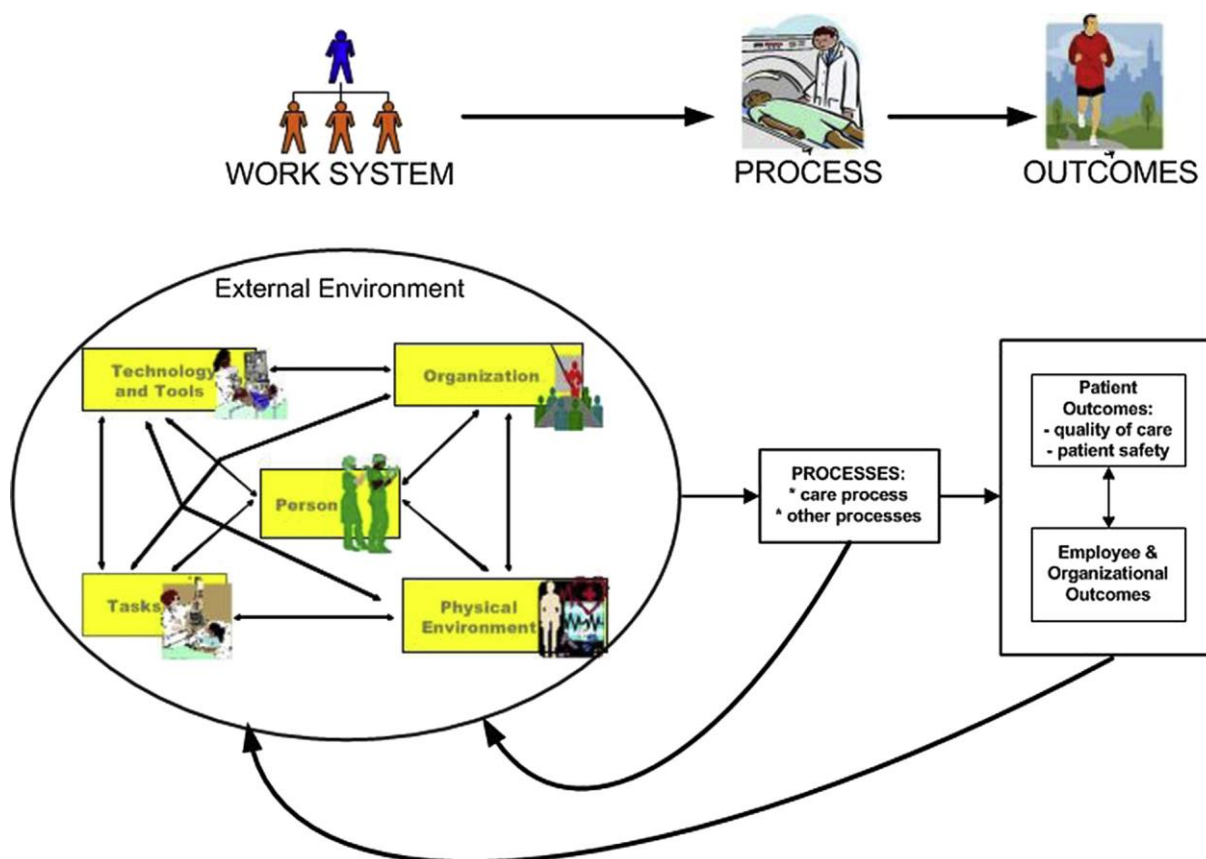
- uporabnik zdravstvenih storitev in njegova pričakovanja,
- potrebe zaposlenih in ocena primernosti izvajanja postopkov,
- upravljanje – učinkovita uporaba virov.

Glavni problemi v zdravstvenem sistemu na Portugalskem, povezani s kakovostjo storitev, so bili: pomanjkanje varnosti za pacienta, visoki stroški, nezadovoljni uporabniki storitev, neenakost v dostopu do zdravstvenega varstva in dolge čakalne dobe. Zato so izvajalci zdravstvenih storitev začeli z uvajanjem sistemov vodenja kakovosti, in to najprej v bolnišnicah, nato pa postopoma še v primarnem zdravstvenem varstvu. Cilj uvajanja sistemov vodenja kakovosti v zdravstvene ustanove je bil predvsem optimizacija delovnih procesov, prepoznavanje kritičnih procesov in opredelitev kazalnikov kakovosti, ki najbolj pomagajo prepoznati probleme in metode za njihovo reševanje. (Duarte & Fonseca, 2017, str. 251–264)

V okviru projekta DUQuE je bilo v raziskavo vključenih 74 bolnišnic iz 7 držav (Češka, Francija, Nemčija, Poljska, Portugalska, Španija in Turčija). Študija proučuje odnose med različnimi ukrepi. Rezultat raziskave je bila ugotovitev, da lahko bolnišnice s samoocenjevanjem in kazalniki kakovosti ocenijo zrelost lastnega sistema ter na ta način prav tako izboljšujejo kakovost lastnih storitev. Vendar pa zunanja presoja (certifikacija ali akreditacija) omogoča veliko obširnejši posnetek stanja zrelosti organizacije v smislu kakovosti. (Wagner et al., 2014, str. 66–73)

Rushforth et al. (2015, str. 1–10) so v Združenem kraljestvu oblikovali kazalnike kakovosti iz priporočil kliničnih smernic, ki se jih lahko meri iz rutinsko zbranih podatkov. Raziskavo so začeli predvsem zaradi omejenih organizacijskih zmogljivosti in zapletenosti oskrbe v primarnem zdravstvenem varstvu ter zaradi finančne spodbude vlade za upoštevanje kazalnikov uspešnosti. Razvili so 17 kazalnikov uspešnosti, ki pa se na žalost osredotočajo le na kronične bolezni in ne merijo kakovosti oskrbe teh pacientov.

Carayon et al. (2014, str. 14–25) v svoji študiji govorijo o velikem vplivu delovnega sistema na varnost pacientov in zaposlenih. Zlasti izpostavljajo vrednost systemskega pristopa, ki opredeljuje vse vidike delovnega sistema, ki lahko vplivajo na varnost pacienta. V središču pa so: pomanjkanje strokovnosti, slaba uporabnost informacijskih tehnologij, neustrezen delovni prostor, hierarhična kultura in neupoštevanje smernic (Slika 2.1), zato je nujno treba delovni sistem uravnotežiti, da bi lahko povečali varnost pacienta in zaposlenih.



Slika 3. Model delovnega sistema in varnosti pacientov. Prirejeno iz »Human factors systems approach to healthcare quality and patient safety«, po P. Carayon et al, 2014, Applied Ergonomics, 45, str. 15

Alameddine et al. (2015 str. 1–14) v svoji študiji ugotavljajo, da je za izvedbo organizacijskih sprememb zelo pomembna pripravljenost zaposlenih. Izvedli so raziskavo pripravljenosti zaposlenih za poročanje o kazalnikih kakovosti v primarnem zdravstvenem varstvu v Libanonu. Sodelovalo je 108 zdravstvenih centrov na primarni ravni. 66 % anketiranih je pripravljenih poročati o kazalnikih kakovosti. Najnižja ocena pripravljenosti za poročanje je pri zdravnikih, predvsem na področju poročanja neželenih dogodkov, saj je prisoten strah pred kaznovanjem. Zato bi bilo treba med zaposlenimi krepiti timsko delo in skupno odgovornost ter zavedanje, da gre največkrat za systemske napake. Prav tako bi bilo treba zdravstveno osebje poučiti o pomenu poročanja o kazalnikih kakovosti, saj se le-ti spremljajo z namenom povečanja učinkovitosti in iskanja področij priložnosti za izboljšavo. Pri medicinskih sestrah je pripravljenost za poročanje najnižja na področju osebne valence – kakšne osebne koristi bodo imele od poročanja o kazalnikih kakovosti. Raziskava pokaže, da se medicinske sestre pritožujejo nad preobremenjenostjo in da večinoma same poročajo o kazalnikih kakovosti, zato bi bilo v tem primeru zelo pomembno prestrukturiranje, da bi jim tako omogočili več časa za poročanje omenjenih kazalnikov.

V avstralskih bolnišnicah so zakonsko določili, da se mora doseči določena kakovost in varnost za paciente. V času te zakonske določbe je postalo vprašanje vodenja kakovosti

najpomembnejše, še posebej pri obvladovanju tveganj. Večina bolnišnic v Avstraliji je uvedla uslužbenca za kakovost, ki ga pogosto imenujejo koordinator zagotavljanja kakovosti. Največkrat gre za zdravstvenega delavca z delovnimi izkušnjami s področja vodenja in strokovnega področja, s strokovnim znanjem ter z usposobljenostjo za upravljanje kakovosti. Problem je le, da gre največkrat za mlade uslužbenke, ki nimajo vpliva na oblikovanje politike kakovosti. Koordinatorji kakovosti so odgovorni za izvajanje, vključevanje in usklajevanje sistema vodenja kakovosti s ciljem:

- izboljšati kakovost oskrbe pacientov ter spodbujati učinkovito porabo sredstev in virov,
- zagotoviti administrativno, tehnično in izobraževalno podporo pri razvoju kakovosti.

Zdravstveno osebje pogosto narobe razume dejstvo, da je naloga vodje kakovosti povedati, kako mora biti klinično delo opravljeno. Manager kakovosti je usposobljen strokovnjak, katerega naloga je upravljati s programom kakovosti. Le nekaj bolnišnic se lahko pohvali z managerjem kakovosti. Za to bi morale poskrbeti univerze, ki bi morale ustvariti programe, primerne za usposabljanje tovrstnih kadrov. Še boljše bi bilo, da bi za takšne programe usposabljanja zagotovile tudi štipendije. (Wilson, 2000, str. 127–130)

V današnjem času je na voljo tehnologija za preprečevanje škode pri pacientih in s tem zmanjševanje stroškov v zdravstvu. Vendar žal primanjkuje preventive, da ne bi prihajalo do neželenih dogodkov v zdravstvu. Po podatkih British Medical Journala so zdravniške napake zdaj na 3. mestu najpogostejših vzrokov smrti v ZDA. Raziskave kažejo, da so vzrok za neželene dogodke (zdravniške napake) predvsem izgorelost zaradi številnih birokratskih nalog. Zato bi morale preprečevanje neželenih dogodkov postati del kulture razmišljanja v zdravstvu, saj lahko le s pomočjo prepoznavanj potencialnih tveganj in evidentiranjem dejanskih napak stvari predvidimo in preprečimo ter tako zmanjšamo škodo za pacienta in znižamo stroške v zdravstvu. Dokazi, da ima organizacija povezano, dosledno in učinkovito upravljanje, so:

- dokumentirani procesi s kazalniki učinkovitosti in dokumentirana politika kakovosti,
- jasno opredeljeni in merljivi kazalniki učinkovitosti,
- izvajanje rednih certifikacijskih presoj,
- procesi, ki se vsak dan izvajajo po definiranih metodah, ne samo za presoje. (Dotan, & Koski, 2017, str. 1–10)

Zadnje raziskave kažejo (Krczal & Mock, 2016, str. 1–8), da so kot kazalniki kakovosti v primarnem zdravstvu najpomembnejša pričakovanja in potrebe ljudi. Kot najpomembnejša izmed njih sta izpostavljena dostopnost do zdravljenja oz. do zdravstvene oskrbe in odnos med pacientom in zdravnikom. Pričakovanja in potrebe ljudi bi bilo nujno potrebno upoštevati pri oblikovanju primarne zdravstvene oskrbe.

Minister za zdravje v OECD je poudaril, da je treba začeti vlagati v ukrepe, ki bodo pomagali oceniti, ali naši zdravstveni sistemi zagotavljajo to, kar je za ljudi pomembno. Smrtnost in klinični kazalniki namreč le delno predstavljajo vrednost zdravstvene oskrbe za ljudi. Ta ministrova izjava je potrdila načrte za program dela, kjer bodo pacienti poročali o uspešnosti zdravstvenega sistema. Predvsem poročanje pacientov o ukrepih bi naj postala nova valuta za merjenje uspešnosti zdravstvenega sistema in za primerjavo ocene uspešnosti med zdravstvenimi sistemi. Dosedanje ankete so namreč prinesle le povratne informacije o postopkih zdravstvene oskrbe, ne pa tudi podatkov o učinkih. Zato bo treba na novo oblikovati vprašalnike za paciente, katerih rezultati bodo pomagali pri izbiri ustreznih ukrepov za izboljšanje zdravstvene oskrbe. Vprašalniki bi naj pokazali, kako je zdravje pacienta povezano s kakovostjo življenja. Izpostavljen naj bi bil predvsem vpliv bolezni na posameznika, vpliv zdravljenja, delovanje posameznika in čustveno počutje obolelega. Če želimo izvedeti, kaj je pomembno za paciente, je prav te treba vprašati, katere zdravstvene rezultate bi bilo po njihovem mnenju pametno meriti. Izpostavljeni naj bi bili trije vidiki za paciente:

- kaj je za pacienta pomembno, da kljub svojemu zdravstvenemu stanju dobro živijo,
- zmanjševanje odvisnosti od drugih in od zdravljenja,
- zmanjševanje stigme in osamljenosti.

Predvsem pa je pomembno zavedanje, da pacienti ob namenjanju svojega časa za reševanje anket želijo biti prepričani, ali bodo za to nagrajeni z boljšo zdravstveno oskrbo. (Coulter, 2017, str. 1–2)

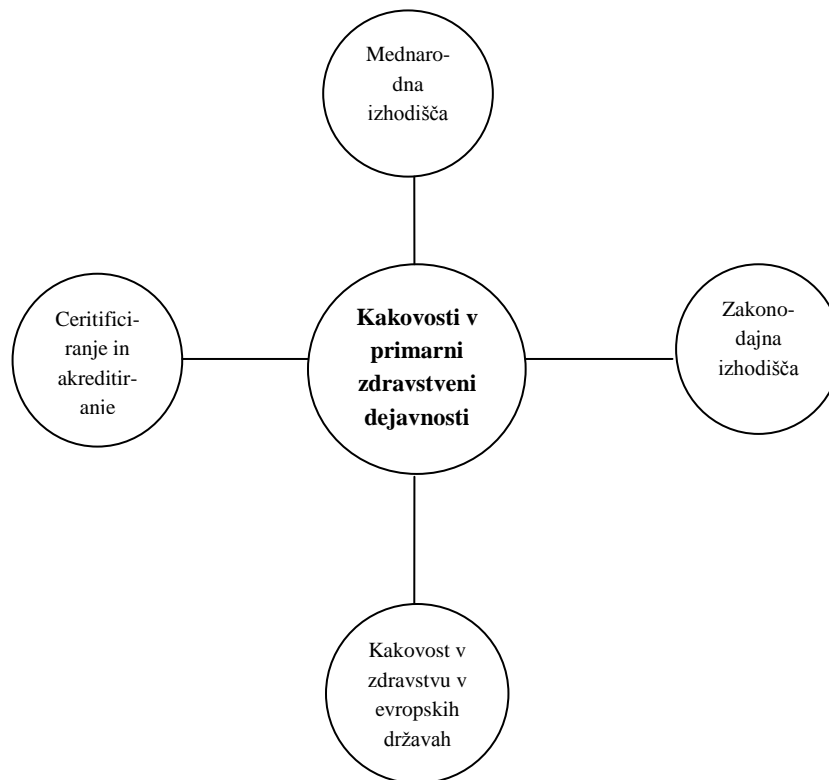
3 Metoda

3.1 Zbiranje podatkov

Opravljen je bil pregled strokovnih in znanstvenih del na temo kakovosti v zdravstvu, sistemov vodenja kakovosti v zdravstvu, kazalnikov kakovosti, certificiranja in akreditiranja. Uporabljena je bila analiza del tujih in slovenskih avtorjev. Uporabili smo tudi mednarodna izhodišča za razvoj kakovosti v zdravstvu, zato smo uporabili nekoliko starejše vire, ki opredelijo izvor, namen in razvoj tovrstne kakovosti. Prav tako smo utemeljili razliko med certificiranjem in akreditiranjem, ki sta osnovni izvor kazalnikov kakovosti. Prikazali smo tudi stanje certifikacije zdravstvenih domov v Sloveniji.

3.2 Model raziskave

Model raziskave prikazuje vidike, ki smo jih upoštevali pri raziskovanju kakovosti v zdravstvu. Sem sodijo iskanje mednarodnih izhodišč, zakonodajnih izhodišč, obvladovanje kakovosti v zdravstvu v drugih evropskih državah ter razlika med certificiranjem in akreditacijo zdravstvenih organizacij.



Slika 4. Model raziskave

4 Rezultati

4.1 Sistemi vodenja kakovosti v zdravstvu v državah članicah EU in v Sloveniji

Z vstopom Slovenije v Evropsko unijo in s tem prevzemanjem skupne odgovornosti za državljane držav članic EU so nastale zahteve za celovito vodenje in usklajevanje kakovosti na ravni posameznih držav. Do leta 2010 so morale države članice zagotoviti, da se zdravstveno varstvo osredotoči na izide zdravljenja na vseh ravneh. (Ministrstvo za zdravje, 2006, str. 19)

Zaradi mobilnosti pacientov je namen EU zagotoviti kakovostno zdravstveno obravnavo za vse njene državljane, zato morajo izvajalci zdravstvene dejavnosti v teh državah dokazati, da imajo:

- vzpostavljene organe za kakovost (agencije in centre ali inštitute za kakovost v zdravstvu na ravni države, oddelke ali komisije za kakovost na ravni bolnišnic);
- delujočo notranjo presojo – samoocenjevanje;
- delujočo zunanjo presojo – akreditacijo;
- urejeno nenehno izboljševanje kakovosti (klinične smernice, klinične poti, merjenje in poročanje kazalnikov izidov in drugih kazalnikov kakovosti, urejeno poročanje o zdravstvenih napakah, urejeno upravljanje varnosti pacientov);

- uvedeno izobraževanje za kakovost. (Ministrstvo za zdravje, 2006, str. 22)

Leta 2001 je bil pripravljen dokument *Kakovost v sistemu zdravstvenega varstva v Republiki Sloveniji*, ki opisuje stanje v državi in nekatere mehanizme, ki so na voljo za zagotavljanje vsaj najnujnejših standardov. Pozneje je bil oblikovan Nacionalni program zdravstvenega varstva Republike Slovenije – *Zdravje za vse do leta 2004*. Leta 2003 je bil izdelan osnutek zdravstvene reforme, v katerem so opisane usmeritve za sistematično vpeljavo kakovosti v zdravstvu v RS. Ker ni bilo ustanovljenega nacionalnega telesa za kakovost v zdravstvu, je bil leta 2004 ustanovljen Oddelek za kakovost pri Ministrstvu za zdravje. (Ministrstvo za zdravje, 2006, str. 32)

»V središču dogajanja so pacienti in drugi uporabniki. Za paciente je najpomembnejši dober izid zdravljenja, o čemer govorijo kazalniki izidov in drugi kazalniki kakovosti. Kazalnike izidov in kakovosti prikazujemo za posamezne specifične bolezni, stanja, postopke in podobno. Da bi dosegli dobre izide zdravljenja, moramo imeti urejene sisteme s strukturami in procesi, ki jih tudi merimo s kazalniki – kazalniki struktur in kazalniki procesov. Metode in orodja kakovosti se uporabljajo za doseganje dobrih kazalnikov izidov in drugih kazalnikov kakovosti.« (Ministrstvo za zdravje, 2006, str. 39)

Izvajalci pa so med drugim odgovorni tudi za sodelovanje pri nacionalnem programu kazalnikov kakovosti in programu *Kakovost v zdravstvu* ter za uporabo kazalnikov kakovosti za izboljševanje sistemov, kliničnih poti in procesov. Zato bi morali izvajalci zdravstvene dejavnosti postopoma uvesti metodo uravnoveženih kazalnikov, pri čemer upoštevajo vse razsežnosti delovanja (kazalnike poslovanja, varnosti pacientov, klinične kazalnike, kazalnike izkušenj in zadovoljstva pacientov in drugih uporabnikov ter zaposlenih. (Ministrstvo za zdravje, 2006, str. 54)

Novembra 2010 je izšel *Priročnik o kazalnikih kakovosti*, ki ga je izdelala delovna skupina za pripravo nabora in metodologije kazalnikov kakovosti. Njihovo delo pa je koordiniral Oddelek za kakovost pri Ministrstvu za zdravje (Pribaković Brinovec et al., 2010, str. 7). Nabor kazalnikov v *Priročniku o kazalnikih kakovosti* vključuje predvsem sekundarno in terciarno raven zdravstvene dejavnosti. V njem je zelo malo kazalnikov, ki so uporabni v primarni zdravstveni dejavnosti.

Saut et al. (2017, str. 1–9) v študiji ocenjevanja vpliva akreditacij v brazilskih zdravstvenih organizacijah ugotavljajo, da so glavni razlogi, ki so zdravstvene organizacije vzpodbudili k izvajanju programov izboljševanja kakovosti predvsem stroški zdravstvenega varstva, neželeni dogodki, zapletenost novih tehnologij, staranje prebivalstva in hitro širjenje prenosljivih bolezni po svetu. V navedeni študiji primanjkuje dokazov o korelaciji med varnostjo pacientov in akreditacijo. Varnost predpisujejo predvsem brazilski zakonodaji, po kateri je obvezno mesečno poročanje o neželenih dogodkih. Prav tako ni bil kot ustrezen potrjen učinek akreditacij na finančne rezultate zdravstvenih organizacij, zato bi bilo

smiselno, da se zdravstvene organizacije usmerijo na spremljanje in merjenje kazalnikov kakovosti, vrednotenje in ukrepe iz le-teh.

Carayon et al. (2014, str. 14–25) v svoji študiji govorijo o velikem vplivu delovnega sistema na varnost pacientov in zaposlenih. Zlasti izpostavljajo vrednost systemskega pristopa, ki opredeljuje vse vidike delovnega sistema, ki lahko vplivajo na varnost pacienta. V središču pa so: pomanjkanje strokovnosti, slaba uporabnost informacijskih tehnologij, neustrezen delovni prostor, hierarhična kultura in neupoštevanje smernic. Zato je nujno potrebno uravnovežiti delovni sistem, da bi lahko povečali varnost pacienta in zaposlenih.

V današnjem času je na voljo tehnologija za preprečevanje škode pri pacientih in s tem zmanjševanje stroškov v zdravstvu. Vendar žal primanjkuje preventive pred neželenimi dogodki v zdravstvu. Po podatkih British Medical Journala so zdravniške napake zdaj na 3. mestu najpogostejših vzrokov smrti v ZDA. Raziskave kažejo, da je vzrok za neželene dogodke (zdravniške napake) predvsem izgorelost zaradi prevelikega števila birokratskih nalog. Preprečevanje neželenih dogodkov bi moralo postati del kulture razmišljanja v zdravstvu, saj le s pomočjo prepoznavanj potencialnih tveganj in z evidentiranjem dejanskih napak lahko stvari predvidimo in preprečimo ter tako zmanjšamo škodo za pacienta in znižamo stroške v zdravstvu. (Dotan, & Koski, 2017, str. 1–10)

Minister za zdravje v OECD je poudaril, da je treba začeti vlagati v ukrepe, ki bodo pomagali oceniti, ali naši zdravstveni sistemi zagotavljajo to, kar je za ljudi pomembno. Smrtnost in klinični kazalniki namreč le delno predstavljajo vrednost zdravstvene oskrbe za ljudi. Ta ministrska izjava je potrdila načrte za program dela, kjer bodo pacienti poročali o uspešnosti zdravstvenega sistema. Predvsem poročanje pacientov o ukrepih po izvedenih anketah bi naj postala nova valuta za merjenje uspešnosti zdravstvenega sistema in primerjavo ocene uspešnosti med zdravstvenimi sistemi. Dosedanje ankete so namreč prinesle le povratne informacije o postopkih zdravstvene oskrbe, ne pa podatkov o učinkih. Zato bo treba na novo oblikovati vprašalnike za paciente, iz katerih bo možno izvesti ukrepe za izboljšanje zdravstvene oskrbe. Vprašalniki bi naj pokazali, kako je zdravje pacienta povezano s kakovostjo življenja. Predvsem pa je pomembno zavedanje, da pacienti ob namenjanju svojega časa za reševanje anket želijo biti prepričani, da bodo nagrajeni z izboljšanjem zdravstvene oskrbe. (Coulter, 2017, str. 1–2)

4. 2 Certifikacija zdravstvenih domov v Sloveniji

Tabela 4.2.1 Stanje certificiranih zdravstvenih domov v Sloveniji v letu 2017

| Območne enote ZZZS | Zdravstveni dom | SIQ* | BV* | necertificiran | |
|--------------------|---------------------------------------|---------|-----|----------------|---|
| OE Celje | Celje | x | | | |
| | Laško | x | | | |
| | Radeče | | | x | |
| | Slovenske Konjice | | x | | |
| | Šentjur | | | x | |
| | Šmarje pri Jelšah | | | x | |
| | Žalec | | | x | |
| OE Koper | Iliriska Bistrica | | x | | |
| | Izola | | x | | |
| | Koper | | x | | |
| | Piran | | x | | |
| | Postojna | | x | | |
| | Sežana | | x | | |
| OE Kranj | Osnovno zdravstveno varstvo Gorenjske | | | x | |
| OE Krško | Brežice | | | x | |
| | Krško | | | x | |
| | Sevnica | | | x | |
| OE Ljubljana | Domžale | | | x | |
| | Cerknica | | x | | |
| | Ribnica | | | x | |
| | Kamnik | x | | | |
| | Grosuplje | x | | | |
| | Hrastnik | | | x | |
| | Idrija | | | x | |
| | Ivančna Gorica | | x | | |
| | Kočevje | | x | | |
| | Litija | | x | | |
| | Ljubljana | x | | | |
| | Logatec | | x | | |
| | Medvode | | x | | |
| | Trbovlje | | | x | |
| | Zagorje ob Savi | | x | | |
| | Vrhnika | | | x | |
| | ZD študentov Ljubljana | | | x | |
| | Železničarski ZD | | | x | |
| | OE Maribor | Lenart | | | x |
| | | Maribor | x | | |
| Ormož | | | | x | |
| Ptuj | | | x | | |
| OE Murska Sobota | Slovenska Bistrica | | | x | |
| | Gornja Radgona | | | x | |

»se nadaljuje«

| | | | | |
|----------------------|--------------------------------------|-----------|-----------|-----------|
| »nadaljevanje« | Lendava | | x | |
| | Ljutomer | | | x |
| OE Nova Gorica | Murska Sobota | x | | |
| | Ajdovščina | | x | |
| | Nova Gorica | x | | |
| | Tolmin | | | x |
| OE Novo Mesto | Zobozdravstveno varstvo Nova Gorica | x | | |
| | Črnomelj | x | | |
| | Metlika | | x | |
| | Novo Mesto | x | | |
| OE Ravne na Koroškem | Trebnje | | x | |
| | Dravograd | | x | |
| | Radlje ob Dravi | | | x |
| | Ravne na Koroškem | | x | |
| | Slovenj Gradec | | | x |
| | Velenje | | x | |
| | Zdravstveno reševalni center Koroške | | | x |
| | Mozirje | | | x |
| Skupaj | | 59 | 11 | 22 |
| | | | | 26 |

Opomba: Podatki so vzeti s spletnih strani zdravstvenih domov Slovenije

Seznam zdravstvenih domov je povzet po ZZZS, 2017, str. 15–30

*SIQ – Slovenski inštitut za kakovost in meroslovje v Sloveniji

BV – Bureau Veritas

5 Razprava

Razvoj kakovosti v zdravstvu izhaja iz dokumenta Nacionalne usmeritve za razvoj kakovosti v zdravstvu v letu 2006. Leta 2010 izide Nacionalna strategija za kakovost in varnost v zdravstvu.

Zakaj kakovost v zdravstvu?

Odgovor lahko iščemo v zelo pogostih odklonih zdravljenja, ki jih lahko merimo kot kazalnik kakovosti. Šele ko imamo opravljene meritve, lahko na podlagi podatkov izvedemo izboljšave. V gospodarstvu so sistemi vodenja kakovosti prisotni že dolga leta, predvsem zaradi obstoja posameznih podjetij na trgu, kjer vlada huda konkurenca. Kazalniki kakovosti bi morali biti javno dostopni podatki, saj se lahko le tako uporabniki zdravstvenih storitev in tudi zdravniki ob napotitvah odločijo za ustreznega izvajalca zdravstvenih storitev.

Primarno zdravstveno varstvo je največkrat vstopna točka uporabnikov zdravstvenih storitev v zdravstveni sistem, zato je razvoj primarne zdravstvene dejavnosti še toliko bolj prioriten. Primarno zdravstveno varstvo se poleg diagnostike in zdravljenja ter rehabilitacije bolezni ukvarja še s preventivo, s katero lahko najbolj vplivamo na poznejše stroške zdravljenja.

Vstop Slovenije v Evropsko unijo je prinesel zahteve za celovito vodenje in usklajevanje kakovosti v vseh državah članicah le-te. Države članice Evropske unije so posledično sprejele dokument Zdravje 21 – zdravje za vse v 21. stoletju.

Zaradi ugotovitve, da zdravniške napake povzročajo največ stroškov in trpljenja pacientov, je WHO leta 2002 opomnila članice, naj posvetijo večjo pozornost varnosti pacientov in oblikujejo sisteme za izboljšanje le-te. (Ministrstvo za zdravje, 2006, str. 18)

Glavni vzroki za oblikovanje in uvajanje sistemov vodenja kakovosti v zdravstvu v državah članicah Evropske unije so veliki odkloni zdravljenja, neuspešnost delovanja organizacij, neučinkovita uporaba tehnologije, visoka cena napak v zdravstvu oziroma nizka kakovost storitev, nezadovoljstvo uporabnikov storitev, neenakost v dostopu do zdravstvenih storitev, dolge čakalne dobe in visoka cena zdravstvenih storitev. (Ministrstvo za zdravje, 2006, str. 20)

Zato morajo izvajalci zdravstvene dejavnosti dokazati, da imajo vzpostavljene organe za kakovost, samoocenjevanje, zunanjo presojo in sistem nenehnega izboljševanja kakovosti (Ministrstvo za zdravje, 2006, str. 22)

Slovenija je leta 2001 sprejela dokument Kakovost v sistemu zdravstvenega varstva v Republiki Sloveniji. Na podlagi tega je bil oblikovan Nacionalni program zdravstvenega varstva v Republiki Sloveniji – Zdravje za vse do leta 2004. Leta 2003 je bil izdelan osnutek zdravstvene reforme, leta 2004 pa ustanovljen oddelek za kakovost pri Ministrstvu za zdravje. (Ministrstvo za zdravje, 2006, str.32)

Leta 2006 je bilo v splošni dogovor z ZZS prvič vpisano določilo o spremljanju kazalnikov kakovosti zdravstvene obravnave. (Kiauta et al., 2010, str. 19)

V središče dogajanja so tako postavljeni pacienti in drugi uporabniki zdravstvenih storitev kot tudi zaposleni v zdravstveni dejavnosti. Slednji so pogosto preobremenjeni, zato nimajo časa za ukvarjanje s kakovostjo. Posledično so zdravstvene organizacije pristopile k certifikaciji ali akreditaciji, saj so le tako uspele pridobiti skrbnika sistema vodenja kakovosti, in začele s spremljanjem kazalnikov kakovosti v zdravstvu. Tako je leta 2010 izšel Priročnik o kazalnikih kakovosti v okviru Ministrstva za zdravje, ki ga je oblikovala delovna skupina. V njem so opredeljeni kazalniki kakovosti, ki so uporabni na sekundarni ravni zdravstvene dejavnosti, kazalniki, ki so navedeni (prvih 20) kot primerni za primarno zdravstveno dejavnost, pa na primarni ravni niso uporabni in merljivi. Tako ponovno primarna zdravstvena dejavnost izgublja na pomenu, saj je ravno primarno zdravstveno varstvo tisto, ki se ukvarja s preventivo, terapijo in rehabilitacijo obolenj, kar lahko bistveno zmanjša stroške poznejšega zdravljenja in omogoči višjo kakovost življenja posameznika.

Največji nabor zdravstvenih storitev primarnega zdravstva najdemo v Belgiji, Franciji, Bolgariji, Finski, Litvi, Norveški, Portugalski, Španiji, Švedski in Združenem kraljestvu. V

evropskih državah je predvsem velika razlika v dostopnosti zdravstvenih storitev. (Kringos et al., 2010, str. 742–750)

Primarno zdravstveno varstvo je temelj sistemov zdravstvenega varstva v mnogih delih sveta. V raziskavi, narejeni v 34 evropskih državah v letu 2015, je bilo zaznано predvsem pomanjkljivo usklajevanje zdravstvene oskrbe pri prehajanju uporabnikov zdravstvenih storitev skozi različne nivoje zdravstvene dejavnosti, saj so izidi zdravljenja pri bolnikih s kroničnimi obolenji veliko boljši v državah, ki imajo usklajeno zdravstveno oskrbo. Pozitivne izkušnje prenosa informacij med zdravniki z različnih nivojev zdravstvenega varstva so predvsem na Danskem, Finskem, Litvi, Islandiji in Švedski. Nekoliko je ob tem problematična Danska, saj mnoge majhne zasebne prakse na Danskem ovirajo usklajevanje zdravstvene oskrbe in vodijo v kulturo individualizma. (Rotar Pavlič, 2015, str. 1–11)

Študije so pokazale, da so organizacije, ki so certificirane ali akreditirane, veliko bolj uspešne pri uvajanju organizacijskih sprememb. Problem je skeptičnost zdravnikov do kakovosti, predvsem tistih, ki jim primanjkuje znanja s področja managementa kakovosti, saj so v anketah sami izrazili potrebo po izobraževanju s tega področja (Brubakk et al., 2015, str. 2–8)

Ob uvajanju sistemov vodenja kakovosti tako pogosto naletimo na odpor pri določenih kadrih (predvsem zdravnikih), ki jim primanjkuje znanja s področja sistemov vodenja kakovosti. Posledica tega je napačno dojetje samoocenjevanja organizacije (notranje presoje, internih strokovnih nadzorov), zunanje presoje in izdanih neskladnosti in priporočil. Največkrat zaposleni presoje dojemajo kot nadzor, kontrolo in iskanje napak. Zato je smiselno uvesti izobraževanje s področja kakovosti in varnosti v zdravstvo kot obvezno vsebino za vse zaposlene v zdravstvu. Le tako bomo dosegli, da bodo neskladnosti in priporočila dojemali kot priložnost za izboljšavo in ne kot kritiko svojega dela ali iskanje napak pri tem.

Večina zdravstvenih ustanov pristopi k akreditaciji ali certifikaciji zaradi usmerjenosti v razvoj, samoregulacije in trženja (Shaw et al., 2010, str. 445–451).

V nekaterih državah pa obstajajo zakonske zahteve, da zdravstvene organizacije za vzdrževanje kakovosti zdravstvenih storitev obvezno pristopijo k certifikaciji ali akreditaciji. Tudi v Sloveniji je predlog za leto 2018, da se v splošni dogovor glavnim odjemalcem zdravstvenim storitev (ZZZS) zapiše določilo, da bodo zdravstvene organizacije, ki niso certificirane ali akreditirane, sankcionirane (finančne kazni). Žal nismo še prišli do nivoja, da bi bile organizacije, ki so certificirane ali akreditirane, motivirane in nagrajene s finančno podporo.

Težko je dokazati vpliv akreditacije ali certifikacije, da bi lahko organizacije upravičile čas in denar, ki so ga porabile za sisteme vodenja kakovosti. Oba sistema pa vzpodbujata strukture in procese, ki podpirajo varnost bolnikov in tako dosegajo višjo kakovost zdravstvenih storitev. (Shaw et al., 2014, str. 100–107)

Na Portugalskem so leta 2003 začeli z zdravstveno reformo, pri čemer so vse enote zdravstvenega varstva povezali v mrežo zdravstvenih ustanov. Leta 2007 so nadaljevali z reformo in ustanovili tako imenovane družinske zdravstvene enote, da bi zagotovili večjo dostopnost do storitev, krajše čakalne dobe in višjo kakovost storitev. Ker se pogledi strokovnjakov na kakovost zelo razlikujejo, so določili tri dimenzije za spremljanje kakovosti v zdravstvu:

- uporabnik zdravstvenih storitev in njegova pričakovanja,
- potrebe zaposlenih in ocena primernosti izvajanja postopkov,
- učinkovita uporaba virov.

Glavni problemi portugalskega zdravstvenega sistema so bili pomanjkanje varnosti za pacienta, visoki stroški, nezadovoljni uporabniki zdravstvenih storitev, neenakost v dostopu do storitev in dolge čakalne dobe, zato so začeli s sistematičnim uvajanjem sistemov vodenja v bolnišnicah, nato pa še na primarni ravni zdravstvene dejavnosti. (Duarte & Fonseca, 2017, str. 251–264)

Alameddine et al. (2015, str. 1–14) v raziskavi o pripravljenosti poročanja o kazalnikih kakovosti in neželenih dogodkih ugotovijo, da je o teh pripravljenih poročati 66 % anketiranih zdravstvenih delavcev. Najnižja ocena pripravljenosti je bila pri zdravnikih, predvsem pri pripravljenosti poročanja o neželenih dogodkih, saj jih je ob tem strah sankcij.

Zelo pomembno je torej timsko delo in zavedanje, da gre pri napakah v zdravstvu pogosto za sistemske napake, ki jih je možno preprečiti z boljšo komunikacijo in boljšim sodelovanjem sodelavcev v timih.

Do zdaj so se med pacienti izvajale le ankete, ki so prinesle zgolj informacije o uspešnosti postopkov zdravstvene oskrbe, ne pa tudi o učinkovitosti. Zato bi bilo treba oblikovati nove vprašalnike, ki bi pokazali, kako je zdravje pacienta povezano s kakovostjo življenja. Predvsem bi moral biti izpostavljen vpliv bolezni na posameznika, vpliv zdravljenja na delovanje posameznika ter njegovo počutje. (Coulter, 2017, str. 1–2)

Pri razvoju kakovosti v zdravstvu se vse preveč pozablja na primarni nivo zdravstvenega varstva, kjer lahko številne bolezni preprečimo, zdravimo in uporabnike storitev tudi primerno rehabilitiramo za še kakovostno sprejemljiv nivo življenja. Le tako lahko znižamo veliko število obravnav na sekundarnem in terciarnem nivoju zdravstvenega varstva in s tem posledično stroške nepotrebnih zdravstvenih obravnav in zdravljenja. V prvi vrsti bi moral biti cilj kakovosti v zdravstvu predvsem pacient, ki lahko v ustrezni fazi kronična obolenja prepreči in tako ostane še vedno samostojen v osnovnih življenjskih funkcijah. Zato bi morala biti uvedba sistemov vodenja kakovosti v primarni zdravstveni dejavnosti ena od prioritarnih nalog Vlade in voditeljev posameznih zdravstvenih organizacij. S sistemom vodenja kakovosti je omogočeno, da organizacije spremljajo kazalnike uspešnosti in učinkovitosti, o katerih poročajo in ki so dostopni širši strokovni in laični javnosti. Zgolj tako je uporabniku zdravstvenih storitev omogočeno, da izbere izvajalca, ki ima najboljše kazalnike uspešnosti,

(tudi kazalnike izidov) in s tem sebi omogoči čim boljši izid preventive in zdravljenja, zdravstveni sistem pa posledično zniža stroške zdravstvenih storitev.

6 Zaključek

Zahteva Evropske unije je celovito vodenje in usklajevanje kakovosti v zdravstvu v vseh njenih članicah. Ob tem se v ospredje postavi varnost pacientov, saj se le tako lahko zmanjšajo trpljenje pacienta in stroški učinkovitosti zdravljenja. Glavni problemi zdravstva, povezani s kakovostjo, so namreč pomanjkanje varnosti za pacienta, visoki stroški zdravljenja, nezadovoljni uporabniki zdravstvenih storitev, neenakost pri dostopu do zdravstvenih storitev in dolge čakalne dobe. Zato so izvajalci zdravstvene dejavnosti zavezani uvesti in vzpostaviti sisteme vodenja kakovosti na vseh ravneh zdravstvene dejavnosti. Ker je primarna zdravstvena dejavnost prva raven zdravstvene oskrbe v bližini doma pacienta in vključuje tako preventivo kot kurativo, bi moral biti razvoj sistemov vodenja kakovosti na primarni ravni zdravstvene dejavnosti prioriteta. Primarna raven zdravstva bi morala biti bolj odzivna na potrebe prebivalstva, saj z vsemi svojimi dejavnostmi vpliva na delovanje vseh ostalih nivojev zdravstva. Ob tem je pomembno usklajeno delovanje vseh ravni zdravstvene dejavnosti, saj ima le tako pacient možnost dobrega izida zdravljenja, kar je pomemben kazalnik kakovosti zdravstvenih storitev. Kazalniki kakovosti bi zato morali biti javno dostopni podatki, saj le tako lahko zdravnik in pacient izbirata med izvajalci zdravstvenih storitev, ki imajo najboljše kazalnike izidov. Te kazalnike pa najpogosteje spremljajo samo zdravstvene ustanove, ki imajo sisteme vodenja kakovosti.

Raziskave kažejo, da je premalo pozornosti posvečene razvoju sistemov vodenja kakovosti v primarni zdravstveni dejavnosti, ki je vstopna točka skorajda vsakega pacienta v sistem zdravstva. Članek je lahko v pomoč različnim organom za kakovost, ki morajo svoja prizadevanja za razvoj kakovosti v zdravstvu usmeriti predvsem na primarno raven zdravstvene dejavnosti. Družba bo tako dobila učinkovitejše primarno zdravstveno varstvo, kjer bo lahko posameznik nekatere bolezni preprečil, ozdravil in se po njih rehabilitiral. Posledično ne bo napoten na sekundarno raven in s tem se mu bo omogočila kakovostnejša raven življenja, saj bo bolezen ali preprečena ali hitreje ozdravljena. Hkrati pa se bodo skrajšale dolge čakalne dobe v zdravstvu na sekundarni ravni in zmanjšali stroški zdravljenja.

Raziskava je omejena na raziskavo teoretičnih izhodišč začetka in nadaljevanja razvoja kakovosti v zdravstvu in uvajanje sistemov vodenja kakovosti v zdravstvu, zato bi jo bilo smiselno nadgraditi z raziskovanjem spremljanih kazalnikov kakovosti v primarni zdravstveni dejavnosti.

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Abstract: **Quality Assurance System at Primary Level of Healthcare**

Purpose: Purpose of the research is to clarify the basis, development and the state of the art of quality assurance systems at primary level of healthcare.

Method: As a method, quality assurance in healthcare literature overview and analysis was used.

Results: Research provided basic for the introduction and development of quality assurance as well as encouragement for further development of quality assurance in primary healthcare system

Organization: institutions of primary healthcare system will be enabled to understand the quality assurance in healthcare systems in EU and Slovenia.

Limitations/Future Research: Research is limited with relatively low amount of relevant sources. In the further research it would be necessary to define, which indicators shall be used in assessing the quality of primary healthcare services, and consequently to develop new model of requested indicators which shall be monitored in the primary healthcare systems.

Keywords: quality, quality assurance systems, primary healthcare sector, healthcare services, patients' safety.

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Tourism in Slovakia, especially in Small Carpathians

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Abstract:

Purpose and Originality: Article is trying to understand the touristic potential of Small Carpathians region in Slovakia. It explores the tourism of individual municipalities as well as of broader territories. The article further analyses the current status of tourism in the area under review by assessing all relevant elements such as the natural environment, cultural and historical monuments, and infrastructure.

Method: Descriptive method, content analysis of primary data and evaluation method were used in the article.

Result: Small Carpathian region in Slovakia has strong potential that individual places can become a popular tourist centres. However, the analysis showed the insufficient mutual communication at different levels in different spheres of municipalities and towns, insufficient promotion and providing low quality support services.

Limitation: The main setback of the article is lack of the comparison of different countries and even within Slovakia, the article is concentrated on Small Carpathians region.

Keywords: tourism, Small Carpathians, Slovakia, tourism potential, cultural heritage.

1 Introduction

Tourism in recent years is one of the most dynamically developing sectors of the economy. Slovakia is a country with high potential for travel tourism, who offered many historical and natural attractions.

One of the most attractive places in Slovakia is currently mountains Little Carpathians. For somebody cannot know the place for other known mainly highest peak Záruby. Cerveny Kamen castle, Plavecký castle, city Modra, offers the opportunity to spend an active free days.

Article focuses on all the attractions which towns and villages have, as natural environment, cultural - historical monuments as well as the possibilities for accommodation and meals are.

In this article, we provide not only the basic information in the field of tourism Slovakia, but also deeper focus on individual places and options for community development of villages and cities investigated area of the Small Carpathians in tourism.

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2 Protection of cultural heritage by ministry of culture of Slovak Republic

Protection of cultural monuments of the country is very important in order to preserve and explore the cultural heritage of the people from the country to foreign tourists. Slovak Republic is governed by established laws and regulations intended to protect the monuments of the country.

For more effective implementation of conservation and restoration of monuments directs the National Council Act No.49 / 2002 on the protection of monuments (as amended by Act no. 479/2005 Coll.) 19. 12. 2001 approved with effect from 1 April 2002, who made several amendments to the philosophy of protection of monuments in Slovakia. The effect of this law changed competencies of heritage authorities, which previously fulfilled the role of the advisory bodies of state authorities. Basically, conservation authorities have wide powers but they were not allowed to decide the fate of cultural monuments. The law resulted into formation of a new organization monuments - Monuments Board of Slovak Republic, legally acquired jurisdiction and became part of specialized state administration. [9]

Taking care of cultural heritage in Slovakia has not always been as widespread as at present. The occurrence of the said Act and Monuments Board of the Slovak Republic took place in a couple of changes affecting the protection of cultural monuments.

In 1951 Heritage Institute established and in 1958 the first special law on cultural heritage was adopted by. The role of the institute at the time of its creation was particularly the finalization of a national list of cultural monuments and processing inventory of monuments in Slovakia, which was published in the sixties. In 1987, the Act no. 27/1987 Coll. was accepted as the preservation of historical monuments. In December 2001 the National Council Act no. 49/2002 Coll. for Heritage Protection, which brings a number of organizational, methodological and terminological changes, particularly establishing specialized state administration in the field of cultural heritage protection, which in addition to the Ministry of Culture as the central government body is also formed by Monuments Board of the Slovak Republic and Regional Monuments Boards. [10]

Cultural heritage can be protected, managed and used only in accordance with their physical, historical and cultural values of quality, including the environment to prevent his possible physical alteration, damage, theft or destruction. Conditions and methods of rescue, use and presentation of cultural heritage, scope and responsibilities of competent authorities are governed by the relevant laws protecting individual species and parts of cultural heritage.

3 Tourism - the definition and description of terms

Tourism is among the most dynamically developing sectors of the world economy. Tourism contributes to the GDP in European Union an average of 13.5%. The positive effects of tourism are reflected in the economic and non-economic areas. In the economic sphere, it is,

for example, consumption goods and services, which is reflected in the growing incomes of enterprises, regions and countries, businesses tourism creates jobs, thereby addressing the problem of unemployment. The non-economic areas, it is as the promotion of international understanding, learning about national cultures, information exchange, education and health promotion. (Jarábková, 2007)

Tourism as a concept and attempts to single definition is dated around the year 1942. During this period, provided the definition of tourism as authors Hunziker and Kapf. All definitions of tourism from various authors have two identical characteristics and it is the movement and stay.

International association of experts tourism AIESA defines tourism as a set of relationships and phenomena arising from the travel and stay of persons if the stay is not connected to a permanent establishment and implementation of employment. The team of Slovak authors defines tourism as "a set of activities in a particular environment to meet the needs of people related to travel outside their place of residence, irrespective of whether the reason for their travel is relaxing or irregular duty or Business".(Jarábková, 2007)

According to Preobrazhensky, one of the founders of geography tourism, tourism is complex socioeconomic phenomenon, which cannot be determined unambiguously. This term is simultaneously expressed by the following definitions:

- a special kind of migration of the population, who studies demography, geography
- population and related sciences;
- sector of the economy, which is one of the socio-cultural spheres of meeting
- needs of the population, studying her economics and economic geography;
- way to spend free time outside the permanent place of residence, they studied sociology
- geography and tourism. (Mariot 1983)

According to Otruba tourism in its broadest sense includes all forms travelling at home and abroad for the purpose of rest, recreation, learning new, entertainment, culture and sports, the stay of visitors is reflected in economic life of the visited sites. (Krnáčová a al., 2005)

4 Slovak republic and tourism

Slovakia as an independent republic was established 1.1.1993. According to the statistical office had to 30.9.2009 5, 421,937 inhabitants. With its area of 49035square kilometres, compared with other states between small countries. Slovakia is administratively divided into 79 districts, 138 towns and 2,883 villages. 2 of which are large cities - Bratislava and Kosice. The city has more than 57 percent of the population.

Slovakia occupies part of Carpathian Mountain Area, south of the Carpathians is Pannonian Basin, along the Danube stretches Danubian Plain, the east stretches Eastern Slovak Lowland.

The northernmost point of Slovakia is Babia Mountain in the Orava region, southernmost point near Patince in Komarno, in the westernmost Záhorská Ves and the easternmost point of Slovakia is located in New Sedlica. From Záhorská Ves after Nova Sedlica Slovakia is 428 km. Slovakia heights range from 94 m asl in Kline over Bodrogom to 2655 m asl High-Gerlach High Tatras.(Linhart, 2006)

Slovakia is a landlocked country, located in Central Europe. It borders with Hungary, with which it has the longest border at 679 km, with the Czech Republic, Poland, Austria and Ukraine, with which the shortest border line at 98 km.

In terms of the position of the neighbouring states Slovakia offers possibilities for different combinations of customers, allowing know the whole Central European region. It is a natural crossroads Network West - East and North - South and good communication is available. In terms of transport facilities it is part of the Western European motorways, which extends through Austria to Bratislava. It is also very convenient highway connection Bratislava - Prague. Air is a convenient opportunity arrival through the airport in Bratislava, Vienna and Budapest. In terms of domestic traffic is not very well connected.

It is necessary to invest in construction of highways and roads, road signs and directions revitalization stations. Just poor quality infrastructure, weaker tourism services and insufficient promotion of attractions are often Slovakia becoming a transit country in which the visitor does not remain longer.

It is endowed with many tourist attractions. So far, Slovakia is discovered and registered 1,200 caves, of which 12 are open to the public. Between the most important caves are: cave Driny, Harmanecká cave, Bystrianska cave, Ice cave, Demänovská cave of liberty, Važecká cave, Belianska cave, ice cave, Aragonite cave, Gombasecká cave, Domica, Jasovská cave. (<http://www.ssj.sk/jaskyne/spristupnene/>)

Although Slovakia is a small country has nine national parks and 14 protected landscape areas, which entails the most valuable of Slovakia nature. National parks of Slovakia are the High Tatras, Low Tatras, Big Fatra, Small Fatra, Slovak Paradise, Slovak Karst, Muran Plateau, Pieniny and Poloniny national park. More than 40% of the Slovak territory is covered by forests. Numerous mountain ranges with distinct segmentation and diversity of mountainous terrain attract more and more visitors. A specific area of peculiar geological and morphological peculiarities, climate, flora and fauna of the national parks. In many places can admire the unspoiled nature, intact civilization influences. (Linhart, 2006)

The most important and oldest cultural and historical monuments in Slovakia include castles, palaces and manor houses. Slovakia is among the countries with the greatest number of castles in Europe. There are 425 and 180 mansions castles, together with a castle ruins. Castles originated from the 13th century, initially to protect the territory from enemies. They guarded the entrances to cities and important trade routes.

Museums and galleries own precious collections of cultural heritage of the nation and the state. In Slovakia, there is 70 museums and 19 galleries and more than 100 other exposures commemorative rooms and open-air museums. With its diverse focus and orientation clarify issues related to the development of society and culture in our country. (Slovak Republic, 2009)

Slovakia is on the UNESCO list of monuments registered 7 - 5 Cultural and 2 natural. The first three locations in Slovakia in the list of World Heritage – Banska Stiavnica, Spis castle and Vlkolinec were recorded in 1993. The fourth and fifth site is the historic core of the town Bardejov and eight wooden churches. Slovakia-Hungarian project Caves of Slovak and Aggtelek Paradise was adopted in 1995. The last natural monument registered on the World Heritage List is Bukovske forests in the Eastern Carpathians. (UNESCO heritage).

The mentioned facts are clear signals for a possible economic, economic, social development resulting from facilities still above facts. Their use in Slovakia is the insufficient level. The result of non-use and unrealized offered potential and existing infrastructure and superstructure as a basis for a positive environment of tourism and its progress compared to the level of tourism in neighbouring and for us readily available countries can for example decrease in the total number of tourists, restrictions on foreign investment and lack of interest of foreign investors in doing business in Slovakia, low incomes.

Table 1 shows that major countries of origin of tourists in Slovakia between 2003 and 2008 according to the order: Czech Republic, Poland, Germany, Hungary and Austria. These are primarily countries with which the neighbours.

Table 1. Tourists in Slovakia by the country of origin

| Country | Number of tourists | | | | | |
|---------------|--------------------|---------|---------|---------|---------|---------|
| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
| Czech | 469 991 | 419 273 | 424 900 | 455 381 | 490 986 | 537 180 |
| Poland | 215 383 | 179 078 | 198 479 | 224 159 | 243 917 | 308 437 |
| Germany | 175 746 | 188 067 | 194 158 | 190 422 | 176 059 | 164 694 |
| Hungary | 100 546 | 111 065 | 121 615 | 121 981 | 93 979 | 90 123 |
| Austria | 51 365 | 55 609 | 55 630 | 60 560 | 62 661 | 62 052 |
| Italy | 37 996 | 50 201 | 59 344 | 60 971 | 58 184 | 54 722 |
| Great Britain | 26 062 | 34 349 | 51 720 | 63 137 | 63 193 | 66 628 |

Source: www.economy.gov.sk/pk/480-2007-1000/ma.htm

5 Analysis of tourism in the Small Carpathians

The Small Carpathians are together with Austrian Hainburger Berge (Hainburghills) a landscape unit Fatra-Tatra area. The highest peak is the peak Záruby- 768 m asl. It is a modest highlands zone of about 100 km in length. Small Carpathians begin on the Danube in Bratislava (strip of territory north of Devin by Bratislava castle hill) and extend to Nove Mesto nad Váhom. A significant part of the central seat of the saddle Baba mountains. In 1976, they were declared a protected landscape area with a flat 64,610 hectares. Geomorphological are divided into: Devin Carpathians, Pezinske Carpathians, Carpathians and Brezovske Čachticke Carpathians. (Szomolányi a al., 1986). Defined researched area is just Pezinské Carpathians.

The Small Carpathian area has the environment with strong potential in different aspects of the economic development. Tourism as one of the possible directions of such development is under Small Carpathian space an integral part. Based on various present facts, which are designed and conceived at different levels can raise the importance of tourism to a higher personality, character level. The basis for such an understanding of this area are already initial positional information and the convenient location close to the capital city as well as the proximity of the border with the three neighbouring countries - Czech Republic, Austria, Hungary.

The Small Carpathian region in particular its eastern part is one of the best wine sites in Slovakia, with a long tradition of wine-growing, cradle-known wine brands, whose reputation goes beyond the borders of Slovakia. And where there is good wine is also good will, pleasant atmosphere and harmonious life, which are clear signals for tourism development in this area. (www.mkvc.sk)

5.1 The basic characteristic of the western part of the Small Carpathians

The precise demarcation is necessary to determine the territory on the map. Demarcation of the reference area on the east side of the Little Carpathians form the cadastral areas of a city. The southern border is formed by the cadastral areas of Borinka Marianka and around Stupava. Northern boundary cadastral area of the village Cerová. Common border study area on the west side and the east side of the Small Carpathians mountain ridge forms.

From the geomorphologic point of view is the area bounded on the west Borski lowlands, it forms the eastern border mountains back Pezinské Carpathians. Pezinské Carpathians within the Small Carpathians are geomorphological unit as defined precisely in the municipalities selected according to such criteria. Entire territory quite deeply affects the PLA Little Carpathians. In connection with the capital it allows part of the territory just interfering in the PLA Little Carpathians use the rich network of tourist footpaths and paved forest roads suitable for cycling.

The total area is 382 km² as the total surface area of all villages representing that territory. Total population, which permanently inhabit investigated territory, according to official data of the Statistical Office 26654 residents. Density of population per 1 km² is 70 people.

It is important to mention that in the restricted area is the cadastral area Turkish top, which is under the administration of the Ministry of Defence. It is a military training area within the military district Záhorie. This space is for an ordinary person freely temporary and can move in it. By the time training is guarded and into the area where the training takes place directly input is strictly prohibited.

The first reference to individual municipalities ranges from early 13th century to the 16th century. The oldest villages are Jablonové and Kuchyna, first mentioned 1206, while the youngest municipalities are Sološnica first mentioned in 1520 and the municipality Rohožník in 1504. At the proposal of the Ministry of Economy in 2003-2004, the new regionalization of tourism in Slovakia was developed. It was based on Slovak territory divided into 21 regions. City Stupava falls under this regionalization in the Danube region with significant summer seasonality and supra-regional importance (Linhart, 2006).

The villages and towns combining their historical development, which is then reflected in their parallel culture. A common feature, characteristic for the unprofessional public for municipalities is their relationship to wine. This also applies to Záhorie region.

For comparison, the west side of the Small Carpathians has a number of villages and towns the same, i.e. 14. The total area of the examined area is 371.7 square kilometres as the total surface area of all municipalities representing this area. Total population, who reside permanently explored territory, according to official data of the Statistical Office of 31.12.2009 is 51236 inhabitants. Population density per 1 km² is 138 people.

5.2 The natural potential of the western part of the Small Carpathians

Small Carpathians belong to the Alpine-Himalayan system. Under this system they are part of the subassembly Carpathian sub-province Inner Western Carpathians. Small Carpathians as a separate regional unit can be divided into several units lower order.

They are: 1. Devínske Carpathians, 2. Pezinské Carpathians, 3. Brezovské Carpathians, 4. Čachtické Karpaty. Examined territory belongs just to Pezinské Carpathians. Form part of the Small Carpathians between Lamačská gate and Brezovský Carpathians. On the west side these include Homolský Carpathians, Kuchynska Visoka, Stupavské, Plavecke Podhradie and Podhradie. (Szomolányi, 1986).

The Small Carpathians between the Danubian Plain and the Záhorská lowland lifted morphologically very significantly and the foothills they emerge about 450-550 meters. The highest amount of mountain range reaches a peak in the central part of frame with a height of

768 m asl. Today surface ductility Small Carpathians is the result of prolonged exposure geomorphologic processes and the interaction of endogenous and exogenous forces strongly affected by the geological composition of the mountains. Today, the final form of the mountain range is the result of Neogene movements of the earth.

Except platforms are the most common form of mountain valley. Valleys are oriented mostly perpendicular to the mountains and only a few go parallel to the mountain range. They are mainly karst valleys Borinská creek, wet valley over Plavecký Mikuláš and other valleys, especially in karst areas.

The so-called Small Carpathians Karst producing a set of karst mountains, occupy a total of 170 to 180 km². The main karst areas to the west, Záhorská part of the Small Carpathian Mountains are beautiful Borinský and Plavecky. In them they are represented by the surface but also underground karst phenomenon, which just for tourism offers in the appropriate use of possible tools for its development. (Szomolányi, 1986).

On the western part of the Small Carpathians is a cave Deravá skala, dark rock cave, Plavecká cave, small caves along the creek Borinská like Zbojnica cave.

The Deravá skala is located on the right side Mokra valley below the platform Javorinka 561 m asl. in the administrative area Plavecký Mikuláš. It created in the Middle Triassic limestones Choč Nappe frost weathering. About 10 m above the creek is the entrance to the cave. It has the shape of a massive overhang and consists of a 26 m long and 15 m wide portal hall with poor decor. In addition to the geomorphological significance it has a great archaeological value. It was inhabited by man as early as the Paleolithic period. It is part of National Nature Reserve Kršelnica and in 1994 was declared a natural monument. Decree of the Regional Environmental Office in Bratislava declared in 2008 to open to the public. (<http://www.sazp.sk>)

The dark rock cave is located east of holey rock on a steep slope Wet valley. It's sandwiched river-cave with a length of 40m, the horizontal course of the valley below cliffs without stalactite decoration. It is known mainly findings of cave bear bones. He formed alternately corrosion, erosion, mechanical weathering and filling. The cave is an important archaeological and now also characterological site. The cave was discovered findings documenting settlement in Paleolithic and osteological material Pleistocene fauna. Access to the cave is very simple. Directly in Plavecký Mikuláš starts green trail, which includes the top end of the village becomes a nature trail continued Wet valley. On both caves alert notice boards. (<http://www.sazp.sk>)

The Plavecká cave is below Plavecky castle (240 m asl.) in the administrative Village Plavecke Podhradie. Gradually in the Middle Triassic limestones of Choč water created fissure-rútivá 125 m long cave with decorations significantly broken down. It was described in 1885, but the first map was drawn up in 1815. Before the first World War it was the

initiative of count Palffy made available. At present, however, inaccessible. It is an important habitat of numerous colonies of bats.

Plavecky karst was declared as protected area within the NRP Roštún. Roštún is an older name for calcium salts. Lime belonging to the area of municipality Sološnica as the third highest peak of the Small Carpathians to 752 m asl. It offers a magnificent view. The very top of the rocky cliff from which one can see the second highest peak of the Little Carpathians high (754 meters). ([Http://www.sazp.sk](http://www.sazp.sk))

Borinská caves along the creek - Cave in Lower attacked

This area is located east of the village Borinka (Pajštún) and occupies the western slopes of the nature reserve drop-offs (523 m asl). Adjacent to the Črveny and Zbojnicky stream. SPR part of the cave in Lower attacked. The area is located in Borinská Karst and consists of steep slopes with rocky walls that are broken at some places into ravines and ridges. Formation of caves in this area is related to the erosive action of water flows flooded down from crystalline. In addition to the major geomorphologic values, there is also significant flora area. There are Marianka fragrant (*Asperula odorata*), unguates European (*Asarum europaeum*), spurge prerastlíkolistý (*Euphorbia bupleurifolia*), Aaron spotted (*Arum maculatum*), enchanter common (*Circaea lutetiana*) sanicle European (*Sanicula europaea*), impatiens drowsy (*Impatiens noli -Tanger*) and others. The most valuable plant species is deer tongue Fern (*Fhyllitis scolopendrium vulgare*), which occurs on vertical limestone walls. The Small Carpathians to another location has not yet been identified. ([Www.skonline.sk](http://www.skonline.sk))

Geological structure of the mountain range determines the presence and nature of climbing terrain. The most extensive terrains are located in the central part of the mountain facing west.

The castle rock Pajštún is climbing above the village Borinka on extremely strong limestone rock. Sometimes, there are climbers Rock climbing-hosted race.

The Jastabie rock above the village Sološnica has in the area more than 40 routes and variants described. In the past, Jastrabie rocks and the whole ridge of Little Vápenná was closed for hiking and mountaineering.

The Plavecky castle rock, which was created as a rocky ridge Plavecký castle. Rocks in Mokra valley they are visited by the left and right side of the valley.

5.3 The natural potential of the eastern part of the Small Carpathians

One of first natural wonders of the territory is Driny cave, which is 680 meters long, of which 410 meters is accessible. The cave spaces prevailing fissure corridors, which are decorated with rich sinter filling. Typical feature are sinter curtains with indented facing. There are also represented sinter waterfalls and flows, pagoda-like stalagmites, stalactites and pools. It was discovered in 1930 and for the public is made available since 1935 (Jastrabík, 1975).

Another dominant feature, which can be visited and the natural potential of the Valley Hlboča in the village Smolenice.

The natural dominant features and attractions that offer the potential for tourism development and are formed due to geological developments are in addition to the cave and some others. It is Rock area near the village of Modra example. Yew rocks, further Hajduk, Hemlock, Driny Lošonský grove, and Rock Valley Hlboče eye.

The Yew rocks are located north of the town of Modra, near the recreation area Sands, at an altitude of 450-550 m as significant, sometimes punctuated by rocky ridge formed by basal brownish with grey quartzite and lower Triassic. The rock formation was declared natural site. It is interesting that the rocks are very resistant rocks - quartzite, with most rock formations in the Small Carpathians is of calcareous origin. The name is derived from rocks tree yew, which in this area rarities. The Yew rocks are the only place in the Small Carpathians, where they took TIS. In close proximity is located Astronomical and Geophysical Observatory of Comenius University, which is the largest, oldest and most modern after renovation and functional telescope in Slovakia. (www.skonline.sk)

The Hlboča Valley is known for its occasional waterfall, only in the Small Carpathians. Hlboča valley with an area of 123 ha was in 1981 declared a national nature reservation. It has a length of about 1 km and in its upper part is already said the only waterfall in the Small Carpathians height of about 9 m. Most of the year, however, the water from the waterfall lost in the depths of the Smolenice karst. Visitors can observe the beauty in snowmelt and after heavy rain especially in the spring months.

From the above mentioned facts clearly see that the whole territory on the west and on the east side of the Small Carpathians have been only natural view of the many tourists make an offer.

What is important in the development of tourism using the natural environment must be proceed in keeping with the conservation criteria and, of course, legislative provisions. The result of long-term economic uncoordinated human activities and, therefore, activities in the field of tourism, no consideration of landscape protection and nature conservation and protection of natural resources can and unfortunately also leads to deterioration of natural values and the environment. Every development, not only in tourism from the use of the natural environment, but also in any field brings with it many consequences.

In terms of tourism development is the spatial allocation of legislative protected areas as well as a review of the country in terms of land-ecological importance of supporting the premise. Sufficiently allows orientate overall trends, products offered for tourism development in the country in environmentally valuable and interesting sites where potential visitor will find recreation and relaxation. It is very important to proceed in the implementation of each project sensitive to the natural environment which Small Carpathians offer. The only positive impact on the natural environment, the development of tourism has is maintaining cleanliness in the

villages and their surroundings, especially along hiking trails and centres of natural attractions that the other part will be for this very reason in excess attacked pollution.

Other positives that come with tourism already brings social or economic nature in the form of inflow of funds into the region, but also increase environmental education among the population, support the creation of new industries or recovery of original craft industry.

Despite the fact that tourism in the area of the Small Carpathians, not even from afar did not use its potential, its negative effects may manifest. The actual processing project documentation, the declaration area as protected, installation of information boards and demarcation of borders - these are just the first steps to ensure protection. While it would in principle be natural processes in these areas occur spontaneously, it is necessary sometimes to guide their development.

6 Analysis of cultural-historical potential

Artificially - created conditions for tourism created by human activities. Typical for them point spread. In the studied area on the west and east side of the Little Carpathians they are located both in the urban as in rural cadastral areas of villages and towns. When analysing the artificially - created localization assumptions tourism distinguishes Krnáčová a al. (2005) three subgroups assumptions:

- material culture - historical assumptions.
- intangible cultural - historical assumptions.
- cultural - social events.

Material historical and cultural assumptions are very closely linked to the historical and cultural development of the communities studied. Registry of cultural monuments is controlled by Act no. 49/2002 on the protection of monuments, which regulates conditions for the protection of cultural monuments and historic sites and Monuments Fund defines as a set of movable and immovable property as national monuments(www.pamiatky.sk).

Intangible cultural-historical monuments, which include “zvykoslovné”, visual arts, music and Slovak folklore also makes the development of tourism. Despite the fact that these sites almost completely disappeared from everyday life, you need to consciously maintain through various organized events. When analysing this type of artificial assumptions of tourism as an important show place with created conditions for their development. They are mainly museums, site of ethnographic festivals and events, cultural - social clubs and groups. (Krnáčová a al., 2005)

Cultural and historical potential for tourism development can be considered all the castles in the area (Fort Molpír, Bely Kamen, Ostry Kamen Cerveny Kamen, Smolenice castle). Its current attractiveness, however, varies considerably due to their upkeep, respectively lack of upkeep. From that it reflects the possibility of supporting a variety of actions that can be

performed directly at the castle. Currently they meet such a possibility only castle Cervený Kamen and Smolenice. It is a village, located on the east side of the Small Carpathians in what has when compared with the western side of the Small Carpathians great advantage. Its atmosphere but have also kept castles, or for their attractiveness rather preserved remains of the castle. We can therefore conclude that the castles in this area as a cultural and historical potential to have a huge impact, given their number, which is a rare phenomenon.

7 Possibilities for tourism development in Small Carpathians

The designated area has all the prerequisites for this to happen in the future a popular tourist destination. Tourism in each of the communities can build and improve on the existence of facts like:

- interesting natural environment
- cultural heritage
- assumption area for cycling
- conditions for farm tourism
- the annual organization of cultural events
- position the potential and availability of capital.

"The potential of the country for tourism in geographic investigations can be seen as a term which always refers to a territory and expresses the capacity of the area provide conditions for tourism development "(Marion, 1983). Each of the villages as a centre of tourism represents a whole and in terms of subscriber tourism are its objectives. Tourists looking for a place where they could spend their free time by him desired effect. After your stay at the site valuable local tourism through complex services, which were offered during his stay. We offer in different villages thus forming a collective package of services, which must be able to reach potential visitors, and of course it must also convince their qualities.

Some municipalities (Smolenice) have established a Commission of trade and tourism. It is intended to develop tourism, which can be achieved through better promotion of cultural and natural beauty, the resort offers. Its members are mainly local entrepreneurs, who obviously have a strong interest in improving the tourism. Pre future it is important that each municipality had an interest to establish a tourist information office that the tourists offering information about local activities. Pre offered development opportunities in communities that undoubtedly have, it is important to perceive the community or group of communities as a whole, a product that has a tourist offer and sell in the most interesting package. It is not enough to promote itself beautiful nature or cultural monuments. Total product should be made to make it engaging for tourists in every season. Of course, for geographical location and natural environment investigated area is significant that development can be expected mainly in the summer months, but needed a product can be created so that it will be intriguing to potential visitors at any time of the year. To such a state it would be reached, if the individual components of the community at every level began to cooperate together. Every

entrepreneur in the tourism village and the village itself is keen to increase their business revenues in the industry. Each business component also depends on the behaviour of their partners as providers of ancillary services, but also by their competitors. For this reason, it is important to have a dialogue that results would be a plan to sell the most interesting tourist everything the village has to offer. This plan should be developed at various periods during the year and for different lengths of stay of tourists in the village.

8 Conclusion

The Small Carpathians as a whole have enough potential to develop tourism. This also applies to municipalities located in them. They can become a popular tourist destination not only within the region. Its location, which is characterized by the proximity of the capital of the Slovak Republic of Bratislava and the proximity of district and regional towns, as well as their location in beautiful natural surroundings and close proximity to the highest parts of the Small Carpathians, is directly attuned to making tourism in every Of the studied municipalities either in the west or in the East of the Small Carpathians are the basic pillars. This fact is demonstrated not only by the positional potential and the natural environment, but also by the presence of a relatively large number of cultural and historical monuments in this area.

Some municipalities are slowly starting to realize their potential. For example, the development of Dolný Záhoria's tourism development strategy, the use and approval of co-financing of the Marianka Promotion project from European funds to attract visitors and raise awareness of Marian attractions. It is important that similar intentions remain not only in the theoretical plane but also slowly fall into the practical plane. There are still many changes that must be made by each government as well as by society as such. The basis will be a change in the thinking of residents and owners of tourism facilities. It would be very useful if they started to communicate and find common solutions.

In order to attract more tourists, it is very important for individual cultural and historical monuments to be gradually reconstructed and for individual tourists to create an interesting program for the tourist participant by creating complementary activities so that the visit to the village does not become too static.

The impact of cultural - historical and social developments should be the main consequence of the variety in the overall supply of tourist opportunities in the compared territories.

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Povzetek

Turizem na Slovaškom, zlasti v Malih Karpatih

Namen in izvirni prispevek: Članek analizira turistični potencial območja Malih Karpatov na Slovaškom. V članku je predstavljena turistična aktivnost nekaterih občin, kot tudi širših območij. Članek razvoj turizma na analiziranem območju umešča v naravne, kulturne in zgodovinske danosti in dostopnost turistične infrastrukture.

Metoda: Članek se naslanja na opisno metodo, kombinirano z analizo vsebine in deloma evalvacijsko metodo.

Rezultati: Območje Malih Karpatov na Slovaškem ima močan turistični potencial, kjer lahko posamezna naselja postanejo priljubljeni turistični centri na podlagi potencialne ponudbe. Hkrati pa je analiza pokazala na nezadostno medsebojno komunikacijo med različnimi akterji, nezadostno promocijo ter nerazvite podporne storitve.

Omejitve: Ključna omejitev članka je omejenost na malokarpatsko območje na Slovaškem ter posledično omejena sposobnost primerjave tako v okviru Slovaške kot v mednarodnem okvirju.

Ključne besede: turizem, Mali Karpati, Slovaška, turistični potencial, kulturna dediščina.

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